PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (20)

Steve Gwiazdowski, M.D.	Chris Myers, D.O.	John McDermott, FNP-PAC	Michele Herman, M.D.
Angela Brennan, D.O. (Chair)	Christina Lasich, M.D.	Karen Sprague, MSN, CFNP	Mills Matheson, M.D.
Brent Pottenger, 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.	Vanessa Walker, D.O.

Partnership Executive Staff:

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

Regional Medical Directors	Region	Region Directors
Jeffrey Ribordy, MD	Eureka - Del Norte, Humboldt, Mendocino & Lake	Vicky Klakken
Bradley Cox, DO	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Tim Sharp
Colleen Townsend	Fairfield - Napa, Yolo & Solano	Kathryn Power
Lisa Ward, MD	Santa Rosa - Marin & Sonoma	Leigha Andrews
R. Doug Matthews, MD	Chico - Glenn, Butte, Sutter, Colusa & Yuba	Rebecca Stark
Matthew Morris, MD	Auburn - Plumas, Sierra, Nevada & Placer	Jill Blake

Kermit Jones, MD, Medical Director for Medicare Services
Jeffrey DeVido, MD, Behavioral Health Clinical Director
Mark Netherda, MD, Medical Director of Quality Improvement

Directors / Managers / Associate Directors

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

cc: Partnership Commission Chair
Kim Tangermann, Partnership Board Chair

FROM: PAC@partnershipHP.org
DATE: August 8, 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, August 13, 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 5th Street
Eureka, CA

Partnership - Auburn
281 Nevada St.
Auburn, CA 95603

Partnership - Chico
2760 Esplande, Suite 130
Chico, CA 95973

Sutter-Roseville
6 Medical Plaza
Roseville, CA 95661

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

Tahoe Forest Health Systems
10976 Donner Pass Rd., Suite 9
Truckee, CA 96161

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

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

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

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

Date: August 13, 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
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Redding, CA

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Willits, CA 95490

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3260 Kerner Blvd.
San Rafael, CA 94901

PUBLIC COMMENTS	**Speaker**	**2 minutes**
	Speaker	**2 minutes**

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

Welcome / Introductions

I.		**STATUS UPDATES**	**LEAD**		**TIME**
A.	**I**	**Chief Executive Officer Administration Updates**	**Ms. Bjork**		**7:35**
B.	**I**	**Chief Medical Officer Health Services Report**	**Dr. Moore**		**7:50**
C.	**I**	**Regional Medical Director Reports**	**LEAD**		**TIME**
1	**I**	Napa, Yolo & Solano	**Dr. Ribordy**		**8:00**
2	**I**	Marin & Sonoma	**Dr. Ward**		**8:04**
3	**I**	Del Norte, Humboldt, Mendocino & Lake	**Dr. Ribordy**		**8:08**
4	**I**	Glenn, Butte, Sutter, Colusa & Yuba,	**Dr. Matthews**		**8:12**
5	**I**	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	**Dr. Cox**		**8:16**
6	**I**	Plumas, Sierra, Nevada & Placer	**Dr. Matthews**		**8:20**
II.	*I*	*OFFICE PRACTICE UPDATE*	*LEAD*		*TIME*
III.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG**	**TIME**
A.	**A**	**Review of June 11, 2025 PAC Minutes**	**Dr. Brennan**	**5**	**8:24**
B.	**A**	**Consent Review: Agenda Items III. B.1, B.2, B.5, and B.7** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Brennan**	**13 - 149**	**8:26**
1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – June 18, 2025** ***Acceptance of Draft Meeting Minutes:*** • Q/UAC Agenda, June 18, 2025 • Q/UAC Motion Summary, June 18, 2025 • Internal Quality Improvement Meetings June 10, 2025 • Quality Improvement Update – June 2025 ***Special Presentations (for reference only, not included in packet)*** • 2025 Grievance and Appeals Annual Report • 2025 InterQual Summary • 2025 Population Health Management Grand Analysis	**Dr. Brennan**	**13** **15** **29** **44** **N/A**	**8:26**

III.	A	MOTIONS FOR APPROVAL CONTINUED	LEAD	PG	TIME
B.	A	**Consent Review: Agenda Items III. B.1, B.2, B.5, and B.7**	**Dr. Brennan**	**13 - 149**	**8:25**
2	C	***Policies/Procedures/Guidelines for Action –***			**8:26**

Quality Improvement	
MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review) *(New Attachments)*
MPQP1004	Internal Quality Improvement Committee
MPQP1008	Conflict of Interest Policy for QI Activities
MPXG5009	Lactation Clinical Practice Guideline
Utilization Management	
MCUG3134	Hospital Bed/ Specialty Mattress Guidelines
MCUP3041	Treatment Authorization Request (TAR) Review Process
MCUP3044	Urgent Care Services
MPUG3010	Chiropractic Services
MPUP3014	Emergency Services
MPUP3039	Direct Members
MPUP3111	Pulmonary Rehabilitation
MPUP3139	Criteria and Guidelines for Utilization Management
Care Coordination	
MCCP2024	Whole Child Model For California Children's Services (CCS)
MCCP2036	Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities *(New)*
MPCP2014	Continuity of Care
MCCP2020	*Lactation Policy and Guidelines (formerly Breastfeeding Guidelines) (Archived- Moved to Population Health)*
MCCP2021	*Women, Infants and Children (WIC) Supplemental Food Program (Archived- Moved to Population Health)*
Pharmacy Operations	
MCRP4064	Continuation of Prescription Drugs
MCRP4068	Medical Benefit Medication TAR Policy
MPRP4001	Pharmacy & Therapeutics (P&T) Committee
MPRP4062	Drug Wastage Payments
Provider Relations	
MPPR207	Annual Physician Satisfaction Survey
Population Health Management	
MPND9001	Population Health Management Strategy & Program Description
MPND9002	Cultural & Linguistic Program Description
MPNP9004	Regulatory Required Notices
MPNP9007	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)
MPNP9008	Women, Infants and Children (WIC) Supplemental Food Program

Policy Summary
Synopsis of Changes |

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III.	A	MOTIONS FOR APPROVAL	LEAD	PG	TIME
B.	**A**	**Consent Review: Agenda Items III. B.1, B.2, B.3, and B.5**	**Dr. Brennan**	***13 - 149***	**8:26**
3	**C**	**Pharmacy & Therapeutics Committee** • Summary, July 10, 2025 • Approved Criteria	**Dr. Stan Leung**	**62**	**8:26**
4	*C*	*Provider Engagement Group (PEG) Report*	*Ms. Kerlin*		
5	**C**	**Credentials Committee Meeting** • Summary, May 14, 2025 • Credentialed List, May 14, 2025 • Summary, June 11, 2025 • Credentialed List, June 11, 2025	**Dr. Netherda**	**134 138 142 146**	**8:26**
6	*C*	*Pediatric Quality Committee*	*Dr. Ribordy*		
7	*C*	*Quality Improvement Health Equity Committee Meeting Minutes*	*Dr. Jalloh*		
C.	**A**	**Physician Advisory Committee Membership** • Resignation of Dr. Brent Pottenger • Nomination of Dr. Brian Montenegro	**Dr. Brennan**	**150 151**	**8:28**
IV.	*I*	• *Old Business*			
V.		**SPECIAL PRESENTATIONS**	**LEAD**		**TIME**
A.	**I**	**HEDIS© MY2024 Annual Summary of Performance**	**Ms. Gual**	**152**	**8:30**
VI.	**I**	**ADJOURNMENT**	**LEAD**		**9:00**
		Next PAC on September 10, 2025 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: **June 11, 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:	Steven Gwiazdowski, MD *(FF)*	Danielle Oryn, DO	Malia Honda, MD *(E)*	*FF Fairfield*	*MCC Marin Community Clinics*
	Angela Brennan, DO *(FF)*	Darrick Nelson, MD *(R)*	Matthew Zavod, MD *(FF)*	*SR Santa Rosa*	*OMM Office of Dr. Matheson*
	Brent Pottenger, MD *(FF)*	Derice Seid, MD *(MCC)*	Michele Herman, MD *(FF)*	*E Eureka*	*SH Sutter Health Roseville*
	Candy Stockton, MD *(E)*	John McDermott, FNP *(C)*	Mills Matheson, MD *(OMM)*	*R Redding*	*SL Sutter Health Lakeside*
	Chris Myers, MD *(E)*	Karen Sprague, MSN, CFNP	Teresa Shinder, DO *(FF)*	*C Chico*	
	Christine Lasich, MD *(SL)*	Karina Gookin, MD *(AU)*		*AU Auburn*	
Members Excused:	Mustaffa Ammar, MD	Chester Austin, MD	Vanessa Walker, DO		
Members Absent:					

Visitor: Dr. Brian Montenegro, NorthBay Neonatology Associates, Director of Neonatal Intensive Care Unit, NorthBay Hospital, Fairfield, CA

Partnership Staff:	Sonja Bjork, Chief Executive Officer	Robert Moore, MD, Chief Medical Officer	Jeffrey Ribordy, MD, Region Medical Director
	Jennifer Lopez, Chief Financial Officer	Katherine Barresi, RN, Chief Health Services Officer	R. Doug Matthews, MD, Region Medical Director
	Wendi Davis, Chief Operating Officer	Colleen Townsend, MD, Region Medical Director	Marshall Kubota, MD, Region Medical Director
	Leigha Andrews, Regional Director	Mark Netherda, MD, Medical Director for Quality	Teresa Frankovich, MD, Associate Medical Director
	Mary Kerlin, Sr. Dir., Prov. Relations (PR)	Jeffrey DeVido, MD, Behavioral Health Clinical Dir.	Nancy Steffen, Dir., Quality & Perf. Improvement
	Lisa O'Connell, Director of Enhanced Health Services	Stan Leung, Pharm.D., Director, Pharmacy Services	Heather Esget, RN, Director, Utilization Mgmt. (UM)
		Vacant, RN, Assoc. Dir. UM Strategies	Kevin Jarret-Lee, RN, Assoc. Dir. of UM
	Doreen Crume, RN, N. Mgr. Care Coord.	Sue Quichocho, Mgr., Quality Measurement	Kristine Gual, Director, Quality Measurement
	Stephanie Nakatani, Supervisor, Provider Relations Representatives	Amy McCune, Manager of QI Programs	Isaac Brown, Director, Quality Management
		Bradley Cox, MD, Northeast Region Medical Director	Mohamed Jalloh, Pharm.D., Director, Health Equity
	Vicky Klakken, Dir., North Region	James Cotter, MD, Associate Medical Director	Megan Shelton, Project Manager, Quality Improvement
	Brigid Gast, RN, Dir. of CC		DeLorean Ruffin, DrPH, Director, Population Health
			David Lavine, Assoc. Dir. of Workforce Development

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	17/20 – PAC	Committee quorum requirements met (17).	06/11/25

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

I.A. Chief Executive Officer Report	**Partnership's Chief Health Services Officer provided the following Partnership activities on behalf of the Chief Executive Officer (CEO).**
	
	Health Equity Progress
	• Partnership to submit National Coalition for Quality Assurance (NCQA) Health Equity Accreditation (HEA) application on June 17, 2025 and will be formally notified of results in September.
	• Partnership working with Rival to offer Diversity, Equity, and Inclusion (DEI) training to all providers in Partnership's network in compliance with Department of Health Care Services (DHCS) All Plan Letter (APL).
	  • Communicare+Ole has agreed to be a pilot site for training 78 of their clinicians and providing feedback.
	  • A phased approach will be used for new providers joining Partnership's network in the future.
	State Budget
	• Governor Newsom released the May budget revise showing a 12B dollar deficit.
	• Despite that gap, Medi-Cal Medicaid program has increased spending of about $15 billion year-over-year to a total budgeted package of a 195B dollars.
	  • Discussions are being had regarding Proposition 35 dollars, pharmacy benefits, and potential elimination of acupuncture benefits.
	  • The largest impact will be on those who have unsatisfactory immigration status (UIS) proposing a freeze on new enrollments and implementation of a $100 copay for those currently enrolled no sooner than 1 January 2027.
	  • Anticipating a 25% disenrollment rate to MediCal as a result.
	• State budget will be finalized in July 2025
	Federal Budget
	• Monitoring H.R.1 One Big Beautiful Bill Act (OBB) for impacts.
	• Potential Impacts
	  • Freeze on provider taxes
	  • Work requirements all eligible beneficiaries to demonstrate that they are actively seeking work or actively employed beginning 1 January 2029.
	  • Financial penalties for states providing Medicaid benefits to UIS members.
	Legislative Advocacy
	• Several California associations such as Local Health Plans of California (LHPC) and California Primary Care Association (CPCA) have met to discuss state and federal landscape and send letters to California legislature regarding the budget.
	• Partnership executives have attended meetings in Washington D.C. to share members' stories so others understand the potential impacts to real people.
	Dual Special Needs Program (D-SNP)
	• Partnership Advantage to be delayed to 1 January 2027 due to allow adequate testing and implementation of Health Rules Player (HRP) systems integration at Partnership HealthPlan.
	
	Questions
	
	In regard to H.R.1OBB, is there a line item around gender-affirming care? Can we continue to provide for patients? Will their hormones be covered?
	
	California legislators will have to make decisions regarding covering benefits that may be excluded from federal approval based on several factors. Guidance has not yet been provided so it is too soon to know how gender-affirming care will be affected in the future.

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

I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services.**
	
	• **Legislative Update**
	  • Governor Newsom proposed changes to Medicaid for undocumented workers in efforts to save an estimated $5 billion.
	  • Beginning January 2026, new enrollees aged 19 years or older would no longer be accepted if they lack permanent legal status
	  • Those already enrolled will not lose Medi-Cal coverage, and children are still eligible, but adults may face a $100 per month premium starting in 2027.
	• **Partnership Activities**
	  • 2024 Healthcare Effectiveness Data and Information Set (HEDIS©) final results to be submitted in May. Results will be reported in August.
	  • Primary Care Provider Quality Incentive Payments (PCPQIP) checks are in the process of being approved and mailed.
	• **PCP QIP Results**
	  • 390 sites participating, up from 252 in 2023, largely due to geographical expansion and addition of 10 new counties in 2024
	  • Average adjusted score dropped from 68% to 59% due to a couple of factors:
	  • Threshold targets were increased to pre-pandemic thresholds, making them harder to achieve.
	  • Legacy counties reaching 75th percentile received partial credit.
	  • Legacy counties reaching 90th percentile received full credit.
	  • Expansion counties reaching 50th percentile in the first year received full credit.
	  • Approximately $52 million was earned by all the sites for all the different factors, including about $1M for unit of service incentives.
	  • Many sites with at least 50 members assigned scored above 90th percentile in addition to two private practices.
	  • **Private Practice**
	  • West Marin Medical Center (100%)
	  • Shasta Family Care (91%)
	  • **Medical Groups**
	  • Sutter Medical (Yolo) (95%)
	  • NorthBay Center for Primary Care, Hilborn Clinic (93%)
	  • Queen of the Valley Medical Associates, Trancas (92%)
	  • Marin Community Clinics
	  • Larkspur (98%)
	  • Greenbrae (97%)
	  • San Rafael Campus Clinic (94%)
	  • San Rafael Clinic (92%)
	  • Navato (92%)
	  • South Navato (92%)
	  • Communicare+Ole
	  • St. Helena (98%)
	  • Calistoga (98%)
	  • Napa (90%)
	  • Santa Rosa Community Health, Lombardi (93%)
	  • Petaluma Health Center
	  • Petaluma (93%)
	  • Point Reyes (92%)
	  • Mendocino Coast Clinics Pediatric Group (92%)
	  • Open Door Community Health Center Ferndale (90%)

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

I.B. Chief Medical Officer Health Services Report, Continued	• **PCP QIP Results, Continued**
	Notable Achievements in Quality
	  • Lake County Tribal Health, Round Valley Tribal Health and K'ima:w Medical Center scored 75% or higher.
	  • Ampla Health, eight sites scored above weighted average, highest - Yuba City Pediatrics
	  • Northern Valley Indian Health, two sites scored above average, highest – Willows clinic.

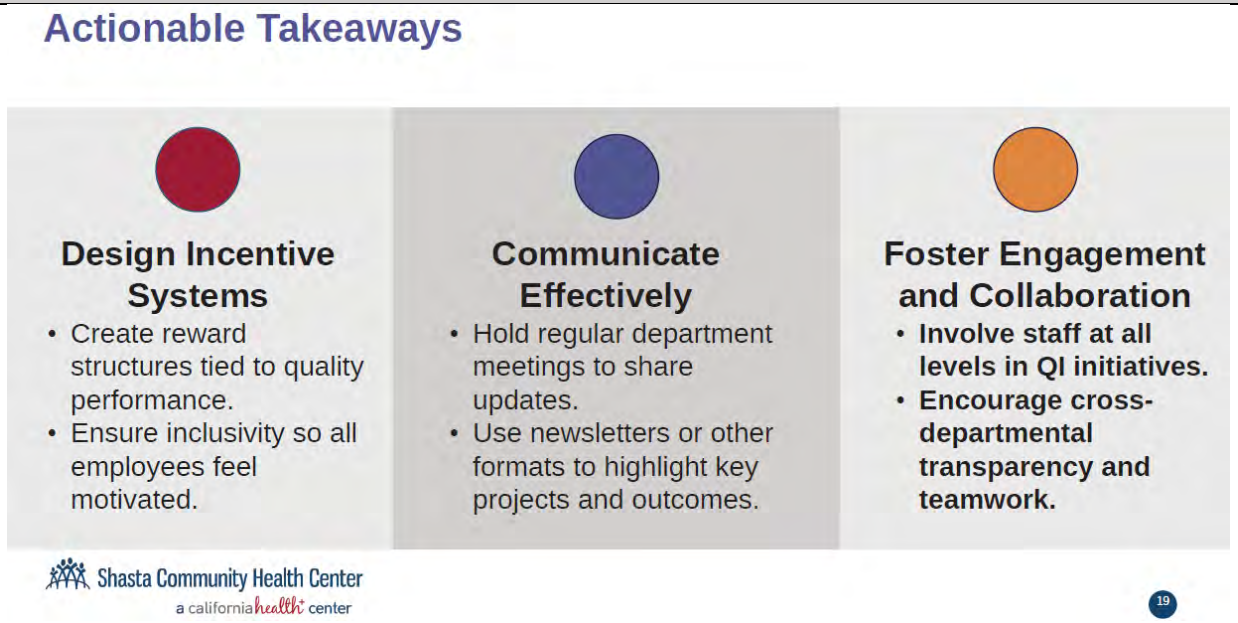
I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • Monica Morales has been appointed Director of Yolo County Health and Human Services. Mike Wood has been appointed as an Administrator. • Partnership's Pharmacy department has continued efforts with Academic Detailing to improve chronic disease management in area clinics. • Kindergarten Roundup vaccination drives are being held in Solano County. • UC Davis in Yolo County saw eight cases of pertussis (whooping cough) and has focused on increasing Tdap vaccination rates. • Several practices are transitioning to the use of Epic for electronic medical records and experiencing reduction in availability due to need to train staff and ensure smooth integration. • Self-swab for cervical cancer screening has been approved by the Federal Drug Administration (FDA). Partnership has contracted with LabCorp Quest for delivery of those units. Training for use of self-swab kits are available for health care providers upon request.
I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Continuing to build relationships through meetings with CEO of Sonoma Valley Community Health, Ms. Sarah Brewer, and CEO of Marin Community Clinics, Ms. Brenda Shipp. • Area regional clinics are meeting with Partnership to cultivate ideas for access grants. • Engaging with Marin Community Health and Wellness in ongoing Quality Improvement efforts. • Alliance Medical Center has expanded Behavioral Health access at its Windsor location.
I.C.3. Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Round Valley Indian Health has appointed Dr. Maria Danilychev as Chief Medical Officer. • Mendocino Community Health Centers is acquiring a new site to expand offerings. • Sutter Lakeside broke ground on a new building in Hidden Valley Lake. • United Indian Health Service in Humboldt County had a grand opening for its Valley East building. • Nitrous Oxide abuse continues to be an increasing problem with significant side effects. Partnership's Clinical Director for Behavioral Health recently held a webinar on the issue recommended to review for providers and is available at Partnership's Office of the Chief Medical Officer site.
I.C.4. Status Update, Regional Medical	**Partnership's Regional Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.** • Centers for Medicare & Medicaid Services (CMS) removed Glenn Medical Center's critical access hospital designation due to distance from competing hospitals. CMS requires a distance of 35 miles or more, and two area hospitals are 33.5 miles and 34 miles away. Glenn Medical Center has filed an appeal. The reimbursement status for the removal of the designation may have long-reaching effects impacting inpatient care beginning in 2026. • Several camps of unhoused individuals have seen increased law enforcement activity, and Partnership is working with Yuba Sutter Public Health to ensure members remain able to access care. • Efforts to create a street medicine program through the Family Practice Residency in Chico are ongoing. • Feather River Tribal Health is expanding in Yuba County. • North Valley Medical Society and Butte Glenn Medical Society has a new Executive director: Bridget McBride.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.C.5. Status Update, Regional Medical	**Partnership's Regional Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Mobile mammography clinics are being held throughout the region. • Banner Lassen's CEO, Ms. Sandy Dugger, is leaving the area. Mr. Thomas Prescott will serve as interim CEO effective 23 June 2025. • Dr. Eric Skoblar has been appointed Chief Medical Officer at Karuk Tribe Health. • Efforts to improve specialty care access are ongoing throughout region with site visits.
I.C.6. Status Update, Regional Medical	**Partnership's Regional Director for Plumas, Sierra, Nevada & Placer presented a brief update on activities.** • Rocklin Dermatology, led by Dr. Anna Chacon, has joined Partnership's network • Eastern Plumas Healthcare hired a full-time physician with the aid of Partnership's recruitment bonus. • Western Sierra Medical Clinic is combining services with Sierra Care Physicians and increasing primary care access, especially in pediatrics. • Well Space Health is planning to open its Placer Community Health Center autumn of 2025. • Chapa Day intends to open a new site in 2026 in Rocklin. • Continuing to meet with area hospitals and discuss mobile clinic possibilities.
II.A Office Practice Update	*No Office Practice Update for June 2025*

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	**May 2025 PAC minutes were presented for approval.**	**MOTION:** Dr. Brennan moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Herman. **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	06/11/25 Motion carried.
III.B. III.B.1 III.B.2 III.B.5 III.B.7	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – May 2025 • Policies, Procedures, and Guidelines for Action Policy Summary May 2025 • Credentials Committee Meeting Minutes and Credentialed List, April 9, 2025 • Quality Improvement Health Equity Committee Meeting Minutes, May 27, 2025	**MOTION:** Dr. Zavod moved to approve Agenda III.B.1, III.B.2, III.B.5 and III.B.7, as presented, seconded by Dr. Herman. **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	06/11/25 Motion carried.
III.C III.C.1	**Physician Advisory Committee (PAC) Membership** Chair Resignation – Dr. Gwiazdowski	**MOTION:** Dr. Pottenger moved to approve Agenda III.C.1, as presented, seconded by Ms. Sprague. **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	06/11/25 Motion carried.
III.C.2	Chair Nomination – Dr. Angela Brennan	**MOTION:** Dr. Herman moved to approve Agenda III.C.2, as presented, seconded by Ms. Sprague . **ACTION SUMMARY:** [17] yes, [0] no, [0] abstentions.	06/11/25 Motion carried.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
IV. A *Old Business*	*None*
AGENDA ITEM	**DISCUSSION / CONCLUSIONS**
V.A Strategies for Engaging Employees in Quality Improvement Dr. Darrick Nelson, Chief Medical Officer, Shasta Community Health Center	This presentation was given at the CPCA Quality and Technology conference in February 2025 in San Ramon, CA. Dr. Nelson recognized the efforts of Mr. Garrett Olin, Chief Information Officer, and Ms. Rae Sanchez, Shasta Community Health Center Director of Quality Improvement, who helped prepare co present in San Ramon, but were not able to be present for the Physician Advisory Committee meeting. **Objectives:** • Identify and implement strategies to align employee incentives with organizational quality goals. • Develop tools to communicate the importance of quality improvement to employees in all roles, fostering a culture of engagement and collaboration. **Shasta Community Health Center (SCHC)** **Who We Are** **Mission:** To provide high-quality health care to our community with compassion and understanding. **Vision:** Removing barriers to healthcare and promoting wellness for our entire community. **Values:** Compassion: Caring with kindness. Adaptability: Finding new ways to meet patients' needs. Respect: Welcoming all with dignity. Education: Creating a learning environment. Service: Dedicated to whole-person care with honesty and integrity. Shasta Community Health Center a californiahealth center **Overview** • Established in 1988 as an FQHC. • 8 Locations: Redding, Anderson, and Shasta Lake City • In 2024, served 36,400 patients with over 159,559 clinical encounters • Services include: ◦ Primary care, pediatrics, dental, vision, mental health, urgent care, HIV care, and more. ◦ Special focus on homeless care, developmental disabilities, and substance abuse treatment. • Team: approximately 500 staff and 100 healthcare providers. 

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Strategies for Engaging Employees in Quality Improvement, Continued	**At SCHC, we embrace this mindset: Every employee, no matter their role, plays a vital part in our mission to provide high-quality care to our patients.** **Our Approach:** • Aligning incentives and goals. • Empowering all staff to see their impact on quality in healthcare. • Fostering a culture of collaboration and shared accountability **Strategies for Engaging Employees in Quality Improvement** • **Staff Education and Engagement** Quality Cares Introduced case studies sent to all staff to engage. A quiz is given at the end of the case study for a chance to win a prize. Employee feedback has been positive. Awareness Month Decoration Contests Engaging departments and increasing participation and awareness. • **Incentives Linked To Quality Performance** Each quarter we'll choose a different measure of focus. At the end of the quarter, the department or the clinic that had the most improvement on the particular challenge received a department pizza party, a nice certificate, and a traveling trophy that goes quarterly from department to department. Annual Incentive for non-Primary Care Staff All staff are eligible for a bonus based on performance around organizational quality goals. “Your efforts, our success.” We wanted to incentivize them more frequently, and so we devise the system. In our primary care departments, we used cervical cancer screening and depression screening in 2023 and gave them weekly updates on how they're performing by clinic or by department. Each clinic has individual targets. • **Tools To Enhance Employee Satisfaction** Supporting our employees leads to better care for our patients. By improving workflows and removing barriers, we create an environment where both staff and patients feel valued and supported. Investing in tools that support employees ultimately enhances the quality of care for patients. • Introduced electronic patient registration where patients can fill out all their paperwork and documents electronically and it goes right into the chart, reducing administrative burden on the staff. • Found a new translation company for interpreter services to quickly connect with translator in under five minutes whereas previous company required hold times of 20 minutes or more. • **Collaboration and Transparency** • Ongoing engagement • Department Updates ▪ This is the weekly update that tells where they are by department so they can start to calculate numbers needed to treat or numbers needed to do a screening and drive improvement efforts. The goal is to keep all staff well informed. • Quality Call-Outs – Sharing what people are doing well.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Strategies for Engaging Employees in Quality Improvement, Continued	
VI. Adjournment	
PAC adjourned at 9:03 a.m.	**Next PAC on Wednesday, August 13, 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: June 18, 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, 3770 Janes Road, 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	*Approval of* • May 21 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 18
2	*Acknowledgment and acceptance of draft minutes of the* • May 13 Internal Quality Improvement (IQI) Committee • May 22 Member Grievance Review Committee (MGRC) • April 30 Over/Under Utilization Workgroup			19 – 44
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	45 – 55
2	HealthPlan Update	Robert Moore, MD	7:40	57 – 59
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:45	61
	G&A PULSE Report / Issue 17 / June 2025			63 – 73
Health Services Departments	**Care Coordination**			
	MCCP2024 – Whole Child Model for California Children's Services (CCS)			75 – 95
	MPCP2014 – Continuity of Care – *new policy number and title change ("Medi-Cal" dropped) as policy will now apply to Medicare too. The policy is bundled here without Attachment C (400 pages of codes).*			97 – 136
	Population Health			
	MCNP9004 – Regulatory Required Notices **(NEW Title)**			137 – 151
	MPNP9007 – Lactation Policy and Guidelines – *the former MCCP2020 in CC is archived on p. 161*			153 – 160
	MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – *the former MCCP2021 in CC in archived on p. 173*			169 – 172

	Item	Lead	Time	Page #
Health Services Departments	**Quality Improvement**			
	MPQP1004 – Internal Quality Improvement Committee			177 – 180
	MPQP1008 – Conflict of Interest Policy for QI Activities			181 – 183
	MPXG5009 – Lactation Clinical Practice Guideline			184 – 188
	Utilization Management			
	MCUG3134 – Hospital Bed/Specialty Mattress Guidelines			189 – 193
	MCUP3044 – Urgent Care Services			195 – 197
	MPUG3010 – Chiropractic Services – *previously MCUG3010*			198 – 200
	MPUP3014 – Emergency Services			201 – 208
	MPUP3039 – Direct Members – *previously MCUP3039*			209 – 221
	MPUP3111 – Pulmonary Rehabilitation – *previously MCUP3111*			223 – 228
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	229 – 233
CC	MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities – **NEW POLICY** – *the 12 attachments are not included in this packet. All executed MOUs are available on the Partnership website at: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx*	Shannon Boyle, RN	7:50	235 – 239
UM	MCUP3041 – Treatment Authorization Request (TAR) Review Process	Tony Hightower, CPhT	7:54	241 – 260
	MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*		7:58	261 – 265
PHM	MPND9001 – Population Health Management Strategy & Program Description – *previously MCND9001 – clean copy begins on p. 323*	Greg Allen Friedman	8:02	267 – 322
	MPND9002 – Cultural & Linguistic Program Description – *previously MCND9002 – clean copy begins on p. 417*	Christine Smith	8:06	371 – 416
VI.	**Presentations**			
1	Population Health Management Grand Analysis – *PowerPoint presentation begins on p. 445* • Population Health Management 2024 Program Impact Analysis *(pp. 471 – 510)* • Population Segmentation *(pp. 511 – 519)*	DeLorean Ruffin, DrPH	8:10	445 – 519
2	Annual Review of UM and InterQual® Criteria – *demonstration by Desiree Payumo, RN, Manager of UM*	Tony Hightower Anna Campbell	8:28	521 – 558
3	Grievance & Appeals Department Annual Report CY 2024	Kory Watkins, MBA-HM	8:45	559 – 576
VII.	PHM Work Plan Final Update			577 – 579
FYI	**Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Aug. 20, 2025 – NO MEETING IN JULY**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, June 18, 2025 / 7:31 a.m. – 9:25 a.m. Napa/Solano Room, 1st Floor

June is Population Health Month

Voting Members Present:
Sara Choudhry, MD
Emma Hackett, MD, FACOG
Brandy Lane, Consumer Member
Brian Montenegro, MD
Meagan Mulligan, FNP-BC
Robert Quon, MD, FACP
Michael Strain, PHC Consumer Member
Chris Swales, MD
Randolph Thomas, MD

Voting Members Absent: Steven Gwiazdowski, MD, FAAP; Phuong Luu, MD; John Murphy, MD; Jennifer Wilson, MD

Partnership *Ex-Officio* Members Present:
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
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
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, Manager, 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, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Director of Quality and Performance Improvement
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

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cotter, James, MD, Associate Medical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Kerlin, Mary, Senior Director of Provider Relations

Guests:
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Population Health
Bontrager, Mark, Senior Director, Behavioral Health
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MBA/MHA, Director of Quality Management, QI
Brunkal, Monika, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Manager of Performance Improvement (Redding)
Erickson, Leslie, Program Coordinator II, QI (scribe)
Frankovich, Terry, MD, Associate Medical Director
Friedman, Greg Allen, Project Coordinator II, Population Health
Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI
Hermosillo, Jesus, Cultural Community Manager, Health Equity
Matthews, Richard "Doug," MD, Regional Medical Director, Chico
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps. Stephanie, Lead Senior Provider Relations Rep, PR
Payumo, Desiree, RN, Manager of Utilization Management, UM
Santos, Rose, RN, Supervisor, Member Safety & Quality Investigations, QI
Smith, Christine, Community Health Needs Liaison, Population Health
Stone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:31 a.m. He welcomed epidemiologist Folo Akintan, MBBS/MD, MPH, MBA, a new member of the Population Health department aiding our QIHEPT (Quality Improvement Health Equity Process Transformation) team. The May 21, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • May 13 Internal Quality Improvement (IQI) Committee • May 22 Member Grievance Review Committee (MGRC) • April 30 Over/Under Utilization Workgroup	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept the other minutes:** Robert Quon, MD Second: Chris Swales, MD *Approved unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Senior Director of Quality and Performance Improvement, QI*	• The Health Rules Payor (HRP) implementation delay means the Primary Care Provider Quality Incentive Program (PCP QIP) network need not experience a two-week blackout of e-Reports in July that would have facilitated the cutover from our current core claims system, Amisys. • Partnership has funded 10 retinal cameras in imaging center deserts across the network. Partnership has received several MOUs from providers and has started issuing payments for devices to impact MY 2025 under this Quality Measure Score Improvement (QSMI) program overseen by the Chronic Disease Management workgroup. • We've been talking over the last few months about working with Exact Sciences and our provider network as a forum to help our providers order Cologuard kits. We did an earlier push around Colorectal Cancer Screening Awareness Month early in March and we are going to offer another multi-patient order opportunity July through September, allowing kits to be received by our members by the end of September and thereby also affecting a really important measure in our QIP. Most recently we worked hard to provide, with our Population Health team, some educational videos on this opportunity, as well as what is a FIT test, in addition to some of the logistics that our providers might benefit from taking on this opportunity. These are detailed on a new web page: https://www.partnership.org/Providers/Quality/Pages/Cologuard.aspx • Pediatric lead prevention is a key Managed Care Accountability Set (MCAS) measure we have made great progress on these last 12-18 month and will continue to do so by offering funding for points of care lead testing devices to eligible providers. • We successfully submitted our HEDIS® (Healthcare Effectiveness Data Information Set) rates for both our accreditation project as well as our Department of Health Care Services (DHCS) managed care accountability project. We will be coming back to you in August to report on those annual rates as well as give a status update on our Member Experience CAHPS® (Consumer Healthcare Providers and Systems) survey. The team is now analyzing those preliminary results. • Much work has been done by many to timely submit many forms of evidence for NCQA (National	*For information only*. Robert Quon, MD, noted that Kaiser had a similar retinal imaging project but had issues finding ophthalmologists to read results and then treat, if necessary. He wondered how Partnership is handling this. Manager of Performance Improvement James Devan replied that these devices come with vendor agreements to read and interpret any findings. "The whole goal is to ease access on optometrists and ophthalmologists in the communities," James said. "These are places that (may) have those providers, (but they may be) very impacted. We are trying to cut down on the screenings to traditional optometry and save the follow up. So far, we haven't seen any instances where there's issues

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Committee for Quality Assurance) Health Equity Accreditation. The results of this first HEA effort will be reported to this and other committees in September.	with follow-up."
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• In the packet we have the updates on performance in the PCP QIP. The checks are going out. We have a list of the sites that did over 90%, as well as what has happened with performance year to year and the reasons for the changes. The 2024 10-county geographic expansion increased the number of participating sites from 252 to 390. Approximately $52.5 million was earned in total, including just over $1 million in Unit of Service (UOS) incentives. o Two private practices, three medical groups, and 14 Federally Qualified Health Center sites each scored 90% or better. o Among Tribal Health Centers, Lake County Tribal sites had their best year ever. Both Round Valley Tribal Health and K'ima:w Medical Center made dramatic improvements above their previous year performance. • The Quality Factor Score for 2023 for all the different health plans is also in the packet. This is old because the State usually delivers in September but didn't until April or so, and so we have finally calculated that. The big summary is that our four regions that were still in place in 2023 show a wide variety of different levels of performance related to the underlying socio demographic factors we have talked about in the past. • As you have been hearing over the years, we have been planning to implement a new core claims system called Health Rules Payor or Health Edge. In the final testing phase, we found some substantial issues needing many, many months of work to resolve, thus preventing us from going live this month as planned. Unfortunately, this postponement has a cascading effect. We had a new core management system called Jiva, which was going live after Health Edge. And the Jiva system was essential for us to be able to go live with our Dual-Eligible Special Needs Plan (D-SNP). So, we notified DHCS that we are unable to go live with our Medicare product on Jan. 1, 2026. We were prepared to go live in so many ways: we had a perfect score on our Model of Care. Our bid was ready to go in. We had already selected our optional benefits. We were about halfway through all the policy revisions that needed to happen, so it wasn't for a want of effort; it was this unexpected problem with an upstream issue, our core claims system. Going live with the core claims system problems unfixed would have resulted in a massive nonpayment to our providers, which is unacceptable, plus it would put the entire Plan as risk on the core Medi-Cal business. We told DHCS we had to delay until Jan. 1 2027, and they are processing a monitoring plan to watch the status of our activities towards that goal. • Many of you are following the status of the State and Federal budgets. Both have major potential impacts on Medicaid. The US Senate is leaning towards bigger Medicaid cuts to prevent a larger deficit. The State went in the opposite direction. The State Assembly has a budget that calls upon larger borrowing to cover projected shortfalls. That sets it up for the Governor to make the line cuts to balance the budget. We'll have more of a sense in a couple of weeks. None of these activities	*For information only*. Q/UAC Consumer Member Michael Strain asked if current Medi-Medi members will be affected by the D-SNP implementation delay. Dr. Moore replied that those with current Medi-Medi coverage will not be affected as they will retain their existing coverages. Opting in to Partnership Advantage (D-SNP) will remain a choice for Partnership's eligible Medi-Cal members who live in the eight counties when the product goes live Jan. 1, 2027.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	instantly affect Partnership. Many of the changes proposed kick in over six months, a year or two years. Our Finance Committee is reviewing the year-long budget that Partnership is proposing, and Partnership's tentative plan is to come back with a six-month revision when we have the more information from both State and Federal entities.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	G&A PULSE Report / Issue 17 / June 2025 ***Health Services Policies*** <u>Care Coordination</u> MCCP2024 – Whole Child Model for California Children's Services (CCS) MPCP2014 – Continuity of Care – *new policy number and title change ("Medi-Cal" dropped as policy will apply to Medicare too. The policy is bundled here without its 400-page list of codes known as Attachment C)* <u>Population Health</u> MCNC9004 – Regulatory Required Notices *(new title)* MPNP9007 – Lactation Policy and Guidelines – *the former MCCP2020 in CC is now archived* MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – *the former MCCP2021 in CC is now archived* <u>Quality Improvement</u> MPQP1004 – Internal Quality Improvement Committee MPQP1006 – Conflict of Interest Policy for QI Activities MPXG5009 – Lactation Clinical Practice Guideline <u>Utilization Management</u> MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3044 – Urgent Care Services MPUG3010 – Chiropractic Services – *previously MCUG3010* MPUP3039 – Direct Members – *previously MCUP039* MPUP3111 – Pulmonary Rehabilitation – *previously MCUP3111*	Motion to **approve slate as presented:** Robert Quon, MD Seconds: Randy Thomas, MD & Meagan Mulligan. FNP *Approved unanimously* <u>Next Steps</u>: Aug. 13 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*		
MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal	**This new policy outlines** that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: • A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. • All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions.	Motion to **approve as presented:** Robert Quon, MD Seconds: Brian Montenegro, MD, & Meagan Mulligan, FNP *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Managed Care Plans and Third-Party Entities – **NEW POLICY**	• MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. • MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. • The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU. • The MOU parties must support the timely and frequent exchange of Member information and data. • The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness • Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. • Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. Shannon stated that this new policy touches many things, including the Whole Child Model, local health departments, and different behavioral health entities we contract with too. The BHP definition was added at IQI. Robert Quon, MD, commented that such MOUs can pose issues when the Plan's quality metrics are not part of vendors' deliverables. He urged caution and recommended that Partnership look at adding in a "broad, vague" quality statement contract by contract to the effect of "in order to be one of our vendors, these are the quality aspects you must uphold." Dr. Moore replied that we can look at language additions as we have leverage over those whom we pay; however, this policy mainly covers community-based and county-based organizations where no money is exchanged. "The State has asymmetrically said 'Partnership, you must do an MOU' but they have not told those other entities that they are required to do an MOU," Dr. Moore noted.	Next Steps: Aug. 13 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3041 – Treatment Authorization Request (TAR) Review Process	**Section I:** Two Related Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services **Section V.** An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing. **Section VI.A.2.** In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.A.5** was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. **Section VI.B.2.b.** This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written	*There were no questions.* Motion to **approve as presented:** Robert Quon, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: Aug. 13 PAC Dr. Moore noted that the

