PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (22)

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.
Harry Ko, M.D.
John McDermott, FNP-PAC
Karen Sprague, MSN, CFNP
Karina Gookin, M.D.
Leigh Vall-Spinosa, 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.
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
Lauren Strickland, D.O.	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Jayme Botke
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
Irem Conery, Director, Member Experience
Dorian Roberts, Senior Manager, Provider Relations Reps.
James Devan, 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: October 30, 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, November 4, 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-Lakeside
5176 Hill Rd. East
Lakeport, CA 95453

Winters Healthcare
172 E. Grant Ave.
Winters, CA 95694

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

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

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

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: November 4, 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
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Eureka, CA

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

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. Jones**		**7:45**
II.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	A	**Review of October 14, 2026, PAC Minutes**	**Dr. Brennan**	**5**	**8:00**
B.	A	**Consent Review: Agenda Items II. B.1, B.2, B.3 and B.5** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Brennan**	**16 - 328**	**8:02**

1	C	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments –**
		
		October 2026
		Acceptance of Meeting Materials
		• Internal Quality Improvement Meetings, October 13, 2026
		  • Agenda
		  • Minutes
		• Quality / Utilization Advisory Committee, October 21, 2026
		  • Agenda
		  • Minutes
		  • Quality Improvement Update
		
		Special Presentations (for reference only)
		• *Health Equity Disparities Grand Analysis*
		• *Health Equity 2026 to 2027 Workplan*
		• *Health Equity Strategic Plan Overview*
			Dr. Brennan	**16**
				18
				
				28
				30
				42
				
				54
				85
				88
					8:02

<table>
<tr><th>II.B</th><th>C</th><th>MOTIONS FOR APPROVAL, Continued</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>2</td><td>C</td><td>
<table>
<tr><td colspan="2"><u>Policies/Procedures/Guidelines for Action</u>
Redline versions appear in the packet.</td></tr>
<tr><td colspan="2">Behavioral Health</td></tr>
<tr><td>MCBP8015</td><td>Coordination of Care for Child Welfare-Involved Members</td></tr>
<tr><td>MPBP8007</td><td>Screening and Treatment for Substance Use Disorders</td></tr>
<tr><td>MPBP8013</td><td>Eating Disorder Management Policy</td></tr>
<tr><td colspan="2">Member Services</td></tr>
<tr><td>MP316</td><td>Provider Request to Reassign Member & Assistance with Inappropriate Member Behavior</td></tr>
<tr><td colspan="2">Pharmacy Operations</td></tr>
<tr><td>MCRP4066</td><td>AB1114 Benefit Implementation and Oversight</td></tr>
<tr><td colspan="2">Quality Improvement</td></tr>
<tr><td>MCQP1021</td><td>Initial Health Appointment</td></tr>
<tr><td>MPQG1005</td><td>Adult Preventive Health Guidelines</td></tr>
<tr><td colspan="2">Utilization Management</td></tr>
<tr><td>MCUG3032</td><td>Orthotic and Prosthetic Appliances Guidelines</td></tr>
<tr><td>MCUG3038</td><td>Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities</td></tr>
<tr><td>MCUG3118</td><td>Prenatal & Perinatal Care</td></tr>
<tr><td>MCUP3013</td><td>Durable Medical Equipment (DME) Authorization</td></tr>
<tr><td>MCUP3020</td><td>Hospice Services</td></tr>
<tr><td>MCUP3114</td><td>Physical, Occupational and Speech Therapies</td></tr>
<tr><td>MCUP3128</td><td>Cardiac Rehabilitation</td></tr>
<tr><td>MCUP3130</td><td>Osteopathic Manipulation Treatment</td></tr>
<tr><td>MCUP3133</td><td>Wheelchair Mobility, Seating and Positional Components</td></tr>
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Policy Summary
Synopsis of Changes
</td><td>Dr. Brennan</td><td>96
101
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226
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235
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91</td><td>8:02</td></tr>
<tr><td>3</td><td>C</td><td>Pharmacy & Therapeutics Committee, October 8, 2026
• Meeting Minutes
• Approved Criteria</td><td>Stan Leung, Pharm.D</td><td>247
258</td><td>8:02</td></tr>
<tr><td>4</td><td>C</td><td>Provider Education & Networking (PEN) Meeting</td><td>Mr. Brincko</td><td></td><td></td></tr>
<tr><td>5</td><td>C</td><td>Credentials Committee Meeting, September 9, 2026
• Summary
• Credentialed List</td><td>Dr. Netherda</td><td>313
319</td><td>8:02</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, September 15, 2026</td><td>Dr. Jalloh</td><td></td><td></td></tr>
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III.	I	LEADERSHIP INTRODUCTION	LEAD	PG	TIME
A.	I	Dr. Lauren Strickland, D.O., Regional Medical Director, Redding	Dr. Strickland		8:05
IV.	**I**	**REGIONAL MEDICAL DIRECTOR REPORTS**	**LEAD**		**TIME**
A.	I	Napa, Yolo & Solano	Dr. Townsend		8:10
B.	I	Marin & Sonoma	Dr. Ward		8:13
C.	I	Del Norte, Humboldt, Mendocino & Lake	Dr. Ribordy		8:16
D.	I	Glenn, Butte, Sutter, Colusa & Yuba,	Dr. Matthews		8:19
E.	I	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Dr. Strickland		8:22
F.	I	Plumas, Sierra, Nevada & Placer	Dr. Morris		8:25
V.	*I*	*Old Business*			
VI.	**I**	**SPECIAL PRESENTATIONS**	**LEAD**	**PG**	**TIME**
A.	A	Enhanced Care Management Quality Incentive Program Measure Set Proposal for 2027	Ms. Watson	329	8:28
B.	I	California Health Care Foundation (CHCF) Cohort 24 California Health Care Improvement Project (CHIP) Presentation	Dr. Chris Myers	*N/A*	8:35
VII.	**I**	**ADJOURNMENT**	**LEAD**		**TIME**
		Next PAC on January 13, 2027 at 7:30 a.m.	Dr. Brennan		9:00

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **October 14, 2026 - 7:30 to 9:00 a.m.**

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

Members Present:	Betzabel Kunkel, MD *(FF)* Brian Montenegro, MD *(FF)* Michelle Herman, MD *(FF)* Matthew Zavod, MD *(FF)* Teresa Shinder, MD *(FF)* Chester Austin, MD *(C)* John McDermott, FNP *(C)*	Candy Stockton, MD *(E)* Chris Myers, MD, *(E)* Malia Honda, MD *(E)* Darrick Nelson, MD *(R)* Leigh Vall-Spinosa, MD *(SR)*	Christina Lasich, MD *(SL)* Danielle Oryn, DO *(AL)* Mills Matheson, MD *(OMM)* Karen Sprague, MSN, CFNP *(WH)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn*	*MCC - Marin Community Clinics* *OMM - Office of Dr. Matheson* *SL - Sutter Health Lakeside* *WH - Winters Healthcare* *AL – Aliados Health*
Members Excused:	Angela Brennan, DO Steven Gwiazdowski, MD	Zoe Cappe, MD Karina Gookin, MD *(AU)*	Derice Seid, MD		
Members Absent:					

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	17/22 – PAC	Committee quorum requirements met (17).	10/14/26

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Health Services Officer presented an administrative update on Partnership activities on behalf of the Chief Executive Officer.** **Service Recovery Program** • Member experience was identified as a core activity of the health plan. • Partnership launched its Service Recovery Program in October, reflecting its enduring commitment to its mission and to members as they experience health care and interact with Partnership. • The program is led by Irem Conery, Director of Member Experience, together with a broad interdisciplinary team across several Partnership departments. • The program is distinct from existing call center and grievances and appeals functions; it will review trends, conduct root-cause analyses, and identify patterns in member experiences. • Feedback from other Partnership committees may be referred to the program team for deeper review and to provide a proactive lens on the difficulties members and communities experience in health care each day. • The program is centered on listening and learning in an unbiased way, with true accountability throughout the organization. Additional information will be provided as the program develops. • **Unsatisfactory Immigration Status (UIS) Transition to Medi-Cal Fee for Service (FFS)** • Effective January 1, 2027, members in UIS status will transition out of managed care for general Medi-Cal benefits and into the state Medi-Cal fee-for-service delivery system, affecting approximately 83,000 Partnership members with the highest concentrations in Napa, Marin, Sonoma, and Solano Counties. • The transition work is substantial and Partnership teams have begun work to minimize disruption to care for affected members. • The Department of Health Care Services (DHCS) began a statewide text-messaging campaign to all impacted members, consisting of 90-, 60-, and 30-day messages, with the 90-day campaign launched in early October. DHCS will send a statewide letter to all impacted members no later than December 1, 2026, 30 days before the transition. Partnership and the other Medi-Cal managed care plans received and reviewed a copy. • Messages were sent in threshold languages to all available phone numbers on file for transitioning members. • Members received one of two messages: (1) beginning January 1, their Medi-Cal health plan will no longer be their Medi-Cal managed care plan, with a link to a DHCS public website for more information; or (2) they would not be losing Medi-Cal, but their Medi-Cal would be changing. • Partnership is monitoring its call centers and has not experienced a surge in calls related to the text messages, although it remains early. It was noted that members may not be attending closely to the messages because of the volume of election-related communications. • Partnership is working with DHCS and advocating for escalation pathways so that members with questions in an FFS environment can reach appropriate individuals outside of Partnership, the counties, or their health centers. • DHCS is working to hire a vendor to provide care management and advice nurse line services and anticipates sharing that information with plans in mid-December. • Partnership has received numerous requests for data, such as the number of impacted members in a practice or community and their age groups. Because of the sensitivity of the data, Partnership's financial analytics, legal, and compliance teams are developing standardized templates containing key static, de-identified data elements to assist groups and stakeholders with planning. • Primary care access is not a primary concern, given the many federally qualified health centers (FQHC), rural health centers (RHC), and tribal health centers that serve the safety net. Specialty care access is being examined closely and mapped. • The Provider Relations team surveyed a little over 1,300 providers in the network and received approximately 400 responses, of which 70 percent indicated they will continue to see FFS patients and accept new FFS members after January 1, 2027. • Partnership intends to create a toolkit for the provider network containing data, referral information, and talking points, to be shared with frontline staff, appointment schedulers, referral coordinators, and providers.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report, Continued	**DHCS Navigator Grants** • DHCS announced a series of grants in partnership with the California Primary Care Association (CPCA) related to H.R. 1 clinic navigators and UIS transition navigator programs. • The UIS transition navigator program is statewide, totaling a little over $7.1 million, to assist Medi-Cal members with UIS and their families in maintaining coverage and access through the transition. • CPCA announced that individual grant amounts will range from approximately $150,000 to $500,000, and that 20 to 45 practice sites are anticipated to be awarded. **Question: What will happen with pharmacy services for these patients?** *The pharmacy benefit will remain carved out to Medi-Cal Rx as it is today; physician-administered drugs will go directly to the state for authorization, approval, and payment.*
I.B Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented the following Health Services report.** **Gender-Affirming Care for Minors – DHCS Directive** • In addition to the UIS population, DHCS issued a directive on September 30 that, effective October 13, 2026, gender-affirming care for minors is completely carved out of managed care. • The care remains covered by state statute but is prohibited by the Centers for Medicare & Medicaid Services (CMS) as a managed care benefit. • DHCS moved coverage to Department of Health Care Access and Information (HCAI), which is not a health care delivery system. • Partnership previously contacted affected members with a two-week notice and also contacted their providers. • The receiving entity has not yet defined how it will accept claims. Any claims for gender-affirming care for minors must be sent to that entity or, for now, held until a submission process is determined. **Hospice Quality Network** • Partnership has worked for almost a year on a hospice quality network that narrows the hospice network to high-quality providers; the effort is approximately 98 percent complete. • Some pushback was received from several for-profit hospitals; the final steps are being finalized. • Utilization Management activity initially increased and then stabilized, with a slight decrease. • The provider directory is being updated to reflect the quality network in the near future. **Primary Care Provider Quality Improvement Program (PCP QIP) – 2027** • In assigning points, Partnership is significantly increasing its attention to the potentially preventable admission measure. • The dollar amount at risk for that measure will increase significantly for providers with parent organizations greater than 3,000. • Partnership is committed to developing the infrastructure and data so that providers can identify members who are hospitalized, in the emergency room, or high utilizers in a manner better than at present. • These changes apply to 2027. Providers were advised to begin considering how to case-manage hospitalized patients to keep them out of the hospital and prevent readmission.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.B Chief Medical Officer (CMO) Health Services Report, Continued	**Utilization Trends** • PCP visits per member per year reached a record high of 2.45 over the last year, up from 2.17 in 2022 and approximately 1.9 during COVID. The increase may be partly related to telemedicine making certain visit types easier. • Specialty visits also reached an all-time high of 1,255 per thousand members, up from 1,115 in one year. • Telemedicine now represents a higher percentage of both primary care and specialty care and may be partly driving the increase; which is a good sign for network adequacy. • A prior analysis of PCP capacity needed to meet all needs indicated a requirement of more than double current capacity. **Wellness and Recovery Benefit** • Effective January 1, Partnership will no longer be responsible for the Wellness and Recovery benefit for seven counties because the state changed the regulatory infrastructure. • Two counties, Solano and Mendocino, will take the benefit back in house. The other five counties are working toward an arrangement with California Mental Health Services Authority (CalMHSA). **Finance Committee Update** • Audited financial statements were presented showing a $36 million loss for the last fiscal year, higher than initially anticipated. • In perspective, Partnership's budget is $7.7 billion and it holds financial reserves of between $1 billion and $2 billion, depending on how they are counted. • The estimated loss for the current year is higher than the prior-year loss. • Partnership recognizes that the delivery system faces similar stretches, particularly with a growing uninsured population presenting without Medi-Cal reimbursement.
I.C Deputy CMO Health Services Report	**Partnership's Deputy Chief Medical Officer provided a reported additional Partnership activities.** **Partnership Leadership Changes** • Partnership welcomed Dr. Lauren Strickland, D.O., as the new Regional Medical Director for the Redding area and Zhavontia Crosby, RN, Associate Director of Population Health Management. **Quality Strategic Plan** • Partnership continues to work on its quality strategic plan, which builds upon experience since the prior plan and looks ahead to the organization's quality objectives. The plan will be integrated into the organizational strategic plan. • The plan commits Partnership to five overarching goals with the aim of raising quality metrics above the 67th percentile plan-wide. • Areas of focus include improving member experience; reducing avoidable utilization, such as ambulatory care sensitive admissions (conditions that can be treated outside of the hospital, lowering both risk to the member and financial risk); improving chronic disease outcomes; and improving timely access to prenatal care. • A significant amount of effort is being placed on these goals in regions of the network that have experienced challenges with blood pressure control, well-child visits, and timely prenatal care. Partnership is also focusing on reducing inequities across all of the goals. **PCP QIP Measurement Year 2025 Results** • The PCP QIP for Measurement Year 2025 paid out $55.7 million across 384 sites. • Plan-wide improvement was observed in all 11 clinical measures, including diabetes control through A1C measurement, colorectal cancer screening, blood pressure control, retinal exams, breast cancer screening, and well-child visits for ages three to 21. **Provider Application and Validation Engagement (PAVE) Update** • PAVE is the program to ensure that all ordering, referring, and prescribing providers who provide services to Medi-Cal members are enrolled in Medi-Cal. • DHCS informed plans that it plans to begin phasing in enforcement for prescribing providers in February 2027, with full enforcement for pharmacy claims beginning in July 2027. DHCS has not issued any new All Plan Letters (APL) related to PAVE.

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GENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**September 9, 2026, PAC minutes were presented for approval.**	**MOTION:** Dr. Montenegro moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Herman. **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	10/14/26 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 – September 2026 • Policies, Procedures, and Guidelines for Action Policy Summary, October 14, 2026 • Credentials Committee Meeting Summary & Credentialed List, August 13, 2026 • Pediatric Quality Committee Summary, August 18, 2026 • Quality Improvement Health Equity Committee Summary, September 15, 2026	**MOTION:** Dr. Montenegro moved to approve Agenda II.B as presented, seconded by, seconded by Dr. Herman. **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	10/14/26 Motion carried.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Committee Membership Introduction, Dr. Harry Ko	Dr. Harry Ko, Medical Director at Feather River Tribal Health, introduced himself to the committee. Dr. Ko recently retired from the military. He completed a family medicine residency program in San Bernardino, California, which converted to a regional medical center in Colton, California, and completed his first internship with the Navy in San Diego as a full-scope family physician. He then served three years in Hawaii as an outpatient physician, followed by five years of service in Alaska. He subsequently joined the U.S. Public Health Service and transitioned to the U.S. Coast Guard, beginning flight surgeon duties at Air Station Traverse City in Michigan, followed by five more years in Detroit. He then served five years in Norfolk, Virginia, as the equivalent of the Chief Medical Officer for the Coast Guard, overseeing 42 Coast Guard clinics across the country, before retiring. Dr. Ko is pleased to be in California and looks forward to an eventual retirement in Northern California, and has ties in Southern California.
IV.A Status Update, Regional Medical	**Partnership's Regional Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • Access remains tight in Solano County, and local practices report that recruitment of primary care providers remains difficult. • Over the last couple of months, Jiva Health, a multispecialty group, merged with one of Partnership's primary care practices in Yolo County and is considering expansion in other locations across the region. • Leadership shifts affect all three counties. The Chief Executive Officer of CommuniCare+OLE (now known as Ola Health) stepped down and will move to a health plan; an interim leader familiar with the organization will serve while a national search is conducted. • Solano Family Health Services identified a Chief Medical Officer candidate who will begin in December or January and continues to seek a CEO. • A regional quality meeting was held in person in Napa, focusing on prenatal care access from the primary care perspective. Discussion centered on how prenatal and obstetric practices can work together on timely prenatal care, recognizing that primary care providers often perform the pregnancy test in their setting and that these systems can be leveraged to improve access to timely prenatal care.
IV.B Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Vaccine hesitancy collaborative meetings continue as part of local work in Sonoma County, in collaboration with Aliados Health. The consortium is developing documents, including a frequently asked questions (FAQ) document, drawn from local focus groups of patients known to have vaccine hesitancy; two additional focus groups are under way. • Partnership's Member Services team is tabling at Saturday flu clinics at a local Santa Rosa Community Health provider and piloting different schedules for walk-in flu vaccines, including evening hours for young children, to make vaccines more accessible and attractive to the community. • A Sonoma County perinatal care summit was held on September 25 with 50 attendees, including doulas, community health workers (CHW), hospital leaders, obstetric providers, and community-based organizations (CBO). The summit generated enthusiasm and valuable connections regarding the breadth of services and how organizations and skill sets can work together more fully. • A small health center quality meeting addressed nursing workflows to support hypertension control. Deep-dive meetings were held at Ritter Center and Sonoma County Indian Health Project. • Local energy continues around quality improvement and increased clinician staffing, including local hiring for primary care access expansion. Considerable trepidation exists regarding the pullback from Medi-Cal managed care for members with UIS status. • On September 21, the inaugural County of Marin Health and Human Services and Partnership leadership roundtable was held. Staff members developed a toolkit to help other regions hold similar leadership roundtables, which are planned annually. • Meetings were held with local palliative care providers, including Hospice by the Bay. • Several clinics have expanded their quality departments. A new Chief Medical Officer will begin in February at the Alexander Valley site, which has been without a Chief Medical Officer for more than two years. • Access to gender-affirming care services has shifted for several clinics, and new language in FQHC contracts is making clinics uncomfortable providing gender-affirming services. There is considerable local innovation regarding how to transition people, especially youth under 21, to different access to care for these services.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
IV.C Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Sutter Lakeside hired a new Chief Executive Officer, Tara Overmiller, who begins in November and brings both leadership and rural experience, which is very important for the area. • Mendocino Coast Clinics have been trying to open a same-day clinic and are struggling to obtain the necessary licenses, which must be obtained one at a time in sequence, extending the timeline. The clinic is pursuing increased access in an ongoing but slow process. • Lake County had been seeking a public health officer and is now partnering with Mendocino County to hire a joint public health officer, an approach some smaller counties use or are currently using. • United Indian Health Services (UIHS): UIHS finished its expanded medical site at its main clinic at Potawot, with an expanded number of exam rooms. The site now needs to be filled with providers; a pediatrician is expected to begin next month, and expansion is ongoing. • Lake County Tribal Health will work with Adventist Health on a better birthing project, modeled after the Better Birthing Project between a tribal partner and St. Joseph's, to make the birthing environment at the hospital more welcoming for local tribal members. The project was recently announced and work is beginning.
IV.D Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities as well as activates located in Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties.** • Healthy Rural California and Partnership held a collaborative Advocacy and Medicine series event in Chico. The topic was state ballot measures: how they come about, why they exist, how one is developed, and how it is carried across the finish line. Representation included the public affairs representative of the California Primary Care Association (CPCA), which is interested in this year's ballot measures, and two leaders who have chaired and run ballot initiatives in the past. Better attendance is hoped for at the next event. Members were reminded to vote in November. • Work continues on ambulatory care sensitive hospital admissions and readmissions. The initial regional focus is on working with the hospital and FQHCs in Butte County to streamline efforts. • A hearing was scheduled for Friday, October 16, at 11:00 a.m. in the Eastern District of California bankruptcy court, with indications and rumors of movement toward a sale of Oroville Hospital. • Dr. Lauren Strickland, D.O. started her positions as Redding Regional Medical Director.
IV.E Status Update, Regional Medical	**Update for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties was combined with Glenn, Butte, Sutter, and Colusa Counties.**
IV.F Status Update, Regional Medical	**Partnership's Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities.** • Partnership attended and presented at the Placer Perinatal Provider Forum, hosted by First 5 Placer, to bring perinatal service providers together to discuss available services and create opportunities for collaboration. The event was well attended; Partnership presented on the services it covers, and participation is expected to continue. • Partnership co-sponsored the 12th annual Latino Leadership Council event, themed "bridging the gap between immigration policy and its relationship to our communities." The keynote speaker, Dean Kevin Johnson of the UC Davis School of Law, discussed overall immigration policy and health care-related policy, how they affect the Latino community, and ways to continue supporting that community. • Partnership trained Nevada County social services eligibility staff on upcoming Medi-Cal eligibility changes related to work and community service requirements. It was a repeat of a March training that was well attended; participants asked many questions and requested that Partnership return for an additional training.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
IV.F Status Update, Regional Medical, Continued	• Partnership hosted a regional quality meeting on quality metrics, with a specific focus on hypertension management and a "back to basics" approach, beginning with taking blood pressures accurately. Depending on the study, between 15 and 30 percent of blood pressure measurements in clinical settings may be taken inaccurately. • Chapa-De continues work to open its Rocklin clinic, anticipated for spring 2027. Dr. Lenia Stevens was promoted to Chief Clinical Officer, and the organization is recruiting for her prior medical director position overseeing clinics in Grass Valley, Auburn, and the soon-to-open Rocklin site. • Partnership planned a day-long pow-wow celebration of indigenous communities and dance, honoring the diversity of American cultures and traditions, to be held on Saturday, October 17, 2026.
V. Old Business	*No old business.*
VI.A Strategic Plan for Quality Improvement, 2026-2029	**National Committee for Quality Assurance (NCQA) / Healthcare Effectiveness Data and Information Set (HEDIS®) Star Rating** Partnership reports a much larger measure set to NCQA than the Measured Care Accountability Set (MCAS) measure set, and that larger set comprises the health plan rating, a star rating from one to five. NCQA applies current benchmarks and typically returns the information in September. This year, Partnership chose to wait for NCQA's results rather than project a rating, so that a final health plan rating could be provided. The 2025 health plan rating is three stars, the same rating received in 2024 and a decrease from 3.5 stars in 2023. Partnership is still absorbing the ten additional counties that joined its network in 2024 and is working to manage the large measure set; this is believed to have contributed to the rating not improving. Partnership came close to 3.5 stars but did not reach it. Improvement in the star rating has been out of reach to date. Partnership is examining new approaches to improving quality scores, which will be a topic of future meetings and communications.
VI.B, Quality Improvement Strategic Plan	**Quality Improvement Strategic Plan** The Quality Improvement Strategic Plan is a strategic plan for quality improvement for the entire organization. Partnership maintains an organization-wide strategic plan on a three-year schedule and is in the planning process for the new plan, which will be in effect from 2027 to 2029. Other strategic planning efforts are under way, including a health equity strategic plan and a member experience strategic plan being developed by Member Experience. Partnership is striving for alignment among all of these plans so that the organization moves in the same direction. **Rationale for the Plan** • Partnership's mission is to help its members and the communities it serves be healthy. The plan is intended to define for the entire organization how Partnership can make a significant impact on member health through quality improvement, and to ensure that the organization and network move in the same direction rather than individual departments choosing their own direction. • Quality performance nationwide has changed dramatically in recent years, including the benchmarks and the level of accountability expected. Partnership's year-over-year composite performance trend is not aligned with statewide and national trends, creating urgency to match the trajectory of other Medicaid plans. • Partnership has a very diverse network in which some areas perform very well on quality measures and member health and others struggle. Partnership seeks consistency, a way of describing equity, because excellent health care and good community health should not depend on where one lives.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.B, Quality Improvement Strategic Plan, Continued	**Planning Process** • Planning began in May and engaged many quality leaders, the Chief Medical Officer, and the Deputy Chief Medical Officer, using information gathering, focus groups, interviews, review of core documents, and leadership input. • A strengths, weaknesses, opportunities, and threats (SWOT) analysis was developed. • To narrow the many ideas generated to a cohesive plan that is implementable in three years, ideas were evaluated against three criteria: o Whether the idea will significantly improve member health across the network o Whether it will contribute to a positive member experience o Whether it will help reduce financial risk for poor performance on measures. • Ideas that did not meet most of the criteria generally did not make the final plan. • The plan is final, and Partnership is now focused on communication. This forum was offered as an opportunity to provide feedback, and members were invited to reach out with feedback after the meeting. The plan will ultimately be presented to the Board. • Implementation will follow immediately, examining the plan on a tactical level with partner departments and the network and setting SMART (specific, measurable, achievable, relevant, time-bound) goals for each focus area. **Strategic Goals** • The goals are bold and SMART, and the intent is to achieve all of them, or make significant progress toward them, by the end of 2029. They fall into five areas: • **Goal 1 – Improve member experience:** Priority Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey measures were identified as the most essential areas for improvement, with a target of performance at a high-performance level, defined as the 67th percentile or higher plan-wide. • **Goal 2 – Reduce avoidable utilization:** This is a very high priority for Partnership, focused on ambulatory care sensitive admissions and hospital readmissions. Partnership currently performs at approximately the 90th percentile on its central hospital readmissions measure and intends to maintain that performance while reducing ambulatory care sensitive admissions plan-wide, with a goal of a 10 percent or greater annual reduction. • **Goals 3 through 5 – Outpatient care:** These align with the regional goals set when the HEDIS annual summary of performance was presented a few months earlier: improving pediatric preventive care, improving chronic disease outcomes, and improving timely access to prenatal care. • Specific goals were set around well-child visits, pediatric immunizations, diabetes and hypertension control, and the first prenatal visit, with a target of performance at the 67th percentile or higher in all three DHCS rating regions. **Vision and Measures of Success** • The long-term vision is for Partnership to become an NCQA five-star plan; Partnership has a way to go and will proceed one step at a time. • Two composite measures will be monitored: (1) the NCQA health plan rating, a key performance indicator of success; and (2) the MCAS measure quality factor score, a composite score of performance across MCAS measures that can be compared with the performance of other California plans. Partnership wants to move up in its ranking among California plans. • The plan places specific focus on rural regions, where the greatest need exists, and on reducing health inequities; an equity lens will be applied to all goals.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.B, Quality Improvement Strategic Plan, Continued	**Focus Areas** • The five focus areas are intended to show how the strategic goals will be achieved, as these are the areas within the network and organization where the greatest success in moving the goals is expected. • Focus Area 1 – Access to care: Strengthening network capacity and stability in prioritized communities and expanding alternative access models to meet community needs. Quality will partner with Network Services, Provider Relations, Workforce Development, the Regional Directors, and Health Equity. • Focus Area 2 – Provider engagement: Described as Quality's "wheelhouse": building the capacity of the network in many aspects beyond primary care, including inpatient behavioral health and supportive services, toward high performance on prioritized quality measures aligned with the strategic goals. • Focus Area 3 – Member experience and engagement: Ms. Conery's strategic plan will build infrastructure to understand and act on member experience drivers and to address and close out the biggest problems identified. Member engagement is centered on improving outcomes for high-risk populations, including the highest-need members, the work of Care Coordination, and programs such as CalAIM, the emerging Dual Special Needs Plan (D-SNP) line of business, and health equity initiatives, to provide the support the most vulnerable members need to achieve good health. • Focus Area 4 – Data analytics and technology: Building capacity for quality measurement and analytics that are proactive rather than limited to retrospective look-backs, so that action can be taken in real time to resolve an issue and close a care gap, and using data to maximize opportunities to improve member health and data interoperability. • Focus Area 5 – Organizational excellence and culture of quality: The executive team will create a shared understanding of, and accountability for, quality improvement organization-wide, including a special partnership with the Finance department. In the current cost-conscious environment, every dollar spent must have an impact, so resources will be directed toward initiatives with the greatest potential to improve member health. **Questions and Discussion** Centralized quality system and interoperability (Focus Area 4): Is Partnership considering a particular software platform to build a centralized quality system? Will Partnership encourage systems to move to Epic, noting the potential of artificial intelligence capabilities? *It was also noted that Kaiser has an advantage within its own integrated system, whereas outside it there is a mosaic of electronic medical records (EMR); that a number of systems are moving to Epic (Adventist recently, North Bay by the end of the year); and that Epic's Care Everywhere capability allows clinicians to view records across systems.* DataLink initiative is a step in that direction, although labor intensive, with the knowledge that a long-term strategy may involve working on fewer platforms. Partnership's CHSO added that digitizing health care information requires interoperability and meaningful data sharing, and organizations are starting from very different points in terms of technology, finances, and other factors. The CHSO and the Chief Information Officer (CIO) are leading Partnership's interoperability work for CMS-0057-F, Interoperability and Prior Authorization Final Rule, which includes patient-facing application programming interfaces (API), and that Partnership has a two- to three-year strategic plan specific to interoperability. CMS also recently flagged interoperability for pharmacy prior authorizations, and federal and commercial payers are pushing the industry into this space, creating a race among technology vendors. Locally, Partnership is mapping where each organization stands so that, at a minimum, it creates doors for technology to plug into and then scaffolds toward truly bi-directional information sharing. Over-interpretation of information-sharing requirements must be eased in order to deliver care seamlessly as patients expect.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B, Quality Improvement Strategic Plan, Continued	**Questions and Discussion, Continued** Hospital readmissions (Goal 2): A slight increase in hospital readmissions was reported and a question was raised about the strategic direction for building network capacity to reduce hospital readmissions. Partnership uses a multi-layered approach in phases, beginning with patient-specific interventions such as complex case management through Care Coordination, standing extended length of stay (ELOS) meetings with hospital partners and concurrent inpatient case managers, and moving to broader levers such as those built into hospital and primary care QIPs through the quality programs. The approach aims to reduce not only readmissions but also length of stay. Post-COVID, Partnership is using technology and telehealth and partnering with the Quality department to look strategically at more localized, real-time approaches, such as deploying vendors or resources upon discharge. Benefits and pilot programs have been implemented through the years, but outcomes have not come as quickly as desired. Community Supports and Enhanced Care Management through CalAIM were intended to address some of this and may be doing so anecdotally in some pockets, but not at a broad population level as needed. *No further questions were asked. Committee members may direct questions to Partnership's Quality Improvement department. Meeting adjourned.*

AGENDA ITEM	ADJOURMENT
PAC adjourned at 8:47 a.m.	**Next Physician Advisory Committee announced for November 4, 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**

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

Date: Tuesday, Oct. 13, 2026 **Time: 1:30 - 3:30 p.m.**

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

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

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

	Item	Lead	Time	Page #
I.	**Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes**			
I	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of Sept. 8, 2026	Isaac Brown, MHA/MBA	1:30	5 – 11
2	*Acceptance of the minutes of the* • Aug. 27 Member Grievance Review Committee (MGRC) • Sept. 24 Substance Use Internal Quality Improvement (SUIQI) Committee • June 18 SUIQI Committee • Feb. 5 SUIQI Committee			13 – 41
II.	**Old Business - None**			
III.	**New Business – Consent Calendar**			
	Consent Calendar	All	1:37	43
	2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025			45 – 49
	Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County			51 – 52
Health Services Policies	**Behavioral Health**			
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members			53 – 57
	MPBP8007 – Screening and Treatment for Substance Use Disorders			59 – 74
	MPBP8013 – Eating Disorder Management Policy			75 – 83
	Quality Improvement			
	MCQP1021 – Initial Health Appointment			85 – 94
	Utilization Management			
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			95 – 98
	MCUP3020 – Hospice Services			99 – 114
	MCUP3114 – Physical, Occupational and Speech Therapies			115 – 121
	MCUP3128 – Cardiac Rehabilitation			123 – 128
	MCUP3130 – Osteopathic Manipulation Treatment			129 – 131
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			133 – 135
Non-HS Policy	**Member Services**			
	MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE**			137 – 149
IV.	**New Business – Health Services Policy Discussions**			

	Item	Lead	Time	Page #
	Synopsis of Changes		--	151 – 155
	Quality Improvement			
	MPQG1005 – Adult Preventive Health Guidelines	Mark Netherda, MD	1:45	157 – 170
	Utilization Management			
	MCUP3013 – Durable Medical Equipment (DME) Authorization	Tony Hightower, CPhT	1:53	171 – 186
	MCUG3118 – Prenatal & Perinatal Care	Colleen Townsend, MD	2:00	187 – 205
	MCUG3038 – Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities	Tony Hightower, CPhT	2:07	207 – 218
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components		2:14	219 – 230
V.	**Presentations**			
1	Quality Improvement Update	Issac Brown, MHA/MBA	2:21	231 – 242
2	Primary Care Provider Quality Incentive Program (PCP QIP) CY 2025 Evaluation	Athena Beltran-Nampraseut	2:26	243 – 268
3	MY 2025 NCQA Health Plan Rating • 5 Star Strategic Plan for Quality Improvement – 2026-2029 *begins on p. 277* • The MY2025 / RY 2026 Healthcare Effectiveness Data and Information Set (HEDIS®) Health Plan Accreditation (HPA) Summary of Performance was not finalized when IQI reviewed the Managed Care Accountability Set (MCAS) Summary of Performance in July; *the HPA white paper begins on p. 335 and its URL is listed below under FYI*	Kristine Gual, PMP, CPHQ	2:41	269 – 296
4	Health Equity Disparities Grand Analysis: MY 2025 / RY 2026 • MCED6001 Health Equity and Community Reinvestment Strategy and Program Description was presented in August committee meetings and approved at the Sept. 9 Physician Advisory Committee (PAC). *A clean copy is included at the end of this packet for context; see p. 399* • FY 2026-2027 Work Plan *begins on p. 329* • Health Equity Strategic Plan (2027 – 2030) *begins on p. 333*	Mohamed Jalloh, Pharm.D	3:01	297 – 334
VI. FYI	HEDIS® MY 2025 / RY 2026 NCQA HPA Summary of Performance can be found here: https://edge.sitecorecloud.io/partnershipae75-partnership4b61-production30f9-46fc/media/Project/partnership-sites/partnershiphp/files/PDF/HEDIS-MY2025-Summary-of-Performance_HPA_COMSFINAL.pdf			335 – 398
	MCED6001 - Health Equity and Community Reinvestment Strategy and Program Description			399 – 433
	Adjournment by 3:25 p.m. to 1:30 p.m. Tuesday, Nov. 10, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Oct. 13, 2026 / 1:33 – 2:44 PM

Members Present:	Innes, Latrice, Compliance Manager, Grievance & Appeals
Ayala, Priscila, Director of Network Services	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Klakken, Vicky, Regional Director (NW-Eureka)
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Krznarich, Jackie, RN, Manager, Member Safety – Quality Inspections
Brincko, Aaron, Director of Provider Relations	Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Emeritus Chair)
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Crosby, Zhavontia, BSN, RN, PHN, Associate Director of Population Health	Newman, Rachel, RN, BSN, Associate Director, Credentialing
Devan, James, Director of Quality Improvement, QI	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI	Villasenor, Edna, Senior Director, Member Services and Grievance
Guevarra, Angela, RN, Director of Care Coordination	Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
Hightower, Tony, CPhT, Associate Director, UM Regulations	
Members Absent:	Hanusiak, Kenzie, Assoc. Dir., Regulatory Affairs & Compliance
Andrews, Leigha, Regional Director (SW)	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Leung, Stan, Pharm.D, Director of Pharmacy Services
Bjork, Sonja, JD, Chief Executive Officer	Randhawa, Manleen, Senior Health Educator, Population Health
Davis, Wendi, Chief Operating Officer	Ruffin, DeLorean, DrPH, Director of Population Health
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Vaisenberg, Liat, Director of Health Analytics
Guests:	Morris, Matthew, MD, Regional Medical Director (Auburn)
Aarons, Rose, Quality Training Specialist & Dental Liaison, QI	Muncy, Kellie, Senior Manager of Configuration, Configuration
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health	Nguyen, Tom, Manager of Health Analytics, Finance
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)	O'Leary, Hannah, MPH, CHES, Manager of Population Health
Bikila, Dejene, Manager of Data Science, Finance	Quichocho, Sue, Manager of Quality Measurement, QI
Chebolu, Radha, Sr. Health Data Analyst II, Finance	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Clark, Kristen, Manager of Quality & Training, Member Services	Rednic, Hanny, Program Manager I, Utilization Management
Durst, Jennifer, Senior Manager of Performance Improvement, QI (Santa Rosa)	Roach, Erika, Program Manager II, Network Services
Harris, Vander, Senior Health Data Analyst I, Finance	Rhorer, Jeanelle, Supervisor of Configuration, Configuration
Hendrix, Hillary, Executive Assistant, Behavioral Health	Roberts, Dorian, Associate Director, Provider Relations
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Salehi, Tiphanie, Senior Health Data Analyst II, Finance
Kim, Amanda, Improvement Advisor, QI (Redding)	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health
Kubota, Marshall, Associate Medical Director	Stark, Rebecca, Regional Director (Chico)
Kung, Jen, Sr. Health Data Analyst II, Finance	Stites, Jaylyn, Program Manager II, Provider Relations (Redding)
Lee, Donna, Manager of Claims, Claims	Thomas, Penny, Senior Health Data Analyst I, Finance
Ling, Samuel, Sr. Health Data Analyst I, Finance	Tryan Tiffany, Manager of Performance Improvement, QI (Redding)
Leung, Paul, Sr. Health Data Analyst I, Finance	Watson, Deanna, Program Manager I, QI (ECM QIP)
Ling, Samuel, Sr. Health Data Analyst I, Finance	Williams, Tracy, Executive Assistant to the Chief Health Services Officer
Mednick, Christy, Sr. Health Data Analyst I, Finance	Yu, Fei, Sr. Data Scientist I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Announcements • Approval of Minutes	Senior Director of Quality & Performance Improvement Isaac Brown, MHA/MBA, called the meeting to order at 1:32 p.m. from the Fairfield-West office. • Approval of the Sept. 8 IQI Minutes. • *Acceptance of the draft minutes of the* o Aug. 27 Member Grievance Review Committee (MGRC) o Sept. 24, June 18, and Feb. 5 Substance Use Internal Quality Improvement Committee (SUIQI) Isaac welcomed Zhavontia Crosby, RN, now in her third week as Partnership's Associate Director for Population Health. Zhavontia has worked in healthcare for more than 28 years, mostly in federally qualified health centers (QHCs) pushing forward quality initiatives.	Motion to approve the IQI minutes as presented: Mark Netherda, MD Second: Lisa Ward, MD *Motion passes unanimously* Motion to accept the other minutes as presented: Mark Netherda, MD Second: Lisa O'Connell, MHA *Motion passes unanimously*
II. Old Business – None.		
III. New Business Consent Calendar (Committee Members as applicable)		
2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025 Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County **Health Services Policies** <u>Behavioral Health</u> MCBP8015 – Coordination of Care for Child Welfare-Involved Members MPBP8007 – Screening and Treatment for Substance use Disorder MPBP8013 – Eating Disorder Management Policy <u>Quality Improvement</u> MCQP1021 – Initial Health Appointment – ***pulled for remark*** <u>Utilization Management</u> MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP2020 – Hospice Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3128 – Cardiac Rehabilitation MCIP3130 – Osteopathic Manipulation Treatment MPUP3116 – Positron Emission Tomography Scans (PET Scans) **Non-Health Services Policies** <u>Member Services</u> MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE – *pulled*** **Leslie Erickson pulled MCQP1021 to note that Attachment A,** a sample provider welcome letter to a new member, is now translated into all threshold languages, including Punjabi. **Hanny Rednic pulled MP316 as its definition of "medical home" differed from that seen in other Partnership policies.** Senior Director of Member Services and Grievance Edna Villasenor noted that MP316's definition was pulled from Partnership's Managed Care Plan (MCP) contract with the Department of Health Care Services (DHCS). She read it into the record. IQI members discussed	Motion to **approve the slate without MCQP1021 and MP316:** Lisa Ward, MD Second: Kristine Gual *Motion passes unanimously* <u>Next Steps</u>: • Oct. 21 Quality/Utilization Advisory Committee (Q/UAC) • Nov. 4 Physician Advisory Committee (PAC) Motion to **approve MCQP1021 as presented:** Mark Netherda, MD Second: Kristine Gual *Motion passes unanimously* Motion to **approve MP316 as amended:** Mark Netherda, MD Second: Lisa Ward, MD *Motion passes unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

whether it adequately captured when an individual primary care provider (PCP) or site might serve in such capacity. **IQI voted to approve the policy with an amended definition,** which was honed post-meeting via email from Santa Rosa Medical Director Lisa Ward, MD, and agreed to by several senior leaders. The first sentence below is drawn from the Contract:

> Medical Home: Medical home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety. The Medical Home may refer to a provider organization or an individual primary care provider who is responsible for managing the Member's primary care needs and coordinating specialty services.

"Medical Home" is mentioned and/or defined in approximately 20 other Partnership policies. IQI's motion to approve as amended also included a proviso that staff may update their policy definition, where they exist, to match the new definition in MP316 without bringing that policy through IQI/Q/UAC/PAC.

In a separate concern, Senior Manager of Configuration Kellie Muncy asked how a policy could be on consent, rather than discussion, at committees if it involved a business or other systemic change, particularly in the adjudication of claims? She specifically called into question MCUP3114 – Physical, Occupational and Speech Therapies. Chief Medical Officer Robert Moore, MD, and Medical Director for Quality Mark Netherda, MD, both noted that the age and timing changes Kellie cited had been previously discussed and approved at committee. (Post meeting research revealed that the configuration changes were approved at PAC Sept. 10, 2025, but may not have been configured at that time.)

IV. New Business – Discussion Policies

Hanny Rednic pulled MCUG3118 – Review Guidelines for Member Placement in Extended Care … for more work. UM intends to bring the policy to November Quality meetings.

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for each discussion policy):

MPQG1005 – Adult Preventive Health Guidelines

Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*

☐ Important Provider Notice (IPN)	☒Provider Education/Training	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐	☐	☐
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ Other *(specify below):*
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

This policy is updated to align with All Plan Letters (APLs) 26-014 (Cognitive Health) **and 26-015** (Immunization Requirements).

Section III. – Partnership Advantage definition updated.
Section VI.A.8 is added: For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract.
Section VI.B.2 is modified: Providers must ensure timely provision of immunizations to *adult* Members in accordance with *a recommendation from the CDC/ACIP (*Advisory Committee on Immunization Practices), *ACOG, AAP, or any modification or*

Motion to **approve with one amendment:** Robert Moore, MD, MPH, MBA
Second: Kristine Gual
Motion passes unanimously

Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	supplement to that recommendation adopted by the California Department of Public Health (CDPH) regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each *adult* Member's need for immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2). **Section VI.B.3 is modified:** Partnership, per APL 26-014, is no longer required to verify whether providers have completed DHCS Dementia Care Awareness cognitive health assessment training. Providers are no longer required to complete this training prior to billing for annual cognitive assessments. Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit *including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.)* Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. **Attachment A:** A line detailing Cognitive Health Assessment for members 65 years and older is added to the Behavioral Conditions section. Dr. Netherda went through the synopsis. Senior Manager of Configuration Kellie Muncy initiated a conversation about codes, stating that some Medicare G codes are now crossing over into Medi-Cal usage. Dr. Moore noted that the G0438 annual wellness code is not exclusive to cognitive testing and is not a denial for other codes: one code may be used for Medicare, another for Medi-Cal billing. **As Partnership no longer needs to verify whether providers are trained in administering cognitive testing, "certified" is struck from VI.B.3.a, now amended to read, in part, "~~Certified~~ Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit including, but not limited to, an office visit, …"**	Oct. 21 Q/UAC Nov. 4 PAC
MCUP3013 Durable Medical Equipment (DME) Authorization		
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*		
☒ **Important Provider Notice (IPN)**	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☒ **Update of TAR Requirements (MCUP041-A)**	☒ **Other *(specify below): We need to determine the process for how IPNs are approved and when they are published so that we do not see misalignment between policies and IPNs.***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	
Section I.F. - Policy MPUP3139 – Criteria and Guidelines for Utilization Management was added as a Related Policy. **Section III.B. -** The DHCS definition of DME was added **Section VI.A.1. –** This paragraph regarding the information required on a DME prescription was moved to the top of the policy. Note was also added to that a prescription can be written or the "electronic equivalent." **Section VI.A.2. –** The list of criteria we consider when authorizing DME was modified to include our policy MPUP3139 – Criteria and Guidelines for Utilization Management in lieu of "InterQual." Policy MPUP3139 provides a more thorough description of all criteria that Partnership would consider, including InterQual. **Section VI. F.2.b**. – This section regarding bathroom equipment was updated to say "When a TAR is required" because an IPN has been posted which now states that No TAR is required for several bathroom equipment items.		*There were no questions.* Motion to **approve as presented:** Lisa O'Connell Second: Brigid Gast, RN *Motion passes unanimously* Next Steps: Oct. 21 Q/UAC Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Section VI. F.3.and VII.G. – This section regarding Compression Garments was removed and transferred to a different policy, MCUG3032 Orthotic and Prosthetic Appliances Guidelines, to be in alignment with where the criteria is shared in the DHCS Provider Manual. The Reference to the BREW form for Compression Garments at VII.G. was also removed and transferred to the other policy. **Attachment A:** The only change to this document was on page one to update policy reference to section VI.B. for Rental Only with a 10-month limit. **Attachment B:** Codes E0658 and E0659 were added to the list of Lymphedema pumps/compression devices, and a policy reference was updated to VI.E. for information on DME provided to disabled parents or guardians.		
MCUG3118 Prenatal & Perinatal Care **Policy Owner: Utilization Management –** *Colleen Townsend, MD, Regional Medical Director (Southeast)* ☐ Important Provider Notice (IPN) | ☒ **Provider Education/Training** | ☐ Provider Fax Blast *(specify provider type(s):* ☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):* ☐ Call Center Script Change | ☐ Update of TAR Requirements (MCUP041-A) | ☒ Other *(specify below):* ***Provider Contracting to use updated Attachment A document as Contract Addendum*** ☐ Configuration of HRP and/or Claims Editor System (CES) | ☐ Configuration of Essette/Jiva		
This policy was updated to align with APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members. **Section I** – Policy numbers were updated as necessary. Policy MCQG1015 Pediatric Preventive Health Guidelines was removed from the Related Policies list and policy CLPM31 Obstetrical Services was added at I.K. **Section III.I** – Definition for Professional Organization was added to describe those recognized by DHCS for clinical guidance as per APL 26-005. **Section VI.B.** – Statement added to say, "No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable." **Section VI.C.3.** – Paragraph updated to clarify requirements for different types of perinatal services programs. **Section VI.C.4.c.3)b)i.** – "Comprehensive Assessments" was added as a specific measure to be evaluated in quality monitoring of PHPS providers **Section VI.C.5.b.** – Statement added to say "Members may choose a midwifery provider outside of their capitated facility if that facility does not offer midwifery services for delivery." **Section VI.C.8. and 9.** – Regulatory requirement sources for perinatal services were updated to reference APL 26-005 and links to CPSP information were updated. Screening required by various agencies were separated into section VI.C.9 **Section VI.C.10.** - Statement added to say "Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs." **Section VI.C.12.** – Reference was added for our policy MPNP9006 Doula Services Benefit. **Section VI.D.1.a.** - Statement added in the PHPS Standards of Perinatal Case Management section to say, "The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member." **Section VI.D.4.** – Specified that every PHPS program "must" have a designated Clinical Director.		*There were no questions.* Motion to **approve as presented:** Lisa Ward, MD Second: Aaron Brincko *Motion passes unanimously* Next Steps: Oct. 21 Q/UAC Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.D.12.b.1) b) and VI.G.2.a.-e.– In the Nutrition Education Services section and the Diabetes Care in Pregnancy section, we updated the certification title for Certified Diabetes Care and Education Specialists (CDCES). **Section VI.D.12.c.1) a)i.** – Statement added to say "Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation." **Section VI.E.3.a.** – Specified that standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary <u>each trimester</u> and at the post-partum visit, <u>more frequently as needed</u>. **Section VI.E.7.a.** – Specified that Perinatal Services providers will maintain an updated list of staff working for them and their qualifications and "These will be provided to Partnership upon request and submitted with PHPS applications and updates." **Section VI.H.1.** - Statement added to say "PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs." **Section VI.H.3.** - Statement added to say "WIC programs in each county may provide lactation services for Members. PHPS/CPSP programs that do not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based lactation services." **Section VI.I.2.** – Added reference to policy MCUP3124 Referral to Specialists (RAF) Policy **Section VI.I.2.a.** – Statement added to say "Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management." **Section VII. References** - Reference C. was updated to reflect APL 26-005. Hyperlinks were updated throughout as needed. Reference I was added for USPSTF Perinatal Depression Interventions and References J. – L. were added for recommended depression screenings cited in the policy. **Attachment A** – The PHPS Application and Update Form and Contracted Provider Addendum was updated to specify that all licensed program staff must be credentialed with Partnership or with a Partnership delegate, if applicable, "<u>prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements</u>" by July 2026.	
MCUP3133 Wheelchair Mobility, Seating and Positional Components **Policy Owner: Utilization Management –** *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*		
☒ **Important Provider Notice (IPN)**	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ Other *(specify below):*
☒**Configuration of HRP and/or Claims Editor System (CES)**	☐ Configuration of Essette/Jiva	
This policy was updated due to align with new DHCS terminology and a new benefit code K0462. **Section III.B. and C.** – The previous definition for "Custom Rehabilitation Equipment" was updated to define a new term, "Complex Rehabilitation Technology (CRT)." Ad new definition for a "CRT Supplier" was also added. **Section III.K. and L.** – The acronym and definition for a Qualified Health Care Professional (QHCP) was updated. The definition of a Qualified Rehabilitation Technical Professional (QRTP) was also updated. **Section VI.** - Language was updated throughout to reflect "Complex Rehabilitation Technology" or CRT in lieu of "custom rehabilitation equipment."		Motion to **approve with one amendment:** Mark Netherda, MD Second: Kristine Gual *Motion passes unanimously* <u>Next Steps</u>: Oct. 21 Q/UAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.3. – Statement added to say, "Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device." **Section VI.D.** - Language was added in the section on Seating and Positioning Component Coverage Criteria to say "Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered." **Section VI.F. –** This section regarding Loaner Rental During Repair was updated to reflect new DHCS benefit coverage instead of Partnership's previous coverage as a BREW benefit. Code K0462 for rental of a power wheelchair during extended repair will now be covered with no TAR requirement for up to two one-month rental periods per year. Associate Medical Director Marshall Kubota asked for **clarity on VI.D:** *Seating and Positioning Component Coverage Criteria: SPC are covered when criteria 1. 2. and 3., at least one of 4. – 9., and 10. – 19. (if applicable) are met….*, questioning whether all or just one of 10-19 needed to be met? **Tony agreed to wordsmith this section based on a suggestion from Dr. Moore, and IQI agreed.** Kellie Muncy asked about the effective date. A DHCS bulletin announced the code K0462 would be effective Aug. 1, 2026. DHCS also updated a section of the Provider Manual in July, so IQI agreed to use Aug. 1 as the effective date.	Nov. 4 PAC **VI.D. is amended to begin: …** SPC are covered when criteria 1. 2. and 3. and at least one of criteria 4. – 9. are met. Criteria 10. – 19. will then be applied if relevant features are requested. …

V. Presentations

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

- The Electronic Clinical Data Set (ECDS) Datalink Scaling Project (DataLink) is moving along. To date, 246,714 distinct Members are currently represented in the DataLink data across Partnership's service area. Six of 24 counties have reached the MY2026 target of 33% of county membership within the data pulls. Seven additional counties are within five percentage points of the 33% target.
- Quality Measure Score Improvement (QSMI) workgroups have created measure-specific toolkits, which Process Improvement managers are now reviewing.
- The Equity & Practice Transformation (EPT) Project officially concludes for provider practices in November 2026; however, Partnership is still required to submit a MY2026 data deliverable in 2027 to determine payment eligibility for practices who met the 90th percentile in their Population of Focus HEDIS-like measures.
- Each year, Shasta County Public Health organizes a free community-wide influenza vaccination event. This year's drive-through clinic in scheduled for Saturday, Oct. 17, from 10 a.m. to 2 p.m. at Partnership, 351 Hartnell Ave., Redding. Questions should be directed to Chandler Ackerman at cackerman@partnershiphp.org.

There were no questions for Isaac.

CY 2025 Primary Care Provider Quality Incentive Program (PCP QIP) Evaluation – *Athena Beltran-Nampraseut, CPhT, Program Manager II, QI*

The program covered 18 clinical measures across chronic disease management, preventative screening, pediatric access, and monitoring-only categories across three practice types: Family Medicine, Internal Medicine, and Pediatrics. Also included were five non-clinical measures across hospital utilization, primary care utilization and patient experience, with full and partial points targets varying according to internal benchmarks. Participation in the 11 unit-of-service (UOS) measures was optional, and one – extended office hours – was incentivized outside of the QIP. Most of the CY 2025 core measures continued from CY 2024 with the addition of well-child visits in the first 15-30 months of life (Pediatrics only) and chlamydia screening (16-18 year-olds (Pediatrics only) in the clinical measures; the deletion of risk-adjusted readmissions in the non-clinical measures, and the addition of five monitoring measures: well-child visits in the first 15-30 month of life (Family Medicine), chlamydia screening (16-24 y-o in Family Medicine) chlamydia screening (18-24 y-o in Internal Medicine) and topical fluoride in children (Family Medicine and Pediatrics only). The 2024 UOS measures continued in 2025, although dental fluoride varnish was deleted and academic detailing was added. Other 2025 adjustments included reducing healthcare disparity as a new optional clinical measure. Partial points target thresholds were raised back to the pre-Covid 75th percentile.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Eleven of the carryover clinical measures showed relative performance improvement ranging from .83% to 12.17% above 2024 marks plan-wide, Athena said. Moreover, most met or performed above the Healthcare Effectiveness Data Information Set (HEDIS®) minimum performance level (MPL), most significantly in cervical cancer screening and colorectal cancer screening. Dr. Moore commented that we did a 100% "chart chase" in HEDIS, so why the difference in the two chlamydia measures? Athena replied that different denominators applied; also, we do not look at the sexual activity of the children involved.

Relative improvement (RI) points were available for most existing clinical measures where a provider site met the 75th percentile target AND achieved an RI score of 15% or higher. Lead screening in children and diabetes – HbA1c good control had the highest RI scores plan-wide pushing providers to full points. 2025 participation was higher than in 2024 in five of nine UOS measures, Athen noted when discussing payouts. The highest UOS payouts were $524,000 for advanced care planning; $358,850 for early administration of the first HPV dose; and $344,802.57 for the new (and optional) reducing healthcare disparity measure.

In all, 384 provider organizations earned $55.7M in incentive payments, with Sonoma POs the highest earners by county of the 64-PO Santa Rosa region total of $13,002,478.62, and Solano POs the highest earners by county of the 62-PO Fairfield region total of $11,928,573.64.

In summary, 2025 programmatic changes saw six measures added, two removed, and partial points thresholds increase from the 50th percentile to the 75th percentile. Nine clinical measures ended above the MPL; five hit >= 50th; three finished >= the 75th and one achieved the 90th percentile. Among the non-clinical measures, three met full points thresholds, including the new-for-2025 hospital follow-up within 7 days after discharge. One non-clinical measure met its partial points threshold.

For CY 2027, six clinical measures will transition to ECDS reporting, (i.e., DataLink) in alignment with DHCS expectations. Thresholds will increase for patient experience, and improvement plans will be required where these thresholds are not met. (This is both a 5-Star NCQA Health Plan accreditation goal and a DHCS "withhold measure.") Two non-clinical measures will be renamed to "potentially preventable admissions" and "low-acuity non-emergent ED visits" in alignment with DHCS nomenclature. Tobacco use screening is moving to "monitoring" in alignment with HEDIS® and the UOS ECDS measure will be removed as DataLink is added in alignment with DHCS reporting requirements.

Dr. Moore commented that he didn't see anything that would require changes in addition to those described. Dr. Kubota expressed surprise at the "half million" paid out for advance care planning. Dr. Moore noted that national data shows that individuals who have such a plan have fewer end-of-life care issues. Partnership, however, has not independently analyzed this, Dr. Moore added as he acknowledged that this incentive is "controversial." He suggested that medical directors Matthew Morris, MD, and Bettina Spiller, MD, next year could sample the quality of care provided during these ACP discussions. Athena asked if the Member Safety Inspections team could partner in this effort, and team Manager Jackie Krzanich, RN, said yes. Dr. Netherda wondered if the Health Equity team is doing something along these lines? Dr. Moore concluded that working backwards from death in the hospital is difficult but can be done. He suggested that the matter might be a topic for a future annual Hospital Symposium.

Motion to accept the 2025 PCP QIP Evaluation as presented: Kristine Gual/James Devan

MY 2025 National Committee on Quality Assurance (NCQA) Health Plan Rating (HPR) and **5-Star Strategic Plan for Quality Improvement 2026-2029**
– Kristine Gual, PMP, CPHQ, Director of Quality Measurement, QI

Kristine in July presented our HEDIS® outcomes for 2025 Managed Care Accountability Set (MCAS) measure set and today circled back to talk about our NCQA Health Plan Rating. The timing is a little out of sync, she said: we don't hear from NCQA with our final outcomes usually until late August or early September. Our final HPR is 3-Stars. We did use the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey for the health plan rating in 2025, and our county ratings were nearly identical to 2024 (which was the first year that our 10 incoming counties joined the Plan) yet we saw a decrease from 3.5-Stars to 3-Stars. We are still working on regaining that lost ground. Everyone is encouraged to look at the white paper in today's packet under FYI for more information, including a county-level breakdown on all of the 44 measures that make up the HPR.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Moving on to the Five-Star Strategic Plan for Quality Improvement 2026-2029, Kristine said that the last time we updated our strategic plan for the Quality Improvement department was in 2019. Today, we are in a different world, so it was definitely time for an update. A white paper that goes along with this presentation is also in the today's packet under FYI.

Every three years, Partnership updates its org-wide strategic plan, which looks at things much beyond the scope of quality improvement. This is in process right now with our Executive team and Board. They will come up with a set of "pillars," which have goals associated with them. The pillars are not yet defined, but in our last strategic plan we had a pillar for quality of care and health equity. We anticipate that there will be a similar pillar, and this is where we can see this QI plan located. There are many other departments' strategic plans going on now, including Health Equity and Member Experience. We all work together, and the idea is that everybody aligns; we may have different focus areas, but we are all moving in the same direction.

A little bit about the urgency of accelerating our performance at this time: we saw it in our health plan ratings that national trends in quality performance are outpacing Partnership. We are improving but not at the trajectory that we need to keep up with national Medicaid benchmarks or with performance by other California managed care plans. There is an enormous financial risk associated with this performance as well as to our members' health, which is really our mission. Finally, we want to see consistency across our network. We have a very diverse network, and performance on the quality plan is sometimes dependent on where you are located, what community you are part of, and so this is why that is related to equity.

Kristine then went through the plan's development process, which began in May with outside consultants, focus groups and interviews. We were able to develop a very comprehensive SWOT (Strengths, Weaknesses, Opportunities and Threats) as summarized in the white paper. We needed a criteria to bump that against so that we could come up with a focus plan that was achievable in three years. The criteria included member health and experience, regulatory and financial impact, and organizational capacity. We want to make sure that anything we decide to put time and effort into is sustainable, fits into our timeline and that we are able to have a regional approach. We are in the midst of our communications now and are interested in provider feedback on this plan. It will go to our Board on Oct. 28. Then we will go right into implementation, setting up tactical goals with the impacted departments and the provider network.

Kristine then went over the high-level strategic "aggressive" goals for the next three years. We can achieve these goals or make significant progress towards achieving all of them, she said. Improving member experience is actually a goal for our entire organization. Some needed metrics are getting needed care and getting care quickly. We want to perform at the 67th percentile or higher.

Our second strategic goal is around reducing avoidable utilization in things like ambulatory sensitive admissions. Our goal is to reduce by 10% or more annually plan-wide and to retain our actually high level of performance on hospital readmissions. This is where lower is better. We are currently performing at the 90th percentile. We want to retain that and keep that high performance. The final three strategic goals are around areas of preventive care: improving pediatric preventive care defined by well-child visits and immunizations, improving chronic disease outcomes like diabetes and hypertension, and improving timely access to prenatal care. This is consistent with what we shared this summer on our HEDIS® outcomes. Kristine noted. Our goal across our DHCS rating regions is to perform at the 67th percentile or higher in each of those rating regions.

We have a special focus on our rural regions because we know this is where the need is greatest and on reducing health inequities. Composite key indicators that will show us we are moving in the right direction include our NCQA Star rating. We will start with moving from a 3-Star to a 3.5-Star and then onward up to 4 and then 5. Our second success measure is our Quality Factor Score on our MCAS measures. We don't yet have that information from DHCS to compare across California, but we will share when DHCS releases that information for 2025.

How will we focus? We have objectives and lead departments defined to move the needle on five strategic goals: access to care, provider experience, member experience, data analytics and organizational excellence and culture. In access to care, the idea is not only to strengthen our network capacity, it is also to expand alternative access models to meet the needs of the community, like telehealth and mobile units. Provider engagement is Quality's wheelhouse: building the capacity of the network towards high performance on the prior unprioritized quality measures. Our Member Experience department is focused on better understanding drivers and resolving some of the highest priority gaps in the member journey. Member engagement is focused on improving outcomes for high needs populations. for example, D-SNP, high-needs care coordination and CalAIM. Finally, we are able to provide retrospective analytics, but the idea is to include real time analytics that maximizes opportunities for closing

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
care gaps and improving member health. Lastly, in this time of economic uncertainty, we want to make sure our resources as well directed and that we receive a return on investment for every initiative we launch. Although the Board is expected to final this on Oct. 28, we are still interested in conversations, discussions, and questions about the plan and we welcome provider engagement. We will be talking with our lead departments on finalizing smart goals around these different focus areas and building tactical plans. We will report annually on our progress. Kristine said she is "thankful" for new Director of Member Experience Irem Conery and is eager to work with her to align QI and Member Experience efforts. Dr. Moore noted that Chief Executive Officer Sonja Bjork, JD, has reviewed this plan, and that her sole recommendation is that Behavioral Health be involved.		
MY 2025 / RY 2026 Health Equity Disparities Grand Analysis – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
Dr. Jalloh was unable to attend the meeting. He will present at the Oct. 21 Q/UAC.		
VI. FYI/Adjournment		
Isaac Brown adjourned the meeting at 3:25 p.m. IQI next will meet Tuesday, Nov. 10, 2026.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* Issac Brown, MHA/MBA Senior Director, Quality & Performance Improvement		

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

Date: Oct. 21, 2026 **Time: 7:30 – 8:45 a.m.**

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

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health, 11670 Atwood Road, Auburn
La Clinica, 1450 Fruitvale Ave., Oakland

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 will 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	Announcements	Mark Netherda, MD	7:30	--
2	*Approval of* Sept. 16, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes			5 – 11
3	*Acknowledgment and acceptance of draft minutes of the* • Sept. 8 Internal Quality Improvement (IQI) Committee • Sept. 15 & July 21 Quality Improvement Health Equity Committee (QIHEC) • Sept. 24, June 18, & Feb. 5 Substance Use Internal Quality Improvement (SUIQI) Committee • Aug. 27 Member Grievance Review Committee (MGRC)			13 – 85
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:40	87 – 98
2	HealthPlan Update	Robert Moore, MD, MPH, MBA	7:45	--
III.	**Old Business – None.**			
IV.	**New Business - Consent Calendar**			
Reports	Consent Calendar	All	7:50	99
	Primary Care providers Quality Incentive Program (PCP QIP) CY 2025 Evaluation – *direct questions to Athena Beltran – Nampraseut, CPhT*			101 – 126
	Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County			127 – 128
	2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025			129 – 133
HS Policies	**Behavioral Health**			
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members			135 – 139
	MPBP8007 – Screening and Treatment for Substance Use Disorders			141 – 156
	MPBP8013 – Eating Disorder Management Policy			157 – 165

	Item	Lead	Time	Page #
	Quality Improvement			
	MCQP1021 – Initial Health Appointment			167 – 177
	Utilization Management			
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			179 – 182
	MCUP3020 – Hospice Services			183 – 198
	MCUP3114 – Physical, Occupational and Speech Therapies			199 – 205
	MCUP3128 – Cardiac Rehabilitation			207 – 212
	MCUP3130 – Osteopathic Manipulation Treatment			213 – 215
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			217 – 219
Non-HS	**Member Services**	All	--	
	MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE –** *CLEAN copy of the policy begins on p. 235*			221 – 239
V.	**New Business – Health Services Discussion Policies**			
	Synopsis of Changes		--	241 – 245
	Quality Improvement			
	MPQG1005 – Adult Preventive Health Guidelines **–** *CLEAN copy of the policy begins on p. 261*	Mark Netherda, MD	7:55	247 – 264
	Utilization Management			
	MCUP3013 – Durable Medical Equipment (DME) Authorization	Tony Hightower, CPhT	8:01	265 – 280
	MCUG3118 – Prenatal & Perinatal Care	Colleen Townsend, MD	8:07	281 – 299
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components	Tony Hightower, CPhT	8:13	301 – 312
VI.	**Presentations**			
1	MY 2025 NCQA Health Plan Rating – *PowerPoint begins on p. 313* • 5 Star Strategic Plan for Quality Improvement – 2026 – 2029 – *PowerPoint begins on p. 315; FYI report begins on p. 361* • The MY2025 / RY 2026 Healthcare Effectiveness Data and Information Set (HEDIS®) Health Plan Accreditation (HPA) Summary of Performance was not finalized when Q/UAC reviewed the Managed Care Accountability Set (MCAS) Summary of Performance in July; *the HPA white paper is included in today's packet under FYI and may also be found here:* https://edge.sitecorecloud.io/partnershipae75-partnership4b61-production30f9-46fc/media/Project/partnership-sites/partnershiphp/files/PDF/HEDIS-MY2025-Summary-of-Performance_HPA_COMSFINAL.pdf	Kristine Gual, PMP, CPHQ	8:19	313 – 321
2	Health Equity Disparities Grand Analysis: MY 2025 / RY 2026 - *PowerPoint begins on p. 323* • MCED6001 Health Equity and Community Reinvestment Strategy and Program Description was presented in August committee meetings and approved at the Sept. 9 Physician Advisory Committee (PAC). *A clean copy is included for context under FYI* • FY 2026-2027 Work Plan – *begins on p. 355* • Health Equity Strategic Plan (2027 - 2030) – *begins on p. 359*	Mohamed Jalloh, Pharm.D	8:30	323 – 360
VII. FYI	5-Star Strategic Plan for Quality Improvement 2026-2029 Report			361 – 379
	HEDIS® HPA white paper			381 – 444
	MCED6001 – CLEAN			445 – 479
	Adjournment scheduled by 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 18, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Quality and Utilization Advisory Committee (Q/UAC) Meeting Minutes

Wednesday, Oct. 21, 2026 / 7:33 a.m. – 9:00 a.m.

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

Voting Members Present:	Emma Hackett, MD, FACOG	John Murphy, MD
Sara Choudhry, MD	Brian Montenegro, MD	Randy Thomas, MD
Steven Gwiazdowski, MD, FAAP	Meagan Mulligan, FNP-BC	Jennifer Wilson, MD, MPH
Voting Members Absent: Brandy Lane, Consumer Member; Robert Quon, MD, FACP; Michael Strain, Consumer Member; Chris Swales, MD		
Partnership *Ex-Officio* Members Present:	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Bontrager, Mark, Senior Director of Behavioral Health	Newman, Rachel, RN, BSN, Assoc. Dir., Credentialing	
Brown, Isaac, MBA/MHA, Senior Director of Q & P Improvement	O'Connell, Lisa, Director, Enhanced Health Services	
Cox, Bradley, DO, Regional Medical Director (Northeast)	Randhawa, Manleen, Senior Health Educator, Population Health	
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Ruffin, DeLorean, DrPH, MPH, Director of Population Health	
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Thornton, Aaron, MD, Associate Medical Director	
Krznarich, Jackie, RN, Mgr, Member Safety – Quality Inspections	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Leung, Stan, Pharm.D, Director of Pharmacy Services	Ward, Lisa, MD, Regional Medical Director (Southwest)	
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	Watkins, Kory, MBA-HM, Director, Grievance & Appeals	
Partnership *Ex-Officio* Members Absent:	Guillory, Ledra, Senior Manager of Provider Relations Representatives	
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Hightower, Tony, CPhT, Associate Director, UM Regulations	
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs	
DeVido, Jeff, MD, Behavioral Health Clinical Director	Katz, Dave, MD, Associate Medical Director	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Spiller, Bettina, MD, Associate Medical Director	
Guests:	Gual, Kristine, Director, Quality Measurement, QI	
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Hendrix, Hillary, Executive Assistant, Population Health	
Bottke, Jayme, Regional Director (Northeast)	Kubota, Marshall, MD, Associate Medical Director	
Brincko, Aaron, Director of Provider Relations	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)	
Campbell, Anna, Health Policy Analyst, UM Regulations	Morris, Matthew, MD, Regional Medical Director (Auburn)	
Crosby, Zhavontia, BSN, RN, Associate Director, Population Health	O'Leary, Hannah, MPH, Manager of Population Health	
Devan, James, Director of Quality Management	Quichocho, Sue, Manager of Quality Measurement, QI	
Durst, Jennifer, Senior Manager, Quality Incentive Programs, QI	Rednic, Hanny, Program Manager I, Utilization Management	
Elder, Alaina, Manager of Provider Network Services, Provider Relations	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health	
Frankovich, Terry, MD, Associate Medical Director	Stites, Jaylyn, Program Manager II, Provider Relations	
George, Michael, MD, Associate Medical Director		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Introductions	Committee Vice Chair and Medical Director for Quality Mrk Netherda, MD, sitting in Fairfield called the meeting to order at 7:33 a.m. • The Sept. 16 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* o Sept. 8 Internal Quality Improvement (IQI) Committee o Sept. 15 & July 21 Quality Improvement Health Equity Committee (QIHEC) o Sept. 24, June 18, & Feb. 5 Substance Use Internal Quality Improvement (SUIQI) Committee o Aug. 27 Member Grievance Review Committee (MGRC) • Introductions: o Dr. Netherda welcomed new Associate Director of Population Health Zhavontia Crosby, RN, to her first Q/UAC meeting. She joined Partnership at the end of September.	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept other minutes:** Steve Gwiazdowski, MD Second: Randy Thomas, MD *Accepted unanimously*

II. Standing Updates

Quality and Performance Improvement Program – *Isaac Brown, MBA/MHA, Senior Director of Quality & Process Improvement*

- Organizations will soon be sent contract amendments for signature to participate in the Calendar Year 2027 Quality Incentive Programs (QIPs).
- DataLink is quickly scaling up. DataLink is able to go in and extract data from the electronic health record that is critical for proving the work was done by our clinicians. We are up to 246,714 members that are currently being represented in the data. Six of our counties have reached their target of 33%.
- Our Quality Management Score Improvement (QMSI) work groups work cross functionally on different measures to try to improve scores. One of their new activities is building out some measure specific toolkits to help different providers focus on specifics. We will be sharing these in the coming months.

