PARTNERSHIP HEALTHPLAN OF CALIFORNIA

PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members:

Jeffrey Bosworth, M.D.  Michele Herman, M.D.  Mitesh Popat, M.D.
Angela Brennan, D.O.  Willard Hunter, M.D.  Teresa Shinder, D.O.
Jeffrey Gaborko, M.D. (Chair) - Excused  Mills Matheson, M.D.  Matthew Symkowick, M.D.
David Gorchoff, M.D.  Danielle Oryn, D.O.  Suzanne Eidson-Ton, M.D.
Steve Gwiazdowski, M.D.  Thomas Paukert, M.D.  Lisa Ward, M.D.

PHC Staff:  Liz Gibboney, Chief Executive Officer  Robert Moore, MD, MPH, Chief Medical Officer – Acting Chair
Watti McFarland, Chief Financial Officer  Peggy Hoover, RN, Senior Director, Health Services
Marshall Kubota, MD, Regional Medical Director  Mary Kerlin, Senior Dir., Provider Relations (PR) Dept.
Jeffrey Ribordy, MD, Regional Medical Director  Colleen Townsend, MD, Regional Medical Director
Stan Leung, Pharm.D., Director, Pharmacy Services  Erika Robinson, Director, Quality & Performance Improvement (S)
Debra McAllister, RN, Dir. of Utilization Mgmt. (UM)  Nancy Steffen, Director, Quality & Performance Improvement (N)
David Glossbrenner, MD, N. Regional Medical Director

Ad Hoc PHC  Sonja Bjork, Chief Operating Officer  Kevin Spencer, Director of Member Services
Members:  Kirt Kemp, Chief Information Officer  Michael Vovakes, MD, Associate Medical Director
Chloe Secor-Schafer, Northern Regional Manager  James Cotter, MD, Associate Medical Director
Tahereh Daliri Sheratif, N. Region Mbr Services & PR Dir.  Bettina Spiller, MD, Associate Medical Director
Sharon Hoffman-Spector, RN, N. UM Manager  Mark Glickstein, MD, Associate Medical Director
Margaret Kisluk, Behavioral Health Administrator  Ladra Guillory, Senior Prov. Relations Rep. Manager
Rebecca Boyd Anderson, RN, Director, Population Health  Margarita Garcia-Hernandez, Manager, Health Analytics
Katherine Barresi, RN, Director, Care Coordination  Vic Patel, Pharm.D., Senior Clinical Pharmacist
Diane Wong, Pharm.D., Senior Clinical Pharmacist  Rachael French, Assoc. Dir., Quality & Perf. Improvement
Jeffrey Devido, MD, Behavioral Health Clinical Director  Doreen Crume, RN, N. Manager, Care Coordination

cc:  PHC Commission Chair  Gabriel Samuel Chua, MD  Kali Stanger, MD  Volutaire Velarde, MD
Richard Fogg  Amy Brom, Psy.D  Karen Relucio, MD
David Danzeisen, MD  Jeremy Austin, MD  Bela T. Matyas, MD  Susan Foster, MSN, FNP-BC
Karen Sprague, NP

FROM: Linda Largent
DATE: June 3, 2020

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

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

DATE: Wednesday, June 10, 2020
TIME: 7:30 a.m. – 9:00 a.m.

LOCATIONS – DUE TO COVID-19 AND SOCIAL DISTANCING, ACCESS IS LIMITED

See Agenda for Call-In Information:

Via Video Conference

Partnership HealthPlan of CA  PHC – Sonoma Office  PHC – Redding Office
4665 Business Center Drive  495 Tesconi Circle  2525 Airpark Drive
(Please Park in Front of Bldg.)  Santa Rosa  Redding
Fairfield, CA

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 (PAC) - AGENDA

Date: June 10, 2020    Time: 7:30 – 9:00 a.m.    Location: PHC

Per Governor Newsom’s Executive Order, N-25-20 that relates to social distancing measures being taken for COVID-19: The Executive Order authorizes public meetings with Brown Act requirements to be held via teleconference or telephone. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/or other personnel of the body as a condition of participation for a quorum. However, the Executive Order requires at least one public location consistent with ADA requirements to be made available for members of the public to attend the meeting, so PHC offices will be available for members of the public to attend the meeting in-person.

To Join by Telephone:
1-844-621-3956  Access code: 807 289 275

REMINDER – PLEASE MUTE PHONE WHEN NOT INTERACTING WITH THE COMMITTEE

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<tr>
<th>PUBLIC COMMENTS</th>
<th>Speaker</th>
<th>2 minutes</th>
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This Brown Act meeting may be recorded. Any audio or video tape record of this meeting, made by or at the direction of PHC, is subject to inspection under the Public Records Act and will be provided without charge, if requested.

Welcome / Introductions

I. Approval of Minutes – Acting Chair  5 – 15  7:30

II. Standing Agenda Items

<table>
<thead>
<tr>
<th>A. Status Update</th>
<th>Lead</th>
<th>Pg #</th>
<th>Time</th>
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<tbody>
<tr>
<td>• Administration</td>
<td>Ms. Gibboney</td>
<td>7:40</td>
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<td>• Medical / Health Services Report</td>
<td>Dr. Moore</td>
<td>7:50</td>
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<td>• Regional Medical Director Reports</td>
<td>Dr. Townsend</td>
<td>7:55</td>
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<td>- Napa &amp; Southeast Counties</td>
<td>Dr. Kubota</td>
<td>7:58</td>
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<td>- Southwest Counties</td>
<td>Dr. Ribordy</td>
<td>8:01</td>
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<td>- Northwest Counties</td>
<td>Dr. Glossbrenner</td>
<td>8:04</td>
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A1. Update from County Public Health Departments  Available Representative(s)  8:07

A2. Committee Member Highlight  Dr. Shinder tentative  8:10

B. Quality / Utilization Advisory Committee (Q/UAC) Activities Report with attachments – Consent Review

Acceptance of Meeting Minutes:

- Activities & Minutes of the May 20, 2020 meeting: -
  - Minutes – Internal Quality Improvement meeting 04/07/2020
  - Quality Improvement Update – May 2020

Approval of Committee’s Action Items & Material Reviewed:

Policies & Procedures: Policy Summary - See Pages 44 - 48

Note – only pages with significant changes are included for policies
- Complex Case Management (MCCP2007) – Excerpt, Redline
- Cultural & Linguistic Program Description (MPLD7001) Redline
- Site Review Requirements and Guidelines (MPDP1022)
- Lactation Policy and Guidelines (MCCP2020)
- Scope of Primary Care – Behavioral Health & Indications for Referral (MPCP2017)
- Screening & Treatment for Substance Use Disorders (MCUP3101) – Excerpt, Redline
- Acupuncture Services Guidelines (MCUG3002)
- Physical, Occupational & Speech Therapies (MCUP3114) Excerpt
- PHC TAR Requirements List (Attachment to MCUP3041, MCUP3049, MCUG3007) – Excerpt, Redline
- Dental Services (MPUP3048) Redline
- Quarterly Grievance Report
- Update on PHC Oversight, Provision and Coordination of Mental Health Services
- Summary of Beacon Services, and PHC’s Membership Impact during COVID-19

B.1. Utilization Management Program Description (MPUD3001) – Amendment to April 2020 (Excerpt)  Approval Required  Ms. McAllister  191 - 192  8:20

B.2. Lactation Clinical Practice Guidelines (MPXG5009) – see attached Approval Required  Dr. Moore  193 - 206  8:20

Continued
C. Pharmacy & Therapeutics (P&T) Committee / Consent Review

Acceptance of Meeting Minutes:

Approval of Committee’s Action Items & Material Reviewed:
No Meeting in May

Dr. Leung / Dr. Moore

D. *** Provider Advisory Group (PAG) Report – Consent Review

Acceptance of Meeting Minutes:

Approval of Committee’s Action Items & Material Reviewed:
Minutes / Material for the May 15, 2020 meeting (attached)

Ms. Sherafat / Ms. Kerlin

E. Credentialing Committee Meeting Summary (Committee Approved)

Acceptance of Meeting Minutes:

Approval of Committee’s Action Items & Material Reviewed
Summary and Credentialed List for the April 8, 2020 meeting (attached)

Dr. Kubota

F. *** Pediatric Quality Subcommittee

Acceptance of Meeting Minutes:

Approval of Committee’s Action Items & Material Reviewed
Minutes / Material Reviewed at the May 6, 2020 meeting (attached)

Dr. Ribordy

G. Recommended Committee Appointments / Resignations:

Dr. Moore

III. Old Business

IV. New Business

A. Hospital Quality Improvement Program (HQIP) – New Measure Proposal for 2020/2021 (see attached) Approval Required

Ms. Stewart / Ms. Robinson

B. Final version of 5-Star Quality Strategic Plan (see attached)

Dr. Moore

C. Discussion Topic - Increasing Outpatient Services: Experiences of Committee Members

Dr. Moore

V. Adjournment

8:55

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.
**Per Governor Newsom’s Executive Order, N-25-20 that relates to social distancing measures being taken for COVID-19: The Executive Order authorizes public meetings with Brown Act requirements to be held via teleconference or telephone. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/or other personnel of the body as a condition of participation for a quorum. However, the Executive Order requires at least one public location consistent with ADA requirements to be made available for members of the public to attend the meeting, so all PHC offices will be available for members of the public to attend the meeting in-person.**

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<thead>
<tr>
<th>Members Present</th>
<th>Members Excused</th>
<th>Members Absent</th>
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<tr>
<td>Jeffrey Bosworth, MD – TC</td>
<td>Thomas Paukert, MD</td>
<td>Mitesh Popat, MD</td>
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<td>Angela Brennan, DO - TC</td>
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<td>Jeffrey Gaborko, MD (Chair)</td>
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<td>David Gorchoff, MD - W</td>
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<td>Steve Gwiazdowski, MD - W</td>
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<td>Michele Herman, MD - W</td>
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<td>Willard Hunter, MD – TC</td>
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<td>Mills Matheson, MD – TC</td>
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<td>Danielle Oryn, DO - W</td>
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<td>Teresa Shinder, DO - TC</td>
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<td>Matthew Symkowick, MD – W (7:48am start)</td>
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<td>Suzanne Eidson-Ton, MD - W</td>
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<td>Lisa Ward, MD - TC</td>
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<th>PHC Staff Present</th>
<th>Note: via Video Conf. (VC) via WebEx (W) via Teleconference (TC)</th>
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<tr>
<td>Liz Gibboney, Chief Executive Officer - W</td>
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<td>Wendi West, Northern Executive Director - VC</td>
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<td>Lynn Scuri, Regional Director - VC</td>
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<td>Mary Kerlin, Sr. Dir., Provider Relations (PR)</td>
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<td>Tabereh Daliri Serafat, N. Member Services</td>
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<td>and PR Director- W</td>
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<td>Chloe Secor-Schafer, N. Regional Mgr - W</td>
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<td>Doreen Crume, RN, N. Care Coord. Mgr.– W</td>
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<td>Tara Fogliasso, N. QI Project Manager - W</td>
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<td>Anthony Sackett, S. QI Project Manager - W</td>
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<td>Robert Moore, MD, Chief Medical Officer</td>
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<td>Peggy Hoover, RN, Senior Dir., Health Services - TC</td>
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<td>Colleen Townsend, MD, Regional Med. Director</td>
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<td>Mark Netherda, MD, Assoc. Medical Dir., Quality-W</td>
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<td>Jeffrey DeVido, MD, Behavioral Hlth Clinical Dir. - W</td>
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<td>James Cotter, MD, Assoc. Medical Director - W</td>
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<td>Stan Leung, Pharm.D., Director, Pharmacy Svs - TC</td>
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<td>Rachel Peterson, N. Manager Clinical Quality - W</td>
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<td>Melissa Stewart, S. QI Project Manager - W</td>
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<td>Dorian Roberts, N. QI Project Manager – W</td>
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<td>David Glossbrenner, MD, N. Regional Medical Dir. - VC</td>
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<td>Marshall Kubota, MD, Regional Medical Director - VC</td>
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<td>Jeffrey Ribordy, MD, Regional Medical Director - W</td>
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<td>Bettina Spiller, MD, Associate Medical Director – TC</td>
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<td>Erika Robinson, Dir., S. Quality &amp; Perf. Improvement – W</td>
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<td>Nancy Steffen, Dir., N. Quality &amp; Perf. Improvement - W</td>
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<td>Debra McAllister, RN, Director, Utilization Mgmt. - VC</td>
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<td>Sharon Hoffman-Spector, RN, N. UM Mgr.– VC</td>
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<td>Margarita Garcia-Hernandez, Mgr. Health Analytics-W</td>
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**Note – All Telephone Participants may not be listed – Unidentifiable on Report**

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<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>Public Comments Quorum</td>
<td>The Committee Chairperson, asked for public comments. None were presented.</td>
<td>N/A</td>
<td>N/A</td>
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<td>I. Approval of Minutes</td>
<td>The Committee’s Chair presented the meeting minutes</td>
<td><strong>MOTION</strong>: Dr. Gwiazdowski moved to approve Agenda Item [I.] as presented, seconded by Dr. Eidson-Ton. <strong>ACTION SUMMARY</strong>: [12] yes, [0] no, [0] abstentions. Motion carried.</td>
<td>05/13/20</td>
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<td>AGENDA ITEM</td>
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| II.A. Status Update Administration | The HealthPlan’s Chief Executive Officer (CEO), provided the following report on PHC activities.  
- COVID-19 – The vast majority of PHC staff continue to telework, the success of which stems from the great support received from PHC’s Information Technology (IT) team.  

The member outreach call campaign (TLC4C19) continues. Staff is targeting over 60,000 highest risk individuals in an effort to check on their well-being and ensure they are aware of resources available in their community, and that they have access to Beacon mental health services, etc. Staff has been able to reach a higher than normal number of members, which is not surprising. There has been a very positive response from those reached.  

Dr. Bosworth expressed appreciation that PHC is conducting this major outreach to members. He asked if the messaging includes information on the efforts health centers are doing to ensure their environment is safe for patients who need to come into the facility. Shasta Community Health Centers has done some outreach on their own, which has helped patients to feel more at ease coming into the center. PHC’s CEO noted that the initial call campaign is about ensuring members have the basics. But, the messaging has also included a reinforcement that, if they need assistance, they should contact their PCP office, and making sure they know who their PCP is. If another campaign is done, or if the current script is revised, that important information will be incorporated into the messaging.  

In terms of PHC’s provider network, staff continues to monitor any closures or reduction in practice site hours, sending regular reports to the Department of Health Care Services (DHCS). Some provider payments have also been accelerated, specifically to hospitals, so they can have access to those funds earlier. And, with the Board’s approval, unearned Primary Care Provider (PCP) Quality Improvement Program (QIP) funds will be repurposed to further support virtual health access and workforce initiatives, which will be in the form of grants in the near future. The pandemic has had a significant impact on the State’s budget, which will impact Partnership. Though still nominal, PHC is already seeing increases to its membership, due to the staggering unemployment being experienced across the nation. PHC is expecting tens of thousands new members (low end projection around 60,000.)  

Dr. Herman addressed the absorption of the expected increase in membership volume, and how that will impact practices. Currently, some La Clinica sites are losing staff. Last year, the PCP QIP Gateway measure and other provisions were not met. It may be impossible for these practices to absorb additional patients, and still give quality services to their existing patients. What is being done to help support that shortfall? PHC’s CEO advised that Partnership will continue to utilize the capacity that each PCP site has indicated they can accommodate, based on their staffing ability. Additional members would not be assigned if staffing at the practice cannot absorb those patients. With that said, Partnership has seen a significant reduction in membership over the past one to two years, and believes this has been due to improvements in the economy and individuals qualifying for employer-based coverage. Theoretically, there should be some capacity in the primary care network to absorb an increase.  

PHC’s Senior Director of Provider Relations (PR) shared that staff have received calls from network providers, wanting to ensure that, should their commercial patients become Medi-Cal, there was a process by which Partnership used to keep those patients with the practice. PR staff will be working with PHC’s Member Services department in this regard.  

Dr. Ward asked if PHC is aware of small practices temporarily closing within its network, due to the site’s inability to perform telemedicine or obtaining personal protective equipment (PPE). PHC’s CEO noted that the majority of what has been seen is a reduction in hours for some PCP practices. However, there are some specialty practices that have temporarily closed. PHC’s Chief Medical Officer noted that those closures have often been driven by the
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<td>II.A. Status Update Administration</td>
<td>providers being in the high-risk category. Partnership’s Associate Medical Director shared that there are some small practices impacted with challenges in obtaining sufficient PPE to re-open their practice.</td>
<td>For information only, no formal action required.</td>
<td>05/13/20</td>
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<td>State -</td>
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<td>- California Advancing and Innovating Medi-Cal (CalAIM) – The State is not spending much time on its ambitious 5-Year Waiver proposal, which was in the midst of being finalized for submission to the Centers for Medicare &amp; Medicaid Service (CMS) when the pandemic hit. PHC believes the State is waiting on a one-year extension for the current Waiver, delaying the new proposal by one year. However, that is unconfirmed, and not yet approved by CMS.</td>
<td>For information only, no formal action required.</td>
<td>05/13/20</td>
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<td>- State Budget – Tomorrow, the Governor will be releasing the May Revise for the State’s Budget, which is the update to the Budget proposed in January. There is a staggering $30 billion to $54 billion deficit, due to the expenditures around COVID-19. The Governor’s Department of Finance is on the high side, as it does not include any Federal financial relief from pending requests. The lower estimate released by the State’s Legislative Analyst’s Office (LAO) this week assumes some Federal funding.</td>
<td>For information only, no formal action required.</td>
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<td>II.A. Status Update Medical</td>
<td>The HealthPlan’s Chief Medical Officer (CMO) presented an overview of some Health Services activities.</td>
<td>For information only, no formal action required.</td>
<td>05/13/20</td>
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<td>- Regional Medical Director Forums – The first of two virtual forums was held last Friday, which had a great turnout. Based on feedback, some improvements to the presentation will be made before the next virtual meeting on May 22. The plan is to record that session and have it available on PHC’s website for any provider staff who would benefit.</td>
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<td>- PHC PCP Blog – Updates regarding COVID-19 and public health being sent out to primary care providers is being added to PHC’s Primary Care Blog so that providers can reference. (phcprimarycare.org)</td>
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<td>- Quality Expectations – The State and National Committee for Quality Assurance (NCQA) have adjusted some quality expectations for health plans amidst the pandemic. NCQA assigns a Star Score to different health plans. If plans are unable to collect the hybrid data during the Healthcare Effectiveness Data and Information Set (HEDIS®) process (due to COVID-19), it will cause an inequity in 2019 aggregate scores for some plans. NCQA has offered that health plans can count their previous year as hybrid data for generating the plan’s score for NCQA’s Star Score. This sounds fair, but, is really problematic when attempting to implement. In the end, there are four administrative measures left, while all other measures are hybrid.</td>
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<td>1) Anti-Depressant Medication – starting and continuing</td>
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<td>2) Breast Cancer Screening</td>
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<td>3) Asthma Medication Ratio</td>
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<td>4) Chlamydia Screening</td>
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<td>The most recent update from DHCS is that they will only hold health plans accountable for these same measures. Details on PHC’s HEDIS® scores will be brought to this Committee at a later date. For next year, with practices minimizing visits due to COVID-19, almost all the measures will be severely impacted.</td>
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| II.A. Status Update Medical, Continued | Consequently, any benchmarks practice sites use for the previous year will be useless. It may be that DHCS decides to simply dismiss the measurements for 2020. Given past delays in receiving instructions around HEDIS® measures, it may be 2021 before PHC has that information. Another possible scenario DHCS may take will be to focus on the highest priority measures. DHCS has hired a nationally renowned consulting group, who are experts on Medicaid pay-for-performance measures. This may signify that they are looking at a complete overhaul of the measurement framework.  

- Better Collaboration – One consequence stemming from the pandemic seems to be increased communication and better collaboration between county health departments and primary care organizations. To some extent, each county has their own challenges around PPEs, etc. PHC is pleased to do what it can to help in those efforts.  
      
  PHC’s Regional Medical Director for Napa and the Southeast (SE) counties presented a brief update.  

- COVID-19 – Responses have varied between the three SE counties, but, all have been robust. Looking at data, Solano County has had a few mild outbreaks, and one pretty significant outbreak at a skilled nursing facility (SNF). In Yolo County, two SNFs were impacted, though the number of cases have settled down for each county this past week. Napa County has been somewhat insulated from cases, but, has a robust testing process in place. Even with the expanded testing, the number of cases have not increased proportionately.  

- Quality Meeting – On June 4, a meeting on quality has been scheduled for the SE Region. Medical directors are encouraged to participate in the meeting, which will review the new QIP measures. This will be a great opportunity for medical directors to address those measures for the SE Region. Though it is a challenging time, it is also a good time to help drive the work forward.  

- Provider Education – Meetings regarding the Asthma Medication Ratio (AMR) continue. Webinars are being scheduled out, which will allow primary care teams to receive their data and review new clinical guidelines, with respect to treating asthma. Meetings also continue for the Perinatal QIP, which are in webinar format, versus in-person.  
      
PHC’s Regional Medical Director for the Southwestern (SW) counties presented a brief overview.  

- COVID-19 – Along with the Redwood Community Health Coalition (RCHC), PHC staff is conducting weekly teleconferences to address what needs to occur for practices to reopen. Strategies include the types of visits, regaining the confidence of both staff and public, and how best to conserve the supply of PPE. There has been high interest and participation in the meetings, and gives a venue to discuss a more consistent approach for practices.  

In Marin and Sonoma counties, the new demographic hot spot is the Hispanic community, where they are disproportionately testing positive. These individuals tend to be more economically challenged, and work in industries considered essential, but, there is the potential of being exposed to the virus. In addition to focus testing on first responders, clinicians, and nursing homes, Sonoma County is now going to expand that focus into small community grocery stores, which seems to be an area of great concern. | For information only, no formal action required. | 05/13/20 |

05/13/20
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| II.A. Status Update Medical, Continued  | **PHC’s Associate Medical Director of Quality shared that Sonoma County has increased its testing, which is close to the goal of 800 tests per day, and the level to allow for more business openings, based on the Centers for Disease Control and Prevention (CDC) recommendations.**  
- Access – There is a new rheumatologist at Petaluma Health Center, who will be open to referrals.  
- Provider Education – Changes to the QIP are being discussed with clinical directors on a one-to-one basis. A readmission project is underway with hospitals showing high rates of readmissions. The project will explore what can be done to improve those rates.  

**PHC’s Regional Medical Director for the Northwestern (NW) counties presented a brief overview.**  
- COVID-19 – The area had been seeing around one new case per week, until this week, when seven new cases were confirmed. Three of those cases (one staff person and three residents) are associated with an assisted living facility in Eureka. So far, others at the facility have tested negative. This is especially concerning when factoring in the elderly population in the area.  
- Access – Many of the area providers are utilizing telemedicine for their patients. St. Joseph’s Hospital is starting to open up outpatient surgeries.  

**PHC’s Northern Regional Medical Director presented a brief overview.**  
- COVID-19 – Fortunately, the number of cases are stable in the area, which is encouraging. Hospitals in the area have started doing elective surgeries. With the pandemic shutdown, hospitals (as well as a number of small practices) are financially stressed. The effects of the shutdown will be felt for some time to come.  
- Access – There is currently nothing to report regarding network changes.  

II.A1. Update Cnty Public Health | There was no epidemiology update presented to the committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | For information only, no formal action required. | 05/13/20 |
<p>| II.A2. – Committee Member Highlight | Partnership’s Director of Utilization Management shared some of her background, and what brought her to PHC. Ms. McAllister is a native to California, being raised in Albany, which is a relatively small city adjacent to Berkeley. She wanted to be a nurse from an early age, and received her Registered Nurse (RN) license more than 35 years ago. Her nursing career has been multi-faceted and she feels fortunate for having those experiences. Those included working with the geriatric population at a SNF, home care and hospice, case management, utilization review, and holding leadership roles. When Ms. McAllister was a child, her cousin joined the army and was sent to Vietnam. In a short time, he was seriously injured by an active expendable decoy (AED). When he returned home he required a lot of care, having lost one leg and part of the other, and most of his abdominal cavity. His care was shared among the extended family, which included her home. Though he struggled and was paralyzed, the care he received from many nurses and family members allowed him to improve to the point of having a functional life. This was inspiring, and solidified her need to be someone giving care to others. | N/A | -- |</p>
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<td>II.A2. – Committee Member Highlight, Continued</td>
<td>After high school, Ms. McAllister attended a medical assistant program. Her first position in health care was in Richmond, working for a pediatric medical group (Rainbow Pediatrics.) With five pediatricians, the office was very busy and saw many children. Though she enjoyed her position, she wanted to expand her career, so applied to the Samuel Merritt University School of Nursing in Oakland, and was accepted. To help pay her tuition, she took on a second job on the weekends as the night shift clerk at Herrick Hospital Emergency Room in Berkeley. Her first shift was slow, and she struggled staying awake, until an ambulance arrived at 3:28 in the morning along with an unruly crowd. A fight broke out, followed by two people being shot, which confirmed to her that emergency room medicine was not her path.</td>
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<td>While attending Samuel Merritt University, Ms. McAllister took the academics at St. Mary’s College in Moraga. After graduating, she accepted a full-time night shift position at Merritt Hospital in their orthopedic unit. After two years of being sleep deprived, she decided to find a position that allowed her to work days. Her next adventure was working the day shift at the Alta Bates Hospital in their medical / surgical unit. She loved patient care and teaching, and discovered she had an affinity for wound care. She was mentored by the wound nurse, and encouraged to take the Wound, Ostomy and Continence Nurses (WOCN) training, which she completed.</td>
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<td>Ms. McAllister was a nurse at Alta Bates Hospital for 13 years, which included work with the Kidney Transplant Team, a unit that assisted patients dealing with Kaposi’s sarcoma, and part of an eighteen month team dedicated to building, testing and training on an electronic document system, which crashed seven months after implementation. During that time, she met and married her husband, David, which was over 30 years ago. He too is a nurse and works in the emergency department at Contra Costa County. They have two grown children, who returned home after college so that each could save for their own homes, which has not yet come to fruition. Her daughter is a dolphin trainer at Six-Flags (dream job), and her son is a robot technician supervisor at Tesla. After having her children, Ms. McAllister wanted to work less hours, so she ventured out as a wound consultant, then joined a specialty bed company that became KCI. Aside from consulting on wound care, she was expected to rent or sell a quota of specialty beds.</td>
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<td>This venture lasted five years, at which time one of her clients sought her out for another opportunity. She was introduced to utilization management (UM) while working at Kindred Hospital as the Director of Nursing. That position was responsible for cost containment and appropriate utilization. Ensuring patients received appropriate and quality care became a passion for her. Learning about Medi-Cal and Medicare regulations was intriguing, and regulatory guidelines and staffing ratios were initiated. After four years of being in this corporate realm, she took a couple months off before accepting a position as a utilization review (UR) nurse at the Chinese Community Health Plan in San Francisco, thinking that working in the city would be exciting. Not speaking Chinese was a challenge, but, she had the opportunity to learn more about commercial and Medicare / Medi-Cal (Medi-Medi) health plans, as well as regulatory guidelines. The commute home took a toll, sometimes taking upwards of 3 hours, especially on “Game Day.” After four years, she was prompted by one of her medical directors to apply for a UM position at Partnership HealthPlan, which was almost nine years ago. Ms. McAllister is now the Director of UM at PHC, lives in American Canyon, and has a commute of 15 minutes each way. PHC’s vision of caring for those who cannot care</td>
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## AGENDA ITEM

### II.A2. – Committee Member Highlight, Continued

For themselves is a daily impetus for her, and she learns something new daily. She works with a talented, passionate and dynamic administration, and the UM teams (working in multiple regions) is cohesive and dedicated to members and the providers they serve. Staff evaluates the needs of each individual person. There is collaboration within PHC’s departments, as well as with the partners at network hospitals, offices, clinics, and providers, which has contributed to the high regard and effective reputation PHC has earned. Ms. McAllister is proud to be part of the organization.

### II.B. Quality/ Utiliz.


There were no items pulled by the Committee from the Consent Calendar.

#### II.C. Pharmacy & Therapeutics Committee

PHC’s CMO advised that Susan Foster is a nurse practitioner and the Medical Director at Hill Country Health & Wellness Center, and has expressed her interest in participating on the Credentialing Committee. Her appointment is recommended.

#### II.E. Credentialing Committee

PHC’s Director of Pharmacy Services presented highlights from the P&T Committee meeting in April.

- Removing from formulary: hydroxychloroquine and chloroquine – This is to ensure there is sufficient supply available for those who have U.S. Food and Drug Administration (FDA) indications. Any person who was already prescribed one of these drugs will be grandfathered in. Any new starts will require a Treatment Authorization Request (TAR). If the drug is being used for a clinical trial, or outside the emergency use protocol, documentation will need to be provided. There is currently a limitation of a 30-day supply on hydroxychloroquine, but, that can be extended to 90 days if specifically requested by the provider noting medical necessity.
- Xopenex HF and the generic Novolog have been added to the formulary for ease of access.
- Enoxaparin (generic for Lovenox) – The fill limit (previously 2 per year) has been removed, along with the limit of 10 days’ supply per fill (which is consistent to the package labeling.)

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<td>II.A2. – Committee Member Highlight, Continued</td>
<td>for themselves is a daily impetus for her, and she learns something new daily. She works with a talented, passionate and dynamic administration, and the UM teams (working in multiple regions) is cohesive and dedicated to members and the providers they serve. Staff evaluates the needs of each individual person. There is collaboration within PHC’s departments, as well as with the partners at network hospitals, offices, clinics, and providers, which has contributed to the high regard and effective reputation PHC has earned. Ms. McAllister is proud to be part of the organization.</td>
<td>For information only, no formal action required.</td>
<td>05/13/20</td>
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<td>II.B. Quality/ Utiliz. Advisory Committee, II.B.1. Clinical Practice Guidelines – Diabetes Mellitus, II.B.2. Annual Physician Satisfaction Survey policy, II.C. Pharmacy &amp; Therapeutics Committee II.E. Credentialing Committee</td>
<td>There were no items pulled by the Committee from the Consent Calendar.</td>
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<td>II.G. Committee Membership</td>
<td>PHC’s CMO advised that Susan Foster is a nurse practitioner and the Medical Director at Hill Country Health &amp; Wellness Center, and has expressed her interest in participating on the Credentialing Committee. Her appointment is recommended.</td>
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| IV.A. Pharmacy & Therapeutics (P&T) Committee Highlights | PHC’s Director of Pharmacy Services presented highlights from the P&T Committee meeting in April.  
- Removing from formulary: hydroxychloroquine and chloroquine – This is to ensure there is sufficient supply available for those who have U.S. Food and Drug Administration (FDA) indications. Any person who was already prescribed one of these drugs will be grandfathered in. Any new starts will require a Treatment Authorization Request (TAR). If the drug is being used for a clinical trial, or outside the emergency use protocol, documentation will need to be provided. There is currently a limitation of a 30-day supply on hydroxychloroquine, but, that can be extended to 90 days if specifically requested by the provider noting medical necessity.  
- Xopenex HF and the generic Novolog have been added to the formulary for ease of access.  
- Enoxaparin (generic for Lovenox) – The fill limit (previously 2 per year) has been removed, along with the limit of 10 days’ supply per fill (which is consistent to the package labeling.) | For information only, no formal action required. | |

**MOTION:** Dr. Gwiazdowski moved to approve Agenda Items [II.B., II.B.1., II.B.2., II.C., and II.E.] as presented, seconded by Dr. Eidson-Ton.  
**ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.  
Motion carried.

**MOTION:** Dr. Gwiazdowski moved to approve Agenda Item [II.G.] as presented, seconded by Dr. Herman.  
**ACTION SUMMARY:** [13] yes, [0] no, [0] abstentions.  
Motion carried.

For information only, no formal action required.
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| IV.B. Primary Care Provider (PCP) Quality Improvement Program (QIP) COVID-19 Revised Measures 2020 | PHC’s Southern Quality Project Manager (Project Manager) for the PCP QIP presented recommended changes to the Primary Care Provider (PCP) Quality Improvement Program (QIP) 2020 Measurement Set, which is a direct result of COVID-19 and was included in the meeting packet.

Changes include:
- Suspension of the Gateway Measure
- Only full points will be allocated (no partial)
- Based on HEDIS®, the 50th percentile will be used as the threshold, Colorectal Cancer Screening will use the 25th percentile as its threshold
- The Relative Improvement (RI) is being removed for points
- Reducing the core measurement to just clinical measures plus PCP utilization.
- No major changes to the Unit of Service, just some modifications to specifications to accommodate the current pandemic

Clinical Domain / Family Medicine:
Balance of measures to include:
- Well Child Visits (first 15 months)
- Controlling High Blood Pressure *
- Colorectal Cancer Screening *
- Diabetes Management: HbA1C Good Control *
- Childhood Immunization Combo 10
- Asthma Medication Ratio (5 to 64 years of age) *

* Applies to Internal Medicine

Non-Clinical Domain:
The PCP Office Visit measure will be retained as the Non-Clinical Measure, using 2.1 as the average, with the proviso that the QIP Team and leadership will continue to monitor the data as received through encounter data, and may modify the target based on that information.

Dr. Herman recognized the challenges of trying to adjust the measures in time of COVID-19. But, she needs to address those changes as they will impact practice sites and those in the field. There has been a reduction in staffing, so there are fewer providers. Last year, La Clinica Vallejo was only able to hit 1.46 for the Office Visit measure. Add on the expectation for additional enrollment, and the takeaway for the clinic will be that their focus needs to be on the sickest population, even those who are only temporarily on Medi-Cal. These factors raise concerns for the viability of the clinic. This may result in the clinic deciding to close to new patients, since they cannot accommodate them and increase the number of visits for their other patients. Additionally, the all or nothing approach places exceeding pressure on providers to focus more on meeting the goals than medical care, leaving a feeling of hopelessness for providers. PHC’s CMO noted that the previous Gateway Measure was all or nothing, which has been reduced to 15%, and virtual visits count. DHCS has not altered their minimum performance level from the 50th percentile. It is intended that the threshold for the PCP Office Visit measure will be reevaluated later in the year.

Dr. Ward offered that the members assigned to practice sites, who do not actively seek medical care, are a significant drag on the office visit average. Santa Rosa Community Health Centers (SRCHC) would like to collaborate on strategies to ensure SRCHC is being assigned patients in their geographic area with working phone numbers, which would help them to address the issue of noncompliant patients. There is also a heightened challenge for practices who see homeless members. PHC’s CMO acknowledged this significant challenge, noting that incorrect telephone numbers is an issue across all PHC regions. There are some processes in place to cleanup bad contact information, which is not always addressed at the county level when Medi-Cal applications are processed.
IV.B. Primary Care Provider (PCP) Quality Improvement Program (QIP) COVID-19 Revised Measures 2020

PHC’s Northern Executive Director shared that a system is being used to track down hard to find members, and staff utilize the lists provided by individual practices (several of which have been part of the most recent project.) Staff has had relatively good success (26% to 28%) in tracking down these members. The correct information is maintained in PHC’s system, and staff has worked with the counties to ensure they are also updated. Work with counties has been more streamlined, whereas, they will accept the new information without receiving an official reply from the member. Counties have also been instructed by the State to enhance their efforts in tracking down more accurate contact information for Medi-Cal members. Another initiative being used is when patients present to emergency rooms (who do not have or use their PCP) and using that opportunity to get correct contact information. Any facility who has a list of unreachable members can contact Partnership so that staff can work on improving those contacts.

