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

### Members:

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<tr>
<th>Members</th>
<th>Willard Hunter, M.D.</th>
<th>Danielle Oryn, D.O.</th>
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<tr>
<td>Jeffrey Bosworth, M.D.</td>
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<td>Shandi Fuller, M.D. *alternates</td>
<td>M. Tracy Johnson, M.D.</td>
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<td>Jeffrey Gaborko, M.D. (Chair)</td>
<td>Melissa Marshall, MD</td>
<td>Thomas Paukert, M.D.</td>
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<td>Michael Ginsberg, M.D.</td>
<td>Antoinette Martinez, M.D.</td>
<td>Mitesh Popat, M.D.</td>
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<td>Steve Gwiazdowski, M.D.</td>
<td>Mills Matheson, M.D.</td>
<td>Michael Stacey, M.D. *alternates</td>
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<td>Michele Herman, M.D.</td>
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<td>Colleen Townsend, M.D.</td>
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<td>Lisa Ward, M.D.</td>
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### PHC Staff:
- Liz Gibboney, Chief Executive Officer
- Robert Moore, MD, MPH, Chief Medical Officer
- Margaret Kisliuk, Northern Executive Director
- Peggy Hoover, RN, Senior Director, Health Services
- Patti McFarland, Chief Financial Officer
- Mary Kerlin, Senior Dir., Provider Relations (PR) Dept.
- Marshall Kabota, MD, Regional Medical Director
- Mark Netherda, MD, Regional Medical Director
- Michael Vovakes, MD, Northern Regional Med. Dir.
- Jeffrey Ribordy, MD, Regional Medical Director
- James Cotter, MD, Regional Medical Director
- Jessica Thacher, Director, Quality & Performance Improvement
- Debra McAllister, RN, Director of Utilization Mgmt.
- Stan Leung, Pharm.D., Director, Pharmacy Services
- Scott Endsley, MD, Associate MD of Quality
- Kevin Spencer, Director of Member Services

### Ad Hoc PHC Members:
- Sonja Bjork, Chief Operating Officer
- Paula Fredericson, Senior Claims Director
- Kirt Kemp, Chief Information Officer
- Bettina Spiller, MD, Associate Medical Director
- Lynn Scuri, Regional Director
- Mark Glickstein, MD, Associate Medical Director
- Kelley Sewell, N. Region Mbr Services & PR Director
- Carolyn Stewart, Senior Director of Financial Analysis
- Diane Wong, Pharm.D., Senior Clinical Pharmacist
- Jennifer Chancellor, Northern Regional Manager
- Betsy Campbell, Senior Health Educator
- Nancy Steffen, Northern Region Manager, QI Programs
- Karen Stephen, Ph.D., Mental Health Clinical Director
- Linda Melshheimer, RN, Program Manager
- Ledra Guilyard, Senior Prov. Relations Rep. Manager
- Carly Fronfield, RN, N. Region, Health Services Director
- Rachael French, Manager, Quality Improvement Prgsms
- Margarita Garcia-Hernandez, Manager, Health Analytics
- Rebecca Boyd Anderson, RN, Director, Care Coord.
- Robin Krohn, N. Region Manager, Cure Coordination

### cc:
- PHC Commission Chair
- Craig Lindquist, MD
- Harris Levin, MD
- Gabriel Samuel Chua, MD
- Marie Mulligan, MD
- Gregory Baldwin, MD
- Kali Stanger, MD
- Voltaire Velarde, MD
- Richard Fogg
- Jerry Douglas, MD
- Amy Brom, Psy.D.

### FROM:
Linda Largent

### DATE:
June 8, 2017

### SUBJECT:
PHYSICIAN ADVISORY COMMITTEE MEETING

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

### DATE:
**Wednesday, June 14, 2017**

### TIME:
7:30 a.m. – 9:00 a.m.

### LOCATIONS:

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<tr>
<th>Via Video Conference</th>
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<tr>
<td>Partnership HealthPlan of CA 4665 Business Center Drive (Please Park in Front of Bldg.) Fairfield, CA</td>
<td>Marin Clinic 1177 E. Francisco Blvd. Suite B, San Rafael</td>
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<tr>
<td>PHC – Sonoma Office 495 Tesconi Circle Santa Rosa</td>
<td>United Indian Health 1600 Weeot Way Arcata</td>
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<tr>
<td>PHC - Eureka Office 1036 5th Street, Suite E Eureka</td>
<td>Shasta Community Health Centers 1035 Placer Street Redding</td>
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<tr>
<td>PHC – Redding Office 2525 Airpark Drive Redding</td>
<td>Redwood Community Health Coalition 1310 Redwood Way, #135 Petaluma</td>
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<tr>
<td>Baechtel Creek Medical 1245 S. Main Street Willits</td>
<td>Ole Health 1141 Pear Tree Lane Napa</td>
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<tr>
<td>Ole Health 2051 John Jones Road Davis</td>
<td>CommuniCare Health</td>
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Please contact me at (707) 863-4228, or e-mail llargent@partnershiphp.org if you are unable to attend.
REGULAR MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA’S
PHYSICIAN ADVISORY COMMITTEE - MEETING AGENDA

Date:  June 14, 2017     Time:  7:30 – 9:00 a.m.     Location:  PHC

PUBLIC COMMENTS

<table>
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Welcome / Introductions

II. Approval of Minutes – Chair 5 – 14  7:30

Standing Agenda Items

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<td>Ms. Gibboney</td>
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<td>Dr. Moore</td>
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A. Status Update
- Administration
- Medical / Health Services Report
- Regional Medical Director Reports
  - Napa County
  - Southeast Counties
  - Southwest Counties
  - Northwest Counties
  - Northeast Counties

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II. Standing Agenda Items

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<th>A1. Update from County Public Health Departments</th>
<th>Available Representative(s)</th>
<th>8:10</th>
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B. Quality / Utilization Advisory Committee Activities Report with attachments – Consent Review
Minutes of the May 17, 2017 meeting
- Minutes – Internal Quality Improvement meeting 04/11/17 (attached)

*P&Ps: NOTE – * See Policy Summary for all reviewed Page 36

Note – only pages with significant changes are included for policies
- Quality Improvement Update
- TAR Requirements List (updated to incl. Fecal Microbiota Transplant)
- Chronic Kidney Disease Program (MCCD2012)
- Fecal Microbiota Transplant (FMT) New Policy (MCUP3126)
- Provider Preventable Condition (PPC) Reporting (MPQP1035)

Policies Reviewed at April 19 meeting Pages 82 through 96
- Gender Identity Disorder (MCUP3125)
- Insulin Infusion Pump Guidelines (MPUG3025)

C. Pharmacy & Therapeutics (P&T) Committee / Consent Review
No meeting in May

D. Provider Advisory Group (PAG) Report – Consent Review
Minutes from meeting May 19, 2017 (attached)

E. Credentialing Committee Meeting Summary – Committee approved Summary of the April 12, 2017 meeting (attached)

F. Recommended Committee Appointments / Resignations
Pharmacy & Therapeutics Committee / Approved at P&T Meeting 01/12/17

Appointments:
- Haley Park, Pharm.D., Walgreens
- Harvey Katzman, Pharm.D., Ole Health, Napa
- Kathy DiMaggio, MAS, RDE

Resignation: effective 2/1/2017

| Dr. Moore | 77 | 8:15 |

III. Old Business

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A. Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Overall Results of Patient Satisfaction Survey (from October 2016 meeting) Postponement continued pending information from DHCS

IV. New Business

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A. Physician Advisory Committee policy (MPQP1003) – Action Required

| Dr. Moore | 78 – 80 | 8:16 |

B. Transportation Benefit (discussion)

| Ms. Hoover | -- | 8:18 |

Continued
C. Discussion Topic: How many issues should be addressed by a provider in a medical visit? (discussion / see attached) | Dr. Moore | 81 | 8:40

D. Additional Business:  
- Meeting Evaluation  
- No Meeting in July | Dr. Moore Committee Chair | – | 8:55

VI. Adjournment | 9:00

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item 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 Administrative 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 PHC regional offices (see locations under the Meeting Notice). It can also be found online at www.partnershiphp.org.

In compliance with the Americans with Disabilities Act, PHC 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 Administrative Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (707) 863-4228 or by email at llargent@partnershiphp.org. Notification in advance of the meeting will enable PHC to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

### Meeting Notes – Physician Advisory Committee – 06/14/2017

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<td>Public Comments</td>
<td>Committee Chairman, Dr. Gaborko, asked for public comments. None were presented and no members of the public were in attendance.</td>
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<td>I. Approval of Minutes</td>
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<td>II.A. Status Update Administration</td>
<td>The HealthPlan’s Chief Executive Officer (CEO) provided the following status report on PHC activities. - American Health Care Act (AHCA) – Last week, the House of Representatives (House) voted to approve the AHCA, with a narrow margin, which sends the Bill to the Senate. There were many Amendments made over the past several weeks, but most of those pertained to the Exchanges, which Partnership does not participate in. The Plan’s focus is on the Medicaid provisions, which have not changed recently. It is expected that the Senate will take longer reviewing the</td>
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<td>II.A. Status Update Administration, Continued</td>
<td>policy and fiscal implications, and may opt to rewrite a new version. The Congressional Budget Office (CBO) score for the Bill passed by the House should be out in a couple of weeks. The Plan continues its advocacy work with its associations and lobbyists in Washington, D.C., has shared its position with the two California Senators, and is now working with the Board of Supervisors in each of the fourteen counties toward a formal action opposing the AHCA so that it is on record regarding those provisions. Some providers may be called upon to help in those efforts.</td>
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<td>Three Year Strategic Plan – Partnership has resumed its work on the new 3-Year Strategic Plan, which had slowed some due to the uncertainties at the Federal level. A draft has been completed and will be presented to the Strategic Planning Committee later in the morning, with the goal of taking the revised Strategic Plan to the Board at the end of June. The three major priorities have not changed (high quality care, financial stewardship, and operational excellence), but goals and objectives within those areas are being updated with focus on the National Committee for Quality Assurance (NCQA) Accreditation, technology support, use of data, etc. The 3-Year Strategic Plan will be brought to this Committee when completed.</td>
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<td>Strategic Use of Reserves (SURs) – At their April meeting, the Board passed a $25 million SUR to address housing and homeless initiatives within the Plan’s fourteen counties. Staff expects to have a Request for Proposals (RFP) out for consideration by the counties in the next couple of months. Funds will be allocated on a county-level basis by the ratio of PHC members within the county. Focus for staff will be on ensuring that funds are applied toward Partnership members, as well as programs that will facilitate discharge from inpatient hospital status (if the patient is ready for discharge), along with supportive housing for substance use treatment. More to come as it becomes available.</td>
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<td>Budget – Staff will be taking the proposed budget for the HealthPlan to the Board in June. Given all the concerns around immigration at the Federal level, a flat, if not a slight decline in, membership is expected.</td>
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<td>State / Department of Health Care Services (DHCS) -</td>
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<td>State Budget – May Revise – Revisions to the January Budget are expected to be available tomorrow morning.</td>
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<td>II.A. Status Update Medical</td>
<td>The HealthPlan’s CMO presented an overview of some Health Services activities.</td>
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<td>Regional Medical Directors’ Meeting – Last Friday, the first in the series of Regional Medical Directors’ meetings was held in Novato. Meetings in Redding and Eureka are scheduled for next week, with a meeting scheduled in Mendocino the following week. This Committee will receive a copy of the detailed notes, which will be distributed via e-mail.</td>
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| II.A. Status Update Medical, Continued | One item from the meeting in Novato that received a lot of discussion was the topic mentioned at this meeting last month regarding the results of the Financial Audit (Audit) at San Mateo Medical Center (SMMC). Fortunately, it is less complicated than what is transpiring in Washington, D.C. In summary:  
- In 2014 there was an Audit of SMMC’s 2010 Prospective Payment System (PPS) methodology.  
- Auditor found some of the measures (Pay for Performance [P4P] offered by SMMC) were not excludable from their cost report. Thus, approximately half of the P4P dollars were determined for repayment to the State.  
- SMMC appealed this decision, which took 2 years for processing. An Administrative Law Judge at DHCS overturned the decision, in favor of SMMC.  
- DHCS has the ability to overrule its own Judge, so authorized a new Judge to review the case. The new official overturned the first Judge’s ruling, and went even further, nullifying the entire P4P as being excludable. The justification was based on their interpretation of a 17 year old letter from the Centers for Medicare and Medicaid Services (CMS) to the then Medicaid Director.  
- SMMC is not appealing through DHCS. They will file suit against the ruling.  

Since the argument is very tenuous, staff and providers do not need to become anxious that this will be the new policy going forward. California’s Local Health Plans initiative is coordinating their efforts to advocate clarity regarding this ruling and case.  

Dr. Townsend asked about the factors of the metrics used when the finding was determined. The Plan’s CMO advised that the initial metrics were billed in claims. (I.E. a well-woman visit was billed and paid on a claim, with a notation that the payment was to be counted as P4P.)  

PHC’s Regional Medical Director for Napa County presented a brief overview.  
- Housing Coalitions in Napa County – Having participated on several of these coalitions, the Strategic Use of Reserves funds being allocated by Partnership is really appreciated. It is clear that a number of entities are working on this issue, but those efforts are not necessarily connected. It is a complex issue, and the portion involving healthcare is just part of the whole.  
- Ole Health – A new Chief Medical Officer started yesterday. Dr. Townsend advised that Ole Health’s new CMO, Dr. Steve Ramirez, comes from Oklahoma and Texas and is moving here after spending 5 to 8 years doing medical leadership / clinician work at community health centers. He will be coming on board full-time in June. His focus will be bringing a renewed interest in quality improvement and experiencing driving success in organizations across multiple sites.  
- Intensive Outpatient Care Management (IOPCM) – There are multiple sites participating in this program. Site visits were recently done at Hill Country and Mountain Valley. Both are very small sites, and very isolated with no support, but both are doing a great job with their care management. Average sites have about 40 patients in the program.  
- Palliative Care – PHC’s benefit starts July 1. Information regarding grant applications was distributed to the sites yesterday. It is expected to have palliative care across the region by late summer. | For information only, no formal action required | 05/10/17 |
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<td>II.A. Status Update Medical, Continued</td>
<td>PHC’s Regional Medical Director for the Southeastern (SE) counties presented a brief overview. <strong>Yolo County</strong>  - Harbor Medical Center – It was learned last week that Harbor Medical was purchased by Elica Medical Centers, which is primarily centered in Sacramento. This should not affect PHC members, though Provider Relations (PR) will need to address.  - Winters Healthcare – It is understood that their new building may have gotten delayed. <strong>Solano County</strong>  - PHC PR representative for most of Solano County has changed to Tondenisha Smith-Coleman, while Nick Barajas will be taking the Dixon area and act as the back-up to Vacaville. Gloria Turner will be covering Napa County temporarily.  - NorthBay Healthcare – Staff is working with NorthBay regarding an issue with specialty referrals, to ensure there is sufficient coverage for members. Some patients may be required to go out of county for services. <strong>Lake County</strong>  - Safe Rx Lake organization, which may become a not-for-profit entity, was founded primarily due to the Opioid SafeRx activities and is looking to expand beyond opioid related issues to general health. They are also considering areas such as education, economic opportunity, and environment.  - Opioid Use in the News – Two overdose deaths were reported this past month in Mendocino County, both individuals were young. On April 25, the Press Democrat reported that there were 5 deaths due to heroin overdose during the ten days prior to that date. The ages of the individuals were 27 through 66 (3 men and 2 women), three of them were homeless. Naloxone may have prevented these deaths. There are a lot of community organizations dispensing Naloxone, received through various grants. Partnership believes that co-prescriptions are more effective, and the co-prescription rates are very low in the county, which includes non-PHC patients. The HealthPlan encourages clinics to adopt a policy around co-prescribing Naloxone. If there was a wider distribution and use of Naloxone some of these deaths may have been averted. Dr. Townsend addressed the Naloxone distribution, as many primary care providers (PCPs) also recognize the value of co-prescribing. This process is difficult for the PCP, as many pharmacies do not like dispensing, nor do they understand the process. It is her opinion that the pharmacies do not know how to bill for the co-prescription. Often when she co-prescribes, she receives a prior authorization, which is subsequently declined. None of Napa’s community pharmacies seem to understand how to bill State Medi-Cal. As a result, they will not dispense this costly medication without a means of reimbursement. The SW Regional Medical Director noted that a Treatment Authorization Request (TAR) is not required by the State. The process would be similar to that of billing for an anti-psychotic medication. PHC’s Pharmacy</td>
<td>For information only, no formal action required.</td>
<td>05/10/17</td>
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| II.A. Status Update Medical, Continued | department is actively working at getting this information out to pharmacies. Parameters for Medicare related prescriptions may be different. It is expected that the demand will drive the effort to some extent.  

Dr. Marshall shared that she was struck by the data that was presented at the Medical Directors’ Forum, regarding the number of prescriptions per county, and the perception that providers have regarding what they are prescribing. Her take away from those discussions is that something is not going right operationally, and she believes the issue merits additional investigation.  

The SW Regional Medical Director appreciated Dr. Marshall’s feedback, and added that there is a Naloxone toolkit available under Partnership’s website, under the Managing Pain Safely section. The Plan’s CMO acknowledged the data mentioned by Dr. Marshall, which shows a shocking low number of prescriptions paid by Drug Medi-Cal. That information is by county, and not provider. At the end of today’s agenda is the Pharmacy Quality Improvement Program (QIP), which now includes a pay-for-performance for independent pharmacies to provide Naloxone. It is expected that this will help with that segment of pharmacies. Secondly, the State has authorized a huge amount of Naloxone for distribution by providers. Instead of having to rely on the prescription method, each organization can distribute directly and should contact their county about getting a supply.  

- Residency Program – The first classes of this new Residency Program is targeted to start at Kaiser, Santa Rosa in July 2018. This will be a six residents per year program that should benefit the Northern California area.  
- Coastal Health Alliance and West County Health Centers are actively discussing the potential of merging their operations.  

PHC’s Regional Medical Director for the Northwestern (NW) counties presented a brief overview.  
- Access – There has not been a lot of provider movement in the region. One clinic in Fortuna (Drs. Olkin and Jones) joined the St. Joseph’s Medical Center system. However, Dr. Jones has retired, leaving Dr. Olkin (who is also due to retire) along with one physician assistant. They are actively recruiting.  
- In the news yesterday, Dr. David Obrien, previously the President of St. Joseph’s Hospital, resigned, and will be taking a position in Takoma. Dr. Obrien had a unique connection and perspective, as he had started as a family practitioner in Eureka and was in the area about 10 years. His leaving will be a loss to the region.  

