

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



Members: (21)

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

Partnership Executive Staff:

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

Regional Medical Directors

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

Region

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

Region Directors

Vicky Klakken
Tim Sharp
Kathryn Power
Leigha Andrews
Rebecca Stark
Jill Blake

Kermit Jones, MD, Deputy Chief Medical Officer	Mark Netherda, MD, Medical Director for Quality Improvement
Jeffrey DeVido, MD, Behavioral Health Clinical Director	Vacant, MD, Medical Director for Medicare Services

Directors / Managers / Associate Directors

Isaac Brown, Interim Snr. Director, Quality & Performance Improvement	Ledra Guillory, Senior Manager, Provider Relations Reps.
Mary Kerlin, Senior Director, Provider Relations	Amy McCune, Manager, Quality Incentive Programs
Brigid Gast, RN, Senior Director, Care Management	Sue Quichocho, Manager, Quality Measurement
Stan Leung, Pharm.D., Director., Pharmacy Services	Kevin Jarrett-Lee, RN, Assoc. Dir. of Utilization Management
Mohamed Jalloh, Pharm.D., Director of Health Equity	Marshall Kubota, Associate Medical Director
Lisa O'Connell, Director, Enhanced Health Services	Bettina Spiller, MD, Associate Medical Director
DeLorean Ruffin, DrPH, Director, Population Health Management	Teresa Frankovich, MD, Associate Medical Director
Heather Esget, RN, Director of Utilization Management	
Vacant, Director, Health Analytics	
Kristine Gual, Director, Quality Measurement	
Priscila Ayala, Director, Network Services	

cc: Partnership Commission Chair

Kim Tangermann, Partnership Board Chair

FROM: PAC@partnershipHP.org

DATE: November 7, 2025

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

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

DATE: Wednesday, November 12, 2025

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 5 th Street Eureka, CA
Partnership - Auburn 281 Nevada St. Auburn, CA 95603	Partnership - Chico 2760 Esplande, Suite 130 Chico, CA 95973	Sutter-Roseville 6 Medical Plaza Roseville, CA 95661	Aliados Health 1310 Redwood Way Petaluma, CA 94999
Tahoe Forest Health Systems 10976 Donner Pass Rd., Suite 9 Truckee, CA 96161	Office of Dr. Mills Matheson 1245 S. Main St. Willits, CA 95490	Marin Community Clinic 3260 Kerner Blvd. San Rafael, CA 949013	

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

Date: November 12, 2025 **Time:** 7:30 – 9:00 a.m. **Location:** Partnership

Partnership HealthPlan of California 4605 Business Center Drive Fairfield, CA	Partnership – Santa Rosa Office 495 Tesconi Circle Santa Rosa, CA	Partnership – Redding Office 2525 Airpark Drive Redding, CA	Partnership – Eureka Office 1036 5 th Street Eureka, CA
Partnership - Auburn Office 281 Nevada St. Auburn, CA 95603	Partnership - Chico 2760 Esplande, Suite 130 Chico, CA 95973	Aliados Health 1310 Redwood Way Petaluma, CA 94999	Sutter-Roseville 6 Medical Plaza Roseville, CA 95661
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PUBLIC COMMENTS			Speaker	2 minutes																			
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This Brown Act meeting may be recorded. Any audio or video tape record of this meeting, made by or at the direction of Partnership, is subject to inspection under the Public Records Act and will be provided without charge, if requested.																							
Welcome / Introductions																							
I.		EXECUTIVE OFFICE UPDATES	LEAD	TIME																			
A.	I	Chief Executive Officer Administration Updates	Ms. Bjork	7:35																			
B.	I	Chief Medical Officer Health Services Report	Dr. Moore	7:45																			
II.	A	MOTIONS FOR APPROVAL	LEAD	PG	TIME																		
A.	A	Review of October 8, 2025 PAC Minutes	Dr. Brennan	5	7:55																		
B.	A	Consent Review: Agenda Items III. B.1, B.2, and B.5 *Consent review allows multiple agenda items to be approved with one motion.	Dr. Brennan	20-138	7:57																		
1	C	Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – October 15, 2025 <u>Acceptance of Draft Meeting Minutes:</u> <ul style="list-style-type: none"> • Q/UAC Agenda • Q/UAC Activities & Minutes • Internal Quality Improvement Meetings October 7, 2025 <ul style="list-style-type: none"> • Agenda • Minutes Quality Improvement Update – October 2025	Dr. Brennan	20 22	8:00																		
2	C	Policy Summary November 2025 <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;"><u>Policies/Procedures/Guidelines for Action</u></th> </tr> </thead> <tbody> <tr> <th colspan="2" style="text-align: center;">Care Coordination</th> </tr> <tr> <td style="width: 15%;">MPCP2017</td> <td>Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>Archived – new MBPB8011</i>)</td> </tr> <tr> <th colspan="2" style="text-align: center;">Enhanced Health Services</th> </tr> <tr> <td>MPAP7003</td> <td>CalAIM Community Supports (CS) (<i>New</i>)</td> </tr> <tr> <th colspan="2" style="text-align: center;">Grievance & Appeals</th> </tr> <tr> <td>CGA022</td> <td>Member Discrimination Grievance Procedure</td> </tr> <tr> <th colspan="2" style="text-align: center;">Pharmacy</th> </tr> <tr> <td>MCRP4066</td> <td>AB114 Benefit Implementation and Oversight</td> </tr> </tbody> </table> All versions linked within Policy Summary (See page 57)	<u>Policies/Procedures/Guidelines for Action</u>		Care Coordination		MPCP2017	Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>Archived – new MBPB8011</i>)	Enhanced Health Services		MPAP7003	CalAIM Community Supports (CS) (<i>New</i>)	Grievance & Appeals		CGA022	Member Discrimination Grievance Procedure	Pharmacy		MCRP4066	AB114 Benefit Implementation and Oversight	Dr. Brennan	36 38 47	8:00
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3	C	<p>Pharmacy & Therapeutics Committee</p> <ul style="list-style-type: none"> • Summary, October 9, 2025 • Approved Criteria, October 9, 2025 	Dr. Stan Leung	63 77	8:00																																										
4	C	<i>Provider Education & Networking (PEN) Meeting</i>	<i>Ms. Kerlin</i>																																												
5	C	<p>Credentials Committee Meeting</p> <ul style="list-style-type: none"> • Summary, September 10, 2025 • Credentialed List, September 10, 2025 	Dr. Netherda	115 120	8:00																																										
6	C	<i>Pediatric Quality Committee</i>	<i>Dr. Ribordy</i>																																												
7	C	<p>Quality Improvement Health Equity Committee</p> <ul style="list-style-type: none"> • Summary, September 16, 2025 	Dr. Jalloh	125	8:00																																										
C.	A	<i>Physician Advisory Committee Membership</i>	<i>Dr. Brennan</i>																																												
D.	A	<p>Long Term Care Quality Incentive Program (QIP) Measurement Year 2026 Measure Set Proposal</p>	Ms. Watson	139	8:03																																										

III.	I	REGIONAL MEDICAL DIRECTOR REPORTS	LEAD		TIME	
A.	I	Napa, Yolo & Solano	Dr. Townsend		8:06	
B.	I	Marin & Sonoma	Dr. Ward		8:09	
C.	I	Del Norte, Humboldt, Mendocino & Lake	Dr. Ribordy		8:12	
D.	I	Glenn, Butte, Sutter, Colusa & Yuba,	Dr. Matthews		8:15	
E.	I	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Dr. Cox		8:18	
F.	I	Plumas, Sierra, Nevada & Placer	Dr. Morris		8:21	
IV.	I	<i>OFFICE PRACTICE UPDATE</i>	<i>LEAD</i>	<i>PG</i>	<i>TIME</i>	
V.	I	<i>OLD BUSINESS</i>	<i>LEAD</i>	<i>PG</i>	<i>TIME</i>	
VI.	I	SPECIAL PRESENTATIONS	LEAD		PG	TIME
A	I	Health Equity Community Reinvestment	Dr. Jalloh	142	8:25	
B.	1	2025 Primary Care Physician & Obstetrician Vacancy Survey Results Measurement Year 2026 Measure Set Proposal	Mr. Lavine	150	8:30	
VII.	I	ADJOURNMENT	LEAD		9:00	
Next PAC on January 14, 2026 at 7:30 a.m.			Dr. Brennan			

This agenda contains a brief description of each topic for consideration. Except as provided by law, no action shall be taken on any topic not appearing on the agenda.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular committee meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The committee has designated the Executive Assistant to the Chief Medical Officer as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection.

The Physician Advisory Committee Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all Partnership regional offices (see locations under the Meeting Notice). It can also be found online at the [Physician Advisory Committee](#) webpage, linked below.

<https://www.partnershiphp.org/Providers/HealthServices/Pages/Physician-Advisory-Committee.aspx>

In compliance with the Americans with Disabilities Act (ADA), Partnership meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Executive Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (707) 863-4228 or by email at pac@partnershiphp.org. Notification in advance of the meeting will enable Partnership to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

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

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

Committee: Physician Advisory Committee
Date / Time: October 8, 2025 - 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) Karen Sprague, MSN, CFNP (FF) Matthew Zavod, MD (FF) Steven Gwiazdowski, MD (FF) Teresa Shinder, DO (FF)	Malia Honda, MD (E) Chris Myers, MD (E) Karina Gookin, MD (AU) Chester Austin, MD (C) Mills Matheson, MD (OMM) Danielle Oryn, DO (A)	FF Fairfield SR Santa Rosa E Eureka R Redding C Chico AU Auburn	MCC Marin Community Clinics OMM Office of Dr. Matheson SH Sutter Health Roseville SL Sutter Health Lakeside A Aliados Health
Members Excused:	Mustaffa Ammar, MD	Christina Lasich, MD	Derice Seid, MD	Michele Herman, MD
Members Absent:	Vanessa Walker, DO	Candy Stockton, MD	John McDermott, FNP	Darrick Nelson, MD
Visitor:	Matthew Goudy, Chief Operating Officer, MDstaffers			
Partnership Staff:	Sonja Bjork, Chief Executive Officer Jennifer Lopez, Chief Financial Officer Wendi Davis, Chief Operating Officer Leigha Andrews, Region Director Vicky Klakken, Region Director Brigid Gast, RN, Sr. Dir., Care Management Mary Kerlin, Sr. Dir., Provider Relations Lisa O'Connell, Dir. Enhanced Health Services Doreen Crume, RN, Mgr. Care Coord. Stephanie Nakatani, Supervisor Provider Relations Representatives	Katherine Barresi, RN, Chief Health Services Officer Robert Moore, MD, Chief Medical Officer Kermit Jones, MD, Deputy Chief Medical Officer Colleen Townsend, MD, Region Medical Director Jeffrey Ribordy, MD, Region Medical Director Bradley Cox, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Matthew Morris, MD, Region Medical Director Lisa Ward, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Marshall Kubota, MD, Associate Medical Director	DeLorean Ruffin, DrPH, Director, Population Health Mohamed Jalloh, Pharm.D., Director, Health Equity Vacant, Sr. Dir., Quality & Performance Improvement Isaac Brown, Director, Quality Management Kristine Gual, Director, Quality Measurement Amy McCune, Manager of QI Programs Sue Quichocho, Mgr., Quality Measurement Megan Shelton, Project Manager, Quality Improvement Heather Esget, RN, Director, Utilization Mgmt. (UM) Kevin Jarret-Lee, RN, Assoc. Dir. of UM Robby Potter, RN, Supervisor of Inpatient UM David Lavine, Assoc. Dir. of Workforce Development	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	12/20 – PAC	Committee quorum requirements met (12).	10/08/25

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
<p>I.A. Chief Executive Officer (CEO) Report</p>	<p>Partnership’s Chief Health Services Officer (CHSO) provided the following report for Partnership activities on behalf of Partnership’s CEO.</p> <p>Transportation Services</p> <ul style="list-style-type: none"> • Transportation Services has implemented a new mobile phone app available for iPhone and Android. <ul style="list-style-type: none"> • Partnership Members can call Transportation directly, Monday through Friday, 7 a.m. to 7 p.m., at (866) 828-2303 to request for access to Kinetik Health App. • Members will be asked to provide their email address and phone number to “opt in.” • A Partnership Transportation representative will email a personalized access link that includes their individual access code so they may begin requesting and scheduling rides to and from appointments using the app. • The app is only available in English at the moment, but other threshold languages are in the process of being added. <p>Changes related to prohibitive entities for prohibitive services under HRI</p> <ul style="list-style-type: none"> • Claims will be working with family planning clinics to inform them of changes to service coverage due to the temporary restraining order (TRO) filed in July 2025. • Claims will be paid for any services provided prior to July 3, 2025. Claims for services provided between July 4 and September 11, 2025 may still be submitted. • Claims for services provided after September 11, 2025 must be submitted directly to the Department of Health Care Services (DHCS). • There are few service codes affected by this change, but abortion access is affected ambiguously due to state level versus federal law because abortion-related services are covered under MediCal. • The guidance is not yet clear but being followed very closely by Partnership Healthplan teams. <p>Rural Health Transformation Grant</p> <ul style="list-style-type: none"> • Center for Medicare and Medicaid Services (CMS) released guidance relating to the availability of rural health transformation grant funds stating a point-scoring system will be applied to states. • States must apply for the funds, and California is in the process of evaluating the methodology for an estimated score. • CMS has indicated they are interested in grants focused on maternal health in rural communities, chronic disease management, and rural access to care. • There is no legislation to determine a set dollar amount allocated to states. Each state must apply. • CMS is evaluating for impactful outcomes and relying heavily on data from reporting. • California Department of Health and Human Services (CHHS), DHCS, along with several others are determining how what should be included in California’s application.
<p>I.B. Chief Medical Officer (CMO) Health Services Report</p>	<p>Partnership’s Chief Medical Officer presented a brief update for Health Services.</p> <ul style="list-style-type: none"> • COVID Vaccinations for Children <ul style="list-style-type: none"> • Vaccines for Children (VFC) has not shipped any stock of COVID vaccinations. • California passed Assembly Bill 144 to establish vaccine guidance for children independent of guidance provided by the Centers for Disease Control (CDC). • Coverage of COVID vaccinations for children is mandated for managed care plans (MCP). • Medi-Cal will continue to cover COVID-19 vaccinations for all persons age 6 months and older, consistent with current California Department of Public Health (CDPH) recommendations and regardless of federal Advisory Committee on Immunization Practices (ACIP) recommendation, pursuant to AB 144. • DHCS will be making an update to All Plan Letter (APL) 24-008 Immunizations Requirements in the near future, but published an announcement of these changes on September, 17, 2025. • Stock of purchased COVID vaccinations may be given to patients who consent to receive it. • Awaiting DHCS guidance for claims handling for private pay vaccines.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.B. Chief Medical Officer (CMO) Health Services Report, Continued	<p>Partnership’s Chief Medical Officer presented a brief update for Health Services.</p> <ul style="list-style-type: none"> • COVID Vaccinations for Children, continued <ul style="list-style-type: none"> • CDC announced the current version of the COVID vaccine would be approved with the contingency that a shared decision-making process be available, opening the possibility for allowing VFC shipments to occur. • Legislative Advocacy <ul style="list-style-type: none"> • Senate Bill 669, Rural hospitals, standby perinatal medical services, was passed and is awaiting Governor Newsom’s signature. • Assembly Bill 55, Alternative birth centers: licensing and Medi-Cal reimbursement was passed and is awaiting Governor Newsom’s signature. • Physician Orders Life Sustaining Treatment (POLST) <ul style="list-style-type: none"> • Coalition for Compassionate Care California (CCCC) shared an update regarding an electronic POLST registry, a project led by California Emergency Medical Services Authority (EMSA). • Data sharing agreements are in the process of being drafted for Kaiser, Dignity Woodland, Sutter, Providence, and Adventist health systems. • The goal is to have an organization-wide Data Use Agreement in place and approved so the project can proceed with little delay when the ePOLST registry is ready to absorb existing POLST forms. • ePOLST registry is estimated to be ready to absorb existing forms by spring of 2026. • The ePOLST registry serves as an opportunity to reeducate palliative care clinicians, social workers, nurses, and physicians on the correct rules around the use of the POLST forms where large knowledge gaps were revealed in a survey of 3,000 palliative care providers of many types. • Partnership Leadership <ul style="list-style-type: none"> • Dr. Kermit Jones, Internal Medicine, Medical Director for Medicare Services, has been appointed Deputy Chief Medical Officer. • Dr. Jones will continue to support the preparation of Partnership Advantage, a dual eligible special needs program (D-SNP) for implementation in January 2027 in the interim. • Remote Inpatient Monitoring <ul style="list-style-type: none"> • California Health Care Foundation (CHCF) has been awarded a grant for remote inpatient monitoring which allows patients to use a home-based device to measure data and transmit it electronically to the care provider. • There are questions regarding the efficacy and utility of the data and how it is received and analyzed. • Partnership’s CMO asked PAC voting members for their experiences in experimentation of remote inpatient monitoring. <ul style="list-style-type: none"> • One provider in Santa Rosa shared experience in working with a vendor for blood pressure monitoring and diabetes management with a glucometer and stated implementation requires a large amount of upfront work to integrate the data transmitted to the provider. Workflows must be monitored closely because the data does not always go directly to the provider. It created an opportunity to develop the role of the nurses but required a set up time of almost a year and ongoing technical support. Patient trust was also an issue, and many chose not to consent to in-home monitoring. • Another provider shared the experience of remote glucometer monitoring regarding data integration. Once the health system transitioned to Epic, the technical support required was strained to prioritize the ongoing commitment needed. A benefit highlighted was the ability of a nutritionist to view the data and call patients to discuss their care and alleviate some of the physician workload.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.C.1. Status Update, Regional Medical	<p>Partnership’s Deputy CMO presented a brief update on activities on behalf of Regional Medical Director for Napa, Solano, and Yolo Counties.</p> <ul style="list-style-type: none"> • Partnership’s Chief Health Services Officer organized and hosted a summit for CalAIM Justice Involved providers in Fairfield. • Partnership has been working with many providers to focus on chlamydia screening and self-swab cervical cancer screening. • Napa Opioid Safety Coalition hosted an awareness concert featuring roughly 20 live bands to play for young audiences. They shared information about the negative effects of opioids and distributed naloxone among attendees. • Area clinics are continuing recruiting efforts. NorthBay Health has been successful in hiring Primary Care Physicians (PCP), but Vallejo-area clinics are still struggling.
I.C.2. Status Update, Regional Medical	<p>Partnership’s Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.</p> <ul style="list-style-type: none"> • Regional Quality meeting with area providers was held October 7, 2025 where the theme of the meeting was vaccine hesitancy. The event was attended by 35 providers and 10 Partnership staff members. Partnership’s Chief Health Equity Officer served as a panelist to discuss communication strategies related to vaccine hesitancy. The meeting resulted in planning two focus groups to analyze flu vaccine hesitancy and will be assisted by a Partnership’s Health Equity team member whose expertise includes elder care. • Alliance Medical Center held an annual fundraising gala. • Aliados Health will be supporting the implementation of eConsult services to expand telehealth options. • Four area clinics have hired new Chief Medical Officers in efforts to stabilize leadership in the area. • Physical Therapy (PT) services continue to be constrained. Marin Health recently lost PT providers and has pushed back expansion visits until early 2026. • American Academy of Family Physicians Congress of Delegates had a California delegation presenting strong themes which included expanding policy on universal health insurance, training for family medicine, restrictions on medication abortion, and advocacy against sweeps in unhoused communities and encampments in addition to reinforcing policy for evidence-based recommendations for vaccine administration.
I.C.3. Status Update, Regional Medical	<p>Partnership’s Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.</p> <ul style="list-style-type: none"> • Lake County <ul style="list-style-type: none"> • Regional Medical Director and Region Director have been visiting clinics and providers in Lake County. • The Hope Center, which advocates for the unhoused, is a substance use recovery center that will be doubling capacity with an expansion. They will also provide community supports services such as medically tailored meals and housing navigation. • Sutter Lakeside is opening an infusion center to reduce the need to travel to Santa Rosa where most members receive chemotherapy and other infusion services. • Dr. Robert Bernstein has been appointed the new Public Health Officer for Lake County. • Humboldt County <ul style="list-style-type: none"> • Humboldt County Public Health Officer presented to the Board of Supervisors a 40% reduction in opioid overdose deaths attributed to the availability of Narcan; 279 reversals were reported. Hepatis C cases have also been reduced due a robust needle exchange program and treatment available. • Mendocino County <ul style="list-style-type: none"> • Pediatricians have been hired at Adventist Health Clearlake, Mendocino Coast Clinics, and Mendocino Community Health.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.C.4. Status Update, Regional Medical	<p>Partnership’s Regional Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.</p> <ul style="list-style-type: none"> • Attended CCCC annual summit where Butte County physician, Dr. Aldebra Schroll of Butte Home Health and Hospice, presented impacts to caring for chronically ill and dying patients amidst camp and park fires attributed to climate change. • Enloe Hospital is transitioning out of home health and hospice care. • Palliative care and hospice care are notably underutilized in Partnership expansion county areas. • Healthy Rural California (HRC) has begun a new cycle of medical education clubs in high schools to encourage careers in medicine. This parallels with efforts of Enloe Hospital, UC Davis, and Touro University. • In Chico, for resident Graduate Medical Education (GME), looking to host a gathering of Butte County area resident following a Partnership sponsored Advanced Life Support in Obstetrics (ALSO) course at Enloe Hospital. • Glenn Medical Center Emergency Department (ED) in Willows has closed. There are three remaining Partnership members as part of the swing-bed program; two are being discharged and the remaining member will be transitioned to Colusa Hospital System. • Glenn Medical Center’s impending closure has garnered press attention with concerns about rural hospital access and the subsequent challenges that may occur. The goal is to stabilize the area as best as possible. • Enloe Hospital has invited Partnership leadership to tour its new cancer center projected to opened in the summer of 2026. • Access to oncology remains constrained in the area.
I.C.5. Status Update, Regional Medical	<p>Partnership’s Regional Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.</p> <ul style="list-style-type: none"> • Redding Rancheria Tribal Health <ul style="list-style-type: none"> • Dr. Barbara Knox has been appointed Chief Medical Officer. • Shauna Hicks has been selected as a new clinical director. • Dr. Syed Mustafa, Internal Medicine, will join the staff. • Recruiting for Nurse Practitioner. • Mayers Memorial in Fall River, CA has begun offering magnetic resonance imaging (MRI) services and billing for care. • Surprise Valley in Cedarville, CA will have the ability to perform CT scans in November. • Shasta Community Health Center held a discussion focused on universal screening for those aged 16 to 24 years.
I.C.6. Status Update, Regional Medical	<p>Partnership’s Regional Director for Plumas, Sierra, Nevada & Placer presented a brief update on activities.</p> <ul style="list-style-type: none"> • Well Space Health, a federally qualified health center (FQHC) in Sacramento and Placer County, held ribbon-cutting ceremony for new community center in Roseville on September 24, 2025. The facility will be 16,000 square feet offering primary care, pediatrics, women’s health, behavioral health, and dental care to serve an estimated 40,000 patients, many of whom are Partnership members. • Placer County Well Space facility hosts a 16-bed recovery center designed to house those receiving inpatient substance use disorder (SUD) treatment who are transitioning to residential care facilities or are coming out of incarceration. • Commons Resource Center in Grass Valley, CA held a ribbon-cutting ceremony for their facility expanding community supports services for unhoused individuals or those at risk of becoming unhoused. The facility offers SUD treatment, behavioral health services, MediCal enrollment assistance, and laundry, shower, and communal respite areas. • Plumas District Hospital opened its new 36-bed skilled nursing facility (SNF).

II.A Office Practice Update	<p style="text-align: center;">DISCUSSION / CONCLUSIONS</p> <p style="text-align: center;">For information only, no formal action required.</p>
<p>NorthBay Neonatology and Associates, Dr. Brian Montenegro</p>	<p>NorthBay Neonatology and Associates, Dr. Brian Montenegro, shared information regarding the practice and his passion for medicine.</p> <p>Passion Outside of practice, Dr. Montenegro shared his passion for serving children of the community through volunteer work as a council leader at a camp over the summer. He described an exercise where children were asked to share one thing they were struggling with by anonymously writing it on a piece of paper. Four notes stood out and read:</p> <ol style="list-style-type: none"> 1. "I struggle with anxiety and separation anxiety. My parents are divorced." 2. "I don't think people like me. I try and try but I'm not enough." 3. "I don't have many friends and I don't feel very seen. My dog just died and I feel a little overwhelmed." 4. "I struggle with fear." <p>Dr. Montenegro further recommended the book, The Anxious Generation, by Jonathan Haidt and advocated for awareness of children's mental health.</p> <p>About NorthBay Neonatology and Associates Northbay Neonatology Associates is an inpatient newborn, Neonatal Intensive Care Unit (NICU), and pediatric service serving Solano County, CA.</p> <ul style="list-style-type: none"> • Main Hub: Northbay Medical Center in Fairfield, CA <ul style="list-style-type: none"> • ≈ 1500 deliveries/year • ≈ 150 NICU admissions/year (range 127-173) with stays ranging from weeks to several months. • Solano County ED consults + Clinic consults • Interfacility collaboration and transfers with: <ul style="list-style-type: none"> • David Grant Medical Center, UCSF, UC Davis, Sutter, and Kaiser • Between Sacramento and Berkeley, it is the only hospital staffed with neonatologists. <p>Northbay Neonatology and Associates is led by Dr. Steven Gwiazdowski, Dr. Burkheimer, and Dr. Montenegro. Other neonatologists include Dr. Elena Minakova, and Dr. Chad Tarter. Dr. Burkheimer was one of the founders who has since retired.</p> <p>Trends</p> <p>Obesity in pregnancy rates have increased over 30 years. California has a maternal obesity rate of 26%. From 2016 to 2019, rates increased 11%.</p> <p>Infants born to obese patients may struggle to eat well, have respiratory distress, and/or heart conditions. Poorly controlled diabetes in pregnancy can result in kidney and/or neurological malformations.</p> <div data-bbox="1291 1039 2005 1347"> <p>Adverse Neonatal Effects:</p> <ul style="list-style-type: none"> • Difficult Extraction -> Birth Injury and Hypoxic Ischemic Encephalopathy • Prematurity • Hypoglycemia (often requiring central lines to deliver sufficient glucose) • Feeding difficulties • Respiratory Distress Syndrome • Hypertrophic Cardiomyopathy • Diabetic Fetopathy – Renal dysplasia, Neurologic Malformations </div>

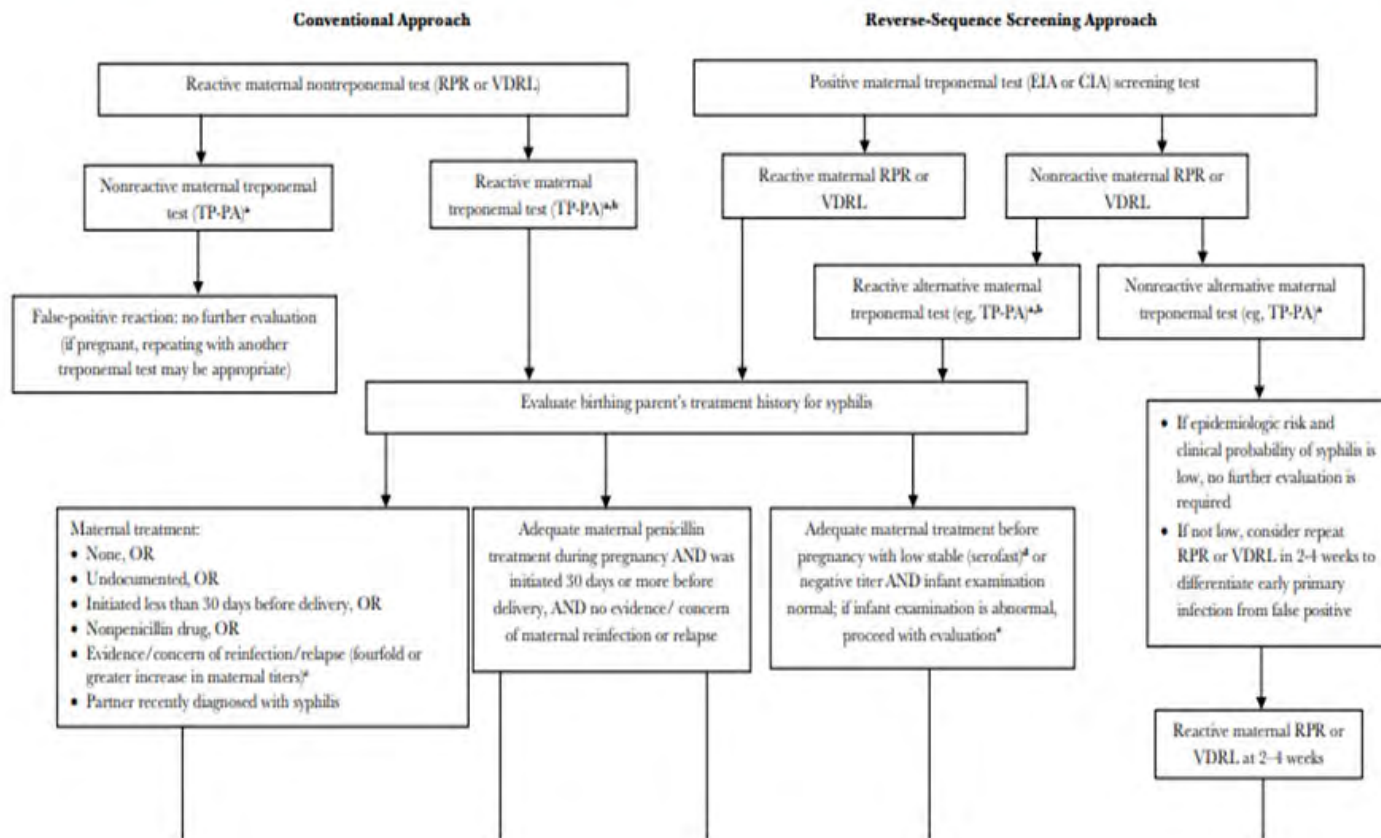
**AGENDA
ITEM**

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

Challenges

Congenital syphilis rates are rising across the country. Treatment for syphilis can be challenging based on changing guidance and factors such as consistent prenatal care, screening and treatment during pregnancy, at which point in gestation patient was treated, number of doses received, and titers at different intervals.

FIG 3.18. ALGORITHM FOR DIAGNOSTIC APPROACH OF INFANTS BORN TO MOTHERS WITH REACTIVE SEROLOGIC TESTS FOR SYPHILIS



B30

SYPHILIS

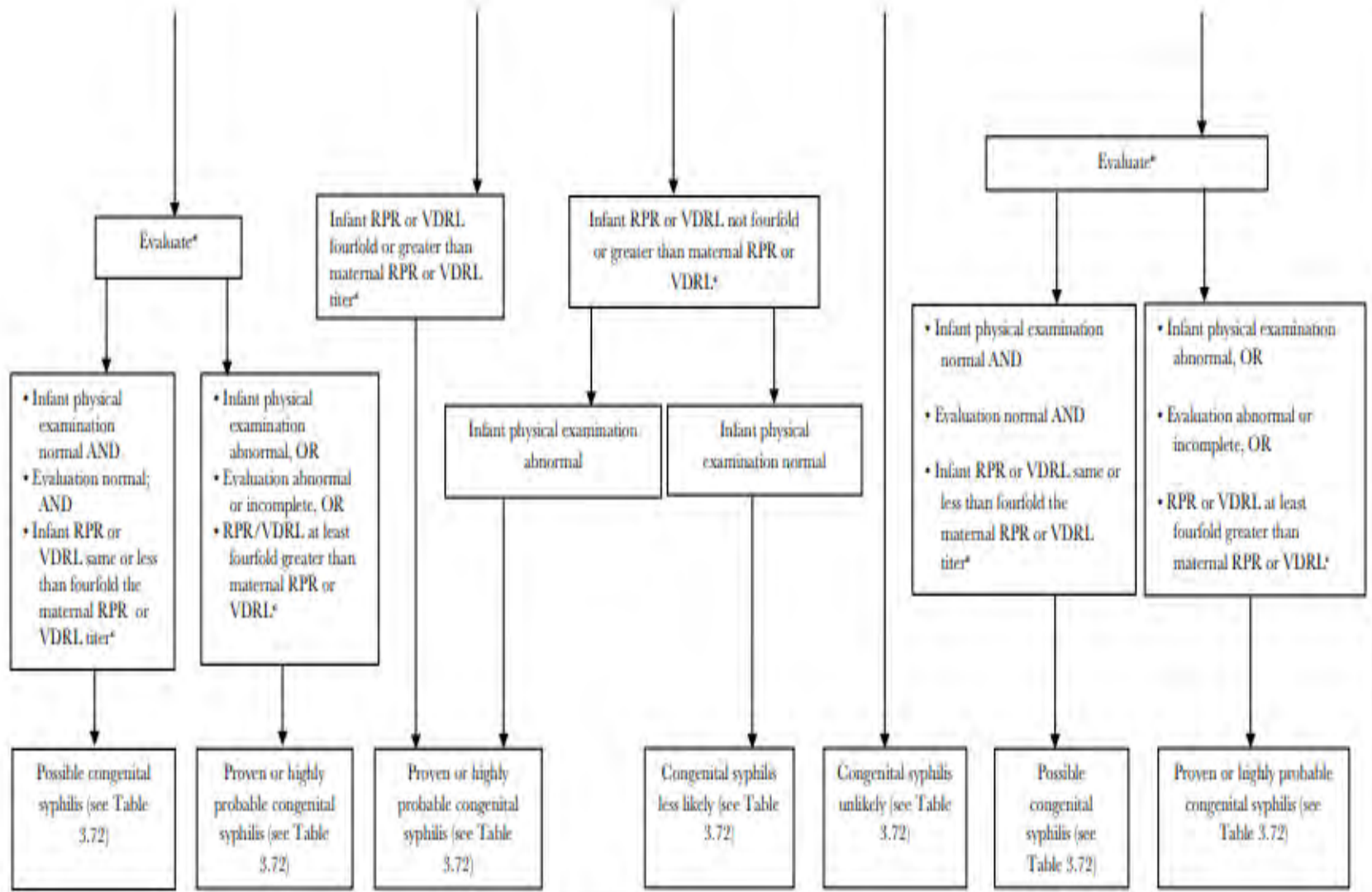
II.A Office
Practice
Update,
Continued

**AGENDA
ITEM**

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

II.A Office
Practice
Update,
Continued

Challenges Continued



SYPHILIS

AGENDA ITEM

II.A Office Practice Update, Continued

DISCUSSION / CONCLUSIONS

For information only, no formal action required.

Predictions for the Future

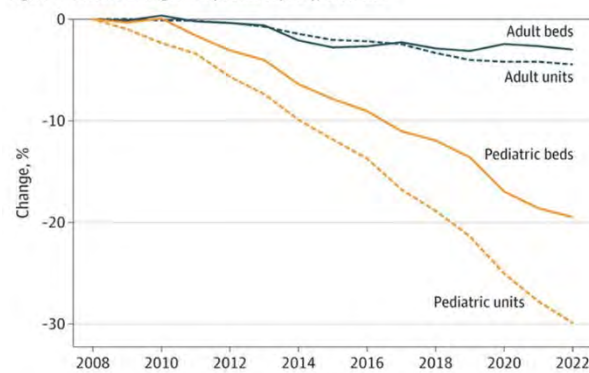
Fewer pediatricians (30% pediatric residency programs unfilled in 2024).

The United States has an infant mortality rate almost twice that of other developed nations according to data shared by Organisation for Economic Co-operation and Development (OECD). There are a number of political and social factors for the higher rates of infant mortality, but fewer pediatricians to treat infants does not help. Birthing parents continue to have higher rates of illness and obesity contributing to delivery complications and reduced outcomes for infants. Neonatology is projected to see 12.5% reduction in fellows and a 7% decrease in clinical time. The workforce has changed to newer physicians wanting to work fewer hours. NorthBay Neonatology has served Solano County for 40 years and still going strong.

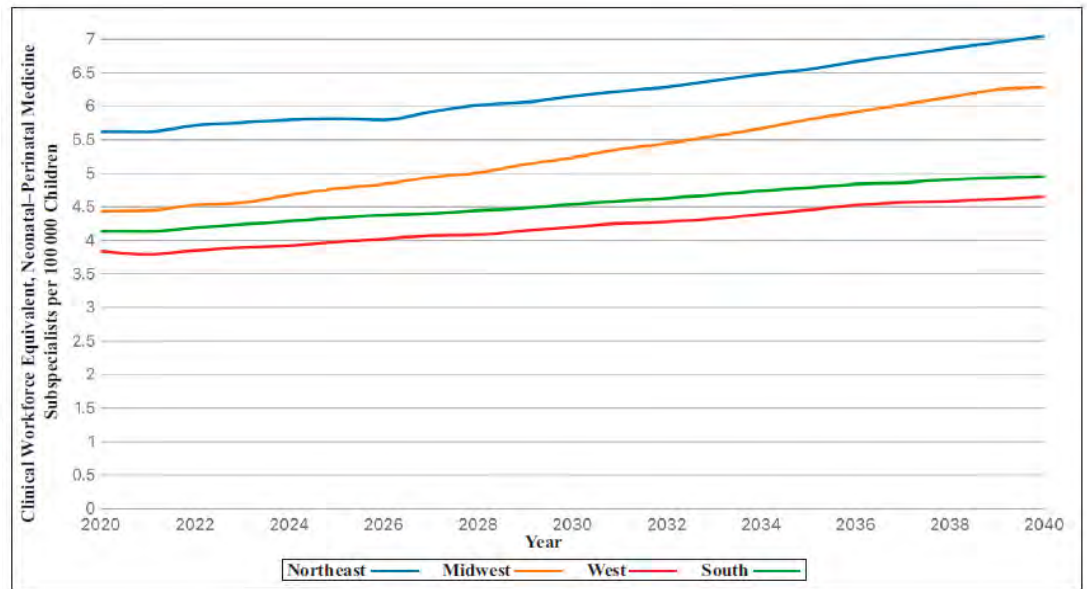
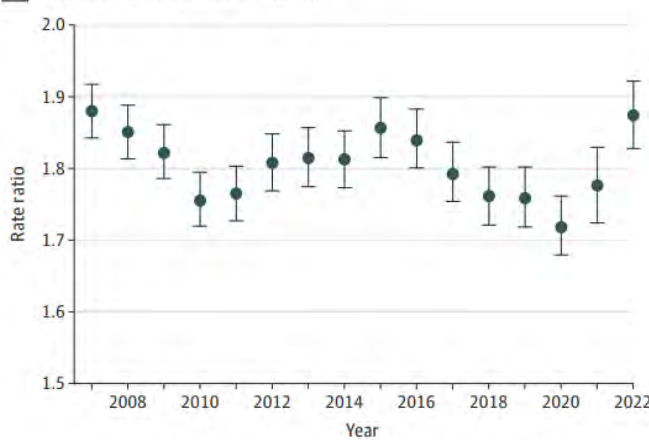
The authors have concerns regarding an insufficient number of neonatologists in the future based on 3 “likely” scenarios

- a 12.5% decrease in fellows
- a 7% decrease in clinical time
- workforce attrition

Figure 1. Relative Changes in Inpatient Capacity, 2008-2022



C Rate ratios among infants <1 year old



AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	September 2025 PAC minutes were presented for approval.	MOTION: Dr. Gwiazdowski moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Shinder. ACTION SUMMARY: [11] yes, [0] no, [1] abstentions.	10/08/25 Motion carried.
III.B. III.B.1 III.B.2 III.B.5	Consent Calendar Review • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – September 2025 • Policies, Procedures, and Guidelines for Action Policy Summary October 2025 • Credentials Committee Meeting Minutes and Credentialed List, August 13, 2025	MOTION: Nurse Sprague moved to approve Agenda III.B.1, III.B.2, and III.B.5 as presented, seconded by Dr. Montenegro. ACTION SUMMARY: [11] yes, [0] no, [1] abstentions.	10/08/25 Motion carried.
III.C.	Physician Advisory Committee Membership • Nomination of Dr. Zoe Cappe, Medical Director, La Clinica	MOTION: Dr. Zavod moved to approve Agenda III.C., as presented, seconded by Dr. Gwiazdowski. ACTION SUMMARY: [12] yes, [0] no, [0] abstentions	10/08/25 Motion carried.
V. V. A V. B V.C	Quality Incentive Proposals – Measurement Year 2026 • Palliative Care Quality Incentive Program (QIP) • Enhanced Care Management (ECM) QIP • Primary Care Physician (PCP) QIP	MOTION: Dr. Montenegro moved to approve Agenda V.A., as presented, seconded by Nurse Sprague. ACTION SUMMARY: [12] yes, [0] no, [0] abstentions. MOTION: Dr. Gwiazdowski moved to approve Agenda V.B., as presented, seconded by Dr. Montenegro. ACTION SUMMARY: [12] yes, [0] no, [0] abstentions. MOTION: Dr. Gwiazdowski moved to approve Agenda V.C., with modification to include language explaining pilot program to incentivize early administration of HPV vaccine did not increase rates and thus would no longer be incentivized for MY2026 in addition to information regarding other Partnership programs to increase HPV vaccination acceptance rates, seconded by Dr. Shinder. ACTION SUMMARY: [12] yes, [0] no, [0] abstentions.	10/08/25 Motion carried. 10/08/25 Motion carried. 10/08/25 Motion carried.