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. **Section VI.B.2.b.** Added language to say TARs are not required for "certain" services because the list has been growing and we did not want to limit services to only those specified . **Section VI.B.4.** Removed "diagnostic imaging" from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI **Section VI.F.** Removed the entire Communication Services section because the language is duplicate in policy MPUP3064 Communication Services, which has been listed at the top in Section I. as a Related Policy. **Attachment A:** Policy numbers updated throughout. **H. Diagnostic Studies;** Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services. Tony prefaced the above synopsis by saying many of the edits were a general clean-up and removing language redundant to a few of our other policies, as well as adding in some language per DHCS guidance. A significant change was the removal of TAR requirements for CT scans and MRIs.	implementation of removing most TARS for CTs and MRIs may take Configuration until September to arrange, and he urged Q/UAC members to have their organizations continue with business as usual until such time as Partnership informs providers that the reconfiguration is complete.
MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*	**This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027.** **Section VI.B.2.a. 2)** Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. **Section VII.B and C.** Added two new references for "Contractual obligations with the Department of Health Care Services (DHCS)" and "Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)" **Attachment A:** Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Tony noted that this policy was updated for the now delayed Medicare product line, affecting the hierarchy of criteria sets.	*There were no questions.* Motion to **approve as presented:** Chris Swales, MD Second: Robert Quon, MD *Approved unanimously* <u>Next Steps</u>: Aug. 13 PAC
Policy Owner: Population Health – *Presenter: Greg Allen Friedman, Project Coordinator II, Pop Health*		
MPNP9001 – Population Health Management Strategy & Program Description – *previously MCND9001*	**Changed to MPND9001 to reflect applicability also to the coming D-SNP program.** Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 5 Introduction:** new paragraph explaining Partnership's Medi-Cal and D-SNP services, and Partnership Advantage. **P. 6 Data Analysis and Strategy:** fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. **P. 8-11 under Data Analysis and Strategy:** updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11 to p. 14.	*There were no questions.* Motion to **approve as presented:** Brian Montenegro, MD Second: Meagan Mulligan, FNP *Approved unanimously* <u>Next Steps</u>: Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	P. 13 under Population Needs and Community Needs Assessments: added language about Community Advisory Committee (CAC). **P. 16-17 under Social Drivers of Health and Community Needs:** added language about covered behavioral health services for Medicare Advantage members. **P. 22 Basic Population Health Management:** added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes. **P. 36 Practitioner Education and Training; Health Education Interventions: re**written to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. **P. 39-42 under Community Engagement and Coordination of PHM Programs:** updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated vendor names and terminology and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership's monitoring of performance for delegates. **P. 48-51 under Team Roles and Responsibilities**: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others. Greg went through the synopsis. Dr. Moore commented that this program description has undergone extensive review: he has read it twice himself.	
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Pop Health*		
MPND9002 – Cultural & Linguistic Program Description – *previously MCND9002*	**Changed to MPND9002 to reflect applicability also to the coming D-SNP program.** This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: **Alignment with DHCS Review Tool** Added reference to the regulatory required notices Attachment A & Attachment B (pg.8). Added details around written information in either traditional or simplified Chinese characters (pg.11). Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS' OCR, and HHS' OCR (pg.9). Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (pg.9). Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (pg.12). Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (pg.14). Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (pg.14). **DSNP Language** Changed policy name from MCND9002 to MPND9002 throughout document	*There were no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Updated the list of member correspondence items to include "Notices of Organization and Coverage Determinations to encompass DSNP notices" *(pg.9*) **Attachments A-E updated with new "MPND" policy coding.** Other specifics below. **Updating Attachment D:** Process for Translation Services Document from our translations vendor updated with branding reflecting that they are now owned by Propio. **Updating Attachment E:** Community Advisory Committee Name changed from "*Consumer*" to "*Community* Advisory Committee." More detailed diversity statement added. Edits made to include the committee's feedback on the subject of CHA/CHIP work with counties. Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership's member population. Added detail about representation ratios. Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee. Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. Updated references to DHCS's Medi-Cal Member Advisory Committee (MMAC). Updated Partnership office addresses. After Christine presented the synopsis, Medical Director for Quality Mark Netherda, MD, thanked her and Greg for "great presentations on complicated policies" and for explaining "QR Codes" as "quick response codes," a definition he had not heretofore known.	
VI. Presentations		
Population Health Grand Analysis, including the Population Health Impact Analysis, Segmentation Report, and Work Plan *DeLorean Ruffin, DrPH, Director of Population Health*	DeLorean introduced the Grand Analysis by saying that these three documents meet our NCQA standards and that opportunities exist to include other measures to better streamline this in future. We realize that not all goals were met; however, we are continuously striving for improvement. Today's presentation includes mostly those measures that showed significant statistical difference in 2024, and not all current measures encompassed by the PHM program at-large. **Our Growing Together Program has three pillars: Healthy Moms, Healthy Babies, Healthy Kids.** This is where we get into our prenatal section of outreach where we enroll members as identified as pregnant to receive targeted program outreach and support. Our staff offers support for prenatal care and reinforces the importance of Tdap vaccinations during pregnancy. We remind them of the importance of postpartum care and well-child visit (WCV) vaccinations in the first months following delivery. In 2024, the flu vaccinations were added as an incentivized component of this program; however, some of those results are not reviewed in the Impact Analysis.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The first goal for the prenatal intervention was that 75% of members engaged in the program during 2024 would have had a Tdap vaccination within 120 days or four months prior to delivery. The rate of our engaged members was 73%. Engaged members had a statistically significant higher rate of completing the Tdap vaccination before delivery compared to member who were declined, members who were unable to reach and members who were not referred. Our current campaign is making some measurable difference within our Hispanic population; however, further analysis may be warranted due to the small sample size of other ethnic groups. Although this goal was narrowly missed, the engaged results are looking good, DeLorean continued. While the data shows statistical significance in the engaged category compared to other campaign categories, the control groups are not randomized to the degree necessary to account for any bias that may have resulted from conversations with the Pop Health staff. So, if propensity for answering the phone and having a conversation with Partnership (staff is associated with probability of also seeking out and obtaining vaccination), then the additional effect of the educational intervention can't be determined. (We can't account for the engagement bias by having two different phone messages given to those who answer the phone and are willing to engage. One group can conclude information from the Tdap vaccine while another group can focus on consideration for breastfeeding their baby; e.g., this builds in a control group with a subset of members who are otherwise equally engaged.) Our Growing Together Postpartum Program also offers a campaign for members to attend their postpartum care visits and encourages early interests in their care by bringing their child to those well-child visits (WCVs). The postpartum goal was for 75% of members engaged to attend a postpartum visit within 60 days of delivery. We met that goal. The white population had a statistically significant lower rate of members with postpartum visits when compared to American Indian, Asians and Hispanics. This data seemed to demonstrate that our current campaign is making a measurable difference in the lives of our non-white population. This may be due to that phone conversation and/or the individual member incentives for the postpartum visits, but analysis may be affected by underlying differences in the population willing to be engaged with this effort. Our Growing Together Healthy Babies Program enrolls infants under the age of 12 months. Incentives are also offered for this program for completing their well-child visits with immunizations throughout the duration of the program. The goal was for 80% of members engaged in the program to be compliant with at least 50% of their vaccinations during that program period. The goal was met at 92%. The secondary goal was that 25% of engaged members would attend **all** the well-child visits within 12 months of engagement. This was met at 67%. Note that the engaged white population had a statistically significant lower rate of completing vaccinations and WCVs compared to the Hispanic population. *In July 2024, the enrollment age was modified to include infants under 24 months, and this will be reflected in next year's report.* Significantly more members completed vaccines from July 2023 through June 2024 than in the 2022-23 fiscal year. This may be associated with the county expansion in 2024. In total, 3,629 members were compliant with all of those recommended well-child visits. A subset of this goal was that 65% of engaged members would be compliant with **at least half** of those recommended WCVs. This goal was met at 89%. Engaged members had a strategically higher rate of completing those visits when compared to other categories. The white population had a statistically significant lower rate of completing 3+ or 2+ WCVs (83%) when compared to Hispanics (92%). In January 2023, Partnership transitioned away from the Healthy Kids pilot to create a program designed to reach all children between the ages of three to six. The program aims to reach all these children who have not had a well-child visit in the last 11 months of longer. Once identified, members were incentivized to complete the well-child visit prior to their next birthday.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	The goal was that 50% of members in the program would have a well-child visits within 120 days of the phone call. At 32%, that goal was not met. However, the higher statistical significance found among the engaged members (79%) compared to the other campaign categories suggests that the program is making some impact among the eligible member population. Our Transitions of Care focuses on members who are transitioning across settings or the benefit structure. Partnership's Care Coordination team provides to the vulnerable populations to ensure implementation of the discharging facilities' transition plan and connects members to medical care and community resources that support health and wellness following a transition. At the close, a Partnership coordinator contacts the member by phone to complete a member satisfaction survey: responses are agreed, neutral, disagree or no response. In our weighted responses, members also have the opportunity to provide commentary. In 2024, 191 adults completed the transition of care services; 150 of them completed surveys. The first goal was that 75% of members surveyed would agree with each statement of the Adult TOC Satisfaction Survey. This goal was met. Goal 2 was that 75% of the pediatric members would agree with each statement of the satisfaction survey. Sixty-five members completed the TOC interventions, and 41 of them completed the survey, revealing a high satisfaction rate among families reporting good outcomes for our pediatric members. Complex Case Management is support for members who have multiple chronic conditions, social determinants of health barriers, and/or having difficulties navigating a healthcare system without the intensive support of a care coordinator and individualized care plan. Individual goals are timebound; however, a member may remain in complex case management for an extended period of time. [The goal that 75% of members would agree with each statement of the member satisfaction survey was met for both adult and pediatric populations, although the sample size was too small or members had insufficient time with the program per NCQA standards to quality for a satisfaction survey in 2024.] In summary, our member experience measures for CCM and TOC programs were met and demonstrate the significant value of these programs for Partnership. Our Hispanic members have statistically significant higher results than other races and ethnicities for attendance in postpartum visits, well-child vaccinations in the first years of life, attendance at well-child visits and attendance at well-child visits from three to six years old. While not all our NCQA goals were met, we are continuously striving for improvement, and most individuals demonstrated improved outcomes compared to those not engaged or referred. We will continue to explore more means to leverage new benefits and resources offered through the CalAIM initiative to bolster member support and improve the overall health of our population. Dr. Netherda clarified that the scales used ran from zero to 3. He pointed out that one slide must be corrected before the Aug. 13 PAC presentation: pediatric members are define as those under the age of 21, not 20. Dr. Quon said he was happy to see in the documentation that Partnership is looking at adding texting campaigns in future efforts to engage members, speculating that today's parents fall in a demographic that doesn't answer the phone. He found lower participation among white populations to be of interest and wondered if this is because diversity, equity, and inclusion efforts are working "or are we alienating somebody because the goal is to leave no one behind"? DeLorean replied that there had not been that deep a dive; however, she would like to work closely with QI, Health Equity and Health Analytic staff to create a framework for short- and long-term reviews of what and where the disparities are, and where she can best deploy both Health Education and PHM teams for further outreach and resource/support services.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Randy Thomas, MD, was curious whether the white population disparities were uniform across the network or more concentrated in certain areas. DeLorean said disparities were more concentrated in rural areas. Dr. Thomas said that he had suspected this, adding that vaccine hesitancy can keep some members from pursuing well checks. DeLorean acknowledged this and said she has been conversing with Partnership's Regional Directors and staff about how best to further combat misinformation through our health education strategies and approaches. Dr. Thomas, noting our effort to get pregnant persons their Tdaps, asked if it is just information that is shared with them or videos too? "Videos of babies with pertussis is very compelling," he said. DeLorean said that right now it's just information but she is exploring different means to mitigate hesitancy: "visuals are imperative." Regional Medical Director Colleen Townsend, MD, also noted that in speaking with providers in our perinatal network, they are always asking for tools, for information they can share while they are waiting. She invited Dr. Thomas to share with her any resources he has found of help. Dr. Netherda commented that during one outbreak of pertussis in California perhaps 20 years ago, there was an ad campaign directed at pregnant persons, adding that the Jennifer Lopez narrated ads had audio of babies coughing and was very effective in getting pregnant persons to get Tdap vaccines. Brian Montengro, MD, as a newborn doctor, said that "we have been seeing for years a decrease in the amount of uptake in the newborn period of the three routine vaccinations or medications that newborns are administered, specifically Hepatitis B." He is increasingly concerned and notes that since the Covid pandemic some parents are refusing vitamin K for their newborns. He has seen an uptick in this in the last six months. "I can guarantee that we're going to start to see newborns show up in the ER with GI bleeds, with intracranial bleeds," Dr. Montenegro said. "It's a tough thing to change a parent's mind in the newborn nursery period. It would be helpful to target this in prenatal visits." He has slides he said he will share with DeLorean. (Dr. Thomas asked if parents refusing vitamin K shots for their newborns were accepting oral vitamin K. Dr. Montenegro said that is not the standard of care and "the efficacy is questionable.") Dr. Quon asked if Partnership has its own YouTube, Slack, or other such channel. "The way people get information today is via influencers, via what is online," he said. "Something that gets a million likes will end up in everyone's inbox. We can't counter all the misinformation or the inaccurate information, but we can put out the information we want our members to see and hear." He wondered if vaccine hesitancy has aways been present. Dr. Montenegro said the misinformation really got started during Covid and continues to worsen in today's political environment. DeLorean sees opportunities to do something different but said DHCS has erected some barriers and that Partnership staffing availability may not be adequate. She wondered if this could be "stood up in our Communications department." Dr. Moore replied that generally Partnership "is not going to be a content generator for primary health advocacy materials. That's a necessity that we meet through our Health Education program. We love links to high quality materials that are put out by others, which we can amplify through our social media presence and through our communications. We've used Kaiser's over the years." **Motion to accept and approve the Population Health Grand Analysis in all its parts:** Robert Quon, MD; Second: Randy Thomas, MD. *Approved unanimously.*	
UM 2A Clinical Criteria for UM Decisions Factors 4 and 5 – Annual	Tony noted that InterQual® is a clinical decision tool developed and continuously peer reviewed based on the principles of evidence-based medicine. It is utilized by our medical directors and nursing staff to support medical necessity determinations. InterQual® is designed for integration on both the payor side and into TAR processing platforms. As a tool, it supports our move toward interoperability between payors and providers and assures that our members receive appropriate care. In the event that InterQual criteria is not available for a service request,	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Review of UM and InterQual® Criteria *Tony Hightower, CPhT, Assoc. Dir., UM Regulations* and *Desiree Payumo, RN, Manager of UM*	Partnership refers to our in-house hierarchy of criteria, which is outlined in our policy discussed earlier, MPUP3139 Criteria and Guidelines for Utilization Management. Partnership purchases new InterQual® criteria modules as needed. Presently, Partnership utilizes 14 modules in its UM decision-making process, including four that are new to us this year: Level of Care (LOC) Criteria Long-term Acute Care 2025 LOC Criteria Inpatient Rehabilitation 2025 LOC Criteria Subacute/Skilled Nursing Facility 2025 Medicare: Post Acute & Durable Medical Equipment Criteria 2025 In the future, we may purchase other modules relating to Medicare as we move closer to our D-SNP product, Partnership Advantage, now scheduled to go-live Jan. 1, 2027. A summary of content for each of the 14 modules Partnership utilizes is provided in today's agenda packet. Arrangement can be made to provide further criteria for review upon request to UMHelpDeskSR@partnershiphp.org. Before demonstrating the InterQual® tool, Desiree disclaimed that the case and member information being presented was fictitious in compliance with HIPAA. She then exemplified the tool's utility via Acute Adult Criteria and then General Surgical Criteria subsets in evaluating a 72-year-old female who had fallen and fractured her hip, her evaluation in the ER, and what happened after her admittance to a general med/surg floor for surgery the next day. "Jane's" condition, however, changed on day three, so the general surgical subset no longer applied. Desiree demonstrated clearing InterQual® and resetting it with another subset as suggested by a key word being typed into its search engine. "Jane" met that criteria, and her treatment continued. If at any time during "Jane's" stay she did not meet InterQual® criteria, her case would be sent to a Partnership Medical Director for secondary review. Dr. Moore commented that it was nice to see demonstrated a case over several days wherein the situation and thus the criteria changes. Dr. Quon asked why some modules were blacked out on the initial criteria page included in the packet. Anna Campbell replied this was because Partnership has not purchased those modules. Dr. Quon suggested footnoting an explanation to that affect, and Dr. Moore agreed that was a good idea. There were no other questions. **Motion to approve the use of InterQual® as part of our UM process:** Robert Quon, MD; Second: Brian Montenegro, MD. *Approved unanimously* **Post-meeting note:** *Corrected InterQual summary documents were sent out to the committee after the meeting. Anna removed the redactions and instead highlighted the modules Partnership has purchased.*	
Annual Grievance & Appeals Report CY 2024 *Kory Watkins, MBA-HM, Director, Grievance & Appeals*	The Grievance & Appeals department – in concert with the Medical Directors and various departments including Provider Relations, Transportation, Compliance, Member Services, and Quality Improvement – ensures that member concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies, with a focus on timeliness, fairness, and improving the overall member experience. G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). Additionally, interrater reliability reviews (IRR) are conducted quarterly to assess the appropriateness of cases not referred for PQI review. In 2024, 207 grievances were referred for PQI review. G&A in 2024 partnered with the Transportation department to capture the names of individual drivers (not just the company) involved in transportation-related concerns. This change allows for more precise data analysis and better identification of driver specific trends. Once a case is received from a member, the Member Services department or other source, a clinical assessment occurs where appropriate, and	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	G&A contacts the member and sends an acknowledgment letter to let them know the complaint is under review. (This contact is not mandated but is considered best practice.) An investigation is conducted, followed by a letter of resolution and call. G&A processes member complaints about dissatisfaction with services, care, or experience within 30 days; "exempt" grievances are resolved quickly without the formal grievance process ; "expedited" grievances within 72 hours in situations where loss of function, limb and/or life is possible; appeals wherein a member disagrees with a denied service or treatment; and state fair hearings before an administrative law judge regarding a denied service. Annual case volume is increasing each year, although the reasons why vary, so trending analysis is difficult. G&A closed 7,556 cases (8.34 per 1,000 members) in 2024 which saw 10 new counties join Partnership, compared to 5,690 (8.39 per 1,000 members) in 2023 when Transportation came in-house, and 4,085 (6.40 per 1,000 members) in 2022 when Covid-19 was still concerning. In 2024, just 35% of grievances received were clinical in nature; however, 63% of appeals involved clinical concerns. Just 28 of 213 case filings were deemed to meet the criteria for expedited resolution. As in years past, the most typical 2024 filer was a white, English-speaking middle-aged female residing in a northern county where access concerns are most prevalent. The top three counties by grievances per 1,000 members were Lassen (15.4), Modoc (13.6) and Siskiyou (12.3). (Transportation-related issues drove these numbers.) Sutter County had the fewest grievances (3.7). The top grievance categories were Transportation (49%); Provider Service (24%); Access (17%), and Partnership Service (10%). In 2024, Partnership provided 1,166,701 rides and received 4,472 transportation-related concerns (< .4% of total rides, down from .6% in 2023.) Excluding Transportation, Provider Services accounted for 46% of concerns (down from 50% in 2023) and Access accounted for 34% (up from 30% in 2023). Treatment plan disputes accounted for 39% of provider issues; long wait times for appointments accounted for 37% of access issues. Members may allege discrimination for many reasons, Kory noted; however, this report contains only substantiated findings of civil rights allegations, which may fall into one or more of 16 categories, the top two of which are disability and race or ethnicity. In 2024, just 10% of civil rights allegations were substantiated, down from 22% in 2023. After we have done our full investigation, such matters are reviewed by our Health Equity team. We have certified civil rights coordinators that do these reviews; in some of these cases, our medical directors will take a look. A member may feel they were discriminated against because of their disability and their age, and we will count those individually so that all voices are heard in all aspects The top Appeals in 2024 were Transportation related (49%); followed by Treatment Authorization Requests (TARs) (35%): most of these had to do with DME, primarily wheelchairs. Referral Authorization Forms (RAFs) came in at 12% of appeals; and Claims (4%). Most claims appeals had to do with reimbursement of services paid out of pocket by the member. In 2024, 69.6% of Appeals filed were upheld, while 15.5% were overturned, largely because more clinical or other information was received. In cases that were referred to an administrative law judge, 45.8% were withdrawn before any hearing; 28.2% were dismissed; and 17.6% were upheld. In 2024, only 53 state hearings actually occurred before an administrative law judge, and just 11% of those were overturned in full or in part. Kory concluded her presentation by saying that 2025 department performance is thus far meeting goals, an improvement above some 2024 quarters wherein the 98.6% timeliness threshold was narrowly missed for case closures and acknowledgement letters because of staffing, training, or other issues, including the addition of 10 counties. G&A has now instituted a multi-step nurse review protocol: when one nurse determines documentation is essential, a second nurse now confirms or disagrees. If disagreement occurs, the case is escalated to a Medical Director for a final decision. This process ensures cases are pended only when necessary (e.g., left open while awaiting a provider's response) and improves oversight on delayed resolutions.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	In 2025, G&A is looking forward to the Jiva implementation because our current case management platform is antiquated, Kory said. G&A is working on a Behavioral Health transition as Partnership ends some delegation to Carelon. (We are bringing in-house substance use disorder and mental health grievances.) Staffing has accordingly ramped up. And although Partnership Advantage go-live has been delayed one year, G&A is still preparing to ready staff for the CMS reporting the department must do. Dr. Moore found it "striking" that the civil rights allegations went up quarter by quarter in 2024 and he wondered if the reasons why might be internal or external. Kory replied it was a little of both. Members, she said, are more aware of their rights than they used to be, and they do not need to use the word "discrimination" for staff to flag incidents as possibly such. There were no further questions. **Motion to accept this annual report:** Brian Montenegro, MD; Second: Robert Quon, MD. *Approved unanimously*	
VII. FYI Attachments and Adjournment		
FYI: PHM Final Work Plan Update – *refer questions to DeLorean Ruffin, DrPH*		
Q/UAC adjourned at 9:25 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Aug. 13, 2025 – **No meeting in July**		

Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, June 10, 2025 / 1:32 – 3:41 PM

Members Present:	Kubota, Marshall, MD, Associate Medical Director
Andrews, Leigha, MBA, Regional Director (Southwest)	Leung, Stan, Pharm.D, Director of Pharmacy Services
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health	Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Brown, Isaac, MHA/MBA, Director of Quality Management, Quality Improvement	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services	Randhawa, Manleen, Senior Health Educator, Population Health
Brunkal, Monika, RPh, Assoc. Dir., Population Health	Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management	Sharp, Tim, Regional Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management	Stone, Kelly, RN, Director of Care Coordination, Care Coordination
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Innes, Latrice, Manager of Grievance & Appeals Compliance	Villasenor, Edna, Senior Director, Member Services and G&A
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer	Ward, Lisa, MD, Regional Medical Director (Southwest)
Jones, Kermit, MD, JD, Medical Director for Medicare Services	
Members Absent:	
Ayala, Priscila, Director of Network Services	Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Bjork, Sonja, JD, Chief Executive Officer	Kerlin, Mary, Senior Director, Provider Relations
Davis, Wendi, Chief Operating Officer	Klakken, Vicki, Regional Director (Northwest)
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Guests:	Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination
Akintan, Folo, Epidemiologist, Population Health	Kim, Amanda, Senior Project Manager, Quality Improvement
Arrazola, Kelcie, Lead Trainer, Provider Relations	Kubota, Marshall, MD, Associate Medical Director
Bikila, Dejene, Manager of Data Science, Finance	Lee, Donna, Manager of Claims, Claims
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance	Morris, Matthew, MD, Regional Medical Director (Auburn)
Broadhead, Candi, Project Manager II, QI	Nguyen, Tom, Manager of Health Analytics, Finance
Caldwell, Mariyah, Administrative Assistant II, Network Services	Power, Kathryn, Regional Director (Southeast)
Chebolu, Radha, Senior Health Data Analyst II, Finance	Quichocho, Sue, Manager, Quality Measurement, QI
Clark, Kristen, Mgr, Quality & Training, Member Services	Rathnayake, Russ, Senior Health Data Analyst I, Finance
Conner, Maria, Improvement Advisor, QI (Auburn)	Robertello, Kimberley, PhD, Sr. Medicare QI Program Manager
Conners, Denese, Improvement Advisor, QI (Auburn)	Roberts, Dorian, Sr. Mgr of PR Representatives, Provider Relations
Cook, Dawn R., Program Manager II, QI (NCQA)	Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast)
Cunningham, Aryana, Policy Analyst, Care Coordination	Sackett, Anthony, Program Manager II, QI
Devan, James, Manager of Performance Improvement, QI (Northeast)	Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Donahue, Celena, Improvement Advisor, QI (Eureka)	Seale, J'aime, PR Lead, Network Services
Erickson, Leslie, Program Coordinator II, QI (scribe)	Shorter, Ayana, Supervisor of Credentialing, Network Services
Friedman, Greg Allen, Project Coordinator II, Population Health	Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Gual, Kristine, Director of Quality Measurement, QI	Smith, Christine, Community Health Needs Liaison, Population Health
Harris, Vander, Senior Health Data Analyst I, Finance	Stark, Rebecca, Regional Director (Chico)
Hermosillo, Jesus, Cultural Community Manager, Health Equity	Stokes, Sarah, Project Coordinator II, QI

Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Thomas, Andrea, Project Manager I, QI
Jamali, Shahrzad, Improvement Advisor, QI (Chico)	Trosky, Renee, Manager of Provider Relations Compliance
	Vance, Brooke, Program Manager I, Network Services

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Introductions • Approval / Acceptance of Minutes	Chief Medical Officer/Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 1:32 p.m. • Several staff in IQI attendance for the first time introduced themselves: o Jesus Hermodillo, is Health Equity's new Cultural Community Manager o Greg Allen Friedman, Project Coordinator, Pop Health, attended to present a program description o Christine Smith, Community Health Needs Liaison, Pop Health, attended to present two policies o New Improvement Advisors Denese Conners and Maria Conner each work out of the Auburn office under Brandy Isola's leadership • Approval of the May 13 IQI Minutes • Acceptance of the draft minutes of the o April 30 Over/Under Utilization Workgroup o May 22 Member Grievance Review Committee (MGRC)	Motion to **approve IQI Minutes**: Katherine Barresi, RN Second: Lisa O'Connell, MHA Motion to **accept other minutes**: Lisa O'Connell, MHA Second: Tony Hightower, CPhT
II. Old Business - None		
III. New Business Consent Calendar (Committee Members as applicable)		
G&A PULSE Report / Issue 17 / June 2025 ***Health Services Policies*** <u>Pharmacy</u> MCRP4064 – Continuation of Prescription Drugs MCRP4068 – Medical Benefit Medication TAR Policy MPRP4062 – Drug Wastage Payments <u>Population Health</u> MPNP9007 – Lactation Policy and Guidelines – *the former MCCP2020 in CC is now archived* MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program – *the former MCCP2021 in CC is now archived* <u>Quality Improvement</u> MPQP1004 – Internal Quality Improvement Committee – ***pulled for update*** MPQP1006 – Conflict of Interest Policy for QI Activities MPXG5009 – Lactation Clinical Practice Guideline <u>Utilization Management</u> MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3044 – Urgent Care Services MPUG3010 – Chiropractic Services – *previously MCUG3010* MPUP3111 – Pulmonary Rehabilitation – *previously MCUP3111* ***Non-Health Services Policies*** <u>Network Services (Credentialing)</u>	Motion to **approve slate without the pulled policies**: Richard "Doug" Matthews, MD Second: Mohamed Jalloh, Pharm.D <u>Next Steps</u>: Health Services policies go to June 18 Quality/Utilization Advisory Committee (Q/UAC) and to Aug. 13 Physician Advisory Committee (PAC) Credentialing policies go to July 9 Credentials Committee. Member Services' MC341 goes to the department for director approval/signature

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPCR700 – Assessment of Organizational Providers MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements *Credentialing Staff prior to the meeting **pulled** the following policies for more work and will bring them back to Aug. 12 IQI:* • MPCR15 – Doula Credentialing and Re-credentialing Criteria • MPCR100 – Credential and Re-credential Decision Making Process • MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities • MPCR602 – Reporting Actions to Authorities • MPNET101 – Wellness and Recovery Access Standards and Monitoring <u>Member Services</u> MC341 – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program – *previously MC305A* ***– pulled for discussion*** Associate Medical Director Marshall Kubota, MD, **expressed wording concerns about MCUG3134**'s pediatric beds **and MCUP3044.** Anna noted that both policies soon will be coming back with more changes but asked that they be passed as presented today, and Dr. Moore agreed. Anna explained that the Urgent Care policy is long overdue because it was being held back in anticipation of the formation of a workgroup charged with reviewing urgent care services. The workgroup has just recently been convened and will require multiple meetings, so the policy is being reviewed now with only minimal updates, and will return to committee with additional changes after the workgroup completes its review. She said the language in the policy is focused on site review and provider credentialing and as such probably does not belong in UM. This policy, she added, will most likely be archived and with language dispersed into other exiting policies, and Dr. Moore concurred. **Both policies were approved as presented under the Matthews/Jalloh motion.** **MPQP1004 was pulled** to add two positions mistakenly left off the staff voting list: Senior Director, Behavioral Health and Policy Analyst, Utilization Management. VI.A.5 was amended to read "Voting: Standing Members, including the Regional Medical Directors and Associate Medical Directors specifically assigned by the CMO to sit on this committee, will vote and the Chair will acknowledge consensus." **Motion to approve with these changes: Anna Campbell/Kermit Jones, MD, JD** Anna **pulled MC341** to note that three counties will be overlapping the Medi-Cal and the coming Partnership Advantage (Medicare) program, wondering if this policy should be marked as a straight Medi-Cal-only ("MC") policy. Dr. Moore noted that Medicare will supersede the entire W&R program. Mark Bontrager concurred that the first payer would be Medicare once Partnership Advantage goes live, adding that providers seeing "Medi-Medi" patients already know to bill Medicare first. Dr. Moore said this policy will remain noted as "MC." **Motion to approve: Lisa O'Connell/Mark Bontrager**	
IV. New Business – Discussion Policies – *Dr. Moore explained the "MC," "MP," and "PA" policy nomenclature for the benefit of new staff.*		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance*		
MCCP2024 – Whole Child Model for California Children's Services (CCS)	**Policy edits due to DHCS WCM Readiness Deliverables** **Related Policies Updated:** MCCP2014 renamed to MPCP2014 MCCP2030 renamed to MPTP2503 **Definition Updated:.** Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.	*There were no questions.* Motion to **approve as presented**: Stan Leung, Pharm.D Second: Isaac Brown, MHA/ MBA <u>Next Steps</u>:

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	VI.A.3. added via fax or secure File Transfer Protocol (SFTP) as a form of communication to transmit referrals to the counties **VI.C.1. added:** Partnership WCM case management and care coordination is a member and family centered care approach which ensures needed clinical and non-clinical services for the CCS eligible condition. Partnership collaborates with the WCM member, member's family, or authorized representative of the WCM member to identify needs, goals, and preferences in accessing such diagnostic and treatment services. **VI.C.5.e.2. added:** Partnership identifies needs, goals, barriers, and interventions to access diagnostic and treatment services including access to primary and specialty care by a CCS-Paneled Provider and preventive care services with specialty care services through the collaborative case management and care coordination process with WCM members. Partnership evaluates Risk Assessments, ICP's, AMR's, ongoing case management with the WCM Member, family or authorized representative, and available data to identify referred services in plan of care and confirm member received referred treatments. **VI.C.5.g. added:** If a member chooses to receive both CCS Case Management and ECM services, Partnership may assign some or all CCS Case Manager functions to be delivered by qualified ECM Providers. ECM providers must meet all existing CCS and WCM requirements to provide Case Management services. ECM providers must have previous experience directly providing CCS Case Management and/or CCS clinical services. **VI.J.3.a-d added:** Disputes submitted to DHCS via email with subject "Request for Resolution" will include a summary of the disputed issue(s) and a statement of the desired remedies, a history of the attempts to resolve the issue(s), justification of the desired remedy and any additional documentation that are relevant to resolved the dispute, if applicable. **Reference updated:** DHCS APL 23-029- Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 01/08/2025)	June 18 Q/UAC Consent Aug. 13 PAC
MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities – **NEW POLICY**	**NEW Policy** To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities. This policy outlines that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: 1. A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. 2. All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions. 3. MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. 4. MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. 5. The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU.	Motion to **approve as amended**: Anna Campbell Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC

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	6. The MOU parties must support the timely and frequent exchange of Member information and data. 7. The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness 8. Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. 9. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. Dr. Moore asked whether quarterly meetings with individual counties have started and if some counties will "bundle" together so there might not need to be, for example, 24 "First Five" meetings. Senior Director of Care Management Brigid Gast, RN, replied that some meetings have occurred, and that bundling too will happen should participants agree. In addition, some public health agencies are asking for *ad hoc* meetings. Mark Bontrager noted that Partnership also does bundle Behavioral Health MOU meetings. Dr. Moore also asked whether this policy makes it clear that the templates may change and if we link interested persons to the executed MOUs. Anna Campbell noted that we are displaying executed MOUs on a webpage on the external Partnership website. .**Shannon will check if it is appropriate to add a link in the Reference section before this policy goes to Q/UAC June 18.** Anna noted that **Related Policy B and E alphanumerics must be updated.** Chief Health Services Office Katherine Barresi, RN, noted the first MOU was created in 2023 as part of Partnership meeting its 2024 DHCS Contract. Brigid added that this new policy and our WCM as presented today have been delivered to DHCS, which has yet to provide feedback.	
MPCP2014 – Continuation of Care – *new policy number and name change: "Medi-Cal" is dropped as policy will now apply to Medicare too*	**This policy was updated to include regulations for Partnership Advantage D-SNP line of business that will be effective Jan. 1, 2027.** Policy number updated from MCCP2014 to MPCP2014 to reflect Multi Plan Policy **Related Policies Updated:** MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142 updated to reflect new policy number MCAP7003- CalAIM Community Supports (CS) **1. Definitions Added:** Dual Eligible Special Needs Plans (D-SNPs) Partnership Advantage (PA) **Purpose: added additional population the policy applies to:** Members newly enrolled in Partnership Advantage's Dual Eligible Special Needs Plan (D-SNP) **VI.E.1. revised to include** Prior to the date of the members' initial enrollment in the D-SNP for a non-emergency visit as an additional way for Partnership to determine that the member has an ongoing relationship with the provider **VI.E.3. added** Current Medicare fee schedule **VI.E.7. Partnership Advantage members section added:** D-SNPs are network based for Partnership Advantage members, with the following exceptions:	Motion to **approve as presented**: Brigid Gast, RN Second: Anna Campbell Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

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	1. Partnership Advantage members are allowed to continue receiving care from an out-of-network provider for up to 12 months after enrolled if they have an acute or serious chronic medical condition as referenced in VI.A.3. 2. Partnership Advantage members must submit a request to their Medicare plan including documentation from current medical provider. **VI.F. added** D-SNP to the section **VI.H.2 updated** County Mental Health Plans (MHPs) to County Behavioral Health Plans (BHPs) **VI.L.8.d. added:** D-SNP retroactive requests for Partnership Advantage members must be accepted if submitted more than 30 days after the first service if the provider can document that the reason for the delay is that the provider unintentionally sent the request to the incorrect entity and the request is sent within 30 days of the denial from the other entity. **References Updated:** DHCS All Plan Letter 24-015: California Children's Whole Child Model Program (12/02/2024) **References Added:** DHCS CalAIM Dual Eligible Special Needs Plan Policy Guide- Contract Year 2026 (2025) Medicare Managed Care Manual: Chapter 11- Medicare Advantage Application Procedures and Contract Requirements, Rev. 83 (04/25/2007) **In response to a question posed by Dr. Moore**, Senior Director of Behavioral Health Mark Bontrager clarified that this policy is an umbrella of sorts, providing oversight of BHPs, some of which may be delegated by individual counties. Anna Campbell noted that the draft 2026 Member Handbook utilizes the new term "Behavioral Health Plan (BHP)" instead of "Mental Health Plan (MHP)" to refer to the county side.	
Policy Owner: Pharmacy – *Presenter: Stan Leung, Pharm.D, Director of Pharmacy Services*		
MPRP4001 – Pharmacy & Therapeutics (P&T) Committee	**Definition G is added**: **Biosimilar:** a biologic medication that is highly similar to and has no clinically meaningful differences from an existing FDA-approved biologic, called a reference product. **B.1.g.1) is added:** Upon market launch or assignment of a HCPCS code, biosimilar products will be assigned to the same criteria as their reference product in PHC's MDL while they await annual class review. This automatic assignment will not require P&T committee approval, and the effective date will be the date of market launch and/or the date of code activation.	*There were no questions.* Motion to **approve as presented**: Stan Leung, Pharm.D Second: Kermit Jones, MD, JD <u>Next Steps</u>: July 10 P&T Committee Aug. 13 PAC
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3041 – Treatment Authorization Request (TAR) Review Process	**Section I:** Two Related Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services **Section V.** An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing.	*There were no questions.* Motion to **approve as presented**: Doug Matthews, MD

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	Section VI.A.2. In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.A.5** was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. **Section VI.B.2.b.** This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. **Section VI.B.2.b.** Added language to say TARs are not required for "certain" services because the list has been growing and we did not want to limit services to only those specified . **Section VI.B.4.** Removed "diagnostic imaging" from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI **Section VI.F.** Removed the entire Communication Services section because the language is duplicate in policy MPUP3064 Communication Services, which has been listed at the top in Section I. as a Related Policy. **Attachment A:** Policy numbers updated throughout. **H. Diagnostic Studies;** Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services. Dr. Moore noted that Partnership is already implementing these changes to no longer require prior authorization for CT scans or MRIs, which Configuration will communicate to the Provider Network after Aug. 13 PAC approval.	Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC
MPUP3014 – Emergency Services – *previously MCUP3013*	**Section VI.F:** A new section was added to describe coverage for Services Rendered Outside of the United States, including Canada and Mexico. **Section VII.G**: A new Reference was added for the Medicare Claims Processing Manual Chapter 1 (Rev. 12909, Issued: 10-24-24), Section 10.2.1 FI Payment for Emergency and Foreign Hospital Services (Rev. 1, 10-01-03)	*There were no questions.* Motion to **approve as presented**: Anna Campbell Second: Kermit Jones, MD, JD Next Steps: June 18 Q/UAC Consent Aug. 13 PAC
MPUP3039 – Direct Members – *previously MCUP3039*	This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027. It has also been updated with a crosswalk to show new "Health Conditions" categories that will be used when go live with the HRP core claims system in the future. **Section III.C.** Definition of Partnership Advantage has been added. **Section IV.** The title of Attachment A was updated to "Direct Member/ Health Conditions Category Designation Grid." **Section VI.A** Clarifying language was added to say we will have Medicare providers in our network as applicable to Partnership Advantage Members.	Motion to **approve as presented**: Anna Campbell Second: Lisa Ward, MD Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