Dr. Herman noted that looking ahead to the coming year, there are a number of people who may be in the midst of life transitions. Expending resources on those who may only be with the clinic a few months will limit the number of appointments available to see existing patients. If there is already a strain on appointment availability and resources, outreach to schedule office visits for noncompliant members seems out of reach. She is hoping that these factors will be taken into consideration when looking at the metrics of the measure. PHC’s CMO shared that the utilization of virtual medical visits was a consideration when revising the measure, as a means to ensure that capitated providers are actively using a virtual system.

Based on the Committee’s discussion, PHC’s CMO recommended removing the threshold number of 2.1 for the PCP Office Visits, since the data is intended to be reevaluated at a later date. For simplicity, the measure will be amended by removing the 2.1 threshold, and stating “to be determined” in its stead. Dr. Herman was in favor of this change.

MOTION: Dr. Gwiazdowski moved to approve Agenda Item [IV.B.] as Amended, seconded by Dr. Ward.
ACTION SUMMARY: [13] yes, [0] no, [0] abstentions. Motion carried.

IV.C. Perinatal QIP Proposed Measures – Fiscal Year 2020/2021

PHC’s S. QIP Project Manager presented the Perinatal QIP, which is recommended for implementation, ending its pilot phase. This QIP will be on a fiscal year cycle, as opposed to the calendar year cycle used for the PCP QIP, with a starting date of July 1, 2020. This program is invitational only, as there are currently a core set of providers participating and engaged in the program. The two items of mention is that changes will be proposed...
### AGENDA ITEM

**IV.C. Perinatal QIP Proposed Measures – Fiscal Year 2020/2021, Continued**

To the postpartum care measure, and how that information will be captured. Currently, information is captured through uploads to eReports. The proposal is to move away from that method and use accurate billing, thus being captured through claims encounters.

A new measure being proposed is to encourage electronic clinical data systems (ECDS) use, and will allow QIP staff to capture information through the provider’s electronic health record (EHR), as it pertains to depression tools and screening.

The N. QIP Project Manager noted that organizations eligible for Proposition 56 funds for timely tetanus, diphtheria, and pertussis (Tdap) vaccines, and postpartum incentives, will not be eligible for those funds under the Perinatal QIP. Those organizations include non-Federally Qualified Health Centers (FQHCs), non-Tribal Health, and non-Rural Health Centers (RHCs). Staff will be referencing this restriction when reports are sent out to practice sites. This will also be clearly stated in the Perinatal QIP material.

Referring to Dr. Eidson-Ton’s earlier question regarding the process automation for this program, it was noted that staff is working toward capturing this data administratively, and working with the team to develop reports that will be sent to providers more regularly throughout the year, showing their progress. Development of an automation process has been put on hold, due to other constraints.

PHC’s Behavioral Health Clinical Director offered that the Perinatal QIP continues to include the requirement for Depression Screening at the first prenatal visit. Last week, there was a Dutch report published regarding the lower number of prenatal visits being done, due to the fears around COVID-19 that women have. It is unknown what the long-term impacts will be on the mental health for these women who have opted to cancel appointments during their prenatal or perinatal term. This could be a particular population hit with significant mental health issues down the road, due to the concerns around the virus, which makes the depression screening that much more important.

In the interest of time, PHC’s S. Project Manager for this program gave a very high level overview of the Hospital QIP Evaluation for 2019, as more detailed information was provided in the meeting packet. Twenty-five hospitals participated in the 2018/2019 fiscal year program, with an average score of 80%. There were 10 hospitals recognized for scoring 90% or higher, which is an increase from 8 hospitals receiving those levels for the 2017/2018 measurement year. PHC distributed approximately $12.6 million. The exclusive breastmilk feeding measure, as well as the hospital acquired Venous Thromboembolism (VTE) both showed performance improvements, and there was a stable performance under readmissions, elective deliveries and the Nulliparous, Term, Singleton, Vertex (NTSV) C-Section rates.

There are ongoing discussions on how PHC can help smaller hospitals with their readmission rates, due to the impact of those readmissions on the hospital. Quality staff also continues to work with PHC’s Quality Collaborative partners like the California Maternal Quality Care Collaborative and the Collaborative Healthcare Patient Safety Organization (CHPSO). PHC’s CMO noted that next year’s measures will be brought to this Committee next month.

### RECOMMENDATIONS / ACTION

**MOTION:**
Dr. Eidson-Ton moved to approve Agenda Item [IV.C.] as presented, seconded by Dr. Gwiazdowski.

**ACTION SUMMARY:**
[13] yes, [0] no, [0] abstentions. Motion carried.
### AGENDA ITEM

**IV.E. Discussion Topic:** Increasing Outpatient Services: Readiness and Communication

**DISCUSSION / CONCLUSIONS**

PHC’s CMO noted that a version of guidelines for reopening medical offices was included in the meeting packet for consideration. The American Medical Association (AMA) also put out guidelines about one week ago, which are referenced (along with others) in his COVID-19 update distributed to medical directors yesterday. In review of the packet information and the section for Staffing Aspects, Dr. Matheson questioned what constitutes exposure to the virus. PHC’s CMO acknowledged that there is a lot controversy around that topic. The various scenarios make that determination very difficult to pinpoint. Dr. Matheson shared that at the California Department of Public Health’s last meeting, they were leaning toward allowing health care workers, who were exposed, to continue to work. That may be more applicable in New York City, but, he would be nervous allowing that to occur in Willits, where there is no community spread. PHC’s CMO noted that this brings up another factor of what the area’s workforce looks like, as compared to the area’s health care needs. Thus, exposure factors would include prevalence in community, nature of exposure (distance, length of time), personal protective equipment (PPE) used at the time, and what the community practice has been.

The Committee’s Chair acknowledged those who have been very strict in their approach, quarantining first responders who had been exposed to COVID-19. They soon found their workforce was decimated using that approach. Kaiser Permanente Vacaville is currently conducting around 2,000 tests per day, which get turned around in 24 hours. They are finding very few, if any, transmissions at work, but, staff is also being vigilant adhering to precautions and using their PPE.

Dr. Eidson-Ton shared that staff at CommuniCare Health Centers are using the CDC’s criteria for high, medium, and low risk exposure. When using those guidelines, you do not have to exclude staff from work, unless they have had a medium or high risk exposure, which does not occur unless they are not using their recommended PPE.

PHC’s SW Regional Medical Director offered that there is a fairly detailed table showing risk classifications and “what to do when” under the CDC website, Interim Guidance.

**RECOMMENDATIONS / ACTION**

For discussion purposes only, no formal action required.

**DATE RESOLVED**

05/13/20

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**Adjournment**

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

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The foregoing minutes were APPROVED AS PRESENTED on:  ___________________________________________________________________________________________

Date  ___________________________  ____________________________________  Robert Moore, M.D., Acting Committee Chairman

The foregoing minutes were APPROVED WITH MODIFICATION on:  ___________________________________________________________________________________________

Date  ___________________________  ____________________________________  Robert Moore, M.D., Acting Committee Chairman

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**PER Governor Newsom’s Executive Order, N-25-20 that relates to social distancing measures being taken for COVID-19. The Executive Order authorizes public meetings with Brown Act requirements to be held via teleconference or telephone. It waives the Brown Act requirement for physical presence at the meeting for members, the clerk, and/or other personnel of the body as a condition of participation for a quorum. However, the Executive Order requires at least one public location consistent with ADA requirements to be made available for members of the public to attend the meeting, so all PHC offices will be available for members of the public to attend the meeting in-person.**

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<tr>
<td>Gwiazdowski, Steven, MD, FAAP (via phone)</td>
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<td>Lane, Brandy, PHC Consumer Member (via phone)</td>
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<td>Montenegro, Brian, MD (via phone)</td>
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<td>Murphy, John, MD (via phone)</td>
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<td>Quon, Robert, MD (via phone)</td>
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<td>Stockton, Candy, MD (via phone)</td>
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<td>Swales, Chris, MD (via phone)</td>
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<td>Thomas, Randolph, MD (via phone)</td>
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<td>Threlfall, Alexander, MD (via phone)</td>
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<td>Wilson, Jennifer, MD (via phone)</td>
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<tr>
<td>Borde, Madhusudan, MD</td>
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<td>Choudhry, Sara, MD</td>
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<td>Strain, Michael, PHC Consumer Member</td>
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<tr>
<td>Banks, La Rae, Director of Grievance and Appeals</td>
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<td>Boyd Anderson, Rebecca, RN, Director of Population Health</td>
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<td>DeVido, Jeff, Behavioral Health Clinical Director</td>
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<td>French, Rachael, Associate Director of Quality and Performance Improvement</td>
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<td>Glickstein, Mark, MD, Associate Medical Director</td>
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<td>Guillory, Ledra, Manager of Provider Relations Representatives</td>
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<td>Hoover, Peggy, RN, Senior Director of Health Services</td>
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<td>Katz, Dave, MD, Associate Medical Director</td>
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<td>Kubota, Marshall, MD, Regional Medical Director</td>
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<td>Leung, Stan, PharmD, Director of Pharmacy Services</td>
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<td>McAllister, Debra, RN, Director of Utilization Management</td>
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<td>Moore, Robert, MD, MPH, MBA Chief Medical Officer – Chairman</td>
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<td>Netherda, Mark, MD, Associate Medical Director of Quality</td>
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<td>Ribordy, Jeff, MD Regional Medical Director</td>
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<td>Robinson, Erika, Director of Quality and Performance Improvement</td>
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<td>Scuri, Lynn, Regional Director</td>
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<td>Spiller, Bettina, MD, Northern Region Associate Medical Director</td>
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<td>Steffen, Nancy, Northern Region Director of Quality and Performance Improvement</td>
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<td>Townsend, Colleen, MD, Regional Medical Director</td>
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<td>Vovakes, Michael, MD, Associate Medical Director</td>
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<tr>
<td>Barresi, Katherine, RN, Director of Care Coordination</td>
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<td>Cotter, James, MD, Associate Medical Director</td>
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<td>Glossbrenner, David, MD, Regional Medical Director</td>
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<th>Guests:</th>
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</thead>
<tbody>
<tr>
<td>Crume, Doreen, RN, Manager of Care Coordination</td>
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<tr>
<td>Devan, James, Manager of Performance Improvement</td>
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<tr>
<td>French, Alison, Director of Partnerships, Beacon Health Options</td>
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<tr>
<td>Hoffman-Spector, Sharon, RN, Manager of Utilization Management</td>
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<tr>
<td>Kisluk, Margaret, Behavioral Health Administrator</td>
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<td>Klinger, Ron, RN, Manager of Care Coordination</td>
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<tr>
<td>Leslie, Liz, Program Manager II, Wellness and Recovery Program</td>
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<tr>
<td>Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep</td>
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<tr>
<td>O’Connell, Lisa, Manager of Provider Education</td>
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<tr>
<td>Peterson, Rachel, RN, Performance Improvement Clinical Specialist I</td>
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<td>Roepcke, Meagan, Senior Project Manager</td>
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<td>Schiewe, Janet, Project Coordinator II</td>
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<td>Vij, Namita, Provider Education Specialist</td>
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<tr>
<td>AGENDA ITEM</td>
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<tr>
<td>I. Call to Order</td>
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<tr>
<td>Public Comment</td>
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<td>Approval of Minutes</td>
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<td>II. Standing Agenda Items</td>
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<td>I. Status of Open Action Items</td>
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2. Quality Improvement (QI) Department Update

Erika Robinson and Nancy Steffen provided the QI update found on page 26.

- The payment process was completed at the end of April for our Primary Care Provider (PCP) Quality Incentive Program (QIP), Palliative Care QIP, Long Term Care (LTC) QIP and Hospital QIP. In response to COVID-19, we have made adjustments to the PCP QIP program, and have reduced the measure set and the number of clinical and non-clinical measures and have also revisited our use of service measures.
- PHC is looking at the types of interventions that we are hoping to do for members and want to ensure they are thoughtfully being considered in light of what current patient behavior is and the recommendations from our health departments and DHCS. Erika advised that PHC is continuing to do workarounds on one of our performance improvement projects for the well-child visits for children 0-15 months of age and asked the committee members what their practices are doing in terms of reintroducing members and patients and encouraging them to come in with their children for the well care visits and immunizations.
- Dr. Quo advised at Kaiser, they originally didn’t have anyone coming in and it was only by referral, so all of their care went virtual and after a member spoke to a physician if they felt you needed to come in, there were people in the clinic that could see you and a sane day appointment would be arranged. As the crisis went on, Kaiser realized that we needed to get our children in to get their well care visits and vaccinations because once they are off they are not able to catch up for many of them. In family medicine and pediatrics, appointments were separated by time of day, and morning would only be for well care visits and then in the afternoon would be the urgent care appointments for when a child needed to be seen.
- Dr. Thomas advised at Sutter they had all the well checks not come in with the exception of the infants that were up to 18 months of age so they could stay on schedule with their vaccines. When they did come in we separated them by time, having the well checks come in the morning. Additionally, well checks were only seen in certain rooms and other rooms in a different section is where the sick visits were seen. At this point we are trying to get all the well checks in, but initially was actively trying to get the younger ones in.
- Dr. Stockton advised they don’t see children under age 12 at her practice, but initially they did separate appointments by time of day. Now they have segregated the clinic and have a sick side and well side that are shut off from each other and they have a provider and medical assistant that only see sick patients and the rest of the staff doesn’t see anyone who has contagious symptoms.
- Dr. Swales advised in Woodland they have done something similar. They have well visits in the morning and sick visits in the afternoon. They have been doing well child visits via telehealth and a nurse visit for the vaccines.
- The QIP team has integrated the Tableau-based Immunization Dose Reports which are available within eReports. The reports provide a member level view and is meant to help improve visibility.
for providers as they track progression of immunizations. Initially these reports were available quarterly on an ad hoc basis, but due to provider feedback, PHC has made these reports available on demand and they are now refreshed monthly in our eReports system.

- Most of the northern region (NR) providers participating in the extended Birthday Club are still participating in this member incentive offering to drive improvement in the Well-Child Visits for 3-6 Year Olds (W34) measure. This represents 37 unique PCP health centers or clinic sites across the NR. PHC will honor all members presenting their birthday cards, regardless of when this annual visit is completed during 2020. Some providers have opted out of PHC offered birthday club reminder calls to members, with only 2 NR providers asking to temporarily pause all participation due to COVID-19 response priorities.

- A new enhancement called ePrompts is coming to PHC’s Call Center and the member portal in May. This new feature will grant PHC staff using Call Center and members logging into the member portal, visibility to individual member screening needs for multiple low performing HEDIS measures, ranging from diabetes care to specific adult preventive screening needs. This enhancement is designed to help member facing employees engage and support our members in staying healthy while at the same time directly supporting HEDIS score improvement. User Acceptance Testing (UAT) completed in April and a pilot will kick off in our NR in mid-May. The results of the 90-day pilot will be reviewed by leadership to determine if more testing or a fuller scale implementation will be pursued. All measure specific details being presented to members, be it verbal or online, were prepared with sensitivity to the current COVID-19 response in mind.

#### 3. HealthPlan Update

Dr. Moore provided the HealthPlan update.

- Dr. Moore’s HealthPlan update was focused on the governor’s May revise and the impacts it has to Medi-Cal. In summary, this is the biggest Medi-Cal cut that we’ve seen; even the cutbacks during the 2008 recession were not as sweeping as these are. It includes a retro-active cut for this current year for all managed care plans of 1.5%, with additional cutbacks of efficiency factors. The state is giving a rate increase to Skilled Nursing Facilities (SNFs), but they are asking the health plans to pay for it without any additional revenue; therefore it’s an additional cut to the HealthPlan. Other cuts include:
  - Almost all Proposition 56 funding, including the behavioral health QIP that we received $50 million worth of requests for
  - The proposal to cover undocumented older adults has been withdrawn
  - Elimination of the 340B supplemental payment pool which was intended to mitigate the effect of the pharmacy carve out on FQHCs and of the FQHC special carve outs
  - All of the CalAIM proposals that were planned for 2021 have been abandoned
  - CBAS programs
  - Multipurpose Senior Services Programs
  - Adult services for dental, audiology, speech therapy, optometry, podiatry, acupuncture, occupational therapy and physical therapy
  - Pharmacy delivered services
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT) for opioids, but not for alcohol as that is federally required
  - Diabetes Prevention Program
  - Pain nurse anesthetists
  - Incontinence Cream
  - Post-partum mental health expansion
  - Hearing aids for higher income California Children’s Services (CCS) kids

For information only, no formal action required. 05/20/2020
PHC’s finance committee will be going through this massive list of proposed cuts. It will be difficult for PHC to know when this will be finalized, as it needs to go through the legislative process in the next month. The budget is due June 15th, so we’ll have to see what survives that process. PHC will also need to determine what programs from that list that could lead to higher costs if cut, and therefore we would continue to cover them.

Dr. Kubota asked if the Medi-Cal Rx and 340B Program will be eliminated. Dr. Moore confirmed that it is proposed to be eliminated. Dr. Moore’s understanding is that the FQHCs are now anticipating working with the legislature to convince them to not do the pharmacy carve out. The finance department of the state is leading this and they still believe the pharmacy carve out will save money. If the legislature wins out there’s a possibility the pharmacy carve out might not occur.

Dr. Thomas commented that there are studies that suggest that stopping the dental care in adults would increase the risk of cardiovascular disease. Dr. Moore agreed there are studies not just for cardiovascular but also emergency room visits for dental emergencies. Dr. Moore confirmed that dental is one of those benefits that is being partially eliminated, and believes they are keeping some amount of services, such as emergency services, but not cleanings.

Dr. Swales asked if PHC will be sending something out to advise what is changing, and what providers can and cannot do. Dr. Moore confirmed that this is the proposal from the May revise and will be finalized in June. Dr. Moore suggested that if a practice was thinking about doing something new on that list that he would probably hold off for a month to see if it is going away. The next Q/UAC meeting will be right after the budget passes, and we should be able to share a summary then.

Dr. Devido asked if the physician loan repayment programs that had gone into effect are being eliminated. Dr. Moore advised they are not going to take away the commitments they have already made but there are three additional years’ worth of repayments and believes those may be eliminated. Dr. Moore advised that Prop 56 going forward is subject to elimination. This includes the incentive payments, loan repayment, behavioral health integration grants, and family planning funding.

### III. Old Business (Committee Members as Applicable)

None

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

<table>
<thead>
<tr>
<th>Consent Calendar</th>
<th>Member Services</th>
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<tbody>
<tr>
<td>MP300</td>
<td>Notification of Provider Termination or Change in Location</td>
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<tr>
<td>MCQ1047</td>
<td>Advance Directives</td>
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<tr>
<td>MPQP1016</td>
<td>Potential Quality Issue Investigation and Resolution</td>
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<tr>
<td>MPQP1055</td>
<td>Provider Preventable Condition (PPC) Reporting</td>
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<td>Care Coordination</td>
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<td>MCCP2007</td>
<td>Complex Case Management</td>
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<td>MCCP2026</td>
<td>Diabetes Prevention Program</td>
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<td>Utilization Management</td>
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<td>MCUG3023</td>
<td>Infant Monitor Guidelines</td>
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<tr>
<td>MCUG3118</td>
<td>Prenatal &amp; Perinatal Care</td>
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<td>MCUP3028</td>
<td>Mental Health Services</td>
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<tr>
<td>MCUP3052</td>
<td>Medical Nutrition Services</td>
</tr>
<tr>
<td>MCUP3127</td>
<td>Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services</td>
</tr>
</tbody>
</table>

Motion to approve: Dr. Wilson
Second: Dr. Quon
All consent policies were approved with no changes.

All members present voted yes with no exceptions.

05/20/2020
| 1. MPLD7001 – Cultural & Linguistic Program Description | Rebecca Boyd Anderson reported on MPLD7001 found on page 139.  
- Throughout the Program Description all instances of Group Needs Assessment (GNA) have been updated to Population Needs Assessment (PNA).  
- Page 2: Removed paragraph about Appendix A, and changed Health Services Department to PHC’s Population Health (PH) unit. Added Quality, Communications, Compliance, Information Technology, and Regional Leadership as departments we work with on the program. Changed Management Department to Quality and Health Analytics team.  
- Page 3: Changed Administration department to Communications and Compliance. Added paragraph about Regional Leadership’s role to address cultural and linguistic needs of PHC’s membership. Removed Health Education and Cultural and Linguistic action plan and added corresponding actions. Removed paragraph about GNA and sentence about services.  
- Page 4: Added core content of the PNA for DHCS PNA goals and what PNA identifies.  
- Page 5: Clarified that the community health resources are found on the PHC website and that it shows services offered.  
- Page 6: Removed action plan annual updates and added Population Health Program Evaluation. Added community health fairs and outreach. Removed all references to GNA.  
- Appendix A: Replaced slide with new Population Health Management (PHM) Committee Structure. | Motion to approve: Dr. Gwiazdowski  
Second: Dr. Quon  
Approved with no changes.  
All members present voted yes with no exceptions. | 05/20/2020 |
|---|---|---|---|
| 2. MCQG1005 – Adult Preventive Health Guidelines | Dr. Moore reported on MCQG1005 found on page 147.  
- Section VII.C: Updated link.  
- Section VII.I: Change Policy Letter to APL and added a link to the APL.  
- Attachment A:  
  - Updated to reflect the current guidelines for Hepatitis C and Glaucoma Screening.  
  - Wordsmithing for clarity under Lung Cancer Screening and Diet, Behavioral Counseling in Primary Care to Promote a Healthy Lifestyle. | Motion to approve: Dr. Quon  
Second: Dr. Montenegro  
Approved with no changes.  
All members present voted yes with no exceptions. | 05/20/2020 |
| 3. MCQP1021 – Initial Health Assessment (IHA) and Behavioral Risk Assessment | Rachel Peterson reported on MCQP1021 found on page 158.  
- Section IV: Attachments were updated and added the Staying Healthy Assessment (SHA) Frequently Asked Questions (FAQs) and the Three Attempt Outreach Tracker.  
- Section VLE.3.d: Medi-Cal Managed Care Division (MMCD) was identified. Deleted sentence regarding the website as it is not located on the PHC website.  
- Section VI.I.1: New monitoring process for IHA.  
- Section VI.I.2: Deleted “high volume” as report being pulled does not filter only high volume. Deleted section-we are educating providers on Site Reviews in regards to IHA and emailing sites a reminder of newly assigned members that are due for an IHA.  
- Section VLS: Deleted duplicate information. | Motion to approve: Dr. Quon  
Second: Dr. Gwiazdowski  
Approved with no changes.  
All members present voted yes with no exceptions. | 05/20/2020 |
| 4. MPQP1022 – Site Review Requirements and Guidelines | Rachel Peterson reported on MPQP1022 found on page 187. Dr. Moore advised that the changes made to the attachments are mandated by DHCS and have been vetted over the past year by site reviewers throughout the state. Rachel confirmed that the state has updated all of their tools and the planned go live date is July 1, 2020.  
- The policy was updated per APL 20-006 Site Reviews: Facility Site Review and Medical Record Review (Supersedes PLs 14-004 and 03-002, and APL 03-007) published 03/04/20.  
- DHCS Facility Site Review and Medical Record Tools updated to 2019 version and goes live 07/01/20 (unless further guidance is received from DHCS regarding COVID).  
- Section IV: Attachments were updated. | Motion to approve: Dr. Wilson  
Second: Dr. Quon  
Approved with no changes.  
All members present voted yes with no exceptions. | 05/20/2020 |
- Section VI: Removed PCP verbiage throughout the policy to follow NCQA guidelines broadening scope to include multiple types of providers.
- Section VI.A.1 Site Review Personnel Changes:
  - DHCS Recertifies Master Trainers (CMT) every three years.
  - Master Trainers must complete 20 reviews and have 1 year experience as a Certified Site Reviewer.
  - Certified Site Reviewer Initial Certification requires the completion of 10 reviews alongside the CMT.
  - Certified Site Reviewers must complete a minimum of 20 reviews between recertification.
- Section VI.A.2: Full Scope Site Review information remains the same from previous policy. Changed formatting to follow APL flow.
- Section VI.A.2.d: Pediatric and Adult Preventative Section is now required for PCP sites that provide OB care.
- Section VI.A.3.b.1): Pre-contracted providers who do not pass the initial Facility Site Review (FSR) within two attempts may reapply to PHC within six months.
- Section VI.A.3.d.5)a): A site relocation requires an initial FSR within 60 days or discovery of completed move.
- Section VI.A.4.a.1)a): Verbiage change to “assigned member population” to broaden scope to follow NCQA guidelines.
- Section VI.A.4.a.1)d): APL changed shared vs separate medical records.
- Section VI.A.4.a.1)e): Multiple providers not sharing records must be reviewed individually.
- Section VI.A.4: Deleted duplicate sections.
- Section VI.A.5: Scoring will vary based on N/A answers.
- Section VI.A.6: If site fails Medical Record Review (MRR) or FSR members will not be assigned to the site until all corrective action plan (CAP) deficiencies are corrected. Must pass by third attempt to remain a PCP.
- Section VI.A.7: Focused review is broken into sections for easier readability and table was relocated.
- Section VI.A.8: Table was added from the APL. Duplicate paragraphs were removed.
- Section VI.A.12 and 13: Removed sections that were duplicates.
- Section VI.A.11: Time frame was deleted. This is not in the APL.
- Section VI.A.12.c: Verbiage change to midpoint to allow flexibility in multiple timeframes.
- Section VI.A.17: Removed duplicate section.
- Section VLE: Added more specific reporting guidelines.
- Section VII: References were updated.

5. MPXG5009 – Lactation Clinical Practice Guidelines

Ron Klinger reported on MPXG5009 found on page 509. Ron advised that throughout the policy, we have generalized the policy and removed language that essentially was reprinted from the authoritative bodies that were referenced in the policy. This was cleaned up in favor of referencing these which led to a new Useful Resources section.

- Section V: Shortened the Purpose Statement.
- Section VI.A: Updated the introduction statement under General Breastfeeding Guidelines.
- Section V.B.1.d: Updated the Growing Together Program (GTP) references.
- Section VI.B.2: Updated “Timing of Lactation Support Service” to reflect early Post-partum period of 84 days to reflect the current HEDIS standard.
- Section VLE: Created “Useful Resources” section to cite resources for information that aren’t directly referenced in the policy.

Motion to approve: Dr. Wilson
Second: Dr. Stockton
Approved with no changes.

All members present voted yes with no exceptions.

05/20/2020
### 6. MCCP2020 – Lactation Policy and Guidelines

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>VII</td>
<td>Removed outdated research references.</td>
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<tr>
<td>III.B</td>
<td>Updated the definition of Women, Infant and Children (WIC) Supplemental Nutrition Program to include services for parents and other family members.</td>
</tr>
<tr>
<td>V.A</td>
<td>Changed time frame for recommended duration for exclusive breastfeeding to “4 – 6 months.”</td>
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<tr>
<td>VI.A.1</td>
<td>Updated paragraph describing the health benefits of breastfeeding.</td>
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<tr>
<td>VI.B.1.d</td>
<td>Updated paragraph describing how the Care Coordination department will assist members planning to breastfeed through specific programs and case management. Removed reference to GTP program.</td>
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<tr>
<td>VI.B.1.f</td>
<td>Provided new link for UNICEF/WHO Baby Friendly Hospital Initiative.</td>
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<tr>
<td>VI.B.1.f.2</td>
<td>Changed time frame for early mother-infant contact and breastfeeding to “within one half-hour of birth.”</td>
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<tr>
<td>VI.B.1.g</td>
<td>Changed time frame for exclusive breastfeeding to “about six months.”</td>
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<tr>
<td>VI.C.1</td>
<td>Changed end of time frame for early postpartum period to 84 days instead of 56 and changed start of time frame for late postpartum period to 84 days instead of 56.</td>
</tr>
<tr>
<td>VI.B.3</td>
<td>Updated description of symptoms which warrant emergent or urgent psychiatric evaluation. Dr. Devido changed this to be more specific to ascertain if symptoms are being experienced.</td>
</tr>
<tr>
<td>VI.B.4</td>
<td>Updated language and terminology for conditions to be evaluated by PCP. Changed term “psychological” to “psychiatric” for consistency.</td>
</tr>
<tr>
<td>VI.C.2.b</td>
<td>Clarified which entity will provide substance use disorder and substance use misuse services in different counties as per the Wellness &amp; Recovery benefit.</td>
</tr>
<tr>
<td>VI.C.3</td>
<td>Added “substance-related and addictive disorders” to the list of behavioral health conditions for which a PCP may determine a provisional diagnosis.</td>
</tr>
<tr>
<td>VI.C.4 and 5</td>
<td>Clarified terminology for conditions and risk factors. Added “Inability to adequately self-care” and “Ongoing substance misuse” as risk factors for further deterioration of behavioral health conditions.</td>
</tr>
<tr>
<td>VI.C.6</td>
<td>Added clause, “For mental health conditions” at the start of this section describing when a PCP should refer a Medi-Cal only member to Beacon. This was clarified because instructions would vary by county if member required substance use disorder services.</td>
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### 7. MPCP2017 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>Dr. Devido</td>
<td>Reported on MPCP2017 found on page 532. Dr. Devido advised there was no significant change in scope; it was mainly changed to make language more reflective of psychiatric clinical relevance. Dr. Devido advised the Wellness and Recovery (W&amp;R) benefit has a go live date of July 1, 2020 and includes Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties. Other counties are not a part of the regional model at this time.</td>
</tr>
<tr>
<td>VI.B.3</td>
<td>Updated description of symptoms which warrant emergent or urgent psychiatric evaluation. Dr. Devido changed this to be more specific to ascertain if symptoms are being experienced.</td>
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**Motion to Approve:**

| Dr. Quon | Second: Dr. Gwiazdowski |
| Approved with no changes. | All members present voted yes with no exceptions. | 05/20/2020 |
### 8. MCUP3101 – Screening and Treatment for Substance Use Disorders (SUD)

Liz Leslie reported on MCUP3101 found on page 542. Liz advised that this policy needed to be updated for the new W&R benefit that is going live July 1, 2020.

- **Section VI.A.2**: This policy was updated to describe the W&R benefit through PHC.
- **Footer**: A note was added in the footer for pages 2 -9 to clarify that the W&R benefit is not anticipated to begin until July.
- **Section VI.B.1.a.4**: Added that Beacon’s call center activities are another process through which a member might be identified and referred for SUD counseling and treatment.
- **Section VI.C.8.b**: Removed statement: “Treatment for alcohol use disorders is not currently covered by PHC” as that statement will no longer be true with the W&R benefit.
- **Section VII.H-L**: Added references for W&R benefit.

Motion to approve: Dr. Gwiazdowski
Second: Dr. Stockton
Approved with no changes.

All members present voted yes with no exceptions.

05/20/2020

### 9. MCUG3002 – Acupuncture Services Guidelines

Debbie McAllister reported on MCUG3002 found on page 556. Debbie advised the policy was modified to align with Medi-Cal guidelines.

- **Section VI.A and B.1**: Specified that we are allowing 2 acupuncture visits/month for members who meet Medi-Cal medical necessity guidelines. Also removed language describing services for under age 21 as there are no age distinctions for services in the Medi-Cal guidelines.
- **Section VI.B.3**: Removed reference to members over age 21 and removed list of specific treatment types. Replaced with language from Medi-Cal guidelines that describes types of acupuncture treatment services allowed.
- **Section VI.C**: Added podiatrist as a type of physician who may administer acupuncture according to Medi-Cal guidelines.
- **Section VI.D**: Specified that speech therapy and occupational therapy (OT) are limited to two services per month per Medi-Cal guidelines.
- **Section VI.C**: Deleted this section specifying our PHC criteria for speech therapy because speech therapy is now a state benefit and fits the criteria already noted in this policy for OT and physical therapy (PT).

Motion to approve: Dr. Quon
Second: Dr. Gwiazdowski
Approved with no changes.

All members present voted yes with no exceptions.

05/20/2020

### 10. MCUP3114 – Physical, Occupational and Speech Therapies

Debbie McAllister reported on MCUP3114 found on page 559. Debbie advised this policy was updated per State Bulletin announcing that, effective for dates of service on or after January 1, 2020, speech therapy services previously eliminated as part of the optional benefits exclusion are reinstated as full Medi-Cal benefits.

- **Section I.C**: Added policy MCCP2024 - Whole Child Model for California Children’s Services (CCS) as a Related Policy.
- **Section III.E**: Updated code references for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program.
- **Section VI.B.1**: Specified that speech therapy and occupational therapy (OT) are limited to two services per month per Medi-Cal guidelines.
- **Section VI.C**: Deleted this section specifying our PHC criteria for speech therapy because speech therapy is now a state benefit and fits the criteria already noted in this policy for OT and physical therapy (PT).

Motion to approve: Dr. Wilson
Second: Dr. Gwiazdowski
Approved with no changes.

All members present voted yes with no exceptions.

05/20/2020
### Section VI.C.a
In the new section C, wording was updated to describe CCS referrals and explain that CCS will determine eligibility and then PHC will authorize and case manage.

### Section VI.C.b
Removed specific reference to speech therapy benefits under EPSDT and broadened reference to include all types of therapy in this policy. Referred reader to section VI.D for full EPSDT section.

### Section VI.D.1 and 2
Updated regulatory references for EPSDT as per APL 19-010.

### Section VII: References
References were updated.

#### 11. MCUG3022 – Incontinence Guidelines
Debbie McAllister reported on MCUG3022 found on page 566. Debbie advised this policy was updated per State Bulletin announcing that Effective March 16, 2020, the TAR requirement was removed from incontinence cream and wash product billing codes A4335 and A6250. Additionally, corrections were made throughout policy and attachments to reflect change in cost threshold for when a TAR is required for incontinence supplies. (Changed from $125 to $165)

- **Section VI.A.2.h:** Changed wording to say skin wash and cream do NOT require a TAR unless quantities exceed supply limit stated in Attachment A.
- **Section VI.A.5 and 6:** Changed cost limit from $125 to $165 for when incontinence supplies require a TAR.
- **Attachment A:** On page 2, removed TAR requirement statement “Approved only with documented history of skin breakdown” from the Incontinence Skin Care section because a TAR is no longer required unless quantities are exceeded. Statement was moved below to occur with a special note. Also added to specify new frequency/quantity limits for codes A6250 and A4335. A TAR is now only required if those limits are exceeded.

Debbie advised that the vendors are allowed to fill out the portions that don’t require a medical signature, but it does require that a physician sign it. Currently, due to COVID-19 and the fact that many of the doctor’s offices are closed, we are giving a 60-day reprieve until the offices are reopened. The providers of the incontinence supplies are working very closely with physicians to ensure they realize that it is mandated by the state.

#### 12. MCUP3041-A MCUP3049-A MCUG3007-B PHC TAR Requirements List
Debbie McAllister reported on PHC TAR Requirements List found on page 575. Debbie advised that the PHC TAR requirements List is the only attachment that is allowed to be approved without the policy as it affects multiple policies. The PHC TAR Requirements List was updated to reflect the changes made in policy MCUG3022 Incontinence Guidelines.

- **Page 3, Section Y.11.a:** Changed cost threshold from $125 to $165 for when incontinence supplies require a TAR.
- **Page 3, Section Y.11.b:** Changed wording to say skin washes and creams do NOT require a TAR unless quantities exceed new frequency/quantity limits for codes A6250 and A4335.

Motion to approve: Dr. Wilson  
Second: Dr. Quon  
Approved with no changes.  
All members present voted yes with no exceptions.

Dr. Moore advised that this policy was discussed last month but was not approved until additional research could be completed to determine the intent for the pre-op exam.

Dr. Swales asked if the primary care providers are doing the History & Physical (H&P), where do they send it if the dental anesthesia is not done at their hospital. Dr. Ribordy advised that a dentist cannot do

### 13. MPUP3048 – Dental Services (including Dental Anesthesia)
Debbie McAllister reported on MPUP3048 found on page 583.

