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.
Vacant, 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 9, 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, October 14, 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

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: October 14, 2026 Time: 7:30 – 9:00 a.m. Location: Partnership

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

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

Partnership – Redding Office
2525 Airpark Drive
Redding, CA

Partnership – Eureka Office
1036 5th Street
Eureka, CA

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

PUBLIC COMMENTS	Speaker	2 minutes
	Speaker	2 minutes

This Brown Act meeting may be recorded. Any audio or video tape record of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions

I.		EXECUTIVE OFFICE UPDATES	LEAD		TIME
A.	I	**Chief Executive Officer Administration Updates**	**Ms. Barresi**		**7:35**
B.	I	**Chief Medical Officer Health Services Report**	**Dr. Moore**		**7:45**
C.	I	**Deputy Chief Medical Officer Activities Report**	**Dr. Jones**		**7:55**
II.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	A	**Review of September 9, 2026, PAC Minutes**	**Dr. Moore**	**5**	**8:05**
B.	A	**Consent Review: Agenda Items II. B.1, B.2, B.5, B.6, and B.7.** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Moore**	**21 - 185**	**8:07**

1	C	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments –**
		
		September 2026
		Acceptance of Meeting Materials
		• Internal Quality Improvement Meetings, September 8, 2026
		  • Agenda
		  • Minutes
		• Quality / Utilization Advisory Committee, September 16, 2026
		  • Agenda
		  • Minutes
		  • Quality Improvement Update
		
		Special Presentations (not included in the packet, for reference only)
		Grand Analysis: Network Access Assessment of Network Adequacy – Calendar Year 2025
			Dr. Moore	**21**
				23
				
				30
				32
				39
					8:07

II.B	C	MOTIONS FOR APPROVAL, Continued	LEAD	PG	TIME
2	C	***Policies/Procedures/Guidelines for Action*** *Redline versions appear in the packet.* **Provider Relations** MPPRGR210 — Provider Grievance **Quality Improvement** MPQD1002 — Quality/Utilization Advisory Committee MPQP1008 — Conflict of Interest Policy for QI Activities MPQP1022 — Site Review Requirements & Guidelines (with four changed attachments) MPQP1053 — Peer Review Committee **Utilization Management** MCUG3022 — Incontinence Guidelines MCUG3058 — Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities MCUP3115 — Community Based Adult Services MPUP3059 — Negative Pressure Wound Therapy (NPWT) Device/Pump MPUP3078 — Second Medical Opinions **Policy Summary** **Detailed Synopsis of Changes**	**Dr. Moore**	**55** **59** **64** **67** **105** **110** **121** **128** **137** **142** **52** **53**	**7:58**
3	*C*	*Pharmacy & Therapeutics Committee*	*Dr. Stan Leung*		
4	*C*	*Provider Education & Networking (PEN) Meeting*	*Mr. Brincko*		
5	C	**Credentials Committee Meeting, August 13, 2026** • Summary • Credentialed List	**Dr. Netherda**	**145** **153**	**8:07**
6	C	**Pediatric Quality Committee, August 18, 2026** Meeting Minutes	**Dr. Ribordy**	**161**	**8:07**
7	C	**Quality Improvement Health Equity Committee, September 15, 2026** • Meeting Minutes	**Dr. Jalloh**	**170**	**8:07**
III.	**I**	**EXECUTIVE MEMBER UPDATE**	**LEAD**	**PG**	**TIME**
A.	**I**	**Dr. Harry Ko, Medical Director, Feather River Tribal Health**	**Dr. Ko**	**186**	**8:10**
V.	**I**	**REGIONAL MEDICAL DIRECTOR REPORTS**	**LEAD**		**TIME**
A.	**I**	**Napa, Yolo & Solano**	**Ms. Power**		**8:20**
B.	**I**	**Marin & Sonoma**	**Dr. Ward**		**8:23**
C.	**I**	**Del Norte, Humboldt, Mendocino & Lake**	**Dr. Ribordy**		**8:26**
D.	**I**	**Glenn, Butte, Sutter, Colusa & Yuba,**	**Dr. Matthews**		**8:29**
E.	**I**	**Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama**	**Dr. Matthews**		**8:32**
F.	**I**	**Plumas, Sierra, Nevada & Placer**	**Dr. Morris**		**8:35**
V.	*I*	*Old Business*	*Dr. Moore*		

VI.	I	SPECIAL PRESENTATIONS	LEAD	PG	TIME
A.	**I**	**National Coalition for Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set (HEDIS©) Star Rating**	**Ms. Gual**	**188**	**8:38**
B.	**I**	**Quality Improvement Strategic Plan**	**Ms. Gual**	**196**	**8:43**
VII.	**I**	**ADJOURNMENT**	**LEAD**		**TIME**
		Next PAC on November 4, 2026 at 7:30 a.m. *Adjusted for Veterans' Day Holiday on November 11, 2026*	**Dr. Moore**		**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: **September 9, 2026 - 7:30 to 9:00 a.m.**

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

Members Present:

Angela Brennan, DO *(FF)*
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)*
Karina Gookin, MD *(AU)*
Darrick Nelson, MD *(R)*
Leigh Vall-Spinosa, MD *(SR)*
Christina Lasich, MD *(SL)*
Danielle Oryn, DO *(AL)*
Mills Matheson, MD *(OMM)*
Derice Seid, MD *(MCC)*
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:

Steven Gwiazdowski, MD
Zoe Cappe, MD
Betzabel Kunkel, 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	18/21 – PAC	Committee quorum requirements met (18).	09/09/26

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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 Executive Officer presented an administrative update on Partnership activities.**
	
	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 85,000 Partnership members.
	• The transition work is substantial and Partnership teams have begun work to minimize disruption to care for affected members.
	• Continuity-of-care planning is being prioritized for members receiving specialty services, chemotherapy, physical therapy, and other active treatments.
	• Additional attention is being directed to members with procedures scheduled after the transition date.
	• Care Coordination staff are using treatment authorization request (TAR) data to identify affected members and active services.
	• Provider participation in state Medi-Cal is being assessed so replacement providers can be located when necessary.
	• Clarification is still being awaited from Department of Health Care Services (DHCS) regarding the state TAR, including how Partnership authorizations will be received and honored as well as what additional provider steps would be required.
	• Although the scale and complexity of the transition is challenging, Partnership experienced a similar transition of approximately 90,000 members to Kaiser under a direct contract in 2024.
	• The present transition is more variable because provider approaches would differ across the state.
	• Partnership intends to transmit TAR information to the state and advocate for a process that minimizes provider burden.
	• Specific state contact information, telephone numbers, websites, and responsible divisions were requested so that providers and referral staff would know where assistance could be obtained beginning January 1.
	• Reliable guidance for specific state contact information, telephone numbers, websites, and responsible division will be translated into clear instructions and distributed to the provider network as it becomes available.
	
	Community-engagement Requirements and Medical-frailty exemptions
	• Preparation for new community-engagement requirements is occurring concurrently with the transition work.
	• Major eligibility-system changes are being developed by California while additional direction continues to be received from Centers for Medicare & Medicaid Services (CMS).
	• Recent CMS guidance on medical-frailty exemptions was summarized as a three-tier approach.
	  o **Tier 1:** Automatic exemptions are expected to be generated from qualifying ICD-10 diagnosis codes without individual clinician letters.
	  ▪ Acute systolic heart failure and alcohol dependence with withdrawal delirium were cited as examples from preliminary federal materials.
	  ▪ California's final Tier 1 list has not yet been determined and will require CMS approval.
	  ▪ State Tier 1 lists will need to be auditable and actively maintained.
	  o **Tier 2:** Case-management notes, utilization patterns, and other data could be considered when no single qualifying diagnosis code was present but the record demonstrated that the requirement could not reasonably be met.
	  o **Tier 3:** Manual clinical review and supporting documentation will be required for short-term circumstances or cases unresolved through Tiers 1 or 2.
	• Diagnoses could be added when demonstrated that affected members could not meet the requirements and removed when the exemption is not justified.
	• California's implementation approach remains under development because the CMS guidance has only recently been released.
	• During the first year, members are expected to be allowed to self-attest monthly that a medical condition prevents compliance.
	• The final self-attestation form and submission method has not yet been provided.
	• Self-attestation will not be permanent and will need to be completed for each applicable month.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report, Continued	**Community-engagement Hours and Unemployment exemptions** • The federal requirement could be satisfied through either 80 monthly hours or a specified earnings threshold. • Because California's minimum wage is higher, fewer than 80 work hours might be required to meet the earnings threshold. • An automatic county-level exemption was described for residents of counties with unemployment above 8 percent or 1.5 times the federal unemployment rate. • The exemption would be calculated monthly by the state rather than individually claimed. • Administration would be complicated because final unemployment data became available only after the month ended. • The exemption was expected to support retroactive eligibility determinations. • Potential federal enforcement mechanisms were discussed, including concern that delayed Medicaid payments would be especially disruptive.
I.B Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented the following Health Services report.** **Developmental Screening for Children and Follow-up Care** • A partnership between Chapa-De Indian Health and the UC Davis MIND Institute has a promising pilot with lessons that may be useful to the broader network. • A chart review showed recommended developmental screening was completed only in approximately one in three children. • Timely diagnostic follow-up has been difficult to obtain, and the piloted model would allow health centers to assume selected diagnostic functions commonly performed by regional centers in terms of diagnostic workup at various levels. • A webinar on developmental screening and follow-up is planned for September. Organizations are encouraged to send clinical or administrative staff involved in pediatrics or pediatric developmental care. **National Coalition Quality Assurance (NCQA)/ Healthcare Effectiveness Data and Information Set© (HEDIS) results and Statin performance** • Final NCQA/HEDIS results are planned for committee review in October after ratings are available. • Preliminary review had identified four statin-related measures outside the Managed Care Accountability Set (MCAS) as significant contributors to the plan rating. • Statin use among members with conditions including diabetes and coronary artery disease had fallen below minimum performance levels (MPL). • Improving each of the four measures by one performance level could have increased the overall rating by approximately one-half star. • Academic detailing with Partnership Pharmacy staff is available to obtain provider-specific prescribing data and review organizational patterns. • Participation in pharmacy consultation is encouraged because it also supports an existing Quality Incentive Program measure.

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AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**August 12, 2026, PAC minutes were presented for approval.**	**MOTION:** Dr. Montenegro moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Austin. **ACTION SUMMARY:** [17] yes, [0] no, [1] abstentions.	09/09/26 Motion carried.
II.B. II.B.1 II.B.2 II.B.3 II.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – August 2026 • Policies, Procedures, and Guidelines for Action Policy Summary, September 9, 2026 • Credentials Committee Meeting Summary & Credentialed List, July 8, 2026 • Quality Improvement Health Equity Committee Summary, July 21, 2026	**MOTION:** Dr. Austin moved to approve Agenda II.B.1, II.B.2, II.B.5 and II.B.7 with modification to policy MCUP3052, Medical Nutrition Therapy (MNT) Services, to correct CDE (Certified Diabetes Educator) to CDCES (Certified Diabetes Care and Education Specialist), consistent with the Certification Board for Diabetes Care and Education, seconded by Dr. Herman. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
II.C	**PAC Member Nomination of Dr. Harry Ko**	**MOTION:** Mr. McDermott moved to approve Agenda item II.C.A as presented, seconded by Dr. Zavod. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.A	**Enhanced Care Management Quality Improvement Program (QIP) Measure Set Proposal 2027**	**MOTION:** Dr. Austin moved to approve Agenda item VI.A as presented, seconded by Dr. Montenegro **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.B	**Extended Care Center QIP Measure Set Proposal 2027**	**MOTION:** Dr. Montenegro moved to approve Agenda item VI.B as presented, seconded by Dr. Herman. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.C	**Hospital QIP Measure Set Proposal 2027**	**MOTION:** Dr. Shinder moved to approve Agenda item VI.C as presented, seconded by Dr. Zavod. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.
VI.D	**Quality Improvement Trilogy** • Closeout Summary of FY 2025-2026 QI Work Plan • Summary of QI Trilogy Documents QI Trilogy Documents • 2025-2026 QI Evaluation • 2026-2027 QI Work Plan • 2026-2027 QI Program Description	**MOTION:** Dr. Herman moved to approve Agenda item VI.D as presented, seconded by Dr. Stockton. **ACTION SUMMARY:** [18] yes, [0] no, [0] abstentions.	09/09/26 Motion carried.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer	**Partnership's Deputy Chief Medical Officer provided a brief report discussing additional Partnership activities.** **DHCS Clinical Efficiency Adjustments — Calendar Year (CY) 2027 Rate Development** **Process: Plan feedback changed the outcome** • Engagement ran from the February 2026 All-Plan CFO meeting through workgroups in March, May, June and July, plus multiple rounds of written feedback. • Three proposed adjustments were dropped and the targeted efficiency level (TEL) was held rather than raised for now. • California Children's Services (CCS) members and long-term care institutional members were added as readmissions exclusions in direct response to plan comment. • De-duplication between inpatient adjustments was accepted as a concern and addressed. **Mechanism: What the target efficiency level does** - DHCS applies Actuarial Standard of Practice (ASOP) No. 49 adjustments only where attainable and achievable • Gross finding - Clinical review identifies inefficient spend – 3.5% of inpatient dollars for readmissions • TEL discount - Only a set fraction is removed. At 50%, half comes out: 1.7% after TEL • Why it exists - A deliberate buffer for review error, misclassification and implementation runway • What is disclosed - The value — 50% across Readmissions, Cesarean Mix and PPA • *What is not* - The derivation. No method is sown for why 50% rather than 35% or 65% **The Central Methodological Issue** Absence of documentation is treated as evidence of avoidability. • The readmissions flag turns on whether an outpatient visit appears in the record — not on whether care occurred. • Encounter completeness is not random. It tracks delivery system structure, Federally Qualified Health Center and subcapitated arrangements. • The base period closed before the standard was set, and submission windows have passed. **Reproducibility: What remains unresolved** • TEL derivation - The 50% value is public. How it was selected is not — and DHCS intends to raise it. • Clinical review standards - No criteria set, reviewer credentials, dual review, or inter-rater agreement reported. • Encounter-level dispute - Policy consultation exists. There is no path to contest a specific flagged admission. • Hierarchy run order - PPA and readmissions can both claim the same admission. Sequence is undisclosed. • Sample versus census - Not stated. Regional figures are smaller subsamples with wider uncertainty. • Operational thresholds - Any professional visit exempts a readmission, regardless of relatedness or timing.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer, Continued	**Outcome: Final Decisions for CY 2027** - *DHCS will reevaluate TELs for CY 2028 with a view toward raising them where attainable. Cellulitis, short stay, and Durable Medical Equipment/radiology will not be implemented based on reviewed analyses.*

Adopted

- Readmissions: 50% TEL
- Cesarean Mix: 50% TEL
- Potentially preventable admissions: 50% TEL, unchanged
- Low acuity non-emergent: Code definitions updates

50% TEL: Readmissions

Physical health admissions within 30 days of a prior discharge, any facility, any diagnostic-related group (DRG).

- Clinical global exclusions removed, plus ages under three and over 84 — now also CCS and long-term care members.
- Not avoidable: unrelated readmissions, elective admits, expired discharge status, against medical advice (AMA) discharge, or any professional visit beforehand.
- Flagged: readmissions related to the index stay with no documented outpatient visit before them.

Region	Before TEL	After TEL
Statewide	**3.5%**	**1.7%**
Bay Area	3.7%	1.9%
South Non-Coastal	3.2%	1.6%
Southern California	3.1%	1.5%
North Non-Coastal	4.4%	2.2%
Coastal	3.8%	1.9%

Impact: Readmissions – Regional Results

Adjustment as a percentage of hospital inpatient dollars. North Non-Coastal carries the highest adjustment of any region — about 45% above Southern California. Limited outpatient infrastructure and use of emergency departments for routine or urgent access were identified as possible contributors.

50% TEL: Cesarean Mix

A benchmarked ratio that re-mixes delivery counts rather than subtracting encounters.

- Statewide cesarean rate is 29.4%. Of those, 10.3% were judged medically unnecessary.
- A portion of potentially avoidable cesareans is shifted to vaginal births, re-mixing the maternity supplemental payment.
- Estimated statewide reduction of $7.3M to CY 2027 maternity supplemental payment dollars.
- Mercer reviewed 437 diagnosis codes against NTSV and accepts eight conditions NTSV does not.

Region	Cesarean %	Avoidable %	PMPD impact
Statewide	**29.4%**	**10.3%**	**-0.7%**
Bay Area	25.3%	8.6%	-0.5%
South Non-Coastal	31.4%	10.3%	-0.8%
Southern California	29.5%	11.0%	-0.8%
North Non-Coastal	29.5%	10.1%	-0.8%
Coastal	26.8%	9.0%	-0.4%

NTSV cesarean rate = Nulliparous, Term, Singleton, Vertex, the proportion of live term singleton births in first-time mothers delivered by cesarean section, a primary cesarean rate measure.

Impact: Cesarean Mix – Results and a Known Gap - Known misclassification: Placenta accreta and partial previa are NTSV-recognized indications but sit in the potentially avoidable pool for CY 2027. DHCS says they are under 1% of cases, were factored into the TEL, and will be added for CY 2028.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. Executive Leadership Update, Deputy Chief Medical Officer, Continued	**What to prepare for in CY 2028** • TELs are expected to rise where DHCS judges the reduction attainable. A 50% buffer should not be assumed to persist. • Placenta accreta and partial previa move into the medically supported set, modestly shrinking the cesarean adjustment. • Herpesvirus is slated for annual code review. • Cellulitis, Short Stay and DME/Radiology were declined for CY 2027, not withdrawn permanently. • Clinical efficiencies are expected to feature in the forthcoming Hospital Value Strategy, cascading to provider contracting. **Context: NEJM on Pay for Performance** • **R**ethinking the Role of Pay for Performance in Federal Health Care Quality Programs**, (**Chernew and Schneider, 2026) revealed after two decades, pay-for-performance has produced only moderate gains in care processes and outcomes, at substantial administrative cost. • The shortcomings are structural, not fixable by refinement — measurement, scoring and financial incentives each have inherent limits. • Performance tracks patient and social factors absent from risk adjustment, so programs penalize plans and organizations serving marginalized populations. • Payment tied to measures shifts effort toward documentation and scoring rather than care delivery. • Recommended shift: a narrow set of high-impact measures, targeted support for poor performers, and comfort with doing nothing when action will not close a gap. **Summary** • Plan feedback through the workgroup channel changed the outcome — that channel is our leverage for CY 2028. • TEL derivation, clinical review standards, run order and a dispute path remain undisclosed, and TELs are expected to rise. • Penalties tied to imperfect measures burden plans serving marginalized members without clear evidence of better care. • Greater transparency is requested.
IV.A Status Update, Regional Medical	**Partnership's Regional Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • The recent Yolo County Perinatal Care Summit was reported as the second event in a series jointly sponsored by regional directors and regional medical directors. More than 50 participants attended from federally qualified health centers (FQHC), hospitals, community-based organizations (CBO), First 5, Enhanced Care Management (ECM) providers, doula programs, and other local organizations. Networking, service sharing, and exercises following patients through the continuum of care were used to strengthen regional coordination. • Similar summits had previously been held in Solano County and are being planned for additional regions. • Members interested in planning are invited to contact their regional medical director.
IV.B Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • A regional quality meeting was held on September 3, 2026 focusing on updated hypertension-management guidelines, health disparities, promotion, and nursing support for blood-pressure management. • Vaccine uptake is being prioritized through findings from four completed focus groups, with two additional groups scheduled. • Efforts are being directed toward communities with lower vaccination rates and children from birth through age five. • Provider organizations and community-based partners are being engaged. • A Marin/Sonoma Perinatal summit is scheduled for September 25, with approximately 80 participants expected to attend. • Workforce growth is reported through new quality leadership and quality-improvement staff at local health centers and tribal clinics.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
IV.C Status Update, Regional Medical	**No activities to report for Lake, Mendocino, Humboldt, and Del Norte Counties in September.**
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.** • Graduate medical education leaders are scheduled to meet in Redding to coordinate regional workforce strategy. • Residency-program expansion is creating opportunities for more deliberate recruitment and retention throughout Northern California. • Two psychiatry residencies located approximately 20 miles apart and producing about 14 graduates annually were cited as resources that could be coordinated strategically. • Access and telehealth had been identified as major priorities during a recent regional seminar and workforce discussion, particularly in the Yuba-Sutter area. • Expanded telehealth is expected to support outpatient management of diabetes, chronic heart failure, and other conditions associated with potentially avoidable hospitalization. • The transition to Partnership's trusted hospice network was reported as complete, with 19 contracted providers participating. • A process is being developed to document unavailable contracted hospice providers so that use of noncontracted providers could be evaluated and tracked consistently.
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.** • Plumas District Hospital emphasized Partnership's primary-care-provider calling-center program and hypertension management. • Development of standby perinatal services is continuing following passage of relevant state legislation. A closer facility had been purchased to improve emergency access. A former offsite facility was expected to be repurposed as housing for traveling clinical staff. • Tahoe Forest was reported to have opened a Tahoe City clinic offering urgent and primary care services. • Nevada County's first robotic surgery was performed. • A physician recruitment event is being planned in Grass Valley for residents and practicing physicians. • Reduced infusion-center hours caused by staffing changes are an ongoing access issue, especially for patients requiring recurring treatment. • An academic-detailing event is planned with WellSpace focused on hypertension and diabetes management. • Nevada County reported an approximately 50% reduction in opioid-related deaths over two years. • Patients were reported to be presenting with opioid-withdrawal-like symptoms despite denying opioid use; certain convenience-store products, such as Kratom, are suspected and testing is being pursued. • Clinicians are advised to consider such products when similar presentations occur.
V. Old Business	*No old business.*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.A Proposed 2027 Enhanced Care Management Quality Incentive Program (ECMQIP) Measurement Set	**Summary of Proposed Measure Changes for Measurement Year 2027** **No proposed changes. Existing measures will be used for measurement year 2027** **Gateway Measure: Timely Reporting** Providers are required to submit three monthly reports on or before their due date. Incentive: $100 per member per month 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.

Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 Days 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.	**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.
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.	**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.

No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.B Proposed 2027 Extended Care Center Quality Incentive Program (EXTQIP) Measurement Set	**Summary of Proposed Measure Changes for Measurement Year 2027** • No changes were proposed to the three gateway measures: CMS Five-Star Overall Rating; California Immunization Registry (CAIR) Enrollment; Quality Assurance and Performance Improvement (QAPI) Plan Submission • A CAIR Connect component was added to Measure 3, Percentage of long-stay residents who needed and got a flu shot and Measure 4, Percentage of long-stay residents who received a vaccine to prevent pneumonia requiring successful entry of care-related data. • All remaining measures were updated per CMS. • **A new Measure 10 was added under the health-equity impact-analysis plan.** **ADD: Measure 10 – Health Equity Impact Analysis and Plan** Facilities are required to submit an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures listed below: • Percent of high-risk residents with pressure ulcers • Percent of residents who lose too much weight • Long-stay residents who needed and received a flu shot • Long-stay residents who received a vaccine to prevent pneumonia • Percent of residents experiencing one or more falls with major injury • Percent of residents who have/had a catheter inserted and left in bladder Points: 10 Target: Full Points No Partial Points *Providers are required to submit analysis and plan by August 31, 2027. Partnership will review and notify facilities if approved or rejected.* *No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**HQIP 2027 Calendar Year Measurement Set (January 1 – December 31, 2027)** Providers have the potential to earn points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

2026 Six-Month Bridge Set July 1 – December 31, 2026	2027 Calendar Year Measure Set Recommendations
Risk Adjusted Domain 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support 10. Increasing Mammography Capacity 11. Vaccines For Children Enrollment **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT) **Operations / Efficiency Domain** 14. Hospital Quality Improvement Platform	**Risk Adjusted Domain** 1. Risk Adjusted Readmissions (RAR) 2. 7-Day Follow-up Clinical Visit (RAR) **Palliative Care Domain** 3. Palliative Care Capacity **Clinical Domain** 4. Elective Delivery Before 39 Weeks 5. Exclusive Breast Milk Feeding Rate 6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate 7. Vaginal Birth After Cesarean (VBAC) 8. Expanding Delivery Privileges 9. Doula Support ~~10. Increasing Mammography Capacity~~ ~~11. Vaccines For Children Enrollment~~ 10. Hepatitis B Vaccination 11. ALSO & BLSO Certification Training **Patient Safety Domain** 12. Patient Safety Organization Participation 13. Substance Use Disorder – 7-Day Follow-up After ED Visit (FUA) **Operations / Efficiency Domain** 14. QI Capacity 15. Hospital Quality Improvement Platform **Patient Experience Domain** 16. Cal Hospital Compare-Patient Experience 17. Health Equity

Key: Change to Measure Design || Proposed New Measure || Removed Measures

AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**Revisions to Existing Measures** **Measure 8: Expanding Delivery Privileges -** It is proposed that this measure include a partial points option for X-Large size hospitals who are still working on expanding privileges to family physicians and midwives, and it is proposed to change the language from family physicians and midwives to "or" midwives for large and small-size hospitals. The change to "or" is in recognition that for some of our smaller hospitals in rural areas, the resources may not exist to have both provider types. **Requirement Targets** his multi-phase measure began with Phase One in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With Phase One completed in 2024-25, this measure moved into Phase Two for the 2025-26 HQIP Measurement Year. Now, in 2027, the measure requirements are delineated by sizes as noted below: **X-Large Hospitals with >100 LGA Beds:** o Full Points (5 points): By December 31, 2027, hospitals must ensure access to family physicians and certified nurse midwives for deliveries by either employing them directly or maintaining active contracts, as demonstrated, by granted clinical privileges for these providers. Evidence of deliveries from these providers is required. o Partial Points (2.5 points): Phase Two Requirement: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges. **Small & Large Hospitals with between 25 and 99 LGA Beds:** o Full Points (5 points): Small and Large-size hospitals will remain in Phase 2 as follows: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and/or family physicians to hold delivery privileges, must now show evidence that they are actively recruiting these providers and/or share their provider privileges list of midwives and/or family physicians who have been granted delivery privileges. *NOTE: Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital.* **Measure 9: Doula Support -** This measure began in 2025 with Phase 1. It is proposed to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals as noted below. **Specifications** This measure is being implemented over multiple years, starting with Phase One in the 2025-26 measurement year. For 2027, the measure is now in Phase Two of implementation requiring hospitals to work toward actively recruiting and/or allowing doulas who accept Partnership HealthPlan to provide support during labor and delivery. **Phase Two Measure Requirements** 1. Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery, and 2. Hospitals will submit evidence of active recruitment of doulas who are credentialed with Partnership. *NOTE: Hospitals with policy and procedure developed before 2027 allowing doulas to provide support during labor and delivery and that are utilizing them will get full points for the measure.*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**Revised Measures Continued** **Measure 13 – Substance Use Disorder 7-Day Follow-up After ED Visit (FUA) -** It is proposed to align the Substance Use Disorder Referral measure with the HEDIS FUA measure for 7-Day Follow-up After ED Visits. This will move this measure from focusing on prescribing buprenorphine and MAT to a broader range of services to a broader range of members. This measure will also pinpoint a shorter follow-up window moving from the previous 60-day follow-up window to 7 days. **Specifications** The percentage of emergency department visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was a follow-up within 7 days of the ED visit (8 days total). **Numerator:** Follow-up visit or pharmacotherapy dispensing event on the ED visit date or within 7 days after the ED visit (8 days total). **Denominator:** The number of ED visits for members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose* on or between January 1 and December 1 of the measurement period. Full Points Target (10 pts): > 32.60% Partial Points Target (5 pts): Between 26.90 – 32.5 % Hospital's percentages will be rounded to the nearest 10th. **New Measures/Returning Measures** **Measure 10 - Hepatitis B Vaccination:** It is proposed to remove the VFC Enrollment Measure and replace it with the Hepatitis B Vaccination measure. We have had a similar measure in past years, so it is familiar to our hospitals. Despite changing CDC recommendations, Partnership believes it is important to continue to encourage Hepatitis B vaccination within 24 hours of delivery. **Specification for Hospitals Providing Maternity Services:** Numerator: Newborn Hepatitis B Vaccine entered in CAIR within first day of life Denominator: Newborn births at the hospital between January 1, 2027, and December 31, 2027 **Measure 11, ALSO & BLSO Certification Training measure** was added to encourage Advanced Life Support in Obstetrics (ALSO) for birthing hospitals and Basic Life Support in Obstetrics (BLSO) for non-birthing hospitals. • **Hospitals with Obstetrics**: o Full Points Target (5 pts): 30% of Physicians, i.e. MDs & CNM's and 30% of Nurses working regularly in Labor and Delivery are currently certified in ALSO o Partial Points Target (2.5 pts.): 15% of Physicians, i.e. MDs & CNM's and 15% of Nurses working regularly in Labor and Delivery are currently certified in ALSO • **Hospitals without Obstetrics:** o Full Points Target (5 pts): 30% of ED Clinicians, i.e. MDs & PAs and 30% of Nurses working regularly in the Emergency Department are currently certified in BLSO. Alternative simulation-based trainings in Emergency Obstetrical Care (such as Stanford's GO-MOMS-USA simulation program, done in-person at the hospital) may also be acceptable; they would be reviewed on a case-by-case basis. o Partial Points Target (2.5 pts): 15% of Physicians, i.e. MDs & PA's and 15% of Nurses working regularly in the Emergency Department are currently certified in BLSO.

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI.C Proposed 2027 Hospital Quality Incentive Program (HQIP) Measurement Set	**New Measures/Returning Measures Continued** • **Measure 14 - Quality Improvement Capacity:** This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. We had removed this measure for the 6-month bridge set for logistical reasons and propose to bring the measure back for the 2027 calendar year. There are no changes to the measure from previous measurement years. • **Measure 16 - California Hospital Compare:** This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. This measure was removed for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. It is proposed to bring this measure back for the 2027 calendar year. The measure will return in the same form as it was during the 2025-26 measurement year. • **Measure 17 – Health Equity -** This measure is designed to encourage hospitals to work toward reducing health disparities that exist in their area or patient populations. This measure was removed for the 6-month bridge period, and we propose to bring the measure back for the 2027 calendar year. It is proposed that the measure switch from hospitals submitting a CMS Commitment to Health Equity report to submitting a copy of their HCAI Health Equity Report that is required by California Assembly Bill 1204. Hospitals shall submit a copy of their most recently published annual HCAI Health Equity Measures Report to Partnership by December 31, 2027. The submitted report should be the same report hospitals sent to HCAI during the measurement year which was due to HCAI by September 30th. **Removal of Existing Measures for 2027** • **Increased Mammography Capacity** - It is proposed to remove this measure because we cannot continue to ask for increased capacity each year. Capacity at many hospitals increased during the year and a half the measure was in place. • **Vaccines For Children (VFC) Enrollment** - It is proposed to remove the Vaccines For Children (VFC Enrollment) and replace with the Hepatitis B Vaccination measure. This is consistent with what was planned for the measure from the beginning. *No questions. Proposal was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

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AGENDA ITEM	DISCUSSION / CONCLUSIONS MOTION REQUIRED
VI. D. Quality Improvement Trilogy	**Trilogy Document Summary** • The Quality Improvement Program Description documents departmental structure, responsible staff, committees, delegated functions, and emerging programs. • The Work Plan establishes annual goals for clinical quality, safety, service quality, and member experience. • The Program Evaluation assesses whether program structures and interventions produced intended results, identifying barriers, and directing future adjustments. • The trilogy package was acknowledged to total approximately 600 pages. • Duplication was being reduced and future documents streamlined without loss of required NCQA content. **FY 2025–2026 Work-plan Closeout** • Of 72 formal FY 2025–2026 work-plan goals, 59 were reported as completed. • Several goals were marked as unmet only because dashboard and reporting workflows were automated or transferred to vendors. • Other goals were delayed because the Health Rules Payor (HRP) claims system remained pending, the Dual Special Needs Program (D-SNP) launch had moved to 2028, or federal rulings had changed QIP requirements. • DataLink participation increased from six practices to more than 30, enabling capture and HEDIS© validation of clinical information not readily visible in claims. • A dental-provider directory was developed with demographics, estimated volume, and other access information. • QIP validation was strengthened so providers would receive credit for all earned incentives. • Approximately 109 mobile-mammography event days and nearly 2,500 mammograms were completed in 2025, with emphasis on rural imaging deserts and previously unscreened members. • The mobile model was being expanded to address cervical-cancer screening and blood-pressure assessment during the same visit where staffing and facilities allowed. • Cozeva was discontinued because scale and functionality were not proportionate to expected initial D-SNP membership. • Future reconsideration could occur as Medicare enrollment and county coverage expanded. *No questions. Entire QI Trilogy package was accepted and will be shared with Partnership Board of Commissioners for final approval in October.*

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AGENDA ITEM	ADJOURMENT
PAC adjourned at 8:47 a.m.	**Next Physician Advisory Committee announced for October 14, 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, Sept. 8, 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 Aug. 11, 2026	Isaac Brown, MHA/MBA	1:30	5 – 14
2	*Acceptance of the draft minutes of the* • July 29 Over/Under Utilization Workgroup			15 – 21
II.	**Old Business - None**			
III.	**New Business – Consent Calendar**			
	Consent Calendar	All	1:37	22
	Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct any questions to Latrice Innes*			23 – 54
Health Services Policies	**Pharmacy**			
	MCRP4066 – AB1114 Benefit Implementation and Oversight			55 – 59
	Quality Improvement			
	MPQP1002 – Quality/Utilization Advisory Committee			61 – 65
	MPQP1008 – Conflict of Interest Policy for QI Activities			67 – 69
	MPQP1022 – Site Review Requirements & Guidelines (with revised Att. E and **ARCHIVED** Att. L)			71 – 98
	MPQP1053 – Peer Review Committee			99 – 103
	Utilization Management			
	MCUG3022 – Incontinence Guidelines			105 – 115
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities			117 – 123
	MCUP3115 – Community Based Adult Services			125 – 159
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump			161 – 165
	MPUP3078 – Second Medical Opinions			167 – 169
Non-HS Policies	**Network Services – Credentialing**			
	MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT			171 – 174
	MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities			175 – 178
IV.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	179 – 180
Non-HS Policie	**Provider Relations**			
	MPPRGR210 – Provider Grievance – *CLEAN copy begins on p. 185*	Aaron Brincko, MPH	1:40	181 – 187
	MPPR210 – Long-Term Services and Supports Liaison – *CLEAN copy begins on p. 192*		1:47	189 – 194

	Item	Lead	Time	Page #
V.	**Presentations**			
1	Quality Improvement Update	Issac Brown, MHA/MBA	1:55	195 – 207
2	Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set	Tony Sengdara	2:05	209 – 211
3	Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026	Stan Leung, Pharm.D / Tony Hightower, CPhT	2:15	213 – 225
4	Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025	Renee Trosky, BSRRT, MOL	2:30	227 – 247
VI.	**Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, Oct. 12, 2026**			

Sengdara,

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES

Tuesday, Sept. 8, 2026 / 1:33 – 2:44 PM

Members Present:	Hanusiak, Kenzie, Assoc. Dir., Regulatory Affairs & Compliance
Ayala, Priscila, Director of Network Services	Innes, Latrice, Compliance Manager, Grievance & Appeals
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Krznarich, Jackie, RN, Manager, Member Safety – Quality Inspections
Brincko, Aaron, Director of Provider Relations	Leung, Stan, Pharm.D, Director of Pharmacy Services
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Brunkal, Monika, RPh, Associate Director of Population Health	Randhawa, Manleen, Senior Health Educator, Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Villasenor, Edna, Senior Director, Member Services and Grievance
Devan, James, Director of Quality Improvement, QI	Vaisenberg, Liat, Director of Health Analytics
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI	
Members Absent:	Klakken, Vicky, Regional Director (NW-Eureka)
Andrews, Leigha, Regional Director (SW)	Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Bjork, Sonja, JD, Chief Executive Officer	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Davis, Wendi, Chief Operating Officer	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Newman, Rachel, RN, BSN, Associate Director, Credentialing
Guevarra, Angela, RN, Director of Care Coordination	Ruffin, DeLorean, DrPH, Director of Population Health
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Guests:	Leung, Paul, Sr. Health Data Analyst I, Finance
Aarons, Rose, Quality Training Specialist & Dental Liaison, QI	Mednick, Christy, Sr. Health Data Analyst I, Finance
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health	Moraghebi, Roudabeh, Manager of Health Analysts, Finance
Allen, Angier, Senior Data Scientist I, Finance	Newell, Amber, CPhT, Program Manager I, QI
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)	Nguyen, Tom, Manager of Health Analytics, Finance
Bikila, Dejene, Manager of Data Science, Finance	O'Leary, Hannah, MPH, CHES, Manager of Population Health
Brackett, Jacquelyn, Administrative Assistant I, Pharmacy	Quichocho, Sue, Manager of Quality Measurement, QI
Clark, Kristen, Manager of Quality & Training, Member Services	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Cunningham, Aryana, Policy Analyst, Care Coordination	Rednic, Hanny, Program Manager I, UM
Durst, Jennifer, Senior Manager of Performance Improvement, QI	Roach, Erika, Program Manager II, Network Services
Elder, Alaina, Manager of Provider Network Teams, Provider Relations	Salehi, Tiphanie, Senior Health Data Analyst II, Finance
Harris, Vander, Senior Health Data Analyst I, Finance	Sengdara, Tony, Program Manager I, QI
Hendrix, Hillary, Executive Assistant, Behavioral Health	Smith, Christine, Community Health Needs Liaison, Population Health
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Spiller, Bettina, MD, Associate Medical Director
Kubota, Marshall, Associate Medical Director	Thomas, Penny, Senior Health Data Analyst I, Finance
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance	Trosky, Renee, Manager of Provider Relations Compliance, Network Services
Lee, Donna, Manager of Claims, Claims	Vance, Brooke, Program Manager I, Network Services
Legere, James, Project Coordinator I, Regional Admin, Chico	Watson, Deanna, Program Manager I, QI (ECM QIP)
Ling, Samuel, Sr. Health Data Analyst I, Finance	Yu, Fei, Sr. Data Scientist I, Finance
	Zhao, Li Sr. Health Data Analyst I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Announcements • Approval of Minutes	Senior Director of Quality & Performance Improvement Isaac Brown called the meeting to order at 1:33 p.m. from the Fairfield-West office. He announced that the IQI chair will rotate between him, Senior Director of Care Management Brigid Gast, RN, and physician leadership during the next several months as Partnership prepares for Chief Medical Officer Robert Moore's retirement. Likewise, the Quality/Utilization Advisory Committee (Q/UAC) chair will rotate between Deputy Chief Medical Officer Kermit Jones, MD, JD, and Medical Director for Quality Mark Netherda, MD. • **The Aug. 11 IQI Minutes were approved with one amendment proposed by Anna Campbell:** o **Add the following meeting postscript** to the discussion of MCUP3052 – Medical Nutrition Therapy (MNT) Services: Further offline discussion on whether members utilizing the MTM benefit through Community Supports can simultaneously utilize the MNT benefit has determined that Department of Health Care Services' (DHCS) guidance would technically allow that. • **The July 29 Over/Under Utilization Workgroup minutes were accepted after some discussion**. o Anna Campbell pointed out that the Treatment Authorization Request (TAR) volume captured seemed high as UM only had 162,000 for the same reporting period. Dr. Jones speculated the O/U reported number included Transportation, and Associate Medical Director Marshall Kubota, MD, agreed. Isaac added that the reported number does jibe with dashboard figures. *After IQI*, Anna conferred with UM Program Manager Kandice Dixon, who seemed certain the O/U capture was really "prior authorizations," which included both TARs and Referral Authorization Forms (RAFs).	Motion to approve IQI minutes with the one change: Lisa O'Connell, MHA Second: Aaron Brincko, MHA *Motion passes* Motion to accept the O/U minutes as presented: Stan Leung, Pharm. D Second: Kristine Gual *Motion passes*
II. Old Business – None.		
III. New Business Consent Calendar (Committee Members as applicable)		
Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct any questions to Latrice Innes* **Health Services Policies** Pharmacy MCRP4066 – AB1114 Benefit Implementation and Oversight Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee MPQP1008 – Conflict of Interest Policy for QI Activities MPQP1022 – Site Review Requirements & Guidelines (with only revised attachments E, L, & M; ARCHIVING old L) MPQP1053 – Peer Review Committee Utilization Management MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities MCUP3115 – Community Based Adult Services MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump MPUP3078 – Second Medical Opinions **Non-Health Services Policies** Network Services - Credentialing MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT – ***pulled for discussion*** MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities – ***pulled for discussion***	Motion to **approve the slate without the 2 Credentialing policies:** Lisa O'Connell Second: Edna Villasenor *Motion passes* Next Steps MCRP4066: • Oct. 8 Pharmacy & Therapeutics Committee (P&T) • Nov. 4 Physician Advisory Committee (PAC) Next Steps rest of Health Services' Slate: • Sept. 16 Q/UAC • Oct. 14 PAC Motion to **approve MPCR12 as amended:** Kristine Gual Second: Lisa O'Connell	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Anna Campbell pulled both Credentialing policies to ask questions. Re MPCR12, she suggested that the private duty nursing services definition should be identical to Care Coordination's MCCP2031, which mentions licensed practical nurses (LPNs). Anna also suggested that if Attachment A – Individual Nurse Agreement is our form that it be placed on Partnership letterhead or otherwise branded as our document. Lastly, Anna suggested that "nurse practice act B" be better described in the first paragraph of Attachment A. **Anna will send her notes to Renee Trosky, who will work with Rachel Newman, RN, to update the policy for the Credentials Committee's consideration Sept. 9.** Re MPCR200, Anna said that if PAC is to be an approver, some policy language may need to change. Also, as the Board of Commission By-laws delegates policy approval only to Finance, PAC, and the Credentials Committee, there is no need to add PAC as an additional approver after the Credentials Committee has already approved a policy. Anna suggested Kenzie Hanusiak, Rachel Newman and Board Clerk Ashlyn Scott look at the By-laws, as compliance with that language is part of our DHCS Contract. **Dr. Jones said this meeting should happen soon so that the policy can come back to Oct. 13 IQI, and Chief Medical Services Officer Katherine Barressi, RN, then tabled further IQI consideration until that time.**	*Motion passes* MPCR200: Priscila Ayala said a meeting to answer expressed concerns would occur within the next five business days.
IV.	**New Business – Discussion Policies**	
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*		