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	Section VI.B. Footnote describing CCS counties is deleted because all counties are now Whole Child Model counties. **VI.E.1.c.2:** Statement was added to say that Partnership Advantage Members may appeal a Direct Member status decision according to the process outlined in Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (ODAG). **Section VII.C.:** New Reference was added for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations **Attachment A:** The Direct Member Designation Grid was updated to include "Health Condition Categories throughout. A new column was added to "crosswalk" current Direct Member Designations to future Health Condition Categories that will be used when HRP goes live. **H5 Continuity of Care/ Transplant Category**: Added language to include CAR T-cell therapy and gene therapy with Bone Marrow transplants and change time period from one year to two years for when a Direct Member receiving those services would become eligible for assignment to PCP Dr, Moore noted that a subgroup is working on this policy, which will likely get a major revision and new title closer to Medicare go-live. **"Effective when HRP is activate" will replace the erroneous Q3 2025 effective date placeholder at the top of the Attachment A Health Conditions Category Designation Grid**	
MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*	**This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027.** **Section VI.B.2.a. 2)** Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. **Section VII.B and C.** Added two new references for "Contractual obligations with the Department of Health Care Services (DHCS)" and "Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)" **Attachment A:** Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	*There were no questions.* Motion to **approve as presented**: Kermit Jones, MD, JD Second: Anna Campbell Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Population Health*		
MCNP9004 – Regulatory Required Notices **NEW Title**	**This policy's name was updated from Regulatory Required Notices and Taglines to simply "Regulatory Required Notices."** This policy was updated to reflect changes per APL 25-005 - Standards For Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services, And Alternative Formats (Supersedes APL 21-004) and organizational changes: **I. Related Policies -** Cultural and Linguistic Program Description policy number updated from MCND9002 to MPND9002 **III. Definitions** • Updated references from APL 21-004 to the new APL 25-005. • Updated citations within the nondiscrimination notice description. • Updated "Language Assistance Taglines" to their new name, "Notice of Availability." **IV. Attachments**	*There were no questions.* Motion to **approve as presented**: Anna Campbell Second: Katherine Barresi, RN Next Steps: June 18 Q/UAC Consent Aug. 13 PAC

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	• Updated name of attachment B to "Notice of Availability." **VI. Policy/Procedure** • Revised: MCPs must adhere to the nondiscrimination notice and *notice of availability* requirements in *APL 25-005* when sending the required grievance and appeals notifications to members. • Added reference to MPND9002 (formerly MCND9002) Cultural and Linguistic Program description. **VII. References** • Reference section is updated with hyperlinked citations and language from APL 25-005: o California Welfare and Institutions Code (WIC) 14029.91(e)(1)-(5) o California Department of Health Care Services (DHCS) APL 25-005 Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Services and Alternative Formats (02/12/2025) o U.S Department of Health and Human Services (HHS) 45 CFR section 92.10(a) **Attachment A:** Nondiscrimination Notice updated to current February 2025 version **Attachment B:** Notice of Availability updated to version going live August 2025 **Attachment C:** NOA Your Rights under Medi-Cal Managed Care updated to current December 2024 version **Attachment D:** NAR Your Rights under Medi-Cal Managed Care updated to most current December 2024 version	
Policy Owner: Population Health – *Presenter: Greg Allen Friedman, Project Coordinator II, Population Health*		
MPNP9001 – Population Health Management Strategy & Program Description – *previously MCND9001*	**Changed to MPND9001 to reflect applicability also to the coming D-SNP program.** Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 5 Introduction:** new paragraph explaining Partnership's Medi-Cal and D-SNP services, and Partnership Advantage. **P. 6 Data Analysis and Strategy:** fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. **P. 8-11 under Data Analysis and Strategy:** updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11to p. 14. **P. 13 under Population Needs and Community Needs Assessments:** added language about Community Advisory Committee (CAC). **P. 16-17 under Social Drivers of Health and Community Needs:** added language about covered behavioral health services for Medicare Advantage members. **P. 22 Basic Population Health Management:** added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes. **P. 36 Practitioner Education and Training; Health Education Interventions: re**written to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. **P. 39-42 under Community Engagement and Coordination of PHM Programs:** updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated	*There were no questions for Greg,* who said he would update an APL and a p. 11 Reference before resubmitting the policy for Q/UAC's consideration June 18. Motion to **approve as will be amended prior to Q/UAC**: Kermit Jones, MD, JD Second: Anna Campbell Next Steps: June 18 Q/UAC Discussion Aug. 13 PAC

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	vendor names and terminology and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership's monitoring of performance for delegates. P. 48-51 under Team Roles and Responsibilities: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others.	
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Population Health*		
MPND9002 – Cultural & Linguistic Program Description – *previously MCND9002*	**Changed to MPND9002 to reflect applicability also to the coming D-SNP program.** This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: **Alignment with DHCS Review Tool** • Added reference to the regulatory required notices Attachment A & Attachment B (pg.8). • Added details around written information in either traditional or simplified Chinese characters (pg.11). • Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS' OCR, and HHS' OCR (pg.9). • Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (pg.9). • Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (pg.12). • Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (pg.14). • Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (pg.14). **DSNP Language** • Changed policy name from MCND9002 to MPND9002 throughout document • Updated the list of member correspondence items to include "Notices of Organization and Coverage Determinations to encompass DSNP notices" *(pg.9*) **Attachments A-E updated with new "MPND" policy coding.** Other specifics below. **Updating Attachment D:** Process for Translation Services • Document from our translations vendor updated with branding reflecting that they are now owned by Propio. **Updating Attachment E:** Community Advisory Committee • Name changed from "*Consumer*" to "*Community* Advisory Committee." • More detailed diversity statement added. • Edits made to include the committee's feedback on the subject of CHA/CHIP work with counties. • Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership's member population. • Added detail about representation ratios. • Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee.	*There were no questions.* Motion to **approve as presented**: Kermit Jones, MD, JD Second: Katherine Barresi, RN <u>Next Steps</u>: June 18 Q/UAC Discussion Aug. 13 PAC

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	• Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. • Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. • Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. • Updated references to DHCS's Medi-Cal Member Advisory Committee (MMAC). • Updated Partnership office addresses	
V. Presentations		
QI Update – *Nancy Steffen, Senior Director, Quality Improvement and Performance*		
Nancy noted that the printed report was submitted before it was known that the Health Rules Payor (HRP) claims system implementation would be delayed. Therefore, the QIP team has no need to do a changeover: **no two-week blackout period to the PCP QIP will be necessary in July.** • The Chronic Disease Workgroup continues to work on getting retinal cameras into imaging center deserts across the network to increase access to retinal screenings for diabetic members. Partnership has so far funded 10 cameras. • The 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 materials, including educational videos. The Cologuard overview outlines all available screening options and includes guidance on how to effectively access care gaps. Interested providers can begin submitting their orders for testing kits on July 21. • Partnership continues to support the Partnering for Pediatric Lead Prevention (PPLP) program, which provides funding for point-of-care lead testing devices to eligible practices. Applications are accepted year-round. Click this link. • Consumer Assessment of Healthcare Providers and Systems results are coming in and our CAHPS team is validating them. Give the Healthcare Effectiveness Data Information Set team a shout out: HEDIS® will be reported out in August IQI, Q/UAC, and PAC. • Our Health Equity Accreditation Initial Survey is scheduled for June 17. Our evidence has been submitted. Some persons may be asked to do additional work this summer. Official accreditation notice is likely to be received in September.	*For information only.* Dr. Moore asked if the PCP QIP payments will go out this week. Nancy said yes. Dr. Moore will announce this at June 11 PAC.
Population Health Management Grand Analysis – *DeLorean Ruffin, DrPH, Director of Population Health*		
DeLorean introduced the Grand Analysis by saying it covers both the Pop Health Impact Analysis and the Segmentation Report. The Analysis mainly meets NCQA standards but there is an opportunity to include other measures in the future. This presentation mainly covers the results showing statistically significant differences, so not all measures are covered in the oral presentation. The 2024 Impact Analysis looks at all parts of our Growing Together Program (GTP) and some member feedback from other Partnership programs. This presentation today looks at statistically significant results for one or two goals for the Prenatal Program and the GTP Postpartum (together known as Healthy Moms), the GTP Healthy Babies (0-30 months), the GTP Healthy Kids (ages 3-6), and Transitions of Care. Data was drawn from a variety of sources, including Partnership and DHCS claims data, and immunization data available through the California Immunization Registry (CAIR). DeLorean went through the "engagement categories," defining "engaged" as members who qualified for the program, were reached by phone and opted in to program participation. Goal One of the Prenatal Program was that 75% of engaged members would have a Tdap vaccine within 120 days (four months) of delivery. The goal was barely missed at 73%. Still, engaged members (38% of 1,212 deemed eligible to participate) had a statistically	There are some opportunities that exist to improve the design of PHM interventions along with broader systemic factors addressing the environment of care. Partnership will explore means to leverage new benefits and resources offered through the CalAIM initiative to bolster member support and improve

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	significant higher rate of completing the vaccine compared to members who declined to participate. The engaged white population had a statistically significant lower rate of completing the Tdap (65%) compared to the Hispanic population at 80%. Further analysis may be warranted because of the small sample size for some groups. Goal One of the Postpartum Program was that 75% of engaged members would attend a postpartum visit within 60 days of delivery. The goal was met. The white population had a statistically significant lower participation rate (63%) than did American Indians (86%), Hispanics (81%), and other/unknown (73%). The data demonstrates that the campaign made a measurable difference in the lives of certain non-white population groups, although the sample size for some was small. Members engaged only in the postpartum program had a statistically significant lower rate of attending a postpartum visit within 60 days of delivery when compared to members who were engaged in the prenatal program. Population Health enrolls infants under 12 months of age in the Healthy Babies GTP the month they become Partnership members. (In July 2024, the enrollment age was modified to include infants under 24 months of age; this shift will be reflected in next year's report.) The program provides health education and promotion of well-child visits and timely vaccinations. Incentives are offered. Goal One was that 80% of engaged members would be compliant with 50% or more of their vaccinations during the program period. This goal was met at 92%. Engaged members has a statistically higher rate of completing 9+ or 4+ vaccines than did non-engaged members. The engaged white population has a statistically lower rate of completing 9+ or 4+ (79%) than did Asians (96%), Hispanics (97%), and other/unknown (89%). Goal 2.1 was that 25% of engaged members would attend all the well-child visits. This goal was met at 67%. Goal 2.2 was that 65% of engaged members would be compliant with at least one-half of the recommended well-child visits. This goal was met at 89%. Once again, for both goals the white population had lower compliance rates than did other racial/ethnic groups. The engaged member result for Healthy Babies vaccines "looked pretty good," DeLorean reported. Significantly more members completed vaccines between July 2023 and June 2024 than in the previous period (1,424 compared to 514); however, this increase may be associated with Partnership's 10-county expansion that occurred in January 2024. Overall, the Healthy Babies campaign made a measurable difference in the lives of our Hispanic population. Healthy Kids aims to reach all children ages 3 through 6 who have not had a well-child visit in the prior 11 months or longer. Once identified, these members are offered an incentive to encourage complete an annual well-child visit before their next birthday. Goal One was that 50% of engaged members would have a WCV within 120 days of agreeing by phone to participate. This goal at 32% was not met; however, engaged members had a statistically significant higher completion rate than non-engaged members, suggesting that the program continues to have an impact. In all, 1,947 (23%) of 8,411eligible children were engaged, and 1,535 (79%) of those engaged completed a WCV during the fiscal year. There was no significant difference between the white population and other ethnic groups. Transitions of Care (TOC) services focus on members who are transitioning across settings or benefit structures. Partnership's Care Coordination team provides TOC to the vulnerable population to ensure implementation of the discharging facility's transition plan and connects members to medical care and community resources that support health and wellness. Adult member TOC criteria includes discharging home from an acute care after hospital length of stay longer than four days, or discharging home from an out-of-county hospital with any length of stay, or having more than one admission in 10 days. (It excludes members in long-term care or in a long-term care psychiatric facility.) Pediatric members (i.e., under the age of 21) qualify by discharging home from an acute care hospital stay with an admissions date longer than 60 days from date of birth and having any length of stay. At the close of the TOC services, Partnership contacts the members by phone to complete a weighted member experience survey that includes opportunity for comment. TOC goals were that both 75% or adult members and 75% of pediatric members would agree with each of the eight statements of the relevant survey. These goals were met, each survey question well exceeding the goal average of 2.5 (on a one to three scale).	the overall health outcomes of the population. Isaac Brown asked if, when messages are left, members call us back. Most often they do not call back, DeLorean replied. In response to further questions from Isaac, DeLorean said that member interactions can change depending on whether the pregnancy is a first or not. She did not know if members used these interactions with Partnership to pose unrelated questions. Nancy Steffen thanked DeLorean for the presentation and suggested that we build on these results via provider engagement. DeLorean observed that promoting the GTP with providers does help: we have seen this in the CHA/CHIP (Community Health Assessment/Community Health Improvement Plan) efforts. **Motion to accept all parts of the Grand Analysis** (PD, Impact Analysis, Segmentation Report and Work Plans): Kermit Jones, MD, JD Second: Nancy Steffen Next Steps: June 18 Q/UAC Aug. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Finally, Complex Case Management is a support for members who have multiple chronic diseases, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. Individual goals are time-bound; however, a member may remain in CCM for an extended period. Goals one and two were that 75% of adult and pediatric members, respectively, would agree (score of "3") with each statement of the relevant CCM satisfaction survey. These goals were met but for "I feel my ability to manage my child's healthcare needs is better after working with CM," which scored just 2.5. In 2024, Partnership refined its program offerings based on insights and successes from previous years. Lessons learned have shown that the most effective program utilizes multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. Among the clinical measures, program goals were met for vaccination rates among infants enrolled in the Healthy Babies program. For utilization measures, we met our goal of newborns attending well child visits who are linked to members engaged in the prenatal and postpartum program. We also met the goal for members to attend postpartum visit among members enrolled in the postpartum program. Furthermore, we met the goal for members to attend well child visits who were enrolled in the Healthy Babies program and one of the goals for kids to attend well child visits who were enrolled in the Healthy Kid's program. As for member experience measures, we met all but one goal under both the Transitions of Care and Complex Case Management programs. A significant finding that has carried on through 2024 is the feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner. This finding, based on both member and provider-level data, highlights the greatest areas of need for innovative solutions and will inform multidisciplinary efforts to support providers in delivering this essential service. Member experience measures highlighted the significant value that Partnership's programs provide. In 2024, Partnership integrated member experience questions into a broader range of member interactions to gain deeper insight into member barriers to care and to promote the overall experience members have with Partnership. In 2024, Partnership conducted analyses of program outcomes stratified by race and ethnicity. An interesting finding was the white population had statistically significant lower rates for certain well-child attendance visit goals, and postpartum visits when compared to other racial groups. Under the Prenatal Program, there was no statistical significance between the white population and other non-white populations for the linked newborns to well child visits measure. Moreover, Partnership's members enrolled in Population Health Management (PHM) programs demonstrated improved outcomes compared to those who were not engaged or not referred to the programs.	
Annual Review of UM and InterQual® Criteria – *presentation only; demonstration will occur at June 18 Q/UAC – Tony Hightower, CPhT*		
	Tony noted that InterQual® is a clinical decision tool developed and continuously peer reviewed based on the principles of evidence-based medicine. It is utilized by our medical directors and nursing staff to support medical necessity determinations. InterQual® is designed for integration on both the payor side and into TAR processing platforms. As a tool, it supports our move toward interoperability between payors and providers and assures that our members receive appropriate care. In-house, Partnership maintains a policy library, which is especially useful when there is no InterQual® set for a specific service or procedure. Partnership purchases new InterQual® criteria modules as needed. Presently, Partnership utilizes 14 modules in its UM decision-making process, including four that are new to us this year: • Level of Care (LOC) Criteria Long-term Acute Care 2025	*There were no questions.* Desiree Payumo, RN, will demonstrate inpatient use of the criteria at the June 18 Q/UAC.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• LOC Criteria Inpatient Rehabilitation 2025 • LOC Criteria Subacute/Skilled Nursing Facility 2025 • Medicare: Post Acute & Durable Medical Equipment Criteria 2025 In future, we may purchase other modules relating to Medicare as we move closer to our D-SNP product, Partnership Advantage, now scheduled to go-live Jan. 1, 2027. A summary of content for each of the 14 modules Partnership utilizes is provided in today's agenda packet. Arrangement can be made to provide further criteria for review upon request to UMHelpDeskSR@partnershiphp.org.	
Annual Grievance & Appeals Report CY 2024 – *Kory Watkins, MBA-HM, Director, Grievance & Appeals*		
	The Grievance & Appeals department – in concert with the Medical Directors and various departments including Provider Relations, Transportation, Compliance, Member Services, and Quality Improvement – ensures that member concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies, with a focus on timeliness, fairness, and improving the overall member experience. G&A works closely with the Medical Director for Quality, who reviews all clinical grievances flagged by nurses for potential quality issues (PQI). Additionally, interrater reliability reviews (IRR) are conducted quarterly to assess the appropriateness of cases not referred for PQI review. In 2024, 207 grievances were referred for PQI review. G&A in 2024 partnered with the Transportation department to capture the names of individual drivers (not just the company) involved in transportation-related concerns. This change allows for more precise data analysis and better identification of driver specific trends. Once a case is received from a member, the Member Services department or other source, a clinical assessment occurs where appropriate, and G&A contacts the member and sends an acknowledgment letter to let them know the complaint is under review. (This contact is not mandated but is considered best practice.) An investigation is conducted, followed by a letter of resolution and call. G&A processes member complaints about dissatisfaction with services, care, or experience within 30 days; "exempt" or "expedited" grievances within 72 hours in situations where loss of function, limb and/or life is possible; appeals wherein a member disagrees with a denied service or treatment; and state fair hearings before an administrative law judge regarding a denied service. Annual case volume is increasing each year, although the reasons why vary, so trending analysis is difficult. G&A closed 7,556 cases (8.34 per 1,000 members) in 2024 which saw 10 new counties join Partnership, compared to 5,690 (8.39 per 1,000 members) in 2023 when Transportation came in-house, and 4,085 (6.40 per 1,000 members) in 2022 when Covid-19 was still concerning. In 2024, just 35% of grievances received were clinical in nature; however, 63% of appeals involved clinical concerns. Just 28 of 213 exempt case filings were deemed to meet the criteria for expedited resolution. As in years past, the most typical 2024 filer was a white, English-speaking middle-aged female residing in a northern county where access concerns are most prevalent. The top three counties by grievances per 1,000 members were Lassen (15.4), Modoc (13.6) and Siskiyou (12.3). (Transportation-related issues drove these numbers.) Sutter County had the fewest grievances (3.7). The top grievance categories were Transportation (49%); Provider Service (24%); Access (17%), and Partnership Service (10%). In 2024, Partnership provided 1,166,701 rides and received 4,472 transportation-related concerns (< .4% of total rides, down from .6% in 2023.) Excluding Transportation, Provider Services accounted for 46% of concerns (down from 50% in 2023) and Access accounted for 34% (up from 30% in 2023). Treatment plan disputes accounted for 39% of provider issues; long wait times for appointments accounted for 37% of access issues.	*There were no questions for Kory.* "Goals and Focus Areas for 2025" dates will be updated before this document goes to June 18 Q/UAC: • Jiva Implementation – Launching a new case management platform in *2025* to enhance… • Partnership Advantage Prep – Preparing for January *2027* launch of the new D-SNP line of business…

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Members may allege discrimination for many reasons, Kory noted; however, this report contains only substantiated findings of civil rights allegations, which may fall into one or more categories, the top two of which are disability and race or ethnicity. In 2024, just 10% of civil rights allegations were substantiated, down from 22% in 2023. Kory said her department is working closely with Southeast Regional Medical Director Colleen Townsend, MD, to outreach to involved providers so they do not repeat any discriminatory practices. The top Appeals in 2024 were Transportation related (49%); Treatment Authorization Requests (TARs) (35%); Referral Authorization Forms (RAFs) (12%); and Claims (4%). In 2024, 69.6% of Appeals filed were upheld, while 15.5% were overturned, largely because more clinical or other information was received. In cases that were referred to an administrative law judge, 45.8% were withdrawn before any hearing; 28.2% were dismissed; and 17.6% were upheld. Only 2.8% were overturned. Kory concluded her presentation by saying that 2025 department performance is thus far meeting goals, an improvement above some 2024 quarters wherein the 98.6% timeliness threshold was narrowly missed for case closures and acknowledgement letters because of staffing, training, or other issues, including the addition of 10 counties. G&A has now instituted a multi-step nurse review protocol: 1. When one nurse determines documentation is essential, a second nurse now confirms or disagrees 2. If disagreement occurs, the case is escalated to a Medical Director for a final decision This process ensures cases are pended only when necessary (e.g., left open while awaiting a provider's response) and improves oversight on delayed resolutions.	
FYI: PHM Final Work Plan Update – *refer questions to DeLorean Ruffin, DrPH*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:41 p.m. IQI will meet next on Tuesday, Aug. 12, 2025. **There is no meeting in July.**		

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

Approval Signature: *Date:*

Robert Moore, MD, MPH, MBA
Chief Medical Officer and Committee Chair

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
JUNE 2025
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER (PCP) QIP	• Measurement Year (MY) 2024 PCP QIP payment is on track to distribute the week of 06/09/2025. In total, $51.8 million in performance rewards are being distributed, representing an increase of $13.3 million from MY2023. This increase represents improvements in the new Equity Adjusted Per Member Per Month rates and the addition of the expansion county providers. A comprehensive evaluation of MY 2024 PCP QIP will be presented to quality committees this fall. • MY2026 measure development is in progress. • The QIP team is preparing the network for a 2-week blackout period taking place in July, to support the new core claims system (HRP) go-live and cut-over processes.
PALLIATIVE CARE QIP	• The July – December 2024 payment are distributing in June. • The program in MY2025 will shift from requiring participating providers to submit assessment data into a palliative care data registry and instead, require them to submit results from administered Patient Satisfaction surveys directly to Partnership. This is in response to the recent dissolution of the Palliative Care Quality Collaborative (PCQC).
PERINATAL QIP	• Fiscal Year (FY)2025/2026 begins next month and will include a new gateway measure focused on provider participants contracting with DataLink, Partnership's certified NCQA HEDIS Data Aggregator (DAV). • FY2025/2026 specifications will be posted by the end of June.
ENHANCED CARE MANAGEMENT QIP	• 2025 payments for second quarter are in process and will be distributed this month.
HOSPITAL QIP (HQIP)	• The new FY2025/2026 measurement year kicks off in July. • FY2025/2026 specifications will be posted by the end of June.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• PQD 2025 is expected to be released after the launch of HRP later this year. The Final PCP QIP Payment Summary Dashboard for MY2024, however, is on track for release with upcoming distribution of payments.
EREPORTS	• 2025 eReports is in the final stages of preparation for the HRP go-live. This platform will go down for a two-week period in July and re-launch with HRP data

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**DHCS-required PDSAs** • Progress reports on mandated PDSAs in the Redding and Eureka Regions are due to DHCS by 06/11/2025. Updates will be included on the following topics: o Pediatrics Measures ▪ Fluoride Varnish application improvement ▪ Well visit data capture and expediting enrollment o Chronic Disease Measures ▪ Academic detailing for diabetes and asthma ▪ Data improvement for asthma and diabetes medications o Reproductive Health and Cancer Prevention Measures ▪ Mammography access via mobile mammography and fixed imaging ▪ Chlamydia and cervical cancer improvement projects • Similarly, progress reports representing mandated PDSAs in the Fairfield and Santa Rosa Regions are due to DHCS by 06/11/2025. Updates will be included on the following topics: o Pediatrics Measures ▪ Blood Lead Screening improvement ▪ Fluoride Varnish application improvement
QUALITY MEASURE SCORE IMPROVEMENT	Brief status highlights from the domain specific Quality Measure Score Improvement workgroups at Partnership: • **Elder Care**: This workgroup continues deepening foundational knowledge of the Dual Special Needs Plan (D-SNP) program and related measures. HRP transition will affect ability to review baseline data. • **Pediatric:** No updates this month. • **Behavioral Health**: Phase I of the Institute for Health Improvement (IHI)/ Behavioral Health Collaborative ends on 06/11/2025. The goal of this collaborative effort between Partnership and Nevada County Behavioral Health was to establish strong data sharing practices and understanding. Although this collaboration will continue, Partnership and Nevada County have decided not to participate in the optional Phase II within the IHI structure. • **Chronic Disease Management**: Partnership funded ten (10) retinal cameras in imaging center deserts across the network. Partnership has received several memorandums of understandings from providers and has started issuing payments for devices to impact MY2025. • **Women's Health & Perinatal**: On 05/09/2025, the FDA approved a completely at-home test collection device created by Teal Health. Partnership's Performance Improvement team has been in contact with Teal Health since early March to discuss how to make this option available to our members and use it to improve our cervical cancer screening rates. Currently, we are awaiting Teal Health to be an approved Medi-Cal, telehealth provider.

IMPROVEMENT ACADEMY	• Attendance at the 2025 Improving Member Outcomes (IMO) webinars, occurring over February through April, ranged from 53-90 attendees, with each session representing 28-45 unique organizations. Of attendees who completed the post-session evaluations for all six webinars, 99% selected *Strongly Agree* or *Agree* when asked if the webinar was relevant and useful. • The ABCs of Quality Improvement was offered via three in-person sessions this fiscal year. Attendance ranged from 21-48 attendees, representing 8-15 unique organizations. 100% of respondents rated this session as *Extremely Satisfied* or *Satisfied*. During each training session, an evaluation was implemented at the start of each of the four sections to measure participants' baseline knowledge. The same evaluation was launched after completion of each section. Participants' baseline knowledge was compared to post-session evaluation results to document improvements in content knowledge, comprehension or application as a result of the training. Each post-session evaluation revealed higher percentages of *Strongly Agree* and *Agree* as compared to pre-session evaluations. • The Preventive Care Dashboard microlearning is currently under development and projected to be completed late June/early July.
JOINT LEADERSHIP INITIATIVE (JLI)	• Joint Leadership Initiative meetings for the 4 selected providers in the Chico and Auburn regions are scheduled for fall 2025. • Fairfield Region: Held 2nd Quarter meeting with Solano Family Health Services on 05/06/2025. Sonja Bjork and Amy Turnipseed were in attendance, along with regional & QI leadership: Katheryn Power, Dr. Townsend, Flor Torres, Isaac Brown, and Jennifer Durst. Next Meeting is 08/05/2025. • Santa Rosa Region: No JLI participants. • Eureka Region: Open Door Community Health Center is scheduled 06/26/2025 and Adventist Health is 07/09//2025. • Redding Region: Fairchild Medical Center is scheduled 07/01/2025.
REGIONAL IMPROVEMENT MEETINGS	• Regional Quality meetings have been scheduled for the Chico and Auburn regions for July 21st and 24th respectively. • Fairfield: The second quarter meeting was held on 05/20/2025. CommuniCare+OLE shared their experience with the cervical self-swab pilot. • Santa Rosa: The regional team continues working to establish a Santa Rosa Regional Quality Meeting. Dr. Lisa Ward, the Regional Medical Director for Partnership, has socialized the idea with regional health center leaders and is distributing a survey regarding logistics and topics of interest. The goal is to hold the first meeting in third quarter of 2025. • Redding: The second quarter meeting is scheduled for 06/23/2025. • Eureka: The second quarter meeting was recently completed on 06/04/2025.

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 24/25 Org Goals and FY 25/26 Org Goals	**CAHPS® Regulated Measurement Year (MY) 2024 / Report Year (RY) 2025 Survey - Closed** **Preliminary Year-Over-Year Survey Respondent Rate Comparisons:** • Adult Population o 2023-2024 - 15.3% (3,375/510) o 2024-2025 - 15.4% (3,375/511) • Child Population o 2023-2024 - 16.1% (4,125/659) o 2024-2025 - 15.8% (5,000/783) **Additional Updates** • The National Committee for Quality Assurance (NCQA) provided results and member-level files to both Press Ganey, the plan's survey vendor, and the HEDIS team. • The HEDIS team is now in the process of validating the NCQA survey results. • The preliminary analysis is underway for the FY 2024/25 ME 7: Member Experience Grand Analysis (MEGA) report. **Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)** • The Partnership Project Review Board (PRB) approved the Project Charter in May. • The kickoff for the Member Experience Organizational Goal is set for early July.
Exact Sciences: Promoting Colorectal Cancer Screenings	**Colorectal Cancer Web Page** The 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: • Educational videos on Cologuard, developed by the Population Health Team • Information on how to order FIT tests • Links to materials for providers and patients The Cologuard overview outlines all available screening options and includes guidance on how to effectively address care gaps. If you're interested in reviewing the page, you can find it at https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx
Equity & Practice Transformation Project	**Program Overview** The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives

Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC).

PDPP Participation and Deliverables

- All twenty-seven (27) provider organizations invited by DHCS to participate in the PDPP accepted by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. Accepted provider organizations span Partnership's sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhance Provider Engagement (EPE) program.
- Following a statewide budget revision, DHCS recalculated the final PDPP award amounts. While other MCP's experience a 5% dropout rate in their EPT cohorts, all 27 of Partnership participating providers have remained enrolled and actively engaged. DHCS has recalculated the final award amounts, due to budget revisions.
- As part of their continued participation, practices that were unable to submit their required 2024 deliverables by the original 11/01/2024 deadline now have until 11/01/2025 to fulfill those requirements. These deliverables include:
    - the Empanelment Assessment and Policy & Procedure under the Empanelment and Access milestones
    - the Data Governance and HEDIS Reporting Assessment, along with a corresponding Policy & Procedure under the Population Health Management (PHM) milestones
- Similarly, practices that did not submit the May 2025 deliverables by the 05/01/2025 deadline are also granted an extension to 11/01/2025. These deliverables include the PHM Implementation Plan and stratified HEDIS-like measures.
- If a practice did not complete the Year 2 PhmCAT by the extended 05/19/2025 due date, they will not have another opportunity to submit this deliverable for future submission. They will also be ineligible for any associated EPT payment for this deliverable.
- PHLC is currently reviewing submissions and will update practices and MCPs on the status – whether they were accepted, rejected, not submitted, or flagged for resubmission during the next submission period.

Revised EPT Payment Methodology

DHCS delayed the 2024 EPT payments due to CMS required changes. In response, MCPs and EPT practices received an updated payment methodology and detailed explanation for the delay. One key change from CMS was the exclusion of D-SNP members from assigned member counts. This adjustment prompted DHCS to request new member counts from participating MCPs, which were then used to recalculate payment amounts.

	• Under the original methodology, each practice was eligible for a total potential payment of $250K regardless of their assigned member counts. Practices with more than 2,001 assigned lives earned an additional $20 per assigned life. The new payment methodology introduces a tiered system, where payments are based on specific member count ranges and the per-member payment rate decreases as the number of assigned lives increases. • This change had a mixed impact on practices. While some saw an increase in their maximum potential payment, six (6) of our participating practices experienced a reduction. **Statewide Learning Collaborative** • The Statewide Learning Collaborative (SLC) is meant to support practices awarded PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. • In June, the Redwood Learning Community hosted a two-part session to ensure flexibility in attendance. Part 1 was offered on 06/23/2025 and 06/24/2025, followed by Part 2 on 06/25/2025 and 06/26/2025. These sessions focused on strengthening core elements of the REPT care model and translating clinical transformation strategies into real-word practices.
Preventative Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventative Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering was designed as a limited grant program; whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Pilot 1. **Pilot 1 Summary and Funding Model** A total budget of $250,000 was approved for Pilot 1 with some funding remaining; participants received up to: • $45,000 when hiring a Physician. • $31,600 when hiring an Advanced Practicing Clinician. The Grant was paid in two installments: • 50% upon signing the agreement. • 50% upon completion of the four-week assignment and submission of a post-program survey. **Program Implementation and Participation** The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods were carried out asynchronously through

January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician.

Pilot 1 Provider Specific Outcomes

Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements. Despite an extension through May 2025, Round Valley Indian Health was ultimately unable to recruit a locum and complete the grant-related activities.

Pilot 2 Funding and Planning

Pilot 2 has been approved with a total budget of $480,000, to support up to five (5) locum providers for three-month assignments aiming to:

- Increase provider capacity;
- Reduce appointment backlogs;
- Improve WCV and CCS HEDIS® priority preventive care measures.

By addressing access barriers through targeted locum support—and by proactively guiding providers to maximize these resources through clear onboarding, scope alignment, and data tracking—the pilot offers a cost-effective, high-impact strategy for improving clinical quality scores, reducing quality withholds and sanctions tied to low visit rates, and enhancing the overall member experience.

Pilot 2 Objectives:

- Refine effective strategies for using short term locum support to increase preventive care visit rates in the near term.
- Develop a practical locum toolkit that providers can integrate into their practices with a high probability of success with minimal disruption.

Pilot 2 Implementation:

Four providers have submitted applications and will be awarded up to $96,000; one additional application is pending while exploring member reassignments.

- Ampla Health
- Western Sierra Medical Clinic
- Shasta Community Health
- Open Door Community Health
- La Clinica (application pending)

Participating providers will be required to meet obligations outlined in the agreement and will be monitored through weekly progress reports and regular check-ins with the Partnership program team.

<table>
<tr><td></td><td>Kick-off meetings will be scheduled with participating providers to establish structured support during the recruitment and preparation period. Providers aim to have locums in place in time to optimize well-child visit capacity during the critical summer months.</td></tr>
<tr><td>Mobile Mammography Program</td><td>Upcoming Event Days (FY Q4) – no changes from last month's report
<table>
<tr><th colspan="4">Upcoming Event Days
04/01/2025 – 06/30/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Chico</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>Eureka</td><td>4</td><td>4</td><td>4</td></tr>
<tr><td>Fairfield</td><td>1</td><td>2</td><td>2</td></tr>
<tr><td>Redding</td><td>4</td><td>4</td><td>4</td></tr>
<tr><td>Santa Rosa</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Plan Wide</td><td>14</td><td>16</td><td>16</td></tr>
</table>
• Scheduling for Mobile Mammography event days for FY 25/26 Q1 and Q2 (July – December 2025) is currently in progress.</td></tr>
<tr><td>Partnering for Pediatric Lead Prevention Program</td><td>LeadCare II Device Access and Evaluation
Partnership continues to support the Partnering for Pediatric Lead Prevention (PPLP) program, which provides funding for point-of-care lead testing devices to eligible practices. Applications are now accepted year-round. Details can be found on the PLPP page on Partnership's website. PPLP Webpage</td></tr>
<tr><td>QI Trilogy Program</td><td>• Updates for the FY2024/25 QI Work Plan have been finalized.
• Updates for the FY2024/25 QI Evaluation are currently being compiled.
• Goal submissions for the FY2025/26 QI Work Plan are due 06/18/2025.
• All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Work Plan; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan) are on track to be submitted in July for formal quality committee approval.</td></tr>
<tr><td colspan="2"><u>D-SNP</u></td></tr>
<tr><td>ACTIVITY</td><td>UPDATE</td></tr>
<tr><td></td><td>• In preparation for Partnership Advantage Star Strategy performance, leaders across the organization have designated Sponsors, Business Owners (BOs) and Process Owners (POs) for all Quality D-SNP measurements including Stars measures (CMS Part C and Part D), display measures, DHCS Quality metrics and Model of Care accountable measures. Sponsors, BOs and POs will meet with QI</td></tr>
</table>

	Department members to understand the monitoring process and assist in stakeholder feedback for data visualization. • The QI Department is collaborating with Wakely (part of HMA) to develop a HEDIS visualization dashboard and a Stars analytics tool. • D-SNP is collaborating internally with the Project Management Office (PMO) and Regulatory and Compliance (RAC) in development of the D-SNP Metrics Monitoring project. This project will give departments across the organization real time data on Partnership Advantage performance metrics. • "Capturing Patient Acuity through Coding Part 2", a webinar addressing coding acuity for D-SNP, is tentatively scheduled on Wednesday, 10/08/2025 at 12 p.m. and will be led by Dr. Kermit Jones. 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.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **04/24/2025 TO 05/26/2025**	• 19 PQI referrals were received with 12 coming from Grievance and Appeals, 4 from Utilization Management, 2 from Care Coordination, and 1 from QI Patient Safety. • 25 cases were processed and closed. 74 PQI cases are currently open. • One case was discussed at Peer Review Committee (PRC) on 05/21/2025 and there is one case awaiting PRC review. • Five cases were sent to the Medical Review Institute of America (MRIoA) for subject matter expert (SME) review, and one case was referred to an external SME physician. • The upgrade of the Sugar CRM PQI application (Processing, Documentation, and Tracking System) is ongoing and currently in the testing phase, with an updated completion target set for June 2025.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **4/21/2025 TO 5/23/2025**	• As of 5/29/2025, we have a total of 477 PCP and OB sites with an additional 35 reviews due to multiple check-ins (totaling 512 reviews). **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	5	4	0	1
Chico	2	2	0	2
Eureka	5	1	0	1
Fairfield	2	1	1	1
Redding	3	5	0	3

Santa Rosa	6	5	2	2

New sites opened this period →
- Eureka: United Indian Health-Valley East Village
- Fairfield: CommuniCare Ole Travis

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The HEDIS team submitted final MY2024 measure rates to HSAG (designated DHCS HEDIS auditor) and Advent Advisory (designated NCQA accreditation HEDIS auditor) on 05/23/2025. Advent Advisory has approved Partnership's final HEDIS rates for Health Plan Accreditation; HSAG's approval is pending. • Partnership will also submit final rates for MCAS measures at the county level by 06/06/2025. County rates, which will not go through the MY2024 auditing process, will be used by DHCS for their accountability programs for the first time in MY2024. (Note that the 10 incoming counties to Partnership in 2024 will be exempt from sanctions for MCAS measure performance.)
HEDIS® Program Overall	• Partnership participates in DHCS's Quality Sanctions Workgroup and recently responded to DHCS's proposal to sanction MCP's at the County level for MCAS measures performing below the Minimum Performance Level (50th percentile). At issue is DHCS' proposal for sanctioning county-level measures with small denominators, defined by DHCS as measure denominators with under 100 members – this describes 43 of 252, or 17%, of Partnership's county-level measures eligible for sanctions for MY2024 MCAS measures. Of note, DHCS' 100-member threshold for county-level measures is inconsistent with NCQA's Technical Specifications guidance on hybrid measure sampling criteria, which sets a threshold of 411 members to generate a statistically significant measure rate. • DHCS proposes that county-level measures with small denominators be aggregated with neighboring counties with small denominators until the 100-member threshold is met. Partnership submitted a counterproposal recommending that all county-level measures be evaluated for sanctions at the Rating Region level, which is consistent with the Withhold and Incentive accountability program that DHCS is also implementing in MY2024 and would generate eligible populations of at least 411 members across the MCAS measure set. We will learn DHCS final decision on quality sanctions methodology for MY2024's MCAS measures in July 2025.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• HPA Mock File Reviews were held with our new NCQA consultant, Managed Healthcare Resources (MHR), in April and May 2025. Most file review

<table>
<tr><td></td><td>requirements are Must-Pass requirements, and an organization must receive a MET score on all must-pass requirements to achieve or maintain accreditation. These Mock File Reviews will help to ensure Partnership remains in compliance throughout the look-back period. Some risks and opportunities for improvement were identified by MHR and results were shared with the applicable Business Owners. Business Owners have submitted Action Plans to address each finding/recommendation. Next steps include targeted Mock File Reviews with selected teams prior to the start of the look-back period in September 2025. Additional Mock File Reviews will take place with all applicable teams within three (3) months of implementation of the new system, Jiva, later this year.</td></tr>
<tr><td>NCQA Health Equity Accreditation (HEA)</td><td>

Partnership’s HEA Initial Survey is scheduled for 06/17/2025. The NCQA Program Management Team has uploaded all evidence into NCQA’s online survey tool, the IRT, and is finalizing our submission. There are several post-survey activities, which include:
<table>
<tr><th>Date</th><th>Activity</th></tr>
<tr><td>07/11-15/2025</td><td>Receive and address initial issues</td></tr>
<tr><td>07/16/2025</td><td>Survey Conference Call with NCQA to discuss and clarify initial issues</td></tr>
<tr><td>07/17-21/2025</td><td>Respond and submit additional existing documentation to NCQA</td></tr>
<tr><td>08/04/2025</td><td>Closing Conference Call with NCQA</td></tr>
<tr><td>Week of 08/11/2025*</td><td>NCQA provides the preliminary report with scoring and assessment</td></tr>
<tr><td>08/12-25/2025*</td><td>Comment period on preliminary report; provide final responses to NCQA</td></tr>
<tr><td>September 2025*</td><td>Official Accreditation notice received</td></tr>
</table>
*Estimated dates
NCQA is offering survey accommodations to organizations to support implementation of the Executive Orders issued in January 2025. These accommodations are effective for all accreditation surveys submitted on or after 02/12/2025 and will remain in effect until 06/30/2026. Partnership will self-score the identified standards as “NA” or “Met”, based on the approved scoring guidance issued by NCQA. Partnership will not submit evidence applicable to the identified standard(s) and will remove bookmarks and annotations in evidence that have approved scoring changes. The HEA Compliance Dashboard has been updated to reflect the scoring modifications. The total applicable points for Partnership is now 26, and our overall compliance rate is 100% based on our consultant’s review and approval of our HEA evidence. Changes and updates have been communicated to the impacted Business Owners during May Business Owner Check-in meetings.