There were no questions for Isaac.

Health Plan Update – *Robert Moore, MD, MPH, MBA – Chief Medical Officer*

Dr. Moore announced that he is about eight months from retirement. Until that time, Kermit Jones, MD, and Mark Netherda, MD, will rotate chairing the monthly meetings of this committee while Dr. Moore provides coaching support.

- Partnership has established what we call the Hospice Quality Network. Our hospice provider network is a smaller group of high quality providers that are largely not-for-profit in an effort to ensure individuals get what they need. That's going pretty well. We are updating our Provider Directory.
- The Primary Care Provider Quality Incentive Program (PCP QIP) for the coming year will pay increased attention to potentially preventable admissions, previously known as the ambulatory care sensitive admissions. We are going through this at our PCP advisory group meeting with external advisors later this morning. The bottom line is that this is the second biggest penalty from the State in terms of quality penalties, and it is related to admissions that are felt to be preventable across several disease states. Congestive heart failure is the biggest one. Complications of diabetes is a close second. We are committed to building out infrastructure to really communicate much more closely in real time to the PCPs who are their patients admitted to the hospital or even seen in the emergency room. We are striving to have that up and running by January to help PCPs monitor and more closely case manage the folks that are utilizing those services.
- We are looking at the drivers for current financial challenges: what is different between 2024 and 2025? Partnership in 2025 hit its highest ever number of PCP visits per member per year and also the highest ever specialty visits per member per year. This is not a bad thing, although it does drive expenses a little. I dare say it is not the adequate network that we are looking for across the board: we have really good access in some areas and others not so good.
- About the loss of part of the Wellness & Recovery Program that was Partnership's contract with seven of our counties to take on their drug Medi-Cal organized delivery system, the State changed the regulatory framework to make it impossible for the counties to contract with us for that. So, that will end as of Dec. 31. Solano and Mendocino counties are going to run their own organized delivery system. The other five small counties are going to work parts of managing the

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

delivery system. This is still in development.

- Big picture, the State for many years was moving services from fee-for-service Medi-Cal over to managed care. This peaked in 2024. The State now has new challenges, one of which is what to do with the individuals with uncertain or unsatisfactory immigration status (UIS). Then there is also a federal government prohibition against providing gender affirming care to non-adults. The State has decided to take those services back in-house, which I think reflects a bit of new blood at the Department of Health Care Services (DHCS) who have no idea what it is like to run a delivery care system. As of Jan. 1, the entire UIS population, including kids and pregnant women will cycle over to DHCS. There is a solid probability that they are going to ask us in December to continue to provide services for a few more months because they will not have their delivery system up and running. There is a history of that with the pharmacy benefit. For the gender affirming care, on Sept. 30 with two weeks' notice, DHCS notified the health plans that they would no longer be allowed to pay for gender affirming care for any non-adult; on the other hand, statutorily, the California Legislature mandated that that care be covered. DHCS felt overwhelmed with the UIS population and asked if anyone else could take this. So HCAI (California Department of Health Care Access and Information), which has never provided care delivery or paid bills before, will run that service. HCAI has yet to develop agreements with providers, and we had to notify our members and our providers that are providing care for them not to bill us anymore or we will be denying those claims. It's not that members will be denied care: the care is going to be paid for by HCAI.
  - *Regional Medical Director Jeff Ribordy, MD, said "those of us that actually practiced in the fee-for-service world, there is no network., no system, any kind of care coordination or help. The patient is the provider's responsibility, so most of these things are going to fall on our provider network." Dr. Moore acknowledged this was true but that things are changing with the standing up of call centers and contracts with others to provide care coordination services, adding HCAI is attempting to put together services similar to those provided by managed care plans. "That's the rub," he said. "Probably the Finance people thought 'we're going to save a bunch of money moving back to the State.' But if the State turns around and contracts for all these services, the cost saving will disappear."*
  - *Regional Medical Director Colleen Townsend, MD, commented "thinking about pregnancy care, with the new All Plan Letter (APL) that came out this year, there is a strong emphasis on the health plan or health plan entity to provide a high level of care coordination that connects people, particularly high-risk individuals with any people, and pregnant people after they leave the hospital. I haven't heard that they have their own system in place to make themselves accountable to or comply with their own DHCS policy."*
  - *Dr. Netherda asked Dr. Moore to explain who HCAI is. Dr. Moore responded that HCAI works on workforce and also runs the Rural Health Transformation grant program. "They are a master data collector for the hospitals. They collect a lot of the data for hospital quality. But (a history of) delivering care is not there."*

There were no other questions for Dr. Moore.

III. Old Business – None.

IV. New Business – Consent Calendar (Committee Members as Applicable)

Primary Care Providers Quality Incentive Program (PCP QIP) CY 2025 Evaluation – *direct questions to Athena Beltran – Nampraseut* Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County 2026 Annual Oversight: Carelon – Notice of Final Audit Results CY 20025 **Health Services Policies** <u>Behavioral Health</u> MCBP8015 – Coordination of Care for Child Welfare-Involved Members MPBP8007 – Screening and Treatment for Substance Use Disorders MPBP8013 – Eating Disorder Management Policy	*Q/UAC voters posed no questions.* Motion to **approve the slate as presented:** John Murphy, MD Second: Meagan Mulligan, FNP *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Quality Improvement MCQP1021 – Initial Health Appointment [1] Utilization Management MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3020 – Hospice Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3128 – Cardiac Rehabilitation MCUP3130 – Osteopathic Manipulation Treatment MPUP3116 – Positron Emission Tomography Scans (PET Scans) **Non-Health Services Policy** Member Services MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE**		Next Steps: Nov. 4 Physician Advisory Committee (PAC)

V. New Business – Discussion Policies (Committee Members as Applicable)

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for each discussion policy):

MPQG1005 Adult Preventive Health Guidelines

Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*

☐ Important Provider Notice (IPN)	☐ Provider Education/Training	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ **Other *(specify below):***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

This policy is updated to align with All Plan Letters (APLs) 26-014 (Cognitive Health) **and 26-015** (Immunization Requirements). **Section III.** – Partnership Advantage definition updated. **Section VI.A.8 is added**: For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract. **Section VI.B.2 is modified:** Providers must ensure timely provision of immunizations to *adult* Members in accordance with *a recommendation from the CDC/ACIP (*Advisory Committee on Immunization Practices), *ACOG, AAP, or any modification or supplement to that recommendation adopted by the California Department of Public Health (CDPH)* regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each *adult* Member's need for immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).	*Q/UAC voters posed no questions.* Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Nov. 4 PAC

[1] MCQP1021 Attachment A – Provider's Sample Welcome Letter to New Members – is now available in Punjabi.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Section VI.B.3 is modified: Partnership, per APL 26-014, is no longer required to verify whether providers have completed DHCS Dementia Care Awareness cognitive health assessment training. Providers are no longer required to complete this training prior to billing for annual cognitive assessments. Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit *including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.)* Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. **Section VI.B.3.a is added** to address DHCS Additional Information Request (AIR): On or after June 30, 2025, Partnership is no longer required to verify whether Providers have completed cognitive assessment training to be eligible for reimbursement for conducting a Medi-Cal annual cognitive health assessment for eligible members. **Attachment A:** A line detailing Cognitive Health Assessment for members 65 years and older is added to the Behavioral Conditions section.		
MCUP3013 Durable Medical Equipment (DME) Authorization **Policy Owner: Utilization Management –** *Hanny Rednic, Program Manager I, UM* ☒ **Important Provider Notice (IPN)** ☒ **Provider Education/Training** ☐ Provider Fax Blast *(specify provider type(s):* ☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):* ☐ Call Center Script Change ☒ Update of TAR Requirements (MCUP041-A) ☒ **Other** ***(specify below): We need to determine the process for how IPNs are approved and when they are published so that we do not see misalignment between policies and IPNs.*** ☐ Configuration of HRP and/or Claims Editor System (CES) ☐ Configuration of Essette/Jiva		
Section I.F. - Policy MPUP3139 – Criteria and Guidelines for Utilization Management was added as a Related Policy. **Section III.B. -** The DHCS definition of DME was added **Section VI.A.1. –** This paragraph regarding the information required on a DME prescription was moved to the top of the policy. Note was also added to that a prescription can be written or the "electronic equivalent." **Section VI.A.2. –** The list of criteria we consider when authorizing DME was modified to include our policy MPUP3139 – Criteria and Guidelines for Utilization Management in lieu of "InterQual." Policy MPUP3139 provides a more thorough description of all criteria that Partnership would consider, including InterQual. **Section VI. F.2.b**. – This section regarding bathroom equipment was updated to say "When a TAR is required" because an IPN has been posted which now states that No TAR is required for several bathroom equipment items. **Section VI. F.3.and VII.G**. – This section regarding Compression Garments was removed and transferred to a different policy, MCUG3032 Orthotic and Prosthetic Appliances Guidelines, to be in alignment with where the criteria is shared in the DHCS Provider Manual. The Reference to the BREW form for Compression Garments at VII.G. was also removed and transferred to the other policy. **Attachment A:** The only change to this document was on page one to update policy reference to section VI.B. for Rental Only with a 10-month limit. **Attachment B:** Codes E0658 and E0659 were added to the list of Lymphedema pumps/compression devices, and a policy reference was updated to VI.E. for information on DME provided to disabled parents or guardians.		*Q/UAC voters posed no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

MCUG3118 Prenatal & Perinatal Care

Policy Owner: Utilization Management – *Colleen Townsend, MD, Regional Medical Director (Southeast)*

☐ Important Provider Notice (IPN)	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☒ Other *(specify below):* ***Provider Contracting to use updated Attachment A document as Contract Addendum***
☒ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

This policy was updated to align with APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members.

Section I – Policy numbers were updated as necessary. Policy MCQG1015 Pediatric Preventive Health Guidelines was removed from the Related Policies list and policy CLPM31 Obstetrical Services was added at I.K.
Section III.I – Definition for Professional Organization was added to describe those recognized by DHCS for clinical guidance as per APL 26-005.
Section VI.B. – Statement added to say, "No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable."
Section VI.C.3. – Paragraph updated to clarify requirements for different types of perinatal services programs.
Section VI.C.4.c.3)b)i. – "Comprehensive Assessments" was added as a specific measure to be evaluated in quality monitoring of PHPS providers
Section VI.C.5.b. – Statement added to say "Members may choose a midwifery provider outside of their capitated facility if that facility does not offer midwifery services for delivery."
Section VI.C.8. and 9. – Regulatory requirement sources for perinatal services were updated to reference APL 26-005 and links to CPSP information were updated. Screening required by various agencies were separated into section VI.C.9
Section VI.C.10. - Statement added to say "Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs."
Section VI.C.12. – Reference was added for our policy MPNP9006 Doula Services Benefit.
Section VI.D.1.a. - Statement added in the PHPS Standards of Perinatal Case Management section to say, "The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member."
Section VI.D.4. – Specified that every PHPS program "must" have a designated Clinical Director.
Section VI.D.12.b.1) b) and VI.G.2.a.-e.– In the Nutrition Education Services section and the Diabetes Care in Pregnancy section, we updated the certification title for Certified Diabetes Care and Education Specialists (CDCES).
Section VI.D.12.c.1) a)i. – Statement added to say "Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation."
Section VI.E.3.a. – Specified that standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary each trimester and at the post-partum visit, more frequently as needed.
Section VI.E.7.a. – Specified that Perinatal Services providers will maintain an updated list of staff working for them and their qualifications and "These will be provided to Partnership upon request and submitted with PHPS applications and updates."

Q/UAC voters posed no questions.

Motion to **approve as presented:** Jennifer Wilson, MD
Second: Brian Montenegro, MD
Approved unanimously

Next Steps:
Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.H.1. - Statement added to say "PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs." **Section VI.H.3.** - Statement added to say "WIC programs in each county may provide lactation services for Members. PHPS/CPSP programs that do not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based lactation services." **Section VI.I.2.** – Added reference to policy MCUP3124 Referral to Specialists (RAF) Policy **Section VI.I.2.a.** – Statement added to say "Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management." **Section VII. References** - Reference C. was updated to reflect APL 26-005. Hyperlinks were updated throughout as needed. Reference I was added for USPSTF Perinatal Depression Interventions and References J. – L. were added for recommended depression screenings cited in the policy. **Attachment A** – The PHPS Application and Update Form and Contracted Provider Addendum was updated to specify that all licensed program staff must be credentialed with Partnership or with a Partnership delegate, if applicable, "prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements" by July 2026. Dr. Towsend remarked we will be asking practices that participate in our Partnership HealthPlan Perinatal Services (PHPS)[2] program and anyone who offers case management during pregnancy as an obstetric practice to both apply or verify their provision of those services, reflect who are their providers in their network, and that they are compliant with the maternity care services APL from the State.	

MCUP3133 Wheelchair Mobility, Seating and Positional Components		
Policy Owner: Utilization Management – *Anna Campbell, MPH, Policy Analyst, UM,*		
☒ **Important Provider Notice (IPN)**	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ Other *(specify below):*
☒ **Configuration of HRP and/or Claims Editor System (CES)**	☐ Configuration of Essette/Jiva	

This policy was updated due to align with new DHCS terminology and a new benefit code K0462. **Section III.B. and C.** – The previous definition for "Custom Rehabilitation Equipment" was updated to define a new term, "Complex Rehabilitation Technology (CRT)." A new definition for a "CRT Supplier" was also added. **Section III.K. and L.** – The acronym and definition for a Qualified Health Care Professional (QHCP) was updated. The definition of a Qualified Rehabilitation Technical Professional (QRTP) was also updated. **Section VI.** - Language was updated throughout to reflect "Complex Rehabilitation Technology" or CRT in lieu of "custom rehabilitation equipment."	*Q/UAC voters posed no questions.* Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Randy Thomas, MD

[2] CPSP-like services that are equivalent to, or substantially similar to, the services defined by the California Department of Public Health-defined CPSP program.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.3. – Statement added to say, "Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device." **Section VI.D.** – In the section of Seating and Positional Component Coverage Criteria, our application of criteria 10-19 was clarified, and language was added to say "Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered." **Section VI.F. –** This section regarding Loaner Rental During Repair was updated to reflect new DHCS benefit coverage instead of Partnership's previous coverage as a Benefit Review and Evaluation Workgroup (BREW) benefit. Code K0462 for rental of a power wheelchair during extended repair will now be covered with no TAR requirement for up to two one-month rental periods per year.	*Approved unanimously* Next Steps: Nov. 4 PAC

VI. Presentations

MY 2025 National Committee on Quality Assurance (NCQA) Health Plan Rating and **5-Star Strategic Plan for Quality Improvement – 2026-2029**
Kristine Gual, PMP, CPHQ, Director of Quality Measurement, Quality Improvement

Kristine presented the Healthcare Effectiveness Data Information Set (HEDIS®) outcomes for the 2025 Managed Care Accountability Set (MCAS) to this committee in July.

Today, she circled back to talk about our NCQA Health Plan Rating. (She noted the timing is a little out of sync: we do not usually hear from NCQA with our final outcomes until late August or early September.) Our final HPR is 3-Stars. We did use the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey for the HPR in 2025, and our county ratings were nearly identical to 2024 (which was the first year that our 10 incoming counties joined the Plan), yet we saw a decrease from 3.5-Stars to 3-Stars. We are still working on regaining that lost ground. Everyone is encouraged to look at the white paper in today's packet under FYI for more information, including a county-level breakdown on all of the 44 measures that make up the HPR.

Neonatologist and Q/UAC voter Steven Gwiazdowski, MD, asked if there was a big factor that drove the Star rating down? Do we focus 80% of our effort on 20% of the systems to go back?

Kristine replied that one positive thing is we do have a nice alignment now between the MCAS measures set and the measures that are in the prevention population domain, although we have yet to see that result in a higher Star rating. That is such an area of focus for us: the measures like the well child visits, the vaccinations, the prenatal/postpartum care. Where we really need to improve is probably in the treatment domain: it is a little different from the MCAS measure set because it is very focused on chronic disease outcomes, behavioral health transitions of care, and care coordination. We know that we need to do more in terms of things like data completeness for our behavioral health transition of care measures. There are other chronic disease measures like statins that we are actively working on, folding those into programs like Academic Detailing.

Dr. Gwiazdowski continued: is there a way to align the provide incentives and crosswalk for the things that we want to change?

Kristine: Yes. It takes a while. It's like turning an ocean liner, but I think that is ultimately the plan. Dr. Moore added that, from a measure perspective, that is the way to think about it. If you look at it from a population or geographic perspective, basically, if you took the Bay Area counties, we would be a 4-Star plan; Bay Area plus the North, we would be a 3.5-star plan, but all three together, it is a 3.0. There's an opportunity to bring those new counties up to a higher level.

Kristine segued into the Five-Star Strategic Plan for Quality Improvement 2026-2029.

The last time we updated our strategic plan for the Quality Improvement department was in 2019. We are in a different world than we were back then, so it was definitely time for an update. There is a white paper that goes along with this presentation in the packet under FYI.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Every three years, Partnership updates its org-wide strategic plan, which looks at things much beyond the scope of quality improvement. This is in process right now with our Executive team and Board. They will come up with a set of "pillars," which have goals associated with them. The pillars are not yet defined, but in our last strategic plan we had a pillar for quality of care and health equity. We anticipate that there will be a similar pillar, and this is where we can see this QI plan located. There are many other departments' strategic plans going on now, including Health Equity and Member Experience. We all work together, and the idea is that everybody aligns; we may have different focus areas, but we are all moving in the same direction.

A little bit about the urgency of accelerating our performance at this time: we saw it in our health plan ratings that national trends in quality performance are outpacing Partnership. We are improving but not at the trajectory that we need to keep up with national Medicaid benchmarks or with performance by other California managed care plans. There is an enormous financial risk associated with this performance as well as to our members' health, which is really our mission. Finally, we want to see consistency across our network. We have a very diverse network, and performance on the quality plan is sometimes dependent on where you are located, what community you are part of, and so this is why that is related to equity.

Kristine then went through the plan's development process, which began in May with outside consultants, focus groups and interviews. We were able to develop a very comprehensive SWOT (Strengths, Weaknesses, Opportunities and Threats) as summarized in the white paper. We needed a criteria to bump that against so that we could come up with a focus plan that was achievable in three years. The criteria included member health and experience, regulatory and financial impact, and organizational capacity. We want to make sure that anything we decide to put time and effort into is sustainable, fits into our timeline and that we are able to have a regional approach. We are in the midst of our communications now and are interested in provider feedback on this plan. It will go to our Board on Oct. 28. Then we will go right into implementation, setting up tactical goals with the impacted departments and the provider network.

Kristine then went over the high-level strategic "aggressive" goals for the next three years. We can achieve these goals or make significant progress towards achieving all of them, she said. Improving member experience is actually a goal for our entire organization. Some needed metrics are getting needed care and getting care quickly. We want to perform at the 67th percentile or higher.

Our second strategic goal is around reducing avoidable utilization in things like ambulatory sensitive admissions. Our goal is to reduce by 10% or more annually plan-wide and to retain our actually high level of performance on hospital readmissions. This is where lower is better. We are currently performing at the 90th percentile. We want to retain that and keep that high performance. The final three strategic goals are around areas of preventive care: improving pediatric preventive care defined by well-child visits and immunizations, improving chronic disease outcomes like diabetes and hypertension, and improving timely access to prenatal care. This is consistent with what we shared this summer on our HEDIS® outcomes. Kristine noted our goal is to perform at the 67th percentile or higher in each of the three DHCS rating regions.

We have a special focus on our rural regions because we know this is where the need is greatest and on reducing health inequities. Composite key indicators that will show us we are moving in the right direction include our NCQA Star rating. We will start with moving from a 3-Star to a 3.5-Star and then onward up to 4 and then 5. Our second success measure is our Quality Factor Score on our MCAS measures. We don't yet have that information from DHCS to compare across California, but we will share when DHCS releases that information for 2025.

How will we focus? We have objectives and lead departments defined to move the needle on five strategic goals: access to care, provider experience, member experience, data analytics and organizational excellence and culture. In access to care, the idea is not only to strengthen our network capacity, it is also to expand alternative access models to meet the needs of the community, like telehealth and mobile units. Provider engagement is Quality's wheelhouse: building the capacity of the network towards high performance on the prior unprioritized quality measures. Our Member Experience department is focused on better understanding drivers and resolving some of the highest priority gaps in the member journey. Member engagement is focused on improving outcomes for high needs populations. for example, D-SNP, high-needs care coordination and CalAIM. Finally, we are able to provide retrospective analytics, but the idea is to include real time analytics that maximizes opportunities for closing care gaps and improving member health. Lastly, in this time of economic uncertainty, we want to make sure our resources as well directed and that we receive a return on investment for every initiative we launch.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Pediatrician and Q/UAC voter Randy Thomas, MD, asked for examples of efforts to improve chronic disease outcomes in pediatric measures. "Our family practitioners are wonderful, but as we are getting more and more obesity, more and more family practitioners are seeing children with Type 2 diabetes and sometimes think that you apply the same treatment that you do for adults to the children." Kristine expressed appreciation for his "great call out."

Kristine said this report and plan will be considered Oct.28 at the Board of Commission, after which this will be considered "final." We will then talk with our lead departments on finalizing smart goals around these different focus areas and building tactical plans. We will report annually on our progress. Kristine closed by inviting Q/UAC members to engage with our Quality Improvement Advisors and Provider Relations too, particularly on Member Experience and improving Health Equity.

Kristine said she is "thankful" for new Director of Member Experience Irem Conery and is eager to work with her to align QI and Member Experience efforts. Dr. Moore noted that Chief Executive Officer Sonja Bjork, JD, has reviewed this plan, and that her sole recommendation is that Behavioral Health be involved.

Health Equity Disparities Grand Analysis MY2025/RY2026 Summary of Performance
Mohamed Jalloh, Pharm.D., Director of Health Equity (Health Equity Officer)

Dr. Jalloh took a three-prong approach: a review of the Grand Analysis, his specific plan that Health Equity looking to do, and a preview of what our Health Equity Strategic Plan will be as well. He spoke about what we actually did well on this past year, what measures still require support, and then which to prioritize for the upcoming year.

Dr. Jalloh and team calculated these health disparities and assessed them according to both DHCS and NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation) accountabilities. He then did a statistical analysis on "estimated race," one actually done at the National Institutes of Health (NIH) and other organizations. Many members do not have any race designated with their name, he said, so for some they will have the race designated as "black" or "Hispanic/ Latino" but for some, it could be "other." So, we actually did a statistical technique where we estimated a race based upon a member's zip code, their name and other factors. (Keep in mind, we did this solely for this statistical analysis; we did not put this on people's individual profile.) And then the final thing we did is compare shared measures based upon the data that we were looking at. When we looked at the MCAS sample, we compared each race group to the Minimum Performance Level (MPL). And then when we looked at our QIP data, we also looked and compared everyone to our white community.

Dr. Jalloh then talked about the health disparities seen in five organizational and Quality MCAS measures of focus. He was particularly "excited" to see that blood pressure control – below the MPL threshold for all race groups in MY2024 – improved to above the MPL for nearly all race groups in MY2025. While we didn't achieve that with our tribal community, they are trending upward. Four disparities were eliminated, four improved, and no disparities worsened. CHW-Barber Program Charter development launched in 2026 and Academic Detailing may have played a big factor here, he noted.

In HbA1c Poor Control, (where the lower number is better), we have seen improvement across all race groups and are excited to see our Asian/Pacific Islander and our Hispanic/Latino communities cross the MPL threshold.

The final one Dr. Jalloh pronounced "interesting" was postpartum care visits and the mostly positive change from the previous year. This is one where we actually had a textbook definition of health disparity where most all the race groups were actually doing very well, but then when we looked at our black community, they were not doing well in MY2024. They were not at the MPL. We did some additional work and the black community improved 6% to the 82.72 percentile, meeting the State's MY2025 threshold.

Dr. Jalloh then segued into measures where we typically see health disparities. In adolescent immunizations, Asian/Pacific Islanders and Hispanic communities have both been consistently above the State's MPL and have actually improved these past two years. Our black and our white communities have improved but still do not meet the threshold. The one community that actually worsened is our American Indian/Alaska Native or "tribal" community. They are trending downward where everyone else is trending upward.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

When we looked at timely prenatal care, all but our tribal community trended up, although only the black and Hispanic communities broke the MPL threshold. The tribal community is actually trending downward.

In the child and adolescent well care visits, we see our Hispanic community consistently (perform above the MPL. Our Asian/Pacific Islanders were not at the minimum in 2024 but now they are. Our black and white communities also trended upward, but our tribal community trended down compared to the previous year.

Dr. Jalloh included a secondary MCAS Measures of Focus for Disparities as Appendix A to his presentation about which he said there is likely a systems issue at play. For example, in cervical cancer screening, all race groups are below the MPL and actually worsened this past year. So, there may be more a systems issue that is driving this versus something specific to one race group or another. Similarly, breast cancer screening decreased in all race groups; however, Asian/Pacific Islanders and Hispanics remained above the MPL. For chlamydia screening, we improved across all race groups but none reached the MPL. When we looked at childhood immunization status, the one group that actually performed worse, where others performed better, is our black community, which is below the minimum and trended downward. With lead screening, we improved across the board, and only our tribal community is still below the MPL. Lastly, our white and tribal communities trended downward for well child visits in the first 15 months of life while the other groups trended up and met the MPL.

We did a review of our MCAS data when we did our HEDIS® assessment, and Dr. Jalloh did a review of our pay-for-performance data where we actually have a separate data set for participating organizations. We have seen this data is very robust where we are not limited by sample size, he said. We have all the measures stratified by race, but you may see that the race stratifications are different compared to the ones that we have for our HEDIS® measures.

So, one may wonder, 'well, we have so many disparities, which ones are we likely to prioritize?' Dr. Jalloh said he would be happy to say more offline, but said we essentially identified looking at two data sets, the QIP data set and the HEDIS® data set that we just reviewed. When we looked at them separately, we came up with an assessment identifying should we act on that disparity, plan upon it, monitor, or not do anything? We think there is a system issue likely driving these measures, including cervical cancer and chlamydia screenings and topical fluoride, because no race or linguistic group has met the State's MPL. So that's why we didn't really want to spend too much energy on trying to initiate targeted interventions that we would do for the other disparities.

Dr. Jalloh quantified the impact of what we have been doing as an organization. He calculated 46 disparities across 2024 measures simply by looking at how many were below the MPL. We were able to address 19 of these in 2025, which he said is "impressive" for a health plan. DHCS has bold goals they want us to meet, and we were able to meet three of them this past year. Focusing on only the top five measures that the QI team wants to focus on, 23 disparities were identified in MY 2024, and we addressed 10 of them in MY 2025.

Pop Health and Health Equity have separate work plan, Dr. Jalloh noted. Health Equity's is geared toward the health disparities themselves. (This workplan is in today's meeting packet. Pop Health's focuses on the cultural and linguistic activities that we must do for NCQA.) The Heath Equity workplan is somewhat extensive because we have our NCQA Health Outcomes Accreditation activities that we have to notate. Our entire 2026-2027 annual work plan is on pp. 355-357. Page 359 in somewhat of an overview of our health equity strategic plan. We also understand that this is a perfect time to align with our QI team, but what we ultimately did is provide a view of their mission as well as what the long term vision is for the Health Equity Strategic Plan for the organization.

We have three core strategies that we are going to implement to help as many of the health disparities as we can. The first is to increase members' health literacy and motivation to access, understand and apply accurate health information to make informed judgments regarding disease prevention and treatment. Two, we want to equip local communities, especially where they are dense with health disparities, with resources to provide basic Medi-Cal navigation, as well as to help empower them to co-design community-based solutions. Three, we want to try to focus on working with our health systems to increase access to excellent quality multilingual services and help ensure that we have diverse practitioners, ancillary staff, community health workers, doulas, helping our members in the community.

Dr Moore commented: for those measures where the Native American population is dropping, I remember that in prior years, we noted that where performance was lower in certain groups, it was often not a reflection of some group-within difference, but it was the PCP that was providing care was deficient in their quality. Dr. Jalloh replied that a preliminary assessment suggested that one provider is indeed a big driver in the tribal population, and that this is reminiscent of a past situation

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

in the African American community where when one large provider was low, thus driving down total performance.

Neonatologist and Q/UAC voter Brian Montenegro, MD, wondered if the universal improvement in A1c indicated mass use of GLP-1s? What's going on?, he asked. Dr. Jalloh relied that we recognize that when we went through the expansion, our data trended down. But today, looking at 24 counties against 24 counties? Maybe our data is improving with Datalink whereas before we relied on manual submissions.

Dr. Montenegro said it stands out for him because "it's a diet and lifestyle thing and that's very difficult to get people to change despite access." Family Medicine physician and Q/UAC voter Jennifer Wilson, MD, commented that many clinics now have access to in-house A1c testing, so one is not dependent on sending someone out to the lab to be able to get the value. So, a value, like not having an A1C, is the same as not having it controlled. She said she thought those to be details worth capturing.

Kristine Gual agreed: speaking from the data completeness perspective, one thing to remember is the rate for diabetes A1c and controlling blood pressure for people with hypertension is these are still hybrid measures. We are still taking a random sample of charts, 100 per county if we can get them, to come up with these annual rates. And so, this is why our annual HEDIS® rates are still not based on the entire population, but that is something we are moving towards within the next few years. This is actually nationally mandated. These measures are converting to what is called ECDS and basically must include the entire population. So, there is some transition going on. We are being proactive: DataLink is part of that. The idea that a point-of-care test, even if it is not submitted with a CPT2 coding, can now be extracted from an Electronic Medical Record (EMR) and brought into our HEDIS® engine to actually do rate reporting. That's what I mean when I say that, opposed to retrospective data, having these current year updates that we can use in real time to really look at our progress is going to be much more sophisticated way of monitoring across the network.

Isaac Brown added that with the new counties, we are just seeing overall improvement in some of these areas. We have got a good QIP in place to some support them that they didn't have previously.

Pediatrician and Q/UAC voter Randy Thomas, MD, asked how much do we need to increase the Asian/Pacific Islander and Hispanic population to get to 4-Stars? Dr. Jalloh replied that is a data question that he could perhaps bring to the data team to see if they have sample size estimates. Kristin said this was a good point, and we know we will see big population changes over the next year: we will see an impact on our quality scores as well as challenges around access. We do have some headwinds, but that makes the strategic planning we are doing all the more important.

Dr. Moore added that the new federal Office of Management and Budget (OMB) requirements that have to be implemented by 2029 for basically changing the way that California addresses the Hispanic ethnicity group is going to dramatically decrease the individuals in that category and increase all the other categories: kind of scrambles all the math instantly and make any kind of comparisons difficult, he said. DHCS is moving very slowly to implement that.

Brian Montenegro. MD/Jennifer Wilson. MD to approve and accept the Grand Analysis. Motion unanimously carried.

VII. Adjournment to 7:30 – 9:00 a.m. Nov. 18, 2026

Dr. Netherda adjourned the meeting at 9 a.m.

Respectfully submitted by: Leslie Erickson, Program Coordinator II

Signature/Date of Approval:

Mark Netherda, MD
Medical Director for Quality and Committee Vice Chair

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
OCTOBER 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** • CG-CAHPS results from Press Ganey have been received. Survey reports will be shared with providers in early October • The 2025 PCP QIP Evaluation will be presented in October's committee meetings
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 for 2026 Measure Period I (January 1 – June 30) is being finalized and is on track for payment distribution by September 30, 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** • Preliminary Payment Summaries were sent to providers for the 2025-26 Measurement year. Work continues within the DataLink workgroups to validate how to utilize the data received to help score the perinatal providers for timely prenatal visits with depression screenings. The PQIP is inviting several more providers to join the PQIP in 2027, which includes several Tribal Health Providers across our network.
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** • The 2027 ECM QIP measurement set was presented and approved at the Physician's Advisory Committee this month. Because there are upcoming ECM changes by DHCS which may affect the ECM QIP, the 2027 measurement set will remain the same as the 2026 measurement year.

	• Plaques were ordered for five 2025 Top Performers and will be distributed next month. • Measure scoring for 2nd quarter 2026 begins the last week of September with final payment distribution scheduled for end of October.
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** • With all submissions submitted for the 2025-26 measurement year, the hospitals' preliminary scores were calculated throughout the month, and hospitals will receive their Preliminary Payment Summary in the beginning of October. A Hospital Quality Symposium Planning Committee has been created to prepare for the 2027 HQS, which will be held on June 15th and 17th 2026. Part of the HQS will honor Dr. Moore's contributions to hospital quality.
EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	**Program Overview** The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • The 2027 EXT QIP measurement set was presented and approved at the Physician's Advisory Committee this month. Changes include adding a California Immunization Registry (CAIR) entry to the CMS influenza and pneumonia vaccination measures and a new Health Equity Impact Analysis and Plan measure. • Performed outreach this month to facilities showing no QAPI Plan and Attestation form submissions.

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

	Program Update • No updates
ECDS PROJECT (DATALINK)	**Program Overview** The Electronic Clinical Data Set (ECDS) Datalink Scaling Project (DataLink) is designed to transition Partnership from a successful pilot program to an enterprise-scale clinical data strategy that supports NCQA's move toward ECDS reporting, improves quality performance reporting, reduces reliance on manual chart review, and creates a sustainable interoperable clinical data asset across Partnership's provider network. Through governance, provider onboarding, data validation, and expanded use of structured clinical data, the project aims to improve quality measure reporting, mitigate regulatory and financial risk, and establish Datalink as a scalable long-term solution for quality measurement and population health initiatives. Partnership has prioritized receiving clinical data for members in eligible populations for high-priority HEDIS measures that have transitioned or are in process of transitioning to ECDS measures: • Childhood Immunization Status: Combination (CIS-E) • Immunizations for Adolescents (IMA-E) • Chlamydia Screening (CHL) • Lead Screening for Children (LSC-E) • Cervical Cancer Screening (CCS-E) • Colorectal Cancer Screening (COL-E) • Breast Cancer Screeening (BCS-E) • Controlling High Blood Pressure (CBP) • Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) **Program Update** • 246,714 distinct members are currently represented in the DataLink data across the service area. • 6 of 24 counties have reached the MY2026 target of 33% of county membership within the data pulls (approximately the population share represented by the measures listed above). • 7 additional counties are within 5 percentage points of the 33% target. Provider onboarding and data exchange expansion remain key priorities, alongside a significant effort to validate, monitor, and operationalize incoming clinical data to ensure data quality, reporting readiness, and sustainable integration into quality measurement and operational workflows. These activities are particularly focused on underperforming counties where several high-volume PCP organizations remain in discovery, onboarding, or have not yet begun implementation.

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** • No New Update.
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** ***Strategic Shift in Approach to Quality Measure Performance Improvement (QMSI)*** QMSI workgroups have historically served as a cross-functional driving force for plan-wide HEDIS measure score improvement. Earlier in 2026, the Performance Improvement (PI) Leadership team, in coordination with our HEDIS Data Team, evaluated accountable measure performance across our 24-county footprint and identified priority measures by geography that needed to be prioritized according to several factors, including financial risk. At that time, leadership decided that performance varied enough by geography that a regionally focused strategy was needed. Additionally, it was recognized that the primary lever for improvement is through Partnership's already established improvement coaching program. To support this shift, QMSI will evolve to support regional improvement work and improvement coaching through 1) Serving as subject matter experts in their family measure domain (e.g. pediatrics, chronic disease, women's health, and behavioral health) and 2) Provide support to regional improvement teams as needed. The cornerstone activity of supporting regional coaching teams is for QMSI workgroups to develop measure-specific improvement toolkits for high-priority improvement measures of focus. These toolkits will serve as resources for the improvement coaches to use when a provider wants to do measure specific improvement. Going forward, this report will be reorganized to better align with shifting strategies and accountability. **Workgroup Updates** • Measure Specific toolkits are drafted and being reviewed by PI Managers
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

Performance Improvement in Action
Program Overview
The Performance Improvement in Action training helps participants move from identifying problems to testing real solutions, guiding participants through the full quality improvement process using a real challenge from their site. Participants learn how to define a strong problem statement, understand the current state of the issue through observation, and analyze contributing factors using tools such as Pareto charts, and the Five Whys. The series then focuses on developing practical change ideas and testing them through a Plan-Do-Study-Act cycle.

Program Update: A pilot is currently in progress

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

Program Update: No new update

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 new 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: No new update

	Microlearning **Program Overview** These short, focused modules deliver key concepts in easily digestible formats. **Program Update:** No new update
JOINT LEADERSHIP INITIATIVE (JLI)	**Program Overview** The Performance Improvement team facilitates Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. **Update:** No new updates
REGIONAL IMPROVEMENT MEETINGS	**Program Overview** Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that are regionally important and learn from Partnership regarding any program changes and/or priorities. **Update:** No new updates

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
EQUITY & PRACTICE TRANSFORMATION PROJECT	**Program Overview** The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19-driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care. Currently, 22 providers are participating in the EPT Program, with total estimated funding of $13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable

	practice transformation. The last and final opportunity to submit eligible deliverables for milestone achievement is in November 2026 when the program concludes. Payments for the November 2026 successfully completed milestones will be paid out early 2027.
	
	Program Updates
	• The final EPT submission cycle is underway (October 1 – November 2). Providers may submit outstanding milestones from prior cycles, along with final performance-based milestones tied to Assigned & Seen KPI's and Population of Focus HEDIS-like measures.
	• October Learning Community sessions are focused on sharing lessons learned, highlighting practice successes, and preparing providers to sustain improvement efforts after the program concludes.
	• The EPT program officially concludes for provider practices in November 2026, however, MCPs are still required to submit a MY2026 data deliverable in 2027 to determine payment eligibility for practices who met the 90th percentile in their Population of Focus HEDIS-like measures.
	
	Data Updates
	• Two Partnership-sponsored practices achieved milestone-eligible performance at or above the 90th percentile for MY2024 measures:
	  ○ Ampla Health for Depression Screening.
	  ○ West County Health Centers for Well-Child Visits in the First 15 Months of Life.
	• Several additional Partnership-sponsored practices achieved 90th percentile performance on individual measures but were not eligible for milestone payments due to Population of Focus requirements or minimum denominator thresholds.
	• Partnership submitted MY2025 data to PHLC in August. Review of submitted MCP data is nearing completion.
	• Draft guidance for MY2026 data submission has been released, with final MCP feedback expected to inform the reporting requirements and timeline for 2027 data processing.

EXPANDED COUNTIES REINVESTMENT IN QUALITY (E-RIQ)	**Program Overview** *The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic $2 million investment to improve health outcomes and member experience across the ten expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter.* *Funding is allocated through two pathways:* • ***Phase I: $500,000 (****$50K allocated to each county) to strengthen community-based engagement and access across priority focus areas* • ***Phase II: $1.5 million*** *for Provider opportunities to drive measurable improvements in quality priority measures through targeted initiatives and activities.*

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Program Updates:

- ***Phase I:*** All 10 counties applied, 9 have received awards, 1 is revising their application.
- ***Phase II:*** 22 providers have been invited to the September 28 informational webinar launching the program. Applications will be accepted through October 30.

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<tr><td>Mobile Mammography Program</td><td>

Program Overview

The Mobile Mammography Program Aims to boost breast cancer screening (BCS-E) 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

<table>
<tr><th colspan="3">Event Days
07/01/2026 – 12/31/2026</th></tr>
<tr><th>Region</th><th># of Provider Event Days</th><th># of Community Event Days</th></tr>
<tr><td>Auburn</td><td>4</td><td>0</td></tr>
<tr><td>Chico</td><td>12</td><td>1</td></tr>
<tr><td>Eureka</td><td>17</td><td>0</td></tr>
<tr><td>Fairfield</td><td>8</td><td>0</td></tr>
<tr><td>Redding</td><td>12</td><td>0</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>0</td></tr>
<tr><td>Plan Wide</td><td>57</td><td>1</td></tr>
</table>

- Planning for November to December 2026 in progress.

</td></tr>
<tr><td>Partnering For Pediatric Lead Prevention Program (PPLP)</td><td>

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

</td></tr>
<tr><td>Abbott Cancer Diagnostics:</td><td>

Program Overview

</td></tr>
</table>

Promoting Colorectal Cancer Screenings	Abbott Cancer Diagnostics, formerly known as Exact Sciences, continues to work directly with providers to support care-gap orders for Cologuard kits. These care-gap orders no longer have a 300 patient minimum.
	
	Providers interested in placing a care-gap order should contact their Abbott Cancer Diagnostics representative. Providers who are unsure who their representative is may contact Abbott's support line at 1-844-870-8870 or complete the online contact form at https://www.cologuardhcp.com/contact-us.
	
	Partnership's Cologuard Care-Gap Orders page continues to be available as a resource for general information.
	
	Since a minimum is no longer required for care-gap orders, Partnerships facilitated orders will be discontinued after our current offering (further details below). If you have any questions, please reach out to the Performance Improvement team at PIT@partnershiphp.org.
	
	Program Updates
	• Partnership's last facilitated order launched on 07/20/2026 with a final submission date of 08/17/2026.
	  ○ Three provider organizations participated including Providence, Achieve Community Health Center, and Dignity Health St Elizabeth.in
	  ○ Pre-shipment patient letters were mailed on 09/18/2026 with the kits shipping on 09/28/2026.

Shasta County Drive-thru Flu Clinic	**Project Overview** Each year, Shasta County Public Health organizes a free community-wide influenza vaccination event, made possible by grant funding. This annual event plays a dual purpose. First, it helps Shasta County PH practice and evaluate mass vaccination operations in preparation for a potential pandemic while also increasing community access to the flu vaccination. Partnership plays a key role in supporting this event by providing the venue, assisting with marketing and outreach activities, identifying populations of focus to help improve HEDIS and QIP performance rates, and providing nursing staff to administer vaccines during the event day. **Project Update** • This year's annual Shasta County Drive-Thru Flu Clinic is scheduled for Saturday, October 17, 2026 from 10 a.m. to 2 p.m. at Partnership's building, located at 351 Hartnell Ave, Redding, CA 96002. If you have any questions regarding this event, please reach out to Chandler Ackerman at cackerman@partnershiphp.org.

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
	• All QI Trilogy documents (FY2026/27 QI Program Description; FY2025/26 QI Work Plan; FY2025/26 QI Evaluation; and FY2026/27 QI Work Plan) have been submitted reviewed and approved by the following Committees: and Board approval. Scheduled review and approval dates area as follows:
	  • Internal Quality Improvement (IQI) Committee – 08/11/2026
	  • Quality Utilization Advisory Committee (Q/UAC) – 08/19/2026
	  • Physician Advisory Committee (PAC) – 09/09/2026
	  • The documents are to be submitted to the Board of Directors for review and approval on– 10/28/2026.

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** • Partnership will begin coordination activities for the July – December Progress Check-In with K'ima:w by November 2026.
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. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site.

	Program Update • No new update
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 08/19/2026 TO 09/25/2026	**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** • 30 referrals were received with 27 coming from Grievance and Appeals, 1 from a Associate Director, 1 from a Regional Medical Director and 1 from Utilization Management • 42 cases were processed and closed • 91 cases are currently open • Three cases were discussed at Peer Review Committee (PRC) on 9/16/2026 and there are four cases awaiting PRC review. • One case was sent to an external Subject Matter Expert for review. • Two nurses provided an overview of the PQI process to the HEDIS team on September 23, 2026.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No new updates
HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)	
ACTIVITY	**UPDATE**
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members.

	Program Update • No updates
HEDIS® Program Overall	**Program Updates** • NCQA has published the MY2025 Health Plan Ratings on September 15, 2026. Partnership received 3.0 Stars for its MY2025 performance. • The MY2025 Annual Summaries of Performance for NCQA Health Plan Accreditation and DHCS MCAS Measure Set have been published on the Partnership website.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be Health Plan (HP) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • Partnership's NCQA Health Plan Accreditation renewal survey is scheduled for October – November 2026.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update** • No new updates

Health Equity Disparities Grand Analysis

MY2025/RY2026 Summary of Performance

Presented by:

Mohamed Jalloh, PharmD, Director of Health Equity

Outline

- Review of Managed Care Accountable Measures (MCAS)
- Review of MY2025 MCAS Improvements in Disparities
- Review of MY2025 MCAS Measures that Need Support
- Review of MY2025 QIP Measures
- Prioritization and Annual Plan Review

MCAS: Accountable Measures MY2025

Domain	Measure	
Behavioral Health	FUA-30	F-Up after ED Visit for Substance Use
	FUM-30	F-Up after ED Visit for Mental Illness
Pediatric	WCV	**Child & Adolescent Well Care Visits****
	CIS-E	**Childhood Immunizations****
	DEV	Developmental Screening in 0-3yrs
	IMA-E	**Immunizations for Adolescents****
	LSC	Lead Screening in Children
	TFL-CH	Topical Fluoride for Children
	W30+6	**Well Child Visits: 0-15 Months****
	W30+2	**Well Child Visits: 15-30 Months****

Domain	Measure	
Chronic Disease	GSD	**Hemoglobin A1c Poor Control (>9%)****
	CBP	**Controlling High BP****
	AMR	Asthma Medication Ratio
Reproductive /Cancer Prevention	BCS-E	Breast Cancer Screening
	CCS-E	Cervical Cancer Screening
	CHL	Chlamydia Screening
	PPC-Pre	**Timeliness of Prenatal Care****
	PPC-Post	**Postpartum Care****

** Designates a Quality Withhold measure

- 18 measures in MY2025
- All 18 measures from MY2024 continue in MY2025
- Accountable measures must meet or exceed the Minimum Performance Level (MPL) (i.e. 50th percentile national Medicaid percentile) to avoid sanctions
- Quality Withhold Measures must show significant year-over-year improvement or exceed 67th percentile for full points
- Community Reinvestment additional 5% triggered by 1+ measure < MPL in each measure domain

Methodology

Measure Identity

MCAS measure stratification per DHCS and NCQA Needs

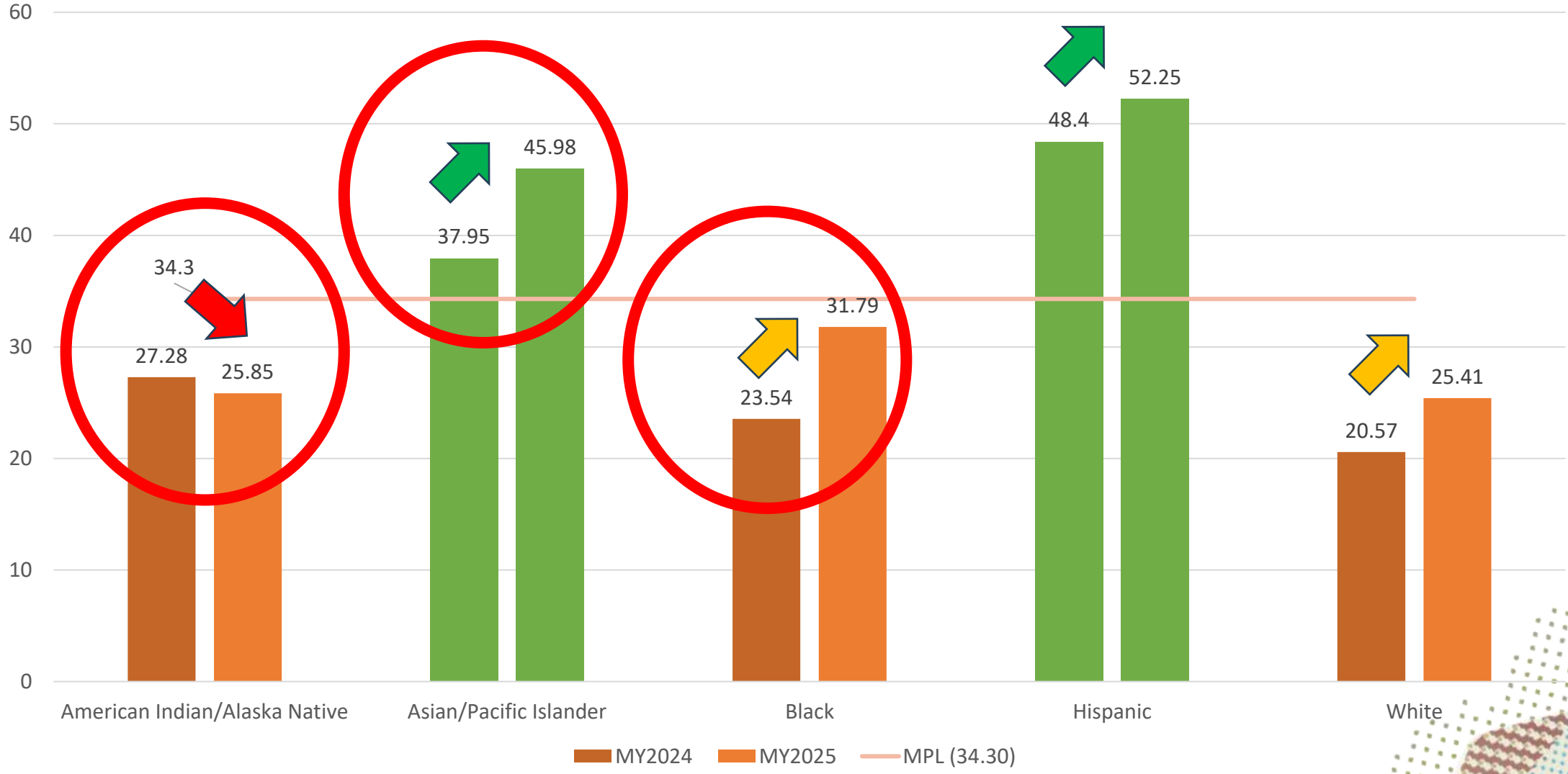
Measure Calculation

Health Analytics Statistical Analysis using “Estimated Race” (Race Stratification)

Measure Prioritization

MCAS measure comparison with MPL (MCAS Sample)	QIP measure comparison with white population (QIP)

Example Measure Evaluation



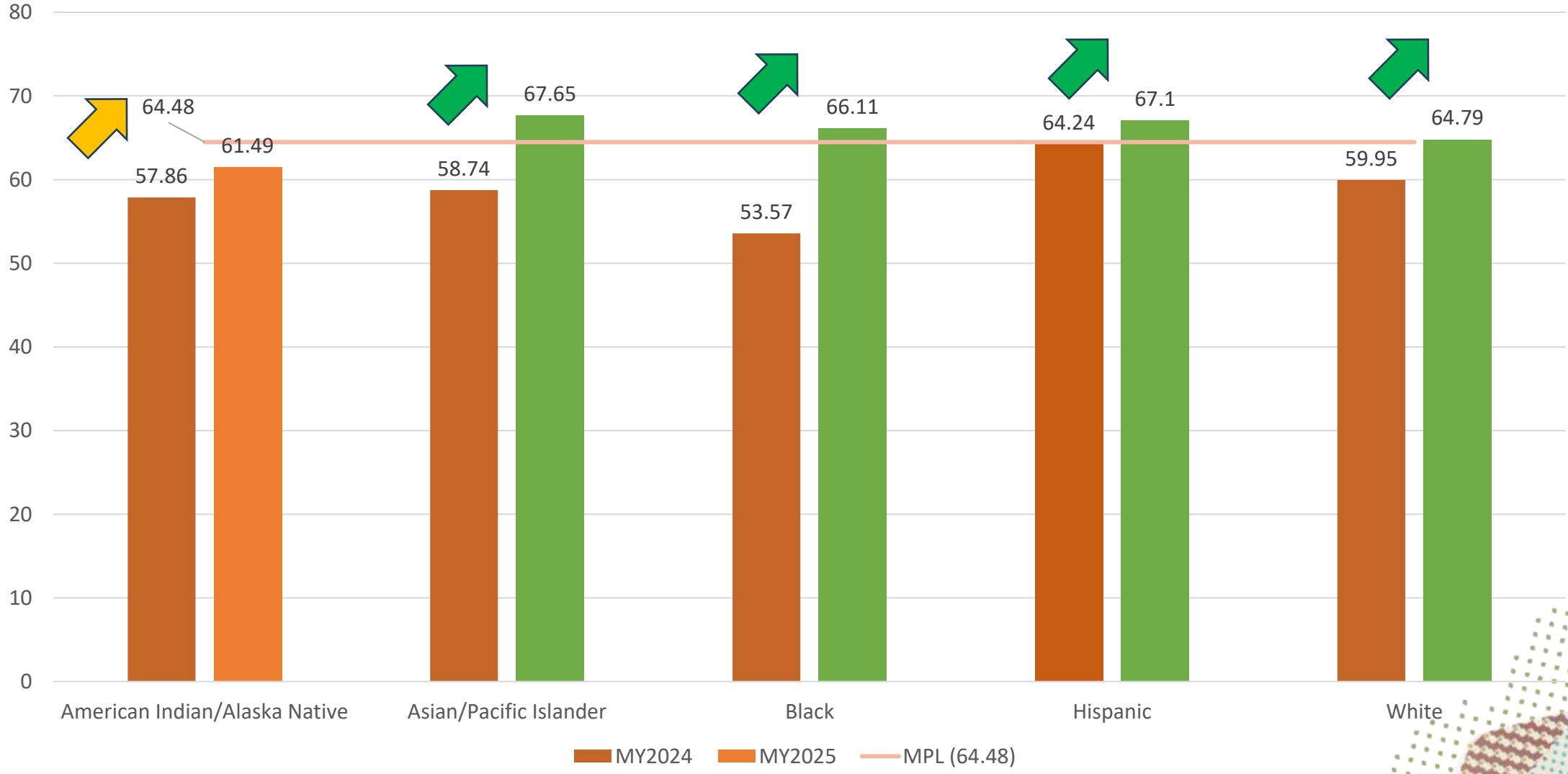
Organization Quality MCAS Measures of Focus

- Child and Adolescent Well Care Visits (WCV)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for People with Diabetes (GSD)
- Adolescent Immunizations (IMA-2)
- Timely Prenatal Care (PPC-PRE)



Review of MY2025 MCAS Improvements in Disparities

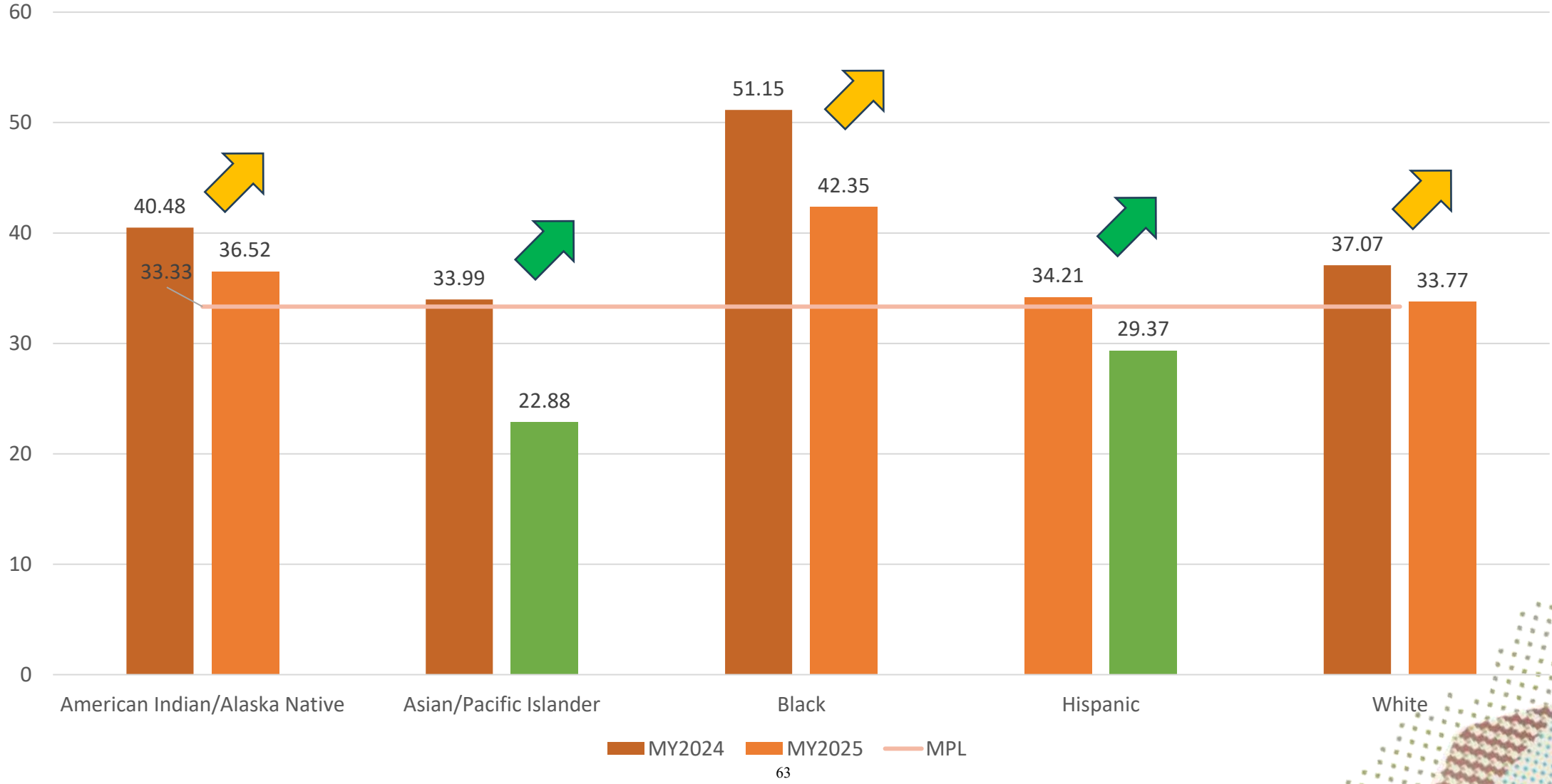
Controlled Blood Pressure (CBP)



Preliminary Impact Analysis for CBP

- Four Disparities Eliminated; Four Disparities Improved; Zero Disparities Worsened
- CHW-Barber Program Charter Development (Launched in 2026); Academic Detailing
- Health Equity Pay-for-Performance (QIP) Bonus launch

HbA1c Poor Control (>9%) (GSD)



Preliminary Impact Analysis for GSD

Two Disparities Eliminated; Five Disparities Improved; Zero Disparities Worsened

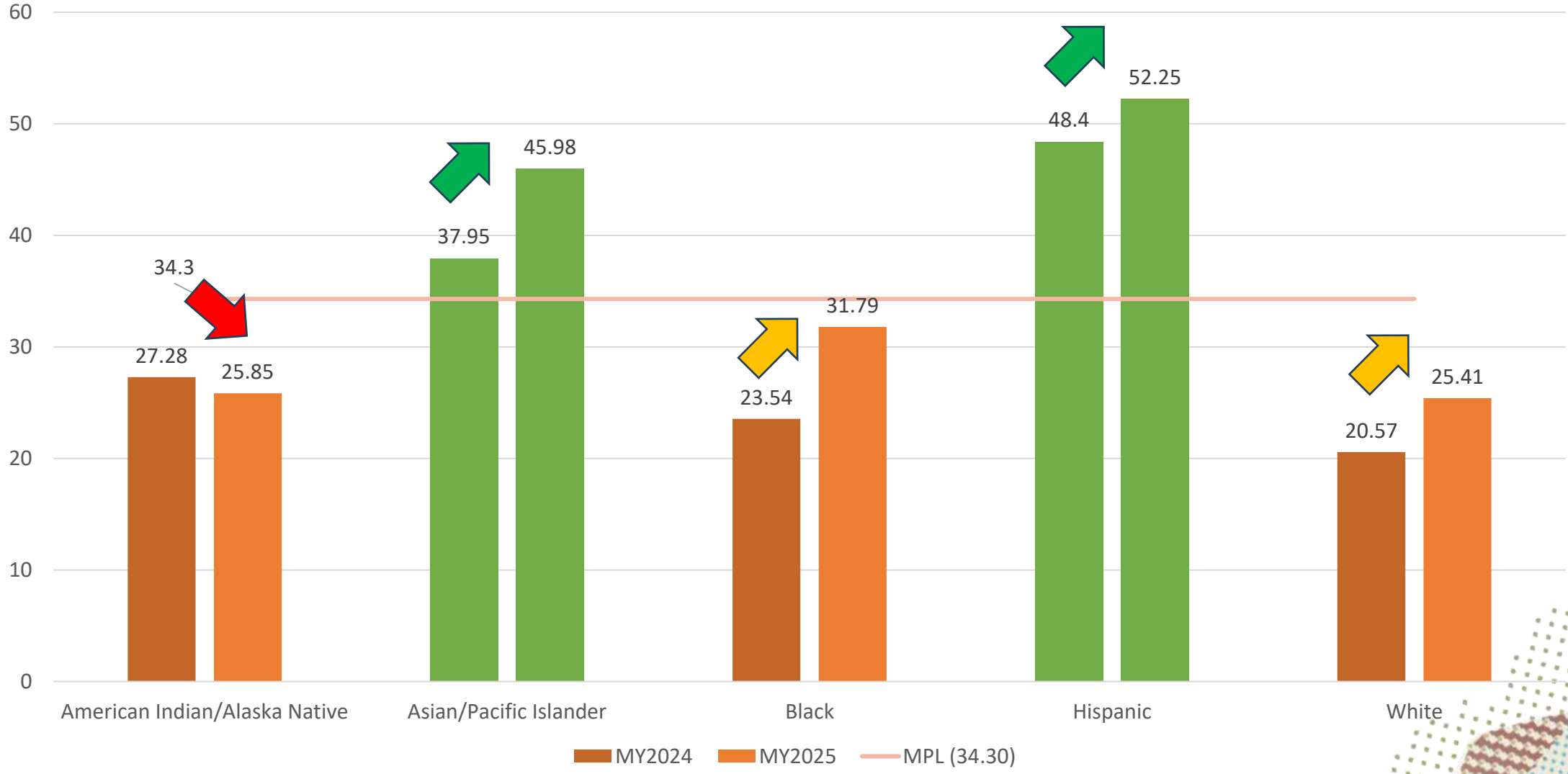
Academic Detailing

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Prenatal and Postpartum Care: PostPartum Care (PPC-POST)	**86.9** (~+6%)	**90.2** (~+4%)	**82.72** (~+6%)	**92.07** (~+2%)	**83.93** (~+1%)



Review of MCAS Measures That Continue to Need Support

Adolescent Immunizations (IMA-2)

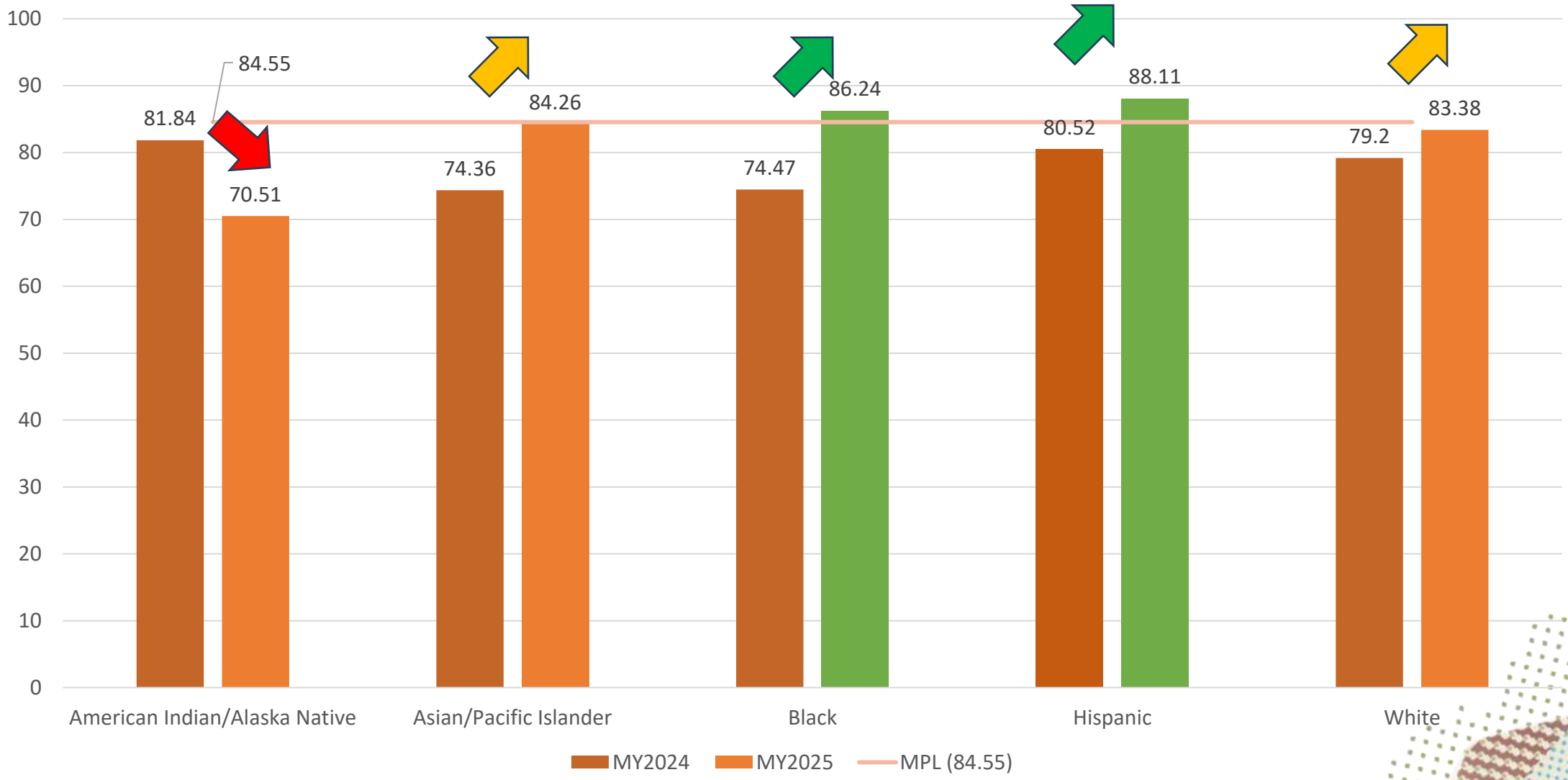


Preliminary Impact Analysis of IMA-2

Zero Disparities Eliminated; Two Disparities Improved; One Disparity Worsened

Focus Groups Planned but not executed in CY2025

Timely Prenatal Care (PPC-PRE)



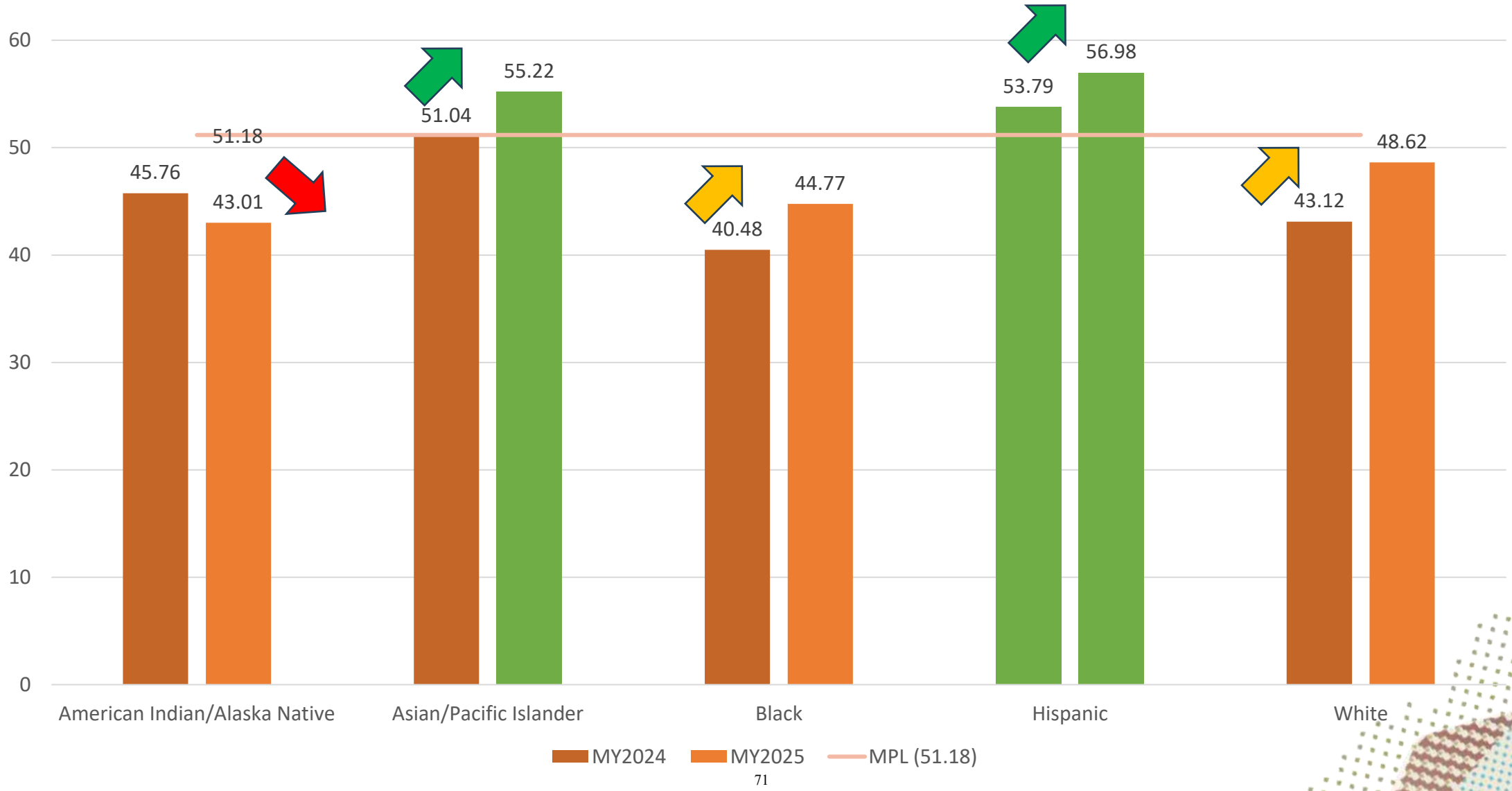
Preliminary Impact Analysis of PPC-PRE

Two Disparities Eliminated; Two Disparities Improved; One Disparity Worsened

Tribal Perinatal Program Recruitment

Maternal Photoshoots Pilot; Perinatal Growing together Program in MY2025

Child and Adolescent Well Care Visits (WCV)