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

☒ **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	

MPPRGR210 – Provider Grievance	**This policy was pulled from July 7 IQI consideration for more edits. During this subsequent review, policy edits were made to incorporate Provider Relations' standing up of an internal mechanism to track provider grievances outside of Claims, Provider Dispute Resolutions (PDRs), and Treatment Authorization Requests (TARs).** **I. Related Policies** – updated to include CLPM-41 Claims Provider Dispute Resolution Mechanism and CMP38 Escalation and Corrective Action **II. Impacted Departments** – updated to "All Departments" as multiple departments may be impacted by a provider issue **III. Definitions** – updated Network Provider, PDR, and Provider Grievance definitions. **V. Purpose** – updated to reflect the updated Provider Grievance process by which provider grievances are submitted, reviewed, and resolved. **VI.B. Intake** – To describe the Provider Relations' process for accepting and reviewing submitted provider complaints. 1. Informal complaints will be resolved by the PR team, with help from impacted departments	Motion to **approve as amended:** Anna Campbell Second: Kermit Jones, MD, JD *Motion passes* Next Steps: Sept. 16 Q/UAC Oct. 14 PAC ***Meeting postscript***: Alaina emailed Sarah Browning on Sept. 21 that PR would like to verbally change the title of its intake form mentioned at VI.B.3 from Provider

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	2. For formal grievances, upon review, PR ensures that all Partnership appeal processes have been exhausted. 3. Providers must submit their complaint within 180 days of the initial incident date. **VI.C Review/Resolution** – provides the grievance resolution cycle, including steps and timeline **IX. Position Responsible for Implementing Procedure** – updated to the Director of Provider Relations to reflect the new departmental organization Aaron noted that this policy had not been updated for some time and that it is now refreshed with some observations from Regulatory Affairs and Compliance (RAC). Instead of 45 days, providers now have 180 calendar days from the incident date to formally or informally report any concerns to Provider Relations. If the PR team is unable to adjudicate the grievance within 30 business days, the matter may be referred to the Executive Committee, which has a further 15 days to determine a final decision. Anna Campbell wondered if it would be more correct to check the follow-up box for "Provider Education" instead of "IPN" as claims may not be grieved. Aaron acknowledged this, clarifying that providers may grieve how the PDR *process* worked. **This policy's Purpose statement is amended to read, in part,** "This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/ Pharmacy ***appeals process*** or Medi-Cal Member Grievance processes."	*Grievance* Intake Form to Provider *Concern* Intake Form at the Oct. 14 PAC.
MPPR210 – Long-Term Services and Supports Liaison	**This policy was reviewed in accordance with All Plan Letters (APLs) 26-010, 26-011, and 26-012. It had been an internal policy but is coming to IQI now as an external policy. This policy outlines the role of our Long-Term Services and Supports (LTSS) Liaison, including their contact information, training received, and responsibilities.** **Related Polices**: Several EHS, UM, and PR policies are added. **Definitions:** Long-Term Care, (LTC) Long-Term Services and Support (LTSS) and Network Provider as defined. **VI.A.** – The LTSS Liaison serves as the Health Plan's point of contact for LTSS providers. **VI.B.** – The LTSS Liaison receives training on the full spectrum of rules, regulations, policies and procedures pertaining to Medi-Cal covered Long-Term Care (LTC), including but not limited to: a. Payment and coverage policies b. Prompt claims payment requirements c. Provider dispute resolution policies and procedures (P&Ps) d. Care management e. Care coordination f. Transitional Care Services (TCS) policies **VI.C.7** – The LTSS Liaison will facilitate quarterly "office hours" webinars for all eligible Network Providers furnishing LTC services. **References**: Updated to include the three APLs listed above. Aaron noted the intent is to make this policy sound less like a job description. The policy deliberately uses DHCS's long term care definition, and Aaron asked if this runs contrary to how Partnership defines its like term. Anna Campbell said Partnership UM further defines the variations of long term care in MCUG3038 -	After discussion, IQI agreed to defer action on this policy until Aaron Brincko and Kenzie Hanusiak could do further work together. ***Meeting postscript***: PR will further discuss this policy on Sept. 22. This policy may come back to IQI on Oct. 13.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Review Guidelines for Member Placement in Extended Care (Custodial/Long-Term Care, Skilled or Subacute) Facilities to make it clear where extended care takes place vs. other levels of inpatient care that may occur in, for example, acute rehab facilities as defined in MCUG3024 – Inpatient Utilization Management. Partnership usually thinks of long term care as custodial care, Anna said. Anna and Janet Rudd, RN, (UM's Manager of Long Term Support Services) have sent to Alaina Elder a draft of MPPR210 that aligns with MCUG3038. The draft includes UM's definition of extended care facilities. RAC Associate Director Kenzie Hanusiak noted this liaison position is contractually defined by DHCS, and she wondered if updating the policy definitions may affect how the liaison interacts with any one site. Kenzie recommended that PR again review this policy to make sure that our liaison is not over committed. Our current liaison, she said, does not provide coaching and oversight for LTAC (long term acute care).	

V. Presentations

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

- Early in 2026, the Performance Improvement leadership team, in coordination with our Healthcare Effectiveness Data Information Set (HEDIS®) 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 performance varied enough by geography that a regionally focused strategy was needed. Today, additional geographic stratification is required.
- 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.
- Partnership's next National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Renewal Survey is scheduled for Sept. 15. We are projecting a 3.0 Star rating utilizing the Consumer Assessment of Healthcare Providers and Systems' (CAHPS®) Child Survey.
- We are looking at expanding medical record review of W30.

There were no questions for Isaac.

Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set – *Tony Sengdara, Program Manager I, QI*

There are no changes proposed for the Gateway measures. Measures 1 through 9 are changing in available point targets. An additional expectation of "successful entry into the California Immunization Registry (CAIR)" s being added to Measures 3 and 4: Percentage of long-stay residents who needed and got a flu shot, and percentage of long-stay residents who received a vaccine to prevent pneumonia, respectively.

Measure 10 – Health Equity Impact Analysis and Plan – is being added. Facilities are required to submit by Aug. 31, 2027 for Partnership review/approval/rejection an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures:

- Percent of high-risk residents with pressure ulcers
- Percent of residents who lose too much weight
- Long-stay residents who receive a vaccine to prevent pneumonia
- Percent of residents experiencing one or more falls with major injury
- Percent of residents who have/had a catheter inserted and left in the bladder

There were no questions for Tony.

Isaac noted that Partnership is endeavoring to wrap each of its 2027 measure sets by the end of September 2026 so to proceed to contracting.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026 – *Stan Leung, Pharm.D, Director of Pharmacy Services, and Hanny Rednic, Program Manager I, UM*

Stan reported that in both Q1 and Q2 2026, Pharmacy was 100% compliant in overall timeliness of denials notification in Adverse Benefit Decision (ABDs) determinations resulting from medical necessity review and benefit coverage reviews. Pharmacy also exceeded the 95 percent threshold with 100% compliance in each quarter for urgent/concurrent (within 72 hours), urgent pre-service, non-urgent pre-service, and post-service (within 30 calendar days) requests. Between Jan. 1 and June 30, 2026, 3,907 or 86.15% of 4,535 TARs were approved, and 897 or 19.78% were denied. (The numbers do not add to 100% because they include modified approvals, Stan noted.) The Pharmacy Inter-Rater Reliability (IRR) 90% concurrence threshold was also exceeded across both pharmacy technicians (99%) and pharmacists (99%). Only one Pharmacy appeal decision was overturned during this time period.

UM enjoyed a similar compliance record but fell a bit short of the 95% timeliness threshold in two categories in Q2 with 94.9% in urgent preservice and 94.2% in non-urgent preservice TARs. Hanny noted that one reason why is that UM changed its pediatric rates, allowing for staff training. Overall, UM approved 73.53% of 159,225 (117,078) non-Behavioral Health TARs while denying 27.64% (44,017). All UM teams scored well above the 90% IRR concurrence threshold: inpatient nurse coordinators (96.6%), outpatient nurse coordinators (99.67%), long-term services and supports (LTSS) nurse coordinators (96.3%), and physicians (98.8%). Month-over-month across all regions during the first half of 2026, inpatient UM nurse coordinators averaged 9.7 non-Behavioral Health TARs each day; outpatient nurse coordinators averaged 20.86 TARs each day, and LTSS nurse coordinators averaged 6.9 TARs each day.

There were no ABD determinations resulting from medical necessity and benefit coverage reviews for Behavioral Health during Q1 and Q2. (No TARs are required for low to moderate behavioral health, Hanny noted.) Month-over-month, however, two UM nurse coordinators each averaged 4.4 Wellness & Recovery TARs per day.

Hanny concluded that, based on Q3 and 4 2025, UM is on track to similarly finish 2026.

There were no questions for either Stan or Hanny.

Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025 – *Renee Trosky, BSRRT, MOL, Manager of Provider Relations Compliance, Network Services*

NCQA standards for network management guide the creation of the NET reports, Renee began. This NET 3 report covers three categories: availability of practitioners, accessibility of services and a final assessment of network adequacy. Availability is the geographic distribution of practitioners, along with the appropriate type and number of practitioners to meet the needs of our members. Accessibility is the extent to which a member can obtain available services when they are needed. The overall assessment of network adequacy looks at availability, accessibility, and "member experience" via member grievances, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores and out-of-network referrals.

Plan-wide, Partnership met the provider to member ratio standard for all PCP practitioners. We also met the provider ratio standards for all our chosen high-volume specialty providers. We met the performance goal plan-wide for geographic distribution of primary care and the individual performance standard for each type of PCP; however, when we look at a breakdown of the data at a county level, we see that Lassen County did not meet the performance goal for any of the three types of primary care despite the family practice to member ratio being 1:1,300. Renee said this is indicative of a rural county where the population is widely dispersed, and the providers are in or near towns and cities. Plan-wide, Partnership met the performance goal for the geographic distribution of high volume and high impact specialties. Partnership Epidemiolgist Folo Akintan, MBBS/MD, asked if Lassen's shortcomings are more than geographical and if telehealth couldn't fill some gaps? Renee replied that while telehealth can indeed fill some care gaps, it cannot be utilized to meet geographic standards.

Four sparsely populated counties (i.e., Modoc, Siskiyou, Lassen and Del Norte) are too small to sustain a practice for many specialties and thus did not meet the time or distance standard for specialty care access. Our 3NA survey results show that plan-wide we did not meet our 2025 performance goal for non-urgent adult, pediatric, or newborn primary care appointments. For specialty care, we met the 2025 goal for non-urgent specialty care appointments but did not meet the goal for urgent specialty care appointments. In a closer look at non-urgent specialty care by region, Cardiology and Dermatology fell below the established median 15-day appointment standard. Ob-Gyn fell short in the Eureka region, Ophthalmology in the Fairfield and Santa Rosa regions, and Orthopedic Surgery in the Santa Rosa region.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

When we look at member grievances regarding access, we see that we met the threshold of 3.12 grievances per 1,000 in 2025 despite small increases from 2024. Breaking down the access grievances between primary and specialty care, the majority of grievances are related to primary care in all three areas: appointment availability, office availability, and telephone availability.

Looking at CAHPS®, the adult composite score for getting needed care and getting care quickly both increased slightly, however, both failed to meet the ≥33rd Partnership benchmark. We see the same scenario for the child composite scores. This indicates we continue to have dissatisfaction with member access, which influences health plan ratings.

Partnership did meet the out-of-network request (≤20 per 1,000 members) and utilization performance (≤10 per 1,000 members) standards for 2025: both OON requests and claims decreased from 2024 totals.

When we put all the data together, an opportunity for improvement was identified in appointment access to non-urgent primary care. Partnership has fallen short of the goal for a second year in a row. To address this, the provider recruitment program was refined and extended to incentivize providers to join and remain in the network. The PRP offers sign-on bonuses for providers new to the Partnership network, including providers practicing outside our 24-county service area, as well as graduates completing training programs within our service area. We have seen success with this approach: in 2025, Partnership approved 185 awards. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51% of the awards compared to 57% in 2024.

There are other opportunities that can be identified and several other initiatives are going on, but for the purposes of this report and NCQA, we select one opportunity to highlight. Renee concluded her presentation, reiterating that this is the NET3 report. Persons interested in the NET1 and NET2 reports may contact her for more information.

VI. Adjournment

Isaac Brown adjourned the meeting at 2:44 p.m. IQI next will meet Tuesday, Oct. 13, 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: Sept. 16, 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

Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

Partnership Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape recording of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.
Welcome / Introductions / Public welcome at cited Partnership locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* Aug. 19, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 14
2	*Acknowledgment and acceptance of draft minutes of the* • Aug. 11 Internal Quality Improvement (IQI) Committee *as amended at IQI Sept. 8* • July 29 Over/Under Utilization Workgroup			15 – 31
3	Announcements			--
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:40	33 – 45
2	HealthPlan Update	Robert Moore, MD	7:50	--
III.	**Old Business – None.**			
IV.	**New Business - Consent Calendar**			
Reports	Consent Calendar	All	8:00	46
	Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set – *direct questions to Tony Sengdara*			47 – 49
	Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026 – *direct questions to Stan Leung, Pharm.D, and Tony Hightower, CPhT*			51 – 63
	Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct questions to Latrice Innes*			65 – 78
HS Policies	**Quality Improvement MPQP1008**			
	MPQP1002 – Quality/Utilization Advisory Committee			79 – 83
	MPQP1008 – Conflict of Interest Policy for QI Activities			85 – 87
	MPQP1022 – Site Review Requirements & Guidelines (with four changed attachments)			89 – 126
	MPQP1053 – Peer Review Committee			127 – 131

	Item	Lead	Time	Page #
	Utilization Management			
	MCUG3022 – Incontinence Guidelines			133 – 143
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities			145 – 151
	MCUP3115 – Community Based Adult Services			153 – 187
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump			189 – 193
	MPUP3078 – Second Medical Opinions			195 – 197
V.	**New Business – Discussion Policy**			
	Synopsis of Changes		--	199 – 200
	Provider Relations			
	MPPRGR10 – Provider Grievance – *CLEAN copy begins on p. 205*	Aaron Brincko, MPH	8:10	201 – 207
VI.	**Presentations**			
1	Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025	Renee Trosky, BSRRT, MOL	8:20	209 – 228
VII.	**Adjournment scheduled by 8:45 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Oct. 21, 2026**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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

Wednesday, Sept. 16, 2026 / 7:31 a.m. – 8:25 a.m.

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

Voting Members Present:

Sara Choudhry, MD
Hackett, Emma, MD, FACOG
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Strain, Michael, Consumer Member
Thomas, Randy, MD
Jennifer Wilson, MD, MPH

Voting Members Absent: Steven Gwiazdowski, MD, FAAP; Brandy Lane, Consumer Member; Brian Montenegro, MD; Robert Quon, MD, FACP; Chris Swales, MD

Partnership *Ex-Officio* Members Present:

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

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
DeVido, Jeff, MD, Behavioral Health Clinical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health

Guests:

Beard, Alyssa, RN, Manager of CC Regulatory Performance
Brunkal, Monika, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, UM Regulations
Cunningham, Aryana, Policy Analyst, Care Coordination
Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health
Devan, James, Director of Quality Management
Durst, Jennifer, Senior Manager, Quality Incentive Programs, QI
Elder, Alaina, Manager of Provider Network Services, Provider Relations
Frankovich, Terry, MD, Associate Medical Director
George, Michael, MD, Associate Medical Director
Isola, Brandy, Manager of Performance Improvement (Chico)
Krznarich, Jackie, RN, Mgr, Member Safety – Quality Inspections
Kubota, Marshall, MD, Reg. Medical Director
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Morris, Matthew, MD, Regional Medical Director (Auburn)
Stites, Jaylyn, Program Manager II, Provider Relations
Thornton, Aaron, MD, Associate Medical Director
Trosky, Renee, Manager, Network Services Compliance, Network Srvcs

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Announcements	Committee Chair and Chief Medical Officer Robert Moore, MD, MPH, MBA, sitting in Fairfield called the meeting to order at 7:31 a.m. • The Aug. 19 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* o Aug. 11 Internal Quality Improvement (IQI) Committee as amended at Sept. 8 IQI o July 29 Over/Under Utilization Workgroup • Announcements: o Medical Director for Quality Mark Netherda, MD, welcomed Jackie Krznarich, RN, and Jennifer Durst in their new respective roles as manager of Member Safety-Clinical Inspections and senior manager of Quality Improvement Programs.	Motion to **approve the Q/UAC minutes:** John Murphy, MD Second: Meagan Mulligan, FNP *Approved unanimously* Motion to **accept other minutes:** John Murphy, MD Second: Meagan Mulligan, FNP *Accepted unanimously*

II. Standing Updates

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

- The DataLink pilot has scaled up, and our vendor is helping us pull in data that we wouldn't normally be able to pull in from the various electronic health records (EHRs) at different provider organizations (POs). We have 26 POs on board; another 31 are in the process of getting DataLink at their sites. We hope this will result in acknowledgment of the great work that our network has already done and that we see this materially improve our Healthcare Effectiveness and Data Information Set (HEDIS®) rates.
- We have also had some changes to our Quality Score Measure Improvement (QSMI) groups. Historically, these have been cross functional groups that worked at a plan level. Now these groups are working on regional goals, still using subject matter expertise across the organization, but focused on the priorities we have for each region. So, there are some slight adjustments coming.
- We've also launched a new training program. As budgets have run tighter, we saw a need to provide some additional training to the network around Performance Improvement in Action. The idea here is for organizations, whether community-based organizations (CBOs), skilled nursing facilities (SNFs), primary care providers (PCPs), or counties, etc., would be able to take a problem that they are experiencing and work on it throughout this training program, six sessions over 12 weeks: to make good progress towards identifying a solution that they would like to implement. This is going Sept. 8 through Nov. 17. We encourage organizations to participate, especially if they haven't as many project managers or improvement resources as they have had in the past.

There were no questions for Isaac.

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

- Partnership is hosting a webinar on developmental screening for young children. (See Dr. Moore's monthly Medical Directors newsletter emailed Sept. 17 for registration information.) The Sept. 24 event will be hosted primarily by the University of California, Davis and Chape de Tribal Health. They developed a partnership where Chape de has moved the diagnostic part of the workup for kids who screen positive for developmental problems to their health center with individuals with specialized training, not relying on the regional centers, which were having a huge backlog. It's a strong model and has been put together well. I recommend that pediatric providers and health center leaders attend.
- You will recall last month that Kristine Gual presented the HEDIS® results. In October, we will be going through the Health Plan Accreditation (HPA) measures, which include additional measures above and beyond the Managed Care Accountability Set (MCAS). One notable group of those measures is the use of statins in individuals with diabetes, coronary artery disease, etc. Although clearly best practice and recommended by all specialist societies, the rates within our network were not as high as we would hope. (We do not have a pay-for-performance program.) This has impacted our overall National Committee on Quality Assurance (NCQA)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Stars score, so the Pharmacy team is willing to do an analysis on prescribing data within your organization and give individual-level information so that individual can be reminded to appropriately prescribe the statins. Please remind your providers to follow the national guidelines on the use of statins and to request academic detailing from Partnership. • The Partnership Leadership Academy to assist up and coming leaders in our primary care network (complete with) a heavy dose of quality improvement methodology and learning) has just had its second session. There are 35 participants very dedicated to the community they serve. It's very inspiring to be working with them. This is a one-year pilot, and depending upon the finances, we will see if we can continue it in the future. • As you are aware, persons with uncertain immigration status (UIS) are going to be carved out of Partnership, effective Jan. 1. This will include populations we have had all along, including kids with complex care needs (CCS) and pregnant women. This is a big transition. The State is not prepared to take on all the roles. They specifically had a strategy to move all the care they were responsible for to the Managed Care Plan (MCPs) a couple of years ago, and now they seem to have a strategy to bring it back in. It will be sort of a two-tiered system. More to come on that. • The State had worked with the federally qualified health centers (FQHCs) for several years to try and bring up an alternative payment methodology (APM) for FQHC care in the Medi-Cal system. Version 1 was not ultimately approved by the Centers for Medicare & Medicaid Services (CMS), and it was never implemented. The State proceeded with a Version 2 without CMS approval: CMS just formally disapproved the entire APM pilot a couple of weeks ago. The lesson there is just because you like a project do not assume it will be approved. It will be work to go backwards: we will have to repay based on the old system for all the care provided on the APM. • The H.R. 1 work requirements now have several tiers. (CMS squashed DHCS initial approach to make anything slightly plausible to be disabling a suitable condition for exemption.) Now, the work requirements from CMS have several tiers. Tier 1 is really people in the hospital. Tier 2 is some other diagnoses where other data sources can be involved. Tier 3 requires a clinician to sign off. There is much detail. The State now has to take the CMS framework and then create their regulations. • Our Board met last month and honored the high performers in the PCP QIP. It was a nice recognition. There were so many high performers, we had a separate Board session just for the recognitions. • Partnership's Board of Commission has approved a budget that involves a shortfall. Partnership will be spending down reserves this year with something like a $50M loss. It is a considerable shortfall, but compared to the size of the business, it is not gigantic. Partnership has been doing well with that balance sheet for some time; other plans are not doing so well and are doing layoffs, among other things. The financial strength of our organization allows us to weather tough times, which is a critical message to get out. *Q/UAC voter and pediatrician Randy Thomas, MD, asked about the Sept. 24 webinar. Dr. Moore reiterated the high points and added it is covering bringing in or training an in-house specialist – but not at the same level as someone who has completed a neuro-psych fellowship program – sufficient to do the initial screening to figure out autism and other developmental issues. Based on that, children would be triaged to the right location.*	
III. Old Business – None.		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set- *direct questions to Tony Sengdara* Pharmacy/Utilization Management Treatment Authorization Request (TAR) Timeliness, Inter-Rater Reliability (IRR) and UM Rates Reports – Quarters 1 & 2 2026 – *direct questions to Stan Leung, Pharm.D or Tony Hightower, CPhT* – **Dr. Moore pulls** Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct questions to Latrice Innes* **Health Services Policies** <u>Quality Improvement</u> MPQP1002 – Quality/Utilization Advisory Committee_		*Q/UAC voters posed no questions.* Motion to **approve the remaining slate as presented:** Randy Thomas, MD Second: Meagan Mulligan, FNP

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1008 – Conflict of Interest Policy for QI Activities MPQP1022 – Site Review Requirements & Guidelines (with three revised attachments and one **archived** attachment) MPQP1053 – Peer Review Committee Utilization Management MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities MCUP3115 – Community Based Adult Services – **Anna Campbell pulls** MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump MPUP3078 – Second Medical Opinions MCUP3115: Anna Campbell said UM has confirmed with Regulatory Affairs & Compliance (RAC) that paragraph VI.K can be deleted. Darling v. Douglas Settlement mention dating from 2012 is no longer necessary. Dr. Moore called Q/UAC's attention to the semi-annual Pharmacy/UM report. Pharmacy is hitting timeliness and has a low and "acceptable" overturned appeal rate. UM is also hitting timeliness goals. Q/UAC voter John Murphy, MD, asked what medications Partnership is responsible for and what goes through Medi-Cal Rx? Director of Pharmacy Stan Leung, Pharm.D, replied "our department is responsible for all the physician administered drugs (PADs). Medi-Cal Rx is responsible for all the pharmacy dispensed drugs and also certain home infusion drugs that go through the pharmacy."	*Approved unanimously* Motion to **approve MCUP3115 as amended:** Randy Thomas, MD Second: Meagan Mulligan, FNP *Approved unanimously* Motion to **approve the Pharmacy/UM Report as presented:** Randy Thomas, MD Second: John Murphy, MD *Approved unanimously* Next Steps: Oct. 14 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*		
MPPRGR210 – Provider Grievance	**This policy was pulled from July 7 IQI consideration for more edits. During this subsequent review, edits were made to incorporate Provider Relations' standing up of an internal mechanism to track provider grievances outside of Claims, Provider Dispute Resolutions (PDRs), and Treatment Authorization Requests (TARs).** **I. Related Policies** – updated to include CLPM-41 Claims Provider Dispute Resolution Mechanism and CMP38 Escalation and Corrective Action **II. Impacted Departments** – updated to "All Departments" as multiple departments may be impacted by a provider issue **III. Definitions** – updated Network Provider, PDR, and Provider Grievance definitions. **V. Purpose** – This policy establishes the process by which Network Providers may submit, and Partnership HealthPlan of California (Partnership) may review and resolve provider grievances. This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/Pharmacy appeals or Medi-Cal Member Grievance processes. This policy is also separate from the Provider Dispute Resolution (PDR) process. Claims payment disputes, overpayment disputes, and other claim- related matters must first be addressed through the PDR process and are not eligible for review through the Provider Grievance process unless all applicable PDR processes have been exhausted. Providers not contracted with Partnership are not eligible to submit provider grievances. **VI. B. Intake** – To describe the Provider Relations' process for accepting and reviewing submitted	*Q/UAC voters posed no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Oct. 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	provider complaints. Informal complaints will be resolved by the PR team, with help from impacted departments For formal grievances, upon review, PR ensures that all Partnership appeal processes have been exhausted. Providers must submit their complaint within 180 days of the initial incident date. **VI.C Review/Resolution** – provides the grievance resolution cycle, including steps and timeline **IX. Position Responsible for Implementing Procedure –** updated to the Director of Provider Relations to reflect the new departmental organization. Aaron noted that one of the main components PR looks at for grievances is the timeline. That timeline now includes an 180-day submission deadline or any contracted provider who would like to grieve something within Partnership, usually a process. A formal provider grievance must be written. We will acknowledge that within a five-day time period and respond within 60 days. Within that 60-day time period, there is an opportunity for Provider Relations' PPO (Provider Performance Oversight) team to investigate. If there is additional review needed by the Executive team, we allow 15 days for that review and an additional 15 days to draft a letter, get all the necessary approvals, and respond. Each provider grievance is tracked in PR's customer resource management (CRM) tool. One other main highpoint is that this policy now differentiates the provider grievance process from a Claims PDR or a UM appeal, Aaron added. That's important because we want to preserve the integrity of those processes. Therefore, a provider cannot grieve an individual decision that has been an outcome of one of those processes; however, they can appeal the process. Dr. Moore called VI.E.1 to attention, noting that the informal process is where most issues come up where people are inquiring, if nothing else. It's different than for members where any expression of dissatisfaction bumps another grievance process, he said, and Aaron agreed, adding that the Health & Safety Code has more built into the requirements for member grievances versus provider grievances. Most of our questions or inquiries from providers do not have to be handled as a formal grievance. Most things can be resolved through conversation and minimal research. Finally, this policy is consistent with a couple of other sister plans.	
V. Presentations		
Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025 *Presented by Renee Trosky, BSRRT, MOL, Manager, Network Services Compliance, Network Services*		
Dr. Moore prefaced Renee's high-level report by noting it meets an NCQA standard. NCQA standards for network management guide the creation of the NET reports, Renee began. This NET 3 report covers three categories: availability of practitioners, accessibility of services and a final assessment of network adequacy. Availability is the geographic distribution of practitioners, along with the appropriate type and number of practitioners to meet the needs of our members. Accessibility is the extent to which a member can obtain available services when they are needed. The overall assessment of network adequacy looks at availability, accessibility, and "member experience" via member grievances, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores and out-of-network referrals.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Plan-wide, Partnership met the provider to member ratio standard for all PCP practitioners. We also met the provider ratio standards for all our chosen high-volume specialty providers. We met the performance goal plan-wide for geographic distribution of primary care and the individual performance standard for each type of PCP; however, when we look at a breakdown of the data at a county level, we see that Lassen County did not meet the performance goal for any of the three types of primary care despite the family practice to member ratio being 1:1,300. Renee said this is indicative of a rural county where the population is widely dispersed, and the providers are in or near towns and cities. Plan-wide, Partnership met the performance goal for the geographic distribution of high volume and high impact specialties.

Four sparsely populated counties (i.e., Modoc, Siskiyou, Lassen and Del Norte) are too small to sustain a practice for many specialties and thus did not meet the time or distance standard for specialty care access. Our 3NA survey results show that plan-wide we did not meet our 2025 performance goal for non-urgent adult, pediatric, or newborn primary care appointments. For specialty care, we met the 2025 goal for non-urgent specialty care appointments but did not meet the goal for urgent specialty care appointments. In a closer look at non-urgent specialty care by region, Cardiology and Dermatology fell below the standard. Ob-Gyn fell short in the Eureka region, Ophthalmology in the Fairfield and Santa Rosa regions, and Orthopedic Surgery in the Santa Rosa region.

When we look at member grievances regarding access, we see that we met the threshold of 3.12 grievances per 1,000 in 2025 despite small increases from 2024. Breaking down the access grievances between primary and specialty care, the majority of grievances are related to primary care in all three areas: appointment availability, office availability, and telephone availability.

Looking at CAHPS®, the adult composite score for getting needed care and getting care quickly both increased slightly, however, both failed to meet the ≥33rd Partnership benchmark. We see the same scenario for the child composite scores. This indicates we continue to have dissatisfaction with member access, which influences health plan ratings.

Partnership did meet the out-of-network request (≤20 per 1,000 members) and utilization performance (≤10 per 1,000 members) standards for 2025: both OON requests and claims decreased from 2024 totals.

When we put all the data together, an opportunity for improvement was identified in appointment access to non-urgent primary care. Partnership has fallen short of the goal for a second year in a row. To address this, the provider recruitment program was refined and extended to incentivize providers to join and remain in the network. The PRP offers sign-on bonuses for providers new to the Partnership network, including providers practicing outside our 24-county service area, as well as graduates completing training programs within our service area. We have seen success with this approach: in 2025, Partnership approved 185 awards. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51% of the awards compared to 57% in 2024.

There are other opportunities that can be identified and several other initiatives are going on, but for the purposes of this report and NCQA, we select one opportunity to highlight.

Dr. Moore commented that Partnership has sponsored feasibility studies and other ways for the formation of primary care residencies in our area. About 15 years ago, there were two primary care residencies in our service area. Now, there is about 13 to 15. There's a new one starting up in Del Norte.

He added that, for the OON requests, we probably had a spike in 2024 with the new counties because we hadn't finalized all our contracts: specialty referrals in the new region were going to specialists who had not yet been contracted and thus were captured as OON referrals. It's not that 2025 was down but that 2024 was an anomaly on the high side, he clarified. One note on specialty access, Fairfield and Santa Rosa are not rural but urban, and those are the areas where we struggle with access. Dr. Moore asked Director of Provider Relations Aaron Brincko if he had any reflections on the specialty access in our suburban southern part of the region. Aaron responded that a perhaps more informative way to look at the data would be to differentiate time and distance standards by whether a county is either rural or suburban.

Dr. Moore recalled that CMS froze new federally funded residency slots back in 1998, commenting "It takes a while to have a ripple, but it has now as retirements

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	happen and the number of residencies coming into the system is stable (but) not growing with the population. The shortage is a nationwide phenomenon. One of the things that saved us a little bit is that nurse practitioners and PAs came into the system to save us from the fact that we were undertraining primary care clinicians. We are seeing many more PAs and NPs joining specialty practices. It comes at a cost of less training and experience but at the same time it allows access." Dr. Moore added that "many specialists don't like the fee-for-service Medi-Cal reimbursement rate," and that an acute shortage of specialists will continue even as the UIS population is carved out from Partnership's membership rolls. "One solution on the specialty side, because of the economic forces, is to have the health centers do what they have been doing and hire their own specialists, at least on the outpatient side." Associate Medical Director Marshall Kubota, MD, asked if the specialty distance measures are irrespective of county borders and also account for telehealth. Dr. Moore responded that our computer systems account for both. Q/UAC voter John Murphy, MD, asked if the thresholds in this report were set by DHCS, internally, or some of both. Dr. Moore replied that these are NCQA thresholds and offered to further discuss this offline. Q/UAC voter Randy Thomas, MD, said about 30% of the persons he refers to Dermatology do not need to go but they wanted to before even trying an adequate trial of therapy. "I wonder if webinars to try to make primary doctors more comfortable with their skills could be helpful with reducing that?" he asked. Dr. Moore suggested primary care providers talk "we'll try this, and if it doesn't work, we'll try that, and if that doesn't work, we'll send you to Dermatology." Medical Director for Quality Mark Netherda, MD, suggested that PCPs do know how to have these conversations but "are just burned out and tired of patients coming in and demanding things and being angry at them when they say no. The grievances I get are 'I went in and asked to see a cardiologist just so I could get checked out, and they said no. I went in for genetic testing, and they said no.'" Dr. Moore acknowledged this is a problem, adding it is particularly hard when a patient the doctor doesn't know comes in and asks for such. *Motion to approve the Grand Analysis: Jennifer Wilson, MD/Randy Thomas, MD. Unanimously approved.*	
VI. Adjournment to 7:30 – 9:00 a.m. Oct. 21 2026		
Dr. Moore adjourned the meeting at 8:25 a.m. *Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI* Signature of Approval: _____ Date: _____ *Robert Moore, MD, MPH, MBA* *Chief Medical Officer and Committee Chair*		

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
September 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** • During August's PAC meeting, the PCP QIP proposed measure set for MY2027 was reviewed and approved. • The PCP QIP team will begin specifications write-up for MY2027.
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) has begun with payment distribution being completed no later than 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** • The Perinatal Quality Dashboard was updated with Quarter 4 data and perinatal providers received their Q4 / Preliminary Reports for the 2025-26 measurement year. Most of the providers in the PQIP have connected with DataLink or are in the process of connection. DataLink is working to provide updated data to Partnership that will include capturing Estimated Date of Delivery to progress toward not needing monthly manual submissions for the PQIP timely prenatal care visits measures.
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 proposed 2027 ECM QIP measurement set will be presented to PAC this month.

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • The HQIP 6-month Bridge period kicked off July 1 and a Kickoff webinar was held on July 14th. The proposed 2027 HQIP Measurement Set will go to PAC in September for approval. This set includes several revised measures, aligning the Substance Use Measure with HEDIS, the return of a Hepatitis B measure removal of a couple measures and a new measure encouraging hospitals to get staff certified in Advanced Life Saving in Obstetrics (ALSO) or Basic Life Saving in Obstetrics (BLSO).
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 proposed 2027 EXT QIP measurement set will be presented to PAC this month.

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** • N/A
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** • N/A
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. **Program Update** • The ECDS/Datalink Project is transitioning from pilot to scale, with governance now established and planning underway to support expanded provider onboarding, data quality validation, and broader use of electronic clinical data for HEDIS, QIP, and future business needs. The project continues to build the infrastructure, resources, and cross-functional processes needed to support program growth while advancing Partnership's long-term ECDS strategy. Currently, 26 provider organizations have completed onboarding and are actively sending data, while 31 additional organizations are progressing through 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** • BH Non-clinical PIP submitted for the second year on 08/06/26. HSAG will validate and provide feedback no later than 10/01/26. The resubmission date is 10/27/26. • Clinical PIP final report submitted on 08/06/26. HSAG will validate and provide feedback no later than 10/01/26. The resubmission date is 10/27/26.
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: 1. Child and Adolescent Well Care Visits (WCV) 2. Adolescent Immunizations (IMA-2) 3. Controlling High Blood Pressure (CBP) 4. Glycemic Status Assessment for People with Diabetes (GSD) 5. Timely Prenatal Care (PPC-Pre) **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. The first drafts of toolkits for QMSI workgroups are scheduled to be completed by 9/30/2026. Going forward, this report will be reorganized to better align with shifting strategies and accountability. **Workgroup Updates** • **Pediatrics:** Developing Toolkit materials for Child and Adolescent Well Care Visits (WCV), Well Child Visits during the first 30 months of life (W30+6 and +2). • **Women's Health & Perinatal:** Developing toolkit materials for Timely Prenatal Care (PPC-Pre). • **Chronic Disease:** Developing Toolkit materials for Controlling High Blood Pressure (CBP) and Colorectal Cancer Screening (COL). • **Behavioral Health:** No new updates. Behavioral Health measures are not currently prioritized for improvement activity. The workgroup is focused on improving data completeness.
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. • The pilot for this new training program launched on 09/08/2026 with 20 provider participants and will run through 11/17/2026. **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** • Fall 2026 cohort kicks off 09/01/2026. There are currently 135 individuals enrolled. **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
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS | *ORG GOALS – FY 25/26 MEMBER EXPERIENCE*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)*** •

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** • No new updates at this time.
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.* **Program Updates:** • ***Phase I:*** All 10 counties applied, 9 have received awards, 1 is in discussions to explore the proposed intervention. • ***Phase II:*** Proposed framework has been developed and is currently in review. • ***Phase III:*** Vendor exploration is in progress.
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and

<table>
<tr><td></td><td>sanctions associated with unmet benchmarks, and enhancing the overall member experience.

Project Update
No new updates</td></tr>
<tr><td>Mobile Mammography Program</td><td>Program Overview
Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings.