- **Section VI.D:** Removed phrase “for children under 12” because dental anesthesia services require a TAR for all ages.
- **Section VI.H.5:** Added a paragraph to say documentation of a recent pre-op exam performed by the member’s primary care physician should be submitted with all TARs for dental procedures requiring intravenous sedation or general anesthesia.

Motion to approve: Dr. Thomas  
Second: Dr. Wilson  
Approved with no changes.  
All members present voted yes with no exceptions.
an H&P that is needs to be done by a physician. He stated when he was in practice, he did them for the local dental center and it was just a form they have on their site, that basically is attesting that the patient is healthy enough to have anesthesia. Debbie advised that we realize this is not as easy as it sounds but it is a requirement by the state.

V. Presentations

1. Quarterly Grievance Report
   La Rae Banks presented the Q1 2020 Grievance Report. Refer to the report found on page 587 for detailed information. Highlights from the report include:
   - There was a total of 5,440 cases closed in 2019, and through Q1 2020 1,137 have been closed. There has been a decrease in the number of cases so far in 2020; however, we expect this to change with the high unemployment rate which will lead to an increase in PHC membership.
   - Q1 2020 highlights include:
     - 7 expedited cases; 2 grievances and 5 appeals
     - 0 overturned State Hearings
     - 13 COVID-19 cases
     - 32 CCS cases
   - Medical Transportation Management (MTM) concerns represented 27%. In regards to MTM, there were 111,129 trip legs, or rides, serving 10,077 unique members and there are a total of 304 MTM cases. Overall, they continue to do a good job for our members.
   - Top member-reported concerns are benefit disputes and issues with experience and service.
     - Members contest pharmacy denials more frequently than any other benefit and there is a desired use of brand-name, non-formulary, plan exclusions and excessive day supply; 28% are related to opioids. Solutions include clearer denial letters and provider education.
     - MTM gas mileage reimbursement (GMR) claims include those with missing or invalid documentation, denied claims for non-appearance to appointments or late filing, and incorrectly denied claims. Experience and service claims include those for missed failed rides, including taxis too early, late or never showed, and Lyft never showed. Non-medical transportation (NMT) solutions include new Notification of Action (NOA) letters and provider education.
     - The top reported concern regarding services by providers is member disagreement with their provider’s plan for their health. Solutions include clearer denial letters, leveraging care coordination to assist members and provider education.
   - There have been 5 total cases regarding COVID-19. Members are reporting issues with access including barriers to COVID-19 testing, delayed or rescheduled appointments and access to specialty providers.
   - Quality metrics were reviewed. PHC is required by DHCS to process our cases within a certain timeframe. PHC met its performance goals for Q1 2020. There is an opportunity to improve timeliness on mailing acknowledgement letters which led to new workflows being implemented to improve this metric.
   - The Inter-rater reliability (IRR) had a 100% pass rate, indicating that accurate clinical assessments are being done.

2. Update on PHC Oversight, Provision and Coordination of Mental Health Services
   Dr. Devido and Margaret Kisliuk presented the Update on PHC Oversight, Provision and Coordination of Mental Health Services. Refer to the update found on page 623 for detailed information. Highlights of the report include:
   - An overview of the Medi-Cal mental health benefit delivery system was provided. PHC provides the mild to moderate benefit through Beacon and our PCPs; the counties provide serious mental health services.
   - Changes being proposed by the state pre-COVID were included and have to do with better aligning the systems.
- Dr. Devido gave an overview of the activities he has been involved in as the Behavioral Health Clinical Director at PHC.
  - The advent of Integrated Rounds, where cases are reviewed and discussed. Regional Medical Directors and representatives from Beacon also attend.
  - The review of potential quality incidents, which fortunately, have been very few.
  - A deep dive review of random case sampling from Kaiser and Beacon.
  - Outreach to providers and community agencies.
- Data was provided on the percentage of people we are serving within the Beacon system and also with PCPs. The data is separated by children and adults.
- Our goal is to reach a 7% penetration rate of unique members served in the Beacon network.
- A summary of the areas where we monitor Beacon and Kaiser is included. The only corrective action plan in place at this time has to do with encounter data in our reconciliation of finances, which is a work in progress between our finance and IT departments and Beacon.
- Next steps include:
  - Continued work to enhance delegation oversight.
  - Build/enhance network resources to better address eating disorders and maternal mental health.
  - Work with PCPs and behavioral health providers to promote integrated care within the community.
  - Prepare for expected increase in needs projected post-COVID.

Dr. Moore encouraged the committee members to review their county’s data to get a sense of what’s going on and to remember there is an overlap between the PCP and Beacon columns.

### Summary of Beacon Services, and Partnership’s Membership Impact during COVID-19

Alison French, Director of Partnerships of Beacon Health Options presented the Summary of Beacon Services, and Partnership’s Membership Impact during COVID-19. This report was in follow up to a request from the January 2020 meeting for Beacon to provide a presentation on their services. Refer to the report found on page 640 for detailed information. Highlights of the report include:

- There has been a huge decrease in call volume over the past few months, especially when comparing April 2020 to April 2019, there is about a 50% decrease in calls. This is not unique to PHC, Beacon sees this across all the California health plans they work with.
- Screening and referrals have also decreased, as there are a fewer number of people asking for services. Beacon attributes this to less people going into a PCP office or community service center where someone would fill out a referral for them.
- There has been a huge increase in telehealth visits and Beacon expects this to continue to increase. A breakdown of visits by county was included.
- There were 4,547 unique utilizers, all PHC members, accessing mild to moderate health benefits in Q1 2020. These are psychiatrist and therapy appointments.
- Information was provided on how to access services for members. Beacon has providers available who can get members in for a telehealth appointment within 48 hours.
- Beacon’s website has resources available to members and providers. Information about Beacon’s weekly webinar series is available. These webinars cover a variety of topics that range from triaging referrals to suicide.
- Information was provided on work Beacon is doing in terms of the telehealth network.

Dr. Kubota asked if Beacon has information on total visits, and not just the number of telehealth visits. Alison indicated that she can get that information and will provide it to the group.
Lynn commented that PHC has heard from providers that the no show rate has declined, and that the transition to telehealth has gone quite smoothly.

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<tr>
<th>VI. Additional Business</th>
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<td>Next Meeting: June 17, 2020</td>
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Respectfully submitted by: Karen Garnick, Project Coordinator II

Signature of Approval: ____________________________ Date: ____________________________

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

Committee: Internal Quality Improvement (IQI) Meeting  
Date/Time: Tuesday, April 7, 2020 / 1:30 PM – 3:30 PM Napa/Solano Conference Room

<table>
<thead>
<tr>
<th>Members Present:</th>
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<tbody>
<tr>
<td>Barresi, Katherine, RN, Director of Care Coordination</td>
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<td>Daliri Sherafat, Tahereh, NR Director of MS and PR</td>
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<td>French, Rachael, Associate Director of Quality and Performance Improvement</td>
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<td>Gibboney, Elizabeth, MA, Chief Executive Officer</td>
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<td>Hoffman-Spector, Sharon, Team Manager, UM</td>
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<td>Hoover, Peggy, RN, Senior Director, Health Services</td>
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<td>Kubota, Marshall, MD, Regional Medical Director</td>
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<th>Guests:</th>
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<tr>
<td>Azeltine, Diana, Manager of Utilization Management</td>
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<td>Cabrera, Maria, Supervisor of Member Services</td>
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<td>Campbell, Anna, Administrative Assistant II</td>
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<td>Crimea, Doreen, Manager of Care Coordination</td>
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<td>DeVido, Jeffrey, MD, Behavioral Health Clinical Director</td>
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<td>Enos, Mary, Associate Director Enrollment</td>
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<td>Glossbrenner, David, MD, Regional Medical Director</td>
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<td>Guevarra, Angela, Manager of Care Coordination</td>
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<td>Hightower, Tony, Associate Director of Pharmacy Operations</td>
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<td>Malvo, Lisa, Director of Claims</td>
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<td>O’Connell, Lisa, Manager of Provider Education</td>
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<td>Plascencia, Dolores, Project Manager I</td>
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<th>Members Absent:</th>
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<tbody>
<tr>
<td>Banks, La Rae, Associate Director of Grievance and Appeals</td>
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<td>Bjork, Sonja, JD, Chief Operating Officer</td>
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<td>Boyd Anderson, Rebecca, RN, Director of Population Health</td>
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<td>Ingram, Jeff, Director of Financial Planning &amp; Analysis</td>
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<td>Kerlin, Mary, Senior Director of Provider Relations</td>
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## AGENDA ITEM

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<th>DISCUSSION</th>
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| I. Call to Order  
Approval of Minutes |
| Dr. Robert Moore called the meeting to order at 1:30 p.m.  
Minutes from the March 10, 2020 IQI meeting were reviewed and approved. |

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<tr>
<th>RECOMMENDATIONS / ACTION</th>
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| Motion to Approve: Peggy Hoover  
Second: Dr. Netherda  
Approved with no changes |

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<tr>
<th>DATE RESOLVED</th>
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<tr>
<td>04/07/2020</td>
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## II. Standing Agenda Items

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<tr>
<th>I. Status of Open Action Items</th>
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III. Old Business

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IV. New Business (Committee Members as Applicable)

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<tr>
<th>Consent Calendar</th>
<th>AGENDA ITEM</th>
<th>DISCUSSION</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>DATE RESOLVED</th>
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<tr>
<td>MC340 – Continuation of Insurance Premium (CIP)</td>
<td>Member Services</td>
<td>The following policies were pulled from the Consent Calendar for discussion: MC340 and MP316</td>
<td>04/07/2020</td>
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<td>MP316 – Provider Request to Discharge Member &amp; Assistance with Inappropriate Member Behavior</td>
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<td>MP350 – Weight Management Program</td>
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<td>Provider Relations</td>
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<td>Motion to approve: Dr. Netherda</td>
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<td>MPCR34 – Identification of HIV/AIDS Specialists</td>
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<td>Second: Peggy Hoover</td>
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<td>MPCR12 – Credentialing of Independent Nurses under EPSDT</td>
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<td>The remaining policies were approved with no changes.</td>
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<td>MPCR13 – Credentialing of Pain Management Specialist</td>
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<td>MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist</td>
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<td>MPCR13B – Buprenorphine Prescriber Credentialing</td>
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<td>MPCR13C – Osteopathic Manipulation Treatment Credentialing</td>
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<td>MPCR14 – Pharmacy Provider Assessment Criteria</td>
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<td>MPCR16 – Lactation Consultant Credentialing Policy</td>
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<td>MPCR19 – Skilled Nursing Facility Providers (SNFists) Credentialing Policy</td>
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<td>MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment</td>
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<td>MPCR100 – Credential and Re-credential Decision Making Process</td>
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<td>MPCR300 – Physician Credentialing and Re-credentialing Requirements</td>
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<td>MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements</td>
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<td>MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements</td>
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<td>MPCR303 – Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements</td>
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<td>MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements</td>
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<td>MPCR400 – Provider Credentialing and Re-credentialing Verification Process and Record Security</td>
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<td>MPCR602 – Reporting Actions to Authorities</td>
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<td>MPCR800 – Delegation of Credentialing and Re-credentialing Activities</td>
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<td>MPQR203 – Provider Enrollment Status Guidelines</td>
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<td>MPQR207 – Annual Physician Satisfaction Survey</td>
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<td>MPQR208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information</td>
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<td>Quality Improvement</td>
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<td>MPQP1053 – Peer Review Committee</td>
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<td>MCCP2025 – Pediatric Quality Committee</td>
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<td>MCUP3047 – Tuberculosis Related Treatment</td>
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<td>MCUP3119 – Sterilization Consent Protocol</td>
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<td>MCUP3130 – Osteopathic Manipulation Therapy</td>
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<td>MCUP3135 – Hysterectomy Review Policy (Archived – Refer to MCUP3041)</td>
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<td>MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21</td>
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| MPUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21 | Discussion on MC340 and MP316:  
- Anna questioned why “W&R” (Wellness and Recovery) was added to the Applies To section in the header of the policy, and asked if all policies should be updated to add this. Dr. Moore confirmed that W&R is a benefit and not a line of business and that is should be removed from the header. The committee agreed to this change. | Motion to approve: Dr. Netherda  
Second: Dr. Townsend  
Approved with change:  
- Header: Remove “W&R” from the Applies To section. | 04/07/2020 |
| 1. MC305A – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program | Mary Enos reported on MC305A found on page 202. Mary advised that this is a new policy for the distribution of member rights and responsibilities for the new Wellness and Recovery (W&R) Program. The policy mirrors what is stated in the W&R Handbook that has been approved by the state.  
Anna questioned why “W&R” was added to the Applies To section in the header of the policy, and asked if all policies should be updated to add this. Dr. Moore confirmed that W&R is a benefit and not a line of business and that is should be removed from the header. The committee agreed to this change. | Motion to approve: Dr. Netherda  
Second: Dr. Townsend  
Approved with change:  
- Header: Remove “W&R” from the Applies To section. | 04/07/2020 |
| 2. MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus | Stan Leung reported on MPXG5002 found on page 205.  
- Section VI.A.1: Corrected > to ≥ as per American Diabetes Association (ADA) 2020 guidelines.  
- Section VI.B.1 and 2: Additions made to formulary medications  
- Section VI.C.1: Clinical measures were updated.  
- Section VI.C.2: QIP measures were updated.  
- Section VII: Reference was updated to reflect 2020 guidelines and link was updated. | Motion to approve: Erika Robinson  
Second: Peggy Hoover  
Approved with no changes. | 04/07/2020 |
| 3. MCUG3023 – Infant Monitor Guidelines | Debbie McAllister reported on MCUG3023 found on page 210. Debbie advised that this policy was approved in March at IQI, but was pulled at QUAC for further discussion on Section VI.E.1. Dr. Moore advised that this is still under review and no update was available at the time of IQI. | No action needed. | 04/07/2020 |
| 4. MCUP3013 – DME Authorization | Debbie McAllister reported on MCUP3013 found on page 212.  
- Section I.D: Added MCUG3134 as a related policy.  
- Section III.D and E: Added definitions of Medical Therapy Unit (MTU) and Medical Therapy Program (MTP) as these programs prescribe Durable Medical Equipment (DME) for California Children’s Services (CCS) kids.  
- Section IV.E: Added New Attachment E-MTU DME Review Process and Example Form.  
- Section VI.B: Removed the date reference as 2004 is so long passed.  
- Section VI.E: Section on DME for Disabled Parent was moved up (reorganized) in policy and wording was clarified to be clear about "parent, stepparent, foster parent, or legal guardian".  
- Section VI.F.1: Added Medi-Cal description of Portable Ramps because there have been increased Provider inquiries for ramps far beyond this description.  
- Section VI.F.4: Added description of TAR review for Defibrillator Vests.  
- Section VI.F.5: Added description of TAR review for Home Oxygen Therapy.  
- Section VI.F.6: Added description of TAR review for Ventilators.  
- Section VI.F.7: Added description of TAR review for Tumor Treating Field Devices.  
- Section VI.F.8: Added description of TAR review for Pediatric Adaptive Equipment.  
- Section VI.G: Added criteria for Reauthorizations.  
- Section VI.H: Updated descriptions of Non Covered Items to match wording used in Medi-Cal Guidelines.  
- Section VII.H: Added Reference for CCS NL 09-0703. | Motion to approve: Dr. Kubota  
Second: Dr. Netherda  
Approved with change:  
- Section VI.F.4: Remove “Requests for defibrillator vests are reviewed in 1 month increments.” | 04/07/2020 |
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| Attachment A | Deleted codes E0450, E0460, and E0461 which are no longer in use.  
Added new ventilator codes, E0465 and E0466.  
Added code E0766 for Tumor Treating Field Devices.  
Added code K0606 for defibrillator vests. |  |  |
| Attachment B | Added section for Items Requiring Initial Rental Prior to PHC’s Consideration for Purchase.  
Listed two items: Hospital Beds and Manual Wheelchairs. |  |  |
| Attachment C | The Oxygen Request Verification Form was updated per current guidelines. |  |  |
| Attachment D | New attachment added: “Medical Therapy Unit (MTU)/ Durable Medical Equipment (DME) Review Process.” This attachment describes the process and includes a suggested sample form to submit with TAR. |  |  |

Dr. Kubota asked to confirm the process for defibrillator vests in Section VI.F.4. Debbie confirmed that the initial authorization is for three months, then after that they are reviewed monthly. Dr. Moore added that most of the requests that PHC receives are for less than three months and end up billing by the day; only occasionally is a request for longer than three months. Dr. Kubota suggested to remove the last sentence of this section “Requests for defibrillator vests are reviewed in 1 month increments”. The committee agreed to this change.

5. MCUP3049 – Pain Management Specialty Services  
Debbie McAllister reported on MCUP3049 found on page 227.  
Attachment A – TAR Requirements List:  
- Page 1: Deleted reference to MCUP3135, Hysterectomy policy, because it is being archived.  
- Page 4: Added codes 15769, 15771 - 15774, for Graft of Autologous Soft Tissue and Fat Harvested as per request from Tamie Hedrick-Configuration. Dr. Moore reviewed and agreed all should be added.  
- Page 4: Added code 28296 for correction of bunion as per Provider complaint and review by Annie Kufner-code should be included.  
- Page 6: Deleted reference to MCUP3135, Hysterectomy policy, because it is being archived.  
- Page 6: Added codes 66987 and 66988 for Extracapsular Cataract Removal with insertion of intraocular lens prosth.

Attachment B – Medical Necessity Criteria for Pain Management Procedures:  
- Page 2, Codes 64479 to 64484 at 5: Changed frequency to no more frequently than every 3 months for injections so it would not contradict statement in 4.  
- Page 3, Codes 64633 to 64636: Changed minimal interval to 6 months instead of 12 to match InterQual® criteria.  

Motion to approve: Erika Robinson  
Second: Peggy Hoover  
Approved with no changes.  
04/07/2020

6. MCUP3115 – Community Based Adult Services (CBAS)  
Angela Guevarra reported on MCUP3115 found on page 240.  
- Section II.D: Added Provider Relations as an Impacted Department.  
- Section IV.A: Attachment A was updated to use the State’s latest form dated July 2019.  
- Section VI.C.1.b, h. and i: Added other providers who request CBAS services, other than a Physician, also stated that the request can be initiated by PHC’s internal reports or PHC’s Care Coordination staff.  
- Section VI.C.2: Clarified wording for how members are recommended for CBAS.

Motion to approve: Peggy Hoover  
Second: Dr. Netherda  
Approved with no changes:  
- Sections VI.B.2.b and VI.C.1.b: add “physician assistant” to the list.  
04/07/2020
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|             | • Section D: CBAS Eligibility Interview removed as we are proposing a new process where PHC nurses will no longer need to do the Face-to-face assessments. Instead, the providers can submit the new IPC form with the TAR to be approved.  
• Section VI.E:4: Added that “Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by PHC requires a face to face review.”  
• Section VI.G: Added that PHC requires a discharge plan when transfer of service occurs.  
• Section VI.I: Added section on Quality and Monitoring.  
• Section VI.J: Edited title to the Darling vs. Douglas Settlement since language could be confused with upcoming Enhanced Care Management (ECM) benefit.  
• Section VII. D: Added APL 19-004 as a Reference.  

In Sections VI.B.2.b. and VI.C.1.b. Dr. Netherda suggested to add “physician assistant” to the list as physicians, nurse practitioners and physician assistants are three most common providers that PHC receives requests from. The committee agreed to this change. | Motion to approve: Peggy Hoover  
Second: Dr. Netherda  
Approved with no changes. | 04/07/2020 |
| 7. MPUP3048 – Dental Services (including Dental Anesthesia) | Debbie McAllister reported on MPUP3048 found on page 272.  
• Section VI.D: Removed phrase “for children under 12” because dental anesthesia services require a TAR for all ages.  
• Section VI.H:5: Added a paragraph to require a History and Physical (H&P) in the last 6 months be submitted with all TARs for dental procedures requiring intravenous sedation or general anesthesia. This is a requirement in APL 15-012 but we needed to state it more clearly for providers. | Motion to approve: Peggy Hoover  
Second: Dr. Netherda  
Approved with no changes. | 04/07/2020 |
| 8. MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump | Debbie McAllister reported on MPUP30598 found on page 276.  
• Section VI.A: Specified that initial approval for NPWT is one month.  
• Sections VI.A.1.a. and b: Updated language describing chronic ulcers or wounds.  
• Section VI.A.2: Updated language describing acute surgical or traumatic wounds.  
• Section VI.A.3: Updated language describing ulcers and wounds encountered in an Inpatient Setting.  
• Section VI.B.5: Added “Exposed vasculature, nerves, anastomosis or organs” to the list of conditions for which NPWT will be denied.  
• Section VLD.1.d. and e: Changed time frame from 2 months to 4 months for when coverage of NPWT will typically end.  
• Section VII: Updated References. | Motion to approve: Dr. Netherda  
Second: Dr. Glossbrenner  
Approved with no changes. | 04/07/2020 |
| 9. MCUP3131 – Genetic Screening and Diagnostics | Dr. Townsend reported on MCUP3131 found on page 281. Dr. Townsend advised that updates were made to incorporate DHCS changes and also to follow the National Comprehensive Cancer Network (NCCN) guidelines. Changes were made to Attachment A:  
• Page 12: ICD 10 codes C33, C34.00 – C34.92, were added for billing 81210 BRAF analysis.  
• Pages 23 and 28: Added a special note for codes 81306 NUDT15 and 81335 TPMT to say PHC will also authorize these codes for the purpose of predicting toxicity to azathioprine prior to initiation of treatment for SLE and other recognized conditions when treatment with long term azathioprine is being considered.  
• Page 27: Code description for 81329 was simplified and ICD codes were added. | Motion to approve: Dr. Glossbrenner  
Second: Dr. Netherda  
Approved with changes:  
• Section VI.C.5, add sub-bullets a, b and c:  
  a. Multi-gene testing may be considered for those who have tested negative (or indeterminate) for one particular syndrome but whose personal and family | 04/07/2020 |
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|             | - Pages 34, 35, 38, 42, 47, 54, 56: Statement deleted that said “Claims without documentation showing the preceding criteria have been met will be denied.” for codes 81401, 81402, 81403, 81404, 81405, 81406, 81407.  
- Page 47: TSC1 added for 81405.  
- Page 53: TSC1 and TSC2 added for 81406.  
- Page 55: APOB added for 81407.  
- Page 56: TSC2 added for 81407.  
- Page 58: 81414 was broken out from 81413.  
- Page 59: 81414 was listed independently from 81413.  
- Page 60: 81436 was broken out from 81435. Also path molec no longer requires a TAR for 81435.  
- Page 61: 81439 description of gene sequencing was updated.  
- Page 62: 81455 description of gene sequencing was curtailed.  
- Page 62: 81479 TERT was removed – however TERT is still described on page 29 as 81345.  
- Pages 63-67: Codes 81500, 81503, 81506, 81508-81512 were broken out separately except for 81506 which was deleted.  
- Pages 67-69, 71-73, 74: Codes 81518, 81520, 81521, 81599 were broken out separately except for 81599 which was deleted. For all of these codes, a statement was added to “See note at the end of this table” which was “Note: These benefits are limited to EndoPredict, Oncotype Dx, Prosigna (PAM50 risk of recurrence score) and Breast Cancer Index. Use CPT code 81518 when billing for Breast Cancer Index. Use CPT code 81519 when billing for Oncotype Dx. Use CPT code 81520 when billing for Prosigna. Use CPT code 81521 when billing for MammaPrint. Use CPT code 81522 when billing for EndoPredict. These once-in-a-lifetime benefits may be billed for the same recipient and any provider. Providers need an approved TAR and documentation showing that the recipient has a new second primary breast cancer that meets the necessary criteria as listed above to override the once-in-a-lifetime frequency. Concurrent use of more than one test is not recommended as there is no data to support that ordering multiple assays in an individual patient would be beneficial in guiding treatment decisions.”  
- Page 70: Addition of 81522 Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes CYP2C19 with same note as above.  
- Page 70: 81528 description curtailed.  
- Page 71: 81545 description updated.  
- Page 73 Addition of 81552 Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes.  
- Page 74 Addition of 81596 Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays–frequency “N/A”.  

Dr. Townsend advised that two additional updates are needed to the policy. The committee agreed to these changes:  
- Section VI.C.5, add sub-bullets a, b and c:  
  a. Multi-gene testing may be considered for those who have tested negative (or indeterminate) for one particular syndrome but whose personal and family history is suggestive of an inherited susceptibility.  

- In Attachment A, update the description of BRCA code 81162 on pages 2-5 to reflect NCCN guidelines as well as Medi-Cal guidelines.  

|             | history is suggestive of an inherited susceptibility.  
|             | b. Multi-gene testing may be considered in cases where more than one pathogenic or likely pathogenic variant could influence a condition.  
|             | c. Clinical documentation indicating clinical impact of the testing that supports medical necessity will be required.  
<p>|             | <strong>In Attachment A, update the description of BRCA code 81162 on pages 2-5 to reflect NCCN guidelines as well as Medi-Cal guidelines</strong> |</p>
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|             | b. Multi-gene testing may be considered in cases where more than one pathogenic or likely pathogenic variant could influence a condition.  
|             | c. Clinical documentation indicating clinical impact of the testing that supports medical necessity will be required.  
|             | • In Attachment A, update the description of BRCA code 81162 on pages 2-5 to reflect NCCN guidelines as well as Medi-Cal guidelines.  
|             | Dr. Netherda asked, as reviewers, should NCCN guidelines be used over Medi-Cal? Dr. Moore advised the Medi-Cal will eventually change to match NCCN and that it is best for PHC reviewers to use what is most current. |

**V. Presentations**

| Quality and Performance Improvement Update | Erika Robinson provided the Quality and Performance Improvement Update. Refer to the update found on page 361 for detailed information.  
|                                           | • The Quality Improvement Program (QIP) team is committed to ensure payments to providers will be distributed on 04/30/20 for the Primary Care Provider (PCP), Long Term Care (LTC), and Palliative Care QIPs, while simultaneously working with internal stakeholders to assess payment feasibility given the COVID-19 outbreak. Updates will be communicated to providers and other stakeholders as more information becomes available.  
|                                           | • A 10% bonus payment (in addition to current potential earnings) has been approved for LTC QIP Participants who can demonstrate they have implemented new guidelines preventing the spread of COVID-19. These payments will be distributed with the regular payments.  
|                                           | • Mobile mammography clinics continued in the northwest region in March with clinics offered at the Open Door Community Health Center (ODCHC) McKinleyville and Eureka sites on 03/09/20 and 03/10/20, respectively. Approximately 25 patients were scheduled each day, and despite numerous no-shows, 19 PHC members completed their mammograms. The Open Door team is committed to keeping an ongoing mobile mammogram clinic schedule in the region, in hopes of establishing this avenue for screening as recurring and routine. Although mobile clinics are scheduled in May at the ODCHC Eureka and Del Norte sites; they will be reassessed to determine if they will be held considering the pandemic.  
|                                           | • The 3rd installment of Joint Leadership Initiative (JLI) meetings in the northern region have been scheduled and initiated in March. Senior leadership from PHC met with Shasta Community Health Center on 03/09/20 and Open Door Community Health Centers on 03/25/20 resulting in a series of actions focused on continued collaboration to drive HEDIS improvement. PHC is scheduled to meet with Fairchild Medical Center on 05/07/20. Due to the pandemic, discussion to take place to determine if there will be a pause on the HEDIS improvement work.  
|                                           | • The HEDIS annual medical record project will continue in April. Providers may receive a secondary outreach call in April as the HEDIS team starts to identify specific dates of service to meet HEDIS compliance. The HEDIS team has been working hard to ensure the medical records are received and to determine if workarounds may be needed for COVID-19.  
|                                           | • In preparation for First Survey in November, NCQA has asked for PHC to help them understand what some of the impacts related to COVID-19 may be. A request was sent by the NCQA team to business owners to better understand the impacts; a response is requested by 04/16/20. If any of the teams have questions on what needs to be submitted, please reach out to NCQA team. |

For information only, no formal action required.  
04/07/2020
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| 1. Potential Quality Issue (PQI) and Provider Preventable Conditions (PPC) Report | Rose Santos presented the PQI and PPC report for Q3/Q4 2019, which includes both northern and southern region data. Refer to the report found on page 366 for detailed information. Highlights of the report include:  
  - There was a total of 100 PQI referrals received and a total of 88 processed and closed.  
  - A comparison between 2018 and 2019 reflects a decrease in both the number of PQIs received and in the number closed.  
  - Rose advised that there were several PQI activities that took place that contributed to the decrease in cases, including process improvements, the rollout of the new PQI system and training that was attended by Grievance and Appeals, Utilization Management, Care Coordination and Provider Relations.  
  - Dr. Netherda commented that additionally, 2018 was higher due to the fact that fewer cases were closed in 2017, therefore starting 2018 with a higher number of open cases.  
  - The report included a summary of closed cases by provider county and provider type.  
  - There was a total of 112 providers involved in the 88 cases that were processed.  
  - Dr. Moore commented that 45 of the 112 providers had findings. He suggested to look at the confirmed quality issues to see if there are any trends.  
  - The report included a summary of closed cases by severity rating.  
  - The ratings with the most cases were P0 and S0, which tells us that members are receiving appropriate care from providers.  
  - Ratings P2 and above are referred to the Peer Review Committee (PRC); there where 10 PQI cases reviewed at PRC.  
  - The Provider Track and Trend showed only one individual provider was involved in multiple PQIs (three cases).  
  - There were four confirmed PPCs reported; all of which were reported to DHCS.  
  - Statistical reports, including PQIs by membership rate by county, are included and are found on pages 370-371. | For information only, no formal action required. | 04/07/2020 |
| 2. Pharmacy Operations Update | Stan Leung presented the Pharmacy Operations Update for 2019. Refer to the report found on page 372 for detailed information. Highlights of the report include:  
  - The average cost per prescription remained steady throughout 2019.  
  - Although PHC has made strides in generics and Hepatitis C drugs, other specialty drugs, such as those for Cystic Fibrosis, drives the average cost per brand name prescription up.  
  - The top drug by paid amount is Basaglar Kwikpen (insulin) and Albuterol Sulfate is the only generic that made this list. Albuterol Sulfate is the top drug by fills per member per month (PMPM).  
  - Utilization Management (UM) data for Hepatitis C and data for Specialty Drugs, which includes Hepatitis C, were included and found on pages 377 and 378.  
  - An analysis of narcotics is on page 380. Since PHC began tracking this data in 2014, there has been an 80% reduction in utilization.  
  - All Pharmacy Inter-reliability (IRR) and timeliness goals were met in 2019. | For information only, no formal action required. | 04/07/2020 |
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| 3. Hospital QIP Evaluation | Melissa Stewart presented the Hospital QIP (HQIP) Evaluation for the period of 07/01/18-06/30/19. Refer to the evaluation found on page 382 for detailed information. Highlights of the evaluation include:  
- 25 participating hospitals, 80% average score, 10 hospitals recognized for ≥90%, approximately $12.6 million distributed.  
- There was increased performance in Exclusive Breast Milk Feeding (EBMF) and Venous Thromboembolism (VTE-6) for 2018-19.  
- There was stable performance in Readmissions, Elective Delivery, Nulliparous, Term, Singleton, Vertex (NTSV) C-section for 2018-19.  
- Plan-wide performance influencers for readmissions included two of our small hospitals that scored significantly higher in 2018-19 compared to the previous year.  
- Changes effective July 2018 include:  
  - California Immunization Registry (CAIR) utilization monitoring added to comply with DHCS requirement  
  - Maternity measures added to small hospitals doing deliveries  
- Program successes include:  
  - Data sharing – by June 30, 2019, 25 hospitals went live with the Emergency Department Information Exchange (EDIE) in accordance with measure.  
  - Increased total score from 8 hospitals in 2017-18 scoring > 90% or higher to 10 hospitals in 2018-19 scoring > 90% or higher.  
  - Quality Collaborative – partners like California Maternal Quality Care Collaborative and Collaborative Healthcare Patient Safety Organization (CHPSO) have seen an increase in participation due to HQIP. | For information only, no formal action required. | 04/07/2020 |

For information only, no formal action required.

The next meeting is May 12, 2020

Respectfully submitted by: Karen Garnick, Project Coordinator II

Signature of Approval: ____________________________ Date: ____________________________

Robert Moore, MD, MPH, MBA Chairman
**QUALITY IMPROVEMENT PROGRAMS (QIPs) NEWS-UPDATE – HIGH LEVEL**

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| **PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)**             | ▪ The PCP QIP Team hosted an Advisory Group meeting on 04/10/2020 to discuss proposed changes to the PCP QIP 2020 Measurement Set and address the impact of reduced office visits as a result of the COVID-19 pandemic. The objective is to modify the Measurement Set and enable providers to earn incentive dollars in spite of declining office visits. The revised set will be presented to PAC in May.  
  ▪ Changes to the MY 2021 Measurement Set are expected to be minor.  
  ▪ The QIP Team in collaboration with several internal PHC teams distributed payments for MY 2019 by 04/30/2020. |
| **LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTC QIP)**                    | ▪ The LTC QIP Team in collaboration with several internal PHC teams distributed payments for MY 2019 by 04/30/2020.  
  ▪ The COVID-19 bonus program has concluded. Thank you to the Patient Safety Team for reviewing all submissions. LTC participants who demonstrated they have guidelines in place, or have implemented new guidelines preventing the spread of COVID-19 received the 10% bonus payment with their regular QIP payments. |
| **PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)**       | ▪ The Palliative Care QIP Team in collaboration with several internal PHC teams distributed payments for MY 2019 by 04/30/2020.                                                                                                                                               |
| **PERINATAL QUALITY IMPROVEMENT PROGRAM (PERINATAL QIP)**                   | ▪ A proposal to simplify the process for tracking submitted attestations and reducing PHC and provider staff workload through the Web Team’s automation project has been placed on hold.  
  ▪ Proposed measure changes for the Measurement Period covering 07/01/2020 – 06/30/2021 will be presented to PAC in May.                                                                                         |
| **INTENSIVE OUTPATIENT CASE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (IOPCM QIP)** | ▪ The IOPCM QIP Team in collaboration with several internal PHC teams distributed payments for MY 2019 by 04/30/2020.                                                                                                                                               |
| **HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)**                            | ▪ The new measures to the 2021 Measurement Set will be presented to PAC for approval in May.  
  ▪ The 2020 Hospital Quality Symposium is scheduled for 08/04/20 (Rohnert Park) and 08/06/20 (Redding). Any required adjustments for these events will be communicated in May.  
  ▪ The final evaluation of MY 2019-20 is complete and will presented to IQI, Q/UAC and PAC in the coming months.                                                                                                                                                     |

**DATA TOOL UPDATES**

<p>| PARTNERSHIP QUALITY DASHBOARD (PQD)                                        | ▪ Due to the COVID-19 Pandemic MY 2020 PCP QIP PQD development was paused until final recommended changes to the measure set were resolved;                                                                                                                                             |</p>
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<td>relevant updates will be communicated to our Network as they become available.</td>
<td>The HEDIS Monthly Business requirements were approved on 04/22/2020.</td>
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**EReports**

- The QIP team will have the Tableau-based Immunization Dose Reports available within eReports by 05/08/20. This supplemental report will be refreshed at the beginning of each month, at the same time as Partnership Quality Dashboard views. It offers providers insight into the immunization dose records PHC has captured for their assigned members ranging in age from 0-2 and 9-13 years of age. The intent of these reports is to assure providers' improved visibility of progress against immunization measures.
- Changes coming to the PCP QIP MY 2020 measure set, to accommodate providers focused on COVID-19 response, will be reflected in the eReports Threshold Report (i.e. homepage) by the end of May 2020 or early June, pending PAC approval. Exact timing is in the process of being finalized.