Preliminary Impact Analysis of WCV

One Disparity Eliminated; Two Disparities Improved; One Disparity Worsened (3 Disparities Total)

Healthy Babies Growing Together Program (GTP) Member Incentive continuation in MY2025

Health Equity Pay-for-Performance (QIP) Bonus launch in MY2025



Review of Additional Notable MY2025 MCAS Measures

Appendix A: Secondary MCAS Measures of Focus for Disparities

- Childhood Immunizations (CIS-10)
- Lead Screening (LSC)
- Post-Partum Care (PPC-POST)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Breast Cancer Screening (BCS)	**42.57** (~-2%)	**55.44** (~-2%)	**45.32** (~-5%)	**66.44** (~-3%)	**46.31** (~-2%)
Cervical Cancer Screening (CCS)	**43.56** (~-2%)	**45.76** (~-9%)	**45.1** (-5%)	**53.35** (~-5%)	**44.66** (~-2%)
Chlamydia Screening	**55.22** (~+1%)	**58.08** (~+4%)	**67.32** (~+3%)	**55.22** (~+3%)	**54.56** (~+2%)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Childhood Immunization Status - Combination 10 (CIS-E)	**13.42** (~+5%)	**35.75** (~+1%)	**16.72** (~-2%)	**37.29** (~-2%)	**18.7** (~+6%)
Lead Screening (LSC)	**57.64** (~+5%)	**76.78** (~+5%)	**66.7** (~+5%)	**79.2** (~+5%)	**66.22** (~+5%)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Well-Child in First 15 months	**49.39** (~-12%)	**71.5** (~+7%)	**60.72** (~+7%)	**71.5** (~+1%)	**59.4** (~-3%)

2025 Pay for Performance Data Analysis

Measure Name	ASIAN/ PACIFIC ISL..	BLACK	EAST ASIAN	HISPANIC	NATIVE AMERICAN	OTHER	SOUTH ASIAN	SOUTHEAST ASIAN	UNKNOWN	WHITE
Breast Cancer Screening	54.12	51.41	48.12	69.38	45.53	53.50	58.99	59.26	51.91	49.11
Breast Cancer Screening Monitoring	42.59	37.49	50.32	55.91	35.52	43.58	53.88	48.24	42.67	39.52
Cervical Cancer Screening	52.53	53.44	50.54	67.36	46.86	59.32	59.02	55.81	53.88	50.63
Child and Adolescent Well Care Visits	58.86	50.06	61.71	64.97	50.18	58.56	72.79	55.85	58.76	51.29
Childhood Immunization Status CIS 10	25.23	19.89	27.27	33.56	9.76	20.87	41.41	19.23	20.70	13.50
Chlamydia Screening	16.76	33.00	15.04	28.61	30.63	21.83	14.82	19.01	23.77	26.54
Colorectal Cancer Screening	41.17	35.46	47.39	48.24	29.76	44.76	44.45	47.35	39.12	37.80
Controlling High Blood Pressure	62.72	62.10	68.75	70.52	57.29	68.61	68.28	68.74	64.89	63.18
Diabetes - HbA1C Good Control	71.17	68.73	84.82	75.35	66.35	76.50	80.99	81.14	71.07	71.57
Diabetes - Retinal Eye exam	61.35	53.75	68.75	67.44	49.20	60.48	57.32	63.02	58.07	53.80
Immunization for Adolescents IMA 2	40.74	31.61	38.78	51.87	28.57	31.36	54.95	37.29	28.00	24.19
Lead Screening In Children	84.72	65.12	44.44	82.34	72.41	71.71	84.26	82.05	69.89	67.39
Topical Fluoride in Children Monitoring	6.99	10.18	5.00	14.35	4.08	7.30	9.41	12.24	7.07	5.82
Well Child 15-30 Months	76.14	55.68	66.67	80.68	52.63	67.00	90.00	75.00	70.66	65.30
Well Child First 15 Months	63.24	49.65	66.67	65.93	43.06	48.53	66.13	55.81	54.53	49.35

Partnership Disparity Classifications

Below MPL (HEDIS Sample)
And
Below White Group (QIP)
(Act)

Above MPL (HEDIS Sample)
And
Below White Group (QIP)
(Monitor)

Disparity Prioritizes

Below MPL (HEDIS Samp
And
Above White Group (QIP)
(Plan)
(Quality Concern if White is below MPL)

Above MPL (HEDIS Sample)
And
Above White Group (QIP)
(No Change)

Likely Quality Measure Concerns

Cervical Cancer	Chlamydia Screening	FUM/FUA
Breast Cancer Screening***	Topical Fluoride	Asthma Med Ratio***

Health Equity Executive Measure Assessment (Total Number of Disparities)***

MY2024 (RY2025)

- **Approx Number of Disparities: 46*****
- Number of Disparities Addressed: **N/A**
- DHCS Maternity Bold Goals Achieved (Maternity Care for BIPOC: **Zero**
- DHCS Child Bold Goals Achieved (Well-Child Visit: **One**
- DHCS Child Bold Goals Achieved (Childhood Immunization: **Two**

MY2025 (RY2026)

- **Approx Number of Disparities**: **25*****
- Number of Disparities Addressed: **19 Disparities****
- DHCS Maternity Bold Goals Achieved (Maternity Care for BIPOC: **Three**
- DHCS Child Bold Goals Achieved (Well-Child Visit: **Two**
- DHCS Child Bold Goals Achieved (Childhood Immunization: **Two**

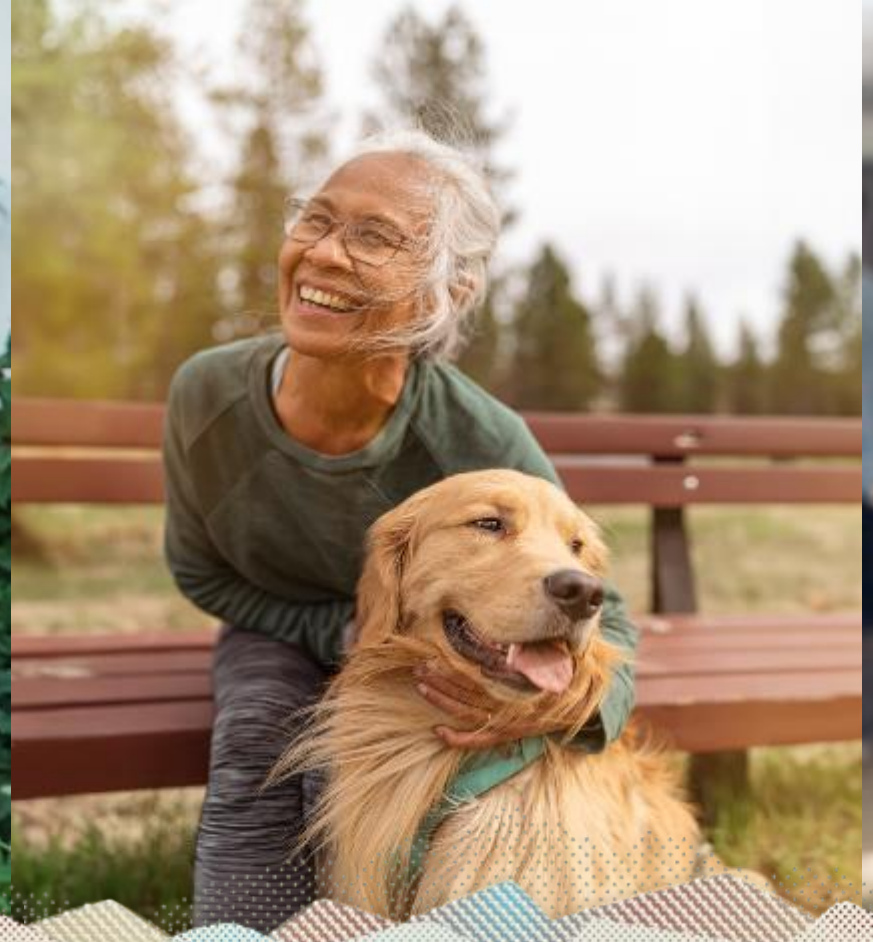
Health Equity Executive Measure Assessment (Total Number of Core Top 5 MCAS Measures)

MY2024 (RY2025)

- Total Number of MCAS disparities: **23 Disparities**
- Number of Disparities Addressed: **N/A**
- Number of QIHEC suggestions Implemented: **Zero**
- Number of reported PHM Campaigns for disparities**: One**
- Number of QIP interventions: **One**

MY2025 (RY2026)

- Total Number of MCAS disparities: **13 Disparities**
- Number of Disparities Addressed: **10 Disparities**
- Number of QIHEC suggestions Implemented: **Two**
- Number of reported PHM Campaigns for disparities: **One**
- Number of QIP interventions: **Two**


Annual Work Plan (MCAS Disparities is HE dept focus; Pop Health is separate with CL work)

Annual Workplan

2026-2027 Annual Workplan

3-Year Health Equity Strategic Plan Overview

Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
1.a. (Health Equity Foundation)	Partnership Health Plan Health Equity 3 Year Strategic Plan Development and Launch	NEW	**Goal #1:** By December 2026, develop a comprehensive 3-year health equity strategic plan to address at least over 50 health disparites assoicated with race, ethnicity, language, disability status, etc across Partnership's six region network	**Measure:** Heatlh Equity Strategic Plan Review and Approval at QIHEC and Q/UAC	**Deliverable 1:** Generate Draft Health Equity Strategic Plan Draft	10/1/2025	9/30/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Host Strategic Planning Session to present to strategic plan to internal staff members for feedback	10/1/2025	9/30/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #5: Submit Final Strategic Areas of Focus document for IQI / Q/UAC review and approval to launch in CY2027	10/1/2026	11/1/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Generate at least 1 project to address health disparities regarding strategic area of focus #1	1/1/2027	7/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #5: Generate at least 1 project to address health disparities regarding strategic area of focus #2	1/1/2027	7/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
1.b. (Health Equity Foundation)	Health Disparities Grand Analysis Analysis and Annual Plan Upates (HE7)	Continued	**Goal #1**: By Oct 2027, complete draft Health Equity and Community Program Description and Strategy, HE Work Plan, and HE Evaluation revisions in preparation for October Quality Committee meetings.	**Measure:** Program Descirption, Disparity Grand Analysis Review, and Annual Plan Approval at QIHEC and Q/UAC	**Deliverable#1:** Statistical Analysis conducted by HA team and sent to HE team to evaluate to prioritize and measure health disparities	11/1/2026	12/10/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #2: Submit MY2025 HE 7 Grand Disparity Analysis sent to External Consultant for review	11/1/2026	12/10/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #3: Submit updated 2027 Work Plan for QIHEC approval, QI / Q/UAC review and approval to launch in CY2027	10/1/2026	2/1/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Finalize 2027 - 2028 HE/CR Program Description Updates	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31**	**Apr 1 - June 30**	**July 1 - Sep 30**	**Oct 1 - Dec 31**	
					Deliverable #5: Finalize 2026 - 2027 HE/CR Program Evaluation.	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31**	**Apr 1 - June 30**	**July 1 - Sep 30**	**Oct 1 - Dec 31**	
					Deliverable #6: Finalzie of 2027 - 2028 HE/CR Work Plan	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
1.c. (Health Equity Foundation)	Providing CARES Training Development for Staff and Network Providers, Subcontractors, etc. to fulfill DHCS All Plan Letter (APL) Requirements.	NEW	**Goal #1:** By Dec 30 2027, achieve at least a 10% CARES overall training completion rate across network providers, subcontractors, etc	**Measure:** CARES Training Submission Receipt from DHCS and training com	**Deliverable #1:** Training Completion Rate presentation in annual grand analysis	1/1/2027	12/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Training Supervisor Name: Naz Sattari	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
1.d. (Health Equity Foundation)	Quality Improvement and Health Equity (QIHEC) Oversight of HE Program	NEW	**Goal #1:** By June 30, 2026, Ensure QIHEC oversight of Partnership's HE Program through annual monitoring of the HE Work Plan	**Measure:** On-Time Quarterly DHCS Submission Demonstrating impact of QIHEC	**Deliverable #1**: By December 30, 2027 HE Trilogy Documents to be reviewed for approval by QIHEC in December 2027, post-review of other Quality committees to include but not limited to: * FY 2027 - HE Annual QIHEC grrand analysis and quarterly DHCS reports	1/1/2026	12/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Administrative Assistant I Name: Bethany Hannah	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
Key American Indian/Alaska Native Health Disparities (Not fully exhausted)														
2.a (Disparity)	Prenatal Care	Continued	**Goal #1:** Improve prenatal care visits by at least 5% by end of MY2027 with a 3-year goal of at least a 15% increase among American Indian/Alaska Native Members	**Measure: T**he percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of deliveries a woman had in the first first trimester **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
2.b (Disparity)	Well Care Visits	Continued	Goal #1: By Dec 31, 2027, Improve well-child visits by at least 3% with a long-term 3-year goal of at least 9% increase among American Indian/Alaska Native Members	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultural Community Manager Name: Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	TBD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
2.c (Disparity)	Controlling Blood Pressure	Continued	Goal #1: By Dec 31, 2027, improve controlled blood pressure rate among American Indian/Alaska Native members by by 1 % by end of MY2027 with a 3 year goal of at least 5% for American Indians/Alaska Natives	**Measure:** Percentage of members with controlled blood pressure per HEDIS- **Numerator:** Number of members who are considered controlled for blood pressure **Denominator:** Total number of eligible members with essential hypertension diagnosis	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
2.d (Disparity)	Breast Cancer Screening	NEW	Goal #1: By Dec 31, 2027, Improve Breast Cancer Screening by 4% with a 3-year goal of at least 10% increase for American Indians/Alaska Natives	**Measure:** Assesses the percentage of women aged 40–74 who had at least one appropriate mammogram to screen for breast cancer **Numerator:** The numerator includes the number of individuals from the denominator who had one or more mammograms during the measurement year or the two years prior. **Denominator:** Total number of eligible for screening	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	

Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
				for screening	**Deliverable #4:** Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
2.e (Disparity)	Poor A1c Control	NEW	Goal #1: By Dec 31, 2027, , imnprove Poor A1C control by 2% by end of MY2027 with a 3-year goal of at least 6% for American Indians/Alaska Natives	**Measure:** Percentage of members with uncontrolled diabetes **Numerator:** Number of members who are considered poor controlled for type 2 diabetes **Denominator:** Total number of eligible members with type 2 diabetes	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
Black Health Disparities														
3.a (Disparity)	Prenatal Care	Achieved	**Goal #1:** Improve prenatal care visits by at least 5% by end of MY2027 with a 3-year goal of at least a 15% increase among African American Members	**Measure: T**he percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of deliveries a woman had in the first first trimester **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify new sites or locations that have largest number of members experiencing disparity	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
3.b (Disparity)	Postpartum Care	Achieved	**Goal #1:** Improve postpartum care visits by at least 2% by end of MY2027 with 3-year goal of at least 5% among African American Members	**Measure:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. **Numerator:** The total number of visits a woman had between 7 and 84 days after delivery. **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify new sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
3.c (Disparity)	Well Care Visits	Continued	**Goal #1:**Improve well-child visits by at least 3% by end of MY2027 with 3-year goal of at least 9% increase among African American Members	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultural Community Manager Name: Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
White/Rural Health Disparities														
4.a (Disparity)	Well Care Visits	Continued	**Goal #1:**By December 2027, Improve well-child visits by at least 1.5% with by end of MY2027 with an overall 3-year goal of at least 4% increase	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2024	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/30/2024	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	1/1/2025	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	6/1/2025	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
Linguistic Health Disparities* **														
					Deliverable #1: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	

Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
5.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #2:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Disability-Related Health Disparities**														
6.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Geographic-Related Health Disparities**														
7.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Gender Identify-Related Health Disparities**														
8.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	

Health Equity Strategic Plan (2027-2030)

Health Equity Mission

To help our members and the communities we serve, be healthy no matter their race, language, disability status, veteran status, rural location, immigration status, etc

Long-Term Vision for Partnership Members, who have experienced disparities

- **ZERO** excessive in-hospital deaths from potentially preventable admissions
- **ZERO** excessive maternal deaths due to complications from pregnancy or childbirth
- **ZERO** excessive infant mortalities

****Key indicators of a population's overall health and healthcare quality. While other factors (hospitalizations, emergency department use, adult mortality rate, literacy rate, etc) have been considered, many organizations (e.g World Health Organization) have attributed the under-5 mortality rate, maternal mortality ratio, etc as core mortality and morbidity proxies****

Health Equity Strategy Development Methodology Overview:

The heath equity strategic plan development was led by the Health Equity Department of Partnership Health Plan. Health Equity leaders conducted a systematic review in PubMed, Google Scholar, CENTRAL database, Google, and DHCS announcements to gather tertiary literature to conduct a Political Environment Analysis, Economic Analysis, Competitor Analysis, and Social Analysis. In addition, the team conducted a systematic review of tertiary literature to review core principles of addressing health disparities. Next, partnership leaders interviewed 30+ internal staff members and 80% of external QIHEC members. Finally, Health Equity leaders did an internal capabilities and portfolio analysis to assess feasibility of strategies and potential tactics. When assessing the potential tactics, Health Equity leaders conducted an assessment of 4A's model of execution and alignment. Located below are the core strategies that will be implemented to address the measurable inequities and tactics will be generated in alignment with them. After internal committee approval, this scope of the strategic plan will be updated within the Health Equity and Community Reinvestment Strategy and Program Description MCED6001. In addition, the Health Equity department will host various design thinking sessions throughout the year within their department, with other departments, and/or the community to design innovative tactics to address the disparities within each core strategy located below.

Health Equity Strategic Plan (2027-2030)

Three Core Strategies to Eliminate Measurable Inequities Overview:

1. Increase members' (who are experiencing disparities) health literacy and motivation to access, understand, and apply accurate health information to make informed judgements regarding disease prevention and treatment.

2. Equip key local communities (in areas with high amounts of disparities) with resources to provide timely basic Medi-Cal navigation, community benefit resource navigation, health education, care coordination to reconnect members back to Partnership and/or their respective medical home. Also, empower such communities to help co-design community-based solutions to address health disparities.

3. Increase access to excellent-quality, affordable, multilingual health services, including preventative, specialized, and complex care provided in various modalities (in-person, digital, peer-led, etc.) and by diverse practitioners, ancillary staff, community health workers, doulas, etc

Strategic Plan Administrative Goals

1.a. (Health Equity Foundation)	Partnership Health Plan Health Equity 3 Year Strategic Plan Development and Launch	NEW	**Goal #1:** By December 2026, develop a comprehensive 3-year health equity strategic plan to address at least over 50 health disparites assoicated with race, ethnicity, language, disability status, etc across Partnership's six region network	**Measure:** Heatlh Equity Strategic Plan Review and Approval at QIHEC and Q/UAC	**Deliverable 1:** Generate Draft Health Equity Strategic Plan Draft	10/1/2025	9/30/2026
					Deliverable #2: Host Strategic Planning Session to present to strategic plan to internal staff members for feedback	10/1/2025	9/30/2026
					Deliverable #5: Submit Final Strategic Areas of Focus document for IQI / Q/UAC review and approval to launch in CY2027	10/1/2026	11/1/2026
					Deliverable #4: Generate at least 1 project to address health disparities regarding strategic area of focus #1	1/1/2027	7/30/2027
					Deliverable #5: Generate at least 1 project to address health disparities regarding strategic area of focus #2	1/1/2027	7/30/2027

Partnership Policy & Procedure Updates

November 2026

Policy Number	Policy/Procedures/Guidelines
The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in ***October 2026.*** *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review the redline drafts and the detailed* ***Synopsis of Changes*** *in the packet.* *The current policies shown in the online Provider Manual are hyperlinked.*	
Behavioral Health	
MCBP8015	Coordination of Care for Child Welfare-Involved Members
MPBP8007	Screening and Treatment for Substance Use Disorders
MPBP8013	Eating Disorder Management Policy
Member Services	
MP316	Provider Request to Reassign Member & Assistance with Inappropriate Member Behavior
Pharmacy Operations	
MCRP4066	AB1114 Benefit Implementation and Oversight
Quality Improvement	
MCQP1021	Initial Health Assessment
MPQG1005	Adult Preventive Health Guidelines
Utilization Management	
MCUG3032	Orthotic and Prosthetic Appliances Guidelines
MCUG3038	Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities
MCUG3118	Prenatal & Perinatal Care
MCUP3013	Durable Medical Equipment (DME) Authorization
MCUP3020	Hospice Services
MCUP3114	Physical, Occupational and Speech Therapies
MCUP3128	Cardiac Rehabilitation
MCUP3130	Osteopathic Manipulation Treatment
MCUP3133	Wheelchair Mobility, Seating and Positional Components

Synopsis of Changes to Discussion Policies

Below is a summary of revisions to the policies that will be discussed at the Oct. 21, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for each discussion policy): [1]

MPQG1005 Adult Preventive Health Guidelines Pages 247 - 264		
Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*		
☐ Important Provider Notice (IPN)	☐ Provider Education/Training	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ **Other *(specify below):***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
This policy is updated to align with All Plan Letters (APLs) 26-014 (Cognitive Health) **and 26-015** (Immunization Requirements). **Section III.** – Partnership Advantage definition updated. **Section VI.A.8 is added**: For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract. **Section VI.B.2 is modified:** Providers must ensure timely provision of immunizations to *adult* Members in accordance with *a recommendation from the CDC/ACIP (*Advisory Committee on Immunization Practices), *ACOG, AAP, or any modification or supplement to that recommendation adopted by the California Department of Public Health (CDPH)* regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each *adult* Member's need for immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2). **Section VI.B.3 is modified:** Partnership, per APL 26-014, is no longer required to verify whether providers have completed DHCS Dementia Care Awareness cognitive health assessment training. Providers are no longer required to complete this training prior to billing for annual cognitive assessments. Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit *including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.)* Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. **Section VI.B.3.a is added** to address DHCS Additional Information Request (AIR): On or after June 30, 2025, Partnership is no longer required to verify whether Providers have completed cognitive assessment training to be eligible for reimbursement for conducting a Medi-Cal annual cognitive health assessment for eligible members.	Health Services Claims Provider Relations Configuration

1

[1] This information will be captured in the meeting minutes.

Synopsis of Changes to Discussion Policies

Attachment A: A line detailing Cognitive Health Assessment for members 65 years and older is added to the Behavioral Conditions section.	

MCUP3013 Durable Medical Equipment (DME) Authorization			Pages 265 – 280
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*			
☒ **Important Provider Notice (IPN)**	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*	
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*			
☐ Call Center Script Change	☒ Update of TAR Requirements (MCUP041-A)	☒ **Other** ***(specify below): We need to determine the process for how IPNs are approved and when they are published so that we do not see misalignment between policies and IPNs.***	
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva		

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Section I.F. - Policy MPUP3139 – Criteria and Guidelines for Utilization Management was added as a Related Policy. **Section III.B. -** The DHCS definition of DME was added **Section VI.A.1. –** This paragraph regarding the information required on a DME prescription was moved to the top of the policy. Note was also added to that a prescription can be written or the "electronic equivalent." **Section VI.A.2. –** The list of criteria we consider when authorizing DME was modified to include our policy MPUP3139 – Criteria and Guidelines for Utilization Management in lieu of "InterQual." Policy MPUP3139 provides a more thorough description of all criteria that Partnership would consider, including InterQual. **Section VI. F.2.b**. – This section regarding bathroom equipment was updated to say "When a TAR is required" because an IPN has been posted which now states that No TAR is required for several bathroom equipment items. **Section VI. F.3.and VII.G**. – This section regarding Compression Garments was removed and transferred to a different policy, MCUG3032 Orthotic and Prosthetic Appliances Guidelines, to be in alignment with where the criteria is shared in the DHCS Provider Manual. The Reference to the BREW form for Compression Garments at VII.G. was also removed and transferred to the other policy. **Attachment A:** The only change to this document was on page one to update policy reference to section VI.B. for Rental Only with a 10-month limit. **Attachment B:** Codes E0658 and E0659 were added to the list of Lymphedema pumps/compression devices, and a policy reference was updated to VI.E. for information on DME provided to disabled parents or guardians.	Claims Configuration Provider Education

MCUG3118 Prenatal & Perinatal Care			Pages 281 – 299
Policy Owner: Utilization Management – *Colleen Townsend, MD, Regional Medical Director (Southeast)*			
☐ Important Provider Notice (IPN)	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*	
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*			

Synopsis of Changes to Discussion Policies

☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☒ Other *(specify below):* ***Provider Contracting to use updated Attachment A document as Contract Addendum***
☒ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
This policy was updated to align with APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members. **Section I** – Policy numbers were updated as necessary. Policy MCQG1015 Pediatric Preventive Health Guidelines was removed from the Related Policies list and policy CLPM31 Obstetrical Services was added at I.K. **Section III.I** – Definition for Professional Organization was added to describe those recognized by DHCS for clinical guidance as per APL 26-005. **Section VI.B.** – Statement added to say, "No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable." **Section VI.C.3.** – Paragraph updated to clarify requirements for different types of perinatal services programs. **Section VI.C.4.c.3)b)i.** – "Comprehensive Assessments" was added as a specific measure to be evaluated in quality monitoring of PHPS providers **Section VI.C.5.b.** – Statement added to say "Members may choose a midwifery provider outside of their capitated facility if that facility does not offer midwifery services for delivery." **Section VI.C.8. and 9.** – Regulatory requirement sources for perinatal services were updated to reference APL 26-005 and links to CPSP information were updated. Screening required by various agencies were separated into section VI.C.9 **Section VI.C.10.** - Statement added to say "Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs." **Section VI.C.12.** – Reference was added for our policy MPNP9006 Doula Services Benefit. **Section VI.D.1.a.** - Statement added in the PHPS Standards of Perinatal Case Management section to say, "The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member." **Section VI.D.4.** – Specified that every PHPS program "must" have a designated Clinical Director. **Section VI.D.12.b.1) b) and VI.G.2.a.-e.–** In the Nutrition Education Services section and the Diabetes Care in Pregnancy section, we updated the certification title for Certified Diabetes Care and Education Specialists (CDCES). **Section VI.D.12.c.1) a)i.** – Statement added to say "Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation." **Section VI.E.3.a.** – Specified that standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary <u>each trimester</u> and at the post-partum visit, <u>more frequently as needed</u>. **Section VI.E.7.a.** – Specified that Perinatal Services providers will maintain an updated list of staff working for them and their qualifications and "These will be provided to Partnership upon request and submitted with PHPS applications and updates." **Section VI.H.1.** - Statement added to say "PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs."	Provider Education Claims Configuration Member Services Provider Contracting

Section VI.H.3. - Statement added to say "WIC programs in each county may provide lactation services for Members. PHPS/CPSP programs that do not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based lactation services." **Section VI.I.2.** – Added reference to policy MCUP3124 Referral to Specialists (RAF) Policy **Section VI.I.2.a.** – Statement added to say "Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management." **Section VII. References** - Reference C. was updated to reflect APL 26-005. Hyperlinks were updated throughout as needed. Reference I was added for USPSTF Perinatal Depression Interventions and References J. – L. were added for recommended depression screenings cited in the policy. **Attachment A** – The PHPS Application and Update Form and Contracted Provider Addendum was updated to specify that all licensed program staff must be credentialed with Partnership or with a Partnership delegate, if applicable, "prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements" by July 2026.	

MCUP3133 Wheelchair Mobility, Seating and Positional Components		Pages 301 – 312
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*		
☒ **Important Provider Notice (IPN)**	☒ **Provider Education/Training**	☐ Provider Fax Blast *(specify provider type(s):*
☐ Member Notice *(specify education/training, external webpage, mailing, member meeting, Member Newsletter, Member Handbook/Evidence of Coverage, etc.):*		
☐ Call Center Script Change	☐ Update of TAR Requirements (MCUP041-A)	☐ Other *(specify below):*
☒ **Configuration of HRP and/or Claims Editor System (CES)**	☐ Configuration of Essette/Jiva	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
This policy was updated due to align with new DHCS terminology and a new benefit code K0462. **Section III.B. and C.** – The previous definition for "Custom Rehabilitation Equipment" was updated to define a new term, "Complex Rehabilitation Technology (CRT)." Ad new definition for a "CRT Supplier" was also added. **Section III.K. and L.** – The acronym and definition for a Qualified Health Care Professional (QHCP) was updated. The definition of a Qualified Rehabilitation Technical Professional (QRTP) was also updated. **Section VI.** - Language was updated throughout to reflect "Complex Rehabilitation Technology" or CRT in lieu of "custom rehabilitation equipment." **Section VI.A.3.** – Statement added to say, "Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device."	Claims Configuration Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Section VI.D. – In the section of Seating and Positional Component Coverage Criteria, our application of criteria 10-19 was clarified, and language was added to say "Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered." **Section VI.F. –** This section regarding Loaner Rental During Repair was updated to reflect new DHCS benefit coverage instead of Partnership's previous coverage as a BREW benefit. Code K0462 for rental of a power wheelchair during extended repair will now be covered with no TAR requirement for up to two one-month rental periods per year.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCBP8015 (previously MCUP3103)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Coordination of Care for Child Welfare-Involved Members</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPUP3039 - Direct Members
B. MCCP2024 - Whole Child Model for California Children's Services (CCS)
C. MPAP7003 - CalAIM Community Supports (CS)
D. MCAP7002 - CalAIM Enhanced Care Management (ECM)
E. MPQD1001- Quality and Performance Improvement Program Description

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Assembly Bill 2083: (Chapter 815, Statutes of 2018) System of Care for Children and Youth Memorandum of Understanding (MOU). This assembly bill requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Entities must develop a coordinated, timely, and trauma-informed system-of-care approach, implementing related MOUs on the county level and establishing a joint interagency resolution team on the state level to assist counties in serving those children and youth.
B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
C. Child Welfare-Involved Youth: Children and youth who meet one or more of the following conditions:
   1. Are under age 21 and are currently receiving foster care in California
   2. Are under age 21 and previously received foster care in California or another state within the last 12 months
   3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
   4. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;
   5. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months
D. Child Welfare Liaison: A Child Welfare Liaison in a Managed Care Plan (MCP) is a designated professional who serves as the key point of contact between the health plan and child welfare agencies. Their role is to

ensure that children and youth in foster care receive coordinated, timely, and appropriate health services.

E. Children in Foster Care: Children who are in out-of-home placement under the care and custody of county welfare and probation departments.

F. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the Member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community- based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

H. ECM Lead Care Manager: A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multidisciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.

I. Medical Home: Medical home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services and quality and safety. The Medical Home may refer to a provider organization or an individual primary care provider who is responsible for managing the Member's primary care needs and coordinating specialty services.

~~I. The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs and coordinating specialty services.~~

J. Resource Family: In California, a Resource Family is a caregiver who provides out-of-home care for children in foster care. The Resource Family is approved to provide care on a temporary (foster care) and/or permanent (adoption and legal guardianship) basis and includes all types of caregivers in the child welfare and probation systems, formerly known as foster parents, approved relatives or approved Non-Relative Extended Family Member.

K. Whole Child Model: ~~This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric Members with a CCS-eligible condition(s).~~A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas or primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe Partnership HealthPlan of California's coordination of care for child welfare-involved youth.

VI. POLICY / PROCEDURE:

A. Partnership communicates with foster care agencies, group homes and resource families for those Members identified as child welfare-involved by the Medi-Cal Eligibility Data System (MEDS).

B. If a Member is identified as being a child welfare-involved youth, a review of medically necessary services that require prior authorization will be performed by Partnership's Utilization Management (UM)

Department.

1. Foster care Members will be assigned to Direct Member status. (See policy MPUP3039 Direct Members)
2. Medically necessary services will be authorized to the in-network or out-of-network provider when indicated and medically necessary and appropriate.
3. Members identified as being high risk are referred to case management. Referrals are indicated for Members who are in need of multiple referrals and services, complex medical needs, or need for coordination of services with multiple agencies.
3.
4. Child welfare-involved youth who are also medically eligible for services under the Whole Child Model (CCS children) are assigned a medical home. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s).
5. Family caregivers of foster care program beneficiaries may be eligible for respite services through CalAIM Community Supports Services as per Partnership policy MPAP7003.

C. The Child Welfare Liaison shall be the primary internal and external contact for any concerns or assistance needed for child welfare-involved youth.
   1. Effective January 1, 2024, as per the Department of Health Care Services (DHCS) All Plan Letter (APL) 24-013 "Managed Care Plan Child Welfare Liaison," Partnership designates a Child Welfare Liaison to ensure the needs of Members involved with child welfare and foster care are met.
   2. Partnership designates an appropriate number of staff to serve as Child Welfare Liaison(s) to meet the health care needs of children and youth involved in child welfare in each county of Partnership's service area.
      a. Additional Child Welfare Liaisons are designated as needed to ensure the health care needs of children and youth involved in child welfare are met. Staffing is commensurate to the number of Members involved in child welfare enrolled with Partnership.
      b. Partnership reassesses staffing levels at regular intervals to ensure effectiveness in serving children and youth involved in child welfare throughout Partnership's service areas.
   3. Roles and Responsibilities of the Child Welfare Liaison
      a. The Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these Members are met.
      b. The Child Welfare Liaison serves as a leader within Partnership to advocate on behalf of children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services.
      c. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member's care coordination, including contracted ECM Lead Care Manager or the Children and Youth Involved in Child Welfare Population of Focus and applicable county child welfare staff as described in APL 24-013.
      d. The Child Welfare Liaison's duties are not intended to duplicate care coordination activities provided by other staff members or Providers, but rather to support and act as a resource to solve escalated issues regarding Partnership's services as they arise.
      e. A centralized internal and external facing mailbox is designated to access support from the Child Welfare Liaisons (ChildWelfareLiaison@partnershiphp.org).
      f. The Child Welfare Liaison's roles and responsibilities include, but are not limited to, the following:
         1) Technical Assistance: Supports internal and external staff in care coordination and issue resolution
         2) Contact Point: Serves as a contact for resolving member service access issues
         3) Referral Pathways: Collaborates with County Child Welfare as well as internal and external ECM staff to ensure effective ECM referral processes

4) Enrollment Support: Assists with member enrollment/disenrollment during County changes
5) Service Coordination: Navigates and coordinates various benefits and services
6) Internal Coordination: Works with additional internal liaisons for specific member populations
7) County Liaison Coordination: Collaborates with designated county liaisons as needed
8) Quarterly Meetings: Attends meetings with county child welfare agencies
9) Quality Improvement Input: Participates in quality improvement activities, including identifying trends, barriers, and escalated issues affecting children and youth involved in child welfare and communicating improvement opportunities to Partnership leadership and quality improvement staff.
10) Training Compliance: Ensures adherence to training provisions of the MOU
11) Foster Youth Rights: Educates staff on the Foster Youth Bill of Rights
12) Trauma-Informed Care: Promotes trauma-informed approaches in interactions

4. To enhance relationships between Partnership and county child welfare agencies for youth involved in child welfare, the Child Welfare Liaison shall:
   a. Participate in Partnership's Community Advisory Committee (CAC), the Quality Improvement Health Equity Committee (QIHEC) Committee, and additional committees and meetings that potentially impact Members involved in child welfare and foster care.
   b. Collaborate with Counties to identify opportunities for coordination of, and alignment with, each County Interagency Leadership Team's efforts in implementing the AB 2083 System of Care for Children and Youth MOU, and participate in the Systems of Care Local Interagency Leadership Team meetings to which Partnership is invited.
   c. Collaborate with other Child Welfare Liaisons internally and with Child Welfare Liaisons in other Managed Care Plans to discuss best practices, lessons learned, and sharing of information and resources.
5. Partnership designates staff for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities and meet the criteria of having the expertise, demonstrable experience, or sufficient training in the following programs, processes, and practices:
   a. Child welfare services and county behavioral health services
   b. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes
   c. Trauma-informed care practices
6. The Child Welfare Liaison's additional expertise, experience, and training shall include, but is not limited to, the following:
   a. Have a Master's degree and/or other additional training in social work, public health nursing, or another related field
   b. Have familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information
   c. Have experience or training in coordinating care within child welfare services and juvenile justice systems and understand the Foster Youth Bill of Rights.
7. Partnership will notify the county child welfare agency and DHCS of a change in the designated Child Welfare Liaison as soon as practicable, but no later than five working days from the change.
8. Partnership will submit the Child Welfare Liaison contact information to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD)-MCP Submission Portal.
   a. For delegated Subcontractors that serve children and youth involved with child welfare, Partnership will submit contact information of the Subcontractor's Child Welfare Liaison(s) to the MCOD-MCP Submission Portal. Partnership shall monitor and ensure Subcontractors' compliance with the requirements of APL 24-013 and applicable delegated oversight requirements.

9. Partnership conducts quality improvement activities pursuant to policy MPQD1001 Quality and Performance Improvement Program Description.

D. As necessary, the Department of Social Services Foster Care Program's Social Workers may be contacted by Partnership Member Services Representatives, the County Child Welfare Liaison, and/or Health Services Case Management staff to facilitate coordination of care.

E. If the child has been placed outside of the counties Partnership serves, the County Child Welfare Liaison, a Member Services Representative, and/or the Care Coordination Department will assist ~~in~~ with ~~the~~ coordination of care and facilitate the change of county process by connecting the foster caregiver, county welfare services agency, county probation department, or ~~any~~ other ~~person~~ authorized decision-maker~~to make medical decision~~ to the Department of Health Care Services (DHCS) Ombudsman as per Assembly Bill (AB) 1512, Torrico Medi-Cal: Foster Children, October 2007.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All County Welfare Directors Letter (ACWDL) 97-02 "Participation of Foster Care and Adoption Assistance Program Children in Medi-Cal Managed Care" (Jan. 13, 1997)

B. DHCS ACWDL 00-22 "Letter To Notify Counties of Three New Aid Codes For Children in the Kinship Guardian Assistance Payment and Adoption Assistance Programs" (April 10, 2000)

C. Other applicable DHCS All County Welfare Directors Letters (ACWDLs) regarding Foster Care as cataloged on this website: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx

D. Assembly Bill (AB) 1512, Torrico. Medi-Cal: Foster Children approved and filed October 11, 2007.

E. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (~~10/11/2023~~revised Aug. 11, 2025)

1. County Social Services Programs and Child Welfare MOU template (DHCS Contract Attachment B)

F. DHCS All Plan Letter (APL) 24-013 Managed Care Plan Child Welfare Liaison (Sept. 18, 2024)

G. California Foster Youth Bill of Rights

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES:

04/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 03/13/19; 03/11/20; 02/10/21; 05/11/22; 05/10/23; 05/08/24; 03/12/25; MCBP8015: 11/12/25; 11/04/26

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

PREVIOUSLY APPLIED TO:

MCUP3103 (04/21/20210 - 11/12/2025)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8007 (previously MCUP3101)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Screening and Treatment for Substance Use Disorders</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/21/2012</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPBP8011 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
B. MPBP8003 – Mental Health Services
C. MCQP1021 – Initial Health Appointment
D. MPQP1022 – Site Review Requirements and Guidelines
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MPQG1005 – Adult Preventive Health Guidelines
G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
H. CMP26 – Verification of Caller Identity and Release of Information.

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Covered Program: pursuant to 42 CFR Part 2 §2.11, means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.

B. Partnership Advantage: Effective January 1, 2028~~7~~, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approvsl.

C. Records: pursuant to 42 CFR Part 2 §2.11, means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral for

Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

D. **SABIRT**: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment: An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:
   1. Screening - a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
   2. Brief intervention - a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
   3. Referral to treatment - a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

   SABIRT represents an expansion of SBIRT with the addition of "brief assessment" (e.g., use of a validated assessment tool to determine if unhealthy alcohol of drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.

E. Standard Alcohol Drink (US definition): 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz "shot" of hard liquor (about 40% alcohol)

F. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with "addiction." According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as "non-medical use" of prescription medications). The most common substance use disorders in the United States include the following:
   1. Alcohol Use Disorder
   2. Tobacco Use Disorder
   3. Cannabis Use Disorder
   4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
   5. Opioid Use Disorder

G. Unhealthy Alcohol Use (UAU): Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder (e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:
   1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks

for adult men over a 2-hour period.

2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.

H. Unhealthy Drug Use (UDU): The United States Preventive Services Taskforce (USPSTF) defines UDU as "the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual." Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, Partnership expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.

I. Unhealthy Drug Use Screening (UDUS): According to USPSTF, UDUS is defined as "asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format." It does not refer to body fluid substance screening.

IV. ATTACHMENTS: Recommended

A. Recommended Tools and Training Resources for SABIRT
B. Pocket Screening and Brief Intervention for Alcohol Use Disorders
C. Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders

V. PURPOSE:

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

VI. POLICY / PROCEDURE:

A. Covered Services:

1. Alcohol and Other Drug Treatment Services covered through the Counties:
   Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California's (Partnership's) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
2. Wellness and Recovery Benefit through Partnership:
   Effective July 1, 2020, Partnership Members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
   a. Member has been determined eligible for full scope Medi-Cal
   b. Member is not institutionalized
   c. Member has a substance-related and addictive disorder per the current "Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition" (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
   d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND

e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County

3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPBP8011 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by Partnership medical providers should be billed to Partnership as any other encounter, using appropriate encounter and management CPT codes.
   a. Many of the medications used to treat addictions (often referred to as Medications for Addiction Treatment, or [MAT]) require no special or additional training or certification.
      1) Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder.
      2) Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice.
         a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
         b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings.
   b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists providing office visits for substance use disorder treatment may use the ICD 10 code F11.xx or F10.xx to avoid the requirement for a Referral Authorization normally required for assigned patients.
   c. Adjunctive counseling for SUD by non-licensed providers is not covered by Partnership, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the Member is a qualifying Member for SUD services through the Wellness and Recovery Program.
4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter (APL) 21-014. These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all Members aged 11 years and older, including pregnant Members.
   a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § 2.14 and may be released in compliance with Partnership policy CMP-26 Verification of Caller Identity and Release of Information.
5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of Members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy MPQG1005 Adult Preventive Health Guidelines.

B. Partnership Responsibility, Related to SUD Services
   1. Identification
      a. Partnership may identify a Member in need of SUD services through one of the following:
         1) Telephone inquiries from Member or Provider
         2) During Prior Authorization and/or Concurrent Review Processes
         3) Through Care Coordination programs activity
         4) Through call center activities performed by Partnership's delegated managed behavioral health organization
   2. Referral

a. Partnership, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the Partnership website (see VI.C.8.c. below for details). If a placement within the Member's service area is not available, the Member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from Partnership is required for referral to outpatient substance use services. (Please note, in Partnership's Wellness & Recovery benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MPUP3144 Residential Substance Use Disorder Treatment Authorization for further information.)

3. Coordination of Care
   a. Partnership will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of Members entering treatment for Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the Member's Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient's consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.
   b. Wherever possible, Partnership will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.

C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
   1. Overview.
      a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act's requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen Members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
      b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood

alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.

c. Unhealthy Drug Use: Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as cocaine and heroin. However, studies have demonstrated significantly positive benefits from various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

2. Non-Covered Services
   a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is "Have you consumed **any** beer, wine or other alcoholic beverage in the past year."
3. Covered Services
   a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to Partnership Members via the evidence of coverage and via Partnership's external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
      1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the Member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
      2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
      3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
   b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant Members, primary care includes clinicians caring for the pregnant Member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
   c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the

Member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, Partnership contracted medical specialists and credentialed SUD counselors. PCPs may also utilize Partnership's delegated managed behavioral health organization using the referral forms and process described in Partnership policy MPBP8011 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting.

4. Training and Proficiency - Primary Care Providers

Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:

a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
   1) Licensed Physician
   2) Physician Assistant
   3) Nurse Practitioner
   4) Psychologist

b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
   1) Licensed Marriage and Family Therapist
   2) Registered Nurse
   3) Certified Nurse Midwife
   4) Licensed Midwife
   5) Licensed Clinical Social Worker
   6) Licensed Professional Clinical Counselor

c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.

d. Other Members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
   1) They have at least 100 hours of clinical experience in their current role.
   2) They are trained to provide the services they are providing
   3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.

e. Providers must develop policies and procedures for SABIRT services. These should include:
   1) The PCP site will maintain a list of licensed and registered professionals and non-licensed Members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
   2) A quality assurance process for SABIRT services
   3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.

f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health Services at Partnership.

5. Training and Proficiency – Brief Behavioral Counseling Intervention/Referral to Treatment Providers
    a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
        1) Licensed Physician
        2) Physician Assistant
        3) Nurse Practitioner
        4) Psychologist
    b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
        1) Licensed Marriage and Family Therapist
        2) Registered Nurse
        3) Certified Nurse Midwife
        4) Licensed Midwife
        5) Licensed Clinical Social Worker
        6) Licensed Professional Clinical Counselor
    c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.
    d. Other Members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
        1) They have at least 100 hours of clinical experience in their current role.
        2) They are trained to provide the services they are providing
        3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
    e. Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services. These should include:
        1) The Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
        2) A quality assurance process for SABIRT services
        3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
6. Screening and Brief Assessment
    a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
    b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
    c. The screening and brief assessment process does not diagnose a disorder, but it does determine whether a problem exists. Providers should consider risks and benefits of administration of

screening and assessment tools, including discussion of these as part of informed consent, as well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.

d. Screening and Brief Assessment Tools
    1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.
    2) Note that a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:
        a) AUDIT (10 question screening and assessment)
        b) AUDIT-C (3 question screening also validated in pregnant individuals)
        c) NIAAA Single Alcohol Screening Question (SASQ)

7. Brief Intervention:
    i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to Members who are identified as having risky or hazardous alcohol use.
    b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the Member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
        1) Personalized feedback
        2) Education and resources
        3) Negotiated action plans
        4) Drinking use diaries, and
        5) Stress management.
    c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team Member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
        1) Feedback to the patient regarding screening and assessment results
        2) Discussion of negative consequences that have occurred and the overall severity of the problem
        3) Supporting the patient in making behavior changes
        4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
            a) Providers must make good faith efforts to confirm whether Members receive referred treatments and document the outcome of referral efforts, including when~~,~~ and where, and any ~~next~~ follow-up actions taken in the medical record.~~steps following treatment.~~

8. SABIRT Referral to Treatment
    a. No prior authorization is required for SABIRT services or for referral to services related to substance use or abuse.
    b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5, or those whose diagnoses are uncertain, should be referred for further

evaluation and treatment.

c. PCPs in counties without Partnership Wellness and Recovery coverage should refer Members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California county contacts for local substance use disorder treatment information and referrals can be found on the Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx under the heading "Alcohol and Drug Treatment." In Partnership Wellness and Recovery counties, the referral process is outlined on the Partnership website at this page: https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx. Referrals to treatment must be documented in the medical record.

9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the Member and the time spent with the Member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
   a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
   b. Documentation should also include:
      1) The service provided (e.g., screen and brief intervention)
      2) The name of the screening instrument and the score on the electronic health record
      3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
      4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
   a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
      1) Review Member's response to an age-appropriate, validated alcohol or drug use screening question
      2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
      3) Conduct Brief Behavioral Counseling Intervention sessions
      4) Refer Members with potential unhealthy alcohol or drug use and/or SUD for treatment
   b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
   c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
   a. The following billing codes should be used for billing SABIRT services to patients with:
      1) Medi-Cal and no other primary insurance coverage (such as Medicare):
         a) Annual alcohol misuse screening: G0442
         b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)
         c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050
      2) Medicare/Medi-Cal Members should have SABIRT billed through Medicare, using approved Medicare codes.

VII. REFERENCES:

A. For clinician support: NIAAA's Clinician Guide "Helping Patients Who Drink Too Much" provides two methods for screening: a "single question" to use during a clinical interview and a written self-report

instrument (AUDIT). http://www.niaaa.nih.gov/guide

B. The AUDIT and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions https://www.samhsa.gov/national-coe-integrated-health-solutions
C. Quick reference guide for screening for drug use in general medical settings: screening_qr.pdf (nih.gov)
D. NIDA Quick Screen and NIDA Modified ASSIST: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf
E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings: https://www.who.int/publications/i/item/978924159938-2
F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: https://www.drugabuse.gov/taps/#/
G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification. J Addict Med. 2011 Sep;5(3):221-6.
H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a
I. Information on the Medicare SBIRT benefit and requirements: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf
J. Substance Abuse and Mental Health Services Administration (SAMHSA) website: https://www.samhsa.gov/disorders/substance-use
K. Operational Instructional Letter (OIL) 398-13
L. DHCS: All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
N. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (~~10/11/2023~~ Revised 8/11/2025)
    1. Specialty Mental Health Services Memorandum of Understanding Template
    2. Substance Use Disorder Treatment Services Memorandum of Understanding Template
O. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)
P. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4), Part 2 §2.11 and § 2.14
Q. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
R. InterQual® Behavioral Health Criteria
S. Medicare Claims Processing Manual 100-04: Chapter 18 Preventive and Screening Services, Section 180 Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. Implementation date 12/27/2011 or any subsequent updates published by CMS.
T. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 210.8 Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse Implementation date 12/27/2011 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

Policy/Procedure Number: MPBP8007 (previously MCUP3101)		Lead Department: Health Services Business Unit: Behavioral Health	
Policy/Procedure Title: Screening and Treatment for Substance Use Disorders		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/21/2012		**Next Review Date: 11/12/202611/04/2027** **Last Review Date: 11/12/202511/04/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 20287)
11/12/25; 11/04/26

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

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

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
AUDIT NIDA - The Alcohol Use Disorders Identification Test (10 questions) ******Meets* **HEDIS** *measure for IHA*	X	X	NIDA DHCS NCQA				X		
AUDIT-C NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) ******Meets* **HEDIS** *measure for IHA*	X		NIDA NIAAA USPSTF DHCS	X			X		
SASQ NIAAA Single Alcohol Screening Question ******Meets* **HEDIS** *measure for IHA*	X		NIAAA USPSTF	X			X		
TAPS-1 Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
TAPS-2 Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
NIDA Quick Screen (4 questions) *(Recommended by DHCS,ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)*	X		NIDA DHCS USPSTF ACOG	X			X	X	X
NIDA-Modified ASSIST NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) *(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)*		X	NIDA DHCS USPSTF				X	X	X

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
DAST-10 Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
DAST-20 Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
4P's Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
4 P's Plus *(Plus includes additional questions about depression and domestic violence)*		X	ACOG	X			X	X	X
CRAFFT Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X *(Appropriate for non-pregnant adolescents)*		X	X	
MAST-G Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
PRO (Prenatal Risk Overview) *(Recommended by USPSTF but official website is no longer available)*			USPSTF	X			X	X	X

*As per VI.C.6.d.2) of policy MPBP8007, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
ACOG	The American College of Obstetricians and Gynecologists	Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
NCQA/ HEDIS	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH)	NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities • Underage and College Drinking Research • Treatment Navigator tool • Surveillance Reports and Epidemiologic Resources • Additional Reports and Resources
NIDA	National Institute on Drug Abuse	Screening and Assessment Tools: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2) https://sbirt.clinicalencounters.com/activity/sbirt-core/ • Four hour training: $49 per individual; group rates are available • CME/CE NYS OASAS Credit approved

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
SAMHSA	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings https://www.samhsa.gov/brss-tacs/video-trainings • Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:
USPSTF	United States Preventive Services Task Force	• Alcohol screening and intervention tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions • Unhealthy Drug Use Screening Tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening • USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation https://edhub.ama-assn.org/jn-learning/audio-player/18514824

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8013 (previously MCUP3145)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Eating Disorder Management Policy</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/10/2022 (MCUP3145)</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPBP8003 - Mental Health Services
B. MCUG3024 - Inpatient Utilization Management
C. MPUP3014 - Emergency Services
D. MCUP3052 - Medical Nutrition Therapy (MNT) Services
E. MPCD2013 - Care Coordination Program Description
F. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
G. MPBP8005 - Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
~~Behavioral Health~~
C. Claims
D. Member Services

III. DEFINITIONS:

A. Behavioral Health Plan (BHP) : A county Behavioral Health Plan in Partnership's service area. BHPs are required to provide and cover all medically necessary SMHS and Substance Use Disorder (SUD) treatment services in accordance with their contracts with DHCS.
B. Eating Disorder: Per the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition, feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.
C. Eating Disorder Treatment Levels of Care:
   1. **Outpatient**: Patient lives at home and attends weekly (usually 1:1) sessions with their provider. Patient is determined to not need daily medical monitoring and patient is psychiatrically stable enough to live at home and engage in prescribed treatment programming. Eating disorder symptoms are under sufficient control such that individual can function normally in social, educational, or vocational situations and continue to make progress in treatment.
   2. **Intensive Outpatient**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs 2 to 3 times per week for at least three (3) hours each time, and groups in addition to 1:1 treatment may be part of the program. The patient is medically and psychiatrically stable enough to live at home, and they will often maintain work and/or school obligations while

engaging in treatment.

3. **Partial Hospital**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs five (5) days per week for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals. Patient remains medically and psychiatrically stable enough to live at home, but requires highly structured, intensive, eating disorder treatment to reduce eating disorder symptoms and achieve progress towards recovery.
4. **Residential**: Patient lives at a specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors. Patient is medically stable. Treatment typically involves programming that occurs daily for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals, and co-occurring psychiatric care. All meals and snacks are supervised and provided in a supportive environment. Depending on the program, more complex medical needs such as nasogastric tube feeding may or may not be available.
5. **Inpatient Eating Disorder Program**: Patient lives at specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors, and lower levels of care have often proven to provide insufficient structure and monitoring to improve eating disorder symptoms. Oftentimes, the patient requires additional medical or psychiatric oversight for complex issues or needs that are not able to be handled in Residential level of care (e.g., nasogastric tube feeding, significant mood or psychiatric instability that requires active daily management). Focus is on weight restoration.
6. **Inpatient Acute Care Medical Hospital**: Patient is medically unstable (i.e., unstable or depressed vital signs, laboratory findings indicative of acute physiologic risk, complications from coexisting medical conditions such as diabetes) and often also psychiatrically unstable (i.e., suicidality, rapidly worsening mood or other psychiatric symptoms). Focus is on weight restoration and stabilization of acute medical abnormalities.
7. **Inpatient Acute Care Psychiatric Hospital**: In most instances, patient is not acutely medically unstable (see Inpatient Acute Care Medical Hospital above), but has active psychiatric symptoms that require specialty inpatient psychiatric care (e.g., significant mood symptoms, suicidality/homicidality, psychosis). Most units will not be equipped to manage lines/tubes. Focus is on achieving stabilization of acute psychiatric symptoms, not necessarily eating disorder treatment.

D. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a DHCS Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.

E. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services* Managed Care Plans (MCPs) are responsible for providing or arranging for medically necessary NSMHS provided to Members which include *(per Reference VII.D)*:

1. Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services
2. Psychological testing, when clinically indicated to evaluate a mental health condition
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

[1] As per APL 22-012 *Revised*, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.
Effective January 1, ~~2027~~2028, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

F. Partnership Advantage: Effective January 1, ~~2027~~2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

G. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services* County Behavioral Health Plans (BHPs) are required to provide and cover all medically necessary SMHS for Medi-Cal Members in accordance with their contracts with the California Department of Health Care Services (DHCS).

1. For Partnership Advantage Members who meet criteria for SMHS provided by a county BHP, Partnership will coordinate with BHP providers to ensure Members have access to and are connected with medically necessary services delivered by the BHP as described in section VI.D. of this policy.

IV. ATTACHMENTS:

A. Eating Disorder Process Flow Chart
B. Eating Disorder Bidirectional Form

V. PURPOSE:

To delineate how appropriate and effective services and treatments for Partnership members with eating disorders are coordinated between Partnership, which provides medically necessary physical health and non-specialty mental health services, and the county Behavioral Health Plans in Partnership's service area, which provide all medically necessary specialty mental health services.

VI. POLICY / PROCEDURE:

A. Coordinating appropriate and effective services and treatment for Members with eating disorders is a shared responsibility between Partnership HealthPlan (Partnership) and each county Behavioral Health Plan (BHP) in Partnership's service area.

1. When evaluating requests for Members under age 21, both Partnership and BHPs will consider EPSDT criteria, including assessment of whether the service is necessary to correct or ameliorate the condition and whether or not the service is generally only available to Members over age 21 (*see policy MCCP2022 Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services*).
~~1.~~2. For Members under age 21, determinations regarding medically necessary eating disorder treatment services shall be made in accordance with EPS~~SP~~DT requirements, including services needed to correct or ameliorate the Member's condition.
~~2.~~3. Effective January 1, 2027, Partnership will coordinate appropriate and effective services and treatment for Partnership Advantage Members who receive both Medi-Cal and Medicare services. For service information specific to Partnership Advantage Members, see section VI.E. of this policy.

B. As a Managed Care Plan, Partnership is responsible for all medically necessary physical health components of eating disorder treatment and providing or arranging medically necessary non-specialty mental health services (NSMHS) (*see III.E. above*) for our Members.

1. Partnership provides inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and

who do not meet criteria for psychiatric hospitalization. Partnership also provides or arranges for NSMHS for Members requiring these services.

2. Partnership covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. Emergency services include professional services and facility charges claimed by emergency departments including, but not limited to the following: professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services that are medically necessary to stabilize the Member.
3. If a Member requires partial hospitalization or a residential eating disorder program, Partnership is responsible for the medically necessary physical health components of the treatment, including locating, arranging, and following up to ensure services were rendered. (The BHP is responsible for the medically necessary Specialty Mental Health Services (SMHS) components.)
~~3.~~4. Partnership shall coordinate with the county Behavioral Health Plan to ensure timely authorization reviews, treatment planning, discharge planning, and continuity of care for Members receiving eating disorder treatment services involving shared responsibility.
~~4.~~5. Partnership provides case management to coordinate and ensure the provision of all medically necessary services, including out of network services if necessary.
~~5.~~6. Registered Dieticians (RDs) may bill Partnership for CPT codes 98970 thru 98972 for monitoring meal plan journals virtually between sessions when treating a Member who has been diagnosed with an eating disorder. No TAR is required for up to 72 units (12 hours) in a rolling 12-month period, inclusive of all three codes, when the Member has an eating disorder diagnosis code on record. Please see policy MCUP3052 Medical Nutrition Therapy (MNT) Services for more information.

C. BHPs are responsible to provide and cover all medically necessary Specialty Mental Health Services (SMHS), *aka Serious and Persistent Mental Health Services*, for Medi-Cal Members in accordance with their contracts with the Department of Health Care Services (DHCS).
   1. If a Member requires partial hospitalization or a residential eating disorder program, the BHP is responsible for the medically necessary SMHS components, and Partnership is responsible for the medically necessary physical health components of the treatment.
   2. Partnership and each county BHP shall execute a Specialty Mental Health Services Memorandum of Understanding (MOU) to document the following:
      a. The division of financial responsibility. In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the BHP for residential level treatment for eating disorders pursuant to APL 22-003.
      b. A plan in the event that Partnership and the BHP cannot agree on how to divide financial responsibility. (*see policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services*)
      c. Details about which plan will be responsible for establishing contracts detailing payment mechanisms with providers.
      d. A requirement that any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both Partnership and the BHP.
      e. Specification of procedures to ensure timely and complete exchange of information by both the BHP and Partnership for the purposes of medical and behavioral health care coordination to ensure the Member's medical record is complete and Partnership can meet its care coordination obligations. These procedures are either incorporated in the MOU or shared with the BHP as part of the related policies which further describe how the provisions on the MOU are carried out.

D. Partnership will not delay the case management and care coordination, as well as the coverage of,

medically necessary services pending the resolution of a dispute. *(see policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services*) Members shall continue to receive medically necessary covered services during the dispute resolution process in accordance with applicable DHCS requirements.

~~D.~~

E. Partnership Advantage Members
   1. Partnership Advantage Members in need of eating disorder treatment will be provided care coordination to ensure they have full access to all medically necessary services for the treatment of eating disorders to which they are entitled.
   2. Partnership is fully responsible for the following levels of care for eating disorders for Partnership Advantage Members:
      a. acute and psychiatric inpatient treatment
      b. partial hospitalization
      c. intensive outpatient program services
      d. outpatient services
   3. Residential treatment for eating disorders is not a Medicare-covered service ~~under Medicare~~. Partnership Advantage Members who require ~~in need of~~ this level of care will ~~be~~ receive ~~provided~~ care coordination to facilitate access to medically necessary services.~~,~~ ~~and treatment services~~ The provision and funding of treatment services will be ~~a~~ shared ~~responsibility~~ between ~~with the~~ Partnership and the Member's county BHP ~~pursuant~~ in accordance with~~to~~ the cost-sharing arrangement ~~agreed~~ established ~~to~~ between Partnership and the respective BHP.
   4. For Partnership Advantage Members who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure Members have access to, and are connected with, medically necessary services delivered by the BHP.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders (03/17/2022)
B. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
C. DHCS APL 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
D. Welfare and Institutions Code (WIC) Section 14184.402 (b)-(d), (f), (i)(1)
E. Title 22 of the California Code of Regulations (CCR) Section 53855
F. DHCS APL 23-029 *Revised* Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (~~01/08/2025~~ Revised 08/11/2025)
   1. Specialty Mental Health Services Memorandum of Understanding Template
G. Practice Guideline for the Treatment of Patients with Eating Disorders: Third Edition. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
H. Alliance for Eating Disorders: Types of Eating Disorder Treatment. https://www.allianceforeatingdisorders.com/types-of-eating-disorder-treatment-levels-of-care/
I. Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database
   1. Article A57480 Billing and Coding: Psychiatry and Psychology Services
   2. Medicare National Coverage Determinations (NCD) Manual 100-03

~~J. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer; Behavioral Health Clinical Director

X. REVISION DATES:
MPBP8013:
06/11/25; 11/12/25; 11/04/26

PREVIOUSLY APPLIED TO:
MCUP3145 08/10/2022 – 06/11/2025

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership HealthPlan of California (PHC) and County share UM responsibilities. PHC may maintain provider lists and contracts with providers

Eating Disorder Identification
PCP, Carelon, County, Health Plan, Hospital, UM identifies Eating Disorder and submits referral for assessment

APL 22-003/ BHIN 22-009

See Provider List below for assessment/Refer Outpatient to Partnership BH Access

Partnership BH Access: Partnership BH Access will locate and refer member to outpatient ED provider based on recommendation **(855) 765-9703**

Screening/Assessment:
- Provider conducts screening & recommends level of care
- Provider notifies PHC BH Team of completed assessment and level of care recommendation
- Member reaches out to PHC and County
- *If member meets criteria for higher level of care, provider will notify PHC CC Team/BH Team to coordinate care*

PHC Team:
Member reaches out to PHC via ED_Collab@partnershiphp.org email address

County Mental Health:
Member reaches out to County Mental Health via Access Team

If member is in Acute Hospital BH Team/County will coordinate services based on need.

Urgent member:
- Members in an acute setting needing transition to another program
- Cases should be handled in an Urgent manner
- BH Team will contact county to discuss coordinate of care
- BH Team/County will determine needed assessments
- Strike Team will meet as needed within a timely manner
- PHC CC Team will provide case management services Partnership and County Behavioral Health will coordinate on members transition of care or placement into facility

Acute/Urgent Cases

County Mental Health:
- County monitors county compliance with MOU
- County pays Share of Cost invoices to Partnership based on agreements
- For disagreements: PHC Strike Team will meet with near immediate response to discuss next steps for complex case. Member will have access to care during determination.
- County will enroll member in appropriate mental health services/programs, if not already enrolled.
- County will maintain clinical coordination with provider.

Email Coordination Bidirectional Form

PHC Strike Team
Strike team can be called to discuss cases as needed

Partnership BH Team:
- BH will track members and status of members
- Monitor/report analytics to stakeholders and provide training on program
- BH will coordinate with County on all care
- BH Team will maintain provider lists, contracts with providers
- BH Team will monitor PHC compliance with agreements
- BH Team will notify County Mental Health of referrals.

Partnership Care Coordination:
- Provides case management for ED members
- Consults with BH Team
- Ensures member has medical necessary services such as dietitians
- CC Coordinates placement provider with County/BH Team
- CC/BH Team schedules admit date, tests, and transportation as needed once approved by PHC UM and County UM. CC will ensure approval prior to placement.

Approval:
- County Behavioral Health will notify Partnership of approval within 48 hours, excluding weekends and holidays via Bidirectional form

Disagreements:
- Partnership Strike Team will meet with near immediate response to determine next steps for complex case. Partnership Strike Team will include Partnership staff and County staff can attend.

Treatment without Prior Authorization:
- Should disputes arise between parties that cannot be resolved at the MCP and MHP level, MCP will follow the dispute resolution process contained in APL 21-013/BHIN 21-034 ("Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans")

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership and County share UM responsibilities. Partnership may maintain provider lists and contracts with providers

Step 1:

- Ensure member has Eating Disorder assessment, can be from any Eating Disorder specialist, BHH preferred.
- Members without assessment can be referred to Bright Heart Health for assessment by calling **925-621-8526** and requesting "Eating Disorder Level of Care Assessment" or by calling Equip Health at (855) 387-4378.

Step 2:

- Partnership and county should be notified of referral to Bright Heart Health at **BH_Collab@partnershiphp.org**
- Once assessment is received, Partnership and/or county will coordinate with the other to determine services needed, locate provider and coordinate next steps
- County and Partnership can coordinate care by sending Bidirectional between parties

Step 2a:
For immediate assistance needed

- Notify Partnership at **BH_Collab@partershiphp.org** for members needing immediate assistance/services
- Partnership will reach out to Member's county and provider submitting referral
- Partnership and county will coordinate care via bidirectional form

Step 3:

- Partnership Care Coordination will reach out and assist member in connecting with PCP for medical needs
- Partnership Care Coordination will coordinate with BH Team for next steps on ED placement
- Partnership Care Coordination will assist member with transportation or other medical services needed

Step 4:

- County and Partnership BH Team will coordinate with provider and make referrals to providers as needed
- Partnership BH Team will submit bidirectional form to leadership for LOA approval
- Partnership BH Team and County will agree on who will contract with provider
- Contracting entity (Partnership or County) will complete contracts with provider
- BH Team will provide County clinical contact to provider

Step 5:

- Partnership and County will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- County and Partnership will receive UM updates from providers
- Partnership BH Team and County will coordinate follow on care for members

Step 6:

- Claims adjudication
- For Medi-Cal only, Partnership and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- For Partnership Advantage Members, Partnership shall be responsible for PHP and IOP levels of care
- Contracting entity (Partnership or County) will adjudicate claims and bill the other party for share of cost
- Contracting entity (Partnership or County) will provide other party copy of claims/invoice for payment

BH Administrator approval
Stamp will go here

Eating Disorder Bidirectional Form

Please submit the form to the Partnership Behavioral Health (BH) Team at ED_Collab@partnershiphp.org

DATE OF REQUEST:
REQUESTER NAME: **EMAIL:**

URGENT (SAME DAY, END OF BUSINESS) ☐ **PRIORITY** (WITHIN 2 BUSINESS DAYS) ☐ **ROUTINE** (WITHIN 4 BUSINESS DAYS) ☐

Level of care recommendation completed: **Yes** ☐ **No** ☐ (Please contact Partnership BH department for assistance with an assessment, if needed)

Member Information

Name:	Address:	Phone:	
PCP:	**County/Agency:**	**CIN:**	**DOB:**
	Select County		

Services Requested

Inpatient: ☐
Residential: ☐
Partial Hospitalization (PHP): ☐
Intensive Outpatient (IOP): ☐
Care Coordination: ☐
Dietitian: ☐

Do you want Partnership to contract with the provider:
Yes: ☐ No: ☐

** For outpatient services, refer to Carelon with standard referral process

Requested Provider Information

** The provider you would like member to be connected to.

Provider:	Address:	Admission Phone:
Contact Name:	**Phone:**	**Email:**

Referral Submitted: **Yes** ☐ No ☐ Admission Date: (If known) Length of Stay: (If known)

Clinical Information

(Included information should be BMI, height, weight, any medical conditions, co-occuring disorders, diagnosis(es), family or social concerns, homelessness, etc.)