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V.A Palliative Care Quality Incentive Program (QIP) Measurement Year 2026 Measure Set Proposal	<p>Palliative Care Quality Incentive Program (QIP) Measurement Year 2026 Measure Set Proposal</p> <p>CHANGE:</p> <p>I. Measure III: Completion of a Palliative Care Survey has been replaced by the new Measure III: Completion of a Standardized Patient Symptom Assessment</p> <p>On February 14, 2025, PCQC informed the Palliative Care QIP team that they were dissolving and closing their doors on April 17, 2025. Measure III: Completion of a Palliative Care Survey was created as a temporary replacement for the former Measure III: Completion of Standardized PCQC Assessment and Use of PCQC Tool for the remainder of MY2025 because PCQC was no longer able to provide the supplemental data required to process payment.</p> <p>II. During the Palliative Care Clinician Workgroup held on April 2, 2025, palliative care providers confirmed they all use of the Edmonton Symptom Assessment System or ESAS and could submit the ESAS data directly to Partnership HealthPlan. The Palliative Care QIP team created a new Measure III: Completion of a Standardized Patient Symptom Assessment based on this feedback.</p> <p>Key:</p> <p>New Measure Change to Measure Design Measure removed</p> <table border="1" data-bbox="296 630 2018 1365"> <thead> <tr> <th data-bbox="296 630 709 678">2025 Measures</th> <th data-bbox="709 630 1136 678">2026 Recommendations</th> <th data-bbox="1136 630 1570 678">2025 Measures</th> <th data-bbox="1570 630 2018 678">2026 Recommendations</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="296 678 1136 719" style="text-align: center;">Utilization</td> <td colspan="2" data-bbox="1136 678 2018 719" style="text-align: center;">Quality</td> </tr> <tr> <td data-bbox="296 719 709 906"> 1. 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AGENDA ITEM	DISCUSSION / CONCLUSIONS				
<p>V.B Enhanced Care Management (ECM) QIP Measurement Year 2026 Measure Set Proposal</p>	<p>Enhanced Care Management (ECM) QIP Measurement Year 2026 Measure Set Proposal</p> <p>No Changes</p> <p>MY 2026 Enhanced Care Management (ECM) QIP Measurement Set Proposal</p> <hr/> <p>Total dollars available are \$100 per member per month. The Timely Reporting gateway measure determines the number of dollars placed in an incentive pool. Providers can earn up to 100% of incentive pool by meeting the other measures.</p> <table border="1" data-bbox="310 428 1425 1068"> <thead> <tr> <th data-bbox="310 428 869 480">Current MY 2025 Measurement Set</th> <th data-bbox="869 428 1425 480">Proposed MY 2026 Measurement Set</th> </tr> </thead> <tbody> <tr> <td data-bbox="310 480 869 1068"> <p>Gateway Measure: Timely Reporting</p> <p><u>Reporting Periods:</u> Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec</p> <p><u>Description:</u> Providers are required to submit three (3) monthly reports (Return Transmission File - RTF, Initial Outreach Tracker File - IOT, and Provider Capacity Survey) on or before their due date.</p> <p><u>Incentive:</u> \$100 per member per month Dollars earned are placed into an incentive pool.</p> <ul style="list-style-type: none"> • 100% incentive will be placed in incentive pool if all reports are received on or before the due date. • 50% incentive will be 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 other program measures. </td> <td data-bbox="869 480 1425 1068"> <p>No changes</p> </td> </tr> </tbody> </table>	Current MY 2025 Measurement Set	Proposed MY 2026 Measurement Set	<p>Gateway Measure: Timely Reporting</p> <p><u>Reporting Periods:</u> Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec</p> <p><u>Description:</u> Providers are required to submit three (3) monthly reports (Return Transmission File - RTF, Initial Outreach Tracker File - IOT, and Provider Capacity Survey) on or before their due date.</p> <p><u>Incentive:</u> \$100 per member per month Dollars earned are placed into an incentive pool.</p> <ul style="list-style-type: none"> • 100% incentive will be placed in incentive pool if all reports are received on or before the due date. • 50% incentive will be 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 other program measures. 	<p>No changes</p>
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V.C Primary Care Physician Quality Incentive Program (QIP) Proposed Changes for Measurement Year (MY) 2026	(A) Core Measurement Set Measures Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Hospital Utilization; 3) Primary Care Utilization; and 4) Patient Experience. Individual measure values will be assigned to the final and approved measurement set.																											
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AGENDA ITEM	DISCUSSION / CONCLUSIONS									
V.A Primary Care Physician Quality Incentive Program (QIP) Proposed Changes for Measurement Year (MY) 2026, Continued	<p>(B) Unit of Service Measures Providers receive payment for each unit of service they provide.</p> <p>Programmatic Changes: I. Descriptions of Potential 2026 Measure Changes for Core Measurement Set A. Change(s) to Existing Measures – Core Measurement Set</p> <p><u>I. Breast Cancer Screening (40-74yo) - Family Practice & Internal Medicine</u> Measure Change: In MY2025, a separate Breast Cancer Screening measure specific to the age population of 40-51yo was created and implemented as a monitoring measure. This was to allow an adjustment period for members and providers to “get caught up” on screening in this eligible population with the anticipation of this population being combined into one measure with 52-74yo population as an active MY2026 core measure for the combined population of 40-74yo. Measure Rationale: In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024).</p> <p><u>II. Chlamydia Screening (Family Practice:16-24yo, Internal Medicine: 21-24yo, Pediatrics: 16-20yo)</u> Measure change: In MY2025, Chlamydia Screening measure was implemented as active measure for pediatric practices only and a monitoring measure for both family and internal medicine practices. This was to allow an adjustment period for family and internal medicine practices, who have a larger measure set than pediatric practices, with the anticipation of this measure moving to an active measure in MY2026. With implementation during MY2026, there are no changes to the denominator/numerator logic. Measure Rationale: The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: “Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV”. Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women).</p>	<table border="1"> <thead> <tr> <th colspan="2" data-bbox="1157 180 2043 212">Unit of Service</th> </tr> </thead> <tbody> <tr> <td data-bbox="1157 212 1577 483"> All Practice Types: 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity 7. Tobacco Use Screening 8. Electronic Clinical Data Systems (ECDS) 9. 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AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Primary Care Physician Quality Incentive Program (QIP) Proposed Changes for Measurement Year (MY) 2026, Continued	<p>B. Potential Additions as New Measures – Core Measurement Set</p> <p><u>I. Kidney Health Evaluation for Patients with Diabetes (Family Practice & Internal Medicine)</u></p> <p>Measure Rationale: Chronic kidney disease (CKD) is a common and serious complication of diabetes, affecting up to 40% of adults with the condition. Diabetes also contributes to higher rates of cardiovascular events, kidney disease or failure, and even early mortality. The Kidney Health Evaluation for Patients with Diabetes (KED) measure promotes early detection in adults aged 18-85 with type 1 or type 2 diabetes who received a kidney health evaluation during the measurement year and incentivizes intervention by ensuring patients receive both an estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR) annually. Despite strong evidence and clear clinical guidelines, fewer than half of adults with diabetes receive both tests each year, highlighting a significant care gap. According to The National Committee for Quality Assurance, “Diabetic kidney disease is one of the most common adverse outcomes of diabetes, affecting 20%–40% of patients with diabetes. CDC simulation studies showed that uACR screening for early detection of CKD was cost-effective in patients with diabetes, at \$50 thousand per quality-adjusted life-year.” Adoption of this measure drives an evidence-based and cost-effective practice which supports better long-term outcomes for patients with diabetes. (NCQA, State of Health Care Quality Report – Kidney Health Evaluation for Patient with Diabetes).</p> <p><u>II. Descriptions of Potential 2026 Measure Changes for Unit of Service Measurement Set</u></p> <p>A. Change(s) to Existing Measures – Unit of Service</p> <p>I. Retirement of the Early Administration of the 1st HPV Dose</p> <p>Rationale: Prior analysis of the Adolescent Immunization Series found that HPV was the most commonly missed immunization in the adolescent series. This resulted in a majority of adolescents not meeting the measure requirements. Partnership offered an incentive for early administration of the 1st HPV dose for adolescents ages of 9-12 years with the intent to increase the HPV vaccine completion rates. When evaluating the effectiveness of this unit of service measure, there was no discernable difference in the completion rates of early administration of 1st or 2nd HPV dose when incentivized. Therefore, Partnership has chosen to retire this measure.</p> <p>II. Retirement of the Early Administration of Initial Flu Vaccine Series</p> <p>Rationale: Prior analysis of the Childhood Immunization Series found that Initial Flu Vaccine series was the most commonly missed vaccines of the entire immunization series. This resulted in a majority of children aging out of the measure before receiving their entire immunization series, therefore not meeting the measure. Partnership offered an incentive for early administration of initial flu vaccine Series in children ages of 7 to 15 months with the intent to increase the flu administration rates. When evaluating the effectiveness of this unit of service measure, there was no discernable difference in the completion rates of early administration of initial flu vaccine series. <i>Therefore, Partnership has chosen to retire this measure.</i></p>
VI. Adjournment	
PAC adjourned at 8:57 a.m.	Next PAC on Wednesday, October 8, 2025, at 7:30 a.m.

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____

_____ **Date**

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

The foregoing minutes were APPROVED WITH MODIFICATION on _____

_____ **Date**

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

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

Date: Oct. 15, 2025

Time: 7:30 – 8:55 a.m.

Locations: Partnership HealthPlan of California

4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:

Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn

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 locations

	Item	Lead	Time	Page #	
I.	Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes				
1	<i>Approval of</i> • Sept. 17 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 14	
2	<i>Acknowledgment and acceptance of draft minutes of the</i> • Sept. 9 Internal Quality Improvement (IQI) Committee • Sept 25 Substance Use Disorder Internal Quality Improvement (SUIQI) Committee			15 – 32	
II.	Standing Updates				
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:37	33 – 42	
2	HealthPlan Update	Robert Moore, MD	7:44	--	
III.	Old Business – None				
IV.	New Business – Consent Calendar				
	Consent Calendar	All	7:52	43	
	Proposed 2026 PCP QIP Measure Set – <i>direct questions to Athena Beltran-Nampraseut</i>			45 – 50	
	Proposed 2026 ECM QIP Measure Set – <i>direct questions to Deanna Watson</i>			51 – 54	
	Proposed 2026 Palliative Care QIP Measure Set – <i>direct questions to Eva Lopez, CPhT</i>			55 – 56	
Health Services Policies	Behavioral Health				
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members (<i>previously MCUP3103</i>)				57 – 61
	MPBP8007 – Screening and Treatment for Substance Use Disorders (<i>previously MCUP3101</i>)				63 – 82
	MPBP8013 – Eating Disorder Management Policy				83 – 90
	Care Coordination				
	MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines – ARCHIVE – <i>see new Behavioral Health policy MPBP8011</i>				91 – 102
	Utilization Management				

	Item	Lead	Time	Page #
Health Services Policies	MCUP3101 – Screening and Treatment for Substance Use Disorders – ARCHIVE – <i>see new Behavioral Health policy MPBP8007</i>			103 – 122
	MCUP3103 – Coordination of Care for Child-Welfare Involved Members – ARCHIVE – <i>see new Behavioral Health policy MCBP8015</i>			123 – 127
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			129 – 131
	MCUP3012 – Discharge Planning (Non-capitated Members)			133 – 135
	MCUP3050 – Medication Abortion in the First Trimester			137 – 149
	MCUP3052 – Medical Nutrition Services			151 – 158
	MCUP3115 – Community Based Adults Services			159 – 167
	MCUP3128 – Cardiac Rehabilitation			169 – 174
	MCUP3130 – Osteopathic Manipulation Treatment			175 – 177
	MPUP3078 – Second Medical Opinions			179 – 181
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			183 – 185
	Non HS	Grievance & Appeals		
	CGA022 – Member Discrimination Grievance Procedure			187 – 192
V.	New Business – Discussion Policies			
	Synopsis of Changes		--	193 – 196
Health Services Policies	Behavioral Health			
	MPBP8003 – Mental Health Services	Jeff DeVido, MD	8:00	197 – 232
	MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>previously MPCP2017</i>)		8:07	233 – 240
	Enhanced Health Services			
	MPAP7003 – CalAIM Community Supports (CS) – <i>previously MCAP7003</i>	Lisa O’Connell, MHA	8:14	241 – 268
	Utilization Management			
MCUP3015 – Family Planning By-Pass Services	Tony Hightower, CPhT	8:21	269 – 272	
MPUP3035 – Preoperative Day Review		8:28	273 – 276	
VI.	Presentation			
1	Health Equity Grand Analysis		8:35	277 – 292
VI.	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 19, 2025			

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES**

Quality and Utilization Advisory Committee (Q/UAC) Meeting

Wednesday, Oct. 15, 2025 / 7:33 a.m. – 8:54 a.m. - Napa/Solano Room, 1st Floor

<p><u>Voting Members Present:</u> Sara Choudhry, MD Steven Gwiazdowski, MD, FAAP Emma Hackett, MD, FACOG</p>	<p>Brian Montenegro, MD John Murphy, MD Meagan Mulligan, FNP-BC Robert Quon, MD, FACP</p>	<p>Michael Strain, PHC Consumer Member Chris Swales, MD Randolph Thomas, MD Jennifer Wilson, MD</p>
<p><u>Voting Members Absent:</u> Brandy Lane, Consumer Member; Phuong Luu, MD</p>		
<p><u>Partnership Ex-Officio Members Present:</u> Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI Bontrager, Mark, Senior Director of Behavioral Health Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement Cox, Bradley, DO, Regional Medical Director (Northeast) DeVido, Jeff, Behavioral Health Clinical Director Esget, Heather, RN, BSN, ACM, Director of Utilization Management Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management Glickstein, Mark, MD, Associate Medical Director Hightower, Tony, CPhT, Associate Director, UM Regulations Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer) Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination Jones, Kermit, MD, JD, Medical Director for Medicare Services Katz, Dave, MD, Associate Medical Director</p>	<p>Leung, Stan, Pharm.D, Director of Pharmacy Services Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair Netherda, Mark, MD, Medical Director for Quality – Vice Chair Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections O’Connell, Lisa, Director, Enhanced Health Services Randhawa, Manleen, Senior Health Educator, Population Health Ribordy, Jeff, MD, Regional Medical Director (Northwest) Ruffin, DeLorean, DrPH, MPH, Director of Population Health Spiller, Bettina, MD, Associate Medical Director Thornton, Aaron, 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</p>	
<p><u>Partnership Ex-Officio Members Absent:</u> Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer</p>	<p>Cotter, James, MD, Associate Medical Director Guillory, Ledra, Senior Manager of Provider Relations Representatives</p>	
<p><u>Guests:</u> Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance Brunkal, Monika, RPh, Associate Director, Population Health Campbell, Anna, Health Policy Analyst, Utilization Management Chiang, Yuen, Program Manager 1, Utilization Management Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health Conner, Maria, Improvement Advisor, QI (Auburn) Cunningham, Aryana, Policy Analyst, Care Coordination Devan, James, Manager of Performance Improvement (Redding) Durst, Jennifer, Senior Manager of Performance Improvement, QI (Santa Rosa) Frankovich, Terry, MD, Associate Medical Director Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI Hendrix, Hillary, Executive Assistant, Behavioral Health</p>	<p>Jamali, Shahrzad, Improvement Advisor, QI (Chico) Jarrett-Lee, Kevin, RN, Assoc. Dir., Utilization Management (Auburn) Kim, Amanda, Improvement Advisor, QI (Redding) Matthews, Richard “Doug,” MD, Regional Medical Director (Chico) McCune, Amy, Manager of Quality Incentive Programs, QI Morris, Matthew, MD, Regional Medical Director (Auburn) Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep, PR Quichocho, Sue, Manager of Quality Measurement, QI Robertello, Kimberly, PhD, Sr. Medicare QI Program Manager, QI Romero, Liz, Improvement Advisor, QI Tryan, Tiffany, Improvement Advisor, QI YoungStone, Kelly, RN, Director of Care Coordination</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p>I. Call to Order</p> <p>Public Comment – <i>none made</i></p> <p>Introductions – <i>none made</i></p> <p>Approval of Minutes</p>	<p>Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m.</p> <p>The Sept. 17 Q/UAC Minutes were approved as presented without comment.</p> <p><i>Acknowledgment and acceptance of draft meeting minutes of the</i></p> <ul style="list-style-type: none"> • Sept. 9 Internal Quality Improvement (IQI) Committee • Sept. 25 Substance Use Disorder Internal Quality Improvement (SUIQI) Committee <p>Matt Goudy from MD Staffers came unannounced into the meeting. He introduced himself to Isaac Brown after the meeting.</p>	<p>Motion to approve the Q/UAC minutes: Brian Montenegro, MD Second: Robert Quon, MD <i>Approved unanimously</i></p> <p>Motion to accept the other minutes: Robert Quon, MD Second: Steven Gwiazdowski, MD <i>Accepted unanimously</i></p>
<p>II. Standing Updates</p>		
<p>1. Quality Improvement (QI) Department Update</p> <p><i>Isaac Brown, Interim Senior Director of Quality and Performance Improvement, QI</i></p>	<ul style="list-style-type: none"> • About 200 students were vaccinated during recent immunization events held in Shasta County. Local community partners aided Partnership in this successful endeavor. • The Partnership Improvement Academy 2026 Improving Measure Outcomes webinar series has been finalized, with six sessions beginning on Feb. 11 with pediatric preventive care (0-30 months) and ending on April 22 with perinatal care. • Several Joint Leadership Initiative (JLI) sessions will happen in our Auburn and Chico regions in October, November and December 2025. • Twenty three of the original 26 provider organizations are continuing to participate in the Equity and Practice Transformation project. Several deliverables are due in November. The EPT program focuses on improving core foundational aspects of our practices (e.g., data policy and procedure, and team-based care) rather than working on specific measures. • Q/UAC members will recall we are now in a second phase of the Preventive Care Bridge Project (formerly known as the Locum Pilot Initiative) to ascertain what type of practices are best able to use locums with the greatest efficiency. We have been focused on well child visits and cervical cancer screenings and trying to understand if a locum is appropriate to help in these areas or whether we need to figure out something else to help increase access. Each of the four participating provider organizations has thus far had varying results successfully overcoming different barriers. Partnership will be sharing our best practices as soon as the pilot ends towards the end of this year. • Partnership in September began a project management training program with a pilot cohort of 20 county, provider, and community-based organization participants interested in learning about and applying project management principles to various interventions. The training curriculum is undergoing final edits, and a dedicated Toolkit Hub webpage is live on the Improvement Academy’s website. The pilot ends in November. The full program launch is planned for first quarter 2026. 	<p><i>For information only. There were no questions.</i></p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p>2. HealthPlan Update</p> <p><i>Robert Moore, MD, MPH, MBA Chief Medical Officer</i></p>	<ul style="list-style-type: none"> Partnership has implemented the use of a mobile phone app, Kinetik, for our members' use in accessing their transportation benefit. To initiate individual use, the member should contact the Transportation department at 866-828-2303. The app empowers members to schedule stand-alone or recurring non-emergency medical transportation (NEMT) and non-medical transportation (NMT) rides. The app allows the member to share health conditions and accessibility needs, apply for gas mileage reimbursement, and view, call, and track the assigned driver. At this time, short notice (less than five days) trips and travel related expense requests are not supported. Q/UAC members will recall that most CTs and MRIs no longer require a Treatment Authorization Request (TAR). A communication will be sent to network radiology providers before the end of October. Thereafter, another communication will be sent to the entire clinician network. As a result of the federal H.R. 1, as of Sept. 11 Partnership may no longer cover family planning services such as IUDs, birth control pills, and women's health exams provided to our members by Planned Parenthood and Women's Health Specialists. Interestingly, these providers can provide and be reimbursed for abortion services because those monies come from state, not federal, funding. We are watching the legal battles and will update Q/UAC as we learn more. Planned Parenthood has seven sites in Partnership's footprint: Chico, Clearlake, Eureka, Fairfield, Napa, Santa Rosa, and Ukiah. Women's Health Specialists has sites in Chico and Redding. H.R. 1 rural health transformation grants purportedly designed to help keep rural hospitals from closing may not have that effect as the states get to decide "rural" criteria. Partnership is advocating that California focus on obstetric and general care in rural areas and not utilize these grants for other projects at the expense of cutting core health services. Gov. Gavin Newsom has just signed both Senate Bill 669 and Assembly Bill 55. SB 669 requires the California Department of Public Health to establish a five-year pilot project to allow critical access and individual and small system rural hospitals to establish standby perinatal medical services. The bill, which took three years to get to the Governor's desk, was conceived by Partnership and marks the first time Partnership has championed health care legislation from beginning to end. This has nothing to do with being a managed care plan, although it does help our network. Partnership and our lobbying organization are "super happy." We are likewise pleased that AB 55 should ease some regulations around free-standing birth centers. Word at the recent Coalition for Compassionate Care for California meeting is that the long-awaited statewide electronic Physician Orders for Life-Sustaining Treatment (POLST) registry may pilot this coming winter. Q/UAC members will recall that legislation passed several years ago, paving the way for emergency medical services and emergency rooms to access an electronic POLST registry in lieu of "relying on paper on the refrigerator." The state organization CalEMS is garnering data use agreements with the larger providers such as Kaiser, Dignity and Sutter to first upload the POLSTs as found in their electronic medical records. Q/UAC members are asked to please "bug" the right people at their organizations to say 'move along on the registry.' 	<p><i>There were no questions.</i></p> <ul style="list-style-type: none"> As directed, staff on Oct. 24 emailed this Kinetik information to Q/UAC voters. For more information on preparing data sharing or use agreements to facilitate uploading POLST agreements into a statewide electronic registry, contact Kevin Chan, Branch Chief, EMSA, Health Information and Data Technologies, at kevin.chan@emsa.ca.gov.
<p>III. Old Business – None</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Consent Calendar (Committee Members as Applicable)		
	<p>Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set – <i>direct questions to Athena Beltran-Nampraseut</i></p> <p>Proposed 2026 Enhanced Care Management (ECM) QIP Measure Set – <i>direct questions to Deanna Watson</i></p> <p>Proposed 2026 Palliative Care QIP Measure Set – <i>direct questions to Eva Lopze, CPhT</i></p>	<p>No questions were asked.</p> <p>Motion to approve slate as presented: Brian Montenegro, MD Second: Chris Swales, MD <i>Approved unanimously</i></p>
	<p>Health Services Policies</p> <p><u>Behavioral Health</u> MCBP8015 – Coordination of Care for Child Welfare-Involved Members (<i>previously MCUP3103</i>) MPBP8007 – Screening and Treatment for Substance Use Disorders (<i>previously MCUP3101</i>) MPBP8013 – Eating Disorder Management Policy</p> <p><u>Care Coordination</u> MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines – ARCHIVE – <i>see new Behavioral Health policy MPBP8011</i></p> <p><u>Utilization Management</u> MCUP3101 – Screening and Treatment for Substance Use Disorders – ARCHIVE – <i>see new Behavioral Health policy MPBP8007</i> MCUP3103 – Coordination of Care for Child-Welfare Involved Members – ARCHIVE – <i>see new Behavioral Health policy MCBP8015</i> MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3012 – Discharge Planning (Non-capitated Members) MCUP3050 – Medication Abortion in the First Trimester MCUP3052 – Medical Nutrition Services MCUP3115 – Community Based Adult Services MCUP3128 – Cardiac Rehabilitation MCUP3130 – Osteopathic Manipulation Treatment MPUP3078 – Second Medical Opinions MPUP3116 – Positron Emission Tomography Scants (PET Scans)</p> <p>Non-Health Services Policies</p> <p><u>Grievance & Appeals</u> CGA022 – Member Discrimination Grievance Procedure</p>	<p><u>Next Steps:</u> The three proposed measure sets were approved at the Oct. 8 Physician Advisory Committee (PAC) meeting.</p> <p>All policies go to the Nov. 12 PAC</p>
V. New Business – Discussion Policies		
Policy Owner: Behavioral Health – <i>Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director</i>		
<p>MPBP8003 – Mental Health Services</p>	<p>Updates made to align with new All Plan Letter (APL) 25-010 Adult and Youth Screening and Transition Tools for Mental Health Services, which allows for a clinician to override the result of the screening tool if it is inconsistent with the clinical presentation of the member. [VI.B.3.c.3]</p> <p>III.A Definition added: (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnership’s</p>	<p>Motion to approve as amended: Robert Quon, MD Second: John Murphy, MD <i>Approved unanimously</i></p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>service area. BHPs are required to provide and cover all medically necessary Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment services in accordance with their contracts with the Department of Health Care Services (DHCS).</p> <p>VI.I.3 adds Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization.</p> <p><i>Footnotes:</i></p> <p>Some mental health treatment services, such as TMS, may be available in both specialty mental health services (SMHS) and non-specialty mental health services (NSMHS) systems of care. Partnership’s coverage of these treatment services through NSMHS is, therefore, not intended to duplicate, supplant, or exclude the potential of those treatment services being offered in the SMHS system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMHS systems of care to ensure Members receive clinically indicated care in the most appropriate mental health system of care. For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of electro convulsive therapy (ECT). Hospital incurred medical costs for ECT (i.e., anesthesia) for Partnership Medi-Cal Members are covered by Partnership.</p> <p>Per discussion at Oct. 7 IQI, MCUP3041, Treatment Authorization Request (TAR) Review Process is added to the Related Policies list because TMS requires prior authorization. Also, APL 25-013 supersedes all APL 22-012 references.</p> <p>Many of you are aware that our previously delegated services that were going to Carelon for non-specialty mental health services. One subset has been brought in-house in Fairfield, which we are very excited about: we have a whole new team of behavioral access guides that are now fielding all of the member-facing phone calls. When you call the same Carelon number that you would call before, it’s now reaching someone at Partnership. We are hoping this gives us an opportunity to be able to make more substantive changes on how referrals happen because we control the call center.</p> <p>There have been some policy language changes to keep it consistent with what the State uses, for example, “behavioral health programs” is meant to subsume both substance use and mental health services.</p> <p>The State has issued transitional tools to provide an objective measure that would help determine what level of care or what system of care – NSMHS or SMHS – would best suit an individual to receive their behavioral health services. APL 25-010 allows clinicians to override the finding of that screening tool should they feel it is in the patient’s best interest, or they feel clinically that there is a more appropriate system of care than what the transitional tool tells them should be the case.</p> <p>In July, the State provided some information on its intention to have TMS covered by NSMHS. TMS is a non-invasive procedure that uses the externally mounted magnets to generate currents to treat depression. Traditionally, this was something that was seen more in SMHS, but the State also wants this to be available in NSMHS, so they added the billing codes 90867, 90868, and 90869 for the diagnosis codes 32.3 and 33.2. We are still working out the details, including developing policies because a TAR is required.</p> <p>In addition to TMS, the State is encouraging NSMHS to also provide Spravato, a brand name for esketamine</p>	<p><u>Next Steps:</u> Nov. 12 PAC</p>

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	<p>nasal spray, a prescription medication used to treat certain types of depression in adults. We are trying to figure out how these services can live in both systems and be non-duplicated. By providing TMS through NSMHS is not meant to supplant or replace TMS that may be provided through the county, but it does add an additional care coordination component to ensure that patients are receiving the services in the system of care that is most appropriate. ECT is another behavioral health intervention that lives in two worlds. There is a component of care that is covered by the managed care plan – hospital costs like anesthesia and whatnot associated with the administration of the ECT – but county specialty mental health is still responsible for paying for the actual procedure itself.</p> <p>The transitional tools issued by the State are included in today’s packet. We don’t have much editorial authority over them. Some of the language changes that we’ve made have already been approved by DHCS.</p> <p>Senior Director for Behavioral Health Mark Bontrager added that “our obligation is to triage these services” and he more closely enumerated the transitional tools’ scoring results that point to the two systems of care, reiterating that the APL permits clinical judgment overrides.</p> <p>Q/UAC voter Robert Quon, MD, suggested that versions of the tools themselves be referenced in the policy. “The only thing that gets a little squishy for me is what do you have to write down and what do you have to document for an override?,” Dr. Quon continued. “I read through this several times because I sit on our mental health committees at Kaiser. With mental health being such a laser focus right now, if somebody says ‘I am going to override this’, whether to up code or downcode it, what is the data that I need to include to do that versus ‘it was just a clinician decision’? Can I feel that the patient’s presentation is just of higher acuity and do it?, which from a policy standpoint a little bit open to interpretation.”</p> <p>Dr. DeVido responded that as a psychiatrist he was not trained to differentiate, based on severity, in what sort of system of care the patient got treatment. This transitional tool is based off of what system of care do you go into? County or NSMS? Right there there’s something that awkward about that for a mental health provider because we were trained to adjustment treatment based on the severity of the patient that’s walking through the door. I hear what you are saying ‘open for interpretation’ can also mean you get your hands slapped later for doing something incorrectly or that somebody else deemed was not done correctly.</p> <p>Dr. DeVido continued: say you are a primary care doc and this person scored low on the screening tool but you think they are more severe. At that point, there is a handoff that’s happening between provider A and then system B. Ideally, there’s communication ‘hey, they scored this, this is what I think is happening and these are the additional factors going into my decision making.’ I get a little worried when things get overly prescriptive when it comes to clinical judgment, especially in a somewhat subjective space, which behavioral health can be. To your first point, absolutely we need to add the version numbers because the State will change that. To your second point, I’m open to suggestions.</p> <p>Dr. Quon noted “You are protecting the floor. You are saying ‘we are not going to go below: if they score a five I’m not going to provide then with a level of care than a five.’ ... Some of these policies are all about how do we protect our most vulnerable patients and how do we make sure that they are not getting left on</p>	

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	<p>the side of the road?”</p> <p>Mark Bontrager provided some clarification: there are two screening tools, adult and youth, that are to be used when a member contacts our call center, and our access guides actually conduct the 12 question screener. If, during the course of that screen, they have a sense that there may be an alternative outcome here, or even in a situation where a member might say ‘I screened a 7 and should be directed to the county but I am sure as heck not going to go there. I had a bad experience,’ that can be overwritten. There is no clinical coding in this scenario; it’s just a way to direct to the right system of care. The transition of care tool is different and is used if a member commences services with a provider, which they can. They can go to one of our providers straight away: the screening tools don’t apply. If during the course of treatment, the provider determines that they actually need a higher level of care, that’s when they employ the transition of care tool: that’s their passport into the specialty mental health system, and vice versa. That’s the only time the TOC is completed. The only time the screening tools are utilized is if the member actually calls a call center. But none of our members have to call a call center. We have this ‘no wrong door’ policy that allows members to start anywhere and then go everywhere.</p>	
<p>MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (previously MPCP2017)</p>	<p>This policy update reflects changes necessitated by the de-delegation of Carelon for triage and referral services: Partnership began handling these calls in-house on Sept. 29.</p> <p>Section V. is updated to read: The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership HealthPlan of California, and for referral to County Behavioral Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between Primary Care Providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.</p> <p>VI.B.3 now contains the following addition: (Note that by Jan. 1, 2026, all California counties are expected to be compliant with SB43 which updates the Lanterman-Petris-Short (LPS) clinical definition of “Grave Disability.” For more information: https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf)”</p> <p>VI.C.4.i is added to the risk factor list of what PCPs should assess: “Risk to self or community due to high risk behaviors and/or impaired judgment (i.e., operating motor vehicles while intoxicated).”</p> <p>References added: APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (June 3. 2025), supersedes APL 22-028. Also, APL 25-013 supersedes APL 22-012.</p> <p>Attachment A Partnership Behavioral Health Referral Form has been modified to reflect the changed relationship with Carelon as these referrals will now be sent directly to Partnership.</p> <p>Dr. DeVido went through the synopsis. SB 43 allowed for the expansion of the definition of grave disability for LPS psychiatric holds. Historically, the criteria used on California for involuntary psychiatric holds was based off the LPS set of legislation. There were three dimensions: suicidality, homicidality, and grave disability. ‘Grave disability’ was the person was disabled due to a mental illness and could not be due to neurocognitive disorders such as dementia or substance use. So, SB 43 is allowing for grave disability that is</p>	<p>Motion to approve as presented: Jennifer Wilson, MD Second: Robert Quon, MD <i>Approved unanimously</i></p> <p><u>Next Steps:</u> Nov. 12 PAC</p>

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	<p>caused by severe substance use, that can be a criteria for psychiatric hold.</p> <p>There have been questions: we can hold people. Now what? Where do we send them? Where are the appropriate placements for someone on an involuntary psychiatric hold for a substance use disorder? This presents some challenges. It's not a primary care provider's duty to do these evaluations; it's simply providing back drop.</p> <p>Associate Medical Director Dave Katz, MD, asked where a provider should best go to learn more. Dr. DeVido said https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf is "fairly digestible":</p> <p style="padding-left: 40px;">SB 43 amends the LPS Act's definition of "gravely disabled" in two ways. "Gravely disabled" now means a condition in which a person: - as a result of a mental health disorder, impairment by chronic alcoholism, severe substance use disorder, or a co-occurring mental health disorder and severe substance use disorder, - is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care.</p> <p>There were no other questions or comments.</p>	
Policy Owner: Enhanced Health Services – Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services		
<p>MPAP7003 – CalAIM Community Supports (CS)</p>	<p>Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services:</p> <p>Deposits [See VI.F.2.]</p> <p>Short-Term Post Hospitalization Housing [See VI.F.4.]</p> <p>Recuperative Care [See VI.F.5]</p> <p>Medically Tailored Meals and Groceries (MTM/G) [See new VI.F.6.]</p> <p>Asthma Remediation – service will be added Jan. 1, 2026 [See new VI.F.11.]</p> <p>Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.)</p> <p>Per discussion at Oct. 7 IQI, "Registered Dietician (RD) or Registered Dietician Nutritionist" is added to the Definition section here because a RDN assessment is required for an individual to qualify for MTM. (This definition is also added to UM's Medical Nutrition policy on today's consent calendar.)</p> <p>Section III Definitions added for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent</p> <p>III.J - Transitional Rent: Effective Jan. 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.</p> <p>Section VI.C Member Identification and Referral for Community Support Services is updated with track and trending provisions.</p> <p>Section VII. References is updated with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and</p>	<p>Motion to approve as presented:</p> <p>Brian Montenegro, MD</p> <p>Second: Steven Gwiazdowski, MD</p> <p style="text-align: right;"><i>Approved unanimously</i></p> <p><u>Next Steps:</u></p> <p>Nov. 12 PAC</p> <p>Partnership in November will train our MTM providers on changes.</p>

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	<p>initial policy references to these APLs are hyperlinked.</p> <p>Attachment A: Deleted the matrix as this information is in the DHCS Policy Guides and codes are listed on our website in other materials. Information changes frequently so decision to delete matrix was made since information is provided in other materials. Updated information and made changes to Deposits, Short-Term Post Hospitalization Housing, Recuperative Care, Medical Tailored Meals/Groceries and added new service, Asthma Remediation.</p> <p>Lisa noted that updates to DHCS Policy Guides Volumes 1 and 2 were made in April, then in June, and more are expected in January; so, this policy soon will come back.</p> <p>There were changes to deposits: they now do not allow for the first and last month’s rent, only the security deposit or deposits. Short-term hospitalization housing and recuperative care now have a 182-day cap within a 12-month period. There were some changes in the medically tailored meals and we have met with the MTM providers as well as some RDNs to evaluate that.</p> <p>We will be adding asthma remediation on Jan. 1, 2026: it will leave CS and become a Medi-Cal benefit. Transitional rent will be its own policy once DHCS reviews it (effective) Jan. 1 for specific populations.</p> <p>Medical Director for Quality Mark Netherda, MD, asked about eligibility and oversight of both asthma education and remediation eligibility. Lisa said we will require that members first do asthma prevention services: education with a community health worker (CHW) and then the CHW will evaluate whether the member qualifies for remediation services. To begin with, the member must have poorly controlled asthma and meet criteria as follows: 1. An emergency department visit of hospitalization or two sick or urgent care visits due to asthma in the past 12 months or 2. Asthma control test core of 19 or lower or 3. Recommendation from a licensed health care provider. No treatment authorization request is required for the education services with the CHW. A TAR will be required for any remediation service.</p> <p>Lisa added that education will be under the contracted provider organization, which would provide and manage the CHWs. One statewide organization, Breathe Easy, is interested. Partnership is having an asthma remediation webinar Nov. 6 with RAMP (Regional Asthma Management and Prevention), another statewide organization that does asthma prevention.</p> <p>Remediation for such items as air filters and air purifiers could occur up to \$7,500 during a member’s lifetime. In response to a question whether remediation would cover mold and cockroaches, Lisa noted it could but “most licensed contractors in the state of California won’t do anything for \$7,500.” Mold removal requests would be unusual because most of the people that would qualify don’t own their own homes. Their landlords would need to be involved.</p> <p>Associate Medical Director Marshall Kubota, MD, asked whether remediation monies could be used for flood damage or smoke damage from house fires? Lisa said the same home ownership issues could apply, although RAMP has examples of how mold removal can be done without doing construction.</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Dave Katz, MD, asked if there will be tracking to see if such asthma control is cost effective? Dr. Moore noted we do have a general plan of looking at the cost effectiveness of our Community Supports in ECM; however, once it becomes a benefit, it doesn't matter: the State just says we have to do it.</p>	
<p>Policy Owner: Utilization Management – Presenter: Anna Campbell, Policy Analyst, UM</p>		
<p>MCUP3015 – Family Planning By-Pass Services</p>	<p>This policy is being updated to describe Prohibited Entities as per H.R.1. and All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025).</p> <p>Section III.A: Added end note 1 to the definition of Bypass Services: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p>Section III.C: Added Definition of Prohibited Entity</p> <p>Sections VI.B., C., and E.: Added end note message (same as described for III.A) regarding Prohibited Entities.</p> <p>Section VI.G.7.: To the list of requirements for a family planning provider to be reimbursed, added, “The provider must not be a Prohibited Entity as defined in III.C. above.”</p> <p>Section VII.F. and G.: Added References for APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) and Public Law No. 119-21, H.R.1, 119th Congress. (2025)</p> <p>Per Oct. 7 IQI discussion, “federal” was added to all end note descriptions of “Medicaid reimbursement.” End note 3 relating to VI.E. Abortion-related services was further altered: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p>Associate Director for UM Regulations Tony Hightower’s attendance was delayed, so Anna Campbell presented. In this policy, we are addressing the federal H.R.1 bill, which DHCS covered in APL 25-011. We defined the term “prohibited entity” and then we added footnotes throughout to reference this bill and the fact that, although we say ‘you can go wherever you want,’ we will not be able to pay prohibited entities.</p> <p>There were no questions and no discussion. Dr. Moore acknowledged that the policy changes were approved without objection.</p>	<p>Motion to approve as presented: Steven Gwiazdowski, MD Second: Brian Montenegro, MD <i>Approved unanimously</i></p> <p><u>Next Steps:</u> Nov. 12 PAC</p>
<p>MPUP3035 – Preoperative Day Review</p>	<p>During annual review, this policy was updated to remove old criteria.</p> <p>Section I.B.: Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management</p>	<p>Motion to approve as presented: Robert Quon, MD</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Section III.: In the Definition of Preoperative Day, description was generalized to refer to “patients admitted before surgery,” without reference to the number of days. Also removed language describing “InterQual®” and specified “medical necessity criteria” instead. Remove language about UM Leadership being involved in the review.</p> <p>Section IV.: Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead.</p> <p>Section VI.B.2. – 2.b.: Updated language describing how a nurse coordinator reviews a preoperative day request. Removed direct reference to InterQual and added reference to policy MPUP3139 Criteria and Guidelines for Utilization Management.</p> <p>Section VIII.A.: Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System.</p> <p>APPENDIX: Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews.</p> <p>This was an annual review, and UM decided to remove what was called Appendix A. For a long time, it said Partnership would look at criteria from the ASA to determine if someone needed a preoperative day, but now we have decided we are using the InterQual® criteria and other things, Anna noted. So, we deleted that appendix and referenced our policy MPUP3139, which defines all the criteria that we might use for management, and then we talked about using InterQual.®</p> <p>There were no questions or comments.</p>	<p>Second: Randy Thomas, MD <i>Approved unanimously</i></p> <p><u>Next Steps:</u> Nov. 12 PAC</p>

VI. Presentation

Health Equity Grand Analysis – Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)

This health disparity analysis compares 2024 performance to that of 2023, stratifying for race and no other demographics. We got the data from Health Analytics team, who did a plan wide assessment of many of our disparities. We then compared these stratifications against the minimum performance level (MPL). And from there were looked at the trending data. We recognize that there is an issue with data quality, so there are certain measures we did not include (e.g., FUM and FUA).

We do have to look at where we have made improvement. The key ones are the Well Child Visits for the First 15 months and the 15-to-30 months, Lead Screening in Children (LCS), and even Blood Pressure Control. In the context of well child visits, a majority of our race groups actually improved in 2024 above 2023 and met what we were looking for; however, although the 15-month plan-wide composite at 67.05% exceeded the minimum performance level, only the Hispanic and Pacific Islander racial groups exceeded the MPL. When we look at Child and Adolescent Well Care Visits, we see that most groups improved in 2024 over 2023 performance; however, only Hispanics and those identified as “multi-racial” exceeded the MPL. This is an example where a systemic issue may be why a majority of all race groups are not able to attend these WCVs.