**Performance Improvement (PI)**

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<td><strong>State Mandated Work: Performance Improvement Project (PIP) &amp; Plan-To-Do-Study-Act (PDSA) Cycle</strong></td>
<td>Module 2 of the Health Equity Performance Improvement Project (PIP) was submitted by the due date of 04/17/20. The module included a process map, failure mode and effects analysis, priority ranking and driver diagram to identify the interventions. Santa Rosa Community Health is our partner for the PIP and the focus is improving the performance of Hispanic members on the Well-Child Visits in the First 15 Months of Life (W15) measure. Given the ongoing COVID-19 response and mitigation efforts, including the current recommendations from medical and public health experts, DHCS has waived all final submissions for health plans working on mandated PDSAs for measures below the minimum performance level (MPL) in HEDIS Reporting Year (RY) 2019. DHCS will re-evaluate PDSA submission requirements once finalized rates are received in July for HEDIS RY 2020. PHC continues to track progress on these interventions even if all we can do is track and analyze progress up until the point of suspending the intervention to focus on COVID-19 response. For interventions paused, PHC will follow-up with provider partners periodically as time passes. Our goal is to summarize these projects through the point of suspension as a means to share any learnings and potential adaptations/spread ability once PCPs can once again focus on these measures.</td>
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<td>The Childhood and Adolescent Health PIP focused on improving Well-Child Visits for 3-6 year olds (i.e. HEDIS W34 measure) continues to make progress with provider partner, Shasta Community Health Center (SCHC). Recently, a PIP submission reporting the outcomes of a failure modes effects analysis and prioritized list of interventions, in terms of impact on W34 measure performance, was submitted to HSAG and DHCS for review and feedback. Given COVID-19 response, the joint PIP team was able to agree upon and develop its first proposed PDSA plan before suspending ongoing meetings for the next several weeks. PHC shared this PDSA plan with HSAG and DHCS</td>
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<td><strong>as part of the most recent submission, requesting review and feedback so the team can swiftly proceed when SCHC is able to resume these improvement activities.</strong></td>
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| **ACCELERATED LEARNING** | ▪ On 04/15/20, the first Accelerated Learning webinar session was offered about pediatric and adolescent well-child visits. Of the 27 external participants, 11 completed evaluations through the Webex platform. All rated the webinar as “excellent” or “good.” Lessons learned and resources on adapting clinical operations and practices during COVID-19 were shared.  
▪ The Accelerated Learning webinar about childhood and adolescent immunizations occurred on 04/29/20. |
| **HEDIS SCORE IMPROVEMENT** | ▪ Due to COVID-19, there are recommended revisions to the HEDIS Measure Score Improvement team goals.  
▪ Most of the NR providers participating in the extended Birthday Club are still participating in this member incentive offering to drive improved W34 performance. This represents 37 unique PCP health center or clinic sites across the NR. PHC will honor all members presenting their birthday cards, regardless of when this annual visit is completed during 2020. Some providers have opted out of PHC offered birthday club reminder calls to members, with only 2 NR providers (Northeastern Rural Health Clinics and Shasta Community Health Center) asking to temporarily pause all participation due to COVID-19 response priorities.  
▪ A new enhancement called ePrompts is coming to PHC’s Call Center and the member portal in May. This new feature will grant PHC staff using Call Center and members logging into the member portal, visibility to individual member screening needs for multiple low performing HEDIS measures, ranging from diabetes care to specific adult preventive screening needs. This enhancement is designed to help member facing employees engage and support our members in staying healthy while at the same time directly supporting HEDIS score improvement. User Acceptance Testing (UAT) is planned for the last week of April with a Northern Region-led pilot targeted for kick off mid-May. The results of a 60-day pilot will be reviewed by leadership this summer to determine if more testing or a fuller scale implementation will be pursued. All measure specific details being presented to members, be it verbal or online, were prepared with sensitivity to the current COVID-19 response in mind. |
| **PARTNERSHIP IMPROVEMENT ACADEMY** | ▪ Given ongoing precautions related to COVID-19 response, the April ABCs of QI event scheduled in Redding was canceled. A broader PHC team is evaluating how this training may be converted to a virtual offering in the near future. The NR team continues preparing with consortia partners for the next NR offering in Eureka this August. Additionally, a post-ABCs of QI webinar series for recent NR attendees continues to be developed with the northern consortia. Over the next year, these webinars will supplement others recorded and posted on root cause analysis and meeting facilitation by offering more depth in quality improvement topics such as run charts in Excel, prioritizing your measures, and patient engagement strategies. |
ACTIVITY | UPDATE
--- | ---
**J OINT L EADERSHIP I NITIATIVE (JLI)** | ▪ The third Joint Leadership Initiative meetings with Fairchild Medical Center and Ole Health are both scheduled for 05/07/20.
▪ PHC is offering small grants to the JLI partner organizations to support clinical performance efforts. Due to impacts related to COVID-19, the deadline for applications was extended to late May. This extension will also apply to the reporting requirement on outcomes achieved through these grant monies, with PHC requesting reporting by the end of June 2021. This is meant to acknowledge the ‘pausing’ of most quality improvement work in the current pandemic. All NR JLI provider organizations have submitted grant applications under this offering with PHC Executive review planned by the end of April.
  □ Grants for calendar years 2019 and 2020 were approved for Shasta Community Health Center.
  □ Applications from the following organizations were reviewed by executive leadership on 04/30/20:
  – Adventist Health - Lake (2019, 2020)
  – Adventist Health – Mendocino (2020)
  – Fairchild Medical Center (2019, 2020)
  – Mendocino Community Health Centers (2019, 2020)
  – Ole Health (2019, 2020)
  – Open Door (2019, 2020)
  – Santa Rosa Community Health (2020)
▪ The 3rd installment of Joint Leadership Initiative meetings in the Northern Region were either completed in March, (e.g. Shasta Community Health Center and Open Door Community Health Centers) or are scheduled in early May (Fairchild Medical Center). This extension will also apply to the reporting requirement on outcomes achieved through these grant monies, with PHC requesting reporting by the end of June 2021. This is meant to acknowledge the ‘pausing’ of most quality improvement work in the current pandemic. All NR JLI provider organizations have submitted grant applications under this offering with PHC Executive review planned by the end of April.

**OFFERING AND HONORING CHOICES** | ▪ No Update.

**OTHER** | ▪ The Health Equity draft recommendations based to the workforce survey will be reviewed by the team goal group in early May.

*Note: Detailed information and recordings of webinars are posted to the PHC Website:* [http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx](http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx)

**QUALITY ASSURANCE AND PATIENT SAFETY TEAM (CROSS REGIONAL UPDATE)**

| ACTIVITY | UPDATE |
--- | --- |
**POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD:** | ▪ 15 PQI referrals were received from the following referral sources: Grievance and Appeals (5), Associate Medical Director (1), Regional Medical Director (5), Other (3), Utilization Management (1).
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<td>▪ 52 PQI cases were processed and closed to completion. 2 PQI cases were presented and reviewed at the Peer Review Committee. There are currently 44 open cases between N/S.</td>
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<td>▪ The Patient Safety team participated in the following:</td>
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<td>- QIP project (LTC/SNF QIP Bonus Point Opportunity COVID Infection Prevention Control Program). The Southern region team reviewed 19 submissions and the Northern region team reviewed 19 submissions.</td>
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<td>- TLC 4 C19 Member Outcall campaign organized by the Population Health Management department.</td>
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<td><strong>Region</strong></td>
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<td>North</td>
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<td>South</td>
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<tr>
<td>New PCP</td>
<td>New PCP – Enterprise Family Health Center</td>
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<td>New OB</td>
<td>New OB – Open Door Women’s Health</td>
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</tbody>
</table>

**HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)**

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>UPDATE</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>▪ DHCS has released additional guidance and revisions to HEDIS reporting in late April. Due to the impacts of COVID-19 on plans ability to collect medical record data, the state has released plans accountability for performance below the MPL (50th percentile) on hybrid measures along with removal of sanctions and corrective action plans. Plans are still required to report rates following DHCS and NCQA guidelines/requirements and will continue to be held accountable for Administrative measures performance below the MPL (50th percentile).</td>
</tr>
<tr>
<td></td>
<td>▪ During the medical record collection period, PHC observed minimal to zero impact on our ability to retrieve medical records due to COVID-19. We extend our greatest appreciation to our network providers for their continuous support during this time.</td>
</tr>
<tr>
<td></td>
<td>▪ PHC is in the final stages of closing out our HEDIS Reporting Year 2020, measurement year 2019 (01/01/2019 – 12/31/2019). Over the next six weeks PHC will undergo an extensive audit on data collected via medical records and formal administrative and Hybrid rate reviews. Early June we will formally lock our rates. Internal and external stakeholder release of Regional and County level performance is targeted for late June.</td>
</tr>
</tbody>
</table>

**QUALITY COMPLIANCE AND ACCREDITATION (NCQA)**

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>UPDATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA)</td>
<td>▪ On 03/20/20, NCQA released a COVID-19 Memo applicable to organizations undergoing survey in 2020 and recognizing that normal operations have been disrupted in many communities, which could affect organizations’</td>
</tr>
</tbody>
</table>
**ACTIVITY**

ability to meet NCQA requirements. In light of the pandemic, NCQA is implementing exceptions for 03/01/20–09/01/20 for future surveys, including PHC’s First Survey scheduled on 11/17/20. NCQA will apply exceptions on a case by case basis, based upon each organization’s unique situation. Exceptions include:

- Three distinct options for file review look-back period.
- NA score available if a requirement is in conflict with a federal/state regulation, including emergency response regulation.
- Flexibility in scoring organization’s performance.
- Flexibility for credentialing out-of-network and out-of-state providers.

- The COVID-19 NCQA Memo is updated on a regular basis, as NCQA learns more about plans’ circumstances across the country. In response to the memo, the NCQA Program Management Team collected information from business owners to assess and evaluate operational impacts to NCQA First Survey requirements due to COVID-19. This information will guide the NCQA Program Management Team in their discussions and advocacy efforts with NCQA to ensure appropriate exceptions are applied to PHC’s First Survey. Furthermore, the NCQA Program Management Team also hosted conversations with NCQA consultant Diane Williams, NCQA, and San Francisco Health Plan to clarify flexibilities. As we continue to seek guidance from NCQA, we will communicate and share up-to-date information with all key stakeholders and NCQA Steering Committee once the new release is available.

- As of 04/16/2020, PHC’s overall compliance rate of non-file review requirements is 94.30% (NCQA-related Department Goal 2). To achieve 100% compliance, business owners are addressing findings and/or gaps pertaining to Diane’s feedback. For requirements which had been deemed compliant in the past, business owners are refreshing their evidence, such as data reports, grand analysis, and material evidence to meet the required First Survey look back period.

- Business owners of file review requirements conducted the third round of mock file reviews with NCQA consultant Diane Williams in April, as part of NCQA-related Department Goal 4. A file review sustainability plan has also been approved by the executive team in March. The plan includes two audit phases to sustain and achieve compliance of PHC’s file review throughout the look-back period (May–November 2020). The purpose of ongoing review is to uncover potential problems that may require corrective action throughout the look-back period.

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<tr>
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<thead>
<tr>
<th>Policy/Procedures/Guidelines</th>
<th>Old Number</th>
<th>New Assigned Number</th>
<th>Comments</th>
<th>Provider Manual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Relations</td>
<td></td>
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<tr>
<td>Provider Grievance Policy</td>
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<tr>
<td>Post-Meeting Correction - This policy referenced in error, as it had been pulled from the meeting agenda. Review by the Committee scheduled for August 2020.</td>
<td></td>
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<tr>
<td>Member Services</td>
<td></td>
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<tr>
<td>Notification of Provider Termination or Change in Location</td>
<td>MP 300</td>
<td>Regular review; references to Wellness and Recovery provider added</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Health Services – Quality</td>
<td></td>
<td></td>
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<tr>
<td>Advance Directives</td>
<td>MCQP1047</td>
<td>Regular review; language regarding Facility Site and Medical Record Review for primary care rewritten for clarity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Potential Quality Issue Investigation and Resolution Attachment: A. Practitioner Performance and Systems Scores Grid</td>
<td>MPQP1016</td>
<td>Regular review; language clarifications added</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Provider Preventable Condition (PPC) Reporting</td>
<td>MPQP1055</td>
<td>Regular review; language clarification added</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Adult Preventive Health Guidelines Attachments: A updated, B unchanged A. Adult Preventive Health Screening Guidelines B. TB Screening Recommendations (Flowcharts)</td>
<td>MCQG1005</td>
<td>Regular review; no changes to guideline content, links updated within document</td>
<td>X</td>
<td></td>
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</tbody>
</table>

Reminder - Effective January 2018, Approval Date reflects that of the Physician Advisory Committee’s meeting date.
### Health Services – Clinical Practice Guidelines

| Lactation Clinical Practice Guidelines | MPXG5009 | Regular review; outdated research references removed; Growing Together Program (GTP) references updated; timing of Lactation Support Service to reflect early postpartum period of 84 days per updated guidelines; throughout guideline, removed specific clinical guidelines in lieu of references to appropriate evidence among governing bodies – providers are directed to appropriate resources versus attempting to summarize various changing guidelines within document | X |

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### Health Services – Population Health

<p>| Cultural &amp; Linguistic Program Description | MPLD7001 | Regular review; all references to Group Needs Assessment updated to Population Needs Assessment (PNA); updated per current processes and oversight | X |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Health Services – Care Coordination</strong></td>
<td></td>
<td></td>
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<tr>
<td>Complex Case Management</td>
<td>MCCP2007</td>
<td>Regular review; language regarding the Initial Assessment process expanded upon for clarity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes Prevention Program</td>
<td>MCCP2026</td>
<td>Regular review; language clarifications added</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lactation Policy and Guidelines</td>
<td>MCCP2020</td>
<td>Regular review; updated to reflect current processes and recommendations by the Academy of Pediatrics (AAP); definition of Women, Infants, and Children (WIC) to include services for parents and other family members; time frame updated for recommended duration of exclusive breastfeeding to about 4-6 months (versus 6 months); References updated</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines</td>
<td>MPCP2017</td>
<td>Regular review; revised per the Wellness &amp; Recovery benefit – language updated includes: description of symptoms that warrant emergent or urgent psychiatric evaluation, which entity will provide substance use disorder &amp; substance use misuse services in the various counties, addition of substance-related and addictive disorders to PCP provisional diagnosis list of behavioral health (BH) conditions, differences between counties or providers identified for processes</td>
<td>X</td>
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<tr>
<td><strong>Health Services – Utilization Management</strong></td>
<td></td>
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<tr>
<td>Infant Monitor Guidelines</td>
<td>MCUG3023</td>
<td>Regular review; general criteria for the authorization of monitors updated for clarity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Prenatal &amp; Perinatal Care</td>
<td>MCUG3118</td>
<td>Regular review; minor language clarifications added</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>MCUP3028</td>
<td>Regular review; term &quot;contractors&quot; replaced with managed behavioral health organization</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Medical Nutrition Services</td>
<td>MCUP3052</td>
<td>Regular review; no changes to policy content</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services</td>
<td>MCUP3127</td>
<td>Regular review; Definitions updated; term entities replaced with managed behavioral health organization(s); language added that annual delegation oversight audit shall be presented to PHC’s Delegation Oversight Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Fecal Microbiota Transplant (FMT)</td>
<td>MCUP3136</td>
<td>Regular review; language clarifications added; References updated</td>
<td>X</td>
<td></td>
</tr>
<tr>
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<tr>
<td>Utilization Management Program</td>
<td></td>
<td>MPUD3001</td>
<td>Sections updated per NCQA – Substance Use Disorder Treatment Services / Wellness &amp; Recovery Program and Annual Program Evaluation</td>
<td>X</td>
</tr>
<tr>
<td>Description – Amendment to April 2020 Board Approval Required</td>
<td></td>
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<td></td>
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<tr>
<td>Podiatry Services</td>
<td></td>
<td>MPUP3129</td>
<td>Regular review; no changes to policy content; References updated</td>
<td>X</td>
</tr>
<tr>
<td>Screening and Treatment for Substance Use Disorders</td>
<td></td>
<td>MCUP3101</td>
<td>Regular review; updated to include information on the Wellness and Recovery Benefit and per DHCS contractual obligations; References updated</td>
<td>X</td>
</tr>
<tr>
<td>Attachments: unchanged</td>
<td>A. Alcohol Misuse Screening and Counseling (AMSC) Training Resources</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>B. Pocket Screening and Brief Intervention for Alcohol Use Disorders</td>
<td></td>
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<tr>
<td>C. Application to be a Contracted Brief Behavioral Counseling Intervention/Referral to Treatment Provider</td>
<td></td>
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<tr>
<td>D. Review Documentation for Applicants to become a Contracted Behavioral Counseling Intervention/Referral to Treatment Provider</td>
<td></td>
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<tr>
<td>Acupuncture Services Guidelines</td>
<td></td>
<td>MCUG3002</td>
<td>Regular review; modified to align with Medi-Cal guidelines; podiatrist added as type of physician who may administer acupuncture, according to Medi-Cal; since a Treatment Authorization Request (TAR) is not required, verbiage updated to reflect same (unless more than 2 visits per month are recommended by provider)</td>
<td>X</td>
</tr>
<tr>
<td>Physical, Occupational and Speech Therapies</td>
<td></td>
<td>MCUP3114</td>
<td>Regular review; revised per Medi-Cal guidelines / State Bulletin (dates of service on or after 01/01/2020, speech therapy services previously eliminated as part of the optional benefits exclusion, reinstated as full Medi-Cal benefits) – services rendered in outpatient setting are limited to a maximum of 2 services per month (initial &amp; 6 month evaluations not subject to limit); language specific to members 21 years of age or older removed; language added regarding PHC’s responsibility under the Whole Child Model benefit; References updated</td>
<td>X</td>
</tr>
<tr>
<td>Incontinence Guidelines</td>
<td></td>
<td>MCUG3022</td>
<td>Regular review; updated per State Bulletin / regulatory update; effective 03/16/20, TAR requirement removed from incontinence cream and wash billing codes A4335 &amp; A6250; language updated throughout guideline to reflect change in cost threshold when a TAR is required for Incontinence supplies; References updated</td>
<td>X</td>
</tr>
</tbody>
</table>

**Attachments:**
A. PHC Maximum / Average Benefit Incontinence Guidelines
B. Incontinence Supplies Medical Necessity Certification form (DHCS 6187)
<table>
<thead>
<tr>
<th>Policy/Procedures/Guidelines</th>
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<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Dental Services (including Dental Anesthesia)</td>
<td>MPUP3048</td>
<td>Regular review; paragraph added that a recent pre-op exam performed by member’s primary care physician should be submitted with all TARs for dental procedures requiring intravenous sedation or general anesthesia; References updated</td>
<td>X</td>
</tr>
<tr>
<td><strong>PHC TAR Requirements</strong></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>TAR Review Process policy</td>
<td>MCUP3041-A</td>
<td>As Attachment only – policies / guideline not reviewed - Updated to reflect changes made under the Incontinence Guidelines (MCUG3022)</td>
<td></td>
</tr>
<tr>
<td>Pain Management policy</td>
<td>MCUP3049-A</td>
<td></td>
<td></td>
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<tr>
<td>Authorization of Ambulatory Care guideline</td>
<td>MCUG3007-B</td>
<td></td>
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</tbody>
</table>
**Policy/Procedure Number:** MCCP2007 (previously MPCP2007)  
**Lead Department:** Health Services

**Policy/Procedure Title:** Complex Case Management  
- [ ] External Policy  
- [ ] Internal Policy

<table>
<thead>
<tr>
<th>Original Date: 06/20/2012</th>
<th>Next Review Date: 04/08/2021/06/10/2021</th>
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<tbody>
<tr>
<td>Last Review Date: 04/08/2020/06/10/2020</td>
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</tbody>
</table>

**Applies to:**  
- [ ] Medi-Cal  
- [ ] Employees

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**5.** Through the Initial Assessment process, the case manager will collect, document and review the information below. The information collected during the assessment process will be analyzed by the case manager to develop the Individualized Care Plan (ICP) for the member. A summary statement of this analysis is captured at either the end of each question or at the end of the Complex Case Management assessment. For any area of the assessment where the information below is not applicable to the member, the case manager will indicate an ‘N/A’ on the assessment next to that question. For the purposes of the required assessment summary(s), N/A’s do not require analysis by the case manager. If a member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, the case manager will note applicable areas. The following will also be reviewed and documented:

- a. The referral source and condition that led to the member’s eligibility for CCM.
- b. A comprehensive clinical history of medical conditions based on available medical records from the 30 days prior to referral to the CCM program, and retrieved from provider offices for diagnostic and treatment information, plan of care and medications. Other resources of treatment history may be obtained by Treatment Authorization Requests (TARs), Service Authorization Requests (SARs), and Medical / Pharmacy Claims.
- c. Member’s ability to function with or without assistance to perform activities of daily living (such as grooming, dressing, bathing, toileting, continence, eating, transferring, walking), caregiver availability and involvement, as well as member’s ability/motivation for self-management.
- d. Age specific questions including developmental milestones, school-related concerns, family interactions, etc.
- e. History of alcohol or other substance use disorders along with any treatment(s) for these conditions, as well as the use of tobacco products and willingness to quit.
- f. Evaluation of mental health status, memory/retention, and cognition. The Patient Health Questionnaire-2 (PHQ-2) is administered to assess for depression, and how often the member feels lonely. Questions included in the assessment ask if the member has trouble getting thoughts out, remembering things, or understanding directions, and the PHC CC Staff are prompted to evaluate the member’s understanding and retention throughout the assessment process.
- g. Potential social barriers to health that may include member’s education, economic stability, or access to safe housing, transportation, food, social support and the healthcare system.
- h. Whether member has family, caregivers, friends and/or care providers who may help make decisions about member’s health. PHC CC Staff will explain and offer Advanced Care Directive and Physician’s Orders for Life-Sustaining Treatment (POLST) forms to the member if they do not currently have these forms completed and available for use.
- i. Evaluation of language preference, cultural or religious beliefs, health literacy, mental health, cognition, memory and understanding, as well as communication needs that include possible visual and hearing accommodations.
- j. Information about available benefits and resources within PHC and the community. This includes, but is not limited to, information regarding copays or pharmacy benefits, dental benefits, enhanced benefits, the authorization process, and community resources on mental health, wellness, nutrition, transportation, In Home Support Services (IHSS) and palliative care programs. The assessment will also evaluate the member’s awareness of their available benefits.
Cultural & Linguistic Program Description

MPLD7001

August 2019

March May

2020

Original Date: 02/19/2014

Revision Date(s): 02/18/15; 01/20/16; 02/15/17; *02/14/18; 09/12/18; 09/11/19; 03/11/2006/10/20

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

Partnership HealthPlan of California (PHC) is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible members with limited English proficiency (LEP) or sensory impairment. PHC’s Cultural and Linguistic Services comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, and 45 C.F.R. Part 80) and the Cultural and Linguistic Services requirements in accordance to the contractual agreement with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and the Centers for Medicare and Medicaid Services (CMS).

The goal of the Cultural and Linguistic Services Program is to ensure that PHC members, expressly members with limited English proficiency (LEP) or sensory impairment, receive equal access to health care services that are culturally and linguistically appropriate. PHC does not discriminate against its members because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental disability.

Program objectives include:

- Comply with state and federal guidelines related to caring for LEP and sensory impaired members.
- Improve the quality of health care services for all PHC members at medical and non-medical points of contact.
- Promote a culturally competent health care and work environment for PHC.
- Promote CLAS “best practices” for implementation by PHC, its network providers and subcontractors.
- Use outcomes, processes and structure measures to monitor and continuously improve PHC activities aimed at achieving cultural competence and reducing health care disparities.

An illustration of the reporting relationships for PHC identifies key staff with overall responsibility for the operation of the Cultural and Linguistic Services Program. (See Appendix A)

The Health Services Department PHC’s Population Health unit is responsible for developing, implementing and evaluating PHC’s Cultural and Linguistic Program in coordination with Quality, Provider Relations, Member Services, Communications, Compliance, Information Technology, Health Analytics, Regional Leadership, and Administration/Compliance.

The Quality Management Department and Health Analytics team (under Health Services), analyzes quality improvement data by race, ethnicity and language to identify health disparities and utilization patterns as it relates to Cultural and Linguistic Services.

Provider Relations is responsible for ensuring that provider network composition continuously meets members’ ethnic, cultural and linguistic needs. Language capabilities of clinicians and other provider office staff are identified during the credentialing process and through an annual, self-reported survey of our primary care provider sites to update PHC’s provider directory.
Member Services record members’ cultural and linguistic capability upon enrollment using data acquired from DHCS. Members are informed that they have access to free oral interpretation in their language and written materials translated into PHC’s threshold languages or provided in alternative formats. Member Services is responsible for supporting PHC’s Consumer Advisory Committee (CAC) in accordance with Title 22, CCR, Section 53876 (c). The CAC meetings are chaired by designated PHC staff. The purpose of the CAC is to provide a link between PHC and the community. CAC advises PHC on the development and implementation of its cultural and linguistic accessibility standards and procedures. The committee responsibilities include advising on cultural competency, educational and operational issues affecting members, including seniors, persons with LEP, and persons with disabilities. The CAC is composed of PHC members and community advocates.

Administration Communications and Compliance is responsible for ensuring that policies and materials for eligible beneficiaries or potential enrollees do not discriminate due to race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex or physical or mental disability. Regional Leadership provide insight into the unique needs of their member population, and maintain relationships with regional providers, counties, and community leaders to ensure the cultural and linguistic needs of PHC’s membership are addressed equitably.

Administration, along with PHC’s executive oversight, also ensures that PHC’s policies and procedures comply with standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. PHC has systems and processes to:

- Assess, identify and track linguistic capability of interpreters, bilingual employees and contracted staff in medical and non-medical settings.
- Conduct a Health Education and Cultural and Linguistic Needs Assessment (PNA) and an action plan with corresponding actions every year for Medi-Cal in order to:
  - Identify member health education and cultural and linguistic needs. Submit PNA report to DHCS as stated in the contract.
  - Continuously develop and improve contractually required health education, cultural and linguistic services, and educational materials
  - Monitor and evaluate the Cultural and Linguistic Services and the performance of individuals providing linguistic services.
- Between each GNA, PHC will conduct an interim, plan-wide analysis of cultural, linguistic, and health disparities data for members and compare this to the cultural and linguistic capabilities of our contracted providers. This will be called the “Interim PHC–GNA.”
- Provide cultural competence, sensitivity, or diversity training for staff, providers or subcontractors at key points of contact.

Linguistic services are provided by PHC to monolingual, non-English speaking or LEP Medi-Cal beneficiaries for population groups as determined by contract. These services include the following:

- No cost linguistic services:
  - Oral interpreters, sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) fully translated into threshold languages, upon request.

Use of California Relay Services for hearing impaired.

During the PNA, PHC regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. Activities include:

- Document reported ethnicity, preferred language, and use of interpreters in PHC’s information system.
- Document member requests to change their reported ethnicity or preferred language.
- Track and analyzing face-to-face and telephonic interpreter service usage rates for all points of contact.
- Instruct providers to record members’ language needs in the medical record and document member requests or refusal of language/interpreter services.
- Utilize the results of Facility Site and Medical Record Review audits to validate provider compliance with documentation requirements.
- Utilize the findings and conclusions from the Population Group Needs Assessment (every 5 years with annual update) and the action plan update to continuously develop and improve the cultural and linguistic services program.
- Gather additional member input through member surveys, focus groups and grievance analysis.

Core content of the PNA

DHCS – PNA goals:
- Evaluating beneficiary health risks
- Identifying member health needs
- Prioritizing health education and C&L services
- Prioritizing QI programs and resources.

PNA Identifies:
- Member health status and behaviors
- Member health education and C&L needs
- Community health education and C&L programs and resources
- Health disparities and gaps in services

PHC continuously assesses the linguistic capabilities of its employees, providers and subcontractors to reduce language barriers, to increase the quality of care LEP members receive, and ensure the plan’s ability to meet members’ ethnic, cultural and linguistic needs. Activities that contribute to the assessment process include:

- Employees
  - Hire staff that demonstrates appropriate bilingual proficiency at medical and non-medical points of contact.
  - Use a contracted vendor to test PHC employee positions that require bilingual
language proficiency.

- Maintain human resource records on staff linguistic skills and relevant training, certification and/or proficiency results.
- Maintain the community health resources page on PHC website showing the services offered in the counties we serve, including the language(s) in which the programs are offered.

- Providers
  - Primary Care Providers (PCP) and Specialists are required to ensure access to care for members with LEP through the provider’s own multilingual staff or through cultural and linguistic services facilitated by PHC.
  - Identify language proficiency of bilingual primary care providers and office staff through a standard self-assessment tool.
  - Reporting provider and office staff language capabilities in the Provider Directory.

- Subcontractors
  - Execute agreements with subcontractors that include compliance with all product lines of business requirements.
  - Execute agreements with contracted translators and interpreters that require staff to be tested for proficiency and experience.

- Maintain records in the Health Services department of community health resources showing the services offered in throughout the counties we serve, including the language in which the programs are offered.

PHC ensures access to interpreter services for all LEP and sensory impaired members through several mechanisms:

- Inform new enrollees of available linguistic services during a welcome call and in welcome packets.
- Provide a Quick Reference Guide to demonstrate to providers how to access our interpreter services.
- Provide an interpreter for scheduled appointments when requested by the provider or member.
- Ensure that members can use face-to-face language and sign language interpreters with advance notice.
- Make 24-hour access to telephonic interpreter services available for all medical and non-medical points of contact as defined in the contract or regulations.
- Monitor the interpreter request process to avoid unreasonable or unnecessary delays when the service is requested by the member or provider.
- Encourage the use of qualified interpreters rather than family members or friends. (The member may choose an alternative interpreter at his/her cost after being informed of the no cost service.)
- Discouraging the use of minors as interpreters except in extraordinary circumstances.
- Maintain records in the Member Services department of the languages available from the interpreter services.
- Translate all written member informing materials into PHC’s threshold languages and make materials available in alternative formats as requested, such as Braille, large print, CD, or audio cassette.
Maintain records in the Member Services department of translated member informing materials.
Ensure members are made aware that they have the right to file a complaint or grievance if their linguistic needs are not met.

PHC has internal systems to meet members’ cultural and linguistic needs. Examples of activities that support these internal systems include:

- Initial and continuing training on cultural competency, sensitivity, or diversity for PHC staff, providers and subcontractors.
- Regular communication and/or training ensuring that staff and providers are informed and aware of PHC’s policies and procedures regarding provision of CLAS.
- Training and educational materials and tools on different cultures and CLAS are made available to PHC staff, and network providers.
- Monitor and evaluate the effectiveness of PHC’s Cultural and Linguistic Services in delivering CLAS is accomplished by review of:
  - Member satisfaction surveys
  - Member complaints and grievances
  - Reports of utilization of interpreter service by language
  - Provider assessments and site reviews
  - Findings from the Health Education and Cultural and Linguistic
  - Feedback on services from the Consumer Advisory Committee (CAC), the Internal Quality Improvement Committee, PHC staff, network providers, community-based organization partners, community health fairs, outreach, and other sources.

As part of the PGNA and the Interim PHC-GNA, health disparities and utilization patterns by race, ethnicity, and language are investigated and, when needed, appropriate interventions are implemented.
Core content of the PGNA and Interim PHC-GNA

DHCS – PGNA goals:
- Evaluating beneficiary health risks
- Identifying member health needs
- Prioritizing health education and C&L services
- Prioritizing QI programs and resources.

PGNA Identifies:
- Member health status and behaviors
- Member health education and C&L needs
- Community health education and C&L programs and resources
- Health disparities and gaps in services

Interim PHC-GNA:
- Analysis of the cultural, ethnic, racial and linguistic needs of our members.
- Analysis of the availability of our provider network to meet these needs.
- Recommendations on any needed adjustments to the provider network to better meet these needs.
The Senior Health Educator has a MS degree and reports to the Senior Director of Health Services. The Senior Health Educator is responsible for developing and evaluating PHC’s Cultural and Linguistic Services in coordination with Provider Relations, Member Services, Administration, Compliance, and Quality Departments. The health education staff report to the Senior Health Educator and are responsible for implementing the C&L Services described above. All responsible staff/departments, or appropriate assigned delegate, report to the Chief Operating Officer. The Chief Medical Officer and Chief Operating Officer report to the Chief Executive Officer.
I. RELATED POLICIES:
A. MCQP1052 - Physical Accessibility Review Survey – SR Part C
B. MPQP1016 – Potential Quality Issue Investigation and Resolution
C. MCUP3101 – Screening and Treatment for Substance Use Disorders
D. MCQP1021 - Initial Health Assessment and Behavioral Risk Assessment
E. MP CR 601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MP PR #208 - Provider Notification of Provider Termination, Site Closure or Change in Location Information
G. MCQG1015 – Pediatric Preventive Health Guidelines
H. MCQG1005 – Adult Preventive Health Guidelines
I. CMP36 - Delegation Oversight and Monitoring
J. MCUG3118 – Prenatal & Perinatal Care
K. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:
A. Provider Relations
B. Health Services
C. Compliance
D. Grievance and Appeals

III. DEFINITIONS:
Primary Care Practice Site – a facility which provides services such as family medicine, internal medicine, pediatrics, and/or obstetrics and gynecology.

IV. ATTACHMENTS:
A. 2019 Site Review Survey Tool and Standards
B. 2019 Medical Record Review Tool and Standards
C. 2019 OB Facility Site Review Tool and Standards
D. OB/GYN FSR Tool
E. OB/GYN FSR Guidelines
F. Medical Record Review Survey Tool
G. OB/GYN MRR Tool
H. Medical Record Review Guidelines
I. 2018 PHC Addendum to Site Review 2019 PHC Addendum to Site Review
I. Provider Self-Assessment Form

I-L. Attachment to Self-Assessment Form

Overview of CAP Process — Conditional Pass
Timeline of CAP Notification and Completion

I-F. Provider Certificate

G. 2019 Non-Accredited Facility Site Review Tool and Guidelines

M-H. Master Trainer Application

VI. PURPOSE:

A. To provide primary care practice sites a comprehensive guideline for Site Review (SR) requirements and processes. A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Record Review (MRR). An Obstetrics–Gynecology (OB/GYN) FSR and a standard MRR tool are used for OB/GYN provider sites. The FSR, OB/GYN FSR, and MRR tools were developed by a collaborative coalition made up of staff from Department of Health Care Services (DHCS) and Medi-Cal Managed Care health plans. The purpose of the SR is to ensure that practicing sites have sufficient capacity to:

1. Provide appropriate primary care and obstetrics/gynecology services;
2. Carry out processes that support continuity and coordination of care;
3. Maintain patient safety standards and practices, and;
4. Operate in compliance with applicable federal, state, and local laws and regulations.

B. Findings of the SR are used to:

1. Provide information for credentialing/re-credentialing decisions;
2. Identify areas where education and technical assistance is needed;
3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VII. POLICY / PROCEDURE:

A. Requirements

1. Site Review Personnel

The Partnership HealthPlan of California (PHC) Chief Medical Officer (CMO) is ultimately responsible for SR activities completed by PHC personnel. PHC has designated a minimum of one Registered Nurse (RN) to be certified as a Master Trainer by the DHCS.

a. The DHCS Certified Master Trainer (CMT) is responsible for training, supervising, and certifying Site Reviewers-RN and physician reviewers and other review team members; in addition to monitoring reviews and evaluating Certified Site Reviewers (CSR) for accuracy, inter-rater reliability.