Contact Information

BH Team Coordinator:	Eric Rushing	**Phone:**	(530) 351-9027	**Email:**	erushing@partnershiphp.org
Partnership Care Coordinator Name:		**Phone:**		**Email:**	
County Clinician Name:		**Phone:**		**Email:**	
County Fiscal Name:		**Phone:**		**Email:**	
Primary Care Doctor:		**Phone:**		**Email:**	

Would you like the provider to send clinical updates to your clinician? **Yes** ☐ **No** ☐

Approval Signatures:

Partnership Behavioral Health Representative

County Representative

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MP316				**Lead Department: Member Services**	
Policy/Procedure Title: Provider Request to ~~Discharge~~Reassign Member & Assistance with Inappropriate Member Behavior				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 7/27/1994			**Next Review Date: 11/4/2027~~09/10/2026~~** **Last Review Date: 11/4/2026~~09/10/2025~~**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☐~~☒~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 11/4/2026~~09/10/2025~~**	

I. RELATED POLICIES:

A. MP301— Assisting Providers with Missed Appointments
B. MP312— Processing PCP/MH Selections and Transfers Requests

II. IMPACTED DEPTS:

A. Provider Relations ~~(PR)~~
B. Care Coordination ~~(CC)~~

III. DEFINITIONS:

A. Provider Request to ~~Discharge~~Reassign: A provider's request to ~~discharge~~ reassign a ~~M~~M~~m~~ember from ~~his/her~~their practice.
B. Re-assignment: The process in which a~~A~~ ~~M~~M~~m~~ember is transferred to the care of another Primary Care Provider or into a -Direct Member category, if applicable.
C. Member Type U: For the purpose of this policy, M~~m~~embers are defined as "Type U Members" if they have been ~~discharged~~ reassigned for reasons other than fraud, sexual comments, and threats of violence and/or violent behavior.
D. Member Type V: For the purpose of this policy, M~~m~~embers are defined as "Type V Members" if they have been ~~discharged~~ reassigned for fraud, sexual comments, and threats of violence and/or violent behavior. ~~Threats of violence includes menacing body language, sexual advances, and/or verbal threats of physical violence.~~
E. Medical Home: Medical home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety. The Medical Home may refer to a provider organization or an individual primary care provider who is responsible for managing the Member's primary care needs and coordinating specialty services.
~~E. A model of care that provides the main functions of primary health care. This includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety. The provider identified as the member's medical home or PCP who is responsible for managing the member's primary care needs.~~
F. Wellness & Recovery (W&R): Partnership's ~~regional~~ Drug Medi-Cal Organized Delivery System that administers substance use benefits for Partnership and other Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. ~~Waiver program in seven counties within Partnership's service area.~~
G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

Policy/Procedure Number: MP316			Lead Department: Member Services
Policy/Procedure Title: Provider Request to ~~Discharge~~ Reassign Member & Assistance with Inappropriate Member Behavior			☒ **External Policy** ☐ **Internal Policy**
Original Date: 7/27/1994		**Next Review Date: 11/4/2027~~09/10/2026~~** **Last Review Date: 11/4/2026~~09/10/2025~~**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

~~F.~~H. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

IV. ATTACHMENTS:

A. ~~Form #6 (Provider Request for Discharge~~Reassignment~~/Assistance with Inappropriate Behavior)~~Form #6 Provider Request for Reassignment/Assistance with Inappropriate Behavior

B. ~~Letter #MS10a (Member~~Member Services Notifies PCP of Decision~~)~~Letter #10a Member Services Notifies PCP of Decision

~~B.~~C. Letter #10b Notification of PCP Reassignment Request Approved

~~C.~~D. ~~Letter #MS10c (Assistance with Inappropriate Behavior at Provider's Office)~~Letter #10c Assistance with Inappropriate Behavior at Provider's Office

~~D. Letter #MS10b (Notification of PCP Discharge Reassignment Request Approved)~~

V. PURPOSE:

To ~~establishd~~~~efine~~outline the criteria and process for ~~under which a~~~~in which a medical~~ provider to ~~may~~ request assistance with inappropriate behavior or ~~assistance for members that display inappropriate behavior and/or request~~ the ~~discharge~~ reassignment of a ~~Partnership member~~Member~~. from his/her practice and the requirements for~~process of member~~Member and provider notification.~~

from their practice

~~.~~

VI. POLICY / PROCEDURE:

A. Assistance with Inappropriate Behavior

1. Criteria for Assistance:

Providers may request ~~contact Partnership for~~ assistance from Partnership when ~~in addressing situations involving~~ a Member and/or the Member's representative exhibits ~~whose conduct is inappropriate,~~ disruptive, verbally abusive, threatening~~,~~ or other inappropriate behavior, or otherwise interferes with the maintenance of a safe, respectful, and professional care environment.

~~Prior to requesting discharge~~reassignment~~, providers may request assistance from Partnership when a member~~Member~~ and/or member~~Member~~'s representative engages in~~displays verbally abusive and/or disruptive behavior in a provider's office.~~

~~1.~~ Examples of inappropriate behavior include but are not limited to the following:

a. Yelling and/or screaming
b. Ethnic slurs or foul language
c. Physical or verbal threats of violence
d. Sexual comments, innuendoes, or advances

2. Provider ~~r~~Request ~~s~~for ~~Partnership a~~Assistance:

~~a. ,~~ The Provider must complete and submit~~ting :~~

~~b.~~a. ~~Completes Partnership's Form #6 titled~~ "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" form (Attachment A) ~~(Attachment A), and~~to ~~faxes it to~~ Partnership's ~~Member~~Member Services Department.

3. Plan Review and Determination:

a. Upon receipt of the request, ~~Member~~Member Services will review~~s~~ the submitted form ~~request~~ to determine whether the criteria for assistance are met.

1) If the form is incomplete or additional information is needed, Partnership's Provider Relation's (PR) Department will contact the provider to request the necessary information.

2) If the requested information is not received within five (5) business days, the request will be denied, and the provider will be notified.

~~2.~~ If the request is approved, Member Services will send notice #10c, Assistance with Inappropriate Behavior at Provider's Office ~~and~~ :

4. ~~Sends~~ ~~sends~~ ~~Mails~~ ~~letter #10c (Attachment C)~~ to the Mmember and ~~the faxes~~ a copy ~~is sent~~ to the requesting provider.

~~3. If provider, is copied.~~

~~4. If the form is Iincomplete forms or additional information is needed, notifies are referred to Partnership's Provider Relation's (PR) Ddepartment and pends the request for Provider Relations contacts the provider to request information to complete the request. and are pended for ffive (5) business days.~~

~~PR contacts the provider to request information needed to complete the request.~~

5. ~~If information is not received within five (5) business days,~~ the request is denied, ~~and~~ the provider is notified.

~~Provider Relations contacts the provider to request information to complete the request.~~

B. ~~Discharge~~ Reassignment Requests

Partnership's best effort is used to provide ~~member~~Members the opportunity to be cared for by medical providers with whom a collaborative provider/patient relationship can be developed. ~~Because the relationship is personal in nature, circumstances may arise under which the relationship between a member~~Member ~~and a provider becomes non-collaborative.~~If that relationship becomes non-collaborative, a provider may request reassignment of the Member. ~~Medical providers are permitted to request that a member~~Member ~~be discharged~~ reassigned ~~from his/her practice in certain circumstances, but i~~It is the sole responsibility of Partnership to determine if the request meets Partnership's ~~discharge~~ reassignment criteria. Providers are expected to have procedures in place that provide guidance to practitioners and staff when dealing with challenging patients.

C. ~~Discharge~~ Reassignment Criteria

1. Upon receipt of a provider's request and supporting documentation, Partnership shall determine if the request meets~~sing the written documentation provided by the provider and the discharge reassignment criteria listed below, appropriate Partnership staff determines if the request for discharge reassignment meets~~ Partnership's ~~discharge~~ reassignment criteria. Designated Member Services staff may consult~~s~~ with ~~the~~ Care Coordination (CC) designees and/or~~,~~ Partnership's Chief Medical Officer (CMO) or designee, as needed. ~~as needed.~~
2. The following behaviors are generally considered appropriate criteria for ~~discharge~~reassignment:
   a. Fraudulently receiving benefits under a health plan contract.
   b. Fraudulently receiving and/or altering prescriptions, theft of prescription pads, or photocopying prescriptions.
   c. Physically or sexually abusive behavior exhibited to the provider or office personnel.
   d. Threatening behavior exhibited in the course of needing or receiving care.
   e. Credible threat of the ~~member~~Member's intent to initiate or pursue legal action (not including a state hearing) against the provider and/or their associates.
   f. Refusal by the ~~member~~Member to follow recommended medical treatment where the provider believes there is no alternative treatment, and that refusal will severely endanger the health of the ~~member~~Member. This situation cannot be improved by repeated attempts by Partnership's CC designee to intervene, and in the judgment of the CMO or designee, a change in provider would clearly benefit the ~~member~~Member's health status.
   g. A determination by Partnership's CC designee and the CMO or designee that deterioration in the provider/patient relationship has occurred to the point where continuation might result in adverse consequences to the ~~member~~Member's health or to the safety of the provider or

provider's staff.

h. If a ~~member~~Member has been previously ~~discharged~~ reassigned from a practice, it is the responsibility of the practice to notify Partnership within sixty (60) days of the ~~member~~Member's initial assignment.

1) ~~.~~Documented evidence that the ~~member~~Member had been ~~discharged~~ reassigned from the practice site before the ~~member~~Member became Partnership eligible is required. Exceptions to the sixty (60) day period can be made at the discretion of Partnership on a case-by-case basis.

~~h.~~i. Disruptive or verbally inappropriate behavior to the provider, office staff, or other patients if counseling and corrective action by the provider has been ineffective. For assistance with inappropriate behavior, refer to section VI.A. Assistance with Inappropriate Behavior.

j. Three (3) or more missed appointments within the previous six (6) month period or four (4) or more missed appointments within the previous twelve (12) month period, if the provider has made a good faith effort to correct the ~~member~~Member's behavior.

1) ~~-~~Good faith effort is defined as at least one verbal and one written warning or at least two written warnings. All verbal and/or written warnings must inform the ~~member~~Member that continued missed appointments will result in ~~discharge~~reassignment.

~~1)~~2) ~~-~~Provider offices must provide documentation of the verbal warning and one written warning or two (2) or more written warnings. The verbal and/or written warnings must be within the specified timeframes of the missed appointments.

~~2)~~3)Exceptions: Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments for the purpose of this policy.

~~If the provider has multiple locations and/or practices, the provider must specify on the Discharge Form #6 titled "Provider Request for Reassignment/Assistance with Inappropriate Behavior" (Attachment A), Reassignment Request Form if the discharge reassignment applies to all locations and/or practices or specific locations and/or practices.~~

D. Requesting ~~Discharge~~ Reassignment Process

1. The provider must notify Partnership's Member Services D~~d~~epartment in writing to request a ~~member~~Member ~~discharge~~reassignment. The provider must provide complete documentation outlining the nature of the problem, including ~~Form #6 titled~~ "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" (Attachment A) and supporting documentation for each ~~member~~Member included in the ~~discharge~~ reassignment request.

a. The request must indicate whether~~if~~ the ~~member~~Member is receiving~~or is not in~~ active care for an acute medical condition and/or if the ~~member~~Member has any diagnostic testing or surgical procedures pending~~eries scheduled~~. ~~If additional information is needed from the provider, the Member Services department will request the additional information through Partnership's PR department.~~

If the provider has multiple locations and/or practices, the provider must specify if the reassignment applies to all locations and/or practices or specific locations.

~~a.~~b.

2. By the end of the second business day from the date of receipt, the designated Member Services staff documents the date the ~~discharge~~ reassignment request was received~~ using the DE Remark Code.~~

3. If additional information is required from the Provider, Member Services shall coordinate with the PR Department to obtain the necessary information.

~~b. In this case,~~

a. ~~When the provider does not provide the required supporting documentation, MS requests assistance from PR to request the additional information from the provider.~~ t~~The request is~~

~~pended~~is ~~pended for five (5) business days.~~ If the requested information is not received within five (5) business days, the request is denied.

E. Provider Notification of ~~-~~Decisions
1. Member Services sends written notification of the ~~ed providers in writing L~~letter ~~#MS10a (Attachment B) to notify providers of the discharge~~ reassignment decision to the provider.~~.~~
2. The provider can call the Member Services D~~d~~epartment at (800) 863-4155 to check the status of a request.

F. Approved Requests
1. ~~Member~~Member Type V:~~ –~~ ~~Discharged~~ Reassigned for fraud, sexual comments, threatening and/or violent behavior.
   a. A~~The~~ copy of the provider's ~~discharge~~ reassignment request~~submission~~ and supporting documentation is sent to the CC designee.
   b. The CC designee determines if the relationship between the provider and ~~member~~Member can be repaired. If the relationship cannot be repaired, CC designee assists the ~~member~~Member in selecting a new ~~medical home or~~ PCP/Medical Home. If the CC designee and/or the ~~member~~Member ~~needs~~need more time to select a new PCP/Medical Home~~medical home or PCP~~, the ~~member~~Member is placed in a limited Direct ~~Member~~Member status for a minimum of thirty (30) to a maximum of sixty (60) days. During this time, the ~~member~~Member can be seen by any Medi-Cal provider willing to see the ~~member~~Member and bill Partnership. If at the end of the limited period, the ~~member~~Member has not informed Partnership of their new PCP/Medical Home~~medical home or PCP~~, Partnership assigns the ~~member~~Member to the next closest open PCP.
2. ~~Member~~Member Type U: ~~–~~ ~~Discharged~~ Reassigned for reasons other than fraud, sexual comment, threats of violence and/or violent behavior.
   a. ~~Member~~Members are placed in a limited Direct ~~Member~~Member status for a minimum of thirty (30) days to a maximum of sixty (60) days.
   b. Referrals are sent to CC if ~~Form #6~~the "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" form ~~form,~~ (Attachment A), indicates any current treatments and/or if the ~~member~~Member has any open Treatment Authorizations Requests/Referral Authorization Forms.
3. ~~Member~~Member N~~n~~otifications – Letter #~~MS~~10b (Attachment D) is sent to the ~~member~~Member within ten (10) business days from the date the request was received. The notification includes Nondiscrimination and Language Assistance notices. ~~-~~The letter provides the following information ~~explains~~:
   a. ~~-T~~the reason for the ~~discharge~~ reassignment and the effective date of the new PCP/Medical Home~~medical home or PCP~~.
   b. How to ~~The letter advises the member~~Member ~~how to~~ choose ~~e~~ a new PCP/Medical Home~~medical home or PCP~~
   c. T~~,~~ to contact Partnership's Member Services De~~de~~partment if they need assistance or have questions.
   d. ~~-H and, if applicable, h~~ow to receive care during the Direct ~~Member~~Member period. ~~Enclosures include, Nondiscrimination and Language Assistance notices.~~

G. Transition of Care
1. If the ~~member~~Member has diagnostic testing, specialty referrals and/or surgical procedures~~eries~~ scheduled for conditions that could adversely affect the ~~member~~Member's health if delayed,

designated Member Services s~~S~~taff requests that the CC D~~d~~epartment work with the ~~member~~Member and appropriate providers to ensure that needed medical care is provided. The ~~member~~Member may be assigned to Direct ~~Member~~Member status, depending on the timing of the ~~discharge~~reassignment.

2. If the ~~member~~Member is medically unstable, the PCP will continue to provide care to the ~~member~~Member until Partnership is able to change the ~~member~~Member's PCP for a period not to exceed two (2) months.

H. Process Approved Request to block system relinking, auto assignment and alert ~~member~~Member facing departments

1. To prevent ~~discharged~~ reassigned ~~member~~Members from relinking or auto assignment, blocks and alerts are added to the appropriate ~~member~~Membership systems.

I. ~~Discharge~~ Reassignment of Direct ~~Member~~Members and W&R "only" ~~member~~Members

1. A provider can terminate care of a Direct ~~Member~~Member or W&R "only" ~~member~~Members, when the provider/patient relationship becomes non-collaborative, by notifying the ~~member~~Member in writing that they will no longer be able to provide care for that ~~member~~Member. If the ~~member~~Member is unstable, the provider should care for the ~~member~~Member until the ~~member~~Member selects another provider, and the provider provides emergency care for at least 30 days.
2. Primary Care Providers should notify Partnership of their intent to ~~discharge~~ reassign a Direct ~~Member~~Member from their practice so that Partnership can document the reason for ~~discharge~~ reassignment and assist with transition of care, as described above in section VI.G Transition of Care.

J. ~~Discharge~~ Reassignment Requests from Specialists, ECM, Community Support and W&R Providers

~~1. A~~ Sspecialty~~ist~~, ECM, Community Support, ~~provider~~ or W&R providers ~~can cease~~may discontinue ~~providing~~ care for ~~any~~ a ~~member~~Member when the provider~~-~~/patient relationship becomes non-collaborative. In these cases,~~, the specialist physician or W&R~~ providers must notify both the PCP and the ~~patient~~ Member that they will no longer provide care to the ~~patient~~Member. The PCP should refer the member to another specialist for treatment, if specialist care is still necessary.

1.

2. In all cases, the provider ~~discharging~~ reassigning a member should assist with continuity of care by transferring appropriate medical records to the new provider.

K. Request for Grievance

1. Members may request a grievance.

L. Reporting Violent and/or Fraudulent Behavior

1. Providers are encouraged to report violent and/or fraudulent behavior to the appropriate authorities.
2. Member Services notifies Partnership's Regulatory Affairs and Compliance department of suspected fraudulent behavior in accordance with CMP 09~~.~~

VII. REFERENCES:

N/A~~N/A~~

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Member Services & Grievance

X. REVISION DATES:

Medi-Cal

04/27/95; 10/13/99; 06/20/01; 08/15/01; 06/19/02 (Hlth Srvcs Policy); 06/18/03 (Mbr Srvcs Policy); 03/05/04; 05/19/04;11/17/04; 11/16/05; 03/07/08; 08/12/08; 01/21/09; 08/19/09; 12/16/09; 03/23/10; 05/11/11; 01/07/2014; 07/14/14; 11/08/17; 02/13/19; 05/13/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/10/25; 11/04/26

Partnership Advantage (effective Jan. 1, 2028~~7~~)

N/A

PREVIOUSLY APPLIED TO: Partnership *Advantage*: MP316 – 01/01/2007 to 01/01/2015; Healthy Kids: MP 316 12/01/2005 to 12/31/2016

Provider Request for Reassignment~~Discharge~~/Assistance with Inappropriate Behavior

Section 1 - What would you like Partnership to do?

- ☐ Would you like Partnership to reach out to the member to counsel them on improving their behavior?
- ☐ Do you want to request that the member be reassigned~~disenrolled~~ from your office(s)? **Must attached required documentation**.

Section 2 - Member Information: **Partnership ID (CIN)** #_____

Name: _____ DOB: _____ Phone #_____

Section 3 - Member Care Information:

1. Is the member in treatment for an active medical condition? ☐ No ☐ Yes - attach description of medical condition
2. Are there any diagnostic testing or surgeries scheduled? ☐ No ☐ Yes - attach list of scheduled procedures and any active TARs and/or RAFs. Please include TAR & RAF #s:

   _____

Section 4 - Provider Submitting Request:

1. PCP/Med Grp Name: _____ PCP/Group's Partnership PCP#: _____
   Does ~~reassignement~~reassignment~~discharge~~ apply to all facilities and/or locations affiliated with the group? ☐ Yes ☐ No
   If yes, list all the Partnership providers or locations that apply:

2. Have you already communicated with the member regarding your concerns? ☐ Yes ☐ No ☐ N/A If yes, what did you advise the member:

   _____

3. Who do we contact if we have questions regarding the member's care or the reason for reassignment~~disenrollment~~:

   Print Name: _____ Phone # _____

4. Who and where do we fax our decision to:

   Print Name: _____ Phone # _____ Fax#: _____

Section 5 - Reason for your request:

Please check all applicable boxes. **If you are requesting to reassign~~disenroll~~ the patient, attach documentation outlined in the policy**. If the action of the member is not specified in the policy, provide documentation outlining the incident or reason for request.

☐ Missed Aa~~a~~ppointments _____ ☐ Disruptive/Vv~~e~~rbally Ii~~n~~appropriate Bb~~e~~havior _____ ☐ Suspected Ff~~r~~aud

☐ Failure to ~~O~~obtain/Mm~~a~~intain a Cc~~o~~llaborative Rr~~e~~lationship _ ☐ Non-Compliance/Rr~~e~~fusal to Ff~~o~~llow Tt~~r~~eatment Pp~~l~~an.*

☐ Inappropriate Ss~~e~~xual Cc~~o~~mments or Aa~~d~~vances

☐ Threats of Vv~~i~~olence and/or Vv~~i~~olent Bb~~e~~havior ~~,~~; Hh~~a~~s behavior been reported to police? ☐ Yes ☐ No If "No" please explain why:

_____

☐ Other: _____

**Note: All requests for reassignment~~discharge~~ for non-compliance are reviewed by a Partnership Medical Director. Presence of a Substance Abuse Disorder alone is not sufficient grounds for reassignment~~discharge~~. Please refer to specialty care or address treatment as necessary.*

Signature of Provider: _____ Date: _____

Print name of Provider: _____

Section 6 - Fax to (707) 420-7580 attention Partnership's **Enrollment Unit:**
Partnership has ten (10) business days to process your request from the date received. Forms that are incomplete or missing the required documentation may be denied.

******************************PARTNERSHIP INTERNAL USE*********************************

Member #: _____

DECISION:

☐ Pended Sent to Dept./Name: _____ Date Ssent: _____ Due Bback By: _____
☐ Approved Effective: _____ New Assignment: _____ Date Aapproved: _____
☐ Request Denied Reason: _____ Date Ddenied: _____

Referral to Case Management: ☐ Yes; date: _____ ☐ No

Letter #_____; Date notice sent to provider: _____

Letter #_____; Date notice sent to member: _____

☐ Call Center/AmisysSystem entries completed on date: _____

COMMENTS:

Member Services:S _____

Care Coordination:CC
_____

Provider Relations:R _____

Member Services Designeeirector Signature: _____ Date: _____

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

Attachment B – Letter 10a
Member Services Notifies PCP of Decision

<DATE>

FAX: **<Fax #>**
<Provider Office>
<Provider's Address>
<Provider's City, State and Zip>

Re: Request to discharge: **<mbr>** Partnership~~PHC~~ **ID #**

Dear **<Provider Name>**~~**<Name>**~~:

Partnership HealthPlan of California has received your request to reassign~~discharge~~ the above member. The documentation submitted by your office has been reviewed by Partnership. Based on the reassignment~~discharge~~ ~~disenrollment~~ guidelines outlined in Partnership's Policy MP 316, your request has been:

☐ Approved. The member will be transferred from your practice, effective **<Date>**.

☐ Denied. It was determined that your request did not meet the reassignment~~ment~~~~discharge~~ guidelines outlined in Partnership's Policy MP 316. You must continue providing services to this member.

☐ Denied. It was determined that your request did not meet the reassignment~~ment~~~~discharge~~ guidelines outlined in Partnership's Policy MP 316. However, the member has requested to be transferred to another primary care provider. The effective date of the transfer is **<Date>**.

☐ Denied. Not enough information has been provided to approve your request. Please provide additional information that specifically details your reason for requesting ~~the~~ to reassign~~discharge~~ the member(s) and resubmit your disenrollment request. See enclosed Provider reassignment Tool to help determine the type of documentation needed. At this time, you must continue to provide services to this member.

☐ Other:

☐ Special message or instructions

If you have questions or concerns regarding this reassignment~~discharge~~ ~~disnerollment~~ request or if you would like to appeal this decision, please contact your Provider Relations Representative at **(707) 863-4100**.

Thank you for the excellent care you provide to our members and your continued support of Partnership~~PHC~~.

PARTNERSHIP
HEALTHPLAN
of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

Sincerely,
Provider Relations Department
Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, California 94534

Attachment C – Letter 10C
Assistance with Inappropriate Behavior at Provider's Office

<Date>

<Member Name>
<Member's Address>
<Member's City, State Zip>

Re: <Member's Name only if minor>

Dear <Member Name or Parent/Legal Guardian>:

This letter is to let you know that Partnership HealthPlan of California was told by <PCP's name and/or name of office>; that <members' name> <enter behavior or reason provider is requesting assistance> <if reporting inappropriate behavior; **add:** may have been inappropriate during a recent medical visit>.

There may be times when something happens at the provider's office that you may not like. It is best to try to solve the issue calmly.

If you are not able to solve problems at your provider's office, call us for help at **(800) 863-4155**.

Visit our website at PartnershipHP.org to use the Member Portal or look at the Member Handbook, Provider Directory, and your Rights and Responsibilities.

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

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

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department

Enclosures: Nondiscrimination and Language Assistance Notice, Member Rights and Responsibilities

4665 Business Center Drive
Fairfield, California 94534

Attachment D – Letter 10B
Notification of PCP Reassignment Request Approved

<DATE>

<Member's Name>
<Member's Address>
<Member's City, State and Zip>

Re: Provider Discharge

Dear <Member Name or Parent/Legal Guardian>

<Current PCP> {insert if provider is requesting discharge from multiple sites} <and all affiliated sites> has asked that **<names of reassigned patients>** be removed from their care. Partnership has approved this request.

You have been removed from your primary care provider (PCP) because <insert appropriate reason(s):> you missed 3 or more appointments in the last 6 months; you have used unkind, upsetting or abusive words; you did not follow your medical treatment plan and put your health at risk; your relationship with your PCP or office staff is not working well; you have given false information to get or change your medication(s); you have been removed from care by a specialist; <other reason>>

{Insert appropriate paragraphs and remove all paragraphs not applicable}

[Member needs to pick a PCP or medical home]
To give you time to pick a new PCP, you have from **<date>** to **<date>** to choose a new PCP. During this time, you may see any Medi-Cal provider willing to bill Partnership for Medi-Cal covered services.

Please pick a new PCP and let us know who you picked by **<date>.** If you do not pick a new PCP by this date, Partnership will choose one for you.

To pick a new PCP, you can look at our Provider Directory on our website at PartnershipHP.org. Pick a PCP that says they are taking new patients. You can tell us the PCP you picked by changing your PCP using our Member Portal on our website. You can also tell us by calling Member Services at **(800) 863-4155**.

[Member has Other Health Coverage (OHC)]
Our records show you have other health coverage. Generally, that means your other health coverage is billed first for your care and Partnership is billed last. Because you have other health coverage and Medi-Cal, you have Direct Member status. This means you can be seen by any Medi-Cal provider that takes your other health coverage and is willing to bill Partnership for Medi-Cal services.

[Members with Medicare]

You have Medicare and Medi-Cal, which means you can be seen by any provider who takes both Medicare and Medi-Cal. The provider must agree to see you and bill Medicare and Partnership for Medi-Cal covered services. Medicare is billed first and Partnership is billed last. This is called Direct Member Status.

[Out of the service area or approved for continuity of care or any other direct member status]
You have Direct Member status, which means you can be seen by any Medi-Cal provider that is willing to bill Partnership for Medi-Cal covered services.

[Insert in addition to any of the above paragraph's anytime a member is an American Indian/Alaska Native]
As an American Indian/Alaska Native, you have the right to get healthcare services from any Indian Health Care Provider. You can also pick an Indian HealthCare Provider for your PCP or any PCP listed in our directory that accepts new members.

[Member is already assigned to a new PCP]
Because you have already changed your PCP, you do not need to pick a new PCP. You can continue to see the PCP that you have selected.

[Closing statement]
Visit our website at PartnershipHP.org to use the Member Portal or look at the Member Handbook, Provider Directory, and your Rights and Responsibilities.

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

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

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department
Partnership HealthPlan of California

Enclosures: Nondiscrimination and Language Assistance Notice, Members Rights and Responsibilities Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCRP4066</td><td colspan="3">Lead Department: Health Services
Business Unit: Pharmacy</td></tr>
<tr><td colspan="3">Policy/Procedure Title: AB1114 Benefit Implementation and Oversight</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/12/2020</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPCR701 Ancillary Care Services Provider-Credentialing and Re-Credentialing
B. MPCR300 Physician Credentialing and Re-Credentialing Requirements
C. MPCR13D Pharmacist Credentialing

II. IMPACTED DEPTS:

A. Utilization Management
B. Provider Relations
C. Configuration

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe Partnership HealthPlan of California's (Partnership's) role related to the implementation, maintenance and oversight of the Medi-Cal benefit for the provision of pharmacist services to Medi-Cal managed care members, pursuant to Welfare and Institutions Code (WIC) Section 14132.968.

A. This policy shall apply in scope and pursuant to DHCS APL 25-013 and~~,~~ Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefit from Managed Care to Medi-Cal Rx (the pharmacy benefit carve-out to Medi-Cal Fee-for-Service [FFS])
    1. Any ~~& all~~ policy ~~items~~ provisions pertaining solely to outpatient pharmacy prescription claims &/or pharmacy drug TARs ~~shall not apply upon implementations of~~are subject to Medi-Cal Rx requirements and shall be administered in accordance with DHCS Medi-Cal Rx guidance.

VI. POLICY / PROCEDURE:

A. Partnership shall provide the specified pharmacy services listed in Section VI.A. as a reimbursable Medi-Cal benefit pursuant to Welfare and Institutions Code (WIC) Section 14132.968~~Assembly Bill 1114 (chapter 602, Statues of 2016~~ and California Department of Health Care Services (DHCS) All Plan Letter (APL) 25-013, as applicable. Services must be provided by a registered pharmacist (see rendering provider below) and must be billed by a Medi-Cal enrolled pharmacy (see billing provider below).

Future services may be added to Section VI.A. as determined by DHCS, authorized by California Business and Professions Code (BPC) and implemented within California Code of Regulations (CCR) by the California Board of Pharmacy (BOP).

1. Furnishing travel medications
2. Furnishing naloxone hydrochloride
3. Furnishing self-administered hormonal contraception
4. Initiating and Administering immunizations
    a. Claims for Pharmacist Service for initiating and administering immunizations must provide evidence vaccine was administered to the member. Evidence may include Medi-Cal Rx pharmacy claim record for the vaccine administered to the member.
    b. Vaccines for Children (VFC) program: Pharmacies providing immunizations through the VFC program must meet all Medi-Cal Rx and VFC program requirements. Pharmacist Services (consultation and assessments [vaccine initiation] fee) will be billed and reimbursed pursuant to MCRP4066. Vaccine Administration Fee and Professional Dispensing Fee must be billed to Medi-Cal Rx
5. Providing tobacco cessation counseling and furnishing nicotine replacement therapy (claim must provide evidence nicotine replacement therapy was dispensed to the member)
6. Furnishing HIV pre-exposure and post-exposure prophylaxis

B. Requirements for rendering provider must include but not limited to the following:
1. A pharmacist with an active license and in good standing status.
2. Enrolled with Medi-Cal as an ordering, referring, and prescribing (ORP) provider with a valid Type 1 National Provider Identification (NPI) number.
3. Credentialed by Partnership as a rendering provider for services pursuant to ~~Assembly Bill 1114.~~WIC 14132.968~~.~~
    a. Credentialing requirements: Evidence, including documentation, ~~for~~ demonstrating completion of a minimum of 1 unit of C.E. related to the service provided within the past 12 months.
4. Services must be provided and billed from a pharmacy that is a Medi-Cal pharmacy provider.

C. Requirements for billing provider must include but not limited to the following:
1. Billing provider must be a pharmacy as defined by CA Business & Professions Code 4037-Board of Pharmacy Regulations.
2. A screened and enrolled pharmacy pursuant to APL ~~19-00~~422-013.

D. Billing Codes: The following billing and administration codes may be submitted for reimbursement under Partnership's benefit. Codes are subject to change pursuant to DHCS requirements.
1. Evaluation and Management (E&M) billing codes:
    a. 99202 – New patient
    b. 99212 – Established patient
2. Administration billing code:
    a. 90471 – Vaccine administration

E. Billing frequency:
1. Rendering pharmacist may bill for an established patient code of each covered service rendered in a visit.
2. The frequency restriction of CPT code 99212 ~~of~~ (six visits within a 90~~-~~day period)~~s~~ may be exceeded ~~with~~ when supported by medical justification ~~provided~~ submitted with the original claim.
3. Rendering pharmacist must provide valid documentation that the patient's acute or chronic condition requires frequent visits in order to monitor their condition with the goal of reducing hospitalizations. Documentation will be reviewed by a Partnership Clinical Pharmacist to determine and confirm validity of medical justification. Documentation that is incomplete or does not ~~support~~ substantiate the requested exception, ~~medical justification~~ as determined by Partnership Clinical Pharmacy

review process, may result in denial of service payment.

4. Documentation for the medical justification to exceed the frequency restriction of CPT code 99212 of six visits in 90 days is subject to audit.

F. Reimbursement Rate and Claims Submission:
   1. ~~(~~87% [or rate different from FFS's 85%] of the physician rate on file for the same billing code~~)~~
   2. Billing provider must submit service claims on a CMS-1500 health claim form or ASC x12N 837P v.5010 transaction.
   3. Service claims submitted on a 30-1, 30-4, or via the National Council for Prescription Drug Programs (NCPDP) standard will be denied.

G. Documentation Requirements: In addition to all requirements outlined by the BOP or other regulatory agencies, eligible Pharmacists and Pharmacies must adhere to the following documentation standards:
   1. Pharmacists providing these services must retain proof of successful completion of required certifications, training, and continuing education (CE).
   2. The pharmacy must retain medical record documentation for services eligible for reimbursement under this benefit. Any undocumented service would be considered to not have been provided.
   3. The pharmacy must retain all required documentation of patient, physician, or other provider interactions.
   4. Medical record documentation must be complete, legible, concise, and adhere to standards outlined in the Medi-Cal Provider Manual and by the American Medical Association (AMA). At a minimum, the records must include the following:
      a. ~~a.~~ Reason for encounter
      b. Appropriateness of therapeutic services provided
      c. Applicable test results (e.g., blood pressure, pulse)
      d. Recipient's relevant medical history
      e. Site of service (if applicable)
      f. Regulatory-required questionnaire
      g. Date, time of service, and identity of pharmacist providing the service
      h. Action taken as a result of the encounter

H. Audit and Oversight
   1. Credentials for the rendering pharmacist and billing pharmacy are subject to audit by Partnership.
   2. Documentation described ~~as listed~~ in Section VI. G. shall be ~~reviewed~~ subject to review by Partnership Pharmacy, which may then pursue a desktop and/or on-site audit for the rendering pharmacist and/or billing pharmacy.
   3. Areas of audit and oversight include, but are not limited to, the following areas:
      a. Record Retention: Partnership personnel will audit a sample of medical records associated with pharmacist-provided services for compliance with state regulatory records and retention requirements.
      b. Billing Pharmacy Requirement: Partnership personnel will utilize the CA Open Data Portal to verify the pharmacy is a screened and enrolled Medi-Cal pharmacy provider.
      c. Pharmacist Provider Requirements: Partnership personnel will audit a sample of pharmacist-providers indicated as having provided eligible services to Partnership members during the previous year. Compliance with eligibility will be verified utilizing the following resources, including but not limited to:
         ~~1)~~ Current licensure/sanction: BOP license verification tool (https://pharmacy.ca.gov/about/verify_lic.shtml)
         1)
         ~~2) ORP Provider: Medi-Cal ORP Provider Enrollment Validation Lookup Beta (http://www.medi-~~

~~cal.ca.gov/ORPEnroll/ORPEnroll.aspx)~~

~~Medi-Cal FFS Provider Listing~~Medi-Cal FFS Provider Listing

~~(https://data.chhs.ca.gov/dataset/medi-cal-ffs-provider-listing~~ (https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers)

~~3)~~2)

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013 Provider Credentialing/Re-credentialing and Screening/Enrollment (July 19, 2022 *supersedes* APL 19-004)

B. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (September 18, 2025 *supersedes* APL 22-012)

~~Welfare and Institutions Code (WIC) Section 14132.968California Assembly Bill 1114, Medi-Cal: Pharmacist Services (2015-16 Session) https://openstates.org/ca/bills/20152016/AB1114/. (09/25/2016)~~

C.

~~C.~~D. Department of Health Care Services (DHCS) All Plan Letter (APL)~~DHCS APL 24-008 Immunization Requirements~~ 24-008 Immunization Requirements (June 21, 2024)

VIII. DISTRIBUTION:

A. Partnership~~HC~~ Provider Manual

B. Partnership~~HC~~ Department Directors

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

X. REVISION DATES:

Medi-Cal

02/12/20; 11/11/20; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 11/12/25; 11/04/26

PREVIOUSLY APPLIED TO:

N/A

XI. POLICY DISCLAIMER:

A. In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:
   1. Consistent with sound clinical principles and processes;
   2. Evaluated and updated at least annually;
   3. If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request.

B. The materials provided are guidelines used by Partnership to authorize, modify, or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

C. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Policy/Procedure Number: MCRP4066			**Lead Department: Health Services** Business Unit: Pharmacy
Policy/Procedure Title: AB114 Benefit Implementation and Oversight			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/12/2020		**Next Review Date:** ~~11/12/2026~~11/04/2027 **Last Review Date:** ~~11/12/2025~~11/04/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCQP1021 (previously QP100121)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Initial Health Appointment</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/18/2000</td><td colspan="3">Next Review Date: ~~03/11/2027~~11/04/2027
Last Review Date: ~~03/11/2026~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~03/11/2026~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
C. MPBP8007 – Screening and Treatment for Substance Use Disorders
D. MCUG3118 – Prenatal and Perinatal Care
E. MCQP1022 – Site Review Requirements and Guidelines
F. CMP36 – Delegation Oversight and Monitoring
G. MPUP3039 – Direct Members
H. MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Member Services

III. DEFINITIONS:

A. An Initial Health Appointment (IHA) is defined as a member's visit to his or her Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
B. Partnership HealthPlan of California (Partnership) defines newly assigned members as those individuals never before enrolled to the health plan or a previously enrolled member's first month back to the plan, who was not continuously enrolled for 120 days in the past eight months, prior to the new member month.
C. Direct Members are those whose service needs are such that PCP assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.

IV. ATTACHMENTS:

A. PCP New Member Letter MC

B. IHA Applicable Visit Codes
C. Two- Attempt Outreach Tracker Template

V. PURPOSE:

~~To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members.~~To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members. The IHA occurs during a Member's Encounter with a Provider within the Primary Care medical setting. During the IHA, the Provider assesses and manages the acute, chronic, and preventative health needs of the Member. The IHA policy is built on the requirements in the California Code of Regulations (CCR), the PHM Policy Guide, and the MCP Contract.

VI. POLICY / PROCEDURE:

A. To meet the Department of Health Care Services (DHCS) contractual requirements, an IHA is to be performed:
   1. Within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 120 days of a member's assignment to a PCP (whichever is most recent).
      a. Refer to ~~Medi-Cal Managed Care Division policy letter APL 22-030 (Dec. 27, 2022~~Department of Health Care Services (DHCS) All Plan Letter (APL) 26-001 (Jan. 7, 2026 supersedes APL 22-030 and 13-017 and Policy Letters 13-001 and 08-003).
      b. Exceptions to this requirement are specified in Section E of this policy.
B. An IHA must be performed by a Provider within the primary care medical setting and must be provided in a way that is culturally and linguistically appropriate for the member.
C. An IHA must include all of the following:
   1. A history of the member's physical and mental health;
      a. History of present illness
      b. Past medical history
      c. Social history
      d. Review of organ systems (ROS) including dental assessment
   2. An identification of risks;
   3. An assessment of need for preventive screens or services; see Section D
   4. Health education
      a. The provider should assure documentation, at initial and subsequent visits, of health education interventions including risk factors addressed, intervention codes, date and PCP's signature or initials. More extensive documentation in the progress notes is encouraged.
   5. The diagnosis and plan for treatment of any diseases.
   6. A Member Risk Assessment
D. Preventive Services
   1. The IHA must bring members up to date with all currently recommended preventive services, including immunizations, or arrange to have the member brought up-to-date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.
      a. Providers must provide: childhood/adolescent immunizations to Members under age 21 in accordance with the most recent childhood/adolescent immunization schedule and recommendations published by AAP (which are set forth in the Bright Futures/AAP Periodicity Schedule), as modified or supplemented by the California Department of Public Health (CDPH), and in accordance with Early and Periodic Screening Diagnostic and Treatment (EPSDT) services; and
      ~~a.~~b. adult immunizations in accordance with the most recent adult immunization schedule and recommendations published by CDPH.

2. The IHA shall follow the United States Preventive Services Task Force (USPSTF) / Advisory Committee on Immunization Practices (ACIP) immunization protocols as set forth in DHCS' ~~APL 24-008.~~ APL 26-015 Immunization Requirements.
   a. If the Medi-Cal provider manual outlines less restrictive criteria than ACIP, immunizations are provided according to the less restrictive guidelines.
3. For members under the age of 21 years, the IHA shall follow these requirements:
   a. The IHA shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et seq., and Title 17, CCR, Sections 6l842 through l6852, except that the PCP shall follow the most recent periodicity schedule (*aka* Bright Futures Recommendations for Periodic Preventive Health Care) recommended by the American Academy of Pediatrics (AAP) as noted in Reference D of this document and in MCQG1015, the Pediatric Preventative Health Guidelines.
      ~~1) All active California Child Health and Disability Prevention Program (CHDP) providers as of June 30, 2024 were automatically enrolled as CPE (Children's Presumptive Eligibility Program) providers on July 1, 2024.~~
   b. For asymptomatic members 21 years and older, the IHA shall follow these guidelines:
      1) The IHA shall include a history and physical examination sufficient to assess and manage the acute, chronic, behavioral, and preventive health needs of the member.
      2) The PCP shall provide the core set of preventive services for adult screening of asymptomatic health members over the age of 21 years consistent with MPQG1005, Adult Preventive Health Guidelines and the Guide to Clinical Preventive Services of the USPSTF.
4. Perinatal Services
   a. Perinatal services for pregnant members will be provided according to the most current standards or guidelines of the American College of Obstetrics and Gynecologists~~gy~~ (ACOG). Refer to the policy MCUG3118, Prenatal and Perinatal Care. For members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, an IHA must be performed by the member's PCP, or other provider of primary care services (e.g., OB/GYN). The pregnancy must be noted and the Initial Prenatal Assessment for pregnant women completed, or referral made to another Partnership provider for initiation of pregnancy-related services, including the required prenatal assessment. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.
   b. Pregnant and breastfeeding members must be referred to the Women, Infants, and Children (WIC) program. Infant feeding plans should be documented during the prenatal period, and infant/breastfeeding status is documented during the postpartum period. See MPNP9008 — Women, Infants and Children (WIC) Supplemental Food Program.
5. Members with Chronic and/or Complex Conditions
   a. For members who have been receiving services for chronic and/or complex conditions prior to enrollment in Partnership, the clinician conducting the IHA must ask specific questions to identify services being provided to members by Local Education Agencies, Regional Centers, early intervention programs, the Whole Child Model (WCM) and other special programs outside of the Partnership network, including those serving aged and/or disabled members, to allow the PCP and Partnership to most effectively accomplish necessary coordination, continuity of care and case management functions.
6. Dual Eligible Members
   a. For members who are dually eligible for Medi-Cal and Medicare, Partnership must adhere to the IHA requirements in the PHM Policy Guide and the MCP Contract.

E. Excluded Members

1. Individual members may be excluded from the IHA requirement under the following circumstances:
   a. The medical records contain documentation of prior health assessments within the 12 months prior to enrollment, and which the member's primary care services provider determines meets the requirements for documentation of the IHA.
   b. Members who are not continuously enrolled in Partnership for 120 days.
   c. Members, including emancipated minors, or a member's parent(s) or guardian, who refuse an IHA. A declination should be documented in the member's medical record.
   d. Members with certain restricted aid codes, except pregnancy, which limit the services to which members are entitled, or to members who are share-of-cost (SOC) Medi-Cal beneficiaries are exempted from the IHA.
   e. The member was dis-enrolled from the plan before an IHA could be performed.
   f. The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least two attempts att~~e~~ outreach to the member.

F. IHA Training
   1. Site Review:
      a. Partnership will provide training for our network providers and staff during the Site Review (SR) and via the Providers' Newsletter on an annual basis. Information includes:
         1) Adequate documentation,
         2) Timelines for performing IHAs, and
         3) Procedures to assure the visit(s) for the IHA are scheduled and that members are contacted for missed IHA appointments.
   2. Provider Relations
      a. New member lists, with address labels, are distributed to providers. Providers may use these lists to document contact attempts. This documentation should be kept for three years.

G. Informing Members
   1. Members will be informed of IHA requirements via the Member's Newsletter and Partnership's website regarding:
      a. Instructions on arranging IHA appointments with appropriate timelines
      b. Importance of scheduling and keeping the IHA appointment

H. IHA Monitoring
   1. Partnership will monitor compliance to the timely provision of IHAs during the regularly scheduled Medical Record Review (MRR), as part of the Site Review. Reviewers provide PCPs with a list of members that claims data identifies as needing an IHA. Reviewers also provide templates for PCPs to document outreach attempts to bring members in for an IHA visit. PCPs or other providers of primary care services must document the performance of an IHA in the member's medical record or state that equivalent information is part of the medical record. All counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted during the IHA should be documented in the medical record. Exemptions from the IHA requirement must be appropriately documented in the medical record or on the PCP member list.
   2. On an annual basis, Partnership pulls claims and encounters with specific visit codes (Attachment B – IHA Applicable Visit Codes) for primary care providers to identify the potential percentage of their newly assigned members who had a visit within 120 days of being newly assigned. Due to limitations and the lack of a singular IHA billing code, this report is only able to show potential IHA's completed.
   3. For members who are dually eligible for Medi-Cal and Medicare, MCPs must adhere to the IHA requirements in the PHM Policy Guide and MCP Contract.

I. Direct Members: Since Direct Members are not generally assigned to a PCP, providers primarily

responsible for their care should perform the IHA per the requirements outlined in this policy. For more information on Direct Members, see MPUP3039 – Direct Members.

J. Delegation of IHA monitoring functions
   1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at Partnership discretion, to perform IHA monitoring functions as part of the Site Review Process. An organization or groups will perform these functions under a formal delegation agreement.
   2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.
   3. Delegated entities will perform IHA monitoring functions for all Primary Care Provider (PCP) sites no less than every three years.
   4. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
   5. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~24-008~~26-015 Immunization Requirements (~~June 21, 2024~~) (July 14, 2026 supersedes APL ~~18-004~~24-008
B. DHCS 26-001 Initial Health Appointment (Jan. 7, 2026 supersedes APL 22-030
C. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021)
D. American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (February 2025)
E. DHCS APL 23-005 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21 (March 16, 2023 supersedes 19-010)
F. DHCS CHDP Provider Notice 22-06 Child Health and Disability Prevention Program Discontinuance (Oct. 21, 2022)
~~G. DHCS CHDP Transition Plan (March 2024)~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer (CMO)

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

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

PREVIOUSLY APPLIED TO:
N/A

To: Primary Care Providers

From: Partnership HealthPlan of California
Provider Relations Department

RE: Mailing Labels/List of New Patients to your Practice

Attached is a list and address labels for members recently assigned to your practice. We are providing this information to assist you in welcoming new patients to your practice and to remind you of the importance of conducting an Initial Health Appointment (IHA) within 90 days of the member's enrollment into Partnership. If the member had a health history and physical exam completed by you or a previous provider within 1 year of joining Partnership, you do not have to complete another initial health appointment, provided that you have a copy in the member's chart. Conducting IHAs is a regulatory requirement by the Department of Healthcare Care Services (DHCS) and is therefore contractually required by Partnership.

The initial health appointment must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screenings or services, health education, and the diagnosis and treatment plan for any diseases. For children and youth (i.e., individuals under age 21) screenings should be conducted according to the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care: Bright Futures periodicity schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). For adults screenings should be conducted according to U.S. Preventive Services Task Force (USPSTF) guidelines.

We've attached sample letters in English, Spanish, Russian, ~~and~~ Tagalog, and Punjabi that you can use to welcome new members to your practice and to encourage them to make an appointment with you so that they can timely receive an IHA.

You should retain documentation of your efforts as Partnership will look for this documentation during your facility site review and sometimes, DHCS audits providers directly to ensure this requirement is met.

Please contact your Provider Relations Representative at (707) 863-4100 if you have any questions. We hope this information is helpful to your practice.

Thank you.

www.partnershiphp.org

SAMPLE WELCOME LETTER MEDI-CAL

Dear Partnership HealthPlan Member,

Welcome to our practice. As your primary care provider, I am looking forward to meeting you and would like to ask that you call the office to schedule a check-up. Both the Partnership HealthPlan and state Medi-Cal program ask that you have this visit within 3 months of becoming Medi-Cal eligible. During this check-up, we will review your past and current medical needs. I would also be happy to answer any questions that you have about your health.

Please take the time to schedule your appointment by calling (___) ___-____. Check-ups are a great way for you to know that you are in good health and also, a good time for your doctor to explain how you can prevent health problems.

Let's work together for your health.

Sincerely,

Estimado miembro del Partnership HealthPlan:

Bienvenido a nuestro consultorio. Como somos su proveedor medico principal, nos encantaría conocerle, y por eso le pedimos que nos llame para hacer una cita con su medico regular. Tanto el Partnership HealthPlan, como el Medi-Cal del Estado de California, requieren que usted haga cita con su médico antes de que pasen tres meses desde la fecha en que le dijeron que era elegible para Medi-Cal. Cuando venga a su cita para que le hagan un examen general, vamos a platicare de su cuidado medico del pasado, y del cuidado medico que necesita en estos momentos. También tendremos el gusto de darle respuesta a cualquier pregunta que tenga sobre su salud.

Por favor, llame al numero (___) ___-____ para hacer su cita para un examen general con el medico. Los exámenes generales son la mejor manera de saber si su salud es buena, y también es la mejor oportunidad de que su doctor le explique en que forma puede prevenir ciertos problemas médicos que pueda tener.

Vamos a colaborar juntos para mantenerlo sano.

Atentamente,

ОБРАЗЕЦ ПРИВЕТСТВЕННОГО ПИСЬМА MEDI-CAL

Уважаемый участник плана Partnership HealthPlan,

Добро пожаловать в нашу организацию. Как ваш основной поставщик медицинских услуг я жду знакомства с вами и прошу вас позвонить администратору, чтобы запланировать проверку здоровья. Правила плана Partnership HealthPlan и программы штата Medi-Cal требуют, чтобы вы посетили нас в течение 3 месяцев с момента получения права на Medi-Cal. Во время этой плановой проверки мы оценим ваши текущие и прошлые потребности в медицинском обслуживании. Я также с удовольствием отвечу на все ваши вопросы о вашем здоровье.

Запишитесь на прием по телефону (___) ___-____. Плановые проверки помогут установить состояние вашего здоровья и обсудить с врачом способы профилактики проблем со здоровьем.

Вместе мы сможем позаботиться о вашем здоровье.

С уважением,

HALIMBAWA NG WELCOME LETTER SA MEDI-CAL

Minamahal na Miyembro ng Partnership HealthPlan,

Welcome sa aming panununungkulan. Bilang inyong tagapagbigay ng pangunahing pangangalaga, inaabangan ko ang ating pagkikilala at gusto kong hilingin sa inyo na tawagan ang opisina para magtakda ng check-up. Hinihingi ng kapwa Partnership HealthPlan at programang Medi-Cal ng estado na pumunta kayo para sa pagbisitang ito sa loob ng 3 na buwan matapos maging kwalipikado para sa Medi-Cal. Sa check-up na ito, rerepasuhin namin ang inyong mga medikal na pangangailangan sa nakaraan at sa kasalukuyan. Ikagagalak ko ring sagutin ang anumang mga tanong ninyo tungkol sa inyong kalusugan.

Maglaan sana ng oras para itakda ang inyong appointment sa pamamagitan ng pagtawag sa (___) ___-____. Ang mga check-up ay magandang paraan para malaman ninyo na nasa mabuting kalusugan kayo at mabuti ring panahon para ipaliwanag ng doktor ninyo kung paano ninyo maiiwasan ang mga problema sa kalusugan.

Magtulungan tayo para sa inyong kalusugan.

Taos-pusong sumasainyo,

ਸਤਿਕਾਰਯੋਗ Partnership HealthPlan ਮੈਂਬਰ,

ਸਾਡੇ ਕਲੀਨਿਕ ਵਿੱਚ ਤੁਹਾਡਾ ਸਵਾਗਤ ਹੈ। ਤੁਹਾਡੇ ਮੁੱਢਲੇ ਦੇਖਭਾਲ ਪ੍ਰਦਾਤਾ ਵਜੋਂ, ਮੈਂ ਤੁਹਾਨੂੰ ਮਿਲਣ ਲਈ ਉਤਸੁਕ ਹਾਂ ਅਤੇ ਤੁਹਾਨੂੰ ਬੇਨਤੀ ਕਰਦਾ/ਕਰਦੀ ਹਾਂ ਕਿ ਤੁਸੀਂ ਆਪਣੀ ਸਿਹਤ ਜਾਂਚ ਦਾ ਸਮਾਂ ਤੈਅ ਕਰਨ ਲਈ ਦਫ਼ਤਰ ਵਿੱਚ ਕਾਲ ਕਰੋ। Partnership HealthPlan ਅਤੇ ਸਟੇਟ Medi-Cal ਪ੍ਰੋਗਰਾਮ, ਦੋਵਾਂ ਵੱਲੋਂ ਇਹ ਬੇਨਤੀ ਕੀਤੀ ਜਾਂਦੀ ਹੈ ਕਿ ਤੁਸੀਂ Medi-Cal ਦੇ ਯੋਗ ਹੋਣ ਦੇ 3 ਮਹੀਨਿਆਂ ਦੇ ਅੰਦਰ ਇਹ ਮੁਲਾਕਾਤ ਜ਼ਰੂਰ ਕਰੋ। ਇਸ ਸਿਹਤ ਜਾਂਚ ਦੌਰਾਨ, ਅਸੀਂ ਤੁਹਾਡੀਆਂ ਪਿਛਲੀਆਂ ਅਤੇ ਮੌਜੂਦਾ ਡਾਕਟਰੀ ਲੋੜਾਂ ਦੀ ਸਮੀਖਿਆ ਕਰਾਂਗੇ। ਮੈਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਵਿੱਚ ਵੀ ਖੁਸ਼ੀ ਹੋਵੇਗੀ।

ਕਿਰਪਾ ਕਰਕੇ (___) ___-____ 'ਤੇ ਕਾਲ ਕਰਕੇ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦਾ ਸਮਾਂ ਤੈਅ ਕਰਨ ਲਈ ਸਮਾਂ ਕੱਢੋ। ਸਿਹਤ ਜਾਂਚ ਕਰਵਾਉਣਾ ਤੁਹਾਡੇ ਲਈ ਇਹ ਜਾਣਨ ਦਾ ਇੱਕ ਵਧੀਆ ਤਰੀਕਾ ਹੈ ਕਿ ਤੁਹਾਡੀ ਸਿਹਤ ਠੀਕ ਹੈ, ਅਤੇ ਨਾਲ ਹੀ, ਇਹ ਤੁਹਾਡੇ ਡਾਕਟਰ ਲਈ ਇਹ ਸਮਝਾਉਣ ਦਾ ਵੀ ਢੁਕਵਾਂ ਸਮਾਂ ਹੁੰਦਾ ਹੈ ਕਿ ਤੁਸੀਂ ਸਿਹਤ ਸਬੰਧੀ ਸਮੱਸਿਆਵਾਂ ਤੋਂ ਕਿਵੇਂ ਬਚ ਸਕਦੇ ਹੋ।

ਆਓ ਤੁਹਾਡੀ ਸਿਹਤ ਲਈ ਮਿਲ ਕੇ ਕੰਮ ਕਰੀਏ।

ਸਤਿਕਾਰ ਸਹਿਤ,

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MPQG1005 (previously MCQG1005 & QG1001050)				**Lead Department: Health Services** Business Unit: Quality Improvement	
Guideline/Procedure Title: Adult Preventive Health Guidelines				☒**External Guideline** ☐ **Internal Guideline**	
Original Date: 04/25/1994			**Next Review Date:** ~~04/14/2027~~11/04/2027 **Last Review Date:** ~~04/08/2026~~11/04/2026		
Applies to:	☐ **Employees**		☒**Medi-Cal**	☒**Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~04/08/2026~~11/04/2026	

I. RELATED POLICIES:

A. MCQP1021 – Initial Health Appointment
B. MCQP1022 – Site Review Requirements and Guidelines
C. MPUP3047 – Tuberculosis Related Treatment
D. MCUP3052 – Medical Nutrition Therapy (MNT) Services
E. ~~MCUP3101~~ MPBP8007 – Screening and Treatment for Substance Use Disorders
F. MPCP2026 – Diabetes Prevention Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Provider Relations
~~C.~~D. Configuration

III. DEFINITIONS:

A. Partnership Advantage: Effective January 1, ~~2027~~2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage ~~Members~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028, and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. Adult Preventive Health Screening Guidelines
B. TB Screening Recommendations (Flowcharts)

V. PURPOSE:

To specify and define Partnership Health Plan of California (Partnership) guidelines for adult health screening and preventive services provided by primary care providers to adults aged 18 and over, as recommended by the United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice. These include the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP). These guidelines address periodic health and behavioral risk screening and preventive services for average risk asymptomatic adults.

Individuals identified as being at high risk for a given condition may require screening at intervals that are more frequent or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those individuals whose risk behaviors, family history, socioeconomic status, or lifestyle is associated with a higher tendency towards a specific disease. "Required" and "recommended" screening interventions for various conditions as adapted from the USPSTF guidelines and other resources are listed in Attachment A. (See VI.C below for Preventive Care for Medicare recipients.) Required interventions are an integral component of primary care. Partnership audits the compliance of each primary care provider (PCP) performing these services at least once every three years during Medical Record Review (MRR). Recommended interventions are considered to constitute good clinical care but are not required by Partnership and are not considered as audit criteria.

VI. GUIDELINE / PROCEDURE:

A. Initial Health Appointment (IHA)

~~A.~~1. ~~An Initial Health Appointment (~~IHA~~)~~ must be completed for all Members within 120 days of assignment to Partnership and periodically re-administered per Department of Health Care Services' Contract and CalAIM: Population Health Management (PHM) Policy Guide requirements.

~~1.~~2. An IHA must be performed by a provider within the primary care medical setting.

~~2.~~3. An IHA is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.

a. If a Member is new to a PCP's practice and received health-screening services from another provider within the past 12 months, the new PCP should request those medical records from the former provider.

~~3.~~4. If a Member has not been seen for an IHA or for a periodic health-screening visit, the PCP should perform the indicated screening, behavioral risk assessment, and preventive interventions during episodic visits or recommend that the Member schedule a health-screening appointment.

~~4.~~5. An IHA must be provided in a manner culturally and linguistically appropriate to the Member.

~~5.~~6. An IHA must be documented in the Member's medical record and include all of the following:

a. A history of the Member's physical and mental health;
b. An identification of risks;
c. An assessment of need for preventive screenings or services;
d. Health education offered, and
e. The diagnosis of and plan for treatment of any diseases.

7. A subsequent risk assessment should be completed annually or as indicated by the Member's needs and according to the provider's clinical judgment.

~~6.~~8. For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract.

B. Documentation

1. Preventive services offered and/or performed, as well as health education provided either verbally or in writing, must be documented in the Member's medical record. Completed and outstanding preventive services should be easily identifiable.
2. Providers must ensure timely provision of immunizations to adult Members in accordance with a recommendation from the CDC/ACIP ~~the most recent schedule and recommendations published by the~~ (Advisory Committee on Immunization Practices), ACOG, AAP, or any modification or supplement to that recommendation adopted by the California Department of Public Health (CDPH) regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each adult Member's need for ~~ACIP-recommended~~ immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).
3. PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older

and who do not have Medicare coverage. (Reference ~~APL 22-025~~APL 22-025 APL 26-014.) ~~Partnership verifies whether providers have completed the required DHCS Dementia Care Aware cognitive health assessment training, using the list of providers who have completed the training provided by DHCS. Providers must complete the required training to bill and receive reimbursement from Partnership~~. As part of new provider training, Partnership educates its providers to bill appropriately for an annual cognitive health assessment according to the Provider billing requirements outlined in APL ~~22-025~~26-014.

~~a. To receive reimbursement for this assessment, providers must complete the DHCS Dementia Care Aware cognitive health assessment training **prior to** billing for the annual cognitive assessments.~~

a. On or after June 30, 2025, Partnership is no longer required to verify whether Providers have completed cognitive assessment training to be eligible for reimbursement for conducting a Medi-Cal annual cognitive health assessment for eligible members.

b. ~~Once certified, P~~providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.) ~~and have~~Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. Approved assessment screening tools include the General Practitioner assessment of Cognition (GPCOG) and the Mini-Cog. Informant tools for family members and close friends, which include the Eight-item Informant Interview to Differentiate Aging and Dementia, the GPCOG, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

c. Providers who bill for the annual cognitive health assessment must provide appropriate follow-up care based on assessment scores including, but not limited to, additional assessments or specialist referrals.

d. ~~Certified P~~providers should use the CPT code 1494F for billing. ~~**Partnership is not required to reimburse non-certified providers.**~~

C. Medicare Preventive Care
1. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
2. All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.
3. The following services are available to both Medicare and Medi-Cal recipients:
   a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
   b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MPCP2026 – Diabetes Prevention Services.
4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to
   a. A "Welcome to Medicare" visit
   b. An annual "adult wellness visit" (AWV)
   c. A cardiovascular behavioral therapy visit (performed by the PCP)
   d. An obesity behavioral therapy visit (performed by the PCP).

D. Monitoring and Quality Improvement
1. Documentation of adult preventive health services is reviewed as a component of the Medical Record Review.

VII. REFERENCES:

A. Department of Managed Health Care All Plan Letter 26-014 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (July 1, 2026 *supersedes* APL 22-025)

~~A.~~B. DHCS (APL) 25-015 Assembly Bill 144 and Coverage of Preventive Care Services (Sept. 18, 2025)

~~B.~~C. ~~California Department of Health Care Services' (~~DHCS~~)~~ CalAIM: Population Health Management (PHM) Policy Guide (updated ~~July 2025~~January 2026) https://www.dhcs.ca.gov/CalAIM/Documents/PHM- Policy-Guide.pdf

~~C.~~D. DHCS All Plan Letter (APL) ~~24-008~~ 26-015 Immunization Requirements (July 14, 2026 ~~June 21, 2024~~, *supersedes* APL ~~18-004~~24-008)

~~D.~~E. DHCS APL ~~22-030~~ 26-001, Initial Health Appointment (~~Dec. 22, 2022~~Jan. 7, 2026, *supersedes* APL ~~13-017~~22-030)

~~E. DHCS APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (Nov. 28, 2022)~~

F. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)

G. American Cancer Society Screening Guidelines: https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html

H. American Academy of Family Physicians (AAFP) 2023 list of assessments that differ from USPSTF: Clinical Preventive Services Recommendations https://www.aafp.org/family-physician/patient-care/clinical-recommendations/aafp-cps.html

D. American College of Obstetricians & Gynecologists (ACOG): http://www.acog.org/ (requires subscription)

E. American College of Physicians (ACP): https://www.acponline.org/clinical-information/clinical-guidelines-recommendations

F. Centers for Disease Control, Vaccines and Immunizations https://www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/index.html

G. American Society for Colposcopy and Cervical Pathology: https://www.asccp.org/guidelines/screening-guidelines/

H. Adult Vaccination Schedule; https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

K. United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/home

L. California Welfare and Institutions Code 14132.171, Annual cognitive health assessment

M. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services

N. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/

~~O. Department of Health Care Services vaccine schedules pending guidance.~~

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

HS-4 - 12/27/95; 08/05/97; 10/10/97 [name change only]; 02/10/99; 06/21/00, 06/20/01; 06/19/02; 10/30/02; 10/20/04; 05/17/06; 09/19/07; 03/18/09; 10/20/10; 03/21/12; 04/17/13; 04/16/14; 04/15/15; 05/18/16; 4/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 03/08/23; 04/10/24; 03/12/25; ~~03/11/26~~04/14/26; 11/04/26

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

PREVIOUSLY APPLIED TO:

Guideline/Procedure Number: MPQG1005 (previously MPQG1005 & QG100105)			**Lead Department: Health Services** Business Unit: Quality Improvement
Guideline/Procedure Title: Adult Preventive Health Guidelines			☒ **External Guideline** ☐ **Internal Guideline**
Original Date: 04/25/1994		**Next Review Date:** ~~04/14/2027~~11/04/2027 **Last Review Date:** ~~04/08/2026~~11/04/2026	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

Partnership Advantage
MPQG1005 - 09/19/2007 to 01/01/2015

Healthy Families
MPQG1005 - 10/20/2010 to 03/01/2013

Healthy Kids
MPQG1005 - 09/19/2007 to 04/17/2013

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

These guidelines for adult health screening and preventive services are derived from the most recent United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice from organizations such as American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), American College of Physicians (ACP), and others. Age, sex and risk factor specific USPSTF recommendations can be found using the ePSS app found on the USPSTF website.

~~Required interventions are italicized and considered to be an integral component of primary care. Consequently,~~ Partnership HealthPlan of California (Partnership) audits the compliance of each PCP performing these services at least once every three years during the Medical Record Review (MRR).

*The USPSTF recommends clinicians discuss these preventive services with eligible patients and offer them as a priority. All these services have received an "A" (strongly recommended) or a "B" (recommended) grade from the Task Force.

PREVENTIVE CARE	FREQUENCY/DETAILS
Aspirin for the Primary Prevention of Cardiovascular Events *	A meta-analysis in the Jan. 22, 2019 issue of JAMA concluded that there was no net benefit for use of aspirin for primary prevention of cardiovascular disease. The USPSTF (April 2022) recommends for adults aged 40 to 59 years with a 10% or greater 10-year cardiovascular disease (CVD) risk, the decision to initiate low-dose aspirin for the primary prevention of CVD should be an individual one. Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit. (Grade C) For adults 60 years or older, the USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD. (Grade D) Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Assessment for Hearing Impairment	Age 65+ at the time of the periodic health examination. For individuals likely to take action based on abnormal testing results, consider a three-question screening: 1. Do you have difficulty with your hearing? 2. How bothered are you by your hearing loss? 3. How motivated are you to do something about it? (Affirmative responses to all three warrants referral for diagnostic evaluation and possible treatment.) Reference: *JAMA March 23/30, 2021, pp. 1162-1163.* The USPSTF concludes current evidence is insufficient re: screening for hearing loss in older adults.
High Blood Pressure Screening *	Upon initial entry into PCP practice, then at least every two years. If elevated, the USPSTF (April 2021) recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment, when feasible.
Hypertensive Disorders of Pregnancy Screening	The USPSTF (September 2023) recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements at each prenatal visit. This includes all pregnant persons without a known diagnosis of a hypertensive disorder of pregnancy or chronic hypertension. (Grade B)

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

PREVENTIVE CARE	FREQUENCY/DETAILS
Colorectal Cancer Screening *	The USPSTF (May 2021) recommends performing screening for colorectal cancer in adults aged 50 to 75 (Grade A) and ages 45 to 49. (Grade B) • Modalities include Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) annually, OR colonoscopy every 10 years; OR flexible sigmoidoscopy every five years OR FIT_DNA test every three years. (See USPSTF for other variations.) CT colonoscopy is technically difficult and Partnership requires a Treatment Authorization Request (TAR). • Recommendations for adults aged 50 to 75 (Grade A) differ from those aged 76 to 85. For adults aged 76 to 85 years, the decision to screen for colorectal cancer is an individual one, taking into account patient's overall health and prior screening for colorectal cancer are more likely to benefit. • The USPSTF does not comment on screening for colorectal cancer in adults older than 85 years of age.
Height & Weight	• Initial entry into PCP practice. • Age 18 to 64: weight at least every two years. • Age 65+: weight at least annually.
HIV Screening and Pre-exposure Prophylaxis to Prevent Acquisition of HIV *	The USPSTF (June 2018 – currently under review) recommends that each adolescent and adult ages 15 to 65 without risk factors be tested for HIV once in their lifetime. In addition, all individuals at increased risk for HIV, regardless of age, should be tested every year. Pregnant persons should be tested with each pregnancy, including those presenting in labor oat at delivery whose HIV status is unknown. The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC, April 19, 2022) The USPSTF (August 2023) also recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.
Hepatitis C Screening*	The USPSTF (March 2020) recommends a one-time screening for average risk adults ages 18 to 79. In addition, adults at increased risk of contracting Hepatitis C (e.g., those using injectable drugs of abuse), should be screened periodically (ungraded recommendation). There is limited evidence to determine how often to screen persons at increased risk.
Lung Cancer Screening *	The USPSTF (March 2021) recommends annual screening for lung cancer with low-dose computed tomography (LCDT; CPT code 71211) in adults ages 50 to 80 years who have a 20+ pack-year smoking history and IN ADDITION currently smoke or have quit within the past 15 years or develop a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (Grade B) Full-dose CT scans are not approved for screening.
Syphilis Infection, Screening – Non-pregnant and Pregnant Persons *	The USPST (September 2022) recommends screening persons at increased risk for syphilis. (Grade A) At highest risk are men who have sex with men and persons living with HIV. Other risk factors ae history of incarceration, history of commercial sex work, male younger than 29 years old, and (in Partnership regions) current homelessness and current use of methamphetamines.

	The USPSTF (September 2018) recommends early screening for syphilis infection in all pregnant persons. Those presenting in labor or at delivery whose syphilis status is unknown should be tested at that time. (Grade A) The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC April 19, 2022) Screen and confirm - Options for testing include traditional screening algorithm: Screen with an initial nontreponemal test (e.g., Venereal Disease Research Laboratory (VDRL) or rapid plasma regain [RPR] test). If positive, confirm with a treponemal antibody detection test (e.g., *T pallidum* particle automated treponemal test (e.g., enzyme-linked or chemiluminescence immunoassay). If positive, confirm with a nontreponemal test.
Latent Tuberculosis Infection (LTBI) Screening	The USPSTF (May 2023) recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk. (Grade B) (See MPQG1004 Attachment B – TB Screening Overview for more specifics.) This recommendation meets the requirements of California's new Tuberculosis screening law, Assembly Bill 2132, which was signed into law Sept. 29, 2024, and took effect Jan. 1, 2025.
Glaucoma Screening	AAFP and USPSTF (May 2022) find insufficient evidence for or against. (Grade I) Medicare recommends screening for those in these high-risk categories: 1. Persons with diabetes, 2. Family history of glaucoma, 3. African American and age 50 or older, or 4. Hispanic and age 65 or older.
Hyperlipidemia Screening (needed for full cardiovascular risk factor evaluation)	The USPSTF recommendations covering lipid screening in adults are archived. UpToDate® ("Screening for lipid disorders in adults" Aug. 2, 2021) recommends obtaining a fasting or non-fasting lipid profile when an adult enters care at a new practice to screen for familial hypercholesterolemia and for cardiovascular risk assessment, with rescreening as part of a cardiovascular risk analysis every five years. Earlier rescreening may be indicated depending on patient-specific factors.
Statin Use for Primary Prevention of Cardiovascular Disease (CVD)	The USPSTF (August 2022) recommends prescribing statins for the primary prevention of CVD for adults ages 40 to 75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking), AND a 10-year cardiovascular risk of ≥10% (Grade B) or 7.5% to <10%. (Grade C) Current evidence is insufficient to assess benefits versus harms in adults > 75 years of age. (Grade I) Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Vaccination	Based on age and risk factors. For updated schedule, reference the CDC guidelines. https://www.cdc.gov/vaccines/schedules/
Diabetes Mellitus in Adults, Screening for Type 2 and Prediabetes *	The USPSTF (August 2021) recommends screening all adults ages 35 to 70 years who are overweight or obese. (Grade B) The screening interval is uncertain, but every three years "may be reasonable." 2023 Standards of the American Diabetes Association: 1. Testing for prediabetes and DM2 in asymptomatic people should be considered in any overweight adult (BMI >25)[1] with one or more risk factors. Risk factors include a first-degree relative with diabetes, high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander), history of

	CVD, hypertension, HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and triglyceride level > 250 mg/dL (2.82 mmol/L), polycystic ovary syndrome, physical inactivity, and/or other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans). 2. Screen all adults beginning at age 35 years. 3. If test results are normal, screen every three years. 4. Acceptable screening tests include fasting plasma glucose, 2-h plasma glucose during a 75-g GTT, and HgbA1c. 5. Persons with HIV should be screened using a fasting glucose test before starting antiretroviral therapy, when switching therapies, and 3-6 months after starting therapy, and then annually, if screening results are normal. [1] *The ADA suggests different BMI parameters for Asian Americans; however, Partnership does not endorse this differentiation.*
Dental Disease and referral to dental provider	The USPSTF (November 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. The AAFP recognizes the PCP may act as a first line of defense by promoting good oral health during patient visits. Their recommendation is to assess for and promote oral health. Ask about brushing and flossing, use of tobacco and other smoked products, consumption of sugary drinks and advocating and assisting with identifying a primary dental office. Frequency includes entry into PCP practice, then yearly or as indicated by the PCP and/or dental care provider.
Alcohol and Drug Misuse and Behavioral Counseling Interventions *	The USPSTF (November 2018 currently under review) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant persons. Screen all adults annually; if present, offer behavioral interventions to reduce unhealth alcohol use. (Grade B) The USPSTF (June 2020) recommends asking about unhealthy drug use in adults aged 18 years or older. When screening is positive, offer or refer for appropriate treatment. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014 – Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment – Oct. 11, 2021)
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Lifestyle – Recommendations for adults with and without known CVD risks *	The USPSTF (July 2022 - currently under review) recommends for adults **without** known CVD risk factors individualizing the decision to offer to refer to behavioral counseling interventions to promote a healthy diet and physical activity. The USPSTF (November 2020 – currently under review) recommends offering or referring adults **with** one of the following: 1. Hypertension 2. Dyslipidemia 3. Mixed multiple risk factors such as metabolic syndrome or a ≥ 7.5% estimated 10-year CVD risk to intensive behavioral/counseling interventions to promote a healthy diet and physical activity for CVD prevention. This recommendation no longer includes adults with other known modifiable CVD risk factors such as abnormal blood glucose levels, obesity, and smoking, as these populations are covered by other USPSTF recommendations. Individuals with a diagnosis of prediabetes should be referred to participate in a Diabetes Prevention Program, if available.