Then there is the classic, even textbook, examples of a health disparity for LSC in Black children and in Immunizations for Adolescents (IMA), especially for our White or Caucasian members. In 2024, results actually trended down from 2023 in LCS for Black members and in IMA for White members. We may want to do an intervention to help address these concerns for these communities.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>For Cervical Cancer (CCS) and Breast Cancer Screening (BCS), a majority of members are not at the MPL. (We do not have colorectal cancer screening data, so that is excluded from this analysis.) Tribal members, although showing a 7.66% gain in 2024 still remain below the BCS MPL. In 2024 BCS, Black members fell slightly below the MPL, while White members remained below the MPL fairly static to 2023 performance. We may want to prioritize BCS for the Tribal community.</p> <p>We looked at the data regarding the prenatal and postpartum care measures. I do recognize that we didn't meet the minimum for both the prenatal and postpartum care, but I recognized too that we really barely met the minimum for the prenatal care measures, so those might be key priorities for us. And then this is another example where we found a specific disparity: our post-partum care measure composite was at 89.5 %, but then again, our Black members, who had the highest 2023 rates, fell below the MPL in 2024. We may want to do an intervention to address this disparity. (The Tribal community showed notable improvement, hovering at the MPL.)</p> <p>Dr. Moore thanked Dr. Jalloh for “the quick and easy to absorb” presentation. Dr. Moore noted that we have previously looked at the LSC disparity in the Black community: because it tends to be concentrated in certain areas, it can be driven by provider performance, as he sees it within the Primary Care Provider Quality Incentive Program (PCP QIP) performance. Other providers, like La Clinica, CommuniCare+OLE, and Northbay, have “high” rates, he said, adding that in this case, the disparity is not a systemic issue as much as a provider targeted issue.</p> <p>Dr. Jalloh thanked him for putting this in context. ‘And that is one way we can approach a lot of these disparities,’ he said. “We recognize that while there’s a big plan-wide measure, we recognize that there are certain health systems that are the big driver: a perfect example is that for African Americans, a majority of them are actually seen at Family Health Services in Solano County, so we recognize that if we do a targeted intervention there, that likely will have the impact at the plan wide measure versus trying to do something across all of our regions.” In another caveat, Dr. Jalloh noted that 2023 results include only the 14 “legacy” counties, while the 2024 results cover Partnership’s current 24 counties. Therefore, a comparison of 2025 data against 2024 could be more telling. Meanwhile, DHCS is still holding us accountable to the data for this year, he said.</p> <p>Dr. Moore said low composite BCS in the Native American community is being driven by a certain provider. In 2023, all of our providers had an equally low rate but in 2024, although not enough to get the rate high, “a couple of providers did really well.” Moore noted that the rates of the K’ima:w Medical Center, which serves the Hoopa, dramatically improved, as did those of the Sonoma County Indian Health Project. Round Valley actually scored the highest on the BCS of any provider for the Native American population, “which is a big victory as they struggled so much with quality,” he said, inviting Q/UAC to “guess what the common denominator was?” It was the mobile mammography units going out to the rural areas. “I think that is a good example of a particular intervention eliminating a disparity, at least in a local area,” Dr. Moore concluded.</p> <p>Doctors Moore, Jalloh, and Associate Medical Director Marshall Kubota, MD, had a brief discussion on how “multi-racial” although not graphed in the presentation’s WCV in the First 15 comparisons can present anomalies. This is something we continue to work on with Health Analytics as “the data from the State is frankly awful,” Dr. Moore said. “We can look for broad trends and make some general conclusions but, to refresh everyone’s memory, if someone picks ‘Hispanic plus anything,’ ‘Hispanic’ trumps, and everything else is ignored. If you’re non-Hispanic, and you pick one race, then you’ll see it. If you pick more than one race, some of them end up in ‘multi-race,’ some end up in ‘unknown,’ some end up in ‘other’ and it is completely uninterpretable. And the percentage of our members who are in those (categories) has been growing dramatically in the last few years. DHCS is planning to make some changes in the next few years as there are new federal requirements for changing the way race is done. The net effect, just so no one is surprised, will be a big decrease in the Hispanic population just because of data. So that will give us a new fresh start to look at it with a little better lens.”</p> <p>Q/UAC voter Robert Quon, MD, said he noticed that the Black demographic dropped in almost every single graph presented, whereas most of the others stayed about the same or climbed: the 10-county expansion alone or a single provider can’t account for this. “We often talk about rural counties (with) mobile mammography, but for our working class people who can’t get to wherever, childcare or whatever, do we think about those mobile resources for those communities that are not rural but are urban and just don’t have access? With Medi-Cal, we provide transportation because these are people that don’t have the same mobility.”</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Dr. Jalloh thanked Dr. Quon for his comments. Dr. Moore added that although there are fewer Blacks in the new counties, they do perform worse than those in the Fairfield region, where most of our African Americans are located. Dr. Jalloh talked of a likely intervention. “One project that we are actually starting is trying to work with integrating community health workers into areas where a lot of African American community members attend,” Dr. Jalloh said. “Key are barber shops for Black men and beauty salons for (many) Black women. And we're currently working in contracting to be actually able to train some of these barbers, these beauty salon people to be CHWs where they can provide a lot of that education so we can hopefully improve that.”</p> <p>Q/UAC voter John Murphy, MD, said “we have a mobile mammography van that Partnership helps us facilitate that is parked a 100 yards away from the Sutter mammography. It’s an access and trust issue, and we get people in that way. We find value in bringing the (mobile) mammography very close and we appreciate Partnership’s flexibility in granting us that.”</p> <p>Dr. Murphy also noted that for the American Indian Alaksa Native, “there were pediatric measure results that essentially doubled, which could be just a performance increase (but) it could also be a data issue. That would be interesting to hear more about. In some measures, there are important structural issues, and in some measures there’s an important element of member choice or parent/guardian choice, especially around IMA. I don’t mean to blame the member. We have to be careful about that. For lead screening, that seems more structural: I haven’t had a parent yet say ‘do not screen my child for lead.’ I wonder how one would tailor an approach to disparity given that framework?”</p> <p>Dr. Jalloh acknowledged this distinction, saying many “members feel a little bit more empowered to say, ‘no, I don't want the flu shot.’ That’s where we may want to tailor our interventions to make sure ones that are more provider leaning” is “where we try to focus with more interventions. The ones that are more member driven, that’s where we may want to focus more community engagement.”</p> <p>Dr. Jalloh added that data is improving with the recent advent of our new vendor, DataLink. Interim Senior Director for Quality and Process Improvement Isaac Brown added that our auditors allowed us to run a supplemental project to look at medical charts for our early well-child visits. “It was a major lift, but in talking to the providers, we felt like they were doing the work. We just weren't seeing it in the data; (with) the supplemental data project, we jumped from the 25th percentile to the 75th percentile.”</p> <p>Manager of Quality Measurement Sue Quichocho noted, in looking at the medical records, that in some cases if the child was brought in for a sick visit, there was enough documentation within that sick visit that met the WCV requirements. At the end of October, we are conducting a “kaizen” to go this because in some instances there were no claims filed.</p> <p>Regional Medical Director Colleen Townsend, MD, said while we’ve seen access improvements in Solano County, “we are still struggling with some of those postpartum follow-ups in particular because the delivery hospital doesn't provide all the postpartum care. We've had a really great system in place for babies, but for the moms that's been a little bit more challenging. We need to look at that more carefully. We have seen some disparities in other counties where the population of Black members is smaller but still has impact in terms of noting the disparity and the decrease over time.” Dr. Murphy concurred: “It would be hard to overstate the significance of the birthing center being across the hill. Even though it seems fairly close compared to a frontier county, that is a barrier, and where we run our data and where we have missing newborns and missing moms, it’s for those patients that weren’t assigned to us: we saw them for their prenatal care and mother and infant just kind of disappeared after they delivered somewhere else.”</p> <p>Q/UAC voter Randy Thomas, MD, said with regard to IMA that “I have seen more refusals, particularly of the HPV. We've had refusals or postponements in the White population for a good while and we've had a lot more refusals in the Black population recently. And some of those refusals aren't total refusals, it's just ‘I don't want it now’ and you know sometimes they might get the vaccine when they're 14 or 15, but that's not included in these statistics.”</p> <p>Dr. Kubota asked if birth order is a factor in postpartum visits. Dr. Townsend said some practices may have anecdotal evidence that they see more primiparous moms following up and fewer multiparous moms but that is not something Partnership has differentiated. Dr. Moore said “overall, the postpartum rate is our best measure</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>across the board at Partnership. It's notable that there was a drop (from 97% to 76.56%) for the African American population. The adolescent vaccination rate is way lower than that.”</p> <p>Q/UAC voter Steven Gwiazdowski, MD, wondered if this is a “regression to the mean kind of thing going on because they (Blacks) were the highest performer there.” Dr. Townsend added this may be an opportunity to better utilize doulas, “particularly in Solano County, (where) we probably have the largest network of doulas of color that may be able to engage differently to support that postpartum visit. Our doula network in 2024 was really just burgeoning, so to speak, and our network has completed a number of local trainings that may really support the educational pathway to help moms get back to their prenatal care provider for a postpartum visit within the first three months.”</p>	
<p>VII. Adjournment</p>		
	<p>Dr. Moore adjourned the meeting at 8:54 a.m.</p> <p><i>Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI</i></p> <p>Signature of Approval: _____ Date: _____</p> <p><i>Robert Moore, MD, MPH, MBA</i> <i>Chief Medical Officer</i></p>	

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

Date: Tuesday, Oct. 7, 2025

Time: 1:30 - 3:25 p.m.

Locations:

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

To Join by Webex:

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

To Join by Telephone:

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

	Item	Lead	Time	Page #
I.	Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes			
I	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of Sept. 9, 2025	Mark Netherda, MD	1:30	5 – 12
2	<i>Acknowledgment and Acceptance of draft minutes of the</i> <ul style="list-style-type: none"> Sept. 25 Substance Use Internal Quality Improvement (SUIQI) Committee 			13 – 22
II.	Old Business – None			
III.	New Business – Consent Calendar Policies			
	Consent Calendar			23
Health Services Departments	Behavioral Health			
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members (<i>previously MCUP3103</i>)			25 – 29
	MPBP8007 – Screening and Treatment for Substance Use Disorders (<i>previously MCUP3101</i>)			31 – 50
	MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>previously MPCP2017</i>)			51 – 58
	MPBP8013 – Eating Disorder Management Policy			59 – 66
	Care Coordination			
	MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines – ARCHIVE – <i>see new Behavioral Health policy MPBP8011</i>	All	1:37	67 – 78
	Utilization Management			
	MCUP3101 – Screening and Treatment for Substance Use Disorders – ARCHIVE – <i>see new Behavioral Health policy MPBP8007</i>			79 – 98
	MCUP3103 – Coordination of Care for Child-Welfare Involved Members – ARCHIVE – <i>see new Behavioral Health policy MCBP8015</i>			99 – 103
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			105 – 107
	MCUP3012 – Discharge Planning (Non-capitated Members)			109 – 111
	MCUP3050 – Medication Abortion in the First Trimester			113 – 125
	MCUP3052 – Medical Nutrition Services			127 – 136

	Item	Lead	Time	Page #
	MCUP3115 – Community Based Adults Services			137 – 145
	MCUP3128 – Cardiac Rehabilitation			147 – 152
	MCUP3130 – Osteopathic Manipulation Treatment			153 – 155
	MPUP3078 – Second Medical Opinions			157 – 159
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			161 – 163
Non HS	Grievance & Appeals			
	CGA022 – Member Discrimination Grievance Procedure			165 – 170
IV.	New Business – Discussion Policies			
	Synopsis of Changes			171 – 173
Health Services	Behavioral Health			
	MPBP8003 – Mental Health Services	Jeff DeVido, MD	1:45	175 – 210
	Enhanced Health Services			
	MPAP7003 – CalAIM Community Supports (CS) – <i>previously MCAP7003</i>	Lisa O’Connell, MHA	1:55	211 – 239
	Utilization Management			
	MCUP3015 – Family Planning By-Pass Services	Tony Hightower, CPhT	2:05	241 – 244
MPUP3035 – Preoperative Day Review	2:15		245 – 248	
V.	Presentations			
1	Quality Improvement Update	Isaac Brown, MHA/MBA	2:25	249 – 258
2	Health Equity Grand Analysis	Mohamed Jalloh, Pharm.D	2:30	259 – 274
3	Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set	Athena Beltran Nampraseut	2:45	275 – 280
4	Proposed 2026 Enhanced Care Management (ECM) QIP Measure Set	Deanna Watson	2:55	281 – 284
5	Proposed 2026 Palliative Care QIP Measure Set	Eva Lopez, CPhT	3:05	285 – 286
VI.	Adjournment by 3:25 p.m. to 1:30 p.m. Tuesday, Nov. 11, 2025			

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

Tuesday, Oct. 7, 2025 / 1:31 – 3:19 PM

Members Present:

Ayala, Priscila, Director of Network Services
 Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
 Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
 Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
 Brown, Isaac, MHA/MBA, Interim Sr. Dir. of Q & P Improvement
 Brundage O’Connell, Lisa, MHA, Director of Enhanced Health Services
 Brunkal, Monika, RPh, Assoc. Dir., Population Health
 Campbell, Anna, Policy Analyst, Utilization Management
 DeVido, Jeff, MD, Behavioral Health Clinical Director
 Esget, Heather, RN, BSN, ACM, Director of Utilization Management
 Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
 Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI¹

Hightower, Tony, CPhT, Associate Director, UM Regulations
 Innes, Latrice, Manager of Grievance & Appeals Compliance
 Jalloh, Mohamed “Moe,” Pharm.D, Health Equity Officer
 Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services
 Klakken, Vicki, Regional Director (Northwest)
 Leung, Stan, Pharm.D, Director of Pharmacy Services
 Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
 Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
 Randhawa, Manleen, Senior Health Educator, Population Health
 Ruffin, DeLorean, DrPH, MPH, Director of Population Health
 Villasenor, Edna, Senior Director, Member Services and G&A
 Ward, Lisa, MD, Regional Medical Director (Southwest)
 YoungStone, Kelly, RN, Director of Care Coordination, Care Coordination

Members Absent:

Andrews, Leigha, MBA, Regional Director (Southwest)
 Bjork, Sonja, JD, Chief Executive Officer
 Davis, Wendi, Chief Operating Officer
 Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
 Kerlin, Mary, Senior Director, Provider Relations

Matthews, Richard “Doug,” MD, Regional Medical Director (Chico)
 Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
 Sharp, Tim, Regional Director (Northeast)
 Townsend, Colleen, MD, Regional Medical Director (Southeast)
 Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Akintan, Folo, MBBS/MD MPH MBA, Epidemiologist, Population Health
 Allen, Angier, Senior Data Scientist I, Finance
 Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)
 Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance
 Bushey, Lindsey, Project Manager I, QI
 Chiang, Yuen, Program Manager I, Utilization Management
 Clark, Kristen, Manager, Quality & Training, Member Services
 Conner, Maria, Improvement Advisory, QI (Auburn)
 Cunningham, Aryana, Policy Analyst, Care Coordination
 Devan, James, Sr. Mgr. of Performance Improvement, QI (Redding)
 Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)
 Escobar, Nicole, Sr. Mgr. of Behavioral Health, Behavioral Health
 Flournoy, Candi, Project Manager II, QI
 Hanusiak, Kenzie, Sr. Mgr., Regulatory Affairs & Compliance (RAC)
 Harris, Vander, Senior Health Data Analyst I, Finance
 Hendrix, Hillary, Exec. Asst. to the Sr. Dir. of Behavioral Health

Lee, Donna, Manager of Claims, Claims
 Legere, James, Administrative Assistant I, Regional Administration (Chico)
 Leung, Paul, Sr. Health Data Analyst I, Finance
 O’Leary, Hannah, Manager of Population Health, Population Health
 McCune, Amy, Manager of Quality Incentive Programs, QI
 Moraghebi, Roudabeh, Manager of Health Analysts, Finance
 Moore, Jordan, Education Specialist, Provider Relations
 Morris, Matthew, MD, Regional Medical Director (Auburn)
 Muncy, Kellie, Mgr of Change Management & Configuration, Configuration
 Quichocho, Sue, Manager of Quality Measurement, QI
 Rathnayake, Russ, Senior Health Data Analyst I, Finance
 Salehi, Tiphonie, Sr. Health Data Analyst I, Finance
 Seale, J’aime, PR Lead, Network Services
 Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
 Smith, Christine, Community Health Needs Liaison, Population Health
 Thomas, Penny, Senior Health Data Analyst I, Finance
 Trosky, Renee, Manager of Provider Relations Compliance, Network Services

¹ Effective immediately, Kristine is now a voting IQI member, and her position title will be added to the IQI policy member matrix on its annual next review, March 2026.

Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Tryan, Tiffany, Senior Improvement Advisor, QI (Redding)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)	Vance, Brooke, Program Manager I, Network Services
Kubota, Marshall, MD, Associate Medical Director	Watson, Deanna, Program Manager I, QI (ECM QIP)
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance (RAC)	Yu, Fei, Senior Data Scientist I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order <ul style="list-style-type: none"> • Introductions • Approval / Acceptance of Minutes 	<p>Medical Director for Quality and IQI Vice Chair Mark Netherda, MD, called the meeting to order at 1:31 p.m. in the planned absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA.</p> <p>RAC Senior Manager Kenzie Hanusiak introduced RAC Policy Analyst Shreya Kulkarni, JD, who is now training to look at policies for an enterprise-wide compliance review. Hillary Hendrix introduced herself as Mark Bontrager’s executive assistant.</p> <ul style="list-style-type: none"> • Approval of the Sept. 9, 2025 IQI Minutes • Acknowledgment and Acceptance of the draft minutes of the <ul style="list-style-type: none"> ○ Sept. 25, 2025 Substance Use Internal Quality Improvement (SUIQI) Committee 	<p>Motion to approve IQI Minutes: Issac Brown Second: Tony Hightower</p> <p>Motion to accept SUIQI minutes: Lisa O’Connell Second: Katherine Barresi, RN</p>
II. Old Business - None		
III. New Business Consent Calendar (Committee Members as applicable)		
<p>Health Services Policies</p> <p><u>Behavioral Health</u></p> <p>MCBP8015 – Coordination of Care for Child Welfare-Involved Members (<i>previously MCUP3103</i>)</p> <p>MPBP8007 – Screening and Treatment for Substance Use Disorders (<i>previously MCUP3101</i>)</p> <p>MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>previously MPCP2017</i>)</p> <p>MPBP8013 – Eating Disorder Management Policy</p> <p><u>Care Coordination</u></p> <p>ARCHIVE MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>now MPBP8011</i>)</p> <p><u>Utilization Management</u></p> <p>ARCHIVE MCUP3101 – Screening and Treatment for Substance Use Disorders (<i>now MPBP8007</i>)</p> <p>ARCHIVE MCUP3103 – Coordination of Care for Child Welfare-Involved Members (<i>now MCBP8015</i>)</p> <p>MCUG3032 – Orthotic and Prosthetic Appliances Guidelines</p> <p>MCUP3012 – Discharge Planning (Non-capitated Members)</p> <p>MCUP3050 – Medication Abortion in the First Trimester</p> <p>MCUP3052 – Medical Nutrition Services – <i>pulled for comment by Anna Campbell</i></p> <p>MCUP3115 – Community Based Adult Services</p> <p>MCUP3128 – Cardiac Rehabilitation</p> <p>MCUP3130 – Osteopathic Manipulation Treatment</p> <p>MPUP3078 – Second Medical Opinion</p> <p>MPUP3116 – Positron Emission Tomography Scans (PET Scans)</p> <p>Non-Health Services Policies</p> <p><u>Grievance & Appeals</u></p> <p>CGA022 – Member Discrimination Grievance Procedure</p>		<p>Motion to approve slate without MCUP3052: Lisa O’Connell Second: Katherine Barresi, RN</p> <p><u>Next Steps</u>: All policies will go to the Oct. 15 Quality/ Utilization Advisory Committee (Q/UAC) and to the Nov. 12 Physician Advisory Committee (PAC)</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Anna Campbell pulled MCUP3052 to discuss alongside MPAP7003 – CalAIM Community Supports (CS). IQI thereafter agreed that MPAP7003 would be amended to define Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) and to see that MCUP3052’s language jibed accordingly. Motion to approve an altered MCUP3052: Anna Campbell/Second: Lisa O’Connell.</p> <p>Kellie Muncy asked if the federal HR1 provisions affected MCUP3050, Medication Abortion in the First Trimester. Anna replied that they do not but they do affect MCUP3015 – Family Planning By-Pass Services, which is one reason that policy is on discussion today.</p>	
<p>IV. New Business – Discussion Policies</p>		
<p>Policy Owner: Behavioral Health – <i>Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director</i></p>		
<p>MPBP8003 – Mental Health Services</p>	<p>Updates made to align with new All Plan Letter (APL) 25-010 Adult and Youth Screening and Transition Tools for Mental Health Services which allows for a clinician to override the result of the screening tool if it is inconsistent with the clinical presentation of the member.[VI. B. 3] Adds Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization [VI.I.3] Section III Definition added for (BHP) county Behavioral Health Plan Footnotes: <ol style="list-style-type: none"> 1. Clarifies how ECT services are covered in Medi-Cal and Medicare Advantage 2. Identifies that TMS is a covered benefit in both systems of care, Specialty Mental Health Services (SMHS) and NSMHS <p>Dr. DeVido noted that many of the language changes reflect the Carelon de-delegation for some call center activities Partnership has now brought in-house. TMS related to treatment of depression and other conditions is newly covered under NSMHS: the State has issued a fee schedule, and the Department of Health Care Services (DHCS) has approved our policy language. Partnership will continue to cover aspects of hospital-based care for electro convulsive therapy (ECT), although the procedure delivery itself is the responsibility of the counties under SMHS; thus, coordination between the two systems of care will be necessary.</p> <p>Kenzie Hanusiak suggested adding MCUP3041 Treatment Authorization Request Review Process to the Related Policies list because TMS does require prior authorization. Dr. DeVido had no objection to this addition, although he noted that a separate TMS TAR policy is in development. The IQI Committee agreed to this amendment. Anna noted also that she will accordingly amend the TAR list (MCUP3041-A), bringing that to November committees for approval.</p> <p>Dr. DeVido added that how we ensure we won’t duplicate services across the two systems of care has yet to be determined and is made difficult because of claims lag with the counties. Very few counties, however, actually offer TMS because it involves purchasing a machine and training personnel in its operation and use. Marin County, for example, utilizes an outside vendor for this purpose, he said.</p> <p>Chief Health Services Officer Katherine Barresi, RN, commented that Partnership may need to impose attestation responsibility on the provider or refer to contracts. She cautioned against becoming “helicopter pilots for all things for all patients at all times.”</p> </p>	<p>Motion to approve as amended: Lisa O’Connell Second: Stan Leung, Pharm.D</p> <p><u>Next Steps:</u> Oct. 15 Q/UAC Nov. 12 PAC</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Kenzie noted that DHCS is telling us we have to report usage within 30 days or we can't keep the monies. Senior Director of Behavioral Health Services Mark Bontrager added that TMS became a NSMHS benefit because it wasn't being provided much under SMHS, adding that Partnership does do a retrospective review to make sure that there isn't duplication of services.</p> <p>Director of Pharmacy Services Stan Leung, Pharm.D, said APL 25-013 (09/18/25) should supersede APL 22-012 in this and other policies. Anna responded she has been waiting to do this because we haven't done gene therapy yet. Dr. DeVido asked if this is inclusive of gene assays? Stan said no, this APL relates to sickle cell anemia therapies. The Committee accepted this amendment too.</p>	
<p>Policy Owner: Enhanced Health Service – Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services</p>		
<p>MPAP7003 – CalAIM Community Supports (CS) (previously MCAP7003)</p>	<p>Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services:</p> <ul style="list-style-type: none"> • Deposits [See VI.F.2.] • Short-Term Post Hospitalization Housing [See VI.F.4.] • Recuperative Care [See VI.F.5] • Medically Tailored Meals and Groceries (MTM/G) [See new VI.F.6.] • Asthma Remediation – service will be added Jan. 1, 2026 [See new VI.F.11.] • Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.) <p>Section III Definitions added for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent</p> <p>III.J - Transitional Rent: Effective Jan. 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.</p> <p>Section VI.C Member Identification and Referral for Community Support Services is updated with track and trending provisions.</p> <p>Section VII. References are updated with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and initial policy references to these APLs are hyperlinked.</p> <p>Attachment A: Deleted the matrix as this information is in the DHCS Policy Guides and codes are listed on our website in other materials. Information changes frequently so decision to delete matrix was made since information is provided in other materials. Updated information and made changes to Deposits, Short-Term Post Hospitalization Housing, Recuperative Care, Medical Tailored Meals/Groceries and added new service, Asthma Remediation.</p> <p>Lisa went through the synopsis. Partnership can no longer cover first and last month deposits; however, we can cover security deposits, she said in response to a question from Dr. Netherda. Members will need to find first and last through other sources.</p>	<p>Motion to approve as amended: Katherine Barresi, RN Second: Isaac Brown</p> <p><u>Next Steps:</u> Oct. 15 Q/UAC Nov. 12 PAC</p> <p>Consider including this definition in any policy mentioning “registered dietician” as it renews: “Registered Dietician (RD) or Registered Dietician Nutritionist (RDN): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Medically Tailored Meals sections are updated to allow more education time, so MTM themselves do not become a lifetime commitment. Metrics have been added for re-authorization. MTM has been removed from the Attachment A grid.</p> <p>VI.F.4.a.3 is corrected to read “meeting of any of the following criteria:”. Dr. Netherda noted that as this policy’s added definition of Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) be carried forward in Medical Nutrition, Lactation and other policies: that is, all policies going forward that only speak of RDs should also mention RDNs. Anna Campbell suggested that Credentialing staff and the Credentials Committee might be consulted. RD/RDN definition is added at III.I for Q/UAC’s consideration Oct. 15.</p> <p>Associate Medical Director Marshall Kubota, MD, expressed concerns that the \$7500 remediation limit for the relief of asthma wouldn’t go very far, and Lisa said these monies will likely be used to pay for air filters, air circulation system, and the like, but licensed contractors cannot be found to work on such small projects. Anna wondered whether these provisions would need to be written into the asthma clinical practice guideline MPXG5001 (due for annual update in May 2026): no one had a ready answer.</p>	<p>Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)”</p>
<p>Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations</p>		
<p>MCUP3015 – Family Planning By-Pass Services</p>	<p>This policy is being updated to describe Prohibited Entities as per H.R.1. and APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025).</p> <p>Section III.A: Added end note 1 to the definition of Bypass Services to say: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p>Section III.C: Added Definition of Prohibited Entity</p> <p>Sections VI.B., C., and E.: Added end note message (same as described for III.A) regarding Prohibited Entities.</p> <p>Section VI.G.7.: To the list of requirements for a family planning provider to be reimbursed, added, “The provider must not be a Prohibited Entity as defined in III.C. above.”</p> <p>Section VII.F. and G.: Added References for APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) and Public Law No. 119-21, H.R.1, 119th Congress. (2025)</p> <p>Tony went though the synopsis. “Prohibited entities” in Partnership’s footprint include all Planned Parenthood clinics and three Women’s Health Specialist clinics organizations. It does not include OB/Gyn practices, Tony said in response to a question from Dr. Kubota.</p> <p>Anna and Kenzie discussed some of the new federal prohibitions. Kenzie clarified that Planned Parenthood can at their own cost provide certain services to our members, but they may not charge Partnership for these services. Kenzie said that footnote 3 as written would seem to imply that Partnership would not reimburse prohibited entities at all when we actually still may reimburse contracted state supportive services using a limited set of codes and not using any federal dollars. Mark Bontrager suggested inserting “federal” before “Medicaid” in all three end notes; both Tony and Kenzie agreed to that clarification. For end note 3 only, Kenzie</p>	<p>Motion to approve as presented: Lisa O’Connell Second: Anna Campbell</p> <p>After further discussion, the policy approval was amended (O’Connell/Campbell) with the changing of footnote 3 to read “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive <i>federal</i> Medicaid reimbursement. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p><u>Next Steps:</u> Oct. 15 Q/UAC</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>recommended removing the second sentence “as such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members” for accuracy.</p>	Nov. 12 PAC
<p>MPUP3035 – Preoperative Day Review</p>	<p>During annual review, this policy was updated to remove old criteria.</p> <p>Section I.B.: Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management</p> <p>Section III.: In the Definition of Preoperative Day, description was generalized to refer to “patients admitted before surgery,” without reference to the number of days. Also removed language describing “InterQual®” and specified “medical necessity criteria” instead. Remove language about UM Leadership being involved in the review.</p> <p>Section IV.: Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead.</p> <p>Section VI.B.2. – 2.b.: Updated language describing how a nurse coordinator reviews a preoperative day request. Removed direct reference to InterQual and added reference to policy MPUP3139 Criteria and Guidelines for Utilization Management.</p> <p>Section VIII.A.: Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System.</p> <p>APPENDIX: Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews.</p> <p>Tony went through the synopsis. There were no questions.</p>	<p>Motion to approve as presented: Lisa O’Connell Second: Lisa Ward, MD</p> <p><u>Next Steps:</u> Oct. 15 Q/UAC Nov. 12 PAC</p>
<p>V. Presentations</p>		
<p>QI Update – <i>Isaac Brown, MPH/MBA, Interim Senior Director, Quality Improvement and Performance</i></p>		
	<ul style="list-style-type: none"> • All are invited to participate in the Improvement Academy’s 2026 Improving Measure outcome webinar series: <ul style="list-style-type: none"> ○ 2/11: Pediatric Preventive Care (0-30 months) ○ 2/25: Pediatric Preventive Care (3-17 years) ○ 3/11: Preventive Cancer Screenings ○ 3/25: Chronic Disease ○ 4/8: Sexual Health Screenings ○ 4/22: Perinatal Care • Joint Leadership Initiative (JLI) sessions are coming up in 2025 to help us raise our scores in the Eastern and Redding regions: <ul style="list-style-type: none"> ○ 10/14: WellSpace Health ○ 10/20: Oroville Hospital ○ 10/21: Shasta Community Health Center ○ 11/3: Ampla Health ○ 11/17: MCHC ○ 12/8: Western Sierra Medical Center • Twenty three of the original 26 providers organizations are still participating in the Equity & Practice Transformation Project. (Fairchild Medical Clinic, Lassen Indian Health Clinic and Northern Valley Indian Health dropped for limited band width or limited staff.) Partnership is proceeding with DHCS-approved option allowing us to submit self-produced quality measure rates using the California Technical Specifications (CATs) so that performance can be tracked for all EPT deliverables that include Healthcare 	<p><i>For information only.</i></p> <p>Dr. Netherda encouraged physicians and coding support personnel to attend Dr. Kermit Jones’ Oct. 8 webinar addressing coding acuity for the Dual-eligible Special Needs Plans (D-SNP).</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Effectiveness Data Information Set (HEDIS®)-like measures. The HEDIS® team will move forward with preparing CATs rates for all EPT sites for Measurement Year 2024.</p> <ul style="list-style-type: none"> • The Preventive Care Bridge Project continues with locum providers at four provider sites. Nearly 1,100 Partnership members have been seen by locums June 30 to date. • The Mobile Mammography program provided services to Partnership members during 21 event days plan-wide in the first quarter of Fiscal Year 2025-2026. • The QI Trilogy team is now reviewing subject matter experts’ suggested opportunities for improvement re tools, resources and practices to enhance document preparation and submission for the upcoming FY 2025-2026 QI Trilogy season. • The Medicare Quality team is developing an approach to share a Stars analytic tool and DHCS measure information with key stakeholder in a centralized, cloud-based format. • The Site Review team conducted 23 facility site reviews (FSR) and 22 medical record reviews (MRR), issuing five FSR Corrective Actions Plans (CAPs) and 12 MRR CAPs across the HealthPlan between Aug. 25 and Sept. 26. 	
<p>Health Equity Grand Analysis – Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)</p>		
<p>This health disparity analysis utilizes Health Effectiveness Data Information Set (HEDIS®) we got in September, and compares 2024 performance to that of 2023, stratifying for race and no other demographic. The Health Analytics team did a plan wide assessment of many of our disparities. We then compared these stratifications against the minimum performance level. And from there were looked at the trending data. We recognize that there is an issue with data quality, so there are certain measures we did not include (e.g., FUM and FUA).</p> <p>We do have to look at where we have made improvement. The key ones are the well child visits for the first 15 months and the 15-to 30 months, lead screening, and even blood pressure control. In the context of well child visits, a majority of our race groups actually improved in 2024 above 2023 and met what we were looking for; however, although the 15-month plan-wide composite at 67.05% exceeded the minimum performance level, only the Hispanic and Pacific Islander racial groups exceeded the MPL. When we look at Child and Adolescent Well Care Visits, we see that most groups improved in 2024 over 2023 performance; however, only Hispanics and those identified as “multi-racial” exceeded the MPL. This is an example where a systemic issue may be why a majority of all race groups are not able to attend these WCVs</p> <p>Then there is the classic, even textbook, examples of a health disparity for Lead Screening (LSC) in Black children and in Immunizations for Adolescents (IMA), especially for our White or Caucasian members. In 2024 results actually trended down from 2023 in LCS for Black members and in IMA for White members. We may want to do an intervention to help address these concerns for these communities.</p> <p>For Cervical Cancer (CCS) and Breast Cancer Screening (BCS), a majority of members are not at the MPL. (We do not have colorectal cancer screening data, so that is excluded from this analysis.) Tribal members, although showing a 7.66% gain in 2024 still remain below the BCS MPL. In 2024 BCS, Black members fell slightly below the MPL, while White members remained below the MPL fairly static to 2023 performance. We may want to prioritize BCS for the Tribal community.</p> <p>We looked at the data regarding the prenatal and postpartum care measures. I do recognize that we didn't meet the minimum for both the prenatal and postpartum care, but I recognized too that we really barely met the minimum for the prenatal care measures, so those might be key priorities for us. And then this is another example where we found a specific disparity: our post-partum care measure composite was at 89.5 %, but then again, our Black members, who had the highest 2023 rates, fell below the MPL in 2024. We may want to do an intervention to address this disparity. (The Tribal community showed notable improvement, hovering at the MPL.)</p> <p>In response to a question from Senior Manager for Regulatory Affairs and Compliance Kenzie Hanisiak, Dr. Jalloh said this information has been shared with the Community Advisory Committee (CAC) but not the Family Advisory Committee (FAC). Epidemiologist Folo Akintan, MBBS/MD, said many of the results looked close, and she suggested we utilize confidence intervals. Dr. Jalloh noted we could do this in future in year-over-year comparisons, although the State does not require it. (We do look at how NCQA wants us to approach disparities, and that informs our composites, he said.) Director of Quality Measurement Kristine Gual supported Dr. Akintan’s suggestion, saying that many of our populations are not big: for some we are looking at no more than 400 medical records, and then we stratify from there.</p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p>Kenzie noted that not all races perform the same across each region. Dr. Jalloh, cautioning that this analysis looks only at race and not other issues such as linguistic preferences or housing status, asked for suggestions on what interventions to address first. Medical Director for Quality Mark Netherda, MD, suggested that WCV interventions in the Black community might also positively impact LCS and IMA. Dr. Jalloh liked this idea.</p>		
<p>Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set – Athena Beltran-Nampraseut, CPhT, Program Manager II, QI</p>		
<p>There isn't much change in 2026 from 2025 apart from an age expansion in the Breast Cancer Screening (BCC) measure, a move of Chlamydia Screening from monitoring to an active clinical domain measure for both Family Practice and Internal Medicine, and the addition of a Kidney Health Evaluation for Patients with Diabetes (KED) in both Family and Internal Medicine. BCS now includes all persons 40-74 years old assigned female at birth. Chlamydia Screening is proposed as an active measure in Family Practice (16-24 y-o), Internal Medicine 21-24 y-o), and in Pediatrics (16-20 y-o) in all persons assigned female at birth or identifying as female. The KED measure promotes early detection in adults aged 18-85 with type 1 or type 2 diabetes who received a kidney health evaluation during the measurement year and incentivizes intervention by ensuring patients annually receive both an estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR).</p> <p>There are no changes to the Pediatric Clinical Domain set. In the Unit-of-Service (UOS) measure set, both the Early Administration of the 1st HPC Dose and the Early Administration of Initial Flu Vaccine Series are being retired because there were no discernable differences in the completion rates of early administration.</p> <p>Dr. Kubota said so many practices have an overlap of patients that perhaps, in future, Partnership should put together program packages, rather than continuing to do "one-offs" in things such as cancer screening in children. Dr. Netherda liked the idea, particularly in patients with diabetes. Athena said this was discussed in 2025 workgroups and could be again in 2026 for MY 2027.</p>		<p>The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar.</p> <p><i>Meeting Postscript:</i> PAC passed the proposal as presented.</p>
<p>Proposed 2026 Enhanced Care Managed (ECM) QIP Measure Set – Deanna Watson, Program Manager, QI</p>		
<p>No changes are proposed for 2026. Quarterly payouts on differing targets for full and partial points remain in effect for three measures: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 days; PHQ9 Depression Screening; and Controlling Blood Pressure (CBP) – Blood Pressure Screening.</p> <p>Dr. Netherda was curious how numbers are reported or counted. Isaac Brown said PointClickCare does the counting for us. He added that we are considering changing the payout to every six months, rather than quarterly because the process is so labor intensive. Auburn Regional Medical Director Matthew Mooris, MD, said that extending the reward farther out from the action can make persons forget why they are doing the action in the first place, and Chico Regional Medical Director Doug Matthews, MD, concurred.</p>		<p>The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar.</p> <p><i>Meeting Postscript:</i> PAC passed the proposal as presented.</p>
<p>Proposed 2026 Palliative Care QIP Measure Set – Deanna Watson, for QIP Program Manager Eva Lopez, CPhT</p>		
<p>Deanna presented because Eva was away at a palliative care conference. No change is recommended on the utilization measure Avoiding Hospitalization & Emergency Room Visits: \$240 PMPM if no inpatient or ED use per calendar month. Providers can still earn \$120PMPM once a signed Physician Order for Life Sustaining Treatment (POLST) is completed.</p> <p>The quality measure Completion of a Palliative Care Survey is changing to a Completion of a Standardized Patient Symptom Assessment because the Palliative Care Quality Collaborative dissolved April 17, 2025, at which time palliative care providers confirmed they all use the Edmonton Symptom Assessment System (ESAS) and could submit ESAS data directly to Partnership. Providers can earn \$120 PMPM if two standardized patient symptom assessments are completed will all essential data elements</p>		<p>The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar.</p> <p><i>Meeting Postscript:</i> PAC passed the proposal as presented.</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	included. Full and partial thresholds apply: 70% or more of all data elements are entered on the assessments equals full points. Partial points (\$60 PMPM) are available for 50-69% of data elements entered.	
VI. Adjournment		
Dr. Netherda adjourned the meeting at 3:19 p.m. IQI will meet next Tuesday, Nov. 11, 2025.		
<p data-bbox="86 337 1098 370"><i>Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement</i></p> <p data-bbox="86 378 321 410"><i>Approval Signature:</i></p> <p data-bbox="753 378 823 410"><i>Date:</i></p> <p data-bbox="86 472 321 505"><i>Mark Netherda, MD</i></p> <p data-bbox="86 505 722 537"><i>Medical Director for Quality and Committee Vice Chair</i></p>		



QI DEPARTMENT UPDATE
OCTOBER 2025
PREPARED BY ISAAC BROWN
INTERIM SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

<u>QUALITY INCENTIVE PROGRAMS (QIPs)</u>	
PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	<ul style="list-style-type: none"> Sprint season (October – December) is upon us! 10/01/2025 is the release of four (4) new upload templates: HbA1c, CBP, W15 and W15-30 All 2025 CG CAHPS results were shared with qualifying providers on September 12th ECDS measure: Late contracting period for 2025 with DataLink runs from 10/01/2025 – 12/31/2025. MY2026 proposed measures will be presented at PAC this month
PALLIATIVE CARE QUALITY INCENTIVE PROGRAM (PALLIATIVE CARE QIP)	<ul style="list-style-type: none"> MY2026 proposed measures will be presented at PAC this month 2025 January – June payment will begin processing this month
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	<ul style="list-style-type: none"> FY24/25 payment will begin processing this month
ENHANCED CARE MANAGEMENT QUALITY INCENTIVE PROGRAM (ECM QIP)	<ul style="list-style-type: none"> Q2 2025 payments will distribute this month MY2026 proposed measures will be presented at PAC this month, no proposed changes to the measure set.
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	<ul style="list-style-type: none"> FY24/25 payment will begin processing this month

<u>QUALITY DATA TOOLS</u>	
TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	<ul style="list-style-type: none"> 2025 PQD has launched! 2025 PQD Kick Off webinar has been posted to the Partnership HealthPlan public facing webpage
eREPORTS	<ul style="list-style-type: none"> 2026 eReports development has begun

<u>PERFORMANCE IMPROVEMENT (PI)</u>	
ACTIVITY	UPDATE
STATE MANDATED WORK: <i>PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE</i>	<ul style="list-style-type: none"> Southern Region (Children’s Health Domain): Work continues in Sonoma County to improve Lead Screening and Fluoride varnish. Northern Region (Children's Health, Chronic Disease, Reproductive Health & Cancer Prevention Domains): Multiple interventions are underway in the North, such as expediting newborn membership enrollment, academic detailing for

	<p>medication-based measures like asthma and diabetes, increasing mammography access through mobile mammography and fixed-imaging, and more.</p> <ul style="list-style-type: none"> • Next update to DHCS due 10/31/2025
<p>QUALITY MEASURE SCORE IMPROVEMENT</p>	<ul style="list-style-type: none"> • Pediatrics: continuing 2024-2025 work on TFL, LSC, W30+2, and W30+6. Finalizing new work on WCV, DEV, CIS 10, and IMA. <ul style="list-style-type: none"> ○ Project Focus: Partnership with Anderson RX in Shasta County to complete 3 school-focused immunization events in August 2025: Over 130 Students vaccinated <ul style="list-style-type: none"> ♣ Next event planned for spring 2026 - more students are anticipated to attend due to additional communication • Chronic Disease: Working to set measure priorities and workplan for 2025-26. DHCS has proposed removing the Asthma Medication Ratio measure from accountability following NCQA removal and is considering a replacement measure. • Women’s Health and Perinatal: No updates • Behavioral Health: The BH workgroup is looking at new proposed DHCS accountable measures and impact on prioritization of existing measures. One potential new measure is depression screening in adolescents and adults. BH workgroup is working on setting measure priorities for MY 2026. • Elder Care: This workgroup is on hiatus as we are preparing for the new DSNP launch date in 2027. The next full workgroup meeting will take place in December 2025. Until then, a smaller planning group will continue to meet monthly.
<p>IMPROVEMENT ACADEMY</p>	<ul style="list-style-type: none"> • The finalized schedule for the 2026 Improving Measure Outcomes Webinar Series has been announced. <ul style="list-style-type: none"> ○ 02/11/2026 - Pediatric Preventive Care (0 - 30 months) ○ 02/25/2026 - Pediatric Preventive Care (3 - 17 years) ○ 03/11/2026 - Preventive Cancer Screenings ○ 03/25/2026 - Chronic Disease ○ 04/08/2026 – Sexual Health Screenings ○ 04/22/2026 - Perinatal Care • Each webinar will cover Partnership’s Primary Care Provider Quality Incentive Program measures. Content will focus on direct application of best practices including eliminating health disparities with examples from quality improvement teams.
<p>JOINT LEADERSHIP INITIATIVE (JLI)</p>	<ul style="list-style-type: none"> • Recent JLI Updates <ul style="list-style-type: none"> • Solano County Family Health Services: Focused JLI on 08/18/2025 <ul style="list-style-type: none"> ○ Welcomed new Chief Operations Officer ○ Onboarding 9 new clinicians ○ Prioritizing improvements to pediatric access • Upcoming 2025 JLI meetings: <ul style="list-style-type: none"> • WellSpace Health 10/14/2025 • Oroville Hospital 10/20/2025 • Shasta Community Health Center 10/21/2025

	<ul style="list-style-type: none"> • Ampla Health 11/03/2025 • MCHC 11/17/2025 • Western Sierra Medical Center 12/08/2025 • Solano Family Health Services 12/09/2025
REGIONAL IMPROVEMENT MEETINGS	<ul style="list-style-type: none"> • The first Regional Quality Improvement meeting for the Santa Rosa Region is scheduled for 10/07/2025 and will focus on the topic of immunization measure improvement, covering strategies for vaccine hesitancy and immunization inventory management. This will take place at the Santa Rosa office, 495 Tesconi Circle in Santa Rosa, and also has a virtual option. To register for in-person attendance click here: https://www.eventbrite.com/e/santa-rosa-regional-quality-meeting-tickets-1636390009569?aff=oddtcreator. To attend virtually please send a request to the Performance Improvement team at PIT@partnershiphp.org. • The Fairfield Regional Quality Improvement meeting was held on 09/16/2025. MY2024 Topics included 2024 QIP and HEDIS rates as well as a presentation on Telehealth • The next Auburn Regional Quality meeting is scheduled for 10/06/2025, and the next Chico Regional Quality meeting is scheduled for 10/27/2025. Both of these meetings will be held virtually. For an invitation to one of these meetings please send a request to the Performance Improvement team at PIT@partnershiphp.org. • The Eureka and Redding Regional Quality Improvement meetings were held on 09/09/2025 and 09/30/2025 respectively. The QI team presented the MY2024 HEDIS results and led discussion around measure barriers and opportunities. QI also shared important dates for the PCP QIP program for the remainder of the 2025 calendar year.