1) The CMT is responsible for overseeing data collection and assuring that reviewers collect Site Review activities comply with the Site Reviewers’ scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the Site Reviewers’ level of education and training, data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute.

b. Licensed Physicians, NP’s, PA’s, and RN’s are eligible to be a CSR. Site Reviewer. Which includes, performing a Site Review independently and signing off on the FSR and MRR tools.

a. Each site review Site Review must have a designated Certified Site Reviewer (CSR) who is responsible for and must sign the FSR and MRR tools. Only Physicians, NP’s, PA’s, or RN’s are eligible to be a CSR. An RN is the minimal level of site review Site Reviewer.
acceptable for independently performing site review.

3) RN reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures.

b. Site Review Training and Certification
1) Physicians, NP’s, PA’s and/or RN’s that are designated to be a Certified Master Trainer or Certified Site Reviewer must meet the certification and recertification requirements outlined in the table below.
2) DHCS will recertify any Master Trainers at a minimum of every three years.
3) Trainers and reviewers, Certified Site Reviewers, will be recertified by a PHC’s Certified Master Trainer a minimum of every three years. Upon certification and recertification, CSR’s Site Reviewers will receive written verification of certification from PHC.

<table>
<thead>
<tr>
<th>Initial Certification Requirements</th>
<th>Certified Master Trainer</th>
<th>Certified Site Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possess a Current RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP or PA license</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Be employed or subcontracted with PHC</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Have experience in conducting training in a health related field, or conducting quality improvement activities, such as medical audits, site reviews, or utilization management activities within the last three years.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Complete twenty FSRs and twenty MRRs and 1 year experience as a CSR. Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Attend didactic site review training or completion of DHCS site review training modules on the current site review tools under supervision of a CMT.</td>
<td>x</td>
<td></td>
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<tr>
<td>Complete ten FSRs and ten MRRs with a CSR or CMT.</td>
<td></td>
<td>x</td>
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<tr>
<td>Achieve an Inter-rater score of 10% in FSR and 10% in MRR with designated CMT.</td>
<td></td>
<td>x</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recertification Requirements</th>
<th>Certified Master Trainer</th>
<th>Certified Site Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possess a Current RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP or PA license</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Be employed or subcontracted with PHC</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Be responsible for staff training on the most current DHCS site review tools and standards</td>
<td>x</td>
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<tr>
<td>Participate in DHCS sponsored site review trainings as well as site review Site Review work group (SRWG) meetings and teleconferences.</td>
<td>x</td>
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<tr>
<td>Maintain CMT certification.</td>
<td>x</td>
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<tr>
<td>Complete a minimum of twenty site reviews following initial certification or recertification.</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Attend DHCS sponsored inter-rater workshops in person every two years.</td>
<td>x</td>
<td>x</td>
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</tbody>
</table>
Policy/Procedure Number: MPQP1022 (previously QP100122) | Lead Department: Health Services
---|---
Policy/Procedure Title: Site Review Requirements and Guidelines | ☒ External Policy
| ☐ Internal Policy
Original Date: 10/30/2002 (vs. 10/16/2002) | Next Review Date: 06/10/2021
| Last Review Date: 06/10/2020
Applies to: ☒ Medi-Cal
| ☐ Employees

**Policy/Procedure Title:** Site Review Requirements and Guidelines

**Policy/Procedure Number:** MPQP1022 (previously QP100122)

**Lead Department:** Health Services

**Original Date:** 10/30/2002 (vs. 10/16/2002)

**Next Review Date:** 06/10/2021

**Last Review Date:** 06/10/2020

**Applies to:** Medi-Cal

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**Achieve a 10% variance on the MRR, on the inter-rater score as defined by the SWRG SRWG and DHCS**

| x |

**Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.**

| x |

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**Inter-Rater Review Process**

1. CMT and CSR certifications must complete an inter-rater review process as part of the initial certification and the recertification process.

   a. The inter-rater for CMT candidates is performed by a DHCS Nurse Evaluator. The inter-rater review process requires the CMT candidate to concurrently complete and score a site review Site Review with a DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.

   b. The inter-rater for a CSR is the PHC CMT. The inter-rater review process requires the CSR to concurrently complete and score a site review Site Review with the PHC CMT according to the DHCS FSR and MRR tools and standards.

2. If the CMT or CSR does not meet the appropriate inter-rater score variance (see chart above), they may repeat the process one time. The appropriate inter-rater and candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review.

   a. CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait 12 months to reapply for certification.

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**Site Reviewers**

Site Reviewers must meet the criteria as addressed in the Medi-Cal Managed Care Division (MMCD) Policy All Plan Letter 0320-02004. This includes having a current California M.D., D.O., RN, or Physician Assistant (PA) license; completion of the DHCS SR training curriculum; conducting site reviews and completion of the inter-rater site review process. At a minimum, PHC review teams will consist of a DHCS Certified Site Reviewer, Physicians, Physician Assistants (PAs), and Registered Nurses (RNs) designated as trainers and reviewers will be required to meet the DHCS criteria for Recertification. DHCS will recertify any Master Trainers. Trainers and reviewers will be recertified by a Master Trainer a minimum of every three years. The Master Trainer may enlist other RNs, Physicians, PAs or Licensed Vocational Nurses (LVNs) as part of the review team.

**Full-Scope Site Review**

A full-scope SR consists of a Certified Site Reviewer or Certified Master Trainer CMT conducting both the FSR and the MRR using review tools required by the DHCS (See Attachments -A-D). PHC may accept SRS completed by other health plans within the past three years if the DHCS tool is used and the reviewer is certified by DHCS or a DHCS certified master trainer. All PHC contracted sites who serve PHC members must receive a minimum passing score of 80% on both tools to be considered as having passed the Site Review.

a. FSR is a review of the practice’s site, processes, and covers the following areas:

   1. Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act
   2. Personnel
   3. Office Management
   4. Clinical Services
   5. Preventive Services
   6. Infection Control

b. OB/GYN FSR is a review of the practice’s site, processes, and covers the following areas:

   1. Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act
   2. Personnel
   3. Office Management
   4. Clinical Services
   5. Preventive Services
   6. Infection Control
   7. Maternity
   8. Pediatrics
2) Personnel
   a) Requires documentation of education/training in Comprehensive Perinatal Services Program (CPSP)

3) Office Management
   a) Requires PHC members have access to CPSP or like services.

4) Clinical Services

5) Preventive Services

6) Infection Control

c. Non-Accredited Sites is a review of the practice’s site, processes, and covers the following areas:

1) Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.

2) Personnel

3) Office Management/Medical Records

4) Clinical Services

5) Preventive Services

6) Infection Control

7) Quality Assurance Performance Improvement

d. Medical record review areas include:

1) Format (All PCP-sites)

2) Documentation (All PCP sites)

3) Continuity/Coordination (All PCP-sites)

4) Pediatric Preventive (Family Practice & Pediatric sites, and OB/GYN sites if applicable)

5) Adult Preventive (Family Practice, Adult Medicine sites, and OB/GYN sites)

6) OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)

g. PHC’s contract with the Department of Health Care Services (DHCS) requires contracted OB/GYN providers to follow current American College of Obstetrics and Gynecology (ACOG) standards as the minimum standards for services to PHC’s pregnant members. In addition, all obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, and psychosocial risks, on all pregnant members at the initiation of pregnancy related services. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period.

1) During the OB/GYN FSR, the reviewers will request documentation to determine if the provider is a Comprehensive Perinatal Services Program (CPSP) or non-CPSP provider.

2) A non-CPSP provider will be asked for documentation regarding the provider’s contractual agreement with a Certified CPSP Provider who will provide the comprehensive risk assessment, medical nutrition, and psychosocial risk assessments. A non-CPSP provider may choose to use CPSP trained staff to do the comprehensive risk assessment and make referrals to the CPSP program for interventions and completion of care plans. The reviewers will request documentation of training for a provider’s CPSP trained staff.

4.3. Initial Site Review Process

a. An initial site review Site Review consists of an initial FSR and an initial MRR. The initial FSR and the initial MRR might not occur on the same date.

b. The FSR is conducted first to ensure the PCP-site operates in compliance with all applicable local, state, and federal laws and regulations. Members are not assigned to providers until the
PCP site has received a passing score and all Corrective Action Plan (CAP) items are completed and signed off. An initial FSR is not required when a new provider joins a PCP site that has a current passing FSR score.

1) These pre-contracted providers who do not pass the initial FSR within two attempts may reapply to PHC after six months.

b. An initial MRR must be completed within 90 days of the date that members were first assigned to the PCP site.

1) This may be deferred an additional 90 calendar days only if the new PCP does not have enough assigned members to complete the MRR on the required minimum number of records (see section 4.a.1d) d (i)).
2) If after 180 days following assignment of members, the PCP still has fewer than the required number of medical records, a MRR on the total number of records available will be completed. Scoring on the MRR tool will be adjusted according to the number of medical records reviewed.

c. Additional Scenarios that require an Initial Site Review, but are not limited to, instances when:

1) A new PCP site is added to the PHC network
2) A newly contracted provider assumes a PCP site with a previous failing FSR and/or MRR score within the last three years
3) A PCP site is returning to the PHC network and has not had a passing FSR within the last three years.
4) A PCP site relocation requires that PHC must:
   a) Complete an initial FSR must be completed within 30-60 days of notification or discovery of the completed move.
   b) Allow existing members to continue to see the provider.
   c) New members will not be assigned to the PCP site until the site receives a passing FSR and MRR score.

If PHC expands to a new service area. The FSR portion of the initial site review must be completed prior to the start of new or expanding operations. Requirements are outlined as follows:

1) Five percent of the PCP sites in the new network service area, or thirty PCP sites, whichever is greater in number.
2) All of the remaining sites in the new network service area within the first six months of expansion.
3) All of the PCP sites in the new network service area if there are thirty or fewer PCP sites.
4) PCP sites that are subject to site review must include a variety of PCP types (Family Medicine, Internal Medicine, Pediatric, etc.) and subcontracted entities (solo practice, medical group, etc.) from throughout the provider network.

6.4. Subsequent Site Reviews

a. Subsequent site reviews consist of a FSR and MRR at least every three years, beginning no later than three years after the initial FSR. Site reviews may be conducted more frequently per county collaborative discussions when determined necessary based on monitoring, evaluation, or CAP follow up issues.

1) Medical Record Portion
   a. The MRR is scored based on a standard review of randomly selected member medical records that represents the assigned member population, per provider, consisting of five pediatric and five adult or Obstetric medical records.
b. For PCP sites that only serve pediatric or adult patients, all ten records must be reviewed using the appropriate preventative care criteria for adults, or pediatrics (pregnant under 21 years) and or obstetrics.

c. During the MRR review, reviewers have the option to request additional medical records for review. If the site reviewer chooses to review additional medical records, the scores must be calculated accordingly.

d. If the PCP site performs patient care by multiple PCP’s practitioners If the site has multiple providers using the in the same medical record, this is considered a shared medical record system. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider. PCP practitioner.

i. The minimum number of records to be reviewed in a “shared” medical record relationship is determined by the number of practitioners at the site, unless otherwise approved by DHCS. See chart below.

<table>
<thead>
<tr>
<th># Practitioners</th>
<th># Medical Records to be reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>10</td>
</tr>
<tr>
<td>4-6</td>
<td>20</td>
</tr>
<tr>
<td>7 or more</td>
<td>30</td>
</tr>
</tbody>
</table>

e. In the event that there are multiple providers in one office that do not share medical records, each provider PCP practitioner must be reviewed separately and receive a separate score on both the FSR and MRR.

7. Full-Scope Site Review

A full scope SR consists of appropriate review personnel completing both the FSR and the MRR using review tools required by DHCS (See Attachments – A-D). PHC may accept SRs completed by other health plans within the past three years if the DHCS tool is used and the reviewer is certified by DHCS or a DHCS certified master trainer. All primary care sites contracted with PHC to serve PHC members must attain a minimum passing score of 80% on both tools to be considered as having passed the Site Review. After the initial full scope Site Review, the maximum time period before the next required full scope Site Review is three years (Periodic SR). PHC may review sites more frequently, or when determined necessary based on monitoring, evaluations or corrective action plans (CAPs).

FSR is an on-site review of the practice site, processes, and covers the following areas:

- Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.
- Personnel
- Office Management
- Clinical Services
- Preventive Services
- Infection Control

OB/GYN FSR is an on-site review of the office site, processes, and covers the following areas:

- Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.
- Personnel
  - Requires documentation of education/training in Comprehensive Perinatal Services Program (CPSP).
- Office Management
  - Requires PHC members have access to CPSP or like services.
- Clinical Services
The FSR contains nine fifteen (15) critical survey elements related to the potential for adverse effect on patient health or safety. Critical elements must be corrected within 10 business days of the survey. (See MMCD Policy Letter 14-004 Facility Site Review Tool for a list of the nine fifteen critical elements). PHC is required to complete a FSR as part of its initial credentialing process when PHC adds a new provider site to the PHC network.

The MRR is a review of randomly selected medical records of PHC members. For initial full-scope reviews, medical records will be reviewed 90 calendar days after members are assigned to the practice site. An extension of 90 days may be allowed if there are an insufficient number of member records to review to meet the requirements. If there remain an insufficient number of records to review after 180 days, the MRR will be completed on the total number of records available. Ten medical records will be reviewed for each practitioner in a solo practice. Practice sites where documentation of patient care by multiple primary care providers (PCPs) occurs in the same record are reviewed as a “shared” medical record. The minimum number of records to be reviewed in a “shared” medical record relationship is determined by the number of practitioners at the site, unless otherwise approved by DHCS.

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</thead>
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<td>20</td>
</tr>
<tr>
<td>7 or more</td>
<td>30</td>
</tr>
</tbody>
</table>

Areas of medical record review include:

1. Format (All PCP sites)
2. Documentation (All PCP sites)
3. Continuity/Coordination (All PCP sites)
4. Pediatric Preventive (Family Practice & Pediatric sites)
5. Adult Preventive (Family Practice, & Adult Medicine sites, and OB/GYN sites)
6. OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)

PHC’s contract with the Department of Health Care Services (DHCS) requires contracted OB/GYN providers to follow current American College of Obstetrics and Gynecology (ACOG) standards as the minimum standards for services to PHC’s pregnant members. In addition, all obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, and psychosocial risks, on all pregnant members at the initiation of pregnancy related services. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period. During the OB/GYN FSR, the reviewers will request documentation to determine if the provider is a Comprehensive Perinatal Services Program (CPSP) or non-CPSP provider. A non-CPSP provider will be asked for documentation regarding the provider’s contractual agreement with a Certified CPSP Provider who will provide the comprehensive risk assessment, medical nutrition, and psychosocial risk assessments. A non-CPSP provider may choose to use CPSP-trained staff to do the comprehensive risk assessment and make referrals to the CPSP program for interventions and completion of care plans. The reviewers will request documentation of training for a provider’s CPSP-trained staff.

47. Initial Full-Scope Site Review – New Service Area

Prior to initiating plan operations in a service area, an initial full-scope Site Review will be completed on 5% of the provider network, or on 30 PCP sites, whichever is greater in number. If there are 30 or fewer PCP sites in the network, 100% of the sites will be completed prior to beginning plan operations. Corrective action plans (CAPs) will be completed as outlined in section III.A.8 below. An initial full-scope Site Review will be completed on 100% of the remaining proposed PCP sites within the first 6 months of plan operation or expansion.
49. Focused Review

Focused reviews are targeted audits consisting of a review of problem areas identified through SR monitoring activities, follow up on CAPs, patient grievances, potential quality issue reports, or from observations by PHC staff. All deficiencies found during a focused review will require the completion and verification of corrective actions according to the CAP timelines.

51. Requirements for New Practitioners at a Site

A SR will not be repeated if a new provider is added to a provider site that has a current passing SR score. If a PCP moves to a site that has not undergone a previous SR, PHC performs a SR at this site.

53. Primary Care Provider Relocation

Site Review nurses will complete a review within 30-60 days of notification of a relocation move by a primary care practice site. Members currently assigned to the primary care practice site may continue to be seen, however new members will not be assigned until the site has passed both the FSR and MRR at the new location.

55. Compliance Levels FSR and MRR Scoring

a. The FSR and the MRR are scored separately by the Site Reviewer.
   1) The FSR tool has a total of 150 points possible. The FSR tool points will differ from site to site, because the “not applicable” items do not factor into the scoring where noted. All standards where review determinations result in a “N/A” (non-applicable) or “No”, shall include an explanation regarding this finding.
   PCP sites providing only OB/GYN care are reviewed with an OB/GYN FSR tool with a total of 141 points possible.
   2) The MRR total points will differ from site to site, depending on the number of physicians and types of records that are selected. The “not applicable” items do not factor into the scoring where noted. All standards where review determinations result in a “N/A” (non-applicable) or “No”, shall include an explanation regarding this finding. The Site Reviewer will advise the practice site of any deficiencies in critical elements during the SR. Compliance level categories include: Exempted Pass, Conditional Pass, and Fail. See correlating table.

6. Failing score on FSR or MRR

a. If a site fails the FSR or MRR, new members will not be assigned to the site until all corrected deficiencies on the CAP are completed.

b. If the site receives a two consecutive Site Review failing Site Review scores (FSR or MRR), then on the third attempt the site must receive a minimum passing score on the FSR and/or MRR to remain in the PHC provider network.

c. If the site fails on the third consecutive attempt, the site will be removed from the PHC provider network and its members will be reassigned. Members will receive a 30 day notice.

7. Focused Review

a. A focused review is a targeted review of one or more specific areas of the FSR or MRR. PHC must not substitute a focused review for a Site Review. Focused reviews may be used to monitor providers between Site Reviews to investigate problems identified through monitoring activities or to follow up on corrective actions.

b. Site Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.

c. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to CAP timelines.

Focused Review

Focused reviews are targeted audits consisting of a review of problem areas identified through SR monitoring activities, follow up on CAPs, patient grievances, potential quality issue reports, or from observations by PHC staff. All deficiencies found during a focused review will require the completion and verification of corrective actions according to the CAP timelines.
identified through SR monitoring activities, follow-up on CAPs, patient grievances, potential quality issue reports, or from observations by PHC staff. All deficiencies found during a focused review will require the completion and verification of corrective actions according to the CAP timelines.

<table>
<thead>
<tr>
<th>Compliance Category</th>
<th>FSR Score</th>
<th>MRR Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempted Pass</td>
<td>90% or above without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control CAP not required</td>
<td>90% or above CAP not required</td>
</tr>
<tr>
<td>Conditional Pass</td>
<td>80-89% OR 90% or above with deficiencies in Critical Elements/Pharmaceutical Services or Infection Control CAP required</td>
<td>80-89% or any section(s) score &lt;80% requires a CAP for the entire MRR regardless of the Total MRR score CAP required</td>
</tr>
<tr>
<td>Not Pass</td>
<td>Below 80% CAP required</td>
<td>Below 80% CAP required</td>
</tr>
</tbody>
</table>

8. Corrective Action Plan (CAP) Requirements and Timelines
   a. CAP Documentation:
      1) CAPs will be completed using a standard format and form. CAPs for non-critical elements may be verified via document submission. CAPs for critical elements must be verified onsite.
      2) The minimum elements to be included on a CAP:
         a) Specific deficiency
         b) Corrective Action needed
         c) Projected date of correction
         d) Actual date of correction
         e) Re-evaluation timeline/dates
         f) Responsible person for each corrective action
         g) Problems in completing corrective action, if any
         h) Education and/or technical assistance provided by PHC
         i) Evidence of the correction
         j) Completion and closure date
         k) Name and title of Site Reviewer

   b3) Timeline for CAP notification and completion:

<table>
<thead>
<tr>
<th>CAP Timeline</th>
<th>CAP Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSR and/or MRR Completion</td>
<td>PHC will provide site with a report containing the FSR and/or MRR scores, any</td>
</tr>
</tbody>
</table>
**Policy/Procedure Number:** MPQP1022 (previously QP100122)

**Lead Department:** Health Services

<table>
<thead>
<tr>
<th>Day</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 10 Calendar days of the FSR and/or MRR</td>
<td>critical element findings, and a formal written request for CAPsS for all critical elements if applicable.</td>
<td>The site must submit a CAP and evidence of corrections to PHC for all deficient critical elements, if applicable. Critical Element deficiencies not corrected within the 10 business days of the visit date will result in a referral to the CMO or designee for consideration of immediate cessation of assignment of new members, a referral to the PHC credentialing committee, and a letter notifying the site of the above and that the lack of correction within 30 days may result in reassignment of their assigned members to other offices. PHC must provide the site with a formal report containing FSR and/or MRR findings along with a CAP for all non-critical element deficiencies. PHC will provide educational support and technical assistance to sites as needed.</td>
</tr>
<tr>
<td>Within 30 calendar days of the FSR and/or MRR</td>
<td>PHC will conduct an onsite focused review to verify that CAPSs with critical elements are completed. The site must submit a completed CAP for all non-critical element deficiencies to PHC. PHC will provide educational support and technical assistance to sites as needed.</td>
<td></td>
</tr>
<tr>
<td>Within 60 calendar days from the date of the FSR and/or MRR</td>
<td>PHC will review, approve, or request additional information on the submitted CAPSs for non-critical findings. PHC will provide educational support and technical assistance to sites as needed.</td>
<td></td>
</tr>
<tr>
<td>Within 90 calendar days from the date of the FSR and/or MRR</td>
<td>All CAPSs must be closed. The site can request a definitive time specific extension period to complete the CAP(s), not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.</td>
<td></td>
</tr>
<tr>
<td>Beyond 120 days from the date of the FSR and/or MRR</td>
<td>PHC may require a CAP regardless of score for other findings identified during the survey that require correction. See APL 20-006, page 7.</td>
<td></td>
</tr>
</tbody>
</table>

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**Critical Elements**

Nine Fifteen (915) DHCS mandated and two (2) PHC mandated critical elements related to the potential for adverse effect on patient health or safety have a scored “weight” of two (2) points. All critical element deficiencies found during a full-scope Site Review, Focused Review, or Monitoring visit must be corrected within 10 business days of the visit date and are to be verified in-person by PHC within 45-30 calendar days of the visit date. PHC mandated critical elements are on the 2018 PHC Addendum to Site Review. Non-critical elements with deficiencies are to be addressed in accordance with CAP timelines detailed in Conditional Pass.
Critical element deficiencies not corrected within 10 business days of the visit date or not verified within 45-30 calendar days, will result in
A referral to the CMO or designee for consideration of immediate cessation of assignment of new members,
A referral to the PHC Credentialing Committee, and
A letter notifying the site of 1) and 2), and that a lack of correction within 30 days may result in re-assignment of their assigned members to other primary care offices.

Conditional Pass
PHC will provide the practice site with a review findings report and a formal written request for corrections of all non-critical, non-immediate deficiencies within 10 business days after the site visit. The practice site must submit the CAP to PHC addressing deficiencies within 45 days of the written initial CAP request date. PHC will then review/revise/approve the CAP. The provider site shall complete corrective action plans, and PHC will close the CAP within 90 calendar days from the CAP request. Under extenuating circumstances, an additional 30-day extension to complete non-critical element deficiencies that have not been addressed may be granted. An extension beyond 120 days from the date of the site review must be approved by DHCS. PHC will re-survey any provider site within 12 months that required an extension period beyond 120 calendar days to complete corrections prior to closing the CAP. Please reference Attachment J for an overview of the CAP process and timelines following a conditional pass and Attachment K for the timeline of CAP notification and completion per DHCS requirements.

CAP Documentation
CAPs will be completed using a standard format and form. The minimum elements to be included on a CAP:
0. Specific deficiency(ies)
0. Corrective Action(s) needed
0. Projected date(s) of correction
0. Actual date(s) of correction
0. Re-evaluation timeline/dates
0. Responsible person(s) for each corrective action
0. Problems in completing corrective action, if any
0. Education and/or technical assistance provided by PHC
0. Evidence of the correction(s)
0. Completion and closure date
0. Name and title of reviewer

Provider Certificates
a. Upon successfully completing the SR (FSR and MRR) with a passing score and correcting all CAP deficiencies, PHC will issue a Provider Site Certificate upon the completion of a passing Site Review score (FSR and MRR) and completed CAP, PHC will issue a provider site certificate using the most up to date DHCS template, in keeping with the current using DHCS template. This certification is effective through the next required periodic review cycle. It will contain the signature of the CMO and a PHC DHCS Master Trainer. The certificate will contain the signature of both the Chief Medical Officer (CMO) and CMT.

b. The provider site certification will be valid for a maximum of three years.

Non-Compliance with Corrective Action Process
Providers who fail to correct deficiencies within established CAP timelines, fail to ask for an extension, or request an extension but do not turn in any CAP documentation within 75 days of the site review will be sent a “Notice of Overdue Corrective Action Plan” to be
<table>
<thead>
<tr>
<th>Policy/Procedure Number: MPQP1022 (previously QP100122)</th>
<th>Lead Department: Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy/Procedure Title:</strong> Site Review Requirements and Guidelines</td>
<td>☒ External Policy □ Internal Policy</td>
</tr>
<tr>
<td><strong>Original Date:</strong> 10/30/2002 (vs. 10/16/2002)</td>
<td><strong>Next Review Date:</strong> 06/10/2021</td>
</tr>
<tr>
<td><strong>Last Review Date:</strong> 06/10/2020</td>
<td>Applies to: ☒ Medi-Cal □ Employees</td>
</tr>
</tbody>
</table>

drafted by the **CSR Site Reviewer** and signed by the **Chief Medical Officer CMO or Director of Quality Medical Director** informing the site that if the CAP is not received within 30 days the site will be closed to new **Partnership PHC** members.

a. **If the site does not complete the CAP within 30 days of the first notice, then a 2nd “Notice of Review” will be drafted by the SR Nurse** and signed by the **Chief Medical Officer CMO and will be sent to the site stating their case is being forwarded to the PHC Peer Review Committee. The Peer Review Committee will make a recommendation to the PHC Credentialing Committee.**

b. **Actions taken by the Credentialing Committee may include, but are not limited to:**

1) **Reassignment of existing members**

2) **Termination of the site from the provider network**

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

DHCS requires health plans to remove a provider from the network regardless of survey scores if criteria are not met or deficiencies are not resolved within established CAP timeline. Refer to **Provider Notification of Provider Termination, Site Closure, or Change in Location (MP PR #208)** for the specific procedures. (Reference [Related Policy F](#))

78. **Not Pass**

--- **Pre-contractual Provider**—PHC will not consider a pre-contract provider who scores below 80% as a network provider. In order to be approved as a network provider, a full scope site review must be completed with a passing score. A CAP will be required as addressed in III.A.3.

--- **Contracted Network Provider**—Survey deficiencies must be corrected by the provider and verified by PHC within the CAP timelines. New members will not be assigned until corrections are verified and the CAP is closed. PHC reserves the right to remove any provider with a “not pass” score from the provider network. Members will be reassigned and given a 30-day notice. Refer to **Provider Notification of Provider Termination, Site Closure or Change in Location Information**—policy MP PR #208 for the specific procedures.

81. Providers who fail the SR Multiple Times

--- Provider sites that score below 80 percent in either the FSR, OB/GYN FSR, or MRR for three consecutive reviews will be removed from the network and PHC members will be reassigned to other network providers. Members will receive a 30-day notice.

82.11. **Provider Appeals**

See the PHC Policy/Procedure MP CR 601 - Fair Hearing and Appeal Process for Adverse Decisions. If evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, PHC will repeat a full scope SR in 12 months. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and PHC will complete an initial full scope SR.

84.12. **Systematic Monitoring Between SRs**

--- Monitoring between regularly scheduled SRs will include, but is not limited to, data gathered through the following sources:

1) Member grievances and appeals (reviewed daily)

2) Potential Quality Issue information (reviewed when identified)

3) Focused review or other on-site visit (based on SR findings, track and trend quarterly
4) Healthcare Effectiveness Data and Information Set (HEDIS®) data collection (annually)

5) Provider Self-Assessment, Interim Review Template – see Attachment I-F and E-1 and Section 10.12 B & C 1 & 2.
   b. Problems identified through these mechanisms will require at a minimum:
      1) Informing the Provider of concerns noted
      2) Request a CAP when a problem is verified and follow the above CAP process (III.A.7.)
   c. Interim Review Process
      1) PHC will request a self-assessment of DHCS standards by provider site staff approximately 16 to 20 months at the midpoint between SRs from the last SR, unless requiring an earlier review. This assessment will include all critical element criteria and previously identified deficiencies noted during the last provider site review.
      a. The CSR Site Reviewer SR Nurse may require an onsite Interim Review in lieu of a self-assessment based on the provider site’s previous Site Review scores or lack of response to self-assessment.
      2) Upon receipt of the provider’s self-assessment, a PHC SR Nurse/CSR Site Reviewer will review the assessment and determine approval status. Any identified areas of concerns will be clarified and a new CAP will be requested where required. Additional follow up activities may include an additional site visit, referral to the CMO and Provider Relations or Credentialing Committee.

85.13. Physical Accessibility Review Survey (PARS)
   During the Initial Site Review and subsequent Periodic SR, a PARS review will be performed in accordance with MMCD Policy Letter 12-006. (Reference B) This will be reviewed review will be conducted every three years at all primary care practice sites within the PHC Medi-Cal network. Refer to policy MCQP1052 - Physical Accessibility Review Survey – SR Part C.

86. Inter-Rater Reliability
   Each Site Reviewer will participate in the DHCS sponsored site review teleconferences or meetings as defined by DHCS-MMCD Site Review Workgroup. In addition, Site Reviewers will participate and complete the DHCS inter-rater medical record review process and achieve an inter-rater score as defined by DHCS (with 10% margin of error). PHC will also conduct periodic inter-rater reliability review and when areas of focus are identified, such as side-by-side review for onsite and medical record review.

88.14. In the case that the below listed contracted providers are not accredited and have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted, Partnership HealthPlan will conduct periodic Site Reviews at a minimum of every three years. The Site Review tool specific to these provider types is Attachment MG.
   a. Hospitals
   b. Home Health Agencies
   c. Skilled Nursing Facilities
   d. Free Standing Surgical Centers
   e. Ambulatory Behavioral Health Facilities
   f. Free Standing Urgent Care Center
   g. Free Standing Radiology Center
   h. Community Based Adult Services (CBAS)
   i. Dialysis Centers

B. Delegation of Site Review functions
   1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at PHC discretion, to perform Site Review functions. An Eligible organization or groups will perform these functions under a formal delegation agreement.
2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both PHC and the delegated entity.

3. Delegated entities will perform Site Review functions for all Primary Care Physician (PCP) sites no less than every three years.

4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

5. Delegated organizations and/or groups will provide timely copies of all Site Reviews conducted at the site level, within PHC’s service area, no less than semi-annually.

6. PHC’s Quality Improvement (QI) department will track all Site Reviews conducted by the delegated entities.

7. For organizations and groups that are over one year past due for a Site Review at the site level or otherwise missing a Site Review, the QI department will refer to PHC’s Delegation Oversight Reporting Sub-Committee (DORS), in which is managed by PHC’s compliance unit, within the Administration department for action.

8. In addition to providing PHC copies of all Site Reviews conducted at the site level, PHC will ensure the delegated entity will provide timely copies and results of Site Reviews to DHCS according to DHCS standards. DHCS has processes in place for overseeing and auditing the quality of Site Review functions.

9. As part of the oversight process, PHC may perform one or more repeat Site Review on sites that have had the Site Review performed by a delegated entity.

C. Potential Quality of Care Issues

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

D. Coordination with County Child Health and Disability Prevention (CHDP) program

PHC Site Reviewers are familiar with the state requirements for providers who see pediatric patients to be a CHDP provider, including requirements around provision and storage of vaccinations. If any site is found to be deficient as a CHDP program provider, PHC QI staff will forward the result of the site review to the County CHDP administrator and PHC’s Provider Relations department. All findings related to CHDP requirements will be considered critical elements, and included as part of the PHC Site Reviewer’s Corrective Action Plan for the site.

E. SR Data Submission to DHCS

SR data will be submitted by PHC to DHCS every six months (July 31 for the period January-June and January 31 for the period July-December) in an approved format uploaded to a designated DHCS secure site. PHC is permitted to submit data more frequently than every six months. For preoperational and expansion site reviews, PHC must submit site review data to DHCS at least six weeks prior to site operation. PHC will include data for Site Reviews conducted by delegated entities in these submissions semi-annually, according to DHCS specifications.

F. Local Collaboration

In an effort to streamline the regulatory process and reduce redundant SR reviews at PCP sites, PHC may collaborate with other health plans having contracts with mutual providers. PHC may accept the SR score assigned by other health plans if the DHCS tools are used and the SR is completed by appropriate certified staff. A site with a non-passing score by a collaborating health plan, that has received site review certification as addressed in of this policy, shall be considered to have a non-passing score by PHC. PHC may choose to repeat the FSR/MRR of a site that had passed a FSR/MRR by another health plan’s reviewers.
VII.VIII. REFERENCES:
A. DHCS All Plan Letter (APL) 20-006 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers
B. MMCD Policy Letter 12-006 Revised Facility Site Review Tool
C. MMCD Policy Letter 03-02 Certification of Managed Care Plan Staff
D. MMCD Policy Letter (PL) 14-004 Facility Site Reviews and Medical Record Review
E. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

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

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

XI.X. REVISION DATES:
Medi-Cal
8/20/03; 10/20/04; 3/15/06; 3/21/07, 3/19/08; 3/18/09; 6/17/09; 9/15/10; 3/16/11; 2/20/13; 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16; 3/15/17, 10/18/17; *10/10/18; 11/13/19; 04/08/20

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

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

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

Healthy Families
10/01/2010 to 3/01/2013
I. RELATED POLICIES:
A. MCQP1052 - Physical Accessibility Review Survey – SR Part C
B. MPQP1016 – Potential Quality Issue Investigation and Resolution
C. MCUP3101 – Screening and Treatment for Substance Use Disorders
D. MCQP1021 - Initial Health Assessment and Behavioral Risk Assessment
E. MP CR 601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MP PR #208 - Provider Notification of Provider Termination, Site Closure or Change in Location Information
G. MCQG1015 – Pediatric Preventive Health Guidelines
H. MCQG1005 – Adult Preventive Health Guidelines
I. CMP36 - Delegation Oversight and Monitoring
J. MCUG3118 – Prenatal & Perinatal Care
K. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:
A. Provider Relations
B. Health Services
C. Compliance
D. Grievance and Appeals

III. DEFINITIONS:
Primary Care Practice Site – a facility which provides services such as family medicine, internal medicine, pediatrics, and/or obstetrics and gynecology.

IV. ATTACHMENTS:
A. 2019 Site Review Survey Tool and Standards
B. 2019 Medical Record Review Tool and Standards
C. 2019 OB Facility Site Review Tool and Standards
D. 2019 PHC Addendum to Site Review
E. Interim Review Template
F. Provider Certificate
G. 2019 Non-Accredited Facility Site Review Tool and Guidelines
H. Master Trainer Application
V. PURPOSE:
A. To provide primary care practice sites a comprehensive guideline for Site Review (SR) requirements and processes. A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Record Review (MRR). An Obstetrics/Gynecology (OB/GYN) FSR and a standard MRR tool are used for OB/GYN provider sites. The FSR, OB/GYN FSR, and MRR tools were developed by a collaborative coalition made up of staff from Department of Health Care Services (DHCS) and Medi-Cal Managed Care health plans. The purpose of the SR is to ensure that practicing sites have sufficient capacity to:
1. Provide appropriate services;
2. Carry out processes that support continuity and coordination of care;
3. Maintain patient safety standards and practices, and;
4. Operate in compliance with applicable federal, state, and local laws and regulations.