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

Partnership Policy & Procedure Updates

August 2025

Policy Number	Policy/Procedures/Guidelines	Version Links
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **June 2025.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed **Synopsis of Changes**.*		
Quality Improvement		
MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review) *(New Attachments)*	C CD RD
MPQP1004	Internal Quality Improvement Committee	C CD RD
MPQP1008	Conflict of Interest Policy for QI Activities	C CD RD
MPXG5009	Lactation Clinical Practice Guideline	C CD RD
Utilization Management		
MCUG3134	Hospital Bed/ Specialty Mattress Guidelines	C CD RD
MCUP3041	Treatment Authorization Request (TAR) Review Process	C CD RD
MCUP3044	Urgent Care Services	C CD RD
MPUG3010	Chiropractic Services	C CD RD
MPUP3014	Emergency Services	C CD RD
MPUP3039	Direct Members	C CD RD
MPUP3111	Pulmonary Rehabilitation	C CD RD
MPUP3139	Criteria and Guidelines for Utilization Management	C CD RD

Care Coordination				
MCCP2024	Whole Child Model For California Children's Services (CCS)	C	CD	RD
MCCP2036	Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities *(New)*	N/A	CD	N/A
MPCP2014	Continuity of Care	C	CD	RD
MCCP2020	*Lactation Policy and Guidelines (formerly Breastfeeding Guidelines) (Archived - Moved to Population Health)*	C	N/A	RD
MCCP2021	*Women, Infants and Children (WIC) Supplemental Food Program (Archived - Moved to Population Health)*	C	N/A	RD
Pharmacy Operations				
MCRP4064	Continuation of Prescription Drugs	C	CD	RD
MCRP4068	Medical Benefit Medication TAR Policy	C	CD	RD
MPRP4001	Pharmacy & Therapeutics (P&T) Committee	C	CD	RD
MPRP4062	Drug Wastage Payments	C	CD	RD
Provider Relations				
MPPR207	Annual Physician Satisfaction Survey	C	CD	RD
Population Health Management				
MPND9001	Population Health Manage Program Description	C	CD	RD
MPND9002	Cultural & Linguistic Program Description	C	CD	RD
MPNP9004	Regulatory Required Notices	C	CD	RD
MPNP9007	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)	N/A	CD	RD
MPNP9008	Women, Infants and Children (WIC) Supplemental Food Program	N/A	CD	RD

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the June 18, 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.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*			
MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities **(NEW Policy)**	235 – 239	**NEW Policy -** To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities. This policy outlines that Partnership shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS). MOU Policy includes the following: 1. A designated point of contact responsible for the oversight and supervision of the terms of all MOUs. 2. All Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions. 3. MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services and coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. 4. MOUs must be reviewed annually for any needed modifications or renewal of responsibilities and obligations. For each MOU Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns. 5. The MOU parties may develop Quality Improvement (QI) activities specifically for the oversight of the requirements of the MOU. 6. The MOU parties must support the timely and frequent exchange of Member information and data. 7. The MOU parties must develop policies and procedures to mitigate the effects of disaster and emergency preparedness 8. Partnership and MOU parties shall negotiate in good faith and execute MOUs to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process. 9. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue.	Administration Compliance Health Services Grievance and Appeals Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		Updates made at June 10, 2025 Internal Quality Improvement (IQI) Committee **Definition added:** Behavioral Health Plan (BHP) is a county behavioral health plan that is responsible for providing behavioral health services outlined in Title 9 CCR and Title 22 CCR. **VI.A.7 added:** All executed MOU's are available on the Partnership website at: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx **References added:** Partnership External Website Memoranda of Understanding (MOU) Documents: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUP3041 – Treatment Authorization Request (TAR) Review Process	241 – 260	**Section I:** Two Relate Policies were added J. MPUP3139 – Criteria and Guidelines for Utilization Management K. MCUP3064 – Communication Services **Section V.** An outdated reference to processing of RAFs was deleted from the Purpose section. This policy now describes only TAR processing. **Section VI.A.2.** In the description of criteria used for review decisions, we added a reference to our policy MPUP3139 Criteria and Guidelines for Utilization Management. **Section VI.A.5** was removed. This paragraph discussed records retention which is the topic of another policy, CMP30 Records Retention and Access Requirements, which is listed in Section I. as a Related Policy. **Section VI.B.2.b.** This paragraph was added per DHCS request to state that requests for DME for dually eligible Medi-Cal/ Medicare Members are exempt from the requirement to submit a TAR with written verification from Medicare that the benefits have been exhausted. This is because Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services. **Section VI.B.2.b.** Added language to say TARs are not required for "certain" services because the list has been growing and we did not want to limit services to only those specified. **Section VI.B.4.** Removed "diagnostic imaging" from the list of services limited to a 6-month authorization period because we are no longer requiring a TAR for CT or MRI **Section VI.F.** Removed the entire Communication Services section because all of the language is duplicate in policy MPUP3064 Communication Services which has been listed at the top in Section I. as a Related Policy. **Attachment A:** Policy numbers updated throughout.	Health Services Claims Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		H. Diagnostic Studies; Paragraphs 1. CT Scans and 2. MRI: were both deleted as we no longer require a TAR for these services.	
MPUP3139 – Criteria and Guidelines for Utilization Management – *previously MCUP3139*	261 – 265	**This policy has been updated for Partnership Advantage (Medicare) applicability, effective Jan. 1, 2027.** **Section VI.B.2.a. 2)** Added description of Medicare standards that may be used for UM decisions including NCDs and LCDs. **Section VII.B and C.** Added two new references for "Contractual obligations with the Department of Health Care Services (DHCS)" and "Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)" **Attachment A:** Added Criteria for Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	Health Services Compliance Provider Relations
Policy Owner: Population Health – *Presenter: Greg Allen Friedman, Project Coordinator II, Pop Health*			
MPND9001 – Population Health Management Strategy & Program Description – *previously MCND9001*	267 – 322 *clean copy pp. 323-370*	**Changed to MPND9001 to reflect applicability also to the coming D-SNP program.** Annual update includes revisions and additional contract and APL references to further align the document with NCQA and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: **P. 5 Introduction:** new paragraph explaining Partnership's Medi-Cal and D-SNP services, and Partnership Advantage. **P. 6 Data Analysis and Strategy:** fine-tuned explanations of PHM processes, its Work Plan, and other analysis and policies. **P. 8-11 under Data Analysis and Strategy:** updated the graphic showing the relationship of PHM and county CHA/CHIP activities, moved PNA Committee explanation from p. 11to p. 14. **P. 13 under Population Needs and Community Needs Assessments:** added language about Community Advisory Committee (CAC). **P. 16-17 under Social Drivers of Health and Community Needs:** added language about covered behavioral health services for Medicare Advantage members. **P. 22 Basic Population Health Management:** added language mentioning Community Health Worker services, and reports being reviewed for members who may be at risk of diabetes.	Grievance, Member Services, Pharmacy, Utilization Management, Communications

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		P. 36 Practitioner Education and Training; Health Education Interventions: rewritten to reflect DEI offerings for providers, and eliminated references to the QIHETP/C&L Work Plan in the context of Health Education. **P. 39-42 under Community Engagement and Coordination of PHM Programs:** updated explanation of Partnership systems, including its case management system and plans to switch to JIVA later in 2025. Updated vendor names and terminology, and added qualifiers for possible different services for Medi-Cal and Partnership Advantage members. Updated list of organizations with MOUs effective January 2025. P. 47 Population Health and Health Education Delegation Oversight and Monitoring: added details explaining Partnership's monitoring of performance for delegates. P. 48-51 under Team Roles and Responsibilities: updated descriptions of various roles, including Chief Medical Officer, Director of Population Health, Health Educator, Healthy Living Coach, and others.	
Policy Owner: Population Health – *Presenter: Christine Smith, Community Health Needs Liaison, Pop Health*			
MPND9002 – Cultural & Linguistic Program Description *– previously MCND9002*	371 – 416 *clean copy pp. 417-444*	**Changed to MPND9002 to reflect applicability also to the coming D-SNP program.** This policy was updated to align with DHCS APL 25-005 Review Tool and other organizational changes. Due to the timing of APL 25-005, additions were needed since the previous April approvals: **Alignment with DHCS Review Tool** • Added reference to the regulatory required notices Attachment A & Attachment B (p. 8). • Added details around written information in either traditional, simplified Chinese characters (p. 11). • Updated details on the content of the Nondiscrimination notice to include information on how to file discrimination grievance with the with Partnership, DHCS' OCR, and HHS' OCR (p. 9). • Added details on the use of quick response codes, otherwise known as QR codes alongside printed notices however cannot be replaced or to be used in lieu of the regulatory required notices (p.9). • Clarified that Members with limited English proficiency (LEP) or disabilities are not required to provide or pay for their own interpreters, nor rely on unqualified staff for interpretation (p. 12). • Included language affirming Members' right to free interpreter services, and that interpreter use will not affect service quality or confidentiality (p. 14).	Grievance & Appeals, Health Equity, Member Services, Pharmacy, Utilization Management, Communications, Quality Improvement

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.*, NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		• Added provisions requiring documentation in the medical record when a Member refuses free interpreter services and requests a family member, friend, or minor to interpret (p. 14). **DSNP Language** • Changed policy name from MCND9002 to MPND9002 throughout document • Updated the list of member correspondence items to include "Notices of Organization and Coverage Determinations to encompass DSNP notices" *(pg.9*) **Attachments A-E updated with new "MPND" policy coding.** Other specifics below. **Updating Attachment D:** Process for Translation Services • Document from our translations vendor updated with branding reflecting that they are now owned by Propio. **Updating Attachment E:** Community Advisory Committee • Name changed from "*Consumer*" to "*Community* Advisory Committee." • More detailed diversity statement added. • Edits made to include the committee's feedback on the subject of CHA/CHIP work with counties. • Added members who receive Long-Term Supports Services (LTSS), and/or individuals representing those members to list of examples of how CAC members may reflect Partnership's member population. • Added detail about representation ratios. • Added a new paragraph explaining responsibilities of the CAC Coordinator, Facilitators, and CAC selection committee. • Updated member responsibilities, adding a qualifier for members with ADA-qualifying disabilities allowing remote attendance. • Responsibilities for choosing replacement members now shared between the CAC Coordinator, Facilitators, and CAC selection committee. • Removed a sentence which described how regional representatives reporting to the Partnership Board of Commissioners would be rotated from region to region. • Updated references to DHCS's Medi-Cal Member Advisory Committee (MMAC). • Updated Partnership office addresses.	

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, July 10, 2025 / 7:30am – 10:00am PT

Practicing Members Present:
Jay Shubrook, DO
Phillip Nguyen, PharmD, BCACP, BCGCP

PHC Members Present:

Chief Medical Officer, Committee Chair:
Robert Moore, MD, MPH, MBA

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

Medical Directors:
Jeffery Ribordy, MD, MPH
Mark Glickstein, MD
Mark Netherda, MD
Bettina Spiller, MD
James Cotter, MD, MPH
Kermit Jones, MD
Teresa Frankovich, MD
Matthew Morris, MD

Pharmacists:
Erin Montegary, PharmD
Lynette Rey, PharmD
Susan Becker, PharmD, BCPS
Kathleen Vo, PharmD
Andrea Ocampo, PharmD
Angela Keough, PharmD

Invited Guests Present:
Dede Damasco, CPhT
Donell Colvin, CPhT
Michael Majeski, PharmD

Department AA's:
N/A

IT Ops & Systems:
Jose Puga
John Lemoine

Practicing Members Absent:
Antonio Olea, PharmD
Kirsten Balano, PharmD
Lilia Vargas-Toledo, RN

PHC Members Absent:
Richard Matthews, MD
Aaron Thornton, MD
Dave Katz, MD
Colleen Townsend, MD
Lisa Ward, MD
Marshall Kubota, MD
Bradley Cox, DO
Jeffrey DeVido, MD
Lisa Ooten, PharmD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	• Introductions • Housekeeping (Announcement: Meeting is being recorded)	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Yes 2 out of 5 members attended Minutes: Approved	*Presented by Stan Leung, PharmD*	N/A
II. Standing Agenda			
1. PHC Update	PHC Updates provided by Dr. Moore: The primary focus for everyone currently revolves around the recent state and federal budget approvals concerning health care. We are still thoroughly examining the implications for our health plan, and there are also significant implications for the broader health care delivery system, which are receiving considerable attention and are a source of concern and effort for our provider network. Key highlights from H.R.1, also known as the "One Big Beautiful Bill Act," include a provision that will financially penalize states' Medicaid funding if they cover individuals with unfavorable immigration status. On the state side, a new requirement will be implemented in the next year or two, introducing a premium for Medicaid coverage, a largely unprecedented move for which the necessary infrastructure is not yet in place, requiring substantial effort. This measure may have been a preventative tactic by the state, aiming to reclassify the coverage as something other than traditional Medicaid due to the premium, thereby potentially avoiding the federal penalty; the premium was initially proposed at $100 per month but was lowered to the $40-$60 range, which is a relatively small premium given the comprehensive health care coverage it provides, suggesting it was likely a tactical decision. However, due to logistical challenges, introducing any barrier, even a low-cost one like a small premium that requires paperwork, will inevitably lead to a loss of individuals from coverage, as individuals may not respond to or check their mail, have other priorities, or move. Another significant change in the federal bill is the increased frequency for re-establishing eligibility, moving from annually to every six months, which is also expected to increase the number of individuals who lose coverage, even if it's transiently. Historically, when eligibility was checked every three months, people would frequently cycle off and on as they	*Presented by Robert Moore, MD, MPH, MBA*	N/A

	forgot or neglected paperwork, only to re-enroll when medical care was needed; unlike commercial insurance where losing coverage means a temporary lapse, Medi-Cal often allows for retroactive coverage, especially for urgent matters, which somewhat mitigates the penalty of these lapses, but this change in re-eligibility frequency will still contribute to a reduction in overall enrollment. The precise implications for health plans remain unclear, though our partnership service region has a relatively lower proportion of individuals with unfavorable immigration status compared to some of our sister plans in the Bay Area and Southern California, making them more apprehensive than we are. Immediately following the passage of H.R.1 on July 3rd, it included a provision to defund organizations, with a definition that effectively targeted only Planned Parenthood, and while the state promptly issued an All Plan Letter (APL) on the same day indicating enforcement, a federal lawsuit on July 7th placed this provision in abeyance, citing it as unconstitutional, so this situation remains in flux. The main outcome will be a considerable increase in effort required to keep people covered, involving proactively identifying individuals nearing eligibility loss and encouraging them to maintain eligibility by completing the necessary paperwork, which will necessitate dedicated teams at the local level. We have prior experience in this area from the pandemic, when the requirement for Medi-Cal re-eligibility was suspended, followed by a gradual return to annual renewals, and counties in our region that actively engaged with increased staffing and public relations campaigns saw a much smaller decrease in Medi-Cal enrollment than counties that did less, demonstrating that local efforts are crucial for preserving Medi-Cal coverage under these circumstances. This will be a significant theme moving forward; while some have asked what "Partnership" will do, it's important to recognize that we are one piece of a larger puzzle, truly requiring a collaborative partnership among counties, especially the larger providers in our service area, and us working together. This collective effort will be essential to reduce coverage losses, creating a mutual win for all: patients remain covered, Partnership receives capitation from the state, and the state receives capitation from the federal government, making this a major area of emphasis in the coming months. Another significant development since our last Pharmacy and Therapeutics (P&T) committee meeting is the decision to delay the rollout of our Medicare product, initially planned for launch in eight counties in 2026, to 2027. This delay stems from unexpected issues discovered during full-scale testing of the IT		

2. Additional Updates	systems, which had been under development for some time; these issues, if not addressed, would have compromised our ability to process claims effectively and meet our Medicare target launch schedule. Despite being on track with various other activities, including identifying our Pharmacy Benefit Manager (PBM) for the Medicare product, this IT-related delay is the other major news within Partnership. These are the key updates, and I am available to answer any questions, acknowledging that a vast amount of additional detail within the bills will be further clarified in the coming months. <u>PHC Updates:</u> I'd like to provide some updates regarding pharmacy, starting with our academic detailing to providers. For the past couple of years, and particularly intensified this year, we have been providing academic detailing to clinicians. This process involves sharing pharmacy data we obtain from the state to identify potential medication therapy gaps or opportunities for improvement, mainly in diabetes, hypertension, and asthma. We've reached out to quite a few clinics, including West County Health Center, Modoc Health Center, Sonoma County Indian Health Project, Dignity Woodland, Ole CommuniCare, Anderson Valley Health, and Santa Rosa Community Health Clinic. Some clinicians even asked us to share recommendations in addition to the data. For example, our analysis identifies patients with chronic diseases who are only taking one drug and have been stable on it for at least six to twelve months, yet are not meeting their blood pressure or diabetes goals. Therefore, some clinics have specifically requested recommendations on how to improve medication management. This truly represents a significant opportunity for collaboration to improve outcomes for these chronic conditions. The second update concerns the Medi-Cal Cell and Gene Therapy Access Model. California was approved by CMS to participate in this model, and as of July 1st, the two gene therapies, Casgevy and Lyfgenia, are now carved out to the state. This means the state will be responsible for paying for these drugs, while the health plan will handle other aspects of the associated care. At this time, only sickle cell disease is eligible for this program, even though Casgevy has another indication for thalassemia. My final update is regarding the Rite Aid closures. As many of you know, Rite Aid filed for bankruptcy and has begun closing	*Presented by Stan Leung, PharmD*	N/A

	numerous stores. A couple of weeks ago, DHCS (Medi-Cal) released guidance for providers and pharmacies on how to help patients transition to new pharmacies. For pharmacies, this mainly involves working to get patient files transferred or calling other pharmacies to transfer prescriptions. For prescribers, it means issuing new prescriptions to the new pharmacy when needed. DHCS released this guidance about two weeks ago, and we have also posted it on our external website to help pharmacies and providers transition members to new pharmacies. Regarding the closures in our service area, the stores that have already closed include Burney, Chico, Clearlake, Colusa, Crescent City, Fort Bragg, Rio Dell, Gridley, Lakeside, Magalia, Napa, Yreka, Ukiah, Willits, and Warwick. In June, Rite Aid announced additional closures which are pending legal settlements and challenges, and these would be Anderson, Auburn, Chico, Eureka, San Rafael, Vallejo, Woodland, and Yuba City. With approximately 20 or so pharmacies having closed, we've heard concerns from providers, particularly in rural counties like Siskiyou, where there are limited pharmacy options. This makes it challenging for members or patients who are on chronic stable opioid doses or other medications to have their prescriptions transferred. Part of the reason for this difficulty is that wholesalers have quotas for what pharmacies can order. Consequently, when there's an influx of new patients added to an existing pharmacy's system, it can be difficult for that pharmacy to absorb such a large group of new patients. I reached out to the California Pharmacy Association to discuss this concern regarding continuity of care. We are currently in discussion and reaching out to wholesalers to see if we can find common ground and solutions to make it easier for pharmacies to get more timely exemptions from those ordering quotas, so that patients are not at risk of abruptly stopping their opioid medications. Next, I'd like to introduce Michael Majewski, the Chief Pharmacist at Sebastopol Family Pharmacy. Michael has been a great advocate for pharmacy, a strong supporter and provider of pharmacist ABLM 14 services, and has even started a pharmacy technician's community health worker program at his pharmacy. My thought was to invite Michael to join our P&T committee. Hopefully, after this meeting, you will consider being a part of this committee. Thank you very much, Michael.		

3. DUR Update	DUR Summary for Monitoring for overutilization of psychotropic medications in youth • Psychotropic overutilization was defined as concurrent use of three or more psychotropic medications. The psychotropic medications monitored included antipsychotics, mood-stabilizers, antidepressants, stimulants, benzodiazepines, and sedatives. • Claims reviewed between 09/01/2024 to 02/28/2025 identified 2,390 youth with claims for 1 or more antipsychotics with 69 members filling 2 or more antipsychotics concurrently. • Claims for members filling 2 or more antipsychotics concurrently were further analyzed to identify whether they were also prescribed mood-stabilizers, antidepressants, stimulants, benzodiazepines, and/or sedatives. • A total of 55 members were identified on 3 or more psychotropic medications meeting our definition of psychotropic overutilization. Most of these members were on a total of 3-4 psychotropic medications, with 7 members on 6 to 7 psychotropic medications. • The prescribers were mental health specialists, but 7 members only had claims from mid-level mental health providers in the past year with no claims from psychiatrists. • Available diagnoses showed members had multiple, complex psychiatric conditions. • Review of the medication profiles for the 55 members showed that most of these members were adherent to their prescribed regimens. Doses and indications appear to be appropriate for most of the drugs prescribed. Only a few potential drug-drug interactions were identified. • Evaluation of whether there was appropriate oversight of mid-levels prescribers is being conducted for some of the members on 6 to 7 psychotropic medications. • Results of the analysis showed about 2.30% (55/2,390) of Partnership's youth population on antipsychotics were on 3 or more psychotropic medications, indicating that overutilization of psychotropic medications appears to have been low during the 6 month period monitored.	*Presented by Lynette Rey, PharmD*	N/A

- Overutilization occurred at a lower rate in Partnership's foster care youth as compared to the non-foster care youth with 1.49% (8/537) of the foster care youth identified as overutilizers, and 2.54% (47/1,853) of non-foster care youth identified as overutilizers.

Psychotropic claims for Partnership youth between 9/1/24 to 2/28/25	**Total # members**	**Non-Foster Care members**	**Foster Care members**
Members with claims for 1 or more antipsychotics	2,390	1,853	537
Members on 2 or more antipsychotics filled concurrently	69	57	12
Members on 3 or more psychotropics filled concurrently	55	47	8
o Claims only by mid-level prescribers in the past year	7	6	1
o Age under 10 years	4	3	1
o On 6 or more psychotropics filled concurrently	7	5	2
o On 3 second generation antipsychotics	2	1	1
o On dose above the maximum recommended	4	3	1

4. Annual Review of Member Language for PADs

Dr. Ocampo presented a change to the annual PHC's PAD and Medi-Cal Rx benefit information that appears in the Member Handbook, Member Newsletter and PHC Pharmacy External Webpage. The annual review was done back in January 2025 but was brought back in July for review due to NCQA documentation requirements. Updated wording for overview of Medi-Cal RX benefit information. NCQA requires the committee review and approve this verbiage. Dr. Ocampo requested feedback and recommendations from the committee to help finalize the drug benefit information and confirm that it is understandable for our members.

Language approved by the committee as presented, without any recommended modifications.

Presented by Andrea Ocampo, PharmD

5. Drug Benefit Review

The classes for this quarter's review are:

- Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear
- Endocrine and Metabolic Agents
- Gastrointestinal Agents
- Miscellaneous Products

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

All changes will be effective 10/01/2025 unless otherwise noted.

Class Reviews:

- Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear
  - Updates to the following were presented, with approved action shown at right.
    - guselkumab, (SC Tremfya™)
    - guselkumab, (IV Tremfya™): new separate criteria for intravenous route
    - fluocinolone implant, (Iluvien™)
    - fluocinolone implant, (Yutiq™): new separate criteria from Retisert
    - fluocinolone implant, (Retisert™)
    - ranibizumab, (Lucentis™)
    - ranibizumab-eqrn, biosimilar, (Cimerli™)

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

Presented by Susan Becker, PharmD, BCPS

Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear Class Review, Approved Actions:

HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J1628	Injection, guselkumab, 1 mg (SC Tremfya™)
J7313	Intravitreal fluocinolone implant, 0.01mg (Iluvien™)
J2778	Injection, ranibizumab, 0.1 mg (Lucentis™)
Q5128	Injection, ranibizumab-eqrn, biosimilar, 0.1 mg (Cimerli™)
Q5124	Injection, ranibizumab-nuna, biosimilar, 0.1 mg (Byooviz™)

10/1/2025

- ranibizumab-nuna, biosimilar, (Byooviz™)
- ranibizumab, (Susvimo™)
- brolucizumab-dbll, (Beovu™)
- aflibercept, (Eylea™)
- aflibercept-ayyh, biosimilar, (Pavblu™)
- aflibercept-abzv, biosimilar, (Enzeevu™): no active NDCs yet
- aflibercept-mrbb, biosimilar (Ahzantive™): no active NDCs yet
- aflibercept-yszy, biosimilar, (Opuviz™)
- faricimab-svoa, (Vabysmo™)
- revakinagene taroretcel-lwey (Encelto™)
- pegcetacoplan, intravitreal, (Syfovre™)
- avacincaptad pegol, (Izervay™)

J2779	Injection, ranibizumab, via intravitreal implant, 0.1 mg (Susvimo™)
J0179	Injection, brolucizumab-dbll, 1 mg (Beovu™)
J0178	Injection, aflibercept, 1 mg (Eylea™)
Q5147	Injection, aflibercept-ayyh, biosimilar, 1 mg (Pavblu™)
Q5149	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg (Enzeevu™)
Q5150	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg (Ahzantive™)
Q5153	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg (Opuviz™)
J2777	Injection, faricimab-svoa, 0.1 mg (Vabysmo™)
New TAR Criteria (see attached criteria for details)	
J1628	Injection, guselkumab, 1 mg (IV Tremfya™)
J7314	Intravitreal fluocinolone implant, 0.01 mg (Yutiq™)
J7311	Intravitreal fluocinolone implant, 0.01 mg (Retisert™)
J3590 (NOC)	Unclassified biologics; revakinagene taroretcel-lwey (Encelto™)
J2781	Injection, pegcetacoplan, intravitreal, 1 mg (Syfovre™)
J2782	Injection, avacincaptad pegol, 0.1 mg (Izervay™)

- Endocrine and Metabolic Agents
  - Updates to the following were presented, with approved action shown at right.
    - romosozumab-aqqg, (Evenity™)
    - teplizumabmzwv, (Tzield™)

Presented by Erin Montegary,, PharmD

Endocrine and Metabolic Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J3111	Injection, romosozumab-aqqg, 1 mg (Evenity™)
J9381	Injection, teplizumabmzwv, 5 mcg (Tzield™)

10/1/2025

- Gastrointestinal Agents
  - Updates to the following were presented, with approved action shown at right.
    - mirikizumab-mrkz, (Omvoh™)
    - risankizumab-rzaa, (Skyrizi™)
    - ustekinumab, (Stelara™)
    - ustekinumab-auub, (Wezlana™)
    - ustekinumab-ttwe, (Pyzchiva™)
    - ustekinumab-aekn, (Selarsdi™)
    - ustekinumab-aauz, (Otulfi™)
    - ustekinumab-kfce, (Yesintek™)
    - ustekinumab-srlf, (Imuldosa™)
    - ustekinumab-stba, (Steqeyma™)

Presented by Erin Montegary, PharmD

Gastrointestinal Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J2267	Injection, mirikizumab-mrkz, 1 mg (Omvoh™)
J2327	Injection, risankizumab-rzaa, intravenous, 1 mg (Skyrizi™)
J3358	Ustekinumab, for intravenous injection, 1 mg (Stelara™)
Q5138	Injection, ustekinumab-auub, biosimilar, intravenous, 1 mg (Wezlana™)
Q9997	Injection, ustekinumab-ttwe, intravenous, 1 mg (Pyzchiva™)
Q9998	Injection, ustekinumab-aekn, 1 mg (Selarsdi™)
Q9999	Injection, ustekinumab-aauz, biosimilar, 1 mg (Otulfi™)
Q5100	Injection, ustekinumab-kfce, biosimilar, 1 mg (Yesintek™)
Q5098	Injection, ustekinumab-srlf, biosimilar, 1 mg (Imuldosa™)
Q5099	Injection, ustekinumab-stba, biosimilar, 1 mg (Steqeyma™)

10/1/2025

- Miscellaneous Products
  - Updates to the following were presented, with approved action shown at right.
    - efgartigimod alfa-fcab, (Vyvgart™)
    - efgartigimod alfa, and hyaluronidase-qvfc, (Vyvgart Hytrulo™)
    - nipocalimab-aahu, (Imaavy™)
    - rozanolixizumab-noli, (Rystiggo™)
    - remestemcel-L-rknd, (Ryoncil™)
    - axatilimab-csfr, (Niktimvo™)
    - inebilizumab-cdon, (Uplizna™)

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

Miscellaneous Products Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J9332	Injection, efgartigimod alfa-fcab, 2mg (Vyvgart™)
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart Hytrulo™)
J9333	Injection, rozanolixizumab-noli, 1 mg (Rystiggo™)
J1823	Injection, inebilizumab-cdon, 1 mg (Uplizna™)
New TAR Criteria (see attached criteria for details)	
J3590 (NOC)	Unclassified biologics: nipocalimab-aahu (Imaavy™)
J3590 (NOC)	Unclassified biologics: remestemcel-L-rknd (Ryoncil™)
J9038	Injection, axatilimab-csfr, 0.1 mg (Niktimvo™)

10/1/2025

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

- Updates to Central Nervous System Agent:
  - esketamine, nasal spray, 1 mg (Spravato™)

Presented by Susan Becker, PharmD, BCPS

Ad hoc Updates		
HCPCS	**HCPCS Description (brand)**	**Approved Action**
S0013	esketamine, nasal spray, 1 mg (Spravato™)	Updates to current criteria (see attached criteria for details)

10/1/2025

- 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 5/20/2025, with an effective date of 7/1/2025.

Presented by Erin Montegary, Pharm D

New HCPCS codes (no prior code or was previously unclassified		
HCPCS	HCPCS Description	Requirements
C9174	Injection, datopotamab deruxtecan-dlnk, 1 mg	TAR
C9175	Injection, treosulfan, 50 mg	TAR
J9341	Injection, thiotepa (tepylute), 1 mg	TAR
J9289	Injection, nivolumab, 2 mg and hyaluronidasenvhy	TAR
J0616	Injection, metoprolol tartrate, 1 mg	NTR, no limits
J1163	Injection, diltiazem hydrochloride, 0.5 mg	NTR, no limits
Q5153	Injection, aflibercept yszy (opuviz), biosimilar, 1 mg	TAR
Q5098	Injection, ustekinumabsrlf (imuldosa), biosimilar, 1 mg	TAR
Q5099	Injection, ustekinumabstba (steqeyma), biosimilar, 1 mg	TAR
Q5100	Injection, ustekinumabkfce (yesintek), biosimilar, 1 mg	TAR
J7356	Injection, foscarbidopa 0.25 mg/foslevodopa 5 mg	TAR
J0618	Injection, calcium chloride, 2 mg	NTR, no limits
J3391	Injection, atidarsagene autotemcel, per treatment	TAR

7/1/2025

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	**HCPCS Description**	**Requirements & prior code**
J3373	Injection, vancomycin hydrochloride, 10 mg	NTR, no limits *(same as prior code J3370)*
J3374	Injection, vancomycin hydrochloride (mylan) not therapeutically equivalent to J3373, 10 mg	NTR, no limits *(same as prior code J3371)*
J3375	Injection, vancomycin hydrochloride (xellia), not therapeutically equivalent to J3373, 10 mg	NTR, no limits *(same as prior code J3372)*
J9276	Injection, zanidatamabhrii, 2 mg	TAR required *(same as prior code C9302)*
J1326	Injection,zolbetuximabclzb, 2 mg	TAR required *(same as prior code C9303)*
Q2058	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	TAR required *(same as prior code C9301)*
J9342	Injection, thiotepa, not otherwise specified, 1 mg	NTR, no limits *(same as prior code J9340)*
J0167	Injection, epinephrine (hospira), not therapeutically equivalent to J0165, 0.1 mg	NTR, no limits *(same as prior code J0171)*
J0168	Injection, epinephrine (international medication systems), not therapeutically equivalent to J0165, 0.1 mg	NTR, no limits *(same as prior code J0171)*
J0165	Injection, epinephrine, not otherwise specified, 0.1 mg	NTR, no limits *(same as prior code J0171)*
J0169	Injection, epinephrine (adrenalin), not therapeutically equivalent to J0165, 0.1 mg	NTR, no limits *(same as prior code J0171)*
J7172	Injection, marstacimab-hncq, 0.5 mg	TAR required *(same as prior code C9304)*

J2312	Injection, naloxone hydrochloride, not otherwise specified, 0.01 mg	Carved out to State *(same as prior code J2310)*	
J2313	Injection, naloxone hydrochloride (zimhi), 0.01 mg	Carved out to State *(same as prior code J2311)*	
J9220	Injection, indigotindisulfonate sodium, 1 mg	NTR, no limits *(same as prior code C9300)*	

- 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.
    - J3392 Injection, exagamglogene autotemcel, per treatment (Casgevy™): On 7/16/25 the State announced postponing the Carveout of Casgevy to 9/1/25 (pending CMS approval).

Consent Items

HCPCS	HCPCS Description	Changes to Biling Requirements
J3394	Injection, lovotibeglogene autotemcel, per treatment (Lyfgenia ™)	Carved out to Fee For Service (FFS) Medi-Cal as of 7/1/25
J3392	Injection, exagamglogene autotemcel, per treatment (Casgevy™)	Postponed Carve out to FFS Medi-Cal until 9/1/25 (pending CMS approval)

N/A

II. <u>Old Business</u> **a. Policy Updates**	• All Policies below submitted for consent with additions, changes and minor reorganization of content, improved wording and updating of references. 1) MPRP4062 and MPRP4062 Attachment A: Drug Wastage Payments and Allowable Waste Drug List: *Added procedure codes and additional drugs to attachment A: Allowable Waste Drug List. Minor updates to references.* *2)* MCRP4064: Continuation of Prescription Drugs: *No policy changes. Minor updates to references.* 3) MCRP4068: Medical Benefit Medication TAR Policy: *No policy changes. Minor updates to references.* 4) MPRP4001 and MPRP4001 Attachment A: Pharmacy & Therapeutics (P&T) Committee and Conflict of Interest Agreement: *Added in the definition of biosimilars and additional note that upon market launch or assignment of HCPCS code, biosimilar products will be assigned same criteria as referenced product.*	*Presented by Stan Leung, PharmD*	8/1/2025
IV. <u>New Business</u>	Welcome Michael Majeski, PharmD: extended invitation to join our P&T Committee.		
V. <u>Additional Items</u>	None		
VI. <u>Adjournment</u>	Meeting adjourned at 9:50am		

APPROVED

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. 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	1) Moderate to severe plaque psoriasis (PSO) 2) Active psoriatic arthritis (PsA) 3) Moderately to severely active ulcerative colitis (UC) 4) Moderately to severely active Crohn's disease (CD) *Note: please see Requirements for Intravenous Guselkumab (Tremfya) for criteria for IV induction dosing for Crohn's Disease and Ulcerative Colitis.*
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	For all indications: 1) Specialist's clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan. 3) Disease Activity Score. 4) 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). ~~4)~~5) Reason(s) why the member is unable to obtain from a pharmacy for self-administration. Active PSO: 1) Documented therapeutic failure after a minimum 3-month trial of (or contraindication to) a TNFI: adalimumab (Humira), etanercept (Enbrel), or certolizumab (Cimzia). *Note that at least one of (a, b, or c) is required for TNFi approval:* a. Documentation of ≥ 10% BSA affected OR b. Documentation of <10% BSA affecting sensitive areas (palms of hands, soles of feet, head/neck, genitalia), OR c. Therapeutic failure after a 3-month trial of 2 or more non-biologic therapies (unless contraindicated): i. Methotrexate ii. Cyclosporin iii. Acitretin (TAR required) iv. Phototherapy in conjunction with methoxsalen (TAR required) Active PsA: 1) Rheumatology clinic notes to confirm diagnosis of PsA AND 2) Severe psoriatic arthritis with erosive disease and functional limitation or 3) Moderate to severe axial involvement or 4) Documented therapeutic failure after a minimum of a 3-month trial of (or contraindication to) at least one each from a (DMARD) and b (TNFi): a. Methotrexate, or other oral DMARD if member is unable to take methotrexate, AND b. TNFi: Adalimumab (Humira), etanercept (Enbrel), subcutaneous

	golimumab (Simponi), or certolizumab (Cimzia). Moderately to severely active UC (maintenance dosing) or CD (induction or maintenance dosing) 1) Documentation of trial and failure to both of the following (a AND b) a. TNF inhibitor (TNFi): adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) b. Ustekinumab.

Age Restriction	18 years and older

Prescriber Restriction	PSO: Dermatologist PsA: Rheumatologist (prescribed or recommend by); a dermatologist may continue treatment that was initiated based on a rheumatologist's recommendation.

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	This medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled *Standard Requirements for Self-Administered Drugs.* Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1628	Injection, Guselkumab, ~~subcutaneous,~~ 1 mg (subcutaneous product only)	~~PSO & PsA, 100 mg at week 0, 4 and then every 8 weeks.~~ Subcutaneous • PSO & PsA, 100 mg at week 0, 4 and then every 8 weeks. • CD Induction: 400mg on weeks 0, 4, and 8. • CD & UC Maintenance:100 mg at week 16 and every 8 weeks thereafter OR 200mg at week 12 and every 4 weeks thereafter.

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	1) Moderately to severely active ulcerative colitis (UC) 2) Moderately to severely active Crohn's disease (CD) *Note: please see Requirements for Subcutaneous Guselkumab (Tremfya) for criteria for plaque psoriasis, psoriatic arthritis, and maintenance dosing for UC and CD.*
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	1) Specialist's clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan. 3) Disease Activity Score. 4) 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). 5) Documentation of trial and failure to both of the following (a AND b) a. TNF inhibitor (TNFi): adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) b. Ustekinumab. 6) For Crohn's Disease: reasons why Subcutaneous Guselkumab (Tremfya) cannot be used for induction dosing.
Age Restriction	18 years and older
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Initial (induction dosing): 3 doses (8 weeks)
Other Requirements & Information	Following IV induction this medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled *Standard Requirements for Self-Administered Drugs.* Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1628	Injection, Guselkumab, 1 mg (intravenous product only)	Intravenous: • CD Induction: 200 mg at week 0, 4, and 8 OR 400mg at week 0, 4, and 8, transitioning to subcutaneous at week 12 or 16. • UC Induction: 200 mg at week 0, 4, and 8, transitioning to subcutaneous at week 12 or 16.