The HealthPlan’s Northern Regional Medical Director presented a brief overview on activities for the Northeastern (NE) counties.  
- Redding Rancheria has opened an addiction recovery center at their Churn Creek medical site. They are taking on PHC and other patients who have any type of addition or substance use problems (i.e. alcohol and methamphetamine). Their medical director is on the local opioid coalition, and very interested in this effort. | For information only, no formal action required. | 05/10/17 |
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| II.A. Status Update Medical, Continued | - Hill Country Clinic in Round Mountain received funds from the County Mental Health and opened a crisis center in downtown Redding last month. The center is open 365 days a year, with hours up to 11:00pm. Benefits include crisis-type mental health evaluations, and assistance with connections to community services.  
- Dignity (Mercy) Maternity Clinic in Redding sees a lot of PHC patients. A survey was conducted regarding reasons some women are not getting prenatal care. The Clinic is doing some pilot programs to try and get pregnant women in sooner for their prenatal care.  
- Naloxone – A lot of the Naloxone in the area is not prescribed, which may be the reason for the numbers being low. Distribution has occurred through grants, along with self-injector kits given out to sites by way of the coalition. However, it has been difficult for patients to get prescriptions filled. The local opioid coalition (NoRxAbuse) will be obtaining some kits to distribute to organized distribution centers (clinics and practice sites). Between Shasta and Humboldt counties, 820 kits will be obtained for dispersing. Each kit contains 2 nasal sprays.  
- Mercy Mt. Shasta Hospital in Siskiyou County is starting a wound care center.  
- McCloud Health Center in Dunsmuir had a relatively new medical director who came from out of state. He took the position of taking all of McCloud’s patients off opioids, and has since been relieved of his duties. The previous medical director has agreed to return one day a week to help during this transition.  
- Dr. Candy Stockton, who works at Shingletown, is moving and will soon be working at Shasta Community Health Center. | N/A | -- |
| II.A1. Update – County Public Health | Dr. Stacey was not available to provide an epidemiology update to the Committee. | | |
| II.B. Quality/ Utiliz. Advisory, II.C. Pharmacy & Therapeutics, II.E. Credentialing committees | There were no items pulled for further discussion. | | |
| II.F. Committee Membership | The Plan’s CMO advised that Dr. Mann, previously the medical director at Ukiah Valley Rural Health in Mendocino County, has served on the Physician Advisory Committee for several years. Dr. Mann has retired, so his resignation is recommended. | | |
| III.B. UM Program Description | The Plan’s Director of Utilization Management advised that the UM Program Description has been deferred several months, due to the All Plan Letter (APL) that came out from DHCS. Per that APL, additional changes were required. Revisions to the document include timeline | | |

**MOTION:** Dr. Gwiazdowski moved to approve Agenda Items [II.B., II.C., & II.E.] as presented, seconded by Dr. Townsend. **ACTION SUMMARY:** [12] yes, [0] no, [0] abstentions. Motion carried.

**MOTION:** Dr. Townsend moved to approve Agenda Item II.F., as presented, seconded by Dr. Martinez. **ACTION SUMMARY:** [12] yes, [0] no, [0] abstentions. Motion carried.
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<td>III.B. UM Program Description, Continued</td>
<td>consistencies, removal of Healthy Kids references, along with the additions of new staff positions and descriptions, per new organizational uniformity. References to “days” were clarified to calendar days, and the term primary care physician was changed to primary care provider. PHC guidelines were replaced with PHC policies, and the full non-discrimination statement was added as required by DHCS. Once approved, the document will be presented to PHC’s Board for approval at their June meeting.</td>
<td><strong>MOTION:</strong> Dr. Gwiazdowski moved to approve Agenda Item III.B., as presented, seconded by Dr. Paukert. <strong>ACTION SUMMARY:</strong> [12] yes, [0] no, [0] abstentions. Motion carried.</td>
<td>05/10/17</td>
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<td>IV.A. Clinical Practice Guideline: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing</td>
<td>The Plan’s CMO summarized the changes to the Clinical Practice Guideline (CPG) for Pain Management. Since the Centers for Disease Control and Prevention’s (CDC’s) recommendation for the maximum safe dosage of long-acting opioids is at 90 morphine equivalents per day, the HealthPlan is updating its policy to reflect that recommendation (previously listed as 120 per day). The new level has also been reflected in the associated recommendations attached to the policy. The term “substance abuse” was also changed to “use disorder”, to reflect current diagnosis codes. Dr. Bosworth opposed the reduction of morphine equivalents per day from 120 to 90. The speed of the change will be difficult for his providers to implement, and offered to share his comments off-line from the meeting. PHC’s CMO advised that the Plan’s pharmacy criteria will not be changed at this time, but at a future date. The policy change will affect staff’s decision making process in cases that are complex, but will not be immediately reflected under pharmacy’s TAR processes, and providers will have ample warning before those changes will go into effect. Napa’s Regional Medical Director advised that the CPG reflects current practices by the medical directors who review cases, and there is no hard-stop at the recommended levels. However, the levels allow for consistency during the review process.</td>
<td><strong>MOTION:</strong> Dr. Townsend moved to approve Agenda Item IV.A., as presented, seconded by Dr. Paukert. Dr. Bosworth opposed. <strong>ACTION SUMMARY:</strong> [11] yes, [1] no, [0] abstentions. Motion carried.</td>
<td>05/10/17</td>
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<td>IV.B. Lactation Clinical Practice Guideline</td>
<td>Partnership’s CMO highlighted the small change to the Lactation CPG. Under the section of purpose, the CPG is to promote breastfeeding exclusively for 4-6 months, with complementary foods (not formula) for at least 12 months, per the American Academy of Pediatrics recommendations. Other changes were for language clarification purposes. Dr. Gwiazdowski addressed a section of the CPG regarding infants with cleft lip and/or palate, where the term Pediatric care provider is used. Typically, that term includes nurse practitioners, physician assistants, etc., whereas, physicians would be handling these cases. He recommended changing that term to Pediatric care physician throughout the section, and flipping the contents under 10(a) and 10(a)i. for clarity.</td>
<td><strong>MOTION:</strong> Dr. Gwiazdowski moved to approve Agenda Item IV.B., as amended, seconded by Dr. Townsend. <strong>ACTION SUMMARY:</strong> [12] yes, [0] no, [0] abstentions. Motion carried.</td>
<td>05/10/17</td>
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<td>IV.C. Primary Care Provider Quality Improvement Program (QIP) Evaluation</td>
<td>PHC’s Quality Incentive Programs Manager (QI Programs Manager) introduced the Plan’s new QIP Analyst under Quality’s team. Today’s evaluation of the Primary Care Provider (PCP) Quality Improvement Program (QIP) is specific to the 2015/2016 year, and payments were distributed to PCPs last October.</td>
<td><strong>MOTION:</strong> Dr. Gwiazdowski moved to approve Agenda Item IV.C., as presented, seconded by Dr. Paukert. <strong>ACTION SUMMARY:</strong> [12] yes, [0] no, [0] abstentions. Motion carried.</td>
<td>05/10/17</td>
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<td>AGENDA ITEM</td>
<td>DISCUSSION / CONCLUSIONS</td>
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| IV.C. Primary Care Provider (PCP) Quality Improvement Program (QIP) Evaluation, Continued | There were over 200 PCPs that participated in the QIP for 2015/2016. The total payout was $44 million. As part of the evaluation, participating providers were surveyed regarding their experience with the QIP. Questions asked providers included:  
  How engaged were providers in the program? - Almost 60 responses were returned, most of which were very positive. Providers also gave high marks to the Quality team and their responsiveness. However, some providers do not agree that the eReports or the non-clinical reports are easy to use. This area has room for improvement, and a lot of enhancements have been done to the eReports data submission system. For the non-clinical measures, staff is in the development phase for the HealthPlan’s Quality Dashboard, which is expected to provide more actionable data for providers. Feedback regarding PHC sponsored webinars was also generally positive.  
  Quality staff saw an upward trend in manual submissions, which is a reflection of improved provider engagement. Results of measures were highlighted for the Southern and Northern Regions. There are ongoing internal staff discussions regarding the relative improvement threshold. Staff believes there is merit in those thresholds, as they move providers in the right direction. Evaluation of the QIP results took various approaches.  
  How were total points and earnings distributed across provider sites? - To determine the median payout ratings for large versus small practices, staff separated the two groups for calculation purposes. The median payment pool level for large sites was 70 points, as compared to small sites at 56.2 points. The correlation between member volume and point earnings was calculated for the three practice types (Adult, Family, and Pediatric). The larger practice sites tended to achieve higher points with the QIP.  
  How did providers perform across the measures relative to performance targets? – Seven providers met the full-point targets for clinical measures. Full points performance place the provider into the 90th percentile, which is across all Medicaid plans and is a very high bar. There was a significant improvement with the HbA1C Good Control measure between 2014/2015 and 2015/2016 years (16.7% improved to 39% in the Southern Region). It was noted that approximately 70% of practice sites in the Southern Region fall under the Family practice category. 2014/2015 was the first year the Northern Region reported on the QIP measures. It is expected that the measurement rates will improve as providers become more familiar with the QIP and they understand the specifications better. This year, staff opted to compare the QIP denominators as a percent of the Healthcare Effectiveness Data and Information Set (HEDIS) denominators. The HealthPlan wants to see improvements in HEDIS scores, and the QIP is a means for that improvement. Approximately 42% of the HEDIS denominators are captured by the QIP denominators. So, improvement in those QIP scores translate into improvement in the HEDIS scores. | | |
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<th>AGENDA ITEM</th>
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<tr>
<td>IV.C. Primary Care Provider (PCP) Quality Improvement Program (QIP) Evaluation, Continued</td>
<td>The Committee’s Chair advised that he looks for quality improvement when reviewing these reports, that the trend is going upward and the differential between clinics is narrowing. It is disappointing to see some measures dropping by a point, but overall, there is improvement and the gap between sites is narrowing. The Plan’s QI Programs Manager referred to one of the slides, which reflects that narrowing. For information only, no formal action required.</td>
<td>05/10/17</td>
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<td>IV.D. Hospital QIP Evaluation for 2015/2016</td>
<td>Due to time constraints, review of the Hospital Quality Improvement Program Evaluation for 2015/2016 was left to the Committee’s own review. This information was included in the meeting packet.                                                                                                         For the Committee’s review only. No formal action required of this agenda item.</td>
<td>05/10/17</td>
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<td>IV.E. Pharmacy Quality Improvement Program 2017/2018 Measurement Sets</td>
<td>The Plan’s CMO advised that the Pharmacy pay-for-performance program has been in place for several years, focusing exclusively on independent pharmacies. Partnership’s Director of Pharmacy Services (Pharmacy Director) presented the proposed measurements for 2017/2018.</td>
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<td>Clinical Quality Domain 1) Comprehensive Medication Review (CMR) for Patients – Pharmacies are required to provide medication reviews to at least 16 PHC members (4 patients per quarter), to help educate the patient and help them become co-managers of their medications. 2) Chronic Pain Medication Oversight – Use of the Controlled Substance Utilization Review and Evaluation System (CURES) for new patients, and quarterly for regular patients. This year, pharmacists will be required to show that they have the Naloxone program in place and to provide education to patients so they know when and how to use Naloxone. Medi-Cal has added nasal spray to the covered medications, which is much easier than the injectable version. Having an easier product to use and ensuring that pharmacists are trained to dispense and appropriately counsel the patient on how to use the drug will hopefully expand the utilization of Naloxone.</td>
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<td>Patient Experience Domain – This is unchanged from last year. Whereas, pharmacies offer affordable medication delivery service so that PHC members with poor available transportation have access to their medications.</td>
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<td>Cost Efficiency Domain 1) Generic Fill Rate – Pharmacies are required to have a generic fill rate of at least 85% 2) Basaglar Conversion (new) – Basaglar is a generic-like version of Lantus. Though the protein sequence is the same and the two medications are basically the same, they are not interchangeable in the pharmacy. This will require the pharmacy to contact the Lantus patient’s physician to authorize the change. This year’s goal is for pharmacies to convert at least 50% of their current Lantus patients to Basaglar. The cost difference between the two medications is around 15%, but Lantus is the Plan’s number one prescribed medication, so it represents a high dollar amount.</td>
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## AGENDA ITEM

### IV.E. Pharmacy Quality Improvement Program 2017/2018 Measurement Sets, Continued

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| Access Domain -  
1) After Hours Access – This requires pharmacies to offer at least 4 hours of after-hours services per week (weekend or evening).  
2) Immunizations – Pharmacies are currently required to offer the four CDC recommended vaccines (influenza, Tdap, pneumococcal, and zoster). The Plan will also require pharmacies to provide their immunization protocol, to ensure the program meets the requirements of the State’s Board of Pharmacy and that the process is safe for the patient and pharmacist. Additionally, as required by the Board of Pharmacy, the pharmacy needs to be registered on the California Immunization Registry (CAIR). The Plan will require evidence to this effect.  
3) Safe Medication Disposal – Pharmacies will be required to have an on-site medication disposal services, allowing patients to drop off medications. If that is not possible for the pharmacy, the HealthPlan will accept adherence to the measure if drug mail-back envelopes are offered to the patient.  

   It was noted that a number of counties have “take back” programs for unused / expired medications. Though this needs to be confirmed, it has been pointed out to the Pharmacy Director that the State requires those entities to be registered as hazardous waste collectors, which incurs considerable fees. The mail-back envelopes are an option for locations reluctant to sign up for the take-back program.  

   Dr. Townsend acknowledged the importance of involving the pharmacies in quality improvement, consistent with what is being done at the PCP level. It would be helpful for PCP practices to get feedback regarding what services are offered by what pharmacies, along with documentation of the services on individual patients when the service occurs. In addition to the vaccination status, it would be beneficial to incorporate the comprehensive medication review in the patient’s electronic medical record. It would also be helpful for providers to know which pharmacies are attesting to do the Basaglar conversions. PCPs can help in supporting those pharmacies practicing high quality pharmaceutical practices.  

| MOTION: | Dr. Johnson moved to approve Agenda item IV.E. as presented, seconded by Dr. Gwiazdowski.  
ACTION SUMMARY: [12] yes, [0] no, [0] abstentions. Motion carried. |
|--------------------------|--------------------------|---------------|

Adjournment  
The Committee adjourned at 8:59 AM  
Respectfully submitted: Linda Largent

05/10/17

The foregoing minutes were APPROVED AS PRESENTED on:  

Jeffrey Gaborko, M.D., Committee Chairman

The foregoing minutes were APPROVED WITH MODIFICATION on:  

Jeffrey Gaborko, M.D., Committee Chairman
## AGENDA ITEM

**I. Call to Order Approval of Minutes**

Dr. Moore called the meeting to order at 7:35 a.m.

Minutes from the 4/11/2017 IQI meeting were reviewed and accepted by the committee.

Minutes from the 4/19/2017 Q/UAC meeting were reviewed

**Motion:** Dr. Gwiazdowski

**Second:** Dr. Manalo

Approved without changes

**TARGET DATE:** 5/17/2017

**DATE RESOLVED:**

## II. Standing Agenda Items

1. **Status of Open Action Items**

   Continue discussion topic: Discharging Patients from a PCP practice: Ethical Issues and Policy Implications. This discussion topic is on the agenda today.

   **TARGET DATE:** 5/17/2017

2. **QI Department Update**

   Jessica Thacher gave the Quality Improvement program update.

   **Quality Improvement Programs**

   - The 2015-16 Primary Care Provider (PCP) QIP Evaluation is complete. Key

   **TARGET DATE:** 5/17/2017

   **DATE RESOLVED:**

---

**Members Present:**

- Choudhry, Sara, M.D.
- Gwiazdowski, Steven, M.D., FAAP
- Manalo, Rod, M.D.
- Montenegro, Brian, M.D.
- Murphy, John, M.D.
- Namihas, Steven, M.D.
- Quon, Robert, M.D.
- Strain, Michael, PHC Consumer Member
- Thomas, Randolph, M.D.
- Wilson, Jennifer, M.D.

**Members Absent:**

- Borde, Madhusudan, M.D.
- Pirruccello, Michael, M.D.
- Paukert, Thomas, M.D.
- Threlfall, Alexander, M.D.

**PHC Members Present:**

- French, Rachael, Senior Manager, Quality Compliance and Accreditation
- Glickstein, Mark, MD, Associate Medical Director
- Fromefield, Carly, NR Health Services Director
- Hooper, Peggy, RN, Health Services Senior Director
- Krohn, Robin, Team Manager Care Coordination
- Liu, Jess, Manager of Quality Incentive Programs
- McAllister, Debra, RN, Utilization Management Director
- Moore, Robert, MD, MPH, CMO – Chairman
- Netherda, Mark, MD, Regional Medical Director
- Russell, Joan, Senior Manager of Provider Education
- Sciri, Lynn, Regional Director

**PHC Members Absent:**

- Boyd Anderson, Rebecca, Director of Care Coordination
- Brandenburg, Heather, Associate Director Provider Relations
- Chancellor, Jennifer, Regional Manager
- Endisley, Scott, MD, Associate Medical Director
- Garcia-Hernandez, Margarita, Manager Health Analytics
- Guillory, Ledra, Senior Provider Relations Representative Manager
- Jenkins, Shauncey, Member Services Supervisor
- Kerlin, Mary, Provider Relations Senior Director
- Kisluk, Margaret, MPP, JD, Executive Director

- Kubota, Marshall, MD, Regional Medical Director
- Leung, Stan, Pharmacy Services Director
- Ribordy, Jeff, Northern Regional Medical Director
- Santos, Rosemenia, Manager of Quality Assurance/Patient Safety
- Sewell, Kelley, Northern Region Director of MS & PR
- Stephen, Karen, PhD, HS Mental Health Director
findings include:
- The total pay-out for the 2015-2016 QIP was $44.8 million. The median score remained consistent at 65 out of 100 points.
- Provider engagement with the program remained high.
- 2015-16 was the first year payment was calculated using two payment pools: Institutional vs. Independent. Practices with no affiliation with large hospitals, medical groups, or federally qualified health centers are considered “independent.” The median points earned among independent providers was 56.3, compared to 70.0 among institutional providers.
- Across all clinical measures, providers in both regions heavily rely on relative improvement to earn points, especially for challenging measures such as Cervical Cancer Screening.
- Across hospital utilization measures, the proportion of providers that met the risk-adjusted targets remained above 80%, suggesting room for lowering the targets to drive improvement.
- For QIP measures that align with HEDIS, the QIP denominators are on average 42% of the HEDIS denominators. Greater overlap between the QIP and HEDIS eligible populations will increase the QIP’s leverage to improve our HEDIS rates.

Long Term Care
The first year of the program has ended. The check payments were issued in April.
- 50 Participating sites
- 6 of the 50 those facilities earned 100 points (range was 25-100 points)

HEDIS Medical Record Collection
The HEDIS medical Record collection process ended on May 15th. We are now in the process in which the auditor checks to ensure the way we have been abstracting data from the medical record is accurate. The good news is tentatively our rates our showing improvement relative to last year though everything is contingent upon passing the audit. We look forward to formally sharing final HEDIS 2017 performance in August.