B. Findings of the SR are used to:
1. Provide information for credentialing/re-credentialing decisions;
2. Identify areas where education and technical assistance is needed;
3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:
A. Requirements
1. Site Review Personnel
   The Partnership HealthPlan of California (PHC) Chief Medical Officer (CMO) is ultimately responsible for SR activities completed by PHC personnel. PHC has designated a minimum of one Registered Nurse (RN) to be certified as a Master Trainer by the DHCS.
   a. The DHCS Certified Master Trainer (CMT) is responsible for training, supervising and certifying Site Reviewers; in addition to monitoring reviews and evaluating Certified Site Reviewers (CSR) for accuracy.
      1) Site Review activities comply with the Site Reviewers’ scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the Site Reviewers’ level of education and training.
   b. Licensed Physicians, NP’s, PA’s, and RN’s are eligible to be a Site Reviewer. Which includes, performing a Site Review independently and signing off on the FSR and MRR tools.
      1) Site Reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures.
   c. Site Review Training and Certification
      1) Physicians, NP’s, PA’s and/or RN’s that are designated to be a Certified Master Trainer or Certified Site Reviewer must meet the certification and recertification requirements outlined in the table below.
      2) DHCS will recertify Master Trainers every three years.
      3) Certified Site Reviewers will be recertified by PHC’s Certified Master Trainer a minimum of every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from PHC.
Initial Certification Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Certified Master Trainer</th>
<th>Certified Site Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possess a Current RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP or PA license</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Be employed or subcontracted with PHC</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Have experience in conducting training in a health related field, or conducting quality improvement activities, such as medical audits, Site Reviews, or utilization management activities within the last three years.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Complete twenty FSRs and twenty MRRs and 1 year experience as a CSR. Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Attend didactic Site Review training or completion of DHCS Site Review training modules on the current Site Review tools under supervision of a CMT.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Complete ten FSRs and ten MRRs with a CSR or CMT.</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Achieve an Inter-rater score of 10% in FSR and 10% in MRR with designated CMT.</td>
<td>x</td>
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</tbody>
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Recertification Requirements

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Certified Master Trainer</th>
<th>Certified Site Reviewer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possess a Current RN, Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP or PA license</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Be employed or subcontracted with PHC</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Be responsible for staff training on the most current DHCS Site Review tools and standards</td>
<td>x</td>
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<tr>
<td>Participate in DHCS sponsored Site Review trainings as well as Site Review work group (SRWG) meetings and teleconferences.</td>
<td>x</td>
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<tr>
<td>Maintain CMT certification.</td>
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<tr>
<td>Complete a minimum of twenty Site Reviews following initial certification or recertification.</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Attend DHCS sponsored inter-rater workshops in person every two years.</td>
<td>x</td>
<td>x</td>
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<tr>
<td>Achieve a 10% variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.</td>
<td>x</td>
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</tbody>
</table>

d. Inter-Rater Review Process

1) CMT and CSR certifications must complete an inter-rater review as part of the initial certification and the recertification process.
   a) The inter-rater review process requires the CMT candidate to concurrently complete and score a Site Review with a DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.
   b) The inter-rater review process requires the CSR to concurrently complete and score a Site Review with the PHC CMT according to the DHCS FSR and MRR tools and standards.
2) If the CMT or CSR does not meet the appropriate inter-rater score variance (see chart above), they may repeat the process one time. The appropriate inter-rater and candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review.
   a) CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait 12 months to reapply for certification.

2. Full-Scope Site Review
A full-scope SR consists of a Certified Site Reviewer or Certified Master Trainer conducting both the FSR and the MRR using review tools required by the DHCS (See Attachments –A-D). All PHC contracted sites who serve PHC members must receive a minimum passing score of 80% on both tools to be considered as having passed the Site Review.

a. FSR is a review of the practice’s site, processes, and covers the following areas:
   1) Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.
2) Personnel
3) Office Management
4) Clinical Services
5) Preventive Services
6) Infection Control

b. OB/GYN FSR is a review of the practice’s site, processes, and covers the following areas:
   1) Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.
2) Personnel
   a) Requires documentation of education/training in Comprehensive Perinatal Services Program (CPSP)
3) Office Management
   a) Requires PHC members have access to CPSP or like services.
4) Clinical Services
5) Preventive Services
6) Infection Control

c. Non-Accredited Sites is a review of the practice’s site, processes, and covers the following areas:
   1) Access/Safety – including the provisions addressed in the most current version of the Americans with Disabilities Act.
2) Personnel
3) Office Management/Medical Records
4) Clinical Services
5) Preventive Services
6) Infection Control
7) Quality Assurance Performance Improvement

d. MRR areas include:
   1) Format (All sites)
2) Documentation (All PCP sites)
3) Continuity/Coordination (All sites)
4) Pediatric Preventive (Family Practice & Pediatric sites, and OB/GYN sites if applicable)
5) Adult Preventive (Family Practice, Adult Medicine sites, and OB/GYN sites)
6) OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)

PHC’s contract with the Department of Health Care Services (DHCS) requires contracted OB/GYN providers to follow current American College of Obstetrics and Gynecology (ACOG)
standards as the minimum standards for services to PHC’s pregnant members. In addition, all obstetrical practitioners are required to provide a comprehensive initial risk assessment that includes medical nutrition, health education, and psychosocial risks, on all pregnant members at the initiation of pregnancy related services. Formal re-assessments must be offered in each subsequent trimester and in the postpartum period.

1) During the OB/GYN FSR, the reviewers will request documentation to determine if the provider is a Comprehensive Perinatal Services Program (CPSP) or non-CPSP provider.

2) A non-CPSP provider will be asked for documentation regarding the provider’s contractual agreement with a Certified CPSP Provider who will provide the comprehensive risk assessment, medical nutrition, and psychosocial risk assessments. A non-CPSP provider may choose to use CPSP trained staff to do the comprehensive risk assessment and make referrals to the CPSP program for interventions and completion of care plans. The reviewers will request documentation of training for a provider’s CPSP trained staff.

3. Initial Site Review Process
   a. An initial Site Review consists of an initial FSR and an initial MRR.
   b. The FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Members are not assigned to providers until the site has received a passing score and all Corrective Action Plan (CAP) items are completed and signed off. An initial FSR is not required when a new provider joins a site that has a current passing FSR score.
      1) Pre-contracted providers who do not pass the initial FSR within two attempts may reapply to PHC after six months.
   c. An initial MRR must be completed within 90 days of the date that members were first assigned to the site.
      1) This may be deferred an additional 90 calendar days only if the new PCP does not have enough assigned members to complete the MRR on the required minimum number of records (see section 4.a.1)d)i.)
      2) If after 180 days following assignment of members and the site still has fewer than the required number of medical records, a MRR on the total number of records available will be completed. Scoring on the MRR tool will be adjusted according to the number of medical records reviewed.
   d. Additional Scenarios that require an Initial Site Review, but are not limited to, instances when:
      1) A new site is added to the PHC network
      2) A newly contracted provider assumes a site with a previous failing FSR and/or MRR score within the last three years
      3) A site is returning to the PHC network and has not had a passing FSR within the last three years.
      4) There is a change of ownership of an existing provider site.
      5) A site relocation requires that PHC must:
         a) Complete an initial FSR within 60 days of notification or discovery of the completed move.
         b) Allow existing members to continue to see the provider.
         c) New members will not be assigned to the site until the site receives a passing FSR and MRR score.
   e. If PHC expands to a new service area. The FSR portion of the initial Site Review must be completed prior to the start of new or expanding operations. Requirements are outlined as following:
      1) Five percent of the sites in the new network service area, or thirty sites, whichever is greater in number.
2) All of the remaining sites in the new network service area within the first six months of expansion.
3) All of the sites in the new network service area if there are thirty or fewer PCP sites.
4) Sites that are subject to Site Reviews must include a variety of PCP types (Family Medicine, Internal Medicine, Pediatric, etc.) and subcontracted entities (solo practice, medical group, etc.) from throughout the provider network.

4. Subsequent Site Reviews
   a. Subsequent Site Reviews consist of a FSR and MRR at least every three years, beginning no later than three years after the initial FSR. Site Reviews may be conducted more frequently per county collaborative discussions when determined necessary based on monitoring, evaluation, or CAP follow up issues.
   1) Medical Record Portion
      a. The MRR is score is based on a standard review of randomly selected member medical records that represents the assigned member population.
      b. For sites that only serve pediatric or adult patients, all records must be reviewed using the appropriate preventative care criteria for adults, pediatrics (pregnant under 21 years) and/or obstetrics.
      c. During the MRR review, reviewers have the option to request additional medical records for review. If the Site Reviewer chooses to review additional medical records, the scores must be calculated accordingly.
      d. If the site has multiple providers using the same medical record, this is considered a shared medical record system. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.
         i. The minimum number of records to be reviewed in a “shared” medical record relationship is determined by the number of providers at the site, unless otherwise approved by DHCS. See chart below.

<table>
<thead>
<tr>
<th># Practitioners</th>
<th># Medical Records to be reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>10</td>
</tr>
<tr>
<td>4-6</td>
<td>20</td>
</tr>
<tr>
<td>7 or more</td>
<td>30</td>
</tr>
</tbody>
</table>

   e. In the event that there are multiple providers in one office that do not share medical records, each provider must be reviewed separately and receive a separate score on both the FSR and MRR

5. FSR and MRR Scoring
   a. The FSR and the MRR are scored separately by the Site Reviewer.
      1) The FSR tool points will differ from site to site, because the “not applicable” items do not factor into the scoring where noted. All standards where review determinations result in a “N/A” (non-applicable) or “No”, shall include an explanation regarding this finding.
      2) The MRR total points will differ from site to site, depending on the number of physicians and types of records that are selected. The “not applicable” items do not factor into the scoring where noted. All standards where review determinations result in a “N/A” (non-applicable), shall include an explanation regarding this finding. The Site Reviewer will advise the practice site of any deficiencies in critical elements during the SR. Compliance level categories include: Exempted Pass, Conditional Pass, and Fail. See correlating table.

6. Failing score on FSR or MRR
   a. If a site fails the FSR or MRR, new members will not be assigned to the site until all corrected deficiencies on the CAP are completed.
b. If the site receives two consecutive failing Site Review scores (FSR or MRR), then on the third attempt the site must receive a minimum passing score on the FSR and/or MRR to remain in the PHC provider network.

c. If the site fails on the third consecutive attempt, the site will be removed from the PHC provider network and its members will be reassigned. Members will receive a 30 day notice.

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

<table>
<thead>
<tr>
<th>Compliance Category</th>
<th>FSR Score</th>
<th>MRR Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exempted Pass</td>
<td>90% or above without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control</td>
<td>90% or above</td>
</tr>
<tr>
<td></td>
<td>CAP not required</td>
<td>CAP not required</td>
</tr>
<tr>
<td>Conditional Pass</td>
<td>80-89%</td>
<td>80-89% or any section(s) score &lt;80% requires a CAP for the entire MRR regardless of the Total MRR score.</td>
</tr>
<tr>
<td></td>
<td>OR 90% or above with deficiencies in Critical Elements/Pharmaceutical Services or Infection Control</td>
<td>&lt;80% requires a CAP for the entire MRR regardless of the Total MRR score.</td>
</tr>
<tr>
<td></td>
<td>CAP required</td>
<td>CAP required</td>
</tr>
<tr>
<td>Not Pass</td>
<td>Below 80%</td>
<td>Below 80%</td>
</tr>
<tr>
<td></td>
<td>CAP required</td>
<td>CAP required</td>
</tr>
</tbody>
</table>

8. Corrective Action Plan (CAP) Requirements and Timelines
   a. CAP Documentation:
      1) CAPs will be completed using a standard format and form. CAPs for non-critical elements may be verified via document submission. CAPs for critical elements must be verified onsite.
      2) The minimum elements to be included on a CAP:
         a) Specific deficiency
         b) Corrective action needed
         c) Projected date of correction
         d) Actual date of correction
         e) Re-evaluation timeline/dates
         f) Responsible person for each corrective action
         g) Problems in completing corrective action, if any
         h) Education and/or technical assistance provided by PHC
         i) Evidence of the correction
CAP Timeline | CAP Action(s)
--- | ---
FSR and/or MRR Completion Day | PHC will provide site with a report containing the FSR and/or MRR scores, any critical element findings, and a formal written request for CAPs for all critical elements if applicable.
Within 10 Calendar days of the FSR and/or MRR | The site must submit evidence of corrections to PHC for all deficient critical elements, if applicable. Critical element efficiencies not corrected within the 10 business days of the visit date will result in a referral to the CMO or designee for consideration of immediate cessation of assignment of new members, a referral to the PHC credentialing committee, and a letter notifying the site of the above and that the lack of correction within 30 days may result in reassignment of their assigned members to other offices. PHC must provide the site with a formal report containing FSR and/or MRR findings along with a CAP for all non-critical element deficiencies. PHC will provide educational support and technical assistance to sites as needed.
Within 30 calendar days of the FSR and/or MRR | PHC will conduct an onsite focused review to verify CAPs with critical elements are completed. The site must submit a completed CAP for all non-critical element deficiencies to PHC. PHC will provide educational support and technical assistance to sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR | PHC will review, approve, or request additional information on the submitted CAP for non-critical findings. PHC will provide educational support and technical assistance to sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR | All CAPs must be closed. The Site can request a definitive time specific extension period to complete the CAP not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR | PHC may require a CAP regardless of score for other findings identified during the survey that require correction. See APL 20-006, page 7.

9. Provider Certificates
   a. Upon the completion of a passing Site Review score (FSR and MRR) and completed CAP, PHC will issue a provider site certificate using the most up to date DHCS template. The certificate will contain the signature of both the Chief Medical Officer (CMO) and CMT.
   b. The provider site certification will be valid for a maximum of three years.

10. Non-Compliance with Corrective Action Process
   a. Providers who fail to correct deficiencies within established CAP timelines, fail to ask for an extension, or request an extension but do not turn in any CAP documentation within 75 days of the Site Review will be sent a “Notice of Overdue Corrective Action Plan” to be drafted by the Site Reviewer and signed by the CMO or Medical Director informing the site that if the CAP is not received within 30 days the site will be closed to new PHC members.

PHC will provide educational support and technical assistance to sites as needed.
b. If the site does not complete the CAP within 30 days of the first notice, then a 2nd “Notice of Review” will be drafted by the Site Reviewer and signed by the CMO and will be sent to the site stating their case is being forwarded to the PHC Peer Review Committee. The Peer Review Committee will make a recommendation to the PHC Credentialing Committee.  
1) Actions taken by the Credentialing Committee may include, but are not limited to:  
   a) Reassignment of existing members  
   b) Termination of the site from the provider network  
Actions taken will be effective until corrections are verified and the CAP is closed. If PHC chooses to remove the site from the network, members will be reassigned and given a 30-day notice.  
DHCS requires health plans to remove a provider from the network regardless of survey scores if criteria is not met or deficiencies are not resolved within established CAP timeline. Refer to Provider Notification of Provider Termination, Site Closure, or Change in Location (MP PR #208) for the specific procedures. (Related Policy F)  

11. Provider Appeals  
See the PHC Policy/Procedure MP CR 601 - Fair Hearing and Appeal Process for Adverse Decisions. If evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, PHC will repeat a full-scope SR. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and PHC will complete an initial full-scope SR.  

12. Systematic Monitoring Between SRs  
a. Monitoring between regularly scheduled SRs will include, but is not limited to, data gathered through the following sources:  
   1) Member grievances and appeals (reviewed daily)  
   2) Potential Quality Issue information (reviewed when identified)  
   3) Focused review or other on-site visit (based on SR findings, track and trend quarterly reports)  
   4) Healthcare Effectiveness Data and Information Set (HEDIS®) data collection (annually)  
   5) Interim Review Template – see Attachment E and Section 12.c.1 & 2.  
b. Problems identified through these mechanisms will require at a minimum:  
   1) Informing the Provider of concern  
   2) Request a CAP when a problem is verified and follow the above CAP process (III.A.7.)  
c. Interim Review Process  
   1) PHC will request a self-assessment of DHCS standards by provider site staff at the midpoint between SRs. This assessment will include all critical element criteria and previously identified deficiencies noted during the last Site Review.  
      a. The Site Reviewer may require an onsite Interim Review in lieu of a self-assessment based on the provider site’s previous Site Review scores or lack of response to self-assessment.  
      2) Upon receipt of the provider’s self-assessment, a Site Reviewer will review the assessment and determine approval status. Any identified areas of concerns will be clarified and a new CAP will be requested where required. Additional follow up activities may include an additional site visit, referral to the CMO and Provider Relations or Credentialing Committee.  

13. Physical Accessibility Review Survey (PARS)  
During the Initial Site Review and subsequent Periodic SR, a PARS review will be performed in accordance with MMCD Policy Letter 12-006. (Reference B) This will be reviewed every three years at all sites within the PHC Medi-Cal network. Refer to policy MCQP1052 - Physical Accessibility Review Survey – SR Part C.
14. In the case that the below listed contracted providers are not accredited and have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted, Partnership HealthPlan will conduct periodic Site Reviews at a minimum of every three years. The Site Review tool specific to these provider types is Attachment G.
   a. Hospitals
   b. Home Health Agencies
   c. Skilled Nursing Facilities
   d. Free Standing Surgical Centers
   e. Ambulatory Behavioral Health Facilities
   f. Free Standing Urgent Care Center
   g. Free Standing Radiology Center
   h. Community Based Adult Services (CBAS)
   i. Dialysis Centers

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

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

D. Coordination with County Child Health and Disability Prevention (CHDP) program
   PHC Site Reviewers are familiar with the state requirements for providers who see pediatric patients to be a CHDP provider, including requirements around provision and storage of vaccinations. If any site is found to be deficient as a CHDP program provider, PHC QI staff will forward the result of the Site Review to the County CHDP administrator and PHC’s Provider Relations department. All findings related to CHDP requirements will be considered critical elements, and included as part of the PHC Site Reviewer’s Corrective Action Plan for the site.
E. SR Data Submission to DHCS
SR data will be submitted by PHC to DHCS every six months (July 31 for the period January-June and January 31 for the period July-December) in an approved format uploaded to a designated DHCS secure site. PHC is permitted to submit data more frequently than every six months. For preoperational and expansion site reviews, PHC must submit site review data to DHCS at least six weeks prior to site operation. PHC will include data for Site Reviews conducted by delegated entities in these submissions.

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

VII. REFERENCES:
A. DHCS All Plan Letter (APL) 20-006 Site Reviews: Facility Site Review and Medical Record Review
B. MMCD Policy Letter 12-006 Revised Facility Site Review Tool
C. MMCD Policy Letter 03-02 Certification of Managed Care Plan Staff
D. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

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

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

X. REVISION DATES:
Medi-Cal
8/20/03; 10/20/04; 3/15/06; 3/21/07, 3/19/08; 3/18/09; 6/17/09; 9/15/10; 3/16/11; 2/20/13; 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16; 3/15/17, 10/18/17; *10/10/18; 11/13/19; 04/08/20; 06/10/20

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

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

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

Healthy Families
10/01/2010 to 3/01/2013
I. RELATED POLICIES:
A. MPXG5009 - Lactation Clinical Practice Guideline
B. MPCR #16 - Lactation Consultant Credentialing Policy
C. MPRP4056 - Pediatric Enteral Nutrition
D. MCUG3118 - Prenatal and Perinatal Care
E. MCUP3041 - TAR Review Process
F. MCCP2021 - Women, Infants and Children (WIC) Supplemental Food Program
G. MCUP3013 - DME Authorization

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

III. DEFINITIONS:
A. Essential Health Benefits - A set of health care service categories that must be covered by certain plans - Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.
B. WIC - Women, Infants and Children Supplemental Nutrition Program - The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) women and children up to the age of five.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
A. To support optimal nutrition in the healthy infant by appropriately supporting the mother’s efforts to initiate and sustain breastfeeding exclusively for about 4-6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.
B. To give the policy framework around provisions of the Affordable Care Act (ACA), Section 4106a, Women’s Health Preventive Services. It is the goal of Partnership HealthPlan of California (PHC) to be fully compliant with this portion of the ACA. This section states that pregnant and postpartum women are eligible to receive as preventive services...
1. Comprehensive lactation services including counseling by a trained health care provider or allied health professional during pregnancy and/or the postpartum period.

2. To have access to breast pumps and breastfeeding equipment and supplies, as indicated to support lactation.

VI. POLICY / PROCEDURE:

A. General Breastfeeding Guidelines

1. Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by PHC and the AAP. Research has demonstrated numerous health benefits of breastfeeding. Additional to—which states “breastfeeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant.” Research has shown that breastfeeding decreases the incidence and/or severity of diarrhea, lower respiratory infection, otitis media, urinary tract infection, bacteremia, bacterial meningitis, botulism, and necrotizing enterocolitis. There is also a possible protection against sudden infant death syndrome, certain chronic diseases and childhood obesity. In addition to health benefits for the mother and infant, breastfeeding also provides social, economic and environmental benefits for both mother and infant.

B. Promotion and Support of Breastfeeding

1. Lactation Education and Support Services: Each county served by PHC has a local Women Infants and Children Nutrition Program (WIC) program that includes lactation education, support and provision of breast pumps, for low-income women, including PHC members. All pregnant members should be referred to WIC. Lactation support for PHC members is a shared goal and responsibility of WIC and the health delivery system provided through PHC, by the following providers:

   a. Primary care providers are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant patients to prenatal breastfeeding classes will ensure they have current evidence based information about breastfeeding.

   b. Prenatal care providers should specifically assess a pregnant member’s knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. The pregnant members and their families should be referred to a breastfeeding class and have access to one-on-one breastfeeding education prenatally and postnatally. This is especially important for members who are first time mothers or have not breastfed in the past.

   c. Comprehensive Perinatal Service Programs (CPSP): PHC strongly supports having all pregnant members receive support services provided through CPSP providers, which provide comprehensive assessments as part of their total perinatal care. CPSP providers may provide their own lactation support services or refer to other community resources to provide breastfeeding promotion, education and counseling.

   d. PHC Care Coordination: Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breastfeeding when indicated. Through specific programs and general case management support, PHC Care Coordination supports breastfeeding in accordance with current guidelines and evidence-based practices. The Growing Together Program at PHC (part of the Care Coordination Department) will maintain and make accessible on the PHC website a list of all high-quality lactation support resources available in PHC counties. In addition, Growing Together staff who have received appropriate training may provide telephonic counseling to members and make referrals to other resources in the community.
e. Postpartum follow-up calls are made to PHC members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.

f. Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative ([https://www.unicef.org/programme/breastfeeding/baby.htm](https://www.unicef.org/programme/breastfeeding/baby.htm)) and will also include:
   1) The hospital should receive information on the member’s prenatal record stating the infant feeding plan. That plan should be confirmed when a woman is admitted for delivery.
   2) Family centered childbirth practices allowing for early mother-infant contact and breastfeeding within one half-hour of birth the first two hours as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.
   3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Mothers can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infants feeding cues.
   4) Members need access to qualified nursing staff and/or International Board Certified Lactation Consultant (IBCLC) to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.
   5) Supplements such as formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.
   6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC, home health, or public health nurse visit specifically to assist the mother with breastfeeding. Whenever possible this should occur within 1-2 days of discharge.
   7) The lactating mother leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if her baby is getting enough milk, and referral to a breastfeeding support group.

g. Infant Care providers should encourage exclusive breastfeeding for about at least four to six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant Care providers should consider a referral to a qualified lactation consultant, Home Health Nurse or Public Health Nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the mother’s health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the mother is to be provided with a breast pump and instructions on how to use it to maintain her milk supply.

h. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive Home Health Nurse visits or Public Health Nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first mother-baby home health visit by a Home Health Nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public Health Nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

C. Partnership Health Plan of California Breastfeeding Services
   1. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate postpartum (in the hospital), early postpartum (from hospital discharge to 5684 days...
after delivery), and late post-partum periods (from 84,56 days to 365 days post-delivery). From a PHC standpoint, care during the postpartum period includes two specifically defined postpartum visits - one occurring prior to 21 days after delivery and the second between 21 to 84,56 days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow-up lactation visits should be encouraged, preferably in the first few days after discharge home. Some women also need lactation education and support after 84,56 days post-delivery. Lactation visits independent of the standard postpartum visits are covered by PHC. See billing and codes section for specific requirements.

2. Providers of Lactation support services:
   a. Basic lactation support services may be provided in a provider office under the supervision of a Physician, or a non-physician clinician, including Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse Midwife (CNM).
      1) Providers offering lactation support services will ensure that the services are provided by an individual who has the appropriate education and knowledge.
      2) Registered Nurse (RN), Registered Dietician (RD), International Board Certified Lactation Consultants (IBCLC), Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted Physician.
   b. IBCLCs with an underlying health professional licensure (RN, RD, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], CNM, NP, PA) may become contracted/credentialed to provide lactation support services through PHC.
      1) Contracted/credentialed IBCLC will ensure that any services provided by an individual within their employment has appropriate education and knowledge.
      2) Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted/credentialed IBCLC.
      3) IBCLCs must be credentialed by the credentials committee, as described under policy MP CR #16 Lactation Consultant Credentialing Policy.

3. Other Health Professionals who are Certified Lactation Consultants or trained Lactation Educators, under the supervision of a PHC contracted/credential IBCLC or provider office, may perform lactation consultation services outside of the hospital setting.

4. Lactation Educators: A Lactation Educator may provide basic lactation education services. The Lactation Educator must always work under the supervision of a PHC contracted/credential IBCLC or provider office, who is ultimately responsible for the patients seen by lactation educators.
   a. If an IBCLC is supervising lactation educators, the following documentation must be maintained in the lactation educator’s personnel file:
      1) Documentation of successful completion of a basic lactation education program.
      2) A letter from their supervising IBCLC describing the training and experience of the Lactation Educator, and the manner in which they are supervised.
   b. The IBCLC must maintain written protocols for the Lactation Educator, listing:
      1) Documentation standards
      2) Topics that the Lactation Educator may address
      3) Indications for referral to the IBCLC, with standards for timeliness of referrals.

5. Lactation Support Services:
   a. No Referral Authorization is required for up to 60 calendar days of services; however, a Treatment Authorization Request (TAR) is required for visits after 60 calendar days, with a written treatment plan and specific request for additional visits. These TARs will be reviewed for medical necessity, according to the usual TAR process.
b. Services provided in a contracted hospital outpatient services, physician office, IBCLC private
office or member’s home may be billed to PHC using the S9445 HCPCS code, billed in 15
minute increments, up to a maximum of 4 units per day. In addition, lactation services provided
by a CPSP program after the post-partum member’s eligibility for CPSP has expired, may also
use the S9445 HCPCS Code.

6. Breast Pumps: When breastfeeding is interrupted or discontinued the use of Breast Pumps and
alternative feeding fluids may be necessary. If mother is unable to feed the baby at the breast due to
a medically based separation or a physical problem of varying duration, and until resolution of any
of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a
covered benefit.
   a. Electric breast pumps may be recommended for infants with feeding problems where a mother
must be separated from or is unable to nurse her baby. PHC strongly recommends the use of an
electric breast pump for adequate maintenance of milk supply when a baby is not able to
breastfeed.
   b. In partnership with local WIC agencies, multi-user electric breast pumps and the breast pump
equipment (Kits) are provided through each county’s WIC program, when available. -They
provide the pump, equipment and education to support appropriate use.
   c. Single-user personal double electric breast pumps are also available for PHC members, or for
lactating mothers whose infant is a PHC member (who is 12 months old or younger). -These
pumps are available by prescription from a number of PHC contracted durable medical
equipment (DME) providers. -No TAR is required. -PHC breast pump benefit is limited to one
pump every three years.
      1) Providers will utilize DME order form with prescription to submit request for pump no
sooner than 30 calendar days prior to the Estimated Due Date (EDD), up to 12 months after
delivery.
      2) Providers will provide supportive pump education on how to successfully use the selected
pump at a health education visit prior to the EDD.
      3) Providers will be reimbursed up to 1 hour for breast pump education utilizing CPSP health
education codes, or billing code S9445. -Office visit codes may also be used, for appropriate
providers.
   d. When infants are born at less than 36 weeks gestation and remain hospitalized, arrangements
will be made on an individual case by case basis to use a multi-phase hospital grade electric
pump for the initiation and maintenance of the mother’s milk supply while the infant is
hospitalized. -Specific instruction and support for the use of this pump will be provided by the
hospital staff.

7. Alternate Feeding Fluids:
   a. Banked Human Milk is available in limited supplies for infants with specific conditions and for
whom their mother’s milk is temporarily not available.
      1) Banked Human Milk for newborns whose mothers are unable to breastfeed due to medical
reasons is a covered benefit under PHC. -Prior Authorization is required.
      2) Donor/-processed banked breast milk requires a prescription from a physician. -The
prescription must specify Processed human milk _# of ounces per day for _# of weeks as
well as the infant’s name and Client Identification Number (CIN) along with the
parent/guardian’s name and phone number and a diagnosis. -The prescription can be faxed
or scanned and emailed to the milk bank.
      3) If the infant requires an increase in supply, a new prescription is needed.
      4) For outpatient infants, the first shipment is usually for one week of milk. -The
parent/guardian can request up to a 2 week supply on subsequent orders.
      5) When a hospital orders the milk, a purchase order number is required, along with the
Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)

Lead Department: Health Services

Policy/Procedure Title: Lactation Policy and Guidelines
(formerly Breastfeeding Guidelines)

☒ External Policy
☐ Internal Policy

Original Date: 04/19/2000
Next Review Date: 06/12/2020
Last Review Date: 06/12/2019

Applies to: ☒ Medi-Cal
☐ Employees

mother’s address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor’s order to the milk bank. PHC does not pay for Banked Human Milk in hospitalized recipients as the bank will bill the hospital directly in those instances.

For some newborn intensive care units (NICUs) in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.

b. Special infant formulas - Special Formulas are available for PHC members through a contracted PHC pharmacy with a physician prescription and through the Treatment Authorization Process (TAR) for specific medical conditions. See policy on Pediatric Enteral Nutrition for details (policy MPRP4056). If special infant formula is denied by PHC, then WIC will provide special infant formula for children up to the age of 5 if prescribed by a physician with a copy of the denial letter and WIC form “WIC Pediatric Referral.”

VII. REFERENCES:
A. American Academy of Pediatrics, Clinical Practice Guideline. 

B. Affordable Care Act, Section 4106a, Women’s Health Preventive Services
C. Infant Risk Center: Call 806-352-2519
E. Department of Health and Human Services/Center for Medicaid and CHIP Services
F. Medicaid Coverage of Lactation Services. CMS Bulletin

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

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

X. REVISION DATES:
MCCP2020 (02/15/17)
*03/14/18; 06/12/19; 06/12/20

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

PREVIOUSLY APPLIED TO:
Medi-Cal (UG100309; MPUG3009; MCUP3009: 04/19/2000 to 02/15/2017)
05/16/01; 05/15/02; 10/20/04; 10/19/05; 08/20/08; 04/21/10; 09/15/10; 10/01/10; 06/20/12; 11/20/13;
08/20/14; 04/15/15; 01/20/16; 10/19/16 to 02/15/17
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MCCP2020 (previously MCUP3009; MPUG3009; UG100309)
Lead Department: Health Services

Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)
☒ External Policy
☐ Internal Policy

Original Date: 04/19/2000
Next Review Date: 06/10/2021
Last Review Date: 06/10/2020

Applies to: ☒ Medi-Cal
☐ Employees

Reviewing Entities:
☒ IQI
☐ P & T
☐ OPERATIONS
☐ EXECUTIVE
☐ COMPLIANCE
☐ DEPARTMENT
☒ QUAC

Approving Entities:
☐ BOARD
☐ COMPLIANCE
☐ FINANCE
☒ PAC
☐ CEO
☐ COO
☐ CREDENTIALING
☐ DEPT. DIRECTOR/OFFICER

Approval Signature: Robert Moore, MD, MPH, MBA
Approval Date: 06/10/2020

I. RELATED POLICIES:
A. MPXG5009 - Lactation Clinical Practice Guideline
B. MPCR #16 - Lactation Consultant Credentialing Policy
C. MPRP4056 - Pediatric Enteral Nutrition
D. MCUG3118 - Prenatal and Perinatal Care
E. MCUP3041 - TAR Review Process
F. MCCP2021 - Women, Infants and Children (WIC) Supplemental Food Program
G. MCUP3013 - DME Authorization

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

III. DEFINITIONS:
A. Essential Health Benefits - A set of health care service categories that must be covered by certain plans - Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.
B. WIC - Women, Infants and Children Supplemental Nutrition Program - The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) women and children up to the age of five.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
A. To support optimal nutrition in the healthy infant by appropriately supporting the mother’s efforts to initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.
B. To give the policy framework around provisions of the Affordable Care Act (ACA), Section 4106a, Women’s Health Preventive Services. It is the goal of Partnership HealthPlan of California (PHC) to be fully compliant with this portion of the ACA. This section states that pregnant and postpartum women are eligible to receive as preventive services:
1. Comprehensive lactation services including counseling by a trained health care provider or allied health professional during pregnancy and/or the postpartum period.
2. To have access to breast pumps and breastfeeding equipment and supplies, as indicated to support lactation.

VI. POLICY / PROCEDURE:
A. General Breastfeeding Guidelines
1. Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by PHC and the AAP. Research has demonstrated numerous health benefits of breastfeeding. Additional to health benefits breastfeeding also provides social, economic and environmental benefits for both mother and infant.

B. Promotion and Support of Breastfeeding
1. Lactation Education and Support Services: Each county served by PHC has a local Women Infants and Children Nutrition Program (WIC) program that includes lactation education, support and provision of breast pumps, for low-income women, including PHC members. All pregnant members should be referred to WIC. Lactation support for PHC members is a shared goal and responsibility of WIC and the health delivery system provided through PHC, by the following providers:
   a. Primary care providers are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant patients to prenatal breastfeeding classes will ensure they have current evidence based information about breastfeeding.
   b. Prenatal care providers should specifically assess a pregnant member’s knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. The pregnant members and their families should be referred to a breastfeeding class and have access to one-on-one breastfeeding education prenatally and postnatally. This is especially important for members who are first time mothers or have not breastfed in the past.
   c. Comprehensive Perinatal Service Programs (CPSP): PHC strongly supports having all pregnant members receive support services provided through CPSP providers, which provide comprehensive assessments as part of their total perinatal care. CPSP providers may provide their own lactation support services or refer to other community resources to provide breastfeeding promotion, education and counseling.
   d. PHC Care Coordination: Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breastfeeding when indicated. Through specific programs and general case management support, PHC Care Coordination supports breastfeeding in accordance with current guidelines and evidence-based practices.
   e. Postpartum follow-up calls are made to PHC members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.
   f. Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative (https://www.unicef.org/programme/breastfeeding/baby.htm) and will also include:
      1) The hospital should receive information on the member’s prenatal record stating the infant feeding plan. That plan should be confirmed when a woman is admitted for delivery.
      2) Family centered childbirth practices allowing for early mother-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer
support, assistance, and education accordingly.

3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Mothers can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infants feeding cues.

4) Members need access to qualified nursing staff and/or International Board Certified Lactation Consultant (IBCLC) to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.

5) Supplements such as formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.

6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC, home health, or public health nurse visit specifically to assist the mother with breastfeeding. Whenever possible this should occur within 1-2 days of discharge.

7) The lactating mother leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if her baby is getting enough milk, and referral to a breastfeeding support group.

g. Infant Care providers should encourage exclusive breastfeeding for about six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant Care providers should consider a referral to a qualified lactation consultant, Home Health Nurse or Public Health Nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the mother’s health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the mother is to be provided with a breast pump and instructions on how to use it to maintain her milk supply.

h. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive Home Health Nurse visits or Public Health Nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first mother-baby home health visit by a Home Health Nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public Health Nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

C. Partnership HealthPlan of California Breastfeeding Services

1. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate postpartum (in the hospital), early postpartum (from hospital discharge to 84 days after delivery), and late post-partum periods (from 84 days to 365 days post-delivery). From a PHC standpoint, care during the postpartum period includes two specifically defined postpartum visits one occurring prior to 21 days after delivery and the second between 21 to 84 days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow-up lactation visits should be encouraged, preferably in the first few days after discharge home. Some women also need lactation education and support after 84 days post-delivery. Lactation visits independent of the standard postpartum visits are covered by PHC. See billing and codes section for specific requirements.