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 diabetic macular edema in patients who have been previously treated with a course of corticosteroids and did not have a clinically significant rise in intraocular pressure (IOP). • The treatment of chronic non-infectious uveitis affecting the posterior segment of the eye.
Exclusion Criteria	• Active or suspected ocular or periocular infection (viral, bacterial or fungal) of the cornea and conjunctiva • Glaucoma with cup to disc ratios of greater than 0.8 • Use in combination with another corticosteroid implant/insert/injection
Required Medical Information	Clinic notes to include: 1) Documentation to confirm diagnosis submitted 2) Cup to disc ratio (C/D) <0.8 3) Prior treatments (if any) that have been tried 4) Baseline intraocular pressure (IOP) 5) Documentation of trial of the following products without any significant rise in IOP: a. Dexamethasone implant (Ozurdex™) (TAR required), can last up to 6 months OR b. Triamcinolone intravitreal injection (Triesence™)) (No TAR required), can last for up to 6 months
Age Restriction	18 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Limit to 1 implant per 36 months
Other Requirements & Information	Renewal criteria, dependent on positive clinical response: • Improvement compared to baseline for: ○ Current BCVA score or similar visual acuity assessment. ○ Current IOP 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
J7313	Intravitreal fluocinolone implant (Iluvien™), 0.01mg	One 0.19 mg implant injected intravitreally in affected eye

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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	Treatment of chronic, noninfectious uveitis affecting the posterior segment of the eye (Choroiditis).
Exclusion Criteria	• Active or suspected ocular or periocular infection (viral, bacterial or fungal) of the cornea and conjunctiva • Use in combination with another corticosteroid implant/insert/injection
Required Medical Information	Clinic notes that document all of the following: 1) Estimated duration of 3 months or more (chronic) and confirmation of posterior segment uveitis 2) Prior treatment (if any) that have been tried 3) Baseline visual acuity from baseline best corrected visual acuity(BCVA) score or similar visual acuity assessment. 4) Baseline intraocular pressure (IOP) ~~5)~~ Documentation of trial of the following products without any significant rise in IOP: ~~6)~~ Dexamethasone implant (Ozurdex™) (TAR required) OR triamcinolone intravitreal injection (Triesence™) both can last up to 6 months ~~AND~~ 5) ~~If requesting fluocinolone implant, Retisert™ then must have a trial of or reason(s) why Yutiq™ cannot be used~~
Age Restriction	Yutiq™: 18 years and older ~~Retisert™: 12 years and older~~
Prescriber Restriction	Ophthalmologist
Coverage Duration	~~Limited to 1 implant per 30 months for Retisert™~~ Limited to 1 implant per 36 months ~~for Yutiq™~~

Other Requirements & Information	Renewal criteria, dependent on positive clinical response:
	• Improvement compared to baseline for:
	  ○ Current BCVA score or similar visual acuity assessment.
	  ○ Current IOP
	• Date of last intravitreal implant.
	
	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Yutiq	J7314	Intravitreal fluocinolone implant (Yutiq™), 0.01 mg	One 0.18 mg implant injected intravitreally in affected eye.
~~Retisert~~	~~J7311~~	~~Intravitreal fluocinolone implant (Retisert™), 0.01 mg~~	~~One 0.59 mg implant injected intravitreallyin affected eye.~~

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PA Criteria	Criteria Details
Covered Uses	Treatment of chronic, noninfectious uveitis affecting the posterior segment of the eye (Choroiditis).
Exclusion Criteria	• Active or suspected ocular or periocular infection (viral, bacterial or fungal) of the cornea and conjunctiva • Use in combination with another corticosteroid implant/insert/injection
Required Medical Information	Clinic notes that document all of the following: 1) Estimated duration of 3 months or more (chronic) and confirmation of posterior segment uveitis 2) Prior treatment (if any) that have been tried 3) Baseline visual acuity from baseline best corrected visual acuity(BCVA) score or similar visual acuity assessment. 4) Baseline intraocular pressure (IOP) 5) Documentation of trial of the following products without any significant rise in IOP: a. Dexamethasone implant (Ozurdex™) (TAR required) OR triamcinolone intravitreal injection (Triesence™) both can last up to 6 months AND b. ~~If requesting fluocinolone implant, Retisert™ then must have a~~A trial of or reason(s) why fluocinolone implant Yutiq™ or Iluvien™ cannot be used.
Age Restriction	~~Yutiq™: 18 years and older~~ ~~Retisert™:~~ 12 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Limited to 1 implant per 30 months ~~for Retisert™~~ ~~Limited to 1 implant per 36 months for Yutiq™~~
Other Requirements & Information	Renewal criteria, dependent on positive clinical response: • Improvement compared to baseline for: o Current BCVA score or similar visual acuity assessment. o Current IOP • Date of last intravitreal implant. Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
~~Yutiq~~	~~J7314~~	~~Intravitreal fluocinolone implant (Yutiq™), 0.01 mg~~	~~One 0.18 mg implant injected intravitreally in affected eye.~~
Retisert	J7311	Intravitreal fluocinolone implant (Retisert™), 0.01 mg	One 0.59 mg implant injected intravitreallyin affected eye.

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	1) Diabetic macular edema (DME) 2) Diabetic retinopathy in patients with DME (DR w/ DME); or proliferative DR without DME (PDR, +/- DME) 3) Neovascular (wet) age-related macular degeneration (AMD) 4) Macular edema following retinal vein occlusion (RVO) 5) Myopic Choroidal Neovascularization (mCNV)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score ~~2)~~ If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) 3)
Age Restriction	18 years and older.
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	Limited to a maximum of 13 injections per 12 months (per eye).
Other Requirements	Renewal authorizations will be based on documentation of benefit from therapy (may be indicated on TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline or 2) Decrease in rate of vision loss compared to baseline For members on Susvimo intravitreal implant, requiring additional ranibizumab doses: Documentation supporting the medical necessity of supplemental doses must include at least one of the following: 1) A decrease of 15 ETDRS letters or more from the best recorded visual acuity score (BCV) A at baseline/since starting Susvimo, OR 2) An increase of 150 mm or more in retinal thickness measured by central subfield thickness (CST) on spectral-domain OCT (SD OCT) from the lowest CST measurement since starting Susvimo, OR 3) An increase of 100 mm or more in CST on SD OCT from the lowest CST measurement since starting Susvimo associated with a decrease of 10 ETDRS letters or more from the best recorded BCVA at baseline/since starting Susvimo Requests for off-label use: See Partnership criteria document, *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

HCPCS	Description	Dosing, Units
J2778	Intravitreal injection, ranibizumab, per 0.1 mg	AMD, RVO, mCNV: 0.5mg (5units) every 28 days DME/DR w/DME, PDR: 0.3mg (3 units) every 28 days

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

PA Criteria	Criteria Details
Covered Uses	1) Diabetic macular edema (DME) 2) Diabetic retinopathy in patients with DME (DR w/ DME); or proliferative DR without DME (PDR, +/- DME) 3) Neovascular (wet) age-related macular degeneration (AMD) 4) Macular edema following retinal vein occlusion (RVO) 5) Myopic Choroidal Neovascularization (mCNV)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	~~1) Diagnosis of AMD, macular edema following RVO, or mCNV:~~ ~~2)~~1) Clinic notes to confirm the diagnosis submitted ~~3)~~2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) ~~4) Documentation of trial and failure to, or reason(s) why Lucentis or preferred biosimilar, Byooviz cannot be used~~ ~~5)~~ ~~6) Diagnosis of DME, DR w/DME, PDR:~~ ~~7) Clinic notes to confirm the diagnosis submitted~~ ~~8) Baseline visual acuity score~~ 4) Documentation of trial and failure to, or reason(s) why preferred ranibizumab product, Lucentis, cannot be used
Age Restriction	18 years and older.
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	Limited to a maximum of 13 injections per 12 months (per eye).
Other Requirements	Renewal authorizations will be based on documentation of benefit from therapy (may be indicated on TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline or 2) Decrease in rate of vision loss compared to baseline For members on Susvimo intravitreal implant, requiring additional ranibizumab doses: Documentation supporting the medical necessity of supplemental doses must include at least one of the following: 1) A decrease of 15 ETDRS letters or more from the best recorded visual acuity score (BCV) A at baseline/since starting Susvimo, OR 2) An increase of 150 mm or more in retinal thickness measured by central subfield thickness (CST) on spectral-domain OCT (SD OCT) from the lowest CST measurement since starting Susvimo, OR 3) An increase of 100 mm or more in CST on SD OCT from the lowest CST measurement since starting Susvimo associated with a decrease of 10 ETDRS letters or more from the best recorded BCVA at baseline/since starting Susvimo Requests for off-label use: See Partnership criteria document, *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

HCPCS	Description	Dosing, Units
Q5128	Intravitreal injection, ranibizumab-eqrn (cimerli), per 0.1 mg	AMD, RVO, mCNV: 0.5mg (5units) every 28 days DME/DR w/DME, PDR: 0.3mg (3 units) every 28 days

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	1) Neovascular (wet) age-related macular degeneration (AMD) 2) Macular edema following retinal vein occlusion (RVO) 3) Myopic Choroidal Neovascularization (mCNV)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	~~1) TAR submissions are to include:~~ ~~2)~~1) Clinic notes confirming the submitted diagnosis 2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) 4) Documentation of trial and failure to, or reason(s) why preferred ranibizumab product, Lucentis, cannot be used
Age Restriction	18 years and older.
Prescriber Restriction	Must be prescribed or recommended by an Ophthalmologist.
Coverage Duration	Limited to a maximum of 13 injections per 12 months (per eye).
Other Requirements	Renewal authorizations will be based on documentation of benefit from therapy (may be indicated on the TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline OR 2) Decrease in rate of vision loss compared to baseline For members on Susvimo intravitreal implant, requiring additional ranibizumab doses: Documentation ~~of~~ supporting the medical necessity of supplemental doses must include at least one of the following: 1) A decrease of 15 ETDRS letters or more from the best recorded visual acuity score (BCV) A at baseline/since starting Susvimo, OR 2) An increase of 150 mm or more in retinal thickness measured by central subfield thickness (CST) on spectral-domain OCT (SD OCT) from the lowest CST measurement since starting Susvimo, OR 3) An increase of 100 mm or more in CST on SD OCT from the lowest CST measurement since starting Susvimo associated with a decrease of 10 ETDRS letters or more from the best recorded BCVA at baseline/since starting Susvimo Requests for off-label use: See Partnership criteria document, *Case-by-Case TAR Requirements and Considerations*

Medical Billing:

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

HCPCS	Description	Dosing, Units
Q5124	Injection, ranibizumab-nuna, 0.1 mg	0.5ml every 28 days nAMD: treatment interval may be extended after the initial 4 doses.

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

PA Criteria	Criteria Details
Covered Uses	• Neovascular (wet) age-related macular degeneration (AMD) • Diabetic Macular Edema (DME) • Diabetic Retinopathy (DR)
Exclusion Criteria	• Members with active ocular or periocular infection • Concurrent use of other ophthalmic VEGF inhibitors, with the exception of supplemental ranibizumab & biosimilars (Byooviz™, Lucentis™, Cimerli™)
Required Medical Information	~~Diagnosis of AMD~~All Indications: 1) Clinic notes to confirm the diagnosis submitted 2) Documentation of at least 2 prior doses of intravitreal injections of a VEGF inhibitor with demonstrated anatomic and visual response: • Central subfield thickness (CST) reduction • Improvement in visual acuity from baseline 3) Documentation of reasons why a preferred extended dosing interval products cannot be used: aflibercept hd (Eylea HD™) or faricimab-svoa (Vabysmo™) (A TAR is also required for both products)
Age Restriction	18 years and older.
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist.
Coverage Duration	Initial approval and renewal: 6 months (1 implant fill).
Other Requirements	Renewal will be based on documentation of benefit from therapy (may be indicated on TAR unless clinic notes are specifically requested). Baseline and updated vision status may be requested with evidence of: 1) Improvement or stabilization compared to baseline or 2) Decrease in rate of vision loss compared to baseline Requests for off-label use: See Partnership criteria document, *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

HCPCS	Description	Dosing, Units
J2779	Injection, ranibizumab, via intravitreal implant (Susvimo), 0.1 mg	2 mg every 6 months. Maximum treatment dose reimbursed is 20 units (2 mg) per eye every 6 months, and waste should be billed separately per Partnership Policy MPRPR4062, Drug Wastage Payments. Maximum authorized TAR units per eye: 100 units, equivalent to 10 mg vials (allowing 2 mg dose + 8 mg waste).

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

PA Criteria	Criteria Details
Covered Uses	1) Neovascular (wet) age-related macular degeneration (AMD) 2) Diabetic Macular Edema
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR)
Age Restriction	18 years and older.
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist.
Coverage Duration	Initial: Up to 8 injections per eye in 12 months Renewal: Up to 7 injections per eye in 12 months
Other Requirements	Renewal will be based on documentation of benefit from therapy (may be indicated on TAR unless clinic notes are specifically requested). Baseline and updated vision status may be requested with evidence of: 1) Improvement or stabilization compared to baseline or 2) Decrease in rate of vision loss compared to baseline Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

HCPCS	Description	Dosing, Units
J0179	Injection, brolucizumab- dbll, 1mg	nAMD: 6mg every 4 weeks for 3 doses, then every 8-12 weeks. DME: 6 mg every 6 weeks for 5 doses, then every 8-12 weeks.

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PA Criteria	Criteria Details
Covered Uses	FDA approved indications per product (not all biosimilars are approved for all conditions): 1) Diabetic macular edema (DME) 2) Diabetic retinopathy in patients with DME (DR w/ DME); or proliferative DR without DME (PDR, +/- DME) 3) Neovascular (wet) age-related macular degeneration (AMD) 4) Macular edema following retinal vein occlusion (RVO) 5) Retinopathy of prematurity (ROP)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	Diagnosis of AMD, macular edema following RVO, DME/DR+DME, or PDR: 1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) ~~2)~~ Diagnosis of ROP: 1) Must have a or b: a. Gestational age of ≤ 32 weeks b. Maximum birth weight of ≤ 1500 g (3.3 lb) 2) Must have diagnosis of a, b or c: a. ROP Zone I stage 1+, 2+, 3, & 3+ b. ROP Zone II Stage 2+, 3+ c. AP-ROP (aggressive posterior ROP) 3) Documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR)
Age Restriction	• DME, DR w/ DME, AMD, macular edema w/RVO: 18 years and older. • ROP: ≤ 52 weeks chronological age
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	• AMD, DME, DR w/ DME, & RVO: Limited to a maximum of 13 injections per 12 months (per eye). • ROP: 1 dose per affected eye per request
Other Requirements & Information	Renewal or retreatment requests: AMD, DME, DR w/ DME, PDR, & RVO: Renewal will be based on documentation of benefit from therapy (may be indicated on the TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline OR

	2) Decrease in rate of vision loss compared to baseline ROP: 1) Current gestational age 2) Continues to be positive for diagnosis of a, b or c: a. ROP Zone I stage 1+, 2+, 3, & 3+ b. ROP Zone II Stage 2+, 3+ c. AP-ROP (aggressive posterior ROP) 3) Has had ≤ 2 prior treatments with aflibercept Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Eylea™	J0178	Injection, aflibercept, 1 mg	AMD (all): 2mg every 4 weeks for 3 doses followed by 2 mg every 8 weeks (may be used monthly) DME & DR w/ DME, PDR (J0178, Q5147, Q5150, Q5153): 2mg every 4 weeks for 5 doses followed by 2mg every 8 weeks (may be used monthly) RVO (J0178, Q5147, Q5150, Q5153): 2mg every 4 weeks ROP (J0178 only): 0.4 mg into the affected eye, may repeat after a minimum interval of 10 days.
Opuviz™	Q5153	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	
Pavblu™	Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	
Enzeevu™	Q5149	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	
Ahzantive™	Q5150	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	

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PA Criteria	Criteria Details
Covered Uses	1) Diabetic macular edema (DME) 2) Neovascular (wet) age-related macular degeneration (nAMD) 3) Macular edema following retinal vein occlusion (RVO)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) 4) Documentation of trial and failure or contraindication to at least one~~1~~ of the following (a, b, or c): a. ~~PHC's preferred ophthalmic VEGF inhibitors: ranibizumab-nuna (Byooviz™),~~ ranibizumab (Lucentis™, or biosimilar~~), ranibizumab-eqrn (Cimerli™)~~) b. ~~,~~aflibercept (Eylea™, or biosimilar)~~)~~ c. ~~,~~brolucizumab-dbll (Beovu™)~~, or off-label bevacizumab (Avastin™).~~
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	Limited to a maximum of 13 injections per eye in 12 months
Other Requirements	Renewal authorization will be based on documentation of benefit from therapy (may be indicated on TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline or 2) Decrease in rate of vision loss compared to baseline Requests for off-label use: See Partnership criteria document, *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

HCPCS	Description	Dosing, Units
J2777	Intravitreal injection, faricimab, per 0.1 mg	**nAMD:** • Initial -- 6 mg (60 HCPCS units) every 4 weeks for the first 4 doses (weeks 1-16): Total of 240 units authorized per eye (480 max units for bilateral treatment) for initial TARs. • Continuation – depending on evaluations at 8 & 12 weeks following the initial 4 doses, subsequent doses may be repeated at 4-16 week intervals. **DME:** Two regimens are FDA approved: • 6 mg every 4 weeks for at least 4 doses. Following resolution of edema, doses are continued every 4-8 weeks (intervals modified +/- depending on CST & visual acuity evaluations) through week 52 OR • 6 mg every 4 weeks for the first 6 doses, followed by 6 mg every 8 weeks over the next 28 weeks. Some may need every 4 weeks dosing after the first 4 doses. **RVO:** • 6 mg every 4 weeks for 6 doses, may be continued at intervals of every 4 weeks or greater for ongoing ME

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PA Criteria	Criteria Details
Covered Uses	Idiopathic macular telangiectasia (MacTel) type 2
Exclusion Criteria	• Idiopathic macular telangiectasia type 1 • Neovascular macular telangiectasia type 2 • Member has evidence of central serous chorio-retinopathy in either eye • Member has a history of ocular herpes virus in either eye
Required Medical Information	Documentation of the following is required for each eye requesting treatment: 1) Diagnosis of MacTel with evidence of fluorescein leakage typical of MacTel and at least one of the other features that include (a, b, c, d, or e): a. hyperpigmentation that is outside of a 500 micron radius from the center of the fovea, or b. retinal opacification, or c. crystalline deposits, or d. right-angle vessels, or e. inner/outer lamellar cavities 2) Photoreceptor inner segment/outer segment (IS/OS PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00 mm2 measured by spectral domain-optical coherence tomography (SD-OCT) 3) Baseline best corrected visual acuity (BCVA) of 54-letter score or better (20/80 or better) as measured by the Early Treatment Diabetic Retinopathy Study (ETDRS) chart at screening. 4) No evidence of neovascular MacTel type 2 Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals (ie denials for medical necessity)
Age Restriction	18 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Once per eye per lifetime
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590 (NOC)	Unclassified biologics: revakinagene taroretcel-lwey (Encelto)	One implant per eye per lifetime. *Each implant contains 200,000 to 440,000 allogeneic retinal pigment 151 epithelial cells expressing recombinant human ciliary neurotropic factor (rhCNTF)*

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PA Criteria	Criteria Details
Covered Uses	Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)
Exclusion Criteria	• Choroidal neovascularization (CNV) in either eye • GA is secondary to any conditions other than AMD (for example, Stargardt disease, cone rod dystrophy, toxic maculopathies) • Ocular or periocular infection • Active intraocular inflammation
Required Medical Information	1) Diagnosis of GA secondary to AMD 2) Best corrected visual acuity (BCVA) ≥ 24 ETDRS letters (20/320 Snellen equivalent or better) 3) GA lesion size ≥2.5 and ≤17.5 mm2 with at least 1 lesion ≥1.25 mm2 4) Presence of extrafoveal lesions
Age Restriction	60 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Initial and renewal: 12 months
Other Requirements & Information	Renewal criteria: documentation of a positive clinical response to therapy which may include a reduction or stabilization in the rate of vision decline, or stabilization or reduction in total area of GA lesions. 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
J2781	Injection, pegcetacoplan, intravitreal, 1 mg	15 mg (0.1 mL) into affected eye(s) once every 25 to 60 days

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PA Criteria	Criteria Details
Covered Uses	Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)
Exclusion Criteria	• Choroidal neovascularization (CNV) in either eye • GA is secondary to any conditions other than AMD (for example, Stargardt disease, cone rod dystrophy, toxic maculopathies) • Ocular or periocular infection • Active intraocular inflammation
Required Medical Information	1) Diagnosis of GA not affecting the foveal center point, secondary to AMD 2) Best corrected visual acuity (BCVA) between 20/25 and 20/320 3) GA lesion size ≥2.5 and ≤17.5 mm2 with at least 1 lesion ≥1.25 mm2
Age Restriction	50 years or older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Initial and renewal: 12 months
Other Requirements & Information	Renewal criteria: documentation of a positive clinical response to therapy which may include a reduction or stabilization in the rate of vision decline, or stabilization or reduction in total area of GA lesions. 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
J2782	Injection, avacincaptad pegol, 0.1 mg	2 mg (0.1 mL) into affected eye(s) once monthly (~every 21 to 35 days)

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 severe osteoporosis in members who are at high risk for osteoporotic fracture, defined as a history of osteoporotic fracture, or who have multiple risk factors for fracture.
Exclusion Criteria	• Risk for osteosarcoma (Paget's disease of bone, history of prior radiation therapy, unexplained elevation of alkaline phosphatase, open epiphyses, prior external beam or implant radiation therapy involving the skeleton). • Primary or secondary hyperparathyroidism. • Other hypercalcemic disorders. • Members who have significant cardiovascular risk such as myocardial infarction or stroke in the preceding 12 months.
Required Medical Information	**All Requests**: 1. Clinic notes documenting osteoporotic fracture history and/or fragility fractures. 2. BMD T-Score. **For High Fracture Risk**: 1. Trial and failure (or contraindication) to **both** preferred treatments (bisphosphonate AND denosumab). a. Documentation of treatment failure defined as a decline in T-score of greater than or equal to 5 percent after 2 years of adherent use with a bisphosphonate and/or denosumab (Prolia™) therapy (both if failure to one; just one if there's a contraindication to the other). 2. Trial and failure or reasons why teriparatide (Forteo™) and abaloparatide (Tymlos™) cannot be used. 3. Documentation of high fracture risk with one of the following: a. History of a prior spine fracture, hip fracture, or fragility fracture; OR b. Femoral neck, total hip, or lumbar spine T-Score ~~<~~ ≤ - 2.5; OR c. Femoral neck, total hip, or lumbar spine T-Score between -1 and -2.4, together with a FRAX score ≥ 3% for hip fracture risk or ≥ 20% for major osteoporotic fracture risk. **For Very High Fracture Risk:** ~~1. Trial and failure or reasons why teriparatide (Forteo™) and abaloparatide (Tymlos™) cannot be used.~~ ~~2.~~1.Documentation of very high fracture risk with one of the following: a. Femoral neck, total hip, or lumbar spine T-Score ~~<~~ ≤ -2.5, with spine, hip, or fragility fracture~~, OR~~ b. Femoral neck, total hip, or lumbar spine T-Score ~~< -3.5~~ ≤ -3.0, regardless of fracture history or status. c. Fractures while on approved osteoporosis therapy d. History of multiple fractures e. Fractures while on drugs that cause skeletal harm (e.g., long-term glucocorticoids) f. Very high probability by FRAX (e.g., major osteoporosis fracture >30%, hip fracture >4.5%)
Age Restriction	18 years and older.

Prescriber Restriction	Prescribed by or recommended by an Endocrinologist or Orthopedist.

Coverage Duration	12 months maximum treatment duration per lifetime.

Other Requirements & Information	Renewal requests beyond the 12-month lifetime maximum will not be approved. Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3111	Injection, romosozumab-aqqg, 1 mg	210mg injected subcutaneously once monthly for a maximum duration of 12 doses.

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

PA Criteria	Criteria Details
Covered Uses	Delay onset of Stage 3 type 1 diabetes (T1D) in adults and pediatric patients 8 years an older with Stage 2 T1D.
Exclusion Criteria	Current diagnosis of Stage 3 T1D
Required Medical Information	Diagnosis of Stage 2 type 1 diabetes confirmed by all of the following: 1) Documentation of at least 2 of the following type 1 diabetes-related autoantibodies within the last 6 months: a. Islet cell autoantibody (ICA) b. Glutamic acid decarboxylase 65 (GAD) autoantibody c. Zinc transporter 8 autoantibody (ZnT8A) d. Insulinoma-associated antigen 2 autoantibody (IA-2A) e. Insulin autoantibody (IAA) 2) Documentation of dysglycemia without overt hyperglycemia within the preceding 2 months defined as one of the following (oral glucose tolerance test preferred): a. Fasting plasma glucose level 100-125 mg/dL; OR b. Two-hour postprandial plasma glucose 140-199 mg/dL; OR c. Postprandial glucose level at 30, 60 or 90 minutes ≥ 200 mg/ dL; OR d. A1C 5.7-6.4% 3) Documentation type 2 diabetes has been ruled out based on clinical history. 4) Body surface area (BSA). 5) Administering facility must be able to accommodate 14 consecutive calendar days of administration.
Age Restriction	8 years and older
Prescriber Restriction	Endocrinologist
Coverage Duration	~~One-time approval,~~ 14-day treatment course only, once per lifetime.
Other Requirements	Note, prior to initiating therapy, provider must have awareness of the following: 1) Completion of age-appropriate vaccinations. 2) No evidence of active serious infections (i.e. Epstein-Barr virus or cytomegalovirus infection). 3) Adequate hepatic function at baseline (i.e. ALT/AST, bilirubin) 4) Adequate hematologic function at baseline (i.e. platelets, hemoglobin, absolute neutrophil count, lymphocytes). 5) Member is not pregnant. Note that each 2 ml single dose vial (SDV) contains 2,000 mcg (2 mg), equivalent to 400 HCPCS billing units per vial. Vials are diluted to 100 mcg/ml and must be administered within 4 hours of being diluted, with remainder discarded (see Partnership Drug Waste policy for billing waste with JW modifier. TARs must include both the dose and anticipated waste amounts. Waste units must be billed separately from the administered dose units, using the JW modifier as stated in Policy MPRP4062, Drug Wastage Payments. The number of units on the authorized

	TAR will be sufficient for both dose and waste claims. 1 vial per day is sufficient for all doses up to a BSA of 1.94 m^2. Requests for more than 1 vial (400 billing units) per day must include the member's current BSA.

Medical Billing:

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

HCPCS	Description	Dosing, Units
J9381	Injection, teplizumab-mzwv, 5 mcg	Administer once daily for 14 consecutive days. A single vial (2 ml=2,000 mcg) is 400 HCPCS units (5 mcg/unit). For BSA </= 1.94 m2, maximum reimbursement is for 1 vial, 400 units (includes dose + waste). Day 1: 65 mcg/m2 body surface area (BSA) Day 2: 125 mcg/m2 BSA IV once daily Day 3: 250 mcg/m2 BSA Day 4: 500 mcg/m2 BSA Day 5 to day 14: 1,030 mcg/m2 BSA once daily If a planned infusion dose is missed, resume dosing by administering all remaining doses on consecutive days to complete the 14-day treatment course.

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	IV induction dosage for the treatment of moderately to severely active ulcerative colitis (UC) and Crohn's Disease (CD) in adults.
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	1) Specialist's clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Disease Activity Score or patient specific symptoms/treatment history to confirm moderately to severely active disease. 3) Treatment plan including dose and schedule of mirikizumab (Omvoh™) requested ~~(Note: the FDA approved induction dose of 300 mg IV given at week 0, week 4, and week 8 is recommended to be followed by 200 mg subcutaneous dose at week 12 and every 4 weeks thereafter)~~ 4) Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (e.g., Quanti FERON-TB Gold test). 5) Baseline liver enzyme and bilirubin levels prior to treatment initiation. 6) Documented therapeutic failure to induce remission with (or contraindication to) both of the following (a and b) a. TNF inhibitor (TNFi): adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) b. Ustekinumab ~~least two of the following: adalimumab, golimumab, infliximab, tofacitinib, ustekinumab, or vedolizumab.~~ Requests for treating indeterminate colitis (where distinction between CD and UC cannot be made) will be considered on a case-by-case basis.
Age Restriction	18 years and older
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Initial approval for 3 doses of 300 mg for induction dose. Member will transition to subcutaneous form for self-administration for maintenance per FDA indicated dosage and will need to obtain through MediCal Rx benefit.
Other Requirements & Information	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J2267	Injection, mirikizumab-mrkz, 1 mg	UC: Induction: IV: 300 mg at weeks 0, 4, and 8. Maintenance: SUBQ dispensed as pharmacy benefit: 200 mg at week 12 and then every 4 weeks. CD: Induction: IV: 900 mg at weeks 0, 4, and 8. Maintenance: SUBQ dispensed as pharmacy benefit: 300 mg at week 12 and then every 4 weeks

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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	~~• Moderate to severe plaque psoriasis (PSO)~~ ~~• Psoriatic arthritis~~ • Moderate to severe Crohn's disease (CD) • Moderate to severe ulcerative colitis (UC)
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	~~**Moderate to severe PSO and psoriatic arthritis:**~~ ~~This medication is typically self-administered by the member or a caregiver at home. See the additional requirements for medical claim TARs in the PHC criteria document titled Standard Requirements for Self-Administered Drugs.~~ **Crohn's Disease/Ulcerative Colitis:** 1) Specialist's clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan. 3) 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). 4) Documented therapeutic failure to induce remission with or contraindication to both of the following (a AND b): a. TNF Inhibitor: adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) ~~such as adalimumab (Humira™), certolizumab pegol (Cimzia™), or infliximab (Avsola™, Inflectra™, Renflexis™)~~ ~~a.~~b. Ustekinumab Requests for treating indeterminate colitis (where distinction between CD and UC cannot be made) will be considered on a case-by-case basis. Requests for moderate to severe plaque psoriasis and psoriatic arthritis: This medication is typically self-administered by the member or a caregiver at home. See the additional requirements for medical claim TARs in the PHC criteria document titled Standard Requirements for Self-Administered Drugs.
Age Restriction	18 years and older
Prescriber Restriction	~~Crohn's Disease:~~ Prescribed or in consultation with a g~~G~~astroenterologist
Coverage Duration	~~Crohn's Disease:~~ 3 months for induction dose only. Member will transition to subcutaneous form for self-administration for maintenance per FDA indicated dosage and will need to obtain through MediCal Rx benefit.

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J2327	Intravenous injection, Risankizumab-rzaa, per dose	CD: Loading Dose (IV): 600 mg on weeks 0, 4 & 8 (Followed by maintenance dose 180 mg to 360 mg SUBQ~~SC~~ starting at week 12 and then every 8 weeks thereafter) UC: Loading Dose (IV): 1200 mg on weeks 0, 4, and 8 (Followed by maintenance dose 180 to 360 mg SUBQ stating at week 12 and then every 8 weeks thereafter)

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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	IV induction dosage (single dose) for the treatment of moderately to severely active Crohn's disease (CD) or ulcerative colitis (UC).
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	1) Specialist's clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan (Note: the single induction dose is recommended to be followed by 90 mg subcutaneous dose 8 weeks after induction dose, and every 8 weeks thereafter). 3) Disease Activity Score or patient specific symptoms/treatment history to confirm moderately to severely active disease. 4) 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).
Age Restriction	18 years and older
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Single fill/date of service. FDA indicated dosing is for a single IV dose for induction, followed by subcutaneous dosing thereafter.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

<table>
<tr><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td>J3358</td><td>Ustekinumab, for IV injections, 1 mg (only indicated for Crohn’s or UC induction)</td><td rowspan="9"><table><tr><td>Member Weight</td><td>Recommended Dose</td></tr><tr><td>≤55 kg</td><td>260 mg IV x 1</td></tr><tr><td>54-85 kg</td><td>390 mg IV x 1</td></tr><tr><td>≥86 kg</td><td>520 mg IV x 1</td></tr></table>
With transition to subcutaneous dosing after the initial IV induction dose</td></tr>
<tr><td>Q5138</td><td>Injection, ustekinumab-auub (Wezlana), biosimilar, intravenous, 1 mg (only indicated for Crohn’s or UC induction)</td></tr>
<tr><td>Q9997</td><td>Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg (only indicated for Crohn’s or UC induction)</td></tr>
<tr><td>Q9998</td><td>Injection, ustekinumab-aekn (Selarsdi), 1 mg (only indicated for Crohn’s or UC induction)</td></tr>
<tr><td>Q9999</td><td>Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg</td></tr>
<tr><td>Q5100</td><td>Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg</td></tr>
<tr><td>Q5098</td><td>Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg</td></tr>
<tr><td>Q5099</td><td>Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg</td></tr>
</table>

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Unless otherwise specified as having renewal requirements, criteria apply to new starts. Requires 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	1) Generalized myasthenia gravis (MG) in adults who are anti-acetylcholine receptor (AChR) antibody positive. 2) Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) (Vyvgart Hytrulo only) *Vyvgart Hytrulo PFS is a self-administered product and will fall under Partnership's Standard Requirements for Self-Administered Drugs*
Exclusion Criteria	• Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • Concurrent use with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists~~ravulizumab (Ultomiris™), eculizumab (Soliris™), rozanolixizumab (Rystiggo™) or zilucoplan (Zilbrysq™).~~
Required Medical Information	Generalized Myasthenia Gravis (MG) 1) Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies 2) Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium 3) Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥5 with at least 50% of the score coming from non-ocular symptoms~~ 6~~ at baseline. 4) Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV 5) Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the following: • Pyridostigmine • Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose AND • Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate • Self-administered efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFS™) Chronic Inflammatory Demyelinating Polyneuropathy (CIDP) (Vyvgart Hytrulo only): ~~See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*~~ 1) Confirmation of diagnosis based on the European Academy of Neurology (EAN/PNS) guidelines (see Other Requirements and Information for EAN/PNS criteria). 2) Electro diagnostic findings of peripheral nerve demyelination. 3) Exclusion of other similar disease states that overlap with similar symptoms, such as but not limited to: a. Neuropathy probably caused by B. burgdorferi infection (Lyme disease), diphtheria, drug or toxin exposure b. Hereditary demyelinating neuropathy c. Prominent sphincter disturbance d. Diagnosis of multifocal motor neuropathy (MMN) e. IgM monoclonal gammopathy with high titer antibodies to myelinassociated glycoprotein (MAG)

	f. Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, and diabetic and nondiabetic lumbosacral radiculoplexus neuropathy; peripheral nervous system lymphoma and amyloidosis may occasionally have demyelinating features 4) Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment 5) Documentation of failure to respond to glucocorticoids (oral or injectable) or reason(s) why glucocorticoids cannot be used such as but not limited to: a. Contraindication b. Severe disability c. Pure motor phenotype d. Fast progressive disease 6) Documentation of inadequate response, significant intolerance, or contraindication to intravenous immunoglobulin (IVIG) or subcutaneous immunoglobulin (SCIG). 7) Documentation of trial and failure, intolerance or reason(s) why self-administered efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFS™) cannot be used.
Age Restriction	18 years and older
Prescriber Restriction	Neurology
Coverage Duration	MG: Initial: 6 months CIDP: Initial: 3 months Renewals (MG & CIDP): 12 months
Other Requirements & Information	Renewal Requests: MG: • Clinical notes with current: • MG-ADL and • MGFA classification. Renewal Requests: CIDP: • Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment. • If symptoms do not improve or continue to progress after an initial two-to-three-month treatment trial, the patient should be reevaluated to verify the diagnosis of CIDP. Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

EAN/PNS 2021 CIDP Guidelines Diagnostic Criteria	
Typical CIDP	1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, and sensory involvement of at least two limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs 4. At least two motor nerves must have abnormalities which

		fulfil the motor conduction criteria. If criteria are fulfilled in only one nerve, the diagnosis is possible typical CIDP. See **Box: Motor Nerve Conduction Criteria** below. 5. Sensory conduction abnormalities must be present in at least two nerves. See **Box: Sensory Nerve Conduction Criteria** below. Note: In patients suspected of having typical CIDP because they fulfil clinical criteria but not minimal electrodiagnostic criteria, the diagnosis of possible typical CIDP may be made if there is objective improvement following treatment with IVIg, corticosteroids or plasma exchange AND if at least one additional supportive criterion (2-5) is fulfilled. See **Box: Supportive Criterion** below.
	Distal CIDP	1. Progressive or relapsing, symmetric, distal sensory loss and muscle weakness predominantly in lower limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 6. Motor conduction criteria fulfilment is required in at least two upper limb nerves to confirm the clinical diagnosis of distal CIDP. The distal negative peak CMAP amplitude should be at least 1 mV. When criteria are fulfilled in two lower limb but not upper limb nerves or if criteria are fulfilled in only one upper limb nerve, the maximum diagnostic certainty is possible distal CIDP. See **Box: Motor Nerve Conduction Criteria** below. 4. Sensory conduction abnormalities must be present in at least two nerves. See **Box: Sensory Nerve Conduction Criteria** below.
	Multifocal CIDP	1. Progressive or relapsing, sensory loss and muscle weakness in a multifocal pattern, usually asymmetric, upper limb predominant, in more than one limb 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 7. Motor conduction criteria fulfilment is required in at least two nerves in total in more than one limb. When criteria are fulfilled in only one nerve, the maximum diagnostic certainty is possible multifocal CIDP. See **Box: Motor Nerve Conduction Criteria** below. 4. Sensory conduction abnormalities must be present in at least two nerves of the affected limbs for the diagnosis of multifocal CIDP. See **Box: Sensory Nerve Conduction Criteria** below.
	Focal CIDP	1. Progressive or relapsing, sensory loss and muscle weakness in only one limb. 2. Developing over at least 8 weeks. 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 8. Motor conduction criteria fulfilment is required in at least two nerves in total in more than one limb to confirm the clinical

		diagnosis of multifocal CIDP and in at least two nerves in one limb for the diagnosis of focal CIDP. When criteria are fulfilled in only one nerve, the maximum diagnostic certainty is possible multifocal or possible focal CIDP. See **Box: Motor Nerve Conduction Criteria** below. 4. Sensory conduction abnormalities must be present in at least two nerves of the affected limb for the diagnosis of focal CIDP and in one nerve of the affected limb for the diagnosis of possible focal CIDP. See **Box: Sensory Nerve Conduction Criteria** below.
	Motor CIDP (and motor-predominant)	1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, without sensory involvement. 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs 9. Motor CIDP must fulfil motor conduction criteria in at least two nerves and sensory conduction must be normal in all of at least four nerves (median, ulnar, radial, and sural) to confirm the clinical diagnosis of motor CIDP. If criteria are fulfilled in only one motor nerve, the diagnosis is possible motor CIDP. See **Box: Motor Nerve Conduction Criteria** below. Note: Motor CIDP with sensory conduction abnormalities in two nerves is diagnosed as motor-predominant CIDP.
	Sensory CIDP (and sensory predominant)	1. Progressive or relapsing, symmetric sensory involvement of at least two limbs, without motor involvement. 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs 4. Sensory CIDP must fulfil sensory conduction criteria and motor conduction must be normal in all of at least four nerves (median, ulnar, peroneal, and tibial) to confirm the clinical diagnosis. The maximum diagnostic certainty is possible sensory CIDP. See **Box: Sensory Nerve Conduction Criteria** below. Note: Sensory CIDP with motor conduction criteria fulfilled in one nerve is diagnosed as possible sensory-predominant CIDP. If motor conduction criteria are fulfilled in two nerves, the diagnostic certainty increases to sensory-predominant CIDP.
	Motor Nerve Conduction Criteria:	One of the following strongly supports demyelination (if the criteria only applies to 1 nerve, it is weakly supportive): 1. Motor distal latency prolongation ≥50% above ULN in two nerves (excluding median neuropathy at the wrist from carpal tunnel syndrome), or 2. Reduction of motor conduction velocity ≥30% below LLN in two nerves, or 3. Prolongation of F-wave latency ≥20% above ULN in two nerves (≥50% if amplitude of distal negative peak CMAP <80% of LLN), or 4. Absence of F-waves in two nerves (if these nerves have distal negative peak CMAP amplitudes ≥20% of LLN) + ≥1 other

		demyelinating parametera in ≥1 other nerve, or 5. Motor conduction block: ≥30% reduction of the proximal relative to distal negative peak CMAP amplitude, excluding the tibial nerve, and distal negative peak CMAP amplitude ≥20% of LLN in two nerves; or in one nerve + ≥ 1 other demyelinating parametera except absence of F-waves in ≥1 other nerve, or 6. Abnormal temporal dispersion: >30% duration increase between the proximal and distal negative peak CMAP (at least 100% in the tibial nerve) in ≥2 nerves, or 7. Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) prolongation in ≥1 nerveb + ≥1 other demyelinating parametera in ≥1 other nerve a. (LFF 2 Hz) median > 8.4 ms, ulnar > 9.6 ms, peroneal > 8.8 ms, tibial > 9.2 ms b. (LFF 5 Hz) median > 8.0 ms, ulnar > 8.6 ms, peroneal > 8.5 ms, tibial > 8.3 ms c. (LFF 10 Hz) median > 7.8 ms, ulnar > 8.5 ms, peroneal > 8.3 ms, tibial > 8.2 ms d. (LFF 20 Hz) median > 7.4 ms, ulnar > 7.8 ms, peroneal > 8.1 ms, tibial > 8.0 ms
	Sensory Nerve Conduction Criteria	1. For a diagnosis of CIPD: Sensory conduction abnormalities (prolonged distal latency, or reduced SNAP amplitude, or slowed conduction velocity outside of normal limits) in two nerves. 2. For a diagnosis of "possible CIPD": a. sensory nerve conduction velocity <80% of LLN (for SNAP amplitude >80% of LLN) or <70% of LLN (for SNAP amplitude <80% of LLN) in at least two nerves (median, ulnar, radial, sural nerve), OR b. Sural sparing pattern (abnormal median or radial sensory nerve action potential [SNAP amplitude] with normal sural nerve SNAP amplitude) (excluding carpal tunnel syndrome).
	Supportive Criterion	1. Objective response to treatment with immunomodulatory agents (IVIg, plasma exchange, corticosteroids). The changes required to define improvement have not been adequately validated. The following which have been used in clinical trials can serve as a guide: a. I-RODS: + ≥4 centile points b. INCAT disability scale: − ≥1 point c. mISS: − ≥2 points d. MRC sum score (0-60): + ≥2 to 4 points* e. Grip strength: Martin Vigorimeter: + ≥8 to 14 kPa* OR Jamar hand grip dynamometer: + ≥10%** 2. Imaging: only recommended when diagnosis is "possible CIDP": before concluding that ultrasound or MRI abnormalities are supportive of CIDP, there should be no laboratory/clinical features that suggest other diseases that mimic CIDP (these are listed).

		a. Ultrasound showing nerve enlargement of at least two sites in proximal median nerve segments and/or the brachial plexus b. MRI showing enlargement and/or increased signal intensity of nerve root(s) on T2 weighted MRI sequences (DIXON/STIR, coronal + sagittal planes) 3. CSF evaluation: only recommended when diagnosis is "possible CIDP": sensitivity of CSF protein elevation for CIDP was 68% using cut-offs of ≥0.5 g/L under the age of 50 years and >0.6 g/L over the age of 60 years. 4. Nerve Biopsy: only recommended when CIDP is suspected but cannot be confirmed with other tests. Factors probably supporting the diagnosis of CIDP may be: a. thinly myelinated axons and small onion bulbs. b. thinly myelinated or demyelinated internodes in teased fibers. c. perivascular macrophage clusters. d. supportive features of demyelination on electron microscopy

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Vyvgart	J9332	Injection, efgartigimod alfa-fcab, 2 mg	10 mg/kg IV once weekly for 4 weeks. Subsequent cycles are repeated at least 50 days from the start of the previous cycle. Members weighing more than 120 kg: Maximum dose is 1.2 g IV.
Vyvgart Hytrulo	J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MG: 1,008 mg efgartigimod alfa/ 11,200 units hyaluronidase once weekly for 4 weeks. Subsequent cycles are repeated at least 50 days from the start of the previous cycle. CIDP: 1,008 mg efgartigimod alfa/ 11,200 units hyaluronidase once weekly

Vyvgart Hytrulo PFS is a self-administered product and will fall under Partnership's Standard Requirements for Self-Administered Drugs

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PA Criteria	Criteria Details
Covered Uses	Generalized myasthenia gravis (MG) in patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive.
Exclusion Criteria	• Myasthenia gravis LRP4 antibody positive or seronegative • Concurrent use with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists
Required Medical Information	1) Positive immunologic binding assay to confirm MG due to the presence of AChR or MuSK antibodies 2) Avoidance of drugs that may exacerbate MG if possible, such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium 3) Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline 4) Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV 5) Current weight 6) Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to ALL of the following: • Pyridostigmine AND • Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose AND • Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate, AND • For anti-AChR antibody positive only: Efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFS™) (preferred) or Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™).
Age Restriction	12 years and older
Prescriber Restriction	Neurology
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal Requests: • Clinical notes with current: o MG-ADL o 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
J3590	Unclassified biologics: Injection, nipocalimab-aahu (Imaavy)	30mg/kg as a single dose, followed 2 weeks later by 15mg/kg given every 2 weeks thereafter.