Screening for Depression and Suicide Risks * in Adults and Perinatal Depression	The USPSTF (June 2023) recommends screening for depression on the general adult population, including pregnant persons and post-partum persons. (Grade B) Screening should be implemented with adequate systems in place to ensure accurate diagnoses, effective treatment, and appropriate follow up. There is little evidence regarding optimal timing for screening. The USPSTF (October 2022) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in the adult population, including pregnant and post-partum persons, as well as older adults. (Grade I) The USPSTF (February 2019) also recommends that pregnant persons at risk of depression should be referred for counseling even if not currently depressed. (Grade B) Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthpPlan 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.
BEHAVIORAL CONDITIONS	**DETAILS**
Anxiety *	The USPSTF (June 2023) recommends screening for anxiety disorders in adults 64 years or younger, including pregnant and post-partum persons who have no recognized signs of symptoms of anxiety. (Grade B) The USPSTF (June 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults 65 years or older. (Grade I)
Cognitive Health Assessment (for members 65 years and older)	PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older and who do not have Medicare coverage. (Reference APL 26-014.). Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit including, but not limited to, an office visit, consultation, or preventive medicine service.
Obesity *	The AAFP recommends screening all adults for obesity (using BMI >30).. The current USPSTF (September 2018) recommendation is that clinicians should offer or refer patients with a BMI of 30 or more to intensive, multicomponent behavioral interventions. (Grade B) $BMI = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$
Tobacco Use and Tobacco Caused Disease Counseling, including for Pregnant Persons *	For all adults who are not pregnant, the USPSTF (January 2021) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and USDA- (FDA-) approved pharmacotherapy for cessation. (Grade A) For all pregnant persons, the USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. (Grade A)

Unintended Pregnancy *	Screen all reproductive aged persons at risk for unintended pregnancy (and males who may cause unintended pregnancy); offer counseling and access to contraceptives, including emergency contraception. (ACOG 2019) Recommended screening question with a modified "One Key Question" method: "Do you, or any of your sensual or sexual partners, want to become pregnant in the coming year?" (AAFP 2021)
OTHER SCREENINGS	**DETAILS**
Abdominal Aortic Aneurysm Screening*	The USPSTF (December 2019) recommends one-time screening for abdominal aortic aneurysm by ultrasound in persons aged 65 to 75 who have ever smoked (≥100 cigarettes smoked) and were assigned as male at birth. (Grade B)
Prostate Cancer Screening (Prostate Specific Antigen blood test) *	USPSTF recommendations (December 2023 – currently under review): • Asymptomatic average risk persons with a prostate aged 55 to 69 years should have shared decision making with their clinician about the pros and cons of screening. (Grade C) • Persons with a prostate aged 70 and older should not be screened. (Grade D) • Persons with a prostate with prostate symptoms may have a PSA as part of their diagnostic evaluation.
Screening for Intimate Partner Violence *	Adapted from USPSTF (June 2025) recommendations: Screen all patients of childbearing age for intimate partner violence when a routine health maintenance exam is performed, including those who are pregnant and postpartum. (Grade B) Providers should refer patients who screen positive to ongoing support services.
Breast Cancer Screening by Mammography *	The USPSTF (April 2024) recommends biennial mammography for persons aged 40 to 74 years with breasts and assigned as female at birth who are asymptomatic. (Grade B) Transgender and Gender Diverse persons: The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" from the World Professional Association for Transgender Health (WPATH) recommends "… health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended.
Breast Cancer, Chemoprevention *	The USPSTF (September 2019) recommends clinicians offer to prescribe risk reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors, to persons at high risk for breast cancer and at low risk for adverse effects of chemoprevention. (Grade B) A breast cancer risk assessment toll is available at www.cancer.gov/bcrisktool
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing *	Adapted* the USPSTF (August 2019) recommends assessment with an appropriate brief family risk assessment tool for persons at high risk of breast and ovarian cancer. Persons with a positive result should be offered genetic counseling and, if indicated after counseling, genetic testing. (Grade B) See MCUP3131 – Genetic Testing policy for details.

Breastfeeding, Behavioral Interventions to Promote *	The USPSTF (April 2025) recommends interventions or referrals during pregnancy and after birth to promote and support breastfeeding. (Grade B)
Cervical Cancer Screening *	USPSTF recommendations (December 2024 – currently under review) • Persons with a cervix aged 21 to 29 should have cervical cytology screening alone every three years. Persons with a cervix aged 30 to 65 may have cervical cytology screening every three years, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or may have high-risk HPV testing every five years. (Grade A) • Persons with a cervix under aged 21 should not be screened. (Grade D) • Persons with a cervix over age 65 should only be screened if they have never been previously screened, or if one of their last three screenings had any type of cervical atypia. (Grade D) • Routine cervical cytology testing should be discontinued (regardless of age) in persons with a history of a total hysterectomy (removal of the cervix along with the uterus) for noncancerous reasons, as long as they have no history of high-grade CIN. (Grade D) • The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (ie, cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. (Grade D) • The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (Grade D) • Note: although the American Cancer Society changed its recommendations in 2020 to recommend later initiation of screening, less frequent screening, and use of HPC screening only under age 30, Partnership continues to recommend following the recommendations of USPSTF / ACOG. 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), American Cancer Society (December 2025) • Clinician-collected specimens are preferred and self-collected vaginal specimens are acceptable • Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years • Following a negative HPV test, self-collected vaginal specimens require repeat testing in 3 years, while clinician-collected vaginal specimens require repeat testing in 5 years • Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for a clinician-collected cervical specimen • Self-collection is not recommended for high-risk individuals, including those with immunosuppression • Use only FDA-approved collection devices and HPV assays
Chlamydia and Gonorrhea Screening *	USPSTF recommendations (September 2021): Annual screening recommended for sexually active women 24 years or younger and for women aged 25 years or older at increased risk for infection. Risks include previous or current STI, a sex partner with a STI, inconsistent condom use when indicated, a history of exchanging sex for money or drugs, and a history of incarceration. (Grade B) Transgender and gender-diverse persons – Gonorrhea and chlamydia screening recommendations should be adapted based on anatomy (i.e., screening

	recommendations for cisgender females should be extended to all transgender males and gender-diverse persons with a cervix.) Screening at the pharyngeal and rectal site for gonorrhea and chlamydia should be considered based on reported sexual behaviors and exposure. (UpToDate®, March 2024)
Osteoporosis in Postmenopausal Persons Assigned as Female at Birth Screening *	USPSTF recommendation (January 2025): Screen persons assigned as female at birth age 65 and older with bone measurement testing to prevent osteoporotic fractures. (Grade B) For post-menopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9 to determine the appropriate need for bone measurement testing. (Grade B) The USPSTF does not speak to the frequency of interval between testing. ACOG (September 2021) recommends repeat testing no earlier than two years after initial screening in those with a borderline result of a change in risk factors. A one-year follow-up test is recommended for patients on chronic glucocorticoid treatment. WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis screening recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.
Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in Postmenopausal Persons Assigned as Female at Birth	The USPSTF (April 2018 – currently under review) recommends against daily supplementals with 400 IU or les of Vitamin D and 1000 mg or les of Calcium for the primary prevention of fractures in postmenopausal persons assigned as female at birth. (Grade D) The USPSTF (April 2018) finds inconclusive evidence that the benefits outweigh the risks for daily Calcium doses greater than 1000 mg of Vitamin D supplementation greater than 400 IU to prevent fractures. (Grade I) WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis prevention recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.

Resources: United States Preventive Services Task Force recommendations, American Academy of Family Physicians (AAFP), American College of Obstetricians & Gynecologists (ACOG), American College of Physicians (ACP), UpToDate®, the American Diabetes Association, "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," Centers for Disease Control and Prevention (CDC).

Distribution: Partnership Provider Manual, Department Heads

* Language updated to be non-gender specific.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3032 (previously UG100332)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/21/1995</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process

B. MCUP3013 – Durable Medical Equipment (DME) Authorization

~~B.~~C. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

~~A. Health Services~~

~~B.~~A. Claims

~~C.~~B. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the criteria for approval of orthotic and prosthetic appliances.

VI. GUIDELINE / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) covers orthotic and prosthetic appliances when such appliances are necessary for the restoration of function or replacement of body parts, or to support a weakened or deformed body member, when~~as~~ prescribed in writing (or electronic equivalent) by a physician, ~~a~~ podiatrist, dentist or a non-physician medical practitioner functioning within the scope of their license.

1. Partnership utilizes Medi-Cal guidelines and ~~InterQual®~~ other criteria as defined in policy MPUP3139 Criteria and Guidelines for Utilization Management to determine medical necessity for authorizations of orthotic and prosthetic devices.
2. External independent consultants may be utilized on a case-by-case basis.
~~1.~~3. Exceptions to these guidelines may be made based on the individual needs of the Member or the unique characteristics of the delivery system.

B. The definition of medical necessity is health care services that are necessary to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed appliances will be covered only as medically necessary to restore bodily functions essential to activities of daily living (ADLs) or instrumental activities of daily living (IADLs), to prevent significant disability or serious deterioration of

health, or to alleviate severe pain.

1. The prescribing physician, ~~or~~ podiatrist, dentist, or non-physician medical practitioner must supply the vendor with information required to document the medical necessity for the requested item.
2. The appliance or service requested must be consistent with the recipient's previous abilities and limitation as they relate to activities of daily living prior to the onset of disability or injury, or must be ~~is~~ appropriate to the recipient's chronological and developmental age.

~~2.~~3. The appliance or service requested ~~is~~must be consistent with the recipient's overall medical condition.

~~B.~~C. A Treatment Authorization Request (TAR) is required when the cost for repair/maintenance, purchase or rental exceeds $250 for orthotics or $500 for prosthetics.

1. TAR requests for orthotic or prosthetic appliances must include the diagnosis related to the functional disability, a copy of prescribing physician prescription, a statement concerning the Member's functional disability that would benefit from the appliance, and a statement explaining the reason more cost-~~-~~effective options would not meet the Member's needs.

~~C.~~D. A repair of an appliance will not be authorized when the repair cost is equal to or exceeds the purchase cost of a new appliance.

~~D.~~E. For appliance claims submitted by report, the vendor must list the item description, manufacturer name, model number, catalog page, suggested retail price, cost of part(s) used, cost of labor per hour and total cost/hours, description of and medical justification for any special features (custom modification or special accessories) and medical condition necessitating the appliance.

~~E.~~F. Orthopedic Shoes

1. Stock orthopedic and stock conventional shoes are a covered benefit when a. or b. is met below:
   a. At least one of the shoes is an integral part of a leg brace and is medically necessary for the proper functioning of the brace or
   b. The recipient has a diagnosis of Diabetes Mellitus and one or more of the following conditions:
      1) Current foot ulcers or a history of foot ulceration
      2) Previous foot amputation
      3) Peripheral neuropathy with evidence of callous formation of either foot
      4) Peripheral vascular disease
      5) Positive monofilament examination indicating diabetic neuropathy
      6) Deformity of either foot, such as rocker bottom foot or Charcot foot
2. Modification of stock conventional shoes or stock orthopedic shoes is covered when the patient's medical need can be satisfied with such modification.
3. Custom-made orthopedic shoes are reimbursable if the recipient's medical need cannot be met by modifications to stock orthopedic or stock conventional shoes. Clinical conditions that might require custom-made shoes include but are not limited to Charcot or rheumatoid foot deformities, some partial foot amputations, or when a patient requires a muscle flap to cover a large or unusual soft tissue foot defect that then is too bulky to be accommodated by an in-depth shoe.
4. The prescribing physician must document the nature, cause and severity of the foot problem leading to the conclusion that a custom-made orthopedic shoe is the only alternative (CCR, Title 22, Section 51315). A custom-made shoe has the following characteristics:
   a. Made and molded to patient model for a specific patient
   b. Constructed over a positive model of the patient's foot
   c. Made from leather or other suitable material of equal quality
   d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants
   e. Has some form of shoe closure

~~F.~~G. Custom Foot Orthotics

1. Orthotics are covered when medically necessary for the following acute or chronic foot conditions:

a. Rehabilitative foot orthotics following foot surgery or trauma
b. Plantar fasciitis
c. Inflammatory conditions such as bursitis of the foot, tenosynovitis, plantar fascial fibromatosis
d. Neurologically impaired feet
e. Vascular conditions of the foot including poor circulation or peripheral vascular disease
f. Musculoskeletal deformities such as bunions, hallux valgus, talipes deformities, toe deformities

2. Foot orthotics are not medically necessary and are not covered for the following conditions:
   a. Back pain
   b. Knee pain
   c. Pes planus (flat feet)
   d. Pronation
   e. Corns or calluses
   f. Hip osteoarthritis
   g. Lower leg injuries

H. Compression Garments
   1. Effective October 1, 2024, Partnership covers over-the-counter (OTC) compression garments as follows:
      a. Procedure code A6593 may be billed for OTC compression garments and will be limited to two units (per limb) every six months.
      b. Claims billed for greater than two units every six months will be denied for exceeding the service limitations.
      c. No prior authorization is required for this service and no invoice needs to be billed with the claim. A written physician prescription is required but does not have to be attached to the claim.
      d. The maximum allowable for this code is $50 per unit.

I. Dynamic Splinting
   1. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a ~~case by case~~case-by-case basis as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Orthotic and Prosthetic Appliances and Services *(ortho)*
~~B. InterQual® Durable Medical Equipment Criteria~~
B. Title 22 California Code of Regulations (CCR) 51315 and 51315.1
C. Partnership Benefits Review and Evaluation Workgroup (BREW) Form #24 OTC/Off-the-Shelf Compression Garments. (07/25/2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

06/1/00; 09/20/00; 12/19/01; 11/20/02; 09/15/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 11/08/23; 11/13/24; 11/12/25; 11/04/26

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

Guideline/Procedure Number: MCUG3032 (previously UG100332		**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines		☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/21/1995	**Next Review Date: 11/12/202611/04/2027** **Last Review Date: 11/12/202511/04/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)			**Lead Department: Health Services** **Business Unit**: Utilization Management	
Guideline/Procedure Title: Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~01/14/2027~~11/04/2027 **Last Review Date:** ~~01/14/2026~~11/04/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~01/14/2026~~11/04/2026	

I. RELATED POLICIES:

~~A.~~ MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~B.~~A. ~~MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities~~
~~C.~~B. MPUP3139 – Criteria and Guidelines for Utilization Management
~~D.~~C. MCUP3020 – Hospice Services
~~E.~~D. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
~~F.~~E. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~G.~~F. MPTP2501 – Transportation Policy for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
~~H.~~G. MPQP1016 – Potential Quality Issue Investigation and Resolution
~~I.~~H. MCRP4068 – Medical Benefit Medication TAR Policy
~~J.~~I. MPAP7003 – CalAIM Community Supports
J. MCAP7002 – CalAIM Enhanced Care Management (ECM)
K. MPCP2014 – Continuity of Care

II. IMPACTED DEPTS:

~~A. Health Services~~
~~B.~~A. Claims
~~C.~~B. Member Services
~~D.~~C. Enhanced Health Services (EHS)
~~E.~~D. Transportation
E. Provider Relations
F. Network Services
G. Quality and Performance Improvement

III. DEFINITIONS:

A. Custodial Care Facility: A non-medical facility (often referred to as a Long Term Care (LTC) facility) that provides basic assistance with daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability.
B. Extended Care Facility (ECF): A healthcare institution that provides on-going medical care, rehabilitation services, and assistance with activities of daily living to individuals who require prolonged or specialized care. This is an all-inclusive term for facilities providing custodial, skilled and sub-acute services.
C. Skilled Nursing Facility (SNF): A facility or part of a hospital that provides short-term medically

necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to complete a course of treatment that is not available in lower levels of care and support an increase in function, safety and independence with activities of daily living.

D. Subacute Care Facility: A facility that provides ~~with~~ a level of care that is less intensive than acute care but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).

E. Subacute Contracting Unit (SCU): A unit within the California Department of Health Care Services (DHCS), responsible for contracting with providers to offer Medi-Cal subacute care services. Contracted facilities may be reimbursed for subacute care services provided to Medi-Cal subacute beneficiaries who meet subacute care criteria as defined in Medi-Cal Manual of Criteria R-15-98E (adult beneficiaries) and Welfare and Institutions Code, section 14132.25 (pediatric beneficiaries). Specific reimbursement rates have been developed for providers of subacute care who have contracted with the DHCS' SCU.

IV. ATTACHMENTS:

A. Bed Hold/Change of Status Report form
B. Skilled Nursing Facility Request Form

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Extended Care Facilities for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Extended Care Facilities (ECFs)
   1. Partnership ensures access to licensed care facilities, irrespective of location in or out-of-network, to Members in need of extended care services. These facilities may include:
      a. Custodial/Long Term Care Facilities
      b. Skilled Nursing Facilities (SNF)
      c. Subacute Care Facilities (pediatric and adult)
   2. A Member in need of extended care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the Member to the appropriate type of facility.
   3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and Partnership Utilization Management (UM) team identifies the most appropriate level of care for the Member and assures that the Member is placed in a health care facility that provides the level of care most appropriate to the Member's medical needs.
      a. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e).
      b. DHCS Title 22 regulations, as well as CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* are utilized by Partnership UM Nurse Coordinators when performing reviews of authorization requests to determine the medical necessity for continued placement in an extended care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended.
   4. Extended Care Classification categories include the following:
      a. Custodial/Long Term Care: These facilities assist members in meeting their activities of daily

living (ADLs) such as eating, bathing, grooming, etc. Members must meet criteria showing need for this level of care. Following admission to the facility, members will continue to be reevaluated periodically to ensure medical necessity is met for continued placement.

b. Skilled Nursing Care: The Member may need a short-term stay for a skilled nursing care need or short-term rehab services and is expected to return to their previous living arrangement or alternate level of care. Facility staff, including case managers, are responsible for coordinating discharge planning for the member.

c. Subacute Care: The Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care can either ~~can~~ be ~~either be~~ short term, where there is potential for the Member eventually being transferred to a lower level of care; or custodial/long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these Members are authorized for time intervals based on the characteristics of the Member's medical condition.

5. The choice of an ECF for a patient is a decision that should include consideration of the following:
   a. What are the medical/ rehabilitation needs for the member and does the facility have the services available to meet the Member's needs?
   b. Is the facility a licensed Medi-Cal provider?
   c. Is the facility contracted with Partnership?
   d. Are there beds available?
   e. If more than one choice is available, is there a family preference (e.g. geographical location) that can be reasonably accommodated?
   f. Are there any benefit coverage limitations?
6. Facility Requirements
   a. An ECF must meet all of the following requirements:
      1) It must be a licensed institution
      2) It must be qualified as a provider of services under Medi-Cal
      3) It must maintain, on the premises, all facilities necessary for medical care and treatment
      4) It must provide such services under the supervision of a physician
      5) It must provide services given by or supervised by a registered nurse AND
      6) The facility must keep medical records on all patients
   b. For Members approved for subacute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

B. Members with Other Healthcare Coverage
1. When Members have other healthcare coverage (e.g., Medicare) Partnership will work to coordinate benefits as applicable.

C. Treatment Authorization Requests (TARs) for Admission to an Extended Care Facility (ECF)
1. In alignment with Manual of Criteria R-15-98E, an initial Treatment Authorization Request (TAR) is required with each admission to an ECF. A TAR is required when the Member:
   a. Is a new admission to the facility
   b. Has exhausted their Medicare benefits
   c. Has received a denial from Medicare or other insurance for extended care
   d. Is readmitted to an ECF from an acute care hospital
   e. Returns to an ECF from an approved leave of absence beyond the approved return date
   f. Is newly eligible with Partnership while residing in the ECF
      1) Partnership will provide continuity of care pursuant to H&S section 1373.96 for Members receiving services who transition from another Managed Care Plan. Partnership will also retroactively approve a continuity of care request and reimburse Providers for services that

were already provided if the request meets all continuity of care requirements outlined in APL 23-022, or any superseding APL. Refer also to policy MPCP2014 Continuity of Care.

~~f.~~g. Changes level of care (e.g. Skilled to Custodial, Custodial to Skilled, Subacute to Skilled)

2. A UM Nurse Coordinator reviews the authorization request for medical necessity and level of care utilizing DHCS Title 22 regulations and/or CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*.
   a. Cases not meeting criteria for medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for review and determination.
   b. Upon review, a UM Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity. Only the CMO/ Physician Designee can deny a TAR for reasons of medical necessity.
   c. A determination will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6 and according to APLs 26-010 and 26-011.
      1) Prior Authorization requests for Members transitioning from an acute care hospital are considered to be expedited and will be processed with a response time of no greater than 72 hours, including weekends.
      ~~1)~~ Non-urgent custodial requests are processed with a response time of no greater than seven (7) calendar days.
      2)
   ~~e.~~d. Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what Partnership approves.
   ~~d.~~e. The facility is responsible for verifying the Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.
3. Extensions of Stay
   a. Extensions of stay in extended care facilities for Medi-Cal Members require re-authorization by Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
   b. Extension requests will be reviewed based on the facility's documentation of the Member's current clinical status and medical need of requested extension, including current services required, anticipated duration of services and progress towards goals of therapy in the prior approved stay, and current discharge disposition/ planning as noted by the facility's team.
4. Admissions on Weekends and Outside Normal Business Hours
   a. If a member is transferred to a facility on a weekend, or outside normal business hours, Partnership must be notified via phone or the Online Services (OLS) portal on the next business day for immediate review of the TAR.
   b. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.
5. Custodial (Long Term Care) TAR Submission Requirements:
   a. Custodial care services require prior authorization by a Partnership UM Nurse Coordinator before admission to a Custodial facility, otherwise, the stay may be denied for not meeting medical necessity.
   b. A custodial care authorization request shall be initiated by the ECF, and the following documentation must be submitted with the initial Custodial Care TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.

b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.

2) MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
   a) For Partnership members with Supplemental Security Income (SSI), the ECF is required to submit the MC171 form to the Social Security Administration (SSA) within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
   b) Partnership's Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form for all Partnership members with SSI. If a facility does not submit the MC171 form, the TAR will be sent to the CMO/Physician Designee for review and denied for "information requested not received." The facility will be notified.
3) Medicare or other Insurance denial letter (if applicable)
4) Completed Minimum Data Set (MDS) dated within the past 90 days
5) PASRR (Preadmission Screening and Resident Review)

c. When a member is admitted for custodial care, a TAR submission may be approved up to a six (6) month period.
d. The Member's condition will be re-evaluated upon submission of a new TAR within 15 days of the expiration date of the previous TAR.
e. Continued Care (Reauthorization) with a new TAR must include the following:
   1) Completed new TAR form
   2) Current MDS dated within 90 days of TAR start date
   3) Social Services annual review/quarterly assessment and progress notes

6. Skilled Nursing Facility (SNF) TAR Submission Requirements:
   a. Skilled level nursing is a covered level of care for Partnership Members. This level of care is short-term for the acute rehabilitation stage of treatment following an illness or injury.
      1) A member in custodial care may be considered for short-term SNF level care for Isolation Days for communicable diseases per California Department of Public Health (CDPH) guidance and per the determination of the local health officer.
   b. Admission to a SNF must be coordinated with a contracted Medi-Cal licensed facility by the discharge planner.
   c. Skilled nursing services require prior authorization by Partnership before a Member's admission to a SNF.
   d. The following documents must be submitted with the initial SNF TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) PASRR (Preadmission Screening and Resident Review)
      3) Acute notes
      4) Medicare or other health coverage denial letter
      5) Eligibility must be "No Other Insurance"
      6) Skilled Nursing Facility Request form (Attachment B)
      7) MD orders as applicable to facility type (see VI.C.8. and 9. below)
   e. The following documents must be submitted for a SNF TAR extension:
      1) MD orders from SNF
      2) Nurse and attending physician/ medical provider notes showing medical need for SNF care (e.g. wound care, IV antibiotics) and anticipated duration of need
      3) Therapy progress report indicating current level of participation, progress notes and goals of

treatment
4) Discharge planning documents

7. Subacute Care Facility TAR Submission Requirements:
   a. The following documents must be submitted with the initial Subacute Care Facility TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      3) Acute notes to include therapy notes (e.g. physical therapy, speech therapy, occupational therapy, respiratory therapy)
   b. Note: For Members approved for sub-acute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
   c. The following documents must be submitted for a Subacute TAR extension:
      1) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services (if dates are applicable)
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      2) Facility progress notes
      3) MD orders
   d. Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of six months.
      1) Extensions are reviewed based on medical need for the care that is provided. Facilities must provide current records showing the Member's current clinical status, participation in therapies, progress toward goals and discharge planning.
   e. Approval for pediatric subacute care services ceases once the Member turns 21 years of age. Authorization requests for pediatric Members should not exceed the Member's 21st birthday; therefore, discharge planning to an appropriate adult level of care must be completed at least two months prior to the Member's 21st birthday.
8. Authorizations for Transfers from Acute Care to an Extended Care Facility (ECF)
   a. Please Note: If admission from acute care occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. The ECF is required to notify Partnership before any admission. Prior authorization is required for all admissions.
   c. UM Nurse Coordinator will review documents and provide initial determination approval.
   d. The transfer must be coordinated by the hospital discharge planner or case worker.
9. Admission from Home to an Extended Care Facility
   a. Please Note: If the admission from home occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. An ECF facility is required to notify Partnership before any admission. Prior authorization is required for all admissions from home.

1) The following information must be submitted with the TAR:
   a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in an ECF and the physician's certification that placement in the particular ECF is the appropriate level of care for the Member.
   b) If placement follows an acute hospital stay within the past 30 calendar days, the hospital history and physical and discharge summary must be submitted.
   c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months must be submitted.

10. Bed Hold Change of Status Reporting
    a. This occurs when a Member residing in an ECF is transferred to an acute care hospital or has an approved leave of absence, which must be reported through the Bed Hold/ Change of Status Report form (Attachment A).
    b. The maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
    c. The following documents must be submitted when reporting a Bed Hold change of status:
       1) MD orders
       2) Bed Hold/Change of Status Report form (Attachment A)
    d. When a custodial Member returns to the ECF prior to or on the 8th calendar day, the existing ECF TAR is still valid.
    e. If a Partnership Member returns to an ECF after 8 calendar days, a new ECF TAR and all required attachments must be submitted (see initial TAR submission requirements described above according to facility type.)
    f. NOTE: The ECF must notify Partnership when a Member is readmitted to the ECF. Claims will not be paid if the readmission is not appropriately reported to Partnership.

D. Denials
   1. Cases determined not to meet ECF admission criteria or continued stay criteria based on DHCS Title 22 regulations, CMS regulations, other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* and the information available at the time of review, are managed as follows:
      a. If the UM Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
      b. Denials of medical necessity are determined only by the Partnership CMO/ Physician Designee.
      c. UM staff will ensure the Member, provider, and facility are notified verbally and/or in writing as appropriate. Notice of Action letters will include the applicable appeal rights as described in policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions*.

E. Criteria for Ending or Modifying an Active TAR
   1. Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
      a. Member's death (Partnership must be notified within 24 hours of Member expiring)
         1) If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable
         2) Notification of a Member's death should include whether the death occurred within the ECF

or in an acute care facility.

b. Exhausted 7 calendar day bed hold
c. Discharge to other health insurance payor (e.g., Medicare)
d. Discharge to hospice care (see policy MCUP3020 Hospice Services for requirements)
e. Discharged to home or transfer to another ECF
f. Change in level of care (e.g. Custodial to Skilled or Skilled to Custodial)

2. For all of the above, Partnership recommends that the ECF submits a Bed Hold/Change of Status Report form (Attachment A).
   a. For all circumstances except death (which requires notification within 24 hours), a Bed Hold/Change of Status form (Attachment A) should be submitted within seven (7) days.

F. Quality Monitoring and Review
1. The UM Nurse Coordinator assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies as requested.
2. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue, the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.

G. Policies for Other Services or Supports
1. Facility Therapy Services
   a. Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.
      1) Therapy services provided to the Member that are covered by the per diem rate include, but are not limited to:
         a) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
         b) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
         c) Care to prevent formation and progression of decubiti, contractures and deformities, including:
            i. Changing position of bedfast and chairfast recipients
            ii. Encouraging and assisting in self-care and activities of daily living
            iii. Maintaining proper body alignment and joint movement to prevent contractures and deformities
2. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in an ECF, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, *Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components*, regarding provision of wheel-chairs for Members residing in a skilled nursing facility.
   b. The ECF is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.

3. Transportation
   a. For all transportation needs, please refer to Partnership's policy MPTP2501 Transportation Policy for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
4. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM) for further details.
   b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For Members currently in a LTC setting who may benefit from Community Supports, please refer to Partnership policy MPAP7003 CalAIM Community Supports (CS)
5. Partnership has a Long-Term Services and Supports (LTSS) Liaison who assists facilities in addressing claims and payment inquiries and coordinates support for LTSS providers to best meet Members' needs. Contact information for Partnership's LTSS Liaison can be found on this webpage: https://www.partnershiphp.org/providers/medi-cal/dhcs-directed-payments-programs~~https://www.partnershiphp.org/Providers/Medi-Cal/Pages/DHCS%20Directed-Payments-Programs.aspx~~

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual:
   1. Subacute Care Programs: Level of Care for Adults and Children (*subacut lev*)
   2. Subacute Care Programs: Adult *(subacute adu)*
   3. Subacute Care Programs: Pediatric (*subacut ped*)
   4. Leave of Absence, Bed Hold, and Room and Board *(leave)*
   5. TAR for Long Term Care: 20-1 Form *(tar ltc)*
   6. TAR for Long Term Care (Form 20-1): Inpatient Services *(tar ltc ip)*
   7. TAR Completion for Long Term Care *(tar comp ltc)*

~~B. InterQual® criteria~~

~~C.~~B. Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services

~~D.~~C. Title 22 California Code of Regulations (CCR) Sections 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51134, 51335, 51335.5, 51335.6, 51321(h), 51535, 51535.1, 72520

~~E.~~D. Title 42 Code of Federal Regulations (CFR) Section 483.15e

~~F.~~E. Welfare and Institutions Code (WIC) §14132.25

F. Health and Safety Code (HSC) § 1373.96

G. Title 28, CCR § 1300.67.1 *Continuity of Care*

H. DHCS All Plan Letter (APL) 15-018 dated 07/09/2015 -Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components

I. All County Welfare Director's Letter ACWD 25-02 2025 Statewide Average Private Pay Rate for Nursing Facility Services (01/22/2025)

J. DHCS APL ~~24-009~~26-010 Skilled Nursing Facilities - Long Term Care Benefit ~~Standardization and Transition of Members to~~Under Managed Care (~~09/16/2024~~06/10/2026)

K. DHCS APL ~~24-010~~26-011 Subacute Care Facilities - Long Term Care Benefit ~~Standardization and Transition of Members to~~ Under Managed Care (~~09/16/2024~~06/10/2026)

L. DHCS Subacute Care Program and Manual of Criteria R-15-98E

M. California Department of Public Health Healthcare-Associated Infections Program: Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California

Skilled Nursing Facilities (2025 – 2026)

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

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

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

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

PREVIOUSLY APPLIED TO:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

REGULATOR APPROVAL:
DHCS – last approved on 04/02/2025 for APL 24-009
DHCS – approved on 02/14/2025 for APL 24-010
DHCS – approved on 09/23/2024 for APL 23-027

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Prenatal & Perinatal Care</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/22/1994 (Policy HS-1)</td><td colspan="4">Next Review Date: ~~10/08/2026~~11/04/2027
Last Review Date: ~~10/08/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/08/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3141 – Delegation of Inpatient Utilization Management
B. MPQP1022 – Site Review Requirements and Guidelines
C. MPBP8003 – Mental Health Services
D. ~~MPCP2017~~ MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
E. MP~~C~~NP~~D~~9006 – Doula Services Benefit
F. MPCR15 – Doula Credentialing
G. MCUP3124 – Referral to ~~a~~ Specialists (RAF) Policy
H. MCUP3052 – ~~-~~Medical Nutrition Therapy (MNT) Services
I. ~~MCCP2020~~ MPNP9007 – Lactation Policy and Guidelines
J. MCUP3113 – Telehealth Services
K. ~~MCQG1015 – Pediatric Preventive Health Guidelines~~CLPM31 – Obstetrical Services

II. IMPACTED DEPTS:

A. ~~Health Services~~Care Coordination
B. Claims
~~—~~Member Services
C. ~~Care Coordination~~

III. DEFINITIONS:

A. Comprehensive perinatal services are defined as obstetrical, psychosocial, nutritional, and health education services and related case coordination provided by or under the personal supervision of a physician during the perinatal period.
B. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is administered and approved by the CDPH. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*see also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)
C. Certified Nurse Midwife is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing. (*see related definition for Licensed Midwife below)*

D. Doula: A trained birth worker credentialed by Partnership who provides health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.
E. Licensed Midwife is licensed as a Midwife by the Medical Board of California.
F. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *(see also the Comprehensive Perinatal Services Program (CPSP) definition above)*
G. Perinatal Case Manager: Provides ~~services of health education and case management~~health education and case management services in a perinatal program using CPSP or other protocols and under the supervision of the Clinical Director.
    1. A Perinatal Case Manager is equivalent to a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program
H. Perinatal services are defined as pregnancy-~~-~~related services ~~given~~ provided before and during delivery and for a period of 12 months following delivery
I. Professional Organizations: The primary professional organizations representing Obstetricians/Gynecologists, Family Physicians, Nurse Midwives, and Licensed Midwives in the United States are listed below. These organizations develop clinical guidance, provide educational resources, advocates for health care, and set standards of care for obstetric and gynecologic practices.
    1. American College of Obstetricians and Gynecologists (ACOG)
    2. American Academy of Family Physicians (AAFP)
    3. American College of Nurse-Midwives (ACNM)
    ~~2.~~4. National Association of Certified Professional Midwives (NACPM)

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IV. ATTACHMENTS:

A. Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form
B. Partnership Perinatal Case Management TAR Thresholds
C. Applying for the CDPH CPSP program

V. PURPOSE:

To describe, define and provide guidelines for the perinatal services to be provided to Members of Partnership HealthPlan of California (Partnership).

VI. GUIDELINE / PROCEDURE:

A. Goals of the Partnership HealthPlan Perinatal Services (PHPS) Program
    1. To make comprehensive perinatal services accessible to all pregnant Partnership Members.
    2. To assure all Members initiate prenatal care within the first twelve (12) weeks of pregnancy and pregnant Members who are new to the HealthPlan obtain prenatal care on the enrollment start date or within forty-two (42) calendar days after enrollment in the Plan.
    3. To support and expand the range of comprehensive perinatal services provided to Partnership Members.
    4. To strongly encourage obstetrical (OB) providers to become CPSP certified providers or to have an agreement with a CPSP provider to provide comprehensive perinatal services.
    5. To inform all Partnership Members about the availability of comprehensive perinatal services and the added benefits of these programs.
    6. To assist Members with engaging in perinatal services-.
    7. To assess each Member during each trimester and postpartum, utilizing an assessment tool and to develop an individualized care plan that addresses deficiencies for:
        a. Psychosocial Needs/ Risks/ Concerns (prenatal tool / postpartum tool)

b. Health Education Learning Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
c. Nutrition (prenatal tool / postpartum tool)

8. To increase provider awareness of comprehensive perinatal services and the potential benefits for pregnant Members.

B. No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable.

~~B.~~C. Partnership HealthPlan Perinatal Services (PHPS)

1. All pregnant Members are eligible to receive perinatal case management services.
   a. Partnership encourages universal participation in the CPSP and CPSP-like programs, collectively called Partnership HealthPlan Perinatal Services (PHPS). Members are eligible for PHPS services from the time they believe they may be pregnant through 12 months post-partum.
   b. PHC offers a perinatal program called the Growing Together Program, open to all pregnant and post-partum individuals.
   c. For patients with additional needs and risks, Partnership shall refer Members to Partnership Care Coordination and local resources for programs (e.g. Enhanced Care Management (ECM), home visiting programs, Black infant health, targeted case management, etc.).
2. Program materials for PHPS are subject to audit and review during the Site Review process at least every three years for prenatal care providers and Perinatal Case Managers.
   a. A PHPS program may submit claims for services using Z-codes for any affiliated practice site.
   b. PHPS services may be performed in the home, office or via telemedicine, using the appropriate modifiers and place of service codes.
   c. Partnership allows all practices sites of a provider organization that has a CDPH-approved CPSP program to submit claims for perinatal services using applicable CPSP billing codes for the services provided.
3. Modular Approach: All organizations/ Perinatal Services Pro~~-~~grams with or without a CDPH-certified CPSP program are expected to follow the statutory standards. To meet Member needs, PHPS/CPSP providers may provide and bill for a subset of perinatal support services. If a Perinatal Services ~~CPSP~~ program is unable to provide comprehensive services, they are expected to partner with other providers to ensure all Member needs and program requirements are fulfilled. In the event that PHPS or CDPH-certified programs experience a temporary challenge with providing a subset of CPSP/PHPS services due to staffing or capacity challenges, they are also expected to solicit partner organization(s) to fill any gaps. To accomplish this, perinatal providers may submit claims for any CPSP service, whether or not they are providing case management services. For example, “CPSP-like Program A” may provide case management for a member but needs to use a Registered Dietician (RD) at “CPSP-like Program B” to provide nutrition education services. Each program will bill for the services that they provide and ensure that any services and assessments are centralized in the care plan of the program providing primary case management responsibilities (in the example, “CPSP-like Program A”).
4. Partnership Tracking of Perinatal Services Providers: ~~-~~To ensure Partnership oversight of Perinatal Case Management Services, all PHPS providers (including both CPSP programs and providers offering CPSP-like services) need to complete an application (see Attachment A).
   a. All components of the PHPS program relying on outside providers (including delivering providers) require a written letter of agreement from the outside provider.
   b. Providers that may have a PHPS program include: physicians specializing in OB/GYN, Pediatrics, Family Physician; a physician group; a health center, including Federally Qualified Health Centers, Rural Health Centers and Tribal Health Centers; an alternative birthing center; a county run health clinic; a hospital outpatient clinic; a Certified Nurse Midwife run practice; a Licensed Midwife practice.

c. Quality Monitoring of PHPS providers will be completed as follows:
   1) At the time of the Site Review of all PHPS and perinatal providers which occurs at least every three years
   2) Monitoring of grievances
   3) Reviewing administrative data to evaluate quality outcomes and utilization. Specific measures to be evaluated include:
      a) The percentage of all deliveries in which a patient has at least one PHPS service
      b) The percentage of pregnant members with at least one PHPS service who complete at least:
         i. Tthree antenatal and one postpartum PHPS case management -visits/ -(? Comprehensives Assessments)
         ii. Oone mental health service (either PHPS service or other)
         iii. Ffour nutrition services (either PHPS or other)
         iv. Oone doula visit

5. In areas with a hospital capitation agreement, perinatal services including antenatal care, labor and delivery services, should be provided by perinatal providers who deliver at or collaborate with delivery teams at the contracted hospital nearest the Member or a hospital associated with capitation agreements that pertain as related to Member's primary care or other capitation factors.
   a. Exceptions to this include emergency deliveries and out-of-area hospital admissions authorized according to policy MCUP3141 Delegation of Inpatient Utilization Management, Members determined to be high risk who require the services of a perinatologist, and pregnant Members who are not assigned to a primary care provider because they are in a Direct Member category.
   d.b. Members may choose a midwifery provider outside of their capitated facility iof that facility does not offer midwifery services for delivery.

5.6. Obstetrics providers and Perinatal Services Providers are encouraged to refer Partnership Members who are pregnant to Partnership's Growing Together Program for support and to assist Members with connections to community resources when and where appropriate.

6.7. Obstetrics providers are encouraged to refer Partnership Members who are pregnant that may have clinical, behavioral and/or psycho-social risk, or those who have intensive case management and/or care coordination needs to Partnership's Care Coordination department for support.

7.8. All providers of perinatal services must deliver services in conformance with the following:
   a. Current ACOG Standards for Obstetric-Gynecologic Services, (available at this website): https://www.acog.org/clinicalhttps://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187e.ashx

   a.

   b. DHCS All Plan Letter (APL) 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members.

   c. Perinatal Services care should generally follow the CPSP Provider Handbook rogram guidelines
      1) Provider Resource Documents https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Provider-Resource-Document.aspx
      2) CPSP Program page https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx#
      3) CPSP Provider Handbook https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/Archive/CPSP-Provider-Handbook.pdf

   and fulfill screening ns as outlined in DHCS . which can be found in the CPSP Provider Handbook. Updated s to these practice based guidelines may be made, but these should be standardized and memorialized in written clinical policies, procedures and protocols. SpecifPHPS program protocals

~~should include the following ic recommendations for addition are:~~

~~1) Screening for Perinatal Mood Disorder with evidenced based tool such as Edinburgh or PHQ 2 or 9 in the first trimester and throughout pregnancy and post-partum~~

~~2) Screening for Adverse Childhood Events (ACES). See Partnership policy MCQG1015 Pediatric Preventive Health Guidelines~~

~~3) Universal Substance Use Screening using the 4Ps Plus or other evidenced based standardized screening tool to screen for substance use~~

~~4) Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7~~

~~b. Screening for Intimate Partner Violence~~

~~APL 26-0005~~

~~c. Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and by CPSP-like programs.~~

d. Newborn Screening Regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.

e. Hemolytic disease of the Newborn Requirements as set forth in Title 17, California Code of Regulations, Section 6510 et seq.

f. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code.

g. The California Prenatal Screening Program https://www.cdph.ca.gov/Programs/CFH/DGDS/pages/pns/default.aspx~~.~~

9. Updates to individual practice-based guidelines should be standardized and memorialized in written clinical policies, procedures and protocols. PHPS program protocols should include the following screenings:
   a. Screening for Perinatal Mood Disorders at the first prenatal visit, throughout pregnancy, and in postpartum visits using an evidence-based tool such as Edinburgh or PHQ-2 or PHQ-9
   b. Screening for Adverse Childhood Events (ACES)
   c. Universal Substance Use Screening using the 4Ps Plus or other evidenced-based standardized screening tool to screen for substance use
   d. Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7
   e. Screening for Intimate Partner Violence (IPV)

~~Pregnant and post-partum patients must be screened for perinatal mood disorders using a standardized tool~~

~~g. Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation.~~

10. Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs.

~~h.~~ Patients who meet diagnostic criteria or have risk factors for perinatal mood disorders should be referred to a behavioral health specialist for further treatment (see policy MPBP8003 Mental Health Services and/or policy ~~MPCP2017~~ MPBP8011 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines).

a.

~~8.~~11. ~~Perinatal service providers include all of the following~~ Ppractitioners who~~for~~ ~~the purpose of~~ provide~~ing~~ perinatal services include:

a. Physicians who are general practitioners, family medicine physicians, pediatricians, or obstetrician-gynecologists
b. Certified Nurse Midwives
c. Licensed Midwives
d. Nurse Practitioners
e. Physician Assistants
f. Registered Nurses, Licensed Vocational Nurses, Social Workers, Health Educators, Childbirth Educators, Registered Dietitians, Comprehensive Perinatal Health Workers or Perinatal Case Managers

~~9.~~12. Doulas can provide non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion ~~in accordance with Doula policy : XXXX~~ as described in policy MPNP9006 Doula Services Benefit.

~~C.~~D. PHPS Standards of Perinatal Case Management

1. All obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, mental health and psychosocial risks, on all pregnant Members at the initiation of pregnancy related services.
   a. The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member
2. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period. All identified risk conditions must be followed up by interventions designed to eliminate or remedy the condition or problem in a prioritized manner.
3. Individualized care plans must be developed to include obstetrical, nutritional, health education and psychosocial interventions when indicated by identified risk factors.
4. Every PHPS program must have ~~should have~~ a designated Clinical Director who may be an OB/GYN, a Family Physician, ~~-~~ a Certified Nurse Midwife or Licensed Midwife, Physician Assistant-c, or Nurse Practitioner. The Clinical Director approves all clinical policies, procedures, and protocols; oversees quality oversight of the program; and keeps the staff updated on major advances related to perinatal standards of care.
   a. All Clinical Directors will function within the scope of their license.
5. Perinatal Providers may use group visits for prenatal nutrition, behavioral health and health education issue to address concerns that are identified (using the appropriate group visit CPSP codes)
6. Postpartum health education group visits (using code Z6412) can include topics related to parenting.
7. All services/resources provided must be clearly documented on the Care Plan in the Member's medical record.
8. A non-CPSP provider may choose to use a trained staff person to administer the comprehensive risk assessments and to make referrals to a PHPS or CPSP program or other appropriate program for interventions and completion of care plans.
9. Initial visits with the perinatal case manager are highly recommended to be conducted in-person.
10. Obstetrics care office visits may occur via telemedicine when a clinical exam is not medically needed.
11. Group prenatal obstetrical visits using the centering pregnancy model should include (with appropriate chart documentation) a brief individualized visit with the clinician, which would then qualify as a prenatal care visit.
12. Providers for PHPS
    a. Case management services may be provided by a Perinatal Case Manager/CPHW meeting the qualifications specified by the CPSP program.
    b. Nutrition education services:

1) Perinatal Case managers are expected to provide core educational messages related to nutrition and nutritional risk assessment. These services would be included in their case management services and not billed separately. Targeted nutrition education services may be billed with the nutrition-specific Z-codes, when provided by one of the following:
   a) Nutritionist or Nutrition Coach: General information on healthy diet in pregnancy, which may include motivational interviewing techniques, may be provided by a health educator, a community health worker, or other staff person who has completed at least 6 months of training in nutrition and health coaching. Complex dietary needs or issues would be referred to a Registered Dietician
   b) Certified Registered Dietician: May perform general nutrition education, but also has the expertise to handle more complex issues, such as diet modifications for obesity, gestational diabetes, celiac disease, hyperemesis, food allergies, restrictive diets (such as those with no dairy products or no meat), etc. In addition, many Rregistered Ddieticians (RD) are Ceertified Ddiabetes Care and Eeducationors Specialists (CDCES), and the usual nutritional Z-codes can be used when billing for these services by a Registered Dietician.
   c) Pregnant individuals can be more motivated to make changes, and obesity is usually very difficult to treat with little nutrition services available to non-pregnant individuals; we highly recommend that all individuals with a pre-pregnancy BMI greater than 25 have at least one visit with a Nutritionist or Nutrition coach, with additional visits if the patient needs them to reinforce changed behavior.

c. Mental Health Services
   1) Perinatal Case Managers
      a) Perinatal Case Managers are expected to screen for depression and anxiety as part of their initial, ongoing and post-partum assessments and to recommend and arrange for referrals for birthing individuals who screen positive.
         i. Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation.
      b) Additionally, Perinatal Case Managers / CPHWs are expected to offer support and encouragement and to encourage social activities to build mental health resilience.
      a)c) These services would be included as part of their case management services, but they are encouraged to bill separately for depression screening so such screening can be captured using claims data, using one of the following codes:
         i. Preferred:
            a. HCPCS: G8431 for a positive screen with a plan
            b. HCPCS: G8510 for a negative screen
         ii. Other option:
            a. CPT: 96127 used for each screening tool used (can bill two units if G codes above not used and both the PHQ2 ≥ 9 (for depression) and the GAD 2 ≥ 7 (for anxiety) are used). If the depression screening is reported using the G-codes above, if a GAD is also done, it can be reported using one unit of 96127.
            b. ICD10: use Z13.31 if screening is done on patient without symptoms concerning for depression or anxiety; use a more specific code if a screening is done in response to signs or symptoms.
   2) Mental Health Counselors (including counseling for substance use disorders):
      The United State Preventive Services Task Force (USPSTF) recommends that ALL low-income pregnant individuals receive preventive counseling on building resilience and detecting early signs of depression and anxiety that would require evaluation. Such

preventive counseling, and counseling for mild dysphoria, can be provided by a community health worker (CHW) or health educator with special training on such preventive mental health counseling, under the supervision of a licensed mental health clinician. The mental health Z-codes may be used.

3) Licensed mental health and substance use professionals:
Any licensed mental health or substance use professional may provide mental health and substance use services to pregnant patients using the mental health Z-codes. This includes psychiatrists, clinical psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, certified alcohol and drug abuse ~~counselors etc.~~counselors etc. The CPSP or CPSP-like program hiring these mental health/behavioral health specialists is responsible for ensuring that the clinical problems addressed by the individual professionals match their training and experience.

d. Perinatal Health Education services may be provided by staff with the qualifications outlined in the CPSP program or by educators or health workers with specific training competencies related to one or more aspects of wellness for birthing individuals. Education conducted in the course of routine prenatal/post-partum/peripartum care provided by clinicians or doulas is not separately reimbursable; it is considered a part of their professional services. Separate and stand-alone educational services, whether individual or in a group setting, may be billed by a CPSP program or a CPSP-like program using the education Z-codes. CHW provided education may be billed as a CHW service or a perinatal education service, but not both.

~~D.~~E. CPSP/Perinatal Services Case Management Responsibilities

1. The Perinatal Case Manager/CPHW is expected to plan and ensure the provision of comprehensive perinatal services, including nutrition, health education, and psychosocial assessments and reassessments, individualized care plan development, coordination of services, and referrals. At a minimum, for low-risk individuals, four case management visits are recommended: one in each trimester and one in the post-partum period.
2. The Perinatal Services case manager must assure that the following has been provided to the Member and documented in the medical record:
   a. An orientation about the purpose of the Perinatal program and the guidelines about the services which have been offered
   b. Identify the location/ provider of medical prenatal care, with planned location of delivery.
   c. Review the warning signs and symptoms that warrant urgent attention and office procedures for the perinatal services.
   d. Information about the available adjunctive referral services available to the Member.
   e. Advise the Member about their rights and responsibilities in accepting or refusing the services offered.
   f. Notification regarding Partnership appeal and grievance policies.
   g. ~~An offering~~ Complete ~~of~~ the initial nutrition, health education and psychosocial assessments~~,~~; ~~and~~ develop an individualized care plan~~, development,~~; and offer ~~including~~ both individual and group interventions for each service as recommended in the individualized care plan~~s~~.
   h. Documentation of referrals to services which are not specifically included in the definition of comprehensive perinatal services, but which are appropriate for the medical and/or psychosocial health of the Member, should be noted in the record by the Perinatal case manager.
3. The Perinatal Services case manager must use orientation, assessments, re-assessments, individual and group process interventions and family support participation as methods for the provision of comprehensive perinatal services.
   a. Standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary ~~at least~~ each trimester and at the post-partum visit, more frequently as needed.

1) The CDPH standardized tool or a modification of this tool may be used, but it should be standardized and documented in the provider's organizational policies and procedures and, where feasible, integrated into the shared medical record.

b. Each component of the individualized care plan should identify risk conditions; prioritize the Member's needs, referrals, and proposed interventions including methods, time frames and outcome objectives for psychosocial, health education, and nutrition services.

c. The perinatal provider must document the assessment of the member's obstetrical status at each visit.

4. A Member has the right to decline to participate in any part of the Comprehensive Perinatal Services Program. This should be documented clearly in the medical record.
   a. Members who initially declined should be offered services throughout pregnancy and postpartum period
5. Within 3 business days of completion of an initial problem list and care plan, and upon update of this care plan each trimester, a copy must be transmitted to the prenatal care provider in a manner agreed upon by the PHPS provider and the prenatal care provider. Any urgent changes or developments should be additionally communicated via phone, secure text, a centralized health information exchange, or secure email (as requested by the prenatal care provider).
6. Providers of PHPS must submit a TAR to Partnership for the provision of services in excess of the Partnership maximum frequency allowance for nutrition, psychosocial and health education services.
7. Perinatal Services providers must maintain an updated list of staff working in their program, with their job titles and training/licensure. These will be reviewed at Site Reviews of the perinatal provider at least every 3 years.
   a. These will be provided to Partnership upon request and submitted with PHPS applications and updates.

~~E.~~F. Perinatal Services Health Education Roles

1. Provide education based on the Assessment and Reassessment in the following areas with supervision of licensed clinical staff and referral to Behavioral Health/Nutritionist/Licensed clinical staff per agency protocols:
   a. Pregnancy related nutrition
   b. Behavioral Health self-management, goal setting and motivational interviewing
   c. Lactation support education and lactation counseling

~~F.~~G. Diabetes Care in Pregnancy (formerly known as "Sweet Success" programs)

1. Birthing people with diabetes are at risk of a variety of serious complications for both the birthing person and their baby. A large body of research shows that intensive education, case management and obstetrical support reduces the incidence of complications and improves outcomes (summarized by the American Diabetes Association in the references).
2. To optimize outcomes for pregnant persons with diabetes, the PHPS program allows for the following services:
   a. Diabetes education (including the use of continuous glucose monitoring) may be provided by any Certified Diabetes Care and Education~~or~~ Specialist (CDCES), whether through a PHPS provider or through any other Partnership contracted CDCES. When a Registered Dietitian (RD) performs CDCES services in a PHPS program, the nutrition Z-codes may be used. When a contracted RD performs CDCES services outside of a PHPS program, the codes listed in policy MCUP3052 Medical Nutrition Therapy (MNT) Services may be used. If a nurse within a PHPS program conducts CDCES services, the education Z-codes may be used.
   b. Extra perinatal case management services are required for optimal outcomes in patients with pregnancy and diabetes. Any TARS for increased visit frequencies for diabetes in pregnancy will be evaluated with this in mind.
   c. Diabetes education for pregnant individuals may be done either in-person or through video

telemedicine visits.

d. While any licensed prescriber may adjust medications for diabetes in pregnancy, expertise and experience in this area is associated with tighter control and improved outcomes. Ideally there is a hierarchy of expertise in such prescribing, with all levels thoroughly educated on and in alignment of the goal of excellent blood sugar control in a pregnant individual. The details of the hierarchy can vary, but may include a CDCES-RN adjusting medication via a written protocol under supervision of a physician with expertise in more complex cases. Such medication titration by an RN is typically associated with additional diabetes education and thus can be billed through PHPS using the education Z-codes.

e. The decision as to who will provide CDCES services and who will manage medication must account for the geographic location of the patient, their preferences for telemedicine, regional access to technology that supports telemedicine, visits, the availability of staff with expertise in this area, and the language and cultural concordance of different provider options. Requiring all patients to travel long distances on a frequent basis for care that could safely be provided locally or via telemedicine results in inequitable care as patients choose to forgo the care altogether.

1) Where cellular and internet service are unreliable, PHPS programs can consider "hosting" telemedicine visits at their practice sites with non-local consultants to ease access and avoid long distance travel

H. Lactation Counseling and Education

1. PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs.
2. Basic lactation education, more formal lactation counseling or lactation consultation may be included as part of PHPS case management services, nutrition service or health education services, depending on the credentials of the person providing the services, using the corresponding Z-codes. Non-PHPS providers may also provide lactation counseling or consultation services as outlined in ~~MCCP2020~~ MPNP9007 Lactation Policy and Guidelines.
3. Women, Infants and Children Supplemental Nutrition (WIC) programs in each county may provide lactation services for Members. PHPS/CPSP programs that do~~es~~ not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based l~~L~~actation services.

I. Referral Procedures

1. Specialist care with an obstetrics provider (e.g. Maternal Fetal Medicine or High Risk Obstetrics) does not require an approved Referral Authorization Form (RAF). However, some specialists and practices require a referral and medical records prior to scheduling a consultation.
2. Consultation during pregnancy with a non-Obstetrics specialist (Cardiology, Endocrine) requires that a Referral Authorization Form (RAF) be submitted by the Primary Care Provider (See policy MCUP3124 Referral to Specialists [RAF] Policy)~~.~~
   a. Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management.
3. ~~2.~~ It is the responsibility of the perinatal provider to confirm the Member's eligibility and PCP information with Partnership at each visit.

VII. REFERENCES:

A. Guidelines for Perinatal Care –8th Edition by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017.

B. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code

C. Medi-Cal Guidelines/ Provider Manual: Pregnancy: Early Care and Diagnostic Services (preg early)

~~C.~~D. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~18-022~~26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members~~ – Access Requirements for Freestanding Birth~~

~~Centers and the Provision of Midwife Services~~ (~~12/19/2018~~03/25/2026)

~~D.~~E. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)

~~E.~~F. DHCS APL 23-024 *Revised* Doula Services (11/03/2023)

~~F.~~G. California Department of Public Health CPSP Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

H. American Diabetes Association Professional Practice Committee; 15. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—~~2024~~2026. Diabetes Care 1 January 202~~4~~6; 4~~97~~ (Supplement_1): S321~~282~~–S338~~294~~. https://doi.org/10.2337/dc26-S015 ~~https://doi.org/10.2337/dc24-S015~~

I. United States Preventive Services Taskforce (USPSTF): Perinatal Depression: Preventive Interventions. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions

J. Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care*, 41(11), 1284–1292. doi. 10.1097/01.MLR.0000093487.78664.3C

~~G.~~K. Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

~~H.~~L. Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150(6), 782–786. https://doi.org/10.1192/bjp.150.6.782

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Perinatal Provider~~OB/GYN~~ practice sites
C. Partnership Department Directors

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

X. REVISION DATES: (HS-1 - 12/10/96; 10/10/97 [name change only]; 02/17/99; 06/21/00, 10/17/01; 06/19/02; 10/20/04; 04/20/05; 05/18/05; 05/17/06; 08/15/07; 08/20/08; 06/17/09; 01/16/13; 03/19/14; 09/17/14; 02/18/2015; 01/20/16; 01/18/17; *06/13/18; 06/12/19; 06/10/20; 02/10/21; 03/09/22; 03/08/2023; 11/08/23; 09/11/24; 10/08/25; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Prenatal & Perinatal Care		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/22/1994 (Policy HS-1)	**Next Review Date: 10/08/202611/04/2027** **Last Review Date: 10/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California

Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form and Contracted Provider Addendum

Note: This application does not substitute for the usual provider contracting/credentialing processes. All providers must complete the usual Partnership provider contracting/enrollment/credentialing processes prior to, or concurrent with, the completion of this application.

Check one:

_____ Initial (New Perinatal Case Management Service Program)

_____ Ongoing (long-standing Perinatal Case Management services, but first time completing this form)

_____ Change (Prior completion of this form; this is an update)

Date form completed: _____

Date effective (if services were provided prior to form completion, may be up to 9 months prior): _____

Core Organizational Information: All PHPS provider organizations~~s~~ must be enrolled in the Medi-Cal Program and have an organizational NPI number

Name of Organization: _____

Organizational NPI Number: _____

Organizational Medi-Cal ID Number: _____

Mailing Address of Organization Headquarters:_____

County where Organizational Headquarters is located: _____

Counties primarily served by PHPS program: _____

Contact Person: _____

Email of Contact Person: _____

Name of CEO or signing authority: _____

Email of CEO or signing authority: _____

Name of Clinical Director of PHPS program: _____

Circle one: OB/GYN Family Physician Pediatrician Certified Nurse Midwife Licensed Midwife Nurse Practitioner Physician Assistant-certified

Email of Clinical Director: _____

NPI of Clinical Director: _____

Administrative Director of PHPS program: _____

Email of Administrative Director: _____

Primary phone number for program: _____

Type of Perinatal Services:

_____ Organization has at least one site that is certified by CDPH as a CPSP program (attach letter of approval)

_____ Organization is not currently CPSP-certified, but has applied for this certification (attach a copy of the application cover page)

_____ Organization is not currently certified, nor planning to obtain CPSP-certification status

List ALL sites in your organization that may offer and bill for any Perinatal Case Management or support services:

Site number	Name of site	Complete Address of Site
1		
2		
3		
4		
5		
6		

(Add more rows if needed)

Identify the Perinatal Services Provider at *any* site in your organization:

Service	Check if Provided in-person	Check If Provided virtually	If service is not provided in your organization or is shared with another organization, indicate partner organization(s) who will provide this service (If known/ finalized)	Indicate Capacity to accept outside referrals for this service. **Choose one**: • No outside referrals • Limited outside referrals • None currently but planning capacity for outside referrals • Currently open to all outside referrals
Pre-natal care (Physician/NP/PA or midwife)				
Perinatal Case Management				
Nutrition Services				
Mental Health/ Behavioral health services				
Health Education Services				
Diabetes in Pregnancy Diabetes Education				
Diabetes in Pregnancy Nutrition Education				
Diabetes in Pregnancy: Insulin/Medication titration/adjustment				
Lactation Counseling or Consultation				

Attachments:

- Please attach a list of staff providing these services, with their names, job titles and licensure/credentials. Please include any support staff.

Role	Total FTE	Professional Training RD/CDE/RN/LVN/MPH/MSW, ASW, LCSW, MD (OB/Gyn, Family Med) NP/PA-c CNM/LM	Number of staff in each provider type and training	License/Certification Numbers or equivalent (or send an Employment Roster with the information
Perinatal Case Manager				
Nutrition				
Mental /Behavioral Health				
Medical Providers				
Support Staff				

- If your organization performs perinatal case management, please include a copy of the standard assessment that you use or plan to use.
- All ~~L~~licensed staff must be credentialed with Partnership or with a Partnership delegate, if applicable, prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements, by July 2026.

The Clinical Director's signature below attests that the Perinatal Services staff meet the required background and training to complete their tasks as outlined in policy MCUG3118 *Prenatal & Perinatal Care* for each participating staff member.

_____
Clinical Director's Name and Signature

Submit to: PHPS@partnershiphp.org

For internal use:

Date Perinatal Site Review Last Completed:_____

Date Perinatal Site Review Passed: _____

Date Parent Organization Contract Executed: _____

Parent Organization Provider Number: _____

Other Notes:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3013 (previously UP100313)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Durable Medical Equipment (DME) Authorization</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="3">Next Review Date: ~~10/08/2026~~11/04/2027
Last Review Date: ~~10/08/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~10/08/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
D. MCUG3134 – Hospital Bed/ Specialty Mattress Guidelines
E. MPUP3039 – Direct Members
~~E.~~F. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would ~~be inappropriate~~not meet their care needs. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.
B. ~~DME:~~ Durable Medical Equipment (DME): According the Department of Health Care Services, DME is a broad term that refers to medical devices and equipment that are durable (i.e. can withstand repeated use, which under the federal definition means that it is expected to last at least three years), used for a medical purpose (i.e. prescribed by a provider) and is necessary to support a member in performing activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).
C. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. MTU: Medical Therapy Unit - Outpatient clinics located in designated public schools where Medical Therapy Program (MTP) services are provided.
E. MTP: Medical Therapy Program – A special program within California Children's Services (CCS) that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. Services are provided at Medical Therapy Units (MTUs).

F. RAF: Referral Authorization Form
G. TAR: Treatment Authorization Request

IV. ATTACHMENTS:

A. DME Rental Only
B. DME Limited to Special Circumstances
C. Oxygen O_2 Request Verification Form
D. Certificate of Medical Necessity for all Durable Medical Equipment (DME)
E. MTU DME Review Process and Example Form

V. PURPOSE:

To describe the process of authorizing durable medical equipment (DME) for Partnership HealthPlan of California (Partnership) Members.

VI. POLICY / PROCEDURE:

A. Partnership covers certain durable medical equipment when prescribed by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist).
   1. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription (or electronic equivalent) for rental or purchase must clearly contain the following information:
      a. Full name, address and telephone number of the prescribing provider
      b. Date of prescription (must be current - written within one year of today's date)
      c. Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.
      d. Medical condition necessitating the particular DME item
      e. Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")
   2. Partnership will authorize items of DME in accordance with this policy and other criteria listed below ~~Partnership's MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process policy, as well as Title 22, Medi-Cal Provider Bulletins and InterQual® Criteria~~ to meet the Member's needs for medically necessary equipment. These needs are limited to services or devices necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. Other authorization criteria include, but are not limited to:
      a. Title 22 of the California Code of Regulations
      b. Medi-Cal Guidelines
      c. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process
      d. Partnership policy MCUP3124 Referral to Specialists (RAF) Policy
      ~~a.~~e. Partnership policy MPUP3139 Criteria and Guidelines for Utilization Management.
   ~~2.~~3. Partnership covers durable medical equipment that is the lowest cost to meet the patient's medical needs.

~~B. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription for rental or purchase must clearly contain the following information:~~

~~C.~~B. ~~Full name, address and telephone number of the prescribing provider~~
~~D.~~B. ~~Date of prescription (must be current - written within one year of today's date)~~
~~E.~~B. ~~Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.~~
~~F.~~B. ~~Medical condition necessitating the particular DME item~~
~~G.~~B. ~~Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")~~

~~C.~~B. Partnership Health Services Department will refer to DHCS Medi-Cal Guidelines sections for Durable Medical Equipment including DME: Billing Codes *(dura cd)* and DME: Other DME Equipment (*dura other*) to determine which items may be rented and/or purchased.

1. "DME Rental Only" items are summarized in Attachment A. ~~summarizes "DME Rental Only" items.~~
    a. Partnership follows the guidelines as set forth in Title 22 Div 3 Sub 1 Chap 3 Article 3 51224.5 that when previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and NO FURTHER reimbursement to the provider shall be made for the beneficiary's use of the item UNLESS repair and maintenance is separately authorized.
    b. Ten months of rental is equal to purchase unless otherwise noted in DHCS guidelines/ Attachment A.
    c. Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
    d. For codes that are available for both purchase and rental, if the rental costs exceed purchase, then the provider should be purchasing rather than renting

~~B.~~C. Refer to Attachment B "DME Limited to Special Circumstances" for a list of items that are authorized for specific categories of Members.

D. Modifications of Equipment: ~~—~~If a piece of equipment is provided to a Member whose medical condition has not changed since the time the equipment was provided, and the item does not meet the patient's needs when in actual use, then the provider is responsible for adjusting or modifying the equipment as necessary to meet the patient's medical needs.

E. DME for Disabled Parent: ~~—~~DME items may be covered to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian.
    1. The recipient's need for DME items must be reviewed annually by a physician.
    2. DME items cannot include common household items such as strollers, wraps, slings, or soft-structured carriers.
    3. A TAR is required for DME for a disabled parent, stepparent, foster parent, or legal guardian. The following documentation must be submitted with each TAR:
        a. A prescription from the physician for the specific DME item, and
        b. Documentation from the parent's/guardian's physician, nurse practitioner, clinical nurse specialist or physician assistant of the parent's/guardian's medical disability that justifies the need for the DME item.
    4. Claims for DME for a disabled parent, stepparent, foster parent, or legal guardian must be submitted using HCPCS code A9999, ICD-10 code Z73.6 (Limitation of activities due to disability) and modifier SC (medically necessary service/supply).

F. Specific Equipment Requirements
    1. Augmentative and Alternative Communication Devices – Partnership considers authorization for Augmentative and Alternative Communication (AAC) Devices as a benefit for eligible Members with speech, language and hearing disorders if the following conditions have been met:
        a. The request must be accompanied by an assessment acceptable to Partnership, conducted by a licensed speech and language pathologist.
        b. Additional assessments will be considered from other appropriately licensed providers, such as physical or occupational therapists, if the Member has physical limitations which could impact his/her ability to use the AAC device.
        c. A signed prescription from the Member's physician must accompany the request.
        d. The Partnership Chief Medical Officer or physician designee will apply current Medi-Cal criteria when making a determination.
    2. Bathroom Equipment must be ordered by the Member's PCP or specialist treating the Member

through a referral from the PCP. For Direct Members, the bathroom equipment must be ordered by the physician currently managing the medical care for the Member.

a. The following types of bathroom equipment are covered by Partnership provided that medical necessity has been demonstrated. (Note that DME items are covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability, but not necessarily to restore the Member to previous function.)
   1) Toilet rail or armrest
   2) Raised toilet seat
   3) Tub stool, bench or bath seat
   4) Bathtub safety rail or grab bars
   5) Transfer tub bench
   6) Commode (bedside)

b. When a ~~The~~ TAR is required for bathroom equipment, it must include documentation of medical necessity for use of the device that includes the following information related to the condition:
   1) Length of time Member has been or will be needing the equipment
   2) Assessment of mental status
   3) Evaluation of functional abilities including assessment of body strength/mobility
   4) Information concerning the Member's ability to properly use the bathroom equipment

~~3. Compression Garments – Effective October 1, 2024, Partnership covers Over the Counter (OTC) compression garments as follows:~~

~~a. Procedure code A6593 may be billed for OTC compression garments and will be limited to two units (per limb) every six months.~~

~~b. Claims billed for greater than two units every six months will be denied for exceeding the service limitations.~~

~~c. No prior authorization is required for this service and no invoice needs to be billed with the claim. A written physician prescription is required, but does not have to be attached to the claim.~~

~~d. The maximum allowable for this code is $50 per unit.~~

~~4.~~3. Defibrillator Vests – Partnership reviews authorization requests for defibrillator vests on a case-by-case basis based on InterQual® criteria.