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 25/26 ORG GOALS	<p>CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey.</p> <ul style="list-style-type: none"> • Pre-planning discussions for the regulated CAHPS® Survey (MY 2025) are underway. Considerations include: <ul style="list-style-type: none"> o Oversampling strategy, modifications to the mixed protocols (i.e., phone calls, mailers), and supplemental questions. o Formal population submission for 2026 NCQA Patient Experience Health Plan Star Rating. <p>Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)</p> <ul style="list-style-type: none"> • Organizational goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement.

	<ul style="list-style-type: none"> For more insights on goal progress and milestone accomplishments for Q1, please visit the OpEx PMO internal goal dashboard (Partnership4Me, under Smart Links). <p>NCQA Health Plan Accreditation Requirement Update</p> <ul style="list-style-type: none"> The Member Experience Grand Analysis (ME 7) is under review by QI leadership and Partnership’s NCQA consultant. The analysis will begin making its way through the formal Committee approval process, in November.
<p>EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS</p>	<p>Colorectal Cancer Web Page</p> <p>A new provider-facing webpage is now available on Partnership’s website to support colorectal cancer screening efforts. The page includes a variety of internal and external resources, including:</p> <ul style="list-style-type: none"> Educational Cologuard videos for providers to share with their patients (developed by the Population Health Team) Information on ordering FIT tests Links to provider and patient materials <p>The Cologuard overview outlines available screening options and includes guidance on how to effectively address care gaps.</p> <p>For more information about Colorectal Cancer Screening opportunities and resources visit https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx</p> <p>Bulk Order Offering</p> <p>All providers may bulk order Cologuard directly from Exact Sciences any time during the year by contacting PHC@exactsciences.com. No program enrollment or Partnership pre-approval is required.</p> <p>Partnership Facilitated Order</p> <p>Partnership continues to facilitate multi-patient orders, where orders are submitted on behalf of providers to Exact Sciences. Facilitated Orders removes the two hundred (200) patient minimum requirement that some providers face when placing a bulk order directly with Exact Sciences.</p> <ul style="list-style-type: none"> Seven provider orgs participated in the most recent Facilitated Order. Submissions were accepted from 07/21/2025 through 08/18/2025. Kits are tentatively scheduled to ship date on 09/29/2025. This aligns with QIP’s timeline for addressing 2025 and 2026 PCP QIP Measures. The next Facilitated Order is scheduled to launch on 01/19/2026 and is aligned with Colorectal Cancer Awareness Month in March.

<p>EQUITY & PRACTICE TRANSFORMATION PROJECT</p>	<p>PDPP Participation and Deliverables</p> <ul style="list-style-type: none">• The following three (3) provider organizations have opted out of continuing to participate in the EPT Program due to either limited bandwidth and/or staff.<ul style="list-style-type: none">○ Fairchild Medical Clinic○ Lassen Indian Health Clinic○ Northern Valley Indian Health• Per PHLC, DHCS notified Solano Family Health Services that they were removed from the EPT program for not completing the required Year 2 PhmCAT.• The remaining twenty-three (23) provider organizations are working on completing their milestone deliverables for the November 2025 EPT deliverable submissions due on 11/01/2025.• To continue participating in the EPT program, provider organizations are to follow the updated deliverable submission requirements:<ul style="list-style-type: none">○ By November 2025, practices should complete the 2025 PhmCAT and at least one additional deliverable from program year 1.○ By May 2026, practices should complete the 2026 PhmCAT and successfully submit the following deliverables:<ul style="list-style-type: none">▪ Data Policy & Procedure▪ Empanelment Policy & Procedure▪ Data Implementation Plan▪ Disparity Reduction Plan▪ One Model of Care deliverable <p>EPT MCP Reporting Requirements</p> <p>DHCS is asking Managed Care Plans (MCPs) to produce quarterly rolling quality measure rates using the California Technical Specifications (CaTS) so that performance can be tracked for all EPT deliverables that include HEDIS-like measures. This has been a concern for MCPs because of the risks involved with data sharing, complexity of attribution, and ensuring timely rate production and payment to providers for completed deliverables.</p> <ul style="list-style-type: none">• DHCS provided two (2) possible solutions for the MY2024 CaTS rate delivery:<ul style="list-style-type: none">○ Option 1: (High encouraged by DHCS) MCPs to use a third-party solution contracted by Pop Health Learning Center (PHLC) called Innovaccer to process data and produce rates. Data releases to PHLC and Innovaccer were due on 09/08/2025.○ Option 2: MCPs may submit self-produced rates using CaTS by 10/31/2025.• Partnership will proceed with Option 2. The HEDIS team will move forward with preparing CaTS rates for all EPT sites for MY2024.• All work on the PHLC DSA is suspended.
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	<ul style="list-style-type: none"> The requirement for quarterly rolling year rate delivery will impact the cadence for the HEDIS monthly project going forward. 																																			
<p>PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)</p>	<p>Locum providers are in place at all sites and initial observations include:</p> <ul style="list-style-type: none"> WSMC – Locum has made significant impact and will extend contract. Peds backlog is substantial, limited outreach needed. Strategic use of locum beyond preventive visits. Open Door - Well child visits increased after school resumed; more afternoon appointments being scheduled. August 2025 WCV were over 100 more than August 2024, helping avoid end-of-year crunch. CCS visits continue to show low patient engagement. Shasta – Outreach to unassigned for CCS and under age 5 for WCV. Barriers include inaccurate contact info, lack of patient education and willingness to complete preventive visits, and preference for assigned PCP. Ampla - Outreach and scheduling remain difficult. Temporary provider for Pediatrics (Peds) is hard “sell” to patients. High no-show rate for CCS appointments – expressed need for more patient education. <table border="1" data-bbox="412 995 1507 1514"> <thead> <tr> <th>Provider Org</th> <th>Total Visits</th> <th>PHC Members</th> <th>WCV</th> <th>CCS</th> <th>No-show Rate</th> <th>Avg. Visit/Day (anticipated 16-20/day)</th> </tr> </thead> <tbody> <tr> <td>WSMC <i>Start: June 30</i></td> <td>593</td> <td>466</td> <td>511</td> <td>0</td> <td>26.2%</td> <td>12</td> </tr> <tr> <td>Open Door <i>Start: July 14</i></td> <td>331</td> <td>318</td> <td>271</td> <td>36</td> <td>16.0%</td> <td>9</td> </tr> <tr> <td>Shasta <i>Start: July 28</i></td> <td>263</td> <td>258</td> <td>225</td> <td>38</td> <td>27.3%</td> <td>9</td> </tr> <tr> <td>Ampla <i>Start: Aug 18</i></td> <td>57</td> <td>56</td> <td>19</td> <td>37</td> <td>51.7%</td> <td>6</td> </tr> </tbody> </table>	Provider Org	Total Visits	PHC Members	WCV	CCS	No-show Rate	Avg. Visit/Day (anticipated 16-20/day)	WSMC <i>Start: June 30</i>	593	466	511	0	26.2%	12	Open Door <i>Start: July 14</i>	331	318	271	36	16.0%	9	Shasta <i>Start: July 28</i>	263	258	225	38	27.3%	9	Ampla <i>Start: Aug 18</i>	57	56	19	37	51.7%	6
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<p>PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM</p>	<p>No recent update at this time.</p>																				
<p>QI TRILOGY PROGRAM</p>	<ul style="list-style-type: none"> • All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Work Plan; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan) have been completed and are currently pending Board approval on 10/22/2025. • The following documents have been annotated, bookmarked and submitted to the NCQA Team, in preparation for the mock audit survey in October. All required documents have been reviewed and accepted by the NCQA Team. <ul style="list-style-type: none"> ▪ FY 23-24 QI Program Description ▪ FY 24-25 QI Program Description ▪ FY 24-25 QI Work Plan ▪ FY 23-24 QI Program Evaluation ▪ 2023 & 2025 QUAC Policy ▪ 2025 QUAC & PAC Rosters ▪ QI 1A Compliance Statement ▪ QI 1B Compliance Statement ▪ QI 1C Compliance Statement • In preparation for the upcoming FY 25–26 QI Trilogy season, the Trilogy team is reviewing current tools, resources, and practices to enhance the document preparation and submission process. On 09/12/2025, an internal survey was distributed to all Trilogy subject matter experts (122 participants) to gather input and identify opportunities for improvement. 																				
<p>QI PROJECT TRAINING PROGRAM</p>	<ul style="list-style-type: none"> • The pilot cohort (20 participants) launched 09/10/2025 and will run through November 2025. • The training curriculum is undergoing final edits • A dedicated Toolkit Hub webpage is live on the Improvement Academy webpage • The full program launch is planned for Q1 CY2026 																				

<u>D-SNP</u>	<ul style="list-style-type: none"> The QI Department is continuing its collaboration with Wakely (part of HMA) to develop a HEDIS visualization dashboard and a Stars analytics tool. As an extension of this work, the Medicare Quality team is working with the HEDIS team, IT, Pharmacy and Health Analytics to generate baseline data for all Medicare Stars measures for CY2025. This data will be used as part of the Stars Analytics tool to understand baseline Stars performance headed into program launch. “Capturing Patient Acuity through Coding Part 2”, a webinar addressing coding acuity for D-SNP, is tentatively scheduled for Wednesday, 10/08/2025 at 12 p.m. and will be led by Dr. Kermit Jones, Medical Director of Medicare Services at Partnership. The webinar will be promoted to physicians and coding support personnel in the Partnership Advantage counties. Attendees will be eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation. Ninety-five individuals from 39 organizations have registered for the webinar. Registration is available here. The Medicare Quality team is developing an approach to share Stars and DHCS measure information with key stakeholders in a centralized, cloud-based format. This would allow measure sponsors, business owners and process owners key measure information including data sources, measures descriptions and current interventions. Upon finalization, stakeholders from across the organization will be able to access the material.
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QUALITY ASSURANCE AND MEMBER SAFETY

ACTIVITY	UPDATE																																			
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 08/24/2025 TO 9/29/2025	<ul style="list-style-type: none"> 34 PQI referrals were received with 30 coming from Grievance and Appeals, three from Utilization Management, and one from a Regional Medical Director. 17 PQI cases were processed and closed. 81 PQI cases are currently open. One case was discussed at Peer Review Committee (PRC) on 09/17/2025 and there are three awaiting reviews. One case was sent to an external Subject Matter Expert for review. 																																			
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 08/25/2025-09/26/2025	<ul style="list-style-type: none"> As of 9/26/2025, we have a total of 520 reviews including PCP, OB, Multiple check-ins, and delegated reviews. <p>Primary Care and OB Reviews:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Region</th> <th style="text-align: center;"># of FSR conducted</th> <th style="text-align: center;"># of MRR conducted</th> <th style="text-align: center;"># of FSR CAP issued</th> <th style="text-align: center;"># of MRR CAP issued</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Auburn</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">2</td> <td style="text-align: center;">2</td> </tr> <tr> <td style="text-align: center;">Chico</td> <td style="text-align: center;">9</td> <td style="text-align: center;">10</td> <td style="text-align: center;">1</td> <td style="text-align: center;">6</td> </tr> <tr> <td style="text-align: center;">Eureka</td> <td style="text-align: center;">4</td> <td style="text-align: center;">4</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> </tr> <tr> <td style="text-align: center;">Fairfield</td> <td style="text-align: center;">4</td> <td style="text-align: center;">3</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> </tr> <tr> <td style="text-align: center;">Redding</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> <td style="text-align: center;">1</td> </tr> <tr> <td style="text-align: center;">Santa Rosa</td> <td style="text-align: center;">2</td> <td style="text-align: center;">1</td> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> </tr> </tbody> </table>	Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued	Auburn	2	3	2	2	Chico	9	10	1	6	Eureka	4	4	1	1	Fairfield	4	3	0	1	Redding	2	1	1	1	Santa Rosa	2	1	0	1
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	<p>New sites opened this period →</p> <ul style="list-style-type: none"> • Chico – Sutter North Medical Group • Fairfield – NorthBay Health Primary Care • Redding – Mayers Rural Health Center-OB • Santa Rosa – MarinHealth Medical Network
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HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS®)

ACTIVITY	UPDATE
Annual HEDIS® Projects	<ul style="list-style-type: none"> • The MY2024 Annual Summaries of Performance are posted on the Partnership website. The Annual Summaries of Performance include county-level data on HEDIS measures, as well as year over year performance trends for the fourteen (14) legacy Partnership counties and assessment of results. <ul style="list-style-type: none"> ○ MY2024 DHCS MCAS Annual Summary of Performance ○ MY2024 NCQA Health Plan Accreditation Annual Summary of Performance
HEDIS® Program Overall	<ul style="list-style-type: none"> • DHCS shared its final MY2024 MCAS sanctions methodology with Managed Care Plans, including Partnership, on September 22, 2025. In summary: <ul style="list-style-type: none"> ○ DHCS will move forward with county-level sanctions on the 18 MCAS measures for MY2024 with performance below the Minimum Performance Level (MPL). ○ For counties with small measure denominators (under 100 members), DHCS will aggregate numerators and denominators with neighboring counties in the same Quality Rating Region to meet the minimum eligible population threshold of 100 members. Any aggregated counties will be noted in the first Notice of Intent to Sanction letter that DHCS intends to send in early October. ○ Partnership’s proposal to aggregate county-level measure rates at the Quality Rating Region was rejected. • Partnership expects to receive a Notice of Intent to Sanction letter from DHCS in early October 2025, with Meet and Confer meetings to appeal proposed sanctions to be scheduled in mid-October 2025.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	<ul style="list-style-type: none"> • Evidence for the HPA Mock Renewal Survey scheduled for 10/27-30/2025 has been shared with our consultant, Managed Healthcare Resources (MHR). Since Partnership will be held accountable to the new 2026 HPA Standards and Guidelines for our 2026 HPA Renewal Survey, MHR will review all evidence against the new standards prior to the HPA Mock Renewal Survey. During the four (4) days of the HPA Mock Renewal Survey, MHR will share their findings and provide their recommendations for survey compliance, as needed. Business Owners can submit additional clarifying documents within three (3) days of the scheduled session(s). The NCQA Program Management Team will share an Action Plan (AP) with each

	<p>Business Owner (BO) by 11/13/2025 that will list all recommendations identified by MHR to meet 2026 survey compliance. BOs are required to complete and submit the AP to the NCQA Program Management Team by 12/05/2025.</p> <ul style="list-style-type: none"> • The NCQA Program Management Team has submitted our formal application for the 2026 HPA Renewal Survey to NCQA requesting a survey date of 09/15/2026. For the file review requirements, all files must be in compliance beginning <u>Monday, 09/15/2025 (with the exception of credentialing, the look-back period began on 09/15/2023)</u>. Once NCQA has confirmed Partnership’s survey date, the NCQA Program Management Team will prepare a detailed timeline outlining the pre- and post-survey activities. • The NCQA Program Management Team distributed the 2026 HPA Workbook to all BOs on 09/30/2025. The 2026 HPA Workbook contains the Work Plan and Evidence Submission Library for each BO. BOs are asked to confirm the information prepopulated in the workbook, and provide updates, as needed, along with their attestations. The completed workbook is due to the NCQA Program Managed Team by 10/24/2025. This activity is required as part of the FY 25-26 NCQA-related HPA Key Activities, Milestone 2.
<p>NCQA Health Equity Accreditation (HEA)</p>	<ul style="list-style-type: none"> • NCQA awarded Partnership the official Health Equity Accreditation status on 08/06/2025. To maintain this status, Partnership undergoes a survey every three (3) years. Partnership’s HEA Renewal Survey is tentatively scheduled for 05/16/2028. As of 09/15/2025, NCQA’s website has been updated to reflect Partnership’s Health Equity Accreditation status.



Partnership

Policy & Procedure Updates

November
2025

Policy Number	Policy/Procedures/Guidelines	Version Links
<p>The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in October 2025.</p> <p>**All policy versions hyperlinked for review.</p> <p>Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.</p> <p>Please review all drafts and the detailed Synopsis of Changes.</p>		
Grievance & Appeals		
CGA022	Member Discrimination Grievance Procedure	C CD RD
Enhanced Health Services		
MPAP7003	CaAIM Community Supports (CS)	C CD RD
Care Coordination		
MPCP2017	Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>Archived – new MBPB8011</i>)	C CD <i>RD</i>
Pharmacy		
MCRP4066	AB114 Benefit Implementation and Oversight	C CD RD
Behavioral Health		
MCBP8015	Coordination of Care for Child Welfare-Involved Members (<i>New – Archived from Utilization Management</i>)	<i>C</i> CD RD
MPBP8003	Mental Health Services	C CD RD
MPBP8007	Screening and Treatment for Substance Use Disorders (<i>New – Archived from Utilization Management</i>)	<i>C</i> CD RD
MPBP8011	Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines (<i>New – Archived from Care Coordination</i>)	<i>C</i> CD RD
MPBP8013	Eating Disorder Management Policy	C CD RD
Utilization Management		
MCUP3101	Screening and Treatment for Substance Use Disorders (<i>Archived – new MPBP8007</i>)	C CD <i>RD</i>
MCUP3103	Coordination of Care for Child Welfare-Involved Members (<i>Archived – new MCBP8015</i>)	C CD <i>RD</i>
MCUG3032	Orthotic and Prosthetic Appliances Guidelines	C CD RD
MCUP3012	Discharge Planning (Non-capitated Members)	C CD RD
MCUP3015	Family Planning Bypass Services	C CD RD

Utilization Management <i>Continued</i>			
MCUP3050	Medication Abortion in the First Trimester	<u>C</u>	<u>CD</u> <u>RD</u>
MCUP3052	Medical Nutrition Services	<u>C</u>	<u>CD</u> <u>RD</u>
MCUP3115	Community Based Adult Services	<u>C</u>	<u>CD</u> <u>RD</u>
MCUP3128	Cardiac Rehabilitation	<u>C</u>	<u>CD</u> <u>RD</u>
MCUP3130	Osteopathic Manipulation Treatment	<u>C</u>	<u>CD</u> <u>RD</u>
MPUP3035	Preoperative Day Review	<u>C</u>	<u>CD</u> <u>RD</u>
MPUP3078	Second Medical Opinions	<u>C</u>	<u>CD</u> <u>RD</u>
MPUP3116	Positron Emission Tomography Scans (PET Scans)	<u>C</u>	<u>CD</u> <u>RD</u>

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the October 15, 2025 Quality / Utilization Advisory Committee (Q/UAC) meeting. It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
Policy Owner: Behavioral Health – Presenter: Jeff DeVido, MD, Clinical Director, Behavioral Health			
MPBP8003 – Mental Health Services	197 – 232	<p>Updates made to align with new All Plan Letter (APL) 25-010 Adult and Youth Screening and Transition Tools for Mental Health Services, which allows for a clinician to override the result of the screening tool if it is inconsistent with the clinical presentation of the member. [VL.B.3.c.3]</p> <p>III.A Definition added: (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnership’s service area. BHPs are required to provide and cover all medically necessary Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment services in accordance with their contracts with the Department of Health Care Services (DHCS).</p> <p>VII.3 adds Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization.</p> <p><i>Footnotes:</i></p> <ol style="list-style-type: none"> 2. Some mental health treatment services, such as TMS, may be available in both SMHS and NSMH systems of care. Partnership’s coverage of these treatment services through NSMH is, therefore, not intended to duplicate, supplant, or exclude the potential of those treatment services being offered in the SMHS system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMHS systems of care to ensure Members receive clinically indicated care in the most appropriate mental health system of care. 3. For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of electro convulsive therapy (ECT). Hospital incurred medical costs for ECT (<i>i.e.</i>, anesthesia) for Partnership Medi-Cal Members are covered by Partnership. <p>Per discussion at Oct. 7 IQI, MCUP3041, Treatment Authorization Request (TAR) Review Process is added to the Related Policies list because TMS requires prior authorization. Also, APL 25-013 supersedes all APL 22-012 references.</p>	Health Services Claims Member Services
MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral	233 – 240	<p>This policy update reflects changes necessitated by the de-delegation of Carelon for triage and referral services: Partnership began handling these calls in-house on Sept. 29.</p> <p>Section V. is updated to read: The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and</p>	Health Services Claims Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
Guidelines (previously MPCP2017)		<p>2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership HealthPlan of California, and for referral to County Behavioral Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between Primary Care Providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.</p> <p>VI.B.3 now contains the following addition: (Note that by Jan. 1, 2026, all California counties are expected to be compliant with SB43 which updates the LPS clinical definition of “Grave Disability.” For more information: https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf)”</p> <p>VI.C.4.i is added to the risk factor list of what PCPs should assess: “Risk to self or community due to high risk behaviors and/or impaired judgment (<i>i.e.</i>, operating motor vehicles while intoxicated).”</p> <p>References added: APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (June 3, 2025), supersedes APL 22-028. Also, APL 25-013 supersedes APL 22-012.</p> <p>Attachment A Partnership Behavioral Health Referral Form has been modified to reflect the changed relationship with Carelon as these referrals will now be sent directly to Partnership.</p>	
Policy Owner: Enhanced Health Services – Presenter: Lisa Brundage O’Connell, MHA, Director, Enhanced Health Services			
MPAP7003 (previously MCAP3142)	241 – 268	<p>Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services:</p> <ul style="list-style-type: none"> • Deposits [See VI.F.2.] • Short-Term Post Hospitalization Housing [See VI.F.4.] • Recuperative Care [See VI.F.5] • Medically Tailored Meals and Groceries (MTM/G) [See new VI.F.6.] • Asthma Remediation – service will be added Jan. 1, 2026 [See new VI.F.11.] • Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.) <p>Per discussion at Oct. 7 IQI, “Registered Dietician (RD) or Registered Dietician Nutritionist” is added to the Definition section here because a RDN assessment is required for an individual to qualify for MTM. (This definition is also added to UM’s Medical Nutrition policy on today’s consent calendar.)</p> <p>Section III Definitions added for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent</p>	<p style="text-align: center;">Health Services Claims Finance Member Services Provider Relations Administration</p>

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		<p>III.J - Transitional Rent: Effective Jan. 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.</p> <p>Section VI.C Member Identification and Referral for Community Support Services is updated with track and trending provisions.</p> <p>Section VII. References is updated with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and initial policy references to these APLs are hyperlinked.</p> <p>Attachment A: Deleted the matrix as this information is in the DHCS Policy Guides and codes are listed on our website in other materials. Information changes frequently so decision to delete matrix was made since information is provided in other materials. Updated information and made changes to Deposits, Short-Term Post Hospitalization Housing, Recuperative Care, Medical Tailored Meals/Groceries and added new service, Asthma Remediation.</p>	
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations			
MCUP3015 – Family Planning By-Pass Services	269 – 272	<p>This policy is being updated to describe Prohibited Entities as per H.R.1. and All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025).</p> <p>Section III.A: Added end note 1 to the definition of Bypass Services: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p>Section III.C: Added Definition of Prohibited Entity</p> <p>Sections VI.B., C., and E.: Added end note message (same as described for III.A) regarding Prohibited Entities.</p> <p>Section VI.G.7.: To the list of requirements for a family planning provider to be reimbursed, added, “The provider must not be a Prohibited Entity as defined in III.C. above.”</p> <p>Section VII.F. and G.: Added References for APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) and Public Law No. 119-21, H.R.1, 119th Congress. (2025)</p> <p>Per Oct. 7 IQI discussion, “federal” was added to all end note descriptions of “Medicaid reimbursement.” End note 3 relating to VI.E. Abortion-related services was further altered: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal</p>	<p>Member Services</p> <p>Claims</p> <p>Compliance</p> <p>Regulatory Affairs</p> <p>Config</p> <p>Provider Relations</p> <p>Providers</p> <p>Network Services</p>

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		<p>Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p>	
MPUP3035 – Preoperative Day Review	273 – 276	<p>During annual review, this policy was updated to remove old criteria.</p> <p>Section I.B.: Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management</p> <p>Section III.: In the Definition of Preoperative Day, description was generalized to refer to “patients admitted before surgery,” without reference to the number of days. Also removed language describing “InterQual®” and specified “medical necessity criteria” instead. Remove language about UM Leadership being involved in the review.</p> <p>Section IV.: Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead.</p> <p>Section VI.B.2. – 2.b.: Updated language describing how a nurse coordinator reviews a preoperative day request. Removed direct reference to InterQual and added reference to policy MPUP3139 Criteria and Guidelines for Utilization Management.</p> <p>Section VIII.A.: Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System.</p> <p>APPENDIX: Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews.</p>	Provider Relations



**Partnership HealthPlan of California
Meeting Minutes**

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)		
DATE / TIME:	Thursday, October 9, 2025 / 7:30am – 10:00am PT		
Practicing Members Present: Kirsten Balano, PharmD Michael Majeski, PharmD	PHC Members Present: <i>Deputy Chief Medical Officer, Committee Chair:</i> Kermit Jones, MD <i>Medical Directors:</i> Jeffery Ribordy, MD, MPH Mark Glickstein, MD Mark Netherda, MD James Cotter, MD, MPH Matthew Morris, MD Richard Matthews, MD Marshall Kubota, MD		Invited Guests Present: Donell Colvin, CPhT <i>Department AA's:</i> N/A <i>IT Ops & Systems:</i> Jose Puga John Lemoine
Practicing Members Absent: Jay Shubrook, DO Phillip Nguyen, PharmD, BCACP, BCGCP Antonio Olea, PharmD Lilia Vargas-Toledo, RN	PHC Members Absent: Robert Moore, MD, MPH, MBA Aaron Thornton, MD Bettina Spiller, MD Dave Katz, MD Colleen Townsend, MD Lisa Ward, MD Bradley Cox, DO Jeffrey DeVido, MD Teresa Frankovich, MD Andrea Ocampo, PharmD		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
<p><u>Opening Comments</u></p> <p><u>I. Approval of minutes</u></p> <p><u>II. Standing Agenda</u></p> <p>1. PHC Update</p>	<ul style="list-style-type: none"> • Introductions • Housekeeping (Announcement: Meeting is being recorded) <p>Quorum: Yes 2 out of 6 members attended Minutes: Approved</p> <p><u>PHC Updates provided by Dr. Jones:</u> I just have a few updates to share with everyone. For those of you who weren't at the PAC meeting yesterday, some of these updates are pretty similar, but I wanted to touch on a few key areas: transportation, family planning services, and rural health transformation.</p> <p>As many of you know, we started use of the Kinetik app as an organization in July, which has significantly reduced the number of calls our transportation department receives. As of the end of September, over 3,915 rides have been scheduled through the app, with over 171 unique members using the app during that period. This represents a major step forward for the organization in terms of the use of technology and streamlining a lot of processes. While there were a few initial bugs and glitches, most have been resolved during the process. The app is only available in English right now; however, we are working on expanding the app's language options beyond English.</p> <p>In terms of family planning services related to the H.R.1, DHCS released an APL in September, which states direct plans *the pursuant of the passage of H.R. 1* were forbidden from paying certain family planning and abortion services to groups or organizations who exceed \$800,000 in federal payments in 2023. A temporary restraining order (TRO) was previously in place, granted by the courts, which has since expired, and our Finance and Health Services teams are reviewing the requirements to ensure compliance, particularly regarding the payment deadlines for abortion and non-abortion-related services. Per the TRO, the cutoff date for payment of certain services is after September 11, 2025. This impacts only a subset of codes, and we're working to make sure eligible services are paid appropriately while remaining in compliance with H.R. 1.</p>	<p><i>Presented by Stan Leung, PharmD</i></p> <p><i>Presented by Stan Leung, PharmD</i></p> <p><i>Presented by Kermit Jones, MD JD</i></p>	<p>N/A</p> <p>N/A</p>

<p>2. Additional Updates</p>	<p>Lastly, CMS has announced more details on the Rural Health Transformation Grants. They are approving \$50 billion nationwide, approximately \$1 billion per state. States can submit the application and then there's \$25 billion in funding that's distributed over five years beginning in 2026. California has identified three primary focus areas: maternity care in rural communities, workforce development, and chronic disease management. CMS has given details on the methodology for calculating the applications and awarding funds. We have Stan on the committee supporting the workforce-related components of the state's application. CMS has emphasized that they're seeking tangible outcomes rather than planning grants. So that's where I think the rubber's going to hit the road, is if and when these applications are approved there will be significant reporting and compliance requirements, and we'll need to ensure we're prepared to meet those expectations. That concludes my updates.</p> <p><u>PHC Updates:</u> I would like to formally welcome and introduce Michael Majeski as one of our new external committee members. Michael is the Chief Pharmacist at Sebastopol Family Pharmacy, which is closely affiliated with West County Health Center. He has been intricately involved in several key pharmacy initiatives, including the AB 1114 Pharmacy Services project and the Pharmacy CHW Program. We're also looking forward to collaborating with him and his team on the upcoming Stanford CKD Project. So more to come from Michael and his pharmacy.</p> <p>I just have a couple of pharmacy updates, primarily a few items from Medi-Cal Rx. The first is related to Medi-Cal Rx's (or California's) decision to cease coverage of weight-loss GLP-1 medications starting next year. They are currently holding meetings with various stakeholder groups to discuss the change. In fact, one of those meetings is this afternoon with CSHP, which I will be attending to learn more about the information they plan to share. Additional meetings with CMA and managed care plans are also scheduled later this month to help disseminate information on how this transition will be implemented. One key point noted is that members currently using GLP-1 medications for weight loss will receive 90-, 60-, and 30-day notices regarding the upcoming coverage changes. While coverage for weight-loss-related GLP-1 medications will end, Medi-Cal Rx indicated that coverage for non-weight-loss-</p>	<p><i>Presented by Stan Leung, PharmD</i></p>	<p>N/A</p>
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related conditions will continue and will be reviewed on a case-by-case basis. Additionally, members under 21 may still have GLP-1 coverage under EPSDT with an approved TAR, also on a case-by-case basis. Through these upcoming meetings with stakeholder groups, we hope to learn more about the exception processes and how they will be applied. It's worth noting that weight-loss GLP-1 use represents a significant portion of utilization—nearly half, if not more, among our members. This change will be important to monitor, as weight management plays a major role in reducing cardiovascular risk. Next week, I'll be attending the Health Officers Association of California meeting in San Luis Obispo to discuss the ramifications of this change further.

The second update is regarding the VFC COVID-19 vaccine supply. As Dr. Jones mentioned previously, there have been disruptions in the VFC COVID vaccine supply, largely due to CMS not having full approval of the COVID vaccine recommendations. Since that recommendation was finalized on Monday, we expect VFC vaccine supply distribution to resume soon. In the meantime, VFC providers are unable to obtain the vaccine, so medical providers are using their commercial or purchased stock to fill the gap, and we are working on a process to ensure proper reimbursement. For VFC pharmacies, the situation is a bit more complicated. Medi-Cal Rx made an exception to cover pediatric COVID vaccines—but only for non-VFC pharmacies. This means non-VFC pharmacies can continue to use commercial stock, bill for the vaccine, and receive payment for both the ingredient cost and administration fee. However, for VFC pharmacies, if they use commercial stock, the system recognizes them as VFC providers and will not reimburse them for the vaccine ingredient cost, making it cost-prohibitive to administer pediatric COVID vaccines. We are working with Medi-Cal Rx to identify solutions to this issue. In our service area, we only have one VFC pharmacy, most VFC pharmacies are located in Southern California. So, there is a potential impact, but again, that maybe offset because the COVID vaccine for age three and up is covered at non VFC pharmacies. The issue is somewhat paradoxical, as VFC is designed to support pediatric vaccinations, yet for COVID vaccines, children three and older can receive them at non-VFC pharmacies. Those are the two main updates I wanted to share regarding Medi-Cal Rx.

<p>3. DUR Update</p>	<p><u>DUR Summary for Fraud & Abuse</u></p> <p>Dr. Vo presented the following:</p> <ul style="list-style-type: none"> • DHCS requires managed care plans to monitor and address potential fraud and abuse involving controlled substances, whether by members, prescribing providers, or dispensing pharmacies. • In response, Partnership (PHC) developed a monitoring program to identify members who receive opioid prescriptions from four or more prescribers and four or more pharmacies. This program allows PHC to assess potential fraud and abuse of opioid use. • A biannual review of pharmacy claims was conducted to identify members who had filled opioid prescriptions in the prior 180 days. • Claims for members who had prescriptions from four or more different prescribers and filled these medications at four or more different pharmacies were flagged for further review. • Members receiving hospice, palliative care, cancer treatment, or residing in long-term care (LTC) facilities were excluded from the analysis. • At the Member-Level, we reviewed for patterns of: <ul style="list-style-type: none"> ○ Early refills ○ Short-term fills versus chronic or stable fills ○ Prescription payments made out-of-pocket vs. by insurance ○ Use of providers or pharmacies located far from the member’s home ○ Multiple prescribers with varying specialties • At the Prescriber-Level, we reviewed patterns of: <ul style="list-style-type: none"> ○ Prescribing large quantities or high doses of opioids ○ Frequency of early refills ○ Prescribing to patients who live more than 100 miles from the prescriber • At the Pharmacy-Level, we reviewed patterns of: <ul style="list-style-type: none"> ○ Dispensing early refills ○ Dispensing large quantities of opioids ○ Dispensing to members who live more than 50 miles from the pharmacy • For cases flagged as potential fraud or abuse, further investigation was conducted to determine if any extenuating 	<p><i>Presented by Kathleen Vo, PharmD</i></p>	<p>N/A</p>
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	<p>circumstances contributed to the patterns observed, ensuring that no legitimate reasons were overlooked.</p> <ul style="list-style-type: none"> • A review of pharmacy claims between January 2025 to June 2025 identified over 37K members with fills for opioids. After applying inclusion and exclusion criteria, 19 members were identified for closer review. • 1 member was flagged for potential opioid abuse. During the 6-month lookback period, this member had 22 ER visits and 18 opioid fills. 5 of these opioid fills were not billed through Medi-CalRx. Member also used 2 pharmacies located more than 50 miles away from their home. <ul style="list-style-type: none"> ○ Member was enrolled in Case Management from December 2024 to February 2025, but case was close due to lack of member engagement. ○ From July 2025 to mid-September 2025, this member had an additional 8 ER visits and 10 more opioid fills, 3 of which were not billed through Medi-CalRx. • Review of the other 18 members did show some short-term fills for opioids that matched their ER visits and/or hospital stays, but not as numerous. There were 8 members who received acute on chronic opioid fills with temporary increase in the number of providers and pharmacies used. • In summary, we identified 35 members who had opioid prescriptions from four or more prescribers and filled these medications at four or more pharmacies. Upon detailed pharmacy, CURES, and medical claims analysis, one member was flagged as a potential concern for opioid abuse and has been referred to the RAC for further review. • For the next DUR activity, we may consider focusing on members who receive large quantities of opioids and/or members who are on high MEDs to identify potential fraud and abuse, including potential drug diversion activities. <p><u>DUR Summary for COB:</u></p> <p>Dr. Vo presented the following:</p> <ul style="list-style-type: none"> • DHCS requires managed care plans to monitor members who are prescribed both opioids and benzodiazepines medications at the same time. • In response, Partnership (PHC) implemented a prescriber fax intervention targeting members who were newly started on concurrent opioid and benzodiazepine therapy. The purpose of this intervention is to raise prescriber awareness 		
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	<p>and reduce the risk of concurrent use, whenever clinically appropriate.</p> <ul style="list-style-type: none"> • We conducted monthly retrospective review of pharmacy claims to identify members with concurrent fills for opioids and benzodiazepines, who were newly initiated on either medications within the prior 30 days. We defined concurrent use as overlapping fills of both an opioid and a benzodiazepine for 15 or more cumulative days within a 30-day lookback period. • Members receiving hospice, palliative care, cancer treatment, residing in long-term care (LTC) facilities, and enrolled in Wellness & Recovery program were excluded from the analysis. • For members who met inclusion and exclusion criteria, provider letters were faxed to all involved opioid and benzodiazepines prescribers. The letters included best practices to minimize concurrent opioid–benzodiazepine use along with member’s opioid and benzodiazepine fill history. • We monitored for ongoing concurrent opioid–benzodiazepine use 90 days after provider letters. • Lynette provided interim results for a 6-month lookback period from July of 2024 to December of 2024, at this past April’s P&T committee meeting. • Today, I’m providing final results for the 1-year lookback period from July of 2024 extending to June of 2025. During this 1 year lookback period: <ul style="list-style-type: none"> ○ Almost 7,400 members filled a benzodiazepine and an opioid. ○ Almost 1,100 members were identified as possible new starts ○ After applying inclusion and exclusion criteria and analysis of pharmacy claims and CURES reports, 50 members were identified as new starts for concurrent use opioids and benzos. The remaining members were confirmed to have intermittent use of either opioids or benzos. ○ 111 provider letters were faxed to prescribers. • Outcomes of provider letters were evaluated 90-days post intervention using pharmacy claims and CURES reports. <ul style="list-style-type: none"> ○ 48% of these members no longer had concurrent fills for opioids and benzodiazepines 		
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4. Drug Benefit Review

- 10% showed a reduction in either their opioid or benzodiazepine dose or days' supply.
- 28% showed continued concurrent use with no change
- 14% showed continued concurrent use with either an increase in dose or quantity.
- We hope that our prescriber intervention outreach contributed to these positive changes. We plan to continue with this monitoring and prescriber intervention as part of our efforts to help reduce the risks associated with concurrent opioid and benzodiazepine use.

The classes for this quarter's review are:

- Antineoplastic & Adjunctive Agents
- Hematological Agents
- Nutritional Products
- Psychotherapeutic and Neurological Misc. Agents

No changes proposed to the Nutritional Products Class.

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

All changes will be effective 1/01/2026 unless otherwise noted.

Class Reviews:

- Antineoplastic & Adjunctive Agents
 - Updates to the following were presented, with approved action shown at right.
 - obecabtagene autoleucl (Aucatzyl™): added to existing CAR-T criteria
 - lifileucl (Amtagvi™)
 - afamitresgene autoleucl (Tecelra™)
 - zenocutuzumab-zbco, 1 mg (Bizengri™)
 - telisotuzumab vedotin-tllv, 1 mg (Emrelis™)
 - daratumumab, 10 mg and hyaluronidase-fihj (Darzalex Faspro™): drug specific criteria removed, changed to General antineoplastic case-by-case criteria (not attached)
 - daratumumab, 10 mg (Darzalex™): drug specific criteria removed, changed to General

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

Presented by Erin Montegary, Pharm D

Antineoplastic & Adjunctive Agents Class Review, Approved Actions:	
HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
Q2058	obecabtagene autoleucl (Aucatzyl™)
New TAR Criteria (see attached criteria for details)	
J3590	lifileucl (Amtagvi™)
Q2057	afamitresgene autoleucl (Tecelra™)
J9382	Injection, zenocutuzumab-zbco, 1 mg (Bizengri™)
C9306	Injection, telisotuzumab vedotin-tllv, 1 mg (Emrelis™)

1/1/2026

antineoplastic case-by-case criteria (not attached)

- dostarlimab-gxly, 10 mg (Jemperli™): drug specific criteria removed, changed to General antineoplastic case-by-case criteria (not attached)

- Hematological Agents
 - Updates to the following were presented, with approved action shown at right.
 - epoetin beta, 1 microgram, (for non esrd use) (Mircera™)
 - eculizumab, 2 mg (Soliris™)
 - eculizumab-aagh (epysqli), biosimilar, 2 mg (Epysqli™)
 - eculizumab-aeeb (bkemv), biosimilar, 2 mg (Bkemv™)
 - ravulizumab-cwvz, 10 mg (Ultomiris™)
 - romiplostim, 1 microgram (Nplate™)
 - pegfilgrastim, excludes biosimilar, 0.5 mg (Neulasta / Neulasta Onpro™)
 - pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg (Ziextenzo™)
 - argatroban, 1 mg (for esrd on dialysis)
 - argatroban (auromedics), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis)
 - argatroban, 1 mg (for non-esrd use)
 - argatroban (accord), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis)
 - protamine sulfate, per 10 mg – remove quantity limits
 - argatroban (auromedics), not therapeutically equivalent to J0883, 1 mg (for non-esrd use)
 - argatroban (accord), not therapeutically equivalent to J0883, 1 mg (for non-esrd use)
 - epoetin beta, 1 microgram, (for esrd on dialysis) (Mircera™)
 - iron dextran, 50 mg (Infed™)
 - iron sucrose, 1 mg (Venofer™)

TAR Criteria Updates (drug specific criteria removed, changed to case by case criteria)	
J9144	Injection, daratumumab, 10 mg and hyaluronidase-fihj (Darzalex Faspro™)
J9145	Injection, daratumumab, 10 mg (Darzalex™)
J9272	Injection, dostarlimab-gxly, 10 mg (Jemperli™)

Presented by Susan Becker, PharmD, BCPS

Hematological Agents Class Review, Approved Actions:	
HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J0888	Injection, epoetin beta, 1 microgram, (for non esrd use) (Mircera™)
J1299	Injection, eculizumab, 2 mg (Soliris™)
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg (Epysqli™) – added to Soliris criteria as biosimilar
Q5152	Injection, eculizumab-aeeb (bkemv), biosimilar, 2 mg (Bkemv™)
J1303	Injection, ravulizumab-cwvz, 10 mg (Ultomiris™)
J2802	Injection, romiplostim, 1 microgram (Nplate™)
Removal of TAR requirements	
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Neulasta / Neulasta Onpro™) – added to preferred pegfilgrastim products
Q5120	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg (Ziextenzo™) – added to preferred pegfilgrastim products
Removal of Claim Limits &/or Requirements	
J0884	Injection, argatroban, 1 mg (for esrd on dialysis) – remove age limit
J0899	Injection, argatroban (auromedics), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis) – remove age limit
J0883	Injection, argatroban, 1 mg (for non-esrd use) – remove age limit
J0892	Injection, argatroban (accord), not therapeutically equivalent to J0884, 1 mg (for esrd on dialysis) – remove age limit

1/1/2026

- sodium ferric gluconate complex in sucrose injection, 12.5 mg (Ferrlecit™)
- ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use) (Feraheme™)
- ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for esrd on dialysis) (Feraheme™)
- pegfilgrastim-pbbk, biosimilar, 0.5 mg (Fylnetra™)
- pegfilgrastim-cbqv, biosimilar, 0.5 mg (Udenyca / Udenyca Onbody™)

J2720	Injection, protamine sulfate, per 10 mg – remove quantity limits
Updates to Claim Limits &/or Requirements	
J0898	Injection, argatroban (auromedics), not therapeutically equivalent to J0883, 1 mg (for non-esrd use) – updated ICD-10 limits with updated codes
J0891	Injection, argatroban (accord), not therapeutically equivalent to J0883, 1 mg (for non-esrd use) – updated ICD-10 limits with updated codes
J0887	Injection, epoetin beta, 1 microgram, (for esrd on dialysis) (Mircera™) – adjusted age limit to 3 months and older
J1750	Injection, iron dextran, 50 mg (Infed™) – updated to add D63.1 (Anemia of CKD) to list of covered ICD-10 codes.
J1756	Injection, iron sucrose, 1 mg (Venofer™) – updated to add D63.1 (Anemia of CKD) to list of covered ICD-10 codes.
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg (Ferrlecit™) – updated to add D63.1 (Anemia of CKD) to list of covered ICD-10 codes.
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use) (Feraheme™) – updated to add D63.1 (Anemia of CKD) to list of covered ICD-10 codes and increase QL to 1020mg per DOS.
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for esrd on dialysis) (Feraheme™) – updated to add D63.1 (Anemia of CKD) to list of covered ICD-10 codes and increase QL to 1020mg per DOS.
J2506	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Neulasta / Neulasta Onpro™) – added to preferred pegfilgrastim products, covered with limits: ICD-10: D70.1 or Z51.11 and QL: 12 units per date of service
Q5120	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg (Ziextenzo™) – added to preferred pegfilgrastim products, covered with limits: 12 units per date of service
Addition of Claim Limits &/or Requirements *TAR required*	
Q5130	Injection, pegfilgrastim-pbbk, biosimilar, 0.5 mg (Fylnetra™) – removed from preferred

- Psychotherapeutic and Neurological Misc. Agents
 - Updates to the following were presented, with approved action shown at right.
 - lecanemab-irmb, 1 mg (Leqembi™)
 - donanemab-azbt, 2 mg (Kisunla™)
 - ocrelizumab, 1 mg and hyaluraonidase-ocsq (Ocrevus Zunovo™) – added to existing Ocrevus criteria

In addition to the scheduled class reviews, PHC presented the following:

- Updates to Miscellaneous Agent:
 - remestemcel-l-rknd, per therapeutic dose (Ryoncil™)
- Updates to Dermatological, Anorectal, Mouth – Throat, Dental, Eye – Ear Agent:
 - spesolimab-sbzo, 1 mg (Spevigo™) both IV and SC

	pegfilgrastim products and added to non-preferred criteria (see attached criteria for details)
Q5111	Injection, pegfilgrastim-cbqv, biosimilar, 0.5 mg (Udenyca / Udenyca Onbody™) - removed from preferred pegfilgrastim products and added to non-preferred criteria (see attached criteria for details)

Presented by Erin Montegary, Pharm D

Psychotherapeutic and Neurological Misc. Agents Class Review, Approved Actions:	
HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J0174	Injection, lecanemab-irmb, 1 mg (Leqembi™)
J0175	Injection, donanemab-azbt, 2 mg (Kisunla™)
J2351	Injection, ocrelizumab, 1 mg and hyaluraonidase-ocsq (Ocrevus Zunovo™) – added to existing Ocrevus criteria

Presented by Susan Becker, PharmD, BCPS

Ad hoc Updates		
HCPCS	HCPCS Description (brand)	Approved Action
J3402	Injection, remestemcel-l-rknd, per therapeutic dose (Ryoncil™)	Updates to current criteria (see attached criteria for details)
J1747	Injection, spesolimab-sbzo, 1 mg (Spevigo™) - Code includes both IV and SC formulations	Created separate criteria for SC Spevigo from IV Spevigo, each will have its own criteria

1/1/2026

1/1/2026

- New HCPCS code review – listed at right, listed in 2 sections:
 - 1st time HCPCS code for drug (other than unclassified code)
 - HCPCS code changed but no change in coverage requirements for the drug itself.
 - Codes were announced as benefits by DHCS on 9/29/2025, with an effective date of 10/1/2025.