NCQA Accreditation
The QI team continues to lay the groundwork to become NCQA Accredited. Working hard to build the project plan and continuing to interface with different departments that will be required to be involved.

ADVANCE
The project year has started; there are 13 clinics that are participating. The first in person session will be held in June that will teach participants how to apply QI methods to a QI project.

HEDIS Improvement Strategic Plan
The overall focus is to improve HEDIS scores through a Population Health Management Strategy. More health plans are participating in a Population Health Management Strategy and NCQA is saying health plans should be doing a Population Health Management Strategy. This strategy includes 3 focus areas which are:
- Primary Care Provider (PCP) networks capacity to do Population Health Management and the how the health plan can support that.
- PHC direct to member Population Health Management and engagement strategy. How does PHC interact with their members outside of the Primary
Committee Conversations

NCQA accreditation

A conversation took place around the timeline surrounding NCQA accreditation. Jessica Thacher responded: PHC’s goal is to be interim accredited by September 2019 and to be in compliance with those interim standards by June 30, 2018. This will allow us time to conduct some self-auditing prior to formally undergoing the interim accreditation process.

Dr. Gwiazdowski asked, “Why is PHC moving towards obtaining NCQA Accreditation?” Providing more context to the committee.

Jessica Thacher responded: Accreditation is made up of a few things, 1) compliance with HealthPlan standards which is primarily a roadmap to how we do business. A lot of specifications for how you do Utilization Management, how you do credentialing there are processes in which NCQA wants you to follow which allows the ability to set performance goals across different areas and evaluate performance against set goals and put improvement plans in place. Following those standards is one piece, roughly about 50% of your score. The other 50% of accreditation is based on how the HealthPlan does on HEDIS scores, preventative and chronic care measures and then how we perform on CAHPS survey which is member experience. Other factors to consider when moving towards obtaining accreditation is seeing many HealthPlans going through the accreditation process and provides a way for us to really understand how we are performing relative to other plans nationally. PHC’s vision is to be the highest regarded HealthPlan in California and at this point it is very hard for us to really understand how were doing as there are not great benchmarks. Accreditation allows us to enter this National network where HealthPlans that are rated on the same scale. As we work on operational excellence within the health plan accreditation supplies a framework of how to be operationally excellent.

EyePACS:

Committee member, Michael Strain requested additional information around PHC’s current program, EyePACS.

Dr. Robert Moore shared: There is Type I and Type II Diabetes. Type I, you get all at once and Type II takes a bit longer to develop. With Type II diabetes when you are first diagnosed you may have some eye damage and the recommendation is to start screening right away. For type I, you may start within 5 years of diagnosis. What happens is the high blood sugar causes damages to the blood vessels in the eyes which can cause various problems which can lead to blindness. The nice thing is if caught early on there are treatment to prevent that. In particular, laser treatments. Best prevention of diabetic retinopathy is to manage diabetes well. Screening so we can treat early diabetic retinopathy and keeping diabetes well controlled.

Placing cameras in the PCP setting helps improve access to retinal eye screening at the point of care and timely interpretation by an eye care specialist to determine diabetic
3. HealthPlan Update

**Perinatal Substance Use Disorder Conference**

Care Coordination hosted a conference this May that turned out to be the biggest turnout in PHC history with over 300 attendees from 5 different sites with it being sold out. There were 4 different guest speakers covering four topics; 1) Anthropology in pregnancy with a focus on women who live in single occupancy hotels in San Francisco 2) Buprenorphine in pregnancy 3) effects of substance use on the developing fetus and 4) treating and preventing and the problem of neonatal abstinence syndrome. Attendees were very much engaged.

**Board of Directors Update:**

In April, the Board of Directors approved a co-investment with each of the counties for funding to help fill gaps with a focus on housing where the funding streams have fallen short.

**Pharmacy Update**

Hepatitis C medications continue to be the top 3 most expensive drugs. PHC is fortunate to have a Utilization Management of using the most cost effective treatments. The states reimbursements for Hepatitis C medication is sufficient for PHC, whereas other plans are losing money but we are not. We are trying to switch our patients from Lantus to Basaglar. We are currently at 5% converted.

Dr. Gwiazdowski asked, “How does it work in terms of the reimbursement from the state?”

Dr. Moore responded: The state allocates a certain amount of money per patient, so if we use the most cost effective treatments then we do better than what the state is giving us. The key is working closely with our providers to prescribe the most cost effective treatment.

**State Budget**

The state has been talking about revising the 340B drug prescription program, however after discussion; the state realized that it is not the most beneficial method so they have decided to switch the strategy to include no entity can use a contract pharmacy. There would be a potential substantial financial loss to health centers across our regions if this were to take place. A large lobbying effort is taking place to change the language to say, “if there is a robust compliance program in place then it’s okay to have contracted pharmacies.”

**San Mateo Medical Center – Update**

San Mateo had an audit of their 2010 financials conducted in 2014, 4 years later. Findings stated that some quality measures, not all of them, were not allowed to be considered as quality metrics. They had to be included within payment. The metrics applied, where metrics were being billed through the claims system and paid by claims. Health centers were told they can pull those measures out as not being a quality metric. State flagged this process and looked at it as manipulating the system. San Mateo appealed and the first judge overruled. DHCS has the ability to overrule their own
judge, which is what DHCS had done. DHCS then looked at a 1990 single memo that went out from CMS. Using the letter as the basis, interpretation was anything except for pay for performance, related to cost control or utilization control were not allowed, therefore the entire amount was to be refunded. San Mateo is planning on filing a suit and the healthplans advocacy organization has written a letter to the senior leadership at DHCS to say let’s get together to talk further and better define what is/isn’t included.

**Regional Medical Directors meeting**
The Regional Medical Director meeting are now taking place. This includes meeting with all clinical leadership. There are 42 page packet of notes that will be sent out to the committee. This is a summary of all major activity, which will be covered.

### III. Old Business

There was no old business discussed.

### IV. New Business (Committee Members as Applicable)

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<tr>
<th>Consent Calendar Delegation Reports</th>
<th>Utilization Management / Care Coordination</th>
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<tr>
<td>MCUP3041 – TAR Review Process</td>
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<td>(Changes apply to attachment only; PHC TAR REQUIREMENTS. Attachment starts on page 34)</td>
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<tr>
<td>MCUP3049 – Pain Management Specialty Services</td>
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<td>MCUP3007 – Authorization of Ambulatory Procedures</td>
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<td>MCCD2012 – Chronic Kidney Disease</td>
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<td>MCUG3010 – Chiropractor Services</td>
<td>MCUG3010 – Chiropractor Services</td>
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<td>MCUP3105 – Coordination of Services for Members Requiring Long Term Care</td>
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<td>MCUP3128 – Cardiac Rehabilitation</td>
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<td>MCUP3130 – Osteopathic Manipulation Therapy</td>
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### Provider Relations

- MP CR 4B – Identification of HIV/AIDS Specialists
- MP CR 6 – Non-Physician Medical Practitioner
- MP CR 8 – Non-Physician Medical and Allied Health Practitioner Re-Credentialing Criteria
- MP CR 9 – Fair Hearing Process for Adverse Decisions
- MP CR 11 – Delegation of Credentialing and Re-credentialing Activities
- MP CR 17 - Standards for Contracted Primary Care Providers

#### 1. MCUP3126

Dr. Netherda presented on policy MCUP3126 – Fecal Microbiota Transplant. PHC now covers Fecal Microbiota Transplant. A new policy has been created that addresses the need for Fecal Microbiota Transplant for adults >18 years of age with Chronic Clostridium Difficile Infection (CDI) that have not responded to other treatments. This transplant comes in a few different forms; colonoscopy, g-tube, sigmoidoscopy, jejunal tube and even pill form.

Motion: Dr. Gwiazdowski
Second: Dr. Montenegro
Approved without changes

Motion Gwiazdowski
Second: Dr. Montenegro
Approved without changes

5/17/2017
### Committee Discussion

The question was asked if this was hard to diagnose and/or if this was common. It was said that this condition is easy to diagnose and is becoming more and more common. CDI typically happens to patients in the hospital or a skilled nursing facility that have been given strong antibiotics that kills most of the gut flora bacterial which then causes this organism to run throughout the gut and body. The success rate is about 80%.

### 2. MPQP1055

Jessica Thacher presented on Policy MPQP1055 – Provider Preventable Condition (PPC). This policy is coming through committee early to bring into Final Rule compliance.

Added related policy 700405 – Treatment of recoveries and overpayment to providers. This policy lays out the mechanism to recoup money for PPC’s. In addition, attachments were updated.

Potential PPC was updated to reflect if an incident or activity occurs or flagged within our encounter data, it gets reported to PHC or that PHC flags the incident in our own internal review. The overall final rule requirement is that we have a process in place to monitor our encounter data and flag potential PPC’s that are not necessarily reported to us. Under attachments, we removed attachment A which was a form which could be faxed to PHC then to DHCS to report a PPC which is going away, an online portal is now in place for reporting PPC’s. Attachment B was updated to just include ICD10 codes the plan uses to screen PPC’s, ICD9 codes were removed since they are no longer being used.

Clarified the provider requirement; Providers are required to report directly to DHCS (audit and investigation unit) and notify Partnership HealthPlan in the PQI inbox of a PPC and processed and is a Potential Quality Issue.

Provider reporting and PHC screening are the two ways we screen for PPC. Claims department worked closely with the data warehouse team to create a monthly report to screen for PPC’s. The report is then forwarded to the Quality Department monthly to review and flag for investigation of PPC. Clarified the role of payment recoupment that this lies in the Finance department along with record retention, which lied in the claims department previously. Quality will continue to hold on to records associated with a Potential Quality Issue.

Motion: Dr. Quon
Second: Dr. Murphy
Approved without changes

### 3. Hospital Quality Improvement Program

Jess Liu presented on the Hospital Quality Improvement Program. This was a high-level overview of the approved Hospital Quality Improvement Program measurement set for the 2017 – 2018 Measurement year.

Changes to the 16/17 measurement set, 5 measures were removed.

- Advanced Care Planning (ACP) due to high performance in this measure.
- Introducing Palliative Care measure.
- Vaginal Birth after Cesarean (VBAC), due to the extensive feedback from the hospitals we learned this is a complicated, expensive and risky option for our providers, especially with our smaller hospitals.
- VTE-5 - Venous Thromboembolism (VTE) Warfarin Therapy Discharge Instructions was removed due to being aligned with the joint commission, which has phased out this measure to align with CMS.
- STK-4 – Thrombolytic Therapy was removed due to being aligned with the joint commission, which has phased out this measure to align with CMS.
- Electronic Treatment Authorization Requests (E-TARS) due to topped out performance at 95.9% timely in reporting the E-TARS since 2015-2016.

Slight change to existing Health information exchange requirement; added for existing participants we will require lab result and medication data exchange in addition to admission data exchange.

The new measures being introduced are:
- C-Section rate for First time Mothers.
- Palliative Care Capacity.
- California Hospital Patient Safety Organization (CHPSO) Participation
- Quality Improvement Training Option

4. **Hospital Quality Improvement Program Evaluation**

Jess Liu presented on the Hospital Quality Improvement Program Evaluation for the 2015-2016 Measurement year.

10 participating hospitals and $12.6 million within the fiscal year was distributed.

10 measures covering the following domains within the measurement year were:
- Readmissions
- Advanced Care Planning
- Maternal and Perinatal Health
- Patient Safety
- Operations and Efficiency

The purpose of the hospital QIP is to help improve the health outcomes of our PHC members served by our contracted hospitals and to help participating hospitals assess the quality of care provided to their patients by serving as a guide to their existing quality improvement efforts.

In 5 of the measures, a moderate upwards trend shows improvement over the last 3 years.

The 3 District hospitals when compared to the 7 System Hospitals performed lower within the QIP scoring.

Within this measurement set, all hospitals were reporting on the same measurement set, even hospitals with fewer than 50 beds.

The average QIP score for large hospitals was 93%; the average QIP score for small hospitals was 61%.

Overall, there was improvement in 6 of the 8 existing measures. PHC is viewed as a partner in Quality Improvement within the participating hospitals; the Hospital QIP is being used as a driving tool to promote quality improvement.

5/17/2017
<table>
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<tr>
<th>5. V. Additional Business</th>
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<tr>
<td>Discussion Topic: Discharging Patients from a PCP practice: Ethical Issues and Policy Implications. Committee Discussion The discussion took place around what does a PCP do when they have a vaccine refuser in their practice. The consensus amongst the committee said, they would not remove the patient from their practice but will take the initiative to educate their patients about vaccinations, providing them with resources and offer a follow up visit after providing them with vaccination information and pamphlets.</td>
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Respectfully submitted by Sara Stamps, Quality Improvement Project Coordinator

Signature of Approval: ____________________________ Date: ____________________________

Robert Moore, MD, MPH, Chairman
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Committee: Internal Quality Improvement [IQI] Meeting
Date/Time: Tuesday, April 11, 2017 - 1:30PM - 3:30PM Board Room, 3rd Floor

Members Present:
Borsetto, Catherine, Grievance System Manager
Campbell, Betsy, MPH, Senior Health Educator
Cotter, James, MD, Associate Medical Director
Cuellar, Dina, Associate Director, Pharmacy Operations
French, Rachael, Manager of Quality Improvement
Hoover, Peggy, RN, Senior Director, Health Services
Kerlin, Mary, Senior Director of Provider Relations
Krohn, Robin, Care Coordination Team Manager
Kubota, Marshall, MD, Regional Medical Director
Leung, Stan, PharmD, Pharmacy Services Director
McAllister, Debra, RN, Director of Utilization Management

Netherda, Mark, MD, Regional Medical Director
Russell, Joan, Senior Manager of Provider Education
Santos, Rose, Manager, Quality and Patient Safety
Scuri, Lynn, Regional Director
Stamps, Sara, QI Project Coordinator
Steffen, Nancy, Northern Region Associate Director of QI, Analytics, PMO
Stevenson, Lauri, Manager of Clinical Quality and Patient Safety
Thacher, Jessica, MPH, Director, QI/PI
Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Villanueva, Angelica, Quality Manager, Health Services
Vovakes, Michael, MD, Northern Region Medical Director

Members Absent:
Bjork, Sonja, JD, Chief Operating Officer
Boyd-Anderson, Rebecca, Director of Care Coordination
Chancellor, Jennifer, Regional Manager
Frederickson, Paula, Senior Claims Director
Fronefield, Carly, Northern Region Health Services Director
Garcia-Hernandez, Margarita, Manager of Health Analytics
Gibboney, Elizabeth, MA, Chief Executive Officer

Guests:
Balderas, Janie, Enrollment Unit Supervisor
Biasotti, Danielle, Northern Region Pharmacy Operations Manager
Funnell, Stacia, Lead Grievance Coordinator

Jenkins, Shauncey, Member Services MSR Supervisor
Lopez, Eva, Pharmacy Operations Manager
Siblisky, Susanna, Northern Region Health Educator

Members Absent:
Ribordy, Jeff, MD, Regional Medical Director
Rosel, Melissa, Team Manager, Utilization Management

AGENDA ITEM | DISCUSSION / CONCLUSIONS | RECOMMENDATIONS / ACTION | TARGET DATE | DATE RESOLVED
--- | --- | --- | --- | ---
I. Call to Order Approval of Minutes | Dr. Cotter called the meeting to order at 1:32 p.m. Minutes from the 3/7/2017 IQI meeting were reviewed. | Remove Debbie McAllister from March 7, 2017 minutes, she was not in attendance. Motion: Dr. Marshall Kubota Second: Dina Cuellar Approved with changes. | 4/11/2017 |

II. Standing Agenda Items

1. Status of Open Action Items | There were no open action item(s) discussed. | No open action items. | |

2. QI Department Update | Rachael French gave the HEDIS update. The HEDIS team has had tremendous success in the medical record project so far. There are three major areas in determining whether HEDIS medical record procurement and review is on track: Are we retrieving records timely and are the records of high quality | | 4/11/2017 |
allowing our nurses to review and extract the necessary data?
  o As of April 11, 2017 the medical records collection is 80% complete.
  • Are we extracting and over reading our medical records timely?
    o 81% of the medical records retrieved have been extracted and over read.
  • Is the data being abstracted accurately?
    o We outsource our abstraction with a team of nurses, we also hire a team of nurses in-house to ensure there are many levels of oversight. In total we are at a 98% accuracy rate across the project

When there is a grey area that both the vendor and Partnership is struggling with, we submit the scenario directly to NCQA and request clarification.

A major milestone was met when we submitted our convenience sample to NCQA. This is a microscopic version of our large medical record review validation audit. We received a passing score of 100% compliant with NCQA measure specifications.
Jessica Thacher gave the Quality update.

**Partnership Improvement Academy:**

**ADVANCE 2017-18**

- This year’s cohort began on March 30th, with 13 practice teams participating: Fairchild Medical Clinic; Marin Community Clinics; NorthBay Healthcare; River Bend Medical Associates; Santa Rosa Community Health Centers; Shingletown Medical Center; Solano County Family Health Services; Sonoma County Indian Health Project; Humboldt Community Healthcare District; Trinity Health Services; and West County Medical Centers.

- Each team will focus on one of four HEDIS measures (cervical cancer screening, blood pressure management, childhood immunizations, and managing patients on persistent medications). The program will provide monthly learning sessions and participants will check-in weekly to receive coaching and mentoring from a PHC staff.

**Offering and Honoring Choices:**

- May 1-5th, PHC will be celebrating National Healthcare Decision week. This is to promote healthcare planning and to encourage PHC staff to complete an advance care directive.

**Advance Access Collaborative:**

- The Advance Access Collaborative had just wrapped up. Three clinics achieved same day access. One clinic got their wait time down to zero. Another is very close to getting it to zero and two other clinics are still working towards their goal.
**EyePACS Update:**
- MOUs have been developed for the new clinics and for those continuing into a second year of the program. First year clinics will be expected to meet a screening volume of 9 screens per month. Second year clinics will continue to submit screening volume data but the new focus will be achieving an improved screening rate.
- A webinar is scheduled in June to review the process for providers using EyePACS to claim reimbursement for this service. This is part of the project’s strategic goal to promote financial sustainability of the EyePACS model of care for PHC providers.