2. Providers of Lactation support services:
   a. Basic lactation support services may be provided in a provider office under the supervision of a Physician, or a non-physician clinician, including Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse Midwife (CNM).
1) Providers offering lactation support services will ensure that the services are provided by an individual who has the appropriate education and knowledge.

2) Registered Nurse (RN), Registered Dietician (RD), International Board Certified Lactation Consultants (IBCLC), Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted Physician.

b. IBCLCs with an underlying health professional licensure (RN, RD, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], CNM, NP, PA) may become contracted/credentialed to provide lactation support services through PHC.

1) Contracted/credentialed IBCLC will ensure that any services provided by an individual within their employment has appropriate education and knowledge.

2) Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted/credentialed IBCLC.

3) IBCLCs must be credentialed by the credentials committee, as described under policy MP CR #16 Lactation Consultant Credentialing Policy.

3. Other Health Professionals who are Certified Lactation Consultants or trained Lactation Educators, under the supervision of a PHC contracted/credential IBCLC or provider office, may perform lactation consultation services outside of the hospital setting.

4. Lactation Educators: A Lactation Educator may provide basic lactation education services. The Lactation Educator must always work under the supervision of a PHC contracted/credential IBCLC or provider office, who is ultimately responsible for the patients seen by lactation educators.

a. If an IBCLC is supervising lactation educators, the following documentation must be maintained in the lactation educator’s personnel file:

1) Documentation of successful completion of a basic lactation education program.

2) A letter from their supervising IBCLC describing the training and experience of the Lactation Educator, and the manner in which they are supervised.

b. The IBCLC must maintain written protocols for the Lactation Educator, listing:

1) Documentation standards

2) Topics that the Lactation Educator may address

3) Indications for referral to the IBCLC, with standards for timeliness of referrals.

5. Lactation Support Services:

a. No Referral Authorization is required for up to 60 calendar days of services; however, a Treatment Authorization Request (TAR) is required for visits after 60 calendar days, with a written treatment plan and specific request for additional visits. These TARs will be reviewed for medical necessity, according to the usual TAR process.

b. Services provided in a contracted hospital outpatient services, physician office, IBCLC private office or member’s home may be billed to PHC using the S9445 HCPCS code, billed in 15 minute increments, up to a maximum of 4 units per day. In addition, lactation services provided by a CPSP program after the post-partum member’s eligibility for CPSP has expired, may also use the S9445 HCPCS Code.

6. Breast Pumps: When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If mother is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.

a. Electric breast pumps may be recommended for infants with feeding problems where a mother must be separated from or is unable to nurse her baby. PHC strongly recommends the use of an electric breast pump for adequate maintenance of milk supply when a baby is not able to
breastfeed.

b. In partnership with local WIC agencies, multi-user electric breast pumps and the breast pump equipment (Kits) are provided through each county’s WIC program, when available. They provide the pump, equipment and education to support appropriate use.

c. Single-user personal double electric breast pumps are also available for PHC members, or for lactating mothers whose infant is a PHC member (who is 12 months old or younger). These pumps are available by prescription from a number of PHC contracted durable medical equipment (DME) providers. No TAR is required. PHC breast pump benefit is limited to one pump every three years.

1) Providers will utilize DME order form with prescription to submit request for pump no sooner than 30 calendar days prior to the Estimated Due Date (EDD), up to 12 months after delivery.

2) Providers will provide supportive pump education on how to successfully use the selected pump at a health education visit prior to the EDD.

3) Providers will be reimbursed up to 1 hour for breast pump education utilizing CPSP health education codes, or billing code S9445. Office visit codes may also be used, for appropriate providers.

d. When infants are born at less than 36 weeks gestation and remain hospitalized, arrangements will be made on an individual case by case basis to use a multi-phase hospital grade electric pump for the initiation and maintenance of the mother’s milk supply while the infant is hospitalized. Specific instruction and support for the use of this pump will be provided by the hospital staff.

7. Alternate Feeding Fluids:

a. Banked Human Milk is available in limited supplies for infants with specific conditions and for whom their mother’s milk is temporarily not available.

1) Banked Human Milk for newborns whose mothers are unable to breastfeed due to medical reasons is a covered benefit under PHC. Prior Authorization is required.

2) Donor/processed banked breast milk requires a prescription from a physician. The prescription must specify Processed human milk __# of ounces per day for __# of weeks as well as the infant’s name and Client Identification Number (CIN) along with the parent/guardian’s name and phone number and a diagnosis. The prescription can be faxed or scanned and emailed to the milk bank.

3) If the infant requires an increase in supply, a new prescription is needed.

4) For outpatient infants, the first shipment is usually for one week of milk. The parent/guardian can request up to a 2 week supply on subsequent orders.

5) When a hospital orders the milk, a purchase order number is required, along with the mother’s address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor’s order to the milk bank. PHC does not pay for Banked Human Milk in hospitalized recipients as the bank will bill the hospital directly in those instances.

6) For some newborn intensive care units (NICUs) in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.

b. Special infant formulas - Special Formulas are available for PHC members through a contracted PHC pharmacy with a physician prescription and through the Treatment Authorization Process (TAR) for specific medical conditions. See policy on Pediatric Enteral Nutrition for details (policy MPRP4056). If special infant formula is denied by PHC, then WIC will provide special infant formula for children up to the age of 5 if prescribed by a physician with a copy of the
denial letter and WIC form “WIC Pediatric Referral.”

VII. REFERENCES:
A. American Academy of Pediatrics, Clinical Practice Guideline.
   https://pediatrics.aappublications.org/content/pediatrics/129/3/e827.full.pdf
B. Affordable Care Act, Section 4106a, Women’s Health Preventive Services
C. Infant Risk Center: Call 806-352-2519
D. CA WIC Association: Ramping up for Reform-Quality Breastfeeding Support in Preventive Care.
E. Department of Health and Human Services/Center for Medicaid and CHIP Services
F. Medicaid Coverage of Lactation Services. CMS Bulletin

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

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

X. REVISION DATES:
MCCP2020 (02/15/17)
*03/14/18; 06/12/19; 06/10/20

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

PREVIOUSLY APPLIED TO:
Medi-Cal (UG100309; MPUG3009; MCUP3009: 04/19/2000 to 02/15/2017)
05/16/01; 05/15/02; 10/20/04; 10/19/05; 08/20/08; 04/21/10; 09/15/10; 10/01/10; 06/20/12; 11/20/13;
08/20/14; 04/15/15; 01/20/16; 10/19/16 to 02/15/17

Healthy Families:
MPUG3009 - 10/01/2010 to 03/01/2013

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

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

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
I. RELATED POLICIES:
A. MCUP3101 - Screening and Treatment for Substance Use Disorders
B. MCQG1005 - Adult Preventive Health Guidelines
C. MCUP3028 - Mental Health Services
D. MPUP3126 - Behavioral Health Treatment (BHT) for Members Under the Age of 21

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

III. DEFINITIONS:
Specialty Mental Health Services are those provided by County Mental Health Plans, generally for individuals with certain mental health diagnoses and associated impairments, pursuant to Welfare and Institutions Code Sections 14132.03 and 14189, and Title 9 of the California Code of Regulations, Chapter 11.

IV. ATTACHMENTS:
A. Beacon Instructions for Behavioral Health Screening Tool & Referrals
B. Beacon Primary Care Provider (PCP) Referral Form
C. Beacon Health Strategies, Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

V. PURPOSE:
The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for mild to moderate behavioral health conditions to Partnership HealthPlan of California’s (PHC’s) delegated contractors, managed behavioral health organizations, Beacon Health Options (855) 765-9703 and Kaiser Permanente, and for referral to County Mental Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between primary care practitioners and behavioral health specialists and to help identify educational opportunities for the Partnership HealthPlan of California (PHC) provider network.

VI. POLICY / PROCEDURE:
A. PHC utilizes this guideline to generally define the services and responsibilities of Primary Care
Providers (PCPs) and behavioral health providers. PCPs are responsible for all services within the scope of primary care required by the patient except when clinical circumstances preclude the PCP role. The PCP’s services are personal, and his/her responsibility is continuous. The scope of the responsibility is comprehensive, (i.e. all required services including preventive services). The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required. PHC recognizes that differences in skill level exist among PCPs; this document serves as a general guideline to define the scope of services and the indications for specialty referrals. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a specialist and the referral of a patient to a specialist for services. When care by specialists is required, it is the responsibility of the PCP and the specialists to coordinate all services.

B. The primary care provider should be responsible for providing the following in regards to basic behavioral health conditions:

1. Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations.

2. Routinely screen for common behavioral health and substance use disorder conditions. The plan has adopted and PHC contracted providers are expected to follow the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Routine screening for depression is recommended by the USPSTF. Please refer to PHC’s Adult Preventive Health Guidelines policy MPQG1005 for further details. Additionally, current versions of age specific behavioral health screening forms may be found on the Beacon website at this address: https://www.beaconhealthoptions.com/providers/forms-and-resources/ under the button labeled “View Forms, Manuals and FAQ’s.” Screening for alcohol misuse is also recommended. Please refer to policy MCUP3101 - Screening and Treatment for Substance Use Disorders for details.

3. Determine whether high risk factors such as suicidal or homicidal ideation with active planning, threats of physical harm, or psychomotor agitation, or an active substance use disorder exist, and/or whether the member can be considered to be gravely disabled. Ascertain whether individuals are experiencing symptoms that would warrant emergent or urgent psychiatric evaluation, such as significant suicidal or homicidal ideation and/or grave disability, active substance intoxication/withdrawal/use disorder, or disorganized thinking or psychomotoric agitation, and making appropriate referrals to complete these evaluations as clinically indicated.

4. Evaluate and provide ongoing management for the following:
   a. Psychological/Psychiatric factors affecting a medical condition and psychological psychiatric symptoms precipitated by medications being used to treat medical conditions
   b. Psychological/Psychiatric issues or problems which are conditions such as anxiety, depression, substance misuse and conduct/personality problems disorders that do not meet the full criteria for a Diagnostic and Statistical Manual (DSM) diagnosable disorder diagnosis
   c. Medical assessments of members to evaluate and treat general medical conditions causing or exacerbating psychiatric symptoms.
   d. Initial diagnosis and treatment of dementia. Differentiate dementia from other disorders effecting cognition, such as delirium, schizophrenia, substance misuse, and depression from dementia. Manage general medical factors that improve or worsen dementia.

C. The primary care provider should be responsible for the initial evaluation and referral for behavioral health services as follows:

1. Members capitated to Kaiser Permanente: Kaiser will provide Mental Health Services in Sonoma, Napa, Yolo, and Marin counties for mild-to-moderate conditions and in Solano county for mild-to-moderate and severe conditions.

2. Medi-Cal only Members (with no Medicare and not capitated to Kaiser Permanente):
a. All mental health services for these members are provided either by Beacon Health Options’ network of providers for mild to moderate behavioral health conditions or by County Mental Health Plans or Substance Use programs for Specialty Mental Health or substance use treatment services.

a-b. Substance use disorder and substance misuse services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano Counties are provided by Partnership HealthPlan. Substance use disorder and substance misuse services for members in other counties are provided by County Substance Use programs. In all counties, substance use disorder and substance misuse treatment services may also be provided within the PHC network through Medication Assisted Treatment (MAT); see policy MCUP31010 Screening and Treatment for Substance Use Disorders for further information.

2.3. PCP may determine a provisional diagnosis for the following behavioral health conditions: schizophrenia/psychotic disorder, bipolar depression, depression, anxiety disorder, impulse control disorder, adjustment disorder, personality disorder (except anti-social), eating disorder, pervasive developmental disorder, disruptive behavior/attention deficit disorder, feeding and eating/elimination disorders, other disorders of infancy, childhood, or adolescence, somatoform disorders, factitious disorders, dissociative disorders, paraphilias, gender dysphoria, substance-related and addictive disorders.

3.4. PCP should determine the level of functional impairment in the following life domains resulting from the behavioral health condition:
   a. Independent living skills
   b. Social relations
   c. Physical condition (chronic medical condition)
   d. Vocational/ Employment
   e. Sexuality/Sexual Functioning
   f. Self-care
   g. Decision making
   h. Legal
   i. Residential instability

4.5. PCP should determine the probability of deterioration and risk factors linked to the further deterioration of behavioral health conditions such as:
   a. Psychiatric hospitalization
   b. Criminal behaviors and criminal justice system involvement
   c. Suicidal/homicidal ideations and behavior
   d. Transitional age youth with acute psychotic Experiencing psychotic or mood symptoms (especially in youth and transitional aged youth) episode
   e. Self-injurious behavior (especially that which required medical attention)
   f. Sexual aggression with acute risk of re-offending
   g. Inability to adequately self-care
   h. Ongoing substance misuse

5.6. For mental health conditions, PCP should refer Medi-Cal only members to Beacon Health Options when a provisional diagnosis is present or the diagnosis is uncertain, where functional impairment is considered to be in mild to moderate range, and where there are no deterioration/risk factors.
   a. When Member’s needs are outside PCP scope, PCP may refer for Outpatient Behavioral Health Services for therapy or medication management via Beacon’s network of providers by providing the member with Beacon referral number (855) 765-9703. PCP can also fax a Beacon PCP Referral Form (Attachment B) to Beacon at (866) 422-3413 or use secure email to medi-cal.referral@beaconhealthoptions.com Licensed Mental Health Providers at Beacon will screen the patient and determine the appropriate level of care needed and make the actual
referrals including coordination with county MHP if necessary.

b. PCP may request PCP Decision Support related to member diagnostic and medication clarification; the PCP may request a telephone consultation with a Beacon psychiatrist using the PCP Referral Form (Attachment B). Before phone consult with Beacon, PCP should fax medication list and last 2 PCP progress notes for Psychiatrist review. Fax: (866) 422-3413 or secure email: medi-cal.referral@beaconhealthoptions.com

c. PCP may refer for Local Care Management to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community services by sending the PCP Referral Form (Attachment B) to Beacon Fax: (855) 371-2279 or email: MediCal_PHP@beaconhealthoptions.com

d. Primary care sites with integrated behavioral health, not including Kaiser primary care sites, whose mental health professionals are credentialed with Beacon, may co-manage patients who would qualify for the “mild to moderate” mental health benefit.

e. After initial evaluation and/or referral, the PCP may continue to follow and treat a PHC member based on his/her current clinical competence and in collaboration with the behavioral health specialist as appropriate.

6.7. PCP should refer members to County Mental Health Plans when a provisional diagnosis is present and when functional impairment is considered to be in the moderate to severe range, and/or when any risk factor is present.

a. The process of accessing mental health services in each county may be different. For initial telephone contacts, PCPs can consult the Instructions for Behavioral Health Screening Tool & Referrals Partnership HealthPlan Counties (Screening and Referral Instructions) (See Attachment A).

b. Patients with emergency psychiatric conditions should be referred for emergency evaluation, calling the county-designated crisis phone number to arrange for services.

c. After initial evaluation and/or referral, the PCP may continue to follow and treat a PHC member based on his/her current clinical competence and in collaboration with the behavioral health specialist as appropriate.

d. Federally qualified health centers with integrated mental health may provide outpatient services for patients who would otherwise qualify for County Specialty Mental Health Services. These services are billed directly to the state.

7.8. PCP should screen and refer Medi-Cal only Members with substance use disorders as follows:

a. Alcohol Misuse Screening and Counseling (AMSC) should be performed by PCP.

b. The process of accessing substance use disorder services in each county may be different. 1) For Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano Counties, members should be referred to Beacon Health Options (855) 765-9703 for call center assistance to identify screening and referral to substance use services providers. 2) In all other counties, the first point of telephone contact for substance use disorder referrals for each county can be located on the PHC website at the bottom of this webpage under the heading “Substance Use Disorder Services”: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx

c. For details on substance use disorder and alcohol misuse screening and referral, see policy MCUP3101 Screening and Treatment for Substance Use Disorders.

d. Provide ongoing follow-up as jointly determined by the PCP and County Substance Use Disorder treatment provider for members whose substance use disorder conditions have reached a high degree of stability.

e. Psychiatric manifestations of neurologic disorders, developmental neurologic disorders, traumatic brain injury, and encephalopathy are ideally
suited to assist with these cases. Providers can refer to Beacon Health Options to refer members for this service.

Behavioral Health Treatment (BHT) for Medi-Cal only Members Under the Age of 21: BHT is covered by PHC for members under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit. A Treatment Authorization Request (TAR) is required. See policy MPUP3126 - Behavioral Health Treatment (BHT) for Members Under the Age of 21.

School aged children may also have some assessment and treatment covered through their schools. School-based mental health services include a broad range of services, settings, and strategies. These services may include academic counseling, brief interventions to address behavior problems, family counseling, suicide prevention, and assessment and referral to other systems. Further information is available through your County mental health department.

VII. REFERENCES:
A. Latest USPSTF Guide to Clinical Preventive Services
B. County specific Mental Health Plan Memorandum of Understanding (MOUs)
C. Welfare and Institutions Code Sections 14132.03 and 14189
D. Title 9 of the California Code of Regulations, Chapter 11
E. DHCS All Plan Letter (APL) 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans (09/19/18)
F. Attachment 1 to APL18-015 Title 9 Chapter 11
G. Attachment 2 to APL18-015 Memorandum Of Understanding Requirements For Medi-Cal Managed Care Plans and County Mental Health Plans

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

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

X. REVISION DATES: 04/19/17; *06/13/18; 06/12/19; 06/10/20

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

PREVIOUSLY APPLIED TO:
Medi-Cal - MPQP1024
Original Date: 02/18/2004
Revision dates: 05/18/05; 04/19/06; 04/18/07; 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15

Healthy Kids - MPCP2017, MPQP1024 (Healthy Kids Program ended 12/01/2016)
Original Date: 04/18/2007
Revision dates: 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15 to 12/01/2016

Partnership Advantage:
MPQG1024 – 04/18/2007 to 11/17/2010
MPQP1024 – 11/17/2010 to 01/01/2015
# PARTNERSHIP HEALTHPLAN OF CALIFORNIA
## POLICY / PROCEDURE

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<td>Policy/Procedure Title:</td>
<td>Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines</td>
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<td>Approval Signature:</td>
<td>Robert Moore, MD, MPH, MBA</td>
<td>Approval Date:</td>
<td>06/10/2020</td>
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I. RELATED POLICIES:
A. MCUP3101 - Screening and Treatment for Substance Use Disorders
B. MCQG1005 - Adult Preventive Health Guidelines
C. MCUP3028 - Mental Health Services
D. MPUP3126 - Behavioral Health Treatment (BHT) for Members Under the Age of 21

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

III. DEFINITIONS:
Specialty Mental Health Services are those provided by County Mental Health Plans, generally for individuals with certain mental health diagnoses and associated impairments, pursuant to Welfare and Institutions Code Sections 14132.03 and 14189, and Title 9 of the California Code of Regulations, Chapter 11.

IV. ATTACHMENTS:
A. Beacon Instructions for Behavioral Health Screening Tool & Referrals
B. Beacon Primary Care Provider (PCP) Referral Form
C. Beacon Health Strategies, Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

V. PURPOSE:
The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for mild to moderate behavioral health conditions to Partnership HealthPlan of California’s (PHC’s) delegated managed behavioral health organizations, Beacon Health Options (855) 765-9703 and Kaiser Permanente, and for referral to County Mental Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between primary care providers and behavioral health specialists and to help identify educational opportunities for the Partnership HealthPlan of California (PHC) provider network.

VI. POLICY / PROCEDURE:
A. PHC utilizes this guideline to generally define the services and responsibilities of Primary Care
Providers (PCPs) and behavioral health providers. PCPs are responsible for all services within the scope of primary care required by the patient except when clinical circumstances preclude the PCP role. The PCP’s services are personal, and his/her responsibility is continuous. The scope of the responsibility is comprehensive, (i.e. all required services including preventive services). The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required. PHC recognizes that differences in skill level exist among PCPs; this document serves as a general guideline to define the scope of services and the indications for specialty referrals. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a specialist and the referral of a patient to a specialist for services. When care by specialists is required, it is the responsibility of the PCP and the specialists to coordinate all services.

B. The primary care provider should be responsible for providing the following in regards to basic behavioral health conditions:

1. Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations.
2. Routinely screen for common behavioral health and substance use disorder conditions. The plan has adopted and PHC contracted providers are expected to follow the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Routine screening for depression is recommended by the USPSTF. Please refer to PHC’s Adult Preventive Health Guidelines policy MPQG1005 for further details. Additionally, current versions of age specific behavioral health screening forms may be found on the Beacon website at this address: https://www.beaconhealthoptions.com/providers/forms-and-resources/ under the button labeled “View Forms, Manuals and FAQ’s.” Screening for alcohol misuse is also recommended. Please refer to policy MCUP3101 Screening and Treatment for Substance Use Disorders for details.
3. Ascertain whether individuals are experiencing symptoms that would warrant emergent or urgent psychiatric evaluation, such as significant suicidal or homicidal ideation and/or grave disability, active substance intoxication/withdrawal/use disorder, or disorganized thinking or psychomotoric agitation, and making appropriate referrals to complete these evaluations as clinically indicated.
4. Evaluate and provide ongoing management for the following:
   a. Psychiatric factors affecting a medical condition and psychiatric symptoms precipitated by medications being used to treat medical conditions
   b. Psychiatric issues or problems which are conditions such as anxiety, depression, substance misuse and personality disorders that do not meet the full criteria for a Diagnostic and Statistical Manual (DSM) diagnosis
   c. Medical assessments of members to evaluate and treat general medical conditions causing or exacerbating psychiatric symptoms.
   d. Initial diagnosis and treatment of dementia. Differentiate dementia from other disorders effecting cognition, such as delirium, schizophrenia, substance misuse, and depression. Manage general medical factors that improve or worsen dementia.

C. The primary care provider should be responsible for the initial evaluation and referral for behavioral health services as follows:

1. Members capitated to Kaiser Permanente: Kaiser will provide Mental Health Services in Sonoma, Napa, Yolo, and Marin counties for mild-to-moderate conditions and in Solano county for mild-to-moderate and severe conditions.
2. Medi-Cal only Members (with no Medicare and not capitated to Kaiser Permanente):
   a. All mental health services for these members are provided either by Beacon Health Options’ network of providers for mild to moderate behavioral health conditions or by County Mental Health Plans for Specialty Mental Health services.
b. Substance use disorder and substance misuse services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano Counties are provided by Partnership HealthPlan. Substance use disorder and substance misuse services for members in other counties are provided by County Substance Use programs. In all counties, substance use disorder and substance misuse treatment services may also be provided within the PHC network through Medication Assisted Treatment (MAT); see policy MCUP3101 Screening and Treatment for Substance Use Disorders for further information.

3. PCP may determine a provisional diagnosis for the following behavioral health conditions: schizophrenia/psychotic disorder, bipolar depression, depression, anxiety disorder, impulse control disorder, adjustment disorder, personality disorder (except anti-social), eating disorder, pervasive developmental disorder, disruptive behavior/attention deficit disorder, feeding and eating/elimination disorders, other disorders of infancy, childhood, or adolescence, somatoform disorders, factitious disorders, dissociative disorders, paraphilias, gender dysphoria, substance-related and addictive disorders.

4. PCP should determine the level of functional impairment in the following life domains resulting from the behavioral health condition:
   a. Independent living skills
   b. Social relations
   c. Physical condition (chronic medical condition)
   d. Vocational/ Employment
   e. Sexual Functioning
   f. Self-care
   g. Decision making
   h. Legal
   i. Residential instability

5. PCP should assess risk factors linked to the further deterioration of behavioral health conditions such as:
   a. Psychiatric hospitalization
   b. Criminal behaviors and criminal justice system involvement
   c. Suicidal/homicidal ideations and behavior
   d. Experiencing psychotic or mood symptoms (especially in youth and transitional aged youth)
   e. Self-injurious behavior (especially that which required medical attention)
   f. Sexual aggression with risk of re-offending
   g. Inability to adequately self-care
   h. Ongoing substance misuse

6. For mental health conditions, PCP should refer Medi-Cal only members to Beacon Health Options when a provisional diagnosis is present or the diagnosis is uncertain, where functional impairment is considered to be in mild to moderate range, and where there are no deterioration/risk factors.
   a. When Member’s needs are outside PCP scope, PCP may refer for Outpatient Behavioral Health Services for therapy or medication management via Beacon’s network of providers by providing the member with Beacon referral number (855) 765-9703. PCP can also fax a Beacon PCP Referral Form (Attachment B) to Beacon at (866) 422-3413 or use secure email to: medi-cal.referral@beaconhealthoptions.com. Licensed Mental Health Providers at Beacon will screen the patient and determine the appropriate level of care needed and make the actual referrals including coordination with county MHP if necessary.
   b. PCP may request PCP Decision Support related to member diagnostic and medication clarification; the PCP may request a telephone consultation with a Beacon psychiatrist using the PCP Referral Form (Attachment B). Before phone consult with Beacon, PCP should fax medication list and last 2 PCP progress notes for Psychiatrist review. Fax: (866) 422-3413 or
secure email: medi-cal.referral@beaconhealthoptions.com

c. PCP may refer for Local Care Management to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community services by sending the PCP Referral Form (Attachment B) to Beacon Fax: (855) 371-2279 or email: MediCal_PHP@beaconhealthoptions.com

d. Primary care sites with integrated behavioral health, not including Kaiser primary care sites, whose mental health professionals are credentialed with Beacon, may co-manage patients who would qualify for the “mild to moderate” mental health benefit.

e. After initial evaluation and/or referral, the PCP may continue to follow and treat a PHC member based on his/her current clinical competence and in collaboration with the behavioral health specialist as appropriate.

7. PCP should refer members to County Mental Health Plans when a provisional diagnosis is present and when functional impairment is considered to be in the moderate to severe range, and/or when any risk factor is present.
   a. The process of accessing mental health services in each county may be different. For initial telephone contacts, PCPs can consult the Instructions for Behavioral Health Screening Tool & Referrals Partnership HealthPlan Counties (Screening and Referral Instructions) (See Attachment A).
   b. Patients with emergency psychiatric conditions should be referred for emergency evaluation, calling the county-designated crisis phone number to arrange for services.
   c. After initial evaluation and/or referral, the PCP may continue to follow and treat a PHC member based on his/her current clinical competence and in collaboration with the behavioral health specialist as appropriate.
   d. Federally qualified health centers with integrated mental health may provide outpatient services for patients who would otherwise qualify for County Specialty Mental Health Services. These services are billed directly to the state.

8. PCP should screen and refer Medi-Cal only Members with substance use disorders as follows:
   a. Alcohol Misuse Screening and Counseling (AMSC) should be performed by PCP.
   b. The process of accessing substance use disorder services in each county may be different.
      1) For Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano Counties, members should be referred to Beacon Health Options (855) 765-9703 for call center assistance to identify substance use services providers.
      2) In all other counties, the first point of telephone contact for substance use disorder referrals for each county can be located on the PHC website at the bottom of this webpage under the heading “Substance Use Disorder Services”: http://www.partnershipphp.org/Members/Medi-Cal/Pages/Benefits.aspx
   c. For details on substance use disorder and alcohol misuse screening and referral, see policy MCUP3101 Screening and Treatment for Substance Use Disorders.
   d. Provide ongoing follow-up as jointly determined by the PCP and Substance Use Disorder treatment provider for members whose use disorder conditions have reached a high degree of stability.

9. Psychiatric manifestations of neurologic disorders, developmental neurologic disorders, traumatic brain injury, and cognitive impairment: A specialist in neuropsychiatry is ideally suited to assist with these cases. Providers can refer to Beacon Health Options to refer members for this service.

10. Behavioral Health Treatment (BHT) for Medi-Cal only Members Under the Age of 21: BHT is covered by PHC for members under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit. A Treatment Authorization Request (TAR) is required. See policy MPUP3126 - Behavioral Health Treatment (BHT) for
Members Under the Age of 21.

11. School aged children may also have some assessment and treatment covered through their schools. School-based mental health services include a broad range of services, settings, and strategies. These services may include academic counseling, brief interventions to address behavior problems, family counseling, suicide prevention, and assessment and referral to other systems. Further information is available through your County mental health department.

VII. REFERENCES:
A. Latest USPSTF Guide to Clinical Preventive Services
B. County specific Mental Health Plan Memoranda of Understanding (MOUs)
C. Welfare and Institutions Code Sections 14132.03 and 14189
D. Title 9 of the California Code of Regulations, Chapter 11
E. DHCS All Plan Letter (APL) 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans (09/19/18)
F. Attachment 1 to APL18-015 Title 9 Chapter 11
G. Attachment 2 to APL18-015 Memorandum Of Understanding Requirements For Medi-Cal Managed Care Plans and County Mental Health Plans

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

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

X. REVISION DATES: 04/19/17; *06/13/18; 06/12/19; 06/10/20

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

PREVIOUSLY APPLIED TO:
Medi-Cal - MPQP1024
Original Date: 02/18/2004
Revision dates: 05/18/05; 04/19/06; 04/18/07; 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15

Healthy Kids - MPPCP2017, MPQP1024 (Healthy Kids Program ended 12/01/2016)
Original Date: 04/18/2007
Revision dates: 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15 to 12/01/2016

Partnership Advantage:
MPQG1024 – 04/18/2007 to 11/17/2010
MPQP1024 – 11/17/2010 to 01/01/2015

Healthy Families:
MPQP1024 - 11/17/10 to 03/01/2013

******************************************************************************************
2. Heavy Drinking – SAMHSA defines heavy drinking as drinking 5 or more drinks on the same occasion on each of 5 or more days in the past 30 days.

C. Alcohol Misuse Screening and Counseling (AMSC) services: A term for SBIRT related to screening for alcohol misuse in adults ages 18 and older. Alcohol misuse screening and behavioral counseling interventions are delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including appropriate alcohol use. Medi-Cal funded AMSC is not covered for adolescents.

D. Screening, Brief Intervention and Referral to Treatment (SBIRT): A process defined by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:

1. Screening - a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
2. Brief intervention - a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
3. Referral to treatment - a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

The process and tool can be generically applied to many conditions, including depression, substance use, smoking, etc.

IV. ATTACHMENTS:
A. Alcohol Misuse Screening and Counseling (AMSC) Training Resources
B. Pocket Screening and Brief Intervention for Alcohol Use Disorders
C. Application to be a Contracted Brief Behavioral Counseling Intervention/Referral to Treatment Provider
D. Review Documentation for Applicants to become a Contracted Behavioral Counseling Intervention/Referral to Treatment Provider

V. PURPOSE:
To establish procedures for identification, referral and coordination of care for Members requiring alcohol or substance use disorder treatment services.

VI. POLICY / PROCEDURE:
A. Covered Services:

1. Alcohol and Other Drug Treatment Services covered through the Counties:

   Except as noted in VI.A.2. below, alcohol and substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California’s (PHC’s) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of alcohol and substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating alcohol and substance use disorder not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.

2. Wellness and Recovery Benefit through PHC:

   Effective July 1, 2020, PHC members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
   a. Member has been determined eligible for full scope Medi-Cal
b. Member is not institutionalized

c. Member has a substance-related disorder per the current “Diagnostic and Statistical Manual of Mental disorders” (DSM) criteria

d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND

e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County

2.3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines) SUD services provided by PHC medical providers should be billed to PHC as any other encounter, using appropriate encounter and management CPT codes.

a. Medical Specialists who are buprenorphine prescribers (for Medication Assisted Treatment (MAT) of Opioid Use Disorder) may be credentialed by PHC (see policy MP CR 13B Buprenorphine Prescriber Credentialing), which makes them eligible to be noted as buprenorphine prescribers in the PHC provider directory. They may accept referrals for MAT from PHC primary care and be eligible for applicable pay for performance programs.

b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists (who are credentialed as buprenorphine prescribers by PHC) providing office visits for substance use disorder treatment may use the ICD 10 code F11.2x or F10.2x to avoid the requirement for a Referral Authorization normally required for assigned patients.

c. Adjunctive counseling for SUD by non-licensed providers is not covered by PHC, except as part of a cardiac rehabilitation program. (see policy MCUP3128 Cardiac Rehabilitation)

3.4. Alcohol Misuse Screening and Counseling (AMSC) services for alcohol misuse: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in Operational Instructional Letter 398-13 and All Plan Letter (APL) 18-014.

4.5. Screening for alcohol, tobacco, and other substance use is considered a part of the standard of care for primary care of adolescents (members between the ages of 12 and under the age of twenty-one), as noted in policy MCQG1015 (Pediatric Preventive Health Guidelines).

5.6. For adults, in addition to screening for alcohol misuse, primary care providers are expected to screen for tobacco use, alcohol use disorder, and other substance use, as part of routine adult preventive care, as noted in policy MCQG1005 (Adult Preventive Health Guidelines).

B. PHC Responsibility

1. Identification

a. PHC may identify a member through one of the following:
   1) Telephone inquiries from Member or Provider
   2) During Prior Authorization and/or Concurrent Review Processes
   3) Through care coordination programs activity
   4) Through call center activities performed by PHC’s delegated managed behavioral health organization

2. Referral

a. PHC, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the PHC website (see VI. C. 8. b. below for details). If a placement within the Member’s service area is not available, the member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from PHC is required for referral to outpatient substance use services. (Please note, when PHC’s Wellness & Recovery benefit is implemented, prior authorization will be required for placement in a
# Guideline/Procedure Number: MCUG3002 (previously UG100302)

## Lead Department: Health Services

### Guideline/Procedure Title: Acupuncture Services Guidelines

- **External Policy**
- **Internal Policy**

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

**Reviewing Entities:**
- **☒ IQI**
- **☐ P & T**
- **☒ QUAC**
- **☐ OPERATIONS**
- **☐ EXECUTIVE**
- **☐ COMPLIANCE**
- **☐ DEPARTMENT**

**Approving Entities:**
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- **☐ FINANCE**
- **☒ PAC**
- **☐ CEO**
- **☐ COO**
- **☐ CREDENTIALING**
- **☐ DEPT. DIRECTOR/OFFICER**

**Approval Signature:** Robert Moore, MD, MPH, MBA

**Approval Date:** 06/12/2019/06/10/2020

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**I. RELATED POLICIES:**

A. MCUP3124 - Referral to Specialists (RAF) Policy
B. MCUP3041 - TAR Review Process
C. MCUP3042 - Technology Assessment

**II. IMPACTED DEPTS:**

A. Health Services
B. Member Services
C. Claims

**III. DEFINITIONS:**

Medical necessity - Necessary health care services are those needed to protect life, to prevent significant illness or significant disability, or to alleviate pain.

**IV. ATTACHMENTS:**

A. N/A

**V. PURPOSE:**

This guideline describes the conditions under which acupuncture services are authorized and the procedure providers follow to obtain such authorization.