Program Updates

<table>
<tr><th colspan="3">Event Days
07/01/2026 – 10/31/2026</th></tr>
<tr><th>Region</th><th># of Provider Event Days</th><th># of Community Event Days</th></tr>
<tr><td>Auburn</td><td>2</td><td>0</td></tr>
<tr><td>Chico</td><td>9</td><td>1</td></tr>
<tr><td>Eureka</td><td>13</td><td>0</td></tr>
<tr><td>Fairfield</td><td>4</td><td>0</td></tr>
<tr><td>Redding</td><td>8</td><td>0</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>0</td></tr>
<tr><td>Plan Wide</td><td>40</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 at this time.</td></tr>
<tr><td>Abbott Cancer Diagnostics: Promoting Colorectal Cancer Screenings</td><td>Offering Updates
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.</td></tr>
</table>

	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. **Partnership Facilitated Orders** • Partnership's last facilitated order launched on 07/20/2026 with a final submission date of 08/17/2026. Pre-shipment patient letters are expected to be 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 for Committee 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
	  • Board of Directors – 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 to 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.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**

POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 07/31/2026 TO 08/18/2026	**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** • 19 referrals were received with 14 from Grievance and Appeals, 4 from QI Member Safety, and 1 from Utilization Management • 15 cases were processed and closed • 110 cases are currently open • Two cases were discussed at the PRC meeting in August, resulting in two Corrective Action Plans. There are nine cases pending PRC review.
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** • The MY2025 HEDIS Annual project is complete. Partnership received its Final Audit Report from Health Services Advisory Group (HSAG) for the Managed Care Accountability Set (MCAS) measure set on 07/15/2026. The NCQA Health Plan Accreditation (HPA) audit is also complete. Partnership anticipates receiving NCQA's final MY2025 Health Plan Rating in September 15,2026.
HEDIS® Program Overall	**Program Updates** • The HEDIS Annual Summaries of Performance for the DHCS MCAS and NCQA HPA programs will be shared within Partnership, with the Physicians Advisory Committee (PAC) and the Quality Advisory Committee (QUAC), and the Board of Commissioners in August 2026. • In MY2025, MCAS measure rates were reported to HSAG/DHCS as one Plan-Wide rate for each measure. Partnership also reported county-level data to DHCS in

	MY2025. DHCS continues to its intention to use county-level data to sanction Managed Care Plans for measures in the Accountable measure set that did not perform at the Minimum Performance Level (MPL). • Completed NCQA's 2026 Health Plan Ratings (HPR) Projected Ratings process. NCQA projected HPR rating for MY2025 is 3.0 Stars, using the Child CAHPS Survey. • Prospective Medical Review Project (PMR) used to collect medical records for use as supplemental data for administrative measures such as W30 is being prepped to launch September 2026.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Program Management Team uploaded the majority of survey documents, including the file review universes and selected delegates, to the NCQA web-based platform, Interactive Review Tool (IRT). Our consultant, Managed Healthcare Resources (MHR) has reviewed our documentation and is verifying our information completed for each requirement and all Compliance Statements were completed correctly. Submission of all finalized documents to NCQA is on 9/15/2026. • The Post HPA Renewal Survey activities will begin on 10/08/2026, when NCQA provides initial findings and outstanding issues to Partnership. The NCQA Program Management Team, along with affected Business Owners, will review and address the Initial Issues report from 10/9/2026 – 10/13/2026. A survey conference call is scheduled with NCQA on 10/14/2026 during which Partnership can clarify the outstanding issues with the surveyors before providing any additional documents by 10/19/2026. Only documents that existed prior to 9/15/2026 will be accepted as additional documentation. • Departments who participate in File Review have prepared their file universes for the applicable look-back period by completing the File Review System Universe Instruction Workbooks supplied by NCQA. The workbooks will be uploaded to NCQA's online submission portal, IRT, on or before the Renewal Survey submission date, 9/15/2026. Random file samples will be selected by NCQA and provided to Partnership on 10/19/2026. Partnership's Virtual File Review Audit is scheduled for 11/02/2026 and 11/03/2026. Selected files, including Partnership and delegate files, will be reviewed by NCQA surveyors during the Virtual Audit. A Closing Conference Call with NCQA, the Executives and all key stakeholders will also take place on

	11/03/2026, at which time NCQA will review the remaining issues (i.e. identified gaps) with Partnership.
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** • NCQA has confirmed that they will not be releasing a new set of HOA Standards and Guidelines in 2027. Partnership will be assessed against the 2026 HOA Standards and Guidelines (released in December 2025) for the May 2028 HOA Renewal Survey. Although a new set of standards will not be released, the NCQA Program Management Team must continue to monitor for Triannual Policy Updates and FAQs that may change the requirements for the 2026 HOA Standards and Guidelines. We will seek clarification from NCQA to determine if they plan to update the Implementation Plan timeframes (currently applicable through 06/30/2027) or any of the look-back periods, as this may affect the production timelines and planning for several requirements.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• NCQA did not release any Triannual Policy Updates in July 2026. The next updates are scheduled to be released in November 2026.

Partnership Policy & Procedure Updates

October 2026

Policy Number	Policy/Procedures/Guidelines
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **September 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.*	
Provider Relations	
MPPRGR210	Provider Grievance
Quality Improvement	
MPQD1002	Quality/Utilization Advisory Committee
MPQP1008	Conflict of Interest Policy for QI Activities
MPQP1022	Site Review Requirements & Guidelines (with four changed attachments)
MPQP1053	Peer Review Committee
Utilization Management	
MCUG3022	Incontinence Guidelines
MCUG3058	Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities
MCUP3115	Community Based Adult Services
MPUP3059	Negative Pressure Wound Therapy (NPWT) Device/Pump
MPUP3078	Second Medical Opinions

Synopsis of Changes to Discussion Policy MPPRGR210

Below is an overview of the policy that will be discussed at the Sept. 16, 2026 Quality/Utilization Advisory Committee (Q/UAC).
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]

☒ **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	

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*			
MPPRGR210 – Provider Grievance – *CLEAN copy begins on p. 205*	201 – 207	**This policy was pulled from July 7 IQI consideration for more edits. During this subsequent review, policy edits were made to incorporate Provider Relations' standing up of an internal mechanism to track provider grievances outside of Claims, Provider Dispute Resolutions (PDRs), and Treatment Authorization Requests (TARs).** **I. Related Policies** – updated to include CLPM-41 Claims Provider Dispute Resolution Mechanism and CMP38 Escalation and Corrective Action **II. Impacted Departments** – updated to "All Departments" as multiple departments may be impacted by a provider issue **III. Definitions** – updated Network Provider, PDR, and Provider Grievance definitions. **V. Purpose** – This policy establishes the process by which Network Providers may submit, and Partnership HealthPlan of California (Partnership) may review and resolve provider grievances. This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/Pharmacy appeals or Medi-Cal Member Grievance processes. This policy is also separate from the Provider Dispute Resolution (PDR) process. Claims payment disputes, overpayment disputes, and other claim- related matters must first be addressed through the PDR process and are not eligible for review through the Provider Grievance process unless all applicable PDR processes have been exhausted. Providers not contracted with Partnership are not eligible to submit provider grievances.	All Departments

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

Synopsis of Changes to Discussion Policy MPPRGR210

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		VI. B. Intake – To describe the Provider Relations' process for accepting and reviewing submitted provider complaints. 1. Informal complaints will be resolved by the PR team, with help from impacted departments 2. For formal grievances, upon review, PR ensures that all Partnership appeal processes have been exhausted. 3. Providers must submit their complaint within 180 days of the initial incident date. **VI.C Review/Resolution** – provides the grievance resolution cycle, including steps and timeline **IX. Position Responsible for Implementing Procedure –** updated to the Director of Provider Relations to reflect the new departmental organization.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPPRGR210				**Lead Department: Provider Relations**	
Policy/Procedure Title: Provider Grievance				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994			**Next Review Date:** ~~10/13/202/2027~~10/14/2027 **Last Review Date:** 10/14/2026		
Applies to:	☒ **Medi-Cal**		☐ **Employees**		☐ **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: 10/14/2026** ~~04/08/2026~~	

I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System
E. CLPM-41 Claims Provider Dispute Resolution Mechanism
F. CMP38 Escalation and Corrective Action

II. IMPACTED DEPTS:

~~A. **Provider Relations**~~
~~B.~~A. Health Services

III. DEFINITIONS:

A. Network Provider: any Provider or entity that has an Agreement with Partnership and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to Partnership members.
B. Provider Dispute Resolution (PDR): The process by which a provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment is resolved.
~~A.~~C. Provider Grievance: A formal written~~For the purposes of this policy, a Provider Grievance is defined as an~~ expression of dissatisfaction submitted by a Network Provider related to Partnership's policies, processes, procedures, or administrative actions, with the exception of decisions regarding claims or service authorizations~~from a provider that, after exhausting all Plan appeal processes, requests to have their complaint, appeal or dispute submitted to the Provider Grievance Review Committee for final review of the medical or pharmacy decision or how the Plan implemented a regulatory requirement~~. A provider grievance may be submitted after ~~all~~any applicable Partnership reconsideration, appeal, or dispute resolution processes have been exhausted.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy establishes the process by which Network Providers may submit, and Partnership HealthPlan of California (Partnership) may review and resolve provider grievances. This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/Pharmacy appeals or Medi-Cal Member Grievance processes. This policy is also separate from the Provider Dispute Resolution (-PDR) ~~process~~process. Claims payment disputes, overpayment disputes, and other

claim- related matters must first be addressed through the PDR process and are not eligible for review through the Provider Grievance process unless all applicable PDR processes have been exhausted. ~~and claims related dispute shall exhaust the PDR process prior to being addressed as a provider grievance. resolved through that process.~~ Providers not contracted with ~~Partnershi~~Partnership are not eligible to submit provider grievances.
~~To describe the process for resolving provider grievances related to determinations of medical or pharmacy decisions made by Partnership HealthPlan of California, the Plan's implementation of DHCS Regulatory or other State and Federal requirements, or contractual disputes between the Health Plan and providers. The provider grievance process is not applicable to provider appeals filed on behalf of members and as such, is separate and distinct from the member grievance and appeal process. A provider may request a grievance after all applicable Partnership Appeal processes have been exhausted.~~

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California, ~~(Partnership)~~ Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the Partnership Chief Medical Officer, Chief H~~h~~ealth Services Officer, Chief Operating Officer, and ~~Senior~~ Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.

B. INTAKE:

1. Informal complaints and requests for routine assistance are addressed by the Provider Relations team, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters but are available if requested.
   a. ~~If a provider expresses~~Provider concern(s), ~~these~~ should first be addressed ~~attempt to be resolved within~~through the impacted department's internal resolution policies and procedures. The Provider Relations team will connect the caller to the appropriate department to address the issue and respond ~~as appropriate~~appropriately.
2. If unable to resolve, upon receipt, Provider Relations shall review and categorize the grievance to determine:
   a. Appropriate internal routing
   b. Level of urgency
   c. Required escalation
   d. Applicable resolution timeframe
3. Providers have 180 calendar days from the incident date to report any concerns to the Provider Relations team via the Provider Grievance Intake form or formal written notice to prgrievances@partnershiphp.org.

C. REVIEW / RESOLUTION

1. ~~The life cycle of a provider grievance can take up to~~Provider Grievances shall be resolved within sixty (60) business days ~~for final formal resolution by the Executive Committee.~~.
   a. If a provider submits a formal written grievance, Provider Relations team shall acknowledge receipt of a provider grievance within five (5) business days of submission.
   b. If the Provider Relations team is unable to adjudicate the grievance within thirty (30) business days, the grievance may be submitted to the executive committee for final review.
   c. The E~~e~~xecutive C~~c~~ommittee will review and determine final decision of the grievance within fifteen (15) business days of the escalation.
   d. The provider is formally notified within fifteen (15) business days of the Committee's decision.
2. Partnership shall make reasonable efforts to resolve grievances at the lowest appropriate level and within the shortest timeframe practicable.

~~1. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.~~

~~2.~~

~~3. Informal grievances may be registered by the provider, by telephone, letter or visit to the Partnership office. The provider should contact the Provider Relations department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.~~

~~4. Formal grievance is filed in writing at the Partnership offices or by mail within 45 working days of the determination or action that is the subject of the grievance. There is a fifteen (15) working day resolution period during which time the Partnership staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing a Provider Grievance Review Committee (PGRC) hearing.~~

~~5. The PGRC will meet within forty-five (45) working days of receipt of the written provider request for a meeting. PGRC decisions are binding unless reversed by Partnership's Board of Commissioners.~~

~~6. The Provider Grievance Review Committee (PGRC) has been established to provide a formal grievance mechanism.~~

~~7. The PGRC consists of the members of the Peer Review Committee (PRC) who are not Partnership medical directors, excluding any members of the PRC who have a potential conflict of interest. Potential conflict of interest for provider grievances includes being a member of the active medical staff on a hospital if the hospital is the grieving party and otherwise working for a hospital or institution if the grieving party is a physician on the active medical staff of that hospital or institution. PGRC will meet on the same date as the Peer Review Committee.~~

~~8. The Committee's meeting is documented in minutes. The provider and Partnership are advised in writing of the Committee's decision within ten (10) working days of the meeting.~~

~~9. Providers appealing utilization management or pharmacy decisions on behalf of members must follow the procedure outlined in Health Services policy MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a PGRC hearing.~~

~~10. Providers retrospectively appealing a decision to deny or limit payment for a service based on application of UM criteria, for which the member is not financially responsible, should first submit an appeal (which is not on behalf of a member, but on behalf of the billing provider), with additional documentation responding to the reason for the initial denial or limitation. A provider grievance may not be filed until an initial appeal has been completed, which the provider disagrees with.~~

3. If during the review process, ~~the executive committeePGRC determines~~it is determined that a provider may be deficient in rendering or managing care, or problem areas are discovered, a Potential Quality Issue (PQI) referral is made to the Quality Improvement (QI) department via the PQI Referral Intake System. ~~this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI); S~~see MPQP1016 - Potential Quality Issue Investigation and Resolution.

~~11.~~4. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a ~~contracted~~ provider grievance ~~or a non-contracted provider grievance~~.

VII. REFERENCES:

A. ~~California~~ Department of Health Care Services (~~DHCS) All Plan Letter (APL) 21-011 Grievance and~~DHCS) All Plan Letter (APL) 21-011 Grievance and ~~Appeal Requirements~~Appeal Requirements, Notice and "Your Rights" Templates (*revised* Aug. 31, 2022,~~Aug. 31, 2021~~ *supersedes* APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2026~~4~~) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process ~~and Element I, Written Notification of Pharmacy Appeal Rights/Process~~

~~B.~~C. DHCS All Plan Letter (APL) 26-006 Skilled Nursing Facility Workforce Quality Incentive Program (March 30, 2026)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

~~Senior~~ Director of Provider Relations

X. REVISION DATES:

Medi-Cal: 08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 04/08/2026, 10/14/2026

PREVIOUSLY APPLIED TO:

N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPQP1002 (previously QP100102)				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Quality/Utilization Advisory Committee				☒**External Policy** ☐ **Internal Policy**	
Original Date: 12/1998			**Next Review Date:** ~~04/14/2027~~10/14/2027 **Last Review Date:** ~~04/08/2026~~10/14/2026		
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~~10/14/26	

I. RELATED POLICIES:

A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1004 – Internal Quality Improvement Committee
~~B.~~C. MPQP1008 – Conflict of Interest Policy for QI Activities
~~C.~~D. MPQP1016 – Potential Quality Issue Investigation and Resolution
~~D.~~E. MPQP1053 – Peer Review Committee
~~E.~~F. CMP10 – Confidentiality
~~F.~~G. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Grievance & Appeals
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, ~~2027~~2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage E~~e~~nrollees 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 Jan. 1, 2028 and subject to CMS and DHCS approval.

A.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Quality/Utilization Advisory Committee (Q/UAC) is responsible for monitoring the quality of comprehensive medical care and services provided to Partnership HealthPlan of California's members. The

committee's goals are to ensure quality improvement efforts are prioritized, resources are appropriate, and processes are in place for providing quality, appropriate and safe healthcare to members. The Q/UAC reviews Partnership's Health Services departments' activities, makes recommendations, and serves as an appeal body on certain medical care issues. On occasion, the Q/UAC may review Grievance & Appeals, Member Services, and Provider Relations policies. The Q/UAC may establish inpatient and ambulatory review subcommittees as needed to accomplish its responsibilities. A ~~subcommittee~~ clinician subset of the Q/UAC serves in a confidential capacity as part of the Peer Review Committee (PRC).

The Q/UAC provides policy and other recommendations to the Physician Advisory Committee. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Composition

a. The Q/UAC is chaired by the CMO and comprised of formal voting representatives from community primary and specialty care practices and consumer representative(s). Licensed physicians and non-physician advanced practice clinicians (e.g., psychologists, nurse practitioners, physician assistants and certified nurse midwives) may serve on the committee. These clinician members of the committee represent licensed providers of hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The consumer representative(s) must be a consumer from one of the counties served by Partnership.

1) Committee members serve open terms and may submit resignation to the CMO or his designee.

2) Voting members with annual attendance of <50% are evaluated for termination from the Q/UAC.

b. The following Partnership staff or their delegates serve as non-voting members:

Quality/Utilization Advisory Committee Standing Members	
Department Represented	**Position Title**
Administration	Director, Grievance and Appeals
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Deputy Chief Medical Officer
	Medical Director for Medicare Services
	Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Director of Health Equity (Health Equity Officer)
	Director, Population Health Management
	Director, Enhanced Health Services
	Director(s) and Associate Director(s), Utilization Management
	Director(s) and Associate Director(s), Care Coordination
	Director, Pharmacy Services
	Manager, Member Safety - Quality Investigations

	Manager, ~~Clinical Compliance~~Member Safety – Quality Inspections
	Senior Health Educator
Provider Relations	Senior Provider Relations Rep Manager or designee

2. Minutes: Minutes are taken at all meetings. Approved minutes are submitted monthly to Regulatory Affairs and Compliance (RAC) inbox. RAC submits these minutes quarterly to the Department of Health Care Services (DHCS) and forwards the tracking documentation to the designated QI staff.
3. Chair: The CMO chairs the Q/UAC. The Medical Director for Quality serves as vice chair. When neither is available, a Medical Director or a non-Partnership clinician member of the Q/UAC acts as temporary chair.
4. Meetings: The Q/UAC meets at least ten (10) times a year with the option to add additional meetings if needed.
5. Compensation: Non-Partnership clinician and consumer committee members are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by Partnership for management responsibilities). This stipend may be in addition to other compensation when the member serves as a clinical consultant/physician adviser.
6. Voting: Only consumer and non-Partnership clinician members constitute the voting membership, with the CMO or acting chair serving in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members.
7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each committee member signs an annual Confidentiality Agreement prepared and retained by Partnership. This agreement signifies the intent to protect individuals against misuse of information and to ensure all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner.
8. Conflict of Interest: Each committee member signs an annual Conflict of Interest statement prepared and retained by Partnership.

B. Committee Responsibilities

1. Annually reviews, recommends, and approves the Utilization Management Program Description submitted by Health Services' Utilization Management department.
2. Annually reviews, recommends, and approves the Quality Improvement Program Description, Program Evaluation, and Work Plan submitted by Health Services' Quality Improvement department.
3. Annually reviews, recommends and approves the Population Health Management Strategy and Program Description and other Population Health documents as required.
4. Annually reviews, recommends and approves the Cultural & Linguistic Program Description, Program Evaluation, and Work Plan.
5. Annually reviews, recommends and approves the Care Coordination Program Description, status reports, and case management activities.
6. Annually reviews, recommends and approves ~~the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description~~ the Health Equity and Community Reinvestment Strategy and Program Description and other Health Equity documents as required.
7. Annually reviews and makes recommendations for medical policy, new technology, and protocol changes based on guidelines and standards of practice; makes recommendations on Clinical Practice Guidelines (CPGs) and preventive health guidelines to the PAC.
8. Makes recommendations and approves Partnership policies addressing, but not limited to, quality improvement, utilization management, care coordination and health equity activities.
9. Approve and ensure implementation of evidence-based guidelines and policies of medical practice

including preventive, chronic care, and behavioral health initiatives.

10. Identifies, reviews, and recommends improvements in all areas pertaining to the quality and appropriateness of medical care. Advises staff on selection and prioritization of quality improvement activities.
11. Develops and/or approves clinical criteria used by UM staff to perform prospective and concurrent inpatient, ambulatory review or other utilization activities.
12. Reviews utilization, financial, and other staff reports that display the utilization of services and outcomes of quality within the delivery system.
13. Serves as a review body to assist in the interpretation of medical benefit coverage based on medical necessity and appropriateness issues.
14. Provides oversight of delegated utilization management and quality improvement activities.
15. Reviews performance dashboards and make recommendations for corrective action on indicators that fall below established thresholds; ensures follow-up on corrective actions where identified.
16. Reviews and provides recommendations for member-related activities including Consumer Assessment of Healthcare Providers and Systems (CAHPS®), grievances, telephone access, appointment access, availability and other member satisfaction surveys.
17. ~~Oversees the activities of its subcommittee, the Peer Review Committee (PRC), which serves as a peer review body for medical care issues. PRC members include clinician members of the Q/UAC and Partnership staff. PRC's charter is described in both MPQP1053 – Peer Review Committee and MPQP1016 - Potential Quality Issue Investigation and Resolution.~~

C. Committee Accountability
   1. The Q/UAC has oversight responsibility for the development, implementation, and effectiveness of the quality improvement and utilization management programs. The Q/UAC is accountable to the PAC, and through this body, to the Partnership Board of Commissioners on Medical Care.

D. Delegation Oversight and Monitoring
   1. Partnership may delegate~~s~~ quality improvement activities, responsibilities and committee structure.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership conducts oversight and monitoring activities, including ~~an~~ audits ~~not~~ no less than annually, to ensure ~~the~~ appropriate policy and procedures are ~~in place~~maintained.~~.~~
   4. Results from Oversight and Monitoring activities shall be presented to DORS for review and approval.

VII. REFERENCES:

N/A

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer/Committee Chair

X. REVISION DATES:

Medi-Cal

06/21/00; 03/21/01; 05/15/02; 10/16/02; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 04/21/10; 09/19/12; 09/18/13; 04/16/14; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 03/11/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25; 04/08/26; 10/14/26

Partnership Advantage (effective January 1, 2028~~7~~)

N/A

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

PREVIOUSLY APPLIED TO:
PartnershipAdvantage
MPQP1002 - 03/21/2007 to 01/01/2015

Healthy Families
MPQP1002 - 10/01/2010 to 03/01/2013

Healthy Kids
MPQP1002- 03/21/2017 to 12/01/2016 (Healthy Kids program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK Q1201)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Conflict of Interest Policy for QI Activities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~08/13/2026~~10/14/2027 **Last Review Date:** ~~08/13/2025~~10/14/2026		
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:** ~~08/13/2025~~10/14/2026	

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1053 – Peer Review Committee
C. MPQP1002 – Quality/Utilization Advisory Committee
D. MPCR200 Credentials ~~ing~~ Committee and CMO Credentialing Program Responsibilities
~~D.~~E. CMP-21 – Conflict of Interest Code

II. IMPACTED DEPTS:

A. Health Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. Conflict of Interest Agreement

V. PURPOSE:

To describe the mechanism to ensure that a conflict of interest does not exist when contracted providers, who are members of Partnership HealthPlan of California (Partnership) committees, perform peer review or quality improvement activities.

VI. POLICY / PROCEDURE:

A. All non-Partnership persons involved in Partnership peer review activities or committees shall sign a conflict of interest statement annually. Signed statements are retained in Quality Improvement department files.
B. Conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest or ~~fiduciary~~ relationship with the provider under review, or any other involvement in the case that may ~~impact~~ impair objectivity in performing the review. Note – a provider is a broad term that could include physicians or other direct care providers and vendors.
C. Committee members or peer reviewers with a conflict of interest in a particular case will notify the Medical Director for Quality or the Committee Chair, and excuse themselves from receiving related materials and from participating in the review.
D. Should a situation arise wherein this policy is not followed, the appropriate Committee and/or its Chair will determine appropriate action and notify the individuals(s) verbally and in writing.

VII. REFERENCES:

A. Cal. Civ. Code § 43.7 – Immunity from Liability for Peer Review Activities~~N/A~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
01/27/95; 10/10/97 (name change only); 12/98; 6/21/00; 05/16/01; 08/20/03; 09/15/04; 04/19/06; 04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 08/13/25; 10/14/26

Partnership Advantage (effectiveness Jan. 1, 2028~~7~~)
N/A

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

PREVIOUSLY APPLIED TO:
Partnership*Advantage*:
MPQP1008 - 04/18/2007 to 01/01/2015
Healthy Families:
MPQP1008 - 08/15/2012 to
03/01/2013 Healthy Kids: (KK
QI201, MPQP1008)
04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16 to 12/01/16
(Healthy Kids Program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

CONFLICT of INTEREST AGREEMENT

As a voting member of Partnership HealthPlan of California's Peer Review Committee, Quality/Utilization Advisory Committee, Credentials Committee or any other peer review entity involved in peer review, I recognize that absence of conflict of interest is vital to the unbiased and candid decisions necessary for effective peer review activities. Therefore, I agree to report any conflict of interest, potential or confirmed, to the Medical Director for Quality or the specific Committee Chair.

As a peer reviewer with a conflict of interest regarding any matter being reviewed or brought before a committee, I will refrain from participation in or completion of said peer review. I will also refrain from casting a vote on any related issue and shall absent myself from any proceedings of the committee in which such issues are raised for consideration.

A conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest in or relationship with the provider or vendor in question, or any other involvement in the case that may impair objectivity in performing the review.

Furthermore, my participation in peer review and quality improvement activities is in reliance on my belief that the absence of conflicts of interest related to these activities will be similarly ~~preserved~~ maintained by every other member of the committee or other individuals involved. I understand that Partnership HealthPlan of California is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

_____ _____
WITNESS DATE

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1022 (previously QP100122)				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Site Review Requirements and Guidelines				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/30/2002 (vs. 10/16/2002)			**Next Review Date:** ~~01/13/2027~~10/14/2027 **Last Review Date:** ~~05/13/2026~~10/14/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~05/13/2026~~10/14/2026	

I. RELATED POLICIES:

A. MCQP1052 - Physical Accessibility Review Survey – SR Part C
B. MPQP1016 - Potential Quality Issue Investigation and Resolution
C. ~~MCUP3101~~MPBP8007 - Screening and Treatment for Substance Use Disorders
D. MCQP1021 - Initial Health Appointment
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPPR208 - Provider Notification of Provider Termination, Site Closure or Change in Location Information
G. MCQG1015 - Pediatric Preventive Health Guidelines
H. MCQG1005 - Adult Preventive Health Guidelines
I. CMP36 - Delegation Oversight and Monitoring
J. MCUG3118 - Prenatal & Perinatal Care
K. MPCR12 - Credentialing of Individual ~~dependent~~ and Private Duty Nurses Under EPSDT
L. MPCR300 – Provider Credentialing and Re-credentialing Requirements
M. MCQP1025 Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
N. MCUP3044 Urgent Care Services

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services
C. Compliance
D. Grievance and Appeals

III. DEFINITIONS:

A. Primary Care Practice Site: a facility that provides services such as family medicine, internal medicine, pediatrics, and/or obstetrics and gynecology.
B. Supplemental Facility: Mobile, Satellite, School Based, and other Extension Clinics. Supplemental facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.
~~C. Free-Standing Urgent Care Provider: An outpatient facility contracted with Partnership HealthPlan of California to provide in-person visits for Urgent Care Services. These providers/facilities are not contracted to provide comprehensive primary care services and are not owned or administered by a hospital or primary care provider contracted with Partnership~~.
~~D.~~C. Free Standing Urgent Care Center: An outpatient facility contracted with Partnership HealthPlan of

California to provide in-person visits for Urgent Care Services. These providers/facilities are not contracted to provide comprehensive primary care services and are not owned or administered by a hospital or primary care provider contracted with Partnership.

~~E.~~D. Shared Medical Record Practice: Multiple PCP's see the same patients and utilize the same medical records for documentation of patient care. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.

IV. ATTACHMENTS:

A. Facility Site Review Tool
B. Facility Site Review Standards
C. Medical Record Review Tool
D. Medical Record Review Standards
E. Cognitive Assessment Addendum to Site Review
F. Non-Accredited Facility Site Review Tool
G. Non-Accredited Facility Review Standards
H. Private Duty Nursing Site Review Tool and Standards
I. Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool
J. Free Standing Urgent Care Clinic Facility Site Review Tool
K. Urgent Care Medical Record Tool
~~L. PCP providing Urgent Care Facility Site Review Tool~~
~~M.~~L. Palliative Care Facility Site Review Tool
~~N.~~M. Palliative Care Medical Record Review Tool
~~O.~~N. Master Trainer Application
~~P.~~O. Interim Review Template
~~Q.~~P. Provider Certificate

V. PURPOSE:

A. To provide primary care practice sites a comprehensive guideline for Site Review (SR) requirements and processes. A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Record Review (MRR). The FSR and MRR tools were developed by a collaborative coalition made up of staff from Department of Health Care Services (DHCS) and Medi-Cal Managed Care health plans (MCP). The purpose of the SR is to ensure that practicing sites have sufficient capacity to:
   1. Provide appropriate services;
   2. Carry out processes that support continuity and coordination of care;
   3. Maintain patient safety standards and practices;
   4. Operate in compliance with applicable federal, state, and local laws and regulations.
B. Findings of the SR are used to:
   1. Provide information for credentialing/re-credentialing decisions;
   2. Identify areas where education and technical assistance is needed;
   3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:

A. Requirements
   1. **Site Review Personnel**
      The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for SR activities completed by Partnership personnel. Partnership has designated a minimum of one Registered Nurse (RN) to be certified as a Master Trainer by the Department of

Health Care Services (DHCS).

a. Site Review Training and Certification

1) Partnership's Certified Master Trainer (CMT) is responsible for training, supervising and certifying Site Reviewers in addition to monitoring reviews and evaluating Certified Site Reviewers (CSR) for accuracy.
2) Site Review activities comply with the Site Reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the Site Reviewers' level of education and training.
3) Licensed physicians (MDs or DOs), nurse practitioners (NPs), physician assistants (PAs), clinical nurse midwifes (CNM), licensed midwife (LM), and registered nurses (RNs), are eligible to be a Site Reviewer and may perform a SR independently and sign off on the FSR and MRR tools.
4) Site Reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings for further review.
5) DHCS will recertify the Master Trainer(s) every three years.
6) Partnership's CMT will recertify CSRs every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from Partnership.
7) MDs, DOs, NPs, PAs, CNM, LM, and/or RNs that are designated to be a CMT or CSR must meet the certification and recertification requirements outlined in the table below.

Initial Certification Requirements	**Certified Master Trainer (CMT)**	**Certified Site Reviewer (CSR)**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP,PA, CNM or LM license	x	x
Be employed or subcontracted with Partnership	x	x
Have experience in conducting training in a health related field, or conducting quality improvement activities, such as medical audits, Site Reviews, or utilization management activities within the last three years.	x	
Complete 20 FSRs and 20 MRRs and one year experience as a CSR. Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	x	
Attend didactic Site Review training or completion of DHCS Site Review training modules on the current Site Review tools under supervision of a CMT.		x
Complete 10 FSRs and 10 MRRs with a CSR or CMT.		x
Achieve an Inter-rater score of 10% in FSR and 10% in MRR with designated CMT.		x

Recertification Requirements	**Certified Master Trainer**	**Certified Site Reviewer**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, PA, CNM or LM license	x	x
Be employed or subcontracted with Partnership	x	x
Be responsible for staff training on the most current DHCS Site Review tools and standards	x	
Participate in DHCS sponsored Site Review trainings as well as Site Review Work Group (SRWG) meetings and teleconferences.	x	
Maintain CMT certification.	x	
Complete a minimum of 30 Site Reviews following initial certification or recertification. (every 3 years)	x	x
Attend DHCS sponsored inter-rater workshops in person or virtually every three years.	x	x
Achieve a 5 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS	x	
Achieve a 10 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS		x

b. Inter-Rater Review (IRR) Process
   1) CMT and CSR candidates must complete an inter-rater review (IRR) as part of the initial certification and the recertification process.
      a) The IRR process requires the CMT candidate to concurrently complete and score a Site Review with a DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.
      b) The IRR process requires the CSR to concurrently complete and score a Site Review with the Partnership CMT according to the DHCS FSR and MRR tools and standards.

2) If the CMT or CSR does not meet the appropriate inter-rater score variance (see chart above), he or she may repeat the process one time. The appropriate inter-rater and candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review.
   a) CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait six (6) months to reapply for certification.

2. **Full-Scope Site Review**
   A full-scope SR consists of a CSR or CMT conducting both the FSR and the MRR using the most current tools and standards required by the DHCS. (See Attachments A-D.) All PCP and Supplemental sites must comply with the Site Review requirements within DHCS APL 22-017 in order to remain in the Partnership network. Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer (CMO) or the Medical Director of Quality for further guidance.
   a. FSR is a review of the practice's site, processes, and covers the following areas:
      1) Access/Safety
      2) Personnel
      3) Office Management
      4) Clinical Services
      5) Preventive Services
      6) Infection Control
   b. MRR areas include:
      1) Format (All sites)
      2) Documentation (All Sites)
      3) Continuity/Coordination (All sites)
      4) Pediatric Preventive (Family Practice & Pediatric sites, and OB/GYN sites if applicable)
      5) Adult Preventive (Family Practice, Adult Medicine sites, and OB/GYN sites)
      6) OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)
3. **Initial Site Review (SR) Process**
   a. An initial SR consists of an initial FSR and an initial MRR.
   b. The FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Members are not assigned to providers until the site has received a passing score and all CAP items are completed and signed off. An initial FSR is not required when a new provider joins a site that has a current passing FSR score.
   c. DHCS releases sets of DHCS Site Identification (DHCS Site ID) numbers per county and Partnership issues individual ID'S to each site based on the county identification ID'S provided by DHCS. In the event of an ownership change, a new DHCS Site ID will be assigned.
      1) Pre-contracted providers who do not pass the initial FSR within two attempts may reapply to Partnership after six months.
   d. An initial MRR must be completed within 90 days of the date that members were first assigned to the site.
      1) This may be deferred an additional 90 calendar days only if the new PCP does not have enough assigned members to complete the MRR on the required minimum number of records.
      2) If after 180 days following assignment of members and the site still has fewer than the required number of medical records, a MRR on the total number of records available will be completed. Scoring on the MRR tool will be adjusted according to the number of medical records reviewed.
      3) MRR's may be conducted virtually or on-site. The virtual process must comply with all applicable Health Insurance Portability Accountability Act (HIPAA) standards at all times.

e. An Initial Site Review is required when:
   1) A new site is added to the Partnership network;
   2) A newly contracted provider assumes a site with a previous failing FSR and/or MRR score within the last three years;
   3) A site is returning to the Partnership network and has not had a passing FSR within the last three years;
   4) Identification of multiple independent practices that occupy the same site;
   5) There is a change of name or ownership of an existing provider site;
   6) A site relocation requires that Partnership must:
      a) Complete an initial FSR within 60 days of notification or discovery of the completed move;
      b) Allow existing members to continue to see the provider;
      c) New members will not be assigned to the site until the site receives a passing FSR and MRR score.

f. If Partnership expands to a new service area, the FSR portion of the initial Site Review must be completed prior to the start of new or expanding operations. Requirements are outlined as following:
   1) Five percent of the PCP sites in the new network service area, or 30 sites, whichever is greater in number;
   2) All of the remaining PCP sites in the new network service area within the first six months of expansion;
   3) All of the PCP sites in the new network service area if there are 30 or fewer PCP sites;
   4) Partnership may use site reviews of existing county MCP's as evidence of completion of the initial site reviews;
   5) Partnership must submit data and relevant information to DHCS in the format and timeframe to be specified by DHCS for expansion.

4. Supplemental Facilities-Mobile, Satellite, School Based, and Other Extension Clinics
   a. Supplemental facilities that provide primary care services will undergo an initial Site Review and a subsequent site review at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
5. Subsequent Site Reviews
   a. Subsequent SRs consist of a FSR and MRR at least every three years, beginning no later than three years after the initial FSR. Site Reviews may be conducted more frequently per county collaborative discussions, when determined necessary based on monitoring or evaluation, or for CAP follow up issues.

VII. Scoring

A. FSR and MRR scores are based on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method. Scores are based on established scoring procedures, located in the FSR and MRR tools. Sites will receive a separate score for the FSR and/ or MRR.
   1. FSR Scoring
      a. The FSR is composed of critical and non-critical elements. Critical Elements (CE) are indicated on the tool by bold and underlined text. CEs have the largest potential for adverse effects on patient health and safety and therefore, have a scored weight of two points, while non-critical elements have a scored weight of one point.
      b. The Site Reviewer will advise the practice site of any deficiencies in critical elements during the SR.
      c. A CE deficiency will automatically result in a Corrective Action Plan (CAP) for all noted

deficiencies.

d. Partnership will conduct a meeting to verify all CE's are completed.

e. The FSR tool points will differ from site to site because the "not applicable" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" (non-applicable), "R" (refusal) or "No" shall include an explanation regarding this finding.

2. MRR Scoring
   a. All MRR tool elements have a score weight of one point each
   b. The MRR score is based on a standard review of randomly selected member medical records that represents the assigned member population.
      1) For sites that only serve pediatric or adult patients, all records must be reviewed using the appropriate preventative care criteria for adults, pediatrics (pregnant under 21 years) and/or obstetrics.
      2) Pediatric preventative services are provided to members under 21 years of age in accordance with current AAP bright futures recommendations.
      3) Adults age 21 years and older, preventative services are provided in accordance with USPSTF A and B recommendations.
      4) OB/GYN acting as a PCP must provide care in accordance with American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Prenatal Standards Program (CPSP).
         a) All medical records must be reviewed using the preventative care criteria for adults or pediatrics (pregnant members under the age of 21 years) and obstetrics.
         b) During the MRR review, reviewers have the option to request additional medical records for review. If the Site Reviewer chooses to review additional medical records, the scores must be calculated accordingly.
         c) If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records.
         d) If the site has multiple providers using the same medical record, this is considered a shared medical record system. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.
            i. The minimum number of records to be reviewed in a "shared" medical record relationship is determined by the number of providers at the site, unless otherwise approved by DHCS. See chart below

# Practitioners	# Medical Records to be reviewed
1-3	10
4-6	20
7 or more	30

         e) In the event that there are multiple providers in one office that do not share medical records, each provider must be reviewed separately and receive a separate score.
         f) MRR's may be conducted on-site or virtually and must comply with all HIPAA standards.
         g) The MRR total points will differ from site to site, depending on the number of physicians and types of records that are selected. The "N/A" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" shall include an explanation regarding this finding. Compliance level categories include: Exempted Pass, Conditional Pass, and Fail. See correlating table.

3. **Failing score**
   a. Contracted PCP and Supplemental sites who serve Partnership members must receive a passing

score of 80% on both the FSR and MRR to be considered passing. Sites with a score below 80% will be placed on an annual review cycle for their next review.

a. If a site fails the FSR or MRR, new members will not be assigned to the site until a CAP is initiated, completed, and closed.
b. If the site receives two consecutive failing Site Review scores (FSR or MRR), then on the third attempt the site must receive a minimum passing score on the FSR and/or MRR to remain in the Partnership provider network.
c. If the site fails on the third consecutive attempt, the site will be removed from the Partnership provider network and its members will be reassigned. Members will receive a 30-day notice.

4. **Focused Review**
   a. A focused review is a targeted review of one or more specific areas of the FSR or MRR. Partnership must not substitute a focused review for a SR. Focused reviews may be used to monitor providers between SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
   b. Site Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
   c. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to CAP timelines.