**HEDIS Score Improvement**
- For the strategic planning process, we have spoken with seven high-performing Medicaid plans (most are also NCQA accredited). These discussions have been valuable in learning about best practices among them.
- At the March 9th HEDIS Score Improvement team meeting, there was engaging discussion about the common themes from interviewing 15 primary care practices and two community clinic consortia. The discussion centered mainly on practice feedback regarding eReports data and member contact information. The group discussed why these are challenging from the practice perspective and possible ways to improve on the quality, format, and frequency of eReports data and clarifying how practices can address discrepancies in member contact information provided by PHC.
- A strategic planning leadership visioning meeting is planned for April 3rd to present in more depth the best practices learned for the health plan interviews.
- A number of HEDIS Improvement PDSAs continue. Below are a few highlights:
  - In partnership with Shasta County Public Health (SCPH), PHC co-promoted an immunization clinic (the first of three planned) on 2/16 in conjunction with PreTeen Vaccine Week. Adolescents due for HEDIS-designated immunizations were targeted in Member Services’ outreach and offered a readily accessible clinic and member incentive. In total, over 30 members presented and 27 members completed the immunizations necessary to receive a $25 gift card. Although not a large volume, this was triple the typical turnout SCPH sees on average and presented a great member engagement opportunity for PHC.
  - PHC launched the Birthday Club pilot on 3/1 with Churn Creek Healthcare in Redding. This pilot is a PDSA focused on improving the rate of Well Child Visits for 3-6 year olds (W34). Members due for a Well Child Visit receive a Birthday Club invitation corresponding with their birthday month from now through the end of May. If members respond to the invitation by...
scheduling and completing their Well Child Visit in their birthday month, they receive a $25 gift card.

### III. Old Business

There was no old business discussed.

### IV. New Business (Committee Members as Applicable)

| Consent Calendar Delegation Reports | Utilization Management / Care Coordination | Motion: Debra McAllister  
Second: Peggy Hoover | 4/11/2017 |
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<tr>
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<tr>
<td>MCUP3047 – Tuberculosis Related Treatment</td>
<td>MPUP3078 – Second Medical Options</td>
<td>MPUP3006 – Appropriate Service and Coverage</td>
<td>MCUP3115 – Community Based Adult Services</td>
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<tr>
<td>MCUP3057 – Provider Appeals of Health Services Administrative Denials</td>
<td>MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device Pump (attachment A)</td>
<td>MCUP3028 – Mental Health Services</td>
<td>MCUP3127 – Dispute Resolution Between PHC and MHP’s in Delivery of Behavioral Health Services (attachments a-f)</td>
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<tr>
<td>MCUP3124 – Referral to Specialists</td>
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<td>MCUG3024 – Inpatient Utilization Management</td>
</tr>
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<td>MCUP3127 – Dispute Resolution Between PHC and MHP’s in Delivery of Behavioral Health Services (attachments a-f)</td>
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<td>MCUP3124 – Referral to Specialists</td>
<td>MCUG3024 – Inpatient Utilization Management</td>
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**MP CR1**

Mary Kerlin pulled this policy to be the first item of discussion. Policy MP CR1 - Credentials Committee, presented by Mary Kerlin. This policy goes annually to the board as a board resolution because the board is delegating the authority for approval to the credentialing committee. The redlines in the policy are to align with NCQA standards. The board has delegated to the Credentials Committee, which is made up of physicians, the authority to approve, suggest corrective actions, or not approve someone’s credentials from our provider network.

**Recommended Changes:**

- Redline Healthy Kids.
- Throughout the policy it says, “Credentials Committee” and “Credentialing Committee” the policy will be gone through to change all the verbiage to state “Credentials Committee”.

**Motion:** Debra McAllister  
Second: Peggy Hoover  
**Approved with changes**

**MPQP1006**

Rachael French presented on Clinical Practice Guidelines. This policy outlines the process on which PHC manages Clinical Practice Guidelines. The proposed NCQA Standards and Guidelines changes in 2018 propose eliminating the Clinical Practice Guideline Standards. PHC held off on updating the policy relative the 2017 NCQA

**Motion:** Debbie McAllister  
Second: Peggy Hoover  
**Approved with changes**

26 of 81
changes until 2018 Standards are released. Most changes were minor and/ or grammatical.

**Recommended Changes:** In section III subset a, the word HealthPlan has a lowercase “P”, that will be replaced by a capital “P”.

### 3. MCQG1005
Dr. Cotter presented on policy MCQG1005 - Adult Preventative Health Guidelines. Minor formatting and reference changes in the actual policy. Attachment A, Adult Preventative Health Screening Guidelines has a few changes. Aspirin for men and women, ages 50-70, women were added and the ages were slightly changed. The second change is, the colorectal screening which was added that the F.I.T. DNA test will be done every two years. Lung cancer screening added, in addition, a person that has been smoking for 30 years or has quit in the last 15 years are eligible for this test. TB screening, changed the bitage to read, Patients who emigrated “from” other places instead of, persons who immigrated to us.

**Recommended Changes:**
- Attachment 3, change the title with the name of Quantiferon to IGRA.
- Redline Healthy Kids.
- Change the F.I.T. guidelines to state the same as the current HEDIS specifications, from every three years, to every two years.

Motion: Peggy Hoover  
Second: Shauncey Jenkins  
Approved with changes

### 4. MCQP1047
Dr. Cotter presented on policy MCQP1047 - Advance Directives. The changes are minor, mostly formatting.

**Recommended Changes:** remove section VI, b. It is the same as section VI, a.

Motion: Peggy Hoover  
Second: Dina Cuellar  
Approved with changes

### 5. MCUP3125
Dr. Marshall Kubota presented on policy MCUP3125 - Gender Dysphoria/ Surgical Treatment. The title was changed from Gender Identity Disorder/ Surgical Treatment has been changed to Gender Dysphoria/ Surgical Treatment. The changes in section VI, c, reference the APL issued by DHCS. This covers the difference between reconstructive surgery and cosmetic surgery and which are covered benefits.

**Recommended Changes:** Add Rhinoplasty to section VI, 6 as a non-covered benefit.

Motion: Peggy Hoover  
Second: Debra McAllister  
Approved with changes

### 6. MPXG5008
Dr. Cotter presented on policy MPXG5008 – Clinical Practice Guideline: Pain Management, Chronic pain Management, and Safe Opioid Prescribing. The first change is, Substance “Abuse” has been changed to, Substance “Use”. The second change dropping our minimum standard for long acting opioids to 90 milligrams instead of 120 milligrams. 90 milligrams is consistent with the CDC guidelines.

**Recommended Changes:** Add the CDC guideline language from 2016 into the policy

Motion: Shauncey Jenkins  
Second: Marshall Kubota  
Approved with changes

### 7. MPXG5009
Peggy Hoover presented on policy MPXG5009 - Lactation Clinical Practice Guideline. Minor formatting and website link updates.

**Recommended Changes:** Section VI remove Lactation Guideline.

Motion: Peggy Hoover  
Second: Catherine Borsetto  
Approved with changes

### 8. MCQP1025
Lauri Stevenson presented on policy MCQP1025 - Behavioral Health/ Substance Abuse Facility Site Review. This policy was pulled from discussion for further review around delegation requirements.

Policy deferred to May.
<table>
<thead>
<tr>
<th></th>
<th>Policy Code</th>
<th>Presenter</th>
<th>Policy Description</th>
<th>Recommended Changes</th>
<th>Motion</th>
<th>Second</th>
<th>Approved Status</th>
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| 9. | MCCP2007     | Katherine Barresi | Presented on policy MCCP2007 - Complex Case Management. Minor changes discussed. Could have been placed on Consent. | Motion: Peggy Hoover  
Second: Rose Santos  
Approved without changes | 4/11/2017 |
| 10. | MPCP2017     | Katherine Barresi | Presented on policy MPCP2017 - Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines. Minor changes discussed. Could have been placed on consent. | Motion: Debra McAllister  
Second: Rose Santos  
Approved without changes | 4/11/2017 |
| 11. | MPUG3025     | Debbie McAllister | Presented on policy MPUG3025 - Insulin Infusion Pump Guidelines. Streamlined the insulin infusion pumps, how they are ordered and what criteria is to be followed and the continuous glucose monitoring (CGM) is for type 1 diabetes and will be reviewed on a case by case basis. | Motion: Peggy Hoover  
Second: Joan Russell  
Approved without changes | 4/11/2017 |
| 12. | MPUP3048     | Debbie McAllister | Presented on policy MPUP3048 - Dental Services. Healthy Kids was removed and the dates were updated. Could have been placed on consent. | Motion: Shauncey Jenkins  
Second: Betsy Campbell  
Approved without changes | 4/11/2017 |
| 13. | MPUD3001     | Debbie McAllister | Presented on policy MPUD3001 - Utilization Program Management Description. Removed all the Healthy Kids Information, added job descriptions for the 15 new jobs since the last time this policy was updated for both Southern and Northern Regions. Incorporated changes per the new APL, from working days, to Business days. A change from 180 days for the initial determination of an appeal to 60 calendar days. | Motion: Dina Cuellar  
Second: Peggy Hoover  
Approved with changes | 4/11/2017 |
| 14. | MCUP3037     | Debbie McAllister | Presented on policy MCUP3037 - Appeals/ Expedited Appeals of UM Decisions for Medical Necessity Determination. Per the APL, language was added to reflect types of grievances such as, member rights and cultural and linguistic needs can be filed by almost anyone, they can request to look at their chart or have someone else look at their charts. The provider appeal information was updated to state the plan will provide written notice to the member that is written and postmarked within 5 calendar days. | Motion: Dina Cuellar  
Second: Peggy Hoover  
Approved with changes | 4/11/2017 |
| 15. | MCUP3041     | Debbie McAllister | Presented on policy MCUP3041 – TAR Review Process. Changes any verbiage that stated working days to business days. In section VI. 11, a, non-contracting hospital review was removed. In section VI. 11, 2 added, clinical review should be sent to PHC’s nurse coordinator. On attachment A, Gender Dysphoria was added to state that a TAR is required for all treatments and procedures related to gender Dysphoria. | Motion: Dr. Netherda  
Second: Shauncey Jenkins  
Approved with changes | 4/11/2017 |
| 16. | MCUG3007     | Debbie McAllister | Presented on policy MCUG 3007-Authorization of Ambulatory Procedures and Services. Section VI. Subset 6, QUAC committee was removed and replaced with the Chief Medical Officer or Physician Designee. | Motion: Shauncey Jenkins  
Second: Dr. Netherda  
Approved without changes | 4/11/2017 |
| 17. | MPRP4001     | Dina Cuellar  | Presented on policy MPRP4001 - Pharmacy & Therapeutics (P&T) Committee. Educational programs for providers was added under section VI. Subset | | 4/11/2017 |
10. Education programs such as academic detailing, annual surveys in regards to the pharmacy network was within the policy.

**Recommended Changes:** Clarify who will be able to approve this policy. Add PHC in front of Associate Medical Director.

Motion: Debbie McAllister  
Second: Peggy Hoover  
Approved with changes

| 18. MPRP4020 | Dina Cuellar presented on policy MPRP4020 - Restricted Status for Members Receiving Prescriptions Medications.  
Policy CMP09 is now linked to this policy and Grievance and Appeals and Compliance have been added to the impacted departments. MC-609 Form has been added as a related attachment. Pharmacy will be filling out these forms and submitting them to the RAC inbox. Section K highlights the process set forth by the Compliance department to utilize submitting to the RAC inbox. Section M, states notification to members in regards to a change in pharmacy, it states a beneficiary has the rights to change the pharmacy used. | Motion: Shauncey Jenkins  
Second: Rose Santos  
Approve without changes |

| 19. MPRP4034 | Dina Cuellar presented on policy MPRP4034 - Pharmaceutical Patient Safety.  
Added Drug Utilization Review (DUR) Summary, example in the attachments. In section VI. DUR was added to clarify Walgreen’s and MedImpacts roles, summaries and when they will present quarterly data.  
**Recommended Changes:** DUR needs to be spelled out as Drug Utilization Review and put DUR in parenthesis. | Motion: Peggy Hoover  
Second: Shauncey Jenkins  
Approved without changes |

CMP09 - Fraud, Waste and Abuse was added as a related policy. Pharmacy, Finance, and Compliance were added as impacted departments. The purpose has been expanded upon. Section VI. Subset d added language to state; “Reporting: Pharmacy will conduct quarterly review of overpayments by means of Explanation of Audit (EOA) summaries, and present in quarterly Pharmacy Operations Report for evaluation and recommendations to assure accuracy. Annual reporting will be in conjunction with the Plan’s financial reporting to DHCS” | Motion: Betsy Campbell  
Second: Angelica Villanueva  
Approved without changes |

| 21. MPRP4059 | Dina Cuellar presented on policy MPRP4059 - Formulary Utilization Management for Managing Pain Safely Program.  
Added Related policies, MPRP4020 and MPXG5008. Attachments were updated to include Quantity Limit restriction table, External TAR Process for Opioid Requests, Provider Information Form for Medication Prior Authorization and Table for Short-Acting Formulary Changes. The language has been updated surrounding prescribers and beneficiaries in regards to denial or approval of short acting opioid medications. | Motion: Shauncey Jenkins  
Second: Debra McAllister  
Approved without changes |

| 22. MPRP4062 | Dina Cuellar presented on policy MPRP4062 - Drug Wastage Program.  
Policy CMP09 was added as a related policy. Compliance was added as an impacted department. Chemotherapy/ Biological Drug List was added as an attachment. The “Purpose” of the policy was updated to better define the process of billing discarded drugs that fall within the guidelines of Healthcare, Fraud, Waste | Motion: Debra McAllister  
Second: Betsy Campbell |

4/11/2017
and Abuse and the Plan’s reporting of potential findings.  

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<td><strong>23. MPRP4063</strong></td>
<td>Dina Cuellar presented on policy MPRP4063 - Designated Specialty Drugs. Provider notification and the timeliness of reviews were updated to match the requirements from DHCS. Impacted departments and the attachments were updated.</td>
<td>Approved without changes</td>
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| **24. MCRO4018** | Dina Cuellar presented on policy MCRO4018 - Pharmacy TAR Procedure. MPRP4064 was added to related policies, impacted departments was updated to show Pharmacy, Member Services, and Grievance and Appeals. Section VI., c, was updated to state how a TAR can be submitted. Section VI. G, 2 was updated to state that a PHC Clinical Pharmacist and Pharmacy Director were the only ones that could accept a modified TAR. Section VI. G, 4 was removed due to the new final rule. Section VI., k, updated verbiage states that a TAR cannot be pended, it has to be approved, modified or denied. | Motion: Peggy Hoover  
Second: Dr. Kubota  
Approved without changes. | 4/11/2017 |

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| **Cultural and Linguistic Workplan** | Betsy Campbell presented on the Cultural and Linguistic Workplan. The workplan is due to the state next month on the 30th. Some Key projects that are being worked on are:  
- Video Remote Interpreting Pilot Program. Contracts have been signed. We have 3 participants in the North and 3 in the South. Training was held on March 27th & 28th for IT to set up the tablets and install the software.  
- The Postpartum Disparity Project, which will focus on improving postpartum care for African American Women in the South Eastern Region from 59.9% to 60.98% by December 31, 2017. |   | 4/11/2017 |

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| **Health Education and Cultural and Linguistic Group Needs Assessment (GNA)** | Betsy Campbell presented on the Health Education and Cultural and Linguistic Group Needs Assessment. Every 5 years the Cultural and Linguistic Health GNA must be complete per DHCS. The goal of the GNA is to use information to improve the Health outcomes of our members by evaluating their health risks. The demographics show the difference between our members. The Key take away is:  
- The majority of our members, report that English is the majority language.  
- 75% of our members do not need an interpreter when corresponding with their PCP.  
- 74% of our members that do need interpreters know that they are available at no cost to them.  
- 35% of our members do want to use family or friends as an interpreter but about 18% of them their doctors, ask them to bring a family member.  
- 73% of our members reported their health beliefs do not go against their providers. Top concerns are:  
  - There are not enough doctors or appointment times.  
  - Members are more likely to want to speak Spanish with their PCP or have the office staff be able to speak in their language.  
  - Unit 1 (Lake, Marin, Mendocino and Sonoma Counties) members were more likely to feel their health beliefs went against their PCP. |   | 4/11/2017 |
- Unit 2 (Napa, Solano and Yolo Counties) wanted more help from PHC in terms of filling out forms and more information.
- Unit 3 (Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou and Trinity Counties) members stated they were more likely to not receive information from PHC regarding vaccinations and screenings.

| Grievance Report – Quarter 1 | Catherine Borsetto presented on the Quarter 1 Grievance Report. 400 grievances have been filed in the first quarter 2017; this is up by 150, from this time last year. 200 complaints were filed, the top 5 complaints in the area of inappropriate provider care are:
- Members not receiving pain medications
- Upset about their treatment plan
- Wrong test results given
- The prescriber sent the wrong prescription to the pharmacy
- PCP failed to refill the prescriptions
The top 5 in ancillary care are:
- DME delay & the quality of advice received
- Dissatisfaction with ER treatment
- Incorrect chart notes
- Hospital and specialist care. Denial from an oncologist
- ER provided poor treatment/ member claiming medication was administered without her permission.
25 complaints related to PCP, most often this relates to long appointment wait times or cancellation without notice.
15 for access to specialist/ no referral made.
In terms of denials, 132 most are medication denials, some RAF denials, 7 power wheelchair denials.
- 43 complaints were overturned/ modified.
- 56 upheld
- 8 withdrawn
- 13 currently pending in our system
64 state hearings, all were upheld in quarter 1 | 4/11/2017 |

| TAR Timeliness | Eva Lopez presented on TAR Timeliness for the Northern and Southern Regions for September 2017 through February 2017. Timeliness has been maintained at 96%. | 4/11/2017 |

| Inter-rater Reviews | Eva Lopez presented on the Pharmacy Inter-rater Reviews for July 27, 2016-August 30, 2016. 144 samples were pulled an accuracy rate of 97.87% was maintained during this time. | 4/11/2017 |

| Pharmacy Call Auditing | Eva Lopez presented on the Northern and Southern Region Call Accuracy for September 2016 – February 2017. The Northern region maintained a 98% accuracy phone call rate from September to January. From January to February this dropped to 97% accuracy during this audit time. The Southern region maintained a 97.3% accuracy phone call rate during this audit time. | 4/11/2017 |
Quality Improvement Programs (QIPs)

Primary Care Provider Quality Improvement Program (PCP QIP)
- The 2018 PCP QIP Measurement Set was approved by the Physician Advisory Committee. We are developing the accompanying measure specifications document.
- We are finalizing the eReports Business Requirements Document for the abbreviated 2017 measurement year. The next release of eReports will include a number of user enhancements requested by the provider network over the past year.
- Since December 2016, the Northern Region QIP team has conducted 28 in-person QIP trainings with providers. As of the first week of March, we have visited every Northern Region county to provide hands-on training in the program.

Long-Term Care Quality Improvement Program (LTC QIP)
- The data submissions from participating LTCs are complete for 2016. Point earnings ranged from 25 to 100 points for the 50 participating sites. Six facilities earned 100% of potential points across all ten measures.
- 2016 program payments will be distributed at the end of April 2017.