~~5.~~4. Enuresis Alarm Pads – Partnership will cover one enuresis alarm pad per lifetime with no TAR requirement. Outside of this frequency, a TAR is required.

~~6.~~5. Home Oxygen Therapy – Partnership reviews authorization requests for home oxygen therapy based on the criteria as stated in Attachment C of this policy – "Oxygen (O_2) Request Verification Form." Please submit form with TAR.

6. Infant Monitor Guidelines
   a. The monitor must be ordered by the PCP or by a specialist who is treating the Member through a referral from the PCP. For Direct Members, the monitor must be ordered by the physician who is currently managing the medical care for the Member.
   b. A monitor can be ordered for a Member who has a history of bradycardia or apnea.
   c. The TAR must include documentation of medical necessity for use of the monitor that includes the following information related to the condition:
      1) Length of time Member needs the monitor
      2) Description of the history of the condition
   d. Infant monitors are generally authorized until the baby reaches 46 weeks post-conceptual age. Extension beyond this age requires submission of clinical justification.
   e. For all requests, the individual needs of the Member and the characteristics of the delivery system are considered in the authorization process. The general criteria for authorization of monitors are as follows:
      1) Documented apneic spells defined as a cessation of breathing for 20 seconds or longer or a

shorter pause accompanied by bradycardia (<100 beats per minute), cyanosis, or pallor
2) Significant apnea or bradycardia requiring infant stimulation
3) Frequent periods of apnea and/or bradycardia

f. The TAR for an infant monitor should include information concerning the caretaker's ability to properly use the monitor.
g. TARs are typically authorized for rental only. If medical necessity is demonstrated, authorization for purchase may be approved.

7. Knee Scooters require a TAR and may be billed with code E0118 under the following guidelines:
   a. Knee scooters may be billed when a Member is expected to be non-weight bearing for 3 weeks or longer and one of the following criteria are met:
      1) Member has fracture, dislocation, tendon rupture or surgery which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. The Member is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      2) Member has an ulcer or infection which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      3) Member has a neurologic or musculoskeletal condition which makes him/her unable to effectively or safely bear weight on one foot. The knee scooter will greatly increase this person's ability to function independently.
   b. Wheelchairs will not be authorized in conjunction with knee scooters.
   c. The resale of the knee scooter is prohibited. Partnership recommends the equipment be donated to a charitable organization when no longer in use.
8. Pediatric Adaptive Equipment – Requests for pediatric adaptive equipment (e.g. specialty strollers, adaptive car seats, floor sitters/activity chairs, stair climbers, etc.) will be reviewed on a case by case basis using criteria described in CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) *08/08/2003*. For Members enrolled in the Medical Therapy Program, medical appropriateness of devices and/or equipment will be determined and recommended by the Medical Therapy Unit providing services. The MTU must submit a TAR with an MTU DME form and all required information as per the process described in Attachment E - MTU DME Review Process and Example Form.
9. Portable ramps are a covered benefit under Partnership. Prior authorization is required.
   a. Portable ramps are those that meet the following conditions:
      1) Foldable or collapsible
      2) Not attached
      3) Suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations.
   b. Ramps are not considered portable when they are fixed or modular or in any way attached. Non-portable ramps are not a Medi-Cal benefit.
   c. Criteria for authorization are as follows:
      1) The Member utilizes a manual or power wheelchair for home and/or community access (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components).
      2) Access to variable height surfaces at home, to a vehicle, and in the community is needed.
      3) The weight of the Member and wheelchair does not exceed the manufacturer's recommended weight limit for the ramp.
      4) Caretaker / Member must demonstrate the ability to safely use the ramp.
      5) Based on the Member's needs, the portable ramp is safer and more efficacious than permanent structural modifications to the Member's residence.

a) Partnership reimburses for a maximum of one vehicle ramp and one home access ramp. If the ramp is needed for employment, the benefit is to be provided through the Department of Rehabilitation.

d. If the Treatment Authorization Request (TAR) includes all information required, the request is reviewed by a Partnership Nurse Coordinator (and the Chief Medical Officer or physician designee if needed.) If the medical necessity of the request is uncertain or questionable, all information is sent to an independent consultant with expertise in the area of the equipment requested. The consultant evaluates all information and may schedule an appointment with the Member, perform an independent evaluation of the request and submit a report to Partnership with recommendations as to the medical appropriateness of the request.

10. Tumor Treating Field Devices – Partnership reviews authorization requests for tumor treating field devices (electrical stimulation devices used for cancer treatment) on a case-by-case basis based on Medi-Cal criteria. Initial TARs are approved for 3 months rental. Re-authorization may be granted when all of the following criteria are met:
    a. A magnetic resonance imaging (MRI) scan has been performed not more than 2 months prior to date of renewal request and documents no evidence of disease progression, and
    b. The Karnofsky Performance Status score is 60 or higher, and
    c. The patient has been wearing the device at least 18 hours daily.
10. Ventilators – Partnership reviews authorization requests for non-invasive ventilators on a case-by-case basis based on InterQual criteria. Initial TARs are approved for 3 months rental. Reauthorizations can be approved in up to 12-month increments. Authorization requests for invasive ventilators are reviewed on a case-by-case basis based on Medi-Cal criteria.
11. Dynamic Splinting
    a. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case-by-case basis. Authorizations may be approved as follows:
        1) Pre-operatively: As an adjunct to physical therapy for a Member having surgery to correct knee joint stillness or a contracture due to a previous injury or surgery to the knee.
        2) Post-operatively: As an adjunct to physical therapy if there is documentation of joint stiffness or contracture causing functional limitation of range of motion in the subacute post-operative period defined as > 3 weeks and up to 4 months after surgery.
    b. Dynamic splinting is not considered medically necessary for the following:
        1) Pre-operative request unless the surgery is to correct knee joint stiffness or contraction due to previous injury or surgery
        2) No evidence of knee contracture or stiffness in the subacute post-operative period
        3) Chronic joint stiffness or fixed contractures
        4) No significant improvement to the joint after 4 months of use

G. Reauthorization
    1. All authorizations which may recur are subject to the following requirements:
        a. Assessment and demonstration of continued need for treatment/service
        b. Reevaluation of plan of treatment, appropriateness of level care and physician orders
        c. Documentation of patient compliance with treatment/service

H. Non-Covered Items - The following DME items are not included as Medi-Cal or Partnership benefits:
    1. Books or other items of a primarily educational nature
    2. Air conditioners/air filters or heaters
    3. Food blenders
    4. Reading lamps or other lighting equipment
    5. Bicycles, tricycles or other exercise equipment
    6. Television sets
    7. Orthopedic mattresses, recliners, recliners with lift system, rockers, seat lift chairs or other furniture

items
8. Waterbeds
9. Household items
10. Modifications of automobile or other highway motor vehicles
11. Other items not used primarily for health-care and which are regularly and primarily used by persons who do not have a specific medical need for them

I. Monitoring of DME Authorizations
1. A periodic random sample of authorization requests for DME may be audited by the Utilization Management (UM) staff or Chief Medical Officer or physician designee for appropriateness and accuracy. Medical record audits may also include survey for proper use and documentation of DME.

J. Partnership Medical Equipment Distribution Services (PMEDS) Program
1. Members may be able to obtain certain medical devices that do not require a TAR through the Partnership Medical Equipment Distribution Services (PMEDS) program when their Provider submits a request form on their behalf. The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Form and information can be found on the Partnership website at https://www.partnershiphp.org/providers/medi-cal/pmeds-programhttps://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx

VII. REFERENCES:

A. Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME): Overview (*dura*), Billing Codes *(dura cd),* Billing Codes: Frequency Limits *(dura cd fre),* Other DME Equipment (*dura other*) and Oxygen and Respiratory Equipment (*dura oxy*); Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Orthotics (*ortho auth ortho*)
B. DHCS All Plan Letter (APL) 15-018 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
C. Title 22 California Code of Regulations (CCR) Div 3 Sub 1 Chap 3 Article 3 51224.5
D. InterQual Criteria®
E. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
F. CCS Numbered Letter (N.L.) 02-0107 Authorization of Rental of Portable Home Ventilators (01/05/2007)
~~G. Partnership Benefits Review and Evaluation Workgroup (BREW) Form #24 OTC/Off-the-Shelf Compression Garments. (07/25/2024)~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

03/23/95; 10/10/97 (name change only); 02/09/00; 05/17/00; 09/19/01; 09/18/02; 10/15/03; 02/18/04; 10/20/04; 10/19/05; 08/16/06; 04/16/08; 07/15/09; 07/21/10; 06/20/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/12/18; 04/10/19; 05/13/20; 09/09/20; 08/11/21; 08/10/22; 01/11/23; 04/10/24; 08/14/24; 10/08/25; 11/04/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting

date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUG3008 Bathroom Equipment Guidelines was Archived 01/11/2023
MCUG3023 Infant Monitor Guidelines was Archived 01/11/2023

****

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

DME RENTAL ONLY

Decubitus Care Equipment

E0202	Phototherapy (bilirubin) light with photometer (daily rental)

Oxygen and Related Equipment

E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing
E0431 *	Portable Gas Oxygen
E0433 *	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434 *	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439*	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0465 *	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466 *	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0467*	Home ventilator; multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions.
E0481	Intrapulmonary percussive ventilation system and related accessories. This code is reimbursable only for repairs to patient-owned equipment
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High frequency chest wall oscillation air-pulse generator system, includes all accessories and supplies
E1390*	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391*	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392*	Portable oxygen concentrator, rental
K0738*	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing)

*Rental Only without a 10-month limit. (See MCUP3013 VI.B~~C~~. for further information on DME rental limits)

DME RENTAL ONLY

Traction and Trapeze Equipment

E0935	Continuous passive motion exercise device for use on knee only (daily rental)
E0936	Continuous passive motion exercise device for use other than knee (daily rental)

Miscellaneous

E0604	Breast Pump, heavy duty, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.
E0720	TENS device, two lead, localized stimulation [+]
E0730	TENS device, four or more leads, for multiple nerve stimulation [+]
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type must be billed with modifier RR (rental) and KF
E2402	Negative pressure wound therapy electrical pump, stationary or portable (daily rental)
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0743	Suction pump, home model, portable, for use on wounds (modifier RR)

[+]*Partnership does not require prior authorization for TENs units unless the request is outside of the allowable frequency limits per DHCS Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)*

Rental Period

- Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
- Ten months rental is equal to purchase except as noted above by *.

DME LIMITED TO SPECIAL CIRCUMSTANCES

All lymphedema pumps/compression devices (codes as noted below) require authorization and evidence of meeting medical criteria as stated in the Durable Medical Equipment (DME): Other DME Equipment section of the DHCS Medi-Cal guidelines:

HCPCS codes E0650, E0651, E0652, E0655, E0656,- E0657, E0658, E0659, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, -E0673, E0675, E0676, E0678, E0679, E0680, E0681, -E0682

Limited to recipients OVER age 12 (Any request for Members aged 12 and under will require review for medical necessity)

Cervical Traction Device

E0840	Traction frame, attached to headboard, cervical traction
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0860	Traction equipment, overdoor, cervical

Limited to CCS ONLY

A4606	Oximeter replacement probe
E0635	Electric patient lift
E0639	Movable patient lift

Limited to Recipients Who Are Disabled Parents, Stepparents, Foster Parents, or Legal Guardians

Please see section VI.E~~F~~. of this policy MCUP3013 DME Authorization

Items Requiring Initial Rental Prior to Partnership's Consideration for Purchase

Hospital Beds
Manual Wheelchairs
Continuous Positive Airway Pressure (CPAP)
Bi-Level Positive Airway Pressure (Bi-PAP)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3020 (previously UP100320)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Hospice Services</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/12/1995</td><td colspan="4">Next Review Date: ~~01/14/2027~~11/04/2027
Last Review Date: ~~01/14/2026~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☐ Employees</td><td></td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~01/14/2026~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MPUP3039 - Direct Members
C. MPUP3137 - Palliative Care: Intensive Program (Adult)
D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
E. MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
F. MCCP2024 - Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
C. Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.
D. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with a CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

A. Medi-Cal Hospice Program Election Notice *DHCS 8052* (07/2023)
B. Patient Notification of Hospice Non-Covered Items, Services, and Drugs *DHCS 8053* (07/2023)
~~B.~~C. Partnership Application to be a Contracted Hospice Provider

Policy/Procedure Number: MCUP3020 (previously UP100320)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Hospice Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 12/12/1995		**Next Review Date: 01/14/202711/04/2027** **Last Review Date: 01/14/202611/04/2026**
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for a Member to be admitted to a hospice program and to outline compensation structures for hospice services.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program
   1. A patient will be admitted to the hospice program when the following conditions are met:
      a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course.
         1) The patient's physician or the hospice medical director must certify that the Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
      b. A member may elect hospice services in lieu of curative care for the terminal illness. (For specific pediatric hospice guidelines, please see VI.C.4. below.)
      c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
      d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient and family.
      e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
      f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal from the hospice program is possible at any time.
   2. Election of hospice care for Partnership Medi-Cal Members occurs when the Member (or authorized representative) voluntarily completes and signs the Department of Health Care Services (DHCS) Medi-Cal Hospice Program Election Notice *DHCS 8052* (Attachment A) and selects a hospice provider. Signing this form indicates the Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.
      a. Members who qualify for and elect to receive hospice care services, remain enrolled in Partnership while receiving hospice services.
      b. Hospice care services may be initiated or continued in a home or clinical setting. Partnership will remain responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the Member's primary care physician.
      c. A Member who is a resident of a skilled nurse facility (SNF) or an Intermediate Care Facility (ICF) may elect hospice care, and Partnership will provide payment to the hospice for hospice care services at the appropriate level of care.
      d. Partnership does not deny any completed Hospice Program Election Notices nor deny any late referrals to hospice.
      e. Upon receipt of a completed hospice election form, or the member is flagged by DHCS in data sent to the health plan that the member is receiving hospice services, the member is placed into HP 6; a restricted Direct Member designation category. This designation in Partnership's system and online provider portal informs the Member's primary care provider and/or other contracted providers, that the member is currently enrolled in hospice and receiving those services. For more information, see Partnership policy MPUP3039 Direct Members.

B. Hospice Provider Requirements
   1. Consistent with contractual requirements for covered Medi-Cal benefits, and Continuity of Care provisions, hospice coverage is restricted to hospice providers who are contracted with Partnership. Any ~~f~~Federally approved Medicare ~~h~~Hospice in the Partnership ~~s~~Service ~~a~~Area or~~and~~ adjacent

counties may apply to have a contract with Partnership (see Aattachment C), but is not guaranteed approval. If medically necessary services are not available in-Network, or if a member is currently receiving hospice care at the time they become a Partnership member, Partnership will seek an agreement with an out-of-network provider to cover hospice services.

a. An agreement with an out-of-network hospice provider will require the hospice provider to submit necessary documentation for Partnership to ensure that hospice services are provided in accordance with coverage policy, including medical necessity.
b. For out-of-network hospice providers, Partnership will ensure the hospice provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier (NPI) prior to payments of claims.
c. To avoid possible delays in hospice services with out-of-network hospice providers, while Partnership confirms hospice provider qualifications and enters into an agreement with the serving hospice provider, Partnership shall ensure the agreement start date commences with the start of services for those providers who meet necessary criteria.
    1) For providers who are not deemed eligible, a referral to Partnership's Care Coordination department shall occur so that Members are referred timely to an in-network hospice provider.
d. A Partnership Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MPUP3137 Palliative Care: Intensive Program (Adult).

2. The hospice Provider is responsible for the coordination of hospice services. To ensure proper hospice claim processing and reimbursement, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form *DHCS 8052* (Attachment A) to Partnership **within five calendar days** of a Medi-Cal Member's certification and election of hospice services.
    a. In instances where the hospice provider does not timely submit the election form to Partnership, Partnership is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to and accepted by Partnership. These non-covered days are a hospice provider's liability, and the hospice provider cannot bill the Member for them.
    b. DHCS and Partnership may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of our claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.
    c. While no Treatment Authorization Request (TAR) is required to elect hospice care, Partnership will conduct a prepayment review of each claim to verify that the appropriate documentation has been received in order to avoid fraud, waste, and abuse.
        1) See section VI.E. below for further clarification of TAR requirements for inpatient care.
        2) For Mmembers electing hospice in a home or facility (outside of the inpatient setting), the following documents may be required to assure appropriateness for hospice care:
            a) Properly and completely filled out hospice election form.
            b) Medical record of a non-hospice clinician caring for the Mmember that indicates the diagnosis and prognosis of the patient (for example, an oncologist for a Mmember with cancer, a cardiologist for a Mmember with heart failure).
            c) Record of tThe in-person hospice medical director or nurse visit with the Mmember: progress note.
            d) The attestation of the hospice medical director that the Mmember has a terminal medical condition with less than 6 months to live.
            e) The reason that this member cannot be cared for by a hospice contracted by Partnership.

f) (For recertification only):
   i. A copy of the completed POLST form

C. Hospice Benefit
1. Members who elect hospice become case managed Direct Members at Partnership as described in policy MPUP3039 Direct Members.
   a. The status change effective date is the date the hospice election form was signed by the Member or Authorized Representative.
2. All services related to the terminal illness must then be provided or authorized by the hospice provider.
   a. Note that palliative items or services in the context of medical hospice benefits are defined separately from palliative care services as referenced in the DHCS Palliative Care guidelines *(palli care)* or as defined in DHCS APL 18-020 *Palliative Care* (or subsequent revisions).
3. Partnership facilitates Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, while also placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse.
4. Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness. Services not related to the terminal illness are the responsibility of Partnership. The Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)
5. A Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018. For more information on services under EPSDT see Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.
   a. Hospice and palliative care is available for California Children's Services (CCS)-eligible children as detailed in CCS Numbered Letter (NL) 06- 1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care and in CCS NL 12-1119 Palliative Care Options for CCS Eligible Children.
      1) For more information on CCS services for Partnership Members, see policy MCCP2024 Whole Child Model For California Children's Services (CCS).
      2) For more information on pediatric palliative care services, see policy MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21
      3) Partnership will facilitate Continuity of Care as described in policies MCCP2024 Whole Child Model For California Children's Services (CCS) and MCCP2014 Continuity of Care.
   b. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between Partnership (the Managed Care Plan), local CCS programs (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition and will be provided as part of hospice care services as described below at VI.C.6.
6. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness. Physician, and or other Medi-Cal benefits and services not described below must be billed to Partnership separately.
   a. Nursing services
   b. Physical, occupational, and speech therapy
   c. Medical social services under the direction of a physician

d. Home health aide and homemaker services
e. Medical supplies and durable medical equipment
f. Medications and infusion therapy (based on the Hospice Formulary)
g. Hospice physician services
h. Counseling services related to the adjustment of the Member's approaching death, including bereavement, grief, dietary, and spiritual counseling
i. Continuous Nursing services which may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill Member at home.
j. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, SNF or hospice facility
k. Short-term in-patient care for pain control or symptom management in a hospital, SNF or hospice facility (Note that general inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit)
l. Nutritionist services
m. Medical transportation

7. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group to plan, provide, and/or supervise the care and services offered by the hospice provider.
8. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting.
9. Hospice services are not categorized as long term care (LTC) services, regardless of the Member's expected or actual length of stay in a nursing facility while also receiving hospice care.
10. Payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider.

D. Services Not Covered by a Hospice Provider
1. Private pay room and board or residential care
2. Acute in-patient hospitalization unrelated to the terminal illness
3. Level A or Level B Nursing Facility for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice
5. Other necessary services for conditions unrelated to the terminal illness

E. Treatment Authorization Requests (TARs) for Inpatient Care
1. A Partnership TAR is <u>not</u> required for the following services:
   a. Hospice physician services
   b. Routine home care
   c. Continuous home care*
   d. Respite Care*
   e. Hospice Care room and board provided in a SNF or ICF
      1) If a Member currently resides in an Intermediate Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, Partnership continues to be financially responsible for the ICF-DD per diem payment.

   *Note: Although no TAR is required, Partnership may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care. If documentation does not support the levels of care, reimbursement may be reduced to the rate for routine home care, in which case the hospice provider may submit an appeal for reconsideration of payment with additional documentation of the medical necessity for the increased level of care.

2. Only general inpatient care is subject to prior authorization, regardless of whether the services are to be rendered by an in-network and out-of-network provider, and the following documents must be submitted to Partnership with the TAR:
   a. A written prescription signed by the Member's attending physician
   b. Justification for the general inpatient care level of care
   c. A copy of the certification of the Member's terminal condition
   d. A copy of the written initial plan of care; AND
   e. A copy of the Member's signed election form
3. Because the Medi-Cal Fee-For-Service (FFS) program does not permit prior authorization of hospice services, except for inpatient admissions, as outlined in state law, Partnership adheres to the same utilization review standards as required by federal law. Hospice providers must submit the Medi-Cal Hospice Program Election form DHCS 8052 (Attachment A) and addendum forms containing the necessary information and appropriate signatures to Partnership as previously outlined at VI.B.2.
4. For non-emergency inpatient care related to the terminal illness, the Hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.
5. Emergency admission related to the terminal illness is reviewed for medical necessity by the Partnership Utilization Management (UM) nurse and if appropriate, a length of stay assigned. Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.
   a. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
   b. Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.
6. For Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the Member resides in a LTC facility (bed code 658 for SNF or ICF). ~~The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.~~
   a. For Members with Medicare/Medi-Cal coverage, the hospice provider must submit the Medi-Cal Hospice Program Election form *DHCS 8052* (Attachment A) and addendum forms containing the necessary information and appropriate signatures to both DHCS and Partnership when a dual eligible Member elects the Medicare hospice benefit.
7. For Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

F. Hospice Periods of Care
   1. Hospice is a covered Medi-Cal benefit with the following periods of care:
      a. Two 90-day periods, beginning on the date of hospice election
      b. Followed by unlimited 60-day periods
   2. A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 25-013, "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage," and all medications (Rx and OTC) which are dispensed from pharmacies and covered under Medi-Cal Rx must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

3. A Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.

G. Patient Certification and Recertification Required
   1. After a Member has met criteria for admission to a hospice program (section VI.A. above), the hospice provider must maintain an initial certification for the first 90-day period that the patient is terminally ill. Written certification statements must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group, AND the Member's primary care physician)
   2. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the patient is terminally ill. For recertification, a written certification statement must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group.
      a. No more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter, a hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. When an NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less.

H. Revocation of Hospice Care Services
   1. An individual's voluntary election may be revoked or modified at any time during a benefit period.
      a. To revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice agency revoking the individual election for the remainder of the benefit period, including the effective date of the revocation. The effective date may not be retroactive.
      b. The hospice provider must submit the Member's signed hospice revocation statement to Partnership within five calendar days.
      c. At any time after revocation or a discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements, and the 90/90/unlimited 60-day benefit periods of care will restart.
         1) If the Member re-elects hospice care, the hospice provider must submit a new hospice election form to Partnership.
      d. A Member or Authorized Representative may change the designation of a hospice provider once in each benefit period; this is not a revocation of the hospice benefit.
      e. Members who move their legal residence out of Partnership's service area must notify the hospice provider and shall be disenrolled from Partnership.
         1) If members are transferring care to a new managed care plan, Hospice providers must provide transferring members with a transfer summary, including essential information relative to the members' diagnoses, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician.
         2) Consequently, upon enrollment in a new managed care plan, a "change in designated hospice" must be initiated. This may be done only once per benefit period.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care *(hospic)*
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511

D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)
I. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
J. California Children's Services (CCS) Numbered Letter (NL) 06-1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care (10/07/2011)
K. CCS NL 12-1119 Palliative Care Options for CCS Eligible Children (11/18/2019)
L. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

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

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

X. REVISION DATES: 06/21/00; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 01/14/26; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California

Application to be a Contracted Hospice Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization**

2. **Contact Information:**
   Administrative Contact of Parent Organization (if applicable)
   Name

   Title

   Phone

   e-mail

   Billing Department
   Name

   Title

   Phone

   e-mail

   Hospice Program Director

   Name

   Title

   Phone

   e-mail

   Hospice Medical Director (Hospice Medical Director should go through the Partnership Credentialing process)
   Name

   Title

   Phone

   e-mail

3. Does your organization currently contract with Partnership HealthPlan of California?

   Yes ☐ No ☐

4. Medi-Cal provider number:

5. Describe any hospice services *currently provided* by your organization. Include current volume of services, the service delivery model, outcomes and the criteria for enrollment.

6. Number of patients enrolled annually in your organization's hospice program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

7. Number of patients enrolled annually in your organization's ☐ palliative care or ☐ home care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

8. Does your organization provide hospice services to children? ☐ Yes ☐ No

   If Yes, please describe level of experience and training in pediatric hospice/palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible for hospice services?

10. What geographic areas/counties will your hospice program serve? Please note any distance requirements.

11. Describe how your organization will partner with local palliative care providers and/or home health agencies.

12. Attachments:

    a. Medicare Hospice Certification: Please attach evidence

    b. California Department of Public Health Hospice License: Please attach evidence

    c. C.V. of Medical Director of program
    d. Letter of commitment from applicant's parent organization or major funder of a new organization not affiliated with a larger corporate sponsor
    e. Letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology, pulmonology, cardiology)
    f. If organization is not a palliative care provider, a letter or memorandum of understanding with local contracted palliative care organizations who can accept patients who need to step down to palliative care.
    g. Annual Audited Financial Statements

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3114				**Lead Department:** Health Services **Business Unit**: Utilization Management	
Policy/Procedure Title: Physical, Occupational and Speech Therapies				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/20/2012			**Next Review Date:** ~~08/12/2027~~11/04/2027 **Last Review Date:** ~~08/12/2026~~11/04/2026		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~08/12/2026~~11/04/2026	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MCUP3125 – Gender Dysphoria/ Surgical Treatment
D. MPUG3011 – Criteria for Home Health Services
E. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Medical Necessity: Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
E. Physical and Occupational therapy services are designed to:
   1. Assess the existence or extent of a medical condition;
   2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
   3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
   4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
   5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions

due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.
1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist).
2. For all Members, no TAR or RAF is required for the initial evaluation.

C. Services That Do NOT Require a TAR
~~1.~~ For members ages 21 and older, Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for the first twelve (12) PT, OT, or ST visits per member, within a rolling twelve (12) month period, limited to one (1) visit per day. ~~PT, OT, or ST for:~~
~~2. Members age 21 and over: No TAR required for up to 12 visits for a specific diagnosis (limit one visit per day) in a rolling 12-month period of time.~~
~~3.~~1. ~~A TAR will be required for services in excess of 12 visits for a specific diagnosis.~~

D. Services That Require a TAR
1. After an initial evaluation, Partnership does require a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21
   ~~a.~~b. Members age 21 or over ~~the age of 21~~, when additional therapy services beyond twelve (12) visits are being requested
   ~~b.~~c. Non-contracted Providers
   ~~c.~~d. Home Health Services (A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MPUG3011 Criteria for Home Health Services.)
2. Submission Guidelines When a TAR is Required
   a. Partnership Members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist) for one consultation visit, through written prescription, for services to be rendered by a qualified Medi-Cal provider acting within the scope of their practice. As noted above, no TAR or RAF is required for the initial consultation/ evaluation.
   b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
      1) Medical diagnosis necessitating the service with a summary of medical condition

Policy/Procedure Number: MCUP3114	**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Physical, Occupational and Speech Therapies	☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2012	**Next Review Date:** ~~08/12/2027~~11/04/2027 **Last Review Date:** ~~08/12/2026~~11/04/2026

2) Related medical conditions
~~2)~~3) Current functional status and measurable deficits

~~3)~~4)Functional limitations
~~4)~~5)Dates and length of treatment
~~5)~~6)Therapeutic goals of treatment and current functional status of the patient with respect to these goals
~~6)~~7)Dates of planned progress review
~~7)~~8)Specific services to be rendered (e.g. evaluation, treatment, modalities)

c. Partnership authorizes ancillary services on a case-by-case basis, provided that medical necessity has been demonstrated in the submitted documentation.

d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.

1) Occupational and physical therapy may be considered medically necessary when:
   a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
   b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
   c) The services are used to assess the existence or extent of impairment due to a medical condition.
   d) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
   e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
2) Speech Therapy services for Members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the Member and services meet the following criteria:
   a) Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
   b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.
   c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
   d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the Member's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.
   e) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
   a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.
   b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.
   c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.
   d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.
   e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.
   f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family
   g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.
4) The following services are generally not considered “medically” necessary or are not covered:
   a) Recreational therapy
   b) Activities that provide diversion or general motivation
   c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
   d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
   e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities.
      i. For Members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

e. If therapy is required beyond the visits initially approved, a new TAR must be submitted.
f. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to Partnership.
    1) Continued therapy will not be approved once a Member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating PT or OT in conjunction with the patient's referring physician.

3. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
    a. Partnership Members who have a California Children's Services (CCS)-eligible condition are enrolled in the Whole Child Model (WCM) program. The WCM program integrates CCS program-covered services with Members' regular Medi-Cal benefits to provide seamless care for children and youth.
        1) Partnership covers the medical condition of hearing loss for hearing tests, evaluations by audiologists, and medical evaluations by head and neck surgeons and physicians in other clinical specialties.
        2) Under the WCM program, Partnership also covers speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators. For these conditions, the Member should be referred to CCS in the county of residence to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will be provided by Partnership under the WCM program. See policy MCCP2024 Whole Child Model for California Children's Services (CCS).
    b. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
    c. A Member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a Member is receiving medically necessary services through the LEA, Partnership will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the Member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, Partnership will approve the additional two visits per week if criteria are met.

VII. REFERENCES:

A. Social Security Act Section 1905(r)
B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
C. California Children's Services (CCS) Medical Eligibility
D. Consolidated Appropriations Act, 2026 (*extends Medicare telehealth flexibilities through 2027*)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Policy/Procedure Number: MCUP3114	Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Physical, Occupational and Speech Therapies	☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2012	**Next Review Date:** ~~08/12/2027~~11/04/2027 **Last Review Date:** ~~08/12/2026~~11/04/2026

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24; 09/10/25, 08/12/26; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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- Evaluated and updated at least annually
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3128</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Cardiac Rehabilitation</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/18/2015
Effective Date: 08/01/2015</td><td colspan="5">Next Review Date: ~~11/11/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☐ Partnership Advantage</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3052 – Medical Nutrition Therapy (MNT) Services

B. MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. ~~Health Services~~Claims

B. Member Services

~~B.~~C. Care Coordination

III. DEFINITIONS:

A. Cardiac rehabilitation is a medically supervised program that helps improve the health and well-being of people who have heart problems.

1. Phase I cardiac rehabilitation takes place during the acute hospitalization or in an acute rehabilitation setting, of the index diagnosis.
2. Phase II cardiac rehabilitation takes place in a monitored, supervised outpatient setting.
3. Phase III cardiac rehab takes place in an outpatient setting, in a supervised environment without cardiac monitoring, including organized group classes.
4. Phase IV cardiac rehab is a lifetime maintenance of physical conditioning, fitness and wellness, either at home, or other community-based setting.

B. Cardiac rehabilitation programs provide cardiac rehabilitation, including exercise training, education on heart healthy living, and counseling to reduce stress and help Members return to an active life.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy defines covered services and medical necessity criteria for cardiac rehabilitation services. Cardiac rehabilitation services have been found to reduce morbidity and mortality from cardiovascular disease.

VI. POLICY / PROCEDURE:

A. Eligibility

1. Appropriately identified adults with full-scope Medi-Cal are eligible for Phase II Cardiac Rehabilitation services, with the following diagnoses:

a. Myocardial infarction within the past 12 months
b. Coronary artery bypass surgery in the past 12 months
c. Current stable angina pectoris
d. Heart valve repair or replacement in the past 12 months
e. Coronary angioplasty performed or coronary stent placed in the last 12 months
f. A heart or heart-lung transplant in the last 12 months
g. Intermittent claudication due to atherosclerotic disease, with current symptoms.
h. Stable chronic heart failure with an ejection fraction of less than 35% and New York Heart Association (NYHA) class II to IV symptoms in spite of optimal therapy for at least 6 weeks.
i. Other cardiac or major pulmonary surgery, in the past 12 months
j. Sustained Ventricular Tachycardia, Ventricular Fibrillation or survivor of sudden cardiac death.

2. Partnership HealthPlan of California considers cardiac rehabilitation experimental and investigational for all other indications including:
   a. Atrial Fibrillation (other than post Maze procedure)
   b. Atrial Fibrillation with ablation (other than post Maze procedure)
   c. Takotsubo (stress) Cardiomyopathy
   d. Uncompensated congestive heart failure
   e. Uncontrolled arrhythmias (other than PVCs and PACs)
3. Phase II services are only covered when ordered by a licensed physician and when performed in a facility/program meeting Medicare's standards for cardiac rehabilitation programs. These standards include:
   a. The facility meets the definition of a hospital outpatient department or a physician-directed facility.
   b. The facility has available for immediate use all the necessary cardio-pulmonary emergency and therapeutic life-saving equipment to perform defibrillation, administer oxygen and perform cardiopulmonary resuscitation.
   c. The program is conducted in an area set aside for the exclusive use of the program while it is in session.
   d. The program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
   e. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area or immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself, provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible. The examples below are for illustration purposes only. They are not meant to limit the discretion of the contractor to make determinations in this regard.
   f. The non-physician personnel are employees of either the physician, hospital, or facility conducting the program and their services are "incident-to" a physician's professional services.
4. Prior to referral for Phase II cardiac rehabilitation services, a cardiologist or primary care physician with experience and training in evaluation and assessment of cardiovascular disease must complete a diagnostic evaluation of the prospective~~ed~~ cardiac rehabilitation participant. This will include:
   a. Evaluation of chest pain and atypical chest pain. This may include performance of a cardiac stress test or review of a recent stress test
   b. Pre or post-operative evaluation of cardiac operations (if applicable)

c. Review and reconciliation of all medications
d. Review of medical history, including social history, medical history, surgical history
e. Specific recommendations for the exercise regimen to be used in the cardiac rehabilitation program. This can lead to either a prescription or a referral to cardiac rehabilitation. Partnership does not require submission of a Referral Authorization Form (RAF), but Phase II cardiac rehabilitation services do require a TAR as detailed in VI.A.5. below. Partnership may audit the clinical documents to ensure the criteria required in a. – e. have been met.

5. Requests for pediatric cardiac rehabilitation are reviewed on a case-by-case basis in accordance with our Treatment Authorization Request (TAR) Review Process described in policy MCUP3041. Pediatric cases require consultation with an appropriate specialist (e.g. pediatric cardiologist) and must take place at an appropriate facility for pediatric rehabilitation.
6. **A Treatment Authorization Request (TAR) is required for Phase II cardiac rehabilitation services.**
   a. Current Procedural Terminology (CPT)-4 codes 93797 and 93798 may not be reimbursed in the same calendar month as Healthcare Common Procedure Coding System (HCPCS) codes G0422 and G0423, for any provider. Similarly, HCPCS codes G0422 and G0423 may not be reimbursed in the same calendar month as CPT-4 codes 93797 and 93798, for any provider.
   b. Modifiers SA, U7, 24, 25 and 99 are all allowable for CPT-4 codes 93797 and 93798, as well as HCPCS codes G0422 and G0423.
   c. Qualified Practitioners
      1) Licensed practitioners who are eligible for reimbursement of CPT-4 codes 93797 and 93798 include physicians, physician assistants, nurse practitioners and physical therapists.
      2) Licensed practitioners who are eligible for reimbursement of HCPCS codes G0422 and G0423 include physicians, physician assistants, nurse practitioners, psychologists, licensed clinical social workers, marriage and family therapists and physical therapists.
7. For all other indications (individuals who are too debilitated to exercise, and secondary prevention after transient ischemic attack or mild, non-disabling stroke), because of insufficient evidence in the peer-reviewed information, Partnership considers cardiac rehabilitation experimental and investigational and therefore not a benefit.

B. Covered Services
1. Phase I cardiac rehabilitation services are performed while the Partnership Member is in the acute hospital or acute rehab setting. They are integral to the inpatient care provided to Partnership Members for appropriate indications.
2. Phase II cardiac rehabilitation services are performed in an outpatient setting. Services may include:
   a. Medically-supervised exercise program
   b. Nutritional counseling
   c. Stress management
   d. Smoking cessation counseling and support services
3. Phases III and IV cardiac rehabilitation, by themselves, are not covered.
4. Phase II cardiac rehabilitation services do not include the diagnostic evaluation that is required prior to referral to cardiac rehabilitation, which is covered separately.
5. The medically necessary frequency and duration of cardiac rehabilitation is determined by the Member's level of cardiac risk stratification:
   a. High-risk Members have any of the following:
      1) Decrease in systolic blood pressure of 15 mm Hg or more with exercise; or
      2) Exercise test limited to less than or equal to 5 metabolic equivalents (METS); or
      3) Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more

ST depression by electrocardiography (ECG); or
4) Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure; or
5) Resting complex ventricular arrhythmia; or
6) Severely depressed left ventricular function (ejection fraction less than 30 %); or
7) Survivor of sudden cardiac arrest; or
8) Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.

b. Program Description for High-Risk Members:
1) 36 one-hour sessions (e.g., 3 times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring
2) Create an individual out-patient exercise program that can be self-monitored and maintained
3) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.
4) If no clinically significant arrhythmia is documented during the first 3 weeks of the program, the provider may have the Member complete the remaining portion without telemetry monitoring.

c. Intermediate-risk Members have any of the following:
1) Exercise test limited to 6-9 METS; or
2) Ischemic ECG response to exercise of less than 2 mm of ST depression

d. Program Description for Intermediate-Risk Members:
1) 24 one-hour sessions or less of exercise training with or without continuous ECG monitoring
2) Geared to define an ongoing exercise program that is "self-administered."
3) Educational program for risk factor/stress reduction; classes listed below in VI.B.6. c. – f. covered for up to 3 months.

e. Low-risk Members have exercise test limited to greater than 9 METS

f. Program Description for Low-Risk Members:
1) Six 1-hour sessions involving risk factor reduction education and supervised exercise to show safety and define a home program (e.g., 3 times per week for a total of 2 weeks or 2 sessions per week for 3 weeks).
2) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.

g. Intensive Cardiac Rehabilitation (ICR)
1) ICR is a Centers for Medicare & Medicaid Services (CMS) designation (through the National Coverage Determination [NCD] process) for certain programs demonstrated to have:
a) Accomplished one or more of the following for its patients:
i. Positively affected the progression of coronary heart disease
ii. Reduced the need for coronary bypass surgery, OR
iii. Reduced the need for percutaneous coronary interventions; AND
b) Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services:
i. Low density lipoprotein
ii. Triglycerides
iii. Body mass index
iv. Systolic blood pressure

v. Diastolic blood pressure
vi. The need for cholesterol, blood pressure, and diabetes medications

2) Proof of CMS designation should accompany the TAR
3) ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

6. Procedure codes covered:
   a. 93797 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG Monitoring (For intermediate-risk and low-risk Members)
   b. 93798 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG Monitoring (for high-risk Members)
   c. G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session (This code will only be paid to programs approved by CMS, as described above).
   d. G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session (This code will only be paid to programs approved by CMS, as described above.)
   e. Nutrition Therapy services are also covered, as defined in policy MCUP3052 Medical Nutrition Therapy (MNT) Services.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Rehabilitative Services *(rehab)*
B. Up-To-Date: Lynne T Braun, PhD, RN, CNP, Nanette K Wenger, MD, Robert S Rosenson, MD, "Cardiac Rehabilitation Programs" updated 5/15/2024.

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES: 06/17/15; 05/18/16; 05/17/17; *08/08/18; 09/11/19; 09/09/20; 09/08/21; 09/14/22; 10/11/23; 10/09/2; 11/12/25; 11/04/26

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3130</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Osteopathic Manipulation Treatment</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/17/2015
Effective Date: 10/01/2015</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/12/2025</td></tr>
</table>

I. RELATED POLICIES:
MPCR13C - Osteopathic Manipulation Treatment Credentialing

II. IMPACTED DEPTS:
~~A. Health Services~~
~~B.~~A. Member Services
~~C.~~B. Claims
~~D.~~C. ~~Provider Relations~~Network Services

III. DEFINITIONS:
A. Osteopathic medicine is a branch of the medical profession in the United States, whose physicians are known as Doctors of Osteopathy (DO).
B. Osteopathic physicians are trained in Osteopathic Manipulative Treatment (OMT), also known as Osteopathic Manipulative Medicine (OMM), a core set of manual manipulative techniques used to treat somatic dysfunction.
C. Somatic dysfunction means an impaired or altered function of related components of the somatic system, which is the part of the peripheral nervous system associated with the voluntary control of body movements via skeletal muscles.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
This policy describes the conditions under which osteopathic manipulation treatment (OMT) services are a covered benefit.

VI. POLICY / PROCEDURE:
Osteopathic Manipulation Therapy (OMT) Coverage
A. OMT services should only be provided by physicians skilled, trained and experienced in providing these services. This includes Doctors of Osteopathic Medicine (DOs)~~,~~ but may include other medical doctors (MDs) who have completed supplementary training and are certified by the Osteopathic Medical Board of California.
B. Authorization:
1. No treatment authorization is required to perform OMT if it is performed by a primary care clinician or a Doctor of Osteopathic Medicine credentialed by Partnership HealthPlan of California

(Partnership) AND with documentation of skill, training and experience in providing OMT services. Non-credentialed providers will not be eligible for payment for OMT.

2. Only one OMT service should be billed per day. A maximum of 12 treatments may be billed per rolling 12-month period. Reimbursement for OMT services beyond 12 treatments per rolling 12-month period requires a Treatment Authorization Request (TAR) for medical necessity.
3. ~~Codes covered.~~ The following CPT® codes are covered under this OMT policy when billed in conjunction with ICD-10 diagnosis codes M99.01, M99.02, M99.03, M99.04, or M99.05:
   a. 98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved
   b. 98926 Osteopathic manipulative treatment (OMT); 3-4 body regions involved
4. Evaluation and Management (E&M) services may be billed on the same day as OMT services, when medically necessary, using modifier 25 in the following conditions:
   a. If the patient's condition requires a separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the procedure
   b. If a new condition occurs or the patient's condition has changed substantially, necessitating an overall assessment

C. OMT is a proven medical therapeutic option for treatment of musculoskeletal disorders, including acute and chronic lower back pain.

D. OMT is unproven and not medically necessary in the following circumstances/diagnoses:
1. The patient's condition has returned to the pre-symptom state.
2. Little or no improvement is demonstrated within 30 days of the initial visit despite modification of the treatment plan.
3. Concurrent chiropractic manipulative therapy, for the same or similar condition, provided by another health professional whether or not the healthcare professional is in the same professional discipline.
4. When documentation of somatic dysfunction is absent from the patient's medical record
5. Manipulative therapy under anesthesia.
6. Non-musculoskeletal disorders (e.g. asthma, otitis media, infantile colic, etc.)
7. Prevention/maintenance/custodial care
8. Internal organ disorders (e.g., gallbladder, spleen, intestinal, kidney, heart or lung disorders)
9. Scoliosis correction
10. Craniosacral therapy (cranial manipulation)
11. Manipulative services that utilize nonstandard techniques

E. All OMT services conducted should be documented in the medical record, including the diagnosis, any disability that is present, the treatment used, the length of the treatment, and the effectiveness of the treatment.

VII. REFERENCES:

A. Spinal Manipulative therapy for chronic low-back pain. Cochrane abstract. February 13, 2011
B. Spinal Manipulative therapy for acute low-back pain. Cochrane abstract. September 12, 2012
C. Medi-Cal Provider Manual/ Guidelines: Osteopathic Manipulation Treatment (*osteo)*
D. American Osteopathic Association
E. Christopher L Knight, MD et al. Treatment of acute low back pain; UpToDate. Accessed 05/01/2023
F. Roger Chou, MD et al. Subacute and chronic low back pain: Nonpharmacologic and pharmacologic treatment; UpToDate. Accessed 05/01/2023

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

Policy/Procedure Number: MCUP3130		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Osteopathic Manipulation Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/17/2015 **Effective Date:** 10/01/2015	**Next Review Date: 11/0412/20276** **Last Review Date: 11/0412/20265**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

X. REVISION DATES: 05/18/16; 05/17/17; *09/12/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 08/09/23; 09/11/24; 11/12/25; 11/04/26

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Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/18/2015</td><td colspan="3">Next Review Date: ~~05/13/2027~~11/04/2027
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

~~A. Health Services~~
~~B.~~A. Provider Relations
B. Claims
C. Member Services

III. DEFINITIONS:

A. **Activities of Daily Living (ADL):** The activity of dressing/bathing, eating, ambulating (walking), toileting and hygiene.

B. **Complex Rehabilitation Technology (CRT):** (previously known as Custom Rehabilitation Equipment)~~:~~ Durable medical equipment (DME), ~~Any item, piece of equipment or product system,~~ whether modified or customized, that is individually configured for Members to meet their specific and unique medical, physical and functional needs and capacities for ADLs and IADLs, as medically necessary. CRT is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of Members~~individuals~~ with disabilities. CRT may only be provided by an accredited CRT supplier. ~~Custom rehabilitation equipment~~CRT includes, but is not limited to, non-standard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based upon patient height, weight and disability, specialized wheelchair electronics and cushions, custom bath equipment, standards, gait trainers and specialized strollers.

C. **CRT Supplier:** Accredited as a Durable Medical Equipment (DME) CRT supplier that specializes in the evaluation, configuration, fitting, adjustment, modification and/or programming of complex rehab technology to meet the specific and unique medical, physical and functional needs of members with disabilities and complex medical conditions.

~~C.~~D. **Durable Medical Equipment (DME):** Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist) in the treatment of a specific medical condition and which have all of the following characteristics:

1. Can withstand repeated use
2. Is used to serve a medical purpose
3. Is not useful to an individual in the absence of an illness, injury, functional impairment or congenital

anomaly; and

4. Is appropriate for use in or out of a patient's home.

~~D.~~E. **Instrumental Activities of Daily Living (IADL):** Activities that allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

~~E.~~F. **Licensed Practitioners:** Clinical professionals furnishing medical care, or any other type or remedial care recognized under State law within their scope of practice as defined by State Law.

~~F.~~G. **Medical Necessity:** For the purposes of this policy, a wheelchair is considered medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living, in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

~~G.~~H. **Power Mobility Device (PMD):** Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

~~H.~~I. **Power Operated Vehicle (POV):** Chair-like battery power fed mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

~~I.~~J. **Power Wheelchair (PWC):** Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, electronic steering, and four or more wheel non-highway construction.

~~J.~~K. **Qualified Health Ceare Professional (QHCP):** A l~~L~~icensed/certified medical professional such as a physical, occupational, or speech therapist ~~s~~or a practitioner who has specific training and experience in rehabilitation wheelchair evaluations and Member's seating and positioning needs. The QHCP may have no financial relationship with the CRT supplier, QRTP, manufacturer of the recommended CRT product(s) or third-party payor. ~~with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the consumer's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.~~

~~K.~~L. **Qualified Rehabilitation Technical Professional (QRTP):** A professional with competence in analyzing the needs of Members with disabilities, who has direct, in-person involvement in the selection of appropriate assistive technology for the Member's needs and is directly involved with or closely supervises the final fitting and delivery of the wheelchair to Partnership Members. The QRTP must be a W-2 employee of an accredited CRT supplier; hold the credential of Assistive Technology Professional (ATP) or Seating and Mobility Specialist (SMS) from RESNA; and/or hold the credential of CRT Supplier from the International Registry of Rehabilitation Technology Suppliers. ~~Individuals typically certified as Assistive Technology Professionals who are employed by the vendor providing assistive technology devices to Partnership Members. They may have an additional certification of a Certified Rehabilitation Specialist.~~ The QRTP is responsible for ensuring the equipment provided meets the technical needs of the patient.

~~L.~~M. **SPC:** Seating and provisional components

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the policy and processes for review of wheelchairs (manual and electric powered) and Power Operated Vehicles (POV) in accordance with the Department of Health Care Services All Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Component

issued July 9, 2015 as well as the California Children's Services (CCS) Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) issued August 8, 2003 and CCS N.L. 09-0514 Powered Mobility Devices (PMD) issued May 29, 2014.

VI. POLICY / PROCEDURE:

A. An authorization request for rental or purchase of a manual or powered mobility device (wheelchair, POV) requires a written request/prescription from a licensed professional and will be reviewed as follows:

1. Upon receipt of the Treatment Authorization Request (TAR) for complex rehabilitation technology (CRT)~~custom rehabilitation equipment~~ (as per III.B.) and/or powered mobility devices (as per III.H~~G~~.), Partnership HealthPlan of California (Partnership) will arrange for an assessment by an independent Qualified Healthcare Professional (QHCP) who is not employed by or paid by a mobility device vendor/CRT supplier. The purpose of the assessment is to evaluate the appropriateness of the request, document medical necessity for the mobility device, and identify the type of equipment best suited to meet the Member's specific needs. The assessment must be performed in the setting where the Member will use the mobility device. The independent QHCP's written summary of findings and recommendations is required to be submitted to Partnership before a determination decision can be made for the mobility device authorization request. Partnership does not offer incentives or compensation to independent consultants or health plan staff to deny medically appropriate services requested by Members or providers.
2. A prescription for a wheelchair will not be denied on the grounds that it is for use only outside the home.
3. Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device.
4. A TAR is required for all wheelchair requests when Partnership is the secondary payer to Medicare.
   a. 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.
   b. 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.
5. The following sequential questions offer clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. These guiding principles will be used by Partnership in making a benefit coverage determination.
   a. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
      1) Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
      2) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or
      3) Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame
   b. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?

1) Some examples are impairment of cognition or judgment and/or vision.
2) For these beneficiaries, the provision of a wheelchair and seating and provisional components (SPC) might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.

c. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?
   1) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
   2) It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
d. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
   1) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   2) A history of unsafe behavior may be considered.
   3) Additional information may be requested from the Member's treating medical providers.
e. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?
   1) The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
   2) Assess the beneficiary's ability to safely use a cane, crutches or walker.
f. Does the beneficiary's typical environment support the use of wheelchair and SPC?
   1) Determine whether the beneficiary's environment will support the use of medically necessary types of wheel-chair and SPC.
   2) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.
g. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured (SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
   1) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
   2) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light-weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
   3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   4) Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.
h. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
   1) A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC. Three-wheeled devices are not covered.
   2) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.

3) Assess the beneficiary's ability to safely use a POV/scooter.

i. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADLs?

1) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
2) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
4) Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

4. When a manual or powered mobility device authorization is approved, it is the vendor's/CRT supplier's responsibility to have a Qualified Rehabilitation Technical Professional (QRTP) ensure the equipment provided meets the technical needs of the Member. Any customized additions or added features that are not specifically covered under the approved authorization will require submission of another request (for a "custom wheelchair or device") to authorize these additions. Failure on the part of the CRT supplier~~vendor~~ to do so before building and delivering the customized device could result in denial of requests for payment for the additional features.

B. Medical Necessity

1. Manual wheelchairs are medically necessary when:
   a. Criteria 1), 2), 3), 4) and 5) below are met; and
   b. Criterion 6) or 7) is met, and
   c. Criteria is met for specific devices listed below.
      1) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs, and
      2) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, crutches or walker, and
      3) The manual wheelchair supplied to the beneficiary for use in or out of the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
      4) Use of a manual wheelchair will improve the beneficiary's ability to participate in ADLs or IADLs.
      5) The beneficiary has expressed a willingness to use the manual wheelchair that is provided, and
      6) The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
      7) A standard wheelchair may be medically necessary
         a) When the beneficiary is able to self-propel the wheelchair, or
         b) Propel with assistance
      8) A standard hemi-wheelchair may be medically necessary
         a) For disarticulation of one or both lower extremities, or
         b) Requires a lower seat height because of short stature, or
         c) To enable the beneficiary to place his/her feet on the ground for propulsion
      9) A lightweight wheelchair may be medically necessary
         a) When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or

b) For a beneficiary with marginal propulsion skills.

10) A high strength lightweight wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard or lightweight wheelchair, or
   b) The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
11) An ultra-lightweight multi-adjustable wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchairs, and
   b) The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
   c) The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
   d) The beneficiary's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (e.g., pediatric size and growth options)
12) A heavy--duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 250 pounds, as documented in clinical notes within the past 12 months, or
   b) The beneficiary has severe spasticity, or
   c) Body measurements cannot be accommodated by standard sized wheelchairs.
13) An extra heavy--duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 300 pounds, as documented in clinical notes within the past 12 months, or
   b) Body measurements cannot be accommodated by a heavy--duty wheelchair
14) Manual tilt-in-space wheelchairs are medically necessary when
   a) The beneficiary is dependent for transfers, and
   b) The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15) Pediatric sized folding adjustable wheelchairs with seating systems are covered as primary or back-up wheeled mobility when
   a) The beneficiary meets the criteria for wheeled mobility, and
   b) The wheelchair is an appropriate size for the beneficiary, and
   c) The beneficiary meets the criteria for recline and positioning options, and
   d) The wheelchair provides growth capability in width and length

2. Powered Mobility Devices are medically necessary when:
   a. Criteria 1), 2), and 3) below are met, and
   b. Criteria is met for specific devices listed below.
      1) The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more ADL or IADLs, and
      2) The beneficiary's mobility limitation cannot be safely resolved by the use of an appropriately fitted cane, crutches or walker, and
      3) The beneficiary does not have upper extremity function to self-propel an optimally-configured manual wheelchair to perform ADLs or IADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or

deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

A four wheeled Power Operated Vehicle (POV) is covered if all of the basic coverage criteria 1) - 3) have been met and if criteria 4) - 9) are also met.

4) The beneficiary is able to:
   a) Safely transfer to and from a POV, and
   b) Operate the tiller steering system, and
   c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids
5) The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in or out of the home, and
6) The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7) The beneficiary's weight, as documented in clinical notes within the past 12 months, is less than or equal to the weight capacity of the POV that is provided, and
8) Use of a POV will significantly improve the beneficiary's ability to participate in ADLs or IADLs, and
9) The beneficiary has expressed willingness to use a POV

A Power Wheelchair (PWC) is covered if all of the basic coverage criteria 1) – 3) have been met and

a) The beneficiary does not meet coverage criterion 4), 5), or 6) above for a POV; and
b) Criteria 10) – 13) below are met; and
c) Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.

10) The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11) The beneficiary's typical environment (in or out of the home) provides adequate access between rooms, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
12) The beneficiary has expressed willingness to use a power wheelchair.

Power Wheelchairs are segmented into the following groupings:

13) A Group 1 PWC (K0813-K0816) or a Group 2 (K0820-K0829) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
14) Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
   a) The beneficiary requires a drive control interface other than a hand or chin- operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control), or
   b) The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair
15) A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage

criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
   a) The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
   b) The beneficiary uses a ventilator which is mounted on the wheelchair.

16) A Group 3 PWC with no power options (K0848-K0855) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
17) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 3 criteria [17)] are met, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
18) A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 3 criteria [17)] are met, and
   b) The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the beneficiary engaging in frequent ADLs or IADLs cannot be performed in a Group 3 PWC.
19) A Group 4 PWC with Single Power Option (K0877-K0880) or with Multiple Power Options (K0884-K0886) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 4 criteria [19)] are met, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
20) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met; and
   a) The beneficiary is expected to grow in height, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
21) A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met, and:
   a) The beneficiary has been self-propelling in a manual wheelchair for at least one year, and
   b) The beneficiary has a non-progressive disease, and
   c) The beneficiary has successfully completed a two-month trial period (reimbursable with prior approval as a rental).
22) SPC may be included with new wheelchair or billed separately under the following conditions:
   a) Refer to the SPC Coverage Criteria for information concerning coverage of general use, skin protection, positioning, powered and custom made components.
   b) A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
   c) If a beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
   d) A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.

23) If a beneficiary's weight, as documented in clinical notes within the past 12 months, combined with the weight of seating and positioning accessories can be accommodated by wheelchair with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.
24) A power mobility device (PMD) will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

3. Backup manual wheelchairs are medically necessary when
   a. The beneficiary meets the criteria for a powered mobility device, and
   b. The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
   c. The beneficiary is unable to complete ADLs or IADLs without a backup manual wheelchair, and
   d. The backup wheelchair accommodates the SPC on the primary wheelchair.

C. Wheelchairs are NOT covered when:
1. Not medically necessary
2. Not used by the beneficiary
3. Used as a convenience item
4. Used to replace private or public transportation such as an automobile, bus or taxi
5. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them
6. Used in a facility that is expected to provide such items to the beneficiary
7. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of the Code of Regulation section 51321(h)
8. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, by a licensed practitioner after evaluation by a QHCP.

D. Seating and Positioning Component Coverage Criteria:
SPC are covered when criteria 1. 2. and 3. and~~,~~ at least one of criteria 4. – 9. are met.~~, and~~ Criteria 10. – 19. ~~(if applicable)~~ will then be applied if relevant features are requested~~are met~~. (*Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered*):
1. The beneficiary has met the criteria for wheelchair, and
2. The SPC meets the quality standards and coding definitions specified in the APL 15-018. The Medicaid program reserves the right to review any and all coding assignments by vendors/CRT suppliers and the Medicare Pricing, Data Analysis and Coding (MPDAC) web site based on submitted and published product specifications and other relevant information.
3. The primary and back-up wheelchair bases accommodate the SPC.
4. A general use seat cushion and a general use back cushion are covered when 1., 2. and 3. are met.
5. A skin protection seat cushion or decubitus wheelchair pad is covered when 1., 2. and 3. are met and that beneficiary has one of the following:
   a. A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   c. Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease,

multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn, cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or

d. Confined to their wheelchair for more than four (4) continuous hours on a daily basis
e. A well-documented history (as well as current status) of malnutrition.

6. A positioning seat cushion or positioning back cushion, is covered when 1., 2. and 3. are met and the beneficiary has one of the following:
   a. Significant postural asymmetries that are due to but not limited to one of the diagnoses listed in criterion "5." above; or
   b. One of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.
7. A positioning accessory is covered when criteria 1., 2., 3. and 6. are met and specifically:
   a. A headrest or headrest extension (sling support for the head) is covered when the recipient has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
   b. An upper extremity support system (UESS) is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or potential seating or wheelchair features. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). UESS and related accessories are not covered when used solely for activities of daily living.
   c. UESS padding and positioning blocks are covered in addition to a UESS when there is a medical need for stabilization of the UESS due to strong spasticity or exaggerated muscle activity.
   d. Foot-Ankle Padded Positioning Straps (e.g., "ankle huggers") are covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.
8. A combination skin protection and positioning seat cushion is covered when 1., 2., 3., 5. and 6. are met, i.e., the criteria for both a skin protection seat cushion and a positioning seat cushion are met.
9. A custom fabricated seat cushion is covered if the criteria for 8. are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer), which clearly explains why a standard seating system is not sufficient to meet the beneficiary's seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)
10. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual recipient, the cushion must be billed as a customized cushion, not custom fabricated.
11. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
12. Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item.
13. The swing away, multi-positioning or removable mounting hardware upgrade code may only be billed in addition to the codes for a headrest, lateral trunk, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back

cushions, or with PWCs with swing away, fixed or retractable joysticks.

14. A manual tilt in space option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary is dependent for transfers, and
    c. The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15. A power tilt in space option for a PWC is covered when:
    a. Criteria 1. – 3. and 14. above are met, and
    b. The beneficiary has the mental and physical capabilities to safely and independently operate the power tilt in space that is provided.
16. A manual recline option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or
    d. The beneficiary's postural control requires a recline feature.
17. A power recline option for a PWC is covered when:
    a. Criteria 1. – 3. and 16. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
18. A combination manual tilt in space and recline option is covered when criteria 14. and 16. are met and if provided alone will not meet the seating and positioning needs.
19. A combination power tilt in space and recline option is covered when criteria 15. and 17. are met and if provided alone will not meet the seating and positioning needs.

E. Portable Ramps
   1. For Partnership's policy on portable ramps, please see policy MCUP3013 DME Authorization section VI.FG.9.

F. Loaner Rental During Repair
   1. Back-up or loaner rental power wheelchairs are ~~not~~ a Medi-Cal covered benefit with no TAR requirement for up to two (2) one-month rental periods per year.
      a. Providers may bill using HCPCS code K0462 for the separate reimbursement of a one-month rental by using required modifier RR, when a member-owned wheelchair is being repaired or undergoing maintenance that is expected to take more than one day.
      b. A TAR will be required to exceed the frequency limit of two times per year. When a TAR is required, documentation of medical necessity must be included to be reviewed by the Chief Medical Officer or Physician Designee.
      ~~b.~~c. ~~On a case by cases basis, up to a one-month rental of a wheelchair may be considered medically necessary (with maximum of one-month renewal with justification) if a Member-owned wheelchair requires an extended repair.~~ Payment for the rental is based on the type of replacement device that is provided. ~~Requests for loaner powered mobility device rentals will require documentation of medical necessity to be reviewed by the Chief Medical Officer or Physician Designee.~~

VII. REFERENCES:

A. Title 22, CCR Sections 52260, 51321
B. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (*dura wheel guide*) and Bill for Wheelchairs and Wheelchair

Accessories (*dura bil wheel*)

C. Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
D. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
E. CCS Numbered Letter (N.L.) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)
F. Senate Bill No.717 Complex Needs Patient Act, California Legislature 2021-2022 Regular Session, Amended in Senate May 20, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB717

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

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

X. REVISION DATES: 08/17/16; 08/16/17; *09/12/18; 11/13/19; 11/11/20; 11/10/21; 05/11/22; 06/14/23; 08/14/24; 09/10/25; 05/13/26; 11/04/26

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

PREVIOUSLY APPLIED TO:

MCUP3083 - Wheelchair and Power Operated Vehicle Authorization was archived 11/18/2015
Original Date: 04/16/2008
Revision Dates: 07/15/09; 05/18/11

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, October 08, 2026 / 7:30am – 10:00am PT

Practicing Members Present:
Michael Majeski, PharmD
Kirsten Balano, PharmD
Yasmin G Bains, DO

PHC Members Present:

Chief Medical Officer, Committee Chair:
Robert Moore, MD, MPH, MBA

Medical Directors:
Lisa Ward, MD
Richard Matthews, MD
Colleen Townsend, MD
Mark Netherda, MD
Bettina Spiller, MD

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

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

Invited Guests Present:
Donell Colvin, CPhT
Mohamed Jalloh, PharmD

Department AA:
Jacquelyn Brackett

IT Ops & Systems:
Jose Puga
John Lemoine

Practicing Members Absent:
Phillip Nguyen, PharmD, BCACP, BCGCP
Jay Shubrook, DO
Lilia Vargas-Toledo, RN

PHC Members Absent:
Kermit Jones, MD
Dave Katz, MD
Bradley Cox, DO
Jeffery Ribordy, MD, MPH
Marshall Kubota, MD
Jeffrey DeVido, MD
Teresa Frankovich, MD
Aaron Thornton, MD
Michael George, MD
Mark Glickstein, MD
Matthew Morris, MD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	• Introductions • Housekeeping (Announcement: Meeting is being recorded) • Conflict of Interest statement reminder	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Yes, 3 out of 6 members attended Minutes: Approved	*Presented by Stan Leung, PharmD*	
II. Standing Agenda			
1. PHC Update	PHC Updates provided by Dr. Moore: Dr. Moore provided Partnership updates to the committee. He informed the committee of the upcoming transition of members with Unsatisfactory Immigration Status (UIS) from managed care to fee-for-service coverage. He also provided information regarding changes to coverage for gender-affirming care for pediatric members, noting that services would be funded through HCAI state-only funds effective October 13, 2026. Additionally, Dr. Moore discussed forthcoming work requirements and their potential impact on members.	*Presented by Robert Moore, MD, MPH, MBA*	N/A
2. Additional Updates	Pharmacy and Medi-Cal Rx Updates: Dr. Leung presented updates on the Medi-Cal Provider Enrollment requirements that will be effective February 2027, with full enforcement beginning July 2027. He also discussed the Statin HEDIS measures.	*Presented by Stan Leung, PharmD*	N/A
3. DUR Update	**Latent Tuberculosis Infection (LTBI)** Our pharmacy department has been monitoring LTBI since 2018, to support treatment adherence and improve member outcomes. Prior to pharmacy benefits being carved out to the state in 2022, we focused on our community pharmacies by providing LTBI treatment education and claims processing support. Since restarting our LTBI monitoring program, our focus is with our prescribers. We provide our prescribers with notification outreach to support treatment	*Presented by Kathleen Vo, PharmD*	

adherence and completion based on CDC recommended treatment guidelines. Using Medi-Cal Rx pharmacy claims data, we monitor for adherence and identify potential gaps in medication refills that may result in incomplete treatment or incorrect drug/dose for the selected regimen.

We support the health of our communities by providing quarterly treatment updates to our Public Health officers who request this data. We provide semiannual updates to our Medical Directors.

The summary tables below provide collected data for 2025 and partial data for 2026. Data for 2025 showed that across all our 6 regions, LTBI treatment completion rates are comparable at around 62% to 65%. Partial data for 2026 showed that prescriber outreach letters do result in positive responses with treatment completion or restart of treatment. The last set of tables show that 4R regimen appears to be the favored treatment for LTBI across our counties and regions.

Concurrent use of opioids and benzodiazepines (COB)

Our concurrent use of opioids and benzodiazepines (COB) monitoring program is mandated by DHCS. Medical Rx pharmacy claims are used to identify members who meet the inclusion criteria for COB monitoring.

From July 2024 to December of 2025, we conducted prescriber outreach intervention with notification letters. Aggregate data for this period showed ~51% discontinuation rate of COB treatment within 90 days. Of those who stopped COB treatment and maintained PHC eligibility, ~83% did not restart COB therapy in 2026. Of those who continued their COB treatment beyond 90 days, ~21% discontinued COB therapy in 2026.

We wanted to verify if our prescriber outreach intervention impacted COB discontinuation rates. From Jan 2026 to Jun 2026, we continued to identify and track members but did not conduct prescriber outreach. During this period of no intervention, there was ~71% discontinuation rate.

The tables provide a summary of our intervention and no intervention results, and follow-up data for our intervention group into 2026.

	These findings suggest that prescriber outreach may have limited impact on whether COB therapy is continued or discontinued. We plan to continue no prescriber intervention to the end of Dec 2026 to obtain a full year of data. We will continue to identify, analyze, and track COB and present a full year of 2026 data during April 2027 P&T Committee meeting. Before I move on to the next DUR program, I'll pause for questions or discussions. **Fraud and Abuse** I did not prepare a formal presentation on fraud and abuse monitoring, which is also a program mandated by DHCS. We are shifting our lookback period to better align with CMS calendar. A formal presentation will be presented at Jan 2027 P&T Committee meeting. I conducted a follow-up of the 2 members identified during April's P&T meeting. Member #1 was presented during Oct 2025 and April 2026 P&T Committee meetings. Review of ED claims from Jan 2026 to end of Aug showed 25 ED visits and some acute fills for small quantities of opioids, in addition to chronic opioid from PCP. Member #2 was presented at April's 2026 P&T. Review of ED claims from Jan 2026 to end of Aug showed 16 ED visits that resulted in some fills for small quantities of opioids. Both members were enrolled in Case Management to assist with connecting to specialty providers		

4. Drug Benefit Review

The classes for this quarter's review are:

- Antineoplastic & Adjunctive Agents
- Hematological Agents
- Nutritional Products
- Psychotherapeutic and Neurological Misc. Agents

No changes proposed to the Nutritional Products Class.

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

All changes will be effective 1/1/2026 unless otherwise noted.