Compliance Category	FSR Score	MRR Score
Exempted Pass	90% or above *with NO* deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control **CAP not required**	90% or above with all section scores at 80% and above **CAP not required**
Conditional Pass	90% or above with deficiencies in Critical Elements/Pharmaceutical Services or Infection Control **OR** Score of 80-89% regardless of deficiencies **CAP required**	90% and above with one or more section scores below 80% **OR** Score of 80-89% regardless of deficiencies. **CAP required**
Fail	79% and below **CAP required**	79% and below **CAP required**

5. **Corrective Action Plan (CAP) Requirements and Timelines**
   a) CAP Documentation:
      1) CAPs will be completed using a standard format and form. CAPs may be verified via document submission, virtual platform, or an on-site review per nurse reviewer discretion.
      2) The minimum elements to be included in the CAP:
         a) Specific deficiency,
         b) Corrective actions needed,
         c) CAP due dates,
         d) Instructions for CAP submission,
         e) Partnership Contact information
   b. Closed CAP documentation shall include:
      1) Documentation of problems in completing corrective actions (if any),
      2) Education and/or technical assistance provided by Partnership,
      3) Evidence of the correction,
      4) Completion and closure date, and
      5) Name and title of Site Reviewer.
      6) Timeline for CAP notification and completion:

CAP Timeline	**CAP Action(s)**
FSR and/or MRR Survey Day	Partnership will provide the site the following: • Verbal notification of any CE findings and a signed attestation by the PCP/site designee and the MCP staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.) • A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion • The FSR and/or MRR scores the day of the site visit but no later than one business day after the site visit completion;
Within 10 Business days of the FSR and/or MRR	• PCP site must submit CAP and evidence of corrections to Partnership for all deficient CE's if applicable. • Partnership will review, approve, or request additional information on the submitted CAP(s) for all Non-CE • Partnership will provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all Non-CE deficiencies. (This serves as the start of the Non-CE CAP timeline) • Partnership will provide educational support and technical assistance to sites as needed.
Within 30 calendar days of the FSR and/or MRR	Partnership will verify all aspects of the CE CAPs are completed unless an extension was granted (not to exceed 60 calendar days from the date of the FSR). • PCP site must submit a CAP for all Non-CE deficiencies to Partnership. • Partnership will provide educational support and technical assistance to sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR	• Partnership will review, approve, or request additional information on the submitted CAP for non-critical findings. • Partnership will provide educational support and technical assistance to sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR	• All CAPs must be closed. • The Site can request a definitive time specific extension period to complete the CAP not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR	• Partnership will request approval from DHCS to complete a CAP review for extenuating circumstances that prevented completion of a CAP within the established timeline. • Partnership will stop assigning members to sites that do not correct Site Review deficiencies within the established CAP timelines. • Any provider that does not come into compliance with review criteria and CAP compliance within the established timelines will be removed from the network and their members will be reassigned. Members will receive a 30-day notice. • Partnership will conduct a FSR and MRR within 12 months if provider completes CAP and remains in the network.

6. **Provider Certificates**
   a. Upon the completion of a passing SR score (FSR and MRR) and completed CAP, Partnership will issue a provider site certificate using the most up to date DHCS template. The certificate will contain the signature of both the Chief Medical Officer (CMO) and CMT.
   b. The provider site certification will be valid for a maximum of three years.
7. **Non-Compliance with Corrective Action Process**
   a. Providers who fail to correct deficiencies within established CAP timelines, fail to ask for an extension, or request an extension but do not turn in any CAP documentation within 90 days of the Site Review will be sent a "Notice of Overdue Corrective Action Plan" to be drafted by the CSR or CMT and signed by the CMO or Medical Director informing the site that if the CAP is not received within 30 days the site will be closed to new Partnership members.
   b. If the site does not complete the CAP within 30 days of the first notice, then a 2nd "Notice of Review" will be drafted by the CSR or CMT and signed by the CMO or Medical Director. Further escalation, such as referring to the Credentialing team. will be directed by CMO or Medical Director.
      1) Actions taken by the Credentialing team may include, but are not limited to:
         a) Reassignment of existing members
         b) Termination of the site from the provider network

      Actions taken will be effective until corrections are verified and the CAP is closed. If Partnership chooses to remove the site from the network, members will be reassigned and given a 30-day notice.

      DHCS requires health plans to remove a provider from the network regardless of survey scores if criteria is not met or deficiencies are not resolved within established CAP timeline. Refer to MPPR208 - Provider Notification of Provider Termination, Site Closure, or Change in Location (Related Policy F) for the specific procedures.
8. **Provider Appeals**

   Refer to MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions (Related Policy E). If evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, Partnership will repeat a full-scope SR. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and Partnership will complete an initial full-scope SR.
9. **Systematic Monitoring Between SRs**
   a. Monitoring between regularly scheduled SRs will include, but is not limited to, data gathered through the following sources:
      1) Member grievances and appeals (reviewed when identified);
      2) Potential Quality Issue (PQI) information (reviewed when identified);
      3) Focused review or other on-site visit ;
      4) Healthcare Effectiveness Data and Information Set (HEDIS®) data collection (annually);
      5) Interim Review Template – see Attachment J.
   b. Problems identified through these mechanisms will require at a minimum:
      1) Informing the Provider of concern, and
      2) Issuing a CAP when a problem is verified. (Follow the above CAP process.)
   c. Interim Review Process
      1) Partnership will request a self-assessment of DHCS standards by provider site staff at the midpoint between SRs. This assessment will include all critical element criteria and previously identified deficiencies noted during the last SR.

a) The Reviewer may require an onsite Interim Review in lieu of a self-assessment based on the provider site's previous SR scores or lack of response to self-assessment.

2) Upon receipt of the provider's self-assessment, a reviewer will review the assessment and determine approval status. Any identified areas of concern will be clarified and a new CAP will be issued if required. Additional follow-up activities may include an additional site visit, referral to the CMO and/or Credentialing team.

10. As part of its monitoring and oversight of MCPs, DHCS conducts Site Reviews on randomly chosen PCP sites. Partnership collaborates with DHCS on these reviews by notifying selected sites of the upcoming review and processing any corrective action plans that result from the DHCS reviewer findings.
11. **Physical Accessibility Review Survey (PARS)**
    During the Initial Site Review and subsequent Periodic SR, a PARS review will be performed in accordance with MMCD Policy Letter 12-006. (Reference B.) This will be reviewed every three years at all sites within the Partnership Medi-Cal network. Refer to (Related Policy A) MCQP1052 - Physical Accessibility Review Survey – SR Part C.
12. **Non-Accredited Sites**
    a. In the case that the below listed contracted providers are not accredited or have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted, Partnership will conduct an initial review prior to adding the site into the network. If the clinic remains unaccredited at the time of re-credentialing, a periodic Non-Accredited FSR will be completed at a minimum of every three years unless the site becomes accredited.
        1) Home Health Agencies
        2) Free Standing Radiology Center
        3) Community Based Adult Services (CBAS)
        4) Dialysis Center
        5) Free-standing Birthing Center
13. **Specialized Site Reviews**
    a. Obstetric Specialists (utilizes PCP FSR and MRR with a focus in OB care from DHCS Site Review Tool)
        1) Sites will need to pass an initial FSR prior to being added to the network.
        2) MRR will be conducted within 6 months of first billable claim identifying members being seen. MRR will consist of 10 medical records or number of available records based on claims.
        3) Corrective Acton Plans (CAPs) will be completed using a standard format and form. CAPs will be due within 30 days of the site review and will be verified via document submission.
    b. Free Standing Urgent Care Clinic
        1) Urgent Care Site Reviews conducted to assess the quality of care provided for facilities located within our 24 and bordering counties. Reviews will be conducted at a minimum of every three years.
        2) Sites will need to pass an initial FSR prior to being added to the network.
        3) MRR will be conducted within six (6) months of first billable claim identifying members being seen. MRR will consist of 10 medical records or number of available records based on claims.
        4) CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.
    ~~c. PCP providing Urgent Care Services for non-assigned members~~
        ~~1) PCP Providing Urgent Care Facility Site Review Tool will be utilized in addition to the PCP tool.~~
        ~~2) Initial MRR will be conducted within six (6) months of first billable claim identifying~~

~~members being seen. MRR will consist of five (5) medical records or number of available records based on claims utilizing the Urgent Care Medical Record Review tool.~~

~~3) Reviews will be conducted at a minimum of every three years and will be in addition to the PCP tool~~

~~4)~~5)~~CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.~~

~~d.~~c. Palliative Care

1) A Palliative Care report is run monthly by the Inspections Site Review Team. Once it has been identified the site has seen five (5) members, a Site Review is performed.
2) Reviews are conducted at a minimum of every three years.

~~e.~~d. Private Duty Nursing

1) Private duty nursing reviews are conducted to oversee the quality of care provided by RNs or Licensed Vocational Nurses (LVNs) for in-home medical services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services (SS) Program and Private Duty patient care under DHCS-APL 26-009 Private Duty Nursing requirements. ~~APL 20-012.~~
2) The Private Duty Nurse must receive a score greater than 80% on the Private Duty Nurse tool consisting of a combined FSR and MRR tool prior to credentialing, and up to every three years for re-credentialing.
3) For an Independent Nurse Provider (INP), the site audit will be in the member's home.
4) CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.

B. **Delegation of Site Review functions**

1. Organizations or groups who have one or more DHCS Certified Site Reviewer may be determined eligible, at Partnership discretion, to perform SR functions. Eligible 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 SR functions for all PCP sites no less than every three years.
4. Results from oversight and monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.
5. Delegated organizations and/or groups will provide timely copies of all SRs conducted at the site level, within Partnership's service area, no less than semi-annually.
6. Partnership's Quality Improvement (QI) department will track all SRs conducted by the delegated entities.
7. For organizations and groups that are more than one year past due for a SR at the site level or otherwise missing a SR, the QI department will refer them to Partnership's DORS, which is managed by Partnership's compliance unit within the Administration department, for action.
8. In addition to providing Partnership copies of all SRs conducted at the site level, Partnership will ensure the delegated entity will provide timely copies and results of Site Reviews to DHCS according to DHCS standards. DHCS has processes in place for overseeing and auditing the quality of SR functions.
9. As part of the oversight process, Partnership may perform one or more repeat SRs on sites that have had the SR performed by a delegated entity.

C. **Potential Quality of Care Issues**

Potential Quality of Care Issues identified during the course of a Site Review will be processed in accordance with MPQP1016 – Potential Quality Issue Investigation and Resolution. The Site Reviewer will complete a Potential Quality Issue (PQI) Referral via the PQI Referral Intake System for follow up,

and review.

D. **Data Submission to DHCS**
SR data will be submitted by Partnership to DHCS every six months (July 31 for the period January-June and January 31 for the period July-December) in an approved format uploaded to a designated DHCS secure site. Partnership is permitted to submit data more frequently than every six months. For preoperational and expansion site reviews, Partnership must submit site review data to DHCS at least six weeks prior to site operation. Partnership will include data for SRs conducted by delegated entities in these submissions. Partnership will submit the required PHI (collected via the MRR process) in the bi-annual data submission to DHCS as required.

E. **Local Collaboration**
In an effort to streamline the regulatory process and reduce redundant SR reviews, Partnership may collaborate with other health plans having contracts with mutual providers. Partnership may accept the SR score assigned by other health plans if the DHCS tools are used and the SR is completed by appropriate certified staff. A site with a non-passing score by a collaborating health plan, that has received SR certification as addressed in of this policy, shall be considered to have a non-passing score by Partnership. Partnership may choose to repeat the FSR/MRR of a site that had passed a FSR/MRR by another health plan's reviewers.

VIII. REFERENCES:

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

~~A.~~B. DHCS ~~(~~APL~~)~~ 24-001 Street Medicine Provider: Definitions and Participation on Managed Care (Jan. 12, 2024 supersedes APL 22-023)

~~B.~~C. DHCS APL 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006)

~~C.~~D. DHCS APL 20-016 Blood Lead Screening of Young Children (revised Nov. 2, 2020 supersedes APL 18-017)

~~D.~~E. DHCS APL 26-009 ~~APL 20-012~~ Private Duty Nursing Case Management Responsibilities f~~F~~or Medi-Cal Eligible Members Under The Age Of 21 (~~May 15, 2020~~June 1, 2026; supersedes APL 20-012)

~~E.~~F. DHCS Policy Letter 12-006 (Aug. 9, 2012 supersedes PL 11-013)

~~F.~~ G. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

IX. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

XI. REVISION DATES:

Medi-Cal
8/20/03; 10/20/04; 3/15/06; 3/21/07, 3/19/08; 3/18/09; 6/17/09; 9/15/10; 3/16/11; 2/20/13; 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16; 3/15/17, 10/18/17; *10/10/18; 11/13/19; 04/08/20; 06/10/20; 08/12/20; 01/13/21; 02/10/21; 03/09/22; 08/10/22; 01/11/23; 03/08/23; 03/13/24; 03/12/25; 5/13/26; 10/14/26

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

PREVIOUSLY APPLIED TO:
Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1022 – 2/20/13, 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16 to 12/01/16
HKQP1032 – 4/18/2007 to 2/20/2013

Partnership Advantage
3/21/2007 to 11/19/2014

Healthy Families
10/01/2010 to 3/01/2013

Cognitive Assessment
Addendum to Facility Site Review Tool

PCP Name:					
PCP Site Name:	0				
Address:	0			Suite:	0
City:	0	State:	CA	ZIP:	0
Phone Number:	-				
Fax Number:	-				
Name of Individual responsible for securing & maintaining the security of medical records:				0	
Reviewers:	**First Last Name, RN DHCS-CSR**				
Date of Review:	**1/0/1900**				

	Yes	No	NA	Corrective Action (Note Date corrected as well as document correction
1. Was an annual cognitive health assessment ~~performed~~ completed for all eligible members 65 years of age ~~and~~ or older?				
Total:	0	0	0	
ADM Passed:	Yes		n/a	**Score Percentage**
CAP required:				
CAP approved:				
Guidelines for Cognitive Assessment:			**Date approved**	

Per APL ~~22-025~~26-014, PCPs ~~should~~ shall perform ~~include~~ an annual cognitive health assessment for eligible Members ~~who are~~ 65 years of age or older and who do not have Medicare Coverage, in accordance with DHCS requirements.

Documentation in the medical record should include:
- The screening tool or tools that were used.
- Verification that screening results were reviewed by the Provider
- The results of the screening
- The interpretation of the results
- Details discussed with the member and/or authorized representative and any appropriate actions taken in regards to the screening results.

At least one cognitive assessment tool listed below is required.~~Acceptable patient assessment screening tools include, but are not limited to:~~

Patient Assessment Tools:
- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Cog
- ~~Memory Impairment Screen (MIS) (Medicare Approved Tool)~~

Informant Tools (family members and close friends)
- Eight-~~Eight-~~item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly
- ~~Quick Dementia Rating System (Medicare Approved Tool)~~

Modified Facility Site Review Survey
PCP Providing Urgent Care

Site ID:	Phone:	Fax:	Review Date:
Facility Name:		Contact Name/Title:	
Full Address:			
Reviewer Name/Title:			

Visit Purpose		Certifications		Clinic Type	
☐Initial Full Scope	☐Monitoring	☐AAAHC	☐JC	☐Primary Care	☐Community
☐Periodic Full Scope	☐Follow Up	☐CHDP	☐NCQA	☐Rural Health	☐FQHC
☐Focused Review	☐Ed/TA	☐CPSP	☐None	☐Urgent Care	☐Solo
☐Other _____		☐PCMH		☐Medical Group	☐Staff/Teaching
		☐Other _____			

Site Review Scores

	Pts. Poss.	Yes Pts. Given	No's	N/A's	CE*
I. Access/Safety	1				
II. Office Management	1				
III. Clinical Services	3				
IV. Preventive Services	12				
V. Infection Control	2				
VI. Quality Insurance Performance Improvement	6				
	25				
	Total Pts. Poss.	Total Yes Pts.	Total No Pts.	Total N/A Pts.	

Scoring Procedure

1) Add points given in each section.

2) Add total points given for all seven sections

3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.

4) Divide total points given by "adjusted" total points.

5) Multiply by 100 to get the compliance (percent) rate.

_____/_____=_____X100=____%
Pts. given / Total/ Adj. / Decimal Score / Comp. Rate

Compliance Rate

_____**Exempted Pass:** 90% or above (without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control**)**

_____**Conditional Pass**:80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control

_____**Fail**: 79% and Below

_____CAP Required

_____Other Follow-Up

Next Review Due:_____

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Modified Facility Site Review Survey
PCP Providing Urgent Care

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perameters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include: 1) Exempted Pass: 90% or above without deciencies in Critical Elements, Pharmaceutical Services, or Infection Control, 2) Conditional Pass: 80-89%, or 90% and above with deficincies in either Critical Elements, Pharmaceutical Services, or Infection Control, and 3) Fail: 79% and below.

A corrective action plan (CAP) is required for a total score less than 90%, or for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "" **RN/NP/CNM/LPM/MD/PA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all seven (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2:** Add points given for all thirteen (6) sections. (1) Access/Safety (12) Preventive Services (1) Office Management (2) Infection Control (3) Clinical Services (6) QAPI **25 Points**
Step 3: Subtract "N/A" points from 182 total points possible. 25 (Total points possible) - 4 (N/A points) 21 ("Adjusted" total points possible)	**Step 4:** Divide total points given by 190 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points Given / 25 or "adjusted" total or 19 / 21 =0.904 =90%

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I. Access/Safety

Site Access/Safety Survey Criteria	Yes	No	N/A	wt
A. The facility has a waiting area of sufficient size to accommodate patients comfortably and to assure privacy during registration.				1
Totals				
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible in this section.				

Comments:

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II. Office Management

Site Office Management Survey Criteria	Yes	No	N/A	wt
A. There are sufficient health care personnel to provide timely, appropriate health care services.				
22 CCR §53855; 28 CCR §1300.67.1, §1300.80				
1. Transport of emergency patients to appropriate facility. There is evidence staff has received safety training and/or has information available on emergency non-medical and emergency medical procedures.				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 points possible in this section.				

Comments:

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III. Clinical Services:

Pharmaceutical Services Criteria

Site Clinical Services Survey Criteria	Yes	No	N/A	wt
A. Drugs are handled safely and stored appropriately.				
22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351; HSC §117600-118360; 40 CFR, part 261; Current CDC Recommendations				
1. Medications on site are applicable to services offered				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible on this page.				

Comments:

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III. Clinical Services:

Laboratory Services Criteria

Site Clinical Services Survey Criteria (Continued)	Yes	No	N/A	wt
B. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.				
22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov				
1. Minimum tests performed on site include: Urine HCG, hemoglobin or hematocrit, blood glucose & urine dipstick, Rapid Strep, STI collection materials. *off-site laboratory that can provide stat H & H results within 1-hour is acceptable				1
2. Lab supplies on site are applicable to services offered				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 2 points possible on this page.				

Comments:

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III. Clinical Services:

Radiology Services Criteria

Site Clinical Services Survey Criteria (Continued)	Yes	No	N/A	wt
C. Site meets CDPH Radiological inspection and safety regulations.				
17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106				
1. If no radiological equipment on site, immediate access to diagnostic radiology services (plain film x-rays) with urgent results made available to member and PCP a. Chest and Limb x-rays				1
Totals				
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible on this page. 3 points possible in this section.				

Comments:

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IV. Preventive Services and Equipment

Site Preventive Services Survey Criteria	Yes	No	N/A	wt
A.Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.				
22 CCR §53851; 28 CCR §1300.67				
Examination equipment, appropriate for primary care services, is available on site:				
1. EKG machine				1
2. Nebulizer				1
3. Splinting materials				1
4. Suction machine and catheters (Recommended)				1
5. NG tubes (Recommended)				1
6. Wound irrigation supplies				1
7. Eye and Ear irrigation supplies				1
8. Eye tray				1
9. Wood's lamp for dermatologic diagnosis (Recommended)				1
10. Suture kits and materials				1
11. Dressing supplies				1
12. Pulse Oximetry				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 12 points possible in this section.				

Comments:

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V. Infection Control Criteria

Site Infection Control Survey Criteria	Yes	No	N/A	wt
A. Infection control procedures for Standard/Universal precautions are followed.				
8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042				
1. Site has a policy or procedure for ensuring Standard/Universal precautions for infection control is followed.				1
2. Facility has a designated or qualified Infection control professional on staff.				1
Totals:				
Note: Write comments for all "No" (0 points) and "N/A" scores. 2 points possible in this section				

Comments:

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VI. Quality Assurance Performance Improvement

☐ ☐ RN/MD only

Site Quality Assurance Performance Improvement Survey Criteria	Yes	No	N/A	wt
1. Is there a QAPI committee which meets regularly and keeps minutes?				1
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				1
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				1
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches complaints and grievances) and takes appropriate actions.				1
5. The QAPI committee has reviewed surveys, inspections, and reportssubmitted by outside agencies. Corrective action plans are available.				1
6. Is there a designated QA & PI Coordinator?				1
Totals				
Note: Write comments for all "No" (0 points) and "N/A" scores. 6 points possible in this section.				

Comments:

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If more than one Reviewer, both must sign here:

Reviewer Signature: _____ **Reviewer Signature:** _____

Reviewer Name: _____ **Reviewer Name:** _____

Reviewer Title: _____ **Reviewer Title:** _____

Reviewer Comments:

ARCHIVE effective 10/14/26; PCPS providing UC should refer to Attachments J & K

Palliative Care Provider Site Review Survey

MPQP1022 – Attachment ~~M~~L

Health Plan	PHC	**IPA**		**Site ID No.**		**Review Date**		**Last Review Date**	

Provider Name/ Address		**Phone**		**Fax**	

Contact Person/Title		**Reviewer/Title**	

Visit Purpose:

_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____

EHR System used:

Site Scores						**Scoring Procedure**	**Compliance Rate**
	Points Poss.	**Yes Pts. Given**	**No's**	**N/A's**		1) Add points given in each section. 2) Add total points given for all six sections. 3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 6 total points poss. 4) Divide total points given by 6 or by "adjusted" total points. 5) Multiply by 100 to get the compliance (percent) rate.	_____ **Exempted Pass: 90% or above** _____ **Conditional Pass: 80-89%** _____ **Not Pass: Below 80%** _____ CAP Required _____ Other follow-up **Next Review Due:** _____
Interview Question	**1**						
Office Management	**5**						
	6					_____ ÷ _____ = _____ X 100 = _____% **Points Given** **Total / Adjusted Points** **Decimal Score** **Compliance Rate**	
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**			

Palliative Care Provider Site Review Survey

Purpose: Site Review Guidelines provide the standards for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above
2) Conditional Pass: 80-89%
3) Not Pass: below 80%

A corrective action plan (CAP) is required for a total score less than 90%. Compliance rates are based on 6 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for both sections to determine total points given for the site.
3) Subtract all "N/A" items from 6 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 6 points.
4) Divide the total points given by 6 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Subtract "N/A" points from 6 total points possible.
Example: 1 (Interview Question) 5 (Office Management)	6 (Total points possible) – 1 (N/A points) 5 ("Adjusted" total points possible)
Step 3: Divide total points given by 6 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{\text{6 or "adjusted" total}}$ or $\frac{4}{5} = 0.80 \times 100 =$ **80%**	

Palliative Care Provider Site Review Survey

Interview Questions	Yes	No	N/A	Wt.	Responses
1. How many patients are enrolled in the program?				0	Comment answer only
2. Do you provide 24/7 telephonic access to your patients? i.e. outsource after-hours calls, staff rotate taking after hours calls, etc.				1	Comment plus Y/N/N/A
3. Describe the makeup of your team. How often do you meet to discuss each patient?				0	Comment answer only
4. Is your organization a member of the Center to Advance Palliative Care (CAPC)?				0	Comment plus Y/N/N/A
5. How many physicians?				0	Comment answer only
6. How many registered nurses (RN)?				0	Comment answer only
7. How many Licensed Vocational nurses (LVN)?				0	Comment answer only
8. How many Licensed Clinical Social Workers/Masters of Social Work (LCSW/MSW)?				0	Comment answer only
9. How many managers?				0	Comment answer only
10. How many “other” types of staff?				0	Comment answer only
11. How many Chaplains?				0	Comment answer only
12. Notes				0	Comment field for notes

Total points possible 1.

Notes:

Palliative Care Provider Site Review Survey

Criteria	Office Management
1. Current Palliative Care Certifications?	Current Palliative Care Certifications? – All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Physician Certification Nurse Certification Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) Chaplaincy Certification Personnel who are not certified have either 1 year or more of experience, OR received 12 hours didactic training or have 1 year experience in palliative care- There is a documentation on site of a proof of training or 1 year experience in palliative care, including the name of the training or program attended and who conducted the training. Proof can include a certification and copy of the training module. If caring for Pediatric Patients, then all staff caring for Pediatric Patients will have Pediatric Palliative Care Training
2. Designated administrative lead/contact? ~~(PCQN)~~ ~~a.) Who enters information into PCQN? One staff member or multiple?~~	Designated administrative lead/contact? ~~(PCQN) – A designated administrative lead/contact is documented in personnel file, including job responsibilities. Evidence of training about the PCQN must be documented.~~ Site designates staff responsible for completing and submitting required Physician Orders for Life-Sustaining Treatment (POLST) and Edmonton Symptom Assessment System (ESAS) reporting templates to support compliance with Partnership palliative care quality reporting. ~~Document titles of staff members responsible for entering information into PCQN (no points allotted here).~~

Palliative Care Provider Site Review Survey

Office Management	**Yes**	**No**	**N/A**	**Wt.**	**Site Score**
Professional health care personnel have current California licenses and certifications.					
1) Current Palliative Care Certification OR if Personnel do not have certification, there is documentation of at least 1 year of experience in palliative care OR enrollment in to palliative care specific training within 3 months of working for the organization. Training MUST be completed within 6 months and be a minimum of 12 hours.					
a) Physician				1	
b) Nurse				1	
c) Advanced Certified Hospice and Palliative Social Worker (ACHP-SW)				1	
d) Chaplaincy Certification				1	
2) Designated administrative lead/contact? ~~(PCQN)~~ ~~a.) Who enters information into PCQN? One staff member, or multiple?~~ _____				1	
Yes					
No					
N/A					

Total pts possible: 5

Palliative Care Provider Medical Record Review Tool

MPQP1022 – Attachment ~~N~~M

Health Plan	PHC	IPA		Site ID No.		Review Date		Last Review Date	

Provider Name/ Address		Phone		Fax	

Contact Person/Title		Reviewer/Title	

Visit Purpose:

_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____

EHR System used:

Site Scores

	Points Poss.	Yes Pts. Given	No's	N/A's	
Documentation	90~~95~~				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 95 total points poss.
4) Divide total points given by 95 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%

Points Given **Total / Adjusted Points** **Decimal Score** **Compliance Rate**

Compliance Rate

_____ **Exempted Pass: 90% or above**

_____ **Conditional Pass: 80-89%**

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

Palliative Care Provider Medical Record Review Tool

Purpose: Site Review Guidelines provide the standards for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above
2) Conditional Pass: 80-89%
3) Not Pass: below 80%

Compliance rates are based on 9~~5~~ total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for both sections to determine total points given for the site.
3) Subtract all "N/A" items from 9~~5~~ total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 9~~5~~ points.
4) Divide the total points given by 9~~5~~ or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section. Example: 87 points for Documentation	**Step 2**: Subtract "N/A" points from total points possible (9~~5~~). 9~~5~~ (Total points possible) – 1 (N/A points) 8~~9~~4 ("Adjusted" total points possible)
Step 3: Divide total points given by 9~~5~~ or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{100 \text{ or "adjusted" total}}$ or $\frac{87}{8\cancel{9}4}$ = 0.97~~3~~ X 100 = **98~~3~~%**	

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
1. Written patient specific care plan (intake, engagement visit or initial care plan)	
a. Medical History	A complete and accurate history including pre-existing medical conditions and current comorbidities needs to be present in the patients chart.
b. Medication reconciliation	Medication lists need to be addressed and updated at each visit to provide the most current information.
c. Social history	Social history is to include documentation of discussion regarding needs pertaining to patient/family support, grief, legal issues, funeral arrangements, discharge planning.
d. Emotional needs	An ongoing discussion needs to be documented in visit notes that patient and/or family member's emotional state is being discussed and addressed.
e. Spiritual concerns	Identification of patient or family member spiritual needs and/or distress and if further assessment or intervention is needed and completed.
f. Written documentation of goals of care	Documentation of collaboration between PC team and patient/family member to create a personalized plan of care so healthcare professionals know how to respond in the event that the patient is unable to speak for him/herself. This is assessed and updated throughout progression of care.
2. Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?	As a part of the member engagement and enrollment process a multidisciplinary comprehensive assessment is required, which includes: Medical, Social Services, Emotional and Spiritual needs. Services may be refused, but must be documented.
3. **Advance Care Plan**	
a.) Written documentation of ACP discussion	Documentation of a member of the Palliative Care (PC) team directing questions at the patient to identify 1) patient's preferences for care in the event that patient is unable to speak for him/herself and/or 2) patient's preferences about current plan of care. **(PHC Policy- MCUP3137 Attachment C, 1)**
b.) POLST completed and signed by patient and provider	Is there a POLST on File and is it signed by both the provider and the patient/Durable Power of Attorney for Health Care? This is not mandatory to maintain compliance with PHC standards, however there is a monetary bonus that is given for each POLST on file. **(no points associated with this)**
c.) Durable Power of Attorney for Health Care (DPAHC) on file?	If there is someone other than the patient making decisions regarding healthcare, a DPAHC needs to be on file. **(no points associated with this)**
4. Contact was made with member within seven days of referral	Contracted intensive palliative providers will contact members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
5. Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.	Nursing discretion will be used to determine if symptoms associated with individual patient's qualifying diagnosis and comorbidities are consistently addressed and followed up on by the provider (MD, DO, NP, PA, RN)
6. Each visit type documented appropriately? (Spiritual, Medical, Social Services, etc.)	There has to be clear documentation of who is providing care at each visit.
7. Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.	Documentation of a score, 70 or below, on a standardized form. Could be Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
1) Written patient specific care plan upon intake, engagement visit or initial appointment:							
a) Medical history						1	
b) Medication reconciliation						1	
c) Social history						1	
d) Emotional needs						1	
e) Spiritual concerns						1	
f) Written documentation of goals of care						1	
2) Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?						1	
3) **Advance Care Plan**							
a) Written documentation of ACP discussion						1	
b) POLST completed and signed by patient and provider (Y/N only)	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
c) Durable Power of Attorney for Health Care (DPAHC) on file?	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
4) Contact was made with member within seven days of referral						1	
5) Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.						1	
6) Each visit type documented appropriately (Spiritual, Medical, Social Services, etc.)						1	
7) Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.						1	

Total pts possible this page: 60

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?	Does documentation support that each disciplinary team (Medical, Social Services, Emotional and Spiritual) is meeting with member at least monthly.
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD)	Enrolled members must have at minimum: • One in-person or video visit by an RN every month (the RN must see the member face to face at a minimum of once every 12 weeks) • One in-person or video visit by a social worker every month • Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically
~~10) Billing matches medical record documentation?~~	
~~a) PCQN matches medical record?~~	~~The audit of PCQN documentation aligns with documentation in the medical record.~~ ~~*Dates of visits should match dates entered into PCQN, if not, NO point.~~

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?						1	
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD) (5 pts possible)						5	
~~10) Billing matches medical record documentation?~~							
~~a. PCQN matches medical record?~~						~~1~~	
Yes							
No							
N/A							

Total pts possible this page: 3~~05~~. Total pts possible this domain: 9~~05~~

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1053			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Peer Review Committee			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/17/2014		**Next Review Date:** ~~02/11/2027~~10/14/2027 **Last Review Date:** ~~02/11/2026~~10/14/2026		
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:** ~~02/11/2026~~10/14/2026	

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1008 – Conflict of Interest Policy for QI Activities
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. MPCR602 – Reporting Actions to Authorities
E. CMP36 – Delegation Oversight and Monitoring
F. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP): NPMP's are defined as nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM).

~~A.~~B. Partnership Advantage: Effective Jan. 1, 2028, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage 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 Jan. 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Peer Review Committee (PRC) reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendations for actions to prevent reoccurrence of any issues. The PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws (Cal. Civ. Code §43.7.) governing confidentiality of health care peer review activities conducted in good faith.

Policy/Procedure Number: MPQP1053			Lead Department: Health Services Business Unit: Quality Improvement
Policy/Procedure Title: Peer Review Committee			☒ External Policy ☐ Internal Policy
Original Date: 09/17/2014		Next Review Date: 02/11/202710/14/2027 Last Review Date: 02/11/202610/14/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership
   a. The PRC is comprised of one or more licensed physicians in primary care (e.g., Family Medicine, Internal Medicine or Pediatrics), and one or more specialist physicians (e.g., OB/GYN, General Surgery) currently practicing in hospitals, medical groups, and practice sites contracted with Partnership or otherwise regularly seeing Medi-Cal members. Medi-Cal population experienced physicians who have retired from practice within the last two years are also eligible to serve on the PRC. There will be a minimum of three external physician members on the PRC. There is no upper limit to the number of standing members on the PRC.
   b. NPMPs as defined in MPQG1011 who are currently practicing within Partnership's service area may also serve as PRC members. There is no defined number of any type of NPMP who may serve on the PRC.
   ~~b.~~c. The PRC's external clinicians are a subset of the voters of the Quality/Utilization Advisory Committee. As a confidential body, however, the PRC does not report case specifics to the Q/UAC, which is a Brown Act committee. PRC caseload numbers are reported in aggregate by quarter twice each year to both the Q/UAC and the Physician Advisory Committee (PAC).
   ~~c.~~d. Partnership staff physicians are also voting members of the PRC and include, but are not limited to, the Chief Medical Officer, the Deputy Chief Medical Officer, the Medical Director for Quality, the Behavioral Health Clinical Director, the Medical Director for Medicare Services, and Regional and Associate Medical Directors, as assigned by the CMO.
   ~~d.~~e. Additional Partnership non-voting staff attending and supporting the PRC include ~~the Senior Director of Health Services;~~ the Director of Pharmacy or designee; the Director of Health Equity; and members of the Member Safety Quality Inspection and Quality Investigation teams.~~Quality Assurance & Member Safety and Clinical Quality & Member Safety teams.~~
   ~~e.~~f. Members serve open terms and may elect to resign at any time by formally advising the chair.
   ~~f.~~g. Members with annual attendance of < 50% may be barred from future participation in the PRC.
2. Chair: The Chief Medical Officer (CMO) chairs the PRC. When the CMO is unavailable, the Medical Director for Quality is the designated chair. A Regional or Associate Medical Director acts as the temporary chair when needed. The role of the Chair is to assure that all quality matters and concerns are evaluated thoroughly, that there is adequate input to the discussion, that a reasonable effort is made to obtain the facts of the matter, and that matters are fully investigated and any required actions are completed. The Chair must ensure that the process follows protocol; is always fair and unbiased; and, that any providers under scrutiny are afforded due process, receiving adequate notifications and opportunities to respond to the concerns under investigation.
3. Meetings: The PRC meets at least quarterly and on an as-needed basis.
4. Dual Capacity: External physicians and NPMPs are also voting members of the Quality/Utilization Advisory Committee (Q/UAC).
5. Compensation: External members are eligible to receive a financial stipend for each Q/UAC **or** PRC meeting attended to compensate them for travel time and time away from work.
6. Voting: Internal and external physician and NPMP members constitute the voting membership, with the Chair serving in a tie breaking capacity as necessary. A quorum is not required for a meeting to occur, except where formal action needs to take place or in instances where the Chair determines that a quorum is necessary. In this case, the PRC's quorum is comprised of more than 50% of the voting membership. The Chair may not be counted for purposes of a quorum.
   a. NPMPs may vote to score providers and/or systems only in areas in which they possess subject matter expertise. For example, CNMs and LMs may vote only in cases involving obstetrics. Nurse Practitioners and PAs may vote only in cases involving their area(s) of practice, such as outpatient primary care, hospital care, pediatrics, internal or family medicine.

7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each external member signs an annual Confidentiality Statement prepared and retained by Partnership. This statement signifies the intent to protect individuals against misuse of information and to ensure that all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. Partnership staff are governed by similar confidentiality policies, as required elements of employment.
8. Conflict of Interest: The integrity of the Peer Review process requires prevention of input and decision making where a conflict of interest exists. All non-Partnership clinicians taking part in the peer review process, including those on the PRC, are required to adhere to Partnership's Conflict of Interest (MPQP1008) policy. Each external PRC member signs an annual Conflict of Interest Statement prepared and retained by Partnership. Partnership staff are governed by similar conflict of interest policies.

B. Committee Responsibilities
1. The PRC will carefully review the clinical care in all situations in which a quality of care concern has been raised and forwarded for committee review. See MPQP1016 - Potential Quality Issue Investigation and Resolution for details of this process.
2. The PRC will evaluate the quality concern related to clinical care and determine whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
3. Minutes are maintained according to the Confidentiality policy CMP10.
4. External Peer Review
   a. Circumstances that require external review:
      1) Referral for "medical specialist review" when the PRC membership does not include members with adequate expertise or training to fully evaluate the quality of care concern.
      2) The PRC cannot make a determination and requests external review.
      3) An individual whose case is under review requests external peer review.
      4) When dealing with potential litigation that might affect a provider's contracted status.
      5) When dealing with ambiguous or conflicting recommendations from internal reviewers, or when there does not appear to be a strong consensus for a particular recommendation.
5. Subcommittees: Complex or specialized peer review issues may be reviewed by a PRC subcommittee. These subcommittees meet on an *ad hoc* basis when cases identified through the peer review process require specialized peer review. A minimum of three clinicians are assigned to any peer review subcommittee. A minimum of 50% of subcommittee members must participate to take action. The notes, findings, and recommendations of the peer review subcommittee are presented to the next regular peer review meeting for deliberation. The principles of evaluation, confidentiality and recommended rating are the same as for the PRC as a whole. *Ad hoc* subcommittees may be created at the discretion of the CMO or PRC. There are two standing subcommittees:
   a. Medication Safety Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to appropriate use of opioid medications in patients with a diagnosis of chronic pain. Members of this subcommittee will include at least one specialist board certified in pain management and one behavioral health provider.
   b. Substance Use Services Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to the provision of services related to the treatment of Substance Use Disorder (SUD). The subcommittee will be chaired by the Behavioral Health Clinical Director and include at least one outside specialist experienced in addiction treatment or in addiction medicine.

C. Confidentiality
1. As specified in State statute (Cal. Civ. Code §43.7.), peer review activities are not subject to

discovery. The members of the PRC and the records associated with its reviews and actions shall be afforded all of the immunity, protection and privileges under California law. A practitioner under review shall be afforded all rights and protections under California law. The PRC and the CMO shall take all reasonable steps to protect the confidentiality of the committee's deliberations, reviews and actions, including all information obtained at all stages of the investigation, review and decision making process. Any confidential health information obtained during the course of peer review investigations shall be protected from loss, tampering, alteration and unauthorized or inadvertent disclosure of information.

D. Indemnification
   1. Partnership will indemnify, defend and hold harmless the members of the PRC from and against losses and expenses (including attorneys' fees, judgments, settlement and other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act within the scope or quality assessment activities as a member of the PRC. Partnership will retain the responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against PRC members, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on the PRC member's good-faith belief that his or her actions and/or communications are reasonable and warranted and in furtherance of Partnership's peer review, quality assessment, or quality improvement responsibilities.~~,~~ In no event will Partnership indemnify a member for acts of omissions taken in bad faith or in pursuit of the member's private economic interests.

E. Oversight
   1. The PRC is accountable to Partnership's Board of Commissioners on Medical Care.

F. Delegation Oversight and Monitoring
   1. Partnership may delegate Potential Quality Issue (PQI) investigation, including PRC oversight.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership's annual oversight audit.
   4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Cal. Civ. Code §43.7 ~~.~~ Immunity from L~~l~~iability; M~~m~~ental H~~h~~ealth P~~p~~rofessional Q~~q~~uality A~~a~~ssurance C~~c~~ommittees; P~~p~~rofessional S~~s~~ocieties, M~~m~~embers or S~~s~~taff; P~~p~~eer R~~r~~eview or I~~i~~nsurance U~~u~~nderwriting C~~c~~ommittees; H~~h~~ospital G~~g~~overning B~~b~~oard

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=43.7.