Perinatal Quality Improvement Program (Perinatal QIP)
- We had our first Perinatal QIP Technical Workgroup meeting in March where we discussed the draft program proposal and measurement set.
- The program will launch in January 2018. To inform our implementation, we will pilot the program from June to August 2017 with two large perinatal providers.

Hospital Quality Improvement Program (Hospital QIP)
- We will send mid-year reports to hospitals by March 31. These reports will include 2016-17 readmissions data and participation status for two collaboratives: California Maternal Quality Care Collaborative (CMQCC) and California Perinatal Quality Care Collaborative (CPQCC).

Annual Monitoring for Patients on Persistent Medications (MPM) – Staff Incentive Program
- Last October, a Strategic Use of Reserves project was approved targeting the front line staff of provider sites working on improving their MPM rates. Interested providers enrolled and were provided outreach lists for members in need of lab screenings that would make them numerator compliant for the HEDIS measure. Provider offices were eligible for a financial incentive if they met one of the following criteria: outstanding performance (meeting the 90th percentile target), outstanding improvement (showing 30% relative improvement from baseline), or consistent and active engagement in the program, including submission of supplemental lab data to PHC. The payment was higher for those sites that met performance targets or demonstrated improvement.
- Eighty-eight provider sites enrolled in the program. 52% (n=46) of enrolled providers earned one of the three types of incentives. The total payout for this program is just over $75,000, ranging from $500 to $6,300 per site.
Providers receiving an incentive were asked for feedback on the program and their plans on using the incentives for staff rewards before payouts were made. According to survey results, the two biggest challenges mentioned by providers were patient compliance with lab orders and working with a new data set on a shortened time period. Survey participants all said the incentive program lead to at least the same level of motivation (42%) or more motivation (58%) as the standard QIP. Many of the awardees are planning to reward staff with gift cards, while others will offer a staff bonus or use the funds for an employee celebration or outing. Other feedback included thinking about this type of program for other hard to reach measures, more sharing of best practices based on the learnings of this program, or requiring some portion of all QIP funds to be distributed to staff instead of the organization at large.

PHC is evaluating the impact of this program on our overall 2017 (measurement year 2016) MPM HEDIS scores. We want to understand whether sites that participated in the program have higher MPM scores than they would have had in the program’s absence. Thus far, we have determined that the supplemental data has limited impact on our MPM HEDIS scores over traditional encounter data. This means that most of the lab reports sent to us by providers eventually came to PHC via encounter data submission – good sign for our encounter data quality and completeness!

Quality Measurement

HEDIS
- As of March 29, we have collected 5,963 out of 15,625 records and completed over 4,000 medical record reviews. Retrieval is complete for the three largest sites: Open Door Community Health Centers, Shasta Community Health Center, and Santa Rosa Community Health Centers. At this time, 38% of the medical records requested have been retrieved and we are on track to complete the medical record retrieval and review project by the May 15th NCQA audit deadline.
- Upcoming HEDIS 2017 milestones:
  - On March 29, we submitted a convenience sample of numerator-positive medical records to our auditor. This is an opportunity to get early feedback on PHC’s interpretation of medical charts relative to NCQA measure specifications.
  - In mid-April, we will submit our preliminary abstractor accuracy report to our auditor, which demonstrates inter-rater reliability across the project’s nurse abstractors.

Partnership Quality Dashboard (PQD)
- Work continues in partnership with IT and Analytics on Module 1 of the PQD. This module is focused on building the PCP QIP non-clinical measures into the tool. The design phase is scheduled to end in early April. Data validation and user acceptability testing will follow. The IT team is working in parallel on Module 2. This module includes user security and log-in specifications. The goal is to integrate log-ins for eReports and PQD so the process is single sign-on for our primary care providers.

Performance Improvement Academy

ABCs of QI
- PHC hosted an ABCs of Quality Improvement in Santa Rosa on March 2. We had 54 attendees from 21 different organizations. Evaluations were extremely favorable with 98% reporting
satisfaction with the course and 100% reporting that they would recommend the course to a colleague.

- There will be an ABCs of QI offered in Yreka on May 22 in collaboration with the Healthcare Alliance of Northern California (HANC) and the North Coast Clinics Network (NCCN). Another training will be held in American Canyon in the fall of 2017 (date TBD).

**ADVANCE 2017-18**

- This year’s cohort began on March 30th, with 13 practice teams participating: Fairchild Medical Clinic; Marin Community Clinics; NorthBay Healthcare; River Bend Medical Associates; Santa Rosa Community Health Centers; Shingletown Medical Center; Solano County Family Health Services; Sonoma County Indian Health Project; So. Humboldt Community Healthcare District; So. Trinity Health Services; and West County Medical Centers.

- Each team will focus on one of four HEDIS measures (cervical cancer screening, blood pressure management, childhood immunizations, and managing patients on persistent medications). The program will provide monthly learning sessions and participants will check-in weekly to receive coaching and mentoring from a PHC staff member.

**Coaching Development Program**

- Through the assistance of a grant from the California Improvement Network, PHC developed a more formal program to develop performance improvement coaches at PHC. We have historically found this skill set difficult to hire and are excited about this opportunity to build the competencies within existing QI staff.

- Five PHC QI staff are currently engaged in the program and are immediately applying learnings to support practices participating in the ADVANCE program.

**Improvement Initiatives**

**Offering & Honoring Choices (Palliative Care and Advance Care Planning)**

- In light of the state extending the PC benefit start date from April 2017 to July 2018, PHC’s Board of Directors has approved early implementation of the benefit. The palliative care benefit implementation workgroup held their initial meeting on March 9, 2017. Sub-workgroups have been established to develop the provider/program criteria and the billing/payment methodology. Implementation of the benefit is expected July 1, 2017.

- There is a week-long internal PHC Advance Care Planning event scheduled for May 1-5. The event will promote advance care planning and completion of an Advance Directive among PHC staff.

- Externally, PHC sponsored three advance care planning (ACP) trainings in March. The Santa Rosa and Eureka trainings exceeded the registration capacity of 40 individuals, and the Redding training was near capacity. The external trainings were designed for providers, nurses, social workers, and other primary care practice staff who discuss advance care planning with patients.

**Advanced Access Collaborative**

- To date, three of the six clinics participating in the collaborative have achieved the “gold standard” in access, which is, “To offer a patient an appointment TODAY for any problem (urgent or routine) or any reason with their PCP or a teammate in the absence of the PCP.” Although the remaining three teams have not yet met the gold standard they have all shown
marked improvement. On April 4 and 5, the collaborative participants will celebrate their successes at the final in-person learning session in American Canyon. The program evaluation is expected to be complete by June 2017.

**Diabetic Retinopathy Screening (DRS) Program – EyePACS**

- The four clinics participating in the DRS program are screening successfully. February 2017 data shows that providers participating in the project have increased PHC-member eye exam rates by 30.7%, on average, from baseline. As of February, the project has achieved 92% of its annual screening target (target is 540 screens by May 2017). Baechtel Creek Clinic started sharing its camera with Little Lake Health Center (a Mendocino Community Health Centers site in Willits) in March. This will help Baechtel Creek meet the monthly utilization target of 9 screens per month and support the screening efforts of Mendocino Community Health Centers.
- PHC program staff are working to reallocate two additional cameras (returned by former program participants) in the Northern Region. Mountain Valleys Health Centers and Fairchild Medical Clinic both submitted applications for the open cameras and were recently accepted for camera placement. Both of these providers have outlined plans to share the camera with multiple sites within their organizations; this will provide improved access to our very rural diabetic members in the NE region.
- MOUs have been developed for the new clinics and for those continuing into a second year of the program. First year clinics will be expected to meet a screening volume of 9 screens per month. Second year clinics will continue to submit screening volume data but the new focus will be achieving an improved screening rate.
- A webinar is scheduled in June to review the process for providers using EyePACS to claim reimbursement for this service. This is part of the project’s strategic goal to promote financial sustainability of the EyePACS model of care for PHC providers.

**Social Determinants of Health**

- Over the last two months, the Social Determinants of Health (SDH) team has conducted a series of informational interviews with select health centers, community coalitions, and Medicaid health plans. Information gathered from these interviews will be used to guide the SDH strategic plan, which will be finalized by June 2017.

**Managing Pain Safely (MPS)**

- The MPS team is continuing to define the MPS project’s sustainability plan. Moving forward, the group will monitor three measures to determine sustainability.
  - The number of members on opioids (all doses) P100MPM;
  - The total morphine equivalent daily dose (MED) P100MPM; and
  - The number of members on opioids on an unsafe dose (>120MED) P100MPM.

- The following represents the MPS data from January 2014-February 2017.
  - Total Prescriptions, P100MPM: 69% decrease
  - Number of Members on Opioids on an Unsafe dose (>120MED): 76% decrease
  - New Opioid Prescriptions, P100MPM: 48% decrease (calculated from Feb. 2014 due to expansion)
  - Total MEDs, P100MPM: 83% decrease
HEDIS Score Improvement

- For the strategic planning process, we have spoken with seven high-performing Medicaid plans (most are also NCQA accredited). These discussions have been valuable in learning about best practices among them.
- At the March 9th HEDIS Score Improvement team meeting, there was engaging discussion about the common themes from interviewing 15 primary care practices and two community clinic consortia. The discussion centered mainly on practice feedback regarding eReports data and member contact information. The group discussed why these are challenging from the practice perspective and possible ways to improve on the quality, format, and frequency of eReports data and clarifying how practices can address discrepancies in member contact information provided by PHC.
- A strategic planning leadership visioning meeting is planned for April 3rd to present in more depth the best practices learned for the health plan interviews.
- A number of HEDIS Improvement PDSAs continue. Below are a few highlights:
  - In partnership with Shasta County Public Health (SCPH), PHC co-promoted an immunization clinic (the first of three planned) on 2/16 in conjunction with PreTeen Vaccine Week. Adolescents due for HEDIS-designated immunizations were targeted in Member Services’ outreach and offered a readily accessible clinic and member incentive. In total, over 30 members presented and 27 members completed the immunizations necessary to receive a $25 gift card. Although not a large volume, this was triple the typical turnout SCPH sees on average and presented a great member engagement opportunity for PHC.
  - PHC launched the Birthday Club pilot on 3/1 with Churn Creek Healthcare in Redding. This pilot is a PDSA focused on improving the rate of Well Child Visits for 3-6 year olds (W34). Members due for a Well Child Visit receive a Birthday Club invitation corresponding with their birthday month from now through the end of May. If members respond to the invitation by scheduling and completing their Well Child Visit in their birthday month, they receive a $25 gift card.

Patient Safety

Site Review

- PHC conducted seven Facility Site Reviews and seven Medical Record Reviews in March. There are three outstanding Corrective Action Plans (CAPs) from these reviews.
- The use of the new FSR electronic tool including the use of the Tablet during on-site review was piloted this month and resulted in some findings that required revision and enhancement.

Potential Quality Issues (PQI)

- The number of PQI referrals have decreased for both Northern and Southern regions since the implementation of the new Member Services/Complaints, Grievance and Appeals PQI Referral process. A total of 86 PQI referrals were received from February 1 through March 28, 2017 (46 in the South and 40 in the North).
- The second Northern Region Peer Review case was presented at the March Peer Review Committee meeting.
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Chronic Kidney Disease (CKD) Program Description

MCCD2012

Original Date: 01/20/2014
Revision Date(s): 02/17/2016, 05/17/2017
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Partnership HealthPlan of California

Program Description and Purpose
The incidence of chronic kidney disease (CKD) in the US is growing at an alarming rate as supported by corresponding increases in the prevalence of type 2 diabetes and hypertension, two critical factors in CKD. Studies indicate that significant reductions in disease complications and hospitalization costs can be achieved by optimizing several key indices of the quality of care for CKD patients, including: earlier detection of CKD, interventions to delay disease progression, prevention of uremic complications, modification of co-morbidity, and preparation for renal replacement therapy (RRT). Studies stress the need for earlier detection of CKD and indicate that even among high-risk groups, kidney disease (proteinuria >1+, serum creatinine >1.5 mg/dl) is infrequently documented in hospitalized patients. Drug therapy with angiotensin-converting enzyme (ACE) inhibitors, control of blood pressure and blood glucose levels, and restriction of dietary protein intake can retard the progression of kidney disease.

The complications of CKD such as anemia, renal osteodystrophy, and acidosis should be diagnosed early and treated aggressively. Anemia is extremely common in CKD patients and is associated with ventricular hypertrophy, exacerbation of angina, reductions in aerobic capacity, decreased cognition, and sexual dysfunction. While dialysis-associated anemia is well recognized, the vast majority (77%) of CKD patients do not receive an erythropoiesis stimulating agents (ESAs) such as Epogen / Procrit / Aranesp™ for the treatment of anemia, although most are anemic before the start of RRT. Even when therapy is initiated, it is often at a level insufficient to correct the anemia. Likewise, the majority of patients who start dialysis have low serum albumin levels, suggesting malnutrition.

In addition to the above, the co-morbid conditions that accompany CKD such as diabetes, hypertension, cardiac and vascular disease need timely diagnosis, effective prevention, if possible, and aggressive treatment. Finally, as the patient approaches the need for RRT, disease education, RRT modality selection, timely access placement, and timely initiation of dialysis ensure a seamless transition to RRT.

A comprehensive management program that monitors all key indices of quality of care reflects a safer and more efficacious approach to treating CKD and end-stage renal disease (ESRD) patients.

Knowledge is power and the educated patients are well prepared, should they need to start dialysis.

- 4x more likely to choose a home modality (patients are educated on all treatment options equally)
- 2x more likely to start with an ideal access in place (potentially reducing later hospitalizations)
- 2x more likely to begin dialysis in a facility (vs. an unplanned hospital start and all the complications of “crashing”)
Program Goals
The goals for the CKD Program are as follows:

- Provide benefit to the largest number of patients that can effectively be case managed with the resources given
- Help patients understand their condition, its implications, and how to take informed action to best manage their condition
- Reduce the complications of CKD
- Reduce the co-morbid conditions that accompany CKD
- Slow progression to renal replacement therapy (dialysis/ transplant)
- Ensure good Advance Care Planning for all participants prior to RRT
- Reduce the cost of initiation of dialysis
- Encourage early preparation by creation of access for dialysis treatment as clinically appropriate
- Encourage home treatment modalities i.e. Peritoneal dialysis
- Reduce inpatient admissions and or length of stay

Patient Selection
The CKD Program will focus on adult (>20) residents of Napa and Solano counties with primary insurance coverage of Partnership HealthPlan of California (PHC) Medi-Cal who meet the criteria for classification of CKD.

The target population for this program is those patients who have been determined to have Stage 3B, Stage 4, or Stage 5 kidney disease not yet on dialysis.

Patients already receiving dialysis will be excluded from this program but may receive necessary case management services under PHC’s Episodic or Complex Case Management programs as appropriate.

Using extracts from Amisys (PHC’s production system) that are refreshed daily or from other available resources, the membership will be screened for participation using the following data:

- Current Patient Age
- County of residence
- Line of business
- Estimated Glomerular Filtration Rate (eGFR)

Using the results of the estimated Glomerular Filtration Rate (eGFR), each patient will be categorized by stage of chronic kidney disease. The following table describes the stages of Chronic Kidney Disease.
Sources of New Patients
Any of the following may be used for ongoing enrollment of new patients in addition to obtaining refreshed data using the initial patient selection criteria:

- Provider suggested (if provider feels the patient is at risk for high cost that could be modified by being in the CKD program)
- Health plan recommended [by Utilization Management (UM) or Care Coordination staff]
- Recent High Cost (Internal Data)
- Predictive Modeling (Internal Data)
Criteria for Adding Patients

The number of patients in the CKD program optimally is dependent on:

1. The acuity of the patients
2. The number of staff providing services and
3. The skills of that staff

Using hours worked to know if the program should onboard more people, patients can be added when the number of hours related to direct patient care falls below 120hrs/mo per full time employee (FTE) the previous month. This translates to about 26-30 hours per week per FTE of direct patient contact work, including documentation and transportation to see patients. This allows for vacations, illness, meetings, trainings and other non-patient care responsibilities.

Criteria for Disenrollment

Patients are disenrolled from the CKD program in the following circumstances.

- Patient requests to be disenrolled from Care Management services
- Patient enrolls in another medical case management program
- 90 calendar days after patient initiates long term Renal Replacement Therapy i.e. dialysis or transplant
- Patient refuses to attend scheduled medical appointments
- The staff has been unable to locate the patient for >90 days
- Patient death
- Patient opens to intensive palliative care or hospice
- The patient exhibits inappropriate or threatening behavior toward staff, or is under the influence of illegal drugs or alcohol during patient visits, or exhibits repeated narcotic seeking behavior. The patient poses a safety or security risk to staff, other patients, or clinic property
- If after reasonable case management/disease management services have been implemented, the patient demonstrates continuing or repeated non-adherence with the physician/health care provider treatment plan

Patients who reach a lower acuity level (stable) patients are not disenrolled. They will continue to be contacted on an interim basis by phone by program staff.
Initial Intake Process
If a patient is identified as meeting Stage 3B, Stage 4, or Stage 5 kidney disease not yet on dialysis, PHC’s electronic data system will be used to identify demographic information (name, address, CIN#, county of residence, etc), and the identity of the assigned patient’s primary care provider (PCP).

The assigned (PCP) and/or Nephrologist will be contacted to introduce the Program, and the intent to outreach to the patient. The patient’s clinical status will be discussed along with any barriers to care identified by the PCP and/or Nephrologist. Following discussion with the PCP and/or Nephrologist, the patient will be contacted to establish rapport and to introduce the program with the intent to obtain the patient’s permission for enrollment.

Once permission is granted, the Program Manager will initiate an interview with the patient. The interview will include a review of medical history (from the patient’s perspective) and standard forms will be used to determine the patient’s health status and degree of motivation for active participation toward improvement in self-management skills. The following tools will be used:

- PHC Health Risk Assessment
- Patient Activation Measure (PAM)
- Patient Health Questionnaire (PHQ 2 and 9 as appropriate)

During the initial interview process, the Program Manager will initiate conversation regarding Advance Care Planning. The goal of this conversation is to define the patient’s values and goals and initiate Physician Orders for Life-Sustaining Treatment (POLST) or an Advanced Directive if desired by the patient. If the patient is not willing to engage in this type of discussion during the initial interview process, the Program Manager will continue to encourage the discussion intermittently during the entire period of enrollment.