Presented by Susan Becker, PharmD, BCPS

New HCPCS codes (no prior code or was previously unclassified)		
HCPCS	HCPCS Description	Requirements
Q5156	Injection, toclizumabano (avtozma), biosimilar, 1 mg	TAR
J0458	Injection, aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg) (Emblaveo)	TAR
J0681	Injection, cefotetan disodium, 10 mg (Cefotan)	TAR
J1834	Injection, isoniazid, 1 mg	TAR
Q5154	Injection, omalizumabige (omlyclo), biosimilar, 5 mg	TAR (added to Requirements for Xolair criteria)
C9306	Injection, telisotuzumab vedotin-tllv, 1 mg (Emrelis)	TAR
J0163	Injection, epinephrine in sodium chloride (endo), 0.1 mg	NTR, no limits (match code J0165)
J0164	Injection, epinephrine in sodium chloride (baxter), 0.1 mg	NTR, no limits (match code J0165)
J1807	Injection, ethacrynate sodium, 1 mg (Edecrin)	TAR
J3403	Revakinagene tarorecel-lwey, per implant (Encelto)	TAR
Q5155	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	TAR
J0675	Injection, carboprost tromethamine, 0.1 mg (Hemabate)	TAR
J1612	Injection, glucagon (gvoke), 0.01 mg	NTR, no limits
J1809	Injection, fosdenopterin, 0.1 mg (Nulibry)	TAR
Q5157	Injection, denosumabmw (stoboclo/osenvelt), biosimilar, 1 mg	TAR
Q5158	Injection, denosumabnht (bomynta/conexence), biosimilar, 1 mg	TAR
Q5159	Injection, denosumabdssb (ospomyv/xbryk), biosimilar, 1 mg	TAR

10/1/2025

J1370	Injection, esomeprazole sodium, 1 mg (Nexium IV)	TAR
J0582	Injection, bivalirudin (endo), not therapeutically equivalent to J0583, 1 mg	TAR
J3290	Injection, tranexamic acid, 5 mg (Cyklokapron)	NTR, no limits
J7173	Injection, concizumabmtci, 0.5 mg (Alhemo)	TAR
J7174	Injection, fitusiran, 0.04 mg (Qfitlia)	TAR
C9305	Injection, nipocalimabaahu, 3 mg (Imaavy)	TAR
J3402	Injection, remestemcel-lrknd, per therapeutic dose (Ryoncil)	TAR

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	HCPCS Description	Requirements & prior code
J0668	Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg (Zynrelef)	TAR (<i>same as prior code C9088</i>)
J0570	Buprenorphine implant, 74.2 mg	Carved out to Fee For Service (FFS) Medi-Cal (<i>same as prior code J0570</i>)
J0525	Injection, cefotetan disodium, 10 mg (Cefotan)	NTR, no limits (<i>same as prior code S0074</i>)
J2291	Injection, nafcillin sodium (baxter), 20 mg	NTR, no limits (<i>same as prior code J2290</i>)
J0738	Injection, lenacapavir, 1 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) (Yeztugo)	Carved out to Fee For Service (FFS) Medi-Cal (<i>same as prior code J0799</i>)
J0752	Oral, lenacapavir, 300 mg, FDA approved prescription, only for use as HIV pre-exposure prophylaxis (not for use as treatment for HIV) (Yeztugo)	Carved out to Fee For Service (FFS) Medi-Cal (<i>same as prior code J0799</i>)

<p>III. Old Business</p> <p>a. Policy Updates</p> <p>IV. New Business</p> <p>V. Additional Items</p> <p>VI. Adjournment</p>	<p>• Consent items not needing Committee vote: These are codes where configuration changes have been decided internally for processing efficiency and mirror the State’s billing requirements, and that change is not a negative change. Changes to billing requirements shown at right.</p> <p>• All Policies below submitted for consent with additions, changes and minor reorganization of content, improved wording and updating of references.</p> <p>1) MCRP4066: AB1114 Benefit Implementation and Oversight – No changes to policy.</p> <p>None</p> <p>None</p> <p>Meeting adjourned at 9:38am</p>	<table border="1"> <tr> <td>J0614</td> <td>Injection, treosulfan, 50 mg (Grafapex)</td> <td>TAR (same as prior code C9175)</td> </tr> <tr> <td>J9011</td> <td>Injection, datopotamab deruxtecan-dlnk, 1 mg (Datroway)</td> <td>TAR (same as prior code C9174)</td> </tr> <tr> <td>J0759</td> <td>Injection, clevidipine butyrate, 1 mg (Cleviprex)</td> <td>TAR (same as prior code C9248)</td> </tr> <tr> <td>J2151</td> <td>Injection, mannitol, 250mg</td> <td>NTR, no limits (same as prior code J2150)</td> </tr> <tr> <td>J0462</td> <td>Injection, atropine sulfate, not therapeutically equivalent to J0461, 0.01 mg</td> <td>NTR, no limits (same as prior code J0451)</td> </tr> </table> <table border="1"> <thead> <tr> <th colspan="3">Consent Items</th> </tr> <tr> <th>HCPCS</th> <th>HCPCS Description</th> <th>Changes to Billing Requirements</th> </tr> </thead> <tbody> <tr> <td>J0461</td> <td>Injection, atropine sulfate, 0.01 mg</td> <td>Quantity limit removed</td> </tr> <tr> <td>90382</td> <td>Respiratory syncytial virus, clesrovimab (Enflonsia)</td> <td>NTR, age limit of 1 year or younger, VFC modifier</td> </tr> <tr> <td>J3392</td> <td>Injection, exagamglogene autotemcel, per treatment (Casgevy)</td> <td>None: TAR criteria updated to note that use for SCD is Carved out to Fee For Service (FFS) Medi-Cal as of 10/1/25</td> </tr> </tbody> </table> <p><i>Presented by Stan Leung, PharmD</i></p>	J0614	Injection, treosulfan, 50 mg (Grafapex)	TAR (same as prior code C9175)	J9011	Injection, datopotamab deruxtecan-dlnk, 1 mg (Datroway)	TAR (same as prior code C9174)	J0759	Injection, clevidipine butyrate, 1 mg (Cleviprex)	TAR (same as prior code C9248)	J2151	Injection, mannitol, 250mg	NTR, no limits (same as prior code J2150)	J0462	Injection, atropine sulfate, not therapeutically equivalent to J0461, 0.01 mg	NTR, no limits (same as prior code J0451)	Consent Items			HCPCS	HCPCS Description	Changes to Billing Requirements	J0461	Injection, atropine sulfate, 0.01 mg	Quantity limit removed	90382	Respiratory syncytial virus, clesrovimab (Enflonsia)	NTR, age limit of 1 year or younger, VFC modifier	J3392	Injection, exagamglogene autotemcel, per treatment (Casgevy)	None: TAR criteria updated to note that use for SCD is Carved out to Fee For Service (FFS) Medi-Cal as of 10/1/25	<p>N/A</p> <p>11/12/2025</p>
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Requirements for lifileucel (Amtagvi™)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Unresectable or metastatic melanoma in adults previously treated with a PD-1 blocking antibody, and, if BRAF V600 mutation positive, a BRAF inhibitor with or without a MEK inhibitor.
Exclusion Criteria	<ul style="list-style-type: none"> • Uncontrolled brain metastases • Active significant systemic infection • Prior treatment with lifileucel (Amtagvi™) • Prior organ allograft or prior cell transfer • Left ventricular ejection fraction (LVEF) < 45% or New York Heart Association (NYHA) functional classification > Class 1 • Forced expiratory volume in one second (FEV1) of ≤ 60% • Treatment for melanoma of uveal or ocular origin • Patients on systemic steroids for any reason • Eastern Cooperative Oncology Group (ECOG) > 1 • Evidence of liver or kidney dysfunction • Hemorrhage (grade 2 or higher) within 14 days prior to therapy with lifileucel (Amtagvi™)
Required Medical Information	<p>Documentation of ALL of the following must be submitted:</p> <ol style="list-style-type: none"> 1. Histologically confirmed diagnosis of unresectable or metastatic melanoma (Stage IIIc or Stage IV). 2. Clinic notes documenting history and course of melanoma, including current stage of disease, radiologic disease progression, and current line of therapy 3. Member must have at least one resectable lesion (or aggregate of lesions resected) of ≥ 1.5 cm in diameter post-resection to generate TIL (tumor-infiltrating lymphocyte). 4. Projected started date of treatment including tumor tissue procurement (TTP) procedure. 5. Disease has progressed on treatment with a programmed death receptor-1 (PD-1) blocking antibody. Examples of PD-1 blocking antibodies include pembrolizumab (Keytruda™), nivolumab (Opdivo™). Disease progression is defined by worsening signs of cancer, such as increase in the measurable size of tumors or the appearance of new tumors on imaging tests. 6. BRAF V600 mutation status: If positive for BRAF V600E mutation, documentation should be submitted to show disease has progressed (as defined above) on treatment with a BRAF inhibitor with or without a MEK inhibitor. Examples of BRAF inhibitors include encorafenib (Braktovi™), dabrafenib (Tafinlar™), vemurafenib (Zelboraf™). Examples of MEK inhibitors include binimetinib (Mektovi™), cobimetinib (Cotellic™), trametinib (Mekinist™). 7. Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 and an estimated life expectancy of ≥3 months. 8. Documentation that member does not have active infection, and screenings for chronic viral infection have been or will be performed (including but not limited to: Hepatitis B, Hepatitis C, and HIV). 9. Member's current cardiac, pulmonary, liver, and renal function (all organ function must be adequate). Labs should include documentation of the

Requirements for lifileucel (Amtagvi™)

	<p>following (from clinical trial inclusion criteria):</p> <ol style="list-style-type: none"> Absolute neutrophil count (ANC) $\geq 1000/\text{mm}^3$ Hemoglobin $\geq 9\text{g/dL}$ Platelets $\geq 100,000/\text{mm}^3$ ALT/AST < 5 times the upper limit of normal Total bilirubin ≤ 2 mg/dL (members with Gilbert's syndrome must have total bilirubin ≤ 3 mg/dL) Estimated GFR > 40 mL/min <ol style="list-style-type: none"> Echocardiogram to confirm left ventricular ejection fraction $\geq 45\%$. If the member has known or suspected lung disease, pulmonary function testing that shows forced expiratory volume in one second (FEV1) of $> 60\%$. Member does not have uncontrolled brain metastases. Member does not have hemorrhage (grade 2 or higher) within 14 days prior to therapy. Member will receive lymphodepleting chemotherapy (cyclophosphamide, mesna, fludarabine) prior to infusion of lifileucel (Amtagvi™) Member is deemed eligible for and will receive IL-2 (aldesleukin-Proleukin™) therapy following administration of Amtagvi™ according to package label requirement. <ul style="list-style-type: none"> For all requests: Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case
Age Restriction	18 years and older
Prescriber Restriction	Oncologist, to be administered at an Amtagvi™ Authorized Treatment Center (ATC) only.
Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose per lifetime.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Amtagvi™ (lifileucel)	Amtagvi™ is provided as a single dose for infusion containing a suspension of tumor-derived T cells. The dose is supplied in 1 to 4 patient specific IV infusion bag(s) in individual protective metal cassettes. Each dose contains 7.5×10^9 to $7^2 \times 10^9$ viable cells.

Requirements for afamitresgene autoleucel (Tecelra™)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Treatment of unresectable or metastatic synovial sarcoma (SyS) in adults who have received prior chemotherapy, are HLA-A*02:01P, HLA-A*02:02P, HLA-A*02:03P, or HLA-A*02:06P positive (in blood samples) and whose tumor expresses the melanoma-associated antigen A4 (MAGE-A4) antigen as determined by an approved or cleared companion diagnostic device.
Exclusion Criteria	<ul style="list-style-type: none"> • Heterozygous or homozygous for HLA-A*02:05P • Eastern Cooperative Oncology Group (ECOG) > 1 • Prior treatment with Tecelra™ or CAR-T therapy • Prior allogeneic hematopoietic stem cell transplant (HSCT) • Active or clinically significant infections and/or inflammatory disorders
Required Medical Information	<p>Documentation of ALL of the following must be submitted:</p> <ol style="list-style-type: none"> 1. Histologically confirmed diagnosis of unresectable or stage IV synovial sarcoma. 2. Clinic notes documenting history and course of disease, including response to previous therapies to confirm member's disease has progressed following ≥ 1 prior systemic chemotherapy. 3. Results of HLA-A*02 testing to confirm member has at least one of the following inclusion alleles: HLA-A*02:01P, HLA-A*02:02P, HLA-A*02:03P, or HLA-A*02:06P and does NOT have the exclusion allele (Member is NOT heterozygous or homozygous for HLA-A*02:05P). 4. Results of MAGE-A4 testing to confirm tumor expression. 5. Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. 6. Screening for Epstein-Barr Virus, Cytomegalovirus, Hepatitis B Virus, Hepatitis C Virus, Human Immunodeficiency Virus, and any other infectious agents if clinically indicated. 7. Member's current cardiac, pulmonary, liver, and renal function (all organ function must be adequate). 8. Documentation that member will be monitored during and for at least 7 days following administration of Tecelra™ at the healthcare facility, with continued monitoring for least four weeks for signs and symptoms of Cytokine Release Syndrome (CRS) and immune effector cell-associated neurotoxicity syndromes (ICANS). 9. Documentation that member's blood counts will be monitor prior to and for several weeks following administration of Tecelra™ for prolonged severe cytopenia. <ul style="list-style-type: none"> • Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.
Age Restriction	18 years and older
Prescriber Restriction	Oncologist, to be administered at Tecelra™ Authorized Treatment Center (ATC) only

Requirements for afamitresgene autoleucel (Tecelra™)

Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose per lifetime.
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Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .
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Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
Q2057	Afamitresgene autoleucel, including leukapheresis and dose preparation procedures, per therapeutic dose (Tecelra™)	FDA-approved recommended dose is 2.68×10^9 to 10×10^9 MAGE-A4 TCR-positive T cells

Requirements for zenocutuzumab-zbco (Bizengri™)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	<ul style="list-style-type: none"> Treatment of advanced, unresectable or metastatic non–small cell lung cancer (NSCLC) harboring a neuregulin 1 (<i>NRG1</i>) gene fusion in adults with disease progression on or after prior systemic therapy. Treatment of advanced, unresectable or metastatic pancreatic adenocarcinoma (PDAC) harboring a <i>NRG1</i> gene fusion in adults with disease progression on or after prior systemic therapy.
Exclusion Criteria	<ul style="list-style-type: none"> NYHA class III or IV congestive HF, LVEF <50%, or a history of significant cardiac disease Eastern Cooperative Oncology Group (ECOG) > 2
Required Medical Information	<p>Documentation of the following must be submitted:</p> <ol style="list-style-type: none"> Member has advanced, unresectable or metastatic non-small cell lung cancer (NSCLC) or pancreatic adenocarcinoma (PDAC). Tumor has the presence of <i>NRG1</i> gene fusion as determined by FDA-approved or CLIA-compliant test. Member has disease progression on or after prior systemic therapy. Bizengri™ is being requested to use as monotherapy. Eastern Cooperative Oncology Group (ECOG) performance status of ≤ 2. LVEF is within normal limits and will be assessed at regular intervals during treatment. Bizengri™ will be administered in a setting with emergency resuscitation equipment and staff who are trained to monitor for infusion-related reactions (IRR) and to administer emergency medications. Member will be monitored for new or worsening pulmonary symptoms indicative of interstitial lung disease (ILD)/pneumonitis. Females of reproductive age have a negative pregnancy test prior to starting therapy and will use effective contraception during treatment and for at least 2 months following the last dose of Bizengri™. <ul style="list-style-type: none"> For all requests: Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist’s evaluation of the case
Age Restriction	18 years and older
Prescriber Restriction	Oncologist
Coverage Duration	<p>Initial approval for 3 months to ensure clinical efficacy.</p> <p>Continued approval for up to 6 months per request with documented positive response to treatment as defined by stabilization of disease or decrease in tumor size or spread.</p>
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Requirements for zenocutuzumab-zbco (Bizengri™)

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9382	Injection, zenocutuzumab-zbco, 1 mg (Bizengri™)	750 mg once every 2 weeks (dose is the same for either indication)

Requirements for telisotuzumab vedotin-tllv (Emrelis™)

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Treatment of locally advanced or metastatic, nonsquamous non–small cell lung cancer (NSCLC) in adults with high c-MET protein overexpression ($\geq 50\%$ of tumor cells with strong [3+] staining), as determined by an approved test, who have received a prior systemic therapy.
Exclusion Criteria	<ul style="list-style-type: none"> Eastern Cooperative Oncology Group Performance Status (ECOG PS) >2
Required Medical Information	<p>Documentation of all of the following must be submitted:</p> <ol style="list-style-type: none"> Histologically confirmed locally advanced or metastatic NSCLC that is epidermal growth factor receptor (EGFR) wild type. The tumor has high c-Met protein overexpression, defined as $\geq 50\%$ of tumor cells with strong (3+) membrane staining, confirmed by an FDA-approved test. Member has had at least one prior systemic therapy in the advanced or metastatic setting. Eastern Cooperative Oncology Group (ECOG) performance status of ≤ 2. Emrelis™ is being requested to use as monotherapy. Member will be monitored for signs and symptoms of interstitial lung disease (ILD)/pneumonitis throughout treatment with Emrelis™. <ul style="list-style-type: none"> For all requests: Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist’s evaluation of the case
Age Restriction	18 and older
Prescriber Restriction	Oncologist
Coverage Duration	<p>Initial approval for 3 months to ensure clinical efficacy.</p> <p>Continued approval for up to 6 months per request with documented positive response to treatment as defined by stabilization of disease or decrease in tumor size or spread.</p>
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
C9306	Injection, teslisotuzumab vedotin-tllv (Emrelis™)	Emrelis™ dosing is weight-based and should be calculated using 1.9 mg/kg every 2 weeks. Maximum dose: 190 mg in patients weighing ≥ 100 kg.

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	<p>Per FDA approved indications included in the product labeling. CAR-T immunotherapy products included in this criteria:</p> <ul style="list-style-type: none"> • Idecabtagene vicleucel (Abecma™) • Obecabtagene autoleucel (Aucatzyl™) • Lisocabtagene maraleucel (Breyanzi™) • Ciltacabtagene autoleucel (Carvykti™) • Tisagenlecleucel (Kymriah™) • Brexucabtagene autoleucel (Tecartus™) • Axicabtagene ciloleucel (Yescarta™)
Exclusion Criteria	<ul style="list-style-type: none"> • CAR-T will not be approved for use as first-line therapy. • Concurrent or prior treatment with another CAR-T immunotherapy. • Concurrent use with a chemotherapy regimen (excluding the necessary lymphodepleting regimen). • CNS disorders or CNS malignancy/metastasis. • Active infectious disease. • Inability to remain in the vicinity of the REMS certified facility for a minimum of 4 weeks. • ECOG grade 4 or worse.
Required Medical Information	<ul style="list-style-type: none"> • Histologically confirmed diagnosis of one of the FDA approved indication for which therapy is being requested to treat. • Clinic notes documenting history and course of illness, including response to previous therapies. • Documentation that member does not have active infection, and the recommended screenings in the package labeling, or in treatment guidelines, have been or will be performed for (including but not limited to): Hepatitis B, Hepatitis C, and HIV. • Documentation that member does not have an autoimmune disease or graft-vs-host disease requiring immunosuppression. • Documentation that member will undergo the recommended lymphodepleting regimen prior to CAR-T treatment (cyclophosphamide + fludarabine or appropriate alternative as recommended by package labeling or treatment guidelines). • Documentation that member is able to remain in the vicinity of the certified healthcare facility for at least <u>2 weeks</u> 4 weeks post-infusion. • Member's current bone marrow, cardiac, pulmonary, liver, and renal function (all organ function must be adequate). • ECOG (Eastern Cooperative Oncology Group) performance status grade. • Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.
Age Restriction	<p>See prescriber information per drug specific approval information. For most indications, CAR-T may be approved for members aged 18 or older. Noted exception for tisagenlecleucel (Kymriah™) when used for the treatment of</p>

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

	precursor acute lymphoblastic leukemia which is limited to members aged 25 years and younger on the date of the infusion (date of service), not previously treated with any gene therapy.
Prescriber Restriction	Prescribed by a hematologist or oncologist
Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose only per lifetime.
Other Requirements & Information	<p>Additional required information per FDA-approved indication, at time of publication.</p> <p><u>Multiple myeloma, relapsed or refractory:</u> FDA-approved CAR-T therapies with this indication: Abecma™, Carvykti™. Additional information required with request:</p> <ul style="list-style-type: none"> • For Abecma™: Documentation of treatment failure (either due to intolerable adverse reaction or lack of efficacy) with ≥ 2 prior lines of therapy, with at least one from each mechanism of action group listed below: <ol style="list-style-type: none"> a) An anti-CD38 monoclonal antibody: daratumumab (Darzalex™), daratumumab-hyaluronidase (Darzalex Faspro™), or isatuximab (Sarclisa™) b) A proteasome inhibitor: bortezomib (Velcade™), carfilzomib (Kyprolis), or ixazomib (Ninlaro™) c) An immunomodulatory agent: lenalidomide (Revlimid™), thalidomide (Thalomid™, accepted off-label use), or pomalidomide (Pomalyst™) • For Carvykti™: Documentation of treatment failure (due to either intolerable adverse reaction or lack of efficacy) with ≥ 1 prior line of therapy that includes a proteasome inhibitor and an immunomodulatory agent and are refractory to lenalidomide. <p><u>Large B-cell lymphoma, relapsed or refractory:</u> FDA-approved CAR-T therapies with this indication: Breyanzi™, Kymriah™, Yescarta™. Additional information required with request: For all:</p> <ul style="list-style-type: none"> • A confirmed diagnosis of large B-cell lymphoma, including ANY of the following types: <ul style="list-style-type: none"> ▪ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from follicular lymphoma or transformed follicular lymphoma-TFL) ▪ Primary mediastinal large B-cell lymphoma ▪ High-grade B-cell lymphoma ▪ Limitations of use: Not indicated for treatment of primary CNS lymphoma. <p>For Breyanzi™ or Yescarta™:</p> <ul style="list-style-type: none"> • Documentation of treatment of large B-cell lymphoma in adults that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy OR, • Member has relapsed or refractory disease after two or more lines of systemic therapy OR, • For Breyanzi™ only: Member is refractory to first-line chemoimmunotherapy or relapses after first-line chemoimmunotherapy and is not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidity or age. <p>For Kymriah™:</p> <ul style="list-style-type: none"> • Documentation of treatment of relapsed or refractory large B-cell lymphoma in adults after two or more lines of systemic therapy.

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

Follicular lymphoma, relapsed or refractory:

FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™, Yescarta™.**

- Documentation of treatment of relapsed or refractory follicular lymphoma in adults after two or more lines of systemic therapy.

Acute lymphoblastic leukemia (ALL), B-cell precursor, relapsed or refractory:

FDA-approved CAR-T therapies with this indication for children and young adults up to 25 years of age: **Kymriah™.**

FDA-approved CAR-T therapies with this indication for adults 18 years and older: **Tecartus™, Aucatzyl™.**

For **Kymriah™:**

- Documentation of treatment of relapsed or refractory B-cell precursor ALL for member up to 25 years of age.
- Member has a confirmed diagnosis of B-cell precursor ALL and the members condition meets ONE of the additional criteria, as specified below in either item 1 or item 2:
 1. Second or later relapse B-cell precursor ALL after failing at least two lines of adequate treatment (with relapse defined as the reappearance of leukemia cells in the bone marrow or peripheral blood after complete remission with chemotherapy and/or allogeneic cell transplant) OR
 2. Refractory B-cell precursor ALL with refractory defined as failure to obtain complete response with induction therapy (with second or later bone marrow relapse, bone marrow relapse after allogeneic stem cell transplant, or primary refractory or chemorefractory after relapse).
- Members with Ph+ ALL require documentation of failure of 2 tyrosine kinase inhibitors (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at up to maximally indicated doses is required, unless contraindicated or clinically significant adverse effects are experienced, PHC prior authorization may be required for tyrosine kinase inhibitors.

For **Tecartus™ and Aucatzyl™:**

- Documentation of treatment of relapsed or refractory B-cell precursor ALL for member ≥ 18 years of age.
- Members with Ph+ ALL require documentation of failure of tyrosine kinase inhibitors (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at up to maximally indicated doses is required, unless contraindicated or clinically significant adverse effects are experienced, PHC prior authorization may be required for tyrosine kinase inhibitors.

Chronic lymphocytic leukemia (CLL), or small lymphocytic lymphoma, relapsed or refractory:

FDA-approved therapies with this indication: **Breyanzi™.**

- Documentation of treatment of relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma after two or more lines of systemic therapy including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor (Venetoclax-based regimen per NCCN guidelines).

Mantle cell lymphoma, relapsed or refractory:

FDA-approved CAR-T therapies with this indication: **Breyanzi™, Tecartus™.**

Requirements for Chimeric Antigen Receptor T-cell (CAR-T) Therapy

	<ul style="list-style-type: none"> Documentation of treatment of relapsed or refractory mantle cell lymphoma (MCL) in adults after 2 or more lines of systemic therapy, including a Burton tyrosine kinase (BTK) inhibitor. <p>Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.</p>
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Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing
Abecma™	Q2055	Idecabtagene vicleucel, up to 460 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	300 to 460 x 10 ⁶ CAR-T cells, not to exceed the maximum dose of 460 million cells (may be provided in one or more IV bags)
Aucatzyl™	Q2058	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	410 × 10 ⁶ CD19 chimeric antigen receptor (CAR)-positive viable T cells administered as a split dose infusion on day 1 and day 10 (±2 days).
Breyanzi™	Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	50 to 110 x 10 ⁶ CAR-T cells, not to exceed the maximum dose of 110 million CAR-T cells (may be provided in one or more IV bags).
Carvykti™	Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose.	0.5-1.0 x 10 ⁶ CAR-T cells per kg of body weight, not to exceed the maximum dose of up 100 million CAR-T cells (provided in a single IV bag).
Kymriah™	Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Recommended dose varies per indication with range: 0.1 to 6 x 10 ⁸ CAR-T cells, not to exceed maximum dose of 600 million CAR-T cells (provided in single IV bag).
Tecartus™	Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Recommended dose varies per indication with range: 1 to 2 x 10 ⁶ CAR-T cells, not to exceed maximum dose of 200 million CAR-T cells (provided in single IV bag).
Yescarta™	Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	2 x 10 ⁶ CAR-T cells, not to exceed maximum dose of 200 million CAR-T cells (provided in single IV bag).

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Unless otherwise specified as having renewal requirements, criteria apply to new members. Documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	<ul style="list-style-type: none"> Anemia due to chronic kidney disease in adults. Anemia due to chronic kidney disease in pediatric patients 5 to 17 years of age on hemodialysis who are converting from another erythropoiesis-stimulating agent (ESA) after their hemoglobin level was stabilized with an ESA. <p><i><u>Patients on hemodialysis should use J0887: Injection, epoetin beta, 1 microgram, (for ESRD on dialysis), which does not require a TAR when billed by a dialysis center for members over the age of 3 months</u></i></p>
Exclusion Criteria	<ul style="list-style-type: none"> Anemia due to cancer chemotherapy. Estimated glomerular filtration rate (eGFR) greater than 60 ml/min, hemoglobin greater than 12.0 g/dL. Use for anemia is known or suspected to be due a correctable cause such as iron deficiency, folate deficiency or B12 deficiency, infectious or inflammatory process, occult blood loss, hematologic disease (e.g. thalassemia, sickle cell anemia), or hemolysis.
Required Medical Information	<ol style="list-style-type: none"> Clinic notes and laboratory evidence supporting <u>anemia of CKD, including:</u> current hemoglobin (Hgb), hematocrit (Hct), mean corpuscular volume (MCV), iron studies including transferrin saturation (TSAT), ferritin, and estimated glomerular filtration rate (eGFR). Adequate iron stores as indicated by current (within the last 3 months) serum ferritin level greater than or equal to 100 mcg/L or serum transferrin saturation greater than or equal to 20%. Pretreatment hemoglobin less than 10.0 g/dL or maintenance phase hemoglobin less than 11.0 g/dL (based on package insert). Dosing interval should not exceed once every 2 weeks for adults or once every 4 weeks for pediatrics.
Age Restriction	5 years <u>3 months</u> and older.
Prescriber Restriction	Prescribed by, or in consultation with, a hematologist/oncologist or nephrologist.
Coverage Duration	TBD, Up to 6 months updated labs will be requested periodically (e.g. every 3 months for non-dialysis and monthly for dialysis patients) until maintenance phase of ESA therapy is reached
Other Requirements & Information	<p><u>Renewal will require updated labs (Hgb, HCT, iron studies)</u></p> <p>Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.</p>

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

For Mircera for ESRD, please use J0887: Injection, epoetin beta, 1 microgram, (for ESRD on dialysis), which does not require a TAR when billed by a dialysis center for members over the age of 3 months.

HCPCS	Description	Dosing, Units																												
J0888	Injection, epoetin beta, 1 microgram, (for non esrd use)	<p>Starting dose adult CKD patients who are not currently treated with an ESA: 1.2 mcg/kg body weight once every month (SC) OR 0.6 mcg/kg body weight once every two weeks (SC or IV)</p>																												
		<p>Starting dose adult patients currently receiving an ESA:</p>																												
		<table border="1"> <thead> <tr> <th data-bbox="492 787 760 870">Previous Weekly Epoetin alfa Dose (units/week)</th> <th data-bbox="760 787 1044 870">Previous Weekly Darbepoetin alfa Dose (mcg/week)</th> <th colspan="2" data-bbox="1044 787 1497 814">Mircera Dose</th> </tr> <tr> <td colspan="2"></td> <th data-bbox="1044 814 1235 870">Once Monthly (mcg/month)</th> <th data-bbox="1235 814 1497 870">Once Every Two Weeks (mcg/every two weeks)</th> </tr> </thead> <tbody> <tr> <td data-bbox="492 870 760 908">Less than 8000 units</td> <td data-bbox="760 870 1044 908">Less than 40 mcg</td> <td data-bbox="1044 870 1235 908">120 mcg</td> <td data-bbox="1235 870 1497 908">60 mcg</td> </tr> <tr> <td data-bbox="492 908 760 946">8000 units to 16000 units</td> <td data-bbox="760 908 1044 946">40 mcg to 80 mcg</td> <td data-bbox="1044 908 1235 946">200 mcg</td> <td data-bbox="1235 908 1497 946">100 mcg</td> </tr> <tr> <td data-bbox="492 946 760 981">More than 16000 units</td> <td data-bbox="760 946 1044 981">More than 80 mcg</td> <td data-bbox="1044 946 1235 981">360 mcg</td> <td data-bbox="1235 946 1497 981">180 mcg</td> </tr> </tbody> </table>	Previous Weekly Epoetin alfa Dose (units/week)	Previous Weekly Darbepoetin alfa Dose (mcg/week)	Mircera Dose				Once Monthly (mcg/month)	Once Every Two Weeks (mcg/every two weeks)	Less than 8000 units	Less than 40 mcg	120 mcg	60 mcg	8000 units to 16000 units	40 mcg to 80 mcg	200 mcg	100 mcg	More than 16000 units	More than 80 mcg	360 mcg	180 mcg								
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<p><u>Dose adjustment:</u></p> <ul style="list-style-type: none"> • If Hb does not increase by >1 g/dL after 4 weeks increase dose by 25%; do not increase dose more frequently than every 4 weeks. • If Hb increases >1 g/dL in any 2-week period or >2 g/dL in any 4-week period: Reduce dose by 25% to 50% or hold therapy depending on Hb level and rate of Hb increase • If Hb is increasing and approaching the upper target threshold: Reduce dose by 25%; if Hb continues to increase, hold therapy until Hb begins to decrease and reinitiate at 75% of the previous dose 																														

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PA Criteria	Criteria Details
Covered Uses	<ul style="list-style-type: none"> Prevention of chemotherapy-induced neutropenia. Hematopoietic Subsyndrome of Acute Radiation Syndrome [H-ARS]
Exclusion Criteria	<ul style="list-style-type: none"> Use for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. Dosed more frequently than every 14 days for prevention of chemotherapy-induced neutropenia.
Required Medical Information	<p>Clinic notes documenting:</p> <ul style="list-style-type: none"> Diagnosis Specific chemotherapy regimen with dose and frequency Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) Member specific risk factors for developing neutropenia (if any) <p>For prevention of chemotherapy-induced neutropenia:</p> <ul style="list-style-type: none"> Clinical documentation supporting inadequate response to a preferred biosimilar pegfilgrastim product (Neulasta/Neulasta Onpro, Fulphila, Fylmetra, Nyvepria, or Udenyca/Ziextenzo) must be provided. ALSO, must meet ONE of the following: <ol style="list-style-type: none"> Primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if patient has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. OR Secondary prophylaxis of febrile neutropenia in patients who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.
Age Restriction	None
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.

Other Requirements & Information

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Note: preferred pegfilgrastim products (Neulasta, Neulasta Onpro, Fulphila, Nyvepria and Ziextenzo) do not require a TAR when billed with either D70.1 (agranulocytosis due to chemotherapy) or Z51.11 (encounter for antineoplastic chemotherapy), and the maximum dose is not over the limit of 6 mg (12 units).

Product	HCPCS	Description	Dosing, Units
Neulasta, Neulasta Onpro Udenyca, Udenyca OnBody	J2506 Q5111	Injection, pegfilgrastim-cbqv (udenyc), biosimilar, 0.5 mg Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	6mg (12 HCPCS units) once per cycle of chemotherapy, not more often than 14 days
Stimufend	Q5127	Injection, pegfilgrastim-fpgk (stimufend) biosimilar, 0.5 mg	
Ziextenzo Fylnetra	Q5120 Q5130	Injection, pegfilgrastim-pbbk (fynetra), biosimilar, 0.5 mg Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg	

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PA Criteria	Criteria Details
Covered Uses	<ol style="list-style-type: none"> 1) Atypical hemolytic uremic syndrome (aHUS) to inhibit complement mediated thrombotic microangiopathy. 2) Generalized myasthenia gravis (gMG) in adults <u>patients</u> who are anti-acetylcholine receptor antibody-positive (AChR+). 3) Neuromyelitis optica spectrum disorder (NMOSD) in adults who are aquaporin-4-antibody positive. 4) Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
Exclusion Criteria	<ul style="list-style-type: none"> • Unresolved serious <i>Neisseria meningitidis</i> infection • Treatment of Shiga toxin E. coli related hemolytic uremic syndrome • Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • Use along with ravulizumab (Ultomiris™) or efgartigimodum alfa-feab (Vyvgart™) <u>Concurrent use with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists that are not FDA approved for add-on therapy</u> • NMOSD <u>that is</u> negative <u>for</u> AQP4-IgG
Required Medical Information	<ol style="list-style-type: none"> 1) Requirements for atypical hemolytic uremic syndrome (all of the following, a-e): <ol style="list-style-type: none"> a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) d. Documentation that Shiga toxin has been ruled out e. Trial and failure with ravulizumab (Ultomiris™) 2) Requirements for paroxysmal nocturnal hemoglobinuria (all of the following, a-e): <ol style="list-style-type: none"> a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) d. Documentation of trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used e. Trial and failure with ravulizumab (Ultomiris™) 3) Requirement for AChR antibody-related myasthenia gravis (all of the following, a-f): <ol style="list-style-type: none"> a. Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies. b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta-blockers, hydroxychloroquine, gabapentin, lithium. d. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline.

	<ul style="list-style-type: none"> e. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV f. Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the following (i-vi): <ul style="list-style-type: none"> i. Pyridostigmine ii. Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose iii. Oral glucocorticoid sparing immunomodulatory, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate iv. Zilucoplan (Zilbrysq™) v. <u>Self-administered efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo-PFS™) (preferred), or if unable to self-administer: Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™)</u> vi. Ravulizumab (Ultomiris™) <p>4) Requirements for Neuromyelitis optica spectrum disorder (NMOSD) (all of the following a-d):</p> <ul style="list-style-type: none"> a. At least one of the following: <ul style="list-style-type: none"> i. Optic neuritis Acute myelitis ii. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting iii. Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) iv. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions v. Symptomatic cerebral syndrome with NMOSD-typical brain lesions b. Seropositive for AQP4-IgG antibodies c. Documentation of trial and failure or contraindication to Satralizumab (Enspryng™) OR Inebilizumab-cdon (Uplizna™) d. Documentation of trial and failure or contraindication to ravulizumab (Ultomiris)
Age Restriction	<p>aHUS: 2 months of age and older <u>gMG: 6 years and older</u> gMS, NMOSD, PNH: 18 years and older</p>
Prescriber Restriction	<ul style="list-style-type: none"> • <u>PNH</u>: Hematologist • <u>aHUS</u>: Nephrologist, Hematologist • <u>gMGS</u>: Neurologist • <u>NMOSD</u>: Neurologist, Ophthalmologist <p><i>Note: Prescribers must be enrolled in REMS</i></p>
Coverage Duration	<p>Initial: 6 months <u>TAR for loading dose: Approved for 1 to 4 loading doses, depending on indication and weight of the patient (if relevant)</u> Initial TAR for maintenance dose: 6 months</p> <p>Renewal: TAR: Approved for 1 dose per fill for up to 6 months; <u>12 months</u></p>
Other Requirements & Renewal Information	<p>Renewal Requests:</p> <ul style="list-style-type: none"> • <u>Clinical notes with relevant laboratory markers with current documenting positive response to therapy :-</u> • <u>Additional items for gMG:</u> <ul style="list-style-type: none"> ○ MG-ADL ○ MGFA classification

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

Medical Billing:

Use is available only through the restricted Soliris™ REMS program.

Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Dosing, Units																		
J1299	Injection, Eculizumab, 2 mg	<p>aHUS, gMG, NMOSD (≥ 18 yrs):</p> <ul style="list-style-type: none"> 900 mg IV qwk x 4 doses, then 1,200 mg for the 5th dose on week 5, then 1,200 mg q2wks thereafter. <p>Pediatric dosing for aHUS (≥ 2 months) & gMG (≥ 6 years):</p> <table border="1"> <thead> <tr> <th>Weight</th> <th>Induction dose (qwk)</th> <th>Maintenance dose</th> </tr> </thead> <tbody> <tr> <td>≥ 40 kg</td> <td>900 mg x 4</td> <td>1,200 mg at week 5, then q2wks</td> </tr> <tr> <td>30 -39 kg</td> <td>600 mg x 2</td> <td>30 -39 kg 600 mg x2 900 mg at week 3, then q2wks</td> </tr> <tr> <td>0 – 29 kg</td> <td>600 mg x 2</td> <td>600 mg at week 3, then q2wks</td> </tr> <tr> <td>10 – 19 kg</td> <td>600 mg x 1</td> <td>300 mg at week 2, then q2wks</td> </tr> <tr> <td>5 - 9 kg</td> <td>300 mg x 1</td> <td>300 mg at week 2 then q3wks</td> </tr> </tbody> </table>	Weight	Induction dose (qwk)	Maintenance dose	≥ 40 kg	900 mg x 4	1,200 mg at week 5, then q2wks	30 -39 kg	600 mg x 2	30 -39 kg 600 mg x2 900 mg at week 3, then q2wks	0 – 29 kg	600 mg x 2	600 mg at week 3, then q2wks	10 – 19 kg	600 mg x 1	300 mg at week 2, then q2wks	5 - 9 kg	300 mg x 1	300 mg at week 2 then q3wks
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5 - 9 kg	300 mg x 1	300 mg at week 2 then q3wks																		
Q5152	Injection, eculizumab-aeab (bkemv), biosimilar, 2 mg	<p>PNH:</p> <ul style="list-style-type: none"> 600 mg IV qwk x 4 doses, then 900 mg for the 5th dose on week 5, then 900 mg q2wks thereafter. 																		
Q5151	Injection, eculizumab-aagh (epysqli), biosimilar, 2 mg																			

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PA Criteria	Criteria Details
Covered Uses	<ol style="list-style-type: none"> 1) Atypical hemolytic uremic syndrome to inhibit complement mediated thrombotic microangiopathy. 2) Paroxysmal nocturnal hemoglobinuria. 3) Generalized myasthenia gravis (gMG) in adults who are anti-acetylcholine receptor antibody-positive (AChR+) 4) Neuromyelitis optica spectrum disorder (NMOSD) in adults who are aquaporin-4-antibody positive.
Exclusion Criteria	<ul style="list-style-type: none"> • Unresolved serious <i>Neisseria meningitidis</i> infection • Treatment of Shiga toxin E. coli related hemolytic uremic syndrome • Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • <u>Concurrent Use along with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists that are not FDA approved for add-on therapy Eculizumab (Soliris™) or efgartigimod alfa feab (Vyvgart™)</u> • NMOSD that is negative for AQP4-IgG
Required Medical Information	<ol style="list-style-type: none"> 1) Requirements for atypical hemolytic uremic syndrome (all of the following, a-d): <ol style="list-style-type: none"> a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor c. Weight (kg, lb) d. Documentation that Shiga toxin has been ruled out 2) Requirements for paroxysmal nocturnal hemoglobinuria (all of the following, a-d): <ol style="list-style-type: none"> a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor c. Weight (kg, lb) d. Documentation of trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used 3) Requirement for AChR antibody-related myasthenia gravis (all of the following, a-f): <ol style="list-style-type: none"> a. Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium d. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at

	<p>baseline</p> <ul style="list-style-type: none"> e. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV f. Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the following (i-v): <ul style="list-style-type: none"> i. Pyridostigmine ii. Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose iii. Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate iv. Zilucoplan (Zilbrysq™) v. <u>Self-administered efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo-PFS™) (preferred), or if unable to self-administer:</u> Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™) <p>4) Requirements for Neuromyelitis optica spectrum disorder (NMOSD) (all of the following, a-c):</p> <ul style="list-style-type: none"> a. At least one of the following: <ul style="list-style-type: none"> i. Optic neuritis Acute myelitis ii. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting iii. Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) iv. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions v. Symptomatic cerebral syndrome with NMOSD-typical brain lesions b. Seropositive for AQP4-IgG antibodies c. Documentation of trial and failure or contraindication to Satralizumab (Enspryng™) OR Inebilizumab-cdon (Uplizna™)
Age Restriction	<p>aHUS and PNH: ≥ 1 months MG, NMOSD: ≥ 18 years</p>
Prescriber Restriction	<ul style="list-style-type: none"> • aHUS: Nephrologist, Hematologist • PNH: Hematologist • MG: Neurologist • NMOSD: Neurologist, Ophthalmologist <p><i>Note: Prescribers must be enrolled in REMS</i></p>
Coverage Duration	<p>Initial: 6 months Renewal: 12 months</p>
Other Requirements & Information	<p>Renewal Requests:</p> <ul style="list-style-type: none"> • <u>Clinical notes with relevant laboratory markers documenting positive response to therapy</u> • <u>Additional items for gMG:</u>

- MG-ADL
- MGFA classification

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units			
J1303	Injection, Ravulizumab, 10mg	aHUS and PNH ≥ 1 month:			
		Weight	Loading dose	Maintenance dose IV (start 14 days after loading dose)	Maintenance Interval
		5 kg – 9 kg	600 mg	300 mg	4 weeks
		10 kg – 19 kg	600 mg	600 mg	
		20 kg – 29 kg	900 mg	2,100 mg	8 weeks
		30 kg – 39 kg	1,200 mg	2,700 mg	
		40 kg – 59 kg	2,400 mg	3,000 mg	
		60 kg – 99 kg	2,700 mg	3,300 mg	
		≥ 100 kg	3,000 mg	3,600 mg	
		gMG and NSMOD ≥18 years:			
		Weight	Loading Dose	Maintenance dose IV (start 14 days after loading dose)	Maintenance Interval
		40 kg – 59 kg	2,400 mg	3,000 mg	8 weeks
		60 kg – 99 kg	2,700 mg	3,300 mg	
		≥ 100 kg	3,000 mg	3,600 mg	

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Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	<ul style="list-style-type: none"> • Immune thrombocytopenia (ITP) with risk for bleeding • <u>Hematopoietic Syndrome of Acute Radiation Syndrome (H-ARS)</u> <p><u>May be covered for off-label uses including chemotherapy induced thrombocytopenia (CIT) or thrombocytopenia post-hematopoietic cell transplant in accordance with National Comprehensive Cancer Network (NCCN) guidelines</u></p>
Exclusion Criteria	<ul style="list-style-type: none"> • Used to normalize platelet count
Required Medical Information	<p>Requirements for Immune thrombocytopenia (ITP)</p> <ul style="list-style-type: none"> • Clinical documentation to confirm diagnosis of ITP with platelet count <30,000/microL, or platelets count between 30,000 – 50,000/microL in patients with high risk for bleeding (peptic ulcer, use of anticoagulants, high risk of falling) vs malignancy or other determinate cause of thrombocytopenia • Documentation, including length of treatment and labs to confirm inadequate response or reason(s) for failure/clinical contraindication to treatment with ALL of the following <ul style="list-style-type: none"> ○ Oral glucocorticoids ○ IVIG (e.g. Gammagard™) or AntiD immunoglobulin [Rho(D) immune globulin] ○ Eltrombopag (Promacta) or avatrombopag (Doptelet) ○ Splenectomy • <u>Current weight, within past 30 days of request.</u> • <u>Members <18 years old will require documentation of ITP for at least 6 months.</u> <p><u>Requirements for Chemotherapy Induced Thrombocytopenia (CIT)</u></p> <ul style="list-style-type: none"> • <u>Clinical documentation including the current chemotherapy regimen, the expected duration of the chemotherapy regimen, and history of treatment delays due to thrombocytopenia.</u> • <u>Target platelet counts for chemotherapy administration.</u> • <u>Complete blood count with differential as well as additional laboratory evaluations as needed to document that alternative causes of thrombocytopenia (as listed in the NCCN Hematopoietic Growth Factor guidelines) have been ruled out.</u> • <u>Documentation of trial and failure to formulary preferred options (if any) that share the same or greater level of evidence in the NCCN Hematopoietic Growth Factor guidelines.</u> <p><u>Requirements for thrombocytopenia post-hematopoietic cell transplant</u></p> <ul style="list-style-type: none"> • <u>Clinical documentation including the date of transplant, duration and severity of thrombocytopenia, history of platelet transfusions and other treatments used with response to therapy.</u> • <u>Complete blood count with differential as well as additional laboratory evaluations as needed to document that alternative causes of thrombocytopenia (as listed in the NCCN Hematopoietic Growth Factor guidelines) have been ruled out.</u> • <u>Documentation of trial and failure to formulary preferred options (if any) that</u>

	<u>share the same or greater level of evidence in the NCCN Hematopoietic Growth Factor guidelines.</u>
Age Restriction	≥ 1 year
Prescriber Restriction	Must be prescribed or recommended by a hematologist
Coverage Duration	<u>ITP:</u> <ul style="list-style-type: none"> • Initial: 2 months • Renewal: 6 months <u>Off-label uses: case by case, up to 6 months</u>
Other Requirements & Information	Renewal Requirements: current CBC included to indicate benefit with treatment Requests for Hematopoietic Syndrome of Acute Radiation Syndrome (H-ARS) and off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

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

HCPCS	Description	Dosing, Units
J2802	Injection, romiplostim, 1 microgram (Nplate)	Initial: 1mcg/kg (using actual body weight) Adjust the weekly dose of Nplate by increments of 1 mcg/kg until the patient achieves a platelet count ≥ 50k cells/L as necessary to reduce the risk for bleeding; do not exceed a maximum weekly dose of 10 mcg/kg Adjust the dose as follows: <ul style="list-style-type: none"> • If the platelet count is <50k, increase the dose by 1 mcg/kg. • If platelet count is >200k and ≤400k for 2 consecutive weeks, reduce the dose by 1 mcg/kg. • If platelet count is > 400k, do not dose. Continue to assess the platelet count weekly. After the platelet count has fallen to < 200k, resume Nplate at a dose reduced by 1 mcg/kg. Nplate should be discontinued if an increase in platelet count has not been achieved after 4 weeks at maximum allowed/tolerated dose for ITP

Requirements for Iecanemab-irmb IV (Leqembi™)

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Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	For the treatment of Alzheimer’s Disease (AD) in patients with mild cognitive impairment or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.
Required Medical Information	<p><u>Initial Approval Criteria (Must meet all):</u></p> <ul style="list-style-type: none"> • Specialist’s clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness) • Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as: <ul style="list-style-type: none"> ○ Parkinson’s disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD) ○ Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus. • Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer’s Disease (AD) or mild AD dementia and must have at least two of the following: <ul style="list-style-type: none"> ○ Clinical Dementia Rating (CDR)-Global Score of 0.5-1.0 ○ Mini-Mental Examination Status (MMSE) score of 22–30 ○ Montreal Cognitive Assessment (MoCA) score of ≥16 ○ Functional Assessment Staging Tool (FAST) score of 2–4 • Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following: <ul style="list-style-type: none"> ○ Amyloid PET ○ Lumbar puncture: CSF assessment positive for amyloid beta plaque. • Must provide baseline brain magnetic resonance imaging (MRI) dated within 12 months prior to request and MRI must document all of the following: <ul style="list-style-type: none"> ○ Less than 4 brain micro-hemorrhages ○ No prior brain hemorrhage greater than 1cm within the past year ○ No localized superficial siderosis ○ No evidence of acute/subacute cerebral contusion, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory. ○ No evidence of vasogenic edema or brain tumors ○ No severe small vessel, or white matter disease • ALL of the following MUST be documented: <ul style="list-style-type: none"> ○ Member does NOT have a history of cerebrovascular abnormalities or bleeding disorder that would present a risk for ARIA-related bleeding ○ Member does NOT have history of transient ischemic attack (TIA), stroke or seizures within the previous year of screening. ○ Member does NOT have untreated bleeding disorder (platelet count

Requirements for Icanemab-irmb **IV** (Leqembi™)

	<p><50,000 or INR>1.5)</p> <ul style="list-style-type: none"> ○ Member must NOT have contraindications to MRI or PET scans ○ Member does NOT have history of depression and/or clinically unstable psychiatric illness in the past 12 months ○ Member does NOT have a history of alcohol or substance abuse in the past 12 months <ul style="list-style-type: none"> ● If member is receiving an approved AD treatment such as an acetylcholinesterase inhibitor (AChEI) or memantine or both, must be on a stable dose for at least 12 weeks prior to Leqembi treatment initiation ● Member weight must be included ● The requested dose and frequency must be in accordance with FDA-approved labeling and must not exceed dosing guidelines ● <u>Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 3rd, 5th, 7th and 14th infusions.</u>
Age Restriction	<p>50 to 90 years old. Member under 50 years old with early onset Alzheimer’s disease (AD) and met all criteria will be reviewed on a case-by-case basis.</p>
Prescriber Restriction	<p>Neurologist, geriatrician, psychiatrist.</p>
Coverage Duration	<p>Initial, doses 1-4: 2 months’ duration (up to 4 doses of infusion) First Renewals, doses 5-12: 4 months’ duration (up to 8 doses of infusion) <u>Additional Renewals, dose 13 through 18 months total treatment course and later:</u> 6 months’ duration (up to 2 doses/month) <u>Treatment Requests beyond 18 months of use: A subcutaneous autoinjector product, Leqembi IQLIK, is available for self-administration for patients who have completed 18-months treatment of intravenous infusions. Upon completing 18 months of treatment, prescriber should consider transitioning member to this subcutaneous formulation to make treatment less burdensome for the member. The subcutaneous formulation is a pharmacy benefit administered through Medi-Cal Rx. Treatment requests for the IV formulation Treatment duration beyond 18 months <u>duration</u> will be reviewed on a case-by-case basis.</u></p>
Other Requirements & Information	<p><u>First Renewal, must meet ALL:</u></p> <ul style="list-style-type: none"> ● Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND ● Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score of 0.5-1, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score of 22-30, and/or FAST score of 2-4. ● Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 3rd, 5th, 7th and 14th infusion. ● Absence of amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th and 7th infusions as determined by brain MRI. ● Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, anticoagulants). <p><u>Additional Renewals (dose 13 and later), must meet ALL:</u></p> <ul style="list-style-type: none"> ● Provider’s attestation that the potential benefit outweighs known risks as evidence by one of the following:

Requirements for lecanemab-irmb **IV** (Leqembi™)

- A reduction in amyloid beta plaque buildup compared from baseline in PET imaging of brain.
- A slowing/reducing cognitive decline from baseline in CDR-SB score or MMSE score.
- Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score of 0.5-1, Montreal Cognitive Assessment (MoCA) score of ≥ 16 , MMSE score of 22-30, and/or FAST score of 2-4.
- Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 14th infusion.
- Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, or anticoagulants).
- Member must continue maintenance therapy at the recommended dosage per product labeling
- ~~Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 14th infusion.~~

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J0174	Injection, lecanemab-irmb <u>Intravenous product only</u>	<u>Initial dosing: 10 mg/kg once every 2 weeks for 18 months.</u> <u>Maintenance dosing: After 18 months, may continue 10 mg/kg once every 2 weeks or switch to 10 mg/kg once every 4 weeks or change to the subcutaneous formulation.</u> <u>Injection:</u> NDC 62856-0215-01: 500 mg/5 mL (100 mg/mL) in a single-dose vial NDC 62856-0212-01: 200 mg/2 mL (100 mg/mL) in a single-dose vial

Note: Requests for the subcutaneous product, Leqembi IQLIK, should be submitted to Medi-Cal Rx as a pharmacy benefit

DHCS statement:

Guidance for Dually Eligible/Medi-Medi Enrollees: Leqembi is covered under Medicare Part B. Medi-Cal

Requirements for Icanemab-irmb **IV** (Leqembi™)

is obligated to pay the coinsurance and/or deductibles. Medicare covers the drugs with traditional FDA approval in this class when a prescribing clinician or their staff decides the Medicare coverage criteria is met and also submits information to help answer treatment questions in a qualifying study. Providers can participate in the CMS National Patient Registry (or another CMS-approved study) to get Medicare payment for treating their patients with Leqembi.

For additional details, see:

<https://www.cms.gov/newsroom/press-releases/statement-broader-medicare-coverage-leqembi-available-following-fda-traditional-approval>

Requirements for Donanemab (Kisunla™)

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Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	For the treatment of Alzheimer's Disease (AD) in patients with mild cognitive impairment (MCI) or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.
Required Medical Information	<p>Documentation must include all of the following:</p> <ul style="list-style-type: none"> Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness). Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as: <ul style="list-style-type: none"> Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD) Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus. Gradual progressive change in memory function, reported by the patient or informant, over at least 6 months. Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer's Disease (AD) or mild AD dementia and must have at least two of the following: <ul style="list-style-type: none"> Clinical Dementia Rating (CDR)-Global Score of 0.5-1.0 Mini-Mental Examination Status (MMSE) score of 22-30 Montreal Cognitive Assessment (MoCA) score of ≥ 16 Functional Assessment Staging Tool (FAST) score of 2-4 Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following: <ul style="list-style-type: none"> Amyloid PET imaging Lumbar puncture: CSF assessment positive for amyloid beta plaque. All of the following must be documented on baseline MRI: <ul style="list-style-type: none"> Member does NOT have presence of amyloid-related imaging abnormalities of edema/effusion at baseline Member does NOT have more than 4 cerebral microhemorrhages Member does NOT have more than 1 area of superficial siderosis Member does NOT have any intracerebral hemorrhage > 1cm Member does NOT have severe white matter disease If the member is being treated with other medications for Alzheimer's disease, or others that may impact cognition, member must be on a stable dose for 30 days prior to initiating treatment with Kisunla™. Testing for ApoE $\epsilon 4$ status should be performed or offered, and corresponding risk of ARIA considered by both provider and patient before initiating treatment.
Age Restriction	60 years and older

Requirements for Donanemab (Kisunla™)

Prescriber Restriction	Neurologist, Geriatrician, Psychiatrist
Coverage Duration	<p>Initial dose (Infusion 1): 1-month duration</p> <ul style="list-style-type: none"> Baseline MRI required before initiating treatment <p>First Renewals (Infusion 2-4): 3-month duration</p> <ul style="list-style-type: none"> MRI required before 2nd, 3rd, and 4th infusions <p>Additional Renewals (Infusion 5-7): 3-month duration</p> <ul style="list-style-type: none"> MRI required before 7th infusion <p>Additional Renewals (Infusion 8 and beyond): 6-month duration</p> <p>Treatment duration beyond 18 months will be reviewed on a case-by-case basis</p>
Other Requirements & Information	<p>For first renewal, member must meet all of the following:</p> <ul style="list-style-type: none"> Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤ 1 Montreal Cognitive Assessment (MoCA) score of ≥ 16, and MMSE score of ≥ 22, and/or FAST score of 2-4. Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 2nd, 3rd, and 4th <u>and</u> 7th infusions. <ul style="list-style-type: none"> Attestation that dosing will be suspended if results show moderate to severe ARIA-E or ARIA-H, or symptomatic ARIA-H of any severity. <p>For additional renewals, member must meet all of the following:</p> <ul style="list-style-type: none"> Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤ 1, Montreal Cognitive Assessment (MoCA) score of ≥ 16, and MMSE score of ≥ 22, and/or FAST score of 2-4. Provider attestation that the potential benefits outweigh the known risks. Provider attestation that clinical evaluation (including MRI) will be performed if patient demonstrated symptoms suggestive or ARIA. Treatment remains at the recommended dosing per package instructions. <p>Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.</p>

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J0175	Injection, donanemab-azbt	<p>NDC: 00002-9401-01 350mg/20mL (17.5mg/mL)</p> <p><u>Titration dosing:</u></p> <ul style="list-style-type: none"> <u>week 0: IV: 350 mg once</u> <u>week 4: IV: 700 mg once</u> <u>week 8: IV: 1050 mg once</u> <u>week 12 and thereafter: 1400</u>

Requirements for Donanemab (Kisunla™)

mg once every 4 weeks

First 3 infusions: 700mg IV every 4 weeks
Maintenance dosing: 1400mg IV every 4 weeks

Requirements for ocrelizumab (Ocrevus™), ocrelizumab & hyaluronidase-ocsq (Ocrevus Zunovo™) and ublituximab-xiiy (Briumvi™)

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PA Criteria	Criteria Details
Covered Uses	<ul style="list-style-type: none"> Treatment of relapsing forms of multiple sclerosis (MS), including clinically isolated syndrome (CIS), relapsing-remitting disease, and active secondary progressive disease in adults. <u>Ocrevus™ and Ocrevus Zunovo™ are also FDA-approved for treating primary progressive multiple sclerosis (PPMS) and as such PPMS is a covered use for these agents</u>
Exclusion Criteria	<ul style="list-style-type: none"> History of life-threatening infusion reaction to ocrelizumab or ublituximab. Active hepatitis B virus (HBV) infection. Concurrent use of other disease-modifying therapies or immunosuppressives.
Required Medical Information	<p>New Start: Clinical evaluation by neurologist with documentation of the following:</p> <ul style="list-style-type: none"> <u>For all 3 products, a diagnosis of relapsing form of MS, to include CIS, relapsing-remitting disease, and active secondary progressive disease OR for Ocrevus™ or Ocrevus Zunovo™, a diagnosis of primary progressive MS is also appropriate for requesting treatment</u> <u>Documentation should include the diagnosis</u> as confirmed by brain MRI reports, lab reports, documentation of any planned diagnostic workup that has not yet been completed. MRI must show at least one demyelinating event. Submission of CSF study with oligoclonal banding &/or other diagnostic workup results (such as spinal MRI) should be included if brain MRI report is inconclusive. Documentation that member does not have an active hepatitis B infection (as confirmed by Hepatitis B Surface Antigen [HBsAg] and anti-HBV tests). For patients who are negative for HBsAg and positive for Hepatitis B core antibody [HBcAb+] or are carriers of HBV [HBsAg+], consultation with liver disease experts before starting and during treatment is required. <p>Renewals: Include any diagnostic workup that was still pending at time of prior request (additional imaging, CSF evaluation, etc.) and/or documentation of clinical response with therapy requested.</p>
Age Restriction	Minimum Age: 18 years
Prescriber Restriction	Must be prescribed or recommended by a Neurologist
Coverage Duration	3 months when additional diagnostic workup is pending. 12 months if all supporting documentation is complete at time of initial TAR submission. Renewals for continuation of care with documentation of positive clinical response: 12 months
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Requirements for ocrelizumab (Ocrevus™), ocrelizumab & hyaluronidase-ocsq (Ocrevus Zunovo™) and ublituximab-xiiy (Briumvi™)

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Ocrevus	J2350	Injection, Ocrelizumab, 1 mg	Initial Dose: 300 mg once on day 1, followed by 300 mg once 2 weeks later; Subsequent doses, starting 6 months after 1 st infusion: – 600 mg every 6 months
<u>Ocrevus Zunovo</u>	<u>J2351</u>	<u>Injection, ocrelizumab, 1 mg and hyaluronidase-ocsq</u>	<u>920 mg/23,000 units (920 mg ocrelizumab and 23,000 units hyaluronidase) as single 23-mL SC injection in abdomen over ~10 minutes every 6 months</u>
Briumvi	J2329	Injection, ublituximab-xiiy, 1 mg	Initial Dose: 150 mg once on day 1, followed by 450 mg once 2 weeks later; Subsequent doses of 450 mg are administered once every 24 weeks (beginning 24 weeks after the first dose of 150 mg)

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PA Criteria	Criteria Details
Covered Uses	The treatment of steroid-refractory acute graft versus host disease (SR-aGVHD) in pediatric patients
Exclusion Criteria	<ul style="list-style-type: none"> • Age \geq18 years • Skin only grade B aGVHD
Required Medical Information	<ol style="list-style-type: none"> 1) Diagnosis of grade B–D aGVHD with symptoms involving skin, liver, and/or GI tract (excluding skin-only grade B aGVHD) <ol style="list-style-type: none"> a. See definition of grading in the Other Requirements & Information section. b. For cases for aGVHD outside of the classical presentation (such as occurring >100 days post-transplant, or presenting with symptoms usually associated with chronic GVHD) histologic confirmation of diagnosis is required. 2) <u>Baseline staging of disease by organ with relevant labs or descriptions as found in the Bone Marrow Transplant Registry Severity Index (see Other Requirements & Information section).</u> 2)3) Steroid refractory disease defined as progression within 3 days or no improvement within 7 days of consecutive treatment with 2 mg/kg/day methylprednisolone or equivalent). 3)4) Documentation that the GVHD prophylactic regimen has been optimized <u>based on the transplant type, such as for example,</u> achieving adequate trough concentrations of calcineurin inhibitors (200-300ng/ml for cyclosporine, or 15ng/ml for tacrolimus), or reasons why these levels cannot be achieved. 4)5) Documentation of trial and failure or reasons why Ruxolitinib (Jakafi™) cannot be used (in members \geq12 years old only). <p>Policy MCUP3138 External Independent Medical Review may apply, enabling Partnership to obtain a specialist’s evaluation of the case prior to both denials and approvals (ie denials for medical necessity).</p>
Age Restriction	2 months to 17 years only
Prescriber Restriction	Oncologist, hematologist, BMT specialist, or other qualified prescriber
Coverage Duration	Initial or subsequent flare following complete response: 4 weeks (8 doses) Renewal for partial or mixed response: 4 weeks (4 doses)
Other Requirements & Information	<p>Renewal requirements:</p> <ul style="list-style-type: none"> • Requests for continuation following a partial or mixed response: <ul style="list-style-type: none"> ○ Documentation of partial response (organ improvement of \geq1 stage without worsening of any other organ) or mixed response (improvement in \geq1 evaluable organ stage with worsening in another) following an initial 4-week course of 8 doses. • Requests for re-treatment following a complete response: <ul style="list-style-type: none"> ○ Documentation showing complete response defined as resolution of aGVHD in all involved organs following the initial 4-week course of Ryoncil. ○ Current aGVHD flare (grade B–D progression after achieving

complete response)

Definition of International Bone Marrow Transplant Registry Severity Index grades A - D:

Organ	Stage	Description
Skin	1	Maculopapular rash over <25% of body area
	2	Maculopapular rash over 25-50% of body area
	3	Generalized erythroderma
	4	Generalized erythroderma with bullous formation and often with desquamation
Liver	1	Bilirubin 2.0-3.0 mg/dL
	2	Bilirubin 3.1-6.0 mg/dL
	3	Bilirubin 6.1-15.0 mg/dL
	4	Bilirubin >15.0 mg/dL
Gut	1	Diarrhea >30ml/kg or >500ml/day
	2	Diarrhea >60ml/kg or >1000ml/day
	3	Diarrhea >90ml/kg or >1500ml/day
	4	Diarrhea >90ml/kg or >2000ml/day; or severe abdominal pain with or without ileus
International Bone Marrow Transplant Registry Severity Index		
A – stage 1 skin involvement; no liver or gut involvement		
B – stage 2 skin involvement; stage 1 to 2 gut or liver involvement		
C – stage 3 skin, liver, or gut involvement		
D – stage 4 skin, liver, or gut involvement		

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3402	Injection, remestemcel-L-rknd, per therapeutic dose (Ryoncil)	<p><u>Initial:</u> IV: 2×10^6 mesenchymal stromal cells (MSC)/kg/dose twice weekly for 4 consecutive weeks (total of 8 infusions). Doses should be separated by at least 3 days. Assess clinical response after 28 ± 2 days</p> <p><u>Retreatment:</u> May consider retreatment after 28 days if: Partial or mixed response or GVHD recurs after complete response;</p> <ul style="list-style-type: none"> • <i>Partial or mixed response:</i> IV: 2×10^6 mesenchymal stromal cells (MSC)/kg/dose once weekly for 4 additional weeks (total of 4 infusion). • <i>Recurrence of GVHD after complete remission:</i> IV: 2×10^6 mesenchymal stromal cells (MSC)/kg/dose twice weekly for 4 consecutive weeks (total of 8 infusions). Doses should be separated by at least 3 days. • <i>No response:</i> Consider alternative therapy.

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Generalized pustular psoriasis (GPP) flares <i>For the treatment of generalized pustular psoriasis NOT in a flare, please see Requirements for Spesolimab-sbzo SC injection (Spevigo)</i>
Exclusion Criteria	<ul style="list-style-type: none"> • Primary plaque psoriasis vulgaris without presence of pustules • Pustules that are restricted to psoriatic plaques • Diagnosis other than for the treatment of a GPP flare
Required Medical Information	<ol style="list-style-type: none"> 1) <u>Initial dose, each distinct flare:</u> <ol style="list-style-type: none"> a. Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). b. Current weight ≥ 40kg c. Clinical notes confirming a diagnosis of moderate to severe GPP flare, including: <ol style="list-style-type: none"> i. Skin biopsy results and ii. Presence of fresh or worsening pustules with both <ol style="list-style-type: none"> a. The mean Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) total score of ≥ 3 (at least moderate severity) b. GPPGA pustulation sub score of at least 2, with pustules & erythema covering an involved body surface area of 5% or greater. 2) <u>Second dose per flare:</u> <ol style="list-style-type: none"> a. Clinical notes with evaluation having occurred between 7-14 days <u>after the first dose</u>, and which include all of the following to confirm need for second dose: <ol style="list-style-type: none"> i. GPPGA score ≥ 2 ii. GPPGA pustulation sub score of ≥ 1 b. The second dose must be administered no sooner than 7 days and no later than 14 days <u>after</u> first dose (ie, with first dose being day 1, 2nd dose should be day 8 to day 15).
Age Restriction	12 years and older
Prescriber Restriction	Prescribed or recommended by a dermatologist
Coverage Duration	One dose (900 mg) per TAR request, with maximum of 1 TAR renewal if needed per flare (a 2 nd 900 mg dose per flare when requirements are met).
Other Requirements & Information	Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:

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

HCPCS	Description	Dosing, Units
J1747	Intravenous i njection, spesolimab-sbzo, 1 mg_ <i><u>Intravenous product only</u></i>	900 mg IV once; if flare persists, an additional 900 mg IV may be given one week later. Each dose is billed as 900 HCPCS units.

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Generalized pustular psoriasis maintenance therapy not in a flare <i>For Generalized pustular psoriasis flare treatment, please see Requirements for Spesolimab-sbzo IV injection (Spevigo IV)</i>
Exclusion Criteria	<ul style="list-style-type: none"> • Primary plaque psoriasis vulgaris without presence of pustules • Pustules that are restricted to psoriatic plaques
Required Medical Information	<ol style="list-style-type: none"> 1. Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). 2. Current weight ≥ 40kg 3. Clinical notes confirming a diagnosis of moderate to severe GPP, NOT experiencing a flare, including all of the following: <ol style="list-style-type: none"> a. Skin biopsy results and b. Generalized Pustular Psoriasis Physician Global Assessment (GPPGA) score of 0 or 1 4. Documentation of at least two moderate to severe flares in the past 12 months with at least one associated with fever, elevated C-reactive protein level, elevated white blood cell count, asthenia or myalgia. <ol style="list-style-type: none"> a. If on concomitant GPP treatment with retinoids, methotrexate or cyclosporine, must have had at least one flare during treatment or following dose reduction/treatment discontinuation. 5. Medical reasons why the member or a caregiver cannot be trained to self-administer Spevigo in the home. Loading doses of 600mg may be self-administered using the 300mg/2ml syringe product.
Age Restriction	12 years and older
Prescriber Restriction	Prescribed or recommended by a dermatologist
Coverage Duration	Case-dependent (medical office single dose requested vs outpatient hospital with multiple doses requested). Limited to the number of doses needed until the member is able to resume self-administration at home.
Other Requirements & Information	<p>This medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled <i>Standard Requirements for Self-Administered Drugs</i>.</p> <p>Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.</p>

Medical Billing:

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

HCPCS	Description	Dosing, Units
J1747	Injection, spesolimab-sbzo, 1 mg <i>Subcutaneous products only</i>	Subcutaneous Dosage for Treatment of GPP When Not Experiencing a Flare: <ul style="list-style-type: none">• Loading dose of 600mg, followed by 300mg every 4 weeks. Initiating or Reinitiating Subcutaneous Spevigo After Treatment of a GPP Flare with Intravenous Spevigo: <ul style="list-style-type: none">• 300mg every 4 weeks, starting 4 weeks after treatment with IV Spevigo

Note: Spevigo SC is available in a 300mg/2 mL and 150mg/1 mL prefilled syringe:

- When using Spevigo 300 mg/2 mL prefilled syringe: If the healthcare professional determines that it is appropriate, a patient 12 years of age or older may self-inject or the caregiver may administer the loading dose and the subsequent doses of Spevigo after proper training in subcutaneous injection technique.
- When using Spevigo 150 mg/mL prefilled syringe: If required, the 600 mg subcutaneous loading dose of Spevigo is to be administered by a healthcare professional. For subsequent 300 mg doses a patient 12 years of age or older may self-inject or the caregiver may administer Spevigo.

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

Committee: Credentials Committee
 Date: 09/10/2025 7:00 AM
 Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Madeleine Ramos, MD*; Bradley Sandler, MD*
 by phone conference*

PHC Staff: 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; Heidi Lee, Senior Manager of Systems and Credentialing; Ayana Shorter, Credentialing Supervisor; J' aime Seale, Credentialing Team Lead; Nolan Smith, Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda Arguello, Lead Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Medical Director Quality Improvement Mark Netherda, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by J' aime Seale Credentialing Team Lead. Dr. Netherda reminded everyone that all items discussed are confidential. a. Partnership Medical Director Quality Improvement Mark Netherda, MD, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Dr. Netherda reminded the committee that all information discussed is confidential in nature.			9/10/2025 9/10/2025
II. Review and approval of 8/13/2025 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for 8/13/2025 were reviewed by the Committee.	II. Summary were reviewed. A motion for approval of the Summary was made by Bradley Sandler, MD and seconded by Michele Herman, MD. Meeting Summary were unanimously approved without changes.		9/10/2025
III. Old Business. a. No Old Business to Report	III. Old Business – a. No Old Business to Report			9/10/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
<p>IV. New Business</p> <p>a. Review and Approval of Routine Practitioner List.</p> <p>b. Review and Approval of Revised Policies.</p>	<p>IV. New Business</p> <p>a. Dr. Netherda referred the Credentials Committee to review the routine list of practitioners. Dr. Sandler asked Partnership Staff why Optometrists are listed on the routine list of practitioners. J'aime Seale Credentialing Team Lead explained that Optometrists who render services for Retinopathy and are not delegated are credentialed by Partnership. Dr. Netherda further explained that diabetic patients would require the service for retinopathy. Dr. Gorchoff stated that diabetes doesn't normally give Optometrists the privilege to screen. Dr. Netherda answered that the provider must specifically state they are performing Retinopathy. Dr. Gwiazdowski added that some optometrists may not be trained to perform retinopathy or be rendering services in specific services (i.e. NCIU services). Dr. Ribordy replied that PCP providers may forward pictures to the Optometrist to check to see if there are any abnormalities. Dr. Gwiazdowski agreed, stating that Telemedicine is utilizing this service more often, as long as the Optometrist is credentialed and has the proper training to complete the service. Dr. Netherda stated Partnership can make sure adult screening only for retinopathy and should be for Diabetic Retinopathy only.</p> <p>b. Review and Approval of Revised Policies presented by J'aime Seale Credentialing Team Lead. J'aime explained the Policies presented are MPCR12 –</p>	<p>IV. New Business</p> <p>a. The Committee reviewed the list of practitioners. A motion to approve the list of practitioners was made by Bradley Sandler, MD and seconded by Steven Gwiazdowski, MD. The Committee unanimously approved the routine list.</p> <p>b. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Madeleine Ramos, MD and seconded by David Gorchoff,</p>		<p>9/10/2025</p> <p>9/10/2025</p>

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
<p>c. CR5 Semi-Annual Evaluation of Practitioner Specific Member Complaints</p> <p>e. NCQA CR8 Update</p>	<p>Credentialing of Individual and Private Duty Nurses Under EPSDT, MPCR15 – Doula Credentialing and Re-credentialing Criteria, MPCR100 – Credential and Re-credential Decision Making Process, MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities, MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements and MPCR602 – Reporting Actions to Authorities. Policies MPCR12, MPCR15, MPCR200 and MPCR304 are all Consent Calendar updates. MPCR100 contains updates for Transportation and MPCR304 contacts updates for practitioners who are credentialed, Electrologist added.</p> <p>c. Dr. Netherda referred the Credentials Committee to CR5 Semi-Annual Evaluation of Practitioner Specific Member Complaints. Dr. Netherda explained that this report will now be reported Quarterly going forward, so the name will change to Quarterly from Semi-Annual. Furthermore, a typo was made regarding agenda language. Agenda original stated “Number of Complaints from Perform Quality Improvement (PQI) is 36, Dr. Netherda stated it should read “Number of Complaints from Potential Quality Issue (PQI) is 36”. <i>Information Only.</i></p> <p>e. Dr. Netherda explained to the Credentials Committee the National Coalition of Quality Assurance (NCQA) had made changes to the 2025 Credentialing standards. The new standard is CR8 now requires Partnership to monitor to ensure appropriate oversight of credentialing Information Integrity. Partnership will accept the information integrity audits from the following delegates: Partnership HealthPlan of California, Dignity, Lucile Packard, Sutter Pacific Medical Foundation/Palo Alto Medical Foundation, Sutter Medical Foundation, University of California Davis and University of California San Francisco. <i>Information Only</i></p>	<p>MD. The Committee unanimously approved the revised policies.</p> <p>d. <i>Information Only</i></p> <p>e. <i>Information Only</i></p>		<p>9/10/2025</p> <p>9/10/2025</p>
<p>V. Ongoing Monitoring of Sanctions Report and</p>	<p>V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.</p>	<p>V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.</p>		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
<p>Practitioner Monitoring List.</p> <p>a. Review and Approval of Ongoing Monitoring of Sanctions Report.</p> <p>b. Practitioner Monitoring List.</p>	<p>a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report.</p> <p>b. The Credentials Committee was asked to review the Practitioner Monitoring List. Dr. Netherda reminded the committee that the credentialing department monitors these boards for any actions regarding our providers. <i>Information only.</i></p>	<p>a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Bradley Sandler, MD and seconded by Madeleine Ramos, MD. The Committee unanimously approved.</p> <p>b. <i>Information only.</i></p>		<p>9/10/2025</p> <p>9/10/2025</p>
<p>VI. Review and Approval of Consent Calendar Items.</p> <p>a. Report of Long Term Care Facility, Hospital, and Ancillary provider list.</p> <p>b. 2nd Quarter Delegated Credentialing ICE Audits</p>	<p>VI. Review and Approval of Consent Calendar Items.</p> <p>a. Dr. Netherda asked the Credentials Committee members to review the report of Long Term Care Facility, Hospital, and Ancillary provider list.</p> <p>b. Dr. Netherda presented to the Credentials Committee the 2nd Quarter Delegated Credentialing ICE Audits for the following delegated entities: Carelon Behavioral Health, DHMG North State, Sierra Nevada, Mercy Medical Group, Woodland Clinic, Stanford Health Care Children's/ Lucile Packard, Solano CPN, SIP: Sutter Independent Physicians, Sutter Medical Group SacPlacer, Solano, Yolo, Mills Peninsula Medical Group, Palo Alto Medical Foundation CPN/Employed, Sutter East Bay Medical Foundation CPN/Employed, Sutter Medical Group of the Redwoods CPN/Employed, Sutter West Bay Medical Group CPN/Employed, University of California Davis, University of California San Francisco and Vision Service Plan (VSP).</p>	<p>VI. Review and Approval of Consent Calendar Items.</p> <p>a/b. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Bradley Sandler, MD and seconded by Steven Gwiazdowski, MD. The Credentialing Committee unanimously approved.</p>		<p>9/10/2025</p>
<p>VII. Meeting Adjourned.</p>	<p>VII. Meeting adjourned.</p>			

Credentials Meeting Summary for 9/10/2025 respectfully prepared and submitted by J'aime Seale Credentialing Team Lead.



