PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (22)

Steve Gwiazdowski, M.D. (Chair)	Chris Myers, D.O.	Karina Gookin, M.D.	Noemi Doohan, M.D.
Angela Brennan, D.O.	Christina Lasich, M.D.	Malia Honda, M.D.	Suzanne Eidson-Ton, D.O.
Brent Pottenger, M.D.	Danielle Oryn, D.O.	Matthew Zavod, M.D.	Teresa Shinder, D.O.
Brian Evans, M.D.	Darrick Nelson, M.D.	Michelle Herman, M.D.	Vanessa Walker, D.O.
Candy Stockton, M.D.	John McDermott, FNP-PAC	Mills Matheson, M.D.	
Chester Austin, M.D.	Karen Sprague, MSN, CFNP	Mustafa Ammar, M.D.	

Partnership Executive Staff:

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

Regional Medical Directors	Region	Region Directors
Jeffrey Ribordy, MD, Region Medical Director	Del Norte, Humboldt, Mendocino & Lake	Vicky Klakken, Region Director
Bradley Cox, DO, Region Medical Director	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Tim Sharp, Region Director
Colleen Townsend, MD, Region Medical Director	Napa, Yolo & Solano	Kathryn Power, Region Director
Marshall Kubota, MD, Region Medical Director	Marin & Sonoma	Leigha Andrews, Region Director
R. Doug Matthews, MD, Region Medical Director	Glenn, Butte, Sutter, Colusa & Yuba	Rebecca Stark, Region Director
Vacant, Region Medical Director	Plumas, Sierra, Nevada & Placer	Jill Blake, Region Director

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
Stan Leung, Pharm.D., Director., Pharmacy Services
Mohamed Jalloh, Pharm.D., Director of Health Equity
Brigid Gast, RN, Director, Care Coordination
DeLorean Ruffin, DrPH, Director, Population Health Management
Heather Esget, RN, Director of Utilization Management
Margarita Garcia-Hernandez, Director, Health Analytics
Ledra Guillory, Senior Manager, Provider Relations Reps.
Kristine Gual, Manager of Performance Improvement
Amy McCune, Manager, Quality Incentive Programs
Sue Quichocho, Manager, Quality Measurement
Kevin Jarrett-Lee, RN, Assoc. Dir. of Utilization Management
Lisa O'Connell, Associate Dir. of Housing & Incentive Programs
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: November 8, 2024

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

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

DATE: Wednesday, November 13, 2024 **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	**Marin Community Clinic** 3260 Kerner Blvd. San Rafael, CA 94901	**Ampla Health** 935 Market Street Yuba City, CA 95991
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	**Aliados Health** 1310 Redwood Way Petaluma, CA 94999	**Sutter-Roseville** 6 Medical Plaza Roseville, CA 95661

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: November 13, 2024 Time: 7:30 – 9:00 a.m. Location: Partnership

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

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

Partnership – Redding Office
2525 Airpark Drive
Redding, CA

Partnership – Eureka Office
1036 5th Street
Eureka, CA

Partnership - Auburn Office
281 Nevada St.
Auburn, CA 95603

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

Marin Community Clinic
3260 Kerner Blvd.
San Rafael, CA 94901

Ampla Health
935 Market Street
Yuba City, CA 95991

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

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

Sutter-Roseville
6 Medical Plaza
Roseville, CA 95661

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**	**PG #**	**TIME**
A.	**I**	**Chief Executive Officer Administration Updates**	**Ms. Bjork**		**7:35**
B.	**I**	**Chief Medical Officer Health Services Report**	**Dr. Townsend**		**7:45**
C.	**I**	**Regional Medical Director Reports**	**LEAD**	**PG #**	**TIME**
1	**I**	Napa, Yolo & Solano	**Dr. Townsend**		**7:55**
2	**I**	Marin & Sonoma	**Dr. Kubota**		**7:58**
3	**I**	Del Norte, Humboldt, Mendocino & Lake	**Dr. Ribordy**		**8:01**
4	**I**	Glenn, Butte, Sutter, Colusa, Yuba, Plumas, Sierra, Nevada & Placer	**Dr. Matthews**		**8:04**
5	**I**	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	**Dr. Cox**		**8:07**
II.	**I**	**COMMITTEE MEMBER HIGHLIGHT**	**LEAD**	**PG #**	**TIME**
A.	**I**	**Dr. Brent Pottenger** Medical Director of Behavioral Health Solano County Health & Social Services	**Dr. Pottenger**	**5**	**8:10**
III.	**A**	**MOTIONS FOR APPROVAL**	**LEAD**	**PG #**	**TIME**
A.	**A**	**Review of October 9, 2024 PAC Minutes**	**Dr. Townsend**	**7 - 19**	**8:20**
B.	**A**	**Consent Review: Agenda Items III. B.1, B.2, B.4, and B.5** **Consent review allows multiple agenda items to be approved with one motion.**	**Dr. Townsend**	**20 - 146**	**8:21**
1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – October 16 , 2024** ***Acceptance of Draft Meeting Minutes:*** • Q/UAC Agenda • Q/UAC Activities & Minutes • Internal Quality Improvement Meetings October 8, 2024 Quality Improvement Update – October 2024	**Dr. Townsend**	**20** **22** **37** **49**	**8:21**

III.	A	MOTIONS CONTINUED	LEAD	PG #	TIME
B.	A	**Consent Review: Agenda Items III. B.1, B.2, B.3, B.5, and B.7**	**Dr. Townsend**		**8:21**
2	C	***Policies/Procedures/Guidelines for Action***		**N/A**	**8:21**

Quality Improvement	
MPQP1008	Conflict of Interest Policy for QI Activities
Health Equity	
MCED6001	Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description
Utilization Management	
MCUG3032	Orthotic and Prosthetic Appliances Guidelines
MCUP3020	Hospice Services
MPUP3116	Positron Emission Tomography Scans (PET Scans)
MCUG3038	Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
MCUP3049	Pain Management Specialty Services
MCUG3058	Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
Care Coordination	
MCCP2032	CalAIM Enhanced Care Management (ECM)
MCCP2023	New Member Needs Assessment
Population Health Management	
MCND9002	Cultural & Linguistic Program Description
Grievance and Appeals	
CGA022	Member Discrimination Grievance
Pharmacy Operations	
MCRP4066	AB1114 Benefit Implementation and Oversight
MPRP4062	Drug Wastage Payments

*All versions linked within Policy Summary (See page **63**)*

- Policy Summary **63**
- Detailed Synopsis of Changes **64**

III.	A	MOTIONS CONTINUED Consent Review: Agenda Items III. B.1, B.2, B.3, B.4, B.5	LEAD	PG #	TIME
B.	**C**	**Consent Review: Agenda Items III. B.1, B.2, B.3, B.5, and B.7**	**Dr. Townsend**	**20 - 146**	**8:21**
3	**C**	**Pharmacy & Therapeutics Committee** • Minutes, October 10, 2024 • Approved Criteria. October 10, 2024	**Dr. Stan Leung**	**70** **83**	**8:21**
4	*C*	*Provider Engagement Group (PEG) Report*	*Ms. Kerlin*		
5	**C**	**Credentials Committee Meeting** • Summary, September 11, 2024 • Credentialed List, September 11, 2024	**Dr. Kubota**	**130** **134**	**8:21**
6	*C*	*Pediatric Quality Committee*			
7	**C**	**Quality Improvement Health Equity Committee** Minutes, September	**Dr. Jalloh**	**137**	**8:21**
C.	**A**	**Physician Advisory Committee (PAC) Membership** • Resignation of Dr. Noemi Doohan • Resignation of Dr. Brian Evans • Nomination of Dr. Derice Seid	**Dr. Townsend**	**147** **148** **149**	**8:22**
D.	**A**	**Palliative Care Quality Improvement Program Proposal** Measurement Year 2025	**Ms. Eva Lopez, CPhT**	**152**	**8:25**
IV.	*I*	*Old Business*			
V.		**SPECIAL PRESENTATIONS**	**LEAD**	**PG #**	**TIME**
A.	**I**	**Partnership Initiatives for Obstetrical and Perinatal Care** • Ensuring Access to Safe Obstetrical Care (EASOC) • Partnership HealthPlan Perinatal Services (PHPS)	**Dr. Townsend**	**153**	**8:30**
VI.	**I**	**ADJOURNMENT**	**LEAD**		**9:00**
		Next PAC on January 8, 2025 at 7:30 a.m.	**Dr. Townsend**		

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.

Contact

www.linkedin.com/in/epistemocrat (LinkedIn)
www.epistemocrat.blogspot.com (Blog)
www.brentpottenger.com (Personal)

Top Skills

Healthcare
Nutrition
Community Outreach

Brent Pottenger, MD, MHA

Physician
Fairfield, California, United States

Experience

Solano County
Medical Director
May 2022 - Present (2 years 5 months)

California Department of State Hospitals
Psychiatrist
July 2021 - May 2022 (11 months)
Napa, California, United States

Johns Hopkins Medicine
Resident Physician
July 2016 - June 2021 (5 years)

JHM Armstrong Institute for Patient Safety and Quality
Healthcare Systems Leadership Fellow
May 2015 - May 2016 (1 year 1 month)

Ancestral Health Society
Co-Founder
August 2010 - June 2015 (4 years 11 months)

AncestralHealth.org

Academic Impact, LLC
Co-Founder
August 2007 - August 2013 (6 years 1 month)

UC Davis Medical Center
7 years

Volunteer
2004 - March 2011 (7 years)

Clinical research

Emergency Medicine Research Associate Program
June 2004 - May 2006 (2 years)

Sutter Health

Administrative Resident

September 2007 - September 2009 (2 years 1 month)

Administrative Residency for Master of Health Administration (MHA) at USC.

Education

The Johns Hopkins University School of Medicine

MD, Medicine · (2011 - 2016)

University of Southern California

Master of Health Administration (MHA) · (2007 - 2009)

University of California, Davis

Bachelor of Science, Human Physiology, Financial Management, and Contemporary Leadership · (2002 - 2007)

Jesuit High School

· (1998 - 2002)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **October 9, 2024 - 7:30 to 9:00 a.m.**

Brown Act flexibilities have ended. Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:	Steve Gwiazdowski, MD (Chair) Karen Sprague, MSN, CFNP *(FF)* Candy Stockton, MD *(E)* Teresa Shinder, DO *(FF)* Brent Pottenger, MD *(FF)*	Darrick Nelson, MD *(R)* Karina Gookin, MD *(AU)* John McDermott, FNP *(C)* Malia Honda, MD *(E)*	Mills Matheson, MD *(OMM)* Melanie Thompson, DO *(MCC)* Danielle Oryn, DO *(AD)* Matthew Zavod, MD *(FF)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn*	*MCC - Marin Community Clinics* *OMM - Office of Dr. Matheson* *AM – Ampla Health*
Members Excused:	Angela Brennan, DO Chester Austin, MD	Noemi Doohan, MD Michelle Herman, MD	Christina Lasich, MD Suzanne Eidson-Ton, MD	Chris Myers, MD Vanessa Walker, DO	
Members Absent:	Brian Evans, MD Mustaffa Ammar, MD *(AM)*				
Visitor:	Dr. Derice Seid, Marin Community Clinics				
Partnership Staff:	Katherine Barresi, RN, Chief Executive Officer *(acting)* Patti McFarland, Chief Financial Officer Wendi Davis, Chief Operating Officer Vacant, Regional Director Mary Kerlin, Sr. Dir., Prov. Relations (PR) Lisa O'Connell, Director of Enhanced Health Services Doreen Crume, RN, N. Mgr. Care Coord. Stephanie Nakatani, Supervisor, Provider Relations Representatives Vicky Klakken, Dir., North Region Brigid Gast, RN, Dir. of CC	Robert Moore, MD, Chief Medical Officer Katherine Barresi, RN, Chief Health Services Officer Colleen Townsend, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Vacant, RN, Assoc. Dir. UM Strategies Sue Quichocho, Mgr., Quality Measurement Amy McCune, Manager of QI Programs Bradley Cox, MD, Northeast Region Medical Director James Cotter, MD, Associate Medical Director	Jeffrey Ribordy, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Marshall Kubota, MD, Region Medical Director Teresa Frankovich, MD, Associate Medical Director Nancy Steffen, Dir., Quality & Perf. Improvement Heather Esget, RN, Director, Utilization Mgmt. (UM) Kevin Jarret-Lee, RN, Assoc. Dir. of UM Kristine Gual, Mgr. of Performance Improvement Isaac Brown, Director, Quality Management Mohamed Jalloh, Pharm.D., Director, Health Equity Megan Shelton, Project Manager, Quality Improvement Monika Brunkal, RPh, Interim 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	13/23 – PAC	Committee quorum requirements met (13).	10/09/24

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

I.A. Chief Executive Officer Administration Updates	**Partnership's Chief Operations Officer (COO) provided the following report on Partnership activities on behalf of Partnership's Chief Executive Officer.**
	• **Department of Health Care Services (DHCS) Updates**
	  • DHCS signaled that they are going to be starting the data pull process with certain provider types starting their trajectory towards the new minimum wage care law, SB525, that was passed, which requires minimum wage for covered care employees to be $25 per hour by June 2028. Many health centers quickly adjusted to raise the wage to $25 per hour preemptively. Partnership will be monitoring impacts to staffing in an already challenging environment for recruitment and retention.
	  • DHCS released the Community Reinvestments policy sending out the guidelines to MediCal Managed Care Plans (MCPs) requiring reinvestment of a certain about of base profits based on quality and financial measurement performance.
	  • Local health plans have been reinvesting in communities for many years, and there are concerns about credit being received for programs Partnership has already implemented.
	  • Local Health Plans of California (LHPC) conducted a poll spanning dates from 2019 to the present revealing health plans have invested $800 million back into the communities served. DHCS has suggested a reinvestment rate of five to seven percent, but Partnership has been investing roughly 20% and has questioned if credit will be received.
	  • Drafted language suggests DHCS is looking at the legal permissibility of having another shared governance structure for a decision-making authority body with regards to where these investments are made.
	  • Partnership will be working closely with financial partners and Finance Team to ensure firm and confirmed rates to project positive revenue.
	• **National Coalition for Quality Assurance Health Equity Accreditation (NCQA)**
	  • A mock audit with a consultant revealed Partnership would pass the measures needed to obtain NCQA Health Equity Accreditation.
	  • Partnership departments focus internally and with the provider network to ensure systems and processes are in place to achieve quality outcomes.
	
	Questions – None

I.B. Chief Medical Officer Health Services Report	**Partnership's Chief Medical Officer (CMO) presented a brief update on Health Services.**
	
	• **DHCS Updates**
	  • Dental data received from DHCS has not categorized all of the dental visits for Federally Qualified Health Centers (FQHC), tribal health clinics, and rural health clinics. Within the medical file, absent dental files, the data only shows if the appointment took place and not if fluoride was applied. Fluoride application is a Managed Care Accountability Set (MCAS) measure.
	  • Partnership has been aggressively working with DHCS to elevate the issue of missing data and measure accountability.
	  • Partnership proposed to DHCS three reporting regions to match MCAS regions to the financial reporting regions.
	• **Network Engagement**
	  • Partnership has been piloting events for new medical residents to welcome them to the communities.
	  • Partnership held the second tribal health convening with great attendance where the topics of workforce, behavioral health, tribal perinatal initiatives, data sovereignty, and public health were presented and discussed.
	• **California Medical Association (CMA)**
	  • CMA House of Delegates meeting will be held at the end of October highlighting rural health equity and reproductive and obstetrical (OB) access.
	  • CMA is often dominated by urban areas. Counties proposed having a rural health caucus within CMA for a forum to discuss rural health issues.
	  • OB access needs legislative advocacy; three proposals have been offered for consideration.
	  • Allowing alternative birthing centers to be accredited rather than licensed in order to be a contracted MediCal provider
	  • Allowing rural hospitals to have standby perinatal units without the need for continuous staffing but could be staffed when patients are there
	  • Training rural nurses to have a broad range of skills to be cross-trained in many areas.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
I.C.1. Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Yolo, and Solano Counties presented a brief update on activities.** • LaClinica, Communicare+Ole in Napa, and Community Medical Centers have all recruited new providers. • Community Medical Centers CEO has announced retirement in November. • Doula applications for contracting and credentialing across the regions are increasing. • Drug Safe Solano hosted a medication assisted treatment (MAT) collaborative and invited all provider practices in the community as well as the local hospitals to have a discussion about how to bring together better access to MAT treatment. This will be an ongoing avenue for clinicians to get to understand from each other how they are prescribing, how to help individuals get through the systems and get access to MAT, and provide tools and support to primary care providers (PCP) and mental health professionals.
I.C.2. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Partnership Santa Rosa will be hosting a fall meeting with FQHCs in the region to address any questions about the Quality Improvement Program (QIP). • E-Consults continue to fill gaps in specialty access. • Leigha Andrews joined Partnership as the new Region Director for Sonoma and Marin Counties.
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.** • Adventist Health Mendocino Coast in Fort Bragg had contracted a third party to run operations since 2020 and has sent a desire to restructure the terms of the agreement. Negotiations will take place over 60 days, but there is no additional information at this time. • The California Attorney General, Rob Bonta, has filed a lawsuit against Providence St. Joseph Hospital for denying emergency medical abortion care as required by California law. Although the patient was not a Partnership member, there are implications for all members of the community, and the outcome will be closely monitored.
I.C.4. Status Update, Regional Medical	**Partnership's Regional Medical Director for Glenn, Butte, Sutter, Colusa, Yuba, Plumas, Sierra, Nevada, and Placer Counties presented a brief update on activities.** • Jill Blake has joined Partnership as the Chico Office Region Director. • Oroville Hospital expansion is progressing with hopes for electrical switches for the electrical system to be placed on a generator by the end of the year in efforts to open a new hospital wing in 2025. • Orchard Hospital in Gridley, CA is linking up with Partnership Telemedicine for hospitals and clinics. • Recently held meeting with Sierra Nevada Memorial Hospital to build relationships with Chapa De clinics, providers, and the medical residency program. • Plumas District Hospital is in the process of building a skilled nursing facility (SNF) and working diligently on the building structure ahead of expected inclement weather in the winter months. Once opened, 30 beds will be available for the region. • Met with Healthy Rural California to discuss continued medical education efforts, focusing on underrepresented groups, including the American Indian Alaska Native population, to encourage all students in the region to consider careers in medicine. • Yuba-Sutter-Colusa Medical Society and Placer-Nevada County Medical Society have merged to become Sierra Foothills Medical Society. • Butte County is seeing an increase in advanced colorectal cancer. Partnership's Chico Medical Director will be meeting with other area providers to brainstorm ideas for addressing the issue through access to endoscopy and brining colorectal cancer screening rates closer to the national average of 70-80%.
I.C.5. Status Update, Regional Medical	**Partnership's Regional Medical Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Dignity Health Sierra Pacific Regional Cancer Center had a groundbreaking ceremony on September 24, 2024. The $70 million, 40,000 sqft facility will serve the Redding area and hope to attract more oncologists and bolster the cancer program to keep Redding patients close to home.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
II.A. Executive Member Highlight, Ms. Jennifer Lopez, Chief Financial Officer	**Ms. Jennifer Lopez, Partnership Chief Financial Officer, provided her background and introduced herself to PAC attendees.** Ms. Lopez joined Partnership as the Deputy Chief Financial Officer in March 2023 and has been appointed the Chief Financial Officer in October 2024 following the retirement of Ms. Patti McFarland. She has years of experience working in Medicaid for the California Department of Finance, previously overseeing all of the healthcare premium payments and setting healthcare premiums for MediCal across the state for several years. She is also familiar with Medicaid policy working alongside the legislature and on the social services side. DHCS is transforming MediCal and she understands many of the social service aspects through community support and had an opportunity to design some of those supports. Additionally, she previously worked for Local Health Plans of California (LHPC) as the Director of Finance were she advised CEOs and CFOs across the state on all financial matters related to Medicaid.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
III.A.	**October 2024 PAC minutes were presented for approval.**	**MOTION:** Dr. Shinder moved to approve Agenda III.A as presented, seconded by, seconded by Nurse Sprague. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.B. ▪ III.B.1 ▪ III.B.2 ▪ III.B.4 ▪ III.B.5	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – October 2024 • Policies, Procedures, and Guidelines for Action Policy Summary October 2024 • Provider Engagement Group (PEG) Report - September 2024 • Credentials Committee Meeting – August 14, 2024	**MOTION:** Dr. Shinder moved to approve Agenda III.B.1, III.B.2, III.B.4 and III.B.5, as presented, seconded by Nurse Sprague. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.C	**Physician Advisory Committee Membership** Resignation of Dr. Melanie Thompson from PAC	**MOTION:** Dr. Zavod moved to approve Agenda III.C, as presented, seconded by Dr. Shinder. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.
III.D	**Primary Care Physician (PCP) Quality Improvement Program (QIP) Proposal**	**MOTION:** Nurse Sprague moved to approve Agenda III.D, as presented, seconded by Dr. Shinder. **ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.	10/09/24 Motion carried.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
IV. Old Business	
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	**Primary Care Physician Quality Improvement Program (QIP) Proposal** Summary of Proposed Measure Changes for Measurement Year 2025 Providers have the potential to earn a total of 100 points in four measurement areas. (A) Core Measurement Set Measures - 1) Clinical Domain 2) Appropriate Use of Resources 3) Access and Operations 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

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

2024 Measures	2025 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Care: HbA1c Control 7. Diabetes Management: Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children	**Family Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Diabetes Management: Eye Exams 9. Controlling High Blood Pressure 10. Immunizations for Adolescents – Combo 2 11. Well-Child Visits in the First 15 Months of Life 12. Lead Screening in Children 13. Chlamydia Screening in Women (both age groups: 16-24yo) – **Monitoring** 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. **Reduction of Inequity Adjustment (Participation is Optional)**
Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)	**Family Medicine & Internal Medicine:** 1. Ambulatory Care Sensitive Admissions 2. ~~Risk Adjusted Readmission Rate (RAR)~~ 3. Follow-up within 7 days after Hospital Discharge
Access and Operations	
All Practice Types: 1. Avoidable ED Visits 2. PCP Office Visits	**All Practice Types:** 1. Avoidable ED Visits 2. PCP Office Visits
Patient Experience	
All Sites: 1. Patient Experience	**All Sites:** 1. Patient Experience

2024 Measures	2025 Recommendations
Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Comprehensive Diabetes Care: HbA1c Control	**Internal Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Colorectal Cancer Screening
5. Controlling High Blood Pressure 6. Diabetes Management: Eye Exams	5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure 7. Diabetes Management: Eye Exams 8. Chlamydia Screening in Women (21-24yo) - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children 6. Chlamydia Screening in Women (16-20yo) 7. Well-Child Visits in the first 15-30 months of life 8. Topical fluoride in Children - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	**Programmatic Changes:** **I. Descriptions of Potential 2025 Measure Changes for Core Measurement Set** A. Change(s) to Existing Measures – Core Measurement Set i. Retire Risk Adjusted Readmission Rate (RAR) and replace with Follow-up within 7 days after Hospital Discharge. See rational in section I.B. B. Potential Additions as New Measures – Core Measurement Set i. Breast Cancer Screening (Family Practice & Internal Medicine: *Monitoring* for age group: 40-49yo) – In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024). Because members and providers are used to the recommendation to start at age 50 years, an adjustment period is indicated to allow member and provider to "get caught up" on screening of eligible members aged 40-49 years. For this reason, this new measure will be a monitoring measure only for 2025. All Primary Care Providers seeing members from the eligible population (all persons assigned as female at birth aged 40-74 years) should initiate screening now, in accordance with the guidelines. As the screenings are recommended for every other year, any screening done in 2025 will count for numerator compliance when the measure moves to an active measure in 2026 (anticipated). ii. Chlamydia Screening in Women (Family Practice: *Monitoring* for age groups: 16-24yo, Internal Medicine: *Monitoring* for age group: 21-24yo, Pediatrics: **Active** for age group: 16-20yo) – The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: "Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV". Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women) iii. Well-Child Visits in the first 15-30 months of life (Family Practice: *Monitoring* & Pediatrics: **Active**) – Members who turned 15 months and 1 day - 30 months old during the MY and had two or more well child visits. This measure will be separate from the W15. According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits. iv. Topical fluoride in Children (Family Practice & Pediatrics: *Monitoring*) – Age range will mirror HEDIS, 1-4yo, with a minimum of 2 applications per MY. This will be a 2025 monitoring measure for Family Medicine & Pediatrics. Topical fluoride varnish (TFV) application is recognized as one of the most effective strategies for preventing dental caries and improvement of oral health in all children (8). In addition to prevention, TFV has the potential to re-mineralize existing caries and halt the progression from caries to cavities. According to the CDC, the prevalence of untreated cavities (tooth decay) in the primary teeth of children (aged 2 to 5) from low-income households is about three times higher than that of children from higher income households. Young children are seen in primary care settings earlier and more frequently than in dental offices, making well child visits an ideal opportunity for early detection of caries and varnish application.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	v. Reduction of Inequity Adjustment – Participation is optional. Partnership HealthPlan of California (PHC) is actively engaged in HE initiatives that bring equitable awareness and result in improved quality performance within the 24 counties we serve. We highly encourage provider organizations to partner with us in these efforts and together, we can help move our communities toward equitable access to healthcare. In reviewing the performance of our clinical measures, we recognize there are underlying disparities among our member populations based on location, access and Social Determinants of Health (SDOH). To help our provider organizations with identifying and addressing disparities in their member populations, we have created the Disparity Analysis dashboard housed within eReports which promotes the identification of disparities across all PCP QIP clinical measures based on race/ethnicity groups. This new clinical measure will incentivizing participating sites with set dollar amount if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the main focus, followed by Childhood Immunization Status Combo 10, Immunization in Adolescents, Breast Cancer Screening & Colorectal Cancer Screening). The sites selected priority group must be performing below the 25th percentile in a particular measure of focus with the goal to improve performance by at least 20% or reaching the 50th percentile at the end of the measurement year. vi. Follow-up within 7 days after Hospital Discharge (Family Practice & Internal Medicine) – A readmission occurs when a patient is discharged from a hospital and then admitted back into a hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d). Inclusion of this measure and benchmark determination is supported in alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768). A follow up with a hospitalist, a primary care clinician or a specialist within a week after discharge from the hospital can help reduce readmissions back to the hospital. While this can be a struggle, a good strategy to attain this goal is to have a proper discharge summary which can be communicated with the follow-up provider. ***Questions*** **Will primary care clinics be expected to administer fluoride rather than dental offices?** This is a complicated measure because DHCS has held MCPs accountable for two dental fluoride varnish applications per year for all children under the age of 20, but there is also a separate standard related that requires four times per year, but most children only see the dentist twice in a year. DHCS is lacking this data. This measure is intended to address preventative dental care access. Partnership's CMO explained clinics have been providing treatment either in clinic or sending the treatment home with parents to administer. Partnership's Senior Director for Quality Improvement mentioned previous pilots where clinics were partnered with a registered hygienist in a primary care setting to teach medical assistants how to administer. The pilot revealed clinics preferred dental clinics administer because of access challenges in securing well child visits. Partnership could always go back to offering those in-services because we hired that registered hygienist to serve in the clinical quality side of our team, but it was not successful in some of the more rural health centers. Partnership's Medical Director reiterated the treatment could be done by a nurse and is not required of the physician.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
III.D Primary Care Physician Quality Improvement Program (QIP) Proposal	(B) Unit of Service Measures - Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites:	**All Sites:**
1. Advance Care Planning Attestations	1. Advance Care Planning Attestations
2. Extended Office Hours	2. Extended Office Hours
3. PCMH Certification	3. PCMH Certification
4. Peer-led & Pediatric Group Visits	4. Peer-led & Pediatric Group Visits
5. Health Information Exchange	5. Health Information Exchange
6. Health Equity	6. Health Equity
7. Blood Lead Screening	~~7. Dental Fluoride Varnish Use~~
8. Dental Fluoride Varnish Use	8. Tobacco Use Screening
9. Tobacco Use Screening	9. Electronic Clinical Data Systems (ECDS)
10. Electronic Clinical Data Systems (ECDS)	10. Early Administration of the 1st HPV Dose
	11. Early Administration of Flu Initiation and Booster Doses
	12. Academic Detailing

Descriptions of Potential 2025 Measure Changes for Unit of Service Measurement Set

A. Change(s) to Existing Measures – Unit of Service

i. Peer Led and Pediatric Group Visits – Expanding the qualifying pediatric well child group visit from exclusively Well-Child Visits in the First 15 Months to both Well-Child Visits in the First 15 Months and Well-Child Visits in the First 15-30 months of Life

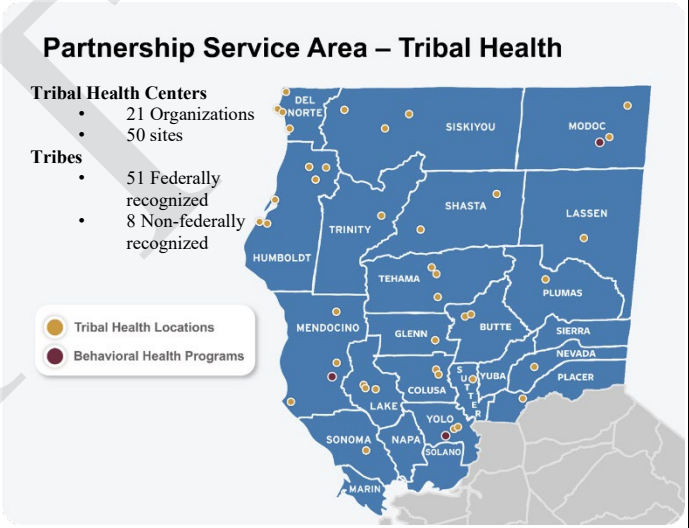
ii. Retired Dental Fluoride Varnish Use – In comparing Partnership's reporting to the State's DentiCal reporting, we have identified large gaps of discrepancies between the data. These discrepancies are not an accurate reflection of the services provided to the PCPs assigned patients and their overall performance. This is an opportunity for Partnership to continue to work with the State in ensuring we are receiving the most appropriate dental varnish application data for our members.

B. Additions as New Measures – Unit of Service

i. Academic Detailing - Medication management is an important component of disease state management, such as diabetes, hypertension, and asthma. Effective medication management requires the clinician and care team to have complete, accurate, and current data on pharmacy claims. PHC Pharmacy Academic Detailing partners clinicians with the PHC clinical staff to provide a review of actionable pharmacy claims data to address gaps in care such as medication non-adherence, suboptimal asthma medication therapy, and gap in statin therapy for people with diabetes and/or cardiovascular disease. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The purpose of this new unit of service measure is to incentivize provider organizations for hosting a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director.

AGENDA ITEM	DISCUSSION / CONCLUSIONS

V.A Undercounting of the American Indian Population	**Erasure**
	• Erasure of previous cultures and beliefs has occurred throughout history
	  o Settler or conqueror societies discount and eliminate the presence of indigenous peoples, cultures, and languages.
	  o Tools of erasure:
	  ▪ Massacre
	  ▪ Educational content
	  ▪ Framing in media/entertainment
	  ▪ Suppression of cultural practices
	  ▪ Suppression of language
	  ▪ Re-defining identity
	  ▪ Official census data collecting
	
	Consequences of Erasure
	• Lost with erasure:
	  o Cultural knowledge
	  ▪ Environmental stewardship practices
	  o History
	  o Religions, philosophies, and worldviews
	• Other consequences:
	  o Trans-generational trauma adversely impacts mental and physical health
	  o Loss of cultural identity impacts self-esteem
	  o Persistent discrimination
	
	Indigenous Erasure in the United States
	• Strategies for American Indian **erasure** have included:
	  o Genocide: large scale massacres of indigenous people
	  o Forcible removal of children to attend boarding schools, where they were not permitted to speak their native language
	  o Teaching of U.S. history that ignores Indian massacres
	  o Portrayal of American Indians in a stereotypical negative light in movies, TV
	  o Federal tribal termination policies of the 1950s and 1960s.
	  o 1870 Census definition of those of mixed Indian-white heritage, living off-reservations as white.



AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	**Systematic Undercounting of AI/AN** • In July, 2024 DHCS reported that, as of April 2024, there were: • 14,981,547 Californians with Medi-Cal, but only 50,996 of them were classified as being Native American or Alaska Native:

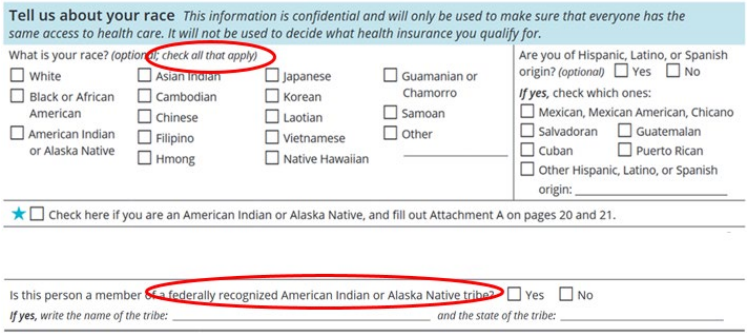
Race/Ethnicity	Number of Certified Eligibles	Percentage of Total
African-American	1,022,292	6.8%
American Indian/Alaskan Native	50,996	0.3%
Asian/Pacific Islander	1,393,671	9.3%
Hispanic	7,710,166	51.5%
Not Reported	2,408,724	16.1%
White	2,395,698	16.0%
Total	14,981,547	100.0%

Census Data Not Consistent with DHCS Data

- 2020 Census of the California population
  - 1.6% identified as AI/AN alone
  - Additional 2.0% identified as AI/AN in combination with some other race.
  - Total 3.6%
- If we assume the proportion of AI/AN with Medi-Cal is about the same as the population as a whole, then about 3.6% of the Medi-Cal population should be identified as AI/AN, not 0.3%.
- This represents a 12-fold undercounting. Put another way, the true number of AI/AN with Medi-Cal is 1200% higher than that presented by DHCS.
- This means the number of individuals state-wide with Medi-Cal who identify as fully or partly AI/AN is approximately 600,000 instead of 50,000.

Why is the DHCS number so low?

Better data is collected on the Medi-Cal application:


Tell us about your race *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? *(optional; check all that apply)*

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other

Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

☐ Mexican, Mexican American, Chicano
☐ Salvadoran ☐ Guatemalan
☐ Cuban ☐ Puerto Rican
☐ Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

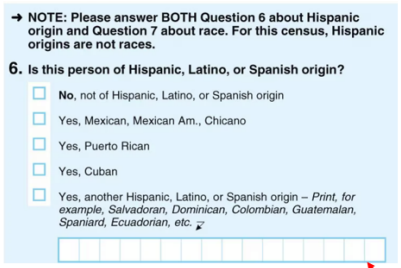
If yes, write the name of the tribe: _____ *and the state of the tribe:* _____

DHCS Chooses One Race

- The membership file (834) DHCS sends to Health Plans associates just one race with each Medi-Cal enrollee. Of note Hispanic ethnicity is reclassified as a race.
- Here are the options:
  - White
  - Black
  - Hispanic (No subgroups included)
  - Asian Pacific Islander (specific subgroup is identified in membership file from 12 options)
  - Native American/Alaska Native
  - Unknown/Missing
  - Other
- The algorithm used by DHCS to determine which race is chosen is not transparent, but can be inferred.

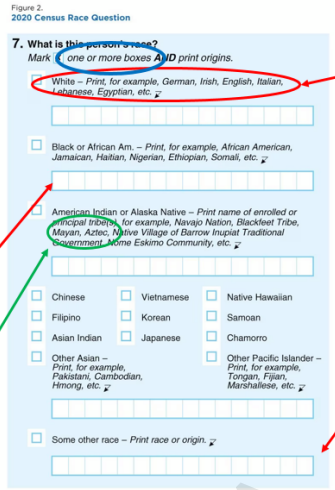
AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	

Race and Ethnicity in 2020 Census



Sixteen-letter maximum in text fields prevent describing more than one or two descriptions.

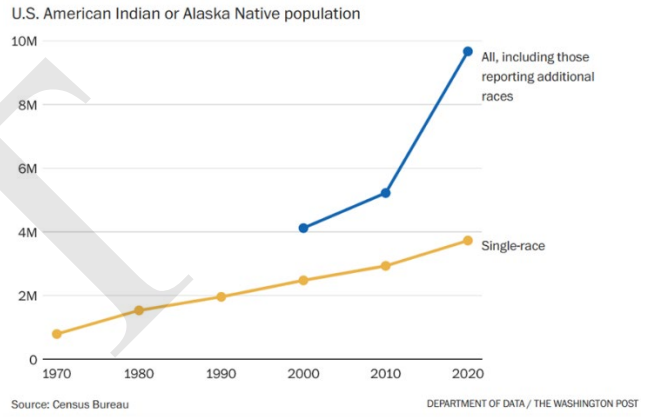
Indigenous individuals from outside the United States are encouraged to select a tribe, which classifies them in the American Indian category.