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer or designee

X. REVISION DATES:

Medi-Cal
09/17/14; 11/19/14; 01/20/16; 3/16/16; 3/15/17,* 06/13/18; 05/08/19; 5/13/20; 5/12/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25; 02/11/26; 10/14/26

Partnership Advantage (effective Jan. 1, 2028)
N/A

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

PREVIOUSLY APPLIED TO:
N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3022 (previously UG100322)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Incontinence Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 07/24/1994		**Next Review Date:** ~~02/11/2027~~10/14/2027 **Last Review Date:** ~~02/11/2026~~10/14/2026		
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:** ~~02/11/2026~~10/14/2026	

I. RELATED POLICIES:

MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Certificate of Medical Necessity (CMN) Form: Incontinence Supplies Medical Necessity Certification Form *DHCS 6187*
B. Incontinence supplies: ~~Medicaid defines incontinence supplies as~~ ~~m~~Medically necessary products used to manage urinary and/or bowel incontinence, typically including disposable briefs (adult diapers), protective underwear (pull-on products), underpads, belted undergarments, shields, liners, pads and reusable underwear.
C. Medical Practitioner: For the purposes of this policy, the medical practitioner is a physician, nurse practitioner or physician assistant.

IV. ATTACHMENTS:

A. Partnership Maximum/ Average Benefit Incontinence Guidelines
B. Incontinence Supplies Medical Necessity Certification form (DHCS 6187)

V. PURPOSE:

To outline the process by which coverage of incontinence supplies is an available Medi-Cal benefit to Partnership Health Plan of California Members. Incontinence supplies are a Medi-Cal benefit that must be prescribed by the physician, nurse practitioner, or physician assistant (medical practitioner) who is currently responsible for the care of the Member and has evaluated the Member's bladder and bowel incontinence within the past year. All Members with a diagnosis of incontinence should be evaluated by the current medical practitioner to determine whether consultation with a specialist is indicated.

VI. GUIDELINE / PROCEDURE:

A. TREATMENT AUTHORIZATION REQUEST (TAR) PROCESS
   1. A TAR is required for all incontinence supplies*. The TAR must contain documentation regarding the Member's history of incontinence, along with information regarding the medical necessity for the

*See VI.A.3 for two code exceptions.

supplies ordered.

2. For incontinence supplies over $165 per month (including sales tax), a state mandated Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (Attachment B) must accompany the TAR and will include the following information:
   a. Medical condition / diagnosis causing bowel and bladder incontinence
   b. Type of urinary / bowel incontinence
   c. Evaluation and treatments attempted and outcomes (including urologist assessment or reports)
   d. Documentation of the reasons why other options (pharmacologic, drugs, behavioral techniques or surgical interventions) are not appropriate to decrease or eliminate incontinence
   e. Prognosis for controlling incontinence
   f. Brief summary of the incontinence therapeutic intervention plan
   g. Explanation if medical practitioner orders supplies in **excess** of the thresholds listed in Attachment A and information regarding medical necessity for the additional use
3. Codes A4335 and A6250 for skin wash and skin cream do not require a TAR unless they are ordered above normal supply limit. (See Attachment A for supply limits.) However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be valid for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.
4. The requested item must be the lowest cost medically appropriate item to meet the Member's medical needs.
5. If the Member has chronic, non-treatable incontinence as confirmed by the primary care practitioner or a urologist, the TAR can be approved for up to one (1) year.
6. If the approval is granted for an interval greater than 30 days, the provider of service has the responsibility to verify that the Member remains eligible for Medi-Cal coverage with Partnership on a monthly basis and in NO instance will Partnership reimburse for supplies in excess of a 60 day supply dispensed at any one time. (For Example: If Partnership approves supplies for a one-year time frame, the provider will NOT be reimbursed for the entire year at one time. Billings are to occur incrementally on a monthly basis as the Member's eligibility status may change.) See Attachment A for supply limits.
7. Incontinence supplies such as disposable briefs (diapers), liners, underpads, etc. over $165 per month (including sales tax) require a completed Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (CMN form) (see Attachment B) submitted with the TAR.
8. Incontinence supplies $165 per month or less require a TAR with the prescription attached, but do not require the CMN form.
9. Note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.

B. Incontinence supplies for Members in a skilled nursing facility (SNF) and Intermediate Care Facility (ICF)/Developmentally Disabled (DD) or ICF are part of the facility per diem rate and are not billable separately to Partnership. Incontinence supplies for Members in ICF/DD- Habilitative (H) or ICF/DD- Nursing (N) are not part of the facility per diem and are separately billable to Partnership. Incontinence supplies for Members in ICF/DD-H or ICF/DD-N can be approved for up to one (1) year. The same requirements as per VI.A.7 apply.

C. Incontinence supplies for Members under age five may be covered under the Medi-Cal for Kids & Teens benefit (formerly Early & Periodic Screening, Diagnostic and Treatment (EPSDT)) Services benefit ~~(now referred to as Medi-Cal for Kids and Teens)~~ where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence.

D. The CMN form (Attachment B) must be dated within 12 months of the date of service on the claim and must be signed by the Member's current medical practitioner.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Incontinence Medical Supplies (*incont*); List of Contracted Incontinence Absorbent Products; List of Contracted Incontinence Creams and Washes; List of Incontinence Medical Supplies Billing Codes
B. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 11-1223 Authorization for Purchase of Incontinence Medical Supplies (12/19/2023)
C. Welfare & Institutions Code, Section 14125.4

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 01/01/96; 04/28/00; 06/20/01; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 11/18/09; 07/21/10; 06/20/12; 08/20/14; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 02/12/20; 06/10/20; 09/09/20; 02/10/21; 05/12/21; 08/11/21; 08/10/22; 09/13/23; 10/09/24; 02/12/25; 02/11/26; 10/14/26

*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.

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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
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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Incontinence Products (Briefs/Diapers) ~~(See Notes 1, 2)~~				
Adult Sizes				
T4521	Adult sized disposable incontinence product, brief/diaper, **small**	each	200 in a 27-day period	225 /month
T4522	Adult sized disposable incontinence product, brief/diaper, **medium/regular**	each	192 in a 27-day period	216 /month
T4523	Adult sized disposable incontinence product, brief/diaper, **large**	each	216 in a 27-day period	243 /month
T4524	Adult sized disposable incontinence product, brief/diaper, **extra-large (XL) and double extra-large (XXL)**	each	192 in a 27-day period	216 /month
T4543	Adult sized disposable incontinence product, protective brief/diaper, **triple extra-large (XXXL) or above**	each	200 in a 27-day period	225 /month
Youth Size				
T4533	**Youth sized** disposable incontinence product, brief/diaper	each	200 in a 27-day period	225 /month
Pediatric Sizes				
T4529	Pediatric sized disposable incontinence product, brief/diaper, **small/medium**	each	200 in a 27-day period	225 /month
T4530	Pediatric sized disposable incontinence product, brief/diaper, **large**	each	200 in a 27-day period	225 /month

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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Incontinence Products (Protective Underwear/Pull-Ons) ~~(See Notes 1, 2)~~				
Adult Sizes				
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, **small**	each	120 in a 27-day period	135 /month
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, **medium**	each	120 in a 27-day period	135 /month
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, **large**	each	120 in a 27-day period	135 /month
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, **extra-large (XL) and double extra-large (XXL)**	each	120 in a 27-day period	135 /month
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, **triple extra-large (XXXL) or above**	each	120 in a 27-day period	135 /month
Youth Size				
T4534	**Youth sized** disposable incontinence product, protective underwear/pull-on	each	200 in a 27-day period	225 /month
Pediatric Sizes				
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, **small/medium**	each	200 in a 27-day period	225 /month
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, **large**	each	200 in a 27-day period	225 /month

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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Liners/Shields/Pads/Undergarments *(See Note 1~~2~~)*				
T4535	Disposable liners	each	180 in a 27-day period if only one product type billed. 300 in a 27-day period if two or more product types billed.	202 or 338 /month
T4535	Disposable shield	each		202 or 338 /month
T4535	Disposable pad	each		202 or 338 /month
T4535	Disposable undergarment (belted or beltless)	each		202 or 338 /month
Disposable Underpads ~~*(See Note 2)*~~				
T4541	Incontinence product, disposable underpad, **large size** (core mat area size equal to or greater than 676 sq. in.)	each	120 in a 27-day period	135 /month
T4542	Incontinence product, disposable underpad, **small size** (core mat area size less than 676 sq. in.)	each	120 in a 27-day period	135 /month
A4554	Disposable underpads, breathable	each	None *Restricted to patients using low air flow beds.* TAR required	—
Incontinence Reusable Pants (Any Size)				
T4536	Incontinence product, protective underwear/pull-on, reusable, **small, medium, large, XL, XXL**	each	2 units per claim, one claim per calendar month and 12 claims in a 12 month period	2 /month
Reusable waterproof sheeting				
T4537	Reusable waterproof sheeting	each	2 per year	—
Incontinence Skin Care *(See Note 2~~3~~)*				
A4335	Incontinence wash	ml	2880 ml in an 81-day period	1081 /month
A6250	Incontinence cream/ointment	g/ml	1620 g/ml in an 81-day period.	608 /month

PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Note 1: If justification is provided, liners, shields, pads and disposable undergarments ~~Disposable Briefs/ Diapers and Disposable Protective Underwear/ Pull-Ons~~ may be mixed and matched, not to exceed 300 total units in a 27-day period or 338/ month. Medical justification must be stated in Section C, field 12 on the DHCS form 6187, Incontinence Supplies Medical Necessity Certification, which is Attachment B to this policy. Please reference the following link for quantity limits:
List of Incontinence Medical Supply Billing Codes

~~**Note 2:** The "NU" code modifier is NOT to be used for disposable incontinence supplies.~~

Note ~~2~~3: Skin Cream and Skin Wash Codes A4335 and A6250 do not require a TAR unless they are ordered above normal frequency limit. However, providers are encouraged to include these items on the incontinence supplies TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

Additional Notes:

- The "NU" code modifier is NOT to be used for disposable incontinence supplies.
- Kimberly-Clark Products are not a Medi-Cal Benefit.
- Enuresis Alarm Pads are a covered benefit as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization.

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION

SECTION A: Incontinence Provider Information

1. Contact Person	2. Contact Telephone Number	3. Contact Fax Number

SECTION B: Patient Information

4. Patient Name– Last, First, Middle (as appears on card)

5. Medi-Cal ID Number	6. Gender Male ☐ Female ☐	7. Date of Birth (mm/dd/yy)	8. Age

9. Type of Residence
☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N ☐ Other _____

SECTION C: Documentation Supporting Medical Necessity

Note: If necessary, include supporting documentation on an attachment

10. Does the patient **meet the Code 1 Restriction**? Yes ☐ No ☐
If yes, indicate the primary and secondary diagnosis name and ICD-10-CM codes.
_____
_____
_____
If no, provide clinical evidence and describe in detail the medical conditions and/or extenuating circumstances to support the medical necessity.
_____
_____
_____
_____

11. Have any **previous treatments** (for example, drug therapy, behavioral techniques, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? Yes ☐ No ☐
If yes, describe treatment(s), treatment results, and patient's responsiveness.
_____
_____
_____
_____
If no, explain reasons why other treatments are not appropriate to decrease or eliminate incontinence.
_____
_____
_____
_____

SECTION C: Documentation Supporting Medical Necessity (Continued)

12. Is this patient **prescribed multiple absorbent product types** to be used during the same time period? Yes ☐ No ☐
If yes, explain in detail the need for multiple varieties of supplies.

_____
_____
_____
_____
_____
_____

13. Does this request include a billing code that **requires prior authorization?** Yes ☐ No ☐
If yes, list billing code(s) and supporting documentation of medical need.

_____
_____
_____
_____

14. Does the patient require a quantity that **exceeds the quantity limits** for any of the supplies needed? Yes ☐ No ☐
If yes, list billing code(s), provide clinical evidence and describe in detail the acute medical condition and/or extenuating circumstances for increased need for additional quantities.

_____
_____
_____
_____
_____
_____
_____
_____

15. Does the patient require supplies (except creams and washes) that **exceed the $165 per month allowable**? Yes ☐ No ☐
If yes, provide a detailed explanation to support the need for supplies exceeding $165 per month.

_____
_____
_____
_____
_____

16. Does this request have an attachment for additional supporting documentation? Yes ☐ No ☐

NOTE: Medical justification must be complete and thorough to process this request. If necessary, provide the supporting documentation and any additional information on an attachment.

SECTION D: List All Prescribed Product Types (For example, briefs, protective underwear, etc.)

17. Complete the table below for the supplies prescribed. Enter the last date of service (DOS) if previously billed.

Billing Code	Product Type	Last DOS	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units

18. This prescription is valid for _____ months. **NOTE:** The maximum allowed is 12 months. The physician's signature date below must be within 12 months of the date of service on the claim.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

By my signature below, I verify that I have physically examined the patient within the last 12 months and certify to the best of my knowledge that the information contained in this form is true, accurate and complete. I have prescribed the items on this form and will maintain a copy of this prescription in the beneficiary's medical record to meet Medi-Cal documentation requirements.

19. Physician's Name	20. Physician's National Provider Identifier

21. Physician's Business Address (number, street)	City	ZIP Code

22. Physician Telephone Number	23. Physician's Signature	24. Date

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION INSTRUCTIONS

SUBMISSION REQUIREMENTS: This form must accompany each Treatment Authorization Request (TAR) and must contain all supplies needed for the time period, not just supplies needing a TAR.

SECTION A: Incontinence Provider Information

1. Enter the name of the individual to contact for TAR questions.
2. Enter the phone number where the contact person can be reached.
3. Enter the fax number to receive information.

SECTION B: Patient Information

4. Enter the patient's last name, first name and middle initial.
5. Enter the Medi-Cal Identification Number.
6. Check the appropriate box.
7. Enter the complete date as 2-digit month, 2-digit day, and 2-digit year.
8. Enter the patient's current age.
9. Check the appropriate box.

SECTION C: Documentation Supporting Medical Necessity

10. – 15. An answer to each question is required. Depending on the response further explanation to support medical justification is required and if needed may be included on an attachment.
    NOTE: Medical justification must be complete and thorough in order to process the request.
16. Indicate if an attachment is included with this form.

SECTION D: List All Prescribed Product Types

17. This table must include **all supplies prescribed** for this patient's use during the number of months covered by this prescription.
    - Billing Code - Enter the HCPCS billing code for each supply item. Refer to the *List of Incontinence Medical Supplies Billing Codes*
    - Product Type – For each billing code enter the corresponding product type name (for example, cream, wash, disposable brief, protective underwear, pad, liner and underpad). Do not list brand name.
    - Last DOS – Enter the last date of service if product type was previously billed.
    - Daily Usage – Enter the estimated number of units the patient will use daily
    - Monthly Usage – Enter the estimated number of units the patient will use monthly.
    - Monthly Cost – Enter the estimated monthly cost for this supply, including markup and sales tax (unit cost multiplied by the monthly usage plus markup and sales tax)
    - Total units – Enter the total number of units for each supply item prescribed (monthly usage multiplied by the total number of months covered by this prescription).
18. Enter the number of months covered by this prescription. The maximum allowed is twelve (12) months.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

NOTE: This section must be completed by the attending physician. The physician's personal signature in ink and date of signature is required. Signatures stamped, printed or initials are not acceptable.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3058 (previously UG100358)				**Lead Department:** Health Services **Business Unit**: Utilization Management	
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities				☒**External Policy** ☐ **Internal Policy**	
Original Date: 03/19/2003			**Next Review Date:** ~~01/14/2027~~10/14/2027 **Last Review Date:** ~~01/14/2026~~10/14/2026		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
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~~10/14/2026	

I. RELATED POLICIES:

A. MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Subacute or Skilled) Facilities
B. MCUP3041 Treatment Authorization Request (TAR) Review Process
C. MPTP2501 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
~~C.~~D. CLPM15 Claims Processing and Payment Standards for Partnership

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. BH: Bed Hold
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
D. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled. The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system.
E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
F. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
G. Form HS 231: State of California Department of Health Care Services form entitled "Certification for Special Treatment Program Services"
H. LOA: Leave of Absence
I. Managed Care Plan (MCP): Partnership HealthPlan of California is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.
J. Regional Centers: Nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities throughout California. Partnership Members with intellectual and developmental disabilities are

identified through coordination with the Regional Centers and in the course of utilization and case management services. Regional Centers providing services in Partnership's service area are as follows:

1. Alta California Regional Center provides services in Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties.
2. Far Northern Regional Center provides services in Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity counties
3. Golden Gate Regional Center provides services in Marin county
4. North Bay Regional Center provides services in Solano, Napa, and Sonoma counties
~~1.~~5. Redwood Coast Regional Center provides services in Del Norte, Humboldt, Lake, and Mendocino counties

IV. ATTACHMENTS:

A. Bed hold/TAR Process
B. Bed Hold & Change of Status Report

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in an ICF/DD for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. As a Managed Care Plan (MCP), Partnership provides all medically necessary covered services for Members residing in or obtaining care in an ICF/DD facility/home, including home services, professional services, ancillary services, and transportation services. Partnership also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 26-012 ~~(APL) 24-011~~ and in adherence to DHCS contract requirements and the DHCS Population Health Management (PHM) Policy Guide.
B. Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities
   1. Federal regulations require California to provide a program of independent professional review of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD-N) that provide services to Medi-Cal recipients. This process is referred to as utilization review. Its purpose is to control unnecessary utilization of services by evaluating patient needs and the appropriateness, quality and timeliness of service delivery.
   2. Patient Placement Requirements
      a. Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures "as needed" are not appropriate for ICF/DD-H and ICF/DD-N placement.
      b. Please refer to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care (LTC) Facilities
   3. Per Diem Services
      a. Services covered under the daily rate of an ICF/DD, ICF/DD-H and ICF/DD-N include:
         1) Services of the direct care staff
         2) Services of the facility's interdisciplinary team
         3) Services of qualified intellectual disabilities professional
         4) Case conference reviews
         5) Development of service plans
         6) In-service training of direct care staff and consultation on individual recipient needs

7) Transportation services (see policy MPTP2501- Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
8) Equipment and supplies necessary to provide appropriate care
9) Room and Board

4. ICF/DD-H/DD-N TAR Submission
   a. Submitting with a Treatment Authorization Request (TAR):
      1) Completed new TAR form 20-1
      2) Submit form HS 231 with initial and reauthorization TARs within 15 business days from date of service.
   b. Certification Period:
      1) For the ICF/DD-H or ICF/DD-N level of care, form HS 231 must be certified by the Regional Center director or designee.
      2) Certification may be granted for a period of twelve months at a time.
      3) The Regional Center director or designee assesses new patients within a reasonable amount of time.
      4) When the certified period expires, the Member must be re-assessed and a new form HS 231 must be filled out and signed by the Regional Center director or designee.
5. Readmission and New Certification:
   a. ICF/DD-H or ICF/DD-N Member who is discharged and subsequently readmitted must be re-assessed. A new form HS 231 must be filled out and submitted with a new TAR.

C. Leave of Absence
1. Leave of Absence Qualifications
   a. A leave of absence (LOA) may be granted to a recipient in an ICF/DD-N or ICF/DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined below:
      1) A visit with relatives or friends
      2) Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons
2. Leave of Absence Maximum Time Period
   a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
      1) Developmentally disabled recipients can receive a leave of absence for relatives/friend visits or summer camp for up to seventy-three (73) days per calendar year.
         a) A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.
      3) These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the patient's bed (bed hold) as described below.

D. Bed Hold (BH) Qualifications
1. Partnership covers the stay when a recipient residing in a ICF/DD facility/ home is admitted to an acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then requires a return to an ICF/DD Home. Providers must bill bed hold (BH) days (see Attachment B). Reimbursement for bed hold days is limited to a maximum of seven (7) days per hospitalization, subject to the following:
   a. The attending physician must order the acute hospitalization.
   b. The ICF/DD facility/home must hold a bed vacant when requested during the entire hold period, maximum of 7 days for each bed 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.

2. General Leave of Absence and Bed Hold Requirements
   a. General requirements for LOA and BH are outlined below:
      1) Day of departure is counted as one day of LOA/BH, and the day of return is counted as one day of inpatient care.
      2) Facility holds the bed vacant during LOA/BH
      3) LOA or BH (hospitalization) is ordered by a licensed physician
      4) Recipient's return from LOA/BH must not be followed by discharge within 24 hours
      5) LOA/BH must terminate on a recipient's day of death
      6) Facility claims must identify the inclusive dates of leave
3. Additional Leave of Absence Requirements
   a. Requirements specific to LOA are listed below:
      1) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H, or ICF/DD-N.
      2) Re-admission TAR's are not necessary for recipients returning from a leave of absence if a valid TAR covering the return date exists.
      3) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
      4) Recipient's records maintained in an ICF/DD, ICF/DD-H, or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
   b. Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
   c. At the time of admission, if a recipient has not been an inpatient in any custodial/long term care facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations.
4. Patient Failure to Return from Leave of Absence
   a. If recipients have used their total leave days, they may still be allowed a leave of absence during the same calendar year. However, the facility will not receive reimbursement for those authorized leave days.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Sections 483.400 – 483.480
B. Title 22 California Code of Regulations (CCR) Section 51535
C. California Department of Developmental Services (DDS) Guidelines
D. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities *(util review)*; Leave of Absence, Bed Hold, and Room and Board *(leave)*; TAR for Long Term Care: 20-1 Form *(tar ltc)*
E. Lanterman Developmental Disabilities Services Act
F. DHCS APL 26-012 ~~APL 24-011~~ Intermediate Care Facilities for Individuals w~~W~~ith Developmental Disabilities - Long Term Care Benefit Under Managed Care ~~Standardization and Transition of Members to Managed Care (09/16/2024)~~ (06/10/2026)
G. DHCS Population Health Management Guide
H. DHCS form HS 231 Certification for Special Treatment Program Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

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

*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

REGULATOR APPROVAL:
DHCS – last approved on 4/2/2025 for APL 24-011
DHCS – approved on 9/23/2024 for APL 23-023

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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:

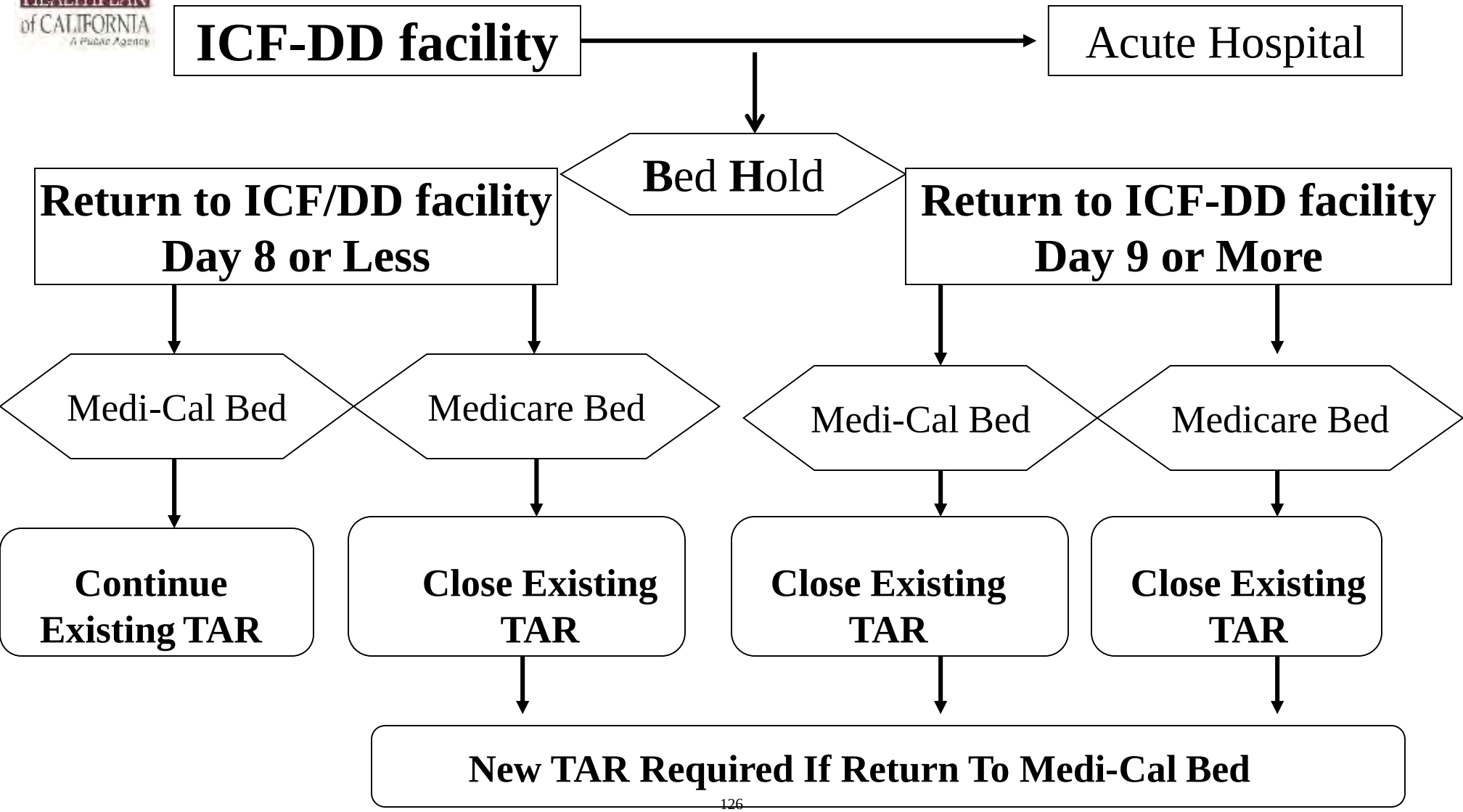
- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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 A Public Agency

Bed Hold / TAR Process After Acute Hospitalization



Partnership HealthPlan of California
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

MCUG3038 Attachment A 01/14/2026
MCUG3058 Attachment B 01/14/2026

BED HOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

NO.	MONTH -	DAY OF THE WEEK																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	NAME:																															
	TAR NUMBER:																															

Please note, member discharge /transfer to acute requires a MD order.

Fax to **707 - 863 - 4118**

REMARKS:

NO.	

LEGEND:

A - Discharge to Acute (use after 7 day BH)
B - Discharge to B & C
B/H - Bed Hold
E - Expired
E/A - Expired in Acute
TL - Therapeutic Leave

H - Discharge to Home
I - Discharge to ICF
M - Discharge to Medicare Bed

P - Discharge to Private Pay
R - Return to Medi-Cal Bed
S - Discharge to Other SNF
X - Discharge to Hospice

Prepared By: _____

Telephone #: _____

Fax #: _____

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3115				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Community Based Adult Services				☒**External Policy** ☐ **Internal Policy**	
Original Date: 10/17/2012 (Effective 07/01/2012)		**Next Review Date:** ~~11/12/2026~~10/14/2027 **Last Review Date:** ~~11/12/2025~~10/14/2026			
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:** ~~11/12/2025~~10/14/2026	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. CGA024 – Medi-Cal Member Grievance System
E. MPCR700 – Assessment of Organizational Providers
F. MPCR500 – Ongoing Monitoring of Sanctions ~~and Interventions~~

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Community Based Adult Services (CBAS): An outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services and transportation to qualified beneficiaries.
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. Emergency Remote Services (ERS): Temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, to allow for immediate response to a Member's need when an emergency restricts or prevents them from receiving services at their CBAS center.
D. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

IV. ATTACHMENTS:

A. CBAS Individual Plan of Care (IPC) Form (DHCS 0020)

V. PURPOSE:

Effective July 1, 2012, Partnership HealthPlan of California assumed responsibility to provide benefits for the services provided at Community Based Adult Service (CBAS) agencies. Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses Adult Day Health Care (ADHC) centers and CDA certifies them for participation in the Medi-Cal Program. The purpose of this policy is to define the process required to access CBAS services.

VI. POLICY / PROCEDURE:

A. CBAS Objectives
   1. The primary objectives of the CBAS program are to:
      a. Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
      b. Delay or prevent inappropriate or personally undesirable institutionalization
      c. The program stresses partnership with the participant, the family and/or caregiver, the primary care provider (PCP), and the community in working toward maintaining personal independence.

B. Eligibility Criteria
   1. To be eligible for CBAS services through Partnership HealthPlan of California, the person must be at least 18 years of age. They must be an eligible Member of Partnership's Medi-Cal program.
   2. The Member must also meet all the following criteria:
      a. Must have one or more chronic or post-acute medical, cognitive, or mental health conditions.
      b. A physician, physician assistant, nurse practitioner or other health care provider has, within his/her scope of practice, requested CBAS services for the person.
      c. The person requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health provider to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive or mental health condition.
      d. The person requires CBAS services that are individualized and planned to support the individual and his or her family or caregiver in the living arrangement of his/her choice and to avoid or delay the use of institutional services, including but not limited to, hospital services, inpatient mental health services or placement in a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
      e. Any person who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS care services if that resident has disabilities and a level of functioning that are of such a nature that without supplemental intervention through CBAS care, placement to a more costly institutional level of care would likely occur.
   3. Medical Necessity Criteria
      a. Except for participants residing in an ICF/DD-H, authorization or reauthorization of a CBAS Treatment Authorization Request (TAR) shall be approved only if the participant meets all of the following medical criteria:
         1) The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization:
            a) Monitoring
            b) Treatment

c) Intervention

2) The participant's network of daytime health care support is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
   a) Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
   b) Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant
   c) Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
   d) A high potential exists for the deterioration of the Participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
3) The Member meets the criteria for Emergency Remote Services (ERS) as defined in Section VI.F below.

C. CBAS Authorization Process
1. Initial Request: A request for initiation of CBAS services may come from one of the following sources:
   a. Community Based Adult Services Center
   b. A licensed physician, physician assistant, nurse practitioner or other health care provider within their scope of practice and board certification
   c. Nursing Facility
   d. Hospital
   e. Individual Member
   f. Family member
   g. Community Based Organization
   h. Partnership's internal report with CBAS indicator
   i. Partnership's Care Coordination staff
2. To recommend a Member for CBAS services, all other requesting entities besides the CBAS center itself must refer to the CBAS center. This inquiry may be done verbally or in writing. The following information should be included at the time of the request:
   a. Member's Name
   b. Identification Number
   c. Date of Birth
   d. Contact Information of Member, caregiver and referring agent. (Name, address, phone number)
   e. Reason the Member needs CBAS services
   (Specific information may vary by the requesting entity)

D. TAR Submission
1. The CBAS agency will begin their Multidisciplinary Team assessment process and complete the Individualized Plan of Care (IPC), (see Attachment A). When the evaluation and IPC is complete and CBAS staff determines the Member to be appropriate for services, the CBAS agency must electronically submit a TAR to Partnership. The TAR must include the codes and description of the services to be provided and a copy of the IPC, with anticipated level of service, as well as any other clinical documentation available (i.e. History and Physical).
2. An initial face-to-face review is not required when Partnership or DHCS or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. Partnership determines that a Member is

eligible to receive CBAS, and that the receipt of CBAS is clinically appropriate, based on review of the IPC and clinical information submitted with the TAR.

a. If Partnership or DHCS or its contractor(s) cannot determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses, then the initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by DHCS.

3. Partnership will approve, modify or deny the requested CBAS services within seven ~~five~~ (7~~(5~~) calendar~~business~~ days of receipt of the TAR, in accordance with Health and Safety Code 1367.01. Decisions for requests on behalf of Members in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who are at high risk for admission to a hospital or SNF (e.g., an expedited or urgent request) will be made within 72 hours of receipt of the TAR, in accordance with CMS Letter Number 11-W100193/9 (CalAIM) Special Terms and Conditions (STCs). If the TAR is approved, the facility will be notified via copy of the authorization.
4. If the TAR is modified or denied, a Notice of Action (NOA) letter will be sent to the Member and CBAS provider.
5. If the plan does not have sufficient information to make a determination, Partnership will extend the time frame one time by up to 14 calendar days. The Member and the CBAS provider are notified immediately in writing of the extension and what additional information is required to complete the review. If no additional requested information is received, the TAR may be denied via the NOA letter. The letter will include appeal rights and responsibilities.
6. CBAS providers can contact Partnership at (800) 863-4155 with all inquiries related to CBAS eligibility determinations, authorization requests, and care planning. The call will be triaged to the appropriate department, where the appropriate assigned Case Manager/Care Team will be identified and notified for follow-up. Partnership will coordinate with CBAS providers, treating practitioners, and other appropriate care team participants for the timely exchange of coordination of care information, including but not limited to:
   a. Updates to Member's IPC and/or discharge plan
   b. Reports of incidents that threaten the welfare, health, and safety of the Member
   c. Significant changes in the Member's condition

E. Reassessment and Reauthorization

1. Eligibility for ongoing receipt of CBAS is determined at least every six (6) months through the reauthorization ~~process~~process, ~~-~~ or up to every twelve (12) months for ~~individuals~~ Members determined by Partnership to be clinically appropriate based on medical necessity and clinical stability.
2. A CBAS center ~~requests~~ initiates the reassessment process by submitting a request for continued CBAS services, including an updated IPC and any supporting clinical documentation.~~and submits a request to begin the CBAS reassessment process.~~
   a. Examples:
      1) Prior authorization end date is approaching
      2) Due to a change in level of service
3. A TAR is created and sent to Partnership with an IPC and a Level of Service recommendation.
4. Partnership receives the prior authorization request from the CBAS center, which includes a completed IPC and level of service recommendation. Partnership will handle the recommendation through existing TAR process which includes:
   a. Partnership will approve, modify or deny prior authorization request within seven~~five~~ (7~~5~~) calendar~~business~~ days, in accordance with Health and Safety Code 1367.01.
   b. If Partnership cannot make a decision within seven~~five~~ (7~~5~~) calendar ~~business~~ days, a 14-day pend letter will be sent to the Member and center.

c. Partnership notifies the CBAS center of the authorization determination within 24 hours of the decision. The plan notifies the Member within 48 hours of the decision.

5. Any d~~D~~enial of ongoing CBAS ~~in~~ services or reduction in the requested level, frequency, or duration of services ~~number of days for services of ongoing CBAS~~ by DHCS or by Partnership requires a face-to-face review.
   a. Process must be completed in accordance with the Health and Safety Code 1367.01 and ensure timelines are met.
6. CBAS services continue.

F. Emergency Remote Services (ERS)
1. Pursuant to the CalAIM 1115 waiver authorized by Centers for Medicare and Medicaid Services (CMS) in January of 2022, CBAS Emergency Remote Services (ERS) are available to Members who are approved and participate in services delivered by a CBAS center.
   a. ERS are defined as the temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, ~~-~~to allow for immediate response to a Member's needs when an emergency restricts or prevents them from receiving services at their CBAS center.
2. Prior to delivery or approval of ERS services, CBAS centers are required to complete the necessary two-step process for obtaining approval from the California Department of Aging (CDA).
   a. Prior to authorizing CBAS ERS services, Partnership shall track and ensure contracted CBAS providers have completed the approval process as required.
   b. Partnership shall regularly check the CDA website for updated CBAS and ERS letters.
3. Effective October 1, 2022, CBAS providers are required to provide ERS when Members experience ~~emergencies~~ unique circumstances as defined below:
   a. Public Emergency: The CBAS center is located in a region that is impacted by S~~s~~tate or local disaster(s) as determined by DHCS or Partnership, regardless of whether formally declared. Partnership will allow for the provision of ERS prior or subsequent to an official public health emergency declaration, as determined by DHCS or Partnership. These public emergencies may include, but are not limited to: earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc. ~~and/or~~
   b. Personal Emergency: The Member enrolled in CBAS is experiencing a time-limited serious illness or injury, crisis or care transition, which temporarily prevents or restricts ~~affects~~ their ability to ~~safely and appropriately participate in~~ receive CBAS ~~-~~services in-person at the CBAS center location, subject to approval by Partnership. For the purposes of ERS, DHCS has defined this as:
      1) Serious illness or injury that prevents the Member from receiving CBAS services within the facility and that providing medically necessary services/supports to the Member would protect life, address or prevent significant illness or disability, and/or alleviate pain.
      2) Crisis means that the Member is experiencing or threatened with intense difficulty, trouble or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
      3) Care transitions occur when the Member is moving to or from care settings such as returning to home or another community setting after a hospital or nursing facility stay.
4. Members who are hospitalized or admitted to a skilled nursing facility (SNF) are not eligible for ERS services while they are admitted or in those facilities.
5. ERS provided during a care transition shall address service gaps and Member/caregiver needs but should not duplicate responsibilities assigned to intake or discharging entities.
6. To request ERS services:
   a. The Registered Nurse and Social Worker at the CBAS center must first assess the emergency

and make updates to the Member's IPC above (Attachment A).

b. If there is no active TAR on file for CBAS services, the CBAS provider must submit a new TAR to Partnership requesting ERS services along with:
   1) A copy of the Member's IPC
   2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
   3) Anticipated time/duration of ERS services

c. If there is already an active TAR on file for CBAS services, the CBAS provider must submit a TAR modification request to Partnership requesting ERS services along with:
   1) An updated copy of the Member's IPC
   2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
   3) Anticipated time/duration of the ERS services

d. During the TAR review process for ERS services, Partnership staff shall work collaboratively with contracted CBAS providers regarding the method of ERS services.

7. ERS services are time-limited and may be authorized for up to three (3) consecutive months for Members who are experiencing a public or personal emergency.
   a. Members may choose to cease ERS services at any time.
   b. For Members who may require ERS beyond the initial three (3) consecutive months:
      1) The CBAS center shall complete a new assessment documenting the continued need for remote/telehealth delivery of CBAS services and supports at least every three (3) months. A TAR modification request shall be submitted to Partnership requesting a continuation of ERS along with the Member's updated IPC for review.
8. Through the TAR review process for ERS services, Partnership shall coordinate with the CBAS center(s) to ensure that Members have their service and support needs met throughout the duration of ERS services.

G. CBAS Facility Selection
   1. ~~The~~ Members may choose any contracted CBAS Center that is available and capable of meeting the Member's needs and is ~~as long as it is~~ within the selected facility's time, access, ~~and~~ transportation, and distance requirements.~~criteria for transportation.~~

H. Reduction in Services or Discharge from CBAS Services
   1. If a Member is going to experience a reduction in CBAS or ERS services, the CBAS center must submit an updated IPC to Partnership.
   2. If the Member will be discharged from a CBAS center, the CBAS center must update the Member's IPC and/or complete a discharge plan for the Member. A copy of the revised IPC and/or discharge plan must be submitted to Partnership for review. The discharge plan must include the following:
      a. The Member's name and ID number
      b. The name(s) of the Member's physician(s)
      c. If applicable, the date the NOA denying authorization for CBAS was issued
      d. If applicable, the date the CBAS benefit will be terminated
      e. Specific information about the Member's current medical condition, treatments, and medications
      f. Potential referrals for medically necessary services and other services or community resources that the Member may need upon discharge
      g. Contact information for the Member's case manager
      h. A space for the Member or the Member's representative to sign and date the discharge plan or IPC
   3. If a Member has already been discharged, the CBAS center must submit the updated IPC and/or discharge plan to Partnership within 30 days.
   4. Partnership shall review the IPC and/or discharge plan to determine ~~if~~ whether the Member has ~~additional needs.~~ongoing health, behavioral health, LTSS, social service, or care

coordination needs requiring additional intervention or referral.

a. For Members that possess additional needs, Partnership shall make a referral to appropriate care coordination or case management services.
b. Members who are discharged from a CBAS program involuntarily may file a grievance with Partnership or request a fair state hearing or independent medical review within 180 calendar days of the date of the involuntarily discharge.
   1) A Member who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
   2) A CBAS participant may file a grievance with Partnership as a written or oral complaint as described in Partnership policy CGA024 Medi-Cal Member Grievance System. The Member or their authorized representative may file a grievance at any time that they experience dissatisfaction with the services or quality of care provided to them.