Chairman Signature of Approval _____
Mark Netherda, M.D., PHC Credentialing Chairman

Date 9/10/2025

September 2025
Routine Practitioner List

App. Ty	Full Name	NPI Number	Provider Type	Cr	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
I	Abadi, Steven DPM	1922729383	SPEC		Dignity Health Wound Care	Tehama	Foot Surgery	AB of Foot and	3/14/2023	Yes	Admitting Agreer	None
I	Aboody, Daniella A.,Doula	1740091909	SPEC		Dandelion Doula Services	Sonoma	Doula	None		No	None	None
I	Ajduuah, Valerie O.,PA-C	1013348507	PCP		One Community Health - Inf	Yolo	Physician Assis	National Comm	11/14/2013	Yes	None	None
I	Aladag, Belis M.,MD	1295994275	W&R		Redwood Recovery Center	Humboldt	Addiction Medic	ABMS of Family	04/07/2012	Yes	Admitting Agreer	None
I	Alexander, Erika C.,BCBA	1821556879	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	02/25/2022	Yes	None	None
I	Alvarez-Nutting, Mary L.,FNP-C	1447732409	PCP		Marin City Health & Wellness Center		Family Nurse P	American Acad	09/24/2018	Yes	None	None
I	Anderson, Randy BCBA	1750946935	BHP		Nexus Therapies LLC	Solano	BCBA	Behavior Analy	05/13/2021	Yes	None	None
R	Andreassi, Paolo MD	1497730162	SPEC		Adventist Health Physicians	Lake	Urology	Confirmed per /		No	Adventist Health	Active
R	Anello, Melanie FNP	1225336696	SPEC		NBHG: Gastroenterology, A	Solano	Family Nurse P	American Acad	09/01/2010	Yes	None	None
I	Ani, Michael BCBA	1811446446	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	11/30/2019	Yes	None	None
R	Anro, Giancarlo R.,BCBA	1386369015	BHP		Multiplicity Therapeutic Serv	Humboldt	Behavioral Hea	Behavior Analy	08/24/2022	Yes	None	None
I	Arnedo, Regine Paola G.,PT	1932996568	Allied		NBHG: Northbay Rehab Sei	Solano	Physical Therap	None		No	None	None
R	Avila Powell, Tiffany J., MD	1528275864	SPEC		Providence Medical Group,	Humboldt	Neurosurgery	ABMS of Neuro	05/04/2019	Yes	Admitting Agreer	None
R	Avina, Mayra P.,FNP-C	1336597004	PCP		Ole Health	Napa	Family Nurse P	American Acad	09/20/2016	Yes	None	None
I	Azarov, Mariya S.,FNP-C	1528636891	PCP		California Medical Center	Yolo	Geriatric Medic	None		No	None	None
I	Bako, Esmeralda PA-C	1770372039	SPEC		Berman Skin Institute Medic	Solano	Physician Assis	National Comm	04/03/2025	Yes	None	None
I	Banks, La Rae R.,Doula	1982444741	SPEC		Yes I Doula	Contra Costa	Doula	None		Not Applica	None	None
I	Baptiste Youngston, Tracy NP	1609156868	SPEC		NorthBay Health	Solano	Nurse Practitior	None		No	None	None
I	Baracco, Mary J.,CNM	1255429528	SPEC		DBA: Mary Baracco, CNM		Certified Nurse	American Midw	01/01/1997	Yes	None	None
I	Barnas, Christi, FNP	1700297801	PCP		California Medical Center	Yolo	Family Nurse P	American Acad	12/12/2017	Yes	None	None
R	Baron, Maria S.,FNP-BC	1891319455	PCP		West County Health Center:	Sonoma	Family Nurse P	American Nurs	06/07/2023	Yes	None	None
R	Bashir, Muhammad T.,MD	1720081342	SPEC		Comprehensive Renal Care	Butte	Nephrology	ABMS of Intern	11/20/1996	Yes	Enloe Medical C	Active
I	Bedolla, Stephanie L.,ANP-C	1265717565	PCP		Petaluma Health Center	Sonoma	Adult Nurse Pr	American Acad	08/01/2011	Yes	None	None
R	Bellum, Venugopal MD	1225131105	PCP		Elica Health Centers - North	Placer	Family Medicin	ABMS of Family	12/08/2006	Yes	Admitting Agreer	None
I	Berkey, Brittney S.,PA-C	1528837564	PCP		Providence Medical Group,	Sonoma	Physician Assis	National Comm	01/25/2024	Yes	None	None
R	Berna, Zoe D.,MD	1740377118	PCP		Adventist Health Mendocino	Mendocino	Family Medicin	ABMS of Family	07/10/2004	Yes	Adventist Health	Active
I	Berrong, Stacy J.,DO	1760407787	PCP		Northern Valley Indian Health	Yolo	Family Medicin	ABMS of Family	07/21/2005	Yes	Admitting Agreer	Active
I	Blaine, Dennis P.,PA-C	1457443368	SPEC		Enloe Cardiology Services &	Butte	Physician Assis	National Comm	10/10/2002	Yes	None	None
I	Blaylock, Nicole B.,Doula	1225846918	SPEC		Belit Birth Doula	Solano	Doula	None		Not Applica	None	None
R	Bowen, Trina L.,MD	1609878917	PCP		West County Health Center:	Sonoma	Family Medicin	ABMS of Family	07/08/1983	Yes	Admitting Agreer	Active
I	Boyle, Jesse PT	1760054886	Allied		Family Physical Therapy	Placer	Physical Therap	None		No	None	None
I	Brewer, Cyndi L.,PA-C	1790861516	PCP		Enloe Health and Wellness		Physician Assis	National Comm	09/13/2003	Yes	None	None
I	Brewer, Steven W.,FNP-C	1235020991	PCP		Sonoma Valley Community	Sonoma	Family Nurse P	American Acad	06/16/2025	Yes	None	None
I	Butler, Gary FNP-C	1417434358	PCP		Open Door Community Hea	Humboldt	Family Nurse P	American Acad	06/29/2018	Yes	None	None
I	Carrillo, Jacqueline L.,AGNP-C	1063178861	PCP		NBHG: Center for Primary C	Napa	Adult-Gerontolc	American Acad	10/18/2021	Yes	None	None
I	Carvajal, Trojan A.,FNP-BC	1336954395	PCP		Trinity Community Health CI	Trinity	Family Nurse P	American Nurs	05/30/2025	Yes	None	None
R	Charlebois, Stephanie BCBA	1538676101	BHP		Autism Learning Partners	Humboldt	BCBA	Behavior Analy	03/17/2021	Yes	None	None
I	Chaudrue, Viki NP	1184196271	PCP		Round Valley Indian Health	Mendocino	Nurse Practitior	None		No	None	None
I	Chen, Ann-Chi OD	1215243365	SPEC		Ampla Health Yuba City	Sutter	Optometry	None		No	Admitting Agreer	None
R	Chen, Lily MD	1861819815	SPEC		Providence Medical Group-	Napa	Cardiovascular	ABMS of Intern	12/14/2020	Yes	Admitting Agreer	None
R	Clause, Faith C.,FNP	1093250862	SPEC		Catalyst Neuromedical Cent	Shasta	Family Nurse P	American Acad	11/21/2016	Yes	None	None
R	Collins, Sharon L.,AGPCNP-BC	1851804983	PCP		NBHG: Center for Primary C	Solano	Adult-Gerontolc	American Nurs	08/04/2017	Yes	None	None
R	Cooper, Elisabeth M.,PA-C	1114969003	PCP		SCHC: Shasta Community I	Shasta	Physician Assis	National Comm	10/13/2005	Yes	None	None
R	Corona, Mario L.,MD	1679670301	SPEC		East Bay Nephrology Medic	Solano	Nephrology	Previously Boar	11/06/1990	Yes	Sutter Alta Bates	Active
I	Crenshaw, Kaelyn Doula	1932532983	SPEC		Raya Health	Solano	Doula	None		No	None	None
I	Criswell, Sherina Doula	1477327542	SPEC		Not Yo Mama 415 Doula Services		Doula	None		Not Applica	None	None
I	Cruz, Ariana Doula	1477369924	SPEC		Raya Health	Solano	Doula				None	None
I	Cuthbert, Melinda A.,PMHNP-BC	1508109828	PCP		One Community Health - Inf	Yolo					None	None
I	Danielson, Diana Doula	1114810074	SPEC		Diana Danielson	Shasta	Doula	None		Not Applica	None	None

September 2025
Routine Practitioner List

App. Ty	Full Name	NPI Number	Provider Type	Cr	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
I	Del Chiaro, Cara N.,PA-C	1841938057	PCP		Western Sierra Medical Clin	Nevada	Physician Assis	National Comm	05/17/2022	Yes	None	
I	DeLaney, Sara E.,FNP-C	1548697733	PCP		One Community Health - Inf	Yolo	Family Nurse P	American Acad	06/03/2019	Yes	None	
R	Dhanuka, Promila MD	1225094469	SPEC		Promila Dhanuka / PACE C;	Shasta	Medical Oncolo	ABMS of Intern	11/13/2007	Yes	None	Mercy Medical C Courtesy
R	Dickson, Takara M.,PA-C	1184249146	SPEC		NBHG: Heart and Vascular	Solano	Physician Assis	National Comm	08/25/2021	Yes	None	
R	Dipsia, Antoine G.,MD	1013093558	PCP		Elica Health Center	Placer	Family Medicin	ABMS of Famili	07/12/1985	Yes	None	Admitting Agreeer None
R	Doud, Robert B.,MD	1184721821	SPEC		East Bay Nephrology Medic	Solano	Nephrology	ABMS of Intern	10/19/1976	Yes	None	Alta Bates Medic Active
I	Dragoljevic, Jelena PA-C	1104606979	SPEC		Telehealth Specialty Medica	Yolo	Physician Assis	National Comm	09/11/2023	Yes	None	
I	Dudley, Benjamin C.,MD	1669682811	SPEC		NBHG: Center for Specialty	Solano	Urology	ABMS of Urolo	02/28/2013	Yes	None	NorthBay Medicæ Temporary
I	Dundas, Susan H.,PA-C	1003253824	PCP		One Community Health - Inf	Yolo	Physician Assis	National Comm	04/25/2013	Yes	None	
R	Elmes, Cornelis M.,MD	1245280460	SPEC		NBHG: Orthopaedics and P	Solano	Orthopaedic Su	ABMS of Ortho	07/13/2007	Yes	None	NorthBay Medicæ Active
R	Eng, Maia L.,MD	1043604515	SPEC		Adventist Health Physicians	Napa	Cardiovascular	ABMS of Intern	10/04/2021	Yes	None	Adventist Health Provisional
I	Esmailzadeh, Jasmine M.,PA-C	1922830330	PCP		One Community Health - Inf	Yolo	Physician Assis	National Comm	11/06/2024	Yes	None	
I	Evans, Deidre BCBA	1285134304	BHP		Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	07/01/2020	Yes	None	
R	Fadness, Julie M.,FNP-C	1740625516	PCP		MVHC: Mt. Shasta Health C	Siskiyou	Enhanced Care	None		Not Applica	None	
I	Fakiri, Zarlasht DO	1821265448	PCP		5 Rivers Health Inc.	Placer	Internal Medicir	ABMS of Intern	10/27/2020	Yes	None	Admitting Agreeer None
I	Fehrenbacher, Monica I.,FNP-C	1134967144	PCP		One Community Health - Inf	Yolo	Family Nurse P	American Acad	08/14/2023	Yes	None	
I	Fiman, Keith H.,MD	1578564506	SPEC		NBHG: Gastroenterology, A	Solano	Gastroenterolo	ABMS of Intern	11/03/1993	Yes	None	NorthBay Health Provisional Ac
R	Fjarli, Delmer D.,MD	1154783421	SPEC		Adventist Health Clearlake	Lake	Ophthalmology	ABMS of Ophth	05/08/1974	Yes	None	Adventist Health Affiliate
I	Flandez, Judith A.,PA-C	1316482250	SPEC		NBHG: Heart and Vascular	Solano	Physician Assis	National Comm	11/28/2016	Yes	None	
R	Franck, Shannon J.,NP	1407974066	SPEC		Women's Babies' and Child	Shasta	Nurse Practitior	None		No	None	
I	Frankie, Rebekah s., LM	1366737264	SPEC		Family First Maternity Cente	Shasta	License Midwife	None		No	None	
I	Freeman, Andrew M.,DO	1033167697	PCP		UIHS - Crescent City Health	Del Norte	Family Medicin	ABMS of Famili	07/04/1989	Yes	None	Admitting Agreeer None
R	Freeman, Marlene H.,MD	1811960966	SPEC		NBHG: Center for Women's	Solano	Obstetrics and	ABMS of Obste	01/12/2001	Yes	None	NorthBay Medicæ Active Attendi
I	Friend, Jessica L.,FNP-C	1447911029	SPEC		Adventist Health Physicians	Napa	Family Nurse P	American Acad	10/21/2021	Yes	None	Adventist Health Allied Health
R	Galera, Edgardo D.,ACNP	1548597388	SPEC		NBHG: Heart and Vascular	Solano	Nurse Practitior	American Nurs	11/03/2009	Yes	None	
R	Gallo, Christine J., NP	1972847770	PCP		Pediatric Medical Associate:	Yolo	Nurse Practitior	None		No	None	
R	Gandhi, Nandini G.,MD	1578761755	SPEC		Shriners Hospitals for Childr	Yolo	Ophthalmology	ABMS of Ophth	06/03/2012	Yes	None	Shriners Hospita Consulting
I	Garcia Vera, Yvonne LCSW	1588011910	BHP		Burnett Therapeutic Service	Napa	Licensed Clinic:	None		No	None	
I	German De la Cruz, Margaret T.,	1710369657	PCP		One Community Health - Inf	Yolo	Pediatrics	ABMS of Pedia	10/18/2018	Yes	None	Sutter Medical C: None
I	Ghohestani-Bojd, Sara PA-C	1710500848	SPEC		NorthBay Health Urgent Car	Solano	Physician Assis	National Comm	05/21/2020	Yes	None	
R	Gobea, Joanna FNP-C	1083389019	PCP		Marin Community Clinic: Sa	Marin	Family Nurse P	American Acad	08/27/2021	Yes	None	
R	Gogna, Mudita MD	1235391640	SPEC		Sacramento Ear Nose & Thi	Yolo	Allergy & Immu	ABMS of Allerg	11/30/2015	Yes	None	Admitting Agreeer None
I	Gordon, Kenyetta M.,MD	1013101161	PCP		Open Door Community Hea	Del Norte	Family Medicin	Meets MPCR #	12/07/2010	Yes	None	Admitting Agreeer None
I	Gorman, Shaelyn B.,BCBA	1285309583	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	03/24/2025	Yes	None	
R	Goss, Erick K.,PT	1487602942	Allied		Cascade Physical Therapy	Shasta	Physical Therap	None		No	None	
I	Granada, Mark Jason AGNP-C	1386353761	PCP		One Community Health - Inf	Yolo	Adult-Gerontolc	American Acad	10/25/2022	Yes	None	
I	Granillo, Lesvy J.,CADC II	1871786038	W&R		Aegis Treatment Centers, LI	Shasta	Wellness and R	California Cons	05/10/2018	Yes	None	
R	Grierson, Kevin R.,DPM	1154770048	SPEC		Providence Medical Group,	Sonoma	Podiatry	Confirmed per /			None	Petaluma Valley Active
I	Griffin, Elana L.,Doula	1629875935	SPEC		ELG Doula Services	Humboldt	Doula	None		Not Applica	None	
R	Guthrie, Todd B.,MD	1871555334	SPEC		Todd B. Guthrie MD	Siskiyou	Orthopaedic Su	ABMS of Ortho	07/15/1994	Yes	None	Mercy Medical C Active
I	Hanna, Craig P.,FNP-C	1134814809	SPEC		NorthBay Health Urgent Car	Solano	Emergency Nur	American Acad	03/12/2023	Yes	None	
R	Hanson, Brent W.,MD	1437560703	PCP		CommuniCare Ole - Salud C	Yolo	Family Medicin	ABMS of Famili	11/06/2017	Yes	None	Admitting Agreeer None
R	Hedrick, Guadalupe N.,MD	1164417093	PCP		Providence Medical Group,	Sonoma	Pediatrics	Meets MPCR #		No	None	Admitting Agreeer None
I	Hidrogo, Priscilla BCBA	1114517117	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	08/24/2024	Yes	None	
I	Hoang, Thanh D.,DO	1316400401	SPEC		Colusa Indian Health Clinic	Colusa	Internal Medicir	ABMS of Intern	08/29/2022	Yes	None	Enloe Medical C: Active
I	Hoover, Bradley PT	1457244691	SPEC		SPOT, Inc.	Shasta	Physical Therap	None		No	None	
R	Hopper, Ian C.,DO	1396206587	PCP		Petaluma Health Center	Sonoma	Pediatrics	ABMS of Pedia	10/13/2022	Yes	None	Petaluma Valley Active
R	Hyde, Manly R.,MD	1841359437	SPEC		Adventist Health Physicians	Napa	Surgery	ABMS of Surge	05/08/1985	Yes	None	Adventist Health Active
I	Iwanciov, Stephanie BCBA	1770273963	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	09/30/2013	Yes	None	

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App. Ty	Full Name	NPI Number	Provider Type	Cr	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
I	Jackson, Jennifer RD	1053579284	Allied		Kimaw Medical Center	Humboldt	Registered Diet	Commission of	12/06/2004	Yes	None	
I	Jackson, Monica L.,PT	1043791353	Allied		Auburn Orthopedic & Sports Nevada		Physical Therap	None		No	None	
R	Johnston, Casey A.,MD	1699055293	PCP		Mendocino Community Hea	Mendocino	Pediatrics	ABMS of Pedia	10/20/2016	Yes	Adventist - Ukiah	Active
R	Kalra, Ruben MD	1245228766	SPEC		Bay Area Surgical Specialis	Contra Costa	Pain Medicine	ABMS of Anest	09/12/2009	Yes	John Muir Medic	Active Office-f
R	Kang, Tyler Y.,MD	1164691820	SPEC		NBHG: NorthBay Cancer C	Solano	Oncology	ABMS of Intern	10/28/2008	Yes	Adventist Health	Active
R	Kannier, Dean M.,PT	1407931751	Allied		North Valley Physical Thera	Shasta	Physical Therap	None		No	None	
R	Kaplan, Adam G.,MD	1306078050	SPEC		Providence Medical Group,	Sonoma	Urology	ABMS of Urolo	02/28/2018	Yes	Santa Rosa Merr	Active
I	Kasperek, Kimberly PAC	1679905822	SPEC		NBHG: NorthBy Health	Solano	Physician Assis	National Comm	06/30/2013	Yes	None	
I	Kaur, Sukhdeep FNP-C	1073089074	SPEC		NorthBay Health Urgent Car	Solano	Family Nurse P	American Acad	08/23/2018	Yes	None	
I	KC, Dilip MD	1528684818	PCP		5 Rivers Health Inc.	Placer	Internal Medicir	ABMS of Intern	08/28/2023	Yes	Adventist Health	Active
R	Keck, Sara A.,MD	1770743312	SPEC		Providence Medical Group,	Sonoma	Medical Oncolo	ABMS of Intern	10/24/2012	Yes	Santa Rosa Merr	Affiliate
R	Khan, Sumerra DO	1154731818	BOTH		NBHG: Center for Primary C	Solano	Family Medicin	ABMS of Famil	07/01/2017	Yes	NorthBay Medic	Active Non-At
R	Kobe, Kay E.,DC	1568496743	SPEC		Shasta Lake Chiropractic	Shasta	Chiropractic	None		No	None	
R	Kular, Rajdeep S.,MD	1467913061	BOTH		NBHG: Center for Primary C	Solano	Family Practice	ABMS of Famil	07/01/2022	Yes	NorthBay Medic	Active Non-At
I	Kumar, Nikhail A.,OD	1801785118	SPEC		North Valley Eye Care (Rid	Butte	Optometry	None		No	Admitting Agree	Active/Admitti
I	Kvale, John J.,PT	1336379874	Allied		Western Physical Therapy, I	Shasta	Physical Therap	None		No	None	
I	Lacey, Savauna BCBA	1053881656	BHP		Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	07/23/2021	Yes	None	
I	Leasure, Bailey BCBA	1679175624	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	03/11/2025	Yes	None	
I	Lebel, Jacqueline C.,PA-C	1235752346	SPEC		Tahoe Forest MultiSpecialty	Nevada	Physician Assis	National Comm	08/30/2021	Yes	None	
I	Lee, Kevin DO	1356367213	PCP		MRCH: Willow Creek-Six Ri	Humboldt	Family Practice	Meets MPCR#1	07/08/1988	No	Mad River Comr	Active
R	Leshikar, Holly B., MD	1629389853	SPEC		Shriners Hospitals for Childr	Yolo	Orthopaedic Su	ABMS of Ortho	07/24/2018	Yes	Shriners Hospita	Active
R	Lezcano, Sheila D.,MD	1295098390	SPEC		Adventist Health	Tehama	Rheumatology	None		No	Adventist Health	Active
I	Lind, Mary BCBA	1063081735	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	04/22/2025	Yes	None	
I	Linder, Mandela Doula	1376332155	SPEC		Mendocino Coast Doula	Mendocino	Doula	None		Not Applica	None	
I	Lopez, Alan PMHNP-BC	1689429326	SPEC		Tahoe Forest MultiSpecialty	Nevada	Psychiatric Mer	American Nurs	03/08/2024	Yes	None	
I	Lopez, Darien BCBA	1215483243	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	11/30/2019	Yes	None	
R	Lorenzo, Lorissa J.,PA-C	1053970327	SPEC		North Pacific Dermatology	Humboldt	Physician Assis	National Comm	05/23/2019	Yes	None	
I	Lo-Vang, Ying FNP-C	1790221497	SPEC		Butte County Public Health	Butte	Family Nurse P	American Acad	08/30/2016	Yes	None	
I	Loveridge, Cameron PT	1306686191	Allied		Auburn Orthopedic & Sports	Placer	Physical Therap	None		No	None	
I	Maciel, Hibris Doula	1699573725	SPEC		Breeze Doula Services	Solano	Doula	None		No	None	
I	Maganito, James Paul C.,DO	1063692440	PCP		Mendocino Community Hea	Mendocino	Gynecology	American Oste	04/30/2011	Yes	Adventist Health	Active
R	Magliocco, Mai S.,MD	1205102662	PCP		Marin Community Clinic: Sa	Marin	Internal Medicir	ABMS of Intern	08/12/2015	Yes	Admitting Agree	None
R	Mancherje, Cyrus R.,MD	1659398543	SPEC		NBHG: Heart and Vascular	Solano	Cardiovascular	ABMS of Intern	11/20/1985	Yes	Admitting Agree	None
I	Maples, Holly N.,FNP-C	1497314793	PCP		Trinity Community Health CI	Trinity	Family Nurse P	American Acad	08/29/2019	Yes	None	
I	Martin, Tatiana Doula	1285432104	SPEC		Sacred Bond Doula Service	Solano	Doula	None		No	None	
I	McCaffrey, Shawna FNP	1205312774	PCP		SCHC: Shasta Community I	Shasta	Family Nurse P	American Acad	07/05/2018	Yes	None	
R	McCurtain, Loretta R.,FNP-C	1235338096	PCP		MRCH: Mad River Health C	Humboldt	Family Nurse P	American Acad	11/01/1999	Yes	None	
I	Memmott, Jacob FNP-C	1497370001	PCP		Open Door Community Hea	Humboldt	Nurse Practitior	American Acad	06/01/2020	Yes	None	
R	Menacho, Anthony PA-C	1386290195	PCP		CommuniCare Ole -Hansen	Yolo	Physician Assis	National Comm	06/13/2019	Yes	None	
R	Mendoza, Lizette RD	1194445924	Allied		La Clinica - North Vallejo	Solano	Registered Diet	Commission of	08/06/2022	Yes	None	
I	Mercier, Nicholas PT	1487326260	Allied		Rolling Hills Clinic	Shasta	Physical Therap	None		Not Applica	None	
I	Minhas, Navjok K., MD	1720615529	PCP		Adventist Health	Tehama	Family Medicin	ABMS of Famil	07/01/2023	Yes	Adventist Health	Provisional
R	Mizoguchi, Michael B.,MD	1861418808	SPEC		Humboldt Medical Eye Assc	Humboldt	Ophthalmology	ABMS of Ophth	06/11/2006	Yes	Mad River Comr	Active
I	Montgomery, Craig OD	1265986392	SPEC		Ampla Health Yuba City	Sutter	Optometry	None		No	Admitting Agree	Active
R	Montgomery, Keri FNP-C	1881925154	SPEC		Adventist Health St Helena	Napa	Family Nurse P	American Acad	10/01/2009	Yes	None	
I	Mudrenko, Pavel PA-C	1487402251	SPEC		Adventist Health Physicians	Yuba	Physician Assis	National Comm	05/06/2024	Yes	None	
I	Mueller, Shelby H.,AGPCNP-BC	1538611355	PCP		One Community Health - Inf	Yolo	Adult-Gerontolc	American Nurs	09/14/2016	Yes	None	
I	Munoz-Sigala, Carmen Doula	1114733789	SPEC		Raya Health	Solano	Doula	None		No	None	
I	Murphy, Robert B.,MD	1205984416	SPEC		Lake County Tribal Health C	Lake	Obstetrics and	ABMS of Obste	12/07/2012	Yes	Admitting Agree	None

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App. Ty	Full Name	NPI Number	Provider Type	Cr	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
I	Niazi, Enayatullah MD	1609404748	PCP		Niazi Family Medicine & Urg	Yolo	Internal Medicin	ABMS of Intern	08/28/2023	Yes	NorthBay Health	Active Attendi
I	Niazi, Hayatullah PA-C	1932612306	PCP		Niazi Family Medicine & Urg	Yolo	Physician Assis	National Comm	10/12/2017	Yes	None	
I	Nieto, Yadira LCSW	1063976918	SPEC		Ampla Health Lindhurst Mec	Yuba	Licensed Clinic:	None		No	None	
I	Noyce, Lynn T.,AGPCNP-BC	1134867260	PCP		One Community Health - Inf	Yolo	Adult-Gerontolc	American Nurs	07/09/2022	Yes	None	
I	O'brien, Grace A.,PA	1184963928	SPEC		Pacific Skin Institute	Yolo	Physician Assis	National Comm	12/13/2012	Yes	None	
I	Oda, Lindsay Doula	1952094328	SPEC		Raya Health	Solano	Doula	None		No	None	
R	Olivolo, Catherine FNP-C	1710035993	PCP		Fairchild Medical Clinic (PCI	Siskiyou	Family Nurse P	American Acad	11/01/2006	Yes	None	
I	Onwuli, Chinyere J.,PMHNP-BC	1851890131	PCP		One Community Health - Inf	Yolo	Psychiatric Mer	American Nurs	07/27/2018	Yes	None	
R	Pabla, Sharon K.,PA-C	1043594047	PCP		NBHG: Center for Primary C	Solano	Physician Assis	National Comm	09/01/2011	Yes	None	
R	Pagtalunan, Maria Enrica D.,MD	1629175310	SPEC		East Bay Nephrology Medic	Solano	Nephrology	ABMS of Intern	11/10/1994	Yes	Sutter Solano Me	Courtesy
R	Parkin, Jay D.,MD	1780679340	SPEC		Northbay Health Orthopedic	Solano	Orthopaedic Su	ABMS of Ortho	07/11/1996	Yes	Providence Que	Active
I	Patel, Chirag A., MD	1558772830	SPEC		Northern California Vasecto	Solano	Family Plannin	ABMS of Fa	11/08/2017	Yes	Admitting Agree	None
R	Peterson, Snow DO	1477809093	SPEC		Adventist Health Physicians	Napa	Sleep Medicine	AOA of Sleep M	06/19/2018	Yes	Adventist Health	Courtesy
I	Reboja-Dirige, Frances BCaBA	1689175887	BHP		Learning Arts	Yolo	BCABA	Behavior Analy	02/27/2020	Yes	None	
I	Reiter, Samuel J.,MD	1285941195	SPEC		Samuel J. Reiter, MD, PC	Solano	Ophthalmology	ABMS of Ophth	09/21/2019	Yes	Sutter Health - C	Courtesy
I	Reynoso, Tanya E.,LCSW	1215390869	SPEC		Tahoe Forest MultiSpecialty	Nevada	Licensed Clinic:	None		No	None	
R	Rhodes, Jenna BCBA	1801225677	BHP		Teach, Acquire, Thrive	Solano	Behavioral Hea	Behavior Analy	08/31/2014	Yes	None	
R	Roblez, Maricel C.,ANP-C	1811294283	SPEC		NBHG: NorthBay Cancer C	Solano	Adult Nurse Pr	American Acad	11/29/2016	Yes	None	
I	Roggenbuck, Valerie J.,PA-C	1104990274	SPEC		NorthBay Health Urgent Car	Solano	Physician Assis	National Comm	03/05/2018	Yes	None	
I	Rojas, Cristian AMFT	1275002396	W&R		Recover Medical Group	Solano	Associate Marri	None		No	None	
R	Rojo-Cuckovich, Jessica BCBA	1427508282	BHP		Maxim Healthcare Services	Yolo	Behavioral Hea	Behavior Analy	08/31/2016	Yes	None	
R	Romanowski, Kathleen S.,MD	1396075966	SPEC		Shriners Hospitals for Childr	Yolo	Surgery	ABMS of Surge	05/06/2014	Yes	Shriners Hospita	Active
I	Ruiz-Sosa, Monica PA	1255107025	PCP		Mendocino Community Hea	Mendocino	Physician Assis	National Comm	10/28/2024	Yes	None	
R	Sabet, Farzad H.,MD	1164454591	SPEC		Shasta Orthopedics & Sport	Shasta	Physical Medici	Previously Boar	07/01/2006	No	Admitting Agree	None
I	Sarsour, Zahiah BCBA	1861936940	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	02/14/2021	Yes	None	
I	Schroeder, Shannon M.,MD	1831752203	SPEC		Providence Medical Group, Sonoma	Sonoma	Gastroenterolog	None		No	Admitting Agree	None
R	Schwartz, Paul E.,MD	1780796904	SPEC		Shasta Orthopedics & Sport	Shasta	Orthopaedic Su	ABMS of Ortho	07/10/1992	Yes	Mercy Medical C	Active
R	Servioli Verde, Maria J.,MD	1205169109	SPEC		Catalyst Neuromedical Cent	Shasta	Neurology	ABMS of Psych	09/19/2013	Yes	Mercy Medical C	Courtesy
R	Shaw, Elizabeth A.,MD	1740443555	PCP		Marin Community Clinic: So	Marin	Family Medicin	ABMS of Family	07/15/2010	Yes	Admitting Agree	None
R	Shieh, Emil I.,MD	1700960770	SPEC		North Bay Eye Associates Ir	Sonoma	Ophthalmology	ABMS of Ophth	06/07/1998	Yes	Sutter Santa Ros	Active
R	Shiu, Perkin M.,MD	1134375272	SPEC		John Muir Cardiovascular M	Solano	Cardiovascular	ABMS of Intern	11/06/2009	Yes	John Muir Medic	Active
I	Shore, Samara BCBA	1881268530	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	03/18/2025	Yes	None	
R	Simon, Peter J.,MD	1114244175	PCP		Marin Community Clinic: Sa	Marin	Pediatrics	ABMS of Pediar	10/24/2013	Yes	Admitting Agree	None
R	Sloat, Kelsey E.,MD	1588044606	SPEC		Mayers Rural Health Center	Shasta	Obstetrics and	ABMS of Obste	10/27/2023	Yes	Mercy Medical C	Active
I	Smith, Raven Doula	1114720299	SPEC		Loula Perinatal Health Servi	Solano	Doula	None		Not Applica	None	
R	Sprague, Karen R.,FNP-BC	1992887566	PCP		Community Medical Centers	Solano	Family Nurse P	American Nurs	09/01/1995	Yes	None	
I	Stiltz, Michael C.,SUDCC II	1114301686	W&R		Recover Medical Group	Solano	Wellness and F	California Subs	01/02/2025	Yes	None	
R	Stone, Christina L.,CNM	1649348376	SPEC		CommuniCare Ole - Salud C	Yolo	Certified Nurse	American Midw	08/01/2006	Yes	None	
R	Sue, Austin Y.,MD	1487916045	SPEC		Providence Medical Group, Sonoma	Sonoma	Hospice and P	ABMS of Family	11/20/2018	Yes	Petaluma Valley	Affiliate
R	Talebi, Parviz S.,MD	1326097411	PCP		Adventist Health	Butte	Family Medicin	ABMS of Family	07/17/2004	Yes	Adventist Health	Active
I	Tang, Michael M.,MD	1912469446	PCP		NBHG: Northbay Health Prir	Yolo	Internal Medicin	ABMS of Intern	08/29/2022	Yes	NorthBay Medic	Active Non-At
I	Taylor, Katrina A.,CADC III	1184142168	W&R		Siskiyou County Behavioral	Siskiyou	Wellness and F	California Cons	09/19/2023	Yes	None	
R	Taylor, Thomas H.,MD	1942244967	SPEC		North Pacific Cardiology	Humboldt	Wound Care	None		No	Mad River Comr	Active
R	Thakur, Dineshkumar M.,MD	1245243716	SPEC		John Muir Health Cancer Se	Solano	Cardiovascular	ABMS of Intern	11/03/1999	Yes	John Muir Medic	Courtesy
I	Thomas, Lisa M.,PA-C	1295264760	SPEC		NorthBay Health Urgent Car	Solano	Physician Assis	National Comm	06/15/2017	Yes	None	
R	Thompson, Daniel BCBA	1811504673	BHP		Sped Behavior Analysis Sol	Sonoma	Behavioral Hea	Behavior Analy	11/04/2021	Yes	None	
I	Tidwell, Grace MD	1437579786	PCP		One Community Health - Inf	Yolo	Family Medicin	ABMS of Family	06/26/2017	Yes	Admitting Agree	None
R	Tinkelenberg, James W.,PA-C	1205978392	PCP		WeCare Southern Trinity He	Trinity	Physician Assis	National Comm	01/11/2007	Yes	None	
I	Treat, Justin OD	1316553886	SPEC		Royo Eye Care (Ridge Eye	Yuba	Optometry	None		No	Admitting Agree	None

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App. Ty	Full Name	NPI Number	Provider Type	Cr	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
I	Turner, Andrew E.,DO	1366895831	PCP		Open Door Community Hea	Del Norte	Family Medicin	ABMS of Family	07/01/2019	Yes	Admitting Agreeer	None
R	Valdez, Tomas C.,DPM	1811092687	SPEC		Tomas Valdez, DPM	Solano	Podiatry	AB Podiatric M	10/15/1997	Yes	Seton Medical C	Active
R	Vance, Stephen G.,MD	1215909379	BHP		Mendocino Community Hea	Mendocino	Behavioral Hea	None		No	Admitting Agreeer	None
I	Vangala, Hemalatha MD	1356374029	PCP		Marin Community Clinic: No	Marin	Internal Medicir	ABMS of Intern	08/20/2002	Yes	Admitting Agreeer	None
I	Vasquez, Lorraine BCBA	1376121582	BHP		Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	11/30/2019	Yes	None	
I	Vaughn, Deidre PA-C	1437519931	SPEC		Providence Medical Group, Sonoma	Sonoma	Physician Assis	National Comm	02/25/2016	Yes	None	
I	Villalpando, Nancy M.,DC	1023885647	SPEC		Western Sierra Medical Clin	Nevada	Chiropractic	None		Yes	None	
R	Wakil, Fred W.,MD	1710931464	PCP		WeCare Southern Trinity He	Trinity	Primary Care	MP CR# 17 Re		No	Admitting Agreeer	None
I	Ward, Lindsey R.,FNP-C	1487095261	PCP		One Community Health - Inf	Yolo	Family Nurse P	American Acad	07/24/2024	Yes	None	
I	Weiss, Morgan BCBA	1992307102	BHP		Center for Social Dynamics	Solano	BCBA	Behavior Analy	05/22/2025	Yes	None	
I	Wharton, Jenson K., Doula	1215740675	SPEC		Jenson Wharton	Shasta	Doula	None		No	None	
I	Whiston-Lemm, Kathryn ACNP	1972942522	PCP		Ole Health	Napa	Acute Care Nur	American Nurs	11/19/2012	Yes	None	
I	Williams, Emily CADC II	1346039104	W&R		Aegis Treatment Centers, LI	Shasta	Wellness and R	California Cons	06/24/2024	Yes	None	
I	Williams, Valerie BCBA	1659166627	BHP		Bloom Behavior LLC	Butte	BCBA	Behavior Analy	04/10/2025	Yes	None	
I	Woodall, Jasha BCBA	1861004970	BHP		Pantogran LLC dba Center	Yolo	BCBA	Behavior Analy	03/22/2025	Yes	None	
I	Woods, Bradley BCBA	1457244550	BHP		Best Behavior, LLC	Shasta	BCBA	Behavior Analy	05/23/2025	Yes	None	
R	Yost, Jason L.,MD	1932544632	PCP		Open Door Community Hea	Humboldt	Family Medicin	ABMS of Family	07/01/2016	Yes	Mad River Comr	Active
R	Ziran, Navid M., MD	1891704284	SPEC		NBHG: Orthopaedics and P	Solano	Orthopaedic Su	ABMS of Ortho	07/24/2014	Yes	NorthBay Medic	Active
I	Zuniga, Angelica SUDCC	1457158701	W&R		Aegis Treatment Centers, LI	Shasta	Wellness and R	California Subs	07/13/2025	Yes	None	



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MEETING Minutes

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

Date: 9/16/25

Time: 7:30 a.m.- 9:30 a.m.

Facilitator: Mohamed Jalloh, HEO

Coordinator: Bethany Hannah

Meeting Locations:

- WebEx

Attendees:

Shannon Boyle, Isaac Brown, Monika Brunkal, Anna Campbell, Kristina Coester, Dawn Cook, Nicole Curreri, James Devan, Jeffery DeVido, Heather Esget, Margarita Garcia-Hernandez, Kristine Gual, Bethany Hannah, Tony Hightower, Mohamed Jalloh, Amanda Kim, Mary Kerlin, Vicky Klakken, Marshall Kubota, Yolanda Latham, Sue Lee, Stan Leung, Amanda McNair, Robert Moore, Mark Netherda, Rachel Newman, Hannah O'Leary, Sue Quichocho, Manleen Randhawa, Denise Rivera, Liz Romero, Delorian Ruffin, Anthony Sacket, Rebecca Stark, Wendy Starr, Nancy Steffen, Amanda Smith, Christine Smith, Ben Spencer, Chloe Ungaro, Vicquita Velazquez, Edna Villasenor, Emily Wellander, Kory Watkins

Absent: Priscilla Ayala, Katherine Barresi, Robert Bides, Sonja Bjork, Mark Bontrager, Cathryn Couch, Wendi Davis, Noemi Doohan, Greg Allen Friedman, Shandi Fuller, Brigid Gast, Ledra Guillory, Nisha Gupta, Latrice Innes, , Rachel Newman, Katheryn Power, Dorian Roberts, Lynn Scuri, Tim Sharp, Stephen Stake, Amy Turnipseed, Liat Vaisenberg



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External Advisory Members

Name	Affiliation	Org Type	1/21/25	3/18/25	5/20/25	7/15/25	9/16/25	11/18/25
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC		X	X	X	X	
Eugene Durrah Equity Services Manager	Solano County	County						
Ian Kim Chief Medical Officer	Communicare+ Ole	FQHC				X	X	
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System		X		X		
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department				X		
Eva Julien Senior Manager, Quality Improvement	Providence	Health System	X		X	X	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	X		
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital	X	X				
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department		X	X		X	
Robin Schurig, MPH, CPH	Health Alliance of	Community	X	X				



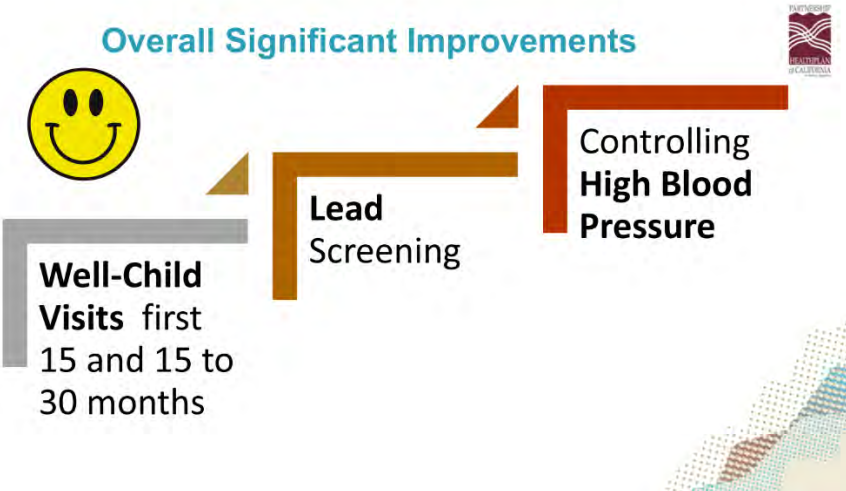
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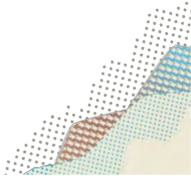


Agenda Topic	Notes	Action Item
<p>Agenda Item 3</p> <p>CMO Health Plan Updates</p> <p>Speaker: Dr. Jones</p>	<p>3. Health Plan Updates (Presented by Dr. Kermit Jones on behalf of Dr. Moore)</p> <p>Updates from CMO office:</p> <ul style="list-style-type: none"> - Revised recommendations for Vaccines: - Emergency legislation has been proposed to allow non-CDC recommended vaccinations through organizations such as the American Academy of Pediatrics, the California Department of Public health and the American Academy of Family Physicians. Details and clarification still need to be worked out amongst these departments. <p>State and Federal Legislation</p> <p>Two BILLS:</p> <p>SB669 – Bill that aims to address the shortage of maternity and perinatal care services in rural California communities has one last vote in the full assembly. Partnerships have been very involved in the negotiations of these last amendments which models stand by models for perinatal care.</p> <p>AB55 – Bill that addresses the alternative Bill birth centers, licensing and medical reimbursement requirements, which aims to streamline the licensing requirements for those centers. There is one last vote in the Senate for this bill to pass, it was last amended on September 2nd</p>	
<p>Agenda Item 4</p> <p>CARES Training Updates</p>	<p>Cares Training Administrative updates/data:</p> <ul style="list-style-type: none"> A. One LHPC Plan had a 2.3% DEI training completion rate B. July, we had 235 practitioners due for credentialing, out of those only 12 took the training which gave us a 5.1% completion rate. C. For August we had 2 people complete the training out of the 209 practitioners assigned to the training which was a completion rate of 0.96%. The overall 	





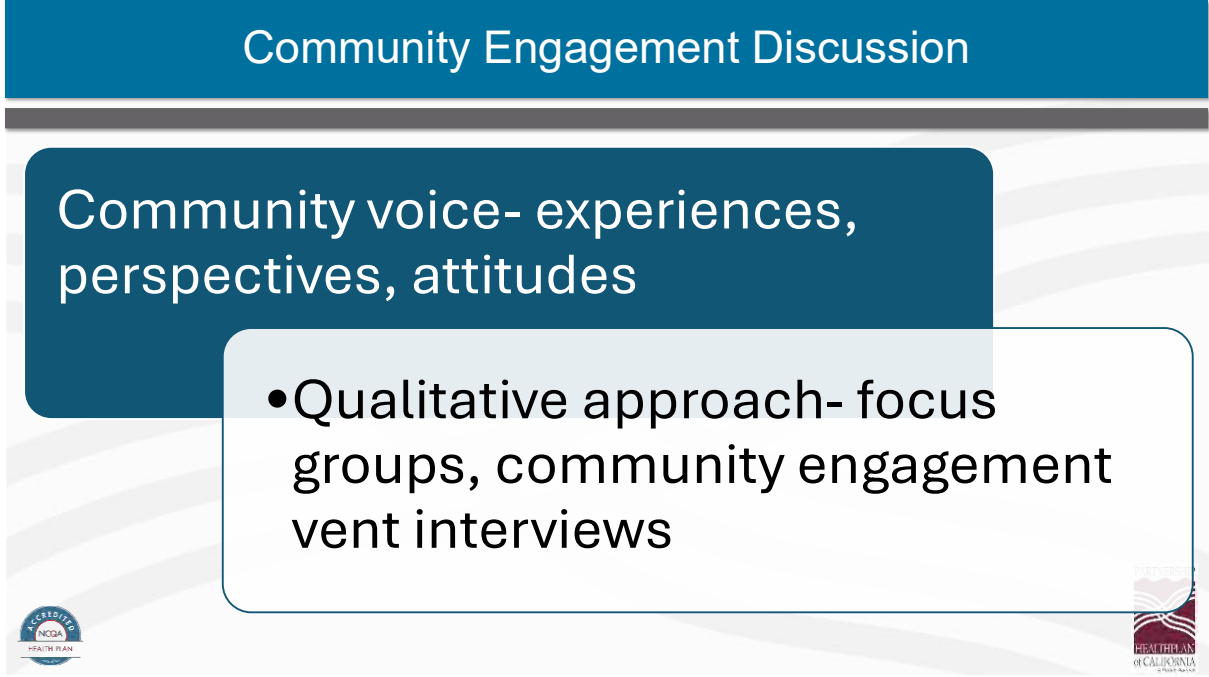
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Agenda Topic	Notes	Action Item
<p>Speaker: Naz Sattari</p>	<p>completion rate based on the two months was 3.2% The data was stratified by region and by practitioner.</p> <p>D. Feedback for the training overall has been very positive.</p> <p>Questions:</p> <p>A. Dr. Ian Kim asked what a target completion rate goal would be, to which Naz responded ideally 100% but realistically 60%. Naz communicated that there will be an increase in completion rates with the official announcement from Partnership</p> <p>B. Dr. Jalloh highlighted that there is not a universally accepted rate but hoping for 20 to 60% range (with 60% being ideal)</p> <p>C. Catheryn Couch asked whether there is a tie to accreditation with this training, she shares that she is very surprised to see how low the completion rate is and asked why the rate is so low. Dr. Jalloh explained that it is a combination of factors, one factor being that the training is not a requirement for the practitioners to complete and because there is no consequence for not completing the training, they may feel they don't want to take the time or do not have the time to prioritize this training.</p> <p>D. Dr. Jalloh also clarified that if providers have a discrimination grievance, then they would also be required to take this training.</p> <p>E. Sue from NCQA highlighted that NCQA are proposing to remove the Health Equity Training and that the NCQA team will release the final updates in Dec 2025.</p>	
<p>Agenda Item 5</p> <p>Grand Analysis: HEDIS/MCAS/ QIP Disparity Analysis (Race</p>	<p>Health Disparities Preliminary Review (updated analysis to be presented later this year)</p> <p>A. Membership Demographics as of Sept. 2025</p> <ul style="list-style-type: none"> -898,094 members -59% Female -52% Aged 21-64 -37.9% White, 34.2% Hispanic, 13.2% unknown 	

Agenda Topic	Notes	Action Item
<p>and Language Stratifications) Speaker: Dr. Jalloh</p>	<p>-10,458 CCS Kids - Sonoma, Solaono, Butte, Shasta, and Placer have the highest number of members</p> <p>Overall Significant Improvements</p>  <p>The infographic features a yellow smiley face at the top left. Below it, three L-shaped boxes are connected by arrows pointing right. The first box is grey and contains the text 'Well-Child Visits first 15 and 15 to 30 months'. The second box is brown and contains 'Lead Screening'. The third box is orange and contains 'Controlling High Blood Pressure'. A small logo of the Partnership HealthPlan of California is in the top right corner of the infographic area. A map of California is partially visible in the bottom right corner.</p>	

Agenda Topic	Notes	Action Item
	<p style="text-align: right;"></p> <p>Trends for Child and Adolescent Measures</p> <ul style="list-style-type: none"> • Well-Care visits(WCV) and Childhood Immunizations (CIS-10) continue to remain below MPL for majority of race groups • Lead screening in Children (LSC) is lower in Black members • Immunizations for Adolescents (IMA) is significantly lower for White members  <p style="text-align: right;"></p> <p>Trends for Cancer Screening Measures</p> <ul style="list-style-type: none"> • Cervical Cancer screenings(CCS) rates continue to remain below MPL for majority of race groups • Breast cancer screenings (BCS) rates continue to have multiple groups below MPL with Tribal members having the lowest rate • Colorectal Cancer screenings (CCS) evaluation Not included 	

Agenda Topic	Notes	Action Item
	<p style="text-align: right;"></p> <p>Trends for Prenatal and Postpartum Measures</p> <ul style="list-style-type: none"> • Timeliness of Prenatal Care Measures remain competitive above 85% completion rate • Postpartum Care Measures significantly high with 89.54% completion rate <ul style="list-style-type: none"> ○ Black group below MPL when compared to other races <p style="text-align: right;"></p> <p>B. Discussion Question: Any thoughts on these findings?</p> <p>- Dawn comments that the immunization rates in the Northern region seem to be lower than the Southern region and speculates whether the data from this year includes the expansion counties. Dr. Jalloh agrees that this could be a factor but also that we are still wanting to hear from the other members to see if they have any ideas as to why we might be seeing these numbers as well. Dr. Jalloh also explains that competing with Kaiser would also influence the data.</p> <p>- Eva Julien from Providence states that some of the work they have been doing at Providence has been to understand root causes of barriers and find solutions. She states that one barrier they have been mitigating is providing resources and CHW services to help offer services for translation in other languages specifically for scheduling upcoming wellness visits.</p> <p>-Dr. Kim shares that in Yolo County many patients were displaced by Dignity Health and were placed with Communicare Ole and as a result many children could not get</p>	

Agenda Topic	Notes	Action Item
	<p>all their well child visits. Across Solano, Napa and Yolo counties, Communicare+OLE changed EMRs from ECW to Epic starting in August of 2024. This transition meant that there was lower access for several months and the new EMR is still catching up about a year from the date.</p> <p>Dr. Jalloh recommended that sites reach out to their QI reps if they have questions about accessing the the dashboard where health systems can log in to see Care Gaps and share the data with providers as well.</p>	
<p>Agenda Item 6</p> <p>Community Feedback</p> <p>Speaker: Jesus Hermosillo</p>	<p>Community Engagement Discussion</p>  <p>The slide features a blue header with the text "Community Engagement Discussion". Below the header, a dark blue box contains the text "Community voice- experiences, perspectives, attitudes". A white callout box with a blue border contains a bullet point: "• Qualitative approach- focus groups, community engagement vent interviews". At the bottom left of the slide is the NGA logo, and at the bottom right is the HealthPlan of California logo.</p>	

Methodology

Interviews

- Focus Groups (45min-1hr)
 - Virtual
 - In-person
- Interviews at Community engagement events
 - MS/PHM
 - HE

Disparities Mem. Demo.