Multi-generation white Americans will write "American" instead of one or more groups from Europe/Middle East

Many Hispanics don't want to choose one of the race options, and so will write Hispanic or Mexican under some other race.

2020 U.S. Census



Examples

Medi-Cal Application	Census	DHCS Membership File
Race: AI/AN Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Yurok	Race: AI/AN and lists Yurok, Karuk, and Hupa tribes Ethnicity: non-Hispanic	Single Race: AI/AN Principle: Non-Hispanic ethnicity with only one race chosen.
Race: Other: Mexican Ethnicity: Hispanic: Mexican	Race: AI/AN: Aztec tribe Ethnicity: Hispanic: Mexican	Single Race: Hispanic Principle: Hispanic Status trumps any race choice
Race: White and AI/AN selected Ethnicity: non-Hispanic Enrolled in Federally Recognized Tribe: Round Valley	Race: White: German and AI/AN: Concow, Pomo (runs out of room so cannot include others) Ethnicity: non-Hispanic	Single Race: Other/Missing Principle: Non-Hispanic ethnicity with more than one race.

Slighly muddled counts of Native American origins

U.S. Native Americans, by self-reported origin, 2020

Search in table Page 1 of 118

TRIBE OR ENTITY	SINGLE-ORIGIN	ALL
Aztec	387,122	583,981
Navajo Nation	315,086	423,412
Cherokee	214,940	1,513,326
Maya	180,359	300,519
Choctaw	69,454	255,557

Aztec and Maya added as specific Options in 2020

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	**Dividing up the AI/AN category** • Offering Aztec and Maya choices increased number of Latin American Indians identified • Increased self-identification of AI/AN mixed with other race • Census category of AI/AN might more properly be called Indigenous people of the Americas

Table 1.
American Indian and Alaska Native Alone and Alone or in Any Combination Regional Groups: 2010 and 2020

Regional group	Alone			Alone or in any combination		
	2010	2020	Percent change	2010	2020	Percent change
Alaska Native	120,260	133,311	10.9	166,120	241,797	45.6
American Indian	1,935,910	2,159,802	11.6	3,232,465	6,363,796	96.9
Canadian Indian	6,435	7,723	20.0	14,825	72,701	390.4
Latin American Indian	172,280	766,112	344.7	269,050	1,319,523	390.4

Note: The 2010 counts shown were created using 2020 processing and tabulation and may not match official counts from the 2010 Census. Information on suppression, confidentiality protection, nonsampling error, definitions and guidance on using the data are available at <https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/detailed-demographic-and-housing-characteristics-file-a/2020census-detailed-dhc-a-techdoc.pdf>. The U.S. Census Bureau reviewed this data product for unauthorized disclosure of confidential information and approved the disclosure avoidance practices applied to this release. CBDRB-FY23-POP001-0150.
Source: U.S. Census Bureau, 2010 Census special tabulation; 2020 Census Detailed Demographic and Housing Characteristics File A.

Another estimate of undercounting
The 2021 American Community Survey (a random sample from across the country) framed the questions differently, not including indigenous people from outside the United States. It calculated that 330,959 individuals have Medi-Cal, which is 660% higher than official estimates, but less than the 600,000 extrapolated from the U.S. Census.

Impact of undercounting AI/AN
- Erroneous framing in Native and non-Native populations
- Insufficient prioritization of policies
- Inequitable resource allocation
- Incorrect conclusions drawn from invalid data

Resolving Over Counting
- New OMB 2024 standard for categorizing race/ethnicity
  - Must be implemented by 2029 at the latest
  - The Middle-eastern/north African population was carved out of the white category.
  - Moves Latino/Hispanic to be a co-equal race/ethnicity category, instead of carved out ethnicity category
    - This will solve the Hispanic over counting issue
  - Anticipated result: Less Hispanic race, more of all other categories.
  - Official options for categorizing individuals who select more than one race
    1. "Alone or in combination" *(intermediate complexity, less granular analysis possible)*
    2. "Most frequent multiple responses" *(most complex to convey and analyze)*
    3. "Multiracial" categorized as "other" or "mixed" *(simplest but least useful for analysis)*
  - Tribal Consultation was not done to select the current method of conveying racial data.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
V.A Undercounting of the American Indian Population	**DHCS Remedies** • Since it has such a large impact on the American Indian data, formal Tribal Consultation should be done before a decision is made. • Partnership recommends: o DHCS should adopt the "Alone or in combination" option for categorizing data. o Share detailed ethnicity data with Managed Care plans at least monthly. o Develop framework for analyzing racial disparities/inequities using more inclusive racial categories. • Urgency: o Undercounting is a health inequity, a form of structural racism. o New Federal Standards offer an opportunity to change the standard for sharing racial data. o Tribal consultation should be done early in this decision-making process, especially if there is significant controversy and major implications of the policy *DHCS announced a plan to offer data to the health plans through a new product called MediCal Connect, for which Partnership has enrolled for the pilot. The data is expected sometime in 2025. Partnership asked for a one-time, preliminary data feed for the raw data on multi-racial patients so Partnership data analytics team can begin to evaluate. These federal standards are beginning to come down and health centers will need to be mindful of electronic health records and the data contained.* ***Questions*** **Are Hawaiians considered AN/AI?** No. Hawaiian natives are classified with Pacific Islanders.
VI. Adjournment	
PAC adjourned at 9:02 a.m.	**Next PAC on Wednesday, October 9, 2024 at 7:30 a.m. Brown Act flexibilities have ended.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____ _____
Date **Steve Gwiazdowski, M.D., Committee Chairperson**

The foregoing minutes were APPROVED WITH MODIFICATION on _____ _____
Date **Steve Gwiazdowski, M.D..., Committee Chairperson**

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

Date: Oct. 16, 2024 **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

Other Locations:

Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603

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	Welcome Phuong Luu, MD, QUAC's newest member	Robert Moore, MD	7:30	--
2	*Approval of* • Sept. 18 Quality/Utilization Advisory Committee (Q/UAC) Minutes			5 -14
3	*Acknowledgment and acceptance* of • Sept. 10 Internal Quality Improvement (IQI) Committee Meeting Minutes • July 25 Substance Use Internal Quality Improvement (SUIQI) *draft* Meeting Minutes			15 - 26
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:37	27 - 40
2	HealthPlan Update *Q/UAC voters are asked to help with NCQA Health Equity Accreditation efforts by completing this survey:* https://www.surveymonkey.com/r/QUACDEI	Robert Moore, MD	7:42	--
III.	**Old Business –** None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:50	41
	Proposed 2025 PCP QIP Measures Summary – *refer questions to Athena Beltran-Nampraseut*			43 - 48
	Proposed 2025 Palliative QIP Measures Summary – *refer questions to Eva Lopez, CPhT*			49
	Quality Improvement Policy			
	MPQP1008 – Conflict of Interest Policy for QI Activities			51 - 53
	Utilization Management Policies			
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			55 - 57
	MCUP3020 – Hospice Services Guidelines			58 – 62
	MPUP3116 – Positron Emission Tomography (PET Scans)			63 - 65

	Item	Lead	Time	Page #
	Grievance & Appeals Policy			
	CGA022 – Member Discrimination Grievance Procedure			67 - 72
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	73 - 78
	Care Coordination			
	MCCP2032 – CalAIM Enhanced Care Management (ECM)	Lisa O'Connell, MHA	7:55	79 - 109
	Population Health			
	MCND9002 – Cultural & Linguistic Program Description – *CLEAN policy copy begins on p. 165; C&L/QIHETP Work Plan follows at packet's end*	Hannah O'Leary, MHA	8:00	111 - 187
	Health Equity			
	MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description – *CLEAN copy begins on p. 211; C&L/QIHETP Work Plan follows at packet's end*	Mohamed Jalloh, Pharm.D	8:05	189 - 228
	Utilization Management			
	MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	Tony Hightower, CPhT	8:10	229 - 238
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		8:15	239 - 243
	MCUP3049 – Pain Management Specialty Services		8:20	245 - 266
VI.	**Presentations**			
1	Grand Analysis: Health Equity – *Health Equity Standards – HE 6: Reducing Healthcare Disparities begins on p. 297*	Moe Jalloh, Pharm.D Dorian Roberts	8:25	267 - 381
2	2025 C&L/QIHETP Work Plan – *Excel file*	Moe Jalloh, Pharm.D		383 - 385
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 20, 2024			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Oct. 16, 2024 / 7:30 a.m. – 9:00 a.m. Napa/Solano Room, 1st Floor

Q/UAC has now returned to in-person meetings governed by Brown Act requirements following the Feb. 28, 2023 lifting of California's Public Health Emergency.

Voting Members Present	Brian Montenegro, MD	Michael Strain, PHC Consumer Member
Sara Choudhry, MD	Meagan Mulligan, FNP-BC	Randolph Thomas, MD
Steven Gwiazdowski, MD, FAAP	John Murphy, MD	Jennifer Wilson, MD
Phuong Luu, MD	Robert Quon, MD, FACP	
Voting Members Absent: Emma Hackett, MD, FACOG; Brandy Lane, PHC Consumer Member; Chris Swales, MD		
Partnership *Ex-Officio* Members Present:	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Cox, Bradley, DO, Regional Medical Director (Northeast)	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections	
Devido, Jeff, MD, Behavioral Health Clinical Director	O'Connell, Lisa, Director, Enhanced Health Services	
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Randhawa, Manleen, Senior Health Educator, Population Health	
Frankovich, Terry, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Ruffin, DeLorean, DrPH, Director of Population Health	
Glickstein, Mark, MD, Associate Medical Director	Spiller, Bettina, MD, Associate Medical Director	
Hightower, Tony, CPhT, Associate Director, UM Regulations	Steffen, Nancy, Senior Director of Quality and Performance Improvement	
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Thornton, Aaron, MD, Associate Medical Director	
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Kubota, Marshall, MD, Regional Medical Director (Southwest)	Watkins, Kory, MBA-HM, Director, Grievance and Appeals	
Leung, Stan, Pharm.D, Director of Pharmacy Services		
Partnership *Ex-Officio* Members Absent:	Guevarra, Angela, RN, Associate Director, Care Coordination (SR)	
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)	
Cotter, James, MD, Associate Medical Director	Katz, Dave, MD, Associate Medical Director	
Guillory, Ledra, Senior Manager of Provider Relations Representatives	Kerlin, Mary, Senior Director of Provider Relations	
Guests:		
Andrews, Leigha, Regional Director (Southwest)	Erickson, Leslie, Program Coordinator I, QI (scribe)	
Bontrager, Mark, Sr. Director of Behavioral Health, Administration	Garcia-Hernandez, Margarita, PhD, Director, Health Analytics, Finance	
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Lopez, David, PR Representative II, Provider Relations	
Brown, Isaac, Director of Quality Management, QI	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)	
Campbell, Anna, Health Policy Analyst, Utilization Management	McCune, Amy, Manager of Quality Incentive Programs	
Chishty, Shahrukh, Sr. Mgr of Foster Care Programs, Behavioral Health	Miller, Andrew, MD, Director of Community Health, Enloe Hospital (Chico)	
Cook, Dawn R., Program Manager II, QI (NCQA HEA)	O'Leary, Hannah, Manager of Population Health	
Devan, James, Manager of Performance Improvement	Sackett, Anthony, Program Manager II, QI (CAHPS)	

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 7:32 a.m. He introduced • Partnership Commissioner and Bi-County Public Health Officer Phuong Luu, MD as Q/UAC's newest voting member. • Partnership Commissioner Andrew Miller, MD, who is considering joining Q/UAC. Dr. Miller is the Director of Community Health at Enloe Hospital in Chico. The Sept. 18, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Sept. 10 Internal Quality Improvement (IQI) Committee • July 25 Substance Use Internal Quality Improvement (SUIQI)	Unanimous Approval of Q/UAC Minutes as presented: John Murphy, MD Second: Jennifer Wilson, MD Unanimous Acceptance of other Minutes: Robert Quon, MD Second: John Murphy, MD *Meeting Postscript:* Dr. Miller will not join Q/UAC at this time but will look at other Partnership committees perhaps better aligned to his interests.
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Sr. Dir. of Quality and Performance Improvement*	• Correction: the new date for payments on our Fiscal Year Quality Incentive Programs (Perinatal QIP and Hospital QIP) is Nov. 18. • As you know, we have a very robust Quality Measure Score Improvement series of workgroups by measure domain both to serve Department of Heal Care Services (DHCS) Measure Core Accountability Set (MCAS) as well as our National Committee on Quality Assurance (NCQA) Health Plan Accreditation (HPA) Measure Set. In our Blood Lead Screening measure, a particular focus of MCAS, we have had great improvement coupled with ongoing efforts to bring Point-of-Care devices to the primary care settings. We have up to 30 devices available for distribution as part of our third round review. • We continue to update the narrative around the Equity and Practice Transformation Program (QTP). This is a great opportunity to help some of our primary care providers develop capacity and infrastructure improvements. We had a total of 27 provider organizations who applied to this program last year. Our 27 provider organizations (POs) accepted last year into the ETP are still continuing with the program despite the 80% funding cut resulting from the May Revise of the State budget. These 27 include five expansion providers from the expansion counties, eight Tribal health POs and seven "legacy" county POs already engaged in ongoing enhanced provider engagement opportunities. We have a better sense now of what those practices need to contribute in terms of deliverables, beginning Nov. 1, 2024 through Oct. 31, 2025, things around empanelment and access: data to enable what they are calling a population health milestone, data governance, and full quality measurement capture under key preventive screening and chronic disease measures. POs are required to attend 80% of the learnings that have been constructed statewide: Partnership's participating POs are in the "Redwood Learning Community" collaboration.	For information only: no formal action required. There were no questions for Nancy.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• As many of you know, when we went through contract termination with Dignity earlier this year, we focused on those more than 64,000 Partnership members who were displaced across several counties in our service region. We offered what we called "capacity enhancement grants" to the provider organizations in primary care who accepted new member assignments during this time. This was also an opportunity for us in QI to evaluate what are meaningful ways to help enhance capacity in our system network. Seventeen of 19 POs who we identified as eligible for this grant opportunity had their first installment of funding earlier this year. Most recently, we reviewed progress reports. Some of the short-term activities summarized by these participating practices revolve around retaining staff, locum recruiting, and expanding clinic hours into Saturday. Longer term, we are helping to invest in longer retention activities. Second and final payment installment is now pending with our Finance team. • Our Health Plan Rating, as projected in August and posted by NCQA in September, continues at 3.5 Stars as expected.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• On today's agenda, you will notice a link to respond to a survey as part of our Health Equity Accreditation efforts. Q/UAC voters are encouraged to respond. • CEO Sonja Bjork, LD, returns next week from an prolonged medical leave. We are excited to welcome her back. • A series of activities focused on residency programs is part of the approximate 50 interventions Partnership has underway to improve access across the network. This year, we piloted meetings with residents and faculty too: to date, five events have occurred, each different from the other not least, because each residency program has its own culture. The local medical societies have partnered with us in these efforts. In February, Partnership will convene with residents presenting their quality projects, as they are required to do during their residencies, to a group of judges and each other. • The California Medical Association House of Delegates is meeting soon. This year, they chose to focus on two major areas, the first is rural health equity, and the second is reproductive and OB access, both of which are major priorities for Partnership. We are sending a group of medical directors to those meetings. A number of us are delegates. We certainly encourage everyone to participate in organized medicine and these Partnership priorities. Ninety percent of the membership of the CMA is in urban areas that are not affected by rural OB access, so it is important for us to interact with our colleagues in urban areas to help them understand the reality in these rural California. • As a side note on legislative efforts to improve OB access, we have narrowed it down to three issues we hope will be introduced in the upcoming legislative session: o A proposal for a statutory change to allow accreditation to be a standard for contracting for Medi-Cal alternative birthing centers. Right now, Medi-Cal does not allow members to go to these alternative birthing centers. o A new designation for a stand-by perinatal unit in rural areas so staffing can be more flexible and affordable.	New Q/UAC voting member Phuong Luu, MD, asked how the Partnership Advantage Pharmacy benefit might jibe with the carve-out Medi-Cal Rx. She wants to make sure it will not be confusing for Medi-Medi beneficiaries.. Partnership Pharmacy Director Stan Leung, Pharm.D, clarified that Partnership Advantage will include Part D and that, if something is excluded from Part D coverage, our system will tell pharmacists to bill Medi-Cal Rx. The Partnership Advantage Model of Care will be presented to

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Support for training rural nurses. Training programs for rural nurses tend to be more broad. They come out being able to move about different parts of the hospital. • Partnership's second annual Tribal Health convening was Oct. 7 in Sacramento. We had good representation from the 21 Tribal Health centers in our region. We talked about workforce; we had some guest speakers from UC Davis as well as others through our region, behavioral health, Tribal Perinatal program. Data sovereignty was a big issue and, more generally public health. This convening may become an annual event: our underlying goal is engagement to build trust and to work together. • The Dual Special Needs Plan (D-SNP) that Partnership will offer to eight of our 24 counties effective Jan. 1, 1026 will be known as "Partnership Advantage." These counties along the coast and touching San Pablo Bay represent about 44% of our members eligible for D-SNP. This will be almost a boutique product at first: we anticipate perhaps only five percent of eligible members – because they have to voluntarily opt in – will sign up in year one. The "Model of Care," which describes the activities Partnership will commit to doing for this population, is now in development. A Pharmacy Benefit Manager should be hired by the end of this year. • As we have mentioned a few times, we have the "modified QIP" where primary care sites that score extremely low on their pay-for-performance measures get put on a modified QIP with a smaller number of measures and a coach assigned. A part of that is a meeting with their governing organization, most often a board, to go over quality parameters. We are now in full-blown board season. Hopefully, we will cycle through those meetings in the next couple of months. On Oct. 15, I was up in Round Valley in Mendocino County with one of the most interesting boards anywhere.	Q/UAC at its Feb. 19, 2025 meeting. *Meeting postscript:* Dr. Moore's October Medical Directors Newsletter was emailed Oct. 30 to Q/UAC providers.
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	Proposed 2025 PCP QIP Measures Summary – *direct questions to Athena Beltran-Nampraseut* Proposed 2025 Palliative Care QIP Measures Summary - *direct questions to Eva Lopez, CPhT* ***Health Services Policies*** <u>Quality Improvement</u> MPQP1008 – Conflict of Interest Policy on QI Activities <u>Utilization Management</u> MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3020 – Hospice Services Guidelines MPUP3116 – Positron Emission Tomography (PET Scans) <u>Grievance & Appeals</u> CGA022 – Member Discrimination Grievance Procedure Dr. Moore noted that the Physician Advisory Committee (PAC) will look at Palliative Care on Nov. 13.	Nothing was pulled from the Consent Calendar. **Motion to approve as presented:** Robert Quon, MD Second: Michael Strain *Approved unanimously* <u>Next Steps</u>: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	PAC approved the PCP QIP on Oct. 9. Dr. Moore noted that there are three major changes in the 2025 measure set, including adding chlamydia screening and well-child visits between the ages of 15-30 months to expectations of pediatric-only providers. For larger practices, an academic detailing is added: our Pharmacy team will go and visit a couple of times with each site's clinicians to go over their pharmacy prescription data that we get from Medi-Cal Rx, and look for ways to improve quality.	
V. New Business – Discussion Policies		
Policy Owner: Enhanced Health Services – *Presenter: Lisa O'Connell, Director, Enhanced Health Services*		
MCCP2032 – CalAIM Enhanced Care Management (ECM)	**Related Policies.** Changed MPPR200 policy title to *Partnership* Provider Contracts. Added: MCCP2033 Community Health Worker (CHW) Services Benefit MCCP2034 Transitional Care Services (TCS) **Impacted Departments**: Added Enhanced Health Services **Definitions.** Added: Closed Loop Referral CHW, differentiating it from CHW Services Point-Click-Care. **Section VI.A.** Based on the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032, we made some additional edits to be in compliance. The adult individual experiencing homeless population of focus definition to include under other homeless deferral status. Re the Serious Mental Health/Substance Use Disorder Population, the policy was missing the original criteria of "Are experiencing at least one complex social factor influencing their health." **Section VI.B.** Justice Involved Initiative DHCS requirements added to prepare for the JI ECM population of focus and ECM JI provider requirements. **Section VI.C.** Adding Target Case Management (TCM) programs and CHW services benefit to ECM exclusion criteria. **Section VI.D.5.d.4):** Removed "palliative care" from the enhanced coordination of care section as it caused provider confusion. Palliative care is duplicative of ECM. **Section VI.D.6.a.** Changed "PHC's Care Coordination Department" to "Partnership's designated staff." **Section VI.D.7.** Adding new ECM referral and standards language based on the DHCS 2024 August ECM policy guide and ECM Referral Standards and Form Templates guidance. **Section VI.G.** Continuity of Care additions based on DHCS requirements that include if a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a LOA until an agreement is reached, Partnership will assign the member to their existing ECM provider to ensure the member's relationship is not disrupted. **Section VI.I.** Specific language added around ECM provider network development that covers DHCS requirements around collaborating with other MCPs, building a sufficient network, and achieving network overlap	There were no questions. Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.J.1.a.2)e)i. Model of Care for Justice Involved providers includes specific DHCS JI ECM provider requirements around a JI MOC with warm hand off plan, meeting with member within 1-2 days of release, ensuring a 2nd follow up ECM appointment happens within 1 week of release, and leverage of the re-entry plan for ECM care management planning. **References:** Updated the ECM policy guide link, August 2024 https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf Added ECM Referral Standards and Form Templates link https://www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf Lisa noted that this policy will soon come back to QI committees with more changes as DHCS regulations change. Meanwhile, this policy as presented today adds both some definitions and "justice-involved" language. The policy further clarifies target case management and CHW services excluded from ECM.	
Policy Owner: Population Health – *Hannah O'Leary, MHA, Manager of Population Health*		
MCND9002 – Cultural & Linguistic Program Description	**Annual Update includes extensive revisions and has expanded to continue alignment with NCQA Health Equity requirements.** Added language: • As suggested by Partnership's NCQA consultant • Expanding references to Health Equity, including references to the Quality Improvement & Health Equity Transformation Program (QIHETP) • Detailing our current Language Data Collection processes and criteria for threshold languages, including how we collaborate around this with Local Health Jurisdictions (LJHs) • Expanding the Language Assistance Services section, including more info around where and how nondiscrimination notices and language assistance taglines are posted and distributed, and more details around the requirements we meet for translations, interpreters, and alternative formats • Detailing Partnership's commitment to its evidence-based DEI trainings and program • Detailing the Population Needs Assessment Committee and the Quality Improvement & Health Equity Committee (QIHEC), the latter which replaced the PHM&HE Committee, including recruiting criteria • Expanding the 2024-2025 Goals section, including a list of approving committees and per-goal descriptions from the C&L/QIHETP Work Plan New 2024 goal section: to provide at least 1 mailing in a member's preferred alternate format to 90% of members who have a standing request on file • Updating PHM position names and responsibility descriptions • Updated all diagrams • Added new hyperlinked references and footnotes **Updated Attachment F:** FAC Charter • Updated with new expansion counties • Minor updates throughout (instances of PHC changed to "Partnership," etc.)	There were no questions. Motion to **approve as presented:** Brian Montenegro,, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	At Dr. Moore's request, Hannah gave an overview of the program before summarizing the synopsis of changes. This Program Description summarizes the C&L services that we have here: translation, interpreter services, requests for alternate formats. It includes information on the different trainings that we offer staff and providers. We did do some extensive updates recently to cover some DHCS requirements and to align with some NCQA requirements as well.	
Policy Owner: Health Equity – *Mohamed "Moe" Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	• Updated the duty descriptions of the Medical Officer for Quality and the Director of Population Health Management. • Removed mentions of Population Health Management and Health Equity (PHMHE) Committee due to its dissolution and the concurrent creation of the Population Needs Assessment (PNA) Committee. ○ The Population Needs Assessment Committee (PNA) is an internal subcommittee of IQI and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with IQI, Q/UAC, QIHEC, PAC, and Partnership's Board of Commissioners. • Updated the NCQA Accreditation Program Management section, noting the timeline to HEA implementation by Jan. 1, 2026. • Updated Data Sources section with "DHCS Bold Goals" that step out identification and evaluation of racial/ethnic disparities in well-child and immunization measures, maternity care for Black and Native American persons, and to improve maternal and adolescent depression screening and follow-up for mental health and substance use disorders to close gaps by 50%. • Revised how Pop Health, Grievance and Appeals, and Human Resources departments will collaborate with Health Equity. • Updated Annual Program Evaluation components to include Community Reinvestment Act recommendations, and regional Quality and Health Equity team compositions per Medi-Cal guidelines. • Updated title page date to PAC date and updated signature page with this year's dates and the current Board Chair's name Dr. Jalloh summarized: we are making changes based on DHCS' APLs. We retired the previous PHM&HE Committee and updated it with the PNA Committee. We updated how we calculate and how we determine what health disparities we prioritize. We also talked about how we are going to be working with our subcontractors with their health equity work, and we identified/clarified what data we will be doing an annual evaluation for: we organized the list to make it easier for everyone.	There were no questions. Motion to **approve as presented:** Randy Thomas, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Moore thanked Moe for his summation, saying "these quick reviews belie the many, many hours of work" that occurs before policies are brought to Q/UAC. "Our goal is to have it pretty fleshed out so when it comes to you, we catch everything," Dr. Moore said.	
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, Utilization Management Regulations*		
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	This policy has been updated to include language for subacute care facilities as per DHCS 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care. **Section I:** The new Provider Relations policy MPPRXX – Long Term Support Services Liaison has been added as a Related Policy. **Section III.E and F.:** The definition of Subacute Care Facilities was updated and the acronym SCU was defined as Subacute Contracting Unit. **Section VI.A.1.a. – c.** The three facility types discussed in this policy, SNF, Subacute, and ICF, were referred back to Section III. for full Definitions. **Section VI.A.5.b.** Added language to specify that "For members approved for subacute services, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU." **Section VI.C.1.** Added language to specify that at TAR is required with each admission to a LTC Facility "In alignment with Manual of Criteria R-15-98E." **Section VI.C.2.g.** Added "SNF to Subacute" as a potential level of care scenario. **Section VI.E.1.** Replaced "LTC" with "SNF" for facility type that is discussed in this paragraph. **Section VI.E.2.** Added language to say that "Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations. **Section VI.F.** Throughout this section, language was updated to cite the Continuity of Care requirements that were effective January 1, 2024 through June 30, 2024 for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care. Previously, this section of the policy described a similar COC provision for Members transitioning for a SNF in 2023. At the end of section VI.F. we specify that automatic continuity of care does not apply after the specified time frames (ended 07/01/2023 for SNFs and 07/01/2024 for Subacute). Thereafter, Members newly enrolling with Partnership must request continuity of care following the process established by APL 23-022. **Section VI.H.4.** Updated Bed hold scenario to include "When a Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence." **Section VI.H.4.b.** Added language where we specify that a Maximum bed hold is 7 calendar days to also say "The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days." **Section VII. Added the following References:**	There were no questions. Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	A. Medi-Cal Provider Manual Guidelines: Subacute Care Programs: Level of Care for Adults and Children (subacut lev); Subacute Care Programs: Adult (subacute adu); Subacute Care Programs: Pediatric (subacut ped); Leave of Absence, Bed Hold, and Room and Board (leave) B. InterQual® Criteria D. Title 22 CCR sections: 51535, 51535.1, 72520 E. Title 42 Code of Federal Regulations (CFR) Section 483.15e F. Welfare and Institutions Code (WIC) §14132.25 L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023) M. DHCS Subacute Care Program and Manual of Criteria R-15-98E C Before Tony went through the synopsis, Dr. Moore gave some context: Partnership has had the long-term care benefit since our 1994 inception. It was only added in the past year or so to other local initiatives and other plans. As it has become a more broad benefit, DHCS has written and continues to write more regulations that Partnership must include in this policy.	
MCUG3058 – Utilization Review Guidelines ICF/DD. ICF/DD-H, ICG/DD-N Facilities	This policy has been updated according to DHCS APL 23-023 Revised Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023) **Section I:** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) has been added as a Related Policy. **Section III:** A definition was added for MCP to explain that Partnership HealthPlan of California is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). Definitions of acronyms for NF-A and NF-B were removed as these types of nursing facilities are not discussed in this policy. **Section VI.A.** New paragraph was added to specify that Partnership provides all medically necessary covered services for Members residing in an ICF/DD and also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 23-023. **Section VI.B.4.a.7)** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) was added as a reference **Section VI.C.2.a.1)** Paragraph for non-developmentally disabled recipients was removed as that is not the topic of this policy. **Section VI.C.2.a.1)a)** Sentence was added to specify that a physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled. **Section VI.D.1.** Various settings were described for when a bed hold would apply for a Member residing in a ICF/DD facility. **Section VI.D.3.a. and a.5):** Language regarding NF-A and NF-B facilities was removed as provisions for LOAs from those facilities is not the topic of this policy. **Section VII. Added the following References:**	Motion to **approve as presented:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	A. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) H. DHCS Population Health Management Guide **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer	
MCUP3049 – Pain Management Specialty Services	**Section IV. Attachments:** Attachment A, the Partnership TAR Requirements List, was removed from the list of Attachments. Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. **Section VI.E.:** In lieu of previous Attachment A to this policy, (which was a shared document between three policies), a reference and hyperlink was added in this section to refer the reader to policy MCUP3041 Treatment Authorization Request (TAR) Review Process -Attachment A (Partnership TAR Requirements) for a list of pain management services that require a TAR. **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer **Attachment A:** This document was updated minimally for code corrections. These changes will be applied where the Partnership TAR Requirements list is also shared as MCUP3041-A and MCUG3007-B. • Code 62287 was moved from the Pain Management CPTs Requiring a TAR list to the Outpatient Surgical Procedures CPTs Requiring TAR list. • On page 8, codes 63658, 63661 and 63688 were deleted for the list. Then this Attachment A will be ARCHIVED from this particular policy. The reasoning for this is to reduce confusion by narrowing to one source document for our Partnership TAR Requirements list. **Former Attachment B - New Attachment A:** Former Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. Codes 62633 and 62264 were added with criteria. Code 63688 was removed. Dr. Moore noted that "pain management" means different things to different people and asked Tony to say what it means in the scope of this policy. Tony replied this policy specifically outlines our medical-necessity criteria for pain management and includes references to specific codes related to pain management. This update was pretty straightforward, Tony said. The big change was in removing Attachment A, which was our general TAR criteria. That had been previously attached to three different policies, so we are consolidating that to only attach to our main TAR policy. In this policy, we are pointing the reader to refer to our main TAR policy for general TAR requirements. Attachment B to this policy will now be Attachment A. That is where our specific criteria and codes to pain management reviews are included. In this update we did some minor updates to codes to reflect the State's requirements. Dr. Moore added that the pain management CPTs requiring TARs are generally involved with interventions, injections, etc. that involve the spinal column.	Motion to **approve as presented:** Robert Quon, MD Second: John Murphy, MD *Approved unanimously* Next Steps: Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Q/UAC voter John Murphy, MD, asked why, if this policy is necessary, there isn't a like policy for endocrine specialty services or for every sub-specialty? Dr. Moore replied that, in part, the relevant section of code is longer than other TAR-required code list. Further, pain management historically has been at risk for over utilization. Q/UAC voter Randy Thomas, MD, looking at the broad TAR list included in the packet asked why a TAR is required for more than two chiropractic visits per month? Anna Campbell said a TAR is required if a member needs more than two visits. Dr. Moore added that the State does the same, except that they say two visits in a broad category: if you get one podiatry and one chiropractic, then the third of anything in the same month is denied by the State unless you get a TAR. There were no other questions.	
VI. Presentations		
Grand Analysis: Health Equity MY 2023 & 2025 C&L/QIHETP Work Plan *Mohamed Jalloh, Pharm.D, Health Equity Officer*	**Q/UAC unanimously accepted the Health Equity Grand Analysis and Work Plan on the motion of Robert Quon, MD, and second of Jennifer Wilson, MD, after a 45-minute presentation and discussion.** Dr. Jalloh began by saying that this is the second annual Grand Analysis (GA) and its methodology has improved over the first year largely through internal discussions. Neither DHCS nor NCQA has provided much guidance. This second GA is based on 2023 data and thus covers only the 14 "legacy counties." The 2024 GA data will also encompass the 10 "expansion" counties that onboard Partnership Jan. 1. 2024. Data was received the data from our HEDIS® team, and submitted it to our Health Analytics team who did the analysis to evaluate whether there were statistically significant differences. When we looked at the raw data, we saw so many disparities that the challenge became which ones do we act upon or try to prioritize. We defined "strong disparity" – where we should probably invest our time and resources – if it met these three criteria: there was a statistical difference, that it was large, and not only large but consistent across multiple regions. There wasn't any statistical difference between racial groups for the Controlling Blood Pressure measure, and when compared to the 50th percentile Minimum Performance Level (MPL) to which the State holds us accountable, every group met that MPL. Some groups actually improved over 2022, while others did not. The interesting one was the Poor Hemoglobin Control (>9%). It is counter-intuitive where lower is better. Our Asian community actually had the best control compared to other groups, which, unfortunately, were not doing well. Our Asian community was statistically superior when compared to the comparison group and well below the MPL. Our Tribal, Black and Native Hawaiians were all above what the State would like to see. Not only did we categorize it by race, we also stratified across our regions. We can see that in certain regions, the disparity is pretty pronounced: in the Northwest, we saw many of our groups not meeting the minimums. When we looked at our composite, we saw that the Southeast region was pushing much of the data composite for each race group. Re Timeliness of Prenatal Care, we found a statistical difference with one group compared to another. There was significant difference between our Tribal and White communities. Tribal communities were clearly lower than the MPL; we saw this in our Black and Native Hawaiian communities too. This was really driven in our Northeast and Northwest regions, where many groups were not even meeting the 25th percentile much less the 50th percentile MPL. Same thing when we look at our Northeast region. This told us there may be more	

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	of a quality issue: probably lower prenatal care access in our Northern region because of the rurality of that area. We may wish to prioritize Timeliness of Prenatal Care in our Tribal community to meet both DHCS' "bold goal" and in alliance with our NCQA Health Equity Accreditation (HEA) measures. The NE, NW, and SW regions each averaged 20 percent below the MPL. For our Black community, we did not see a statistical difference; however, we saw our Northern regions average 30% below. We calculated that if we really want to improve the disparities in that group, bringing them up to the MPL, we need to increase our prenatal care by 10% in the Northeast and 50% in the Northwest. Post-partum Care was a very good example of a disparity or an inequity. All the race groups, but our Tribal community, when we stratified it across the years, is doing well. We found the statistical difference in our Northeast region when we compared the Tribal community to the White community: they were well below the 25th percentile where everyone else was doing pretty well. We calculated that if we wanted to improve Tribal post-partum care to reach the MPL, we would have to increase the values by 25% in the NE, 5% in the NW, and 5% in the SE. There seems to be consensus that access issues are affecting everyone for Well-Child Visits (WCV). Only the Hispanic community met the 50th percentile MPL. Further, when we looked at it at the regional level, some groups actually performed statistically better than did our White community: our Hispanic and Asian communities in the NE, and in the NW, our Hispanic community did statistically better as well. Statistic results were mixed in the SE and SW. This led us to look at it on two different levels. One, we recognize it may be a quality issue where we see a majority of the race groups were not able to meet the minimums the State wants, and it tells us it's an access issue, especially in our rural community. We have seen across all groups that what we have to focus at the quality level is the Well-Child Visits. When we looked at our American Indian/Alaska Native (AI/AN) group, the big issues were prenatal and post-partum care. Prenatal care was our big concern in the Black community. We would like to prioritize WCV for our White and Rural Community. Based upon that, we developed a Work Plan. That does not mean we are going to prioritize only these; this is only for submitting for our HEA. The "Big Three" are Health Equity Strategic Plan (disparity analysis, hiring bilingual employees, submitting DEI training), Culturally and Linguistically Appropriate Services or CLAS (providing timely translation materials to members), and Measures, specifically Prenatal Care and WCV. Dr. Jalloh reminded Q/UAC that there are limitations with our analysis: the data is old and, with lack of DHCS guidance, we created internal methodologies. We did not only factor comparing certain race group to the White community but also compared all race groups against the State's MPLs. We welcome feedback with suggestions how we can improve the methodology to identify and prioritize addressing the disparities. Dr. Jallon and Dr. Moore will be attending a conference in November, at which they hope to buttonhole any NCQA attendees. Q/UAC voter Randy Thomas, MD, notice that the Hispanic community seems to be doing well, and he asked if good performance was concentrated in certain providers like La Clinica and OLEHealth. Doctors Moore and Jalloh agreed that this performance is plan-wide, and county-wide amongst almost every provider. Dr. Jalloh added that the WCV measure is an administrative measure where all data is required. NCQA only requires a sample for all other measures. Dr. Moore said we see similar patterns when sampling via PCP QIP data: generally, big picture performance across all groups ranks Asian, Hispanic, White, Black and AI/AN.	