Based upon the patient’s responses to the interview process the Program Manager will work with the patient, his/her PCP and or Nephrologist to develop the patient’s individualized care plan. The framework of the Care Plan includes the following four domains:

**Problem:** What is the modifiable risk?

**Assets:** What strengths does the patient bring?

**Solutions:** How will we know an adequate solution is in place?

**Tasks:** What are we going to do? Short term and long term goals.

The focus of the Care Plan includes:

- Ensuring access to care/services
- Optimizing Physical Health
- Optimizing Psychosocial Health
- Optimizing Self-Management
**Interventions**

Care management methodology will include setting an agenda, use of Motivational Interviewing and Coaching for Activation. Interventions will be tailored to the need of the individual patient but will include, at a minimum, the following:

- Care Plan development with the patient, his /her PCP and Nephrologist
- Setting timely intervals for follow up
- Providing ongoing education and encouragement on the relationship between co-morbidities and kidney disease in a classroom (Kidney Smart) and 1:1 to complement provider CKD education. Focusing on goals including:
  - Maximizing self-management
  - Optimizing blood pressure
  - Optimizing blood glucose
  - Anemia management
  - Medication compliance
  - Diet compliance
  - Healthy lifestyle adherence to include flu, pneumonia and hepatitis B vaccines
  - Coordinating referrals as appropriate that may include but are not limited to:
    - Registered Dietician
    - Specialty Care
    - Counseling/Social Worker
  - Achieving optimal collaborative relationships with providers
  - Overcoming barriers to appointment compliance
- Review of all patients who are hospitalized to determine any changes in the program that might have prevented the hospitalization
- Coordination with PHC UM and Care Transition Coach if any participant is hospitalized
- Accompanying patients to PCP, Nephrology and Cardiology appointments as indicated
- If clinically indicated, and if patient desires dialysis, working with providers and patient to establish early access in preparation for dialysis treatment

**Outcome Measurement**

The outcomes include comparison of the patients participating in the program > 6 months to a control group consisting of patients with Stage 3B, Stage 4, or Stage 5 kidney disease not yet on dialysis and not in a high touch case management program.
The following information will be collected on both the control group and program participants:

- Patient Age
- Patient Gender
- Patient Ethnicity
- County of residence
- Labs
  - Estimated Glomerular Filtration Rate (eGFR)
- Did patient initiate dialysis? (Yes or No) If yes:
  - What was the first date of dialysis?
  - Was the first dialysis started in a hospital or dialysis center?
  - Did the patient have a working permanent access prior to initiation of dialysis? (Yes or No) If No:
    - Is there a maturing access?
  - Did the patient initiate dialysis in a home treatment modality?
- Number of Inpatient days sorted by “Related” vs. “Not Related to CKD”
- Comparative cost of care
- Morbidity
  - In the event of death, patients who die will have their costs followed for 6 months after their death, to allow collection of all claims information and to account for decreased costs associated with improved Advanced Care Planning and appropriate use of the POLST form.

For patients participating in the program, the following additional information will be collected:

- PHC Health Risk Assessment
- PAM Scores
- PHQ 2/9 Scores
- Percentage of patients who have:
  - Had the Advance Care Planning discussion
  - Completed an Advance Directive
  - Completed a POLST
- Patient demonstrates education enhancement regarding options for end stage renal replacement modalities of dialysis and transplant
- Patient has active Nephrology involvement prior to initiation of dialysis
- Patient initiates dialysis with hemoglobin greater than or equal to 11
- Number of Inpatient days during CKD program participation and first 90 days of ESRD treatment with associated diagnosis and an analysis of whether the admission could have been prevented in any way. Only PHC costs will be included in the outcome measurement.
I. RELATED POLICIES:
MCUP3041 - TAR Review Process

II. IMPACTED DEPTS:
A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:
A. Fecal microbiota transplantation (FMT) – the transfer of a processed stool specimen from a healthy donor to a diseased recipient for the purpose of restoring a normal population of bacteria to the colon of the recipient. Also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.
B. Clostridium difficile infection (CDI) - confirmed stool test positive for toxigenic C. difficile.
C. Mild to moderate CDI – CDI with documented diarrhea (> 3 loose or watery stools per day for at least 2 consecutive days or > 8 loose stools in 48 hours)E.
D. Recurrent or relapsing CDI (RCDI) - Three or more episodes of mild to moderate CDI following a 6-8 week taper with vancomycin with or without another antibiotic (e.g., rifaximin, nitazoxanide) or at least 2 episodes of CDI resulting in hospitalization and associated with significant morbidity.C.
E. Severe CDI - CDI with serum albumin <3 g/dl and WBC ≥ 15,000 cells/mm³ or abdominal tenderness without other complicationsD.
F. Complicated/fulminant CDI – CDI associated with hypotension, shock, sepsis, ileus, toxic megacolon, or perforation.
G. Standard CDI Treatment - Metronidazole 500 mg orally 3X daily for 10-14 daysE.
H. Alternate/severe CDI treatment – for metronidazole treatment failures or contraindicated case or in cases of severe (not fulminant) CDI - Vancomycin 125 mg orally 4X daily for 10-14 daysE.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
The purpose of the FMT policy is to assist Utilization Management (UM) staff with decision making when reviewing treatment authorization requests (TARs) for FMT to treat confirmed CDI that has failed standard CDI treatment.
VI. POLICY / PROCEDURE:
   A. A Treatment Authorization Request (TAR) is required for all FMT procedures.
   B. Partnership HealthPlan of California (PHC) considers FMT medically indicated in cases of CDI as follows:
      1. Eligibility Criteria - Must meet ALL criteria below:
         a. Member must be 18 years of age or older
         b. Documentation of current CDI.
         c. Documentation of at least moderate RCDI (as defined above), unresponsive to standard AND alternate treatments OR documentation of severe or complicated/fulminant CDI.
         d. Patient is not immunocompromised.
         e. All other uses of FMT are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.
      2. Methodology
         a. FMT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
         b. The provider performing the FMT and facility providing the transplant materials must comply with the U.S Food and Drug Administration’s regulations regarding FMT.

VII. REFERENCES:
   B. TJ Borody, MD et al. Fecal microbiota transplantation in the treatment of recurrent Clostridium difficile infection; UpToDate. Accessed 03/17/2017
   E. Cohen S et al. Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA); Infect Control Hosp Epidemiol 2010;31(5):431-455

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES:

PREVIOUSLY APPLIED TO:
N/A

In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:
**Policy/Procedure Number:** MCUP3136  
**Lead Department:** Health Services

**Policy/Procedure Title:** Fecal Microbiota Transplant (FMT)  
- ☒ External Policy  
- ☐ Internal Policy

<table>
<thead>
<tr>
<th>Original Date: 05/17/2017</th>
<th>Next Review Date: 05/17/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Review Date: 05/17/2017</td>
<td></td>
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</tbody>
</table>

**Applies to:**  
- ☒ Medi-Cal  
- ☐ Employees

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

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

MPQP1016 - Potential Quality Issue Investigation and Resolution  
FIN 700-405 (internal policy) – Treatment of Recoveries of Overpayments to Providers

II. IMPACTED DEPTS.:
A. Quality Performance Improvement  
B. Claims  
C. Finance  
D. Provider Relations  
E. Utilization Management  
F. Compliance

III. DEFINITIONS:

Provider Preventable Condition (PPC): specified and defined Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (OPPC) which are medical conditions or complications that a patient develops during a hospital stay, or ambulatory surgical encounter that was not present at admission. See CMS code section §447.26(b), and section 1886(d)(4)(D)(iv) of the Affordable Care Act and Medicare’s inpatient hospital statutory language for original documentation related to these terms.

Potential PPC: An incident or activity being reported to Partnership HealthPlan of California (PHC), or flagged during internal PHC encounter data audits, as a possible PPC, before it has been investigated and confirmed.

According to DHCS, here are the definitions of OPPC and HCAC (http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx)

Other Provider Preventable Conditions (OPPC) for purposes of Medicaid include the following (may occur in any setting):
A. Wrong surgery or wrong invasive procedure  
B. Surgery or invasive procedure on the wrong body part  
C. Surgery or invasive procedure on the wrong patient

Health Care Acquired Condition (HCAC or HAC) for purposes of Medicaid include the following (for inpatient settings only):
A. Air embolism
B. Blood incompatibility
C. Catheter-associated urinary tract infection (UTI)
D. Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
E. Foreign object retained after surgery
F. Iatrogenic pneumothorax with venous catheterization
G. Manifestations of poor glycemic control
   1. Diabetic ketoacidosis
   2. Nonketotic hyperosmolar coma
   3. Hypoglycemic coma
   4. Secondary diabetes with ketoacidosis
   5. Secondary diabetes with hyperosmolarity
H. Stage III and IV pressure ulcers
I. Surgical site infection following:
   1. Mediastinitis following coronary artery bypass graft (CABG)
   2. Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
   3. Orthopedic procedures for spine, neck, shoulder, and elbow
   4. Cardiac implantable electronic device (CIED) procedures
J. Vascular catheter-associated infection
K. For non-pediatric/obstetric population, deep vein thrombosis (DVT)/pulmonary embolism (PE) resulting from:
   1. Total knee replacement
   2. Hip replacement

IV. ATTACHMENTS:

   A. Department of Health Care Services Audits & Investigations (DHCS A&I) PPC Form 7107
   B. List of ICD 10 codes used by Claims to screen for PPCs

   A. List of ICD 10 codes used to screen for PPCs

V. PURPOSE:
Pursuant to Title 42 of the Code of Federal Regulations, Section 447.26, states are prohibited from permitting payment to Medicaid providers for treatment of PPCs. Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specified that managed care organizations must participate in reporting PPC-related encounters.

This policy serves to define the mechanism for screening, investigating, processing and reporting of PPCs.

VI. POLICY / PROCEDURE:
A. Reporting Requirements
   1. Providers must report potential PPCs directly to the DHCS Audits & Investigations Unit (A&I) after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. Online reporting guidance at: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx. Reporting is required for all Medi-Cal beneficiaries, including those eligible for Medicare or other insurance coverage.
   2. Any potential PPC pertaining to a PHC member must also be reported directly to PHC. Providers should forward potential PPCs to the Quality Improvement Department at PQI@partnershiphp.org.
3. PHC follows-up on all provider self-reported potential PPCs to ensure that appropriate notification has also been sent by the provider to DHCS A&I.

4. Potential PPCs may also be reported to the QI Department by PHC staff or community members, per the Potential Quality Issue identification methods identified in MPQP1016.

B. Initial notice about a potential PPC

4.5. Request for information about the PPC process or how to report a PPC may be referred to the Peer Review group at the Quality Improvement Department at PQI@partnershiphp.org.

B. Incoming reports of PHC Screening for PPCs

1. PHC screens encounter data on a PPC may be a monthly basis, including data received by phone, email, fax or mail. In all cases from network providers, for the material should be forwarded to the Quality Improvement Department at PQI@partnershiphp.org.

2. Presence of PPC-specific billing codes listed in Attachment B. Encounters identified by the Claims Department by screening for PPC-specific billing codes are forwarded to PQI@partnershiphp.org at the end of each month in a report format, and are reviewed by QI Department staff.

3.1. Non-contracted providers (fee-for-service providers) are required to file their report directly with the DHCS Audits & Investigations Unit (A&I) online reporting guidance at: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

C. Processing potential PPC. This section is also called the PPC Clinical Review:

C. of Potential PPCs

1. Potential PPCs are investigated according to the processes outlined in MPQP1016—Potential Quality Issue (PQI) Investigation processes outlined in MPQP1016.

2. The scope of review includes both a medical record and Resolution to determine if there is a confirmed PPC claims history review.

2. Preventable Conditions Report Received from External Provider:

3. If the All potential PPCs are forwarded to the Chief Medical Officer or physician designee for secondary review.

4. Potential PPC cases may be reviewed by the PHC Peer Review Committee for additional potential PPC was self-reported, the reviewer contacts the provider, or provider contact, to ensure the incident was reported actions/remedies, as noted in MPQP1016.

D. Reporting Confirmed PPCs

1. The QI Department reports all confirmed PPCs to the DHCS A&I unit via the online reporting module: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

a. The POI Peer Review Lead will e-mail a copy of the PPC report to the appropriate PHC claims staff. The Claims Department staff will conduct a claims inquiry and forward results to the POI Peer Review Lead.

b. The POI Peer Review Lead attaches the claim inquiry to the potential PPC case file and forwards it to the Chief Medical Officer or physician designee for a secondary review.

2. The CMO or physician designee has 30 calendar days from date of receipt of medical file to complete the secondary review. The result of this review may be to determine the case is a confirmed PPC or that it is not a PPC. Notification of the reported incident is also sent to PHC's internal Compliance department (RAC Inbox@partnershiphp.org).

E. Payment Recoupment for Confirmed PPCs

2. If the case is determined to be a PPC, the medical record will be reviewed to determine which, if any extra procedures, length of hospitalization, medications or other items were provided to the member exclusively because of the PPC. Documentation of this review will be placed in the QI Department POI case file.

3. Non-confirmed PPC notifications: the provider who reported the potential PPC to PHC will be
4. Confirmed PPCs
   a. Confirmed PPCs will be reviewed by the PHC Medical Director or Peer Review Committee for additional potential actions/remedies, as noted in MPQP 1016.

D. Processing confirmed PPC
   1. The PQI Peer Review Lead completes the PPC 7107 form and e-mails it to the DHCS A&I unit: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.

E. Determination and processing of potential recoupment. This section is also called the PPC financial review.
   1. In preparation for determination of recoupment, the following is evaluated:
      - The payment mechanism for the hospitalization: capitation, percentage of billed charges, diagnostic related group or other.
   2. The CMO or physician designee will meet with a representative of Claims, Finance – Cost Avoidance Unit, Provider Relations and Utilization Management Departments who are well versed in hospital provider reimbursement. Using the results of the PPC clinical review, and a review of the federal code, this group will recommend which, if any, charges are recommended for recoupment. This recommendation will be reviewed and approved by the Chief Medical Officer (CMO) and the Chief Financial Officer (CFO) of PHC.
   3. This recommendation will be reviewed and approved by the Chief Medical Officer and the Chief Financial Officer in accordance with PHC Policy FIN 700-405 – Treatment of PHC.
   4. Tracking financial results: the final decision on financial recoupment will be forwarded to Providers.

F. PHC Claims Communication
   a. The QI Department will track incidents and maintain records for recoupment at: claimshelpdesk@partnershiphp.org.
   1. PHC Finance Department to execute any recoupment required at: aphelpdesk@partnershiphp.org. The Finance department will be responsible of notifying the hospital of the results of the potential PPC clinical investigation (as provided by the quality department).
   2. For confirmed PPCs, the Finance – Cost Avoidance Unit will communicate with the provider the recommendations of the PPC financial review and the mechanism of recoupment proposed.

G. Any objections raised by the hospital/provider regarding final case determinations will be escalated to the CFO and CMO for review.

H. Training
   1. Provider training. The Provider Relations Department provides routine education of the contracted provider network through provider newsletters and bulletins on the requirement to report PPCs for PHC members directly to DHCS and PHC.
   2. Employee training: PHC staff that review hospital records and hospital inpatient quality issues will be trained on this policy. This includes the Quality Staff involved in the peer medical record review process, Claims staff reviewing hospital claims, and Utilization Management and Care Coordination staff reviewing hospital care. These trainings will be conducted at the department level during the orientation process, and when the policy is updated.
   3. Delegate notification: Each year, as part of the delegate oversight process, each delegated health care provider will be notified of their responsibility to report PPCs to PHC when they occur.

I. Document Retention
   1. Copies of all PPC submissions to DHCS by PHC or PHC providers, and supporting medical record evidence, will be maintained by PHC in accordance with PHC document retention policy.
VII. REFERENCES:

A. APL 16-011
B. DHCS Medi-Cal Guidance on Reporting PPCs
C. DHCS PPC FAQs
D. DHCS PPC Online Reporting System
E. Medicaid regulations on PPC effective July 1, 2011
F. Medicare's provisions on PPC
G. PPC Categories and Rules
H. COHS Boilerplate – Exhibit A
I. CMS – PPC – FAQs

VIII. DISTRIBUTION:

Provider manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Chief Medical Officer

X. REVISION DATES:

10/19/16, 06/14/2017

PREVIOUSLY APPLIED TO:

CMP 36, Provider Preventable Conditions – 09/03/2013 to 10/19/2016, now archived.
I. RELATED POLICIES:
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   B. Potential PPC: An incident or activity reported to Partnership HealthPlan of California (PHC), or flagged during internal PHC encounter data audits, as a possible PPC, before it has been investigated and confirmed.
   C. According to DHCS, here are the definitions of OPPC and HCAC
      (http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx )
   D. Other Provider Preventable Conditions (OPPC) for purposes of Medicaid include the following (may occur in any setting):
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      4. Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
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| 7. Manifestations of poor glycemic control |
| a. Diabetic ketoacidosis |
| b. Nonketotic hyperosmolar coma |
| c. Hypoglycemic coma |
| d. Secondary diabetes with ketoacidosis |
| e. Secondary diabetes with hyperosmolarity |
| 8. Stage III and IV pressure ulcers |
| 9. Surgical site infection following: |
| a. Mediastinitis following coronary artery bypass graft (CABG) |
| b. Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery |
| c. Orthopedic procedures for spine, neck, shoulder, and elbow |
| d. Cardiac implantable electronic device (CIED) procedures |
| 10. Vascular catheter-associated infection |
| 11. For non-pediatric/obstetric population, deep vein thrombosis (DVT)/ pulmonary embolism (PE) resulting from: |
| a. Total knee replacement |
| b. Hip replacement |

### IV. ATTACHMENTS:

A. N/A

### V. PURPOSE:
Pursuant to Title 42 of the Code of Federal Regulations, Section 447.26, states are prohibited from permitting payment to Medicaid providers for treatment of PPCs. Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specified that managed care organizations must participate in reporting PPC-related encounters.

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2. Any potential PPC pertaining to a PHC member must also be reported directly to PHC. Providers should forward potential PPCs to the Quality Improvement Department at PQI@partnershiphp.org.

3. PHC follows-up on all provider self-reported potential PPCs to ensure that appropriate notification has also been sent by the provider to DHCS A&I.

4. Potential PPCs may also be reported to the QI Department by PHC staff or community members, per the Potential Quality Issue identification methods identified in MPQP1016.

5. Request for information about the PPC process or how to report a PPC may be referred to the Peer Review group at the Quality Improvement Department at PQI@partnershiphp.org.

#### B. PHC Screening for PPCs

1. PHC screens encounter data on a monthly basis, including data received from network providers, for the presence of PPC-specific billing codes listed in Attachment B. Encounters identified by screening for PPC-specific billing codes are forwarded to PQI@partnershiphp.org at the end of each month.
C. Clinical Review of Potential PPCs
   1. Potential PPCs are investigated according to the Potential Quality Issue (PQI) investigation processes outlined in MPQP1016.
   2. The scope of review includes both a medical record and claims history review.
   3. All potential PPCs are forwarded to the Chief Medical Officer or physician designee for secondary review.
   4. Potential PPC cases may be reviewed by the PHC Peer Review Committee for additional potential actions/remedies, as noted in MPQP1016.