- Disparities defined by HEDIS Data
 - Current focus-broad metrics impacting all regions
- Demographics and regions aligned with HEDIS data

Engagement Areas

- Large community events (turn out)
- Events aligned with department priorities
- Current focus:
 - Maternal health
 - Health Fairs



Focus Group Findings

Demo & Settings

- Auburn: 9 Latino-identifying (in person)
- Fairfield: 8 Black/African American (in-person/Virtual)

Focus Area

- Access
- System Navigation
- Health Equity

Format



Access

- Limited services/providers

System Navigation

- Confusion PHC vs. Medical
- Low awareness on PHC services

Preventative Care

- Limited education on screenings/vaccines

Health Equity

- Immigration status

Auburn
Region

Access

- Low appointment availability
- Providers did not return phone calls

System Navigation

- Low awareness of PHC services
- No point of contact (e.g. billing, eligibility)

Health Equity

- Dismissal of concerns
- Institutional mistrust
- Immigration status

Fairfield
Region



Agenda Topic	Notes	Action Item
	<div style="text-align: center; background-color: #0072bc; color: white; padding: 5px; border-radius: 10px; margin-bottom: 10px;"> <h2 style="margin: 0;">Community Engagement Interviews</h2> </div> <div style="display: flex; justify-content: space-around;"> <div style="border: 2px solid #0072bc; border-radius: 20px; padding: 10px; width: 30%; background-color: #e6f2ff;"> <p>Settings</p> <ul style="list-style-type: none"> Fairfield (18), Eureka (9), Satna Rosa (3), Chico (4) Maternal Health (e.g. Baby showers) Resource/Health fairs <p>Focus Area</p> <ul style="list-style-type: none"> Access System Navigation Health Equity <p style="text-align: center; background-color: #0072bc; color: white; border-radius: 50%; padding: 5px; margin-top: 10px;">Format</p> </div> <div style="border: 2px solid #0072bc; border-radius: 20px; padding: 10px; width: 30%; background-color: #e6f2ff;"> <p>Access</p> <ul style="list-style-type: none"> Low appointment availability Providers did not return phone calls <p>System Navigation</p> <ul style="list-style-type: none"> Low awareness on PHC services No translation services <p>Health Equity</p> <ul style="list-style-type: none"> Immigration status Dismissal of concerns <p style="text-align: center; background-color: #0072bc; color: white; border-radius: 50%; padding: 5px; margin-top: 10px;">Fairfield Region</p> </div> <div style="border: 2px solid #0072bc; border-radius: 20px; padding: 10px; width: 30%; background-color: #e6f2ff;"> <p>Access</p> <ul style="list-style-type: none"> Limited services/providers <p>System Navigation</p> <ul style="list-style-type: none"> Low awareness of PHC services Poor coordination of appointments <p>Health Equity</p> <ul style="list-style-type: none"> Dismissal of concerns Institutional mistrust <p style="text-align: center; background-color: #0072bc; color: white; border-radius: 50%; padding: 5px; margin-top: 10px;">Eureka Region</p> </div> </div> <p>Questions/Comments:</p> <p>F. Anthony Sacket commented on a pilot idea, partner with a low performing provider site invest into an infotainment setup, computer TV monitor content member testimonies et cetera, loop in partnership prevention care information, tailoring language formats. Partnership can fund the equipment and content management the providers will, with improve their QIP scores, and our members when living healthier lives which Jesus felt was a great idea.</p>	



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Agenda Topic	Notes	Action Item
<p>Agenda Item 7: Disparity Discussions: Systemic Concerns</p> <p>Speaker: All</p>	<p>Open discussion on what could be key drivers for Disparities</p> <p>A. Majority of race groups have the following disparities:</p> <ul style="list-style-type: none"> -Well Child Visits -Childhood Immunizations -Cervical Cancer Screenings -Breast Cancer Screenings <p>- Issac Brown asks if anyone from the group has seen any issues with the age range being lowered in terms of recommendations for breast cancer screenings. Dr. Kim shares anecdotally he feels that women are eager to have breast cancer screenings in general and he does not get much push back related to that. He also feels that patients are asking much earlier to be screened for colon cancer. He also states that now they can use Cologuard and that it is a more convenient way to screen for colon cancer and he is curious to see how this will impact. Issac asks if they are using the self-swab for cervical cancer and if they are seeing good results at Communicare Ole. Dr. Kim responds that this is a great way to screen in a non-invasive way, and he has had several colleagues successful with this screening.</p> <p>B. Dr. Jalloh asks how we should consider ranking the disparities in terms of priority?</p> <ul style="list-style-type: none"> -Post partum rate for African American Mothers -Immunization for Adolescents for White Members -Lead Screening in Black Members - Breast Cancer Screening for tribal members 	



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Agenda Topic	Notes	Action Item
	<ul style="list-style-type: none"> - Dr. Netherda states that in his opinion, prioritizing Breast cancer screenings for tribal members would save the most lives and be the disparity he would choose to focus on. C. Dr. Jalloh asks what members think is a key driver could for some of these disparities. <ul style="list-style-type: none"> - Jesus Hermosillo states that the lack of understanding/promotion on the reason of why to have the screenings/vaccines done within a certain time. - Dr. Jalloh states that we will be stratifying the data by race, language and homeless population and will be presenting that data this coming year. D. Goal is to increase Post Partum PPC-PPN rate by 5% for black mothers by Dec 2026 to achieve MPL goal by 80%. <ul style="list-style-type: none"> -We will vote on policy suggestions in future QIHEC meetings as well as any QMSI interventions and community-based interventions for the disparities we reviewed/identified. <p>-Dr. Kim states that there is an issue with the current Political climate is causing families to make different choices about vaccines and we will need to be intentional about educating families. Dr. Jalloh agrees and goes on to say that we should take a stance on social media regarding vaccines as well as give information and education on why they are necessary and important as well as to combat misinformation due to the speed of misinformation spreading.</p>	
<p>Agenda Item 8: Next Meeting</p> <p>Speaker: Dr. Jalloh</p>	<p><i>November 18, 7:30 am to 9:00 am PST</i></p>	

Proposed 2026 LTC QIP Measurement Set

Key:

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

2023 Measures	Proposed 2026 Measures
<p>Gateway Measure 1: CMS Five-Star Quality Rating</p> <p>Points: N/A</p> <p>Target: 2 or more stars to be eligible for other program measures</p>	No changes
<p>Gateway Measure 2: California Immunization Registry (CAIR) Enrollment</p> <p>Points: N/A</p> <p>Target: CAIR enrollment required to be eligible for other program measures</p>	No changes
	<p>Gateway Measure 3: Quality Assurance and Performance Improvement (QAPI) Plan Submission</p> <p>Points: N/A</p> <p>Target: Submission by 6/30/26: Full credit Submission between 7/1/26 - 12/31/26: 50% decrease</p> <p>Submission after 12/31/26, will result in gateway not met and ineligibility for other program measures.</p>
Clinical Domain	
<p>Measure 1: Percentage of long-stay high-risk residents with pressure ulcers</p> <p>Points: 10</p> <p>Target: Full Points: < 5.1% Partial Points: 5.1 – 5.3%</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> 2025 Natl AVG: 5.4% 2025 CA AVG: 5.1% </div>	No changes
<p>Measure 2: Percentage of long-stay residents who lose too much weight</p> <p>Points: 10</p> <p>Target: Full Points: < 4.3% Partial Points: 4.3 – 5.4%</p> <div style="border: 1px solid black; padding: 2px; display: inline-block;"> 2025 Natl AVG: 5.5% 2025 CA AVG: 4.3% </div>	No changes

<p>Measure 3: Percentage of long-stay residents who needed and got a flu shot AND successful entry into CAIR</p> <p>Points: 10</p> <p>Target: Full Points: > 98.4% Partial Points: 93.5 – 98.4%</p>	<p>Remove CAIR entry requirement</p> <div data-bbox="558 247 836 342" style="border: 1px solid black; padding: 2px;"> <p>2025 Natl AVG: 93.4% 2025 CA AVG: 98.4%</p> </div>
<p>Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia AND successful entry into CAIR</p> <p>Points: 10</p> <p>Target: Full Points: > 98.5% Partial Points: 93.5 – 98.5%</p>	<p>Remove CAIR entry requirement</p> <div data-bbox="558 558 836 653" style="border: 1px solid black; padding: 2px;"> <p>2025 Natl AVG: 93.4% 2025 CA AVG: 98.5%</p> </div>
Functional Status Domain	
<p>Measure 5: Percentage of long-stay residents experiencing one or more falls with major injury</p> <p>Points: 10</p> <p>Target: Full Points: < 1.7% Partial Points: 1.7 – 3.2%</p>	<p>No changes</p> <div data-bbox="578 888 836 982" style="border: 1px solid black; padding: 2px;"> <p>2025 Natl AVG: 3.3% 2025 CA AVG: 1.7%</p> </div>
<p>Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder</p> <p>Points: 10</p> <p>Target: Full Points: < 1.2% No Partial Points</p>	<p>No changes</p> <div data-bbox="578 1167 836 1262" style="border: 1px solid black; padding: 2px;"> <p>2025 Natl AVG: 1.2% 2025 CA AVG: 1.2%</p> </div>
Resource Use Domain	
<p>Measure 7: Number of hospitalizations per 1,000 long-stay resident days</p> <p>Points: 15</p> <p>Target: Full Points: < 1.83% Partial Points: 2.17 – 1.83 %</p>	<p>No changes</p> <div data-bbox="558 1461 836 1556" style="border: 1px solid black; padding: 2px;"> <p>2025 Natl AVG: 1.83% 2025 CA AVG: 2.18%</p> </div>
Operations & Satisfaction Domain	
<p>Measure 8: Health Inspection Star Rating</p> <p>Points: 10</p> <p>Target: Full Points: 4 or more stars Partial Points: 3 stars</p>	<p>No changes</p>

<p>Measure 9: Staffing Rating</p> <p>Points: 15</p> <p>Target: Full Points: 4 or more stars Partial Points: 3 stars</p>	<p>No changes</p>
<p>Measure 10: QI Training</p> <p>Points: 5</p> <p>Target: Full Points: Facilities attending PHC's Hospital Quality Symposium do not need to submit evidence of attendance. Facilities attending other trainings must submit evidence of training attendance by February 2023.</p> <p>No Partial Points</p>	<p>Remove measure due to concern with not meeting current criteria for a pay-for-performance measure</p>
<p>Measure 11: Health Equity</p> <p>Points: 5</p> <p>Full Points: Facilities will submit a project addressing Health Equity at the beginning of the measurement year. The submission will be an outline of their project that PHC will review and approve or reject.</p> <p>No Partial Points</p>	<p>Remove measure due to concern with not meeting current criteria for a pay-for-performance measure</p>

Community Reinvestment

Review of Requirements and Funding Ideas

Mohamed Jalloh, PharmD

Health Equity Officer

What Are The Minimum Funding Calculations?

Base Community Reinvestment Requirement

MCPs **and** Qualifying Subcontractors with positive net income must contribute:

- 5% of annual income if **net revenue is less than or equal to 7.5%**
- 7.5% of annual income if **net revenue is greater than 7.5%**

**Annual net revenue for initial cycle must come from their Medi-Cal contract revenues for 2024.*

Quality Achievement Requirement

MCPs with positive net income must contribute:

- **An additional 7.5%** of their annual net income for counties with an Enforcement Tier 2 or 3 assignment
 - *Tier 2: assigned to any county where MCP has 2 or more measures below MPL in any 1 MCAS domain*
 - *Tier 3: assigned to any county where MCP has 3 or more measures below MPL in 2 or more MCAS domains*

**Funding will be 100% allocated to improving quality measures below target for counties within Enforcement Teir 2 or 3*

What Are We Allowed to Fund?

DHCS will require MCPs to allocate Community Reinvestment funds toward a defined set of categories tailored to the specific needs of their communities.



Cultivating Neighborhoods & Built Environment

(e.g., neighborhood revitalization, affordable housing, new wing of a rural health clinic)



Cultivating a Health Care Workforce

(e.g., training programs to address workforce shortages and establish career pipeline for Medi-Cal members; additional staffing to support weekend hours at a community clinic)



Cultivating Well-Being for Priority Populations *(e.g., tailored support for foster children & youth, justice-involved, maternal/child populations, individuals experiencing homelessness)*



Cultivating Local Communities

(e.g., education initiatives, employment & training programs, wellness initiatives to address social isolation)



Cultivating Improved Health Outcomes

(e.g., initiatives to address immediate and long-term health outcomes by targeting improvements in quality measures in which the MCP underperformed)

Developing the Healthcare Workforce Examples

- **Funding scholarships** for allied health professional students.
- **Designing or expanding programs to locally recruit, train, and fill high-demand healthcare jobs** to expand the pipeline of high school and college-age individuals within underserved communities.
- **Funding high school-based doula training programs to align with the Medi-Cal Enrollment Requirements and Procedures for Doulas** in rural and underserved areas.
- **Supporting programs to promote the career pipeline, representation, and advancement of under-represented populations in the health tech sector.**

What are the investing requirements per county?

- For CY 2024, an **MCP in its first year of operation in a given county** is subject to Community Reinvestment beginning the following year in that county.
- For example, an **MCP in its first year of operation within a given county in CY 2024**, Community Reinvestment requirements beginning with the MCP's **CY 2025 annual net income** and **CY 2025 MCAS measure performance**

Investment Period 1 (2025 to 2028) for 14 Legacy Counties



Investment Period 1 (2025 to 2028) for 10 Expansion Counties

Initial Community Reinvestment Plan (Phase 1)

Due Q3 CY 2026

CY 2025 Net Income



Subsequent Community Reinvestment Plan (Phase 2)

Due Q3 CY 2027

CY 2026 Net Income



Subsequent Community Reinvestment Plan (Phase 3)

Due Q3 CY 2028

CY 2027 Net Income

INITIATE + PLAN

- Develop project charter and plan
- Identify core project team
- Have kick-off meeting

EXECUTE + CONTROL (Q3 2025)

- Develop program framework for allocating and managing community reinvestment activities
- Stakeholder engagement and communication
- Identify data reports, existing assessments, and data elements necessary to prioritize community needs

EXECUTE + CONTROL (Q4 2025)

- Develop a preliminary Community Reinvestment strategy
- Circulate initial Community Reinvestment Plan draft for internal review; revise as needed

EXECUTE + CONTROL (Q1 2026)

- Present Partnership's Community Reinvestment Plan to external stakeholders; revise as needed
- Develop/refine Phase II project deliverables and timelines

Special Meeting in December 😊

Q2
2025

Q3
2025

149

Q4
2025

Q1
2026



2025 Primary Care and OB Vacancy Rate Survey

David Lavine

Associate Director of Workforce Development



Survey Overview

Purpose: Track provider vacancy data across 24 counties, compare year-over-year trends, and inform future workforce strategies

Background and Methodology

- The 2025 Point-in-Time Provider Vacancy Rate Survey assesses gaps between current and desired staffing for primary care and OB providers.
- Builds on the 2024 survey with consistent methodology for year-over-year comparison.
- Minor question updates ensure continuity and comparability.
- Captures point-in-time vacancy rates as of Q2 2025.

Vacancy Rate = Vacant FTE / (Working FTE + Vacant FTE)

Provider Vacancy Rate Survey



Survey Sample Size

104 healthcare organizations (500+ members) surveyed across 24 counties.



Response Rate

80% response rate, with 83 organizations participating - strong engagement.



Geographic and Organizational Reach

Respondents represent 271 medical sites, reflecting diverse geographic and organizational settings in sample.



Focus on Provider Vacancies

The survey identifies notable provider vacancies, with persistent recruitment challenges in primary care and obstetrics.

Primary Care Provider (PCP) Vacancy Overview - 2025

Overall Vacancy Rate: 21.1% (↓ from 25.6%)

Total PCP FTEs: 1,489 (↑ from 1,404)

Vacant Positions: 314 (↓ from 359)

Clinician Type	Working FTE	Vacant FTE	Total FTE	Vacancy %
Physician	557	193	750	25.7%
APC	618	121	739	16.4%
Total	1175	314	1489	21.1%

Key Findings: Primary care staffing gaps remain significant, though vacancy rates overall show modest improvement compared to prior years.

Physician vacancies are higher than those for Advanced Practice Clinicians (APCs), with a 25.7% vacancy rate compared to 16.4%.

PCP Vacancy Rate Survey – Rural Findings

Completely rural counties:

Modoc, Plumas, Sierra and Trinity

Counties with rural populations under 10%:

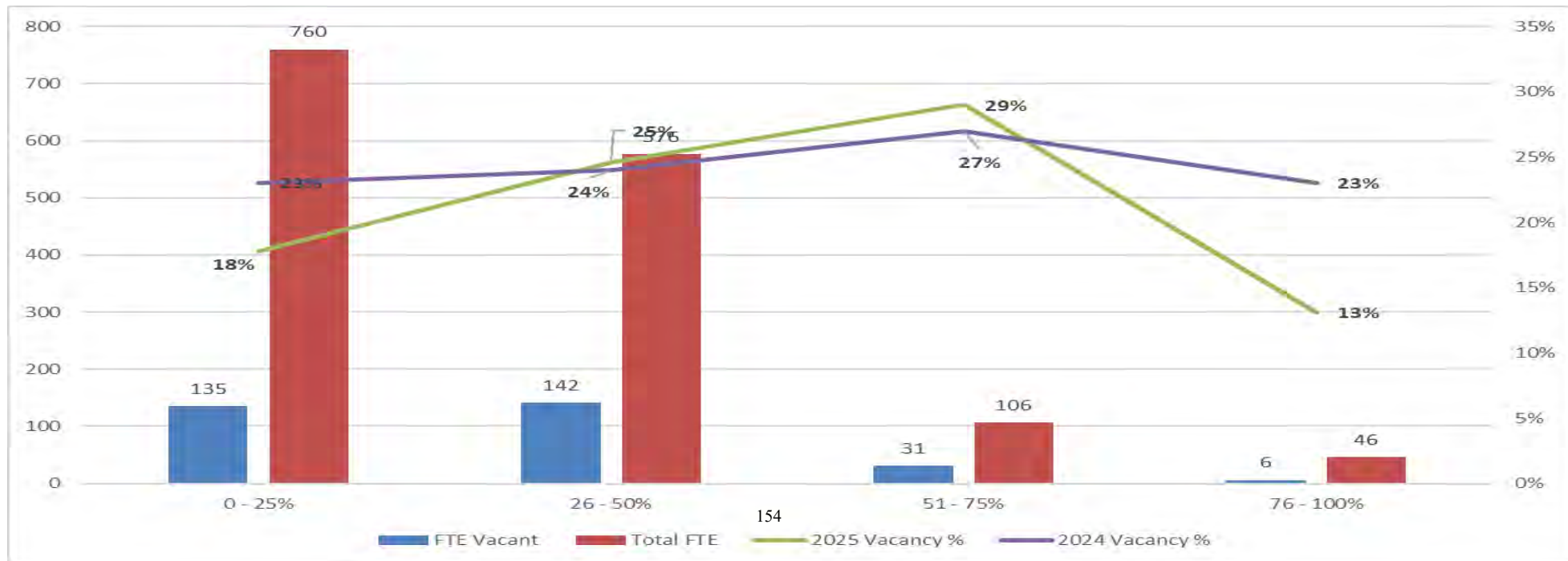
Yolo, Marin, and Solano

Key finding:

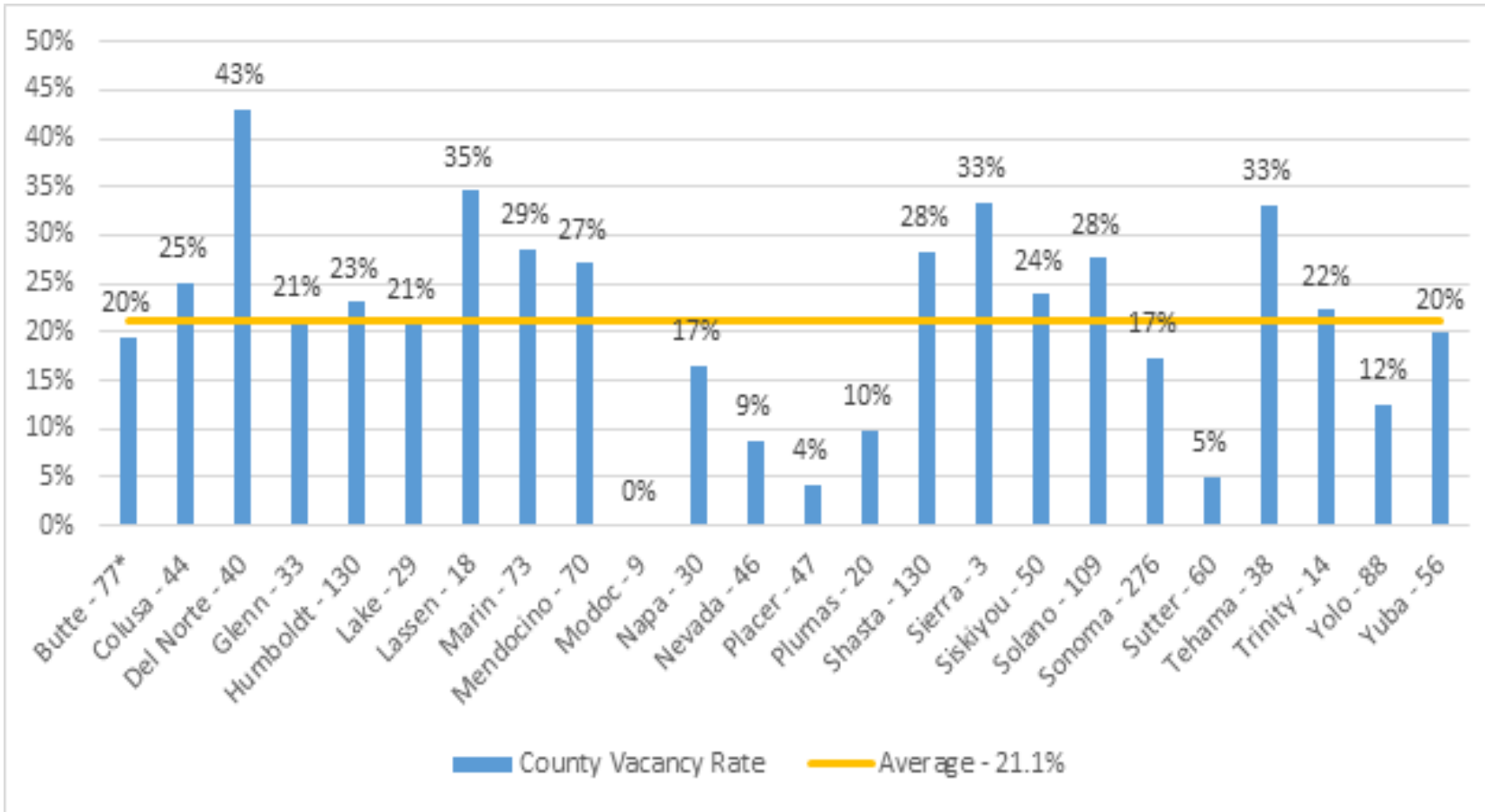
Rurality alone does not predict vacancy

Rural*	Counties
0 - 25%	Solano, Marin, Yolo, Sonoma, Placer, Napa, Sutter, Butte
26 - 50%	Yuba, Humboldt, Shasta, Lake, Glenn, Colusa, Del Norte, Nevada, Mendocino
51 - 75%	Tehama, Siskiyou, Lassen
76 - 100%	Sierra, Modoc, Plumas, Trinity

*County rurality was defined using U.S. Census Bureau classifications



PCP Vacancy Rate County Comparison



Low Vacancy Counties	
Yolo	12%
Plumas	10%
Nevada	9%
Sutter	5%
Placer	4%
Modoc	0%

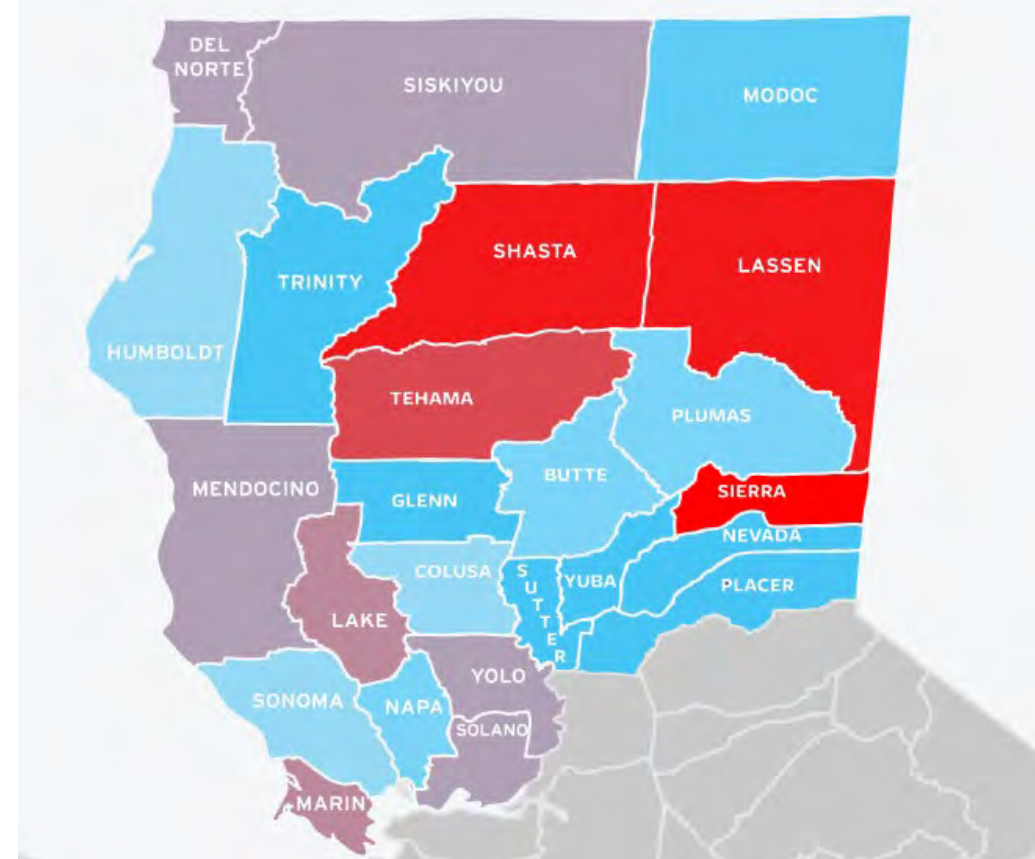
High Vacancy Counties	
Del Norte	43%
Lassen	35%
Tehama	33%
Sierra	33%
Marin	29%
Shasta/Solano	28%

*County and total FTE (working and vacancies)

Key Finding: Vacancy rates vary widely by county—from 0% in Modoc to over 35% in Del Norte and Lassen—highlighting the importance of region-specific workforce strategies.

24/25 Year-Over-Year PCP Vacancy Comparison

County	2024 Vacancy Rate	2025 Vacancy Rate	% Change
Sierra	23.8%	33.3%	9.5%
Shasta	20.4%	28.3%	8.0%
Lassen	26.8%	34.6%	7.8%
Tehama	28.3%	33.1%	4.8%
Marin	27.3%	28.6%	1.3%
Lake	20.3%	21.0%	0.7%
Solano	27.8%	27.6%	-0.2%
Del Norte	43.9%	43.0%	-0.8%
Siskiyou	24.8%	23.9%	-0.9%
Yolo	13.7%	12.4%	-1.2%
Mendocino	28.5%	27.1%	-1.3%
Colusa	29.4%	25.0%	-4.4%
Sonoma	22.3%	17.4%	-4.9%
Humboldt	28.0%	23.0%	-5.0%
Napa	23.8%	16.6%	-7.2%
Butte	27.8%	19.5%	-8.2%
Plumas	18.4%	9.8%	-8.6%
Modoc	12.5%	0.0%	-12.5%
Yuba	34.4%	19.8%	-14.5%
Sutter	20.7%	5.0%	-15.7%
Nevada	24.7%	8.7%	-16.0%
Placer	20.4%	4.3%	-16.1%
Trinity	39.0%	22.2%	-16.8%
Glenn	47.9%	21.2%	-26.7%



Key Finding

From 2024 to 2025, vacancy rates dropped 16–27% in Nevada, Placer, Trinity, and Glenn (led by Glenn), while Sierra, Shasta, and Lassen saw 7–10% increases—reflecting shifting regional workforce trends.

OB Vacancy Overview - 2025

Overall Vacancy Rate: 30.3% (↓ from 33%)

Total OB FTEs: 228 (↓ from 254)

Vacant Positions: 69 (↓ from 82.6)

Orgs providing OB services ≥ 1 county: 45% of respondents

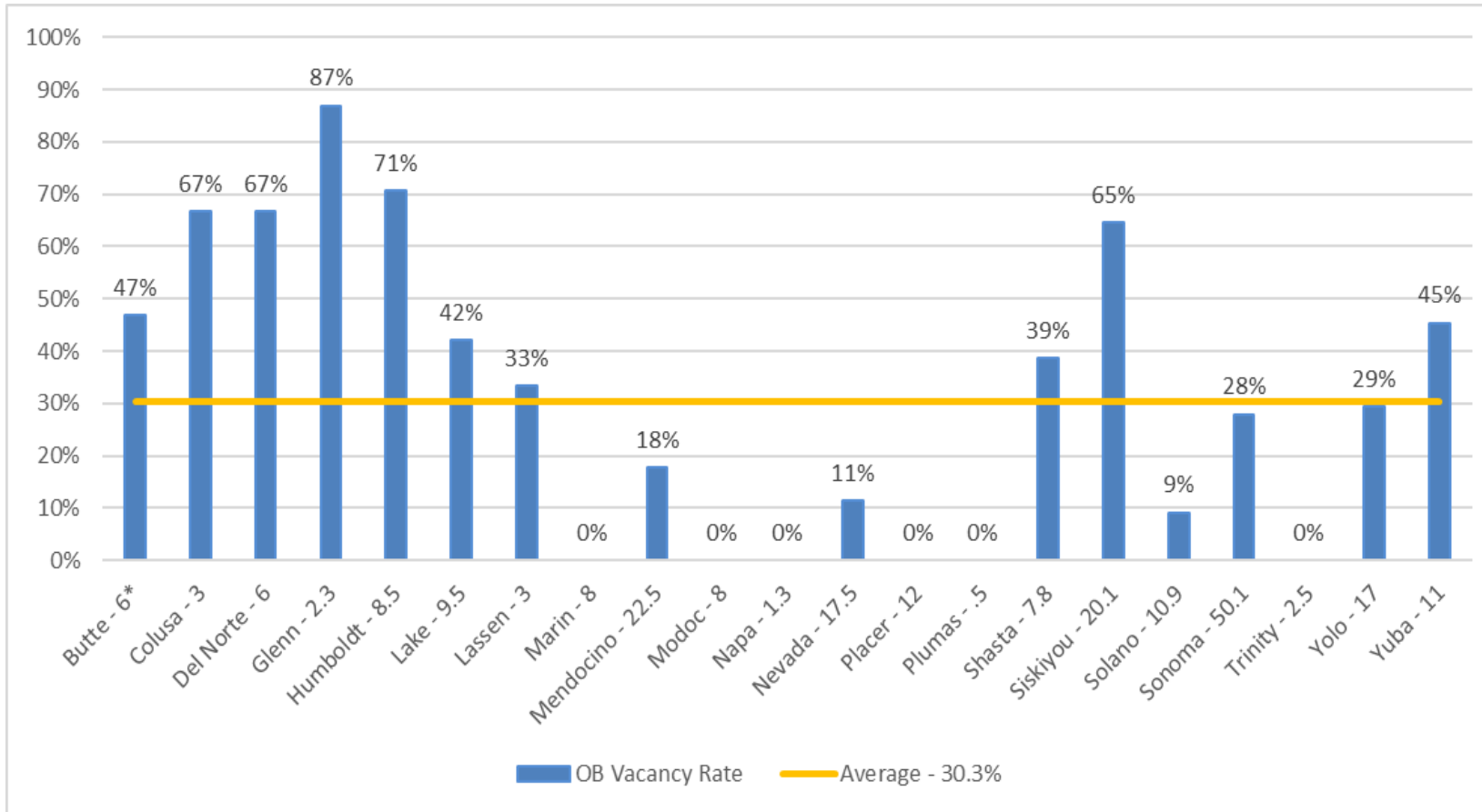
Clinician Type	Working FTE	Vacant FTE	Total FTE	Vacancy %
Physician	118	40	158	25.3%
APC	41	29	70	41.4%
Total	159	69	228	30.3%

Key Findings: The OB vacancy rate declined modestly overall, suggesting some improvement in recruitment and retention.

APC vacancy rate is significantly higher than physician vacancy rate, with a 41.4% vacancy rate compared to 25.3%.



OB Vacancy Rate County Comparison



Low Vacancy Counties	
Modoc	0%
Plumas	0%
Trinity	0%
Napa	0%
Marin	0%
Placer	0%

High Vacancy Counties	
Glenn	87%
Humboldt	71%
Colusa	67%
Del Norte	67%
Siskiyou	65%
Butte	47%

*County and total FTE (working and vacancies)

Key Finding: While more counties exceeded 40% OB vacancy rate in 2025 than in 2024, a greater number of counties also reported being fully staffed in 2025 (six counties as compared to just one in 2024).



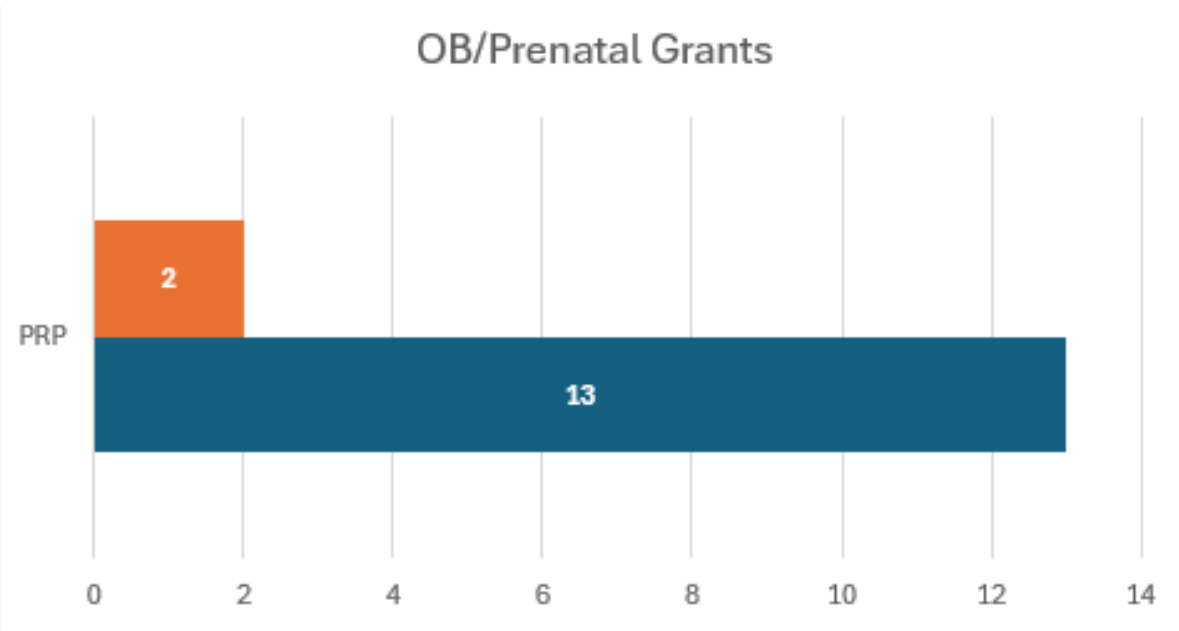
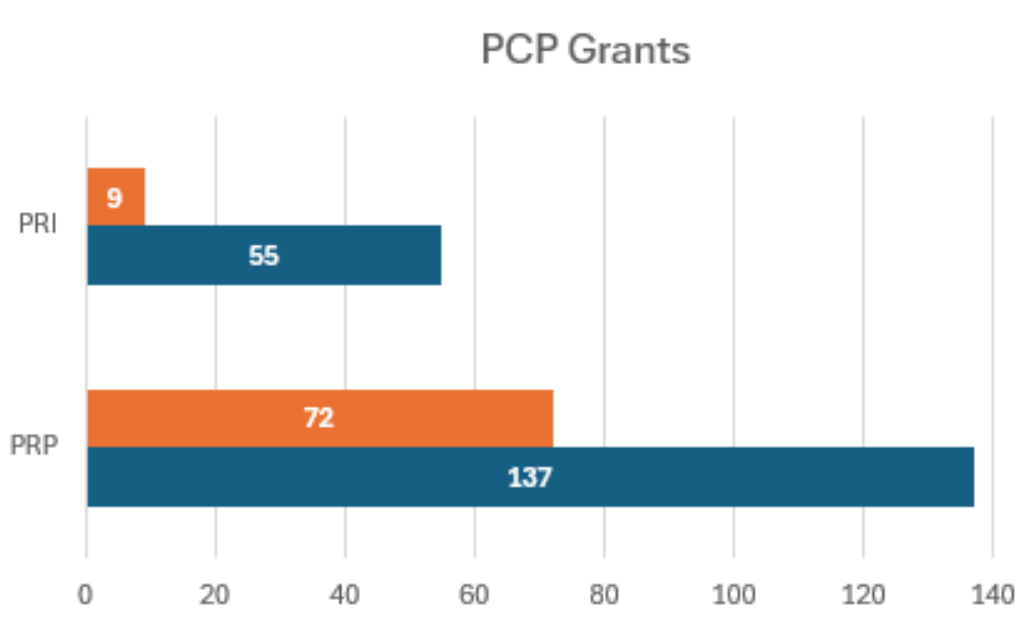
PRP and PRI Grant Activity

Provider Recruitment Program (PRP)

PRP offers up to \$100K over 5 years for PCPs, OBs, and mental health providers

Provider Retention Initiative (PRI)

PRI offers up to \$45k over 3 years for PCPs, OBs, and mental health providers



Year	Total Awards	Vacancy Rate
2024	81	25.6%
2025	192	21.1%

Year	Total Awards	Vacancy Rate
2024	2	33%
2025	13	30.3%

Conclusion & Next Steps



Learn from Success: Capture best practices from improving counties and organizations



Investigate Challenges: Analyze drivers of rising vacancies on a county and organizational level



Strengthen Monitoring: Continue annual tracking across all 24 counties to guide regional strategies