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	Dr. Thomas asked, if this is the case, is it access, capacity, or something else, and he suggested that if the Hispanic community can overcome any perceived barriers, so too can other communities. Dr. Moore said it is more than access. Asian and Hispanic populations show a stronger willingness to vaccinate. For Hispanics in particular, there is a cultural though "first God then the doctor," Dr. Moore commented. "In spite of poverty, there is this strong family culture of connectedness that offers protection against the issues that affect other populations." Q/UAC voter Steven Gwiazdowski, MD, asked if "solutioning" was brought about by actually doing root-cause analysis (RCA), not only for the laggards but for the ones who succeed? If you are hiring bilingual employees and submitting to DEI training, you are applying that to a group like the Hispanics who are over performing, what is the impact? Conversely, if the White population is pretty much speaking English, and they are not actually effected by DEI issues that we are talking about, how is that going to improve performance there? I understand the problem: you have regions, then you have racial and ethnic groups, and then you have all the different measures. You could end up with dozens, if not more, of RCAs that you would have to do. Knowing that, is there a Pareto you could apply to strategize and prioritize? Dr. Jalloh replied a Pareto analysis may help with determining the root cause of specific disparities. Regarding the bilingual hiring issue, Partnership has realized that we do not have as many bilingual employees as we need. This is separate from addressing the HEDIS® measures. NCQA wants us to look at both health disparities and our internal workforce. Dr. Gwiazdowski asked if NCQA would hold Partnership accountable based on the statistically significant disparities. "If you can make the statistically significant insignificant, you start getting into a discussion about methodology and sampling size when you are going up against NCQA," Dr. Gwiazdowski said. Dr. Jalloh replied this has come up in many discussions with colleagues across other health plans and we hope NCQA will make changes in the upcoming year. "The good news is that NCQA has been lenient about how we determine disparity," he said. "They have said that if our methodology makes sense they will be okay with whatever we prioritize." Partnership's Medical Director for Medicare Services Kermit Jones, MD, JD, asked what insights may have come on averages when looking at the distributions/dispersions skews. Dr, Jalloh said a big limitation with the data is our inability to look at it on an epidemiological level. We looked at averages on a regional level. If our Tribal community had 50%, that was the number we used. Dr. Moore added that we didn't do a formal dispersion analysis but instead informally looked at individual providers. "In the PCP QIP, there is the disparity analysis where you can start with a single measure, a single ethnicity, and list all the providers to see what the distribution is," he said. "For the AI population vaccination rates, we see that there is a dispersion that goes from zero to 25; it is consistently low. For the African-American population, with WCVs, we saw a wider range. We had some providers that did really, really well, - pediatric providers tended to perform well – and we saw other practices where the numbers were not so good." Director of Health Analytics Margarita Garcia Hernandez made some remarks. Agreeing with Dr. Moore that we could consider this approach for the next GA. Dr. Jalloh added that other health plans also look at standard deviation differences. Q/UAC voter Robert Quon, MD, said it might be helpful to do a 4-squar multi-variant analysis. Secondary analysis does not go far enough re low sample size, he said. "If we knew that two percent was two persons," maybe we don't worry about that. Dr. Quon also noted that his organization, Kaiser Permanente, has determined that "cultural concordance" can go a long way: one provider who "speaks their culture" can do more than with one ethnic patient set than can hiring more providers or throwing money at an issue.	

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	Dr. Moore noted we see these comparisons done in Provider Relations' work, noting that they will present their Grand Analysis: Network Access and Assessment of Network Adequacy to Q/UAC Nov. 20. Dr. Jalloh said NCQA HEA expects us to do interventions to improve our provider diversity relative to our communities but NCQA does realize there are limitations on the Health Plan itself. Q/UAC voter and Yuba/Sutter Bi-County Public Health Officer Phuong Luu, MD, said our analysis could include the Healthy Places Index, the 'bible' for public health officials in looking at health equity data. Dr. Moore said our Population Health Management Grand Analysis also cover equity data. The Health Equity GA deals with clinical quality measures, while the provider mix is in the Network Access/Adequacy GA. Q/UAC vote John Murphy, MD, expressed appreciation for devoting much time to this presentation. He noted that many QI measures are process rather than outcome measures. " For some of the WVC, are we really mostly interested in infant mortality and maternal mortality?" he asked. "If you were able to tie it into Healthy Places Index or public health data to say it's not just the process but the process and the outcome that could be more impactful and steer scare resources in a particular direction." Dr, Moore noted that probably the tightest connections to significant outcomes is Blood Pressure Control, A1c Control and Colorectal Cancer Screening. Dr. Garcia-Hernandez added that Health Analytics utilizes the Healthy Places Index to "map" every member. Dr. Moore said we use it to adjust the amount of dollars in the PCP QIP and in our risk algorithm to prioritize our members as to who gets care coordination. Q/UAC voter Brian Montenegro, MD, asked if Partnership has data on whether access to care or member hesitancy to access care or both is the issue. "Surveys could have questions that allude to what Dr. Quon was saying: 'do you trust your provider?' 'what would make you trust your provider?' This data would help." Dr. Moore said we cannot prioritize all measures for intervention. He would start, however, with root cause analysis and not Pareto. "What are the big drivers? You get hints in the distribution by various providers. Access isn't always it. Sometimes we have measures where two providers do really well and 10 do poorly. That means it is hard but not impossible. Rather than us guessing, it is good to look at that data and infer factors. It varies measure by measure, and sometimes we have to do interviews with our providers and our members to figure it out. 'Drill downs' oftentimes gives us enough insights to give us some directionality. With the American Indian community, the influence we have over those providers is low: they are sovereign nations that do not like to be told what to do. You have to build trust, and engagement is the main strategy. It needs to be their priority." Dr. Jalloh added we are trying to see how we can work in feedback from our patients in future GAs. When he has spoken with members, he has sometimes heard completely different things that what some of our clinical sites have told us. Regional Medical Director Marshall Kubota, MD, commented that looking at the age of our members may be of interest in gauging Timeliness of Prenatal Care. He thought it likely that the younger the expectant person, the more likely they would delay that first prenatal visit, a supposition Dr. Moore agreed had borne out in another Health Analytics study done in a prior year. Dr. Luu reiterated her encouragement to ask public health departments. "We have this rich qualitative data already through our CHA/CHIP process," she said. "Every five years we need to do a maternal child health (MCA) assessment, and we did the same thing: asked clinical providers, school, nurses. You don't have to totally reinvent the wheel: ask your local public health department." Dr. Moore noted that much of this public health data is already available on Partnership's website.	

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	Dr. Quon built on Dr Kubota's remarks, asking "is there a difference in prenatal care access when they have done it before? Do you say, 'we're going to concentrate on prenatal access for everyone, whether it is your first pregnancy or your sixth,' or do you say 'if we can get you plugged in the first time you are pregnant, the second, third and fourth time, you are more likely to plug in yourself?' That would be a way to narrow that population and narrow that focus, which would also then get to your teens. Then your outreach and communication efforts are different. How you communicate to a pregnant person in her thirties is different from how you communicate to a teen." Dr. Moore noted that Partnership has "zero ability" to see anything until a patient interfaces with the system, and that claims data often is not available until after the patient delivers. "That intervention has to happen in our providers. The variation in prenatal case onset is mainly driven by provider access." Regional Medical Director Colleen Townsend, MD, added that appointment availability and the member knowing how to access their transportation benefit are also significant drivers of timeliness, particularly in rural areas. "Timely prenatal care is all about getting in the first trimester, and you call at six or seven weeks pregnant, and the next available appointment is six or eight weeks out, there is no chance of making it within the first trimester." She then mentioned some possible scenarios of provider collaboration that may be of help. Dr. Thomas asked whether the first prenatal visit could be captured by the primary care provider. Dr. Moore said there are some providers, particularly in rural areas, who may not perform deliveries but will provide prenatal care. It is dependent upon training and experience. Dr. Townsend added that most of our prenatal providers are often Family Medicine or midwifery practices that are part of a primary care practice; however, rural sites do not often have ultrasound to confirm for data, which is typically done during the first visit.	
VIII. **Adjournment** – Q/UAC adjourned at 9:05 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Oct. 16, 2024.		

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, Oct. 8, 2024 / 1:30 – 3:24 PM

Members Present:

Andrews, Leigha, MBA, Regional Director, Southeast
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:

Ayala, Priscila, Associate Director of Provider Relations
Bjork, Sonja, JD, Chief Executive Officer
Davis, Wendi, Chief Operating Officer
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Director, Northwest
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Sharp, Tim, Regional Director, Northeast
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Beltran-Nampraseut, Athena, Program Manager, PCP/QIP
Bikila, Dejene, Manager of Data Science, Finance
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Chishty, Shahrukh, Sr Mgr of Foster Care Programs, Behavioral Health
Clark, Kristen, Manager of Quality & Training, Member Services
Cook, Dawn, Program Manager II, NCQA Health Equity Accreditation
Erickson, Leslie, Program Coordinator II, QI (scribe)
Far, Reza, QI Analyst, Quality Improvement
Gross, Amber, Director of Configuration, Configuration
Gual, Kristine, Manager of Performance Improvement, (SR) QI
Harris, Vander, Senior Health Data Analyst I, Finance
Lee, Donna, Manager of Claims, Claims
Lopez, Eva, CPhT, Program Manager, Palliative Care QIP, QI
McCune, Amy, Manager of Quality Incentive Programs, QI
Muncy, Kellie, Mgr of Change Mgmt & Configuration, Configuration
Newell, Amber, CPhT, Program Manager I, QI
O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Roberts, Dorian, Improvement Advisor, QI
Rodekohr, Dianna, Project Manager I, Configuration
Sivasankar, Shivani, Senior Data Scientist, Finance
Salehi, Tiphanie, Sr. Health Data Analyst, Finance
Spiller, Bettina, MD, Associate Medical Director
Thomas, Penny, Sr. Health Data Analyst, Finance
Townsend, Colleen, MD, Regional Medical Director, Southeast
Vaisenberg, Liat, Associate Director of Health Analytics, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA called in remotely from Sacramento to bring the meeting to order at 1:30 p.m. New Southwest Regional Director Leigha Andrews, MBA, introduced herself. Shahrukh Chishty, who joined Partnership Behavioral Health this past spring as the senior manager of Foster Care Programs, also introduced herself. Approval of Sept. 10, 2024 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • July 25, 2024 Substance Use Internal Quality Improvement (SUIQI)	Motion to approve IQI Minutes as presented: Isaac Brown, MPH/MBA Second: Stan Leung, Pharm.D Motion to accept SUIQI minutes: Isaac Brown Second: Katherine Barresi, RN
II. Old Business – None		
III. New Business (Committee Members as applicable) – Consent Calendar Policies		
Health Services Policies <u>Quality Improvement</u> MPQP1008 – Conflict of Interest Policy for QI Activities <u>Utilization Management</u> MCUG3032 – Orthotic and Prosthetic Appliance Guidelines MCUP3020 – Hospice Services Guidelines MPUP3116 – Positron Emission Tomography (PET Scans) ***Non-Health Services Policies*** <u>Member Services</u> MP300 – Member Notification of Provider Termination or Change in Location <u>Grievance & Appeals</u> CGA022 – Member Discrimination Grievance Procedure – ***pulled for discussion*** <u>Credentialing</u> MPCR15 – Doula Credentialing and Re-credentialing Criteria MPCR17 – Standards for Contracted Primary Care Physicians MPCR200 – Credentials Committee and CMP Credentialing Program Responsibilities MPCR300 – Physician Credentialing and Re-credentialing Requirements <u>Provider Relations</u> MPPR200 – Partnership Provider Contracts ***(new title)*** Anna Campbell pulled CGA022 to ask about the policy's usage of "PCP," which includes Federally Qualified Health Centers (FQHCs) but does not mention physician assistants, for example. Dr. Moore questioned whether the policy is talking about persons or organizations. Edna Villasenor clarified that this policy considers the site, not individual persons. Dr. Moore added that physicians generally dislike the word "provider." A better term when referring to the person is "primary care clinician," and Marshall Kubota, MD, agreed. Furthermore, references to "family practitioner" should be changed to "family physician" when speaking of a licensed M.D. or D.O., Dr. Moore said. Finally, for this policy, the word "contracted" should be added where applicable in reference to	The Consent Calendar but for MP300 was **approved as presented:** Marshal Kubota, MD Second: Isaac Brown <u>Next Steps:</u> • QI, UM, and G&A policies will go to the Oct. 16 Quality/ Utilization Advisory Committee (Q/UAC) and the Nov. 13 Physician Advisory Committee (PAC) • MPPR200 goes from IQI to the CEO for signature. *Post-meeting Note: The Credentials Committee on Oct. 9 passed three of its four policies. MPCR300 will come back to Nov. 12 IQI with additional changes*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
primary care services at a specified site. We do not need to make this change across all policies, Dr. Moore replied to a question from Chief Health Services Officer Katherine Barresi, RN. Edna will add the word "provider" to the policy definition of "subcontractor."		
IV. New Business – Discussion Policies		
Policy Owner Care Coordination: *Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services*		
MCCP2032 – CalAIM Enhanced Care Management (ECM)	**Related Policies.** Changed MPPR200 policy title to *Partnership* Provider Contracts. Added: MCCP2033 Community Health Worker (CHW) Services Benefit MCCP2034 Transitional Care Services (TCS) **Impacted Departments**: Added Enhanced Health Services **Definitions.** Added: • Closed Loop Referral • CHW, differentiating it from • CHW Services • Point-Click-Care. **Section VI.A.** Based on the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032, we made some additional edits to be in compliance. The adult individual experiencing homeless population of focus definition to include under other homeless deferral status. Re the Serious Mental Health/Substance Use Disorder Population, the policy was missing the original criteria of "Are experiencing at least one complex social factor influencing their health." **Section VI.B.** Justice Involved Initiative DHCS requirements added to prepare for the JI ECM population of focus and ECM JI provider requirements. **Section VI.C.** Adding Target Case Management (TCM) programs and CHW services benefit to ECM exclusion criteria. **Section VI.D.5.d.4):** Removed "palliative care" from the enhanced coordination of care section as it caused provider confusion. Palliative care is duplicative of ECM. **Section VI.D.6.a.** Changed "PHC's Care Coordination Department" to "Partnership's designated staff." **Section VI.D.7.** Adding new ECM referral and standards language based on the DHCS 2024 August ECM policy guide and ECM Referral Standards and Form Templates guidance. **Section VI.G.** Continuity of Care additions based on DHCS requirements that include if a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a LOA until an agreement is reached, Partnership will assign the member to their existing ECM provider to ensure the member's relationship is not disrupted. **Section VI.I.** Specific language added around ECM provider network development that covers DHCS requirements around collaborating with other MCPs, building a sufficient network, and achieving network overlap **Section VI.J.1.a.2)e)i.** Model of Care for Justice Involved providers includes specific DHCS JI ECM provider requirements around a JI MOC with warm hand off plan, meeting with member within 1-2 days of release, ensuring a 2nd follow up ECM appointment happens within 1 week of release, and leverage of the re-entry plan for ECM care management planning. **References:** • Updated the ECM policy guide link, August 2024 https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf • Added ECM Referral Standards and Form Templates link	Lisa went through the synopsis and commented that the Department of Health Care Services (DHCS) continues to make changes, meaning IQI soon will see this policy again. There were no questions. Motion to **approve as presented**: Marshall Kubota, MD Second: Lisa O'Connell Next Steps: Oct. 16 Q/UAC Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	https://www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf	
Policy Owner: Population Health – *Presenter: Hannah O'Leary, MHA, Manager of Population Health*		
MCND9002 – Cultural & Linguistic Program Description	**Annual Update includes extensive revisions and has expanded to continue alignment with NCQA Health Equity requirements.** Added language: • As suggested by Partnership's NCQA consultant • Expanding references to Health Equity, including references to the Quality Improvement & Health Equity Transformation Program (QIHETP) • Detailing our current Language Data Collection processes and criteria for threshold languages, including how we collaborate around this with Local Health Jurisdictions (LJHs) • Expanding the Language Assistance Services section, including more info around where and how nondiscrimination notices and language assistance taglines are posted and distributed, and more details around the requirements we meet for translations, interpreters, and alternative formats • Detailing Partnership's commitment to its evidence-based Diversity, Equity, Inclusion (DEI) trainings and program • Detailing the Population Needs Assessment Committee and the Quality Improvement & Health Equity Committee (QIHEC), the latter which replaced the PHM&HE Committee, including recruiting criteria • Expanding the 2024-2025 Goals section, including a list of approving committees and per-goal descriptions from the C&L/QIHETP Work Plan New 2024 goal section: to provide at least 1 mailing in a member's preferred alternate format to 90% of members who have a standing request on file • Updating PHM position names and responsibility descriptions • Updated all diagrams • Added new hyperlinked references and footnotes **Updated Attachment F:** FAC Charter • Updated with new expansion counties • Minor updates throughout (instances of PHC changed to "Partnership," etc.) Hannah went through the synopsis. Anna Campbell asked a question related to the "in alignment with APL 22-002" paragraph of the "Alternate Formats" section on p. 17 of the redlined policy: are there consequences if a member does not request to use password-protected or encrypted electronic communications? Hannah replied no.	Motion to **approve as presented**: Marshall Kubota, MD Second: Edna Villasenor Next Steps: Oct. 16 Q/UAC Nov. 13 PAC
Policy Owner: Health Equity – *Mohamed "Moe" Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
MCED6001 – Quality Improvement and Health Equity	• Updated the duty descriptions of the Medical Officer for Quality and the Director of Population Health Management. • Removed mentions of Population Health Management and Health Equity (PHMHE) Committee due to its dissolution and the concurrent creation of the Population Needs Assessment (PNA) Committee. o The Population Needs Assessment Committee (PNA) is an internal subcommittee of IQI and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and	Dr. Jalloh remoted in from Sacramento to present. There were no questions

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Transformation Program (QIHETP) Program Description	health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with IQI, Q/UAC, QIHEC, PAC, and Partnership's Board of Commissioners. • Updated the NCQA Accreditation Program Management section, noting the timeline to HEA implementation by Jan. 1, 2026. • Updated Data Sources section with "DHCS Bold Goals" that step out identification and evaluation of racial/ethnic disparities in well-child and immunization measures, maternity care for Black and Native American persons, and to improve maternal and adolescent depression screening and follow-up for mental health and substance use disorders to close gaps by 50%. • Revised how Pop Health, Grievance and Appeals, and Human Resources departments will collaborate with Health Equity. • Updated Annual Program Evaluation components to include Community Reinvestment Act recommendations, and regional Quality and Health Equity team compositions per Medi-Cal guidelines. • Updated title page date to PAC date and updated signature page with this year's dates and the current Board Chair's name	Motion to **approve as presented**: Katherine Barresi, RN Second: Leigha Andrews, MBA Next Steps: Oct. 16 Q/UAC Nov. 13 PAC
MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)	**Section I. Related Policies.** Deleted MPQP1004 and ADM21 from list. **Section VI.B.1.b:** Updated number of official voting members to 9 to 15 to ensure ability to meet quorum threshold and ensure progress of the meeting **Section VI.B.6:** Changed meeting frequency from quarterly to every other month due to large number of items that QIHEC will need to review. **Section VI.B.7:** Revised language around the expected content of meeting minutes and the internal departments that receive these minutes and then send them on to DHCS. **Section VI.C.6 & 7:** Added responsibilities to analyze results of Members' grievances around discrimination and any actions taken by the U.S. Equal Employment Opportunity Commission. **Section VI.C.12:** Added that feedback from Partnership's Community Advisory Committee (CAC) will be solicited for continued Diversity, Equity, and Inclusion (DEI) training programs. **Section VI.C.13:** Added that QIHEC will review and provide input on Partnership's Quality Achievement Community Reinvestment activities. This policy was initially approved as presented but questions convinced IQI to instead defer. Dr. Kubota asked why the voting list number is being expanded. Dr. Moore replied we need wide representation, lest the committee be too narrow to function. The policy states these members "should" be from the counties served, a "flexibility" Dr. Moore said was appropriate given that, for example, a committee member may live in non-member county Sacramento but work in member county Placer. Dr. Jalloh said we will be inviting Partnership members to join after they attend a meeting to gauge mutual interest. Partnership will then vote in these members in a manner similar to how other committees onboard new members. (For example, PAC approves those who would onboard to Q/UAC.) Dr. Moore would like to see more explicit onboarding	**After discussion, this policy was pulled for further edits and will come back to IQI Nov. 12.**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	process language included in this policy. Nancy Steffen suggested that such an addition might also be linked to the following found on p. 17 of MCND9002 – the Cultural & Linguistic Program Description: *QIHEC also makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our 24 counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.* Dr. Moore agreed this policy should explain how Partnership values and ensures diversity among QIHEC members. He added that the policy could state members are invited to join at the discretion of the committee chair. Anna asked why ADM21 on stipends was struck from the list of Related Policies. Dr. Jalloh noted QIHEC does not yet have a consumer member onboard. Dr. Moore said we may want to offer them stipends as we do external voters on other committees (e.g., Q/UAC). Dr. Kubota questioned VI.B.1.b.3 stipulating members may serve open terms. Can members stay for life? Dr. Moore replied they can at Q/UAC and PAC. Chief Health Services Officer and Acting CEO Katherine Barresi, RN, wants to see VI.C.13 expanded on how QIHEC will address Partnership's Quality Achievement Community Reinvestment activities.	
MCEP6003 – Race/ Ethnicity, Language, Gender Identity, and Sexual Orientation Individual Member Data Collection/ Storage/ Retrieval – **NEW POLICY**	This new policy was prepared in accordance with 2024 National Committee on Quality Assurance standards as Partnership prepares for our NCQA Health Equity Accreditation in 2025. This policy describes how Partnership collects, stores and retrieves Member data on race/ethnicity and language preference. This policy also incorporates the requirements of the DHCS All Plan Letter 23-025 Diversity, Equity, and Inclusion Training Program Requirements. This policy defines racial/ethnic and sexual orientation terms and also describes how Partnership is able to collect information that helps to provide culturally and linguistically appropriate services (CLAS), primarily through enrollment file data from DHCS 834 files. Currently, Partnership does not receive gender identity and sexual orientation information via the DHCS enrollment files, so the policy describes how we plan to collect this information from Members in the future. The anticipated date to begin collection is Fall 2025. Partnership does collect sex assigned at birth through enrollment file data from DHCS. Two policy Attachments further define our processes for data collection, storage, and retrieval of Sexual Orientation and Gender Identity data collection as follows: **Attachment A**: Framework Document: Individual Member Race/Ethnicity and Language (REaL) and Sexual Orientation and Gender Identity (SOGI) data collection/storage/retrieval by Partnership HealthPlan of California ("Partnership") **Attachment B:** Sexual Orientation and Gender Identity (SOGI) Data Collection/Storage/Retrieval Implementation Plan (Excel file) Dr. Jalloh said this explains how Partnership receives, stores and utilizes DHCS 834 files and that this will be part of evidence submitted for June 2025 NCQA HEA. In future, Partnership may directly solicit this information from members themselves, perhaps by telephone, he said. Dr. Moore noted that Partnership is already using the new 2024 OMB (Office of Management and Budget) federal race categories, something that DHCS has yet to do. He asked if this new process document should stipulate that the current	After discussion, IQI agreed that Dawn Cook should converse with the NCQA HEA consultant whether this external-facing policy can instead be further developed as an internal policy, as Katherine Barresi said she would prefer. Marshall Kubota, MD, motioned and Colleen Townsend, MD, seconded moving ahead with developing this according to the changes discussed today. It was thereafter **confirmed that Health Equity will continue to develop REaL/SOGI data collection as an internal policy.** **It will not be sent to Q/UAC Oct. 16 but finalized and approved at the discretion of the Health Equity Officer.**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	834 files are concurrent with OMB? Both Dr. Jalloh and NCQA HEA Project Manager Dawn Cook said this is not necessary at this time as the intended audience is NCQA. This document is not drafted to any specific DHCS APL. Dr. Kubota said "persons having origins" is not always provable as there are big differences between self-definitions. Does "North African" exclude Libya? Tunisia? Dr. Moore suggested and Dr. Jalloh agreed that this be rephrased as "Middle Eastern/North African." Dr. Kubota also asked how we would capture AI/Alaskan Natives who specify a specific tribal attachment? Dr. Moore said we could capture self-identified cultural affinities (e.g., "Cherokee"), although neither the Medi-Cal application or the federal Census currently delves this deep. Dr. Kubota suggested that descriptors ending with "etc.," instead state "included but not limited to." Dr. Moore agreed with the suggestion. Dr. Moore noted that the gender terminology conflates that assigned at birth and self-identity. He added that traditional "male" and "female" language will not pass Q/UAC should this document rise to the level of an actual policy. He encouraged Moe to contact Q/UAC voter Chris Swales, MD, for guidance here. Dawn noted that this process could also move forward without including this language. Dr. Moore agreed that all definitions of sex and gender identity are to be removed at this time and added in later. We are not removing *how* this information is collected at this time, however, as the processes are not yet implemented. Dr. Jalloh said he will make changes according to this discussion, adding that more changes will be needed as Health Rules Payor (HRP) replaces Amisys as our core claims system. Kristine Gual said she appreciates the defining, and asked if it accounts for all the racial/ethnic categories that DHCS sends us so that we might consistently map. Dr. Moore replied yes *de facto*, though changes are happening: "Hispanic" is becoming a race, rather than an ethnicity. Dr. Moore added this process should make clear that it is up to the member, not the Health Plan, how to identify. Kristine and Dr. Moore both noted that DHCS consider Filipinos as "Asians," not "Pacific Islanders," and asked how this might be resolved. Dr. Jalloh said we need not adhere to absolutes. For example, tribal communities differ whether to identify as "American Indian" or "Native American." Anna asked if this is developed as an internal policy, would it be brought to Q/UAC? Dr. Moore said final approval rests with the department leader on internal policies. Anna also asked if this become an external policy, should it align with MCUP325 – Gender Dysphoria/Surgical Treatment? Both Dawn and Dr. Kubota said no, as this new process is on the collection of data. Dr. Moore directed Dr. Jalloh and Dawn to ask our NCQA HEA consultant whether it would okay not to bring this to Q/UAC. Also, because this considers data collection, could any resulting policy could reside in IT, Admin, or other department? Katherine would prefer this remains an internal policy that Dr. Jalloh would approve as Health Equity Officer.	
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, Utilization Management Regulations*		
MCUG3038 – Review Guidelines for Member Placement in	This policy has been updated to include language for subacute care facilities as per DHCS 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care. **Section I:** The new Provider Relations policy MPPRXX – Long Term Support Services Liaison has been added as a Related Policy. **Section III.E and F.:** The definition of Subacute Care Facilities was updated and the acronym SCU was defined as Subacute Contracting Unit.	There were no questions. Motion to **approve as presented**: Isaac Brown, MHA / MBA Second: Colleen Townsend, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Long Term Care (LTC) Facilities	**Section VI.A.1.a. – c.** The three facility types discussed in this policy, SNF, Subacute, and ICF, were referred back to Section III. for full Definitions. **Section VI.A.5.b.** Added language to specify that "For members approved for subacute services, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU." **Section VI.C.1.** Added language to specify that at TAR is required with each admission to a LTC Facility "In alignment with Manual of Criteria R-15-98E." **Section VI.C.2.g.** Added "SNF to Subacute" as a potential level of care scenario. **Section VI.E.1.** Replaced "LTC" with "SNF" for facility type that is discussed in this paragraph. **Section VI.E.2.** Added language to say that "Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations. **Section VI.F.** Throughout this section, language was updated to cite the Continuity of Care requirements that were effective January 1, 2024 through June 30, 2024 for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care. Previously, this section of the policy described a similar COC provision for Members transitioning for a SNF in 2023. At the end of section VI.F. we specify that automatic continuity of care does not apply after the specified time frames (ended 07/01/2023 for SNFs and 07/01/2024 for Subacute). Thereafter, Members newly enrolling with Partnership must request continuity of care following the process established by APL 23-022. **Section VI.H.4.** Updated Bed hold scenario to include "When a Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence." **Section VI.H.4.b.** Added language where we specify that a Maximum bed hold is 7 calendar days to also say "The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days." **Section VII. Added the following References:** A. Medi-Cal Provider Manual Guidelines: Subacute Care Programs: Level of Care for Adults and Children (subacut lev); Subacute Care Programs: Adult (subacute adu); Subacute Care Programs: Pediatric (subacut ped); Leave of Absence, Bed Hold, and Room and Board (leave) B. InterQual® Criteria D. Title 22 CCR sections: 51535, 51535.1, 72520 E. Title 42 Code of Federal Regulations (CFR) Section 483.15e F. Welfare and Institutions Code (WIC) §14132.25 L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023) M. DHCS Subacute Care Program and Manual of Criteria R-15-98E C	Next Steps: Oct. 16 Q/UAC Nov. 13 PAC
MCUG3058 – Utilization Review Guidelines ICF/DD,	This policy has been updated according to DHCS APL 23-023 Revised Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023) **Section I:** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) has been added as a Related Policy.	There were no questions. Motion to **approve as presented**: Anna Campbell Second: Colleen Townsend, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
ICF/DD-H, ICF/DD-N Facilities	**Section III:** A definition was added for MCP to explain that Partnership HealthPlan of California is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). Definitions of acronyms for NF-A and NF-B were removed as these types of nursing facilities are not discussed in this policy. **Section VI.A.** New paragraph was added to specify that Partnership provides all medically necessary covered services for Members residing in an ICF/DD and also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 23-023. **Section VI.B.4.a.7)** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) was added as a reference **Section VI.C.2.a.1)** Paragraph for non-developmentally disabled recipients was removed as that is not the topic of this policy. **Section VI.C.2.a.1)a)** Sentence was added to specify that a physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled. **Section VI.D.1.** Various settings were described for when a bed hold would apply for a Member residing in a ICF/DD facility. **Section VI.D.3.a. and a.5):** Language regarding NF-A and NF-B facilities was removed as provisions for LOAs from those facilities is not the topic of this policy. **Section VII. Added the following References:** A. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) H. DHCS Population Health Management Guide **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer	Next Steps: Oct. 16 Q/UAC Nov. 13 PAC
MCUP3049 – Pain Management Specialty Services	**Section IV. Attachments:** Attachment A, the Partnership TAR Requirements List, was removed from the list of Attachments. Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. **Section VI.E.:** In lieu of previous Attachment A to this policy, (which was a shared document between three policies), a reference and hyperlink was added in this section to refer the reader to policy MCUP3041 Treatment Authorization Request (TAR) Review Process -Attachment A (Partnership TAR Requirements) for a list of pain management services that require a TAR. **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer **Attachment A:** This document was updated minimally for code corrections. These changes will be applied where the Partnership TAR Requirements list is also shared as MCUP3041-A and MCUG3007-B. • Code 62287 was moved from the Pain Management CPTs Requiring a TAR list to the Outpatient Surgical Procedures CPTs Requiring TAR list. • On page 8, codes 63658, 63661 and 63688 were deleted for the list. Then this Attachment A will be ARCHIVED from this particular policy. The reasoning for this is to reduce confusion by narrowing to one source document for our Partnership TAR Requirements list. **Former Attachment B - New Attachment A:** Former Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. Codes 62633 and 62264 were added with criteria. Code 63688 was removed.	Motion to **approve as presented**: Colleen Townsend, MD Second: Isaac Brown, MHA/ MBA Next Steps: Oct. 16 Q/UAC Nov. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Tony noted this revision adds a few codes that DHCS uses. Dr. Moore asked whether codes requiring prior authorization will live in the TAR policy? Anna Campbell said yes, adding all the codes are still on the requirements list.	
V. Presentations		
1. Quality and Performance Improvement Update *Nancy Steffen, Senior Director of Quality and Performance Improvement*	• Partnership is seeking attestations from all contracted LTC and Skilled Nursing Facilities (SNFs) to confirm a proper Quality Assurance Performance Improvement (QAPI) program, per Centers for Medicare & Medicaid Services (CMS) requirements, is in place at their facility. These requests are being made via Partnership's cross-functional SNF Quality workgroup, which includes representatives from Provider Relations, Utilization Management, Office of the CMO, QI, and Health Analytics. This team is meeting monthly to leverage and enhance existing data, reporting, and processes to fulfill DHCS quality monitoring requirements. • Partnership has completed two rounds of Blood Lead Screening grants for point-of-care devices for primary care providers and has closed its third grant offering. To date, Partnership has delivered 25 POC devices to sites and has secured funding for another 30. BLS is one of the Healthcare Effectiveness Data Information Set (HEDIS®) measures seeing improvement each year. • The Improvement Academy will host three ABCs of QI in-person trainings in Fiscal Year 2024-2025. The first will be Nov. 7 in Fairfield, the second, Jan. 30 in Ukiah. To reserve space, email improvementacademcy@partnershiphp.org. A third training in Redding has yet to be scheduled. • The next bi-monthly "All Managed Care Plans Equity & Practice Transformation" (MCP EPT) meeting is scheduled for Nov. 6. Participants' current milestones involved data governance and HEDIS® reporting requirements. • As Partnership projected, the National Committee for Quality Assurance (NCQA) on Sept. 16 confirmed our Health Plan Accreditation at a 3.5-Star rating.	*For information only.* There were no questions.
2. Grand Analysis: Health Equity and 2025 C&L/QIHETP Work Plan *Moe Jalloh, Pharm.D, Director of Health Equity / Health Equity Officer*	The Grand Analysis (GA) dissects Measurement Year 2023 data around the Health Equity subset of the Managed Care Accountability Set (MCAS) based on the Healthcare Effectiveness Data Information Set (HEDIS®). As such, its findings are based on Partnership's 14 "legacy" counties and does not include the 10 "expansion" counties who joined Partnership, effective Jan. 1, 2024. Dr. Jalloh thanked the Health Analytics team for their work this summer crunching the data through the lens of race. A group-specific inequity rises to the level of "strong disparity" when it meets the following factors: • Group is performing statistically worse in at least one region when compared to the comparator group; • The Absolute Average Percentage deficit between group and the Minimum Performance Level (MPL) is at least 15% in multiple regions or 20% in a single region; and • The group falls below the 25%ile per MCAS measure in two or more regions. All groups met the MY 2023 MPL threshold of at least 61% control for the Controlling Blood Pressure measure; however, the Asian, Native Hawaiian/Other Pacific Islander, and Black or African American groups trended down from their MY 2022 performance. Hispanic/Latino and American Indian/Alaskan Native (AI/AN) groups improved by less than 5% above MY 2022. In particular, Tribal communities in Partnership's Northeast and Northwest regions showed improvement. The Asian community, followed by the Hispanic/Latino and White communities, had the best Hemoglobin Control in MY 2023. (The Asian community did particularly well in Partnership's Southeast Region.) The Native Hawaiian	Motion to **accept this Grand Analysis and Work Plan as presented:** Isaac Brown, MHA/MBA Second: Leigha Andrews, MBA

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	community trended toward improved control; however, the AI/AN and Black communities trended downward from MY 2022. In Timeliness of Prenatal Care, the AI/AN community, which had been above the MPL in MY 2022 Plan-wide, experienced a 25% drop in MY 2023. Asian and Black groups improved above MY 2022, but the Black community is still below that MPL. Black, AI/AN, and White groups and "some other race" each fell below the 25%tile MPL in the Northwest. In the Northeast, Hispanics and White were the only groups to achieve or slightly exceed the 50%ile MPL. Access continues to be an issue in both the NW and NE. In summary, strong disparities exist in the AI/AN and Black communities. A potential goal for the AI/AN community is to increase prenatal care visits by 9% in the NE, 21% in the NW, and 34% in the SW to realize the 50th percentile MPL in 12 to 24 months. Similarly, the Black community could achieve the 50th percentile MPL by increasing prenatal care visits by 5% in the NE and 37% in the NW. All groups but the AI/AN are doing well with postpartum care. The AI community was below the 25th percentile in the NE, and below the 50th percentile in the NW and SE. Interventions could have all regions achieving the 50th percentile in 24 months. The Hispanic community fell below the 50th percentile MPL in the NE for well-child visits (WCV) but was the sole group to exceed the 50th percentile MPL plan-wide, performing significantly better than the White community in all regions. AI/AN performed significantly worse in the SW; Black and Native Hawaiian performed significantly worse in the SE. Although all but Hispanics are still below the MPL benchmark, all but Native Hawaiians improved plan-wide in MY 2023 above MY 2022. The Work Plan proposes interventions that include hiring bilingual employees for Culture and Linguistic and having providers engage in DEI training. Prenatal Care and WCV measures will continue to be the focus as Partnership moves to Health Equity Accreditation in 2025.	
3. Proposed 2025 Palliative Care QIP Measures Summary *Eva Lopez, CPhT, Program Manager*	The 2025 Palliative Care QIP proposed measures have no utilization or quality changes from those of the 2024 measures.	<u>Next Steps</u>: Oct. 16 Q/UAC consent vote Nov. 13 PAC
4. Proposed 2025 PCP QIP Measures Summary *Athena Beltran-Nampraseut, Program Manager*	The proposed 2025 measures continue 2024 measures and adds the following monitoring measures to the Family Medicine clinical domain: Breast Cancer Screening (40-49 years-old), Chlamydia Screening in Women 16-24 years old, Well-Child Visits in the first 15-30 months of life, and Topical Fluoride in Children. The same WCV and Topical Fluoride measures and Chlamydia Screening (16-20 y-o) are proposed for the Pediatric Medicine clinical domain. BCS (40-49 y-o), and Chlamydia Screening in Women (21-24 y-o) are also added to the Internal Medicine clinical domain. Risk-Adjusted Readmission Rate (RAR) is deleted from and "Follow-up within 7 days after Hospital Discharge" is added to the Family and Internal Medicine "appropriate use of resources." A change in measure design is proposed for Unit of Service (UOS) Peer-led & Pediatric Group Visits. The Dental Fluoride Varnish Use measure is deleted from the UOS list.	The PAC approved the proposal on Oct. 9.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:24 p.m. IQI will next meet Tuesday, Nov. 12, 2024.		