I. Unbundled Services
1. If a Member is determined to be eligible for CBAS services but there is no CBAS facility in the Member's service area, the Member may choose to attend a CBAS facility of their choice. If there is no CBAS facility available, Partnership will assist in arranging for those individual services that are Partnership benefits and make appropriate referrals to other agencies for the unbundled services that are not Partnership benefits.
2. Unbundled CBAS covered services are limited to the following:
   a. Professional Nursing Services
   b. Nutrition
   c. Physical Therapy
   d. Occupational Therapy
   e. Speech and Language Pathology Services
   f. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and
   g. Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are covered services

J. Quality and Monitoring
1. Licensing & Program Oversight: Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDA certifies licensed Adult Day Health Care (ADHC) centers as Medi-Cal CBAS providers. CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers, certification renewal, providing on-going training and technical assistance to centers, and initiating adverse certification actions against centers that are substantially out of compliance with program requirements.
   a. Partnership's Provider Relations department shall review All Center Letters (ACL) issued by the CDA and ensure that contracted CBAS providers are meeting all requirements issued in those letters.
2. Credentialing: Partnership's Provider Relations department is responsible for ensuring that all CBAS providers are licensed pursuant to CDA and DHCS regulations, and verifying center credentials (see policy MPCR700 Assessment of Organizational Providers). Pursuant to Partnership policy MPCR500 - Ongoing Monitoring of Sanctions~~and Interventions~~, Partnership's CBAS providers shall be monitored monthly to ensure they remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license.
   a. In addition, Partnership's Network Services department shall review and monitor the CDA website for updates to contracted CBAS providers licensing and/or ERS approval status.
   b. Partnership's Network Services department shall update Partnership Health Services staff when or if a CBAS provider loses their license(s) or ERS approval(s).

c. Partnership Provider Relations and Health Services departments will be responsible for providing written notification and training (if necessary) when substantive updates to CBAS-related policies and procedures are made.

3. In collaboration with Health Services (HS) staff, Partnership's Network Services department shall monitor the documentation and reporting requirements of CBAS providers, including but not limited to IPCs, discharge plans, on-going assessments, progress notes, discharge plans, timely completion of the CBAS Emergency Remote Services Initiation Form (CEIF or CDA 4000), etc.
4. Reporting: CBAS centers shall remit to Partnership all DHCS and/or CDA required reporting pursuant to the templates and frequencies requested by Partnership.
5. In addition to DHCS q~~Q~~uarterly reporting requirements, Partnership Health Services staff shall monitor and track available performance and/or quality measures ~~made available on~~published by the ~~on the~~ CDA ~~website~~, such as the CBAS dashboard, to track, trend and/or evaluate CBAS provider performance and outcomes.

~~K. Darling vs. Douglas Settlement~~

~~1. Members who were considered Members under the DHCS Darling vs Douglas litigation and were determined not to be eligible for CBAS services will continue to receive these services as stipulated in the settlement agreement.~~

VII. REFERENCES:

A. Welfare and Institutions Code, Sections 14525 and 14526.1
B. California Health and Safety Code Section 1367.01
C. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) #19-02 Implementation of New CBAS Individual Plan of Care (IPC) (*Amended* 03/19/2019)
D. Medi-Cal Provider Manual/ Guidelines: Community-Based Adult Services (CBAS) *(community)*
~~E. DHCS All Plan Letter (APL) 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)~~
~~F.~~E. DHCS APL 22-020 *Revised* Community-Based Adult Services Emergency Remote Services (11/02/2022)
~~G.~~F. DHCS APL 21-011 *Revised* Grievance and Appeal Requirements, Notice And "Your Rights" Templates (08/31/2022)
~~H.~~G. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-04 *Revised* Launch of New CBAS Emergency Remote Services (ERS) (10/03/2023)
H. Centers for Medicare and Medicaid Services (CMS) Letter Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) (*Amended* 11/28/2014)
I. Centers for Medicare & Medicaid Services (CMS), California Advancing and Innovating Medi-Cal (CalAIM) Section 1115 Demonstration, Project No. 11-W-00193/9, Special Terms and Conditions (STCs).

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

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

*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

REGULATOR APPROVAL:
DHCS approved on 11/12/2025 for MOR.0254
DHCS approved on 11/07/2025 for MOR.0253
DHCS approved on 8/9/2023 for R.0218
DHCS approved on 4/4/2023 for R.0215
DHCS approved on 3/30/2023 for R.0216
DHCS approved on 3/14/2023 for R.0217
DHCS approved on 2/6/2023 for APL 22-020

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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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3059 (previously UP100359)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/15/2003		**Next Review Date:** ~~04/08/2027~~10/14/2027 **Last Review Date:** ~~04/08/2026~~10/14/2026		
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~~10/14/2026	

I. RELATED POLICIES:

A. MCUP3013 - Durable Medical Equipment (DME) Authorization
B. MCUG3134 - Hospital Bed/ Specialty Mattress Guidelines
C. MCUG3007 - Authorization of Ambulatory Procedures and Services
D. MCUP3041 - Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Negative Pressure Wound Therapy (NPWT) - Involves applying continuous or intermittent topical negative pressure to a special dressing positioned in the wound cavity or over a flap or graft. The pressure distributing wound dressing helps remove fluids from the wound and stimulates the growth of healthy granulation tissue.

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 enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the clinical indications for NPWT [also known as Negative Pressure Wound Therapy or Vacuum-Assisted Closure (VAC)] system to improve wound healing in an outpatient setting for Partnership HealthPlan of California Members.

Policy/Procedure Number: MPUP3059 (previously UP100359)		**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump		☒**External Policy** ☐**Internal Policy**	
Original Date: 10/15/2003		**Next Review Date:** ~~04/08/2026~~10/14/2027 **Last Review Date:** ~~04/08/2025~~10/14/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Initial ~~Coverage~~Authorization:
A Treatment Authorization Request (TAR) must be submitted for NPWT pumps and supplies.
Partnership will ~~approve~~ authorize~~the use of~~ NPWT when either ~~criteria in~~Section VI. ~~on~~ A.1. or A.2. criteria ~~is~~are met AND InterQual® Durable Medical Equipment (DME) criteria are ~~met~~satisfied. NPWT Treatment Authorization Requests (TARs) are reviewed in one-month increments.

1. Ulcers and Wounds in the Home Setting:
   a. The patient has one of the following chronic ulcers or wounds, present for at least two weeks despite appropriate wound care: Stage III or IV pressure ulcer, a neuropathic (diabetic) ulcer, venous or arterial insufficiency ulcer or mixed etiology ulcer.
   b. A complete wound therapy program described below by criterion 1) and criteria 2), 3), or 4) as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT.
      1) For all chronic ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT.
         a) Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
         b) Application of dressings to maintain a moist wound environment, and
         c) Debridement of necrotic tissue if present, and
         d) Evaluation of and provision for adequate nutritional status
      2) For Stage III or IV pressure ulcers:
         a) The patient has been appropriately turned and positioned, and
         b) The patient has used a group 2 or 3 (e.g. low air loss mattress) support surface for pressure ulcers on the posterior trunk or pelvis
         c) The patient's moisture and incontinence have been appropriately managed
      3) For neuropathic (for example, diabetic) ulcers:
         a) The patient has been on a comprehensive diabetic management program, and
         b) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
      4) For venous insufficiency ulcers:
         a) Compression bandages and/or garments have been consistently applied, and
         b) Leg elevation and ambulation have been encouraged.
2. Ulcers and Wounds Encountered in an Inpatient Setting:
   a. When NPWT is initiated in an inpatient setting, the NPWT device is included in the per diem payment and is not separately reimbursable. ~~by the treating physician, i~~It will be covered upon discharge for the first month if no Exclusions from Coverage apply (see section VI.C. below).
   b. NPWT ~~applied~~ initiated in an inpatient setting and continued after discharge will be reviewed ~~as~~ according to the ~~a~~ Continued Coverage ~~request~~ criteria in Section VI.D., rather than as an initial request ~~(see section VI.D. below)~~.

B. Documentation:
1. A written order for the negative pressure wound therapy pump and supplies must be signed and dated by the treating physician and obtained by the supplier prior to delivery of the item. Written order must include:
   a. Patient history, previous treatment regimens (if applicable), and current wound management orders
   b. Any concurrent measurements to support the need for NPWT
   c. Duration of the time the patient is expected to require the NPWT

2. Documentation of the treatment plan must also be submitted with the TAR to include the following:
   a. Detailed wound evaluation, including quantitative wound measurements and documentation of ~~of wound presence of~~ granulation and necrotic tissue characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage)
   b. Comorbid conditions
3. Documentation of wound status indicating progress of healing must be entered at least weekly (using quantitative measurements described in VI.B.2.a. above). The supplier of the equipment and supplies must obtain from the treating clinician an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record.

C. Exclusions from Coverage:
A NPWT will be denied as not medically necessary if one or more of the following are present:
1. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
2. Untreated osteomyelitis within the vicinity of the wound
3. Cancer present in the wound
4. The presence of a fistula to an organ or body cavity within the vicinity of the wound
5. Exposed vasculature, nerves, anastomosis or organs

D. Continued Coverage:
1. For wounds and ulcers described under VI.A. above, once placed on an NPWT, in order for coverage to continue, a licensed medical professional must do the following:
   a. On a regular basis,
      1) Directly assess the wound(s) being treated
      2) Supervise or directly perform the dressing changes
   b. On at least a weekly basis, document changes in the ulcer's dimensions and characteristics.
2. If criteria D.1.a.1) and 2) are not met, continued coverage of this therapy will be denied as not medically necessary.

E. When Coverage Ends:
1. For wounds and ulcers described under VI.A. or VI.C. above, NPWT will be denied as not medically necessary with any of the following, whichever occurs earliest:
   a. Criteria D.1.a.1) and 2) cease to occur, or
   b. In the judgment of the treating physician, adequate wound healing has occurred to the degree that NPWT may be discontinued, or
   c. Any measurable degree of wound healing has failed to occur over a one-month period of treatment. There must be documented in the patient's medical records quantitative measurements of wound characteristics including wound length and width (surface area), and depth, serially observed and documented, over a specified time interval. The recorded wound measurements must be consistently and regularly updated and must have demonstrated progressive wound healing from month to month, or
   d. Four (4) months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using a NPWT in the treatment of any wound.
2. Coverage beyond four (4) months will be given individual consideration on a case-by-case basis. If the wound has not shown progress over the prior month, a patient assessment must be completed by the clinician managing the wound. Documentation should include an evaluation for factors and medical conditions impeding wound healing, such as diabetes, poor nutritional status or infection, with submission of recent, relevant labs (complete blood count [CBC], comprehensive metabolic panel [CMP], albumin, wound cultures, hemoglobin A1C [HbA1c]).

F. Supplies Covered:
1. Coverage is provided up to a maximum of 15 dressing kits per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.
2. Coverage is provided up to a maximum of 10 canister sets per month unless there is documentation

evidencing a large volume of drainage (greater than 90 ml of exudate per day.) For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.

3. Amounts greater than 15 dressing kits per wound per month or 10 canister sets per month in the absence of documentation clearly explaining the medical necessity of the excess quantities will be denied as not medically necessary.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Other DME Equipment (*dura other*) refer to section on Negative Pressure Wound Therapy (NPWT) Devices
B. InterQual® DME Equipment Criteria – Negative Pressure Wound Therapy (NPWT) Pump
C. Centers for Medicare & Medicaid Services (CMS) Standards: Local Coverage Determination (LCD) L33821 Negative Pressure Wound Therapy Pumps 01/01/2024 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028~~7~~)
04/09/25; 04/08/26; 10/14/26

Medi-Cal
10/20/04; 10/18/06; 08/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 04/10/19; 05/13/20; 04/14/21; 05/11/22; 05/10/23; 05/08/24; 04/09/2025; 04/08/26; 10/14/26

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

PREVIOUSLY APPLIED TO:

Healthy Kids MPUP3059 (Healthy Kids program ended 12/01/2016)
10/18/06; 8/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16 to 12/01/2016

PartnershipAdvantage:
MPUP3059 - 10/18/06 to 01/01/2015

Healthy Families:
MPUP3059 - 10/01/2010 to 03/01/2013

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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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3078				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Second Medical Opinions				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/20/2016 – Medi-Cal			**Next Review Date:** ~~11/12/2026~~10/14/2026 **Last Review Date:** ~~11/12/2025~~10/14/2026		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
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:** ~~11/12/2025~~10/14/2026	

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance and Appeals

III. DEFINITIONS:

A. Urgent Request: A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, ***or***
   2. In the opinion of a licensed health care practitioner, with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the indications and process for Second Medical Opinions.

VI. POLICY / PROCEDURE:

A. When a second medical opinion is requested by a Member, a Member's authorized representative and/ or health professional, the request will be reviewed. The Member does not need permission from Partnership HealthPlan of California (Partnership) for a second opinion from a network provider. If there is no provider in the Partnership network who can provide the second opinion, a prior authorization will be required and if approved, Partnership will pay for the second opinion from an approved out-of-network provider who is certified by Medi-Cal. Reasons for second opinions include, but may not be limited to the following:

1. The Member has questions concerning the reasonableness or necessity of a recommended surgical procedure or treatment.
2. The Member questions the diagnosis or course of treatment for a condition that threatens loss of life, limb, bodily function or impairment, including but not limited to a serious chronic condition.
3. The diagnosis is in doubt due to conflicting test results, or the treating practitioner is unable to make an accurate diagnosis of the situation.
4. The current treatment plan is not improving the medical condition within an appropriate period of time for the known diagnosis.
5. The Member has attempted to follow the course of treatment or consulted with the initiating professional and still has serious doubts about the diagnosis or treatment plan.

B. An appropriately qualified health care professional, qualified to render a second opinion, is considered to be a primary care provider or specialist acting within the scope of practice and who possesses a clinical background including training and expertise related to the particular illness, disease or condition associated with the request for a second opinion.

C. The plan reserves the right to limit a Member's choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The Member shall be referred to an out-of-network ~~outside the network to a~~certified Medi-Cal ~~certified~~ provider when ~~there is not~~ a qualified network/contracted professional is not available (see discussion of out of network referrals in policy MCUP3124 Referral to Specialists [RAF] Policy.) Note that any out of network treatments recommended would be subject to the treatment authorization (TAR) process as per policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

D. Timeframes for out-of-network second opinions will be as follows:
   1. If a Member's request requires an urgent review, a determination will be made within 72 hours after receipt of the request.
   2. For a non-urgent request, the Member will be notified within ~~5 business~~seven (7) calendar days as to whether or not the provider ~~he/she~~they requested for a second opinion was approved.

E. If a Member's request for a second opinion is not granted by the primary care provider, the Member may contact ~~the~~ a Grievance Coordinator at Partnership HealthPlan and file a grievance in accordance with Partnership policy CGA024 Medi-Cal Member Grievance System.

F. If the health plan denies a request for a second opinion, the Member will be notified in writing of the reasons for the denial, the Member's right to appeal or file a grievance, and information on how to file an appeal and how to file a grievance.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III, Section 2.3.C.

B. National Committee for Quality Assurance (NCQA) ~~2026~~ Guidelines ~~(Effective July 1, 2025)~~ UM Factor 5 Timeliness of UM Decisions, Element D Interim: Policies and Procedures

VIII. DISTRIBUTION:

A. Partnership Provider Manual

B. Partnership Department Directors

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

X. REVISION DATES:

Medi-Cal:

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

*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.

Note – Policy initially developed under the Healthy Kids Program 11/16/2005

PREVIOUSLY APPLIED TO:
Healthy Kids – MPUP3078, KK UM115 (Healthy Kids program ended 12/01/2016):
11/16/05; 11/21/07; 11/19/08; 10/01/10; 08/19/15; 04/20/16 to 12/01/2016

Healthy Families:
MPUP3078 - 10/01/2010 to 03/01/2013

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

Committee: Credentials Committee
Date: August 12, 2026 7:00 A.M.
Members Present: by phone conference* Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Bradley Sandler, MD* ; Brian Montenegro, MD; Craig Rhoades, PA-C*

PHC Staff: by phone conference* Mark Netherda, MD* Medical Director Quality Improvement; Marshall Kubota, MD*; PHC Associate Medical Director; Robert Moore, MD*, MPH, MBA, PHC Chief Medical Officer; Jeffery Ribordy, MD* Regional Medical Director; Lisa Ward, MD* Regional Medical Director; Matthew Morris, MD* Regional Medical Director; Priscila Ayala, Director of Network Services; Danika Ahedo, Supervisor of Credentialing; J'aime Seale, Credentialing Team Lead; Nolan Smith, Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda Arguello, Lead Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Credentials Chair Mark Netherda, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by Mark Netherda, MD. Mark Netherda, MD reminded everyone that all items discussed are confidential. a. Partnership Credentials Chair Mark Netherda, MD reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Mark Netherda, MD reminded the committee that all information discussed is confidential in nature.			08/12/2026 08/12/2026
II. Review and approval of July 8, 2026 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for July 8, 2026 were reviewed by the Committee.	II. Summary were reviewed. A motion for approval of the Summary was made. First motion approved by Bradley Sandler, MD and the second motion approved by Steven Gwiazdowski, MD. Meeting Summary' motions approved by committee unanimously with no objections.		08/12/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
III. Old Business. a. No Old Business to report.	III. Old Business a. No Old Business to report.	III. Old Business a. No Old Business to report.		08/12/2026
IV. New Business a. Review and Approval of Routine Practitioner List.	IV. New Business a. Mark Netherda, 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 Brian Montenegro, MD. Routine Practitioner List motions approved by committee unanimously with no objections.		08/12/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Mark Netherda, 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 Steven Gwiazdowski, MD and the second motion approved by Brian Montenegro, MD. MPCR200 Clean/Routine list motions approved by committee unanimously with no objections.		08/12/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Danika Ahedo, Supervisor of Credentialing. Danika explained the following policies: • **MPCR12 – Credentialing of Individual and Private Duty Nurses under EPSDT**. Revisions for this	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies MPCR12, MPCR12-A and MPCR200 and a second motion to remove MPCR15 from review and bring back to committee to clarify training information listed was made. First motion approved by Bradley Sandler, MD and the		08/12/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	policy include: Updated Related policy name for Site Review policy from MCQP1022 to MPQP1022. Added MPCR500 "Ongoing Monitoring and Interventions" to related policies. Added Private Duty Nursing Services to definition Purpose updated with updated APL from APL20-012 to 26-009. Changed verbiage throughout policy from Practitioner to Nurse. Updated A6 to clarify Site Review requirements. Reference updated to reflect new APL 26-009. Added new references: APL 22-013 APL 21-003, and NCQA CR 1, 2, 3, 4,5 • **MPCR12-A Attachment A – Individual Nurse Agreement**. Revisions for this policy include: Updated section J to reflect correct staff titles • **MPCR200 Credentials Committee and CMO Credentialing Program Responsibilities.** Revisions for this policy include: Business Unit change on page 112. The business unit changed from Provider Data to Credentialing. Consent Calendar changes change on page 112 – Next review date changed to 9/9/2027, last review date changed to 9/9/2026.	second motion approved by Steven Gwiazdowski, MD. Revised Policies MPCR12, MPCR12-A and MPCR200 motions approved by committee unanimously with no objections. MPCR15 removed from review, will be presented to committee once policy is updated with no objections.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Reviewing Entities change on page 112: IQI and QUAC added. Approving Entities on page 112 added PAC Approval Signature changed on page 112 from Mark Netherda, MD to Robert Moore, MD, MPH, MBA. Approval date changed on page 112 to 9/9/2026. Section I., addition of MPCR300 Physicians Credentialing and Credentialing Requirements. Section IV removed N/A and added MPCR200 – Clean File Approval Form link as an attachment Section V1 B Removed Provider Relations and changed to Network Services Section V1 C3b added MPCR 200-Clean file approval form References added APL 22-013, and added NCQA 2026 CR 2A Elements 1, 2, 3 • **MPCR15 Doula Credentialing and Re-credentialing Criteria**. Dr. Montenegro inquired concerns regarding the training hours required for a Doula's training found in section VI.C.1. Dr. Montenegro wanted further clarification on why only three hours of continued training is needed. He feels this could be a typo due to a physician requiring at least 25 hours of continued training. Motion to remove MPCR15 from list of revised policies and to re-present to the			

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	committee when information on training is clarified in the policy.			
d. Exception Provider	d. Mark Netherda, MD referred the Credentials Committee to information for practitioner. The practitioner wants to be credentialed for cardiovascular disease specialty with a group. The provider filed a harassment lawsuit against their supervisor when employed with the University of Southern California on 7/1/2014. The practitioner claims they were fired in retaliation of the lawsuit. On 10/13/2025 the University of Southern California reported to NPDB the provider took a leave of absence while there was three ongoing cases pending for the provider. NPDB reported the matter is currently under review with no further findings reported as of 10/13/2025. Dr. Netherda explained although there are three cases pending review, the provider's license currently has no sanctions reported. Dr. Moore stated, the practitioner was not obligated to continue working for a company they are suing. Dr. Montenegro asked, wouldn't the practitioner be protected from termination? Dr. Moore explained this protection is only for whistleblowers. Dr. Ribordy asked if this information was also reported to the Medical Board of California? Dr. Moore answered the medical board currently was not notified. Dr. Gwiazdowski asked why was NPDB only reported? Dr. Moore explained the University of Southern California reported due to the	d. The Committee reviewed the Exception Provider. A motion to approve provider with monitoring was made. First motion approved by Brian Montenegro, MD and the second motion approved by Michele Herman, MD. Exception Provider motion approved by committee unanimously with no objections.		08/12/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	provider taking a leave of absence during an investigation. Dr. Ribordy interjected that a leave of absence does not mean the provider no longer is employed with the company. Dr. Netherda answered, as of 11/30/2025 the provider is no longer employed with University of Southern California and the practitioner claims they were fired due to the lawsuit. Dr. Herman asked at what point do we offer an opportunity to the practitioner to offer further information? Dr. Netherda explained the practitioner supplied a statement within the credentialing materials and felt the language was very defensive. Dr. Moore stated that we will not know further information until reported to the Medical Board of California. Dr. Netherda states we could approve with monitoring. Dr. Jones asked what would be monitored? Dr. Netherda explained the Medical Board of California and License. Dr. Sandler interjected that there are no grounds to deny based on the current information received. Dr. Morris agreed and stated they liked the idea of monitoring while waiting for further information from the Medical Board of California. Dr. Montenegro motioned to approve with monitoring.			
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and Approval of Ongoing Monitoring	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. The Credentials Committee members		08/12/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Approval of Ongoing Monitoring of Sanctions Report.	of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report.	reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made. First motion approved by Bradley Sandler, MD and the second motion approved by Michele Herman, MD. Ongoing Monitoring of Sanctions Report motions approved by committee unanimously with no objections.		
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Mark Netherda, MD reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Informational only*.		08/12/2026
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a. Mark Netherda, MD asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a. 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. First motion approved by Michele Herman, MD and the second motion approved by Bradley Sandler, MD. Consent Calendar items motions approved by committee unanimously with no objections.		08/12/2026
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 8/12/2026 respectfully prepared and submitted by J'aime Seale, Credentialing Lead