Class Reviews:

- Antineoplastic & Adjunctive Agents
  - Updates to the following were presented, with approved action shown at right.
    - belantamab mafodotin-blmf, 0.1 mg (Blenrep™)
    - pivekimab sunirine-pvzy (Decnupaz™)
    - tagraxofusp-erzs, 10 micrograms (Elzonris™)
    - obinutuzumab, 10 mg (Gazyva™)
    - imetelstat, 1 mg (Rytelo™)
    - zenocutuzumab-zbco, 1 mg (Bizengri™)

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

Presented by Erin Montegary, PharmD

Antineoplastic & Adjunctive Agents Class Review, Approved Actions:	
HCPCS	**Drug**
New TAR Criteria (see attached criteria for details)	
J9053	Injection, belantamab mafodotin-blmf, 0.1 mg (Blenrep™)
C9313	Injection, pivekimab sunirine-pvzy (Decnupaz™)
J9269	Injection, tagraxofusp-erzs, 10 micrograms (Elzonris™)
J9301	Injection, obinutuzumab, 10 mg (Gazyva™)
J0870	Injection, imetelstat, 1 mg (Rytelo™)
TAR Criteria Updates (see attached criteria for details)	
J9382	Injection, zenocutuzumab-zbco, 1 mg (Bizengri™)

1/1/2026

- Hematological Agents
  - Updates to the following were presented, with approved action shown at right.
    - narsoplimab-wuug, 1 mg (Yartemlea™)
    - eculizumab, 2 mg (Soliris™)
    - eculizumab-aagh (epysqli), biosimilar, 2 mg (Epysqli™)
    - eculizumab-aeeb (bkemv), biosimilar, 2 mg (Bkemv™)
    - luspatercept-aamt, 0.25 mg (Reblozyl™)
    - imiglucerase, 10 units (Cerezyme™)
  - Updates to the following were presented as a consent item with action shown at right.
    - filgrastim-laha (Filkri™) **Criteria: Requirements for Non-Preferred Filgrastim Products**
    - filgrastim-txid (nypozi), biosimilar, 1 microgram (Nypozi™) **Criteria: Requirements for Non-Preferred Filgrastim Products**
    - pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg (Armlupeg™) **Criteria: Requirements for Non-Preferred Pegfilgrastim Products**
    - eflapegrastim-xnst, 0.1 mg (Rolvedon™)
    - caplacizumab-yhdp, 1 mg (Cablivi™)
    - exagamglogene autotemcel, per treatment (Casgevy™)

Presented by Susan Becker, PharmD, BCPS

Hematological Agents Class Review, Approved Actions:	
HCPCS	**Drug**
New TAR Criteria (see attached criteria for details)	
J1289	Injection, narsoplimab-wuug, 1 mg (Yartemlea™)
TAR Criteria Updates (see attached criteria for details)	
J1299	Injection, eculizumab, 2 mg (Soliris™)
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg (Epysqli™)
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg (Bkemv™)
J0896	Injection, luspatercept-aamt, 0.25 mg (Reblozyl™)
J1786	Injection, imiglucerase, 10 units (Cerezyme™)
TAR Criteria Updates (see attached criteria for details) presented as Consent Item	
J3590 (NOC)	Unclassified Biologicals: filgrastim-laha (Filkri™)
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram (Nypozi™)
Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg (Armlupeg™)
J1449	Injection, eflapegrastim-xnst, 0.1 mg (Rolvedon™)
C9047	Injection, caplacizumab-yhdp, 1 mg (Cablivi™)
J3392	Injection, exagamglogene autotemcel, per treatment (Casgevy™)

1/1/2026

- Psychotherapeutic and Neurological Misc. Agents
  - Updates to the following were presented, with approved action shown at right.
    - ocrelizumab, 1 mg (Ocrevus™)
    - ocrelizumab, 1 mg and hyaluronidase-ocsq (Ocrevus Zunovo™)
    - ublituximab-xiiy, 1mg (Briumvi™)
    - lecanemab-irmb, for intravenous injection, 1 mg (Leqembi™)
    - lecanemab-irmb (Leqembi Iqlik™)

Presented by Angela Keough, PharmD

Psychotherapeutic and Neurological Misc. Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J2350	Injection, ocrelizumab, 1 mg (Ocrevus™)
J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq (Ocrevus Zunovo™)
J2329	Injection, ublituximab-xiiy, 1mg (Briumvi™)
J0174	Lecanemab-irmb, for intravenous injection, 1 mg (Leqembi™)
J3590 (NOC)	Unclassified biologics: lecanemab-irmb (Leqembi Iqlik™)

1/1/2026

In addition to the scheduled class reviews, PHC presented the following:

- Updates to Vaccines, Toxoids, Immunizations, Allergenic Extracts, Misc. Agents:
  - immune globulin (Qivigy), 100 mg **Criteria: Requirements for Immunoglobulin (Human)*
  - *Products (IVIG, IMIG, SCIG)**
- Updates to Neuromuscular Agents:
  - nusinersen, 0.1 mg (Spinraza™)
- Updates to Miscellaneous Products:
  - allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq (Tregzi ™)
- Updates to Dermatological, Anorectal, Mouth – Throat, Dental, Eye – Ear Agents:
  - riboflavin 5'-phosphate, ophthalmic solution (epioxa hd/epioxa), up to 2 ml (Epioxa/Epioxa HD™)

Presented by Erin Montegary, Pharm D

Ad hoc Updates		
HCPCS	**HCPCS Description (brand)**	**Approved Action**
J1577	Injection, immune globulin (Qivigy), 100 mg	Updates to current criteria to add new code (see attached criteria for details)
J2326	Injection, nusinersen, 0.1 mg (Spinraza™)	Updates to current criteria (see attached criteria for details)
J3590 (NOC)	Unclassified Biologics: allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq (Tregzi ™)	New drug specific criteria (see attached criteria for details)
J2789	Riboflavin 5'-phosphate, ophthalmic solution (epioxa hd/epioxa), up to 2 ml (Epioxa/Epioxa HD™)	New drug specific criteria (see attached criteria for details)

1/1/2026

- 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 9/29/2026, with an effective date of 1/1/2026.

Presented by Erin Montegary, PharmD
NTR = No TAR Required

New HCPCS codes (no prior code or was previously unclassified		
HCPCS	HCPCS Description	Requirements
J0871	Injection, daptomycin (endo), not therapeutically equivalent to J0878, 1mg	TAR
C9312	Injection, trabectedin (apotex), not therapeutically equivalent to J9362, 0.01 mg (Evdi™)	TAR
C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg (Decnupaz™)	TAR
J3406	Injection, omidubicel-onlv, per therapeutic dose (Omisirge™)	TAR
J9186	Injection, etoposide (avyxa), 1 mg (Avopef™)	TAR
J9191	Injection, fluorouracil (avyxa), 10 mg (Favlyxa™)	TAR
J9066	Injection, bendamustine hydrochloride (avyxa), 1 mg (Avyxa™)	TAR
J1946	Injection, furosemide (lasix onyu), 1 mg (Lasix Onyu™)	TAR
J1757	Injection, tividenofusp alfaeknm, 1 mg (Avlayah™)	TAR
J1818	Injection, pegzilarginasenbln, 0.05 mg (Loargys™)	TAR
J7531	Prednisolone sodium phosphate, orally disintegrating tablet, 1 mg (Orapred ODT™)	NTR
Q5173	Injection, denosumab-adet (ponlimsi), biosimilar, 1 mg (Ponlimsi™)	TAR
Q5172	Injection, filgrastim-laha (filkri), biosimilar, 1 microgram (Filkri™)	TAR
C9311	Injection, eplontersen, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Wainua™)	TAR

10/1/2026

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	**HCPCS Description**	**Requirements & prior code**
J3268	Injection, delafloxacin, 1 mg (Baxdela (IV)™)	TAR *(same as prior code C9462)*
J0014	Cocaine hydrochloride nasal solution (goprelto), 1 mg (Goprelto™)	TAR *(same as prior code C9046)*
J0643	Injection, leucovorin calcium, not otherwise specified, 1 mg	NTR (*(same as prior code J0640)*
J0644	Injection, leucovorin calcium (avyxa), 1 mg (Vykoura™)	TAR *(same as prior code C9310)*
J9187	Injection, etoposide, 1 mg (Etopophos™)	Covered with limits *(same as prior code J9181)*
J9192	Injection, fluorouracil, 10 mg (Adrucil™)	NTR (*(same as prior code J9190)*
J9362	Injection, trabectedin, 0.01 mg (Yondelis™)	Covered with limits *(same as prior code J9352)*
J1947	Injection, furosemide (furoscix), 1 mg (Furoscix™)	TAR *(same as prior code J1941)*
J7524	Mycophenolate mofetil, oral, 5 mg (Cellcept (oral)™)	NTR (*(same as prior code J7517)*
J7526	Injection, mycophenolate mofetil, 5 mg (Cellcept (IV)™)	Covered with limits *(same as prior code J7519)*
J7529	Mycophenolate mofetil, for suspension, oral, 5 mg (Cellcept (oral suspension)™)	NTR (*(same as prior code J7528)*
J7530	Mycophenolate mofetil (myhibbin), oral suspension, 5 mg (Myhibbin™)	TAR *(same as prior code J7514)*
J1957	Injection, levetiracetam, 5 mg (Keppra™)	NTR (*(same as prior code J1953)*
J1958	Injection, levetiracetam in sodium chloride, 5 mg	NTR (*(same as prior code J1953)*

10/1/2026

- 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
S0092	Injection, hydromorphone hydrochloride, 250 mg (loading dose for infusion pump)	Removed EX 86 (not covered benefit) configuration, transitioning to use of specific code
90758	Zaire ebolavirus vaccine, live, for intramuscular use	Updated age limit to 18yrs and older
90587	Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use	Removed TAR (TA) requirement; Added age limit of 9-16 years old; Added (SK) high risk modifier requirement
90747	Hepatitis B vaccine (HepB), dialysis or immunosuppressed patient dosage, 4 dose schedule, for intramuscular use	Removed DX (diagnosis) limit
90750	Zoster (shingles) vaccine (HZV), recombinant, sub-unit, adjuvanted, for intramuscular injection	Updated age limit to 18yrs and older
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use	Removed 2 per lifetime limit
90710	Measles, mumps, rubella and varicella vaccine (MMRV), live, for subcutaneous use	Removed 2 per lifetime limit
90678	Respiratory syncytial virus vaccine, per, subunit, bivalent, for intramuscular use	Changed age limits to read: Payable for pregnant individuals at 32 through 36 weeks gestation. Provider must submit documentation of gestational age. Covered for individuals ages 50 years and older.
90679	Respiratory syncytial virus vaccine, preF, recombinant, subunit, adjuvanted, for intramuscular use	Removed 1 per lifetime limit

N/A

		J0561	Injection, penicillin g benzathine, 100,000 units	State added NDC: 84383-0110-01 (specifically) as reimbursable Under HCPCS Code J0561 due to the ongoing national Bicillin® L-A shortage. Code J0561 already NTR with Partnership. Added NDC as NTR to match State.	
		S5012	5% dextrose with potassium chloride, 1000 ml	EX: 86 block removed in Amysis; claims can now bill using the drug-specific code.	
		S0194	Dialysis/stress vitamin supplement, oral, 100 capsules	EX: 86 block removed in Amysis; claims can now bill using the drug-specific code.	
		J7131	Hypertonic saline solution, 1 ml	EX: 86 block removed in Amysis; claims can now bill using the drug-specific code.	
III. Old Business **a. Policy Update**	• MCRP4066: AB1114 Benefit Implementation and Oversight ▪ Presented for consent with no substantive edits.	*Presented by Stan Leung, PharmD*			11/04/2026
IV. New Business	None				
V. Additional Items	The Chair announced that Yasmin G Bains, DO has accepted the invitation to serve on the committee and welcomed her as a new member.				
VI. Adjournment	Meeting adjourned at 9:57am				

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	For the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent
Exclusion Criteria	• Member is refractory to bortezomib • Member has had prior treatment with anti-BCMA therapy (CAR-T or BiTE)
Required Medical Information	All of the following must be submitted: 1. Histologically confirmed diagnosis of relapsed or refractory multiple myeloma. 2. Clinic notes documenting history and course of illness, including response to previous therapies. 3. Documentation that member has received ≥ 2 prior lines of therapy, including a protease inhibitor and an immunomodulatory agent. 4. Eastern Cooperative Oncology Group Performance Status (ECOG PS) of 0-2. 5. Documentation that member does not currently have corneal epithelial disease. 6. Blenrep is to be given with bortezomib and dexamethasone for the first 8 cycles, then continued as monotherapy. 7. Blenrep will be prescribed and dispensed in accordance with the BLENREP REMS program. 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	Oncologist/Hematologist
Coverage Duration	Initial approval for 6 months. Continued approval requires documentation of clinical benefit and tolerability every 6 months.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9053	Injection, belantamab mafodotin-blmf, 0.1 mg	IV: 2.5 mg/kg (based on actual body weight; in combination with bortezomib and dexamethasone) on day 1 of a 21-day treatment cycle for 8 cycles, followed by 2.5 mg/kg (based on actual body weight; as a single agent) on day 1 of a 21-day treatment cycle until disease progression or unacceptable toxicity

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 blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults.
Exclusion Criteria	• Active CNS involvement • History of Sinusoidal Obstruction Syndrome (SOS) • History of grade 4 capillary leak syndrome • History of non-cardiac grade 4 edema (Exclusions from Pemmaraju N, et al. J Clin Oncol 2026;44:861-873)
Required Medical Information	Documentation of all the following must be included with requests: • Pathology report confirming diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) which includes documentation of CD123 expression. • The request is for use as monotherapy in the FDA approved dosing schedule. 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
Prescriber Restriction	Oncologist/hematologist experienced in the management of BPDCN
Coverage Duration	Initial approval for 3 months to assess clinical response and tolerability. Additional approval for up to 6 months per request with documentation of clinical benefit and continued tolerance to treatment.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
C9313	Injection, pivekimab sunirine-pvzy, 0.01 mg	IV: 0.045 mg/kg once on day 1 of a 21-day treatment cycle; continue until disease progression or unacceptable toxicity

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 blastic plasmacytoid dendritic cell neoplasm (BPDCN) in adults and in pediatric patients ≥2 years of age.
Exclusion Criteria	
Required Medical Information	1. Pathology report confirming diagnosis of blastic plasmacytoid dendritic cell neoplasm (BPDCN) which includes documentation of CD123 expression. 2. Member meets the eligibility criteria for treatment with Elzonris documented by all of the following (criteria from Pemmaraju N, et al. N Engl J Med 2019;380:1628-1637 and is included in NCCN treatment guidelines): a. Baseline serum albumin of ≥ 3.2 g/dL b. LVEF ≥ institutional lower limit of normal c. Creatinine ≤ 1.5 mg/dL d. Bilirubin ≤ 1.5 mg/dL e. AST/ALT ≤ 2.5 x ULN 3. Initial treatment is being administered in an inpatient setting with plan to monitor for at least 24 hours following the last infusion (subsequent treatment can be administered in an outpatient setting). 4. The request is for use as monotherapy at the FDA approved dosing schedule. Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	≥ 2 years and up
Prescriber Restriction	Oncologist/Hematologist with experience treating BPDCN
Coverage Duration	Initial approval for 3 months to assess clinical response and tolerability. Ongoing approval for up to 6 months per treatment request with documentation of continued benefit with no evidence of disease progression or unacceptable toxicity.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9269	Injection, tagraxofusp-erzs, 10 micrograms (Elzonris™)	IV: 12 mcg/kg (based on actual body weight) once daily on days 1 to 5 of a 21-day cycle

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	• Antineoplastic: FDA approved indications. See General Requirements for Antineoplastic Agents, Not Otherwise Having Specific TAR Criteria. • Lupus Nephritis-Criteria below.
Exclusion Criteria	• Members receiving belimumab (Benlysta) and/or voclosporin (Lupkynis) concurrently.
Required Medical Information	Documentation of the following must be submitted: 1. Diagnosis of Class III/IV with or without concomitant class V lupus nephritis confirmed by renal biopsy. 2. UPCR (urine protein-to-creatinine ratio) ≥1 g/g 3. eGFR (estimated glomerular filtration rate) >30 mL/min/1.73 m^2 4. Member will be using obinutuzumab in combination with standard treatment (e.g. glucocorticoids, mycophenolate mofetil, hydroxychloroquine, azathioprine, or cyclophosphamide). 5. Dose requested is consistent with FDA approved dosing for lupus nephritis.
Age Restriction	≥18 years
Prescriber Restriction	Lupus Nephritis: Rheumatologist or Nephrologist Oncology use: Oncologist/Hematologist
Coverage Duration	-Initial approval: 4 doses of 1000 mg for the initial doses at weeks 0, 2, 24, and 26 -Subsequent requests: 2 doses of 1000 mg for 12-month duration (1000 mg every 6 months) -Renewals with documentation of improved or stable lupus nephritis as assessed by eGFR or UPCR and documentation that member will continue to use obinutuzumab in combination with standard therapy for treating lupus nephritis.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9301	Injection, obinutuzumab, 10 mg (Gazyva)	Lupus nephritis, active: • Treatment doses 1 to 4: IV : 1,000 mg once at weeks 0, 2, 24, and 26 • Treatment doses 5 and beyond (beginning 6 months following treatment dose 4): IV: 1,000 mg once every 6 months

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 low- to intermediate-1 risk myelodysplastic syndromes in adults with transfusion-dependent anemia requiring ≥4 RBC units over 8 weeks who have not responded to or have lost response to or are ineligible for erythropoiesis-stimulating agents.
Exclusion Criteria	• Treatment of other causes of anemia
Required Medical Information	For initial requests: 1) Clinic notes confirming the diagnosis of Myelodysplastic Syndrome (MDS). 2) Documentation that disease is low to intermediate risk as defined by one of the following: • Revised International Prognostic Scoring System (IPSS-R) - Very Low, Low, Intermediate (Score 0 to ≤ 4.5) • IPSS - Low/Intermediate-1 (Score 0 to 1) • WHO-Based Prognostic Scoring System (WPSS) - Very Low, Low, Intermediate (Score 0 to 2) 3) Documentation that member has transfusion dependent anemia requiring regular RBC transfusions, defined as at least 4 units of packed red blood cells (pRBCs) in the prior 8 weeks. Documentation should include the member's complete transfusion history over the prior 8 weeks to establish baseline level for transfusion needs and assess response to treatment. 4) Documentation that the member has not responded to or has lost response to or is ineligible for treatment with an erythropoiesis-stimulating agent (ESA). 5) Other causes of anemia (e.g. bleeding, vitamin deficiency, iron deficiency, acute leukemia) have been ruled out. 6) Weight (kg, lb) used to calculate dosing. 7) Member has trial and failure or contraindication to luspatercept (Reblozyl-TAR required). 8) Females of childbearing age: Provider attestation that the member will be counseled on the potential risk and the use of an effective method of contraception during treatment with Rytelo.
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by a Hematologist or Hematologist–Oncologist
Coverage Duration	Initial approval: up to 6 months to align with clinical assessments Renewal: up to 12 months
Other Requirements & Information	Documentation requirement for renewal: • Decrease in transfusion burden after 6 doses (24 weeks of treatment). *Note: Treatment should be discontinued if there has not been a reduction in transfusion requirements or if unacceptable toxicity occurs at any time per FDA label.* 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
J0870	Injection, imetelstat, 1 mg	IV: 7.1 mg/kg once every 4 weeks; discontinue if patient does not experience a decrease in RBC transfusion burden after 24 weeks (after 6 doses) or for unacceptable toxicity.

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 advanced, unresectable or metastatic non–small cell lung cancer (NSCLC) harboring a neuregulin 1 (*NRG1*) gene fusion in adults with disease progression on or after prior systemic therapy. • Treatment of advanced, unresectable or metastatic pancreatic adenocarcinoma (PDAC) harboring an *NRG1* gene fusion in adults with disease progression on or after prior systemic therapy. • Treatment of advanced, unresectable or metastatic cholangiocarcinoma harboring an NRG1 gene fusion in adults with disease progression on or after prior systemic therapy.
Exclusion Criteria	• NYHA class III or IV congestive HF, LVEF <50%, or a history of significant cardiac disease • Eastern Cooperative Oncology Group (ECOG) > 2
Required Medical Information	Documentation of the following must be submitted: 1. Member has advanced, unresectable or metastatic non-small cell lung cancer (NSCLC), pancreatic adenocarcinoma (PDAC) or cholangiocarcinoma. 2. Tumor has the presence of *NRG1* gene fusion as determined by FDA-approved or CLIA-compliant test. 3. Member has disease progression on or after prior systemic therapy. 4. Bizengri™ is being requested to use as monotherapy. 5. Eastern Cooperative Oncology Group (ECOG) performance status of ≤ 2. 6. LVEF is within normal limits and will be assessed at regular intervals during treatment. 7. Bizengri will be administered in a setting with emergency resuscitation equipment and staff who are trained to monitor for infusion-related reactions (IRR) and to administer emergency medications. 8. Member will be monitored for new or worsening pulmonary symptoms indicative of interstitial lung disease (ILD)/pneumonitis. 9. Females of reproductive age have a negative pregnancy test prior to starting therapy and will use effective contraception during treatment and for at least 2 months following the last dose of Bizengri. • For all requests: Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case.
Age Restriction	18 years and older
Prescriber Restriction	Oncologist
Coverage Duration	Initial approval for 3 months to ensure clinical efficacy. Continued approval for up to 6 months per request with documented positive response to treatment as defined by stabilization of disease or decrease in tumor size or spread.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9382	Injection, zenocutuzumab-zbco, 1 mg (Bizengri™)	750 mg once every 2 weeks (dose is the same for either indication)

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	Hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA)
Exclusion Criteria	• Shiga toxin producing E. coli associated hemolytic uremic syndrome • Active, uncontrolled, systemic bacterial or fungal infection requiring antimicrobial therapy • Baseline resting heart rate < 45 beats per minute or > 115 beats per minute • Baseline corrected QT interval calculated by Fridericia's formula > 470 msec • Malignant hypertension (diastolic blood pressure > 120 mm Hg with bilateral hemorrhages or "cotton-wool" exudates on funduscopic examination) • Abnormal liver function tests defined as alanine aminotransferase or aspartate aminotransferase above 5 times the upper limit of normal • Uncontrolled human immunodeficiency virus (HIV) infection • Active, uncontrolled graft-versus-host disease or engraftment failure as the sole cause of cytopenias
Required Medical Information	<u>ALL the following are required (1-7):</u> 1. Date and type of hematopoietic stem cell transplant a. *Additional outside medical review may be requested for autologous transplants (excepting tandem autologous transplants for neuroblastoma)* 2. Clinic notes documenting post-transplant course 3. Baseline resting heart rate and QT interval 4. Liver function tests 5. HIV test 6. Direct Coombs test a. *Additional outside medical review may be requested in cases with a positive direct Coombs test to ensure the positive result is not related to immune hemolysis* 7. Confirmed diagnosis of TA-TMA by ONE of the following criteria (a OR b): a. The 2023 Harmonizing Definition: requires ONE of the following (i OR ii): i. Biopsy proven disease, OR ii. Documentation of at least ≥4 of the following (1-7) at ≥2 timepoints over 2 weeks: 1. Anemia (failure to achieve transfusion independence, new transfusion dependence, or hemoglobin decline by ≥1g/dL) 2. Thrombocytopenia (failure to achieve platelet transfusion independence, increased transfusions needs, transfusion refractor or 50% reduction in platelets) 3. Elevated LDH 4. Spot random urine protein/creatinine ratio (rUPCR) ≥1mg/mg 5. Hypertension (≥140/90 for adults, ≥99th percentile for children) 6. Presence of shistocytes 7. Elevated sC5b-9

	b. Yartemlea Clinical Trial Definition of TA-TMA: requires ALL of the following (i-v): i. Platelet count < 150,000/µL, ii. Evidence of microangiopathic hemolysis (presence of schistocytes, serum LDH greater than the upper limit of normal [ULN] and/or haptoglobin less than the lower limit of normal [LLN]), iii. Doubling of serum creatinine from pretransplant, iv. No clinically apparent alternative explanation for thrombocytopenia and anemia (such as, but not limited to: engraftment failure, poor graft function in the setting of myelosuppressive medications, GVHD, infections, donor/recipient ABO mismatch, or erythropoietic suppression from organ dysfunction [e.g., renal failure]), and v. Negative direct Coombs test Policy MCUP3138 External Independent Medical Review may apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	2 years and older
Prescriber Restriction	Oncologist, hematologist, BMT specialist, or other qualified prescriber
Coverage Duration	Initial: 8 doses over 8 weeks Renewal: maximum of 8 weeks (8 doses for weekly dosing, 16 doses for twice weekly dosing)
Other Requirements & Information	Note: "2025 Consensus Criteria" refers to the *2025 ASTCT, CIBMTR, EBMT, and APBMT Consensus Statement Defining Response Criteria for Hematopoietic Cell Transplantation Associated Thrombotic Microangiopathy Directed Therapy* (PMID 40514012). **These specific criteria are found in the box below the Medical Billing information.** <u>Renewal Requirements for continuation of weekly dosing</u>: 1. Updated clinic notes including relevant laboratory values and organ function testing needed to monitor for hematologic, biochemical and organ response related to the members specific TA-TMA manifestations 2. Updated liver function tests 3. Documentation that member has had a partial response as defined by the 2025 Consensus Criteria and that additional doses are medically necessary 4. Member does NOT meet complete response criteria from the 2025 Consensus Criteria (Yartemlea should be discontinued in the setting of complete response) <u>Renewal Requirements for escalation to twice weekly dosing</u>: 1. Updated clinic notes including relevant laboratory values and organ function testing needed to monitor for hematologic, biochemical and organ response related to the members specific TA-TMA manifestations 2. Updated liver function tests 3. Documentation that the member has received at least 4 doses of Yartemlea at the once weekly dosing schedule 4. Documentation that member has had either (a OR b) a) No response, as defined by the 2025 Consensus Criteria AND the

	member has been on Yartemlea for <8 weeks (received fewer than 8 doses). *If there is no response after receiving 8 doses/8 weeks of Yartemlea, consider discontinuation.* b) Partial response as defined by the 2025 Consensus Criteria and explanation of why more intensive dosing is medically necessary 5. Member does NOT meet complete response criteria from the 2025 Consensus Criteria (Yartemlea should be discontinued in the setting of complete response) <u>Renewal Requirements for continuation of previously approved twice weekly dosing</u>: 1. Updated clinic notes including relevant laboratory values and organ function testing needed to monitor for hematologic, biochemical and organ response related to the members specific TA-TMA manifestations 2. Updated liver function tests 3. Documentation that member has had a partial response as defined by the 2025 Consensus Criteria and that additional doses are medically necessary 4. Member does NOT meet complete response criteria from the 2025 Consensus Criteria (Yartemlea should be discontinued in the setting of complete response) Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

<u>Medical Billing:</u>

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1289	Injection, narsoplimab-wuug, 1 mg (Yartemlea™)	• <50kg: 4mg/kg IV weekly, may increase to twice weekly for inadequate improvement. • ≥50 kg 370mg IV weekly, may increase to twice weekly if inadequate improvement.

<u>2025 ASTCT, CIBMTR, EBMT, and APBMT Consensus Statement Defining Response Criteria for Hematopoietic Cell Transplantation Associated Thrombotic Microangiopathy Directed Therapy</u>

Hematologic/Biochemical Response Definition of Each Diagnostic Criterion			
Feature	At diagnosis	Complete response	Partial response
Anemia*†	RBC transfusion dependent in the 14 days prior to first study drug dose	No RBC transfusions 14 days*,‡ before the response evaluation and hemoglobin within normal range for age§	No RBC transfusion 7 days* before the response evaluation
	RBC transfusion independent in the 14 days prior to first study drug and anemic:	No RBC transfusions 14 days*,‡ before the response evaluation and hemoglobin within normal range for age§	No RBC transfusion 7 days* before the response evaluation and increase in hemoglobin by ≥ 1.0 g/dL over the last value before start of treatment§
Thrombocytopenia*,‡	Platelet transfusion dependent 14 days prior	No platelet transfusions 14 days*,‡ before the	No platelet transfusions in the last 7 days* before

	to first study drug or platelets <20 kcell/uL at study entry	response evaluation and normalization of platelet count§	the response evaluation and platelet count ≥20 kcells/uL§
	Platelet transfusion independent 14 days prior to first study drug and thrombocytopenic	No platelet transfusions 14 days*,‡ before the response evaluation and normalization of platelet count§	No platelet transfusions in the last 7 days* before the response evaluation and platelets ≥50 kcells/uL or platelet count increase by 50% over the last before start of treatment.§
Schistocytes	Present	Absent x 2 time points within 14 days	Decrease in measure of schistocytes ≥1 time point
LDH	LDH above upper limit of normal range for age	Less than ULN for age x 2 time points within 14 days	LDH decreased by at least 25% from TA-TMA diagnosis ≥1 time point
Elevated sC5b-9 level	sC5b-9 level >ULN	Less than ULN reference lab x 2 time points within 14 days	Reduction of sC5b-9 by 25% from TA-TMA diagnosis ≥1 time point

*Transfusion needs should be attributed to TA-TMA; i.e, RBCs or platelets only administered for procedural related risk of bleeding, will not be considered for the evaluation of this criterion.
†Anemia evaluable only if reticulocyte count ≥10,000/ mL to rule out anemia due to poor graft function/production.
‡Thrombocytopenia attributed to microangiopathy. Thrombocytopenia is not evaluable for response if a bone marrow aspiration/ biopsy is obtained and demonstrates absence of megakaryocytes.
§There are no time restrictions or requirements to the improvement in blood counts; they are not required to occur within the same time frame as transfusion independence. In cases where access to sC5b-9 testing is limited, response can be assessed with sC5b-9 omitted from the criteria. Abbreviations: LDH, lactate dehydrogenase; ULN, upper limit of normal; RBC red blood cell.

Hematologic/Biochemical Response Definition			
	Complete response	Partial response	No response
Definition	CR of: anemia, thrombocytopenia sC5b-9 (<ULN) and (CR) of LDH or schistocytes	PR to: anemia, thrombocytopenia sC5b-9 and PR of LDH or schistocytes	Does not meet CR or PR criteria

Abbreviations: ULN, upper limit of normal; LDH, lactate dehydrogenase; sC5b-9, soluble C5b-9.

Organ Response Definition of Each Organ Manifestation			
Manifestation	Organ Dysfunction Definition for Resolution Assessment	Complete response	Partial response
Acute Renal Injury	≥50% reduction in eGFR from pre-HCT conditioning value (if not available, the highest post HSCT value)	GFR/eGFR calculated by serum creatinine or cystatin C return to pre-HCT value or within normal range for age	≥50% increase in GFR/eGFR from study entry or GFR/eGFR ≥ 70 ml/ min/1.73 m2 calculated by serum creatinine or cystatin C.
	For patients on renal replacement therapy at entry:	No renal replacement in the last 14 days before response evaluation and eGFR ≥70 ml/ min/1.73 m2, eGFR return to pre-HCT value, or within normal range for age (lowest value acceptable)	No renal replacement therapy in the last 7 days before the response evaluation
Proteinuria	rUPCR ≥1 mg/mg	Return to pre-HCT value, if not obtained pre-HCT then	≥25% reduction from maximum rUPCR

		<1 mg/mg × 2 time points in 14 days	
Hypertension	For patients not hypertensive before HCT	Blood pressure <140/90 mm Hg (systolic/diastolic) in adults (>18 years old) or <99th percentile for age in children (<18 years old) on at most antihypertensive medication for 14 days	Blood pressure not consistently higher than 140/90 mm Hg (systolic/diastolic) or <99% for age in children on at most antihypertensive medication for 7 days.
	For patients who are hypertensive before HCT	Return to at most additional antihypertensive agent in addition to pre-HCT baseline hypertension management schedule for 14 days	Blood pressure not consistently higher than 140/90 mm Hg (systolic/diastolic) or <99% for age in children on at most additional antihypertensive medication than pre-HCT required medications for 7 days
Pulmonary arterial hypertension	Pulmonary hypertension diagnosed by a cardiologist using cardiac catheterization or pulmonary hypertension criteria on echocardiography (ECHO)	No evidence of pulmonary hypertension measured by ECHO or catheterization in the last 14 days, pulmonary hypertension medications allowed	No evidence of uncontrolled pulmonary hypertension measured by ECHO or catheterization (may receive anti-pulmonary hypertension medications if still on maintenance therapy) in the last 7 days before the response evaluation.
Pulmonary insufficiency	Respiratory insufficiency requiring positive pressure (non-invasive or invasive)	Return to pre-HCT baseline or no oxygen requirement for 14 days	No need for positive pressure support for 7 days (low flow oxygen via nasal cannula acceptable)
Serositis	Clinically significant serositis requiring surgical intervention or mechanical extraction procedures (pericardiocentesis, pericardial window, therapeutic paracentesis) attributable to TATMA or medical management with diuresis	Resolution of clinically significant serositis (not requiring draining or medical management with diuresis) for 14 days	No evidence of clinically significant serositis requiring drainage or medical management with diuresis for 7 days
Gastrointestinal	Presence of biopsy-proven GI TA-TMA. Patients with clinically relevant GI bleeding	No active GI bleeding for 14 days and no evidence of unresolved intestinal strictures (history of surgical stricture correction is acceptable).	No active GI bleeding for 7 days and no evidence of unresolved intestinal strictures (history of surgical stricture correction is acceptable).
CNS	Confusion, altered mental status or seizures without a cause alternative to TA-	No uncontrolled seizures (may be on anticonvulsants), no active	No uncontrolled seizures (may be on anticonvulsants), no

	TMA	PRES (residual radiologic signs are acceptable without clinical symptomatology), no confusion or altered mental status in the last 14 days before the response evaluation	active PRES (residual radiologic signs are acceptable without clinical symptomatology), no confusion or altered mental status in the last 7 days before the response evaluation

Abbreviations: CNS, central nervous system; eGFR, estimated glomerular filtration rate; HCT, hematopoietic cell transplant; GI, gastrointestinal; O2, oxygen; rUPCR, random urine protein to creatinine ratio; ULN, upper limit of normal; PRES, posterior reversible encephalopathy syndrome.

Organ Response Definition			
	Complete response	Partial response	No response
Definition	All involved organs have met complete response criteria	All involved organs have met at least partial response criteria	Any response that is not a CR/PR. Failure to recover any organ function.

Proposed Overall Response Criteria		
Complete response	Partial response	No response
Complete cytopenia, biomarker, and organ response of all involved organs	Partial response of all hematologic/biochemical and organ manifestations	Does not meet criteria for CR/PR. Failure of any organ is an overall NR

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) Atypical hemolytic uremic syndrome (aHUS) to inhibit complement mediated thrombotic microangiopathy. 2) Generalized myasthenia gravis (gMG) in patients who are anti-acetylcholine receptor antibody-positive (AChR+). 3) Neuromyelitis optica spectrum disorder (NMOSD) in adults who are aquaporin-4-antibody positive. 4) Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis. Please note the following are preferred eculizumab products with Partnership HealthPlan: Epysqli Non-preferred eculizumab products: Soliris, Bkemv
Exclusion Criteria	• Unresolved serious *Neisseria meningitidis* infection • Treatment of Shiga toxin E. coli related hemolytic uremic syndrome • Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • Concurrent use with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists that are not FDA approved for add-on therapy • NMOSD that is negative for AQP4-IgG
Required Medical Information	1) Requirements for atypical hemolytic uremic syndrome (all of the following, a-f): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) d. Documentation that Shiga toxin has been ruled out e. Trial and failure with ravulizumab (Ultomiris™) f. If requesting use of Soliris or Bkemvi, additional information regarding reasons why Epysqli cannot be used is required. 2) Requirements for paroxysmal nocturnal hemoglobinuria (all of the following, a-f): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) d. Documentation of trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used e. Trial and failure with ravulizumab (Ultomiris™) f. If requesting use of Soliris or Bkemvi, additional information regarding reasons why Epysqli cannot be used is required. 3) Requirement for AChR antibody-related myasthenia gravis (all of the following, a-g): a. Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies. b. Documentation of meningococcal vaccine given prior to therapy or

	will be given immediately after the first dose of the complement inhibitor. c. Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta-blockers, hydroxychloroquine, gabapentin, lithium. d. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline. e. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV f. Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the following (i-vi): i. Pyridostigmine ii. Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose iii. Oral glucocorticoid sparing immunomodulatory, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate iv. Zilucoplan (Zilbrysq™) v. Self-administered efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo-PFS™) (preferred), or if unable to self-administer: Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™) vi. Ravulizumab (Ultomiris™) g. If requesting use of Soliris or Bkemvi, additional information regarding reasons why Epysqli cannot be used is required. 4) Requirements for Neuromyelitis optica spectrum disorder (NMOSD) (all of the following a-e): a. At least one of the following: i. Optic neuritis Acute myelitis ii. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting iii. Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) iv. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions v. Symptomatic cerebral syndrome with NMOSD-typical brain lesions b. Seropositive for AQP4-IgG antibodies c. Documentation of trial and failure or contraindication to Satralizumab (Enspryng™) OR Inebilizumab-cdon (Uplizna™) d. Documentation of trial and failure or contraindication to ravulizumab (Ultomiris) e. If requesting use of Soliris or Bkemvi, additional information regarding reasons why Epysqli cannot be used is required.

Age Restriction	aHUS: 2 months of age and older gMG: 6 years and older NMOSD, PNH: 18 years and older

Prescriber Restriction	• PNH: Hematologist • aHUS: Nephrologist, Hematologist • gMG: Neurologist • NMOSD: Neurologist, Ophthalmologist *Note: Prescribers must be enrolled in REMS*

Coverage Duration	Initial: 6 months Renewal: 12 months

Other Requirements & Renewal Information	Renewal Requests:
	• Clinical notes with relevant laboratory markers documenting positive response to therapy
	• Additional items for gMG:
	  o MG-ADL
	  o MGFA classification
	
	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Use is available only through the REMS program.

Dose limits & billing requirements (approved TAR is required)

<table>
<tr><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td>J1299</td><td>Injection, Eculizumab, 2 mg</td><td rowspan="3">aHUS, gMG, NMOSD (≥ 18 yrs):
• 900 mg IV qwk x 4 doses, then 1,200 mg for the 5th dose on week 5, then 1,200 mg q2wks thereafter.

Pediatric dosing for aHUS (≥ 2 months) & gMG (≥6 years):
<table>
<tr><th>Weight</th><th>Induction dose (qwk)</th><th>Maintenance dose</th></tr>
<tr><td>≥ 40 kg</td><td>900 mg x 4</td><td>1,200 mg at week 5, then q2wks</td></tr>
<tr><td>30 -39 kg</td><td>600 mg x 2</td><td>30 -39 kg 600 mg x2 900 mg at week 3, then q2wks</td></tr>
<tr><td>0 – 29 kg</td><td>600 mg x 2</td><td>600 mg at week 3, then q2wks</td></tr>
<tr><td>10 – 19 kg</td><td>600 mg x 1</td><td>300 mg at week 2, then q2wks</td></tr>
<tr><td>5 - 9 kg</td><td>300 mg x 1</td><td>300 mg at week 2 then q3wks</td></tr>
</table>

PNH:
• 600 mg IV qwk x 4 doses, then 900 mg for the 5th dose on week 5, then 900 mg q2wks thereafter.</td></tr>
<tr><td>Q5152</td><td>Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg</td></tr>
<tr><td>Q5151</td><td>Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg</td></tr>
</table>

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	• Anemia in adults with beta (β) thalassemia who require regular RBC transfusions. • Anemia in adults with myelodysplastic syndromes (MDS). • Anemia in adults with myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T).
Exclusion Criteria	• Non-transfusion dependent β-thalassemia • Treatment of other causes of anemia • Deep vein thrombosis or stroke within the past 24 weeks prior to start of treatment • Pregnant or breastfeeding
Required Medical Information	Requirements for those with a confirmed diagnosis of β–thalassemia: ALL of the following (1-5): 1) Clinic notes and relevant laboratory values to confirm the diagnosis 2) Other causes of anemia (e.g. bleeding, vitamin deficiency, iron deficiency, acute leukemia) have been ruled out. 3) Weight (kg, lb) 4) Transfusion records to show member is transfusion dependent, as evidenced by both of the following within the past 24 weeks (a AND b): a. Requires regular RBC transfusions with ≥6 units of packed red blood cells (PRBC), AND b. No transfusion free period ≥35 days 5) Serum ferritin levels >1000ng/ml Requirements for those with a confirmed diagnosis of MDS: ALL of the following (1-5): 1) Clinic notes and relevant laboratory values to confirm the diagnosis 2) Other causes of anemia (e.g. bleeding, vitamin deficiency, iron deficiency, acute leukemia) have been ruled out. 3) Weight (kg, lb) 4) Documented lower risk disease as defined by one of the following: a. Revised International Prognostic Scoring System (IPSS-R) - Very Low, Low, Intermediate (Score 0 to ≤ 4.5) b. IPSS - Low/Intermediate-1 (Score 0 to 1) c. WHO-Based Prognostic Scoring System (WPSS) - Very Low, Low, Intermediate (Score 0 to 2) 5) Member requires at least 2 units of packed red blood cells (pRBCs) in the prior 8 weeks Requirements for those with a confirmed diagnosis of MDS/MPN-RS-T: ALL of the following (1-7): 1) Clinic notes and relevant laboratory values to confirm the diagnosis 2) Other causes of anemia (e.g. bleeding, vitamin deficiency, iron deficiency, acute leukemia) have been ruled out. 3) Weight (kg, lb) 4) Documented lower risk disease as defined by one of the following: a. Revised International Prognostic Scoring System (IPSS-R) - Very

	Low, Low, Intermediate (Score 0 to ≤ 4.5) b. IPSS - Low/Intermediate-1 (Score 0 to 1) c. WHO-Based Prognostic Scoring System (WPSS) - Very Low, Low, Intermediate (Score 0 to 2) 5) Documentation of either: a. Ring sideroblasts ≥ 15% OR b. Ring sideroblasts ≥ 5% with an SF3B1 mutation 6) Non-responsive to or intolerant to erythropoiesis stimulating agents (ESA) or ESA is not indicated due to serum erythropoietin > 200 mU/mL 7) Member requires at least 2 units of packed red blood cells (pRBCs) in the prior 8 weeks
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by a Hematologist or Hematologist–Oncologist
Coverage Duration	Initial approval: 3 months Renewal: 3 months for renewals with dose increase until benefit has been confirmed (see Other Requirements & Information), subsequent renewals at a stable dose with confirmation of improvement may be up to 12 months
Other Requirements & Information	<u>Documentation requirement for renewal</u>: 1. Transfusion history since starting Reblozyl 2. Hemoglobin levels since starting Reblozyl 3. Documentation of improvement in transfusion burden (if transfusion dependent prior to Reblozyl) or for MDS, improvement in hemoglobin (if not transfusion dependent prior to Reblozyl) 4. Reblozyl should be discontinued if there has not been a reduction in transfusion requirements after 9 weeks (3 doses) at the maximum dose. o For members with MDS who were not transfusion dependent prior to starting Reblozyl, Reblozyl should be discontinued if there has not been an increase from baseline in hemoglobin after 9 weeks (3 doses) at the maximum dose. 5. Documentation that pre-dose hemoglobin has not exceeded ≥11.5 g/dL (in the absence of transfusions). 6. Documentation that hemoglobin concentration has not increased > 2 g/dl within 3 weeks (in absence of transfusions) (see dosing tables under Medical Billing, increase >2g/dl within 3 weeks should prompt a dose decrease). 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
J0896	Injection, luspatercept-aamt, 0.25 mg	β-thalassemia: 1 mg/kg SC q3weeks Max dose: 1.25 mg/kg q3weeks MDS or MDS/MPN-RS-T: 1 mg/kg SC q3weeks Max dose: 1.75 mg/kg q3weeks

Recommended dose increase schedule based on transfusion response and/or hemoglobin (Hgb) level (per manufacturer package insert):

β – Thalassemia		
Current Dose	Response	Dose Change
1 mg/kg	If after at least 2 consecutive doses (6 weeks) a patient has no reduction in RBC transfusion burden	Increase the dose to 1.25mg/kg every 3 weeks
1.25 mg/kg	If after at least 3 consecutive doses (9 weeks) a patient has no reduction in RBC transfusion burden	**Discontinue treatment**
MDS or MDS/MPN-RS-T – ESA Naive		
Current Dose	Response	Dose Change
1 mg/kg	If after at least 2 consecutive doses (6 weeks) a patient is not RBC transfusion free, OR has a hemoglobin concentration <10 g/dL with hemoglobin increase <1 g/dL since last dose	Increase the dose to 1.33mg/kg every 3 weeks
1.33 mg/kg	If after at least 2 consecutive doses (6 weeks) a patient is not RBC transfusion free, OR has a hemoglobin concentration <10 g/dL with hemoglobin increase <1 g/dL since last dose	Increase the dose to 1.75mg/kg every 3 weeks
1.75 mg/kg	If after at least 3 consecutive doses (9 weeks) a patient has no reduction in RBC transfusion burden, including no increase from baseline hemoglobin	**Discontinue treatment**
MDS or MDS/MPN-RS-T – ESA Refractory/Intolerant		
Current Dose	Response	Dose Change
1 mg/kg	If after at least 2 consecutive doses (6 weeks) a patient is not RBC transfusion free	Increase the dose to 1.33mg/kg every 3 weeks
1.33 mg/kg	If after at least 2 consecutive doses (6 weeks) a patient is not RBC transfusion free	Increase the dose to 1.75mg/kg every 3 weeks
1.75 mg/kg	If after at least 3 consecutive doses (9 weeks) a patient has no reduction in RBC transfusion burden, including no increase from baseline hemoglobin	**Discontinue treatment**

Recommended dose reductions based on hemoglobin (Hgb) level (per manufacturer package insert):

1) Pre-dose hemoglobin ≥11.5 g/dL (in the absence of transfusions):
   Interrupt luspatercept; resume when hemoglobin is ≤11 g/dL.

2) Increase Hgb > 2 g/dl within 3 weeks (in absence of transfusions):

β – Thalassemia	
Current Dose	Reduce to x mg/kg once every 3 weeks
1.25 mg/kg	1 mg/kg

1 mg/kg	0.8 mg/kg
0.8 mg/kg	0.6 mg/kg
0.6 mg/kg	*Discontinue*
MDS or MDS/MPN-RS-T	
Current Dose	Reduce to x mg/kg once every 3 weeks
1.75 mg/kg	1.33 mg/kg
1.33 mg/kg	1 mg/kg
1 mg/kg	0.8 mg/kg
0.8 mg/kg	0.6 mg/kg
0.6 mg/kg	*Discontinue*

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details

Covered Uses		
	Aldurazyme™	Mucopolysaccharidosis I (MPS I) types: (1) Hurler, (2) Hurler-Scheie, and (3) Moderate to severe Scheie form.
	Brineura™	CLN2 Tripeptidyl Peptidase 1 (TPP1) Deficiency (aka Late Infantile Neuronal ceroid lipofuscinosis)
	Cerezyme™,	Gaucher Disease Type 1 and Type 3
	Vpriv™	Gaucher Disease Type 1
	Eleprase™	Hunter syndrome (mucopolysaccharidosis II, MPS II
	Fabrazyme™	Fabry Disease
	Lumizyme,™ Nexviazyme™	Pompe Disease
	Mepsevii™	Mucopolysaccharidosis VII (MPS VII, Sly Syndrome)
	Naglazyme™	Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome)
	Vimizim™	Mucopolysaccharidosis IV (Morquio Syndrome)
	Xenpozyme™	Acid sphingomyelinase deficiency (Niemann-Pick disease)

Exclusion Criteria	None

Required Medical Information	For all products – Clinic notes which include: • Documentation of the FDA approved indication • Subjective findings (complaints) • Objective finding (Enzyme levels, DNA mutation analysis, medical history, physical exam, member weight) • Complications (eg, bony changes or kidney failure) • Quality of life issues (eg, severe, unremitting pain or extreme fatigue) • Treatment plan: Identify the licensed practitioner who will administer the infusion and coordinate care, genetic evaluation & counseling information for the patient and family members. • Goals: Include specific information about the desired outcome, for example: slow progression, allow regular attendance at work or school, or to significantly improve quality of life. • Requests for Nexviazyme™ for members <30 kg require medical justification for inability to use PHC's preferred enzyme replacement therapy (ERT) for Pompe disease, Lumizyme™, which has the same mechanism of action as Nexviazyme™. Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.

Age Restriction	Vpriv™: ≥ 4 yrs Brineura™: 3-18 yrs Nexviazyme™: ≥ 1 yr Fabrazyme™: ≥ 2 yrs Elaprase™: ≥ 5 yrs; 16 months to <5 years-limited data available

Prescriber Restriction	Neurologist, endocrinologist, cardiologist, hepatologist, pulmonologist, genetic disease or other specialist familiar with treating lysosomal storage disorders.

Coverage Duration	Initial & Renewal: 6 months

Other Requirements & Information	Renewal TARs must include follow-up information such as any significant changes in physical findings, laboratory parameters, symptoms and/or quality of life. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Dose greater than that recommended by the manufacture will require documentation of the medical necessity of the requested dose. Maximum recommended doses:

HCPCS	Description	Dosing, Package size
J0180	Injection, agalsidase beta, 1 mg (Fabrazyme™)	1 mg/kg every 2 weeks, 5 mg & 35 mg SDV
J0221	Injection, alglucosidase alfa, 10 mg (Lumizyme™)	20 mg/kg every 2 weeks, 50 mg SDV
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg (Nexviazyme™)	ABW < 30 KG: 40 mg/kg q 2 weeks; ABV ≥30 kg: 20 mg/kg q 2 weeks, 100 mg SDV
J0567	Injection, cerliponase alfa, 1 mg (Brineura™)	300 mg every other week (via aseptic intraventricular infusion into CSF), 150 mg/5mL kit (2 vials)
J1322	Injection, elosulfase alfa, 1 mg (Vimizim™)	2 mg/kg once weekly, 1 mg/mL, 5 mL SDV
J1458	Injection, galsulfase, 1 mg (Naglazyme™)	1 mg/kg once weekly, 5 mg/5 mL SDV
J1743	Injection, idursulfase, 1 mg (Elaprase™)	0.5 mg/kg once weekly, 2 mg/ml, 3ml SDV
J1786	Injection, imiglucerase, 10 units (Cerezyme™)	Individualized based on response. Some pts need more frequent dosing (up to TIW) while others can be dosed every other week. Doses range from 2.5 u/kg TIW to 60 u/kg QOW. State Medical maximum daily dose is 818 billed units (8,180 dose units), without documentation that weight is over 300 lbs, 400 unit SDV
J1931	Injection, laronidase, 0.1 mg (Aldurazyme™)	0.58 mg/kg once weekly, 2.9 mg/5 ml SDV
J0218	Injection, olipudase alfa-rpcp, 1 mg (Xenpozyme™)	Dose is titrated over the course of 14 weeks for adults and 16 weeks in pediatric patients up to a recommended maintenance dose of 3 mg/kg given q 2 weeks, 4 mg or 20 mg SDV.
J3385	Velaglucerase Alfa inj, 100 units (Vpriv™)	60 units/kg every other week, 400 unit SDV
J3397	Injection, vestronidase alfa-vjbk, 1 mg (Mepsevii™)	4 mg/kg every 2 weeks, 2 mg/ml 5 ml vials

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	• Prevention or treatment of chemotherapy-induced neutropenia. • Acute myeloid leukemia (AML) following induction or consolidation chemotherapy • Bone marrow transplantation (BMT) • Severe chronic neutropenia • Peripheral blood progenitor cell collection and therapy • Hematopoietic Syndrome of Acute Radiation Syndrome [HARS] Please note the following are preferred filgrastim products with Partnership HealthPlan and do NOT require a TAR when ICD10 restrictions are met: Nivestym (Q5110), Zarxio (Q5101), Releuko (Q5125), Granix (J1447) Non-preferred filgrastim products (require a TAR): Neupogen (J1442), Nypozi (Q5148), Filkri (J3590)
Exclusion Criteria	None
Required Medical Information	<u>For the prevention of chemotherapy-induced neutropenia</u>: 1) Clinic notes documenting the following: a. Diagnosis b. Specific chemotherapy regimen with dose and frequency c. Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) d. Member-specific risk factors for developing neutropenia (if any). 2) Documentation of a previous inadequate response with preferred Filgrastim-sndz (Zarxio), Filgrastim-ayoq (Releuko) and Filgrastim-aafi (Nivestym) with laboratory evidence or medical rationale as to why Zarxio, Releuko and Nivestym cannot be used must be provided. 3) One of the following: a. Primary prophylaxis of febrile neutropenia in member receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of >20% (high risk) or at least 10-20% (intermediate risk) if member has at least 1 risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. b. Secondary prophylaxis of febrile neutropenia in member who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. c. Treatment of febrile neutropenia in patients who received chemotherapy and have at least one risk factor for poor clinical outcomes or for developing infection-associated complications as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. 4) For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.

	<u>For the treatment of chemotherapy-induced neutropenia:</u> 1) Clinic notes documenting the following: a. Diagnosis b. Specific chemotherapy regimen with dose and frequency c. Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) d. Member-specific risk factors for developing neutropenia (if any). 2) Inadequate response with preferred Filgrastim-sndz (Zarxio), Filgrastim-ayoq (Releuko) and Filgrastim-aafi (Nivestym) with laboratory evidence or medical rationale as to why Zarxio, Releuko and Nivestym cannot be used must be provided. <u>All other FDA approved indications or off-label uses:</u> 1) Documentation of Inadequate response with preferred Filgrastim-sndz (Zarxio), Filgrastim-ayoq (Releuko) and Filgrastim-aafi (Nivestym) with laboratory evidence or medical rationale as to why Zarxio, Releuko and Nivestym cannot be used must be provided. 2) See PHC criteria document *Case-by-Case TAR Requirements and Considerations*

Age Restriction	Per FDA package labeling or accepted off-label use.

Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.

Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

Other Requirements & Information	NOTE: There are no studies that have addressed therapeutic use of Filgrastim for febrile neutropenia in patients who have already received prophylactic pegfilgrastim. However, pharmacokinetic data of pegfilgrastim demonstrated high levels during neutropenia and suggest that additional granulocyte colony-stimulating factors (G-CSF) may not be beneficial, but in patients with prolonged neutropenia additional G-CSF may be considered. Requests for other indications and off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

<u>Medical Billing:</u>

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Neupogen	J1442	Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram	5-10mcg/kg/day, duration based on ANC response / indication
Nypozi	Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	
Filkri	Q5172	Injection, filgrastim-laha (filkri), biosimilar, 1 microgram	

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	• Prevention of chemotherapy-induced neutropenia. • Hematopoietic Subsyndrome of Acute Radiation Syndrome [H-ARS] Please note the following are preferred pegfilgrastim products with Partnership HealthPlan and do NOT require a TAR when ICD10 restrictions and quantity limits are met: Neulasta/Neulasta Onpro (J2506), Fulphila (Q5108), Ziextenzo (Q5120), and Nyvepria (Q5122) Non-preferred filgrastim products (require a TAR): Udenyca/Udencya Onbody (Q5111), Stimufend (Q5127), Fylnetra (Q5130), and Armlupeg (Q5169)
Exclusion Criteria	• Use for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. • Dosed more frequently than every 14 days for prevention of chemotherapy-induced neutropenia.
Required Medical Information	Clinic notes documenting: • Diagnosis • Specific chemotherapy regimen with dose and frequency • Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) • Member specific risk factors for developing neutropenia (if any) For prevention of chemotherapy-induced neutropenia: • Clinical documentation supporting inadequate response to a preferred pegfilgrastim product (Neulasta/Neulasta Onpro, Fulphila, Nyvepria, or Ziextenzo) must be provided. • ALSO, must meet ONE of the following: 1. Primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if patient has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. 2. OR Secondary prophylaxis of febrile neutropenia in patients who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. • For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.
Age Restriction	None
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.

Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

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:

Note: preferred pegfilgrastim products (Neulasta, Neulasta Onpro, Fulphila, Nyvepria and Ziextenzo) do not require a TAR when billed with either D70.1 (agranulocytosis due to chemotherapy) or Z51.11 (encounter for antineoplastic chemotherapy), and the maximum dose is not over the limit of 6 mg (12 units).

Product	HCPCS	Description	Dosing, Units
Udenyca, Udenyca OnBody	Q5111	Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg	6mg (12 HCPCS units) once per cycle of chemotherapy, not more often than 14 days
Stimufend	Q5127	Injection, pegfilgrastim-fpgk (stimufend) biosimilar, 0.5 mg	
Fylnetra	Q5130	Injection, pegfilgrastim-pbbk (fylnetra), biosimilar, 0.5 mg	
Armlupeg	Q5169	Injection, pegfilgrastim-unne (armlupeg), biosimilar, 0.5 mg	

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Prevention of chemotherapy-induced neutropenia
Exclusion Criteria	• Use for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation • Dosed more frequently than every 14 days for prevention of chemotherapy-induced neutropenia
Required Medical Information	For prevention of chemotherapy-induced neutropenia: all of the following (1, 2, AND 3) 1) Clinic notes documenting: • Diagnosis • Specific chemotherapy regimen with dose and frequency • Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) • Member specific risk factors for developing neutropenia (if any) 2) Documentations of inadequate response to pegfilgrastim. 3) Must meet ONE of the following (a OR b): a. Primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if patient has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors, OR b. Secondary prophylaxis of febrile neutropenia in patients who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.
Age Restriction	≥ 18 years
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen
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
Rolvedon	J1449	Injection, eflapegrastim-xnst, 0.1 mg	13.2mg (132 HCPCS units) once per cycle of chemotherapy, not more often than 14 days

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Treatment of acquired thrombotic thrombocytopenic purpura (aTTP), in combination with therapeutic plasma exchange (TPE) and immunosuppressive therapy (administered upon initiation of plasma exchange therapy). *Note: criteria only apply to the initial intravenous dosing. Maintenance dosing which uses the subcutaneous formulation is FDA approved for self-administration and Partnerships Standard Requirements for Self-Administered Drugs will apply.*
Exclusion Criteria	1. Any known cause of thrombocytopenia other than aTTP 2. Congenital TPP
Required Medical Information	1. Documentation of confirmed diagnosis of aTTP (initial or recurrent), which included thrombocytopenia and microscopic evidence of red blood cell fragmentation (for example: schistocytes). 2. Caplacizumab will be used in conjunction with immunosuppressive therapy (for example: systemic corticosteroids or rituximab). 3. Patient requires initiation of plasma exchange (approved by PHC Utilization Management Department). *Note: Special circumstances where TPE is not included in the treatment plan would be considered off-label, thus consideration would be on a case-by-case basis. Such cases may include (but are not limited to) the member has declined the use of blood products, or has had an allergic reaction to plasma.*
Age Restriction	12 years and older
Prescriber Restriction	Hematologist
Coverage Duration	7 days (see "Medical Drug Billing")
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.* For maintenance dosing this medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled *Standard Requirements for Self-Administered Drugs*

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

Medical Offices: Please note maintenance dosing of caplacizumab-yhdp (Cablivi) is FDA approved for self-administration and should be provided to members through the pharmacy benefit. Exceptions for medical billing will be considered if provider explains why member is unable to obtain from a pharmacy.

HCPCS	Description	Dosing, Units
C9047	Injection, Caplacizumab -yhdp, 1 mg (Cablivi™)	First day of treatment: • 11 mg IV at least 15 minutes prior to plasma exchange, followed by 11 mg SC after completion of plasma exchange on day 1. Subsequent treatment days, during TPE: • 11 mg SC qd following TPE Treatment after TPE with normalization of platelet count: • 11 mg SC qd x 30 days following TPE

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 transfusion-dependent β-thalassemia (TDT) in patients 2 years and older *The treatment of sickle cell disease (SCD) in patients 2 years and older with recurrent vaso-occlusive crises (VOCs) is carved out to Fee for Service Medi-Cal. All claims for CGT drugs must be billed directly to DHCS using the appropriate billing code (J3392) and submitted on medical claims using the CMS-1500 (or 837P/I electronic equivalent forms).*
Exclusion Criteria	1) Off-label use 2) Prior use of lovotibeglogene autotemcel (Lyfgenia™), betibeglogene autotemcel (Zynteglo™) or exagamglogene autotemcel (Casgevy™) or other gene therapy 3) Prior receipt of HSCT
Required Medical Information	<u>Requirements for all indications:</u> 1) Confirmation that hematopoietic stem cell transplantation is appropriate for the patient and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥60 (<16 years of age) b. No advanced liver disease; severe hepatic fibrosis or cirrhosis c. eGFR is ≥ 60 ml/min/1.73m^2 d. No cardiomyopathy or severe congestive heart failure (NYHA class III or IV) and baseline LVEF is ≥45% e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding periods of SCD crisis, severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline g. WBC count ≥3x10^9/L and platelet count ≥50x10^9/L (unless related to hypersplenism) h. Documentation that the member does not have any history of severe cerebral vasculopathy: defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [≥200 cm/sec] needing chronic transfusion; or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease. i. No hypersplensim 2) Confirmation that the member does not have an available 10/10 HLA matched related HSCT donor 3) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection 4) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Plerixafor (Mozobil™, TAR required), for mobilization b. Busulfan (TAR required), for myeloablative conditioning <u>Additional Requirements for Transfusion Dependent Beta Thalassemia</u> 1) Genetic testing to confirm beta thalassemia

	2) Documentation of transfusion dependence as evidenced by one of the following a. A history of at least 100 mL/kg/year of packed RBC in the prior 2 years OR b. 10 units/year of packed RBC transfusions in the prior 2 years 3) No severe iron overload in heart or liver or endocrine systems, evaluated within the last 6 months a. Cardiac T2* value must not be less than 10 msec by magnetic resonance imaging [MRI] b. Liver iron concentration must not be ≥15mg/g Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals (ie denials for medical necessity)

Age Restriction	FDA indication: 2 years and older

Prescriber Restriction	Hematologist or Transplant Specialist at an Authorized Treatment Center

Coverage Duration	FDA labeling: Once per lifetime, approval will allow a 12-month duration

Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3392	Injection, exagamglogene autotemcel, per treatment (Casgevy™)	The minimum recommended dose is 3×10^6 CD34+ cells/kg, which is 1 unit.

The treatment of sickle cell disease (SCD) in patients 2 years and older with recurrent vaso-occlusive crises (VOCs) is carved out to Fee for Service Medi-Cal. All claims for CGT drugs must be billed directly to DHCS using the appropriate billing code (J3392) and submitted on medical claims using the CMS-1500 (or 837P/I electronic equivalent forms).

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	• Adults: Treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome (CIS), relapsing-remitting disease, and active secondary progressive disease • Ocrevus™ is FDA-approved for pediatric patients 10 years and older weighing ≥25 kg: relapsing-remitting disease • Ocrevus™ and Ocrevus Zunovo™ are also FDA-approved for treating primary progressive multiple sclerosis (PPMS) and as such PPMS is a covered use for these agents
Exclusion Criteria	• History of life-threatening infusion reaction to ocrelizumab or ublituximab. • Active hepatitis B virus (HBV) infection • Concurrent use of other disease-modifying therapies or immunosuppressives
Required Medical Information	New Start: Clinical evaluation by neurologist with documentation of the following: • For all 3 products, a diagnosis of relapsing form of MS, to include CIS, relapsing-remitting disease, and active secondary progressive disease OR for Ocrevus™ or Ocrevus Zunovo™, a diagnosis of primary progressive MS is also appropriate for requesting treatment • Documentation should include the diagnosis as confirmed by brain MRI reports, lab reports, documentation of any planned diagnostic workup that has not yet been completed. MRI must show at least one demyelinating event. Submission of CSF study with oligoclonal banding &/or other diagnostic workup results (such as spinal MRI) should be included if brain MRI report is inconclusive • Documentation that member does not have an active hepatitis B infection (as confirmed by Hepatitis B Surface Antigen [HBsAg] and anti-HBV tests). For patients who are negative for HBsAg and positive for Hepatitis B core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consultation with liver disease experts before starting and during treatment is required Renewals: Include any diagnostic workup that was still pending at time of prior request (additional imaging, CSF evaluation, etc.) and/or documentation of clinical response with therapy requested
Age Restriction	Minimum Age: 10 years (Ocrevus™) Minimum Age: 18 years (Ocrevus Zunovo™ and Briumvi™)
Prescriber Restriction	Must be prescribed or recommended by a Neurologist
Coverage Duration	3 months when additional diagnostic workup is pending. 12 months if all supporting documentation is complete at time of initial TAR submission. Renewals for continuation of care with documentation of positive clinical response: 12 months

Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Ocrevus	J2350	Injection, Ocrelizumab, 1 mg	Dosing: Adult Initial Dose: 300 mg once on day 1, followed by 300 mg once 2 weeks later; Subsequent doses, starting 6 months after 1 st infusion: – 600 mg every 6 months Dosing: Children ≥10 years and Adolescents: Weight 25 to <35 kg: Initial dose: 150 mg once on day 1, followed by 150 mg once 2 weeks later; Subsequent doses, starting 6 months after 1st infusion: 300 mg every 6 months Weight ≥35 kg: Initial Dose: 300 mg once on day 1, followed by 300 mg once 2 weeks later; Subsequent doses, starting 6 months after 1 st infusion: – 600 mg every 6 months
Ocrevus Zunovo	J2351	Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq	920 mg/23,000 units (920 mg ocrelizumab and 23,000 units hyaluronidase) as single 23-mL SC injection in abdomen over ~10 minutes every 6 months
Briumvi	J2329	Injection, ublituximab-xiiy, 1 mg	Initial Dose: 150 mg once on day 1, followed by 450 mg once 2 weeks later; Subsequent doses of 450 mg are administered once every 24 weeks (beginning 24 weeks after the first dose of 150 mg)

Requirements for Lecanemab-irmb IV (Leqembi™) and Lecanemab-irmb (Leqembi Iqlik™)

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	For the treatment of Alzheimer's Disease (AD) in patients with mild cognitive impairment or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.
Required Medical Information	Initial Approval Criteria (Must meet all): • Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness) • Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as: o Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD) o Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus. • Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer's Disease (AD) or mild AD dementia and must have at least two of the following: o Clinical Dementia Rating (CDR)-Global Score of 0.5-1.0 o Mini-Mental Examination Status (MMSE) score of 22–30 o Montreal Cognitive Assessment (MoCA) score of ≥16 o Functional Assessment Staging Tool (FAST) score of 2–4 • Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following: o Amyloid PET o Lumbar puncture: CSF assessment positive for amyloid beta plaque. • Must provide baseline brain magnetic resonance imaging (MRI) dated within 12 months prior to request and MRI must document all of the following: o Less than 4 brain micro-hemorrhages o No prior brain hemorrhage greater than 1cm within the past year o No localized superficial siderosis o No evidence of acute/subacute cerebral contusion, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory. o No evidence of vasogenic edema or brain tumors o No severe small vessel, or white matter disease • ALL of the following MUST be documented: o Member does NOT have a history of cerebrovascular abnormalities or bleeding disorder that would present a risk for ARIA-related bleeding o Member does NOT have history of transient ischemic attack (TIA), stroke or seizures within the previous year of screening. o Member does NOT have untreated bleeding disorder (platelet count <50,000 or INR>1.5) o Member must NOT have contraindications to MRI or PET scans

Requirements for Lecanemab-irmb IV (Leqembi™) and Lecanemab-irmb (Leqembi Iqlik™)

	○ Member does NOT have history of depression and/or clinically unstable psychiatric illness in the past 12 months ○ Member does NOT have a history of alcohol or substance abuse in the past 12 months • If member is receiving an approved AD treatment such as an acetylcholinesterase inhibitor (AChEI) or memantine or both, must be on a stable dose for at least 12 weeks prior to Leqembi treatment initiation • Member weight must be included • The requested dose and frequency must be in accordance with FDA-approved labeling and must not exceed dosing guidelines • Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 3rd, 5th, 7th and 14th infusions. State the specific dosage form that will be administered during the medical office visit: a) Leqembi Iqlik™ (may be administered by patient or caregiver with proper training after at least 2 consecutive doses are given under the guidance and supervision of a healthcare provider) OR b) lecanemab-irmb IV (Leqembi™) (administered by health care provider) • Treatment plan which includes consideration of starting dose with Leqembi Iqlik™ for convenience of self-administration and lower level of care.
Age Restriction	50 to 90 years old. Member under 50 years old with early onset Alzheimer's disease (AD) and met all criteria will be reviewed on a case-by-case basis.
Prescriber Restriction	Neurologist, geriatrician, psychiatrist.
Coverage Duration	lecanemab-irmb IV (Leqembi™) Initial, doses 1-4: 2 months' duration (up to 4 doses of infusion) First Renewals, doses 5-12: 4 months' duration (up to 8 doses of infusion) Additional Renewals, dose 13 through 18 months total treatment course: 6 months' duration (up to 2 doses/month) Treatment Requests beyond 18 months of use: Treatment requests for the IV formulation beyond 18 months duration will be reviewed on a case-by-case basis. lecanemab-irmb (Leqembi Iqlik™) Initial, doses 1-2: 2 weeks duration (up to 2 doses)
Other Requirements & Information	Note: lecanemab-irmb (Leqembi Iqlik™) is available for self-administration and can be administered by the member or a caregiver at home after at least 2 consecutive doses are given under the guidance and supervision of a healthcare provider. As soon as the member or caregiver can be trained for self-administration, Leqembi Iqlik™ can be provided to the member by a pharmacy for administration at home whenever possible. First Renewal, must meet ALL: • Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND • Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score of 0.5-1, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score of 22-30, and/or FAST score of 2-4.

Requirements for Lecanemab-irmb IV (Leqembi™) and Lecanemab-irmb (Leqembi Iqlik™)

- Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 3rd, 5th, 7th and 14th infusion.
- Absence of amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th and 7th infusions as determined by brain MRI.
- Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, anticoagulants).
- Treatment plan which includes consideration for transitioning to Leqembi Iqlik™) for SUBQ injection following at least 2 consecutive doses are given under the guidance and supervision of a healthcare provider.

Additional Renewals (dose 13 and later), must meet ALL:

- Provider's attestation that the potential benefit outweighs known risks as evidence by one of the following:
  - A reduction in amyloid beta plaque buildup compared from baseline in PET imaging of brain.
  - A slowing/reducing cognitive decline from baseline in CDR-SB score or MMSE score.
- Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score of 0.5-1, Montreal Cognitive Assessment (MoCA) score of ≥16, MMSE score of 22-30, and/or FAST score of 2-4.
- Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 14th infusion.
- Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, or anticoagulants).
- Member must continue maintenance therapy at the recommended dosage per product labeling
- Treatment plan which includes consideration for transitioning to Leqembi Iqlik™) for SUBQ injection following at least 2 consecutive doses are given under the guidance and supervision of a healthcare provider.

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

Requirements for Lecanemab-irmb IV (Leqembi™) and Lecanemab-irmb (Leqembi Iqlik™)

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J0174	Injection, lecanemab-irmb *Intravenous product only*	Initial dosing: 10 mg/kg once every 2 weeks for 18 months. Maintenance dosing: After 18 months, may continue 10 mg/kg once every 2 weeks or switch to 10 mg/kg once every 4 weeks or change to the subcutaneous formulation.
J3590	Unclassified biologics: lecanemab-irmb (Leqembi Iqlik) *Subcutaneous product only*	Initial dosing: 500 mg once weekly for 18 months. Maintenance dosing: after 18 months, 360 mg once weekly, starting 1 week after the last dose of the initial regimen.

Note: Requests for the subcutaneous product, Leqembi IQLIK, should be submitted to Medi-Cal Rx as a pharmacy benefit

DHCS statement:
Guidance for Dually Eligible/Medi-Medi Enrollees: Leqembi is covered under Medicare Part B. Medi-Cal is obligated to pay the coinsurance and/or deductibles. Medicare covers the drugs with traditional FDA approval in this class when a prescribing clinician or their staff decides the Medicare coverage criteria is met and also submits information to help answer treatment questions in a qualifying study. Providers can participate in the CMS National Patient Registry (or another CMS-approved study) to get Medicare payment for treating their patients with Leqembi.

For additional details, see:
https://www.cms.gov/newsroom/press-releases/statement-broader-medicare-coverage-leqembi-available-following-fda-traditional-approval

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, Qivigy, 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, Qivigy, 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) Chronic inflammatory demyelinating polyneuropathy:
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) Dermatomyositis/Polymyositis, severe, life-threatening or refractory:
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. ITP Renewals: 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. Guillain-Barré Renewals: 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
Qvigiy	J1577	Injection, immune globulin (qivigy), 100 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.