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

Approval Signature: *Date:*

Robert Moore, MD
Chief Medical Officer and Committee Chair

QI DEPARTMENT UPDATE
OCTOBER 2024
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• Proposed measurement set changes for Measurement Year (MY) 2025 will be presented to the Physician Advisory Committee (PAC) this month. • CG-CAHPS results from Press Ganey are expected in October to the PCP QIP team. Survey reports will be shared with providers at that time. • The 2023 PCP QIP Evaluation will be presented in committee meetings in the month of November.
LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTC QIP)	• Partnership is seeking attestations from all contracted LTC and Skilled Nursing Facilities (SNFs) to confirm a proper Quality Assurance Performance Improvement (QAPI) program, per CMS requirements, is in place at their facility. These requests are being made via Partnership's cross-functional SNF Quality workgroup. This workgroup includes representatives from Provider Relations, Utilization Management, Office of the CMO, QI, and Health Analytics. This team is meeting monthly to leverage and enhance existing data, reporting, and processes to fulfill DHCS quality monitoring requirements
PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)	• January – June 2024 payment will be distributed at the end of October.
PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP)	• FY 2023-2024 incentive payments are scheduled for distribution by 10/31/2024 • Supplemental incentive payments based on the PQIP Supplemental Incentive plan for providers with assigned Dignity members are scheduled for distribution by 10/31/2024. This payment will be separate from the standard program payment. • PQIP participants interested in Datalink implementation are working directly with DataLink to complete requirements.
ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (ECM QIP)	• 2nd quarter 2024 incentive payments were distributed on 10/10/2024. • The program's new Timely Review of ED/Admission Notifications measure in PointClickCare became effective 10/01/2024. This measure is included in the remainder of MY2024 and in the MY2025 measurement set. • The ECM QIP kick-off webinar was hosted on 09/30/2024.
HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)	• The final 2023-24 HQIP submissions from participating hospitals were reviewed during September. Partnership Medical Directors, Dr. Cotter and Dr. Spiller, reviewed the Palliative Care submissions. Dr. Cotter suggested reworking the Palliative Care attestation and requirements for training. His ideas were presented in September's HQIP Tech Workgroup and were approved. The additional language will be added to the measurement set as a revision. Dr. Jalloh, Partnership's Director of Health Equity, reviewed Health Equity Submissions and gave feedback to hospitals to help them rework their reports to better align with the requirements of the program. • Preliminary Scoring for payment is underway and the Preliminary Period along with payment will be completed in October.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• N/A
EREPORTS	• MY2025 eReports scoping is in progress and development meetings and deliverables will begin after October PAC.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*Institute for Healthcare Improvement (IHI) / DHCS Medi-Cal Child Health Equity Collaborative*
	• This collaborative is focused on improving child health equity, specifically for pediatric well-care visits.
	• Partnership and Stallant Health and Wellness in Del Norte County are collaborating in a project. The populations of focus are Native American / Alaskan Native and Hispanic populations. Defined Aims for targeted populations are as follows:
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase the annual well-care visit completion rates for the Native American/Alaskan Native population who are 3-17 years of age from 8% to 25% by March 2025.
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase their annual well-care visit completion rates for the Hispanic population who are 3-17 years of age from 20% to 40% by March 2025.
	• The 3rd phase of this collaborative began on 08/22/2024 and focuses on conducting a Plan-Do-Study-Act (PDSA) cycle.
	
	IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative
	• DHCS and IHI have also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, along with the Nevada County Behavioral Health Department, were selected by DHCS to participate in this collaborative.
	• The Partnership/Nevada County DBP team is currently selecting an initial intervention to pilot in fall 2024.
	• This collaborative will run April 2024 through June 2025. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
	  ○ % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)

- % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)

Performance Improvement Projects (PIPs) Update
As a contracted managed care plan (MCP), DHCS assigned two (2) PIPs to Partnership that will be completed over 2023–2026. Annual submissions for both PIPs were submitted to DHCS on 09/11/2024.

- Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County:
  - Partnership will pilot an intervention with newborns born at Northbay Medical Center, the only hospital in Solano County that is open to Medi-Cal members. The intervention will pilot the use of navigators. The pilot focuses on assisting these families in enrolling in the Growing Together Program, completing the Newborn PCP Selection Form, and ensuring that they have begun the Medi-Cal enrollment process for their newborns.
  - Cycle 1 of the pilot began on 08/17/2024 and relies on Population Health Department Wellness Navigators for member outreach. Cycle 1 will continue until at least 09/30/2024. Below are preliminary outcomes for the pilot as of 09/18/2024:

Grand Total of Unique Members	**67**
Row Labels	**Count of Outcome**
Agreed To Participation	39
Declined Participation	5
Left Message	37
Participation pending	12
Unable To Reach	17
(blank)	
Grand Total of Outreach Attempts	**110**

Row Labels	**Count of Member Ethnicity**
ASIAN INDIAN	1
ASIAN/PACIFIC ISLANDER	1
BLACK	3
FILIPINO	3
HISPANIC	37
NO VALID DATA REPORTED(MEDS GENERATED)	2
OTHER	7
WHITE	13
Grand Total	**67**

- Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit
  - Partnership will pilot an intervention with a provider organization (PO) to increase rates for follow-up visits for members with a recent ED visit with a mental health diagnosis.

	○ Partnership and the Provider Organization had a kick-off meeting for the intervention and began work on Cycle 1 in September 2024. *DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Based on MY2022 HEDIS performance, DHCS has assigned Partnership additional accountability work around the Behavioral Health, Children's Health, and Reproductive Health and Cancer Prevention measure domains. This work, called the Comprehensive Quality Improvement and Health Equity Process, will require Partnership to complete strategies and action plans for 2024 activities meant to improve HEDIS rates in the included domains. • Partnership received feedback on the July 2024 submission of strategies and action plans to impact measure domains. The strategies and action plans will begin implementation in 2024, with a progress report due to DHCS in October 2024. • An overview of strategies planned to improve performance on each measure domain include: Children's Health: ○ Development of data reporting that will be reviewed with providers highlighting missed opportunities (i.e. episodes where patients were seen via an office visit, but preventative services were not completed) to capture pediatric services such as well child visits. ○ Analysis of the issue of delayed newborn Medi-Cal enrollment's impact on claims capture for the Well Child Visit Birth – 15 Months measure and design of interventions to expedite newborn Medi-Cal enrollment. Behavioral Health Domain: ○ Collection of County Department of Public Health data around Follow-Up Visits for ED Visits with a Mental Health Diagnosis using the Sacramento Valley MedShare Health Information exchange to improve real-time visibility of ED visits, specialty mental health encounters, and outpatient visits. ○ Piloting the use of embedded Community Health Workers in several EDs within Partnership's network to complete referrals for Partnership members presenting with a mental health or substance use diagnosis. Reproductive Health and Cancer Prevention Domain: ○ Improving breast cancer screening rates in imaging center deserts, using mobile mammography events and interventions with imaging centers with significant access challenges. ○ Piloting the use of chlamydia home screening kits with a partner provider(s).

QUALITY MEASURE SCORE IMPROVEMENT	• Partnership has completed two (2) rounds of Blood Lead testing grants for point-of-care (POC) devices for primary care providers and has closed its 3rd grant offering.
	  ○ The first round resulted in ten (10) POC device awardees along with two (2) reimbursements for recently purchased POC devices.
	  ○ The second round has recently finalized with eleven (11) POC device awardees along with fifteen (15) reimbursements for recently purchased POC devices. Second round devices were recently delivered to sites.
	  ○ A third round launched 09/03/2024 and closed on 09/30/2024. Applications are currently under review with up to 30 devices available for distribution.
	• Practice Facilitation coaching continues with nine (9) provider organizations throughout the provider network. At present, most practices are focusing on implementing interventions to impact SMART Aims. Expansion (i.e. Chico and Auburn) Region practices are engaged in optimizing the data tier for their QIP measures and planning a strategy for meeting benchmarks during their first year with Partnership. The following practices will be participating in Practice Facilitation in 2024:
	  ○ Solano County Family Health Services (Fairfield Region)
	  ○ Community Medical Center (Fairfield Region)
	  ○ Consolidated Tribal Health Project (Eureka Region)
	  ○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties (Eureka, Redding, and Chico Regions)
	  ○ Adventist Health Ukiah Valley – Mendocino County (Eureka Region)
	  ○ Ampla Health (Chico Region)
	  ○ Northern Valley Indian Health (Chico and Fairfield Region)
	  ○ Wellspace Health (Auburn Region)
	  ○ Western Sierra Medical Clinic (Auburn Region)

IMPROVEMENT ACADEMY	• As a new offering, development of two microlearnings focused on ePrompts and Human Papillomavirus (Parent-Provider Conversations) is underway. Microlearnings offer short bursts of content in three to five minute sessions which enhance knowledge retention and the ability for learners to receive just-in-time content when needed.
	• For Fiscal Year 2024-25, the Improvement Academy will host three (3) ABCs of QI in- person trainings.
	  ○ 11/07/2024 – Fairfield
	  ○ 01/30/2025 – Ukiah
	  ○ Spring 2025 – Redding
	• Promotion for the 11/07/2024 ABCs of Quality Improvement training held in Fairfield is underway.

JOINT LEADERSHIP INITIATIVE (JLI)	• Fall JLIs are currently in the planning phase and will include Ampla as a new Parent Organization. There are a total of 9 participating organizations representing all regions. • October JLI meetings include:

	○ Ampla Health: 10/14/2024
REGIONAL IMPROVEMENT MEETINGS	• Scheduling for the Northern Region quarterly regional meetings is currently underway for the 4th quarter in November. • The Solano QIP Improvement (SQIP-I) Regional Bi-Monthly meeting is scheduled for 10/03/2024.

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
STATE MANDATED WORK: EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of 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). • Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding. ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). ○ The EPT strategy team continues to explore utilization for the remaining IPIP funds. A subset of funds will be allocated to tribal health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continue to develop. • All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by their 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. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS is recalculating the final award amounts, due to the budget revisions. ○ EPT practices have as early as 11/01/2024 and up until 11/01/2025 to submit the next round of milestone deliverables: ▪ Empanelment and Access Milestone 1: Empanelment Assessment ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure.

	▪ Required Key Performance Indicator (KPI) Reporting on empanelment and access administrative metrics; Empanelment, Continuity, and Third Next Available Appointment. ○ EPT milestone deliverable templates to guide practices on their submissions are available on Population Health Learning Center's website: https://pophealthlearningcenter.org/milestones-and-deliverables/ • The Statewide Learning Collaborative (SLC) is meant to support practices awarded the 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. ○ To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance. ○ Login credentials to the eLearning Hub, PopHealth+, has been sent to EPT practices, Managed Care Plans (MCPs), and EPT stakeholders. ○ All of Partnership's EPT Practices are required to participate in the Redwood Learning Community session on 10/30/2024. ○ Beginning in September, Population Health Learning Center (PHLC) provided ad-hoc office hour sessions through Expert Consultation and will continue this month on the below topics. Practices will be able to attend and ask questions related to the content learned in PopHealth+, Practice Track meetings, and Learning Community sessions. ▪ Understanding and Reporting the Administrative Measure Key Performance Indicators (KPIs) - 10/02/2024 ▪ Data Governance and HEDIS Reporting Assessment - 10/04/2024 ○ In September, PHLC began hosting bi-monthly "All MCP EPT Meetings" to share updates related to EPT technical assistance and the program as a whole. The next meeting will be on 11/06/2024.
CAPACITY ENHANCEMENT GRANTS	• For the first time in Partnership's 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health's contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health. ○ Seventeen (17) out of the nineteen (19) eligible Provider Organizations applied for the CEG and were awarded funding based on the number of Dignity members they would be absorbing. ○ The first installment of CEG funding was distributed on 06/12/2024. ○ CEG Providers submitted the required Progress Report Template on 09/13/2024. ○ The Progress Report Templates were reviewed by the Project Management team and QI leadership. ○ CEG providers summarized the successful and challenging outcomes of their short-term and long-term activities to boost capacity.

	▪ Short-term activities include initiatives to increase and/or retain staffing (sign-on bonuses, hiring additional medical and front-line staff, locum recruiting/employment), extending clinic hours and/or providing Saturday clinic hours, and increasing the number of visits per provider. ▪ Long-term activities include continued hiring/retention activities, work station expenses for additional staff, renovations to expand clinic spaces, purchasing equipment and furniture for newly opened exam rooms. ○ The second and final installment of CEG funding is being processed with Finance.
LOCUM PILOT INITIATIVE	The QI Locum Pilot Initiative 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 is designed as a limited Grant Program, whereby participating Provider Organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period. • A total budget of $250,000 was approved; participating Providers receive up to: ○ $45,000 when hiring a Physician; or ○ $31,600 when hiring an Advanced Practicing Clinician. • The Grant is paid in two installments: ○ 1st installment upon signing the Agreement, 50% of eligible funds ○ 2nd installment upon completing the 4-week assignment and post-program survey, remaining 50% • The initial cohort of providers was selected from those participating in the PCP Modified QIP. ○ Six (6) offers to apply were made and four applications were received. ○ All four (4) applications were reviewed and accepted into the pilot program. • Locum assignment periods will be carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. • Locum Providers are alleviating a backlog of well-child and adolescent visits. • Locum Providers are covering urgent care which allows patients to schedule visits with their preferred physician. • Additional data collection is being completed through a participant debrief meeting on 10/09/2024. • One provider continues to recruit for a Locum candidate and is experiencing limited opportunities due to a short assignment period, spanning less than 3 months. Alternative approaches are being explored. • We are exploring a three (3) month extension to continue funding Community Medical Center. The focus will be well-child visits with priority given to specific direct members designed to address DHCS withhold measures.

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Recipients of the Capacity Enhancements Grant who utilized Locum Tenens as short-term interventions will be surveyed for their experience and best practices to bolster pilot data.

<table>
<tr><th>Provider Organization</th><th>Total Grant</th><th>Locum Assignment and Status</th></tr>
<tr><td>Hill Country Community Clinic</td><td>$31,600</td><td>Start date: September 23, 2024</td></tr>
<tr><td>Pit River Health Service</td><td>$31,600</td><td>Focus: Well Child Visits & Immunizations
07/29/2024 – 08/16/2024 (Part-time) other dates TBD</td></tr>
<tr><td>Round Valley Indian Health</td><td>$45,000</td><td>Actively recruiting. Start date to be determined once matched with Locum.</td></tr>
<tr><td>Community Medical Center</td><td>$31,600</td><td>Focus: Child/Adolescent Well Care & Immunizations
Initial program complete; possible extension is being explored.</td></tr>
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<tr><td>QUALITY MEASURE SCORE IMPROVEMENT
MOBILE MAMMOGRAPHY PROGRAM</td><td>

Between 07/01/2024 to 09/30/2024, Partnership sponsored 23 Mobile Mammography event days with 14 provider organizations at 22 provider sites, resulting in an estimated 470 completed screenings (i.e. final screening data is pending).

Northwest Region: seven (7) event days with two (2) provider organizations at seven (7) provide sites.
Northeast Region: seven (7) event days with five (5) provider organizations at six (6) provider sites.
Southwest Region: four (4) event days with four (4) provider organization at four (4) provider sites.
Southeast Region: two (2) event days with two (2) provider organizations at two (2) event sites.
Eastern Region: three (3) event days with one (1) provider organization at three (3) provider site.

One (1) event day in the Northwest Region was held at a Tribal Health Center in Humboldt County.
One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
Upcoming Mobile Mammography events in October include:

Northeast Region: two (2) event days with two (2) provider organizations at two (2) provider sites.
Southwest Region: one (1) event day at one (1) provider organization at one (1) provider site.

</td></tr>
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	○ Eastern Region: two (2) event days at two (2) provider organizations at two (2) provider sites. • Planning for Mobile Mammography event days for November and December is underway. Targeted providers include those who have Primary Care Provider Quality Incentive Program Breast Cancer Screening (PCP QIP BCS) rates below the 50th percentile benchmark and are located in imaging center deserts with little or no access to local imaging services. • The Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 50th percentile benchmark has been met in the Southwest Region for the measure year.
QI TRILOGY PROGRAM	• The following documents were completed and are currently pending Board approval, in October: ○ FY 2024/25 QI Program Description ○ FY 2023/24 QI Work Plan (Final Updates) ○ FY 2023/24 QI Program Evaluation ○ FY 2024/25 QI Work Plan (Goal Submissions)
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM	• The final 2023/24 Member Experience Grand Analysis (ME 7) will be presented formally at IQI and QUAC in November and the Consumer Advisory Committee (CAC) in December. • Pre-planning discussions for the regulated and non-regulated CAHPS® Survey (MY 2024) are underway. A few considerations include: ○ Oversampling strategy, modifications to the mixed protocols (i.e., phone calls, mailers), and supplemental questions. ○ Formal population submission for 2025 NCQA Patient Experience Health Plan Star Rating. • Fiscal Year 2024-25 Organization Goal #4: Access to Care and Member Experience Improvement: ○ MY2025 PCP QIP Specifications: Modifications to the Unit of Service Patient Experience measure description are currently under review.
GEOGRAPHIC EXPANSION: QI PROGRESS	• The Quality Improvement (QI) Project Plan to onboard the East Region Expansion Counties to QI functions and programs began in June 2023 and will continue over the course of 2024. Status updates include: ○ Resource planning to recruit, hire, and onboard staff dedicated to Expansion Counties is nearly complete. One (1) Improvement Advisor position is planned for posting later in 2024. An additional HEDIS Analyst and Program Coordinator are also planned for posting later this fall. • Provider onboarding events in 2024 are underway with continued planning to build out further offerings, including: ○ PCP QIP focused communications and monthly office hours to assure providers have all the technical assistance needed to make a strong start in the PCP QIP.

- Thirteen (13) external Expansion Region invitees representing eight (8) Expansion organizations attended the September office hour session.
- The October session is canceled; the next session will be on 11/04/2024.

- Perinatal QIP focused communications and orientations to assure all providers have all the support needed to participate in the Perinatal QIP.
  - Onboarding meetings and Letters of Agreement (LOAs) are complete from the following participating East Region providers:
    - Peach Tree
    - Northern Valley Indian Health
    - Ampla Health
    - Chapa-De Indian Health
    - Samuel Van Kirk, MD
    - Tahoe Forest Hospital
    - Well-Space Health
    - Enloe Health
- The HEDIS team began hosting Office Hours in July 2024, and will conclude in November 2024. Thank you to those who have participated in July, we look forward to meeting with you in the upcoming sessions, click on the links below to register:

10/30/2024	MY2023 Annual Summary of Performance • HPA (Health Plan Accreditation) • Managed Care Accountability Set (MCAS)
11/13/2024	Hybrid Measure Overview • Blood Pressure Diabetes • Controlling Blood Pressure • Cervical Cancer Screening • Childhood Immunization Status • Eye Exam for Patients with Diabetes • Hemoglobin A1c Control for Patients With Diabetes • Immunizations for Adolescents • Lead Screening Children • Prenatal and Postpartum Care • Weight Assessment and Counseling on Nutrition and Physical Activity for Children and Adolescents – Body Mass Index

- Partnering with PCP organizations in Regional Performance Improvement initiatives and interventions, like Mobile Mammography.
- Providing in-depth Site Review trainings to address DHCS Site Review changes.
- Regional Engagement is expected later this year to include regional strategic planning on PCP QIP needs and selected participation in the Joint Leadership Initiative.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **08/27/2024 TO 09/26/2024**	• 36 PQI referrals were received during this time. 30 of which were from Grievance and Appeals, 5 from other sources, and 1 from Utilization Management. • 20 cases were processed and closed during this period. • 81 cases are currently open. • Two new cases were presented and scored in the Peer Review Committee on 09/18/2024. • One focus review is being conducted. • Provider Preventable Condition education given to the Hospital Director of Accreditation and Licensing/ Director of Quality and Safety at a local acute hospital. • IT has started the process to upgrade/enhance the SugarCRM PQI application.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **08/26/2024 TO 09/27/2024**	• As of 09/30/2024, we have a total of 454 PCP and OB sites with an additional 28 reviews due to multiple check-ins (totaling 482 reviews). • CHDP training is being offered to providers. This is available as a 1:1 training or online. • We will be reaching out to new counties in efforts to provide Site Review education on new site review tool requirements. **Primary Care and OB Reviews:**

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

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	MY2023 Performance Overview:
	• Partnership received the Final Audit Report (FAR) with zero findings for both audits:
	  ○ DHCS Managed Care Accountability Set (MCAS)
	  ○ NCQA Health Plan Accreditation (HPA)

	• NCQA releases the Health Plan Ratings (HPR) each September. NCQA rates the health plans across the U.S. by assessing how plans perform in key quality areas, based upon the performance of HEDIS® and CAHPS® results. NCQA then rates health plans from 1 to 5 stars. On 09/16/2024, NCQA published the HPR of Partnership at 3.5 stars for MY2023, as projected. • MY2023/ RY2024 final Healthplan Accreditation (HPA) Star Rating was calculated based on the MY2023 Adult CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. 
HEDIS® Program Overall	HRP: Conversion of PHC's core claims system from Amisys to HRP • Another round of testing is planned to begin in October 2024 to support the overall pending implementation of Health Rules Payer-Health Edge (HRP) Geographic Expansion: • Preparation is underway to begin plan-wide reporting as required by DHCS (MCAS) and NQCA (HPA) reporting. • Additional County-Level Oversampling will be conducted for all 24 counties, as proposed and accepted by DHCS. CMS DSNP Preparation: • Planning is underway to prepare for baseline data capture & integration to support the DSNP implementation planned for January 2026.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• NCQA released the new 2025 HPA Standards and Guidelines on 08/30/2024. The NCQA Program Management Team prepared a summary of changes, which included a crosswalk between the 2024 and 2025 HPA Standards and Guidelines. This summary was shared with Business Owners who provided their questions or requests for clarification. The NCQA Program Management Team met with our

	NCQA consultant to assess the changes made to the 2025 HPA Standards and Guidelines and obtained clarification, as needed, for Business Owners. • As part of the HPA Key Activities for FY 24-25, Milestones 2 and 3 require Business Owners to review, and update as needed, the annual HPA Workbook, which consists of the HPA Work Plan and Evidence Submission Library, and the 2024-2026 HPA Report Schedule. The annual workbooks and current report schedules were shared with Business Owners on 09/19 and 09/20/2024. Business Owners are asked to submit their completed workbooks and report schedules by 10/18/2024.
NCQA Health Equity Accreditation (HEA)	• HEA Key Activities for FY 24-25: o Milestone 2 requires that all Business Owners review, and update as needed, the annual HEA Workbook, which consists of the HEA Work Plan and Evidence Submission Library. The annual HEA Workbooks were shared with Business Owners on 09/26 and 09/27/2024. Business Owners are asked to submit their completed HEA Workbooks by 10/25/2024. o Milestone 3 requires Business Owners to provide their acknowledgement by 10/25/2024 that documented processes meet the scope of review throughout the look-back period. Note: Any revisions that impact NCQA requirements must be finalized in November 2024.

Partnership Policy & Procedure Updates

November 2024

Policy Number	Policy/Procedures/Guidelines	Version Links
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **October 2024.*** ***All policy versions hyperlinked for review. Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting.* *Please review all drafts and the detailed **Synopsis of Changes**.*		
Quality Improvement		
MPQP1008	Conflict of Interest Policy for QI Activities	C CD RD
Health Equity		
MCED6001	Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	C CD RD
Utilization Management		
MCUG3032	Orthotic and Prosthetic Appliances Guidelines	C CD RD
MCUP3020	Hospice Services	C CD RD
MPUP3116	Positron Emission Tomography Scans (PET Scans)	C CD RD
MCUG3038	Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	C CD RD
MCUP3049	Pain Management Specialty Services *New Attachment A*	C CD RD
MCUG3058	Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities	C CD RD
Care Coordination		
MCCP2032	CalAIM Enhanced Care Management (ECM)	C CD RD
Population Health Management		
MCND9002	Cultural & Linguistic Program Description	C CD RD
Grievance and Appeals		
CGA022	Member Discrimination Grievance	C CD RD
Pharmacy Operations		
MCRP4066	AB1114 Benefit Implementation and Oversight	C CD RD
MPRP4062	Drug Wastage Payments	C CD RD

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Oct. 16, 2024 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please 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 Number**	**Summary of Revisions** (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Care Coordination – *Lisa Brundage O'Connell, MHA, Director of Enhanced Health Services*			
MCCP2032 – CalAIM Enhanced Care Management (ECM)	79 - 109	**Related Policies.** Changed MPPR200 policy title to *Partnership* Provider Contracts. Added: MCCP2033 Community Health Worker (CHW) Services Benefit MCCP2034 Transitional Care Services (TCS) **Impacted Departments**: Added Enhanced Health Services **Definitions.** Added: • Closed Loop Referral • CHW, differentiating it from • CHW Services • Point-Click-Care. **Section VI.A.** Based on the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032, we made some additional edits to be in compliance. The adult individual experiencing homeless population of focus definition to include under other homeless deferral status. Re the Serious Mental Health/Substance Use Disorder Population, the policy was missing the original criteria of "Are experiencing at least one complex social factor influencing their health." **Section VI.B.** Justice Involved Initiative DHCS requirements added to prepare for the JI ECM population of focus and ECM JI provider requirements. **Section VI.C.** Adding Target Case Management (TCM) programs and CHW services benefit to ECM exclusion criteria. **Section VI.D.5.d.4):** Removed "palliative care" from the enhanced coordination of care section as it caused provider confusion. Palliative care is duplicative of ECM. **Section VI.D.6.a.** Changed "PHC's Care Coordination Department" to "Partnership's designated staff." **Section VI.D.7.** Adding new ECM referral and standards language based on the DHCS 2024 August ECM policy guide and ECM Referral Standards and Form Templates guidance. **Section VI.G.** Continuity of Care additions based on DHCS requirements that include if a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a LOA until an agreement is reached, Partnership will assign the member to their existing ECM provider to ensure the member's relationship is not disrupted. **Section VI.I.** Specific language added around ECM provider network development that covers DHCS requirements around collaborating with other MCPs, building a sufficient network, and achieving network overlap	Claims Configuration Compliance Enhanced Health Services Finance Grievance and Appeals Utilization Management Member Services Project Management Office Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.J.1.a.2)e)i. Model of Care for Justice Involved providers includes specific DHCS JI ECM provider requirements around a JI MOC with warm hand off plan, meeting with member within 1-2 days of release, ensuring a 2nd follow up ECM appointment happens within 1 week of release, and leverage of the re-entry plan for ECM care management planning. **References:** • Updated the ECM policy guide link, August 2024 https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf • Added ECM Referral Standards and Form Templates link https://www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf	
Policy Owner: Population Health – *Hannah O'Leary, MHA, Manager of Population Health*			
MCND9002 – Cultural & Linguistic Program Description	*111 – 187 CLEAN policy copy begins on p. 165*	**Annual Update includes extensive revisions and has expanded to continue alignment with NCQA Health Equity requirements.** Added language: • As suggested by Partnership's NCQA consultant • Expanding references to Health Equity, including references to the Quality Improvement & Health Equity Transformation Program (QIHETP) • Detailing our current Language Data Collection processes and criteria for threshold languages, including how we collaborate around this with Local Health Jurisdictions (LJHs) • Expanding the Language Assistance Services section, including more info around where and how nondiscrimination notices and language assistance taglines are posted and distributed, and more details around the requirements we meet for translations, interpreters, and alternative formats • Detailing Partnership's commitment to its evidence-based DEI trainings and program • Detailing the Population Needs Assessment Committee and the Quality Improvement & Health Equity Committee (QIHEC), the latter which replaced the PHM&HE Committee, including recruiting criteria • Expanding the 2024-2025 Goals section, including a list of approving committees and per-goal descriptions from the C&L/QIHETP Work Plan New 2024 goal section: to provide at least 1 mailing in a member's preferred alternate format to 90% of members who have a standing request on file • Updating PHM position names and responsibility descriptions • Updated all diagrams • Added new hyperlinked references and footnotes	Grievance & Appeals Health Equity Member Services Pharmacy Utilization Management Communications Quality Improvement

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Updated Attachment F: FAC Charter • Updated with new expansion counties • Minor updates throughout (instances of PHC changed to "Partnership," etc.)	
Policy Owner: Health Equity – *Mohamed "Moe" Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*			
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	*189 – 228 CLEAN copy begins on p. 211*	• Updated the duty descriptions of the Medical Officer for Quality and the Director of Population Health Management. • Removed mentions of Population Health Management and Health Equity (PHMHE) Committee due to its dissolution and the concurrent creation of the Population Needs Assessment (PNA) Committee. o The Population Needs Assessment Committee (PNA) is an internal subcommittee of IQI and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with IQI, Q/UAC, QIHEC, PAC, and Partnership's Board of Commissioners. • Updated the NCQA Accreditation Program Management section, noting the timeline to HEA implementation by Jan. 1, 2026. • Updated Data Sources section with "DHCS Bold Goals" that step out identification and evaluation of racial/ethnic disparities in well-child and immunization measures, maternity care for Black and Native American persons, and to improve maternal and adolescent depression screening and follow-up for mental health and substance use disorders to close gaps by 50%. • Revised how Pop Health, Grievance and Appeals, and Human Resources departments will collaborate with Health Equity. • Updated Annual Program Evaluation components to include Community Reinvestment Act recommendations, and regional Quality and Health Equity team compositions per Medi-Cal guidelines. • Updated title page date to PAC date and updated signature page with this year's dates and the current Board Chair's name	Health Equity Health Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, Utilization Management Regulations*			
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	229 - 238	This policy has been updated to include language for subacute care facilities as per DHCS 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care. **Section I:** The new Provider Relations policy MPPRXX – Long Term Support Services Liaison has been added as a Related Policy. **Section III.E and F.:** The definition of Subacute Care Facilities was updated and the acronym SCU was defined as Subacute Contracting Unit. **Section VI.A.1.a. – c.** The three facility types discussed in this policy, SNF, Subacute, and ICF, were referred back to Section III. for full Definitions. **Section VI.A.5.b.** Added language to specify that "For members approved for subacute services, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU." **Section VI.C.1.** Added language to specify that at TAR is required with each admission to a LTC Facility "In alignment with Manual of Criteria R-15-98E." **Section VI.C.2.g.** Added "SNF to Subacute" as a potential level of care scenario. **Section VI.E.1.** Replaced "LTC" with "SNF" for facility type that is discussed in this paragraph. **Section VI.E.2.** Added language to say that "Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations. **Section VI.F.** Throughout this section, language was updated to cite the Continuity of Care requirements that were effective January 1, 2024 through June 30, 2024 for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care. Previously, this section of the policy described a similar COC provision for Members transitioning for a SNF in 2023. At the end of section VI.F. we specify that automatic continuity of care does not apply after the specified time frames (ended 07/01/2023 for SNFs and 07/01/2024 for Subacute). Thereafter, Members newly enrolling with Partnership must request continuity of care following the process established by APL 23-022. **Section VI.H.4.** Updated Bed hold scenario to include "When a Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence." **Section VI.H.4.b.** Added language where we specify that a Maximum bed hold is 7 calendar days to also say "The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires	Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days." **Section VII. Added the following References:** A. Medi-Cal Provider Manual Guidelines: Subacute Care Programs: Level of Care for Adults and Children (subacut lev); Subacute Care Programs: Adult (subacute adu); Subacute Care Programs: Pediatric (subacut ped); Leave of Absence, Bed Hold, and Room and Board (leave) B. InterQual® Criteria D. Title 22 CCR sections: 51535, 51535.1, 72520 E. Title 42 Code of Federal Regulations (CFR) Section 483.15e F. Welfare and Institutions Code (WIC) §14132.25 L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023) M. DHCS Subacute Care Program and Manual of Criteria R-15-98E C	
MCUG3058 – Utilization Review Guidelines ICF/DD. ICF/DD-H, ICG/DD-N Facilities	239 - 243	This policy has been updated according to DHCS APL 23-023 Revised Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023) **Section I:** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) has been added as a Related Policy. **Section III:** A definition was added for MCP to explain that Partnership HealthPlan of California is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). Definitions of acronyms for NF-A and NF-B were removed as these types of nursing facilities are not discussed in this policy. **Section VI.A.** New paragraph was added to specify that Partnership provides all medically necessary covered services for Members residing in an ICF/DD and also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 23-023. **Section VI.B.4.a.7)** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) was added as a reference **Section VI.C.2.a.1)** Paragraph for non-developmentally disabled recipients was removed as that is not the topic of this policy. **Section VI.C.2.a.1)a)** Sentence was added to specify that a physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled. **Section VI.D.1.** Various settings were described for when a bed hold would apply for a Member residing in a ICF/DD facility.	Health Services Claims Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.D.3.a. and a.5): Language regarding NF-A and NF-B facilities was removed as provisions for LOAs from those facilities is not the topic of this policy. **Section VII. Added the following References:** A. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) H. DHCS Population Health Management Guide **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer	
MCUP3049 – Pain Management Specialty Services	245 - 266	**Section IV. Attachments:** Attachment A, the Partnership TAR Requirements List, was removed from the list of Attachments. Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. **Section VI.E.:** In lieu of previous Attachment A to this policy, (which was a shared document between three policies), a reference and hyperlink was added in this section to refer the reader to policy MCUP3041 Treatment Authorization Request (TAR) Review Process -Attachment A (Partnership TAR Requirements) for a list of pain management services that require a TAR. **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer **Attachment A:** This document was updated minimally for code corrections. These changes will be applied where the Partnership TAR Requirements list is also shared as MCUP3041-A and MCUG3007-B. • Code 62287 was moved from the Pain Management CPTs Requiring a TAR list to the Outpatient Surgical Procedures CPTs Requiring TAR list. • On page 8, codes 63658, 63661 and 63688 were deleted for the list. Then this Attachment A will be ARCHIVED from this particular policy. The reasoning for this is to reduce confusion by narrowing to one source document for our Partnership TAR Requirements list. **Former Attachment B - New Attachment A:** Former Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. Codes 62633 and 62264 were added with criteria. Code 63688 was removed.	Health Services Claims Member Services

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, October 10, 2024 / 7:30am – 10:00am PT