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	Generalized myasthenia gravis (MG) in adults who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive.
Exclusion Criteria	• Myasthenia gravis LRP4 antibody positive or seronegative • Concurrent use with other systemic Complement Inhibitors or Neonatal Fc Receptor Antagonists~~ravulizumab (Ultomiris™), eculizumab (Soliris™), zilucoplan (Zilbrysq™) or efgartigimod alfa-fcab (Vyvgart™)~~
Required Medical Information	1) Positive immunologic binding assay to confirm MG due to the presence of AChR or MuSK antibodies 2) Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium 3) Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline 4) Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV 5) Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to ALL of the following: • Pyridostigmine AND • Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose AND • Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate, AND • For anti-AChR antibody positive only: Efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFS™) (preferred), or Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart Hytrulo™).
Age Restriction	18 years and older
Prescriber Restriction	Neurology
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal Requests: • Clinical notes with current: ○ 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
J9333	Injection, rozanolixizumab-noli, 1 mg	Weight based dosing: • Less than 50kg: 420mg • 50kg to less than 100kg: 560mg • 100kg and above: 850mg Dose given by subcutaneous infusion once weekly for 6 weeks. Subsequent cycles are repeated at least 63 days from the start of the previous cycle.

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	The treatment of steroid-refractory acute graft versus host disease (SR-aGvHD) in pediatric patients
Exclusion Criteria	• Age ≥18 years • Skin only grade B aGVHD
Required Medical Information	1) Diagnosis of grade B–D aGVHD with symptoms involving skin, liver, and/or GI tract (excluding skin-only grade B aGVHD) 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) 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) Documentation that the GVHD prophylactic regimen has been optimized, such as 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) Documentation of trial and failure or reasons why Ruxolitinib (Jakafi™) cannot be used (in members ≥12 years old only). 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).
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	Renewal requirements: • Requests for continuation following a partial or mixed response: o Documentation of partial response (organ improvement of ≥1 stage without worsening of any other organ) or mixed response (improvement in ≥1 evaluable organ stage with worsening in another) following an initial 4-week course of 8 doses. • Requests for re-treatment following a complete response: o Documentation showing complete response defined as resolution of aGVHD in all involved organs following the initial 4-week course of Ryoncil. o 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
J3590	Unclassified biologics: remestemcel-L-rknd (Ryoncil)	Initial: 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 Retreatment: May consider retreatment after 28 days if: Partial or mixed response or GVHD recurs after complete response; • *Partial or mixed response:* IV: 2 × 10^6 mesenchymal stromal cells (MSC)/**kg**/dose once weekly for 4 additional weeks (total of 4 infusion). • *Recurrence of GVHD after complete remission*: 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. • *No response*: 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	Treatment of chronic graft-versus-host disease (cGVHD) after failure of at least two prior lines of systemic therapy.
Exclusion Criteria	• Weight ≤40kg
Required Medical Information	1) Documentation of the diagnosis of cGVHD including all clinical, laboratory and histologic work up necessary to confirm the diagnosis based on the National Institutes of Health 2014 Consensus Guideline for Diagnosis and Staging (see reference table under Other Requirements & Information). a. For members who lack any of the NIH **Diagnostic** Features, biopsy, organ specific laboratory studies, or evaluation by appropriate specialist may be required to confirm the diagnosis. 2) Documentation that the GVHD prophylactic regimen has been optimized, such as achieving adequate trough concentrations of calcineurin inhibitors, or reasons why these levels cannot be achieved. 3) Symptoms of cGVHD despite treatment with adequate doses of systemic glucocorticoids AND at least one additional line of systemic therapy, which may include any of the following: a. Ruxolitinib (Jakafi™) b. Ibrutinib (Imbruvica™) c. Belumosudil (Rezurock™) d. Extracorporeal photopheresis e. Mycophenolate mofetil f. Sirolimus g. Rituximab (Rituxan™) h. Bortezomib (Adcetris™) i. Etanercept (Enbrel™) 4) Current weight for dosing; member must weigh at least 40kg
Age Restriction	None
Prescriber Restriction	Oncologist, hematologist, BMT specialist, or other qualified prescriber
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal requirements: • Documentation of symptomatic response based on the 2014 NIH Consensus Criteria. Diagnostic and distinctive clinical manifestations of chronic graft-versus-host disease based on the National Institutes of Health 2014 Consensus Guideline:

Organ/ site	**Diagnostic (sufficient to establish the diagnosis of cGHVD)**	Distinctive (seen in cGVHD, but insufficient alone to establish diagnosis)
Skin	• Poikiloderma	• Depigmentation

	• Lichen planus-like features • Sclerotic features • Morphea-like features • Lichen sclerosus-like features	• Papulosquamous lesions
Nails		• Dystrophy • Longitudinal ridging, splitting, or brittle features • Onycholysis • Pterygium unguis • Nail loss (usually symmetric and affects most nails)
Scalp and body hair		• New onset of scarring or nonscarring scalp alopecia (not associated with recovery from chemotherapy or radiotherapy) • Loss of body hair • Scaling
Mouth	• Lichen planus-type changes	• Xerostomia • Mucocele • Mucosal atrophy • Pseudomembranes • Ulcers
Eyes		• New-onset dry, gritty, or painful eyes • Cicatricial conjunctivitis • Keratoconjunctivitis sicca • Confluent areas of punctate keratopathy
Genitalia	• Lichen planus-like features • Lichen sclerosus-like features • Females: Vaginal scarring or clitoral/labial agglutination • Males: Phimosis or urethral/meatus scarring or stenosis	• Erosions • Fissures • Ulcers
GI tract	• Esophageal web • Strictures or stenosis in the upper to mid third of the esophagus	
Lung	• Bronchiolitis obliterans diagnosed with lung biopsy	• Bronchiolitis obliterans syndrome (BOS) diagnosed with PFTs and imaging
Muscle, fascia, joints	• Fasciitis • Joint stiffness or contractures secondary to fasciitis or sclerosis	• Myositis or polymyositis

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
J9038	Injection, axatilimab-csfr, 0.1 mg	0.3 mg/kg, up to a maximum dose of 35 mg, as an intravenous infusion over 30 minutes every 2 weeks until progression or unacceptable toxicity

Note that in clinical trials, higher doses of 1mg/kg and 3mg/kg were studied but were associated with lower overall response rates (worse efficacy) than the 0.3mg/kg dosing.

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	• Neuromyelitis optica spectrum disorder (NMOSD) in adults who are anti-aquaporin-4 (AQP4) IgG antibody positive. • Immunoglobulin G4-related disease (IgG4-RD)
Exclusion Criteria	• History of a life-threatening infusion reaction to inebilizumab; active hepatitis B infection; tuberculosis (TB) disease (active TB) or untreated TB infection (latent TB). • NMOSD: Use along with IV eculizumab (Soliris™} or SUBQ satralizumab (Enspryng™) • NMOSD negative AQP4-IgG • IgG4-RD: Use along with rituximab
Required Medical Information	All requests should include documentation that member has been screened for hepatitis B virus (HBsAg and anti-HBc measurements) and active tuberculosis prior to treatment initiation. Submit the following per indication: Requests for neuromyelitis optica spectrum disorder (NMOSD) (AQP4 IgG positive) required documentation of ALL of the following: 1) At least one of the following: • Optic neuritis • Acute myelitis • Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting • Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) • Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions • Symptomatic cerebral syndrome with NMOSD-typical brain lesions 2) Seropositive for AQP4-IgG antibodies 3) Baseline Expanded Disability Status Scale (EDSS) score 4) Provider to submit reason(s) why satralizumab (Enspryng™) cannot be used, as the lower- level of care agent. Requests for Immunoglobulin G4-related disease (IgG4-RD) require documentation of ALL the following: 1) Diagnosis of IgG4-RD including documentation to show BOTH of the following: a) Clinical or radiologic evidence of tumor-like swelling of organs involved. b) Biopsy of the involved organs that demonstrates ALL of the following: i) Lymphoplasmacytic infiltrate enriched in IgG4-positive plasma cells ii) Storiform fibrosis (typified by a cartwheel appearance of the arranged fibroblasts and inflammatory cells) iii) Obliterative phlebitis 2) Other conditions (eg. malignancy, infection, other autoimmune disorders

	etc) have been ruled out. 3) IgG4-RD affecting 2 or more of the following organ/sites at any time: • Pancreas • Bile ducts/biliary tree • Orbits • Lungs • Kidneys • Lacrimal glands • Major salivary glands • Retropertioneum • Aorta • Pachymeninges • Thyroids glands 4) Member is experiencing (or recently experienced) an IgG4-RD flare that requires initiation or continuation of glucocorticoid treatment and/or recurrent disease. a. Flare is defined as new or worsening clinical features of IgG4-RD for which no clear alternative diagnosis exists. 5) Refractory to or unable to use glucocorticoids (including glucocorticoid dependence). a. Refractory to glucocorticoids is defined as inability to experience symptom relief, reduction in mass/organ size, improvement in organ function, or adequate decreases in serum IgG4 concentrations from glucocorticoids alone. b. This includes patients who are glucocorticoid-dependent (i.e. unable to reduce glucocorticoid dose to <5 mg/day) without causing disease flare or worsening of symptoms. 6) Trial and failure, or contraindication to, rituximab (biosimilar preferred).or explanation from the provider as to why rituximab is not appropriate.
Age Restriction	18 years and older
Prescriber Restriction	NMOSD: Specialty providers may include n~~N~~eurologist, o~~O~~phthalmologist, immunologist, hematologist or other physician with experience treating NMOSD. IgG4-RD: Specialty providers may include rheumatologists, immunologists, endocrinologists, nephrologists, hepatologists, or other physician with experience in treating IgG4-RD.
Coverage Duration	Initial request with loading dose: 6 months Renewal: 12 months with documentation to indicate a positive response to treatment.
Other Requirements & Information	~~Include with renewal request:~~ ~~Documentation to indicate positive response to treatment.~~ 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
J1823	Intravenous injection, Inebilizumab-cdon, 1 mg	Loading Dose: IV: 300 mg on day 1, followed by 300 mg 2 weeks later on day 15. Maintenance Dose: IV: 300 mg every 6 months (6 months starts after the first 300 mg dose)

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-resistant depression (TRD) ~~in adults in conjunction with an oral antidepressant (excluding monoamine oxidase inhibitors).~~
Exclusion Criteria	• Requests for use exceeding ~~maximum dose of 84 mg per week~~the FDA/manufacturer labeled maximum dose. • ~~Non-adherence with oral antidepressant.~~ • ~~Active substance misuse or use disorder.~~ Failure of the prescriber to provide documentation specified under required medical information indicating an adequate work up of the member was completed. • Any requests in which the medication will be provided directly to the patient for administration outside of a REMS authorized facility. • Active aneurysmal vascular disease or intracerebral hemorrhage or history of intracerebral hemorrhage. • Currently taking a monoamine oxidase inhibiting (MAOI) medication (e.g., isocarboxazid, selegiline). • Active psychosis. • Delirium (within one week of administration). • Hypersensitivity to ketamine or esketamine • Dementia. • Class IV heart failure. *While not an absolute exclusion, due to the risk of hypertensive crisis, care should be exercised when considering esketamine treatment in individuals currently taking psychostimulant medications, including modafinil and armodafinil.
Required Medical Information	All participants in esketamine therapy fulfillment must be enrolled in the Spravato REMS program: The facility drug administration site, the member AND the dispensing pharmacy. All providers must have the infrastructure in place to obtain the medication, store the medication, and administer the medication in accordance with REMS guidelines New Starts require each of the following: 1) ~~A psychiatric consult is required for confirmation of TRD diagnosis.~~Documentation of current and prior depressive episodes with their duration and all prior treatments including any prior electroconvulsive (ECT) or Transcranial Magnetic Stimulation (TMS) with the date and outcome (note that ECT or TMS is not a requirement for Spravato eligibility). 2) Documentation of physical examination and laboratory assessment to rule out other causes of treatment resistant depression including, but not limited to comprehensive metabolic panel (CMP), complete blood count (CBC) and thyroid stimulating hormone (TSH) 3) Baseline (prior to Spravato) standardized depression symptom assessment tool results such as one of the following: a. Beck Depression Inventory (BDI) b. Hamilton Depression Rating Scale (HAM-D) c. Inventory of Depressive Symptomatology-Systems Review (IDS-SR) d. Montgomery-Asberg Depression Rating Scale (MADRS) e. Personal Health Questionnaire Depression Scale (PHQ-9) f. Quick Inventory of Depressive Symptomatology (QIDS)

4) Documentation of ~~"~~failure~~"~~ to remission after an adequate trial ~~(minimum 6 weeks)~~ of 2 ~~each of 4 prior~~ antidepressants from different medication classes at therapeutic doses ~~, and documentation that psychotherapy has been provided in the past year prior to requesting treatment with esketamine (e.g., cognitive behavioral therapy, dialectical behavioral therapy).~~ during the current depressive episode.

a. Applicable anti-depressant classes for this requirement include SSRIs, SNRIs, Bupropion, Mirtazapine, TCAs, MAOIs, Vilazodone or Vortioxetine. Electroconvulsive (ECT) or Transcranial Magnetic Stimulation (TMS) may also be used as one line of prior therapy.

b. If the above antidepressant medications were used concurrently, or with other augmenting agents (i.e., lithium, thyroid hormone, buspirone, second generation antipsychotic) then the regimen taken together for a period of time constitutes one trial.

c. The current episode is considered the continuous time that the patient has been symptomatic and meeting clinical diagnostic criteria for MDD, inclusive of present day. Episodes that are separated by periods of symptom remission such that patients no longer meet clinical diagnostic criteria for MDD during that time represent distinct and separate episodes.

d. Prescriber will attest that the medication trial was adequate to determine treatment failure or intolerance.

~~a. "Failure" is ascertained through use of a standardized scale such as the Antidepressant Treatment History Form.~~

~~2)~~5) Partnership pharmacy claim history (or comparable documentation of pharmacy dispensing) must show adherence to both previous and current oral antidepressant regimens. In the absence of pharmacy claim history providers should provide medication name and response to the trial.

~~3)~~6) Prescriber attestation that they have evaluated for the presence of current and/or past substance misuse/use disorder and that, if present, clinical risks of treatment with esketamine are outweighed by the potential benefits. ~~the patient is not actively misusing substances and/or meets criteria for substance use disorder not in remission, and~~In other words, the prescriber has conducted a thorough substance use history ~~has been obtained~~ (and where history of prior substance misuse or use disorder is ascertained then comprehensive risk/benefit analysis is documented) in addition to attestation that the provider has communicated with the patient about the misuse potential of this medication~~ – this may include use of cannabis and alcohol~~.

~~4)~~7) Urine (or other body fluid) toxicology (UTOX) screening.~~, which may include cannabis and alcohol as clinically indicated.~~

~~5)~~8) Esketamine (Spravato™) ~~T~~treatment plan. ~~(including the planned concurrent oral agent, esketamine dosing schedule).~~

~~6)~~9) Pregnancy test, and for patients who are pregnant or breastfeeding, documentation of comprehensive risk/benefit discussion including contraceptive counseling to those who may become pregnant during treatment.

~~7)~~10) Documentation of appropriate CURES query.

Renewals:

1) Response to therapy assessed with the same standardized rating scale that was provided for the baseline assessment (see above scales listed under requirement 3).

~~2) Partnership pharmacy claim history (or comparable documentation of pharmacy dispensing dates) which supports adherence to an oral antidepressant regimen.~~

~~3)~~2) Urine toxicology with each renewal~~, which may include cannabis & alcohol as clinically indicated~~.

Age Restriction	Age 18 years and up ~~to 65 years~~
Prescriber Restriction	Board certified psychiatrist is preferred, requests from other prescribers will be reviewed on a case-by-case basis. *Providers other than board certified psychiatrists should indicate any formal psychiatric training they have completed on the request.*
Coverage Duration	Initial approval: 8 weeks (672 – 980 units) Renewal (starting at 9th week of treatment): 26 weeks (728 – 2184 units)
Other Requirements & Information	Notes: 1) TAR review will be by CMO or delegate, since treatment of severe disease is generally under the scope of State Medi-Cal fee for service. 2) Partnership is aware that Spravato™ is now also FDA approved for Major Depressive Disorder with acute suicidal ideation. Members experiencing acute suicidal ideation and at risk of acting upon that ideation should be under clinical (psychiatric or medical) observation. Treatment for serious mental health issues is provided by the county mental health plans. The manufacturer's clinical trials for FDA approval did not show a statistically significant decrease in suicidality scores with esketamine vs placebo; note that suicidality decreased in both the treatment and placebo arms and the study was conducted in an inpatient psychiatric facility. The clinical trials excluded individuals with borderline personality disorder (suicidality is a hallmark of BPD). 3) Regarding cannabis or alcohol use: Although legal CNS depressants, use of either agent, and especially if positive for both, does necessitate a certain level of clinical concern for the potential risk of substance~~ject~~ use disorder (SUD). 4) If member declares ~~cannabis or alcohol~~ substance use, or UTOX is positive, TAR requests must have the prescriber documentation as to why this is not a concern or contraindication to administration of esketamine and how benefits outweigh the risks. 5) Regarding members being treated via telemedicine: Telemedicine prescribers are not necessarily exempt from providing esketamine to members as long as all criteria requirements can be incorporated, including Urine Toxicology lab report and administration of esketamine in a REMS enrolled facility with the requisite monitoring post-treatment. 6) Careful review of an individual's current medication list and monitoring of potential drug-drug interactions is standard of care. ~~5)~~7) 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
S0013	Esketamine, nasal spray, 1 mg	Individualized to the least frequent dosing needed to maintain remission/response

FDA Approved Regimens	S0013 units per week	S0013 units per 4 weeks
Induction phase options (weeks 1-4)		
56 mg twice a week	112	448
Week 1: 56mg on day 1, followed by 84mg 3-4 days later *Weeks 2-4*: 84mg twice weekly	Wk 1: 140 Wks 2-3: 168	644
Maintenance, phase 1 options (weeks 5-8)		
56mg once weekly	56	224
84mg once weekly	84	336
Maintenance, phase 2 options (weeks 9 & thereafter)		
56mg every other week	28 *(average of 56 every other week)*	112
56mg once weekly	56	224
84mg every other week	56 *(average of 84 every other week)*	224
84mg once weekly	84	336

Initial TAR period

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

Draft

Committee: Credentials Committee
Date: 05/14/2025 7:00 A.M.
Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Madeleine Ramos, MD*; Bradley Sandler, MD* ; Brent Pottenger, MD

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*; 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 Brambly, Credentialing Specialist I

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 and the Credentials Committee roll call. Dr. Netherda reminded everyone that all items discussed are confidential. a. Mark Netherda, MD, PHC Regional Medical Director, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Dr. Netherda reminded the committee that all information discussed is confidential in nature.			
II. Review and approval of April 9, 2025 Credentials Meeting Minutes.	II. Dr. Netherda referred the Credentials Committee to review the meeting minutes for April 9, 2025. Brent Pottenger, MD noticed a typo for the previous monthly minutes. Dr. Netherda acknowledged the mistake and stated they will be fixed.	II. Minutes were reviewed by the Credentials Committee. A motion for approval of the minutes was made by Bradley Sandler, MD and seconded by Brent Pottenger, MD. Meeting minutes were unanimously approved without changes.		5/14/2025
III. Old Business. a. Update on provider.	III. Old Business – a. Dr. Netherda discussed old business for a provider. The provider's license was placed on a five-year probation effective 8/9/2021 due to gross negligence. Additionally, a two-year probation order was placed on 2/16/2024 to run concurrently with the five-year probation by the Medical Board of California. The Credentials Committee motioned during the April 9, 2025 meeting to defer the	III. Old Business a. Old Business for provider was reviewed by the committee. A motion to defer to the next Credentials Meeting in order for Partnership to further investigate the provider was made by David Gorchoff, MD and seconded by Michele Herman, MD. Deferring was unanimously approved.	6/11/2025	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	provider in order to get more information from MBOC and answers regarding the Medical Board's decisions on the provider's probation. On 4/10/2025 the provider was placed on one-year probation due to violating terms of probation. The Medical Board of California probation inspector assigned to the provider responded to inquiries on 5/5/2025 and stated that the provider is in compliance with their probation orders. Per the contact, only the Medical Board of California can decide to continue to put the provider on probation and unfortunately, the probation inspectors cannot question the Medical Board's decisions, nor disclose why they made said decisions. Dr. Gorchoff stated that the provider's status remains the same and could be in correlation to the shortage of providers in that area for the specialty. Dr. Ribordy also stated that the providers group is more of a billing entity for Mad River and the provider is contracted individually as well. Dr. Kubota also stated that due to the provider's probation they cannot have a solo practice. Dr. Moore agreed and suggests that Partnership should reach out to the provider on how they are meeting MBOC requirements of not having a solo practice and find out if they are actually having supervision. Dr. Gwiazdowski asked if we can reach out to the board again regarding if the provider can be with a group that is only for billing. Dr. Gorchoff brought up that Partnership cannot second guess the Medical Board of California's decisions. Dr. Pottenger asked if Partnership should also reach out to MBOC with a letter to see if they are aware that North Pacific is a billing entity and not a group. Dr. Gorchoff motioned to defer for further investigation regarding the provider's status working with group and if they are having supervision.			
b. Update on provider	b. Dr. Netherda brought to the attention of the committee information for a provider. The provider completed their fourth and final chart review.	b. Old Business for provider was reviewed by the committee. A motion to approve the chart review was made by Brent Pottenger, MD and seconded by Steven Gwiazdowski.		5/14/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
c. Update on provider	c. Dr. Netherda brought to the attention of the committee information for a provider. The provider completed their fourth and final chart review.	c. Old Business for provider was reviewed by the committee. A motion to approve the chart review was made by Brent Pottenger, MD and seconded by Michele Herman, MD.		5/14/2025
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Netherda referred the Credentials Committee to review the routine list of practitioners on pages 129-132.	a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Brent Pottenger, MD and seconded by Madeleine Ramos, MD. The Committee unanimously approved the routine list.		5/14/2025
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Netherda referred the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list on page 133-136. These practitioners are approved by Dr. Netherda pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the list practitioners was made by Brent Pottenger, MD and seconded by Steven Gwiazdowski, MD. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		5/14/2025
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by J'aime Seale. J'aime explained that policy MPCR13D – Registered Pharmacies for AB1114 Credentialing is being presented with Consent Calendar Items only for changes.	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Steven Gwiazdowski, MD and seconded by Brent Pottenger, MD. The Committee unanimously approved the revised policies.		5/14/2025
d. CR5 Semi-Annual Evaluation of Practitioner Specific Member Complaints	d. Dr. Netherda referred the Credentials Committee to the 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". *Information Only*.	d. *Information Only*		5/14/2025
V. Ongoing Monitoring	V. Ongoing Monitoring of Sanctions Report and	V. Ongoing Monitoring of Sanctions Report and		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
of Sanctions Report and Practitioner Monitoring List.	Practitioner Monitoring List.	Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions Report.	a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report on page 141-142.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Madeleine Ramos, MD and seconded by Michele Herman, MD. The Committee unanimously approved.		5/14/2025
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring List on pages 143-144. Dr. Netherda reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Information only*.		
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a. Report of Long Term Care Facility, Hospital, and Ancillary provider list.	a. Dr. Netherda asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list on page 145-146.	a. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Steven Gwiazdowski, MD and seconded by Brent Pottenger, MD. The Credentialing Committee unanimously approved.		5/14/2025
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Minutes for 5/14/2025 respectfully prepared and submitted by J'aime Seale, Credentialing Specialist Lead.

Chairman Signature of Approval _____ ***Date*** ***5/14/2025***

Mark Netherda, M.D., PHC Credentialing Chairman

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Addison, Denise M.,CADC I	1508098229	W&R	Arbor Outpatient Drug Free	Mendocino	Certified Alcohc	California Cons	02/16/2010	Yes	None	
I	Akintunde, Celedor H.,MD	1336152396	SPEC	Bright Heart Health Medical	Solano	Addiction Medic	ABMS of Family	01/01/2020	Yes	Admitting Agree	None
I	Alberty, Janetria BCBA	1265801054	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	05/31/2015	Yes	None	
R	Alvarez, Juana R.,FNP-C	1518049659	PCP	Alliance Medical Center	Sonoma	Family Nurse P	American Acad	01/10/2017	Yes	None	
R	Alway, Tiffany H.,DPM	1740229277	SPEC	Redwood Podiatry Group In	Humboldt	Foot Surgery	Previously Boa	07/29/2003	No	Providence St J	Affiliate
I	Ammar, Nader A.,PA-C	1245914381	PCP	Ampla Health Yuba City	Sutter	Physician Assis	National Comm	12/23/2024	Yes	None	
R	Aryanpur, John MD	1578616686	SPEC	Providence Medical Group,	Humboldt	Neurological Su	ABMS of Neuro	11/10/1994	Yes	St. Joseph Hos	Affiliate
I	Asuncion, Robert J.,PT	1619945821	Allied	Viviant Health - University P	Sacramento	Physical Thera	None		No	None	
I	Bagdasarian, Andrew J.,PT	1831564350	Allied	Viviant Health - University P	Sacramento	Physical Thera	None		No	None	
R	Balcazar, Mirtha L.,MD	1174515969	PCP	Hill Country Comm Clinic-R	Shasta	Internal Medicir	Meets MPCR #		No	Mercy Medical	Courtesy
R	Bartlow, Bruce G.,MD	1316956865	SPEC	Shasta Critical Care Specia	Shasta	Nephrology	ABMS of Intern	06/17/1980	Yes	Shasta Region	Active
R	Beck, Paul V.,MD	1700921103	SPEC	Paul Beck, MD	Shasta	General Surger	ABMS of Surge	01/29/2014	Yes	Shasta Region	Active
I	Bell, Chynna D.,LMFT	1487117750	BHP	Solano County Family Healt	Solano	License Marria	None		No	None	
R	Bell, Norman J.,MD	1194819888	PCP	Open Door Community Hea	Humboldt	Pediatrics	ABMS of Pedia	03/01/1974	Yes	Providence St.	Affiliate
R	Bey, Gina E.,FNP-C	1699906891	PCP	Petaluma Health Center: Rc	Sonoma	Family Nurse P	American Acad	07/27/2021	Yes	None	
I	Bloom, Joshua M.,SLP	1841098241	Allied	SPOT, Inc.	Shasta	Speech & Lang	None		No	None	
R	Botcharnikova, Larissa N.,PA-C	1720122054	PCP	SCHC: Shasta Lake Family	Shasta	Physician Assis	National Comm	10/07/2004	Yes	None	
I	Breshears, Ashley FNP	1811700669	SPEC	Capitol Pediatric Cardiology	Yolo	Nurse Practitior	American Acad	01/13/2025	Yes	None	
I	Buffington, Joleen R.,NP	1699503383	SPEC	Mendocino Community Hea	Mendocino	Nurse Practitior	None		No	None	
I	Bui, Anh PT	1245043124	Allied	Family Physical Therapy	Placer	Physical Thera	None		No	None	
I	Burnam, Holly FNP	1487201091	SPEC	Barton Healthcare System	El Dorado	Nurse Practitior	American Acad	08/01/2019	Yes	None	
I	Candaza, Janelle OT	1851173983	Allied	NBHG: Northbay Rehab Se	Solano	Occupational Th	None		No	None	
I	Capri, Valerie J.,Doula	1376367862	SPEC	Westside Doula Capri	Mendocino	Doula	None		No	None	
I	Carbonell, Antonio J. DC	1003967530	SPEC	Tehama County Health Ser	Tehama	Chiropractic	None		No	None	
I	Casademunt, Claire BCBA	1700583242	BHP	Pantogran LLC dba Center		BCBA	Behavior Analys	03/11/2023	Yes	None	
I	Chahal, Anupam MD	1972780146	SPEC	Arthritis and Rheumatism C	Solano	Rheumatology	ABMS of Intern	10/18/2012	Yes	Admitting Agree	None
R	Chambers, Cynthia J.,MD	1518278357	SPEC	Pacific Skin Institute	Yolo	Dermatology	ABMS of Derma	07/21/2016	Yes	Admitting Agree	None
R	Chatwin, Amber L.,MD	1669582433	SPEC	Adventist Health Clearlake	Lake	Orthopaedic Su	ABMS of Ortho	07/11/2003	Yes	Adventist Healt	Active
I	Chaudhry, Natasha BCBA	1730842196	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analys	10/13/2021	Yes	None	
I	Chen, Peter BCBA	1538636030	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analys	01/19/2022	Yes	None	
I	Choy, Ho-Hin K.,MD	1083008262	SPEC	NBHG: Heart and Vascular	Solano	Interventional C	ABMS of Intern	10/20/2022	Yes	NorthBay Healt	Active
I	Coldwell, Alaura BCBA	1508302449	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	04/22/2021	Yes	None	
I	Coleman, Kayla BCBA	1265978027	BHP	Maxim Healthcare Services	Placer	BCBA	Behavior Analys	05/31/2019	Yes	None	
R	Concepcion, Marc L.,DO	1134159429	PCP	River Bend Medical Associa	Yolo	Family Medicin	ABMS of Family	07/12/1996	Yes	Sutter Medical	Active
R	Cooper, Alan D.,DC	1396885661	SPEC	McCloud Healthcare Clinic	Siskiyou	Chiropractic	None		No	None	
I	Counts, Shaheen M.,MD	1972727063	SPEC	Providence Medical Group,	Humboldt	Ophthalmology	ABMS of Otolar	06/01/2023	Yes	Admitting Agree	None
I	Crane, Shaunda A.,FNP-BC	1558067017	SPEC	Elica Health Centers-Halyar	Yolo	Family Nurse P	American Nurse	11/24/2022	Yes	None	
I	Crowley, Jason S.,FNP-C	1871862565	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	02/13/2020	Yes	None	
I	Cruz, Ashley S.,LMFT	1649585993	BHP	Solano County Family Healt	Solano	License Marria	None		No	None	
I	Cruz, Naomi Doula	1134934714	SPEC	Agape Doula Services LLC	Humboldt	Doula	None		No	None	
I	Cruz, Yuviana BCBA	1992213037	BHP	Peak Potential ABA, LLC	Solano	BCBA	Behavior Analys	03/14/2021	Yes	None	
I	Danilychev, Maria V.,MD	1255419800	PCP	Round Valley Indian Health	Mendocino	Internal Medicir	Meets MPCR#1	08/24/2004	No	Admitting Agree	Active
I	Darbazanjian, Destiny BCBA	1013723717	BHP	Autism Advocacy and Interv	Lake	BCABA	Behavior Analys	12/03/2024	Yes	None	
I	Dasilva, Audrey J.,MD	1548897119	PCP	Barton Healthcare System	El Dorado	Pediatrics	ABMS of Pedia	10/12/2023	Yes	Barton Memoria	Active
I	DeStefano, Nicole BCBA	1437620689	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analys	02/28/2018	Yes	None	
I	Dodd, Sydney G.,FNP-C	1790427714	SPEC	West Sacramento Urgent C	Yolo	Family Nurse P	American Acad	01/31/2022	Yes	None	
I	Doncheva, Diana M.,MD	1609933274	PCP	Elica Health Centers - Arder	Placer	Family Medicin	ABMS of Family	07/18/2007	Yes	Admitting Agree	None
I	Dowd, Molly NP	1093424368	PCP	Barton Healthcare System	El Dorado	Nurse Practitior	None		No	None	
I	Doyle, Michael P.,MD	1265460463	PCP	Barton Healthcare System	El Dorado	Pediatrics	ABMS of Pedia	10/28/1992	Yes	Barton Memoria	Active
I	Evans, Kimberly A.,MD	1457518946	SPEC	Barton Healthcare System	El Dorado	Surgery	ABMS of Surge	03/26/2014	Yes	Barton Memoria	Active
I	Everson, Shianna BCBA	1295304236	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analys	10/18/2021	Yes	None	
R	Ewing, Robert H.,Jr., MD	1548265267	SPEC	Siskiyou Eye Center	Siskiyou	Ophthalmology	ABMS of Ophth	06/07/1986	Yes	Admitting Agree	None
I	Fallon, Kelsey BCBA	1255075644	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analys	04/06/2022	Yes	None	
R	Fear, Daniel R.,MD	1407848948	SPEC	Asante Physician Partners :	Siskiyou	Otolaryngology	ABMS of Otolar	03/26/1996	Yes	Asante: Three I	Active
I	Francois, Carol A.,LAc	1528106002	Allied	Mendocino Coast Clinics In	Mendocino	Acupuncture	None		No	None	
I	Fujii, Scott K.,MD	1235391798	SPEC	Bay Area Foot Care Inc	Yolo	Orthopaedic Su	ABMS of Ortho	07/28/2016	Yes	Mercy San Jua	Active