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 spinal muscular atrophy (SMA)
Exclusion Criteria	Concurrent use with risdiplam (Evrysdi™)
Required Medical Information	<u>Requirements for Members with No Prior Zolgensma or Itvisma</u>: 1. Documentation required for: a. Symptomatic patients: i. Diagnosis of 5q SMA with documentation of genetic lab testing confirming homozygous deletion or any combination of survival motor neuron 1 (SMN1) deletions or point mutations AND ii. Number of copies of SMN2 b. Presymptomatic patients: i. Genetic lab testing to confirm homozygous SMN1 deletion or mutation. ii. ≤ 3 copies of SMN2 2. Age of onset 3. Documentation of at least one validated neuromotor assessment, performed within past 12 months with a score used to establish a clinical baseline. Examples may include: a. Hammersmith Infant Neurologic Exam-Part 2 (HINE-2)_ b. The Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND) c. Hammersmith Functional Motor Scale-Expanded (HFMSE) d. Revised Upper Limb Module (RULM) 4. Baseline pulmonary function tests (e.g. FVC, etc) for ages 4 years and older. 5. Documentation of consideration of less invasive oral treatment (risdiplam, Evrysdi™) and why it cannot be used, or documentation of trial and failure of risdiplam. 6. Requests for Spinraza High Dose: must meet all of the following a. Has been on Spinraza Low Dose (12mg) for at least 12 months b. Has experienced a worsening in clinical status while on the Low Dose regimen as demonstrated by a decline of minimally clinical important difference from highest score achieved on one of the following exams: i. HINE-2: Decline of at least 1 point in Section 2; or ii. HFMSE: Decline of at least 3 points; or iii. CHOP-INTEND: Decline of at least 4 points; or iv. RULM: Decline of at least 2 points c. *Note: both the current neuromotor assessment showing decline, and the prior neuromotor assessment showing the member's highest score achieved must be submitted with the request, and must use the same assessment type*

	<u>Requirements for Members with Prior Use of Zolgensma or Itvisma</u>: 1. Date of Zolgensma or Itvisma administration 2. Baseline neuromotor function test prior to Zolgensma or Itvisma administration 3. Current neuromotor function test which demonstrates a decline of minimally clinical important difference from the member's previous highest score achieved on one of the following exams; a. HINE-2: Decline of at least 1 point in Section 2; or b. HFMSE: Decline of at least 3 points; or c. CHOP-INTEND: Decline of at least 4 points; or d. RULM: Decline of at least 2 points 4. *Note: both the current neuromotor assessment showing decline, and the prior neuromotor assessment showing the member's highest score achieved must be submitted with the request, and must use the same assessment type* Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	None
Prescriber Restriction	Neurologist, or pediatric neurologist
Coverage Duration	Initial: 8 months. Renewal: 12 months with documentation of benefit with treatment
Other Requirements & Information	Renewal Requests: • First renewal of Spinraza low-dose regimen: clinic notes with neuromotor assessment performed at least 6 months after initiation of Spinraza, showing improvement or lack of deterioration (and is within 12 months of the date of the reauthorization request). Documentation that there is no permanent ventilator dependence. • Second or subsequent renewal of Spinraza low-dose regimen: Current clinic notes (within the past 6 months) with assessment of patient, including a neuromotor assessment within 12 months of the reauthorization request, which demonstrates improvement or lack of deterioration. Documentation that there is no permanent ventilator dependence. • Members currently approved for Spinraza low-dose regimen, requesting initial approval of high dose regimen (see Required Medical Information #6) • First renewal of Spinraza high-dose regimen: o Clinic notes with neuromotor assessment performed at least 6 months after initiation of Spinraza high dose (and is within 12 months of the date of the reauthorization request), showing stabilization of decline or improvement as evidenced by one of the following assessments: ▪ HINE-2

	▪ HFMSE ▪ CHOP-INTEND ▪ RULM • Second or subsequent renewal of Spinraza high-dose regimen: Current clinic notes (within the past 6 months) with assessment of patient, specifying neuromotor status and/or drug related toxicity and including a neuromotor assessment within 12 months of the reauthorization request, which demonstrates improvement or lack of deterioration. 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
J2326	Intrathecal solution, nusinersen, 0.1mg (SpinrazaTM)	Spinraza low-dose regimen: Loading Dose: 12 mg q14 days for 3 doses, then 12 mg once 30 days after 3rd dose. Maintenance Dose:12 mg q4 months, starting 4 months after the last loading dose Spinraza high-dose regimen: Loading Dose: 50 mg q14 days for 2 doses. Maintenance Dose:28 mg q4 months, starting 4 months after the last loading dose.

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Matched donor hematopoietic stem cell transplantation with myeloablative preparative regimen, for hematopoietic and immunologic reconstitution and to improve chronic graft-versus-host disease-free survival, in the treatment of adults with hematological malignancies
Exclusion Criteria	1. Prior allogenic hematopoietic stem cell transplant 2. Prior use of Tregzi 3. Planned donor lymphocyte infusion (DLI) 4. Planned pharmaceutical in vivo or ex vivo T cell depletion 5. Currently receiving corticosteroids or other immunosuppressive therapy (excepting topical or oral systemic corticosteroid ≤10mg/day of prednisone equivalent) 6. Allergy to Tacrolimus 7. Uncontrolled autoimmune disease requiring active immunosuppressive treatment 8. Concurrent malignancy or active disease within 1 year (except the current hematologic malignancy for which the member is undergoing transplant, or non-melanoma skin cancers that have been curatively resected) 9. Pregnancy
Required Medical Information	Documentation of ALL the following: 1. Member has an approved authorization for allogenic hematopoietic stem cell transplant for the treatment of a hematologic malignancy through Partnership HealthPlan's Utilization Management Department 2. The hematologic malignancy is intermediate- or high-risk Disease Risk Index (DRI) 3. The member has an 8/8 HLA-matched donor, either related or unrelated 4. Documentation of the transplant type and immunosuppressive regimen planned *(see Exclusion Criteria 3 & 4)* 5. Member is able to receive myeloablative conditioning (MAC) regimen 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	Oncologist, hematologist, BMT specialist, or other qualified prescriber
Coverage Duration	Once per lifetime
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologics: allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq (Tregzi™)	Dosing is once per lifetime; 1 dose should be billed as 1 unit

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	For use in epithelium-on corneal collagen cross-linking for the treatment of keratoconus in adults and pediatric patients aged 13 years and older, in conjunction with the O2n System and the Boost Goggles.
Exclusion Criteria	• History of delayed epithelial healing in the eye to be treated or a current condition that may interfere with or prolong epithelial healing • History of any previous CXL procedure in the eye to be treated • History of prior ocular herpetic infection • Aphakic or pseudophakic without a UV-blocking intraocular lens
Required Medical Information	Documentation that Epithelium-on CXL (Epioxa) using riboflavin and ultraviolet A for the treatment of progressive keratoconus in refractive surgery is medically necessary when ALL the following clinical criteria are met: 1. Diagnosis of keratoconus based on keratometry and corneal mapping with one of the following diagnostic metrics: a. corneal topography b. corneal pachymetry c. corneal epithelial thickness d. posterior corneal topography e. wavefront analysis f. corneal biomechanics 2. At least ONE of the following changes have occurred within the past 24 months: a. An increase of 1 diopter (D) in the steepest keratometry value b. An increase of 1 D in regular astigmatism evaluated by subjective manifest refraction c. A myopic shift (decrease in the spherical equivalent) of 0.50 D on subjective manifest refraction d. A decrease ≥0.1 mm in the back optical zone radius in rigid contact lens wearers where other information was not available. 3. Corrected distance visual acuity worse than 20/20 with properly fitted spectacles or contact lenses 4. Corneal thickness ≥ 300 microns 5. Documentation of treatment in: a. Right eye b. Left eye
Age Restriction	13 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	1 treatment per eye per lifetime. Repeat treatment in the same eye is considered experimental, investigational, and unproven due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes.

Other Requirements & Information	Renewal requests beyond the 1 treatment per lifetime maximum will not be approved. 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:

Each Epioxa kit contains two 2 mL syringes for a total of 2 units:

- **TARs should be approved for 2 HCPCS code units.**

Product	HCPCS	Description	Dosing, Units
Epioxa Cross Linking Kit	J2789	Riboflavin 5'-phosphate, ophthalmic solution (epioxa hd/epioxa), up to 2 ml	Epioxa HD (0.239% solution)/Epioxa (0.177% solution): Ophthalmic: Apply 2 drops of Epioxa HD on the eye every 60 seconds for 4 minutes followed by 2 drops of Epioxa every 30 seconds for 6 minutes.

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

Committee:	Credentials Committee
Date:	September 09, 2026 7:00 A.M.
Members Present: by phone conference*	David Gorchoff, MD*; Michele Herman, MD; Bradley Sandler, MD* ; Brian Montenegro, MD; Craig Rhoades, PA-C*
PHC Staff: by phone conference*	Robert Moore, MD, MPH, MBA, PHC Chief Medical Officer; Kermit Jones, MD Deputy Chief Medical Office; Marshall Kubota, MD*; PHC Associate 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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Chief Medical Officer Robert Moore, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by Robert Moore, MD. Robert Moore, MD reminded everyone that all items discussed are confidential. a. Partnership Robert Moore, MD reminded The Credentials Committee of who the voting members are, and voting is restricted to non-Partnership staff. Robert Moore, MD reminded the committee that all information discussed is confidential in nature.			09/09/2026 09/09/2026
II. Review and approval of August 12, 2026 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for August 12, 2026 was reviewed by the Committee.	II. Summary was reviewed. A motion for approval of the Summary was made. First motion approved by Bradley Sandler, MD and the second motion approved by Brian Montenegro, MD. Meeting Summary motions approved by committee unanimously with no objections.		09/09/2026
III. Old Business.	III. Old Business	III. Old Business		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
a. No old business to report.	a. No old business to report.	a. No old business to report.		09/09/2026
IV. New Business a. Review and Approval of Routine Practitioner List.	IV. New Business a. Robert Moore, MD referred to the Credentials Committee to review the routine list of practitioners.	IV. New Business a. The Committee reviewed the Routine Practitioner List**.** A Motion to approve the Routine Practitioner List was made. First motion approved by Bradley Sandler, MD and the second motion approved by Michele Herman, MD. Routine Practitioner List motions approved by committee unanimously with no objections.		09/09/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Robert Moore, MD referred the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list. These practitioners are approved by Dr. Netherda Pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list was made. First motion approved by Brian Montenegro, MD and the second motion approved by Michele Herman, MD. MPCR200 Clean/Routine list motions approved by committee unanimously with no objections.		09/09/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Danika Ahedo, Supervisor of Credentialing. Danika explained to the committee that policy MPCR12-A Attachment	c. The Committee reviewed the Revised Policies. MPCR12-A Individual Nurse Agreement was pulled from review and will not be voted on. A motion to approve the revised policy MPCR200-		09/09/2026

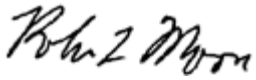
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	A Individual Nurse Agreement will not be voted on. Partnership Internal Quality Improvement (IQI) department pulled the policy pending a definition of Act B. under section A. along with placing the policy on Partnership letterhead. Danika stated that once the revisions are met the policy will be represented to the Credentials Committee. Dr. Moore also stated that only MPCR200-A will be voted on by the Credentials Committee at the 9/9/2026 meeting. • MPCR12-A – Individual Nurse Agreement. Removed from review, no vote. • MPCR200-A – Clean file approval form. Formatting changes made to policy.	A Clean File Approval Form was made. First motion approved by Brian Montenegro, MD and the second motion approved by Bradley Sandler, MD. Revised Policy MPCR200-A Clean file Approval Form motion approved by committee unanimously with no objections		
d. Semi-Annual Evaluation of Practitioner Specific Member Complaints (CR5 Quarterly Report) *Information Only*	d. Robert Moore, MD referred the Credentials Committee to the Semi-Annual Evaluation of Practitioner Specific Member Complaints (CR5 Quarterly Report) for the period of April 1, 2026 through June 30, 2026 (3 months). Summary of Findings: Number of Complaints from Perform Quality Improvement (PQI) is 25. Number of Complaints from Grievance and Appeals (G&A) 36. Per Mark Netherda, MD review, there were a total of 11 practitioners involved with a total of 27 complaints. No trend or significant clinical or service issues were identified. As a result, no further action is needed at this time. *Information Only*	d. *Information Only*		09/09/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
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. First motion approved by Brian Montenegro, MD and the second motion approved by Bradley Sandler, MD. Ongoing Monitoring of Sanctions Report motions approved by committee unanimously with no objections.		09/09/2026
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Robert Moore, MD reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Informational only*.		09/09/2026
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a. Robert Moore, MD asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a/b/c. The Credentials Committee members reviewed the list of Consent Calendar items. A motion for approval was made for Report of Long-Term Care Facility, Hospital and Ancillary provider list, Quarterly Delegation Audits and Annual Delegation Audits. First motion approved by Craig Rhoades, PA-C and the		09/09/2026
b. Quarterly	b. Robert Moore, MD presented the Annual			

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Delegation Audits	Delegation Audits for: • Carelon Behavioral Health • Mercy Medical Group • Woodland Clinic • DHMG North State • DHMG Sierra Nevada • Zipongo Health Provider Group, PA dba Foodsmart Nutrition Network • Lucile Packard Children's Hospital • Solano CPN • SIP : Sutter Independent Physicians • SMFAS • SMG SacPlacer • SMG Solano • SMG Yolo • SNMG : Sutter North Medial Group • MPMG: Mills Peninsula Medical Group • Palo Alto Medical Foundation CPN • Palo Alto Medical Foundation Employed • SEBMF CPN • SEBMF Employed • SPMF: Sutter Medical Group of the Redwoods CPN • SPMF: Sutter Medical Group of the Redwoods Employed • SPMF: Sutter West Bay Medical Group CPN • SPMF: Sutter West Bay Medical Group Employed • UC Davis Health • UCSF Medical Group • Vision Service Plan (VSP)	second motion approved by Brian Montenegro, MD. Consent Calendar items motions approved by committee unanimously with no objections.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
c. Annual Delegation Audits	c. Robert Moore, MD presented the Annual Delegation Audits for: • Zipongo Health Provider Group, PA dba Foodsmart Nutrition Network The audit included Partnerships review and evaluation of the credentialing information integrity results.			
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 9/9/2026 respectfully prepared and submitted by J'aime Seale, Credentialing Lead.



Chairman Signature of Approval _____ ***Date*** ***9/9/2026***

Robert Moore, MD ***Credentialing Chairman***

September 2026
Routine Practitioner List

Ap	Full Name	NPI Number	Provider T	Name/Street	County Name	Specialty Description
I	Abraha, Alemseghed W.,MD	1568726230	PCP	NorthBay Center for Primary Care/ U	Solano	Family Medicine
I	Acosta, Samara FNP-C	1205553112	PCP	Kimaw Medical Center	Humboldt	Family Nurse Practitioner
R	Adams, Robert H.,DO	1396905725	PCP	Eastern Plumas Health Care District	Plumas	Family Medicine
I	Albrecht, Carly M., RD	158338752	Allied	Carly Albrecht, RDN Sustenance Sim	Solano	Registered Dietitian
I	Almanza-Soto, Mariana PA-C	1770414070	PCP	Pediatric Medical Associates of Sacr	Sacramento	Physician Assistant Certified
I	Alsaleem, Talal H.,LMFT	1013100924	BHP	Lassen Indian Health Center	Lassen	License Marriage and Family Therapis
R	Angeli, Daniel G.,MD	1326417916	SPEC	West Coast Kidney	Marin	Internal Medicine
I	Arndt, Elisabeth A.,DO	1548999675	PCP	Western Sierra Medical Clinic (Grass	Nevada	Family Medicine
I	Assefa, Betelhem FNP-BC	1710430129	SPEC	Adobe PH CA Medical Group PC	Solano	Hospice and Palliative Medicine
R	Austin, Chester J.,MD	1689738866	PCP	Northern Valley Indian Health (Conco	Butte	Family Medicine
I	Azizian, Fimi Psy.D	1679763239	BHP	Chapa-De Indian Health (Auburn)	Placer	Psychology
I	Ballou, Willie B.,ANP-C	1548657802	PCP	Adobe PH CA Medical Group PC	Solano	Adult Nurse Practitioner
I	Barnes, Nolan A.,PA-C	1578349858	PCP	SCHC: Shasta Community Health Ce	Shasta	Physician Assistant Certified
I	Bartholomew, Willow A.,PA	1225650450	PCP	Mendocino Coast Clinic	Mendocino	Family Medicine
R	Bauer, Eric J.,MD	1669037271	PCP	Adventist Health Ukiah Valley	Mendocino	Family Medicine
I	Baum, Caroline BCBA	1912570011	BHP	Kadiant, LLC	Solano	BCBA
R	Behrens, Kyle A.,LMFT	1609249812	W&R	UIHS - Potawot Health Village	Humboldt	Wellness and Recovery
I	Benefiel, Jesse P.,SUDRC I	1811816473	W&R	Aegis Treatment Center LLC - Eureka	Humboldt	Wellness and Recovery
I	Benjelloun, Nouhayla BCBA	1609528256	BHP	Kadiant, LLC	Solano	Board Certified Behavior Analyst
I	Biglarderi, Jazmyne M.,BCBA	1164364709	BHP	Oak Soul ABA Therapy	Solano	BCBA
I	Black, Melanie M.,PA-C	1396672036	SPEC	Providence Medical Group, Humbold	Humboldt	Gastroenterology
I	Blake, Tierra R.,Doula	1093672172	SPEC	Loula Perinatal Health Services of Ca	Solano	Doula
R	Bland, Sarah J.,FNP-C	1548781495	PCP	Chapa-De Indian Health (Grass Valle	Nevada	Family Nurse Practitioner
R	Blawn, Janet L.,LCSW	1285905182	BHP	Chapa-De Indian Health (Grass Valle	Nevada	Licensed Clinical Social Worker
I	Blundell, Matthew C.,MD	1073511796	PCP	UIHS - Crescent City Health Center	Del Norte	Internal Medicine
R	Boening, Rebecca R.,MD	1306367982	PCP	Willow Pediatrics	Glenn	Pediatrics
R	Botelho, Ronald J.,MD	1235199373	SPEC	Lake County Tribal Health Center	Lake	Pain Management
I	Boucher, Daniel E.,MD	1164115549	PCP	Adventist Health Clearlake	Lake	Family Medicine
R	Brooks, Michael P.,DPM	1881803047	SPEC	Eastern PLumas Health Care Portola	Plumas	Podiatry
I	Brown, Dawn Doula	1700163607	SPEC	Loula Perinatal Health Services of Ca	Solano	Doula
I	Brown, Derrick S.,MD	1659631372	PCP	Western Sierra Medical Clinic (Grass	Nevada	Family Medicine
I	Brown, Mark R.,FNP-C	1346053048	PCP	NBHG: Center for Primary Care-Vaca	Solano	Family Nurse Practitioner
I	Bruce, Jaye S.,CD	1518777952	SPEC	JAYE BRUCE	Plumas	Certified Doula
R	Buchanan, Russell A.,SUDCC	1144006826	W&R	Ujima Hope Solano	Solano	Wellness and Recovery
I	Bueno, Charlene Mae F.,PT	1376027201	Allied	NBHG: Northbay Rehab Services OT	Solano	Physical Therapy
R	Bugna, Eric E.,MD	1255339099	SPEC	Eastern PLumas Health Care Portola	Plumas	Orthopaedic Surgery
R	Bunting, Michelle A.,BCBA	1871037952	BHP	Kyo Autism Therapy LLC, fka Gatewa	Yolo	BCBA
I	Burch, Stevie BCBA	1578058780	BHP	Autism Learning Partners	Sacramento	BCBA
I	Bush, Cory SUDCC	1548195043	W&R	Ford Street Project - Ukiah Recovery	Mendocino	Wellness and Recovery
I	Calabretta, Natalie PA-C	1942095377	PCP	Western Sierra Medical Clinic	Nevada	Pediatrics
I	Cao, Fei MD	1598299687	SPEC	NBHG: NorthBay Healthcare Pain Ma	Solano	Pain Management
I	Chairez, Luz SUDCC III	1730059320	W&R	Recover Medical Group	Solano	Wellness and Recovery
R	Changezi, Ammar H.,MD	1538428040	PCP	Ampla Health Chico Medical & Pediat	Butte	Pediatrics
I	Chappell, Jeaneen A.,MD	1497915623	SPEC	TeleMed2U	Placer	Dermatology
I	Chavez, Brandi BCBA	1871358382	BHP	Burnett Therapeutic Services, Inc.	Napa	Board Certified Behavior Analyst
I	Clark, Ames BCBA	1710480215	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA
I	Cope, Emily E.,FNP-C	1366375115	PCP	Providence Medical Group, Humbold	Humboldt	Family Nurse Practitioner
I	Cornelius, Alexis BCBA	1023403599	BHP	Peak Potential ABA, LLC	Solano	BCBA
R	Cunningham, Emmett T.,Jr., MI	1083706261	SPEC	West Coast Retina Medical Group-Sa	Marin	Ophthalmology

Ap	Full Name	NPI Number	Provider T	Name/Street	County Name	Specialty Description
I	Davis, Eric BCBA	1528915931	BHP	ACES 2020 LLC	Solano	BCBA
R	DeLaughter, Tina L.,LCSW	1417336835	BHP	Chapa-De Indian Health (Grass Valle	Nevada	Licensed Clinical Social Worker
I	Dentico, Amy Doula	1275466450	SPEC	Loula Perinatal Health Services of Ca	Solano	Doula
I	Deol, Kulwinder K.,FNP-C	1811439573	PCP	Community Medical Centers, Inc Vac	Solano	Family Nurse Practitioner
I	Dhond, Milind R.,MD	1972500676	SPEC	NBHG: NorthBay Healthcare Group	Solano	Cardiovascular Disease
I	Diallo, Ismael MD	1619472503	SPEC	Sutter Coast Community Clinic (PCP	Del Norte	Surgery
I	Diaz, Corrina BCBA	1326407172	BHP	Ambitions Behavioral Health	Solano	Behavioral Health
I	Do, Hulbert N.,MD	1679733760	SPEC	Heart and Vascular Centers of Ameri	Placer	Cardiovascular Disease
I	Donde, Nikunj N.,MD	1235767617	SPEC	NBHG: NorthBay Healthcare Group	Solano	Vascular Surgery
I	Donner, David W.,MD	1760041321	PCP	Enloe Health and Wellness dba Fami	Butte	Family Medicine
I	Dubrouillet, Julie Doula	1093603995	SPEC	NEWMOM	San Mateo	Doula
R	Eaker, Julie A.,PA-C	1689076937	PCP	Redding Rancheria: Trinity Health Ce	Trinity	Physician Assistant Certified
R	Eargle, Amy E.,Psy.D	1629247143	BHP	Chapa-De Indian Health (Auburn)	Placer	Psychology
R	Eisfeld, Ashley BCBA	1548707219	BHP	Aura Behavioral Health LLC	Yolo	Behavioral Health
I	Engle, Anastasia Doula	1225968316	SPEC	Lost Coast Doula	Humboldt	Doula
I	Enright, Masyn DO	1184387201	PCP	Adventist Health Mendocino Coast	Mendocino	Family Medicine
R	Fender, Sarah FNP-C	1083223382	PCP	Chapa-De Indian Health (Grass Valle	Nevada	Family Nurse Practitioner
I	Filbert, Nicole PA-C	1629751292	SPEC	Solano Dermatology Associates, Inc.	Solano	Physician Assistant Certified
I	Flores, Erik BCBA	1215879408	BHP	Advanced Crisis Solutions, Inc.	Shasta	BCBA
I	Fontanilla, Alexandra J.,PNP	1710536628	PCP	Santa Rosa Community Health - Ped	Sonoma	Pediatric Nurse Practitioner
I	Forster, Amber M.,FNP-C	1720343718	PCP	Tahoe Forest MultiSpecialty Clinics P	Nevada	Family Nurse Practitioner
I	Francescone, Cam PA-C	1649660424	SPEC	TeleMed2U	Placer	Physician Assistant Certified
I	French, Emily M.,PMHNP-BC	1184139040	SPEC	Santa Rosa Community Health - Lom	Sonoma	Psychiatric Mental Health Nurse Pract
I	Gaeto, Hollie L.,DO	1114310687	PCP	Providence Medical Group, Sonoma	Sonoma	Family Medicine
I	Galliano, Lynn E.,BCBA	1477006955	BHP	Behavia Therapy	Solano	Board Certified Behavior Analyst
R	Garrido, Health L., PA-C	1336457910	PCP	Northern Valley Indian Health (Conco	Butte	Physician Assistant Certified
R	Gerber, Heather S.,SUDCC	1093409328	W&R	Hilltop Recovery Services - The Ranc	Lake	Wellness and Recovery
I	Goel, Kunal O.,MD	1619610714	PCP	Mendocino Coast Clinic	Mendocino	Internal Medicine
I	Greenlee, Zacharia D.,PA-C	1427469097	PCP	MVHC - Fall River Valley Health Cent	Shasta	Physician Assistant Certified
I	Grenet, Justin E.,MD	1770102915	SPEC	Providence Medical Group, Sonoma	Sonoma	Medical Oncology
R	Gryunshpan, Mariya BCBA	1255763736	BHP	Autism Intervention Professionals	Solano	Behavioral Health
I	Gunter, John D.,SUDRC I	1114847845	W&R	Empire Recovery Center	Shasta	Wellness and Recovery
I	Guy, Samantha L.,PA-C	1467891366	BOTH	NorthBay Health Urgent Care	Solano	Physician Assistant Certified
I	Hall, Sacha B.,PA-C	1093234882	SPEC	Providence Medical Group, Humbold	Humboldt	Physician Assistant Certified
I	Harwood, Jared L.,MD	1942393954	SPEC	Providence Medical Group, Humbold	Humboldt	Orthopaedic Surgery
R	Hazim, Hani BCBA	1275188633	BHP	Autism Intervention Professionals	Solano	BCBA
I	Heldt, Amanda N.,AMFT	1558115949	W&R	Aldea Children and Family Services	Solano	Associate Marriage and Family Therap
R	Hering, Kelly J.,FNP-BC	1124131883	PCP	Redding Rancheria: Churn Creek He	Shasta	Family Nurse Practitioner
I	Herrera, Sarah J.,PA-C	1598005720	PCP	Santa Rosa Community Health - Ped	Sonoma	Physician Assistant Certified
R	Hibler, John T.,DO	1588822670	SPEC	Eastern PLumas Health Care Portola	Plumas	Dermatology
I	Higgins, Tracy K.,FNP-BC	1922726819	PCP	SCHC: Shasta Community Health Ce	Shasta	Family Nurse Practitioner
I	Horvath, Patricia S.,FNP-BC	1124533831	PCP	Modoc Medical Clinic	Modoc	Family Nurse Practitioner
I	Hsieh, Stephanie PA-C	1720868045	PCP	Mendonoma Health Alliance	Mendocino	Physician Assistant Certified
I	Hunt, Joel J.,PA-C	1639320393	PCP	SCHC: Shasta Community Health Ce	Shasta	Physician Assistant Certified
I	Huntley, Vincent L.,FNP-C	1831066299	PCP	Sutter Coast Community Clinic (PCP	Del Norte	Family Nurse Practitioner
I	Ignatova, Elizaveta MD	1669009833	PCP	Tamalpais Pediatrics	Marin	Pediatrics
I	Joe, Julie BCBA	1710417167	BHP	Autism Learning Partners	Solano	Board Certified Behavior Analyst
I	John, Alan K., MD	1346669116	SPEC	Heart and Vascular Centers of Ameri	Placer	Cardiovascular Disease
I	Johnson, Anthony S.,PA-C	1205690310	PCP	Orchard Hospital Medical Specialty C	Butte	Physician Assistant Certified

September 2026
Routine Practitioner List

Ap	Full Name	NPI Number	Provider T	Name/Street	County Name	Specialty Description
R	Johnson, Jeremy V.,MD	1811374549	PCP	CommuniCare Ole - Salud Clinic	Yolo	Family Medicine
R	Jones, Sidney G.,MD	1356519193	SPEC	Adventist Health	Butte	Orthopaedic Surgery
R	Jornlin, William A.,MD	1235112160	PCP	Chapa-De Indian Health (Auburn)	Placer	Family Medicine
I	Juarez Casillas, Jesus E., MD	1003496969	SPEC	Interventional Radiation Oncology of	Solano	Radiation Oncology
R	Kalk, Eileen R.,PA-C	1538268016	PCP	Sutter Lakeside Community Clinic	Lake	Physician Assistant Certified
R	Kanat, Alexandra CNM	1811466097	SPEC	Mendocino Community Health Clinic:	Mendocino	Certified Nurse Midwife
R	Karr, Michael R.,SUDRC II	1508546888	W&R	Archway Recovery Services	Solano	Wellness and Recovery
I	Kellogg, Alexandra K., PA-C	1477236727	SPEC	Providence Medical Group, Humbold	Humboldt	Physician Assistant Certified
R	Kelso, Jessica BCBA	1578040978	BHP	Autism Intervention Professionals	Solano	BCBA
I	King-Jacobs, Mellissa FNP-C	1922568633	SPEC	Center of Excellence in Pediatric Neu	Placer	Pediatric Neurology
R	Kingsley, Jolene A., DO	1639195837	PCP	Redding Rancheria: Churn Creek Hea	Shasta	Family Medicine
I	Koenig, Katherine BCBA	1669906129	BHP	Autism Learning Partners	Solano	BCBA
I	Kolosky, Matthew J.,DO	1023459211	PCP	Sutter Coast Community Clinic (PCP	Del Norte	Pediatrics
I	Kramer, Andrea M.,BCBA	1013169804	BHP	Behavior Matters California, LLC	Solano	BCBA
I	Lafosse, Juan E.,FNP-C	1548774458	SPEC	Adobe PH CA Medical Group PC	Solano	Family Nurse Practitioner
I	Lake, Curtis E.,PA-C	1750892675	SPEC	TeleMed2U	Placer	Physician Assistant
R	Lambert, Emily BCBA	1457917585	BHP	Golden State Behavior	Solano	Board Certified Behavior Analyst
I	Lane, Jack C.,DO	1528037793	PCP	Orchard Hospital Medical Specialty C	Butte	Family Medicine
R	Lazarewicz, Nicolas R.,FNP-C	1053540120	PCP	NBHG: Center for Primary Care-Vaca	Solano	Family Nurse Practitioner
R	Lee, Jennifer BCBA	1578947503	BHP	Autism Intervention Professionals	Solano	Behavioral Health
R	Lee, Nora H.,PA-C	1871977959	SPEC	Adventist Health Physicians Network:	Napa	Physician Assistant Certified
R	LeFever, Danielle L., OD	1609183144	SPEC	UIHS - Potawot Health Village	Humboldt	Optometry
R	Lettow, Lindsay BCBA	1891336905	BHP	Autism Intervention Professionals	Solano	Behavioral Health
I	Lew, Jarrett R.,PA-C	1922698406	SPEC	Redwood Orthopaedic Surgery Assoc	Sonoma	Physician Assistant Certified
R	Linderman, Jessica BCBA	1841768728	BHP	Autism Intervention Professionals	Solano	Behavioral Health
R	Loja, Melissa N.,MD	1578826749	SPEC	NGBHG: NorthBay Heart and Vascul	Solano	Vascular Surgery
R	Lombardo, Delanie BCBA	1053970160	BHP	Sunrise ABA	Marin	Board Certified Behavior Analyst
I	Lopez, Jacob BCBA	1255899472	BHP	Ages Learning Solutions LLC	Solano	BCBA
I	Maalouf, Nicholas DO	1538861281	PCP	NBHG: Center for Primary Care-Gree	Solano	Internal Medicine
I	Macapagal, Sharina C.,MD	1508551391	PCP	Elica Health Centers-Halyard Medica	Yolo	Internal Medicine
I	Magana, Jazzelle BCBA	1376028068	BHP	Intercare Therapy	Solano	BCBA
I	Magnini, Grace CD	1043022981	SPEC	Kairos Advisors, LLC	Napa	Certified Doula
I	Malik, Riaz A.,MD	1003837543	SPEC	Shasta Regional Medical Group	Shasta	Wound Care
I	Malik, Yusria R.,MD	1417299199	SPEC	Providence Medical Group, Humbold	Humboldt	Obstetrics and Gynecology
I	Mansilla, Olivia A.,MD	1376563189	PCP	SCHC: Shasta Community Health Ce	Shasta	Internal Medicine
R	Manzano, Samantha M.,FNP-C	1063035046	PCP	Chapa-De Indian Health (Auburn)	Placer	Family Nurse Practitioner
R	Marinero, Herman BCBA	1457856569	BHP	Autism Intervention Professionals	Solano	BCBA
I	Marwah, Gurjit S.,MD	1780776328	PCP	Ampla Health Family Dental & Medica	Butte	Pediatrics
I	Matson, Lisa PA-C	1578436366	PCP	Western Sierra Medical Clinic (Grass	Nevada	Physician Assistant Certified
I	Mazoury, Shaghayegh DO	1891372140	SPEC	East Bay Nephrology Medical Group	Solano	Nephrology
I	McCarthy, Joshua C.,MD	1841386240	PCP	Santa Rosa Community Health - Park	Sonoma	Pediatrics
I	McNally, Lynn S.,ACNP-BC	1568538205	SPEC	Adobe PH CA Medical Group PC		Acute Care Nurse Practitioner
R	Merlos, Luis BCBA	1881119808	BHP	Autism Intervention Professionals	Solano	BCBA
I	Meyer, Margaret L.,MD	1639289358	SPEC	Synergy Surgicalists PC	Nevada	Orthopaedic Surgery
I	Moon, Taushona L.,Doula	1578388096	SPEC	Taushona Moon	Humboldt	Doula
I	Moore, Timothy M.,MD	1194427278	PCP	UIHS - Potawot Health Village	Humboldt	Family Medicine
R	Mottaghian, Parivash Psy.D	1558554295	BHP	Chapa-De Indian Health (Auburn)	Placer	Psychology
I	Narciso, Angelina Jasmine BCE	1851116404	BHP	Intercare Therapy	Solano	BCBA
R	Navedo, Laura BCBA	1093215436	BHP	Autism Intervention Professionals	Solano	BCBA

Ap	Full Name	NPI Number	Provider T	Name/Street	County Name	Specialty Description
R	Ndulue, Chukwuemeka MD	1134124001	PCP	Chukwuemeka Ndulue, M.D. -Pediatr	Butte	Pediatrics
I	Nguyen, Paul Q.,DO	1659073112	PCP	Santa Rosa Community Health - Vist	Sonoma	Family Medicine
I	Nopwaskey, Sara L.,FNP-C	1871102228	PCP	Shingletown Medical Center	Shasta	Family Nurse Practitioner
I	Ow, Randall A., MD	1336142009	SPEC	Capital Allergy & Respiratory Disease	Placer	Otolaryngology, Head, and Neck Surg
R	Patterson, Nika A.,FNP-C	1932626728	PCP	Adventist Health Howard Memorial	Mendocino	Family Nurse Practitioner
I	Perez, Amanda M.,SUDCC	1639549017	W&R	Recover Medical Group	Solano	Wellness and Recovery
R	Perry, Sara BCBA	1184151862	BHP	Autism Intervention Professionals	Solano	Board Certified Behavior Analyst
I	Pese, Ashika BCBA	1982290995	BHP	Roman Empire ABA Services Inc.	Solano	BCBA
I	Phillips, Destiny L.,MD	1871236158	SPEC	NBHG: Center for Women's Health, A	Solano	Obstetrics and Gynecology
I	Picanco, Annabeth Doula	1134065519	SPEC	Full Heart Doula Services	Humboldt	Doula
I	Poe, Alexandria BCBA	1609440783	BHP	Alongside	Solano	BCBA
I	Polstin, Angelica M.,CD	1073448189	SPEC	Roots & Wings Doula Services LLC	Napa	Certified Doula
I	PRUITT, JAYA M.,Doula	1447011655	SPEC	SISTERWEB COMMUNITY DOULA	Solano	Doula
R	Ramchandani, Avinash N.,MD	1730358532	SPEC	Providence Medical Group, Sonoma-	Sonoma	Physical Medicine & Rehabilitation
I	Ramirez, Maria Doula	1538028113	SPEC	Mujer Tierra Doula Services	Humboldt	Doula
R	Ramirez, Taylor BCBA	1811497241	BHP	Autism Intervention Professionals	Solano	BCBA
R	Ramos, Ruth R.,FNP-C	1194162859	SPEC	West Coast Kidney	Marin	Family Nurse Practitioner
R	Ramsay, Jacqueline C.,MD	1699470211	PCP	Elica Health Centers-Halyard Medica	Yolo	Family Medicine
I	Rashid, Tasneem J.,MD	1205947926	BOTH	Sutter Coast Community Clinic (PCP	Del Norte	Internal Medicine
I	Reginio, Alisha Dana FNP-C	1407798010	SPEC	Parkhill Health Inc dba AFC Urgent C	Solano	Family Nurse Practitioner
I	Reinhardt, Samantha, Doula	1730870650	SPEC	Samantha Reinhardt Doula	Shasta	Doula
I	Rigby, Alison J.,FNP-BC	1871948398	PCP	Rolling Hills Clinic - PCP	Tehama	Family Nurse Practitioner
I	Robinson, Tracey BCBA	1174965800	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA
I	Romero, Michael D.,PA-C	1427673656	SPEC	Providence Medical Group, Sonoma-	Sonoma	Physician Assistant Certified
I	Ross, Charmaine M.,AMFT	1215770961	W&R	Recover Medical Group	Solano	Wellness and Recovery
I	Rubio Garcia, Manolo MD	1497162440	SPEC	Heart and Vascular Centers of Ameri	Placer	Cardiovascular Disease
R	Ruelas, Maria S.,FNP-C	1265922710	PCP	Chapa-De Indian Health (Auburn)	Placer	Family Nurse Practitioner
R	Sakal, Lijun W.,MD	1225017551	PCP	Feather River Tribal Health (Oroville)	Butte	Family Medicine
I	Salisbury, Gabriella FNP-C	1073444139	SPEC	Pacific Skin Institute	Yolo	Family Nurse Practitioner
I	Sanpedro Duarte, Denis BCBA	1902301302	BHP	Sansid ABA services LLC	Solano	BCBA
I	Scharfen, James L.,MD	1871115147	SPEC	Providence Medical Group, Sonoma	Sonoma	Gastroenterology
R	Schneider, Richard L.,AGACNP	1932748860	BOTH	Adventist Health Mendocino Coast	Mendocino	Adult Gerontology Primary Care Nurse
I	Schuetzle, Casey M.,FNP-C	1376481770	SPEC	North Pacific Dermatology	Humboldt	Dermatology
R	Seibel, Thomas A.,LCSW	1083759013	BHP	Chapa-De Indian Health (Auburn)	Placer	Licensed Clinical Social Worker
I	Sekhon, Pavan BCBA	1417788928	BHP	ACES 2020, LLC	Placer	BCBA
I	Shah, Ishan D.,MD	1245851237	SPEC	Enloe Orthopedic & Trauma Clinic	Butte	Orthopaedic Surgery
R	Shanks, Sky P.,DPM	1932541836	SPEC	BAY AREA FOOT CARE INC	Solano	Podiatry
R	Shaw, Happy S.,FNP-C	1376149864	PCP	MVHC - Fall River Valley Health Cen	Shasta	Family Nurse Practitioner
I	Sheikh, Wasiq MD	1588156608	SPEC	Heart and Vascular Centers of Ameri	Placer	Cardiovascular Disease
I	Siddiqui, Reema BCBA	1497378798	BHP	Sansid ABA services LLC	Solano	BCBA
R	Simonian, Michael BCBA	1992273460	BHP	Autism Intervention Professional LLC	Placer	Board Certified Behavior Analyst
I	Simson, Caitlin BCBA	1699232157	BHP	Burnett Therapeutic Services, Inc.	Napa	Board Certified Behavior Analyst
I	Singh, Birti K.,PA-C	1134728983	BOTH	NorthBay UC and PCP	Solano	Physician Assistant Certified
I	Slouka, Jacob BCBA	1174055198	BHP	Alongside	Solano	BCBA
I	Soares, Andrea N.,MD	1194210195	SPEC	Enloe Northstate Cardiology	Butte	Cardiovascular Disease
I	Solis-Ibarra, Mariana AMFT	1285094326	W&R	Recover Medical Group	Solano	Associate Marriage and Family Therap
R	Solorio, Kimberly BCBA	1417639188	BHP	Kyo Autism Therapy LLC, fka Gatewa	Yolo	Behavioral Health
I	Stack, Brittany F.,BCBA	1083186258	BHP	Ages Learning Solutions LLC	Solano	BCBA
I	Sudhakar, Deepthi MD	1811307051	SPEC	Heart and Vascular Centers of Ameri	Placer	Cardiovascular Disease

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Ap	Full Name	NPI Number	Provider T	Name/Street	County Name	Specialty Description
R	Sullivan, Pamela S., GNP-BC	1336267699	SPEC	Valor Oncology-Chico	Butte	Gerentological Nurse Practitioner
I	Sunenshine, Peter J.,MD	1487610937	SPEC	Dignity Health - Mercy Family Health	Shasta	Neurology
R	Sunley, Nicholas BCBA	1265866552	BHP	Autism Intervention Professionals	Solano	Board Certified Behavior Analyst
I	Tan, Sally CPNP-PC	1568244200	PCP	Pediatric Medical Associates of Sacra	Sacramento	Certified Pediatric Nurse Practitioner
R	Taylor, Christopher BCBA	1609582667	BHP	Autism Intervention Professional LLC	Placer	BCBA
R	Tran, Loan N.,MD	1043292410	SPEC	NBHG: NorthBay Cancer Center - Ra	Solano	Radiation Oncology
I	Trottier, Pamela L.,FNP-C	1164667895	PCP	Rolling Hills Clinic - PCP	Tehama	Family Nurse Practitioner
R	Tyagi, Neha MD	1518372986	PCP	Ampla Health Chico Medical & Pedia	Butte	Family Medicine
I	Tymon, Halee BCBA	1992314520	BHP	Roman Empire ABA Services Inc.	Solano	Board Certified Behavior Analyst
R	Vanoeveren, Kris DC	1336267699	SPEC	Harmony Health Medical Clinic and F	Yu	Chiropractic
R	Vasconcellos, Faye BCBA	1306135835	BHP	Autism Intervention Professionals	Solano	BCBA
I	Vasquez Flores, Georgina A.,SI	1376067348	Allied	Proficio Speech Therapy Group, Inc	Solano	Speech & Language Pathology
R	Vega, Amber BCBA	1104314061	BHP	Autism Intervention Professional LLC	Placer	BCBA
I	Vernon, Alyssa B.,FNP-C	1508652249	PCP	Rolling Hills Clinic - PCP	Tehama	Family Nurse Practitioner
I	Vu, Minh Quan MD	1609484641	SPEC	Mercy Redding Heart Center	Shasta	Cardiothoracic Vascular Surgery
R	Wagner, Jeffrey M.,PT	1578798914	BHP	Valponi & Wagner Physical Therapy,	Butte	Physical Therapy
R	Walker, Karen R.,PA-C	1134883010	BOTH	Western Sierra Medical Clinic (Aubur	Placer	Physician Assistant Certified
I	Wang, Melanie C.,PA-C	1982539094	PCP	MVHC - Burney Health Center	Shasta	Physician Assistant Certified
I	Ward, Ashley BCBA	1225552268	BHP	Kadiant, LLC	Solano	Board Certified Behavior Analyst
I	Ward, Emily R.,LMFT	1912480260	BHP	Rose and Resilience Wellness	Solano	License Marriage and Family Therapis
R	Watts-Brown, CADC I	1922611250	W&R	Humboldt Recovery Center	Eureka	Wellness and Recovery
I	Washington, Travis RADT	1063330603	W&R	Ford Street Project - Ukiah Recovery	Mendocino	Wellness and Recovery
R	Wilkins, Alexandra B., FNP-C	1568008092	PCP	Chapa-De Indian Health (Grass Valle	Nevada	Family Nurse Practitioner
I	Williams, Nastassia BCBA	1942936893	BHP	Pantogran LLC dba Center for Autisr	Solano	BCABA
R	Wirth, Steven C.,MD	1609874510	PCP	Mendocino Community Health Clinic:	Lake	Family Medicine
I	Wood, Camryn BCBA	1235708843	BHP	Learning Arts	Yolo	Board Certified Behavior Analyst
I	Woods, Brenna M.,LMFT	1144551060	W&R	Recover Medical Group	Solano	License Marriage and Family Therapis
R	Woods, David J.,MD	1225038185	SPEC	Reeve Woods Eye Center	Butte	Ophthalmology

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Ap	Full Name	Board Name	Initial Cert Date	Board Certified	Hospital Name	Staff Cat
I	Abraha, Alemseghed W.,MD	ABMS of Family Medicine	07/01/2026	Yes	Admitting Agreement	None
I	Acosta, Samara FNP-C	American Academy of Nurse Practition	08/09/2022	Yes	None	
R	Adams, Robert H.,DO	AOB-Family Medicine	12/02/2013	Yes	Eastern Plumas	Active
I	Albrecht, Carly M., RD	Commission of Dietetic Registration	09/11/2023	Yes	None	
I	Almanza-Soto, Mariana PA-C	National Commission on Certification o	05/08/2026	Yes	None	
I	Alsaleem, Talal H.,LMFT	None		No	None	
R	Angeli, Daniel G.,MD	ABMS of Internal Medicine	08/17/2018	Yes	Admitting Agreement	Active
I	Arndt, Elisabeth A.,DO	ABMS of Family Medicine	07/01/2025	Yes	Admitting Agreement	None
I	Assefa, Betelhem FNP-BC	None		No	None	
R	Austin, Chester J.,MD	ABMS of Family Medicine	07/12/2001	Yes	Admitting Agreement	None
I	Azizian, Fimi Psy.D	None		No	None	
I	Ballou, Willie B.,ANP-C	American Academy of Nurse Practition	02/25/2015	Yes	None	
I	Barnes, Nolan A.,PA-C	National Commission on Certification o	02/13/2025	Yes	None	
I	Bartholomew, Willow A.,PA	None		No	None	
R	Bauer, Eric J.,MD	ABMS of Family Medicine	04/28/2023	Yes	Adventist - Ukiah Valley	Active
I	Baum, Caroline BCBA	Behavior Analyst Certification Board	06/08/2021	Yes	None	
R	Behrens, Kyle A.,LMFT	None		No	None	
I	Benefiel, Jesse P.,SUDRC I	California Substance Use Disorder	07/12/2026	Yes	None	
I	Benjelloun, Nouhayla BCBA	Behavior Analyst Certification Board	02/26/2024	Yes	None	
I	Biglarderi, Jazmyne M.,BCBA	Behavior Analyst Certification Board	03/27/2026	Yes	None	
I	Black, Melanie M.,PA-C	None		No	None	
I	Blake, Tierra R.,Doula	None		No	None	
R	Bland, Sarah J.,FNP-C	American Academy of Nurse Practition	06/20/2017	Yes	None	
R	Blawn, Janet L.,LCSW	None		No	None	
I	Blundell, Matthew C.,MD	Meets MPCR#17, Previously Board Ce	08/21/1996	No	Admitting Agreement	None
R	Boening, Rebecca R.,MD	ABMS of Pediatrics	10/15/2020	Yes	Admitting Agreement	None
R	Botelho, Ronald J.,MD	None		No	Adventist Health Clear Lake	None
I	Boucher, Daniel E.,MD	ABMS of Family Medicine	07/01/2026	Yes	Admitting Agreement	None
R	Brooks, Michael P.,DPM	None		No	Eastern Plumas	Active
I	Brown, Dawn Doula	None		Not Applicable	None	
I	Brown, Derrick S.,MD	ABMS of Family Medicine	07/01/2015	Yes	Admitting Agreement	None
I	Brown, Mark R.,FNP-C	American Academy of Nurse Practition	01/13/2025	Yes	None	
I	Bruce, Jaye S.,CD	DONA International		Yes	None	
R	Buchanan, Russell A.,SUDCC	California Substance Use Disorder	11/21/2024	Yes	None	
I	Bueno, Charlene Mae F.,PT	None		No	None	
R	Bugna, Eric E.,MD	ABMS of Orthopaedic Surgery	09/05/1980	Yes	Eastern Plumas	Active
R	Bunting, Michelle A.,BCBA	Behavior Analyst Certification Board	09/02/2020	Yes	None	
I	Burch, Stevie BCBA	Behavior Analyst Certification Board	11/29/2021	Yes	None	
I	Bush, Cory SUDCC	California Substance Use Disorder	12/19/2025	Yes	None	
I	Calabretta, Natalie PA-C	None		No	None	
I	Cao, Fei MD	None		No	NorthBay Medical Center/ NorthBay VacaValley Hospital	Active Non-Attending
I	Chairez, Luz SUDCC III	California Substance Use Disorder	08/04/2026	Yes	None	
R	Changezi, Ammar H.,MD	ABMS of Pediatrics	10/09/2015	Yes	Admitting Agreement	None
I	Chappell, Jeaneen A.,MD	ABMS of Dermatology	07/24/2014	Yes	Admitting Agreement	None
I	Chavez, Brandi BCBA	Behavior Analyst Certification Board	11/25/2025	Yes	None	
I	Clark, Ames BCBA	Behavior Analyst Certification Board	12/13/2021	Yes	None	
I	Cope, Emily E.,FNP-C	American Academy of Nurse Practition	05/08/2026	Yes	None	
I	Cornelius, Alexis BCBA	Behavior Analyst Certification Board	07/25/2025	Yes	None	
R	Cunningham, Emmett T.,Jr., MI	ABMS of Ophthalmology	10/13/1996	Yes	Admitting Agreement	None

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Ap	Full Name	Board Name	Initial Cert Date	Board Certified	Hospital Name	Staff Cat
I	Davis, Eric BCBA	Behavior Analyst Certification Board	01/28/2026	Yes	None	
R	DeLaughter, Tina L.,LCSW	None		No	None	
I	Dentico, Amy Doula	None		Not Applicable	None	
I	Deol, Kulwinder K.,FNP-C	American Academy of Nurse Practition	02/08/2017	Yes	None	
I	Dhond, Milind R.,MD	ABMS of Internal Medicine	11/03/1999	Yes	Plumas District Hospital	Active
I	Diallo, Ismael MD	ABMS of Surgery	03/25/2025	Yes	Sutter Coast Hospital	Active
I	Diaz, Corrina BCBA	Behavior Analyst Certification Board	08/31/2014	Yes	None	
I	Do, Hulbert N.,MD	ABMS of Internal Medicine	11/08/2013	Yes	Admitting Agreement	None
I	Donde, Nikunj N.,MD	Meets MPCR#17, verified residency by		No	Admitting Agreement	None
I	Donner, David W.,MD	ABMS of Family Medicine	08/04/2022	Yes	Admitting Agreement	None
I	Dubrouillet, Julie Doula	None		No	None	
R	Eaker, Julie A.,PA-C	National Commission on Certification c	09/11/2014	Yes	None	
R	Eargle, Amy E.,Psy.D	None		No	None	
R	Eisfeld, Ashley BCBA	Behavior Analyst Certification Board	08/31/2019	Yes	None	
I	Engle, Anastasia Doula	None		Not Applicable	None	
I	Enright, Masyn DO	Meets MPCR#17, verified residency by		No	Admitting Agreement	None
R	Fender, Sarah FNP-C	American Academy of Nurse Practition	07/02/2020	Yes	None	
I	Filbert, Nicole PA-C	National Commission on Certification c	06/09/2023	Yes	None	
I	Flores, Erik BCBA	Behavior Analyst Certification Board	08/31/2017	Yes	None	
I	Fontanilla, Alexandra J.,PNP	Pediatric Nursing Certification Board	04/15/2026	Yes	None	
I	Forster, Amber M.,FNP-C	American Academy of Nurse Practition	06/01/2012	Yes	None	
I	Francescone, Cam PA-C	National Commission on Certification c	01/09/2015	Yes	None	
I	French, Emily M.,PMHNP-BC	American Nurses Credentialing Center	07/29/2025	Yes	None	
I	Gaeto, Hollie L.,DO	ABMS of Family Medicine	07/01/2027	Yes	Admitting Agreement	None
I	Galliano, Lynn E.,BCBA	Behavior Analyst Certification Board	11/30/2016	Yes	None	
R	Garrido, Health L., PA-C	National Commission on Certification c	07/22/2010	Yes	None	
R	Gerber, Heather S.,SUDCC	California Substance Use Disorder	11/12/2025	Yes	None	
I	Goel, Kunal O.,MD	ABMS of Internal Medicine	08/26/2025	Yes	Adventist Health Medocino Coast	Provisional
I	Greenlee, Zacharia D.,PA-C	National Board of Certification & Recer	04/17/2014	Yes	None	
I	Grenet, Justin E.,MD	None		No	Admitting Agreement	None
R	Gryunshpan, Mariya BCBA	Behavior Analyst Certification Board	05/31/2014	Yes	None	
I	Gunter, John D.,SUDRC I	California Substance Use Disorder	06/05/2026	Yes	None	
I	Guy, Samantha L.,PA-C	National Commission on Certification c	06/27/2013	Yes	None	
I	Hall, Sacha B.,PA-C	National Commission on Certification c	05/18/2017	Yes	None	
I	Harwood, Jared L.,MD	ABMS of Orthopaedic Surgery	12/04/2020	Yes	Admitting Agreement	None
R	Hazim, Hani BCBA	Behavior Analyst Certification Board	02/28/2018	Yes	None	
I	Heldt, Amanda N.,AMFT	None		No	None	
R	Hering, Kelly J.,FNP-BC	American Nurses Credentialing Center	12/01/1998	Yes	None	
I	Herrera, Sarah J.,PA-C	National Commission on Certification c	02/14/2013	Yes	None	
R	Hibler, John T.,DO	AOB of Dermatology	11/30/2016	Yes	Eastern Plumas	Active
I	Higgins, Tracy K.,FNP-BC	American Nurses Credentialing Center	06/01/2022	Yes	None	
I	Horvath, Patricia S.,FNP-BC	American Nurses Credentialing Center	09/29/2017	Yes	None	
I	Hsieh, Stephanie PA-C	National Commission on Certification c	06/16/2023	Yes	None	
I	Hunt, Joel J.,PA-C	National Commission on Certification c	09/04/2008	Yes	None	
I	Huntley, Vincent L.,FNP-C	American Academy of Nurse Practition	06/24/2025	Yes	None	
I	Ignatova, Elizaveta MD	ABMS of Pediatrics	10/13/2023	Yes	Marin Health Medical Center	Active
I	Joe, Julie BCBA	Behavior Analyst Certification Board	10/13/2021	Yes	None	
I	John, Alan K., MD	ABMS of Internal Medicine	10/04/2021	Yes	Admitting Agreement	None
I	Johnson, Anthony S.,PA-C	National Commission on Certification c	11/21/2024	Yes	None	

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Ap	Full Name	Board Name	Initial Cert Date	Board Certified	Hospital Name	Staff Cat
R	Johnson, Jeremy V.,MD	ABMS of Family Medicine	04/24/2023	Yes	Admitting Agreement	None
R	Jones, Sidney G.,MD	ABMS of Orthopaedic Surgery	07/24/2022	Yes	Enloe Medical Center	Active
R	Jornlin, William A.,MD	ABMS of Family Medicine	07/09/1999	Yes	Admitting Agreement	None
I	Juarez Casillas, Jesus E., MD	Meets MPCR #17, Verified Residency on	AMA/AOIA	No	Admitting Agreement	None
R	Kalk, Eileen R.,PA-C	National Commission on Certification o	10/14/2004	Yes	None	
R	Kanat, Alexandra CNM	American Midwifery Certification Board	07/01/2019	Yes	None	
R	Karr, Michael R.,SUDRC II	California Substance Use Disorder	07/13/2026	Yes	None	
I	Kellogg, Alexandra K., PA-C	National Board of Certification & Recer	01/15/2025	Yes	None	
R	Kelso, Jessica BCBA	Behavior Analyst Certification Board	05/31/2018	Yes	None	
I	King-Jacobs, Mellissa FNP-C	None		No	None	
R	Kingsley, Jolene A., DO	ABMS of Family Medicine	12/05/2003	Yes	Mercy Medical Center of Redding	Courtesy
I	Koenig, Katherine BCBA	Behavior Analyst Certification Board	08/31/2017	Yes	None	
I	Kolosky, Matthew J.,DO	AOB of Pediatrics	08/02/2017	Yes	Sutter Coast Hospital	Active
I	Kramer, Andrea M.,BCBA	Behavior Analyst Certification Board	06/14/2021	Yes	None	
I	Lafosse, Juan E.,FNP-C	American Academy of Nurse Practition	11/22/2017	Yes	None	
I	Lake, Curtis E.,PA-C	National Commission on Certification o	09/07/2017	Yes	None	
R	Lambert, Emily BCBA	Behavior Analyst Certification Board	01/31/2023	Yes	None	
I	Lane, Jack C.,DO	AOB-Family Medicine	10/25/1996	Yes	Admitting Agreement	None
R	Lazarewicz, Nicolas R.,FNP-C	American Academy of Nurse Practition	08/01/2009	Yes	None	
R	Lee, Jennifer BCBA	Behavior Analyst Certification Board	05/31/2015	Yes	None	
R	Lee, Nora H.,PA-C	National Commission on Certification o	06/11/2015	Yes	None	
R	LeFever, Danielle L., OD	None		No	Admitting Agreement	None
R	Lettow, Lindsay BCBA	Behavior Analyst Certification Board	08/31/2019	Yes	None	
I	Lew, Jarrett R.,PA-C	National Commission on Certification o	02/12/2021	Yes	None	
R	Linderman, Jessica BCBA	Behavior Analyst Certification Board	08/31/2019	Yes	None	
R	Loja, Melissa N.,MD	ABMS Vascular Surgery	05/20/2019	Yes	NorthBay Medical Center/ NorthBay VacaValley Hospital	Active, Attending
R	Lombardo, Delanie BCBA	Behavior Analyst Certification Board	08/31/2019	Yes	None	
I	Lopez, Jacob BCBA	Behavior Analyst Certification Board	02/26/2026	Yes	None	
I	Maalouf, Nicholas DO	Meets MPCR#17, verified residency by		No	NorthBay Health VacaValley Hospital	Active Non-Attending
I	Macapagal, Sharina C.,MD	Meets MPCR#17, verified residency by		No	Admitting Agreement	None
I	Magana, Jazzelle BCBA	Behavior Analyst Certification Board	04/08/2026	Yes	None	
I	Magnini, Grace CD	Childbirth International		Yes	None	
I	Malik, Riaz A.,MD	None		No	Shasta Regional Medical Center	Active
I	Malik, Yusria R.,MD	ABMS of Obstetrics and Gynecology	12/09/2019	Yes	Providence St. Joseph Hospital, Eureka	Provisional
I	Mansilla, Olivia A.,MD	ABMS of Internal Medicine	08/19/2003	Yes	Admitting Agreement	None
R	Manzano, Samantha M.,FNP-C	American Academy of Nurse Practition	07/13/2020	Yes	None	
R	Marinero, Herman BCBA	Behavior Analyst Certification Board	02/28/2018	Yes	None	
I	Marwah, Gurjit S.,MD	ABMS of Pediatrics	10/18/2012	Yes	Admitting Agreement	None
I	Matson, Lisa PA-C	National Commission on Certification o	10/09/2025	Yes	None	
I	Mazoury, Shaghayegh DO	None		No	Admitting Agreement	Active
I	McCarthy, Joshua C.,MD	ABMS of Pediatrics	10/16/2007	Yes	Admitting Agreement	None
I	McNally, Lynn S.,ACNP-BC	American Nurses Credentialing Center	01/21/2005	Yes	None	
R	Merlos, Luis BCBA	Behavior Analyst Certification Board	05/31/2017	Yes	None	
I	Meyer, Margaret L.,MD	ABMS of Orthopaedic Surgery	07/28/2006	Yes	Sierra Nevada Memorial Hospital	Active
I	Moon, Taushona L.,Doula	None		No	None	
I	Moore, Timothy M.,MD	ABMS of Family Medicine	07/01/2026	Yes	Mad River Community Hospital	None
R	Mottaghian, Parivash Psy.D	None		No	None	
I	Narciso, Angelina Jasmine BCE	Behavior Analyst Certification Board	11/13/2025	Yes	None	
R	Navedo, Laura BCBA	Behavior Analyst Certification Board	11/30/2017	Yes	None	

Ap	Full Name	Board Name	Initial Cert Date	Board Certified	Hospital Name	Staff Cat
R	Ndulue, Chukwuemeka MD	Meets MPCR#17, Previously Board Ce	10/28/1992	No	Admitting Agreement	None
I	Nguyen, Paul Q.,DO	ABMS of Family Medicine	07/01/2026	Yes	Admitting Agreement	None
I	Nopwaskey, Sara L.,FNP-C	American Academy of Nurse Practition	06/26/2020	Yes	None	
I	Ow, Randall A., MD	ABMS of Otolaryngology	05/10/1999	Yes	Sutter Roseville Medical Center	Active
R	Patterson, Nika A.,FNP-C	American Academy of Nurse Practition	07/14/2017	Yes	None	
I	Perez, Amanda M.,SUDCC	California Substance Use Disorder	02/12/2026	Yes	None	
R	Perry, Sara BCBA	Behavior Analyst Certification Board	02/28/2017	Yes	None	
I	Pese, Ashika BCBA	Behavior Analyst Certification Board	08/04/2022	Yes	None	
I	Phillips, Destiny L.,MD	Meets MPCR#17, verified residency by		Yes	Admitting Agreement	None
I	Picanco, Annabeth Doula	None		Not Applicable	None	
I	Poe, Alexandria BCBA	Behavior Analyst Certification Board	07/31/2024	Yes	None	
I	Polstin, Angelica M.,CD	DONA International	06/30/2026	Yes	None	
I	PRUITT, JAYA M.,Doula	None		Not Applicable	None	
R	Ramchandani, Avinash N.,MD	ABMS of Physical Medicine & Rehabili	07/01/2012	Yes	Admitting Agreement	None
I	Ramirez, Maria Doula	None		No	None	
R	Ramirez, Taylor BCBA	Behavior Analyst Certification Board	11/30/2017	Yes	None	
R	Ramos, Ruth R.,FNP-C	American Academy of Nurse Practition	09/26/2012	Yes	None	
R	Ramsay, Jacqueline C.,MD	Meets MPCR#17, Previously Board Ce	07/12/1996	No	Admitting Agreement	None
I	Rashid, Tasneem J.,MD	ABMS of Internal Medicine	08/24/1994	Yes	Sutter Coast Hospital	Active
I	Reginio, Alisha Dana FNP-C	American Academy of Nurse Practition	03/17/2026	Yes	None	
I	Reinhardt, Samantha, Doula	None		No	None	
I	Rigby, Alison J.,FNP-BC	American Nurses Credentialing Center	08/20/2015	Yes	None	
I	Robinson, Tracey BCBA	Behavior Analyst Certification Board	04/30/2021	Yes	None	
I	Romero, Michael D.,PA-C	National Commission on Certification o	11/17/2021	Yes	None	
I	Ross, Charmaine M.,AMFT	California Substance Use Disorder	10/01/2025	Yes	None	
I	Rubio Garcia, Manolo MD	ABMS of Internal Medicine	08/13/2020	4/1/2027	Admitting Agreement	None
R	Ruelas, Maria S.,FNP-C	American Academy of Nurse Practition	05/25/2018	Yes	None	
R	Sakal, Lijun W.,MD	ABMS of Family Medicine	07/12/2002	Yes	Admitting Agreement	None
I	Salisbury, Gabriella FNP-C	American Academy of Nurse Practition	05/21/2026	Yes	None	
I	Sanpedro Duarte, Denis BCBA	Behavior Analyst Certification Board	03/25/2022	Unknown	None	
I	Scharfen, James L.,MD	None		No	Admitting Agreement	None
R	Schneider, Richard L.,AGACNP	American Nurses Credentialing Center	09/23/2019	Yes	None	
I	Schuetzle, Casey M.,FNP-C	None		No	None	
R	Seibel, Thomas A.,LCSW	None		No	None	
I	Sekhon, Pavan BCBA	Behavior Analyst Certification Board	04/16/2026	Yes	None	
I	Shah, Ishan D.,MD	Meets MPCR #17, Verified Residency		No	Enloe Medical Center	Provisional
R	Shanks, Sky P.,DPM	None		No	Providence Queen of the Valley Medical Center	Active
R	Shaw, Happy S.,FNP-C	American Academy of Nurse Practition	09/21/2020	Yes	None	
I	Sheikh, Wasiq MD	ABMS of Internal Medicine	10/29/2024	Yes	Admitting Agreement	None
I	Siddiqui, Reema BCBA	Behavior Analyst Certification Board	03/26/2022	Yes	None	
R	Simonian, Michael BCBA	Behavior Analyst Certification Board	06/23/2022	Yes	None	
I	Simson, Caitlin BCBA	Behavior Analyst Certification Board	07/15/2026	Yes	None	
I	Singh, Birti K.,PA-C	National Commission on Certification o	05/04/2022	Yes	None	
I	Slouka, Jacob BCBA	Behavior Analyst Certification Board	02/28/2017	Yes	None	
I	Soares, Andrea N.,MD	ABMS of Internal Medicine	10/28/2025	Yes	Enloe Medical Center	Provisional
I	Solis-Ibarra, Mariana AMFT	None		No	None	
R	Solorio, Kimberly BCBA	Behavior Analyst Certification Board	07/31/2023	Yes	None	
I	Stack, Brittany F.,BCBA	Behavior Analyst Certification Board	06/22/2020	Yes	None	
I	Sudhakar, Deepthi MD	ABMS of Internal Medicine	10/13/2020	Yes	Admitting Agreement	None

September 2026
Routine Practitioner List

Ap	Full Name	Board Name	Initial Cert Date	Board Certified	Hospital Name	Staff Cat
R	Sullivan, Pamela S., GNP-BC	American Nurses Credentialing Center	04/01/2003	Yes	None	
I	Sunenshine, Peter J.,MD	ABMS of Psychiatry & Neurology	04/01/2005	Yes	Banner Lassen Medical Center	Active
R	Sunley, Nicholas BCBA	Behavior Analyst Certification Board	08/31/2017	Yes	None	
I	Tan, Sally CPNP-PC	Pediatric Nursing Certification Board	08/25/2023	Yes	None	
R	Taylor, Christopher BCBA	Behavior Analyst Certification Board	12/13/2022	Yes	None	
R	Tran, Loan N.,MD	ABMS of Radiology	06/12/1996	Yes	NorthBay Medical Center/ NorthBay VacaValley Hospital	Active, Attending
I	Trottier, Pamela L.,FNP-C	American Academy of Nurse Practition	10/01/2008	Yes	None	
R	Tyagi, Neha MD	Meets MPCR#17, verified residency by		Not Applicable	Admitting Agreement	None
I	Tymon, Halee BCBA	Behavior Analyst Certification Board	11/13/2023	Yes	None	
R	Vanoeveren, Kris DC	None		No	None	
R	Vasconcellos, Faye BCBA	Behavior Analyst Certification Board	12/31/2004	Yes	None	
I	Vasquez Flores, Georgina A.,SI	None		Yes	None	
R	Vega, Amber BCBA	Behavior Analyst Certification Board	12/07/2021	Yes	None	
I	Vernon, Alyssa B.,FNP-C	American Academy of Nurse Practition	03/19/2025	Yes	None	
I	Vu, Minh Quan MD	Meets MPCR#17 Confirmed per AMA, AOA, ABFAS, or		No	Mercy Medical Center of Redding	Active
R	Wagner, Jeffrey M.,PT	None		No	None	
R	Walker, Karen R.,PA-C	National Commission on Certification o	10/22/2021	Yes	None	
I	Wang, Melanie C.,PA-C	National Commission on Certification o	04/13/2026	Yes	None	
I	Ward, Ashley BCBA	Behavior Analyst Certification Board	05/31/2017	Yes	None	
I	Ward, Emily R.,LMFT	None		No	None	
R	Watts-Brown, CADC I	California Consortium of Addiction Pro	10/14/2020	Yes	None	
I	Washington, Travis RADT	California Consortium of Addiction Pro	05/04/2026	Yes	None	
R	Wilkins, Alexandra B., FNP-C	American Academy of Nurse Practition	09/16/2019	Yes	None	
I	Williams, Nastassia BCBA	Behavior Analyst Certification Board	08/31/2018	Yes	None	
R	Wirth, Steven C.,MD	ABMS of Family Medicine	07/08/1988	Yes	Admitting Agreement	None
I	Wood, Camryn BCBA	Behavior Analyst Certification Board	09/10/2024	Yes	None	
I	Woods, Brenna M.,LMFT	None		No	None	
R	Woods, David J.,MD	ABMS of Ophthalmology	10/26/2008	Yes	Enloe Medical Center	Active

January 1, 2027 – December 31, 2027 (quarterly incentive payout)

Key: New Measure | Change to Measure | Remove Measure

Approved 2027 Measures (Q1 2027 only)	Proposed 2027 Measures (Q2-Q4 2027)
Gateway Measure: Timely Reporting Providers are required to submit three monthly reports on or before their due date. Incentive: TBD Dollars earned are placed into an incentive pool. • 100% is placed in incentive pool if all reports are received on or before due date. • 50% is placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date. • Reports received after five (5) business days will not be eligible for an incentive pool or participation in program measures.	**Change to measure: TBD** (Incentive pool rate will be equal to 25% of the monthly payment amount (excluding engagement payments).
Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare Providers are required to upload a Care Plan and ROI forms into PointClickCare for all ECM enrolled members within 60 days of TAR request date. Targets: • Full credit: > 70% • Partial credit: 60% - 69% No reporting to Partnership is required.	**Keep measure - no changes**
Measure 2: Depression Screening Depression screening is required for all ECM enrolled members, ages 12 years and older. Targets: • Full credit: > 90% • Partial credit: 80% - 89% Providers will submit a quarterly screening template.	**Remove measure**

Measure 3: Blood Pressure Screening Blood pressure screening is required for all ECM enrolled members ages 18 years and older. Targets: • Full credit: > 80% • Partial credit: 70% - 79% Providers will submit a quarterly screening template.	**Remove measure**
Measure 4: Timely Review of ED / Admissions Notifications in PointClickCare **Part 1:** New ECM providers are required to set up the Notification Alerts function in PointClickCare by contacting PointClickCare for assistance. Targets: • Full credit. • No partial credit **Part 2:** Providers are required to review ED/Admissions notifications received in PointClickCare within 72 hours of receiving notifications. Targets: • Full credit: ≥ 70% • Partial credit: 60-69% No reporting to Partnership is required	**Keep measure - no changes**

.	[9] **New Measure: PCP Connectedness** Description: Providers are incentivized to assist ECM members with reconnecting to their Primary Care Provider (PCP). Data must show at least one (1) PCP encounter (in-person or virtual visit) within the 2027 measurement year (January 1, 2026 – December 31, 2027). Incentive pool allotment: 25% Numerator: One (1) or more billed PCP encounters per year Targets: • Full credit: TBD • No partial credit No reporting to Partnership is required. Partnership will obtain and view data for evidence of PCP encounter(s).
	New Measure: Avoiding ED/IP Visits Description: Providers are incentivized for no avoidable emergency department (ED) visits or inpatient (IP) hospital admissions during one or more months of the quarter. Incentive pool allotment: 25% Numerator: • No avoidable ED visit or hospital admission for three (3) months in a quarter Targets: • Full credit: % TBD • Partial credit: % TBD No reporting to Partnership required. Partnership will obtain and review data as evidence that no visits occurred.