Practicing Members Present:
Jay Shubrook, DO
Kirsten Balano, PharmD
Lilia Vargas-Toledo, RN

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:
Bettina Spiller, MD
Colleen Townsend, MD
James Cotter, MD, MPH
Jeffery Ribordy, MD, MPH
Mark Glickstein, MD
Marshall Kubota, MD
Teresa Frankovich, MD
Richard Matthews, MD

Pharmacists:
Andrea Ocampo, PharmD
Diane Wong, PharmD
Erin Montegary, PharmD
Kathleen Vo, PharmD
Lisa Ooten, PharmD
Lynette Rey, PharmD
Susan Becker, PharmD, BCPS

Invited Guests Present:
Dede Damasco, CPhT
Donell Colvin, CPhT
Amaar Taha, Touro Pharmacy Student

Department AA's:
Janet Ramos

IT Ops & Systems:
Joe Chiminiello

Practicing Members Absent:
Antonio Olea, PharmD
Andrea Jones, PharmD
Jonathan Miano, PharmD
Robert Yam, PharmD
Phillip Nguyen, PharmD, BCACP, BCGCP

PHC Members Absent:
Richard Matthews, MD
Aaron Thornton, MD
Dave Katz, MD
Mark Netherda, MD
Bradley Cox, DO
Kermit Jones, MD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	1. Introductions 2. Housekeeping (Announcement: Meeting is being recorded)	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Yes 3 out of 8 members attended Minutes: Approved	*Presented by Stan Leung, PharmD*	N/A
II. Standing Agenda			
1. PHC Update	PHC Updates provided by Dr. Moore: Dr. Moore announced three updates during the meeting, the first is the dual special needs plan Medicare and Medi-Cal product. Partnership has decided to call the plan The Partnership Advantage, which is the same name we used for our previous special needs plan that we had a decade ago. Partnership got permission from the state to do a phase rollout in 2026 instead of trying to implement, Partnership Advantage in all 24 counties simultaneously. We will be focusing on 8 counties, which are the counties that are along the Pacific coast that touch San Pablo Bay plus the lakes including Del Norte, Humboldt, Mendocino, Sonoma, Marin, Napa, Solano, and Lake County. This will be the plan for Medicare Part D that is in process. We also completed an RFP for selecting a vendor and are working through the various implementation phases for that. The second major update that we have is the quality measures and we have 65 quality measures we gave a report about yesterday to our board in DHCS and NCQA that we have to gather and either report on or get held accountable to which is quite a large number. There are several measures that are impacted by medications that our pharmacy team is playing an important role in by supporting quality to optimize quality measure outcomes. Though we just wanted made aware that the quality team and pharmacy team is involved in those measures where they are particularly helpful. The third update Dr. Moore presented is that the physician advisory committee did approve a unit of service measure during yesterday's meeting involving the measure in our primary care pay for performance program. This would provide a financial incentive to the primary care organizations to host a set of two	*Presented by Robert Moore, MD, MPH, MBA*	N/A

	academic detailing visits with their clinicians, where we would bring information about prescribing patterns and patients who need medications according to national standards who are not on them et cetera, and with two visits, one initial and then one follow up visit. So we're hopeful that our primary care providers will embrace this opportunity to have our pharmacy and clinical team present this information. <u>Stan provided the following updates:</u> Some of our local sister plans that are currently in DSNP when we talk about what their pharmacy departments do for the part D program and what they shared with us is that a lot of the work that they do for the pharmacists and technicians is to support the clinical part D measures. Primarily there currently are four or five measures. One of them is a comprehensive medication review where a pharmacist reviews the medications with the patient or member and making sure that those medications are accurate, correct, and current. However, there are four other measures relating to medication dispensing. Once our adherence measures meet a goal, a person would have to have 80 % of adherence; meaning that out of 100 days for example, they have to have 80 days of medications for that measure. The three measures for those adherences involves diabetes medication for people with diabetesoral medications & does not involve the insulins. The second is for the hypertension, renin angiotensin system antagonists or blockers. These are ACE and arbs and the third are statins. The other plans' pharmacists monitor these three adherence measures very closely, especially as a person starts to fall below that 80 % adherence level. They will work with the pharmacy and prescribers to try to make sure that the prescription is current so that the person gets their refill to meet that goal. The fourth measure in the part D program is for statin use for people with diabetes. Similarly, the pharmacists for the health plans also monitor the diabetic patients who are in the gap and who did not receive a statin yet. Then they perform outreaches to the prescriber or the primary care physician to remind them to prescribe a statin if it is indicated or second, if there's an exclusion criteria for that member having a history of muscle rhabdomyolysis or muscle breakdown disorders. They would remind the clinician to make sure that the diagnosis gets into the patient's medical record so that the member is excluded from the measure. Several things that the pharmacists do in regards to the	*Presented by Stan Leung, PharmD*	N/A

	measures I mentioned are that they are going to add the new concurrent Benzo and opioid measures. They are also going to add a measure for overuse of anticholinergics and CMS stimulants in the elderly. Two or three more clinical measures where there are opportunities for the pharmacists, whether it is the plan or a vendor, is to work with clinicians to really monitor some of those medications' use. We need to make sure that we can promote the safe use of medications as determined by the measure performance. One of the things Dr. Moore mentioned was the Pharmacy Benefit Manager. We are going through the RFP process and part of the selection process is looking at how well they do on these Star measures. Most of the PBMs have their own clinical teams or they work in conjunction with a subcontractor to work on these Part D measures. Part of our selection process is looking at the health plans supported by these PBMs and how well they do on these Star measures, which is reported in the CMS Part D measure report card, to get a sense of how well these health plans and these PBMs do and certainly it is a consideration. We've met with the PBM's clinical team to get a better understanding and appreciation of not only what they do with Stars in terms of their functions, such as outreach to prescribers and members, but also the data analytic and reporting capabilities. As an important part of the star strategy because with the data analytics, you would get almost a real time picture of the members or patients that are in this measure who are in the gap and what you need to do to close that gap. It is really actionable data that some of the PBMs out there can provide that type of data analytics to support the Star measure performance. We look forward to working with our PBM over the next year to really flesh out those programs and get ready for 2026. One other update, I do have an update that is called the 555555 override that will go live by the 18th of October. Medi-Cal is going to deactivate this code. Back in 2022 when they started this program Medi-Cal Rx really fell behind in terms of processing the TARs their configuration for grandfathering for those members who were on a drug that needed a TAR. When that configuration was not working, what happened was the members with a refill thought that it would just go through or be grandfathered. The claim would pay at the pharmacy, but in fact, because configuration didn't work, the medication would deny at the pharmacy and they would have to submit a TAR and caused a lot of delay and disruption. However, in early 2022, they implemented this kind of an overall override to bypass their TAR		

	system. Now what they announced last week was that they are going to start to wind this down. They did this a couple months earlier to sunset this override for a select group of medications. According to what they announced last week, they are going to deactivate this override code for all medications, which also applies to refills. I did check to see if this was only for new starts, but they informed me that this applies for refills too. What that means is that if a prescriber has a patient on a medication that required a TAR all this time, they were getting it through without any problems or any need to submit a TAR. Even though this is going to be a refill, the next time they refill it after the 18th of October it will require a TAR. Medi-Cal did provide us with a list of providers that really had high utilization of this override. What we were able to do was work with our provider relationship team and fax blasted this particular notice to our provider network informing them that they will need to start submitting TARs or change to a covered drug after 18 October. We will also be sending this out to the pharmacy to remind them also of the need to submit TARs or prepare to submit TARs, starting the 18th of October. Unfortunately, they are going to implement for refills also, and hopefully there won't be too much disruption for patients refilling their medications.		
3. DUR Update	<u>DUR Summary for Concurrent use of Opioids and Benzodiazepines (COB)</u> Dr. Rey presented the following: • PHC implemented a prescriber fax intervention for members recently started on concurrent use of opioids and benzodiazepines, with the intent of minimizing concurrent use. • A monthly retrospective review of pharmacy claims was conducted to identify members with concurrent fills for opioids and benzodiazepines who were newly started on either an opioid or benzodiazepine in the prior 30 days. • Concurrent use was defined as overlapping fills for both a benzodiazepine and an opioid for 15 or more cumulative days within a 30 day look back period. • A review of pharmacy claims between 6/1/24 to 8/31/24 identified 637 members who filled a benzodiazepine and an opioid during the 31 days in August 2024. Ninety-seven	*Presented by , Lynette Rey, PharmD*	N/A

	members were identified as possibly just starting on concurrent opioid and benzodiazepine use in August 2024. • Analysis utilizing MediCal Rx claims and CURES reports going back one year, showed only 3 of these members were just starting concurrent use, with the other members filling either an opioid or benzodiazepine intermittently. • Letters were faxed to the 7 respective prescribers on 9/18/24. • The outcome of the response to the prescriber letters will be evaluated every 30 days post intervention for up to 90 days. Evaluation will assess how many members have discontinued either the opioid or benzodiazepine. • If concurrent use is continued, we will evaluate whether a dose reduction or a reduction in the day supply prescribed occurred. Claims will be evaluated for non-controlled medications that may be prescribed for the associated diagnosis. If concurrent use continues beyond 90 days, a PHC medical director will review the case to determine if additional action is required. • This retrospective review will continue monthly for the next 6 months to evaluate the usefulness and success of the intervention.		
	<u>DUR Summary for Fraud and Abuse of Controlled Substances</u> Dr. Rey presented the following: • To assess potential fraud and abuse of opioids and benzodiazepines, PHC developed a program to monitor members who received prescriptions for both opioids and benzodiazepines from 4 or more prescribers and 4 or more pharmacies. • A quarterly retrospective review of pharmacy claims was conducted to identify members with fills for both opioids and benzodiazepines during the prior 180 days. • To identify possible fraud and abuse by the member, claims were evaluated for early refills; short-term fills vs chronic stable fills; whether the fills were paid for by insurance vs paid out of pocket, use of providers and/or pharmacies that were far from the member's immediate geographic area; and prescriptions from multiple prescribers with different scopes of practices. • To identify possible fraud and abuse by the prescriber, claims were evaluated for prescribing of large quantities and/or high-doses; frequency of early refills authorized;	*Presented by , Lynette Rey, PharmD*	

	and providing non-specialty care for patients who live more than 100 miles from the prescriber's office. • To identify possible fraud and abuse by the pharmacy, claims were evaluated for frequency of dispensing of early refills, and dispensing to members who live more than 50 miles from the pharmacy. • If there were concerns of potential fraud and abuse, additional investigation was done to verify that there were no extenuating circumstances that contributed to the appearance of possible fraud and abuse. • A review of pharmacy claims between 1/1/24 to 6/30/24 identified 2,808 members who filled both benzodiazepines and opioids during the 180 day period. Of these member, only 2 members were identified with 4 or more prescribers and using 4 or more pharmacies. • Further investigation of these 2 members did not identify fraud or abuse by these members. No incidences of potential fraud and abuse by the prescribers and the pharmacies were identified. • The quarterly retrospective review will continue, however, to adequately monitor for fraud and abuse, we will attempt to broaden our efforts by evaluating members who received prescriptions for fills for opioids from 4 or more prescribers and 4 or more pharmacies without also requiring them to be on a benzodiazepine.		
4. Drug Benefit Review	The classes for this quarter's review are: In addition to the scheduled class reviews, PHC presented the following: • Antineoplastic & Adjunctive Agents • Hematological Agents • Nutritional Products • Psychotherapeutic and Neurological Misc. Agents No changes proposed to the Nutritional Products Class. All actions at right were approved by the committee as presented, unless otherwise noted as "*approved as modified*". All changes will be effective 01/01/2025 unless otherwise noted.	*Presented by Susan Becker, PharmD, BCPS and Erin Montegary, Pharm D*	

Class Reviews:

- Antineoplastic & Adjunctive Agents
  - Updates to the following were presented, with approved action shown at right.
    - Cyclophosphamide (Auromedics)
    - Cyclophosphamide (Dr. Reddy's)
    - CAR-T therapies: (Breyanzi™); (Kymriah™); (Tecartus™); (Yescarta™)
    - Pembrolizumab (Keytruda™)-
    - Leuprolide acetate (for depot suspension) (Lupron Depot™)

Presented by Erin Montegary, Pharm D

Antineoplastic & Adjunctive Agents Class Review, Approved Actions:

HCPCS	Drug
Removal of TAR Requirements	
J9071	Injection, cyclophosphamide (Auromedics), 5 mg
J9072	Injection, cyclophosphamide (Dr. Reddy's), 5 mg
Change in TAR Criteria	
J9271	Injection, pembrolizumab, 1 mg (Keytruda™)- removed drug specific criteria and replaced with case-by-case antineoplastic criteria
TAR Criteria Updates (see attached criteria for details)	
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Breyanzi™)
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Kymriah™)
Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Tecartus™)
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Yescarta™)
New TAR Criteria (see attached criteria for details)	
J1950	Injection, leuprolide acetate (for depot suspension), per 3.75 mg, Lupron Depot™

1/1/25

- Hematological Agents
  - Updates to the following were presented, with approved action shown at right.
    - Ferumoxytol, (non-esrd use) (Feraheme™)
    - Ferumoxytol, (for esrd on dialysis) (Feraheme™)
    - Pegfilgrastim-bmez (Ziextenzo™)
    - Etranacogene dezaparvovec-drlb (Hemgenix™)
    - Betibeglogene autotemcel (Zynteglo™)
    - Exagamglogene autotemcel (Casgevy™)
    - Lovotibeglogene autotemcel (Lyfgenia™)
    - Crizanlizumab-tmca (Adakveo™)
    - Eculizumab (Soliris™)
    - Ravulizumab-cwvz (Ultomiris™)
    - Luspatercept-aamt (Reblozyl™)
    - Fidanacogene elaparvovec-dzkt (Beqvez™)
    - Crovalimab-akkz (PiaSky™)
    - Adamts13, recombinant-krhn, 10 iu (Adzynma™)

Presented by Susan Becker, PharmD BCPS

Hematological Agents Class Review, Approved Actions:

HCPCS	Drug
Removal of TAR Requirements	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use) (Feraheme™) – limits added (see below)
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for esrd on dialysis) (Feraheme™) – limits added (see below)
Addition of Claim Limits &/or Requirements	
Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use) (Feraheme™) -- ICD-10 limit, Dose Limit and Age Limit added
Q0139	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (for esrd on dialysis) (Feraheme™) -- ICD-10 limit, Dose Limit and Age Limit added
Q5120	Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg (Ziextenzo™) – changed from Covered with limits to TAR Required
TAR Criteria Updates (see attached criteria for details)	
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose (Hemgenix™)
J3393	Injection, betibeglogene autotemcel, per treatment (Zynteglo™)
J3590 (NOC)	Unclassified biologics (exagamglogene autotemcel) (Casgevy™)
J3394	Injection, lovotibeglogene autotemcel, per treatment (Lyfgenia™)
J0791	Injection, crizanlizumab-tmca, 5 mg (Adakveo™)
J1300	Injection, eculizumab, 10 mg (Soliris™)
J1303	Injection, ravulizumab-cwvz, 10 mg (Ultomiris™)
J0896	Injection, luspatercept-aamt, 0.25 mg (Reblozyl™)
New TAR Criteria (see attached criteria for details)	
C9172	Unclassified biologicals (fidanacogene elaparvovec-dzkt) (Beqvez™)
J3590 (NOC)	Unclassified biologics (crovalimab-akkz) (PiaSky™)
J7171	Injection, adamts13, recombinant-krhn, 10 iu (Adzynma™)

1/1/25

- Psychotherapeutic and Neurological Misc. Agents
  - Updates to the following were presented, with approved action shown at right.
    - Lecanemab-irmb (Leqembi™)
    - Patisiran (Onpattro™)
    - Elivaldogene autotemcel (Skysona™)
    - Donanemab-abzt (Kisunla™)
    - Atidarsagene autotemcel (Lenmeldy™)

Presented by Erin Montegary, Pharm D

Psychotherapeutic and Neurological Misc. Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J0174	Intravenous Injection, lecanemab-irmb, 1mg (Leqembi™)
J0222	Injection, Patisiran 0.1mg (Onpattro™)
New TAR Criteria (see attached criteria for details)	
J3590	elivaldogene autotemcel (Skysona™)
J0175	Injection, donanemab-abzt (Kisunla™)
J3590	atidarsagene autotemcel (Lenmeldy™)

1/1/25

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

- Updates to Endocrine and Metabolic Agent:
  - Updates to Romosozumab-aqqg (Evenity™) criteria

Presented by Susan Becker, PharmD BCPS

Ad hoc Updates		
HCPCS	**HCPCS Description (brand)**	**Approved Action**
J3111	Injection, romosozumab-aqqg, 1 mg (Evenity™)	Updates to current criteria (see attached criteria for details)

1/1/2025

- Unclassified NDC claim benefit changes:
  - Removal of TAR requirements (add to J3490/PAD formulary) for metformin 24 hr
  - Change limits to correlate with FDA-approved maximum daily doses for patiromer
  - Temporary use of NOC (J3490/Z7610) until State announces the new code as a benefit:
    - mResvia™ was presented & approved for paying claims utilizing J3490/Z7610 miscellaneous codes because as of the meeting date, the State had not yet included billing code 90683 as a benefit.
    - Post-meeting addendum: On 10/16/24, in the monthly provider bulletins, DHCS announced 90683 as a benefit. Since PHC has not yet had any claims for mResvia™, there was no need to actually implement the use of J3490/Z7610 for paying mResvia. See New Codes section below for additional 90683 information.
  - Effective dates for unclassified drug coverage: The first of the next quarter following PAC (Physician Advisory Committee) is the standard by when all system processes & databases are to be updated with approved changes. Note that with unclassified drugs the implementation may occur sooner. This happens in cases where a claim is received & reviewed by Rx Dept in the interim time ahead of P & T and PAC; when the requested drug is approved for payment, it is added to the systems necessary for processing as of the claim approval date, with the effective date essentially being the date the drug was approved for reimbursement. For the sake of simplicity, the effective dates are listed in the packet at the first of the next quarter, knowing that the Plan may have authorized earlier payment.

Presented by Erin Montegary, Pharm D

Additions & Changes to Unclassified NDC Coverage (previously only covered for emergency dept.)		
Removal of Limits &/or requirements to Unclassified NDC Coverage (billed with J3490/Z7610)		
Metformin 24 HR 500 & 1,000 mg (Glumetza™) Metformin 24 HR 500 mg & 1,000 mg (Fortamet™)	Patiromer powder packets for suspension (Veltassa™) In 1, 8.4, 16.8, and 25.2 g packets	Respiratory syncytial virus vaccine, mrna (mResvia™)

Effective dates are not used in the NOC databases for covered drugs. NDCs become effective for claims received on/after the date they are entered and are retroactive for any DOS in the 12-month claim submission window. NDCs for drugs at left, or changes in limits to existing NDCs, will be entered into the NOC databases no later than 1/1/25.

- New HCPCS code review – listed at right, listed in 2 sections:
  - 1st time HCPCS code for drug (other than unclassified code)
  - HCPCS code changed but no change in coverage requirements for the drug itself
  - Codes were announced as benefits by DHCS on 9/27/2024, with effective date of 10/1/2024, except for:
    - 90684 effective 6/27/2024
    - J0175 effective 7/2/24
  - Post-meeting addendum: The DHCS October provider bulletins included adding 90683 as a benefit as of 7/1/24, and is listed here to show the new code benefit status, replacing the need to cover mResvia under J3490 as stated in the previous section for unclassified drugs. No need for vote because this is only a billing methodology update and not a change in benefit. The added age limit mirrors State & ACIP recommendations.

Presented by Susan Becker, PharmD BCPS

New HCPCS codes (no prior code or was previously unclassified)		
HCPCS	**HCPCS Description**	**Requirements**
J0138	Injection, acetaminophen 10 mg and ibuprofen 3 mg	QL:400 units/day
Q5135	Injection, tocilizumabaazg (tyenne), biosimilar, 1mg	TAR
J2004	Injection, lidocaine hcl with epinephrine, 1 mg	None
C9169	Injection, nogapendekin alfa inbakiceptpmln, for intravesical use, 1 mcg	TAR
C9170	Injection, tarlatamab-dlle, 1 mg	TAR
J9329	Injection, tislelizumabjsgr, 1 mg	TAR
J2252	Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg	QL: 200 units/day
J2601	Injection, vasopressin (baxter), 1 unit	None
J8541	Dexamethasone (hemady), oral, 0.25 mg	AL: 18 yrs and older QL: 160 units/day
Q5136	Injection, denosumabbbdz (jubbonti/wyost), biosimilar, 1 mg	TAR
C9172	Injection, fidanacogene elaparvovecdzkt, per therapeutic dose	TAR
C9171	Injection, pegulicianine, 1 mg	AL: 18 yrs and older
J0175	Injection, donanemabazbt, 2 mg	TAR
90684	Pneumococcal conjugate vaccine, 21 valent (PCV21), for intramuscular use	None
90683	Respiratory syncytial virus vaccine, mRNA lipid nanoparticles, for intramuscular use (mResvia™)	AL: 60 yrs and older

1/1/25

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	**HCPCS Description**	**Requirements & prior code**
J1171	Injection, Hydromorphone, 0.1 mg	No limits *(same as prior code J1170)*
J8522	Capecitabine, oral, 50 mg	No limits *(same as prior codes J8520 and J8521)*
J2002	Injection, lidocaine hcl in 5% dextrose, 1mg	No limits *(same as prior code J2001)*
J2003	Injection, lidocaine hydrochloride, 1 mg	No limits *(same as prior code J2001)*

II. Old Business

a. Policy Updates

- All Policies below submitted for consent with no substantive changes. Minor re-organization of content, improved wording and updating of references.
  1) MCRP4066: AB1114 Benefit Implementation and Oversight: *Added additional information regarding Vaccines for Children (VFC) program.*
  2) MPRP4062 & MPRP4062: Drug Wastage Payments, Attachment A: Allowable Waste Drug List: *No changes.*

Presented by Stan Leung, PharmD

11/31/24

IV. New Business

None

V. Additional Items

None

VI. Adjournment

Meeting adjourned at 9:55 am

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

APPROVED

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

PA Criteria	Criteria Details
Covered Uses	Per FDA approved indications included in the product labeling. CAR-T immunotherapy products included in this criteria: • Idecabtagene vicleucel (Abecma™) • Lisocabtagene maraleucel (Breyanzi™) • Ciltacabtagene autoleucel (Carvykti™) • Tisagenlecleucel (Kymriah™) • Brexucabtagene autoleucel (Tecartus™) • Axicabtagene ciloleucel (Yescarta™)
Exclusion Criteria	• CAR-T will not be approved for use as first-line therapy. • Concurrent or prior treatment with another CAR-T immunotherapy. • Concurrent use with a chemotherapy regimen (excluding the necessary lymphodepleting regimen). • CNS disorders or CNS malignancy/metastasis. • Active infectious disease. • Inability to remain in the vicinity of the REMS certified facility for a minimum of 4 weeks. • ECOG grade 4 or worse.
Required Medical Information	• Histologically confirmed diagnosis of one of the FDA approved indication for which therapy is being requested to treat. • Clinic notes documenting history and course of illness, including response to previous therapies. • Documentation that member does not have active infection, and the recommended screenings in the package labeling, or in treatment guidelines, have been or will be performed for (including but not limited to): Hepatitis B, Hepatitis C, and HIV. • Documentation that member does not have an autoimmune disease or graft-vs-host disease requiring immunosuppression. • Documentation that member will undergo the recommended lymphodepleting regimen prior to CAR-T treatment (cyclophosphamide + fludarabine or appropriate alternative as recommended by package labeling or treatment guidelines). • Documentation that member is able to remain in the vicinity of the certified healthcare facility for at least 4 weeks' post-infusion. • Member's current bone marrow, cardiac, pulmonary, liver, and renal function (all organ function must be adequate). • ECOG (Eastern Cooperative Oncology Group) performance status grade. • Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.
Age Restriction	See prescriber information per drug specific approval information. For most indications, CAR-T may be approved for members aged 18 or older. Noted exception for tisagenlecleucel (Kymriah™) when used for the treatment of precursor acute lymphoblastic leukemia which is limited to members aged 25 years and younger on the date of the infusion (date of service), not previously treated with any gene therapy.
Prescriber Restriction	Prescribed by a hematologist or oncologist

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

Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose only per lifetime.
Other Requirements & Information	Additional required information per FDA-approved indication, at time of publication. **Multiple myeloma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication**: Abecma™, Carvykti™.** Additional information required with request: • For Abecma™: Documentation of treatment failure (either due to intolerable adverse reaction or lack of efficacy) with ≥2 prior lines of therapy, with at least one from each mechanism of action group listed below: a) An anti-CD38 monoclonal antibody: daratumumab (Darzalex™), daratumumab-hyaluronidase (Darzalex Faspro™), or isatuximab (Sarclisa™) b) A proteasome inhibitor: bortezomib (Velcade™), carfilzomib (Kyprolis), or ixazomib (Ninlaro™) c) An immunomodulatory agent: lenalidomide (Revlimid™), thalidomide (Thalomid™, accepted off-label use), or pomalidomide (Pomalyst™) • For Carvykti™: Documentation of treatment failure (either due to intolerable adverse reaction or lack of efficacy) with ≥1 prior line of therapy which includes a proteasome inhibitor and an immunomodulatory agent, and are refractory to lenalidomide. **Large B-cell lymphoma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™, Yescarta™.** Additional information required with request: For all: • A confirmed diagnosis of large B-cell lymphoma, including ANY of the following types: ▪ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from follicular lymphoma or transformed follicular lymphoma-TFL) ▪ Primary mediastinal large B-cell lymphoma ▪ ~~High grade B-cell lymphoma~~ ▪ Limitations of use: Not indicated for treatment of primary CNS lymphoma. For **Breyanzi™** or **Yescarta™**: • ~~Documentation of treatment of large B-cell lymphoma in adults that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy OR~~ • Member has relapsed or refractory disease ~~has evidence of disease progression~~ after two or more lines of systemic therapy ~~chemotherapy regimens recommended as first or second-line in compendia such as NCCN which may or may not have included therapy supported by allogeneic stem cell transplant~~ OR . • For **Breyanzi™** only: Member is refractory to first-line chemoimmunotherapy or relapses after first-line chemoimmunotherapy and is not eligible for hematopoietic stem cell transplantation (HSCT) due to comorbidity or age. • ~~Limitations of use: Not indicated for treatment of primary CNS lymphoma.~~ For **Kymriah™**: • Documentation of treatment of relapsed or refractory large B-cell lymphoma in adults after two or more lines of systemic therapy. **Follicular lymphoma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™,**

Yescarta™.

- Documentation of treatment of relapsed or refractory follicular lymphoma in adults after two or more lines of systemic therapy ~~chemotherapy regimens recommended as first or second line in compendia such as NCCN that includes a combination of an anti-CD20 monoclonal antibody (e.g. rituximab, obinutuzumab) and an alkylating agent (e.g. bendamustine, cyclophosphamide, chlorambucil)~~

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

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

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

For **Kymriah™**:

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

For **Tecartus**

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

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

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

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

Mantle cell lymphoma, relapsed or refractory:

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

- Documentation of treatment of relapsed or refractory mantle cell lymphoma (MCL) in adults after 2~~.~~ or more lines of systemic therapy, including a Burton tyrosine kinase (BTK) inhibitor.

	~~• Documentation of prior treatment with, or intolerance or contraindication to, all of the following:~~ ~~a) Anthracycline or bendamustine containing chemotherapy~~ ~~b) An anti-CD20 antibody (rituximab)~~ ~~c) BTK (bruton tyrosine kinase) inhibitor (acalabrutinib, ibrutinib, zanubrutinib).~~ Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

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

Requirements for Leuprolide Acetate Injection (Lupron Depot™)

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	• Central precocious puberty • Endometriosis • Uterine leiomyomata (fibroids) • Breast cancer (off-label) (No TAR required with diagnosis code for breast cancer) • Gender dysphoria in adolescents (off-label)
Exclusion Criteria	
Required Medical Information	**Documentation of the following is required per indication:** **Central precocious puberty (CPP):** 1) Specialist consult notes documenting diagnosis of CPP and treatment plan. 2) Baseline height and weight, growth velocity, bone age test results (within the previous 12 months.) Note: leuprolide is not be approved for peripheral precocious puberty. **Endometriosis:** 1) Specialist consult notes documenting diagnosis of endometriosis, treatment history, and treatment plan. Diagnostic evaluation must include ONE of the following: a. Diagnosis confirmed by laparoscopy, OR b. Detailed evaluation which has ruled out other causes of pelvic pain such as gastrointestinal, musculoskeletal, urinary, and neurologic conditions. 2) Member has had an adequate trial (at least 3 months of continuous use, verified through pharmacy claims if available), or contraindication to, an NSAID in combination with continuous hormonal contraceptive within the previous 12 months. 3) Member has had an adequate trial, or contraindication to, at least ONE of the following: a. PHC's preferred formulary GnRH agonist, goserelin (Zoladex™), OR b. GnRH antagonist therapy with elagolix (Orilissa™), which is covered as a pharmacy benefit through Medi-Cal Rx for endometriosis, and 4) Dosing is 3.75 mg per month or 11.25 mg per 3 months for up to 6 months. **Uterine leiomyomata (fibroids):** 1) Diagnosis of uterine leiomyomas confirmed with pelvic imaging. 2) Documentation that member is experiencing symptoms such as heavy or prolonged menstrual bleeding, pelvic pressure or pain. 3) Documentation that therapy is being requested for ONE of the following: a. Request is for use 3-6 months prior to surgery for uterine leiomyomata OR b. Member has anemia due to uterine fibroids AND has failed a one-month trial of iron therapy alone AND request is for a short course of leuprolide to use along with iron preoperatively. 4) If requesting leuprolide to treat heavy menstrual bleed due to uterine fibroids, the following must be submitted: a. Member has tried and failed an adequate trial of first-line treatment options with one or more of the following:

Requirements for Leuprolide Acetate Injection (Lupron Depot™)

	i. Combined estrogen-progestin contraceptives ii. Levonorgestrel-releasing IUD iii. Tranexamic acid iv. Progestin only pills AND b. Member has tried and failed, or contraindication to, at least ONE of the following second-line preferred oral treatment options which are both a covered benefit with Medi-Cal Rx: i. Elagolix-estradiol-norethindrone (Oriahnn™) OR ii. Relugolix-estradiol-norethindrone (Myfembree™) **Gender dysphoria (off-label):** 1) Evaluation by a mental health professional or other health care professional who has the appropriate experience and training treating gender dysphoria. 2) Confirmation of the following in member: a. Well-documented gender dysphoria/gender incongruence. b. Ability to make a well-informed decision. c. Stability of relevant medical and mental health. 3) Documentation that member has experienced puberty development to at least Tanner stage 2. 4) Documentation that pubertal changes have negatively affected member's psychological or social functioning due to increased gender dysphoria.
Age Restriction	-Central Precocious Puberty: ≥1 year and ≤11 years for females; ≤12 years for males. -Endometriosis or uterine fibroids: females of reproductive age. -Gender dysphoria: adolescents who have experienced puberty development to at least Tanner stage 2.
Prescriber Restriction	-Central Precocious Puberty: Endocrinologist -Endometriosis/Uterine leiomyomata: Obstetrician, gynecologist -Gender dysphoria: Endocrinologist or other specialist with appropriate training and experience treating gender dysphoria in adolescents
Coverage Duration	-CPP: 12 months, until resumption of puberty is desired. Renewal requests require current bone age, growth velocity, height, weight and clinic notes with assessment of pubertal progression. -Endometriosis: Initial approval: 6 months. An additional 6 months of treatment may be considered when documentation of recurrence of symptoms and BMD test results within normal limits. The total duration of therapy should not exceed 12 months due to concerns of adverse effects on BMD. -Uterine leiomyomata (fibroids): 3 months. An additional 3 months may be requested with documentation of medical necessity or reason for delay in surgical procedure. -Gender dysphoria: Initial approval: 6 months. For renewal, provider may request 12 months of therapy with documentation of improvement in gender dysphoria.
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
J1950	Injection, leuprolide acetate (for depot suspension), 3.75 mg	Available formulations: Lupron Depot: 3.75 mg and 11.25 mg Lupron Depot-Ped: 7.5 mg, 11.25 mg, 15 mg, 30 mg, and 45 mg

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 adults with moderate to severe hemophilia B (congenital FIX deficiency)
Exclusion Criteria	1. Treatment or use for anything other than hemophilia B 2. Positive Factor IX inhibitor titer test 3. Positive neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test 4. Previous gene therapy treatment with etranacogene dezaparvovec-drlb (Hemgenix™) or fidanacogene elparvovec-dzkt (Beqvez™)
Required Medical Information	Documentation of all of the following (1-7): 1. Clinic notes to confirm moderately severe or severe congenital hemophilia B along with baseline Factor IX level of ≤ 2% of normal 2. Clinic notes to confirm one of the following a. Current use of routine Factor IX prophylaxis as defined as the intent of treating with an a priori defined frequency of infusions for at least the previous 6 months, OR b. Historical life-threatening hemorrhage with required need for Factor IX therapy, OR c. Have repeated, serious spontaneous bleeding 3. Factor IX inhibitor titer test to confirm a negative results in the past 30 days 4. Testing to confirm no neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test 5. Current (within the past 30 days) labs to confirm adequate hepatic function including, ALT/AST/ALP/Total bilirubin less than 2x the upper limit of normal, and INR 6. Current Hepatitis B and Hepatitis C status 7. If HIV positive, current (within the past 30 days) CD4 cell level ≥ 200 cell/microL and a viral load <20 copies/mL Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	18 years and older
Prescriber Restriction	Hematologist
Coverage Duration	Once per lifetime
Other Requirements & Information	No renewal

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
C9172	Injection, fidanacogene elparvovec-dzkt , per therapeutic dose (Beqvez™)	5×10^{11} vector genomes per kg (vg/kg) IV as a single, one-time 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 of adults with hemophilia B (congenital FIX deficiency) who: • Currently use FIX prophylaxis therapy, or • Have current or historical life-threatening hemorrhage, or • Have repeated, serious spontaneous bleeding episodes
Exclusion Criteria	1) Treatment or use for anything other than hemophilia B ~~2)~~ Positive Factor IX inhibitor titer test 2) 3) Previous gene therapy treatment with etranacogene dezaparvovec-drlb (Hemgenix™), fidanacogene elaparvovec-dzkt (Beqvez™) or other gene therapy
Required Medical Information	Documentation of all of the following (1-6): 1) Clinic notes to confirm moderately severe or severe congenital hemophilia B along with baseline Factor IX level of ≤ 2% of normal: 2) One of the following: a. Current use of routine Factor IX prophylaxis as defined as the intent of treating with an a priori defined frequency of infusions for at least the previous 6 months~~Current need for routine FIX prophylaxis therapy for ≥ 2 months with >150 previous exposure days of treatment with factor IX protein~~, OR b. Historical life-threatening hemorrhage with required need for Factor IX therapy, OR c. Have repeated, serious spontaneous bleeding episodes with required need for Factor IX therapy 3) Factor IX inhibitor titer test to confirm a negative results in the past 30 days 4) Current (within the past 30 days) labs to confirm adequate hepatic function including, ALT/AST/ALP/Total bilirubin less than 2x the upper limit of normal, and INR 5) Current Hepatitis B AND Hepatitis C status 6) If HIV positive, current (within the past 30 days) CD4 cell level lab results (≥ 200~~500~~ cell/microL) with anti-viral therapy. Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	18 years and older
Prescriber Restriction	Hematologist
Coverage Duration	Once per lifetime
Other Requirements & Information	Allowed for once in a lifetime treatment. There will be no renewals or retreatment requests approved. *Note: Awareness of potential for hepatotoxicity and hepatocellular carcinoma is important when considering this treatment. Screening for hepatic impairment prior to starting treatment and continued monitoring of liver function for a minimum of 3 months is recommended after administration of etranacogene*

	dezaparvovec-drlb (Hemgenix™).

Medical Billing:

Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Dosing, Units
J1411	Injection, etranacogene dezaparvovec-drlb, per therapeutic dose	2×10^{13} genome copies per kg (equivalent to 2 ml/kg) IV as a single one-time dose.