Chairman Signature of Approval _____ ***Date*** ***8/12/2026***

Mark Netherda, MD ***Credentialing Chairman***

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Abbade, Samantha B.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	02/10/2016	Yes	None	
Adeagbo, Taiye Doula	Doula	None		No	None	
Agarwal, Priyanka MD	Endocrinology	ABMS of Internal Medicine	10/01/2019	Yes	Admitting Agreement	None
Alamshahi, Kaneshka MD	Family Medicine	ABMS of Family Medicine	11/21/2015	Yes	Admitting Agreement	None
Allen, Matthew W.,MD	Radiation Oncology	ABMS of Radiology	06/02/2009	Yes	Mercy Medical Center of Rec	Active
Alsdurf, Jody CADC-CS	Wellness and Recover	California Consortium of Addicti	08/23/2016	Yes	None	
Alvarez, Aaron PT	Physical Therapy	None		No	None	
Anderson, Nathan S.,MD	Cardiovascular Diseas	ABMS of Internal Medicine	11/06/2013	Yes	Providence Santa Rosa Mem	Active
Andros, Jesse BCBA	BCBA	Behavior Analyst Certification Bo	04/22/2026	Yes	None	
Anwar, Tahir M.,DO	Family Medicine	Meets MPCR #17, Verified Resi	11/01/2016	Yes	Admitting Agreement	None
Ashby, Jason PT	Physical Therapy	None		No	None	
Ashouian, Nasrin MD	Nephrology	ABMS of Internal Medicine	11/04/2010	Yes	Admitting Agreement	Active
Aslam, Anisul MD	Urgent Care	None		No	None	
Bagga, Sidharth MD	Internal Medicine	Meets MPCR#17, Previously Bo	08/11/2009	No	Oroville Hospital	Active
Bains, Apar MD	Urgent Care	None		No	Admitting Agreement	None
Banaag, Jhellies BCBA	BCBA	Behavior Analyst Certification Bo	05/07/2020	Yes	None	
Barbo, Cynthia R.,AGNP-C	Adult Gerontology Acu	American Academy of Nurse Pra	06/02/2021	Yes	None	
Barker, Alyssa OT	Occupational Therapy	None		No	None	
Barnes, Kenyatta MD	Family Medicine	ABMS of Family Medicine	04/15/2026	Yes	Admitting Agreement	None
Barrows, Edward B.,MD	Urology	ABMS of Urology	02/29/1992	Yes	Admitting Agreement	None
Bauerle, Kaleigh BCBA	BCBA	Behavior Analyst Certification Bo	07/25/2025	Yes	None	
Beeman, Timothy J.,PT	Physical Therapy	None		No	None	
Begier, Jennifer A.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	03/20/2018	Yes	None	
Bennie, James R.,MD	Family Medicine	ABMS of Family Medicine	07/20/2011	Yes	Admitting Agreement	None
Berkebile, Candice BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	05/31/2013	Yes	None	
Berman, Joel DPM	Foot Surgery	AB of Foot and Ankle Surgery	07/27/2000	Yes	Adventist Health + Rideout	Affiliate
Bermudez-Villalpando, Vanessa I.,MD	Family Medicine	Meets MPCR#17, verified reside		No	Admitting Agreement	None
Bernard, Gary S.,DO	Obstetrics and Gynecc	ABMS of Obstetrics and Gynecc	11/12/1999	Yes	Admitting Agreement	None
Bertolini, Dominique M.,MD	Psychiatry	Meets MPCR#17, verified reside		No	Admitting Agreement	None
Billing, Joshua SUDRC I	Wellness and Recover	None	5/13/2026	No	None	None
Blackwell, Joshua A.,MD	Family Medicine	ABMS of Family Medicine	07/01/2024	Yes	Mercy Medical Center Mt. Sh	Courtesy
Blythe, Tina M.,OT	Occupational Therapy	None		No	None	
Bonfanti, Caroline M.,PMHNP-BC	Psychiatric Mental Hea	American Nurses Credentialing	06/10/2013	Yes	None	
Boothpur, Raghavender R.,MD	Nephrology	ABMS of Internal Medicine	10/23/2012	Yes	Adventist Health + Rideout	Active
Borchardt, Eric BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	02/28/2017	Yes	None	
Bouchard-Hall, Valarie Doula	Doula	None		No	None	
Boyle, Craig M.,DC	Chiropractic	None		No	None	
Bricher, Corrine PA-C	Orthopedic Surgery	None		No	None	
Briggs, Nicole E.,PA-C	Physician Assistant Ce	National Commission on Certific	05/01/2020	Yes	None	
Bristow, Soran BCBA	BCBA	Behavior Analyst Certification Bo	04/14/2025	Yes	None	
Britt, Dale G.,MD	Urgent Care	None		No	Providence Santa Rosa Mem	Active
Budasova, Anastasia FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	05/29/2025	Yes	None	
Burlingham, Lauren BCBA	BCBA	Behavior Analyst Certification Bo	10/21/2025	Yes	None	
Candela, Victor H.,Jr., ACSW	Wellness and Recover	California Substance Use Disorc	04/22/2025	Yes	None	
Casarez, Christina D.,LCSW	Wellness and Recovery			No	None	
Cashman, Anna M.,RD	Registered Dietitian	Commission of Dietetic Registra	03/10/2002	Yes	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Castro Serrato, Brenda SLP	Speech & Language P	None		No	None	
Cetina, Alisha A.,ACSW	Wellness and Recover	None		No	None	
Chan, Crystal PA-C	Physician Assistant Ce	National Commission on Certific	06/16/2025	Yes	None	
Chandan, Aditya M.,AGACNP-BC	Adult Gerontology Acu	American Nurses Credentialing	01/31/2023	Yes	None	
Chappelle, Jozlyn S.,SUDCC	Wellness and Recover	California Substance Use Disorc	06/25/2025	Yes	None	
Chase, Carolyn R.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	12/01/1997	Yes	None	
Chen, Clayton W.,MD	Radiation Oncology	ABMS of Radiology	06/02/2009	Yes	NorthBay Medical Center/ Nc	Active, Attending
Chin, Bonnie M.,RD	Registered Dietitian	Commission of Dietetic Registra	02/09/2018	Yes	None	
Chintamaneni, Sreekanth MD	Rheumatology	ABMS of Internal Medicine	10/08/2009	Yes	Admitting Agreement	None
Chock, Monika K.,MD	Dermatology	ABMS of Dermatology	07/24/2014	Yes	Admitting Agreement	None
Choi, Hyun Ryung MD	Family Medicine	ABMS of Family Medicine	10/13/2025	Yes	Admitting Agreement	None
Choudhry, Sara MD	Internal Medicine	ABMS of Internal Medicine	08/12/2009	Yes	Mercy Medical Center of Rec	Active
Christensen, Kate T.,MD	Internal Medicine	ABMS of Internal Medicine	09/12/1984	Yes	Admitting Agreement	None
Cioffi, Brandon BCBA	BCBA	Behavior Analyst Certification Bc	04/07/2026	Yes	None	
Clark, Mary R.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	12/01/1995	Yes	None	
Cole, Junalyn-Gabrielle BCBA	BCBA	Behavior Analyst Certification Bc	10/24/2025	Yes	None	
Colpitts, Catherine A.,DO	Family Medicine	ABMS of Family Medicine	07/01/2017	Yes	Admitting Agreement	None
Connolly, Joseph III, DO	Neurology	ABMS of Psychiatry & Neurolog	01/27/1998	Yes	Mercy Medical Center of Rec	Active
Daly, Carrie BCBA	BCBA	Behavior Analyst Certification Bc	10/08/2021	Yes	None	
Damle, Neha MD	Hematology	ABMS of Internal Medicine	10/20/2020	Yes	Providence Queen of the Val	Active
Davidson, Anders J.,MD	Vascular Surgery	ABMS Vascular Surgery	05/17/2022	Yes	Providence Santa Rosa Mem	Active
Davis, Emily C.,MD	Family Medicine	ABMS of Family Medicine	07/01/2023	Yes	Admitting Agreement	None
Dekker, Jordan BCBA	Board Certified Behavi	Behavior Analyst Certification Bc	09/30/2024	Yes	None	
Delacruz, Valerieanne N.,PA-C	Physician Assistant Ce	National Commission on Certific	04/23/2026	Yes	None	
Delgado, Selena BCBA	BCBA	Behavior Analyst Certification Bc	09/20/2022	Yes	None	
Delshad, Mitra FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	11/25/2015	Yes	None	
DiGeorge, Sarah H.,AGACNP-BC	Adult-Gerontology Acu	American Nurses Credentialing	11/04/2022	Yes	None	
Dillon, Sarah R.,SUDRC I	Wellness and Recover	California Substance Use Disorc	06/23/2026	Yes	None	
Ebron, Ashley BCBA	BCBA	Behavior Analyst Certification Bc	10/17/2022	Yes	None	
Ehrenberg, Douglas A.,DPM	Podiatry	None		No	Admitting Agreement	None
Eisner, Gabriel PT	Physical Therapy	None		No	None	
Elahi, Foad MD	Pain Medicine	ABMS of Physical Medicine & R	7/1/2011	Yes	Mercy General Hospital of Sa	Active
Ellis-Falik, Elizabeth V.,PA-C	Physician Assistant Ce	National Commission on Certific	10/31/2024	Yes	None	
Ely, Patricia H.,SUDRC II	Wellness and Recover	California Substance Use Disorc	09/06/2025	Yes	None	
Engbretson, Michael R.,PT	Physical Therapy	None		No	None	
Eser, Emmanuel J.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	07/22/2024	Yes	None	
Facemire, Anabel S.,MD	Cardiovascular Diseas	ABMS of Internal Medicine	10/31/2007	Yes	Admitting Agreement	None
Faust, Robert L.,MD	Gastroenterology	ABMS of Internal Medicine	11/09/1995	Yes	Admitting Agreement	None
Fehrenbacher, George MD	Cardiovascular Diseas	ABMS of Internal Medicine	11/08/1989	Yes	Sutter Roseville Medical Cer	Active
Fletcher, Sophie A.,MD	Urology	ABMS of Urology	02/28/2011	Yes	Admitting Agreement	None
Flinders-Flaten, Shanna BCBA	BCBA	Behavior Analyst Certification Bc	08/04/2020	Yes	None	
Flores, Annastasia CADC-CS	Wellness and Recover	California Substance Use Disorc	03/16/2020	Yes	None	
Flores, Chrysteven Doula	Doula	None		No	None	
Fobi, Aloysius N.,MD	Urgent Care	None		No	None	
Freed, Spencer J.,MD	Internal Medicine	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
Freeman, Miranda R.,OT	Occupational Therapy	None		No	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
French, Cody PT	Physical Therapy	None		No	None	
Fuentez, Crystal OT	Occupational Therapy	None		No	None	
Ganesan, Thiyagu MD	Pediatrics	ABMS of Pediatrics	10/09/2015	Yes	Adventist Health + Rideout	Active
Garay, Danahlynn BCBA	BCBA	Behavior Analyst Certification Bo	10/28/2020	Yes	None	
Garchow, Julie C.,MD	Family Medicine	ABMS of Family Medicine	04/17/2018	Yes	Admitting Agreement	None
Garcia, Monica BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	05/21/2026		None	
Garcia, Nancy C.,LCSW	Licensed Clinical Soci	None		No	None	
Garrett, Cassandra BCBA	BCBA	Behavior Analyst Certification Bo	02/25/2020	Yes	None	
Garrison-Jakel, Jared N. MD	Family Medicine	ABMS of Family Medicine	07/01/2013	Yes	Admitting Agreement	None
Gatewood, Nancy BCBA	BCBA	Behavior Analyst Certification Bo	02/27/2025	Yes	None	
Gaulden, Julie A.,AGNP-C	Adult Gerontology Acu	American Academy of Nurse Pra	01/09/2023	Yes	None	
George, Bashari J.,Doula	Doula	None		No	None	
Germain, Rasha MD	Neurological Surgery	ABMS of Neurological Surgery	05/04/2019	Yes	Santa Rosa Memorial Hospit	Active
Ghiassi, Maryam MD	Opthalmology	ABMS of Opthalmology	06/03/2022	Yes	Mercy General Hospital of Sa	Courtesy
Ghods, Ehsan DO	Family Medicine	AOB-Family Medicine	10/08/2003	Yes	NorthBay Medical Center/ No	Provisional
Ghuman, Apar S.,DO	Physical Medicine & R	ABMS of Physical Medicine & R	07/01/2021	Yes	Admitting Agreement	None
Gifford, Glenn E.,PA-C	Physician Assistant Ce	National Commission on Certific	05/16/2013	Yes	None	
Gilbert, Tierra BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	02/28/2019	Yes	None	
Golden, Hannah Doula	Doula	None		Not Appli	None	
Gonzalez Arman, Jesus BCBA	BCBA	Behavior Analyst Certification Bo	05/29/2025	Yes	None	
Gonzalez, Olga L.,MD	Pediatrics	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
Good, Christina BCBA	BCBA	Behavior Analyst Certification Bo	07/27/2022	Yes	None	
Gordon, Kali MD	Internal Medicine	Meets MPCR#17, verified reside		No	Admitting Agreement	None
Gorin, Shawna BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	06/10/2021	Yes	None	
Graham, Travis J.,LAc	Acupuncture	None		No	None	
Greenan, Keara D.,OT	Occupational Therapy	None		No	None	
Greene, Tamara S.,MD	Neurology	ABMS of Psychiatry & Neurolog	09/13/2010	Yes	Admitting Agreement	None
Grosh, Joel T.,SUDCC	Wellness and Recover	California Substance Use Disord	02/25/2026	Yes	None	
Grove, Matthew A., DC	Chiropractic	None		No	None	
Gupta, Vanshika BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	02/23/2022	Yes	None	
Gutierrez, Adriana FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	10/14/2022	Yes	None	
Hall, Ronald RADT	Wellness and Recover	California Consortium of Addicti	01/25/2024	Yes	None	
Hansen, Jodi J.,PT	Physical Therapy	None		No	None	
Hanson, Brian L.,MD	Gastroenterology	ABMS of Internal Medicine	11/04/1998	Yes	Providence Santa Rosa Men	Active
Hartley, Daniel J.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	04/01/2008	Yes	None	
Hattery, Lauren BCBA	BCBA	Behavior Analyst Certification Bo	05/31/2017	Yes	None	
Hefner, Dustin BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	10/10/2024	Yes	None	
Hempstead, Ursula K.,MD	Pediatrics	ABMS of Pediatrics	10/15/2002	Yes	Admitting Agreement	None
Hendrix, Blake W.,RADT	Wellness and Recover	California Consortium of Addicti	04/30/2025	Yes	None	
Hernandez, Marisa BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	06/03/2026	Yes	None	
Herwat, Bridgitte R.,SUDRC I	Wellness and Recover	California Substance Use Disord	05/08/2026	Yes	None	
Hill, Tiffany BCBA	BCBA	Behavior Analyst Certification Bo	05/31/2017	Yes	None	
Hinojosa, Veronica BCBA	BCBA	Behavior Analyst Certification Bo	08/31/2014	Yes	None	
Ho, Bao BCBA	BCBA	Behavior Analyst Certification Bo	01/08/2024	Yes	None	
Holley, Melanie A., CPNP-PC	Certified Pediatric Nurs	Pediatric Nursing Certification B	01/09/2017	Yes	None	
Hu, Lydie X., Lac	Acupuncture	None		No	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Huang, Natalie T., MD	Opthalmology	ABMS of Opthalmology	04/29/2023	Yes	Mercy San Juan Medical Cer	Courtesy
Hunter, Alyssa BCBA	BCBA	Behavior Analyst Certification Bo	08/06/2020	Yes	None	
Inloes, Allison OT	Occupational Therapy	None		No	None	
Ivanusich, Rebecca BCBA	BCBA	Behavior Analyst Certification Bo	06/04/2026	Yes	None	
Jaime, Patricia BCBA	Behavioral Health	Behavior Analyst Certification Bo	11/30/2019	Yes	None	
Jairam, Emily J.,PA-C	Physician Assistant Ce	National Commission on Certific	10/01/2018	Yes	None	
Jamili, Maryam LMFT	License Marriage and	None		No	None	
Janssen, Diane M.,FNP-BC	Urgent Care	None		No	None	
Javier, Elena A.,OT	Occupational Therapy	None		No	None	
Jeno, Taylor BCBA	BCBA	Behavior Analyst Certification Bo	01/12/2026	Yes	None	
Jimenez, Cassandra SUDCC	Wellness and Recover	California Substance Use Disord	03/20/2026	Yes	None	
Johnson, Michael A.,DPM	Podiatry	None		No	Petaluma Valley Hospital	Active
Kamen, Joseph BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	02/27/2020	Yes	None	
Kamiya, Deana OT	Occupational Therapy	None		No	None	
Kancherla, Deepika MD	Nephrology	ABMS of Internal Medicine	10/23/2012	Yes	San Ramon Regional Medica	Provisional
Katsuura, Yoshihiro MD	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/24/2022	Yes	Sutter Santa Rosa Regional	Active
Kaur, Manpreet FNP-C	Urgent Care	None		No	None	
Khaira, Herkanwal S.,MD	Urology	ABMS of Urology	02/28/2008	Yes	NorthBay Medical Center/ No	Active, Attending
Kier, Norman I.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	08/09/2020	Yes	None	
Killingsworth, Kelly RADT	Wellness and Recover	California Consortium of Addicti	06/22/2026	Yes	None	
King, Lucas R.,MD	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/25/2019	Yes	Admitting Agreement	Active
Kohli, Arunima MD	Family Medicine	ABMS of Family Medicine	07/16/2020	Yes	Admitting Agreement	None
Kolli, Divya L.,PA-C	Physician Assistant Ce	National Commission on Certific	05/05/2016	Yes	None	
Kondle, Venu M.,MD	Nephrology	ABMS of Internal Medicine	11/08/2000	Yes	Adventist Health + Rideout	Active
Kucich, Alexander PT	Physical Therapy	None		No	None	
Kumar, Arun MD	Pediatrics	ABMS of Pediatrics	10/28/1998	Yes	Adventist Health + Rideout	Active
Kuybu, Okkes MD	Neurology	ABMS of Psychiatry & Neurolog	09/21/2020	Yes	Mercy Medical Center of Rec	Courtesy
Lakshumanan, Chitra SLP	Speech & Language P	None		No	None	
Lam, Leimalyn BCBA	BCBA	Behavior Analyst Certification Bo	11/30/2014	Yes	None	
Lambert, Teresa L.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	11/19/2020	Yes	None	
Latta, Pushpa FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	12/22/2020	Yes	None	
Lent, Mallory PT	Physical Therapy	None		No	None	
Les, Jessica T.,MD	Family Medicine	ABMS of Family Medicine	07/01/2012	Yes	Admitting Agreement	None
Lestari, Irene OT	Occupational Therapy	None		No	None	
Lin, Jen-Liang J.,MD	Internal Medicine	Meets MPCR#17, Previously Bo	08/30/2007	No	Northbay Medical Center	Provisional
Liu, Fangbing FNP-C	Family Nurse Practitio	American Nurses Credentialing	08/09/2021	Yes	None	
Lloyd, Ryan T.,DC	Chiropractic	None			None	
Loftus, John P.,MD	Vascular Surgery	ABMS of Surgery	05/08/1996	Yes	NorthBay Medical Center/ No	Active
Lor Thao, Kathy BCBA	BCBA	Behavior Analyst Certification Bo	05/02/2022	Yes	None	
Ludwig, Robin BCBA	BCBA	Behavior Analyst Certification Bo	12/31/2004	Yes	None	
Lunsford, Kenny CADC II	Wellness and Recover	California Consortium of Addicti	09/04/2014	Yes	None	
Lurie, Benjamin M.,MD	Orthopedic Surgery	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
MacGregor, Madison PT	Physical Therapy	None		No	None	
Magana-Hernandez, Karla BCBA	BCBA	Behavior Analyst Certification Bo	05/01/2026	Yes	None	
Mai, Marlene C.,PA-C	Physician Assistant Ce	National Commission on Certific	12/11/2024	Yes	None	
Mann, Bimaljit K.,PA-C	Physician Assistant Ce	National Commission on Certific	09/03/2015	Yes	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Marcellus, Mario BCBA	BCBA	Behavior Analyst Certification Bo	12/26/2024	No	None	
Mares, Renee T.,SUDCC II	Wellness and Recover	California Substance Use Disorc	08/07/2025	Yes	None	
Matevosyan, Yelena Psy.D	Psychology	None		No	None	
McClure, Holly AGNP-C	Pain Medicine	None		No	None	
McCubbin, Kelsey BCBA	BCBA	Behavior Analyst Certification Bo	11/30/2017	Yes	None	
McGee, Jeffrey MD	Family Medicine	Meets MPCR#17, verified residency by Residenc		No	Admitting Agreement	None
Meehan, Christina BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	01/31/2011	Yes	None	
Meier-Hanaway, Beverly L.,ANP-C	Adult Nurse Practitione	American Academy of Nurse Pra	08/01/2008	Yes	None	
Mejia Centeno, Melitza PA-C	Physician Assistant Ce	National Commission on Certific	09/07/2021	Yes	None	
Mendez, Jesus Jr., MD	Family Medicine	ABMS of Family Medicine	07/01/2023	Yes	Admitting Agreement	None
Merioles, Shirley P.,PT	Physical Therapy	None		No	None	
Michalsky, Mikayla F.,PA-C	Physician Assistant Ce	National Commission on Certific	02/28/2024	Yes	None	
Michel, Candace L.,LCSW	Licensed Clinical Socia	None		No	None	
Mohajer, Pouya MD	Interventional Cardiolo	None		No	NorthBay Medical Center/ Nc	Active Non-Attending
Molina, Leslie BCBA	Behavioral Health	Behavior Analyst Certification Bo	04/29/2023	Yes	None	
Moody, Toni C.,MD	Pediatrics	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
Moor, Victoria E., FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	06/02/2021	Yes	None	
Morris, Christian B.,MD	Physical Medicine & R	ABMS of Physical Medicine & R	07/01/2022	Yes	Admitting Agreement	None
Mueller Martinez, Ana Celenia Doula	Doula	None		No	None	
Mullen, John F.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	04/02/2014	Yes	None	
Nadalin, Sean M.,PA-C	Physician Assistant Ce	National Commission on Certific	02/18/2020	Yes	None	
Nativo, Megan J.,OD	Retinal Myopathy	None		No	Admitting Agreement	Transfer
Nunez Thomas, Alexandria Doula	Doula	None		No	None	
O'Connell, Timothy E.,SUDCC II	Wellness and Recover	California Substance Use Disorc	06/09/2025	Yes	None	
Odinma, Ruby Doula	Doula	None		Not Appli	None	
O'Hara, John P.,LAc	Acupuncture	None		No	None	
Oliver, Elizabeth D.,PT	Physical Therapy	None		No	None	
Opperman, Joshua M.,PA-C	Physician Assistant Ce	National Commission on Certific	12/27/2007	Yes	None	
Orozco, Natalia P.,FNP-C	Urgent Care	None		No	None	
Otto, Ekei Doula	Doula	None		No	None	
Pandher, Sharandeep K.,FNP-C	Nurse Practitioner	American Academy of Nurse Pra	12/05/2025	Yes	None	
Parker, Edward H.,PA-C	Physician Assistant Ce	National Commission on Certific	12/08/1995	Yes	None	
Parrott, Medie J. PMHNP-BC	Psychiatric Mental Hea	American Nurses Credentialing	03/21/2023	Yes	None	
Parungao, Romina Doula	Doula	None		No	None	
Patee, Mercedes I.,MD	Wellness and Recover	None		Not Appli	Admitting Agreement	None
Patton, Kyle A.,MD	Family Medicine	ABMS of Family Medicine	07/01/2019	Yes	Mercy Medical Center of Rec	Courtesy
Pena, Nathalie FNP-BC	Family Nurse Practitio	American Nurses Credentialing	07/15/2024	Yes	None	
Pena-Pridmore, Mary R.,MD	Family Medicine	Meets MPCR#17, Previously Bo	07/11/1997	Yes	Admitting Agreement	None
Peters, Toni RADT	Wellness and Recover	California Consortium of Addicti	05/27/2026	Yes	None	
Phan, Kristine BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	04/16/2024	Yes	None	
Pinckney, Michael D.,MD	Physical Medicine & R	Meets MPCR#17, Previously Bo	07/01/2006	No	Admitting Agreement	None
Ploude, Johanna BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	11/30/2008	Yes	None	
Porter, Elaine M.,MD	Family Medicine	ABMS of Family Medicine	07/10/1998	Yes	Admitting Agreement	None
Porter, Lindsee BCBA	BCBA	Behavior Analyst Certification Bo	09/30/2010	Yes	None	
Pourang, Aunna MD	Dermatology	ABMS of Dermatology	07/22/2025	Yes	Admitting Agreement	None
Price, Robert A.,SUDCC II	Wellness and Recover	California Substance Use Disorc	06/22/2026	Yes	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Racherla, Harini MD	Pediatrics	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
Ramirez, Acxell F.,SUDCC	Wellness and Recover	California Substance Use Disorc	03/26/2026	Yes	None	
Rana, Naeem A.,MD	Internal Medicine	Meets MPCR#17, Previously Bo	08/23/1995	No	NorthBay Health VacaValley	Provisional
Randhawa, Sartaj S.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	08/20/2025	Yes	None	
Rawal, Amit BCBA	Behavioral Health	Behavior Analyst Certification Bo	09/01/2020	Yes	None	
Rege, Tanvi MD	Internal Medicine	ABMS of Internal Medicine	08/12/2015	Yes	Admitting Agreement	None
Richa, Elie M.,MD	Hematology	ABMS of Internal Medicine	10/30/2018	Yes	Providence St Joseph Hospit	Active
Ricigliano, Denise M.,GNP-BC	Gerontological Nurse P	American Nurses Credentialing	01/21/2009	Yes	None	
Risse, Hayley I.,PA-C	Physician Assistant Ce	National Commission on Certific	01/28/2022	Yes	None	
Romero, Victoriano MD	Urology	ABMS of Urology	2/28/2016	Yes	Mercy Medical Center of Redding	
Rosellini, Doris H.,MD	Family Medicine	ABMS of Family Medicine	07/09/1993	Yes	Admitting Agreement	None
ROZARIO, ALICIA M.,DPM	Podiatry	Confirmed per AMA, AOA, ABFA		No	Admitting Agreement	None
Rozelle, Mary C.,PA-C	Dermatology	None		No	None	
Ruby, Jason D.,PA-C	Physician Assistant Ce	National Commission on Certific	01/26/2012	Yes	None	
Saavedra, Francisco A.,PA	Physician Assistant	None		No	None	
Sadeghi, Mahvash BCaBA	Board Certified Assista	Behavior Analyst Certification Bo	12/12/2024	Yes	None	
Saffier, Kenneth A.,MD	Wellness and Recover	None		No	Admitting Agreement	None
Sanders, Samuel R.,MD	Internal Medicine	ABMS of Internal Medicine	09/12/1984	Yes	Admitting Agreement	None
Sandhu, Jujhar K.,MD	Internal Medicine	ABMS of Internal Medicine	08/13/2012	Yes	Admitting Agreement	None
Sapir, Leora B.,NP	Nurse Practitioner	None		No	None	
Schoenrock, Kelsi L.,MD	Family Medicine	ABMS of Family Medicine	07/10/2020	Yes	Providence Queen of the Val	Active
Schrupp, Laura E., OD	Optometry	None		No	Admitting Agreement	None
Schten, Erik P.,MD	Dermatology	None		No	Novato Community Hospital	Active
Schuld, Christina FNP-BC	Family Nurse Practitio	American Nurses Credentialing	03/29/2011	Yes	None	
Schwenk, Leah M.,SLP	Speech & Language P	None		No	None	
Sebastian, Anne N.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	03/05/2014	Yes	None	
Shackelford, Kimberly L.,PT	Physical Therapy	None		No	None	
Sharma, Manisha FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	09/10/2014	Yes	None	
Sheridan, Eva BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	11/30/2017	Yes	None	
Shriber, Lisa BCBA	BCBA	Behavior Analyst Certification Bo	02/28/2014	Yes	None	
Siddiqui, Gulnazbanu FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	12/22/2023		None	
Simon, Faith S.,NP	Nurse Practitioner	None		No	None	
Sineri, Charles F.,DO	Cardiology	AOB of Cardiology	08/17/2022	Yes	Admitting Agreement	None
Singh, Amitabh DO	Internal Medicine	Meets MPCR#17, verified reside		No	Admitting Agreement	None
Singh, Mandeep FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	06/27/2019	Yes	None	
Sippel, Abigail S.,BCBA	BCBA	Behavior Analyst Certification Bo	06/16/2026	Yes	None	
Skowyra, Allyssa F.,DC	Chiropractic	None		No	None	
Smelser, Andrew A.,SUDRC II	Wellness and Recover	California Substance Use Disorc	02/23/2026	Yes	None	
Smith, Nicole K.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	08/05/2025	Yes	None	
Smith, Taylor BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	03/03/2026	Yes	None	
Snider, Steven P.,PT	Physical Therapy	None		No	None	
Sockell, Mark E.,MD	Internal Medicine	ABMS of Internal Medicine	09/10/1986	Yes	Admitting Agreement	None
Solano Martinez, Elizabeth G.,Doula	Doula	None		Yes	None	
Solomon, Diana Doula	Doula	None		Not Appli	None	
Soo, Kelly BCBA	BCBA	Behavior Analyst Certification Bo	05/31/2011	Yes	None	
Spinale, Michelle BCBA	BCBA	Behavior Analyst Certification Bo	04/24/2023	Yes	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Steele, James G.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	11/13/2004	Yes	None	
Steinheiser, Amanda M.,PA-C	Physician Assistant Ce	National Commission on Certific	06/01/2017	Yes	None	
Sternenberg, Patricia FNP-BC	Family Nurse Practitio	American Nurses Credentialing	02/25/2022	Yes	None	
Streeter, Jennifer BCBA	Behavioral Health	Behavior Analyst Certification Bo	05/31/2014	Yes	None	
Suri, Vikram MD	Nephrology	ABMS of Internal Medicine	11/12/2015	Yes	Sutter Solano Medical Cente	Active
Tannous, Sliman C.,PT	Physical Therapy	None		No	None	
Tate, Matthew P.,PA-C	Urgent Care	None		No	None	
TECKLE, SOLOMON I.,MD	Hospice and Palliative	None		No	Admitting Agreement	None
Telander, David G.,MD	Ophthalmology	ABMS of Ophthalmology	11/14/2004	Yes	Mercy General Hospital of Sa	Active
Thao, Yue Pheng FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	12/09/2024	Yes	None	
Tibble, Courtney J.,MD	Internal Medicine	Meets MPCR#17, Previously Bo	08/27/2009	No	NorthBay Medical Center/ No	Provisional
Tiss, Matthew J.,PT	Physical Therapy	None		No	None	
Tompkins, Bailey BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	06/14/2024	Yes	None	
Torres Almeraya, Jose RADT	Wellness and Recover	California Consortium of Addicti	04/10/2026	Yes	None	
Torres, Gabriela BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	02/19/2025	Yes	None	
Towns, Hannah BCBA	BCBA	Behavior Analyst Certification Bo	09/29/2021	Yes	None	
Trehan, Malu M.,RD	Registered Dietitian	Commission of Dietetic Registra	10/01/1997	Yes	None	
Trieu, Huy T.,MD	Surgery	ABMS of Surgery	03/19/2013	Yes	Providence St Joseph Hospi	Active
Triplett, Katherine BCaBA	BCABA	Behavior Analyst Certification Bo	12/20/2021	Yes	None	
Underwood, Phillip CADC II	Wellness and Recover	California Consortium of Addicti	08/09/2021	Yes	None	
Valdez, Alexyss BCBA	BCBA	Behavior Analyst Certification Bo	02/11/2025	Yes	None	
Valles, Jacqueline SLP	Speech & Language P	None		No	None	
Vedamuthu, Margoschis FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	12/20/2024	Yes	None	
Velazquez, Isabella BCBA	BCBA	Behavior Analyst Certification Bo	12/18/2024	Yes	None	
Vennemeier, Elise BCBA	BCBA	Behavior Analyst Certification Bo	11/30/2018	Yes	None	
Vikstrom, Brian G.,MD	Hematology	ABMS of Internal Medicine	11/18/2005	Yes	NorthBay Medical Center/ No	Active, Attending
Viswanathan, Karthikeyan DO	Internal Medicine	Meets MPCR #17, Verified Resi		No	Admitting Agreement	None
Vonasek, Austin DPM	Podiatry	None		No	NorthBay Medical Center/ No	Active, Attending
Waite, Marissa J.,SUDCC	Substance Use Disord	California Substance Use Disorc	05/04/2025	Yes	None	
Wallace, Kathleen PT	Physical Therapy	None		No	None	
Walsh, Stephanie BCBA	BCBA	Behavior Analyst Certification Bo	11/30/2018	Yes	None	
Warren, Jennifer E.,FNP-BC	Family Nurse Practitio	American Nurses Credentialing	08/03/2017	No	None	
Watson, Hannah MD	Family Medicine	ABMS of Family Medicine	07/01/2015	Yes	Sutter Santa Rosa Regional	Active
Whang, Suk C.,MD	Gastroenterology	ABMS of Internal Medicine	10/07/2009	Yes	NorthBay Medical Center/No	Active
Williams, Donna A.,PA-C	Physician Assistant Ce	National Commission on Certific	12/15/2014	Yes	None	
Williams, Shannon D., FNP	Family Nurse Practitio	American Academy of Nurse Pra	08/30/2016	Yes	None	
Williams IV, Bryant J., SUDCC II	Wellness and Recover	California Substance Use Disorc	03/19/2026	Yes	None	
Wills, Amity BCBA	Behavioral Health	Behavior Analyst Certification Bo	11/30/2019	Yes	None	
Wolk, Peter J., MD	Cardiovascular Diseas	ABMS of Internal Medicine	09/09/1980	Yes	Enloe Medical Center	Active
Wong, Matthew L.,MD	Wellness and Recover	None		No	Admitting Agreement	Active
Woods, Christine M.,SLP	Speech Therapy	None		No	None	
Ya, Marc S.,FNP-C	Family Nurse Practitio	American Academy of Nurse Pra	04/02/2024	Yes	None	
Yang, Duazong BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	09/04/2024	Yes	None	
Yeskey, Brianne N.,PA-C	Physician Assistant Ce	National Commission on Certific	03/04/2026	Yes	None	
Young, Sawar C.,MD	Family Medicine	ABMS of Family Medicine	07/20/2010	Yes	Admitting Agreement	None
Zaker, Alexa M.,SUDCC	Wellness and Recover	California Substance Use Disorc	03/14/2025	Yes	None	

Full Name	Specialty Description	Board Name	Initial Cert Date	Board Ce	Hospital Name	Staff Cat
Zamorano, Tanya S.,DO	Family Medicine	ABMS of Family Medicine	07/31/2008	Yes	Admitting Agreement	None
Zavala-Briseno, Jennifer BCBA	Board Certified Behavi	Behavior Analyst Certification Bo	11/21/2024	Yes	None	
Zea, Milagros BCBA	BCBA	Behavior Analyst Certification Bo	03/31/2009	Yes	None	
Zembsch, Justine I.,LCSW	Licensed Clinical Soci	None		No	None	
Zimmerman, Daniel BCBA	BCABA	Behavior Analyst Certification Bo	06/18/2021	Yes	None	
Zuazua, Erica BCBA	BCBA	Behavior Analyst Certification Bo	05/31/2018	Yes	None	
Zufall, Blake C.,DO	Family Medicine	Meets MPCR#17, verified reside		No	Admitting Agreement	None

MEETING MINUTES

Meeting Name: Pediatric Quality Committee (PQC)
Date: August 18, 2026 **Time:** 1:00 – 2:00 p.m.
Location: Partnership HealthPlan of California

Attendees:

Advising Members			
Alyssa Soto, LVN - Lassen		Marcie Jo Cudziol, RN - Trinity	
Annapurna Vishnubhotla, RN - UCSF - CHO		Paulomi Shah, DO - Sonoma	x
Brenda Harris, RN - Siskiyou		R. Jennifer Olson, MD - CHO	
Carey Venglarcik, MD - Shasta Community Health Center		Rebekah Kim, DO - Yolo	x
Carol Miller, MD - Marin		Shandi Fuller, MD - Solano	
Cheryl Losado, RN - Napa		Sharon Convery, PHN - Mendocino	
Deborah Ard, RN - Lassen		Stephanie Holliday, PHN - Humboldt	
James Huang, MD - UCSF		Steven Gwiazdowski, MD - NorthBay Neonatology Associates	
Katherine Estlin, MD - Humboldt		Victoria Morgese, MD - Napa	x
Lauren Burchfield, RN - Humboldt	x		

Other Members			
Abigale Henderson - Colusa		Katie Magliocca - Nevada	
Alexis Erwin-Mecum - Lassen		Katrina Whitaker - Sutter	x
Alex Rodriguez - Yuba		Laura Farneti - Trinity	
Amerjit Bhattal - Yuba		Kim Tangermann - Lake	
Bré Whitley - Sierra	x	Laura Medina - Nevada	
Celia Su, PHN - Colusa		Leah Northrop - Sutter	
Charlene Weiss-Wenzl - Nevada		Lily Nguyen - Yuba	
Chelsea Linthicum - Sutter		Linda Hunt - Modoc	
Chie Newsom - Nevada		Lisa Richardson - Nevada	
Dana Krinsky - Plumas		Lorri McKey - Colusa	x
Cynthia Hawes - Butte		Marcy Reese - Glenn	
Dawn Pacheco - Glenn		Mariza Manson - Colusa	
DeAnne Blankenship - Butte		Melissa Shaw - Yuba	
Debra Webb - Butte		Meredith Wolfe - Humboldt	x
DeLellis York - Butte	x	Michael Romero - Placer	
Elizabeth Corniel - Yuba		Monica Soderstrom - Butte	
Elizabeth Kelly - Colusa		Nellie Brasier - Siskiyou	
Gina Pasquinelli - Sonoma		Nicole Reinert - Plumas	
Jana McDowell - Plumas		Norma Williams - Del Norte	x
Jenifer Norris - Butte		Rebecca Giammona - Nevada	
Ila Suplizio - Placer		Pica Hernandez - Butte	
Jaime Ordonez - Yolo		Sally Easley - Sierra	
Jamie Fanceschini - Sierra		Rhonda Grandi - Sierra	
Janet Pitcher - Shasta	x	Ryan Gruver - Nevada	
Jeanetty Martinelli - Trinity		Sarah Ludwick - Sutter	
Jennifer Hathaway - Siskiyou		Terri Sides - Modoc	
Jessica Ahmadia - Plumas		Terri Smith - Plumas	x
Jessica Hamon - Placer		Tina Venable - Plumas	
Jill Hobbs - Placer		Twylla Abrahamson - Placer	
Kathy Cahill - Nevada			
Katie Beatty - Nevada			

Partnership Staff			
Aaron Brincko - Provider Relations		Jas Singh - Care Coordination	
Amy Turnipseed - Chief Strategy and Government Affairs Officer		Mohamed Jalloh, PharmD - Health Equity	
Alyssa Beard, RN - Care Coordination		Ron Klinger, MSN - Enhanced Health Services	
Angela Guevarra, RN - Care Coordination	x	Samantha Ogston, RN - Care Coordination	x
Annika Jensen, RN - Care Coordination	x	Robert Moore, MD - Medical Director	
Armando Romo - Care Coordination	x	Shannon Boyle, RN - Care Coordination	x
Breanne Lea - Care Coordination		Sheba Cenzia-Saelee - Care Coordination	x
Brigid Gast, RN - Sr. Director of Care Management	x	Sitara Cavanagh - Care Coordination	x
Doreen Crume, RN - Care Coordination	x	Stan Leung, Pharm.D - Pharmacy	
Jaronna Jackson - Care Coordination	x	Suzanne Trepoy Papadopoulos, RN - Care Coordination	x
Jeff Ribordy, MD - Medical Director	x	Teresa Frankovich, MD - Medical Director	
Julie Payton, RN - Care Coordination		Wendi Davis - Chief Operations Officer	
Katherine Barresi, RN - Chief Health Services Officer	x		

Agenda Topic	Minutes	Action Items
Introductions, Roll Call and Objective of Meeting *Speaker: Jeff Ribordy, MD*	The PQC Committee Chair commenced the meeting. Attendance was recorded.	
Review and Approve Minutes from Previous Meeting *Speaker: Jeff Ribordy, MD*	Motion to approve minutes from PQC held on May 5, 2026 Approved, no objections.	
Policy Review *Speaker: Jeff Ribordy, MD*	Partnership Policy *MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services was* reviewed and approved with no further edits.	

Updates from Previous Family Advisory Committee Meeting *Speaker: Jaronna Jackson*	Families shared requests regarding access to California Children's Services (CCS) information on Partnership's website, including CCS age-out resources, Medical Therapy Unit (MTU) information, and easier navigation. Partnership's Communications team shared that a redesigned website is planned with enhanced navigation, search functionality, and mobile accessibility. Families Members reported both positive and challenging experiences, including fewer authorization issues, and positive recovery progress following a traumatic brain injury. Families also shared experiences regarding difficulty accessing specialty appointments due to provider capacity. Families were connected to their case manager for follow-up on access to care and member inquiries. Whole Child Model (WCM) updates included continued collaboration in Medical Therapy Conferences (MTC) with participating counties, growing interest from additional counties, and improved information-sharing processes supporting annual medical redeterminations. Partnership presented 2026 Population Health Needs Assessment (PNA) findings and highlighted the Keep Your Medi-Cal campaign, including member education, community outreach, and eligibility retention resources. Behavioral Health Member Experience Survey results showed strong satisfaction, with 76% of respondents rating their provider experience 5/5. Of 147 members contacted, 35% were referred to Care Coordination, with feedback focused on service access, provider experience, school supports, and resource needs. Partnership plans to continue the survey annually.	

Whole Child Model Update *Speaker: Brigid Gast, RN*	Partnership continues to collaborate with counties on postmortem notification processes, with ongoing discussions and coordination progressing positively through county meetings. An upcoming Joint Operations Committee (JOC) meeting is scheduled for August 26, 2026. Partnership remains actively engaged in MTC collaboration efforts and ongoing Department of Healthcare Services (DHCS) initiatives related to referral pathways. DHCS has established breakout workgroups focused on Neonatal Intensive Care Unit (NICU) and High-Risk Infant Follow-Up (HRIF) populations. DHCS workgroups regarding the transition of CCS members with Unsatisfactory Immigration Status (UIS) from Managed Care to Fee-For-Service are continuing to meet, and additional updates will be shared as information becomes available. Partnership is participating in these discussions and will provide future updates as appropriate. Angela Guevarra, RN has assumed the role of Interim Director of Care Coordination. Points of contact regarding operational questions remain unchanged. Brigid Gast, RN will continue to serve as the WCM CCS liaison and point of contact for the Memorandum of Understanding (MOU).	
WCM MOU Update *Speaker: Brigid Gast*	Executed MOUs continue to increase, including Local Health Department (LHD) MOUs, WCM MOUs, and Regional Center MOUs. Program collaboration activities are outlined within the LHD MOUs, inclusive of programs and benefits serving our pediatric and youth populations including those with special health care needs. Partnership and stakeholders continue to maintain quarterly meetings, ad hoc meetings as needed, and standing meetings with key partners.	

	Quarterly collaboration meetings have been progressing well and have provided opportunities for participating organizations to highlight and share program initiatives and successes. An example discussed was collaboration related to the Transportation Kinetic application. Partnership is aware that DHCS has communicated a potential update to the WCM MOU template. Updated guidance and materials will be shared once they become available. The Department of Healthcare Services (DHCS) is currently revising NICU and HRIF workflows and counties have expressed revisiting MOU language after these workflows are finalized.	
DHCS CCS Advisory Group Update *Speaker: Katherine Barresi, RN*	Partnership's Chief Health Services Officer provided an overview of key topics discussed during the July 15, 2026, CCS Advisory Group (AG) meeting. DHCS leadership shared remarks regarding HR1 and ongoing policy activities impacting the CCS population. A significant portion of the discussion focused on the transition of the UIS population, which is scheduled to be carved out of Managed Care Plans (MCPs) effective January 1, 2027. The transition will affect both Classic CCS and WCM members. DHCS has released initial transition expectations, and a Partnership workgroup is reviewing the guidance and supporting transition planning efforts. During the CCS AG meeting, Partnership shared best practices based on previous member transitions, including the importance of clear escalation pathways and coordinated communication between counties, MCPs, and providers. Partnership emphasized the need for a DHCS-managed hotline to address eligibility and authorization issues that may arise during the transition and prevent delays in care. The group discussed challenges related to identifying affected WCM members. While Partnership can identify members enrolled in WCM with UIS status, additional DHCS approval is needed before member-level information can be shared for transition planning purposes. DHCS is expected to provide further guidance on data-sharing requirements.	

	Additional transition planning topics included: • Provider education regarding Treatment Authorization Requests (TARs) and Service Authorization Requests (SARs). • Coordination for high-risk members and those receiving specialized services. • Continuity of Care (COC) considerations for members receiving out-of-state services. • The need for DHCS support in ensuring provider participation in Medi-Cal Fee-for-Service. • Ongoing efforts to reconcile differences between the UIS Policy Guide and CCS transition guidance documents, particularly related to authorizations. DHCS indicated that an updated transition policy guide is expected in September 2026. The anticipated timeline for a related All Plan Letter (APL) remains unknown. The next CCS AG meeting is scheduled for October 21, 2026, DHCS continues to post meeting recordings and transcripts on its website. The meeting continued to include discussion of new community engagement requirements for Medi-Cal members. While medical exemptions are expected to apply to many CCS members, additional guidance is pending, and Centers for Medicare & Medicaid (CMS) approval of California's exemption framework remains under review. During the CCS AG meeting, Annette Lee provided an update on CCS quality benchmarks, noting improvements in performance measures, increased staffing, and progress reducing operational backlogs, including efforts to expand the CCS provider network statewide. Partnership's Chief Health Services Officer also shared that Lael from Marin County has retired. Participants recognized her longstanding contributions and commitment to the CCS mission. The group discussed plans for the upcoming 100th anniversary of CCS, which will be celebrated next year. Partnership's WCM Medical Director commented on the Children's Hospital of Oakland's longstanding commitment to serving children with complex healthcare needs and expressed confidence in the organization's willingness to continue caring for CCS	

	members. However, concerns were raised regarding the long-term financial sustainability of pediatric specialty providers. Partnership's Chief Health Services Officer highlighted the need for awareness of impacts to CCS members amid broader Medi-Cal changes, including work requirements. She emphasized the importance of maintaining strong case management, transition planning, and care coordination efforts to ensure CCS members continue to receive needed services.	

Decisions Made		
Notes	**Follow-Up Items**	**Assigned To**
n/a	n/a	n/a
Next Meeting		

Date	Suggestions for Agenda
November 3, 2026	n/a

MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

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

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Adrianne Prado, Amanda Harrison; Amanda Kim, Anna Cambell; Anthony Sackett; Brittany English; Brandon Yadi; Candy Stockton; Chelsea Lingao; Bethany Hannah; Christine Smith; Dawn Cook; DeLorean Ruffin; Denise Rivera; Folo Akintan; Hannah O'Leary; Irem Conery; Isaac Brown; Jesus Hermosillo; Jeffrey DeVido; Jim Huckin; Kermit Jones; John Lemoine; Jose Purga; Katherine Barresi; Katheryn Power; Kory Watkins; Kristine Gual; Lilly Merino; Lisa Ward; Lisa O'Connell; Liz Romero; Liat Vaisenberg; Manleen Randhawa; Matthew Morris; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh, PharmD; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Rebecca Stark; Rod Grace; Roni Schultz; Saskia Garcia; Shahrukh Chishty; Shantal Shamoiel; Sydni Aguirre; Valerie Padilla; Stan Leung, Sue Lee; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Wendy Starr;

Guests: Saskia Garcia; Brittany English; Chelsea Lingao

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta;; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Bridget Gast; Dana Codron; Monica Ferguson; Priscila Ayala; Wendi Davis; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Eugene Durrah; Kelly YoungsStone; Liz Romero; Amanda Kim; Cathryn Couch, DrPH, MPH; Leila Romero; Ben Spencer; Denise Whitsett; Emily Wellander; James Devan; Juan Godinez; Kimberly Robertello; Sunshine Jackson; Vicky Klakken

External Advisory Members

Name	Affiliation	Org Type	3/17/26	5/19/26	7/21/26	9/15/26	11/17/26
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X	X	X	
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim, MD Family Physician	Communicare + Ole	FQHC				X	
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System				X	
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X	X	X	
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X		X	
Jeremy Plumb Systems Director, Quality	Northbay Medical Center	Hospital					

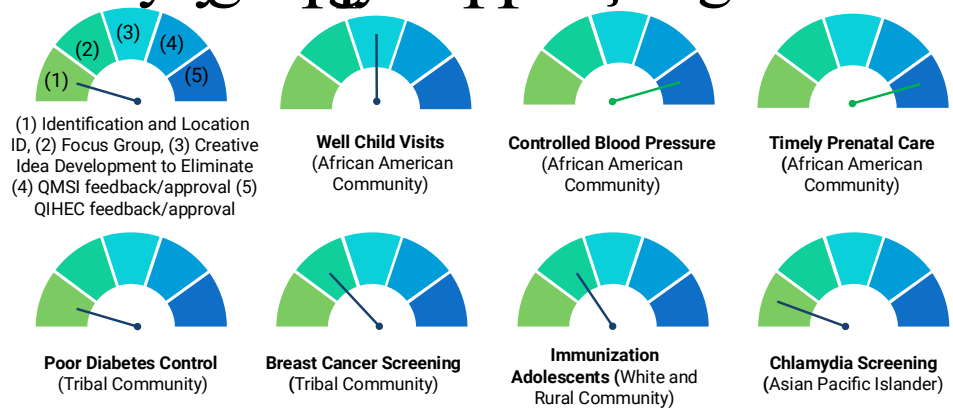
Division							
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department	X	X	X	X	
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X	X		
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X	X		
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

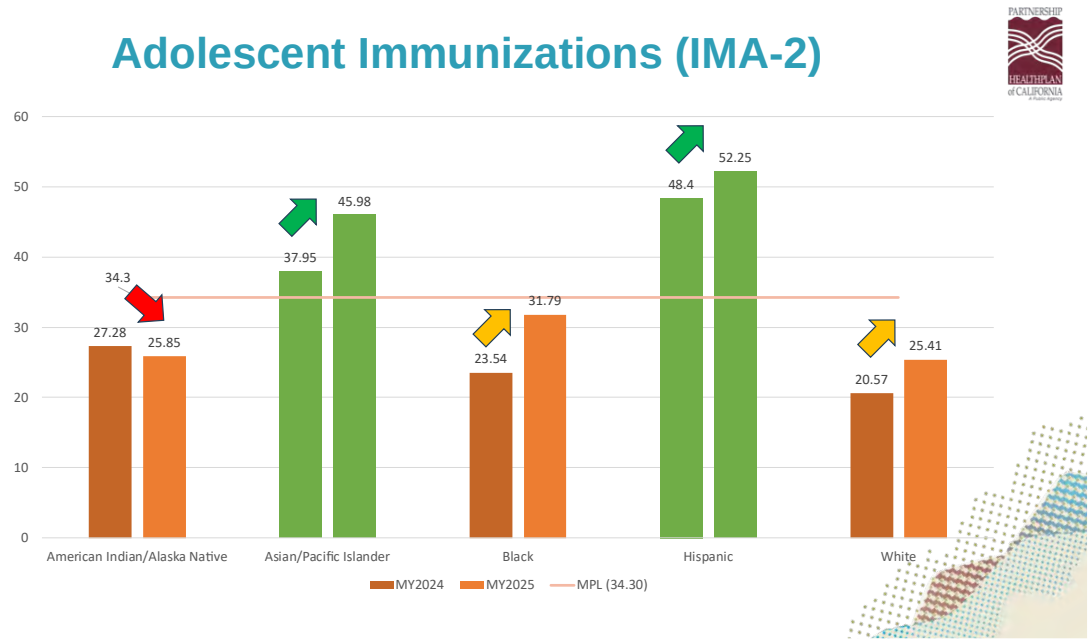
Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. New members we are considering are Saskia Garcia and Brittany English. Saskia is the Director of Strategy and Integration Health Equity Rising. Brittany English is the Director of the Intellectual and Developmental Disability Program at Santa Rosa Community Health Centers out of our Dutton Campus. B. Bethany confirmed that quorum had been met, as 6 external members attended.	Motion to approve meeting minutes from July 2026. 1st: Valerie Padilla 2nd Jason Cunningham

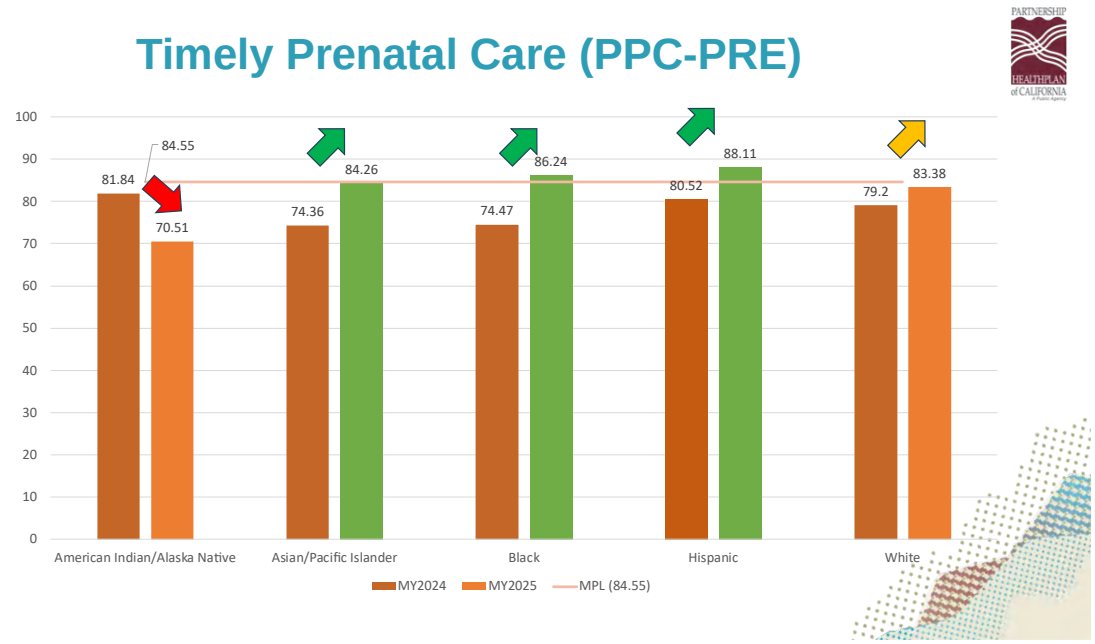
Agenda Topic	Notes	Action Item
	C. Motion to approve meeting minutes from July 2026. 1st: Valerie Padilla 2nd Jason Cunningham	
Agenda Item 2 **CMO Health Plan Updates** *Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA*	A. The first deputy CMO update focuses on the 84,000 current Partnership members that will be transitioned from managed care Medi-Cal to fee for service Medi-Cal. They'll still get their pharmacy through Medi-Cal RX, but they will lose anything Cal Aim affiliated, specifically the enhanced care management community supports, non-medical transportation and a plan coordinating their care. B. Approvals and referrals running through December 31st will not carry over to January, they will have to be resubmitted through whichever fee for service provider that member lands with. C. Another issue is the paid enrollment prerequisite, the DHCS provider application and validation for enrollment system. Every rendering clinician at every service location as part of a practice must be active and paved, not just the group. (This is where some of the speed bumps are coming up) D. Rolling checks every month to try and close that gap. Dr. Leong from pharmacy and other leaders have been meeting with DHCS to clarify how they are implementing this. E. One common question that comes up is "Will fee for service cover an e-consult or telemedicine?" The answer is yes, it will. Our contracted specialists obligated to keep seeing transitioned members. F. For measure year 2025 HEDIS a number of practices feeding clinical data through data link the NCQA data aggregator went from 6 to more than 30. This is important because NCQA is reporting only through CDS electronic clinical data systems by 2029.	