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   1. The QI Department reports all confirmed PPCs to the DHCS A&I unit via the online reporting module: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.
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   2. The CMO or physician designee will meet with a representative of Claims, Finance – Cost Avoidance Unit, Provider Relations and Utilization Management Departments who are well versed in provider reimbursement. Using the results of the PPC clinical review, and a review of the federal code, this group will recommend which, if any, charges are recommended for recoupment. This recommendation will be reviewed and approved by the Chief Medical Officer (CMO) and the Chief Financial Officer (CFO) of PHC.
   3. Recoupment will be processed by the Finance – Cost Avoidance Unit in accordance with PHC Policy FIN 700-405 – Treatment of Recoveries of Overpayments to Providers.

F. Communication
   1. The QI Department will notify the provider of the results of the potential PPC clinical investigation.
   2. For confirmed PPCs, the Finance – Cost Avoidance Unit will communicate with the provider the recommendations of the PPC financial review and the mechanism of recoupment proposed.
   3. Any objections raised by the provider regarding final case determinations will be escalated to the CFO and CMO for review.

G. Training
   1. Provider training. The Provider Relations Department provides routine education of the contracted provider network through provider newsletters and bulletins on the requirement to report PPCs for PHC members directly to DHCS and PHC.
   2. Employee training: PHC staff that review hospital records and hospital inpatient quality issues will be trained on this policy. This includes the Quality Staff involved in medical record review, Claims staff reviewing hospital claims, and Utilization Management and Care Coordination staff reviewing hospital care. These trainings will be conducted at the department level during the orientation process, and when the policy is updated.
   3. Delegate notification: Each year, as part of the delegate oversight process, each delegated health care provider will be notified of their responsibility to report PPCs to PHC when they occur.

H. Document Retention
   1. Copies of all PPC submissions to DHCS by PHC or PHC providers, and supporting medical record evidence, will be maintained by PHC in accordance with PHC document retention policy CMP-31.
<table>
<thead>
<tr>
<th>I. <strong>Oversight</strong></th>
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<tbody>
<tr>
<td>1. A summary PPC report will be presented at PHC’s Internal Quality Improvement Committee (IQI), Quality and Utilization Advisory Committee (Q/UAC) and Compliance Committee at least annually.</td>
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<table>
<thead>
<tr>
<th>VII. <strong>REFERENCES:</strong></th>
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<tbody>
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<td>A. <a href="#">APL 16-011</a></td>
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<td>B. <a href="#">DHCS Medi-Cal Guidance on Reporting PPCs</a></td>
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</tr>
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<td>E. <a href="#">Medicaid regulations on PPC effective July 1, 2011</a></td>
</tr>
<tr>
<td>F. <a href="#">Medicare's provisions on PPC</a></td>
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<tr>
<th>VIII. <strong>DISTRIBUTION:</strong></th>
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<tbody>
<tr>
<td>Provider manual</td>
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<tr>
<th>IX. <strong>POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:</strong></th>
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<tbody>
<tr>
<td>Chief Medical Officer</td>
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<tr>
<th>X. <strong>REVISION DATES:</strong></th>
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<tr>
<td>10/19/16, 06/14/2017</td>
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**PREVIOUSLY APPLIED TO:**
CMP 36, Provider Preventable Conditions – 09/03/2013 to 10/19/2016, now archived.
**MEETING MINUTES**

**Meeting Name:** Provider Advisory Group  
**Date:** May 19, 2017  
**Time:** Lunch: 12:00 | Meeting 12:30-1:30  
**Location:** Ole Health, 1141 Pear Tree Ln, Napa, CA  
**Attendees:** PHC Staff: Sonja Bjork, James Cotter, MD, Denise Surette, Lynne DiModica, Gloria Turner, Stephanie Phipps, Tondenisha Coleman, Rebecca Mannella, Nick Barajas, Carol Parker  
Guests: Alison French, Emily Schuman, Niti Malhotra, Celine Regalia, Corrigan Gommenginger, Josh Buhagiar, Shelby Nelson, Samual She Hon, Greg Johnson, Brittany Speer, Janeine Spencer

### Agenda Topic  
**Agenda Item #1**  
*Standing Agenda Items*  
1.1 Welcome and Introductions – Jamie Bongiovi, Director of Behavioral Health at Ole Health  
1.2 Review of Minutes from the previous meeting  
1.3 Review of Agenda  

**Action Items**  
*Presented as information only*

### Agenda Item #2  
*Presentation*  
Allison French, Program Director at Beacon Health Options, spoke to the group about Mental Health Awareness and Prevention:  
Beacon Health Options and Partnership HealthPlan of California have partnered to provide mental health services.  
Screening and referral to mental health care often begins in the primary care setting. Beacon offers referral pathways to allow PCPs to:  
- Get care coordination support for patients.  
- Get a consultation with a psychiatrist to keep a patient in primary care.  
- Make a referral for behavioral health treatment with Beacon’s network.  
- Beacon can help decide if a member has mild to moderate needs to be served by our network; or more significant needs to be best served by the county.  

**Action Items**  
*Presented as information only*
<table>
<thead>
<tr>
<th>Agenda Item #3</th>
<th>None</th>
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<tbody>
<tr>
<td><strong>Old Business</strong></td>
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<td><strong>Agenda Item #4</strong></td>
<td><strong>New Business</strong></td>
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<tr>
<td><strong>4.1. PHC Update &amp; Report from Physician's Advisory Committee</strong></td>
<td>Sonja Bjork, COO, updated the group on the latest activities at PHC:</td>
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<td>• We continue to monitor the political situation in regards to Healthcare at the Federal level.</td>
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<td>• The recent PHC Employee Engagement Survey has a 91% response rate, and 94% of employees overall say that PHC is a great place to work.</td>
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<td>• PHC is involved in community efforts to help people not only obtain healthcare coverage, but to encourage members to see a doctor for assessment and preventive medicine.</td>
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<td>• The PHC Board of Directors recently approved a grant to address homeless populations in all 14 counties we serve.</td>
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<td>James Cotter, MD, PHC Regional Medical Director, reported on the recent meeting of the Physician’s Advisory Committee:</td>
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<td>• There is still concern over possible repeal or reform of the Affordable Care Act, however, it is unlikely that anything will happen until after 2018.</td>
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<td>• The California Medical Association is asking for more money for Medi-Cal.</td>
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<td>• Napa County has 28,000 PHC Members. Although 98% of the children have health coverage, 21% of children live in poverty. There are various programs to improve the health of homeless and underserved in Napa County.</td>
</tr>
<tr>
<td><strong>4.2. Report from the Claims Department</strong></td>
<td>Rebecca Mannella, Claims Resolution Manager, talked to the group about the Claims Inquiry Form (CIF) and Appeals process:</td>
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<td>• A CIF gives providers 2 chances to make any changes or corrections to a claim</td>
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<tr>
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<td>• An appeal is the final step in the claims appeal process and should only be used if the CIF process has not resolved the issue.</td>
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<tr>
<td><strong>4.3. Report from Provider Relations</strong></td>
<td>Stephanie Phipps reminded the group that Provider Relations Representatives are available to help you navigate Online Services, PHC Systems and to assist with training staff, and any other questions providers and staff may have. Ongoing trainings are held in the counties we serve.</td>
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### 4.4. Report from Provider Relations Education Team

Denise Surette, Provider Education Specialist, updated the group on recent activities in the Provider Education Unit:

Effective July 1, 2017, Partnership HealthPlan of California (PHC), will transition from the PM-160 Form to the CPT-4 National Codes on the CMS-1500 Form, the standard 837 Electronic Claims format, or the UB04 Form, in compliance with state and HIPAA standards.

- Training webinars were recorded, and will be posted on the PHC Website.
- New contract amendments were sent out to providers in our network.
- We encourage providers to track any abnormal findings, since the new forms do not report these findings.

The Provider Education Team can be reached at EsystemsSupport@partnershiphp.org

<table>
<thead>
<tr>
<th>Agenda Item #5</th>
<th>Provider Topics of Interest</th>
<th>Presented as information only</th>
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<tbody>
<tr>
<td><strong>Next Meeting</strong></td>
<td><em>July 21 in Solano County</em></td>
<td>Any suggestions for next agenda</td>
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</table>

Along with PHC’s Offering and Honoring Choices Program, Advance Care Directive initiatives are taking place in Napa County through St. Joseph Queen of the Valley Hospital, Honoring Choices Napa Valley, and Collabria Care (Napa Hospice, Alzheimer’s Resource Center).

PHC is holding a Lunch & Learn Roundtable Meeting on June 22, 2017 in Solano County.

A one-day Palliative Care Extended Pilot Meeting for sites interested in contracting with PHC to provide community-based palliative care services is planned for May 30, 2017. See [http://www.partnershiphp.org](http://www.partnershiphp.org) for details.
## AGENDA ITEM

### I. Meeting called to order

I. PHC Regional Medical Director Marshall Kubota, MD called the meeting to order.

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
</tr>
</thead>
</table>

### II. Review/Approval of previous minutes

II. The Credentialing Committee meeting minutes for March 8, 2017

II. A. Motion made and carried to approve the Minutes of March 8, 2017

### III. Old Business

A. MD-Family Practice

This case was referred by Peer Review.

III. A. MD-Family Practice, This case was referred by Peer Review. III. Motion made and carried to approve PHC’s recommendation to continue credentialing with no further action from PHC.

### IV. New Business

A. Review of Practitioner File

IV. A. Please see approved list of Routine Providers on Pages 3-15

The Committee reviewed and discussed the list of thirty five (35) Physicians, twenty one (21) Non-Physician Medical Practitioners, two (2) Chiropractors, eight (8) Behavioral Health Analysts, one (1) Physical Therapist, and one (1) Acupuncturist for Initial Credentialing, sixty five (65) Physicians, eighteen (18) Non-Physician Medical Practitioners, three (3) Physical Therapists, two (2) Podiatrist, one (1) Speech Language Pathologist, and two (2) Chiropractors for Re-Credentialing.

IV. A. The Committee reviewed and approved the list of thirty five (34) Physicians, twenty one (21) Non-Physician Medical Practitioners, two (2) Chiropractors, eight (8) Behavioral Health Analysts, one (1) Physical Therapist, and one (1) Acupuncturist for Initial Credentialing, sixty five (65) Physicians, eighteen (18) Non-Physician Medical Practitioners, three (3) Physical Therapists, two (2) Podiatrist, one (1) Speech Language Pathologist, and two (2) Chiropractors for Re-Credentialing.

### B. Exception: MD-Family Medicine

One Exception:

B. MD-Family Medicine: Physician does not meet the criteria of PHC Policy MP CR #17- Standards for Contracted Primary Care Providers.

B. The Committee voted to defer credentialing pending additional information.

### VI. Consent Calendar Items

A. Report of Long Term Care Facility, Hospital, and Ancillary provider list

VI. A. Report of Long Term Care Facility, Hospital, and Ancillary provider list

VI. Motion made and carried to approve all items in the Consent Calendar.
## VI. Consent Calendar (cont.)

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
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<td>B. Update of Ongoing Monitoring of Sanctions</td>
<td>B. Update of Ongoing Monitoring of Sanctions</td>
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<td>D. Review of Suboxone/Buprenorphine credentialed primary care providers</td>
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With no further items for discussion, the meeting was adjourned.

Next Meeting Scheduled for May 10, 2017.

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PAC Summary Meeting Minutes for April 12, 2017, respectfully prepared and submitted by Skyler Bellmore - Credentialing Specialist II

Chairman Signature of Approval ____________________________ Date______________________________

Marshall Kubota M.D., PHC Credentialing Chairman
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<th>County</th>
<th>Practice Specialty</th>
<th>Board Certification/Board Status</th>
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<td>Schulman, Joshua M. MD Direct Dermatology Professionals</td>
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<td>Turner, Susan K. CNM St. Helena Women’s Center</td>
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<td>139 RC</td>
<td>Valente, Vincent P. MD Adventist Health</td>
<td>Mendocino</td>
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<tr>
<td>140 RC</td>
<td>Venkatapathy, Ganesan MD Elica Health Center</td>
<td>Yolo</td>
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<td>141 IC</td>
<td>Venkatesan, Aruna MD Direct Dermatology Professionals</td>
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<td>142 IC</td>
<td>Vierregger, Kristen S. MD TeleMed2U</td>
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<td>143 RC</td>
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<td>147 RC</td>
<td>Weber, Lauren D. DO NBHG: Center for Women's Health</td>
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<td>Wolk, Peter J. MD Rolling Hills Clinic</td>
<td>Tehama</td>
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<td>Napa Humboldt</td>
<td>Cardiovascular Disease</td>
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<td>Woodbury, Kristin DO</td>
<td>Solano</td>
<td>Otolaryngology</td>
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<td>Obstetrics &amp; Gynecology</td>
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<td>154 RC</td>
<td>Yinger, Kent E. MD Redwood Ortho Surgery Assoc</td>
<td>Sonoma</td>
<td>Orthopaedic Surgery</td>
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<td>Zane, Linda J. FNP Hill Country Community Clinic</td>
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<td>IC or RC</td>
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<td>Privileges Criteria Hospital Privileges</td>
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<td>Zittel, Scott R. DO Physicians Wound Care</td>
<td>Shasta</td>
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<td>Emergency Medicine - 2000</td>
<td>Shasta Regional Med Center-Consulting</td>
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Medical Director/Physician Approval of Routine List

Marshall Kubota M.D., PHC Credentialing Chairman
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee
FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer
DATE: 6/14/2017
SUBJECT: PHC Committee Memberships

******************************************************

Pharmacy & Therapeutics (P&T) Committee

**Appointments:**

Hayley Park, Pharm.D. of Walgreens has agreed to participate on the P&T Committee. The Committee approved her appointment at their January meeting.

Approval of this new appointment is recommended.

Harvey Katzman, Pharm.D. of Ole Health in Napa has agreed to participate on the P&T Committee. The Committee approved his appointment at their January meeting.

Approval of this new appointment is recommended.

**Resignation:**

Kathy DiMaggio, MAS, RDE, CDE, CLE requested her resignation from the P&T Committee. The Committee approved her resignation at their January meeting.

Approval of this resignation is recommended.
I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
N/A

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. NA

V. PURPOSE:
The Physician Advisory Committee (PAC) is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership HealthPlan of California's members. The PAC reviews the activities of the Quality/Utilization Advisory Committee (Q/UAC), Provider Advisory Group (PAG), Pharmacy and Therapeutics Committee (P&T), the Quality Improvement Program Advisory Group, and the Credentials Committee, makes recommendations, and assists PHC in other ways as defined in this policy.

VI. POLICY / PROCEDURE:
A. COMMITTEE STRUCTURE
1. Membership:
   a. The PAC is comprised of the PHC CEO, Deputy Executive Director/Chief Operating Officer, Chief Medical Officer, Regional Medical Directors, Chief Financial Officer, Health Services Director, Provider Relations Director, Quality and Performance Improvement Director, Pharmacy Director, Member Services Director, and 15-25 other members that may include:
      1) Participating physician representatives from primary and specialty care, including at least one behavioral health provider.
      2) Advanced practice clinicians such as certified nurse midwives, nurse practitioners or physician assistants.
      3) Members representing active medical staffs of hospitals, community-based practices, and medical groups in the PHC service area.
   b. Members with annual attendance of <50% are evaluated for termination from the PAC.
   c. Other health plan staff may make special or periodic reports to the committee or may attend selected meetings ex-officio.
2. Minutes: Minutes are recorded of all meetings and are maintained.
3. Chair: A PHC Physician on the Committee chairs the meeting and when unavailable, the Chief Medical Officer chairs the Committee.
4. Meetings: The Committee meets at least nine (9) times a year, but does not convene in the months of July or December, with the option to add additional meetings if needed.
5. Voting: Only committee members who are not PHC staff may vote. The Chief Medical Officer serves in a tie breaking capacity as necessary. A quorum is that number of members present as described in the PHC by-laws which specifies 50% plus one of voting members.

B. COMMITTEE RESPONSIBILITIES
1. Reviews and makes recommendations for corrective action based upon other committee reports including:
   a. Q/UAC
   b. P&T Committee
   c. Credentials Committee
   d. PAG
2. Annually review, recommend and approve the Quality Improvement Department Program Evaluation and the Quality Improvement Work plan. Performance in utilization management activities is included in the annual Quality Improvement Evaluation.
3. Provides medical opinion regarding technological advances in consideration of benefit enhancements, inclusions, and exclusions.
4. Makes recommendations for health plan policy and protocol changes based on guidelines and standards of practice, and select PHC policies that affect quality improvement, clinical care, or provider issues.
5. Oversight responsibility for utilization, quality, and other staff reports which monitor the utilization of services and outcomes of quality within the delivery system.
6. Reviews and approves Clinical Practice Guidelines adopted by PHC.
7. Provides oversight to the PCP and Hospital Quality Improvement Programs (QIPs) for providers and hospitals, which includes: approval of the measures and payment methodologies; in addition to overseeing the implementation and evaluation of the QIP.
8. Advises and assists in the selection of Chief Medical Officer, as needed.

C. COMMITTEE ACCOUNTABILITY
1. The Physician Advisory Committee has oversight responsibility for the above listed committees and is accountable to the PHC Board of Commissioners.

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Committee Chairman

X. REVISION DATES:
Medi-Cal
10/14/98; 06/14/00; 03/14/01; 06/12/02; 10/13/04; 02/8/06; 04/11/07; 05/14/08; 05/13/09; 06/09/10; 10/10/12; 10/09/13; 04/09/14; 5/13/15; 6/8/16; 6/14/17
Healthy Kids
04/11/07; 05/14/08; 05/13/09; 06/09/10; 10/10/12; 10/09/13; 04/09/14; 5/13/15; 5/11/16

PREVIOUSLY APPLIED TO:
PartnershipAdvantage
MPQP1003 - 04/11/2007 to 01/01/2015

Healthy Families
MPQP1003 - 10/10/2012 to 03/01/2013

Healthy Kids
04/11/07; 05/14/08; 05/13/09; 06/09/10; 10/10/12; 10/09/13; 04/09/14; 5/13/15; 5/11/16 to 12/01/2016
Physician Advisory Committee - Discussion Topic
June 14, 2017
Agenda Item: IV.C.

Title: Number of Problems Addressed in a Visit: Is there a standard?

Summary of Discussion Topic:

How many issues should be addressed by a provider in a medical visit? There are some who say they only do one thing per visit, and the HealthPlan receives a lot of complaints around that. Feedback from this Committee regarding the philosophy around medical visits, and if some standards should be set, will be appreciated.