PA Criteria	Criteria Details
Covered Uses	Treatment of beta thalassemia in adult and pediatric patients who require regular red blood cell transfusions and for whom hematopoietic stem cell transplantation (HSCT) ~~transplantation~~ is appropriate but a human leukocyte antigen (HLA)-matched related HSC donor is not available
Exclusion Criteria	• Requests for treatment of indications other than beta thalassemia • Prior therapy with betibeglogene autotemcel (Zynteglo™) or exagamglogene autotemcel (Casgevy) or other gene therapy • Prior receipt of HSCT • HIV positive
Required Medical Information	Documentation that all conditions have been meet: 1) Genetic testing to confirm beta thalassemia with: a. History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs) OR b. 8 or more transfusions of pRBCs per year in the past 2 years 2) Reasons why preferred gene therapy option for transfusion dependent beta-thalassemia, exagamglogene autotemcel (Casgevy), cannot be used 3) Confirmation that the member does not have an available ~~allogeneic hematopoietic stem cell transplantation is appropriate but a~~ 10/10 human leukocyte antigen (HLA) matched related ~~donor or~~ HSCT donor. ~~(related or non-related) is not available.~~ 4) Confirmation that hematopoietic stem cell (HSC) transplantation is appropriate for the patient ~~with no evidence of~~and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥ 60 (<16 years of age) ~~a.~~b. No advanced l~~L~~iver ~~impairment~~ disease; severe hepatic fibrosis or cirrhosis ~~b.~~c. ~~Renal impairment with Cr~~Cl~~e~~GFR ~~>~~≥ 6~~7~~0 ml/min/1.73m^2 d. No c~~C~~ardiomyopathy or severe congestive heart failure (NYHA class III or IV) e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding periods of severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline ~~c.~~g. WBC count ≥3x10^9/L and platelet count ≥50x10^9/L (unless related to hypersplenism) ~~d.~~ No Hypersplenism h. ~~e. Screening to confirm negative results for:~~ ~~Human immunodeficiency virus HIV-1 and HIV-2~~ ~~Hepatitis B virus (HBV) and hepatitis C virus (HCV) or negative viral load, if previously exposed~~ ~~Human T-lymphotrophic virus 1 & 2 (HTLV-1/HTLV-2)~~ 5) No severe iron overload in the heart or liver or endocrine systems, evaluated within the last 6 months i. ~~Severely elevated iron in the heart (i.e., patients with C~~cardiac T2* value must not be less than 10 msec by magnetic resonance imaging [MRI] ~~f.~~ Liver iron concentration must not be ≥15mg/g~~)~~ j. ~~g. Lupus anticoagulant~~ ~~5)~~6) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus

	(HBV), and Hepatitis C virus (HCV), Human T lymphotrophic virus 1 & 2 (HTLV 1/HTLV 2) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection ~~6)~~7) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Granulocyte-colony stimulating factor (G-CSF, TAR required) b. Plerixafor (Mozobil™, TAR required), for mobilization c. Busulfan (TAR required), for myeloablative conditioning Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both denials and approvals.
Age Restriction	4 years and older
Prescriber Restriction	Hematologist or Transplant Specialist at a Qualified Treatment Center
Coverage Duration	Once per lifetime
Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Medical Billing:

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

HCPCS	Description	Dosing, Units
~~J3590~~ J3393 (although PHC inpatient hospital billing does not generally utilize HCPCS codes)	Intravenous injection, betibeglogene, per dose (Zynteglo™)	Minimum recommended dose: 5 × 106 CD34+ cells/kg

~~Currently in California, there is only one designated treatment center – UCSF Benioff Children's Hospital Oakland.~~

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 sickle cell disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises (VOCs). • The treatment of transfusion-depended β-thalassemia (TDT) in patients 12 years and older
Exclusion Criteria	1) Off-label use 2) Prior use of lovotibeglogene autotemcel (Lyfgenia™), betibeglogene autotemcel (Zynteglo™) or exagamglogene autotemcel (Casgevy™) or other gene therapy 3) Prior receipt of HSCT 4) For Sickle Cell Disease only: Inability to receive RBC transfusions
Required Medical Information	Requirements for all indications: 1) Confirmation that hematopoietic stem cell transplantation is appropriate for the patient and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥60 (<16 years of age) b. No advanced liver disease; severe hepatic fibrosis or cirrhosis c. eGFR is ≥ 60 ml/min/1.73m^2 d. No cardiomyopathy or severe congestive heart failure (NYHA class III or IV) and baseline LVEF is ≥45% e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding periods of SCD crisis, severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline g. WBC count ≥3x10^9/L and platelet count ≥50x10^9/L (unless related to hypersplenism) h. Documentation that the member does not have any history of severe cerebral vasculopathy: defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [≥200 cm/sec] needing chronic transfusion; or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease. ~~h.~~i. No hypersplensim 2) Confirmation that the member does not have an available 10/10 HLA matched related HSCT donor 3) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection 4) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Plerixafor (Mozobil™, TAR required), for mobilization b. Busulfan (TAR required), for myeloablative conditioning 5) 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)

	Additional Requirements for Sickle Cell Disease 1) Genetic testing to confirm severe sickle cell disease genotype: β^s/β^s, β^s/β^0, or β^s/β^+ a. Note that other genotypes may be considered if a severe disease phenotype is demonstrated on a case by case basis 2) Documentation that the member has had at least 4 severe vaso-occlusive events (VOE) in the prior 24 months as defined below while receiving appropriate supportive care (e.g. pain management plan, hydroxyurea) a. No medically determined cause other than a vaso-occlusion b. Event that requires at least one of the following: i. A visit to a medical facility and administration of pain medications (opioids or intravenous non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions ii. OR a ≥ 24-hour hospital or Emergency Room (ER) observation unit visit iii. OR at least 2 visits to a day unit or ER over 72 hours with both visits requiring intravenous treatment. iv. OR acute chest syndrome v. OR splenic sequestration vi. OR Priapism lasting >2 hours OR 4 priapism episodes that require a visit to a medical facility (without inpatient admission) are sufficient to meet criterion 3) Documentation that the member has failed hydroxyurea (HU) at any point in the past or must have intolerance to HU. Failure is defined as >1 VOE or ≥1 Acute Chest Syndrome after HU has been prescribed for at least 6 months Additional Requirements for Transfusion Dependent Beta Thalassemia 1) Genetic testing to confirm beta thalassemia 2) Documentation of transfusion dependence as evidenced by one of the following a. A history of at least 100 mL/kg/year of packed RBC in the prior 2 years OR b. 10 units/year of packed RBC transfusions in the prior 2 years 3) No severe iron overload in heart or liver or endocrine systems, evaluated within the last 6 months a. Cardiac T2* value must not be less than 10 msec by magnetic resonance imaging [MRI] ~~c.~~b. Liver iron concentration must not be ≥15mg/g

Age Restriction	FDA indication: 12 years and older

Prescriber Restriction	Hematologist or Transplant Specialist at an Authorized Treatment Center

Coverage Duration	FDA labeling: Once per lifetime, approval will allow a 12 month duration

Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologicals; exagamglogene autotemcel (Casgevy™)	The minimum recommended dose is 3×10^6 CD34+ cells/kg

~~Currently in California, there is only one planned authorized treatment center - City of Hope National Medical Center; Duarte (near Los Angeles).~~

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 patients 12 years of age or older with sickle cell disease and a history of vaso-occlusive events (VOEs).
Exclusion Criteria	1. Off-label use 2. Prior use exagamglogene autotemcel (Casgevy) or lovotibeglogene autotemcel (Lyfgenia) or other gene therapy 3. Prior receipt of an allogeneic transplant 4. Positive HIV test 5. Inability to receive RBC transfusions
Required Medical Information	1) Genetic testing to confirm severe sickle cell disease genotype: β^s/β^s, β^s/β^0, or β^s/β^+ a. Note that other genotypes may be considered if a severe disease phenotype is demonstrated on a case by case basis 2) Documentation that the member has had at least 4 severe vaso-occlusive events (VOE) in the prior 24 months as defined below, while receiving appropriate supportive care (e.g. pain management plan, hydroxyurea) a. No medically determined cause other than a vaso-occlusion b. Event that requires at least one of the following: i. A visit to a medical facility and administration of pain medications (opioids or intravenous non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions ii. OR a ≥ 24-hour hospital or Emergency Room (ER) observation unit visit iii. OR at least 2 visits to a day unit or ER over 72 hours with both visits requiring intravenous treatment. iv. OR acute chest syndrome v. OR splenic sequestration vi. OR Priapism lasting >2 hours OR 4 priapism episodes that require a visit to a medical facility (without inpatient admission) are sufficient to meet criterion 3) Documentation that the member has failed hydroxyurea (HU) at any point in the past or must have intolerance to HU. Failure is defined as >1 VOE or ≥1 Acute Chest Syndrome after HU has been prescribed for at least 6 months 4) Reasons why preferred gene therapy option for sickle cell disease, exagamglogene autotemcel (Casgevy), cannot be used 5) Human immunodeficiency virus (HIV-1 and HIV-2), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) testing, as well as documentation that the member does not have a clinically significant and active other viral, bacterial, fungal or parasitic infection 6) Confirmation that hematopoietic stem cell transplantation is appropriate for the patient and documentation of the following: a. Karnofsky performance status of ≥ 60 (≥16 years of age) or a Lansky performance status of ≥60 (<16 years of age) b. No advanced liver disease; severe hepatic fibrosis or cirrhosis c. eGFR is ≥ 60 ml/min/1.73m^2 d. No cardiomyopathy or severe congestive heart failure (NYHA class III or IV) and baseline LVEF is ≥45%

	e. Lung diffusing capacity for carbon monoxide (DLCO) is ≥40%, and baseline O2 saturation ≥85% without supplemental oxygen (excluding periods of SCD crisis, severe anemia or infection) f. No clinically significant pulmonary hypertension at baseline g. WBC count ≥$3x10^9$/L and platelet count ≥$50x10^9$/L (unless related to hypersplenism) h. Documentation that the member does not have any history of severe cerebral vasculopathy: defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [≥200 cm/sec] needing chronic transfusion; or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease. ~~h.~~i. No hypersplenism 7) Confirmation that the member does not have an available 10/10 HLA matched related HSCT donor 8) Treatment and medications required for mobilization, and myeloablative conditioning have been approved: a. Plerixafor (Mozobil™, TAR required), for mobilization b. Busulfan (TAR required), for myeloablative conditioning 9) 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	12 years and older
Prescriber Restriction	Hematologist or Transplant Specialist at a Qualified Treatment Center
Coverage Duration	FDA labeling: Once per lifetime, approval should be for a 12 month duration
Other Requirements & Information	Limited to once per lifetime treatment. There will be no renewals or retreatment requests approved.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3394	Injection, lovotibeglogene autotemcel, per treatment	The minimum recommended dose is 3×10^6 CD34+ cells/kg

~~Currently in California, there is only one planned qualified treatment center: Lucile Salter Packard Children's Hospital at Stanford; Palo Alto.~~

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	Sickle Cell Disease
Exclusion Criteria	None
Required Medical Information	1) Current weight (kg) within the last 4 weeks, submitted with initial request and each renewal request. 2) Number of events in the past 365 days, prior to treatment with Adakveo. 3) Documentation of an inadequate response after at least a 3-month trial each of both hydroxyurea AND L-glutamine (Endari) despite compliant use. An inadequate response would be demonstrated when the member continues to have >2 events annually or no decrease in number of events prior to starting the medication.
Age Restriction	16 years and older
Prescriber Restriction	Must be prescribed or recommended by a hematologist
Coverage Duration	6 months
Other Requirements & Information	First ~~R~~renewal request~~s~~: 1) Current weight (kg) within the last 4 weeks 2) Number of events in the past 180 days since starting Adakveo 3) Documentation that the member has continued adherence with their other current sickle cell disease modifying treatments if applicable ~~1)~~4) For members who do not demonstrate a reduction in vasoocclusive events, additional documentation supporting clinically meaningful benefit must be submitted ~~and benefit to treatment such as reduction of events.~~ Subsequent renewal requests: current weight (kg) within the last 4 weeks 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
J0791	Injection, crizanlizumab-tmca, 5 mg (Adakveo™)	Initial dosing limited to 5 mg/kg on week 0 and week 2. Maintenance dosing limited to 5 mg/kg once every 4 weeks. For missed doses – if administered within 2 weeks after missed dose, continued dosing according to original schedule, however if missed dose is administered greater than 2 weeks then then continue dosing every 4 weeks using last date of dosing

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

PA Criteria	Criteria Details
Covered Uses	1) Atypical hemolytic uremic syndrome (aHUS) to inhibit complement mediated thrombotic microangiopathy. 2) Generalized myasthenia gravis (gMS) in adults who are anti-acetylcholine receptor antibody-positive (AChR+). 3) Neuromyelitis optica spectrum disorder (NMOSD) in adults who are aquaporin-4-antibody positive. 4) Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis.
Exclusion Criteria	• Unresolved serious *Neisseria meningitidis* infection • Treatment of Shiga toxin E. coli related hemolytic uremic syndrome • Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • Use along with ravulizumab (Ultomiris™) or efgartigimodum alfa-fcab (Vyvgart™) • NMOSD negative AQP4-IgG
Required Medical Information	1) Requirements for atypical hemolytic uremic syndrome (all of the following, a-e): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) d. Documentation that Shiga toxin has been ruled out e. Trial and failure with ravulizumab (Ultomiris™) 2) Requirements for paroxysmal nocturnal hemoglobinuria (all of the following, a-e): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Weight (kg, lb) ~~c.~~d. Documentation of trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used ~~d.~~e. Trial and failure with ravulizumab (Ultomiris™) 3) Requirement for AChR antibody-related myasthenia gravis (all of the following, a-f): a. Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies. b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta-blockers, hydroxychloroquine, gabapentin, lithium. d. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline. e. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV

	f. Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the following (i-vi): i. Pyridostigmine ii. Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose iii. Oral glucocorticoid sparing immunomodulatory, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate ~~iii.~~iv. Zilucoplan (Zilbrysq™) v. Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™) ~~iv.~~vi. ~~AND~~ Ravulizumab (Ultomiris™) 4) Requirements for Neuromyelitis optica spectrum disorder (NMOSD) (all of the following a-d): a. At least one of the following: i. Optic neuritis Acute myelitis ii. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting iii. Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) iv. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions v. Symptomatic cerebral syndrome with NMOSD-typical brain lesions b. Seropositive for AQP4-IgG antibodies ~~c.~~ Documentation of trial and failure or contraindication to ~~:~~ ~~d.~~ Satralizumab (Enspryng™) ~~-~~ c. OR Inebilizumab-cdon (Uplizna™) ~~e.~~d. Documentation of trial and failure or contraindication to ravulizumab (Ultomiris)
Age Restriction	aHUS: 2 months of age and older gMS, NMOSD, PNH: 18 years and older
Prescriber Restriction	• PNH: Hematologist • aHUS: Nephrologist, Hematologist • gMS: Neurologist • NMOSD: Neurologist, Ophthalmologist *Note: Prescribers must be enrolled in REMS*
Coverage Duration	Initial TAR for loading dose: Approved for 1 to 4 loading doses, depending on indication and weight of the patient (if relevant) Initial TAR for maintenance dose: 6 months Renewal TAR: Approved for 1 dose per fill for up to 6 months.
Other Requirements & Renewal Information	Renewal Requests: • Clinical notes with current: o MG-ADL o MGFA classification Requests for off-label use: See PHC criteria document ***Case-by-Case TAR Requirements and Considerations.***

Medical Billing:

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

Dose limits & billing requirements (approved TAR is required)

<table>
<tr><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td>J1300</td><td>Injection, Eculizumab, 10 mg</td><td>aHUS, gMS, NMOSD (≥ 18 yrs):
900 mg IV qwk x 4 doses, then 1,200 mg for the 5th dose on week 5, then 1,200 mg q2wks thereafter.
aHUS (≥ 2 months):<table><tr><th>Weight</th><th>Induction dose (qwk)</th><th>Maintenance dose</th></tr><tr><td>≥ 40 kg</td><td>900 mg x 4</td><td>1,200 mg at week 5, then q2wks</td></tr><tr><td>30 -39 kg</td><td>600 mg x 2</td><td>30 -39 kg 600 mg x2 900 mg at week 3, then q2wks</td></tr><tr><td>0 – 29 kg</td><td>600 mg x 2</td><td>600 mg at week 3, then q2wks</td></tr><tr><td>10 – 19 kg</td><td>600 mg x 1</td><td>300 mg at week 2, then q2wks</td></tr><tr><td>5 - 9 kg</td><td>300 mg x 1</td><td>300 mg at week 2 then q3wks</td></tr></table>PNH:
600 mg IV qwk x 4 doses, then 900 mg for the 5th dose on week 5, then 900 mg q2wks thereafter.</td></tr>
</table>

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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) Atypical hemolytic uremic syndrome to inhibit complement mediated thrombotic microangiopathy. 2) Paroxysmal nocturnal hemoglobinuria. 3) Generalized myasthenia gravis (gMG) in adults who are anti-acetylcholine receptor antibody-positive (AChR+) ~~3)~~4) Neuromyelitis optica spectrum disorder (NMOSD) in adults who are aquaporin-4-antibody positive.
Exclusion Criteria	• Unresolved serious *Neisseria meningitidis* infection • Treatment of Shiga toxin E. coli related hemolytic uremic syndrome • Myasthenia gravis MuSK antibody, LRP4 antibody positive or seronegative • Use along with Eculizumab (Soliris™) or efgartigimod alfa-fcab (Vyvgart™) • NMOSD negative AQP4-IgG
Required Medical Information	1) Requirements for atypical hemolytic uremic syndrome (all of the following, a-d): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor c. Weight (kg, lb) d. Documentation that Shiga toxin has been ruled out 2) Requirements for paroxysmal nocturnal hemoglobinuria (all of the following, a-d): a. Appropriate labs to confirm diagnosis (e.g. Flow cytometry, CBC) b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor c. Weight (kg, lb) ~~c.~~d. Documentation of trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used 3) Requirement for AChR antibody-related myasthenia gravis (all of the following, a-f): a. Positive immunologic binding assay to confirm MG due to the presence of AChR antibodies b. Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. c. Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium d. Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline e. Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV f. Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to all of the

	following (i-v): i. Pyridostigmine ii. Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose ~~AND~~ iii. Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate iv. Zilucoplan (Zilbrysq™)~~AND~~ v. Efgartigimod alfa-fcab (Vyvgart™) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo™) 4) Requirements for Neuromyelitis optica spectrum disorder (NMOSD) (all of the following, a-c): a. 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 b. Seropositive for AQP4-IgG antibodies c. Documentation of trial and failure or contraindication to Satralizumab (Enspryng™) OR Inebilizumab-cdon (Uplizna™)
Age Restriction	aHUS and PNH: ≥ 1 months MG, NMOSD: ≥ 18 years
Prescriber Restriction	• aHUS: Nephrologist, Hematologist • PNH: Hematologist • MG: Neurologist • NMOSD: Neurologist, Ophthalmologist *Note: Prescribers must be enrolled in REMS*
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 PHC criteria document *Case-by-Case TAR Requirements and Considerations*

Medical Billing:

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

Dose limits & billing requirements, with an approved TAR:

<table>
<tr><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td>J1303</td><td>Injection, Ravulizumab, 10mg</td><td>
aHUS and PNH ≥ 1 month:
<table>
<tr><th>Weight</th><th>Loading Dose</th><th>Maintenance dose IV (start 14 days after loading dose)</th><th>Maintenance Interval</th></tr>
<tr><td>5 kg – 9 kg</td><td>600 mg</td><td>300 mg</td><td rowspan="2">4 weeks</td></tr>
<tr><td>10 kg – 19 kg</td><td>600 mg</td><td>600 mg</td></tr>
<tr><td>20 kg – 29 kg</td><td>900 mg</td><td>2,100 mg</td><td rowspan="6">8 weeks</td></tr>
<tr><td>30 kg – 39 kg</td><td>1,200 mg</td><td>2,700 mg</td></tr>
<tr><td>40 kg – 59 kg</td><td>2,400 mg</td><td>3,000 mg</td></tr>
<tr><td>60 kg – 99 kg</td><td>2,700 mg</td><td>3,300 mg</td></tr>
<tr><td>≥ 100 kg</td><td>3,000 mg</td><td>3,600 mg</td></tr>
</table>
gMG and NSMOD ≥18 years:
<table>
<tr><th>Weight</th><th>Loading Dose</th><th>Maintenance dose IV (start 14 days after loading dose)</th><th>Maintenance Interval</th></tr>
<tr><td>40 kg – 59 kg</td><td>2,400 mg</td><td>3,000 mg</td><td rowspan="3">8 weeks</td></tr>
<tr><td>60 kg – 99 kg</td><td>2,700 mg</td><td>3,300 mg</td></tr>
<tr><td>≥ 100 kg</td><td>3,000 mg</td><td>3,600 mg</td></tr>
</table>
</td></tr>
</table>

APPROVED

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PA Criteria	Criteria Details
Covered Uses	The treatment of adult and pediatric patients 13 years and older with paroxysmal nocturnal hemoglobinuria (PNH) and body weight of at least 40 kg
Exclusion Criteria	• Unresolved serious *Neisseria meningitidis* infection • Use along with Eculizumab (Soliris), ravulizumab (Ultomiris™), pegcetacoplan (Empaveli™) or (Fabhalta™)
Required Medical Information	Documentation of all of the following: 1) Flow cytometry analysis confirming presence of PNH clones 2) Presence of laboratory results, signs and/or symptoms attributed to PNH (Lactate dehydrogenase >1.5x upper limit of normal, hemoglobin <10g/dL, abdominal pain, anemia, dyspnea, extreme fatigue, unexplained/unusual thrombosis) 3) Documentation of meningococcal vaccine given prior to therapy or will be given immediately after the first dose of the complement inhibitor. 4) Weight (kg, lb) 5) Trial and failure or reasons why iptacopan (Fabhalta™) OR pegcetacoplan (Empaveli™) cannot be used 6) Trial and failure or contraindication to ravulizumab (Ultomiris™)
Age Restriction	13 years and older
Prescriber Restriction	Hematologist
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal Requirements: updated clinic notes documenting benefit from treatment and current weight. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologics; crovalimab-akkz (PiaSky™)	Weight ≥40 to <100kg: • 1000mg IV on day 1 • 340mg SC on day 2, 8, 15, 22 • maintenance 680mg SC every 4 weeks starting on day 29 Weight ≥100kg • 1500mg IV on day 1 • 340mg SC on day 2, 8, 15, 22 • Maintenance 1020mg SC every 4 weeks starting on day 29

Note: For patients switching from another complement inhibitor, the first loading dose of PiaSky should be administered no sooner than the time of the next scheduled complement inhibitor administration.

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

PA Criteria	Criteria Details
Covered Uses	• Anemia in adults with beta (β) thalassemia who require regular RBC transfusions. • Anemia in adults with myelodysplastic syndromes (MDS). • Anemia in adults with ~~Myelodysplastic syndromes with ring sideroblasts (MDS-RS) or~~ ~~M~~myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T).
Exclusion Criteria	• Non-transfusion dependent β-thalassemia • Treatment of other causes of anemia • Deep vein thrombosis or stroke within the past 24 weeks prior to start of treatment • Pregnant or breastfeeding
Required Medical Information	For initial requests: 1) Clinic notes to confirm the diagnosis with one of the following: • β–thalassemia • Myelodysplastic Syndrome ~~with ring sideroblasts~~ (MDS~~-RS~~) • Myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T) 2) Other causes of anemia (e.g. bleeding, vitamin deficiency, iron deficiency, acute leukemia) have been ruled out. 3) Weight (kg, lb) 4) Requirement for those with a confirmed diagnosis of β–thalassemia: • Transfusion records to showing member is transfusion dependent, as evidenced by both of the following within the past 24 weeks: o Requires regular RBC transfusions with ≥ 6 units of packed red blood cells (PRBC) AND o No transfusion free period ≥ 35 days o Serum ferritin levels >1,000 ng/ml 5) Requirements for those with a confirmed diagnosis of MDS • Documented lower risk disease as defined by one of the following: o Revised International Prognostic Scoring System (IPSS-R) - Very Low, Low, Intermediate (Score 0 to ≤ 4.5) o IPSS - Low/Intermediate-1 (Score 0 to 1) o WHO-Based Prognostic Scoring System (WPSS) - Very Low, Low, Intermediate (Score 0 to 2) • Member requires at least 2 units of packed red blood cells (pRBCs) in the prior 8 weeks ~~5)~~6) Requirements for those with a confirmed diagnosis of ~~MDS-RS or~~ MDS/MPN-RS-T: • Documented lower risk disease as defined by one of the following: o Revised International Prognostic Scoring System (IPSS-R) - Very Low, Low, Intermediate (Score 0 to ≤ 4.5) o IPSS - Low/Intermediate-1 (Score 0 to 1) o WHO-Based Prognostic Scoring System (WPSS) - Very Low, Low, Intermediate (Score 0 to 2) • Documentation of either: o Ring sideroblasts ≥ 15% OR o Ring sideroblasts ≥ 5% with an SF3B1 mutation

	• Non-responsive to or intolerant to erythropoiesis stimulating agents (ESA) or ESA is not indicated due to serum erythropoietin > 200 mU/mL • ~~Patient~~ Member requires at least 2 units of packed red blood cells (pRBCs) in the prior 8 weeks
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by a Hematologist or Hematologist–Oncologist
Coverage Duration	Initial approval: 6 months Renewal: up to 12 months
Other Requirements & Information	Documentation requirement for renewal: • Decrease in transfusion burden after 3 maximally tolerated doses (9 weeks of treatment). *Note: Treatment should be discontinued if there has not been a reduction in transfusion requirements per manufacturer's recommendation.* Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J0896	Injection, luspatercept-aamt, 0.25 mg	β-thalassemia: 1 mg/kg SC q3weeks Max dose: 1.25 mg/kg q3weeks MDS~~-RS~~ or MDS/MPN-RS-T: 1 mg/kg SC q3weeks Max dose: 1.75 mg/kg q3weeks

Recommended dosing adjustment based on hemoglobin (Hgb) level (per manufacturer package insert:

1) Pre-dose hemoglobin ≥11.5 g/dL (in the absence of transfusions):
   Interrupt luspatercept; resume when hemoglobin is ≤11 g/dL.

2) Increase Hgb > 2 g/dl within 3 weeks (in absence of transfusions):

β – Thalassemia	
Current Dose	Reduce to x mg/kg once every 3 weeks
1.25 mg/kg	1 mg/kg
1 mg/kg	0.8 mg/kg
0.8 mg/kg	0.6 mg/kg
0.6 mg/kg	*Discontinue*
MDS~~-RS~~ or MDS/MPN-RS-T	
Current Dose	Reduce to x mg/kg once every 3 weeks
1.75 mg/kg	1.33 mg/kg
1.33 mg/kg	1 mg/kg
1 mg/kg	0.8 mg/kg
0.8 mg/kg	0.6 mg/kg
0.6 mg/kg	*Discontinue*

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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	Prophylactic or on demand enzyme replacement therapy (ERT) for congenital thrombotic thrombocytopenic purpura (cTTP).
Exclusion Criteria	Other causes of thrombotic thrombocytopenic purpura (TTP)
Required Medical Information	1) Documented diagnosis of cTTP with both of the following: a. Confirmed molecular genetic testing b. ADAMTS13 activity <10% as measured by the fluorescent resonance energy transfer-von Willebrand factor 73 (FETS-VWF73) assay 2) Requests for prophylactic therapy must have a history of at least one documented TTP event or currently be receiving prophylactic therapy
Age Restriction	None
Prescriber Restriction	Hematologist
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal requests: current weight 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
J7171	Injection, adamts13, recombinant-krhn, 10 iu	Prophylactic therapy: • 40 IU/kg every other week, may adjust to 40 IU/kg weekly based on clinical response On-demand therapy: • Day 1: 40 IU/kg • Day 2: 20 IU/kg • Day 3 until 2 days after event resolves: 15 IU/kg once daily

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	• Prevention of chemotherapy-induced neutropenia. • Hematopoietic Subsyndrome of Acute Radiation Syndrome [H-ARS]
Exclusion Criteria	• Use for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. • Dosed more frequently than every 14 days for prevention of chemotherapy-induced neutropenia.
Required Medical Information	Clinic notes documenting: • Diagnosis • Specific chemotherapy regimen with dose and frequency • Current and past absolute neutrophil count (ANC) lab report documenting history of severe neutropenia secondary to chemotherapy (if applicable) • Member specific risk factors for developing neutropenia (if any) For chemotherapy regimens not identified as having high risk (greater than 20%) or intermediate risk (10-20%) of febrile neutropenia (FN) in the absence of any associated patient risk factors, clinical literature supporting intermediate to high risk of FN may be required.
Age Restriction	None
Prescriber Restriction	Prescribed by, or in consultation with, an oncologist or hematologist.
Coverage Duration	TBD based on chemotherapy regimen, up to a maximum of 6 months per authorization.
Other Requirements & Information	For prevention of chemotherapy-induced neutropenia, clinical documentation supporting inadequate response to a preferred biosimilar product (Fulphila, Fylnetra, Nyvepria, or Udenyca~~, or Ziextenzo~~) must be provided. ALSO must meet ONE of the following: (1) Primary prophylaxis of febrile neutropenia in patients receiving myelosuppressive chemotherapy with an expected incidence of febrile neutropenia of greater than 20% (high risk) or at least 10-20% (intermediate risk) if patient has at least one risk factor for developing neutropenia as summarized in the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for use of Myeloid Growth Factors. OR (2) Secondary prophylaxis of febrile neutropenia in patients who experienced neutropenic complication from prior chemotherapy and did not receive primary prophylaxis with a myeloid growth factor and a reduced dose or frequency of chemotherapy may compromise treatment outcome. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

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

Requirements for Elivaldogene Autotemcel (Skysona™)

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 early, active Cerebral Adrenoleukodystrophy (CALD) in boys 4-17 years old.
Exclusion Criteria	• Prior receipt of allogeneic stem cell transplant (allo-HSCT) or gene therapy • Patients with full deletion of the human adenosine triphosphate binding cassette, subfamily D, member 1 (ABCD1) gene • CALD secondary to head trauma
Required Medical Information	1. Diagnosis of early, active CALD as confirmed by ALL of the following criteria: a. Elevated very long chain fatty acid (VLCFA) values per standard reference values of the performing laboratory. b. Genetic testing confirming ABCD1 mutation. c. Active CNS disease established by central radiographic review of brain MRI demonstrating both of the following: i. Loes score between 0.5 and 9 on the 34-point scale ii. Gadolinium enhancement on MRI of demyelinating lesions d. Neurologic function score (NFS) ≤1 2. Member is eligible for a hematopoietic stem cell transplant (HSCT) but does not have a matched sibling donor. 3. Documentation of screening for Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus 1 & 2 (HIV-1/HIV-2), and Human T-lymphotropic virus 1 & 2 (HTLV-1/HTLV-2) prior to collection of cells for manufacturing. Please confirm the following if applicable: a. The patient must discontinue anti-retroviral medications for at least one month before mobilization, and until all apheresis cycles have been completed. b. For patients who require anti-retrovirals for HIV prophylaxis, mobilization and apheresis should be delayed until HIV infection is ruled out. 4. Provider has consulted with a hematology expert prior to requesting treatment with Skysona to ensure adequate monitoring for hematologic malignancy. Consider performing baseline complete blood count with differential, hematopathology review of peripheral blood smear, and bone marrow biopsy (core and aspirate) with flow cytometry, conventional karyotyping, and next generation sequencing (NGS). 5. Policy MCUP3138 External Independent Medical Review may apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.
Age Restriction	Males 4 to 17 years old
Prescriber Restriction	Neurologist, Endocrinologist, Hematologist/Oncologist
Coverage Duration	Once per lifetime
Other Requirements & Information	Allowed for once per lifetime treatment. There will be no renewals or retreatment requests approved *Note: Hematologic malignancies have occurred in patients after administration of*

Requirements for Elivaldogene Autotemcel (Skysona™)

	Skysona; the cancers appear to be caused by the lentiviral vector (Lenti-D). Patients should be monitored for evidence of hematologic malignancy by way of complete blood counts at least every three months. Patients should be assessed for evidence of clonal expansion or predominance at least twice in the first year, and then continue assessments annually. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Unclassified drugs or biologicals, unclassified biologics (Skysona™)	Minimum Dose: 5.0 x 10^6 CD34+ cells/kg Supplied as one to two infusion bags containing 20mL of a frozen suspension of genetically modified autologous cells enriched for CD34+ cells.

Requirements for Lecanemab-irmb (Leqembi™)

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	For the treatment of Alzheimer's Disease (AD) in patients with mild cognitive impairment or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.
Required Medical Information	Initial Approval Criteria (Must meet all): • Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness) • Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as: o Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD) o Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus • Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer's Disease (AD) or mild AD dementia and must have at least two of the following: o Clinical Dementia Rating (CDR)-Global Score of 0.5 to 1.0 o Mini-Mental Examination Status (MMSE) score of 22–30 o Montreal Cognitive Assessment (MoCA) score of ≥16 o Functional Assessment Staging Tool (FAST) score of 2 – 4 • Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following: o Amyloid PET o Lumbar puncture: CSF assessment positive for amyloid beta plaque. • Must provide baseline brain magnetic resonance imaging (MRI) dated within 12 months prior to request and MRI must document all of the following: o Less than 4 brain micro-hemorrhages o No prior brain hemorrhage greater than 1cm within the past year o No localized superficial siderosis o No evidence of acute/subacute cerebral contusion, aneurysms, vascular malformations, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory. o No evidence of vasogenic edema or brain tumors o No severe small vessel, or white matter disease • ALL of the following MUST be documented: o Member does NOT have a history of cerebrovascular abnormalities or bleeding disorder that would present a risk for ARIA-related bleeding o Member does NOT have history of transient ischemic attack (TIA), stroke or seizures within the previous year of screening. o Member does NOT have untreated bleeding disorder (platelet count <50,000 or INR>1.5)

Requirements for Lecanemab-irmb (Leqembi™)

	○ Member must NOT have contraindications to MRI or PET scans ○ Member does NOT have history of depression and/or clinically unstable psychiatric illness in the past 12 months ○ Member does NOT have a history of alcohol or substance abuse in the past 12 months • If member is receiving an approved AD treatment such as an acetylcholinesterase inhibitor (AChEI) or memantine or both, must be on a stable dose for at least 12 weeks prior to Leqembi treatment initiation • Member weight must be included • The requested dose and frequency must be in accordance with FDA-approved labeling and must not exceed dosing guidelines
Age Restriction	50 to 90 ~~85~~ years old. Member under 50 years old with early onset Alzheimer's disease (AD) and met all criteria will be reviewed on a case-by-case basis.
Prescriber Restriction	Neurologist, geriatrician, psychiatrist.
Coverage Duration	Initial, doses 1-4: 2 months' duration (up to 4 doses of infusion) First Renewals, doses 5-12: 4 months' duration (up to 8 doses of infusion) Additional Renewals, dose 13 and later: 6 months' duration (up to 2 doses/month). Treatment duration beyond 18 months will be reviewed on a case-by-case basis.
Other Requirements & Information	First Renewal, must meet ALL: • Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND • Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤1 ~~0.5~~, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score ≥224, and/or FAST score of 2-4. • Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 5th and 7th infusion. • Absence of amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th and 7th infusions as determined by brain MRI. • Patient is not receiving any new medications since last authorization that would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, anticoagulants). Additional Renewals (dose 13 and later), must meet ALL: • Provider's attestation that the potential benefit outweighs known risks as evidence by one of the following: ○ A reduction in amyloid beta plaque buildup compared from baseline in PET imaging of brain. ○ A slowing/reducing cognitive decline from baseline in CDR-SB score or MMSE score. • Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤1 ~~0.5~~, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score ≥224, and/or FAST score 2-4. • Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 14th infusion. • Patient is not receiving any new medications since last authorization that

Requirements for Lecanemab-irmb (Leqembi™)

	would increase risk for ARIA (e.g. tissue plasminogen activator (tPA), antiplatelets, or anticoagulants). • Member must continue maintenance therapy at the recommended dosage per product labeling 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
~~J3490 (NOC) or~~ J3590 (NOC J0174	Injection, lecanemab-irmb ~~Unclassified drugs or Unclassified biologics~~	Injection: NDC 62856-0215-01: 500 mg/5 mL (100 mg/mL) in a single-dose vial NDC 62856-0212-01: 200 mg/2 mL (100 mg/mL) in a single-dose vial ~~PHC reimbursement is the contracted rate (such as AWP+/-) per vial (1 vial = 1 unit of service, 2 vials = 2 units of service), until CMS issues a specific code for Leqembi~~

10 mg/kg ~~(up to 1,200 mg)~~ once every 2 weeks, administered as an intravenous infusion over approximately one hour, once every two weeks.