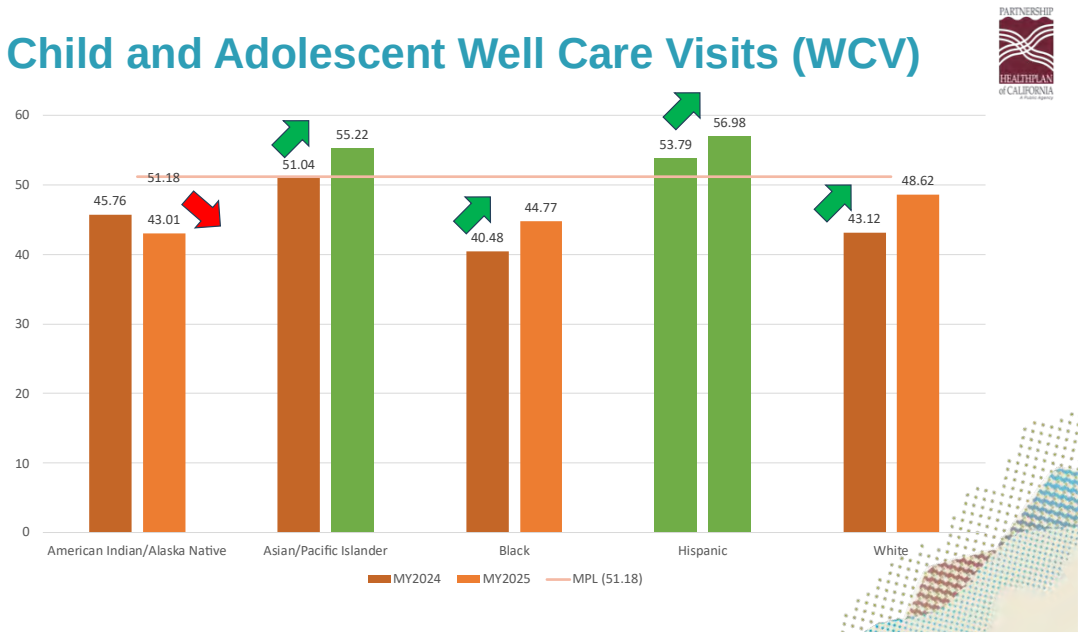
Agenda Topic	Notes	Action Item
	G. Ian Kim asks specifically about his patients who need specialist access and are going to move to a fee for service model. H. Patients who are already seeing a specialist, that is not going to end December 31st. They must make sure that they're enrolled in Pave in order to submit a claim to medical and for that claim to get paid. Finally, they must decide if they are willing to accept fee for service rates at Medi-Cal. I. Saskia Garcia asked a question about data link, to which Dr. Jones didn't have the answer, he asks Saskia to send him an email with her question and he will get back to her with the answer. J. Kristine Gual offers some information on data link, data link is a data aggregator, and it works with EHRs and health information systems to extract data in a structured way. The data will be used for a number of things like quality measure rate generation, at the long term it will be used for things like CMS interoperability framework.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. There is approximately over 80,000 UIS members who will be losing coverage from the Health plan and will be transitioned to fee for service. B. DHCA is changing how their quality withhold function is working. Previously they had funds where instead of paying the Health Plan the full amount for their quality achievement, they would withhold a certain amount and make it that you have to earn it back by addressing specific health disparities. C. We are submitting our community reinvestment final submissions in the next 30 days. The state provided us updated amounts for each County. Partnership will be reaching out to our County contacts to let them know what their updated Community reinvestment amounts. D. Old Business Update a. Dr. Jalloh shared the program description with the group. He shared that the name of the document was changed from QIHETP program description to "Health Equity and Community Reinvestment Strategy and Program	Motion to approve changes made to the program description. 1st Ian Kim 2nd Dr. Romski

Agenda Topic	Notes	Action Item
	description." Updates included: (1) how Partnership calculated health disparities and metrics that we will be measuring on a year-to-year basis per department . Finally, we updated how we are managing the community reinvestment.	
Agenda Item 4 **Grand Analysis** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shared the 18 MCAS accountable measures in MY2025. B. The core measures of focus are child and adolescent well care visits, controlling high blood pressure, glycemic status assessment for people with diabetes, adolescent immunizations, and timely prenatal care. C. In MY2024 we see improvements in lead screening, controlled blood pressure, and well child visits in 0 to 30months. Well-care visits and childhood immunizations remained below minimum performance level for the majority of race groups. Lead screening in children is lower in black members and immunizations for adolescents are significantly lower for white members. D. Dr. Jalloh shared the health disparities equity action score:	*Partnership team members will engage with the Tribal Liaison to conduct a preliminary root-cause-analysis (RCA) to identify if low quality scores are due to* claim lag issues, data submission delays, system limitations or other operational factors that could have contributed to the decline in performance.

Agenda Topic	Notes	Action Item
	 E. Dr. Jalloh shared a graph showing improvement from MY2024 to MY2025 for controlled blood pressure for all race groups. F. A preliminary impact analysis and review of interventions were done. • Four disparities eliminated, four disparities improved and zero disparities worsened. • CHW – barber program charter development was launched in 2026. • Health equity pay for performance QIP bonus was launched. G. Dr. Jalloh shared a graph showing improvement in all race groups for poor A1c control. • Two disparities were eliminated, three disparities improved and zero disparities worsened. H. Measures that do need more support: Adolescent Immunizations.	

Agenda Topic	Notes	Action Item
	 I. Preliminary Impact Analysis and review of interventions: • Zero disparities eliminated, two disparities improved, and one disparity worsened. • Focus groups planned but not executed. J. Dr. Jalloh shared a graph on Timely Prenatal Care	

Agenda Topic	Notes	Action Item
	 K. Preliminary Impact Analysis and review of interventions: • Two disparities eliminated, two disparities improved and one disparity worsened. • Tribal Perinatal Program recruitment • Maternal photoshoots pilot; perinatal growing together program L. Dr. Jalloh shared a graph on child and adolescent well-care visits.	

Agenda Topic	Notes	Action Item
	 M. Preliminary Impact Analysis and review of key interventions: • One disparity eliminated, two disparities improved, and one disparity worsened • Healthy babies growing together program, member incentive continuation • Health equity pay-for-performance QIP bonus launch N. Secondary MCAS measures of focus for disparities: • Childhood immunizations • Lead screening • Post-partum care • Breast cancer screening • Cervical cancer screening	

Agenda Topic	Notes	Action Item
	O. A question was raised as to how we are defining a disparity. Dr. Jalloh explains that we are looking at it in two ways. 1. Not meeting the MPL. 2. Comparing the measures for each race group to the white community. Ian Kim comments that he will be curious to see how the data changes next year as we are losing a significant amount of UIS members. Dr. Jalloh agrees that we are losing people, and therefore their data would not be included. Anthony Sackett asked if there were any claim lag issues, data submission delays, system limitations or other operational factors that could have contributed to the decline in performance Kristine Gual commented that she thinks about claim timeliness but also whether Tribal Health Centers are using local codes that they use to get their PPS rate, that we need to make sure they are captured. Dr. Jalloh will take the questions back to the Tribal liaison as she would be able to speak more on those topics. Any Tribal Health center that has concerns, it is recommended that they reach out to their regional leader and request practice level rates for some of these HEDIS measures. P. For Childhood Immunization status in MY2025 we see the Tribal community improved but in our Black community it has decreased. Lead screening rates have improved across all race groups. For Prenatal and postpartum care in MY2025, the black community has improved. For Well-child visits in the first 15 months it has decreased by 12% for the American Indian/Alaska Native group. For breast cancer screening, we see a decrease across all race groups. For cervical cancer screening and Chlamydia screening we have increased across all groups. Q. Dr. Jalloh shared the 2025 pay for performance data analysis.	

Agenda Topic	Notes	Action Item

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

R. **American Indian/Alaska Native Top Priorities**

- **(Continue)** Improve well-child visits by at least 3% with 3-year goal of at least 9% increase
- **(Continue)** Improve prenatal care visits by at least 5% with 3-year goal of at least 15% increase
- **(Continue)** Improve controlled blood pressure rates among American Indian/Alaska Native members by 2% with a 3-year goal of at least 5% increase
- **(Start)** Improve Breast Cancer Screening by 4% with a 3-year goal of at least 10% increase **OR** Improve Immunization by Adolescents by 2% with a 3-year goal of 12% increase

Agenda Topic	Notes	Action Item
	S. **African American/Black Top Priorities** • **(Continue)** Improve well-child visits by at least 3% with 3-year goal of at least 9% increase • **(Continue)** Improve prenatal care visits by at least 5% with 3-year goal of at least 15% increase • **(Continue)** Improve postpartum care visits by at least 2% with 3-year goal of at least 5% • **(Continue)** Improve controlled blood pressure rates by 3% with a 3-year goal of at least 5% T. **White/Rural Location** • **(Continue)** Improve well-child visits by at least 1.5% with 3-year goal of at least 4% increase U. Total number of MCAS disparities (MY2024): 26 Total number of disparities eliminated (MY2025): 10	
Agenda Item 5 **Grand Analysis discussion and vote** **Speaker: All**	A. Dr. Jalloh asked the group if there are any additional stratifications they would want done. Eva Julien asked what the purpose of stratification is. Dr. Jalloh responded that the purpose of the stratification is to identify if there are health inequities. Arlene Pena suggests stratifying by language. Ian Kim would like the data broken down by County. Dr. Jalloh explains that we do have our data which is a larger data set that we could explore breaking it down by County. Saskia suggested to stratify by race and also by people who receive ECM or community support services. Dr. Jalloh will take that info back to our ECM team to see what we can provide at the next meeting.	*Motion to add language stratification for future meeting.* *1st Arlene Pena* *2nd Ian Kim* *Motion to approve the grand analysis.* 1st Arlene Pena 2nd Eva Julien

Agenda Topic	Notes	Action Item
		Partnership will investigate with the ECM and Health Analytics teams our ability to stratify MCAS measures by specific ECM or CS access
Agenda Item 6 **Health Equity Policy Review** *Speaker: Naz Sattari*	• Community – Access – Respect – Engagement Services (CARES) and Transgender, gender diverse, or intersex training program requirements for internal employees and external practitioners (where applicable) (MCEP6004) • Naz shared the updates to policy MCEP6004. With the following core changes: a. CARES acronym change b. TGI training information addition c. Inclusion of Staff members d. Updated Measures and Annual Reporting	Motion to approve policy changes. 1st Valerie Padilla 2nd Jason Cunningham
Agenda Item 7 **Health Disparities Action Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Health Equity Strategic Plan draft discussion. • Member engagement: Increase members (experiencing disparities)motivation to access, understand and apply accurate health information to make informed judgments regarding disease prevention. • Community engagement: Equip key local communities experiencing disparities with resources to provide timely basic Medi-Cal navigation, community benefit resource navigation, health education, and care	

Agenda Topic	Notes	Action Item
	coordination. Also, equip such communities with resources to co-design community-based solutions to address health disparities. • Provider engagement: Increase access to excellent affordable health services in multiple modalities (in-person, digital, peer-led, etc.) without barriers related to race, language, immigration status, gender identity, rural location or justice involvement. (such as incarceration) B. Dr. Jalloh asks the external advisory committee which of these do they feel we should invest the most in to address health disparities. • Ian Kim feels community engagement is important because people are at risk of losing their coverage. • Saskia feels we should prioritize community engagement. She feels it starts with listening to the community, starting with solutions that are driven by community members. C. Dr. Jalloh asks the group what success stories they have with doing these types of activities. • Eva Julian comments that something that has been a key part of their success is for those patients who they have already established relationship with, beginning to work in the offices with Community Health Workers. D. Dr. Jalloh asks the group, if you had a magic want for the next 3-5 years, what would success look like? • Chelsea Lingao states that one measure of success would be if specific community organizations can refer members to resources, which would build rapport with community members.	

Agenda Topic	Notes	Action Item
Agenda Item 8 **New Committee Member discussion/vote** *Speaker: Bethany Hannah*	A. Saskia Garcia Endorsement: Eva Julien 2nd : Valerie Padilla B. Britanny English Endorsement: Valerie Padilla 2nd: Arlene Pena C. Committee attendance: How many meetings could be missed before being removed from the group? Valerie states 4 meetings missed in a year. Eva states that they should attend at least 3 of the meetings throughout the year. Anna Campbell brings up the idea that on other committees a member could take a sabbatical from the committee for a period of time and then return to the committee.	Saskia Garcia Endorsement: Eva Julien 2nd: Valerie Padilla Britanny English Endorsement: Valerie Padilla 2nd: Arlene Pena
Agenda Item 9 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	A. Next meeting: November **17, 2026 7:30 a.m. - 9:00 a.m. PST**	

CURRICULUM VITAE

HARRY SEUNG-SHIK KO, D.O.

American Board of Family Medicine

❖ Education

- Family Medicine Residency, UC Irvine (1996-1999) Arrowhead Regional Medical Center, Colton, CA
- Western University of Health Sciences, College of Osteopathic Medicine, Pomona, CA (1992-1996): Doctor of Osteopathic Medicine (D.O.).
- University of California, Irvine (1986-1991): Bachelor of Science (B.S.) in Biology.

❖ Professional Credentials

- Licensure: California #20A-7084 (exp 10/31/2026), Alaska #5605 (exp 12/31/2026)
- Board Certification: American Board of Family Medicine (exp 2028)
- BLS (exp 04/2028)

❖ Military Experience

- USPHS/US Coast Guard: 06/2010 to 06/01/2025. Retirement rank: O-6/CAPT
- USPHS/Indian Health Service: 05/2006 to 06/2010
- US Navy (Active Duty/Reserves): 02/1994 to 05/2006

❖ Work History/Accomplishments

➢ **Feather River Tribal Health, Inc: Oroville, CA** (06/2025- present)

- **Medical Director:** Responsible for the clinical operations and management of 24 medical providers providing care to over 7600 empaneled patients through the Oroville and Yuba City clinics. Advises Chief Executive Officer and Board of Directors to shape the direction and scope of the clinical program in conjunction with the Organization's mission, goal, and objectives.
- Staff Family Physician: Provides outpatient medical care for over 300 empaneled patients with diverse medical needs.

➢ **US Coast Guard Health, Safety, and Work-Life Service Center: Norfolk, VA** (07/2020 – 06/2025)

- Chief, Operational Medicine (CAPT/O-6): Technical and Professional authority for Coast Guard's health care system with nearly 200 clinical providers and 1000 support staff members. Maintained, inspected, and supervised the delivery of medical care across all 44 CG clinics and 130 Ashore/Afloat Sick Bays serving over 49,000 active-duty and reserve Coast Guardsmen.
- Supervise and manage Ancillary Support Service Subject Matter Experts (Dental, Pharmacy, Laboratory, Nursing, Case Management, Behavioral Health, Physical Therapy, and Enlisted Health Services Technicians) to align delivery of all aspects of healthcare:

➢ **US Coast Guard Air Station Detroit: Selfridge ANGB, MI** (07/2015 – 07/2020)

- Senior Medical Executive USCG Ninth District (CAPT/O-6), Flight Surgeon, and Designated Medical Officer Advisor: Supervised six physicians and one nurse practitioner located within the eight Great Lakes states, provided healthcare to 2000 empaneled members, and medical advisor to 7 Health Services Technicians and 3 Independent Duty Health Services Technicians who provided medical care to geographically separated units and cutter crews.

➢ **US Coast Guard Air Station Traverse City: Traverse City, MI** (07/2010-07/2015)

- Flight Surgeon/ Designated Medical Officer Advisor (CDR/O-6): Provided healthcare to 2135 empaneled members and medical advisor for 8 Health Services Technicians and 6 Independent Duty Health Services Technicians.

- **Indian Health Service: Southcentral Foundation (SCF): Anchorage, AK (**09/2005 - 06/2010)
    - Assistant Medical Director Primary Care Clinic (2009-2010): Responsible for clinical operations and supervision of 7 medical providers and 40 clinical/administrative staff members who care for 7000 enrolled patients, averaging 90 patients seen per day.
    - Staff Family Physician (2005-2010): Provided outpatient medical care for over 1100 empaneled patients with high medical needs. Provided "in-town" care in addition to multiple "in-village" medical care to 600 patients in 3 geographically isolated villages in rural Alaska.

- **Naval Health Clinic Hawaii, Hawaii: Pearl Harbor, HI** (07/2002-08/2005)
    - Department Head of Primary Care Clinic: Supervised 9 providers and 11 ancillary staff members providing healthcare equivalent to over $2 million/year for 16k pt visits/year.
    - Staff Family Medicine Physician: Provided primary care services to over 3600 patients valued in excess of $1.2 million over three years.

- **Naval Medical Center San Diego, California** (08/1999-07/2002)
    - Staff Family Medicine Physician: Provided full scope family medicine management to include inpatient, obstetrics, and outpatient care.

MY2025 NCQA Health Plan Rating

Partnership’s Strategic Plan for Quality Improvement 2026-2029

Partnership's Strategic Planning Initiatives

Why Partnership Needs a 5-Star Quality Strategic Plan

OUR MISSION

To help our members, and the communities we serve, be healthy

OUR VISION

To be the most highly regarded managed care plan in California

Quality Strategy Purpose:

- Define the priorities, goals, and strategies that guide Partnership's quality improvement work from 2026 to 2029
- Aligning staff, providers, and community partners around measurable improvements in members' health outcomes
- Protecting the organization's regulatory standing and financial sustainability.

WHY THIS MATTERS NOW

One Shared Direction

Without a unifying plan, departments optimize locally. This plan turns individual efforts into one coordinated push toward the same goals, and makes improving member health outcomes the shared responsibility of everyone at Partnership.

Accelerate Performance to Match Recent Trends

Dramatic changes in quality accountability programs and data exchange landscapes have led to quality performance improving nation-wide. Partnership needs to match the performance trajectory of other Medicaid Plans.

Consistency Across a Diverse Network

Consistency shouldn't depend on geography, language, or circumstance. A shared plan closes gaps in care across all communities we serve.

Alignment: *This plan complements Partnership's 2027-29 Strategic Plan, which sets direction for the whole organization, and aligns with the Health Equity Plan and Member Experience Plan.*

Our Strategic Planning Process

✓ Information Gathered

Information from the following sources resulted in a comprehensive SWOT:

- Leadership Input
- HEDIS and CAHPS Results
- QI Trilogy
- DHCS Quality Programs
- Staff and external partner feedback (focus groups and interviews)

✓ Quality Plan Drafted

Goals and Strategies are based on SWOT analysis and the impact on:

- Member Health
- Member Experience
- Regulatory & Financial Impact
- Organizational Capacity
- Timeline
- Sustainable Impact
- Regional Approach for Impact

❑ Communication and Change Management Planning

- ✓ Key stakeholders partner with QI to vet plan and refine goals and supportive strategies for shared ownership.
- ★ Solicit feedback from staff and Committees
- ❑ Share strategic plan with Board as part of CMO Update (October)
- ❑ Lead departments plan SMART Goals for focus areas
- ❑ Implementation begins November

Strategic Goals 2026–2029

Over the next three years, Partnership will pursue improvements across these five strategic goals:

Improve Member Experience - Member ratings of Getting Needed Care and Getting Care Quickly **performing at 67th Percentile or higher plan-wide**

Reduce Avoidable Utilization - Ambulatory-care sensitive admissions **reduced by 10 percent or higher annually plan-wide**, Hospital readmissions **performing at 90th Percentile plan-wide**

Improve Pediatric Preventive Care - Well-child visits, pediatric immunizations **performing at 67th Percentile or higher in all DHCS Rating Regions**

Improve Chronic Disease Outcomes - Glycemic control for diabetic members, Blood pressure control for members with hypertension **performing at 67th Percentile or higher in all DHCS Rating Regions**

Improve Timely Access to Prenatal Care - Prenatal care initiation during first trimester **performing at 67th Percentile or higher in all DHCS Rating Regions**

5 Star Quality Strategic Plan 2026–2029

This plan moves Partnership toward the vision of being **an NCQA 5-Star Plan.**

SUCCESS MEASURES

NCQA Star Rating — Overall quality performance & accreditation readiness

MCAS Quality Factor Score — Overall performance across the MCAS quality portfolio

STRATEGIC GOALS

With a special focus on our **rural regions** and **reducing health inequities,** we will:

- ★ **Improve member experience**
- ★ **Reduce avoidable utilization**
- ★ **Improve pediatric preventive care**
- ★ **Improve chronic disease outcomes**
- ★ **Improve timely access to prenatal care**

Progress will be tracked through Annual SMART goals set for each strategic goal.

FOCUS AREAS + KEY LEADS + OBJECTIVES

1 Access to Care

Network Services + Workforce Dev't + Regional Directors + Health Equity

- Strengthen Partnership's provider network capacity and stability in prioritized communities and services
- Expand alternative access models to meet community care needs

2 Provider Engagement

QI + Partners

- Build the capacity of the provider network toward high performance on prioritized quality measures

3 Member Experience & Engagement

Member Experience + Pop. Health + Health Equity + Care Coordination

- Build infrastructure to understand and act on member experience drivers
- Define and close the highest friction gaps in the member journey
- Improve outcomes for high-risk populations

4 Data, Analytics & Technology

Health Analytics + QI

- Build capacity for centralized quality measurement and analytics that maximize opportunities for improving member health and data interoperability

5 Org. Excellence & Culture of Quality

Administration + Fiscal + QI

- Create shared understanding and accountability for quality improvement org-wide
- Direct QI resources towards initiatives with the greatest impact on member health and financial performance

Next Steps

What Comes Next?

- Communicate to Committees and Board
- Engage with Lead departments to finalize annual SMART goals
- Build Tactical Plans for each Objective
- Annual progress report shared throughout organization and network

How Can My Organization Support?

- Review the Strategic Plan for Quality 2026-29 white paper (in packet)
- Familiarize yourself with the Goals and review your organization's strengths and opportunities
    - Annual Summaries of Performance, Disparity Dashboards, County Data Reports
- Discuss the Strategic Plan for Quality within your organization and how you can align your efforts
- Engage with Quality Improvement and Provider Relation teams and set SMART goals for your organization around priority measures
- Engage with emerging Partnership and community initiatives aligned with the Strategic Plan for Quality
- Embrace improving member experience and reducing health equities as strategies to improve member health

Partnership HealthPlan of California

5 Star Strategic Plan for Quality Improvement

2026–2029

Last updated 10/6/2026

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Purpose

The 5 Star Strategic Plan for Quality establishes Partnership's priorities for improving quality of healthcare for Partnership's members between 2026 and 2029. It defines the goals, focus areas, objectives, and strategies that will align staff, providers, and community partners around a shared commitment to improving member health outcomes and enhancing the patient experience, while protecting the organization's regulatory standing and financial sustainability.

Problem Statement

Since the last Quality Strategic Plan seven years ago, Partnership added 10 additional counties to its service area in 2024, the Global Pandemic and its aftermath led to changes in many parts of the health care delivery system, and DHCS has steadily put in place a series of financial penalties related to plan performance on quality metrics. In addition, the data exchange landscape has been changing dramatically, with clinical quality performance improving nation-wide, leading to re-basing of quality benchmarks by NCQA, which negatively impacted Partnership's Quality Stars rating relative to our sister Plans in California.

For a lengthier summary of current challenges impacting Partnership quality performance, see **Appendix A.**

In the setting of Partnership's stagnant NCQA Star Ratings, there is an urgent need to evaluate and update our strategic approaches to improving quality outcomes.

The Plan at a Glance

Terminology

Success Measures: global composite measures provide a view of overall quality portfolio performance and help identify when strategic priorities or improvement efforts may need to be adjusted.

Strategic Goals: The long-term results Partnership seeks to achieve through this strategic plan.

Focus Areas are broad strategic domains that organize related objectives around a shared focus or theme. Each focus area defines where Partnership will concentrate its efforts over the next three years to make progress on the Strategic Goals.

Objectives: The specific organizational capabilities or improvements Partnership intends to achieve within each focus area over the next three years to advance the Strategic Goals.

Strategic Goals

The 5 Star Quality Strategic Plan for Quality is anchored by five Strategic Goals that define Partnership's highest quality improvement priorities for the next three years. The five Strategic Goals were selected because they represent the greatest opportunity to improve member health, enhance the member experience, and protect Partnership's financial sustainability (priority prioritization criteria - see **Appendix B**). See **Appendix C** for more information about specific measures, including baseline rates and Year 1 (MY2026) SMART goals, that will indicate performance on each Strategic Goal.

An internal analysis identified these measures as those with the greatest immediate financial impact on the organization, due to DHCS Accountability Programs (see **Appendix D** for more information). Failure to improve performance in these areas places significant revenue at risk, limiting Partnership's ability to invest in providers, members, and future quality improvement efforts.

1. **Improve member experience,** as measured by:
    - Member ratings of health care and health plan

2. **Reduce avoidable hospital utilization**, as measured by
    - Ambulatory-care sensitive admissions
    - Hospital readmissions

3. **Improve Pediatric Preventive Care**, as measured by:
    - Well-child visits
    - Pediatric immunizations

4. **Improve Chronic Disease Outcomes**, as measured by:
    - Glycemic control for diabetic members
    - Blood pressure control for members with hypertension

5. **Improve timely access to prenatal care**, as measured by:

- Prenatal care initiation during first trimester

Cross-Cutting Priority: Reduce geographic variation in quality and limit financial penalties for low performance by accelerating improvement in Partnership's rural regions (Rural Upper Central and Rural Upper North) while sustaining high performance across the North Bay Area region.

Cross-Cutting Priority: Reduce healthcare inequities across all five Strategic Goals

Setting Targets and Monitoring Performance

Each Strategic Goal will be translated into annual SMART goals set by QI in partnership with the relevant focus area leads, with particular attention to closing the gap in Partnership's rural regions. Progress will be reviewed quarterly, with results and any needed course corrections reported to the Board annually as part of the CMO Update.

The enterprise Success Measures (MCAS Quality Factor Score, NCQA Star Rating, and future CMS Star Rating) will also be monitored throughout, to confirm that concentrated effort on the five Strategic Goals isn't coming at the expense of Partnership's broader quality portfolio.

Focus Areas, Objectives and Strategies

Achieving improvement in Partnership’s Strategic Goals, while maintaining performance across our broader quality portfolio will require coordinated action across the organization. To support an organization-wide effort, there will be particular efforts aligned with the following five focus areas:

1. Access to Care
2. Provider Engagement
3. Member Experience and Engagement
4. Data, Analytics and Technology
5. Organizational Excellence and Culture of Quality

Accountability is shared. Each focus area has designated staff leads and workgroups responsible for co-creating measurable objectives, implementing strategies, tracking and reporting progress over time.

Focus Area 1: Access to Care

Objectives	Strategies
Strengthen Partnership's provider network capacity and stability in prioritized communities and services	• Use targeted network provider recruitment and retention strategies • Efforts to promote hospital and specialty network stability in rural communities • Strategic investment in community workforce training programs • Support advanced access in primary care settings
Expand ability for **alternative access models** to meet community care needs	• Expand telehealth and digital health care delivery • Prioritize community-based/mobile services and vendor/“bolt-on” service arrangements • Close engagement with California Tribes, Tribal Health Centers, and Tribal CBO’s • Community paramedicine models • Home-based care models for select populations • Maternity care models for rural communities

Focus Area 2: Provider Engagement

Objectives	Strategies
Build the capacity of provider network towards high performance on prioritized quality improvement measures	• Align pay-for-performance measure sets and goals with HEDIS priority goals • Establish clear performance accountability and escalation pathways (e.g., joint leadership review, consequences for sustained underperformance) • Support relationship-building with provider network towards a culture of collaboration • Provide coaching, collaboration and training around measures, QI methodologies, workflows

Focus Area 3: Member Experience and Engagement

Objectives	Strategies
Build the infrastructure to understand and act on member experience drivers	• Create member experience governance structure, data systems and KPI's for understanding drivers of member satisfaction and experience • Develop a cohesive organizational approach to receiving, evaluating, and acting on member feedback • Increase provider engagement around member experience
Define and close the highest-friction gaps in the member journey	• Build key member journey maps to understand members' perceptions of health care and health plan • Implement targeted improvement in prioritized areas identified by key member journey maps
Improve outcomes for high-risk populations (e.g., high utilizers, multiple chronic conditions, communities experiencing inequities, maternal and child health, SMI, DSNP)	• Build systems and programs to deliver effective care management and coordination to specific high-risk populations • Build capacity to use data towards population health intelligence and targeted member and community interventions • Strengthen community and county partnerships • Build robust CHW and doula networks • Co-design community-based interventions to address health disparities

Focus Area 4: Data, Analytics and Technology

Objectives	Strategies
Build capacity for centralized quality measurement and analytics that maximizes opportunities for improving member health and data interoperability	• Leverage health analytics capabilities (e.g., trending, intervention support tools) to support strategic goals • Make key quality performance rates and member level information for current year visible and actionable for provider network • Scale Data Aggregator initiative and other data completeness and validation initiatives plan-wide to support accurate and current network-wide clearinghouse for member data • Consolidation of key quality data platforms

Focus Area 5: Organizational Excellence and Culture of Quality

Objectives	Strategies
Create **shared understanding and accountability for quality improvement** organization-wide	• Make key quality performance rates and trends visible, understandable, and actionable for all Partnership team members • Partnership leaders consistently model and promote the values and habits of quality improvement and excellence. • Set and share annual organization-wide SMART goals for each of the five quality Strategic Goals, with region-specific improvement targets • Strengthen communication of quality priorities across internal teams and partners, clarify roles and accountability for quality improvement • Build internal capability to drive quality improvement

Direct QI resources toward initiatives with the greatest impact on member health and financial performance, including revenue at risk from quality withholds and penalties	• Incorporate ROI and value-based analysis into the evaluation of QI priorities and investments • Establish joint prioritization processes that integrate clinical quality performance, cost impact and operational feasibility into decision making

Background and Planning Process

Alignment with Partnership's Other Strategic Priorities

This 5 Star Strategic Plan for Quality complements and supports Partnership HealthPlan's Strategic Plan, which sets the overall direction of the entire organization to fulfill its mission, and also aligns with other departments' Strategic Plans such as the Health Equity Plan (To specifically reduce health inequities) and the Member Experience Plan, which feed into this Quality Strategy. See **Appendix E** for summaries of these additional department-specific Strategic Plans.

At the time of developing this plan, Partnership is operating under its 2024–2027 Strategic Plan, in which quality is identified as a strategic pillar. Partnership is developing its next enterprise Strategic Plan now. We anticipate that quality will remain an important priority within the next version of the enterprise-wide plan.

Strategic Planning Process Overview

The strategic plan was developed through a comprehensive planning process that incorporated input from Partnership leadership, staff, external partners, and a review of recent quality reports.

The initial information gathering process included a SWOT analysis (see **Appendix A**), interviews with 6 Partnership leaders and 10 external partners, and five focus groups with 38 employees representing perspectives from across the organization. Stakeholders were asked to define what success for quality improvement would look like over the next three years, identify opportunities to improve quality performance, assess organizational and external risks, and identify the capabilities Partnership must strengthen to achieve meaningful improvement.

Several themes emerged from this process. Internal stakeholders consistently emphasized the need to improve performance on measures with significant financial and regulatory implications, including measures associated with quality sanctions and withholds. External stakeholders highlighted access to care as a foundational driver of quality improvement, emphasizing the importance of timely treatment and follow-up care across the continuum, ease of navigating the health care system, and addressing persistent access challenges in Partnership's rural communities.

Based on the insights gathered through the assessment process, Partnership leaders from the QI department developed the 5 Star Strategic Plan for Quality. The plan was then reviewed and refined through engagement with key stakeholders across the organization to ensure alignment

with Partnership's broader strategic priorities, strengthen shared ownership, and validate that the goals and strategies reflected the capabilities and partnerships needed to achieve meaningful quality improvement. Throughout the drafting and refinement process, Partnership staff used a set of agreed-upon criteria (see **Appendix B**) to help inform which outcomes, goals and strategies to prioritize.

Appendix A – Abbreviated SWOT Analysis

Strengths

- Leadership and staff commitment to improving quality
- Strong medical director leadership
- Provider recruitment and retention efforts to support access
- Strong provider and community relationships
    - Accessibility, responsiveness, and flexibility
    - Transparency and open communication
    - QIP is core strength and organizing structure
- Improvement 'bright spots", e.g., mobile mammography
- Established quality infrastructure and governance
- Established NCQA accreditation
- Growing data and analytics capabilities (e.g., data warehouse, HIE, specialized analytics team, Inovalon, PQD, DataLink pilot)
- Expanding health equity, member experience and regional leadership infrastructure
- Significant examples of cross-departmental collaboration (e.g. QSMI workgroups)

Weaknesses

- Significant access challenges, especially in rural areas
    - Behavioral health, maternity, specialty care, transportation, interpretation
- Limited care management and patient navigation partnerships with providers and unclear member handoffs across internal departments
- Overly focused on influencing provider behavior relative to direct member engagement → direct member engagement tools are underdeveloped
- Tendency toward role delineation over shared accountability with providers
- Gaps in alignment between QIP and HEDIS + significant resource allocation to QI without clear ROI
- Fragmented data infrastructure, complicated, not transparent, manual, no whole-person view, long wait times for data support, slow dashboard adoption
- Lots of data (and data collection) without strategic analysis and action
    - Limited use of predictive modeling capabilities
- Process-heavy vs. action/impact-orientation (vs. rush to execution)
- Legacy systems and operating models, outpaced by rapid growth
- Organizational complexity and siloed operations
- Heavy workloads, too many meetings, and operational pressures result in reduced staff capacity, and limit proactive, strategic problem solving
- Unclear roles and accountability for quality across the organization
- Long-tenured staff: cultural resistance to change, people dependencies
- Overall slow to change, low urgency, process- and regulation-driven over performance-driven culture
- Treating NCQA accreditation requirements as "check the box" activities versus leveraging to drive change

Opportunities

- Under-contracting in newest 10 counties
- Counties are developing aging and disability master plans to shape how community resources are coordinated for shared members
- Community Health Improvement Plans could reinforce shared goals and reduce duplication
- Expansion of telehealth, home-based care, and mobile models
- Reduced CalAIM focus → more focus on core Medicaid pop and HEDIS improvement
- D-SNP launch → integrated care redesign (Medicare as sophistication driver)
- MCAS measurement set stabilization will create more capacity to focus on improvement
- Member interest in digital/remote services
- Increased interoperability, HIE growth, broader EPIC adoption
- Expansion of predictive analytics and AI
- Increasing strength, functionality and reach of major HIE partners: PointClickCare and Sac Valley Med Share

Threats

- Membership volatility due to policy and eligibility changes + downstream quality and financial pressures
    - Hospital and provider network instability
    - High potential for quality to deteriorate in near term
- Financial penalties and withholds tied to quality scores (HEDIS, CAHPS, efficiency measures)
- Increasing measurement and policy/regulatory complexity
    - Unprepared for upcoming NCQA electronic data capture requirements
    - Unprepared for Medicare Star ratings complexity
    - Claims system migration poses risk of data disruption and performance reporting issues
- Workforce shortages and provider capacity constraints, especially in rural areas
    - Limited leadership capacity, staffing and infrastructure makes some providers hard to reach with traditional QI supports.
- Increasing healthcare misinformation and distrust

Appendix B – Prioritization Criteria

Given the high volume of quality improvement priorities for the health plan, driven by fiscal, regulatory, clinical and community needs, specific factors were used to determine which goals would be most important to achieve by 2029. Strategic goals, focus areas, and objectives were prioritized using several factors, with the most weight given to the impact on: member health, member access and experience, and the financial health of the organization.

Primary Prioritization Criteria

- **Member Health Impact**
  Goals were prioritized based on their potential to improve the health and well-being of Partnership members. This includes opportunities to improve clinical quality performance (e.g., HEDIS scores), achieve meaningful reductions in preventable illness and death, and address disparities in health outcomes across populations, geographic regions, or other member groups.

- **Member Access and Experience Impact**
  Goals were prioritized based on their ability to improve members' access to timely, appropriate, and high-quality care, recognizing that access to services and providers is a fundamental driver of health outcomes and member satisfaction. Particular emphasis was placed on opportunities to strengthen provider network access, reduce barriers to care, and improve members' ability to obtain the services they need. Goals were also evaluated for their potential to enhance the overall member experience, including satisfaction with care, communication, and interactions with the health plan and health care system.

- **Financial & Regulatory Impact**
  Goals were evaluated for their potential to support compliance with regulatory requirements, reduce the plan’s financial risk, and strengthen performance on key external quality and accreditation measures. Without a solid financial standing, Partnership will be unable to achieve its mission and improve quality, especially during a period of intense federal contraction of the Medicaid program.

Additional Considerations

- **Organizational Capacity**
  Goals were prioritized when the organization has, or can reasonably develop, the leadership, staffing, infrastructure, partnerships, and accountability structures needed to achieve and sustain results.

- **Timeline**
  Priority was given to goals that can demonstrate meaningful progress or achieve intended outcomes within the three-year strategic planning period, while also supporting longer-term improvement efforts.

- **Sustainable Impact**
  Goals were selected based on their potential to create lasting improvements in quality, outcomes, and organizational performance rather than temporary gains.

- **Regional Flexibility Impact**
  Goals were prioritized when they allow for adaptation to local community needs, recognizing that challenges, resources, and opportunities may vary across Partnership's service area.

Appendix C – Strategic Goal Measures and Baseline Performance

Specific improvement targets for each measure will be set annually.

Strategic Goal	Related Measure	MY 2025 Baseline Quality Compass Percentile	MY2026 SMART Goal Quality Compass Percentile
Improve member experience	CAHPS: Getting Care Quickly	Child: 10th percentile Adult: <10th percentile	Child: Pending Adult: Pending
	CAHPS: Getting Needed Care	Child: 33rd percentile Adult: 10th percentile	Child: Pending Adult: Pending
Improve chronic disease outcomes	GSD > 9%	Upper Central: 50th percentile Upper North: 50th percentile North Bay Area: 50th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 67th percentile
	CBP	Upper Central: 10th percentile Upper North: 50th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile
Improve Pediatric Preventive Care	WCV	Upper Central: 33rd percentile Upper North: 33rd percentile North Bay Area: 50th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 67th percentile
	IMA-E	Upper Central: 33rd percentile Upper North: 33rd percentile North Bay Area: 90th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 90th percentile
	W30-2	Upper Central: 50th percentile Upper North: 50th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile

	W30-6	Upper Central: 10th percentile Upper North: 67th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile
Improve timely access to prenatal care	PPC-Pre	Upper Central: 10th percentile Upper North: 25th percentile North Bay Area: 90th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 90th percentile
Reduce avoidable utilization	Ambulatory Care Sensitive Admissions	Plan-Wide: Pending	Plan-Wide: Reduce baseline by 10%
	Plan All-Cause Readmissions (PCR)	Plan-Wide: 90th percentile	Plan-Wide: 90th percentile

Appendix D – Partnership's Quality Accountability Programs, MY2026

Program	Scope	Geographic Impact	Financial Impact	Low Performance Trigger
Quality Withholds and Incentive Program	9 HEDIS measures, 2 CAHPS measures (Child and Adult)	DHCS Quality Rating Regions	$Tens of Millions	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	4 efficiency factors related to inpatient care	Plan Wide	$Tens of Millions	High repeat inpatient utilization by subset of members
Community Reinvestments - Quality	20 HEDIS measures (MCAS)	County	$Millions	2+ measures <50th percentile in any measure domain
Quality Sanctions	20 HEDIS measures (MCAS)	County	$100k - $500k	<50th percentile performance
Quality Factor Score	20 HEDIS measures (MCAS)	Plan Wide	None, reputational	None
NCQA Health Plan Rating	44 HEDIS measures, 4 CAHPS measures (Child or Adult)	Plan Wide	None, reputational	None

Appendix E – Summaries of Additional Strategic Plans Aligned with Strategic Plan for Quality Improvement

Health Equity Strategic Plan Summary, 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, the entire comprehensive 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.

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 access to diverse practitioners, ancillary staff, community health workers, doulas, etc.