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Gaglia, Michael A.,Jr., MD	1528031663	SPEC	Adventist Health Clearlake -	Lake	Interventional C	ABMS of Intern	10/27/2011	Yes	Adventist - Ukia	Provisional
I	Ganguli, Mary BCBA	1396285318	Allied	Sunrise ABA	Marin	BCBA	Behavior Analy	02/28/2019	Yes	None	
I	Garcia, Jorge R.,FNP-C	1225593767	PCP	OLE Health	Solano	Family Nurse P	American Acad	04/01/2019	Yes	None	
I	Gaulter, Constance E.,MD	1508881459	SPEC	Grass Valley Radiation Onc	Nevada	Radiation Onco	None		No	Admitting Agre	None
R	Gerbich, Stephen J.,MD	1538196746	PCP	Gridley Childrens Clinic	Butte	Pediatrics	Confirmed per A		No	Admitting Agre	Active
R	Gohel, Tejshri NP	1558828178	SPEC	Providence Medical Group-	Napa	Nurse Practitior	None		No	None	
I	Gomez Vargas, Berenise RD	1376200311	Allied	La Clinica/Great Beginnings	Solano	Registered Diet	None		No	None	
R	Gordon, Jenna BCBA	1730512526	BHP	Autism Advocacy and Interv	Lake	Behavioral Hea	Behavior Analy	05/31/2017	Yes	None	
R	Grady, Ian P.,MD	1215951371	SPEC	North Valley Breast Clinic	Shasta	Surgical Oncolc	None		No	Mercy Medical	Active
I	Grant, Heather M.,AGPCNP-BC	1821731506	PCP	Southern Humboldt Commu	Humboldt	Adult-Gerontolc	American Nurse	04/29/2021	Yes	None	
I	Grippa, Robyn BCBA	1568803765	BHP	Advance Kids	Placer	BCBA	Behavior Analy	05/31/2013	Yes	None	
R	Hanson, Sharon A.,NP	1780725226	PCP	MVHC - Fall River Valley He	Shasta	Nurse Practitior	None		No	None	
I	Harding, Grace C.,DO	1770962920	PCP	Barton Healthcare System	El Dorado	Family Medicin	ABMS of Family	07/09/2018	Yes	Barton Memoria	Active
R	Hovorka, Gail S.,MD	1417043969	PCP	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Family	07/10/1992	Yes	Admitting Agre	None
I	Howell, Allison BCBA	1306501242	BHP	Pantogran LLC dba Center	Yolo	BCBA	Behavior Analy	02/11/2025	Yes	None	
I	Hsiao, Julia J.,DO	1215133798	SPEC	TeleMed2U	Yolo	Neurology	ABMS of Psych	09/11/2011	Yes	Admitting Agre	None
R	Huang, Stella M.,DO	1760610273	SPEC	NBHG: Center for Women's	Solano	Obstetrics and	ABMS of Obste	01/15/2016	Yes	NorthBay Medi	Active Attending
R	Hunter, Willard M.,MD	1477589323	PCP	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Family	10/30/1977	Yes	Providence St J	Affiliate
I	Ishisaka, Mika PT	1447833991	Allied	Viviant Health - University P	Sacramento	Physical Thera	None		No	None	
I	Jarick, Jocelyn PA-C	1891169397	SPEC	West Sacramento Urgent C	Yolo	Physician Assis	National Comm	11/05/2015	Yes	None	
I	Kanani, Babak MD	1023323813	PCP	Shasta Regional Medical Gr	Shasta	Internal Medicir	ABMS of Intern	08/16/2010	No	Admitting Agre	None
I	Knight, Cathey R.,FNP-C	1205083425	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	07/01/2008	Yes	None	
I	Knight, Liza J.,NM	1699444638	SPEC	Dignity Health - Mercy Mt. S	Siskiyou	Certified Nurse	American Midw	09/01/2021	Yes	None	
I	Korobkin, Rowena K.,MD	1518919729	SPEC	Santa Rosa Community Hea	Sonoma	Psychiatry and	ABMS of Psych	06/30/1977	Yes	Admitting Agre	None
I	Lacap, Marjorie BCBA	1942793880	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analy	07/27/2024		None	
I	Liouh, Charisma BCBA	1245731223	BHP	Behavior Frontiers, LLC	Placer	BCBA	Behavior Analy	05/31/2018	Yes	None	
R	Lupercio, Rafael MD	1174532618	SPEC	Shasta Critical Care Special	Shasta	Pulmonary Dise	ABMS of Intern	11/07/2006	Yes	Shasta Regiona	Active
R	Lyon, Carleigh I.,BCBA	1912678962	BHP	Autism Advocacy and Interv	Lake	Behavioral Hea	Behavior Analy	02/03/2021	Yes	None	
I	Machado, Darcy BCBA	1659841179	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analy	02/22/2020	Yes	None	
I	Maddalone, Antoinette Doula	1417720095	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	
R	Manibusan-Magaoay, Philip BCBA	1598255606	BHP	Behavior Resources, Inc.	Yolo	BCBA	Behavior Analy	11/30/2019	Yes	None	
I	Marshall, Emily E.,DO	1861849283	PCP	Redwoods Rural Health Cer	Humboldt	Family Medicin	American Oste	07/01/2021	Yes	Admitting Agre	None
I	Martin, Brooks MD	1205834306	PCP	Barton Healthcare System	El Dorado	Family Medicin	ABMS of Family	07/10/1981	Yes	Barton Memoria	Active
I	Martin, Lissa SUDRC	1033919915	W&R	Empire Recovery Center	Shasta	Wellness and R	California Subs	12/05/2024	Yes	None	
I	McCormack, Bruce M.,MD	1184636425	SPEC	Bruce M. McCormack, M.D.	San Francisc	Neurological Su	ABMS of Neuro	05/27/1998	Yes	California Pacif	Active
I	Mehboob, Salman MD	1497841795	SPEC	Providence Medical Group,	Humboldt	Interventional C	ABMS of Intern	11/01/2010	Yes	Providence St.	Active/Admitting
I	Meier, Angelena BCBA	1811707300	BHP	Kids Konnect ABA Therapy	Modoc	BCBA	Behavior Analy	12/09/2024	Yes	None	
I	Milanese, Dino R.,SUDRC	1225874514	W&R	Archway Recovery Services	Napa	Wellness and R	California Subs	07/02/2024	Yes	None	
I	Miller, Clara Doula	1609657535	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	
I	Minnal, Deepika MD	1568426161	PCP	Alliance Medical Center	Sonoma	Pediatrics	ABMS of Pedia	10/21/2003	Yes	Admitting Agre	None
R	Mohammed, Imran MD	1174625396	SPEC	Pulmonary Medicine Associ	Yolo	Pulmonary Dise	ABMS of Intern	10/26/2009	Yes	Sutter Roseville	Active
R	Moore, Rain B.,MD	1043419559	PCP	West County Health Center	Sonoma	Family Medicin	ABMS of Family	07/10/2009	Yes	Admitting Agre	None
I	Morales, Ciara BCBA	1013617380	BHP	Behavior Frontiers, LLC	Placer	BCBA	Behavior Analy	03/03/2025	Yes	None	
I	Morta, Mitchell FNP-C	1467812800	PCP	Shasta Community Health C	Shasra	Nurse Practitior	American Acad	02/24/2016	Yes	None	
R	Muller, Caroline BCBA	1083141386	BHP	Inclusive Education and Cor	Solano	BCBA	Behavior Analy	05/31/2015	Yes	None	
I	Murphy, Sarah A.,MD	1528384146	PCP	West County Health Center	Sonoma	Family Medicin	ABMS of Family	08/16/2013	Yes	Admitting Agre	None
I	Nigrini, Elisabeth MD	1689776684	SPEC	Barton Healthcare System	El Dorado	Obstetrics and	ABMS of Obste	12/09/2011	Yes	Barton Memoria	Active
I	Nordstrom, Meagan O.,MD	1265052849	PCP	Barton Healthcare System	El Dorado	Internal Medicir	ABMS of Intern	08/15/2024	Yes	Barton Memoria	Active
I	Norris, Jenifer E.,MD	1992765242	PCP	Barton Healthcare System	El Dorado	Family Medicin	ABMS of Family	07/11/1997	Yes	Barton Memoria	Active
I	Ochsner, Jenette CD	1407545817	DOULA	Loving Care Birth	Sutter	Certified Doula	DONA Internati	06/16/2021	Yes	None	
R	Ohnemus, Julie M.,MD	1770676306	PCP	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Family	07/12/1991	Yes	Mad River Com	Active
I	O'Keefe, Connor O.,PA-C	1851083430	SPEC	Bay Area Foot Care Inc	Placer	Physician Assis	National Comm	05/05/2023	Yes	None	
I	O'Loughlin, Amanda M.,DO	1649849225	PCP	Barton Healthcare System	El Dorado	Family Medicin	ABMS of Family	07/01/2024	Yes	Barton Memoria	Active
I	Ovalle, Alfredo MD	1235111022	PCP	OLE Health	Solano	Family Medicin	Meets MPCR#1	07/30/2005	No	Admitting Agre	None
R	Pardoe, Mark B.,MD	1407930209	SPEC	Providence Medical Group,	Humboldt	Plastic Surgery	ABMS of Plasti	11/13/2004	Yes	Providence St.	Active
I	Perryman, Alexis Doula	1902678246	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Petersen, Anna M.,FNP-C	1174245021	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	06/16/2022	Yes	None	
R	Petersen, Rachel L.,MD	1528353323	BOTH	Northeastern Rural Health C	Lassen	Family Practice	ABMS of Family	11/16/2015	Yes	Banner Lassen	Active
I	Pidermann, Barbara L.,FNP-C	1578529830	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	10/23/2013	Yes	Barton Memoria	Advanced Practice Professio
R	Pile, Elizabeth L.,FNP-BC	1881058022	PCP	Alliance Medical Center	Sonoma	Family Nurse P	American Nurse	06/01/2016	Yes	None	
I	Prasad, Shomal PA-C	1619713229	SPEC	Enloe Surgical Oncology	Butte	Physician Assis	National Comm	09/23/2024	Yes	None	
I	Protell, Tracy R.,MD	1629275235	PCP	Barton Healthcare System	El Dorado	Pediatrics	Meets MPCR#1	10/10/2011	Yes	Barton Memoria	Active
I	Raj, Rashpal S.,PA-C	1851320675	PCP	Ampla Health Yuba City	Sutter	Physician Assis	National Comm	12/17/1999	Yes	None	
R	Ramos, Madeleine S.,MD	1669431318	SPEC	Providence Medical Group,	Humboldt	Allergy & Immu	ABMS of Allerg	10/14/2005	Yes	St. Joseph Hos	Affiliate
R	Reddick, Adrienne FNP	1750997441	PCP	Elica Health Centers - North	Placer	Family Nurse P	American Nurse	08/04/2020	Yes	None	
R	Richert, Edward P.,MD	1376586529	PCP	Modoc Medical Clinic	Modoc	Family Medicin	ABMS of Family	07/08/1979	Yes	Admitting Agree	None
I	Robertson, Jay S.,DO	1467869354	SPEC	Sierra Medical Partnership	Placer	General Surger	American Oste	05/25/2021	Yes	Sutter Roseville	Active
R	Robison, Liliane FNP-C	1053890905	PCP	Mendocino Community Hea	Mendocino	Family Nurse P	American Acad	06/24/2018	Yes	None	
I	Rodriguez, Daniel PT	1700610698	Allied	Viviant Health - University P	Sacramento	Physical Thera	None		Not Applica	None	
I	Ross, John B.,FNP-C	1962251579	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	06/26/2024	Yes	Barton Memoria	Advanced Practice Professio
I	Rudick, Anthony J.,OD	1659502201	SPEC	Ampla Health Yuba City	Sutter	Retinal Myopati	None		No	Admitting Agree	None
I	Rudolph, Clare E.,MD	1902117732	SPEC	Barton Healthcare System	El Dorado	Obstetrics and	ABMS of Obste	12/09/2016	Yes	Barton Memoria	Active
I	Rushmer, Timothy J.,MD	1952895179	SPEC	Interventional Pain Solutions	Butte	Pain Medicine	Meets MPCR #		No	Enloe Medical C	Provisional
I	Russell, Craig S.,DC	1376613661	SPEC	Peach Tree Clinic - Spec	Yuba	Chiropractic	None		No	None	
R	Rydz, Thomas J.,MD	1184781536	SPEC	Providence Medical Group,	Humboldt	Surgery	ABMS of Surge	04/29/1991	Yes	St. Joseph Hos	Active
R	Saidel, Michael A.,MD	1184780330	SPEC	North Bay Eye Associates In	Sonoma	Ophthalmology	ABMS of Ophth	06/11/2006	Yes	Petaluma Valle	Active
R	Sampson, Alan D.,MD	1518046754	SPEC	Alan Sampson, MD	Lake	Ophthalmology	Confirmed per A		No	Sutter Lakeside	Active
I	Sandhu, Hardeep G.,DC	1912435637	SPEC	Ampla Health Yuba City	Sutter	Chiropractic	None		No	None	
I	Sandhu, Manjot BCBA	1477929453	Allied	Ages Learning Solutions LL	Solano	BCBA	Behavior Analy	10/23/2023	Yes	None	
I	Sarkarati, Minoo MD	1588026256	PCP	Lyon-Martin Community Hea	Solano	Internal Medicir	ABMS of Intern	08/17/2020	Yes	Admitting Agree	None
R	Savin, Luiza FNP-C	1982123170	PCP	Alliance Medical Center	Sonoma	Family Nurse P	American Acad	08/15/2017	Yes	None	
R	Scheidemann, Wayne H.,MD	1255332797	SPEC	Sutter Lakeside Community	Lake	Orthopaedic Su	Confirmed per A		No	Sutter Lakeside	Active
R	Schlatter, Margaret A.,MD	1063430031	SPEC	Providence Medical Group-	Napa	Neurology	ABMS of Psych	11/30/1989	Yes	Providence Qu	Active
I	Schrader, Lisa BCBA	1598030058	BHP	Pantogran LLC dba Center	Placer	BCBA	Behavior Analy	11/30/2007	Yes	None	
R	Shea, Brianne P.,PA-C	1841804754	PCP	Providence Medical Group -	Sonoma	Physician Assis	National Comm	12/17/2021	Yes	None	
R	Shepard, Mridu S.,FNP-C	1083085872	PCP	Community Medical Centers	Solano	Family Nurse P	American Acad	08/31/2015	Yes	None	
I	Shepard, William R.,DO	1427310895	SPEC	Barton Healthcare System	El Dorado	General Surger	American Oste	12/19/2018	Yes	Barton Memoria	Active
R	Shiu, Wilfred W.,MD	1619039716	SPEC	SCHC: Shasta Community I	Shasta	Public Health &	ABMS of Preve	01/15/2000	Yes	Admitting Agree	None
I	Simpson, Jennine BCBA	1972192474	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analy	05/31/2019	Yes	None	
R	Singh, Maneesh G.,MD	1225220114	SPEC	La Clinica - North Vallejo	Solano	Rheumatology	ABMS of Intern	10/18/2012	Yes	Admitting Agree	None
R	Sivamani, Raja K.,MD	1811197478	SPEC	Pacific Skin Institute	Yolo	Dermatology	ABMS of Derma	07/25/2013	Yes	Admitting Agree	None
I	Smeltzer, Cary L.,DO	1427366426	PCP	Anderson Valley Health Cer	Mendocino	Family Medicin	AOB-Family Me	12/07/2012	Yes	Admitting Agree	None
R	Smith, Donna L.,MD	1588700660	SPEC	Mendocino Community Hea	Mendocino	Obstetrics and	ABMS of Obste	11/17/1995	Yes	Adventist - Ukia	Active
I	Sneeringer, Mary R.,MD	1336350479	PCP	Barton Healthcare System	El Dorado	Pediatrics	ABMS of Pedia	10/27/2008	Yes	Barton Memoria	Active
R	Snow, Shanna R.,DO	1740483387	SPEC	NBHG: Center for Neuroscie	Solano	Obstetrics and	AOB of Obstetr	10/22/2011	Yes	North Bay Medi	Active Attending
I	Soroken, Sarah A.,LMFT	1992990857	Allied	Solano County Family Healt	Solano	License Marria	None		No	None	
R	Spahr, Madeline J.,CNM	1063921583	SPEC	Planned Parenthood Northe	Solano	Certified Nurse	American Midw	06/01/2017	Yes	None	
R	Staszel, Michael Z.,DO	1417917766	PCP	Michael Staszel, DO	Siskiyou	Family Medicin	Meets MPCR#1	10/06/1997	No	Mercy Medical	Active
R	Swenson, Richard E.,MD	1043301732	BOTH	Fairchild Medical Clinic (PC	Siskiyou	Family Medicin	Meets MPCR#1	07/09/1999	No	Fairchild Medic	Active
R	Tasista, Melissa D.,DO	1447273974	PCP	SCHC: Shasta Community I	Shasta	Family Medicin	ABMS of Family	12/09/2006	Yes	Admitting Agree	None
I	Tempelis, Colin PT	1689235111	Allied	Viviant Health - University P	Sacramento	Physical Thera	None		No	None	
R	Tew, Sean E.,SUDRC	1073258018	W&R	Aegis Treatment Center LLC	Humboldt	Wellness and R	California Subs	04/04/2025	Yes	None	
R	Thibert, Michael D.,PA-C	1659301208	SPEC	Fairchild Medical Clinic Spe	Siskiyou	Physician Assis	National Comm	01/22/1988	Yes	None	
RC	Ting, Tuow MD	1043244437	SPEC	Bay Area Retina Associates	Solano	Ophthalmology	ABMS of Ophth	05/13/2001	Yes	John Muir Medi	Courtesy
R	Tioran, Teresa A.,DO	1265420806	SPEC	Teresa Tioran, Inc	Shasta	Cardiovascular	ABMS of Intern	11/05/2003	No	Mercy Medical	Active
R	Tooma Rostamo, Sabrina BCBA	1336414994	BHP	Pantogran LLC dba Center	Solano	BCBA	Behavior Analy	01/31/2011	Yes	None	
I	Torres, Sasha BCBA	1497186738	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analy	09/30/2013	Yes	None	
R	Trevor, Everett D.,MD	1104931179	SPEC	Jiva Health, Inc- Redding	Shasta	Pulmonary Dise	ABMS of Intern	06/27/1978	Yes	Mercy Medical	Active
I	Usera, Brittni M.,MD	1497259337	SPEC	Grass Valley Radiation Onc	Nevada	Radiation Onco	ABMS of Radio	05/21/2024	Yes	Admitting Agree	None
R	Vallejo, Teresa BCBA	1063911253	BHP	Kyo Autism Therapy LLC, fk	Yolo	Behavioral Hea	Behavior Analy	11/09/2021	Yes	None	
I	Van Den Hengel-Gomez, Viridiana	1124871801	PCP	Winters Healthcare - Espart	Yolo	Physician Assis	National Comm	11/07/2024	Yes	None	
R	Van Kirk, Samuel D.,MD	1417052226	SPEC	Samuel Van Kirk MD	Shasta	Obstetrics and	ABMS of Obste	01/09/2004	Yes	Mercy Medical	Active

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Vazquez, Maria BCBA	1932917234	BHP	Ages Learning Solutions LL	Solano	BCBA	Behavior Analy	12/13/2024	Yes	None	
I	Vial, Kelly FNP-C	1447486295	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Acad	07/01/2009	Yes	None	
R	Villalobos, Joe L.,MD	1770502445	PCP	Redding Rancheria Tribal H	Shasta	Family Medicin	ABMS of Family	07/16/2004	Yes	Mercy Medical	Courtesy
I	Walsh, Leah J.,FNP-BC	1922643386	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Nurse	10/05/2019	Yes	None	
R	West, Kate E.,FNP-C	1295190890	PCP	MVHC - Weed Health Cente	Siskiyou	Family Nurse P	American Acad	11/25/2015	Yes	None	
I	Westphal, Denis R.,MD	1285640243	SPEC	Enloe Trauma & Surgery Cli	Butte	Vascular Surge	ABMS of Surge	05/14/1990	Yes	Enloe Medical (	Active
R	White, Robert A.,MD	1245435791	SPEC	Providence Medical Group,	Sonoma	Surgery	ABMS of Surge	06/07/1988	Yes	Santa Rosa Me	Active
I	Wonnacott, Matthew P.,MD	1144214495	PCP	Barton Healthcare System	El Dorado	Family Medicin	ABMS of Family	07/10/1998	Yes	Barton Healthca	Active
I	Wu, Tianyun LAc	1093031247	Allied	Heavenly Joy Natural Healt		Acupuncture	None		No	None	
I	Xiong, Glen L.,MD	1114945102	PCP	GENERATIVE HEALTH ME	Sacramento	SNFist	None		No	Admitting Agre	None
I	Young, David R.,MD	1952321598	SPEC	Barton Healthcare System	El Dorado	Cardiovascular	ABMS of Intern	10/26/2010	Yes	Barton Healthca	Active
I	Zeffaro, Lauren T.,FNP-BC	1811590813	PCP	Barton Healthcare System	El Dorado	Family Nurse P	American Nurse	01/29/2021	Yes	None	
I	Zheng, Wei MD	1881601789	SPEC	John Muir Specialty Medical	Solano	Urology	ABMS of Urolo	02/28/2003	Yes	John Muir Medi	Active
I	Zittel, Scott R.,DO	1881707545	SPEC	Enloe Wound/Ostomy & Hy	Butte	Wound Care	None		No	Admitting Agre	Active

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

Draft

Committee: Credentials Committee
Date: 06/11/2025 7:00 AM
Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Madeleine Ramos, MD*; Bradley Sandler, MD*; Brent Pottenger, MD

PHC Staff: Robert Moore, MD, MPH, MBA, PHC Chief Medical Officer; Marshall Kubota, MD* Associate Medical Director; Jeffery Ribordy, MD Medical Director; Lisa Ward, MD* Medical Director; Matthew Morris, MD* 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 Brambly, Credentialing Specialist I; Ashnilta Sen, Credentialing Specialist I

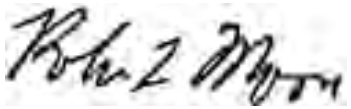
AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Chief Medical Officer Robert Moore, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by J'aime Seale Credentialing Team Lead. Dr. Moore reminded everyone that all items discussed are confidential. a. Robert Moore, MD, Chief Medical Officer reminded The Credentials Committee of who the voting members are, and voting is restricted to Non-PHC staff. Dr. Moore reminded the committee that all the information discussed is confidential in nature.			6/11/2025 6/11/2025
II. Review and approval of 5/14/2025 Credentials Meeting Minutes.	II. The Credentials Committee meeting minutes for 5/14/2025 were reviewed by the Committee.	II. Minutes were reviewed. A motion for approval of the minutes was made by Steven Gwiazdowski, MD and seconded by Brent Pottenger, MD. Meeting minutes were unanimously approved without changes.		6/11/2025
III. Old Business. a. Update on a provider	III. Old Business – a. Dr. Moore explained the old business for the provider. The provider has been placed on five-year probation by the Medical Board of California effective 8/19/2021. Running consecutively with the five-year probation is also a two-year probation and one-year probation effective dates 2/16/2024 and 4/10/2025. The Credentials Committee motioned for Partnership HealthPlan to reach out directly to the provider for more information due to	III. Old Business a. Old Business for a provider was reviewed by the committee. A motion to defer for the provider's response to Mark Netherda, MD's letter was made by Steven Gwiazdowski, MD and seconded by Madeleine Ramos, MD. Unanimously approved without changes.	7/9/2025	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	the Medical Board of California requested information received. Mark Netherda, MD composed a letter to the provider requesting further information and was sent to the provider on 6/5/2025. The Credentials Committee motioned to defer the provider to July in order to get a response.			
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Moore referred to the Credentials Committee to review the routine list of practitioners on pages 8-11 of the meeting packet.	a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Brent Pottenger, MD and seconded by Bradley Sandler, MD. The Committee unanimously approved the routine list.		6/11/2025
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Moore presented the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list on pages 12-14. These practitioners are approved by Robert Moore, MD pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the list of practitioners was made by Steven Gwiazdowski, MD and seconded by Madeleine Ramos, MD. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		6/11/2025
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by J'aime Seale Credentialing Team Lead. Policies MPCR300 – Physician Credentialing and Re-credentialing Requirements, MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements, MPCR302 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements, MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements and MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements were presented to the Committee. J'aime explained each policy was updated with current 2025 NCQA dates and elements revising 180 days compliance to 120 days compliance. There was also a revision source	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Brent Pottenger, MD and seconded by Steven Gwiazdowski, MD. The Committee unanimously approved the revised policies.		6/11/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	of Medi-Cal Verification.			
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions Report.	a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report on pages 50-51.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Madeleine Ramos, MD and seconded by David Gorchoff, MD. The Committee unanimously approved.		6/11/2025
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring List on pages 52-53. Dr. Moore reminded the committee that the credentialing department monitors these boards for any actions regarding our providers. Dr. Pottenger inquired on the red highlighted line on the Monitoring List. J'aime commented to Dr. Pottenger that highlighted names red normally represent providers who are no longer with their group or monitored. Dr. Moore explained that the color key on the monitoring list will be updated to show red color jurisdiction. *Informational Only.*	b. *Informational only*.		6/11/2025
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a. Dr. Moore asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list on pages 54-55. Dr. Gwiazdowski asked why other bigger groups such as North Bay are not on the list. Dr. Moore explained that groups are presented on this list when they are either being initial credentialed or re-credentialed.	a/b/c. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Steven Gwiazdowski, MD and seconded by Madeleine Ramos, MD. The Credentialing Committee unanimously approved.		6/11/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
b. 1st Quarter Delegated Credentialing ICE Audits. c. Annual Delegation Audits.	b. Dr. Moore Presented the 1st Quarter Delegated Credentialing ICE Audits. These are delegated entities who credential their files and Partnership Compliance reviews and Audits them. The Delegated entities reviewed in the 1st Quarter are: Carelon Behavioral Health, Woodland Clinic Medical Group, Dignity Health Medical Group – North State, Mercy Medical Group, Lucile Packard Children's Hospital, Sutter Medical Group – Yolo, Sacramento/Placer, Solano, Sutter Pacific Medical Foundation – Sutter West Bay Medical Group Employed, Mills Peninsula Medical Group, Palo Alto Medical Foundation, Sutter East Bay Medical Foundation - CPN, Employed, Sutter Medical Group of the Redwoods – CPN, Employed, Sutter West Bay Medical Group – CPN, University of California Davis Health and University of California San Francisco Medical Group. c. Dr. Moore presented the Annual Delegation Audit for Vision Service Plan (VSP) was presented to the Credentials Committee for review.			
VII. Meeting Adjourned.	VII. Meeting adjourned.			6/11/2025

Credentials Meeting Minutes for 6/11/2025 respectfully prepared and submitted by J'aime Seale Credentialing Team Lead.



6/11/2025

Chairman Signature of Approval _____ ***Date***_____

Robert Moore, M.D., *Partnership HealthPlan* MPH, MBA, PHC Chief Medical Officer

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Akhimien, Patience R.,FNP	1346617594	PCP	Feather River Tribal Health (	Butte	Family Nurse P	American Acad	05/13/2015	Yes	None	
R	Amacher, Kathryn M.,DO	1366545568	SPEC	Kathryn Amacher, D.O.	Solano	SNFist	None		No	Northbay Medic	Active Non-Attending
R	Anagnostou, Anthony A.,MD	1427450568	SPEC	Providence Medical Group, I	Humboldt	General Surger	ABMS of Surge	06/05/2019	Yes	Providence St. .	Active
I	Andemariam, Lydia G., FNP-C	1114736667	SPEC	West Coast Kidney	Solano	Family Nurse P	American Acad	06/17/2024	Yes	None	
I	Andersen, Jessica PA-C	1184327868	PCP	Open Door Community Heal	Humboldt	Physician Assis	National Comm	09/05/2023	Yes	None	
I	Anudokem, Nkiruka D.,PA-C	1770230021	PCP	Solano County Family Healt	Solano	Physician Assis	National Comm	09/03/2024	Yes	None	
I	Arana, Miriam E., PA-C	1144460130	PCP	Canby Family Practice Clinic	Modoc	Physician Assis	National Comm	05/26/2009	Yes	None	
I	Arnold, Monica BCBA	1285122796	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	11/30/2019	Yes	None	
I	Aros, Jennifer M.,BCBA	1558772251	BHP	BM Behavioral Center, LLC	Solano	Board Certified	Behavior Analys	08/31/2019	Yes	None	
I	Athwal, Pardeep S.,MD	1659697092	SPEC	ARIA Vascular	San Joaquin	Diagnostic Radi	ABMS of Radio	10/21/2017	Yes	Admitting Agree	None
I	Atreya, Prerana BCBA	1245084227	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	07/31/2024	Yes	None	
I	Avalos, Stacy Doula	1255075909	SPEC	Rooted Willows Services, In	Santa Clara	Doula	None		No	None	
I	Banaie, Ali MD	1386613206	SPEC	Providence Medical Group- I	Napa	Gastroenterolo	ABMS of Interna	11/03/2004	Yes	Queen of the V	Provisional
R	Barkdull, Gregory C.,MD	1962418806	SPEC	Providence Medical Group, I	Humboldt	Otolaryngology,	ABMS of Otolar	06/01/2011	Yes	Redwood Mem	Active
I	Barnett, Natalie PA-C	1124730403	SPEC	Adventist Health	Butte	Physician Assis	National Comm	03/08/2024	Yes	None	
R	Baron, John P.,DO	1861471591	SPEC	East Bay Nephrology Medic	Solano	Nephrology	ABMS of Interna	11/20/2007	Yes	Alta Bates Sum	Active
I	Baumann, Amanda M.,PA-C	1174360408	SPEC	Providence Medical Group, S	Sonoma	Physician Assis	National Comm	01/15/2025	Yes	None	
I	Bautista, Gerjel A., FMP-C	1992573984	PCP	Parkhill Health Inc dba AFC	Solano	Family Nurse P	American Acad	10/31/2023	Yes	None	
R	Benedict, Carmen L.,BCBA	1639767510	BHP	Autism Advocacy and Interv	Lake	BCBA	Behavior Analys	08/31/2019	Yes	None	
I	Bennett, Erin M.,FNP	1790181816	SPEC	Adventist Health Clearlake	Lake	Family Nurse P	American Acad	06/17/2020	Yes	Adventist Healt	NURSE PRACTIONER
R	Bergstrom, Richard T.,MD	1679557367	SPEC	Richard Bergstrom, MD	Shasta	Otolaryngology,	ABMS of Otolar	05/25/2004	Yes	Mercy Medical (	Active
R	Bernett, Jorge R.,MD	1366460081	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	11/19/1997	Yes	John Muir Medi	Active
R	Berry, Ashley Psy.D	1790913960	BHP	Jigsaw Diagnostics	Solano	Behavioral Hea	None		No	None	
I	Berry, Janay BCBA	1679107635	BHP	Center for Social Dynamics,	Sonoma	BCBA	Behavior Analys	02/14/2025	Yes	None	
I	Bettencourt, Bailey BCBA	1285207696	BHP	Momentum Behavior Service	Sonoma	BCBA	Behavior Analys	11/06/2024	Yes	None	
I	Blecha, Tami I.,FNP-C	1578156402	SPEC	TeleMed2U	Yolo	Family Nurse P	American Acad	12/08/2020	Yes	None	
R	Bloch, Jonathan H.,DO	1073635967	PCP	Open Door Community Heal	Humboldt	Family Medicine	AOB-Family Me	09/22/2005	Yes	Admitting Agree	None
I	Borge, David J.,MD	1013980481	SPEC	Alliance Medical Center	Sonoma	Obstetrics and (				Admitting Agree	None
R	Brown, Dean B.,PA-C	1417960352	PCP	Northeastern Rural Health C	Lassen	Physician Assis	National Comm	12/30/1966	Yes	None	
I	Brown, Mary K.,MD	1073559704	PCP	Santa Rosa Community Hea	Sonoma	Pediatrics	ABMS of Pediat	10/09/1996	Yes	Admitting Agree	None
R	Brusett, Kent A.,MD	1245234962	SPEC	Kent Brusett, MD	Shasta	Thoracic & Car	ABMS of Thora	06/05/1998	Yes	Shasta Regiona	Active
R	Bullock, Daniel W.,MD	1952383929	SPEC	Fairchild Medical Clinic Spe	Siskiyou	Orthopaedic Su	ABMS of Orthop	07/27/1984	Yes	Fairchild Medic	Courtesy Consulting
R	Burns, Aileen M.,PA-C	1508115841	PCP	Aegis Treatment Center LLC	Humboldt	Wellness and R	None		No	None	
I	Cab, Miguel BCBA	1316543267	BHP	Family First	Butte	BCBA	Behavior Analys	09/06/2024	Yes	None	
R	Caltaru, Daniela MD	1346234762	SPEC	SCHC: Shasta Community H	Shasta	Neurology	ABMS of Psych	09/30/2002	Yes	Admitting Agree	None
R	Carlson, William P.,MD	1760426761	PCP	Open Door Community Heal	Humboldt	Family Medicine	Meets MPCR#1	08/27/1978	No	Admitting Agree	None
I	Carpenter, Cloe J.,Doula	1912735606	SPEC	Cloe Carpenter Doula	Shasta	Doula	None		No	None	
R	Cataldo, Stuart D.,MD	1962507590	PCP	Providence Medical Group, I	Humboldt	Internal Medicin	ABMS of Interna	08/21/2001	Yes	Admitting Agree	None
I	Champagne, Melody M.,RD	1437306016	Allied	Vayu Health	Solano	Registered Diet	Commission of	09/14/2007	Yes	None	
R	Chandramouli, Bukkambudhi V.,MD	1871607796	SPEC	BV Chandramouli, MD	Shasta	Cardiovascular	ABMS of Interna	11/05/1998	Yes	Shasta Regiona	Active
R	Chang, Tony L.,MD	1871784678	SPEC	Shasta Orthopedics & Sport	Shasta	Sports Medicine	ABMS of Family	12/04/2010	Yes	Mercy Medical (	Active
R	Cheng, Jennifer W.,DO	1669791612	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	11/07/2016	Yes	John Muir Medi	Active
R	Chesney, Kathleen B.,PA-C	1528144912	SPEC	Lassen Medical Clinic- Red I	Shasta	Physician Assis	National Comm	10/13/2011	Yes	None	
I	Ciantar, Ryan FNP-C	1861187007	PCP	Modoc Medical Clinic	Modoc	Nurse Practitior	American Acad	10/29/2024	Yes	None	
I	Clement, Micah C.,PA-C	1073991287	SPEC	Recover Medical Group	Solano	Physician Assis	National Comm	01/28/2016	Yes	None	
I	Clow, Selina C.,FNP-C	1821371923	PCP	Karuk Tribal Health Clinic	Siskiyou	Family Nurse P	American Acad	07/01/2011	Yes	None	
I	Clower, Jessica N.,Doula	1902621113	SPEC	Jessica Clower/A New Begir		Doula	None		No	None	
R	Cobb, Luther F.,MD	1386668481	SPEC	Luther Cobb, MD	Humboldt	Surgery	Previously Boar	05/29/1986	No	Mad River Com	Active
R	Coe, John L.,MD	1043304512	PCP	SCHC: Shasta Community H	Shasta	Family Medicine	ABMS of Family	07/10/1987	Yes	Mercy Medical (	Active
R	Cole, Danielle L.,FNP-C	1427520550	PCP	Open Door Community Heal	Humboldt	Family Nurse P	American Acad	09/17/2018	Yes	None	
I	Collman, Mitchell S., MD	1962454884	SPEC	Providence Medical Group, I	Humboldt	Cardiology	ABMS of Interna	09/15/1982	Yes	Admitting Agree	None
R	Colton House, Joyce H.,MD	1891960597	SPEC	BASS Medical Group dba Na	Napa	Otolaryngology	ABMS of Otolar	06/01/2014	Yes	Queen of the V	Active
I	Corona, Pablo S.,FNP-C	1538998034	PCP	Santa Rosa Community Hea	Sonoma	Family Nurse P	American Acad	10/05/2023	Yes	None	
R	Couch, Richard BCBA	1437514114	BHP	BM Behavioral Center, LLC	Solano	Behavioral Hea	Behavior Analys	05/31/2015	Yes	None	
I	Cullum, Pamela Doula	1962227819	SPEC	Pamela Cullum	Sonoma	Doula	None		No	None	
I	Culp, Dana R.,FNP	1699213967	PCP	Plumas Rural Health Center	Plumas	Family Nurse P	American Acad	11/12/2018	Yes	None	
I	Daly, Noelle E.,PA	1033931811	PCP	Sonoma County Indian Heal	Sonoma	Physician Assis	National Comm	10/30/2024	Yes	None	
I	Danial, Erin M.,ANP-BC	1154757755	BOTH	Providence Medical Group, S	Sonoma	Adult Nurse Pra	American Nurse	09/09/2013	Yes	None	
I	Davis Del Castillo, Venetta CATC	1508374091	W&R	Aegis Treatment Centers, LL	Shasta	Wellness and R	California Asso	11/12/2020	Yes	None	
I	Davis, Graham E.,MD	1114423811	SPEC	Adventist Health Howard Me	Mendocino	Surgery	ABMS of Surge	10/17/2023	Yes	Adventist - How	Provisional
I	Debian, Khaldoun A.,MD	1932168796	SPEC	Providence Medical Group, I	Humboldt	Gastroenterolo	ABMS of Interna	11/06/2002	Yes	Admitting Agree	None
I	Del Biaggio, Katrina R.,PA-C	1295301844	SPEC	North Pacific Dermatology	Humboldt	Physician Assis	National Comm	05/11/2021	Yes	None	
I	Denisova, Elizabeth DO	1205456191	SPEC	Oroville Women's Health	Butte	Obstetrics and (	None		No	Admitting Agree	None
R	Ditchey, Roy V.,MD	1629044235	SPEC	Roy Ditchey, MD., Inc	Shasta	Cardiovascular	ABMS of Interna	06/19/1979	Yes	Admitting Agree	None