~~Maximum dose: 1,200 mg every 14 days.~~

DHCS statement:

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

For additional details, see:

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

~~*Under the terms of the NCD, since Aduhelm is not covered by Medicare Part B, CMS considers it a Medicare Part D drug. Since Medicaid does not pay for Part D drugs for full-benefit dually eligible enrollees, regardless of Medicare Part D enrollment status, Medi-Cal will not cover Aduhelm for patients with Medicare-Medicaid coverage (dually eligible enrollees). Medicare-Medi-Cal dual-eligible enrollees are required to obtain the*~~

~~*medication via their Medicare benefit by enrolling in clinical trials.*~~

~~https://files.medi-cal.ca.gov/pubsdoco/aduhelm_faq.aspx~~

Requirements for Donanemab (Kisunla™)

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	For the treatment of Alzheimer's Disease (AD) in patients with mild cognitive impairment (MCI) or mild dementia stage of disease.
Exclusion Criteria	Members with AD having advanced beyond mild stage.
Required Medical Information	Documentation must include all of the following: • Specialist's clinic notes from in-person evaluation (telehealth/virtual visits not acceptable for criteria when establishing diagnosis and staging the illness). • Documentation of diagnostic workup which demonstrates other causes of dementia have been ruled out, such as: o Parkinson's disease, vascular dementia, Lewy Body dementia (DLB), frontotemporal dementia (FTD) o Specific alternative neurodegenerative disease or causative factors such as cobalamin (Vitamin B12) deficiency, Niacin (Vitamin B3) deficiency, meningitis and encephalitis infections, thyroid disease, head trauma, normal-pressure hydrocephalus. • Gradual progressive change in memory function, reported by the patient or informant, over at least 6 months. • Confirmed diagnosis of Mild Cognitive Impairment (MCI) due to Alzheimer's Disease (AD) or mild AD dementia and must have at least two of the following: o Clinical Dementia Rating (CDR)-Global Score of 0.5-1.0 o Mini-Mental Examination Status (MMSE) score of 22-30 o Montreal Cognitive Assessment (MoCA) score of ≥16 o Functional Assessment Staging Tool (FAST) score of 2-4 • Medical imaging results or diagnostic immunoassay confirming the presence of amyloid pathology with one of the following: o Amyloid PET imaging o Lumbar puncture: CSF assessment positive for amyloid beta plaque. • All of the following must be documented on baseline MRI: o Member does NOT have presence of amyloid-related imaging abnormalities of edema/effusion at baseline o Member does NOT have more than 4 cerebral microhemorrhages o Member does NOT have more than 1 area of superficial siderosis o Member does NOT have any intracerebral hemorrhage > 1cm o Member does NOT have severe white matter disease • If the member is being treated with other medications for Alzheimer 's disease, or others that may impact cognition, member must be on a stable dose for 30 days prior to initiating treatment with Kisunla™. • Testing for ApoE ε4 status should be performed or offered, and corresponding risk of ARIA considered by both provider and patient before initiating treatment.
Age Restriction	60 years and older

Requirements for Donanemab (Kisunla™)

Prescriber Restriction	Neurologist, Geriatrician, Psychiatrist
Coverage Duration	Initial dose (Infusion 1): 1-month duration • Baseline MRI required before initiating treatment First Renewals (Infusion 2-4): 3-month duration • MRI required before 2nd, 3rd, and 4th infusions Additional Renewals (Infusion 5-7): 3-month duration • MRI required before 7th infusion Additional Renewals (Infusion 8 and beyond): 6-month duration Treatment duration beyond 18 months will be reviewed on a case-by-case basis
Other Requirements & Information	For first renewal, member must meet all of the following: • Member continues to meet the indication-specific criteria identified in Required Medical Information initial criteria section AND • Continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤1 Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score of ≥22, and/or FAST score of 2-4. • Provider attestation that monitoring for ARIA will be conducted via MRI prior to the 2nd, 3rd, and 4th infusions. o Attestation that dosing will be suspended if results show moderate to severe ARIA-E or ARIA-H, or symptomatic ARIA-H of any severity. For additional renewals, member must meet all of the following: • Member has not progressed to moderate or severe AD with continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤1, Montreal Cognitive Assessment (MoCA) score of ≥16, and MMSE score of ≥22, and/or FAST score of 2-4. • Provider attestation that the potential benefits outweigh the known risks. • Provider attestation that clinical evaluation (including MRI) will be performed if patient demonstrated symptoms suggestive or ARIA. • Treatment remains at the recommended dosing per package instructions. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Kisunla™ (Donanemab-azbt)	J0175	Injection, donanemab-azbt	NDC: 00002-9401-01 350mg/20mL (17.5mg/mL)
First 3 infusions: 700mg IV every 4 weeks Maintenance dosing: 1400mg IV every 4 weeks			

Requirements for Atidarsagene Autotemcel (Lenmeldy™)

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 presymptomatic late infantile (PSLI), presymptomatic early juvenile (PSEJ), or early symptomatic early juvenile (PSEJ) metachromatic leukodystrophy (MLD) in pediatric patients.
Exclusion Criteria	• Prior use of gene therapy with atidarsagene autotemcel • Treatment of adult onset MLD
Required Medical Information	**For all requests, documentation of the following must be submitted**: Testing results to confirm diagnosis of MLD to include ALL the following: 1) Lysosomal enzyme arylsulfatase A (*ARSA*) activity below the normal range in leukocytes or cultured fibroblasts 2) Presence of 2 disease-causing mutations of either known or novel alleles (biallelic pathogenic variants in *ARSA*) 3) Urine sulfatide analysis confirming presence of sulfatides **In addition, documentation of the following must be submitted per subtype**: For presymptomatic late-infantile subtype (PSLI) MLD: 1) Disease onset ≤ 30 months of age (expectant disease onset may be determined by data from older siblings) 2) *ARSA* genotype consistent with PSLI MLD (biallelic null [0] variants) 3) Provider attestation that patient is presymptomatic (negative for neurological signs or symptoms of MLD) For presymptomatic early-juvenile subtype (PSEJ) MLD: 1) Disease onset between 30 months and < 7 years of age (expectant disease onset may be determined by data from older siblings) 2) *ARSA* genotype consistent with PSEJ MLD (one null [0] and one hypomorphic [R-residual] variant) 3) Provider attestation that patient is presymptomatic (negative for neurological signs and symptoms of MLD or physical examination limited to abnormal reflexes or clonus) For early symptomatic early-juvenile (ESEJ) MLD: 1) Disease onset between 30 months and < 7 years of age (expectant disease onset may be determined by data from older siblings) 2) *ARSA* genotype consistent with ESEJ MLD (one null [0] and one hypomorphic [R-residual] variant) 3) Patient is early symptomatic as exemplified by both of the following: a) Gross Motor Function Classification (GMFC)-MLD score of 0 with ataxia or 1 with or without ataxia b) Intelligence quotient (IQ) ≥ 85 on age appropriate neurodevelopment testing For all requests: Policy MCUP3138 External Independent Medical Review may apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.

Requirements for Atidarsagene Autotemcel (Lenmeldy™)

Age Restriction	Pediatric patients age 6 and under (prior to 7th birthday)
Prescriber Restriction	Neurologist, Oncologist/Hematologist
Coverage Duration	1 treatment per lifetime
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
J3590	Unclassified drug or biologicals, Unclassified biologics (Lenmeldy™)	Recommended dosing varies by disease subtype and the number of CD34+ cells in the infusion bag per kg body weight: Subtype / Min. dose (CD34+ cells/kg) / Max dose (CD34+ cells/kg) PSLI / 4.02×10^6 / 30×10^6 PSEJ / 9×10^6 / 30×10^6 ESEJ / 6.6×10^6 / 30×10^6 Lenmeldy is supplied as one to eight infusion bags of 10-20mL, containing 2 to 11.8x106 cells/mL

Requirements for Patisiran (Onpattro™)

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	Polyneuropathy of hereditary transthyretin-mediated amyloidosis (~~hereditary TTM~~ hATTR).
Exclusion Criteria	1) Concurrent use with any of the following: • Inotersen (Tegsedi™) • Diflunisal, tafamidis meglumine (Vyndaqel™) • Tafamidis (Vyndamax™) • Vutrisiran (Amvuttra™) 2) Cause of polyneuropathy other than hATTR
Required Medical Information	Submit medical records with TAR. Must have all of the following documented in the medical record: 1) Biopsy verification of amyloidosis 2) Genetic testing results confirming a TTR gene mutation 3) Patient is experiencing clinical signs and symptoms of the disease such as but not limited to: • Peripheral sensorimotor polyneuropathy • Autonomic neuropathy • Motor disability ~~4) Requires trial and failure/inadequate response, or contraindication to therapeutic alternatives:~~ ~~• A GABA analog such as gabapentin or pregabalin, or~~ ~~• A tricyclic antidepressant such as nortriptyline or amitriptyline~~ 4) Baseline assessment of disease with at least one of the following: • Baseline Polyneuropathy Disability (PND) score • Familial Amyloidotic Polyneuropathy (FAP) stage • Modified Neuropathy Impairment Score + 7 (mNIS + 7) Note: Onpattro treatment leads to a decrease in serum vitamin A levels and supplementation with recommended daily allowance (RDA) of vitamin A is recommended for patients taking Onpattro.
Age Restriction	18 years and older
Prescriber Restriction	Neurologist, Cardiologist, Hematologist
Coverage Duration	Initial: 6 months. Renewal: 12 months with documentation of response to treatment (see Other Requirements & Information)
Other Requirements & Information	Renewal requests: • Documentation to indicate benefit with treatment with current PND score, FAP stage, or mNIS + 7 used to compare benefit from baseline. Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Requirements for Patisiran (Onpattro™)

Medical Billing:

Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Dosing, Units
J0222	Injection, patisiran, 0.1 mg	Dose based on weight: • ≥100 kg 30 mg IV once every 3 weeks • <100 kg 0.3 mg/kg IV once every 3 weeks *Maximum dose: 30 mg (300 billing units) per treatment

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. Include with TAR submission –~~ ~~2.~~1. Clinic notes documenting osteoporotic fracture history and/or fragility fractures. ~~3. –~~BMD T-Score. 2. ~~1. Documentation of adherence with a bisphosphonate (oral or IV) and/or* denosumab (Prolia). *Depending on severity~~ ~~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)~~ **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). ~~1.~~2. Documentation of high fracture risk with ~~In addition,~~ one of the following ~~is also required~~: 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.~~with a bisphosphonate OR denosumab.~~ ~~1.~~2. Documentation of high fracture risk with ~~In addition,~~ one of the following ~~is required~~: 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, regardless of fracture history or status.
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 PHC 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.

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) Treatment of osteoporosis in men and postmenopausal women at high risk for fracture~~.~~ 2) Prevention of bone loss in members at high risk for fracture receiving aromatase inhibitor therapy in women with breast cancer or androgen deprivation therapy in men with non-metastatic prostate cancer~~.~~
Exclusion Criteria	None
Required Medical Information	All Indications: 1) Documentation of treatment failure with oral bisphosphonates and zoledronic acid OR clinical reason to avoid treatment with bisphosphonates. a. Treatment failure is defined as a decline in T-score of greater than/equal to 5% after 2 years of compliant use with bisphosphonate therapy. Additional requirements for the treatment of osteoporosis in men and postmenopausal women at high risk for fracture: 1) Documentation that the member is at high risk for fracture with ONE of the following: a. Osteoporotic vertebral or hip fracture, history of fragility fracture, OR b. Hip or lumbar spine T-Score of -2.5 or less, OR c. If T-score is between -1 and -2.5 must have FRAX score of greater than/equal to 3% for hip fracture or greater than/equal to 20% for combined major osteoporotic fracture. Additional requirements for bone loss prevention in breast or prostate cancer: 1) Currently on aromatase inhibitor therapy for breast cancer, or androgen deprivation therapy for non-metastatic prostate cancer unless the member has undergone an orchiectomy.
Age Restriction	18 years or older.
Prescriber Restriction	None
Coverage Duration	12 months
Other Requirements & Information	~~Treatment failure to formulary bisphosphonates and zoledronic acid, or intolerance/contraindication to formulary bisphosphonates, AND must have documented history of one of the following: osteoporotic vertebral or hip fracture, history of fragility fracture, hip or lumbar spine T-Score of -2.5 or less, If T-score is between -1 and -2.5 must have FRAX score of greater than/equal to 3% for hip fracture or greater than/equal to 20% for combined major osteoporotic fracture. For bone loss prevention in breast or prostate cancer, the following will also be required: Currently on aromatase inhibitor therapy for breast cancer, or androgen deprivation therapy for nonmetastatic prostate cancer unless the member has undergone an orchiectomy.~~

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

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Prolia	J0897	Injection, denosumab, 1 mg	60mg subcutaneously every 6 months
Jubbonti	Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	

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) Prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors. 2) Giant cell tumor of bone. 3) Hypercalcemia of malignancy refractory to bisphosphonate therapy.
Exclusion Criteria	None
Required Medical Information	1) Prevention of skeletal-related events in patients with multiple myeloma or bone metastases from solid tumors: a. Treatment failure or intolerance/contraindication to zoledronic acid. b. For consideration outside of PHC criteria, submit additional patient factors that need to be considered along with the reason why zoledronic acid (Zometa) cannot be used in place of Xgeva. 2) Giant cell tumor of bone: a. Documentation that the tumor is unresectable or surgical resection is likely to result in severe morbidity. 3) Hypercalcemia of malignancy: a. Documentation that hypercalcemia is refractory to zoledronic acid (or member has a contraindication to zoledronic acid) b. Albumin-corrected serum calcium which is reported as greater than 12 mg/dL while member was on prior zoledronic acid therapy
Age Restriction	13 and older when DX is Giant Cell tumor of the bone. 18 and older for other indications. CCS screening and referral occurs as part of TAR review for ages 0 through 20.
Prescriber Restriction	None
Coverage Duration	TBD
Other Requirements & Information	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Xgeva	J0897	Injection, denosumab, 1 mg	Multiple myeloma and bone metastasis from solid tumor: • 120mg subcutaneously weekly Giant cell tumor of bone and Hypercalcemia of malignancy: 120mg subcutaneously weekly for 4 doses, then every 4 weeks
Wyost	Q5136	Injection, denosumab-bbdz (jubbonti/wyost), biosimilar, 1 mg	

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

Committee: Credentials Committee
Date: 9/11/2024 7:00 am
Members Present: Steven Gwiazdowski, MD*; David Gorchoff, MD*; Michele Herman, MD*; Madeleine Ramos, MD*; Bradley Sandler, MD*
Partnership Staff:

Marshall Kubota, MD*; Partnership Regional Medical Director; Robert Moore, MD, MPH, MBA, Partnership Chief Medical Officer; Jeffery Ribordy, MD*; Medical Director; Bettina Spiller, MD* Medical Director; Mark Netherda, MD*; Medical Director; Priscila Ayala, Associate Director of Provider Relations; Heidi Lee, Senior Manager of Systems and Credentialing; Brooke Vance, Credentialing Supervisor; J'aime Seale, Credentialing Specialist; Alex Lopez, Credentialing Specialist; Ashnilta Sen*, Credentialing Specialist; Elizabeth Rios*, Credentialing Specialist; Nolan Smith*; Credentialing Specialist, Maegan Ojeda*; Credentialing Specialist, Mare-Paule Uwase; Credentialing Specialist, Morgan Brambley; Credentialing Specialist, Ashlee Grove; Credentialing Specialist

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Regional Medical Director Marshall Kubota, MD called the meeting to order at 7:00am. Credentials Committee roll call taken by J'aime Seale. Dr. Kubota reminded everyone that all items discussed are confidential. a. Marshall Kubota, MD, Partnership Regional Medical Director, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-Partnership staff. Dr. Kubota reminded the committee that all information discussed is confidential in nature.			
II. Review and approval of 8/14/2024 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for 8/14/2024 were reviewed by the Committee.	II. Summary were reviewed. A motion for approval of the Summary was made by Dr. David Gorchoff, MD and seconded by Dr. Bradley Sandler, MD. Meeting Summary were unanimously approved without changes.		9/11/2024
III. Old Business. a. NONE	III. Old Business – a. NONE	III. Old Business a. NONE		9/11/2024

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Kubota referred the Credentials Committee to review the routine list of practitioners on pages 5-7	a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski, MD. The Committee unanimously approved the routine list.		9/11/2024
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Kubota referred the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list on pages 8-10. These practitioners are approved by Dr. Kubota pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the list practitioners was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		9/11/2024
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by Brooke Vance. Brooke explained that policies were consent calendar items. Dr. Netherda mentioned that the only change made was Partnership changed to Partnership.	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Dr. Bradley Sandler, MD and seconded by Dr. Steven Gwiazdowski, MD. The Committee unanimously approved the revised policies.		9/11/2024
d. MPCR17 for provider	d. Dr. Kubota brought to the attention of the credentials committee the provider does not meet MPCR17. Dr. Kubota stated the issues facing the provider also included that the provider is not board certified and has license issues, issued by the MBOC. Per Dr. Moore's recommendation the provider be approved for Adult Primary care only, however due to the provider's experience and the rural location of the group he suggests the committee makes an exception for approval. Dr. Gwiazdowski asked Dr. Moore what the requirements were to complete the training hours. Dr. Moore responded with 160 hours is what is needed to complete the course. Dr. Gwiazdowski also asked has the physician mentioned why he won't do the reentry program. Dr. Moore stated the provider feels his 13 years of experience should suffice in place of the reentry requirements. Dr. Gwiazdowski stated that if the committee makes this exception for the provider, will	d. The Committee reviewed the information for the provider. A motion for approval was made by Dr. Steven Gwiazdowski and seconded by Dr. Michele Herman. The Committee unanimously approved for Adult Primary Care only with monitoring and quarterly chart reviews. .		9/11/2024

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	this be part of the requirements for similar cases with different providers. Dr. Moore stated this would be reviewed as a case by case situation. Dr. Kubota reviewed the providers experience and work history and the committee determined that the provider can be approved for adult primary care only. Dr. Kubota suggests to the committee that the provider be approved with monitoring and quarterly chart reviews. Dr. Ribordy stated that the provider would not be able to supervise midlevel clinicians since he's being approved for adult primary care. Dr. Herman added that she would prefer a provider with experience over a provider with no experience. Dr. Herman believes that the 13-year experience for the provider makes up for the 5-month residency gap.			
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 page 77.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Dr. Bradley Sandler, MD and seconded by Dr. Michele Herman, MD. The Committee unanimously approved.		9/11/2024
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring List on pages 78-79. Dr. Kubota reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. *Informational only*.		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
VI. Review and Approval of Consent Calendar Items. a. Report of Long Term Care Facility, Hospital, and Ancillary provider list. b. Delegated/Audit Reports	VI. Review and Approval of Consent Calendar Items. a. Dr. Kubota asked the Credentials Committee members to review the report of Long Term Care Facility, Hospital, and Ancillary provider list on page 80 b. Quarterly Audits. i.Carelon Behavioral Health ii. Dignity iii. no report iv. Lucille Packard Children's Hospital v. Sutter Medical Group vi. Sutter Bay and Redwoods vii. Sutter Medical Foundation ix. University of California Davis (UCD) x. University of California San Francisco (UCSF) xi. Vison Service Plan (VSP) c. Annual Audits. i. 2024 Carelon Annual Delegated Audit committee ii. 2024 VSP Annual Delegated Audit committee	VI. Review and Approval of Consent Calendar Items. a/b. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Dr. Steven Gwiazdowski, MD and seconded by Dr. Bradley Sandler, MD. The Credentialing Committee unanimously approved.		9/11/2024
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 9/11/2024 respectfully prepared and submitted by Alex Lopez Credentialing Specialist I.

Chairman Signature of Approval _____ ***Date*** 9/11/2024

Marshall Kubota, M.D., Partnership Credentialing Chairman

App. Ty	Full Name	Provider Type C	Name/Street	County Nam	Specialty Descr	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Cat
I	Aguilar, Bianka J.,MD	PCP	Santa Rosa Community Hea	Sonoma	Family Medicin	ABMS of Family	06/28/2024	Yes	Admitting Agree	None
R	Ahern, Carol Ann B.,MD	PCP	Sonoma Valley Community	Sonoma	Family Medicin	ABMS of Family	07/12/1996	Yes	Admitting Agree	None
R	Ashland, Sarah E.,DO	PCP	Ole Health	Napa	Pediatrics	ABMS of Pedia	10/18/2019	Yes	Admitting Agree	Active
I	Azadi, Hossein MD	SPEC	Adventist Health Howard Me	Mendocino	Preventive Mec	Confirmed per A		No	Adventist - How	Provisional
I	Bailey, Terina M.,SUDRC	W&R	Archway Recovery Services	Solano	Alcohol and Oth	None		No	None	
I	Barlow, Julie A.,ACNP-BC	SPEC	Jason Edward Pope Md Inc	Marin	Acute Care Nur	American Nurse	04/07/2011	Yes	None	
R	Barre, Abduselam H.,MD	PCP	Shasta Regional Medical Gr	Shasta	Family Medicin	ABMS of Family	07/09/1993	Yes	Admitting Agree	None
R	Bertoli, Mara M.,FNP-C	PCP	Providence Medical Group,	Sonoma	Family Nurse P	American Acad	06/10/2014	Yes	None	
R	Bills, Adam D.,DPM	SPEC	Bay Area Foot Care Inc	Yolo	Podiatry	None		No	Mercy San Juai	Courtesy
I	Bippart, Peter E.,MD	SPEC	Oroville Women's Health	Butte	Obstetrics and	ABMS of Obste	12/11/1987	Yes	Admitting Agree	None
R	Bitton-Faiwiszewski, Yonatan MD	SPEC	Adventist Health Clearlake -	Lake	Interventional C	ABMS of Intern	10/20/2020	Yes	Admitting Agree	None
R	Bocc, Edward PA	PCP	Alliance Medical Center	Sonoma	Physician Assis	None		No	None	
I	Brown, Jennifer K.,PA	SPEC	Adventist Health Mendocinc	Mendocino	Physician Assis	None		No	None	
I	Burger, Richard P.,Jr., SUDRC	W&R	Empire Recovery Center	Shasta	Wellness and F	California Subs	06/18/2024	Yes	None	
I	Burnham, Marisa BCBA	BHP	Pantogran LLC dba Center f		BCBA	Behavior Analy	08/19/2022	Yes	None	
R	Chang Sing, Peter D.,MD	SPEC	Providence Medical Group -	Sonoma	Cardiovascular	ABMS of Intern	11/06/1991	Yes	Santa Rosa Me	Active
R	Chiu, May Y.,MD	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Intern	11/20/1996	Yes	John Muir Medi	Active
I	Ciammaichella, Ellia DO	SPEC	Enloe Physical Medicine & F	Butte	Physical Medici	ABMS of Physi	07/01/2022	Yes	Admitting Agree	None
I	Cooper, Cicily R.,FNP-C	PCP	Lyon-Martin Community Hea	Solano	Family Nurse P	American Acad	09/01/2020	Yes	None	
I	Cortez, Colette BCBA	BHP	Center for Social Dynamics	Yuba	BCBA	Behavior Analy	11/30/2014	Yes	None	
I	Daniel, Jesse L.,BCBA	BHP	Advanced Crisis Solutions, I	Shasta	BCBA	Behavior Analy	05/31/2014	Yes	None	
I	D'Avignon, Aimee L.,CNM	SPEC	Oroville Women's Health - M	Butte	Certified Nurse	American Midw	07/01/2023	Yes	None	
I	Denley, Eric C.,MD	PCP	Shingletown Medical Center	Shasta	Internal Medicir	Going to Comm		No	Admitting Agree	Active
I	Dharma, Kalamani R.,MD	SPEC	Northeastern Rural Health C	Lassen	Obstetrics and	ABMS of Obste	01/11/2002	Yes	Admitting Agree	None
I	Dowlearn, Thomas A.,MD	PCP	Petaluma Health Center	Sonoma	Family Medicin	ABMS of Family	07/01/2024	Yes	Admitting Agree	None
I	Edmonds, Jadea Doula	SPEC	Mamaa Wildflower Doula Se	Solano	Doula	None		No	None	
I	Eldridge, Carin T.,MD	PCP	Tahoe Forest MultiSpecialty	Nevada	Pediatrics	ABMS of Pedia	10/18/2019	Yes	Tahoe Forest H	Provisional Active
I	Englent, Collis BCBA	BHP	Center for Social Dynamics	Yuba	BCBA	Behavior Analy	06/28/2024	Yes	None	
I	Farhan, Saif MD	SPEC	Oroville Orthopedic Clinic	Butte	Orthopaedic Su	Meets MPCR#1		No	Admitting Agree	Active
I	Foster, Jessica A.,FNP-C	PCP	Sacramento Community Cli	Sacramento	Family Nurse P	American Acad	06/02/2022	Yes	None	
R	Freeman, Douglas J.,MD	PCP	NBHG: Center for Primary C	Solano	Family Medicin	ABMS of Family	07/10/1998	Yes	NorthBay Medi	Active
I	Fronterhouse, Shawn PA								None	
R	Gamboe, Robert W.,PA-C	PCP	SCHC: Shasta Community H	Shasta	Physician Assis	National Comm	09/22/2011	Yes	None	
I	Gilbert, Gregory D.,LAc	SPEC	In Balance Acupuncture	Nevada	Acupuncture	None		No	None	
I	Gonzales, Nadja Doula	SPEC	Melancentric	Placer	Doula	None		No	None	
I	Guo, Wei-ling PA	PCP	Sacramento Community Cli	Sacramento	Physician Assis	None		No	None	
R	Hebert, Nicole M.,MD	SPEC	Capital OB/GYN, Inc.	Yolo	Obstetrics and	ABMS of Obste	12/08/2023	Yes	Mercy General	Active
I	Hernandez Perez, Janet BCBA	BHP	ACES 2020, LLC	Placer	BCBA	Behavior Analy	06/23/2021	Yes	None	
I	Huang, Daphne L.,DPM	SPEC	Stallant Health - PCP/SPEC	Placer	Podiatry	Meets MPCR#1		No	Admitting Agree	None
R	Hubbard, Willow A.,PA-C	PCP	Adventist Health Mendocinc	Mendocino	Physician Assis	National Comm	12/22/2020	Yes	None	
I	Hunt, Kimberly A.,MD	SPEC	Enloe Women's Services- N	Butte	Obstetrics and	ABMS of Obste	01/22/2019	Yes	Enloe Medical C	Provisional
I	Ignacio, Joy C.,FNP-C	PCP	Sacramento Community Cli	Sacramento	Family Nurse P	American Acad	09/10/2014	Yes	None	
I	Jalao, Ly Kong Pheng FNP	PCP	Sacramento Community Cli	Sacramento	Family Nurse P	American Acad	10/05/2020	Yes	None	
I	Jang, Hyohyun FNP-C	SPEC	Enloe Cardiology Services &	Butte	Family Nurse P	American Acad	11/15/2016	Yes	None	
I	Jason, Robert A.,DO	PCP	UIHS - Crescent City Health	Del Norte	Family Medicin	American Oste	10/26/2018	Yes	Admitting Agree	None
I	Johnson, Ian R.,MD	PCP	Sacramento Community Cli	Sacramento	Family Medicin	ABMS of Family	07/14/1995	Yes	Admitting Agree	None
I	Jones, Tania M.,Doula	SPEC	Glow Mama Glow Doula Se	Solano	Certified Doula	None		No	None	
I	Kaillay, Meena FNP	PCP	Sacramento Community Cli	Sacramento	Family Nurse P	American Acad	10/13/2023	Yes	None	

I	Karmur, Amit B.,DO	SPEC	Oroville Surgical Specialists	Butte	Vascular Surge	ABMS Vascular	05/16/2022	Yes	Admitting Agree	None
I	Kong, Anna W.,MD	PCP	One Community Health - Inf	Yolo	Family Medicine	ABMS of Family	07/01/2018	Yes	Admitting Agree	None
R	Krause, Abigail B.,PA-C	PCP	ODCHC - Eureka Communi	Humboldt	Physician Assis	National Comm	05/28/2015	Yes	None	
I	Kristensen, Marie A.,FNP-BC	PCP	Marin Community Clinic: So	Marin	Family Nurse P	American Nurse	09/19/2013	Yes	None	
R	Lalithmohan, Adamane MD	SPEC	Providence Medical Group,	Sonoma	Cardiovascular	ABMS of Intern	11/04/1993	Yes	Petaluma Valle	Active
I	Lee, Luis MD	SPEC	Active Life Wound Clinic	Yolo	General Surger	Meets MPCR#1		No	Admitting Agree	None
R	Levine, Claudia MD	PCP	Marin Community Clinic: La	Marin	Internal Medicir	ABMS of Intern	08/25/2006	Yes	Admitting Agree	Active
I	Limary, Jeff LCSW	SPEC	Ampla Health Yuba City Pe	Sutter	Licensed Clinic	None		No	None	
I	Lorenzini, Taylor R.,FNP-BC	PCP	Lassen Medical Clinic- Red	Shasta	Family Nurse P	American Nurse	06/10/2024	Yes	None	
I	Ludington, Lance L.,MD	SPEC	Enloe General & Colorectal	Butte	General Surger	ABMS of Surge	05/04/1993	Yes	Enloe Medical (	Provisional
I	Lydon, Shiva BCBA	BHP	Center for Social Dynamics	Yuba	BCBA	Behavior Analy	09/14/2022	Yes	None	
R	Makooi, Mahmood M.,DC	SPEC	Northbay Chiropractic	Solano	Chiropractic	None		No	Admitting Agree	None
I	Mattson, Cynthia L.,LCSW	BHP	Alliance Medical Center	Sonoma	Licensed Clinic	None		No	None	
R	McGraw, Douglas L.,DO	SPEC	North Valley Eye Care (Ridg	Butte	Ophthalmology	American Oste	05/03/2016	Yes	Enloe Medical (	Affiliate Staff
R	McKenzie, Stephen E.,MD	PCP	Mayers Rural Health Center	Shasta	Family Medicine	Meets MPCR#1			Mayers Memori	Courtesy
I	McPhillips, Katie BCBA	BHP	Center for Social Dynamics	Yuba	BCBA	Behavior Analy	04/18/2024	No	None	
I	Mimbs, Jeffrey S.,DO	SPEC	Enloe Neurosurgery & Spine	Butte	Neurological Su	ABMS of Neuro	11/09/2007	Yes	Enloe Medical (	Active
R	Miranda, Summer RADT	W&R	Visions of the Cross	Shasta	Wellness and R	California Subs	06/25/2024	Yes	None	
I	Mirza, Claudia BCBA	BHP	Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	06/08/2022	Yes	None	
I	Nelles, David B.,MD	SPEC	San Francisco Spine Surge	Marin	Orthopaedic Su	Confirmed per A		No	St Mary's Medi	Active
I	Nyland, Christopher R.,MD	SPEC	St. Joseph Home Care Netv	Sonoma	Hospice and Pa	ABMS of Family	11/01/2022	Yes	Providence Sar	Provisional
I	Orbeta, Karen FNP-C	PCP	Sacramento Community Cli	Sacramento	Family Nurse P	American Acad	10/09/2023	Yes	None	
R	Pena, Cynthia L.,MD	SPEC	NBHG: NorthBay Healthcare	Solano	Pain Medicine	ABMS of Anest	09/15/2007	Yes	NorthBay Medi	Active
R	Perez, Xavier MD	PCP	Marin Community Clinic: La	Marin	Family Medicine	ABMS of Family	07/21/2007	Yes	Admitting Agree	Active
R	Peterson, Tara BCBA	BHP	Genesis Behavior Center In	Yolo	BCBA	Behavior Analy	08/31/2014	Yes	None	
I	Pinto, Marisa C.,MD	PCP	Chapa-De Indian Health (Au	Placer	Family Medicine	ABMS of Family	07/01/2024	Yes	Admitting Agree	Active
I	Randolph, Robert E.,MD	SPEC	Enloe Cancer Center	Butte	Medical Oncolo	ABMS of Intern	11/05/2003	Yes	Enloe Medical (	Active
R	Reeves, Colleen FNP-C	PCP	CommuniCare Ole - Davis C	Yolo	Family Nurse P	American Acad	09/26/2017	Yes	None	
I	Reisman, Bruce k.,MD	SPEC	NorthBay Healthcare Ear, N	Solano	Otolaryngology,	ABMS of Otola	10/02/1990	Yes	NorthBay Medi	Active
R	Rios, Eon J.,MD	SPEC	Direct Dermatology Professi	Solano	Dermatology	ABMS of Derma	07/24/2014	Yes	No Direct Patie	None
I	Roach, Kristina L.,FNP-C	SPEC	Enloe Health System Manag	Butte	Family Nurse P	American Acad	08/22/2018	Yes	None	
I	Robinson, Leslie C.,MD	SPEC	Enloe Neurosurgery & Spine	Butte	Neurological Su	ABMS of Neuro	11/05/2022	Yes	Enloe Medical (	Active
I	Saiz, Theresa BCBA	BHP	Burnett Therapeutic Service	Napa	Behavioral Hea	Behavior Analy	05/31/2017	Yes	None	
I	Sanchez, Jennifer C.,FNP-C	SPEC	Enloe Specialty Physicians	Butte	Family Nurse P	American Acad	08/01/2007	Yes	None	
R	Santoro, Angela R.,PT	Allied	Palo Cedro Physical Therap	Shasta	Physical Therap				None	
I	Shapera, Emanuel MD	SPEC	Oroville Medical Clinic	Butte	Surgical	ABMS of Surge	09/23/2019	Yes	Adventist Healt	Provisional
I	Shaw, Lynne B.,PA-C	SPEC	John Muir Cardiovascular M	Contra Costa	Physician Assis	National Comm	12/19/1995	Yes	None	
I	Shikdar, Sufana MD	BOTH	Enloe Specialty Physicians	Butte	Internal Medicir	ABMS of Intern	08/22/2019	Yes	Enloe Medical (	Provisional
I	Shin, Satoshi R.,DO	SPEC	Sacramento Heart & Vascul	Yolo	Cardiovascular	ABMS of Intern	10/09/2023	Yes	Admitting Agree	Active
I	Smith, Briant W.,MD	SPEC	Santa Rosa Community Hea	Sonoma	Orthopaedic Su	ABMS of Ortho	07/09/1993	Yes	Admitting Agree	None
R	Stanger, Jennifer K.,MD	PCP	La Clinica	Solano	Family Medicine	ABMS of Family	07/01/2012	Yes	Admitting Agree	Active
I	Tucker, Ryan N.,BCBA	BHP	Advanced Crisis Solutions, I	Shasta	BCBA	Behavior Analy	08/28/2020	Yes	None	
I	Vollmer, Brittany J.,PA-C	PCP	WellSpace Health J St Com	Placer	Physician Assis	National Comm	09/30/2022	Yes	None	
R	Wei, Katherine MD	PCP	Marin Community Clinic: Sa	Marin	Family Medicine	ABMS of Family	07/24/2020	Yes	San Francisco (	Courtesy
I	Wentz, Nicole BCBA	BHP	Center for Social Dynamics	Yuba	BCBA	Behavior Analy	08/17/2021	Yes	None	
R	Whitley, Teresa B.,MD	PCP	NBHG: Center for Primary C	Solano	Internal Medicir	ABMS of Intern	08/24/1999	Yes	NBHG	Active
R	Wung, William MD	SPEC	John Muir Cardiovascular M	Contra Costa	Cardiology	None		No	John Muir Medi	Active
R	Yang, Lillian MD	SPEC	Eye Care Institute, A Medic	Sonoma	Ophthalmology	ABMS of Ophth	10/07/2018	Yes	Sutter Santa R	Active
I	Yang, Lue PA	PCP	Sacramento Community Cli	Sacramento	Physician Assis	National Comm	08/18/2011	Yes	None	

I	Yousef, Dana FNP-C	PCP	MedZed Physician Services Solano	Family Nurse P American Nurse	04/07/2011	Yes	None

MEETING Minutes

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

Date: September 24, 2024 **Time**: 7:30 AM – 9:00 AM

Facilitator: Mohamed Jalloh, Health Equity Officer (Chair)

Coordinator: Vicquita Velazquez

Meeting Locations:

- WebEx

External Attendees:

Shandi Fuller, MD; Eva Julian; Valerie Padilla; Arlene Pena; Leila Romero; Candy Stockton, MD; Denise Whitsett; Jeremy Plumb; W. Suzanne Edison-Ton, MD;

Absent External Attendees: Eugene Durrah; Rocio Rodriguez; Saveena Sandhu; Tiffani Thomas, EdD; Lisa Wada; Hendry Ton, MD; Harold Wallace

Internal Attendees:

Priscila Ayala; Shannon Boyle, RN; Isaac Brown; Monika Brunkal, RPh; Anna Campbell; Shahrukh Chishty; Dawn R. Cook; Nicole Curreri; Greg Allen Friedman; Jaymee James; Marshall Kubota, MD; Yolanda Latham; John Lemoine; Stan Leung, Pharm.D; Lilian Merino; Mark Netherda, MD; Rachel Newman, RN; Hannah O'Leary; Sue Quichocho; Manleen Randhawa; Dorian Roberts; DeLorean Ruffin, DrPH; Anthony Sackett; Amy Turnipseed; Edna Villasenor; Latrice Innes; Mary Kerlin; Kory Watkins

Absent Internal:

Katherine Barresi, RN, BSN, PHN; Robert Bides, RN; Sonja Bjork; Mark Bontrager; Cathryn Couch; Jason Cunningham; Jeffrey DeVido, MD; Nicole Escobar; Heather Esget, RN; Margarita Garcia-Hernandez, Ph.D.; Nisha Gupta; Amanda Kim; Vicky Klakken; Robert Moore, MD; Katheryn Power; Kimberly Robertello, Ph.D.; Tim Sharp; Tony Hightower; Eva Julian; Kermit Jones, MD; Rachel Joseph; Matthew Konar; Liat Vaisenberg;

Agenda Topic	Notes	Action Item
1. Welcome/ Introductions/ Roll Call *Time: 5 minutes* *Speaker: Mohamed Jalloh, Pharm.D*	Introduction of the committee members. The quorum was met by having 8 members present.	
2. Meeting Minutes *Time: 5 minutes* *Speaker: Mohamed Jalloh, Pharm.D*	Dr. Jalloh brought the committee's attention to last month's meeting minutes.There were no questions, and a motion was made to approve the minutes. • **First motion:** Dr. Stockton • **Second motion:** Valerie Padilla There were no opposed motions.	
3. Updates to the QIHEC Schedule *Time: 20 minutes* *Speaker: ALL*	Dr. Jalloh led the discussion by stating historically, we had meetings quarterly. However due to the growing number of requirements, the committee will now be meeting every other month versus quarterly. It will remain on every third Tuesday at 7:30 to 9:00 AM *Question from Dr. Jalloh:* • Are there any topics you want us to address consistently in every meeting? Response from the committee: None	

Agenda Topic	Notes	Action Item
4. DEI Training Policy Feedback *Time: 20 minutes* *Speaker: ALL*	The group discussed the diversity, equity, and inclusion (DEI) policy draft led by Dr. Jalloh related to rolling out our DEI training plan. The goal was to discuss how we would distribute and manage the training, which will be given to all contracted providers and this is comparable to how other larger plans are distributing their trainings and to lower costThe goal is over three years to have every practitioner complete the training. The training will be organized based on the following categories: A. Foundations of DEI B. Training Modules specific to types of care C. Training Modules specific to groups In addition, Dr. Jalloh shared that we will share a brief report to allow trainees to review the health equity data to raise awareness about what is happening in each region. Training will also be given to those with a discrimination grievance against them, even if they operate in an ancillary function. Those who will not receive training will the following: • Health systems that already have robust DEI training. Instead, they can provide an attestation with their current DEI completion rate. • Health systems who are not in network and do not see at least 1000 or more members *Question from Valerie at Open Door:* Will you be creating a template to submit the attestation? Response from Dr. Jalloh: Yes. There is an example template in the policy. Dr. Kubota mentioned he did not see certain providers in the policy, such as certified nurse midwives, doulas, and substance use counselors.	