Questions:

1. Does your organization have an official policy around this?
2. Is there an informal agreement?
3. Do different providers handle this differently?
4. What do you recommend PHC do to address complaints from members about providers that will only address one problem?
## PHC System Updates

### May 2017

#### Health Services - Quality

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<th>Policy/Procedures/Guidelines</th>
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<td>MPQP1055</td>
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<td>MPQP1003</td>
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#### Health Services Care Coordination

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<td>TAR Requirements List</td>
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<td>Fecal Microbiota Transplant added to TAR Requirements List</td>
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<td>Attachment to policies: TAR Review Process</td>
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<td>MCUP3041</td>
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<td>Pain Management Specialty Services</td>
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<td>Authorization of Ambulatory Procedures</td>
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<td>Coordination of Services for Members Requiring Long Term Care</td>
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<td>MCUP3105</td>
<td>Regular review; minor language corrections</td>
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<td>Cardiac Rehabilitation</td>
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<td>MCUP3128</td>
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### April 2017

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<td>Gender Dysphoria / Surgical Treatment (prev. Gender Identity Disorder)</td>
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<td>MCUP3125</td>
<td>Regular review; policy revised per DHCS contractual obligations under All Plan Letter 16-013; related terms extended in policy for clarification; statement of non-discrimination added; references updated</td>
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<td>Insulin Infusion Pump Guidelines</td>
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<td>MPUG3025</td>
<td>Regular review; language clarification added regarding PCP or specialist ordering the insulin infusion pump; sections added regarding Continuous Glucose Monitoring (CGM) using a non-implanted device, Long-term CGM, and CGM using an implantable glucose sensor; references updated</td>
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I. RELATED POLICIES:
   A. MCUP3041 TAR Review Process
   B. MCUP3039 Special Case Managed Members

II. IMPACTED DEPTS:
   A. Health Services
   B. Claims
   C. Member Services

III. DEFINITIONS:
   A. Gender Identity Disorder (GID)Dysphoria is a formal diagnosis used by psychologists and physicians to describe persons who experience significant dysphoria, describing the emotional distress over a marked incongruence between one’s experienced/expressed gender and assigned gender, (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex. This condition is also known had been previously referred to as gender dysphoriaidentity disorder. This term was removed from DSM V. Affected individuals are commonly referred to as Transgender.

IV. ATTACHMENTS: N/A

V. PURPOSE:
   To define the criteria and process in by which Partnership HealthPlan of California (PHC) will provide benefits for the surgical treatment of Gender Identity Disorder dysphoria.

   NOTE: PHC is currently reviewing APL 16-013 issued by the California Department of Health Care Services (DHCS) regarding access to Medi-Cal services for transgender beneficiaries. PHC will update this policy based upon new guidelines when review has been completed and scope of policy change has been determined.

VI. POLICY / PROCEDURE:
   A. A Treatment Authorization Request (TAR) is required for all procedures related to gender dysphoria.
   B. Continuity of care requests will be reviewed by the PHC Medical Director or physician designee for medical necessity and continued care. There must be a clearly established relationship with the provider and the willingness of the provider to continue care. See policy MCUP3039 Special Case Managed Members.
   C. When reviewing a request for the surgical treatment of Gender dysphoria, Partnership Health Plan of California utilizes the criteria as outlined by the World Professional Association for Transgender Health.
(WPATH) and as defined as a covered benefit according to the APL 16-013 issued by the California Department of Health Care Services (DHCS). All requests will be reviewed by the Chief Medical Officer or Physician Designee.

1. According to the APL 16-013 (excerpted):
   a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender beneficiaries. Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body... to create a normal appearance to the extent possible.” In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.”
   b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.”

2. Gender reassignment surgery is a covered benefit when the individual with GID is at least 18 years of age, has the capacity for fully-informed consent, and the WPATH criteria for the surgery have been met and is a covered benefit according to APL 16-013.
   a. Persistent, well-documented gender dysphoria
   b. Capacity to make a fully informed decision and consent for treatment
   c. Age of majority (or if younger, following the standard of care for children and adolescents)
   d. An assessment of the member by qualified mental health professionals that is in agreement with the surgery within the past year
      1) If significant medical or mental health concerns are present, they must be reasonably well controlled
   e. Documented collaboration with, and agreement to surgery by the beneficiary’s primary care provider or provider of transgender care
   f. The list of surgical procedures may include:
      1) For Male to Female (MtF) patients
         a) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
         b) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
      2) For Female to Male (FtM)
         a) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)
         b) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses
   g. Specific considerations:
      1) For mastectomy in FtM and creation of a male chest in FtM patients – no hormone therapy is required. Pectoral implants are considered cosmetic, not reconstructive and not a covered benefit.
      2) For breast augmentation in MtF – a minimum of 12 months of feminizing hormone therapy prior to breast augmentation surgery to maximize breast growth that may be acceptable without the need for surgery and to obtain better surgical (aesthetic) results.
      3) For hysterectomy, oophorectomy, salpingo-oophorectomy in FtM and for orchiectomy in MtF patients – 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual) – to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention. Other surgery specific preauthorization criteria must be met (Pap testing, sterilization consent and others)
      4) For Metoidioplasty or phalloplasty in FtM patients, including testicular prostheses, and for vaginoplasty in MtF patients
a) 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual).

b) 12 continuous months of living in a gender role that is congruent with the patient’s identity as documented by the member’s PCP or transgender care clinician.

5) For Non-genital, non-breast surgery or treatments that may be considered non-reconstructive and may be considered cosmetic surgery and therefore not a covered benefit, will be considered on a case by case basis including: MtF: facial feminization surgery, thyroid cartilage reduction, hair reconstruction/removal.

6) Liposuction, lipo-filling (with the exception of MtF breast augmentation), voice surgery, gluteal augmentation (implants/liposuction/lipo-filling), facelift, facial lip augmentation/reduction, blepharoplasty, rhinoplasty are considered cosmetic surgery and not a covered benefit unless an integral portion of an already covered and approved procedure.

7) Repeat reconstructive surgery in the absence of physiologic dysfunction (e.g., second breast enhancement) is considered cosmetic and not a benefit.

3. Speech therapy for voice training and modulation is not a covered benefit.

4. Pharmaceutical treatment for gender dysphoria – refer to pharmacy policies/formulary for authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

B. The following surgical procedures are covered when WPATH criteria are met:

1. Mastectomy
2. Orchietomy
3. Hysterectomy
4. Salpingo-oophorectomy
5. Ovariectomy
6. Genital surgery (including placement of testicular prosthesis when indicated)

C. Augmentation mammoplasty for male-to-female individuals (MtF) is a covered benefit only when an appropriate trial of hormone therapy has not resulted in breast enlargement.

D. The following surgeries are considered cosmetic in nature and are not covered PHC benefits:

1. Reduction thyroid chondroplasty
2. Rhinoplasty
3. Facial bone reconstruction
4. Facelift, blepharoplasty
5. Voice modification surgery
6. Hair removal or transplant
7. Liposuction Augmentation
8. Mammoplasty is not a covered benefit for MtF individuals except as noted above.

E.D. Treatment Authorization Review (TAR)

1. TARs must be submitted prior to any surgical procedure referenced in section VI.DB.2.f. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review to determine if the member has met the standard of care and medical necessity requirements under the WPATH criteria.

F.E. Claims Submission

1. Intersex surgery should not be requested or billed using CPT code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed during each operation.

F. Statement of Non-Discrimination

1. PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an
individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the
one to which such health services are ordinarily are exclusively available.

1.2. PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose
additional cost sharing or other limitations or restrictions on coverage, for specific health services
related to gender transition if such denial, limitation, or restriction results in discrimination against a
transgender individual.

VII. REFERENCES:
A. World Professional Association for Transgender Health (WPATH) criteria, version 7.
http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926
B. DHCS All Plan Letter (APL) 16-013: Ensuring Access to Medi-Cal Services for Transgender
Beneficiaries:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2016/APL16-
013.pdf
C. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services

X. REVISION DATES: 01/20/16; 02/15/17; 04/19/17

PREVIOUSLY APPLIED TO:

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

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

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
I. RELATED POLICIES:
   A. MCUP3041 TAR Review Process
   B. MCUP3039 Special Case Managed Members

II. IMPACTED DEPTS:
   A. Health Services
   B. Claims
   C. Member Services

III. DEFINITIONS:
    Gender Dysphoria is a formal diagnosis used by psychologists and physicians to describe persons who experience significant dysphoria, describing the emotional distress over a marked incongruence between one’s experienced/expressed gender and assigned gender. This condition had been previously referred to as gender identity disorder. This term was removed from DSM V. Affected individuals are commonly referred to as transgender.

IV. ATTACHMENTS:
   A. N/A

V. PURPOSE:
   To define the criteria and process by which Partnership HealthPlan of California (PHC) will provide benefits for the surgical treatment of gender dysphoria.

VI. POLICY / PROCEDURE:
   A. A Treatment Authorization Request (TAR) is required for all procedures related to gender dysphoria.
   B. Continuity of care requests will be reviewed by the PHC Medical Director or physician designee for medical necessity and continued care. There must be a clearly established relationship with the provider and the willingness of the provider to continue care. See policy MCUP3039 Special Case Managed Members.
   C. When reviewing a request for the surgical treatment of gender dysphoria, Partnership Health Plan of California utilizes the criteria as outlined by the World Professional Association for Transgender Health (WPATH) and as defined as a covered benefit according to the APL 16-013 issued by the California Department of Health Care Services (DHCS). All requests will be reviewed by the Chief Medical Officer or Physician Designee.
1. According to the APL 16-013 (excerpted):
   a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender beneficiaries. Reconstructive surgery is “surgery performed to correct or repair abnormal structures of the body… to create a normal appearance to the extent possible.” In the case of transgender beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.”
   b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is “surgery that is performed to alter or reshape normal structures of the body in order to improve appearance”

2. Gender reassignment surgery is a covered benefit when the WPATH criteria for the surgery have been met and is a covered benefit according to APL 16-013.
   a. Persistent, well-documented gender dysphoria
   b. Capacity to make a fully informed decision and consent for treatment
   c. Age of majority (or if younger, following the standard of care for children and adolescents)
   d. An assessment of the member by qualified mental health professionals that is in agreement with the surgery within the past year
      1) If significant medical or mental health concerns are present, they must be reasonably well controlled
   e. Documented collaboration with, and agreement to surgery by the beneficiary’s primary care provider or provider of transgender care
   f. The list of surgical procedures may include:
      1) For Male to Female (MtF) patients
         a) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
         b) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
      2) For Female to Male (FtM) patients
         a) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)
         b) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses
   g. Specific considerations:
      1) For mastectomy in FtM and creation of a male chest in FtM patients – no hormone therapy is required. Pectoral implants are considered cosmetic, not reconstructive and not a covered benefit.
      2) For breast augmentation in MtF – a minimum of 12 months of feminizing hormone therapy prior to breast augmentation surgery to maximize breast growth that may be acceptable without the need for surgery and to obtain better surgical (aesthetic) results.
      3) For hysterectomy, oophorectomy, salpingo-oophorectomy in FtM and for orchiectomy in MtF patients – 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual) – to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention. Other surgery specific preauthorization criteria must be met (Pap testing, sterilization consent and others)
      4) For Metoidioplasty or phalloplasty in FtM patients, including testicular prostheses, and for vaginoplasty in MtF patients
         a) 12 continuous months of hormone therapy as appropriate to the patient’s gender goals (unless hormones are not clinically indicated for the individual).
         b) 12 continuous months of living in a gender role that is congruent with the patient’s identity as documented by the member’s PCP or transgender care clinician.
5) For Non-genital, Non-breast surgery or treatments that may be considered non-reconstructive and may be considered cosmetic surgery and therefore not a covered benefit will be considered on a case by case basis including: MtF: facial feminization surgery, thyroid cartilage reduction, hair reconstruction/removal.

6) Liposuction, lipofilling (with the exception of MtF breast augmentation), voice surgery, gluteal augmentation (implants/liposuction/lipofilling), facelift, facial lip augmentation/reduction, blepharoplasty, rhinoplasty are considered cosmetic surgery and not a covered benefit unless an integral portion of an already covered and approved procedure.

7) Repeat reconstructive surgery in the absence of physiologic dysfunction (e.g. second breast enhancement) is considered cosmetic and not a benefit.

3. Speech therapy for voice training and modulation is not a covered benefit.

4. Pharmaceutical treatment for gender dysphoria – refer to pharmacy formulary for authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

D. Treatment Authorization Review (TAR)
1. TARs must be submitted prior to any surgical procedure referenced in section VI.B.2.f. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review to determine if the member has met the standard of care and medical necessity requirements.

E. Claims Submission
1. Intersex surgery should not be requested or billed using CPT code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed during each operation.

F. Statement of Non-Discrimination
1. PHC will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender individual based on the fact that an individual’s sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily are exclusively available.

2. PHC will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.

VII. REFERENCES:
A. World Professional Association for Transgender Health (WPATH) criteria, version 7. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926
C. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Health Services
In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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

The materials provided are guidelines used by PHC to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under PHC.
**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**GUIDELINE / PROCEDURE**

<table>
<thead>
<tr>
<th>Guideline/Procedure Number: MPUG3025 (previously UG100325)</th>
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<tr>
<td><strong>Guideline/Procedure Title:</strong> Insulin Infusion Pump Guidelines</td>
<td>☒ External Policy</td>
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| Approving Entities: | ☐ BOARD  ☐ COMPLIANCE  ☐ FINANCE  ☒ PAC |
| ☐ CEO  ☐ COO  ☐ CREDENTIALING  ☐ DEPT. DIRECTOR/OFFICER |

| Approval Signature: | Robert Moore, MD, MPH |
| Approval Date: | 03/16/2016 04/19/2017 |

**I. RELATED POLICIES:**
A. MCUP3041 - TAR Review Process  
B. MCUG3007 - Authorization of Ambulatory Procedures and Services  
C. MCUP3042 - Technology Assessment

**II. IMPACTED DEPTS:**
A. Health Services  
B. Claims  
C. Member Services

**III. DEFINITIONS:**
A. An **insulin pump**, also known as subcutaneous insulin infusion (CSII), is an external ambulatory infusion device used for managing insulin-requiring Diabetes Mellitus (DM). By continuous administration of short acting insulin at preselected rate, the insulin pump can improve the patient glycemic control and delay, prevent, or reduce his/her risk of complications (e.g. neuropathy, nephropathy, retinopathy).

**IV. ATTACHMENTS:**
A. N/A20156 DME Criteria — Insulin Pump, Ambulatory

**V. PURPOSE:**
The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for an external insulin infusion pump and/or a continuous glucose monitor.

**VI. GUIDELINE / PROCEDURE:**
A. The insulin infusion pump must be ordered by the Primary Care Provider (PCP) or a specialist treating the member through a referral from the PCP. For special members, the insulin infusion pump must be ordered by the physician who is currently managing the medical care for the member.
B. Continuous glucose monitoring feature will be reviewed on a case by case basis for medical necessity.
C. PHC utilizes InterQual criteria to determine the necessity of a pump.
D. The TAR for insulin infusion pumps must include documentation of the medical necessity for home use of the insulin infusion pump that includes the following information related to the condition:
   1. Length of time member has had diabetes.
   2. Documentation that the member's diabetes meets InterQual criteria for insulin pump use per InterQual criteria.

E. Insulin infusion pumps must be ordered by the PCP or specialist treating the member through a referral from the PCP. For special members, the insulin infusion pump must be ordered by the physician who is currently managing the medical care for the member.

F. Insulin infusion pumps should only be prescribed and used by practitioners familiar with this operation.

G. Continuous Glucose Monitoring (CGM) using a non-implanted device by a healthcare provider is proven and considered medically necessary in the following clinical scenarios:
   1. Short-term (3 - 7 days) of continuous glucose monitoring by a healthcare provider for diagnostic purposes is proven and medically necessary for patients with diabetes.
   2. Long-term continuous glucose monitoring for personal use at home is proven and medically necessary as a supplement to self-monitoring of blood glucose (SMBG) for patients with type 1 diabetes who have demonstrated adherence to a physician ordered diabetic treatment plan.
      a. CGM would serve as an adjunct to finger stick testing of blood glucose in adults aged 25 years and older with type 1 diabetes, despite appropriate modifications in insulin regimen and compliance with frequent self-monitoring (at least 4 finger sticks/day).
      b. CGM would serve as an adjunct for younger persons with type 1 diabetes who have had recurrent episodes of severe hypoglycemia (defined as two or more episodes of hypoglycemia (blood glucose less than 50mg/dL) in a 30-day period with unawareness), despite appropriate modifications in insulin regimen and compliance with frequent self-monitoring (at least 4 finger sticks/day).
   3. Long-term continuous glucose monitoring for patients with type 2 diabetes are reviewed on a case by case basis for medical necessity. CGM for patients with type 2 diabetes may be indicated for patients with:
      a. Recurrent severe hypoglycemic unawareness in a patient taking insulin or a.d. Frequent nocturnal hypoglycemia despite modifications to insulin treatment and compliance with frequent glucose self-monitoring (at least four times a day).
      b. CGM using an implantable glucose sensor is investigational, unproven and not medically necessary due to lack of U.S. Food and Drug Administration (FDA) approval.

H. Long term CGM is considered experimental and investigational investigational the long term (therapeutic) use of CGM-for nesidioblastosis (primary islet cell hypertrophy) and for monitoring blood glucose in nondiabetic persons following gastric bypass surgery because there is insufficient evidence of the clinical benefits of this approach for these indications.

I. CGM using an implantable glucose sensor is investigational, unproven and not medically necessary due to lack of U.S. Food and Drug Administration (FDA) approval.

VII. REFERENCES:
   A. InterQual DME criteria – Insulin Pump, Ambulatory
   C. Blue Cross Blue Shield Association (BCBSA), Technology Evaluation Center (TEC). Artificial pancreas device systems. TEC Assessment Program. Chicago, IL: BCBSA; May 2014;28(14).
**Guideline/Procedure Number:** MPUG3025 (previously UG100325)  
**Lead Department:** Health Services

| Guideline/Procedure Title: Insulin Infusion Pump Guidelines | ☒ External Policy  
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**X. REVISION DATES:**
- Medi-Cal  
  04/28/00; 06/20/01; 09/18/02; 09/15/04; 11/16/05; 08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16; 04/19/17  
- Healthy Kids  
  08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16

**PREVIOUSLY APPLIED TO:**
- Healthy Kids MPUG3025 (Healthy Kids program ended 12/01/2016)  
  08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16 to 12/01/2016  
- Healthy Families  
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  [http://www.partnershiphp.org/Providers/Policies/Pages/HealthyKids/ProviderManual_HealthyKids.aspx](http://www.partnershiphp.org/Providers/Policies/Pages/HealthyKids/ProviderManual_HealthyKids.aspx)

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PREVIOUSLY APPLIED TO:
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