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Dominguez, Antonio BCBA	1679107155	BHP	Learning Arts	Yolo	BCBA	None	02/27/2025	Yes	None	
I	Dorame, Whitney A.,CRNA	1992358105	SPEC	Green Anesthesia	Solano	Certified Regist	National Board	07/02/2019	Yes	Admitting Agree	None
R	Duel, Daniel A.,MD	1184100752	W&R	Recover Medical Group	Solano	Wellness and R	None		No	Admitting Agree	None
R	Duncan, Vicki L.,MD	1235230798	SPEC	Marin Pregnancy Clinic- Obs	Marin	Obstetrics and (	ABMS of Obste	12/11/1992	Yes	Admitting Agree	None
R	Einsele, Peggy M.,FNP-C	1194185397	PCP	Karuk Tribal Health Clinic, Y	Siskiyou	Family Nurse P	American Acad	11/13/2024	Yes	None	
I	Elkhoury, Nabil G.,MD	1699965228	SPEC	Sutter Lakeside Community	Lake	Obstetrics and (	ABMS of Obste	01/18/2013	Yes	Sutter Lakeside	Active
R	Estevo, Dana L.,CNM	1730412941	SPEC	Mendocino Community Heal	Mendocino	Certified Nurse	American Midw	01/01/2009	Yes	None	
I	Faucett-Maples, Elayne M.,FNP-C	1659901239	SPEC	NBHG: Center for Primary C	Napa	Family Nurse P	American Acad	06/06/2019	Yes	None	
I	Finn, Joseph BCBA	1730766767	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	04/23/2021	Yes	None	
I	Fitzgerald, Julie E.,PA-C	1982987749	PCP	SCHC: Shasta Community H	Shasta	Physician Assis	National Comm	09/15/2011	Yes	None	
I	Flores-Piegdon, Angelica F.,PA-C	1023721032	PCP	Plumas Rural Health Center	Plumas	Physician Assis	National Comm	02/21/2023	Yes	None	
R	Friesch, Catherine C.,ACNP-BC	1669730230	SPEC	Providence Medical Group, S	Sonoma	Acute Care Nur	American Nurse	03/25/2009	Yes	None	
I	Frye, Patricia MD	1295106078	PCP	La Clinica Oakley	Solano	Pediatrics	ABMS of Pedia	06/22/1986	Yes	Admitting Agree	None
I	Gaddies, Loretta H.,Doula	1912734187	SPEC	Essence of a Doula		Certified Doula	None		No	None	
I	Garcia-Hallman, Jessica Doula	1467263947	SPEC	Activating Light Studio, LLC	Unknown	Doula				None	
I	Garfield, Jennifer BCBA	1255835971	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	08/14/2021	Yes	None	
I	Garvey, Sarah AUD	1811792054	Allied	Sacramento Ear, Nose & Th	San Joaquin	Audiology	None		Not Applica	None	
I	Garza, Dean FNP-C	1568079473	PCP	Mendocino Community Heal	Mendocino	Family Nurse P	American Acad	06/12/2020	Yes	None	
I	Gichuru, Milcah W.,FNP-BC	1700132941	PCP	Sutter Lakeside Medical Pra	Lake	Family Nurse P	American Nurse	09/07/2012	Yes	None	
I	Given, Katherine M.,MD	1124476296	SPEC	Redwood Family Dermatolo	Sonoma	Dermatology	ABMS of Derma	10/24/2020	Yes	Admitting Agree	None
I	Godzich, Micaela C.,MD	1841422599	PCP	One Community Health - Inf	Yolo	Family Medicine	ABMS of Family	07/09/2011	Yes	Admitting Agree	Active
R	Gonzalez, Daniel M.,MD	1861998650	BOTH	Redwood Orthopaedic Surg	Sonoma	Orthopaedics	None		No	Providence San	Active
I	Greacen, Madelaine M.,MD	1881182624	PCP	Providence Medical Group, S	Sonoma	Family Medicine	ABMS of Family	06/29/2021	Yes	Admitting Agree	None
I	Hagele, John E.,MD	1134200629	SPEC	Sierra View Medical Eye, Inc	Nevada	Ophthalmology	ABMS of Ophth	05/07/2000	Yes	Admitting Agree	None
R	Hamilton, Julie H.,MD	1700813425	SPEC	Julie Hamilton, MD	Shasta	Wound Care	None		No	Mercy Medical (	Courtesy
R	Hanlan, Margo E.,PPCNP-BC	1891034328	PCP	Tamalpais Pediatrics	Marin	Pediatric Prima	American Nurse	08/21/2012	Yes	None	
R	Harwood, Daniel W.,MD	1386646180	SPEC	Trinity Community Health Cl	Trinity	Surgery	Previously Boar	03/30/1987	No	Admitting Agree	None
R	Helms, Ileana A.,MD	1225039142	SPEC	Bay Area Surgical Specialist	Contra Costa	Nephrology	ABMS of Interna	11/10/1994	No	John Muir Medi	Active
R	Hernandez, Tania BCBA	1396246351	BHP	ACES 2020 LLC	Solano	BCBA	Behavior Analys	03/25/2022	Yes	None	
R	Herold, Amy M.,MD	1871779017	SPEC	Providence Medical Group- I	Napa	Obstetrics and (	ABMS of Obste	12/07/2012	Yes	Admitting Agree	None
R	Higer, Deborah A.,MD	1437245701	PCP	Shasta Family Care - RHC	Siskiyou	Family Medicine	ABMS of Family	07/09/1993	Yes	Mercy Medical (	Active
I	Hill-Falkenthal, Ryan PA-C	1437780665	SPEC	Napa Valley Orthopaedic Me	Napa	Physician Assis	National Comm	01/21/2020	Yes	None	
R	Hoffman, Amber E.,FNP-BC	1174651913	SPEC	Providence Medical Group, I	Humboldt	Family Nurse P	American Nurse	07/27/2015	Yes	None	
I	Horne, Amanda J.,PA-C	1598389124	PCP	One Community Health - Inf	Yolo	Physician Assis	National Comm	08/25/2020	Yes	None	
I	Jancic, Augustina T.,FNP-BC	1760205017	PCP	Providence Medical Group -	Napa	Family Nurse P	American Nurse	11/06/2024	Yes	None	
I	Javed, Maham PA-C	1780480764	PCP	Communicare OLE Travis	Solano	Physician Assis	National Comm	11/15/2024	Yes	None	
I	Johnson, Brett A.,DO	1265876171	PCP	California Medical Center	Yolo	Family Medicine	Meets MPCR#1	08/05/2016	No	Admitting Agree	None
I	Johnson, Shalee RADT	1710783154	W&R	Humboldt Recovery Center	Humboldt	Registered Alco	California Cons	02/26/2025	Yes	None	
R	Joling, Shantel N.,PA-C	1659605327	PCP	Fairchild Medical Clinic (PCF	Siskiyou	Physician Assis	National Comm	08/13/2009	Yes	None	
I	Katz, Julia L.,FNP-BC	1982468583	PCP	Santa Rosa Community Hea	Sonoma	Family Nurse P	American Nurse	12/27/2023	Yes	None	
R	Kelly, Casey N.,PA-C	1205076015	PCP	Open Door Community Heal	Humboldt	Physician Assis	National Comm	01/22/2009	Yes	None	
I	Khanna, Pavan MD	1891936795	SPEC	ARIA Vascular	San Joaquin	Vascular & Inte	None		No	St Joseph Medi	Active
I	Kheterpal, Meenal K., MD	1700013174	SPEC	Direct Dermatology Professi	Solano	Dermatology	ABMS of Derma	07/25/2013	Yes	Admitting Agree	None
R	Kiener, David J.,MD	1770605495	SPEC	Dermatology Center @ Sacr	Yolo	Otolaryngology	ABMS of Otolar	10/18/1980	Yes	Sutter Roseville	Active
R	Kingsley, Michael C.,DO	1427078393	PCP	Redding Rancheria: Churn C	Shasta	Family Medicine	ABMS of Family	07/16/2004	Yes	Admitting Agree	None
I	Klammer, Veronica C., DO	1821356197	PCP	Ole Health	Napa	Pediatrics	American Oste	08/02/2017	Yes	Admitting Agree	None
I	Knapp, Shannon E.,SLP	1437422060	Allied	Proficio Speech Therapy Gr	Solano	Speech & Lang	None		No	None	
I	Ko, Harry S., DO	1578678728	PCP	Feather River Tribal Health (	Butte	Family Medicine	ABMS of Family	07/09/1999	Yes	Admitting Agree	None
I	Kobe, Christopher L.,DC	1912931197	SPEC	Shasta Lake Chiropractic	Shasta	Chiropractic	None		Not Applica	Admitting Agree	None
R	Krouse, Donald E.,MD	1710977079	PCP	Trinity Community Health Cl	Trinity	Family Medicine	ABMS of Family	07/12/1985	Yes	Trinity Hospital	Active
I	Ladegast, Sherrie L.,FNP-C	1578920955	SPEC	NorthBay Health Urgent Car	Solano	Family Nurse P	American Acad	04/05/2016	Yes	None	
R	Lahsaei, Saba MD	1205141322	SPEC	NBHG: Heart and Vascular	Solano	Cardiovascular	ABMS of Interna	09/26/2017	Yes	Admitting Agree	None
R	Lai, Nina Y.,PA-C	1093254674	SPEC	Redwood Family Dermatolo	Sonoma	Physician Assis	National Comm	01/26/2017	Yes	None	
I	Le, John N.,DO	1366591695	PCP	Woodland Dermatology & Sl	Yolo	Dermatology	None		No	Admitting Agree	Active
I	Leasure, Jordyn BCBA	1356728133	BHP	Pantogran LLC dba Center	Yolo	BCBA	Behavior Analys	05/31/2017	Yes	None	
I	Lewis, Tiffany R.,MD	1902124241	SPEC	NorthBay Health Urgent Car	Solano	Emergency Me	ABMS of Emerg	11/17/2017	Yes	NorthBay Medic	Active Attending
R	L'Heraux, Crystine T.,FNP-C	1255838603	PCP	Adventist Health Clearlake	Lake	Family Nurse P	American Acad	03/06/2018	Yes	None	
R	Linn, Andrew J.,MD	1093908832	SPEC	Advanced Pain Managemen	Solano	Anesthesiology	ABMS of Anestl	04/24/2009	Yes	Admitting Agree	None
I	Lubans Dehaven, Tesa L.,LM	1396403606	SPEC	Family First Maternity Cente	Shasta	Licensed Midwi			No	None	
I	Ly, Karrie V.,PA-C	1598383382	SPEC	ARIA Vascular	San Joaquin	Physician Assis	National Comm	09/15/2020	Yes	None	
I	Maeda, Nicole W.,BCBA	1003585977	BHP	Momentum Behavior Service	Sonoma	BCBA	Behavior Analys	09/08/2021	Yes	None	
I	Maine, Heather L.,FNP-BC	1689472342	PCP	Providence Medical Group- I	Napa	Family Nurse P	American Nurse	01/10/2024	Yes	None	
I	Maithel, Shelley MD	1043694904	SPEC	ARIA Vascular	San Joaquin	Vascular Surge	ABMS of Surge	05/14/2024	Yes	Admitting Agree	None
R	Martinez, Antoinette P.,MD	1891855052	SPEC	UIHS - Potawot Health Villa	Humboldt	Obstetrics and (	None		No	Admitting Agree	None

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Mason, Shannon J.,Doula	1144020280	SPEC	Shannon Mason Doula Serv	Shasta	Doula	None		No	None	
R	Mathew, Allen S.,MD	1417053075	SPEC	Redwood Renal Associates	Humboldt	Nephrology	ABMS of Interna	11/01/1988	Yes	St. Joseph Hos	Active
R	Matthews, Richard D.,MD	1841450145	SPEC	Valor Oncolcogy - Chico	Butte	Colon and Rect	ABMS of Colon	09/17/2011	Yes	Admitting Agree	None
R	Matulich, Melissa C.,MD	1841568664	SPEC	Planned Parenthood Northe	Contra Costa	Complex Family	ABMS of Obste	07/29/2022	No	Admitting Agree	None
I	McAllister, Mark A.,MD	1669934394	SPEC	Retinal Consultants Medical	Yolo	Ophthalmology	ABMS of Ophth	06/07/2024	Yes	Admitting Agree	None
I	McManus, Jennifer SUDC I	1811563166	W&R	Recover Medical Group	Solano	Substance Use	California Subst	06/04/2024	Yes	None	
I	Mehta, Sahil MD	1043426265	SPEC	Providence Medical Group, I	Humboldt	Cardiology	ABMS of Interna	11/02/2012	Yes	Admitting Agree	None
R	Mendenhall, Dale W.,PT	1740453398	Allied	Rolling Hills Clinic	Shasta	Physical Therap	None		No	None	
I	Mercer, Keith B.,MD	1568543049	SPEC	Sierra View Medical Eye, Inc	Nevada	Ophthalmology	ABMS of Ophth	05/08/1983	Yes	Admitting Agree	None
R	Miller, Kevin M.,DPM	1982851549	SPEC	NBHG: Orthopaedics and Pc	Solano	Podiatry Foot a	None		No	NorthBay Medic	Active Attending
I	Miller, Susan K., FNP-C	1134560691	PCP	Shingletown Medical Center	Shasta	Family Nurse P	American Acad	09/10/2014	Yes	None	
R	Mishra-Shukla, Nimisha MD	1487843942	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	10/30/2007	Yes	John Muir Medi	Active
I	Mittal, Manoj K.,MD	1528220720	SPEC	Pulmonary Medicine Associa	Yolo	Neurology	ABMS of Psych	09/22/2011	Yes	Sutter Roseville	Consulting
I	Mohammed, Larai Doula	1275380651	SPEC	Loula Perinatal Health Servi	Solano	Doula	None		No	None	
I	Molina, Frank A.,AGPCNP-BC	1316519341	PCP	One Community Health - Infi	Yolo	Adult-Gerontolo	American Nurse	07/22/2021	Yes	None	
R	Monroe, Forrest R.,MD	1114362019	SPEC	Shasta Orthopedics & Sport	Shasta	Pain Medicine	ABMS of Anestl	09/15/2018	Yes	Shasta Regiona	Courtesy
I	Morales, Gemekia L.,FNP-C	1114528817	SPEC	ARIA Vascular	San Joaquin	Family Nurse P	American Acad	07/13/2020	Yes	None	
I	Moser, Caroline PA-C	1518646397	SPEC	Woodland Dermatology & Sl	Yolo	Physician Assis	National Comm	06/30/2023	Yes	None	
I	Mundh, Camille L.,FNP-C	1083322168	PCP	Feather River Health Solutio	Sutter	Family Nurse P	American Acad	08/30/2022	Yes	None	
R	Murphy, James T.,MD	1578544755	PCP	Alexander Valley Health Cer	Sonoma	Family Medicine	Meets MPCR#1	07/08/1979	No	Admitting Agree	None
R	Namihas, Steven C.,MD	1831293083	PCP	SCHC: Shasta Community H	Shasta	Family Medicine	ABMS of Family	07/13/1990	Yes	Mercy Medical (	Active
I	Ngotho, Alex K.,RN	1912593641	PCP	Alex K Ngotho	Placer	Registered Nur	None		No	None	
I	Nolan, Gary W.,DC	1902934193	SPEC	One Community Health - Infi	Yolo	Chiropractic	None		No	None	
R	Nord, Kelly BCBA	1356479927	BHP	Multiplicity Therapeutic Serv	Humboldt	BCBA	Behavior Analys	03/28/2022	Yes	None	
R	O'Brien, Jonathan PA-C	1851872378	PCP	Elica Health Centers - North	Placer	Physician Assis	National Comm	09/20/2018	Yes	None	
R	Okonski, Gisela C., MD	1518926559	SPEC	Redding Heart	Shasta	Cardiovascular	Meets MPCR#17, Completed Phy		No	None	
R	Omekam, Ofunneka P.,RD	1942941455	Allied	Community Medical Centers	Solano	Registered Diet	Commission of	08/31/2022	Yes	None	
I	Ortiz, Michelle R.,SUDRC	1003550518	W&R	MedMark Treatment Centers	Solano	Substance Use	California Subst	08/31/2024	Yes	None	
I	Ortiz-Lopez, Julio A.,BCBA	1821759077	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analys	03/19/2025	Yes	None	
R	Palmer, Michael A.,MD	1669539862	SPEC	North Coast Surgical Specia	Humboldt	Surgery	ABMS of Surge	05/04/1983	Yes	Mad River Com	Active
R	Pandya, Shalin R.,DO	1659759512	SPEC	Sacramento Ear Nose and T	Yolo	Allergy & Immu	ABMS of Allergy	11/30/2022	Yes	Admitting Agree	None
I	Panza, Eileen R.,PA-C	1497219141	SPEC	Planned Parenthood Northe	Humboldt	Physician Assis	National Comm	01/16/2019	Yes	None	
R	Park, Jeong S.,MD	1528078961	SPEC	Adventist Health Clearlake -	Lake	Cardiovascular	ABMS of Interna	11/06/1991	Yes	Adventist Healtl	Active
I	Parker, Margaret PMHNP-BC	1144791716	SPEC	TeleMed2U	Yolo	Psychiatric Mer	American Nurse	10/25/2018	Yes	None	
I	Patel, Aarti BCBA	1881226033	BHP	Momentum Behavior Service	Sonoma	BCABA	Behavior Analys	12/20/2024	Yes	None	
R	Pearson, Clint T.,MD	1659464113	PCP	Open Door Community Heal	Del Norte	Family Medicine	Meets MPCR#1	07/09/1999	Yes	Sutter Coast Hc	Active Office-Based
I	Pellizzon, Julianne BCBA	1093319360	BHP	Autism Behavior Services In	Yolo	BCBA	Behavior Analys	07/08/2024	Yes	None	
R	Perlroth, Joshua D.,MD	1881807006	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	10/30/2007	Yes	John Muir Medi	Active
R	Powell, Jennifer BCBA	1578691655	BHP	Lost Coast Family Therapy I	Humboldt	BCBA	Behavior Analys	11/30/2014	Yes	None	
R	Purcell, Joseph P.,DO	1326227901	SPEC	Redding Spine and Sports M	Shasta	Physical Medici	ABMS of Physic	07/01/2009	Yes	Shasta Regiona	Affiliate Staff
I	Qaseem, Yasmin MD	1396107314	SPEC	TeleMed2U	Yolo	Dermatology	ABMS of Derma	10/24/2020	Yes	Admitting Agree	None
I	Randolph, Amelia MD	1093739708	PCP	Mendonoma Health Alliance	Mendocino	Family Medicine	ABMS of Family	07/11/2003	Yes	Sonoma Valley	Active
R	Reece, Ronald E.,MD	1144288523	SPEC	Ronald E. Reece, MD.	Shasta	Dermatology	ABMS of Derma	11/03/1986	Yes	Mercy Medical (	Courtesy
R	Ridge, Jeffrey D.,FNP-C	1083180533	PCP	McCloud Healthcare Clinic	Siskiyou	Family Nurse P	American Acad	09/18/2018	Yes	None	
I	Robinson, Khadija S.,FNP-C	1467728444	PCP	NorthBay Health Urgent Car	Solano	Family Nurse P	American Acad	12/01/2010	Yes	None	
R	Ross, Summer L.,PA-C	1699897165	PCP	Redding Rancheria: Churn C	Shasta	Physician Assis	National Comm	10/07/2004	Yes	None	
I	Satterwhite, Shannon M.,MD	1154907244	PCP	One Community Health - Infi	Yolo	Family Medicine	ABMS of Family	07/01/2024	Yes	Admitting Agree	Active
R	Scher, Sarah A.,MD	1437246295	PCP	Open Door Community Heal	Humboldt	Family Medicine	ABMS of Family	07/13/1990	Yes	Admitting Agree	None
I	Seer, NFN MD	1710513692	PCP	Lyon-Martin Community Hea	Solano	Family Medicine	ABMS of Family	08/29/2023	Yes	Admitting Agree	None
I	Sendon, Faith BCBA	1578040390	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analys	03/19/2025	Yes	None	
R	Serna, Stephanie PA-C	1245759810	SPEC	Napa Valley Orthopaedic Me	Napa	Physician Assis	National Comm	08/28/2017	Yes	None	
I	Setzfant, Sara K.,LCSW	1770245896	Allied	Northern Valley Indian Healt	Butte	Licensed Clinic	None		No	None	
I	Shahedi, Shannaleah PA-C	1255071981	PCP	Ritter Health Center	Marin	Physician Assis	National Comm	08/27/2024	Yes	None	
R	Sharma, Konark MD	1114975562	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	10/11/2012	Yes	John Muir Medi	Active
I	Sheehy, Danielle M.,FNP-C	1134932569	PCP	Providence Medical Group, I	Humboldt	Family Nurse P	American Acad	10/23/2024	Yes	None	
R	Shoop, Lee E.,MD	1023143146	PCP	Rolling Hills Clinic - PCP	Tehama	Family Medicine	ABMS of Family	07/08/1988	Yes	St Elizabeth Co	Active
I	Sizer, Emily C., PA-C	1164170064	SPEC	TeleMed2U	Yolo	Physician Assis	National Comm	02/15/2022	Yes	None	
R	Silkiss, Rona Z.,MD	1790758209	SPEC	North Bay Eye Associates In	Sonoma	Ophthalmology	ABMS of Ophth	10/27/1987	Yes	Healdsburg Dis	Consulting
I	Slovek, Annabel P.,AGACNP-BC	1720555386	SPEC	Napa Valley Orthopaedic Me	Napa	Adult-Gerontolo	American Nurse	10/10/2018	Yes	None	
I	Smith, Angela Doula	1174333132	SPEC	Angela Smith	Butte	Doula	None		Not Applica	None	
I	Smith, Susan RD	1386942241	Allied	TeleMed2U	Yolo	Registered Diet	Commission of	10/01/1988	Yes	None	
I	Smith, Tanya PA-C	1053600346	PCP	Northern Valley Indian Healt	Butte	Physician Assis	National Comm	06/24/2010	Yes	None	
I	Souza, Madison E.,NP	1801697602	PCP	OLE Health	Solano	Nurse Practitior	None		No	None	
I	Steenburgh, Sean M.,DPM	1134740293	SPEC	Santa Rosa Community Hea	Sonoma	Podiatry	None		No	Admitting Agree	None

App. Ty	Full Name	NPI Number	Provider Type C	Name/Street	County Name	Specialty Descr	Board Name	Initial Cert Date	Board Certif	Hospital Name	Staff Cat
R	Stock, Debra M.,PA	1376623215	SPEC	Solano Dermatology Associa	Solano	Physician Assis	National Comm	07/19/2002	No	None	
R	Sumsion, Michael A.,MD	1699725507	SPEC	Riverside EyeCare Professic	Shasta	Ophthalmology	ABMS of Ophth	11/24/1991	Yes	Mercy Medical (	Courtesy
R	Swenson, Vina K.,MD	1447341995	PCP	Fairchild Medical Clinic (PCI	Siskiyou	Pediatrics	Meets MPCR#1	10/19/1999	No	Fairchild Medic	Active
R	Syverson, Dale L.,MD	1841360591	SPEC	Modoc Medical Clinic	Modoc	Colon and Rect	ABMS of Colon	09/15/1990	Yes	Admitting Agree	None
I	Taylor, Douglas F.,DO	1649699737	SPEC	NBHG: NorthBay Medical Gi	Solano	Gastroenterolo	ABMS of Interna	11/05/2020	Yes	North Bay Medi	Active Attending
R	Taylor, Mallory M.,MD	1942731815	PCP	Elica Health Centers - Cadill	Placer	Pediatrics	ABMS of Pediat	10/15/2020	Yes	Admitting Agree	None
I	Twardzik, Amanda L.,FNP-C	1427634153	PCP	Providence Medical Group, I	Humboldt	Nurse Practitior	American Acad	02/23/2021	Yes	None	
I	Ugboh, Florence N.,MD	1801276209	PCP	One Community Health - Infi	Yolo	Pediatrics	ABMS of Pediat	10/15/2020	Yes	Admitting Agree	Active
I	Urban, Travis PT	1043642390	Allied	Willows Physical Therapy (M	Glenn	Physical Therap	None		No	None	
I	Ushijima-Mwesigwa, Keiko BCBA	1790300564	BHP	Maxim Healthcare Services,	Solano	BCBA	Behavior Analys	04/02/2021	Yes	None	
R	Van Aken, Terrell B.,MD	1306941430	SPEC	Terrell B Van Aken MD Inc	Solano	Hospice and Pa	ABMS of Family	10/29/2008	Yes	NorthBay Healt	Active Attending
R	Vandeveer, Kim LAc	1306110267	Allied	Alliance Medical Center - W	Sonoma	Acupuncture	None		No	None	
R	Vergara, Yadira BCBA	1083101026	Allied	Autism Learning Partners	Yolo	Behavioral Hea	Behavior Analys	02/28/2018	Yes	None	
I	Veselinov, Ivaylo I.,FNP-BC	1093554172	PCP	Colusa Health Clinic	Colusa	Family Nurse P	American Nurse	04/30/2024	Yes	None	
R	Villalon, Mark L., MD	1720249816	SPEC	NGBHG: NorthBay Heart an	Solano	Interventional C	ABMS of Interna	10/06/2016	Yes	NorthBay Medic	Active Attending
I	Villegas, Monserrat BCBA	1558829762	BHP	Center for Social Dynamics	Contra Costa	BCBA	Behavior Analys	10/14/2022	Yes	None	
R	Vos, Jesse W.,PA-C	1396994745	SPEC	North Pacific Dermatology	Del Norte	Physician Assis	National Comm	08/14/2008	Yes	None	
I	Warden, Nancy A.,MD	1093790305	PCP	Women's Babies' and Childr	Shasta	Pediatrics	ABMS of Pediat	01/19/1986	Yes	Admitting Agree	None
R	Wasserman, Ronald B.,MD	1346268067	SPEC	Bay Area Surgical Specialist	Solano	Infectious Disea	ABMS of Interna	11/06/1990	No	John Muir Medi	Active
I	Weavil, Amanda S.,MD	1841592037	SPEC	Barton Healthcare System	El Dorado	Obstetrics and (	AOB of Obstetri	01/16/2015	Yes	Barton Healthca	Active
I	Wertz, Jarrah N.,BCBA	1790394211	BHP	Momentum Behavior Servic	Sonoma	BCBA	Behavior Analys	08/31/2019	Yes	None	
R	West, Christopher E.,AGNP-C	1316293467	PCP	Open Door Community Heal	Humboldt	Adult-Gerontolo	American Acad	06/19/2017	Yes	None	
I	Will, Scott J.,PA-C	1518051077	SPEC	Adobe PH CA Medical Grou	Solano	Physician Assis	National Comm	06/01/2006	Yes	None	
I	Wilson, Lara J.,LMFT	1982726329	BHP	Northern Valley Indian Healt	Butte	License Marriag	None		No	None	
I	Winetz, Jan A., MD	1790777852	PCP	NBHG: Center for Primary C	Solano	Internal Medicin	ABMS of Interna	09/12/1979	Yes	Admitting Agree	None
I	Wong, David W.,MD	1669549549	PCP	Mendocino Community Heal	Mendocino	Internal Medicin	ABMS of Interna	09/22/1993	Yes	Admitting Agree	None
I	Wong, Janelle K.,MD	1760001945	PCP	Ole Health	Napa	Family Medicine	ABMS of Family	07/01/2023	Yes	Admitting Agree	None
I	Wydermyer, Charde M.,SUDRC	1205303138	W&R	Archway Recovery Services	Napa	Wellness and R	California Subst	01/16/2025	Yes	None	
R	Xunan, Kevin DO	1871029462	PCP	NBHG: Center for Primary C	Solano	Family Medicine	ABMS of Family	07/01/2019	Yes	NorthBay Medic	Clinical Practice Staff
I	You, Hojoon MD	1225455884	SPEC	One Community Health - Infi	Yolo	Infectious Disea	ABMS of Interna	10/24/2019	Yes	Admitting Agree	None
I	Zealear, Matthew S.,MD	1366516981	SPEC	Sierra View Medical Eye, Inc	Nevada	Ophthalmology	ABMS of Optha	10/22/1988	Yes	Admitting Agree	None
R	Zwerdling, Maya L.,MD	1629462254	PCP	Open Door Community Heal	Humboldt	Family Medicine	ABMS of Family	07/01/2018	Yes	Admitting Agree	None

AGENDA ITEM: III.C.
DATE: 08/13/2025

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 08/13/2025

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

Dr. Brent Pottenger resigns his position as PAC voting member. He will be taking a new position as Chief Psychiatrist at Napa State Hospital.

The Physician Advisory Committee thanks Dr. Pottenger for his support of Partnership and wishes him well in his future endeavor.

AGENDA ITEM: III.C.
DATE: 08/13/2025

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 08/13/2025

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Brian Montenegro, Neonatologist, NorthBay Neonatology & Associates, volunteers to serve as a PAC voting member.

His appointment is recommended.

Healthcare Effectiveness Data and Information Set (HEDIS®)

MY2024 / RY2025 Summary of Performance

Presented by:

Kristine Gual, Director of Quality Measurement

Today's Topics

- MY2024 Changes to Reporting Populations for HEDIS Programs

- DHCS Managed Care Accountability Set (MCAS) Results

  MY2024 MCAS Annual Summary of Performance

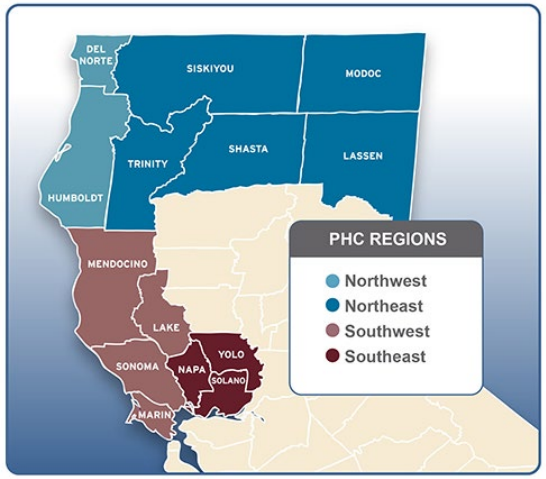
- NCQA Health Plan Accreditation (HPA) - Projected Star Rating

  MY2024 NCQA HPA Annual Summary of Performance

MY2024 HEDIS Project – Changes to Reporting Populations

MY2023 vs. MY2024 Reporting Populations

MY2023



MY2024 **36.7% increase in membership**

Managed Care Accountability Set (MCAS) Reporting	
Northwest	Humboldt, Del Norte
Northeast	Lassen, Modoc, Siskiyou, Trinity, Shasta
Southwest	Sonoma, Marin, Mendocino, Lake
Southeast	Solano, Yolo, Napa
NCQA Health Plan Accreditation (HPA) Reporting	
Plan-Wide	All 14 Legacy Partnership Counties

Population	Description	Purpose
NCQA HEDIS Reporting - DHCS Populations		
Plan Wide	All 24 counties - Plan wide reported rates	DHCS-published HEDIS rates for MCP
County	County level measure rates for each of Partnership's 24 counties	Geographic sanctions and withholds will be applied at DHCS's discretion (applied only to 14 legacy counties in MY2024)
NCQA HEDIS Reporting - HPA Population		
Plan Wide	All 24 counties - Plan wide reported rates	NCQA Star Rating

MY2024 DHCS Managed Care Accountability Set (MCAS) Results

MCAS: Accountable Measures MY2024

Domain	Measure	
Pediatric	W30+6	**Well Child Visits: 0-15 Months****
	W30+2	**Well Child Visits: 15-30 Months****
	WCV	**Child & Adolescent Well Care Visits****
	CIS	**Childhood Immunizations****
	IMA	**Immunizations for Adolescents****
	LSC	Lead Screening in Children
	TFL-CH	Topical Fluoride for Children
	DEV	Developmental Screening in 0-3yrs

Domain	Measure	
Cancer Prevention	BCS-E	Breast Cancer Screening
	CCS	Cervical Cancer Screening
Reproductive	CHL	Chlamydia Screening
	PPC-Pre	**Timeliness of Prenatal Care****
	PPC-Post	**Postpartum Care****
Chronic Disease	GSD	**Hemoglobin A1c Poor Control (>9%)****
	CBP	**Controlling High BP****
	AMR	Asthma Medication Ratio
Behavioral Health	FUA-30	F-Up after ED Visit for Substance Use
	FUM-30	F-Up after ED Visit for Mental Illness

**** Designates a Quality Withhold measure**

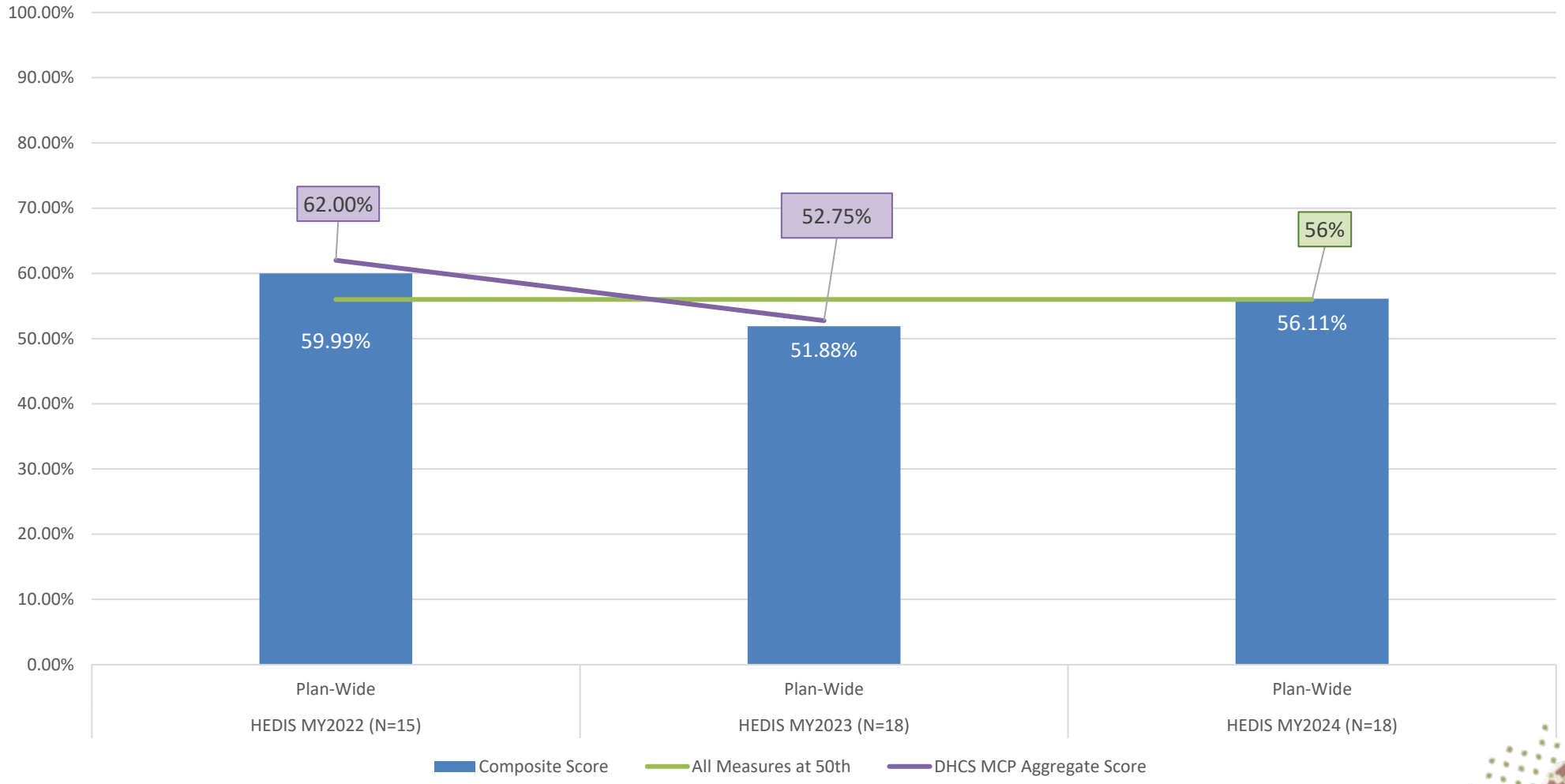
- 18 measures in MY2024
- All 18 measures from MY2023 continue in MY2024
- Accountable measures must meet or exceed the Minimum Performance Level (MPL) (i.e. 50th percentile national Medicaid percentile) or Partnership is subject to enforcement actions

Composite Scoring Methodology

- Partnership receives a composite score from DHCS – **Quality Factor Score.**
- A maximum of 10 points is awarded per measure based on Quality Compass 2024 (i.e. national Medicaid) benchmarks.
- With 18 measures in MY2024, a total of 172 points are possible based on DHCS's scoring system. Our composite score is a **percentage (%)** of 18 measures x 10 points/measure = 180 points.
- Partnership's Composite Score will be **one Plan-Wide score for MY2024**, a transition from four (4) Reporting Unit scores in prior years.

Quality Compass Benchmark	Points Awarded per Measure's Performance
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

MCAS Composite Scoring & Year-over-Year Trends, Complete MCAS Measure Set



MY2024 Plan-Wide MCAS Performance

HEDIS Plan Wide Performance
Report Year 2025; Measurement Year 2024
Performance Relative to Quality Compass® Medicaid Benchmarks

	Plan Wide Performance	National Medicaid Benchmarks			
Measures	Plan Wide	25TH	50TH	75TH	90TH
Asthma Medication Ratio - Total, 5 to 64 Ratios > 0.50	64.71%	59.47%	66.24%	72.22%	76.65%
***Breast Cancer Screening ECDS - Non-Medicare Total	56.29%	47.93%	52.68%	59.51%	63.48%
Cervical Cancer Screening*	59.12%	49.64%	57.18%	61.56%	67.46%
Childhood Immunization Status - Combination 10*	28.22%	22.87%	27.49%	34.79%	42.34%
Chlamydia Screening in Women - Total	55.58%	49.65%	55.95%	64.37%	69.07%
Controlling High Blood Pressure - Non-Medicare Total*	69.59%	59.73%	64.48%	69.37%	72.75%
#Developmental Screening in the First Three Years of Life (DEV) - Total All Ages	29.65%		35.70%		
Follow-Up After ED Visit for Mental Illness - 30 Days Total	29.01%	46.05%	53.82%	63.06%	73.12%
Follow-Up After ED Visit for Substance Use - 30 Days Total	33.27%	26.79%	36.18%	41.86%	49.40%
**Hemoglobin A1c Control for Pts w/ Diabetes - HbA1c Poor Control (>9%)*	32.60%	40.15%	33.33%	29.93%	27.01%
Immunizations for Adolescents - Combination 2*	40.39%	29.72%	34.30%	41.61%	48.66%
Lead Screening in Children (LSC)*	71.78%	53.12%	63.84%	71.11%	79.51%
Prenatal and Postpartum Care - Postpartum care*	89.54%	75.67%	80.23%	83.33%	86.62%
Prenatal and Postpartum Care - Timeliness of Prental Care*	85.40%	79.81%	84.55%	88.58%	91.85%
#Topical Fluoride for Children (TFL - CH) - Numerator 1 Total	12.40%		19.30%		
Well Care Visits (WCV) - Total	48.83%	46.57%	51.81%	58.07%	64.74%
^Well Child 30 (W30) - Well child visits for age15-30 months	72.22%	65.53%	69.43%	73.09%	79.94%
^Well Child 30 (W30) - Well child visits in the first 15 months	67.05%	54.46%	60.38%	64.99%	69.67%

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MPL** (minimum performance level,based on NCQA's Quality Compass Medicaid 50th percentile)

Measure Performance: Plan-Wide Strengths

Plan-Wide: Most Improved Measures

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Lead Screening in Children (LSC)	25th	75th + 12.66%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) **	<10th	75th +24.96%
Well-Child Visits in the First 30 Months of Life - 2+ visits 15-30 months (W30-2) **	37.5th	62.5th +7.67%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Plan-Wide Strengths

Plan-Wide: Newly Above the 50th Percentile

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Breast Cancer Screening (BCS-E)	37.5th	50th +0.77%
Cervical Cancer Screening (CCS)	37.5th	50th +2.77%
Childhood Immunization Status—Combination 10 only (CIS-10) **	25th	50th +0.97%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Plan-Wide Strengths

Plan-Wide: Sustained High Performing Measures

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide	
Controlling High Blood Pressure (CBP) **	50th	75th +6.23%	
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) **^	62.5th	50th -1.48%	WATCH
Immunizations for Adolescents—Combination 2 (IMA-2) **	50th	62.5th +2.43%	
Prenatal and Postpartum Care: Postpartum Care (PPC-Post) **	90th	90th +4.14%	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) **	50th	50th -0.78%	WATCH

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

**** DHCS Withhold measure**
^ Inverse measure, lower rate is better

Measure Performance: Plan-Wide Opportunities

Plan-Wide: Opportunities for Performance Improvement

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Asthma Medication Ratio (AMR)	37.5th	37.5th +0.70%
Chlamydia Screening in Women (CHL)	50th	37.5th -0.42%
Child and Adolescent Well-Care Visits (WCV) **	37.5th	37.5th +1.42%

**** DHCS Withhold measure**

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

Measure Performance: Data Completeness Issues

Plan-Wide: Significant Data Completeness Issues Contribute to Poor Performance

	MY2023 Plan-Wide (Weighted rate)	MY2024 Plan-Wide
Developmental Screening in the First Three Years of Life (DEV)	>50th	<50th -0.38%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up (FUA-30)	25th	37.5th +1.25%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up (FUM-30)	>10th	<10th -2.47%
Topical Fluoride for Children (TFL-CH)	<50th	<50th +12.15%

Benchmark	Pt Value
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10th or <50th (CMS)	1

MY2024 NCQA Health Plan Accreditation Projected Star Rating

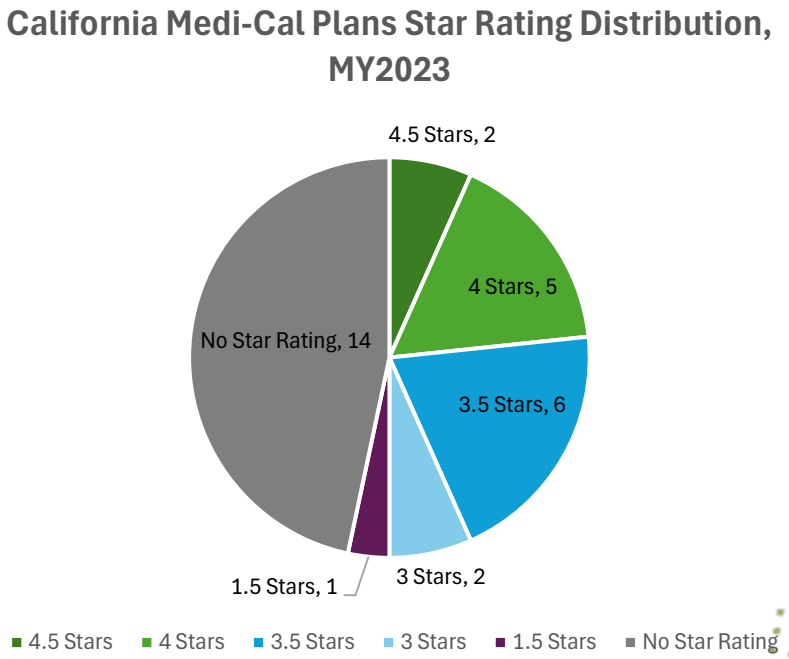
NCQA Health Plan Accreditation (HPA) – Healthplan Rating Methodology

The overall rating is calculated on a 0–5 point scale, to the nearest half point, based on performance in 3 subcategories:

1. **Patient Experience:** CAHPS Survey measures – each year Partnership chooses to submit Child CAHPS or Adult CAHPS Survey

2. **Rates for Clinical Measures:** HEDIS measures designated in 2 domains: 1) Prevention and Population and 2) Treatment

3. **NCQA Health Plan Accreditation:** 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displaying as the final Star rating.



Projected HPR for MY2024

The *projected* HPR rating for MY2024 is **3.5 Stars, using the Child CAHPS Survey**.

	MY2022 – Final Used Child CAHPS	MY2023 – Final Used Adult CAHPS	MY2024 – Projected Used Child CAHPS	MY2024 – Projected If we used Adult CAHPS
Patient Experience (CAHPS)	2.0	1.5	2.5	2.0
Prevention and Population (HEDIS domain)	3.5	3.5	3.5	3.5
Treatment (HEDIS domain)	3.5	3.5	2.5	2.5
Bonus for maintaining Accreditation	0.5	0.5	0.5	0.5
Overall HPR	**3.5**	**3.5**	**3.5**	**3.5**

Questions?

HEDIS Team: hedisteam@partnershiphp.org

MY2024 MCAS Annual Summary of Performance

MY2024 NCQA HPA Annual Summary of Performance