Agenda Topic	Notes	Action Item
	Dr. Jalloh said we will not offer training to those not individually contracted. Dr. Kubota mentioned that it varies because some providers work under a physician, such as a physician assistant (PA), but others do not. *Question from Dr. Jalloh to someone in Provider Relations:* Are certified nurse midwives individually contracted with PHC? *Response from Mary Kerlin:* Certified nurse midwives should be included in the training even though they are part of a more extensive system. *Question from Dr. Jalloh:* What is the current process for certified nurse midwives? Do they submit an attestation? *Response from Mary:* Yes. It is part of the process if we credential them and they are delegates. Dr. Jalloh agreed they should be included. Valerie Padilla from Open Door asks about the requirements for working with contracted providers such as Alinea Mobile Mammography. At an event, a technician refused to accommodate a patient's preference. The incident has been reported back to PHC and Alinea. Dr. Jalloh says he will ask the Quality Improvement team, currently leading the mobile mammography team, to see the current process and update the group. *Question from Mary:* Will this training substitute for the current cultural and linguistic training?	

Agenda Topic	Notes	Action Item
	Response from Dr. Jalloh: 1. Yes, this will be substituting current CL training per correspondence with DHCS. A benefit with this training is we will be able to see in real-time when the training is completed. *Question from Dr. Fuller:* 1. Does the training need to be recorded to qualify for the attestation? 2. Will you be providing the content of the training for it to be approved? *Response from Dr. Jalloh:* 1. No, the training does not have to be pre-recorded. The materials from the training can be sent to us in a different format such as PowerPoint to allow us to review. 2. We will be sending out the attestation letter with a checklist for providers to review and verify if their training meets the criteria requirements. *Question from Dr. Fuller:* 1. I am connected to doulas who are contracted with PHC and who are receiving training already, will I have access to the attestation and checklist even though I am not a contracted provider? *Response from Dr. Jalloh:* 2. Yes, because you are a member of the QIHEC, you will have access to review the materials. An example of the attestation letter is attached to the end of the policy we are reviewing. The training will start in June of 2025. Anyone credentialed after June 2025 will receive the new training. *Questions from Dr. Kubota:* Will we be able to provide training 90 days from the date of hire?	*Follow up on process with QI regarding mammography team taking DEI training.*

Agenda Topic	Notes	Action Item
	Response from Dr. Jalloh: We will provide them with the link for the training at that time as we do for current contracting. Dr. Kubota commented that page 33 of the policy category E point 2 is confusing. It states: Practitioners of any contracted network provider or subcontractor in 24 counties do not care for at least 1000 partnership members per calendar year. What if they do care for 1000 or more members per year? There is no reference to that category. UCSF would fit that category. Dr. Jalloh responded that it is inferred that providers have to complete the training if they care for 1000 members or more. He will work on making the policy clear. Dr. Kubota suggested adding the term Health Equity Officer HEO at the top of the policy instead of at the end. Dr. Jalloh agrees with the recommendation. We will be hiring someone to implement and monitor the DEI program. Question from Dr. Kubota: Will the training be in other languages? Response from Dr. Jalloh: Currently, it is in English only. Some parts are in Spanish, but not all. We have requested they work on other languages, but that will not likely happen when the training is submitted to DHCS. Question from Hannah: Is there a timeline when you will be hiring someone to monitor this project?	*Review the policy language to clarify whether DEI training is required if providers care for 1,000 or more members.*

Agenda Topic	Notes	Action Item
	Response from Dr. Jalloh: The process has been started. We will probably have the person by next year. Dr. Jalloh asked if any QIHEC members would like to see the training and provide feedback. The training is one to two hours. ➢ Dr. Stockton is interested ➢ Dr. Fuller is interested ➢ Dr. Edison-Ton is interested ➢ Leila Romero is interested *Question from Dr. Netherda:* Is the DEI training annual? *Response from Dr. Jalloh:* It will not be annual but every re-credential cycle. We will update the content once per 3 years per our credentialing cycles.	*Include the listed QIHEC members in a session to review the DEI training.*
5. CL/QIHETPWork Plan Discussion *Time: 20 minutes* *Speaker: ALL*	Partnership Health Plan is going through the NCQA accreditation. In California, it is required for all health plans by January 1, 2026. A work plan is a requirement for disparity data and how the goals to eliminate the disparity will be implemented. Last year, we used the goal of lowering blood pressure for Native American/Alaskan Natives and were able to meet that. We are currently reviewing three activities for possible submission to NCQA. Please see attached CL/QIHETP work-plan for further information. • Timely translation requests • High-quality interpreter services • Birth Equity Measures • Well-Care Visits	

Agenda Topic	Notes	Action Item
	These are not the only measures we will be reviewing, but the ones we will be held accountable for health equity accreditation. When we reviewed our HEDIS data, the areas that needed improvement were prenatal care and well-child visits. In the next five years, we would like to improve prenatal visits in our NE or NW regions for AI/AN by 22%. Dr. Jalloh asked the committee if it was a reasonable goal. Dr. Stockton says she is learning not to use “target” when referring to specific groups because it does not read well with them. She also mentioned she wondered about process goals as opposed to outcome goals. Do we know why there are discrepancies, and are they accurate? What do the groups think they need to improve the outcome measures? Do we understand what we are facing? Dr. Jalloh responded we could implement activities to improve process measures. For health equity accreditation, we are held to the outcome measures. We can prove to NCQA feedback that we do not find their approach reasonable. Valerie from Open Door says prenatal care is complex because the patient/member has to initiate the care once they know they are pregnant. Deliverable two says you plan to interview members, and that will be good. She is curious to know how we will recruit members for the interviews. Dr. Jalloh says we will contact members directly to ask their opinions; this has worked in the past. Please advise the committee if there are other disparities we should focus on. The list shared is for health equity accreditation. We will also have a goal for Black/African American prenatal visits because they did not do well. There are many systemic barriers. We hope to make progress over the next two years. The goal is for the NE or NW region, based on our tribal community's dominance in those areas.	

Agenda Topic	Notes	Action Item
	Question from Dr. Kubota: Will the committee choose the region that allows us to focus on the area? Dr. Jalloh says that will be fine. We must define to the group what area is covered by which region. Since we are converting the way we name our regions, there may be confusion, but we are going with the data from 2023. Dr. Kubota suggests we name them by the county, which would be clear. Nancy suggests we list the NE and NW as reporting units and parenthetically list the counties. Question from Nancy: Can you confirm the threshold and performance goal? Response from Dr. Jalloh: DHCS has bold goals and created a minimum performance threshold. Based on national Medic-Caid data, the state holds us to those goals for each clinical measure. Nancy added that we have had strong performance with the perinatal measures in most of our reporting units at a global level. Dr. Jalloh agreed that we are doing a good job; however, when stratifying by race, we see the disparities. Sue mentioned that the team's work on HEDIS had multiple impacts. The HEDIS measures relate to Managed Care Accountability Sets (MCAS), which impacts the overall health plan rating. Arlene says her team currently focuses on mobile health. Many health centers are starting or already have mobile health and are facing challenges with financial sustainability. It would be beneficial for us to have support for some financial analysis related to financial sustainability for	

Agenda Topic	Notes	Action Item
	mobile health programs. We are working with Dr. Townsend and Dr. Elizabeth Tito from Providence, Santa Rosa. It is hard for health centers to sustain programs, so collaborating with hospitals and other organizations is key. It is important to think outside the box. Dr. Jalloh said a health center in Pennsylvania received an award from CMS for that type of work. Dr. Edison-Ton agrees with Arlene because the current financial model for health centers does not work for mobile health. The goal is to serve the community where they need to be served.	
4. Adjournment *Time: 1 minute* *Speaker: Mohamed Jalloh, Pharm.D*	***Next Meeting:*** *November 19, 2024 7:30 am to 9:00 am PT*	

AGENDA ITEM: III.C.
DATE: 11/13/2024

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 11/13/2024

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

Dr. Noemi Doohan, Lake County Public Health Officer, resigns her position as PAC voting member.

The Physician Advisory Committee thanks Dr. Doohan for her time serving.

AGENDA ITEM: III.C.
DATE: 11/13/2024

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 11/13/2024

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

Dr. Brian Evans, Chief Medical Officer at Tahoe Forest Hospital, resigns his position as PAC voting member.

The Physician Advisory Committee thanks Dr. Evans for his time serving.

AGENDA ITEM: III.C.
DATE: 11/13/2024

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

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

DATE: 11/13/2024

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Derice Seid, Medical Director, Marin Community Clinics, volunteers to serve as a PAC voting member.

Her appointment as a voting member is recommended.

DERICE P. SEID, M.D., M.B.A.

derice@gmail.com

PROFESSIONAL EXPERIENCE

2021 – present **MARIN COMMUNITY CLINICS** San Rafael, CA

Medical Director, San Rafael Campus

Establish, review and maintain primary care clinical programs at one of the two busiest sites at the largest federally qualified healthcare center in Marin County, delivering primary care and behavioral health services to its most vulnerable residents. Provide clinical oversight to a team of more than twenty doctors and advance practice providers in primary and subspecialty care. Provide medical and operational management of MCC's Infectious Disease program including HIV care and the Ryan White Program, active tuberculosis and Hepatitis C.

2000 – 2021 **DR. DERALD L. SEID, INC.** San Francisco, CA

Physician

Member of two-physician practice. Provide outpatient care of adult and pediatric patients, including long-term management of chronic diseases. Active medical staff privileges at local medical center to provide inpatient, acute and urgent care. Share call responsibilities for after-hour care and hospital admissions.

1994 **MEMORIAL SLOAN-KETTERING CANCER CENTER** New York, NY

Assistant to the Physician-in-Chief

Designed implementation plan for major reengineering project involving all patient care areas of the hospital. Defined structure for implementation team including roles and responsibilities for senior executives and other key team personnel. Formulated framework for evaluating affiliation options with other institutions. Evaluated potential partners for fit against financial, marketing and strategic objectives.

1993 **CHILDREN'S HOSPITAL OF PHILADELPHIA** Philadelphia, PA

Consultant

Performed environmental and competitive analyses to determine the hospital's current and potential position in the neonatology market. Determined capabilities of the neonatology unit and potential methods for addressing needs of underserved segments. Formulated strategic alternatives and action plans for addressing identified opportunities.

1991 **CALIFORNIA PACIFIC HOSPITAL AND MEDICAL CENTER** San Francisco, CA

Administrative Intern

Performed advisory work for newly merged medical center. Conducted feasibility study of combining individual post-graduate medical residency programs including extensive interviews with heads of departments and study of internal structure at both sites. Coordinated development of expanded internal medicine post-graduate program. Assisted in design of requirements for mandatory clinical clerkships. Prepared evaluation of resident satisfaction with available library services at each hospital site; recommendations led to purchase of improved on-line search system.

1990 **ST. MARY'S HOSPITAL AND MEDICAL CENTER** San Francisco, CA

Administrative Intern

Designed marketing strategy for outpatient spine center. Formed site assessment and recommendation for relocation of hospital laboratory and phlebotomy station. Conducted cost analysis of hospital environmental services; compared costs of repairing and maintaining in-house laundry equipment with costs of contracting outside laundry services.

COMMUNITY ACTIVITIES

2004 – 2022 **HEALTH COUNCIL OF MARIN** San Rafael, CA

Chair, Nominating Committee (2014 – 2015)
Member, Nominating Committee (2012-2015)
Vice President (2008 – 2010)

Active member of advisory body on health issues to the Board of Supervisors and the Marin County Department of Health & Human Services. Advocate for the development and allocation of resources to assure quality and accessible health care to citizens of Marin County.

COMMUNITY ACTIVITIES

2003 – 2006 **SOUTH OF KNOLL PARK RENOVATION COMMITTEE** Tiburon, CA
Co-Chairperson
Founding member and co-chair of Tiburon Town Council subcommittee to renovate and rebuild Tiburon's only public playground. Responsible for raising awareness, documenting need for renovation and coordinating safety study for Town. Designed playground structure, coordinated fundraising efforts and oversaw construction of Tot Lot at the park. Currently involved in design and fundraising for adjacent playground for school age children. Construction scheduled to begin Summer 2008.

2002 – 2004 **CENTER FOR VOLUNTEER AND NONPROFIT LEADERSHIP OF MARIN** San Rafael, CA
Through Junior League of San Francisco, worked with CEO and leadership team to conceptualize, design and establish BoardMatch Marin, an online board matching program. Member of committee that designed the corresponding workshops, including Board 101 and Board Coaching Consultations. Since its February 2003 inception, BoardMatch Marin has trained 98 individuals and matched 39 participants to local nonprofits.

POST-GRADUATE TRAINING

CEDARS-SINAI MEDICAL CENTER Los Angeles, CA
Chief Resident, Combined Internal Medicine and Pediatrics 1998 - 1999
Chairperson, Med-Peds Residency Training Program Recruitment Committee. Group Leader, Pediatric Intensive Care Unit Quality Assurance Team. Member, Housestaff Executive Committee. Intern, Blue Cross of California Medical Department.

CEDARS-SINAI MEDICAL CENTER Los Angeles, CA
Resident Physician, Combined Internal Medicine and Pediatrics 1995 - 1998

EDUCATION

UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE Philadelphia, PA
Medical Doctor

THE WHARTON SCHOOL, University of Pennsylvania Philadelphia, PA
Master of Business Administration
Major in Health Care Management

UNIVERSITY OF SOUTHERN CALIFORNIA Los Angeles, CA
Bachelor of Science
Major in Psychobiology, *with honors*

Palliative Care Quality Incentive Program
Summary of Proposed 2025 Measures

Key:

New Measure | Change to Measure Design

2024 Measures	2025 Recommendations
Utilization	
1. Avoiding Hospitalization & Emergency Room Visits • $240 PMPM if no inpatient or ED use per calendar month	**1. Avoiding Hospitalization & Emergency Room Visits** • $240 PMPM if no inpatient or ED use per calendar month *CHANGE:* *No recommended changes*
Quality	
2. Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool • $120 PMPM once a signed POLST is documented in PCQC	**2. Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool** • $120 PMPM once a signed POLST is documented in PCQC
3. Completion of Standardized PCQC Assessments & Use of Palliative Care Collaborative (PCQC) Tool • $120 PMPM if two (2) standardized PCQC assessments are documented in PCQC, with all essential data elements included. Thresholds: • ≥ 85% of data elements entered on assessments = Full points ($120 PMPM) • 70-84.9% of data elements entered on assessments = Partial points ($60 PMPM)	**3. Completion of Standardized PCQC Assessments & Use of Palliative Care Collaborative (PCQC) Tool** • $120 PMPM if two (2) standardized PCQC assessments are documented in PCQC, with all essential data elements included. Thresholds: • ≥ 85% of data elements entered on assessments = Full points ($120 PMPM) • 70-84.9% of data elements entered on assessments = Partial points ($60 PMPM) *CHANGE:* *No recommended changes*

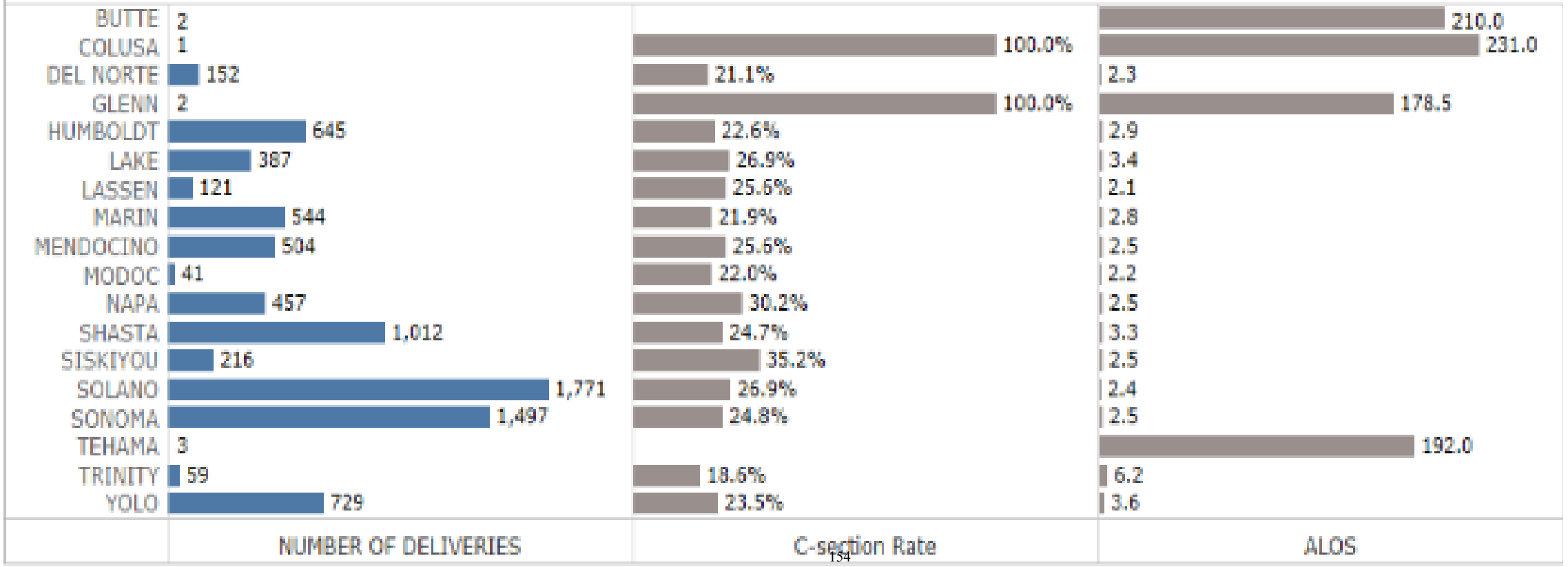
Ensuring Access and Quality in Perinatal Care

Colleen Townsend, MD
Regional Medical Director

Partnership HealthPlan Perinatal Members Served 2023

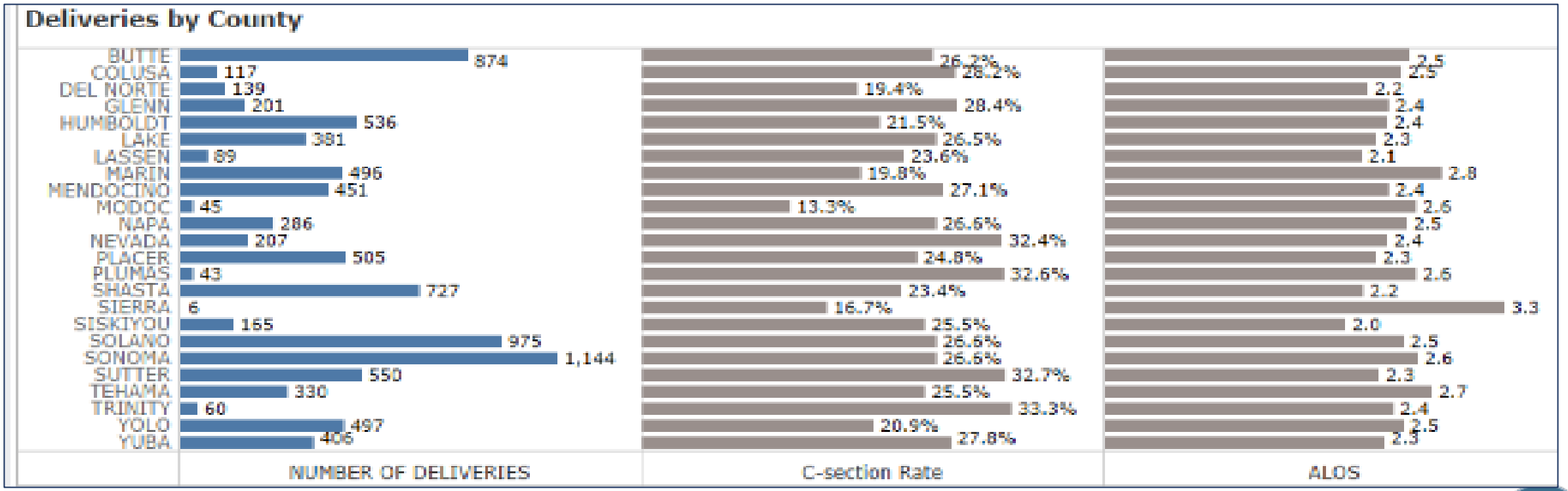
2023	8,143	2.96	25.4%
Year	Deliveries	ALOS	C-Section Rate

Deliveries by County



Partnership HealthPlan Perinatal Members Served 2024

2024	9,230	2.44	25.7%
Year	Deliveries	ALOS	C-Section Rate

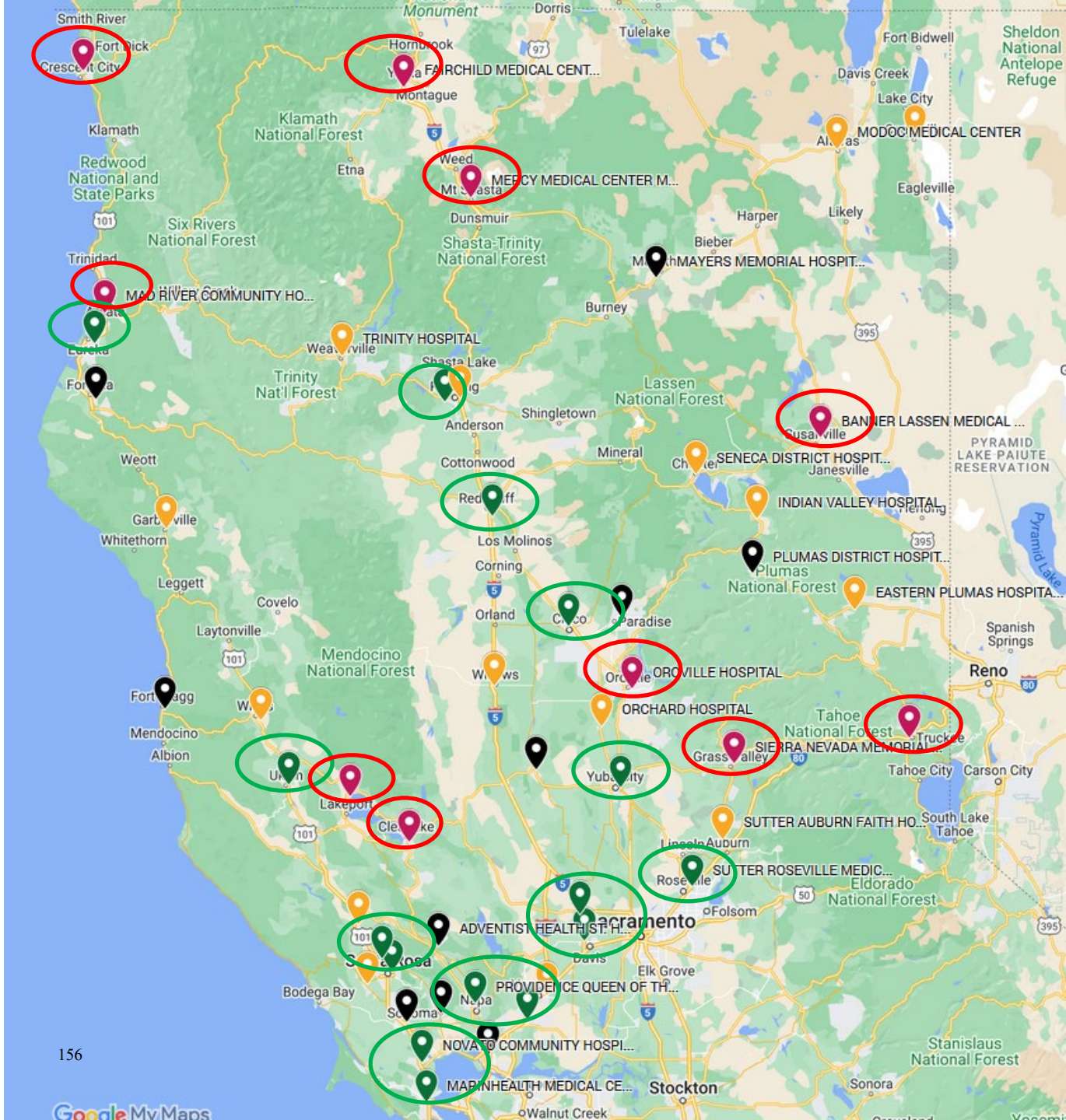


Loss of Maternity Services Over Time

Maternity Units in 50 non-Kaiser hospitals in Partnership service area

- Closed>10 yrs (15)
- Current: >500 Deliveries/year (15)
- Closed <10 yrs (10)
- Current: Risk of Closure (10)

Source: https://www.google.com/maps/d/edit?mid=1Va5GJtG5-CbVWrec3FSt_DSDewv-saw&usp=sharing



The Partnership Perinatal Challenge: Closure of Maternity Units

11 hospitals in 8 years

- Number of hospitals providing OB services decreased from 34 to 24 (excluding Kaiser)
- 29% of hospitals providing OB services closed their units.
- Rate of about 1 closure per year for 8 years or 3% per year.
- This is part of a nation-wide trend.

Half of all rural counties in the U.S. have no maternity services.

Partnership Health Plan Perinatal Portfolio

- **Optimizing Benefits for our Members**
  - Partnership Health Perinatal Services
  - Doula services
  - Enhanced Care Management: Population of Focus Birth Equity
- **Quality Incentive Programs**
  - Perinatal QIP
  - Hospital QIP
  - Enhanced Care Management QIP
- **Provider Education Initiatives**
  - Monthly Webinars
  - Clinical Practice outreach
  - Perinatal Care Symposium
- **Policy**
  - Health Plan Policy
  - Work Force development
  - Regional and Statewide advocacy

Partnership Health Perinatal Services
Comprehensive Perinatal Services 2.0

- **Four Domains of Services**
  - **Health Education and Care Management**
    - Individual Assessments and Individual Care Plans: each trimester and post partum,
    - Health Education and Care Management during and after pregnancy

  - **Behavioral Health**
    - Education Perinatal Case Managers, Comprehensive Perinatal Health Worker (CPHW), LVN, RN
    - Behavioral Health Therapy" PsyD, LCSW, MSW, SUD counsellors
  - **Nutrition Care**
    - Education Perinatal Case Manager, CPHW, RN, LVN
    - Counselling, and Medical Nutrition Therapy (MNT): Nutrition Health Coaches, RD
  - **Prenatal Medical Care**
    - Standardized Clinical care per ACOG guidelines
    - Physicians, Nurse Practitioner, Physician Assistant, Nurse Midwives, Licensed Midwives

Doula Services

- **Non-Clinical pregnancy support** demonstrated to improve pregnancy outcomes and satisfaction with birthing experience

- **Partnership members are eligible for up to 8 regular visits, 3 extended visits, and Labor & Delivery support**
  - No referral or formal recommendation for this service

- **Current Status**
  - 70 contracted doulas serving 17 counties and over 900 claims paid in the last 90 days

Interested doulas can contact doulaservices@partnershiphealthplan.org

Enhanced Care Management: Birth Equity Population of Focus

- **ECM**
  - Focused efforts of outreach and support to prenatal practices and organizations that serve African American/ Black and/or American Indian/ Alaskan Native communities
- **Current Network**
  - Total number of ECM providers:
  - Multiple contracted provider organizations in each counties
- **Current Access/ Utilization**
  - 180 members served

Tribal Birth Equity Initiative Goal

Goal: To create the best possible outcomes for Native American children/babies

Core Curriculum/Trainings

- Case management of pregnant individuals
- California Indian Customized Curriculum

Capacity Building Funding

- IPP funding
- Grants provided to cover educational trainings
- Fund case manager recruitment support

Tribal Perinatal Program

GOAL: enhance and strengthen the maternal care systems in the tribes with evidence based practices and culturally congruent information

- **Shared Curriculum Topics, including**
  - Family Spirit Curriculum (32 hours)
  - Hear Her Campaign (1 hour)
  - Trauma Informed care
  - Mental health first aid
  - Motivational Interviewing (Basic training 4 days)
  - Supporting pregnant individuals with substance use disorder (2 hours initially) Potential 4P's Plus program
  - Business support (customized to the program) 1 hour
  - Case Management Boundary Setting
  - ECM Care Manager Core Training (2 hours)
    - reporting requirements, care plan components
  - Doula Specific Training (16 hours)
  - PHPS Case Manager Core Training
  - Overview of other perinatal resources - CPSP, GTP, Sweet Success (1 hour)

Tribal Perinatal Program Progress

Cohort groups are dependent on when the tribal health center starts the Tribal Perinatal Program.

Cohort 1
April 2024

- Pit River Health Services
- Northern Valley Indian Health
- Lake County Tribal Health

Cohort 1.5
June 2024

- Round Valley Indian Health
- United Indian Health Service

Cohort 2
October & November 2024

- Chapa-De Indian Health Project
- Consolidated Tribal Health Center
- Feather River Tribal Health
- Greenville Tribal Health
- Karuk Tribal Health
- Lassen Indian Health Center
- Redding Rancheria Indian Health SVS
- Sonoma County Indian Health Project

Perinatal Quality Improvement Programs

- **Perinatal QIP**
  - Incentives for perinatal practice for:
    - First Trimester Prenatal Care
    - 2 Post Partum Visits
    - Vaccines in pregnancy: TDAP and Influenza
  - 29 Parent Organizations and 97 sites
  - Year Over Year Improvement in Prenatal and Post Partum Visits
    - Vaccination rates decreased after COVID and starting to rise in some areas
  - Areas of Focus for Improvement
    - Post Partum Care: Prenatal Care rates: Del Norte, Humboldt and Trinity Counties
    - Prenatal Care: Del Norte Humboldt, Lassen, Shasta

Provider Engagement and Education

- **Raising Quality and Improving Outcomes: Clinical Provider Engagement Series**
  - CME earning presentations with individual prenatal care organizations
  - Provides updates in clinical guidelines related to pregnancy care
  - Shares data from State, County and Partnership resources regarding perinatal care
  - Shares practice specific Perinatal Quality Incentive Program data
  - Reviews with each organization best/promising for perinatal care
  - 2025 to focus on PHPS and updated guidelines regarding

- **Perinatal Care Symposium**
  - Next March 10 2025 – New Solutions to Common Challenges
  - 2024 Symposium Shuttering of Maternity Care

Provider Engagement and Education

- **Partnership Health Perinatal Services**
  - Kick Off webinar in Sept 2024
  - Monthly webinars starting in January 2025

- **Building a Doula Network**
  - Partner with local initiatives to train doulas
  - Local outreach and convening of doulas and hospital/ outpatient providers
  - Monthly Introductory Webinars reviewing process for doulas to participate as MediCal provider, contract and credential with Partnership
  - Ongoing trainings to meet the needs of our members:
    - Motivational Interviewing
    - Trauma Informed Care
    - Mental Health First Aid

Provider Engagement and Education

- **Neonatal Airway Management**
  - 2 hour hands on experiential training to learn updated techniques and tools for airway newborn management
  - Focusses on training L&D, Pediatric, Emergency Department and EMS teams
  - Training + Neonatal Airway Scope provided to rural hospitals

- **Basic Life Support/Obstetrics**
  - Day Long experiential training to learn approaches to addressing Obstetric Urgencies
  - For non-medical professionals who work with pregnant individuals/ families - doulas, non-medical first responders, perinatal case managers

- **Advanced Life Support/Obstetrics**
  - Day long experiential, CME eligible training for clinicians to address obstetrical urgencies
  - Focus on clinicians who care for pregnant individuals: Family Medicine Providers, Midwives, Emergency Medicine providers, Nurses, EMTs

Partnership Policy Focused Initiatives

Work Force Development

- Recruitment and Retention policies includes Midwives and
- Incentivize hospitals to include Family Medicine and Midwives as eligible medical staff to provide obstetrics care

Leveraging advocacy through professional organizations

- California Medical Association -- Resolutions Developed and Passed
  - Expansion of Family Medicine+OB fellowship trained physicians to practice in rural areas
  - Integration of Certified Nurse Midwives in obstetrics teams
- California Academy of Family Physicians Resolutions
  - Supports Access to Safe OB Services or All Californians
  - Supports Efforts to have basic hospital maternity services within 60 minutes transport in good weather

Policy Solutions to Consider

- **Adapt /Update Reimbursement Models**
  - Favor changes to reflect the costs for hospital and birth center costs that are not accounted for in current models and are especially harmful to low volume facilities
  - An all-payer model that shifts hospital payments to an annual global hospital budget for inpatient and outpatient service – This was modelled in Maryland successfully

- **Consider Alternative Models for Birth Services**
  - Stand By Perinatal Services
  - Alternative Birth Centers (ABCs) - Revise licensing requirements focusing on existing accreditation standards

There is also PerinatalQIP@partnershiphp.org
It's publicly housed so just making sure
PerinatalQIP@partnershiphp.org
PerinatalQIP@partnershiphp.org

Questions

Please contact

PerinatalQIP@partnershipHP.org

TribalBirthEquity@partnershipHP.org

Or Dr. Colleen Townsend at
ctownsend@partnershipHP.org