**VI. GUIDELINE / PROCEDURE:**

A. **Covered Services/ Benefit Limitations:**
   1. As per Medi-Cal guidelines, members are limited to 2 visits per month.
   2. Acupuncture services for members under age 21 are generally authorized to relieve certain painful conditions such as dysmenorrhea, low back pain, or chronic head pain.
   3. PHC finds insufficient published evidence of any benefits of acupuncture treatment in children under age 12. PHC considers acupuncture in children under age 12 to be experimental. See PHC policy MCUP3042 Technology Assessment for policies concerning investigational services and interventions.
3. Acupuncture services for members age 21 and over are limited to treatment of pain lasting 6 weeks or more of the following types: performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.
   a. Back pain
   b. Shoulder pain
   c. Osteoarthritis
   d. Migraine
   e. Chronic headaches

C. A physician, podiatrist or certified acupuncturist must be qualified to render acupuncture services. Services are not reimbursed when billed as part of an emergency or inpatient service. Services are not reimbursed if rendered by a physician assistant, nurse practitioner, or certified nurse midwife unless the rendering provider is also a certified acupuncturist. Non-acupuncture services rendered by a certified acupuncturist will not be reimbursed.

D. The Primary Care Provider (PCP) must refer the member to the acupuncturist for an initial evaluation only, using a Referral Authorization Form (RAF). Special case managed members can be referred for one consultation visit through a physician order. After the acupuncture provider has completed the initial evaluation, a treatment plan is developed.

E. A Treatment Authorization Request (TAR) must be submitted to PHC by the acupuncturist who indicates the services requested. The request must include the description of medical need and a copy of the treatment plan. The treatment plan must include clinical justification for the proposed treatment and the following information:
   - Medical diagnosis necessitating the service with a summary of the member’s medical condition
   - Dates and length of treatment
   - Therapeutic goals of treatment
   - Dates of planned progress review

F. The Utilization Management (UM) staff reviews the TAR for medical necessity and will consult with the referring physician or acupuncturist as indicated.

G. No Treatment Authorization Request (TAR) is required unless services exceed two visits per month.

H. The UM nurse may approve the initial TAR request for up to 12 visits at any frequency for up to 6 months, provided medical necessity has been demonstrated. No more than 12 visits every 6 months will be approved.

I. The maximum length of acupuncture services covered in a 24 hour period is 45 minutes.

J. Acupuncture CPT codes 97810 through 97814 are covered under this policy. In addition, initial assessments may be billed using CPT code 99202.

VII. REFERENCES:
Medi-Cal Guidelines – Acupuncture (acu)

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

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

X. REVISION DATES:
04/28/00; 09/19/01; 10/16/02; 09/15/04; 09/21/05; 10/17/07; 10/15/08; 01/21/09; 04/21/10; 01/18/12;
10/15/14; 02/18/15; 05/20/15; 08/19/15; 05/18/16; 11/16/16; 11/15/17; *08/08/18; 06/12/19, 06/10/20
GUIDELINE / PROCEDURE

I. RELATED POLICIES:
   A. MCUP3124 - Referral to Specialists (RAF) Policy
   B. MCUP3041 - TAR Review Process
   C. MCUP3042 - Technology Assessment

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

III. DEFINITIONS:
   Medical necessity - Necessary health care services are those needed to protect life, to prevent significant
ilness or significant disability, or to alleviate pain.

IV. ATTACHMENTS:
   A. N/A

V. PURPOSE:
   This guideline describes the conditions under which acupuncture services are authorized and the procedure
   providers follow to obtain such authorization.

VI. GUIDELINE / PROCEDURE:
   A. Acupuncture services are a Partnership HealthPlan of California (PHC) benefit for members who meet
   the Medi-Cal medical necessity guidelines.
   B. Benefit Limitations:
      1. As per Medi-Cal guidelines, members are limited to 2 visits per month.
      2. PHC finds insufficient published evidence of any benefits of acupuncture treatment in children
         under age 12. PHC considers acupuncture in children under age 12 to be experimental. See PHC
         policy MCUP3042 Technology Assessment for policies concerning investigational services and
         interventions.
      3. Acupuncture services for members are limited to treatment performed to prevent, modify or alleviate
         the perception of severe, persistent chronic pain resulting from a generally recognized medical
         condition.
   C. A physician, podiatrist or certified acupuncturist must be qualified to render acupuncture services.
      Services are not reimbursed when billed as part of an emergency or inpatient service. Services are not
reimbursed if rendered by a physician assistant, nurse practitioner, or certified nurse midwife unless the rendering provider is also a certified acupuncturist. Non-acupuncture services rendered by a certified acupuncturist will not be reimbursed.

D. The Primary Care Provider (PCP) must refer the member to the acupuncturist for an initial evaluation only, using a Referral Authorization Form (RAF). Special case managed members can be referred for one consultation visit through a physician order.

E. No Treatment Authorization Request (TAR) is required unless services exceed two visits per month.

F. The maximum length of acupuncture services covered in a 24 hour period is 45 minutes.

G. Acupuncture CPT codes 97810 through 97814 are covered under this policy.

VII. REFERENCES:
Medi-Cal Guidelines – Acupuncture (acu)

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

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

X. REVISION DATES:
04/28/00; 09/19/01; 10/16/02; 09/15/04; 09/21/05; 10/17/07; 10/15/08; 01/21/09; 04/21/10; 01/18/12; 10/15/14; 02/18/15; 05/20/15; 08/19/15; 05/18/16; 11/16/16; 11/15/17; *08/08/18; 06/12/19; 06/10/20

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

PREVIOUSLY APPLIED TO: N/A

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.

PHC’s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.
4) A "reasonable expectation" referenced above shall be based upon evidence based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.

5) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

f. The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:

1) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.

2) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.

3) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.

4) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.

5) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.

6) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family.

7) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.

B. Submission of Treatment Authorization Request (TAR)

1. When the initial request for authorization is approved for medical necessity, the TAR will state the number of treatment visits approved. If therapy is required beyond the visits initially approved, a new TAR must be submitted.
   a. Per Medi-Cal guidelines, occupational and speech therapy services rendered in an outpatient setting are limited to a maximum of two services per month; the initial and six-month evaluations are not subject to the limit.

2. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient’s referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to PHC.

3. The following services are generally not considered “medically” necessary or are not covered:
   a. Recreational therapy
   b. Activities that provide diversion or general motivation
   c. Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
   d. Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
   e. Maintenance physical or occupational therapy to preserve the patient's present level of function
and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/observation of activities of daily living, and supervision of independent transfer activities. Note: For members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

4. When a member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient’s referring physician, continued therapy will not be approved.

C. Speech Therapy Services for Members age 21 Years or Over

0. In July 2009, the State of California Medi-Cal program eliminated the speech therapy benefit for members age 21 or over unless the member met certain exception requirements. The benefit elimination does not apply to the following:

0. Members receiving services through the Genetically Handicapped Persons Program (GHPP)
0. Members receiving benefits through the Medicare Part B program
0. Members receiving care through California Children’s Services
0. Members residing in Skilled Nursing Facilities
0. Partnership HealthPlan of California (PHC) will continue to provide speech therapy benefits for those adult members with a diagnosis of a cerebral vascular accident (stroke) or head or neck cancer. These services require preauthorization by PHC and a TAR, along with documentation to support the medical necessity, must be submitted to PHC for a determination prior to outpatient services. The member and services must meet the following criteria:

--- Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
--- Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.
--- Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the member’s communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and a plan physician.
--- A “reasonable expectation” referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient’s mental alertness to participate in and benefit from the therapy process.
--- An episode of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

D. Physical, Occupational and Speech Therapy for Members Under 21 Years of Age

1. General Guidelines
   a. The medical condition of hearing loss is covered for hearing tests; evaluations by audiologists; medical evaluations by head and neck surgeons and physicians in other clinical specialties, however speech and language therapy for hearing impaired children who have hearing aids or need to use sign language but do not have physical impairment of the articulators is the responsibility of California Children’s Services (CCS) and the member should be referred to...
California Children’s Services in the county of residence or the state where applicable, to determine program eligibility. Once CCS program eligibility is established, PHC is responsible for the provision of all medically necessary covered services under the Whole Child Model including case management and authorization of services. See policy MCCP2024 - Whole Child Model for California Children’s Services (CCS).

b. Additional Speech therapy benefits continue to be available for eligible members under the age of 21. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21 the definition is expanded to include the definition in II.E. above. These Members may also be eligible to receive PT, OT and ST under a supplemental benefit program called “Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits program. See VI.D. below. To qualify for benefits under the EPSDT Supplemental Benefit program, the member must be eligible for the full scope of benefits under Medi-Cal, meet medical necessity criteria for the program, and the provider must follow procedures as outlined in this policy.

c. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.

d. A member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under PHC. If a member is receiving medically necessary services through the Local Educational Agency (LEA), PHC will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, PHC will approve the additional two visits per week if criteria is met.

P.D. Requests for PT, OT and ST under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

1. EPSDT diagnosis and treatment services are covered through PHC, subject to the standards set forth in Section 1905(r) of the Social Security Act (SSA) and Title 42 of the United States Code (USC) Section 1396d(r)(5), provisions of Title 22, CCR, and Section 51340. Members are only eligible for the EPSDT benefit if they are under 21 years of age and qualify for the full scope of Medi-Cal benefits.

2. EPSDT supplemental services are covered subject to the provisions of Title 22, Section 51340 which states as follows:

b.a Requests for review under this program must state explicitly that the request is for EPSDT supplemental services and must be accompanied by the following information:

1) The principal diagnosis and significant associated diagnoses
2) Prognosis
3) Date of onset of the illness or condition, and etiology if known
4) Clinical significance or functional impairment caused by the illness or condition
5) Specific types of services to be rendered by each discipline with physician’s prescription when applicable
6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals
7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
8) Any other documentation available which may assist PHC in making the required determinations

e.b. The service to be provided must meet the following:

1) Are necessary to correct or ameliorate defects in physical and mental illnesses and conditions discovered by the screening services under EPSDT
2) The supplies, items or equipment to be provided are medical in nature
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3) The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of service

4) The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental

5) The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary’s appearance. The correction of a severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary’s appearance.

6) Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well-designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.

7) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary

8) The predicted beneficial outcome of the services outweighs potential harmful effects.

9) The available scientific evidence demonstrates that the services improve overall health outcomes as much as, or more than, established alternatives.

10) Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

2. PHC will review the documents submitted to confirm that the requirements of Title 22, Section 51340(e) and 51340.1 have been met.

VII. REFERENCES:

A. Title 22 California Code of Regulation (CCR) Sections 51340(e) - 51340.1
B. Title 42 United States Code (USC) Sections 1396d(r)(5)
C. Social Security Act Section 1905(r)
D. Department of Health Care Services All Plan Letter (APL) 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (08/14/2019)

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; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20

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

PREVIOUSLY APPLIED TO: N/A
I. RELATED POLICIES:
A. MCCP2022 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
B. MCUP3041 - TAR Review Process
C. MCCP2024 - Whole Child Model for California Children’s Services (CCS)

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

III. DEFINITIONS:
A. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
B. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
C. Speech Therapy (ST) The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.
D. Medical Necessity For members age 21 years and over as defined per Partnership HealthPlan of California (PHC) contract with the Department of Health Care Services (DHCS). Medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
E. Medical Necessity for members under 21 years of age: In addition to the definition noted in III. D, medical necessity for members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
F. Physical and Occupational therapy services are designed to:
   1. Assess the existence or extent of a medical condition;
   2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
   3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
   4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living,
due to a medical condition, surgery or procedure.

5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To define the process by which requests for treatment authorization for physical, occupational and speech therapies are made.

VI. POLICY / PROCEDURE:
A. General Guidelines for Submission of Treatment Authorization Requests (TARs) for PT, OT and ST.
1. The following general guidelines apply to members age 21 years and over or those under age 21 who are not requesting services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits. If services are being requested under the EPSDT supplemental benefits, please see section VI. E. for that process.
   a. PHC members can be referred by a licensed clinician for one consultation visit through a physician order. No TAR or Referral Authorization Form (RAF) is required for the initial evaluation.
   b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
      1) Medical diagnosis necessitating the service with a summary of medical condition
      2) Related medical conditions
      3) Functional limitations
      4) Dates and length of treatment
      5) Therapeutic goals of treatment and current functional status of the patient with respect to these goals
      6) Dates of planned progress review
      7) Specific services to be rendered (e.g. evaluation, treatment, modalities)
   c. PHC authorizes ancillary services on a case by case basis, provided that medical necessity has been demonstrated in the submitted documentation.
   d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of PHC’s reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.
   e. Occupational and physical therapy may be considered medically necessary when:
      1) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
      2) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
      3) The services are used to assess the existence or extent of impairment due to a medical condition.
4) A "reasonable expectation" referenced above shall be based upon evidence based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.

5) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

f. The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:

1) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.

2) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.

3) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.

4) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.

5) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.

6) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family.

7) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.

B. Submission of Treatment Authorization Request (TAR)

1. When the initial request for authorization is approved for medical necessity, the TAR will state the number of treatment visits approved. If therapy is required beyond the visits initially approved, a new TAR must be submitted.

   a. Per Medi-Cal guidelines, occupational and speech therapy services rendered in an outpatient setting are limited to a maximum of two services per month; the initial and six-month evaluations are not subject to the limit.

2. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient’s condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient’s referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to PHC.

3. The following services are generally not considered “medically” necessary or are not covered:

   a. Recreational therapy

   b. Activities that provide diversion or general motivation

   c. Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking

   d. Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health

   e. Maintenance physical or occupational therapy to preserve the patient's present level of function
and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/observation of activities of daily living, and supervision of independent transfer activities. Note: For members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

4. When a member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient’s referring physician, continued therapy will not be approved.

C. Physical, Occupational and Speech Therapy for Members Under 21 Years of Age

1. General Guidelines
   a. The medical condition of hearing loss is covered for hearing tests; evaluations by audiologists; medical evaluations by head and neck surgeons and physicians in other clinical specialties, however speech and language therapy for hearing impaired children who have hearing aids or need to use sign language but do not have physical impairment of the articulators is the responsibility of California Children’s Services (CCS) and the member should be referred to California Children’s Services in the county of residence or the state where applicable, to determine program eligibility. Once CCS program eligibility is established, PHC is responsible for the provision of all medically necessary covered services under the Whole Child Model including case management and authorization of services. See policy MCCP2024 - Whole Child Model for California Children’s Services (CCS).

   b. Additional therapy benefits are available for eligible members under the age of 21. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21 the definition is expanded to include the definition in III.E. above. These Members may also be eligible to receive PT, OT and ST under a supplemental benefit program called “Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental benefits program. See VI. D. below.

   c. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.

   d. A member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under PHC. If a member is receiving medically necessary services through the Local Educational Agency (LEA), PHC will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, PHC will approve the additional two visits per week if criteria is met.

D. Requests for PT, OT and ST under Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

1. EPSDT diagnosis and treatment services are covered through PHC, subject to the standards set forth in Section 1905(r) of the Social Security Act (SSA) and Title 42 of the United States Code (USC) Section 1396d(r)(5). Members are only eligible for the EPSDT benefit if they are under 21 years of age and qualify for the full scope of Medi-Cal benefits.

   a. Requests for review under this program must state explicitly that the request is for EPSDT supplemental services and must be accompanied by the following information:

      1) The principal diagnosis and significant associated diagnoses
      2) Prognosis
3) Date of onset of the illness or condition, and etiology if known
4) Clinical significance or functional impairment caused by the illness or condition
5) Specific types of services to be rendered by each discipline with physician’s prescription when applicable
6) The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals
7) The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
8) Any other documentation available which may assist PHC in making the required determinations

b. The service to be provided must meet the following:
1) Are necessary to correct or ameliorate defects in physical and mental illnesses and conditions discovered by the screening services under EPSDT
2) The supplies, items or equipment to be provided are medical in nature
3) The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of service
4) The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental
5) The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the beneficiary’s appearance. The correction of a severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the beneficiary’s appearance.
6) Are generally accepted by the professional medical and dental community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence, consisting of well-designed and well conducted investigations published in peer-review journals, and, when available, opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can correct or ameliorate the conditions for which they are prescribed.
7) Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary
8) The predicted beneficial outcome of the services outweighs potential harmful effects.
9) The available scientific evidence demonstrates that the services improve overall health outcomes as much as, or more than, established alternatives.
10) Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

2. PHC will review the documents submitted to confirm that the requirements of Title 22, Section 51340(e) have been met.

VII. REFERENCES:
A. Title 22 California Code of Regulation (CCR) Section 51340(e)
B. Title 42 United States Code (USC) Sections 1396d(r)(5)
C. Social Security Act Section 1905(r)
D. Department of Health Care Services All Plan Letter (APL) 19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (08/14/2019)

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; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20

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

PREVIOUSLY APPLIED TO: N/A

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

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.

PHC’s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.
PHC TAR REQUIREMENTS

(TAR to be submitted by the provider performing the service) Revised 05/13/2020/06/10/2020

replacement

f. L8627 Cochlear implant; external speech processor, component, replacement

g. L8628 Cochlear implant; external controller component, replacement

h. L8629 Transmitting coil and cable, integrated, for use with cochlear implant device, replacement

6. Oxygen and related supplies (see policy MCUP3013 DME Authorization)

7. Diabetic Supplies are to be provided by Pharmacies ONLY

8. Nebulizers – When the billed price including tax is $100 or more (see policy MPUG3031 Nebulizer Guidelines)

9. Medical Supplies – If dispensed by PHARMACY, please refer to formulary

10. DME – (see policy MCUP3013 DME Authorization) If dispensed by PHARMACY, please refer to formulary

a. Repairs or maintenance over $250.00 / item (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)

b. No TAR is required for CPAP supplies for a CPAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).

c. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as “Hospital Beds” or “Bathroom Equipment,” are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)

d. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)

e. Purchase of any wheelchairs for Medi-Medi members

f. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. (see policy MCUP3013 DME Authorization)

11. Incontinence Supplies (see policy MCUG3022 Incontinence Guidelines)

a. Incontinence supplies if monthly cumulative cost for all related supplies exceeds $125.00/165.00

b. Washes and creams for members with incontinence do not require a TAR unless claim quantity exceeds the frequency limits of 2,880 ml in an 81-day period for A4335 and 1,620 gm/ml in an 81-day period for A6250. If a TAR is required, it will only be authorized if the physician justifies medical necessity.

12. Nutritional Supplements (Submit TAR to Pharmacy) (see policy MCUP3052 Medical Nutrition Services)

13. ANY UNLISTED OR MISCELLANEOUS CODE
# PARTNERSHIP HEALTH PLAN OF CALIFORNIA
## POLICY/PROCEDURE

<table>
<thead>
<tr>
<th>Policy/Procedure Number: MPUP3048 (previously MCUP3048)</th>
<th>Lead Department: Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy/Procedure Title: Dental Services (including Dental Anesthesia)</td>
<td>☒ External Policy ☐ Internal Policy</td>
</tr>
<tr>
<td>Original Date: 9/20/2000</td>
<td>Next Review Date: 05/08/2020/06/10/2021</td>
</tr>
<tr>
<td>Applies to: ☒ Medi-Cal ☐ Employees</td>
<td>Last Review Date: 05/08/2019/06/10/2020</td>
</tr>
<tr>
<td>Reviewing Entities: ☒ IQI ☐ P &amp; T ☒ QUAC</td>
<td></td>
</tr>
<tr>
<td>☐ OPERATIONS ☐ EXECUTIVE ☐ COMPLIANCE ☐ DEPARTMENT</td>
<td></td>
</tr>
<tr>
<td>Approving Entities: ☐ BOARD ☐ COMPLIANCE ☐ FINANCE ☒ PAC</td>
<td></td>
</tr>
<tr>
<td>☐ CEO ☐ COO ☐ CREDENTIALING ☐ DEPT. DIRECTOR/OFFICER</td>
<td></td>
</tr>
<tr>
<td>Approval Signature: Robert Moore, MD, MPH, MBA</td>
<td>Approval Date: 05/08/2019/06/10/2020</td>
</tr>
</tbody>
</table>

I. RELATED POLICIES:
MCUP3041 - TAR Review Process

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

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To define the coverage under which Partnership HealthPlan of California (PHC) authorizes and reimburses for dental anesthesia and dental services for Medi-Cal.

VI. POLICY / PROCEDURE:
A. PHC provides benefit coverage for medical services related to dental services including medications, laboratory services, pre-admission physical examinations required for admission to an outpatient/inpatient service, facility fees, and dental anesthesia.
B. PHC provides benefit coverage for the topical application of fluoride for children younger than age six (6), up to three (3) times in a 12 month period.
C. PHC is responsible for services related to dental procedures that require general anesthesia and are provided by individuals other than dental personnel, including any associated prescription drugs, laboratory services, physical examinations required for admission to a medical facility, outpatient surgical center services and inpatient hospital services required for a dental procedure.
D. Dental anesthesia services for children under age 12 require prior authorization from PHC. Treatment Authorization Requests (TARS) must be submitted to PHC electronically through PHC’s online services system or in writing via facsimile at (707) 863-4118.
E. A TAR is not required prior to delivering intravenous sedation or general anesthesia as part of an outpatient dental procedure in a state certified skilled nursing facility (SNF) or any category of intermediate care facility (ICF) for the developmentally disabled per California Department of Health Care Services (DHCS) All Plan Letter 15-012 Revised Dental Services - Intravenous Sedation and General Anesthesia Coverage (08/21/2015).
b. Actual decisions for determining medical necessity for dental anesthesia in individual cases take into account the needs for individual patients and the characteristics of the local delivery system.

G. Providers are required to adhere to all regulatory requirements (Federal, State, Licensing Board, etc) for:
   1. Preoperative and perioperative care
   2. Monitoring and equipment requirements
   3. Emergencies and transfers
   4. Monitoring guidelines

H. Criteria
   1. Members may receive treatment for a dental procedure provided under general anesthesia by a physician anesthesiologist in the settings listed below only if PHC determines the setting is appropriate and according to criteria:
      a. Hospital
      b. Accredited ambulatory surgical center (stand-alone facility)
      c. Dental Office; and
      d. A Community Clinic that:
         1) Accepts Medi-Cal dental program
         2) Is a non-profit organization; and
         3) Is recognized by the Department of Health Care Services as a licensed community clinic or a Federally Qualified Health Center (FQHC) or FQHC look-alike.
   2. If sedation is indicated then the least profound procedure should be attempted first. The procedures are ranked from low to high profundity in the following order:
      a. Conscious Sedation via inhalation or oral anesthetics
      b. Intravenous (IV) sedation
      c. General Anesthesia
   3. If the provider documents both a. and b. below, then the member shall be considered for IV sedation general anesthesia:
      a. Failure of Behavioral Modification AND
      b. Failure of conscious sedation, either inhalation or oral
   4. If the provider documents any one of the following then the member shall be considered for IV sedation or general anesthesia:
      a. Failure of effective communication techniques and the inability for immobilization (member may be dangerous to self or staff)
      b. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation
      c. Patient has acute situational anxiety due to immature cognitive functioning
      d. Patient is uncooperative due to certain physical or mental compromising outcomes.

5. Appropriate review of treatment authorization requests for conducting dental procedures under intravenous sedation or general anesthesia requires the member’s medical history, physical status, and indications for anesthetic management. Documentation of a recent (preferably no more than 1 month prior to procedure) pre-operative exam completed by the member’s primary care physician should be submitted with the TAR.

5. Members with certain medical conditions, such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias, and significant bleeding disorders should be treated in a hospital setting or licensed facility capable of responding to a serious medical crisis.

6. The anesthesiologist performing anesthesia or sedation will be responsible for conducting a pre-operative history and focused physical to assess any interaction risk and plan accordingly per the
Dental Services (including Dental Anesthesia)

☒ External Policy
☐ Internal Policy

Original Date: 9/20/2000
Next Review Date: 05/08/2020/06/10/2021
Last Review Date: 05/08/2019/06/10/2020

Applies to: ☒ Medi-Cal
☐ Employees


VII. REFERENCES:
B. Title 10 California Code of Regulations (CCR) Chapter 5.8 Article 3 Sections 2699.6700-6707, 6709-6711
F. Title 22 California Code of Regulations (CCR) Sections 51307 (a) (b) (c) (f) (g) and 51056 (c)

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

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

X. REVISION DATES:
Medi-Cal
10/17/01; 08/20/03; 10/20/04; 10/19/05; 10/18/06; 02/20/08; 04/21/10; 08/18/10; 10/20/10; 03/21/12; 06/19/13; 08/19/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 05/13/20

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

PREVIOUSLY APPLIED TO:
Healthy Kids – KKUM103, MPUP3048 (Healthy Kids program ended 12/01/2016)
02/20/08, 04/21/10; 08/18/10; 10/20/10; 03/21/12; 06/19/13; 08/19/15; 04/20/16 to 12/01/2016

Partnership Advantage:
MPUP3048 - 02/20/2008 to 01/01/2015

Healthy Families:
MPUP3048 - 10/20/2010 to 03/01/2013
Quality Utilization Advisory (QUAC) Committee

Grievance & Appeals

May 20, 2020

La Rae Banks, MBA-HM
Director of Grievance & Appeals
DISCUSSION TOPICS

Reporting Period: 1Q20

STATISTICS
How many members were dissatisfied?

DRIVERS
Why were members dissatisfied?

IMPROVEMENTS
What’s new internally?

QUALITY REVIEW
Did we meet our goals?

Data can fluctuate depending on the date accessed, source, and method. Therefore, statistics are presented with a 95% confidence level. Also, statistics exclude G&A trends from our delegate partners such as Kaiser Permanente and Beacon.
CCPM\textsuperscript{1}: All Case Types
2020 vs. 2019

- Anticipating Trend Increase
  - Increasing Unemployment Rate
  - 7/1/20 New W&R Benefit
  - 1/1/21 Rx Carve Out

\textsuperscript{1}CCPM refers to closed cases per month

130 of 279

Eureka | Fairfield | Redding | Santa Rosa
1Q20 Highlights

- 7 Expedited cases
- 0 overturned State Hearings
- 13 Received COVID-19 cases
- 32 CCS cases
- MTM concerns represented 27%

**STATISTICS**

2020 CCPQ\(^1\) by Quarter

| PHC Mship\(^2\): 533,566 |
| PHC- KP Mship\(^2\): 471,211 |
| # p/1,000 MBRs: 0.805 |

**1Q20 Highlights**

- 7 Expedited cases
- 0 overturned State Hearings
- 13 Received COVID-19 cases
- 32 CCS cases
- MTM concerns represented 27%

**PHC Mship\(^2\): 533,566**

| PHC- KP Mship\(^2\): 471,211 |
| # p/1,000 MBRs: 0.805 |

<table>
<thead>
<tr>
<th>Quarter</th>
<th>1Q20</th>
<th>2Q20</th>
<th>3Q20</th>
<th>4Q20</th>
</tr>
</thead>
<tbody>
<tr>
<td>3% State Hearings</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21% Appeals</td>
<td></td>
<td>234</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19% Exempts</td>
<td></td>
<td></td>
<td>211</td>
<td></td>
</tr>
<tr>
<td>1% 2nd Grievances</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>57% Grievances</td>
<td></td>
<td></td>
<td>654</td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>1,137</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: \(^1\)Refers to Closed Cases per Quarter. \(^2\)Membership calculation are based on PHC’s total average membership during the respective quarter(s) minus members who are assigned to Kaiser Permanente. The data source for membership was [Tableau system](#), retrieved on 4/28/2020.
STATISTICS
1Q20 MTM Trends

TTL CCPM\(^1\) vs. MTM CCPM\(^1\)

1Q20 – Avg 27%

<table>
<thead>
<tr>
<th>Month</th>
<th>TTL Cases</th>
<th>MTM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>357</td>
<td>106</td>
</tr>
<tr>
<td>Feb</td>
<td>380</td>
<td>91</td>
</tr>
<tr>
<td>Mar</td>
<td>389</td>
<td>107</td>
</tr>
</tbody>
</table>

\(^1\) CCPM refers to closed cases per month
\(^2\) % value represents the percentage of Medical Transportation Management (MTM) cases compared to total cases in the stated month
STATISTICS
1Q20 NMT\(^1\) Trends

1 NMT refers to Non-Medical Transportation
Note: Actual scheduled MTM rides maybe slightly higher

<table>
<thead>
<tr>
<th></th>
<th>1Q20</th>
<th>2Q20</th>
<th>3Q20</th>
<th>4Q20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trip Legs</td>
<td>111,129</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Unique Mbrs</td>
<td></td>
<td>10,077</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTM Cases</td>
<td>304</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Eureka | Fairfield | Redding | Santa Rosa
Benefit Disputes
- Medication
- MTM Gas Mileage Reimbursement

Experience & Service
- MTM Missed Rides
- Treatment Plan Disputes with Provider
- Long Wait Times with Provider Offices
Benefit Disputes

Members contest Rx denials more frequently than any other benefit

Desire use of brand name, non-formulary, plan exclusions, & excessive day supply - 28% are related to Opioids

29% of all Appeals overturned - medical justification received

Solutions

Clearer denial letters highlight denial reason(s) and criteria(s) for approval

Provider Education – submit document
• Covers Non-Medical Transportation (NMT) to/from covered Medi-Cal appointment
• Lowest cost option applies, as medically appropriate
• Public transportation, taxi, Lyft, mileage reimbursement to family & friends
• No restriction on number of rides
• Member cannot own personal vehicle
• Benefit managed by Medical Transportation Management (MTM)
Benefit Disputes

MTM Gas Mileage Reimbursement (GMR)

- GMR claim missing, invalid driver’s license, car registration, car insurance
- Denied GMR claim for non-appearance to appointment
- Denied GMR claim for late filing
- Incorrectly denied GMR claims

Experience & Service

Missed Failed Rides

- Taxi too early, late, never showed
- Lyft never showed
Missed/failed Rides | Taxi Co Preference
MTM exploring solutions in high volume missed/failed ride cities
✓ Anderson ✓ Vallejo
✓ Fairfield ✓ W Sacramento
✓ Redding ✓ Sebastopol

Mileage Reimbursement | Denied Trip | Mode of Transportation
MTM to mail new Notification of Action (NOA) Letters when...
✓ A trip is denied due to benefit exclusions
✓ A request for taxi instead of bus is denied
✓ Gas Mileage Reimbursement is denied
✓ Gas Mileage Reimbursement missing credentials (e.g., driver’s license)

Supports All Denials | MTM Service
MTM unable to produce NOAs on multiple G&A cases. Identified MTM not consistently generating NOAs when required. MTM to correct in 1Q20

Provider Education
Promoting GMR, especially when taxi or Lyft service is unfavorable. Suggestions how they can approve GMR during the office visit. Key highlights of benefits messaged in February 2020 Medical Director’s Newsletter

G&A Investigations
Advising grieving members of the GMR benefit. It’s an alternative approved NMT benefit available to help member travel to Medi-Cal covered appointments
Experience & Service

Member disagreement with Provider’s plan for their health

• #1 reported concern regarding services by providers
• Member doesn’t agree with medication, testing, diagnosis, discharge plan, or feels neglected
• Often coupled with poor communication and attitude
• Frequently coupled with an Appeal

Solutions

Clearer denial Letters highlight denial reason(s) and criteria(s) for approval

Leveraging Care Coordination to assist member

Provider Education
Experience & Service

Long Wait Times with Provider Offices

- Appointment availability is limited
- Delay in establishing care as a new patient
- Desire for immediate appointments after urgent or emergency care
- Many COVID-19 cases also involve delayed appointments or services

Solutions

Educating members about provider-reported solutions

Educating members about PHC best practices for scheduling doctor appointments

Leveraging Care Coordination for immediate needs
How does COVID-19 impact members?

5 Confirmed Cases
- 1 Appeal
- 2 Exempts
- 3 Grievances

Members reporting issues with access
- Barriers to COVID-19 Testing
- Delayed or rescheduled appointments or services
- Access to specialty provider
32 Total Cases

**Benefit Disputes**
Durable Medical Equipment (DME)
MTM GMR issues

**Experience & Service**
Transportation - mostly GMR issues
Treatment Plan Disputes
IMPROVEMENTS
IMPROVEMENTS
NCQA Preparations

**Casework – “Must Pass”**

- Classifying Appeals *pre-service* vs. *post-service*
- Ensuring Appeal MD Reviewer is *not a subordinate* of original MD Reviewer
- Conducting full investigation of Appeal, including *historical research from TAR/RAF denial to receipt of current Appeal*
- Siting *formal sources* on member Appeal decision letters: P&P, PHC Handbook, Formulary, etc.
- Identifying *MD Reviewer’s title, credential, specialty* on member Appeal letters
- Offering opportunity for *member to submit evidence* for Appeals
- Using *layman’s language* to explain Appeal decisions
- Ensuring member Letters are *free of* abbreviations, acronyms or health care procedure codes that a layperson would not understand (when Appeal not reviewed by MD Reviewer)
- Member letters include *the Reviewers title* for benefit denials when not reviewed by MD Reviewer
- Offering free copies of all *sources and documents* related to Appeal decision, when member requested
- G&A to identify *practitioner-specific cases* & categorize accordingly

**Policy & Procedures**

- Revisions to P&P CGA-024
- Update all G&A Desktop Procedures
- Create new Desktop Procedures to comply with *System Controls*

**Reporting**

- G&A required to *report RI trends* influencing *CAHPS Survey* & recommend improvement opportunities
- G&A required to *report RI trends* related to members’ Utilization Management & recommend improvement opportunities
- G&A required to *report trends on member-reported practitioner-specific concerns*
QUALITY REVIEW
QUALITY REVIEW
DHCS Compliance

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>STANDARD</th>
<th># COMPLETED</th>
<th># LATE</th>
<th>PERFORMANCE</th>
<th>MET</th>
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<tr>
<td>Closed TAT(^3)-Standard Cases(^1)</td>
<td>(\leq 30) days</td>
<td>1055</td>
<td>1</td>
<td>99.91%</td>
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<tr>
<td>Closed TAT(^3)-Expedited Cases(^2)</td>
<td>(\leq 72) hrs</td>
<td>7</td>
<td>0</td>
<td>100%</td>
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<tr>
<td>Closed TAT(^3)-Extension Cases(^2)</td>
<td>(\leq 44) days</td>
<td>42</td>
<td>0</td>
<td>100%</td>
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<tr>
<td>Mail Acknowledgement Letter(^2)</td>
<td>(\leq 5) days</td>
<td>1004</td>
<td>8</td>
<td>99.5%</td>
<td></td>
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</tbody>
</table>

**Great Performance!**

PHC established very high standards in order to meet the expectation of our members. Our goal is not to exceed 3\(^+\) late Closed TAT cases in any given quarter, regardless of the number of cases received. PHC met its performance goals for 1Q20.

There is an opportunity to improve timeliness on mailing acknowledgement letters. New workflows were implemented in 1Q20 to improve this metric. Monitoring is in process.

Notes: \(^1\) Applies to Grievance, Appeals, Exempt cases. \(^2\) Applies to Appeals and Grievance cases. \(^3\) TAT refers to Turnaround Times

Eureka | Fairfield | Redding | Santa Rosa
Inter Rater-Reliability (IRR)
Internal audit methodology to assess clinical accuracy of Grievance Clinical Nurses

- Sample methodology revised to assess clinical accuracy of completed cases that were **not** previously reviewed by a Physician Reviewer
- Provides clinical oversight on cases at higher risk for errors
- Assessment completed by the Chief Medical Officer (CMO)

### 1Q20 Results

Reviewed: 24 Cases
- 20 Grievances & 4 Second Level Grievances
- Variety of Cases
  - 10 Discrimination Cases
  - 1 Extension Case
  - 2 PQI

---

100% Pass
- Accurate clinical assessments
- Accurate solution paths

### LESSONS LEARNED

**PCP Disenrollment**
- Evaluate PHC’s policy for allowing members to reselect PCP after a period of disenrollment

**Case Categorizations**
- New process pending DHCS re-categorization project

**Discrimination**
- Stronger workflow for improved investigations
- Reevaluation of Section 1557 operationalization
- System changes to capture outcomes
- New Discrimination Letters
Questions
REFERENCES
Note: Cases are reported in multiple reporting categories. Therefore, the total number of report trends will not equal the actual number of total closed cases.
REFERENCE

2020 Trending RIs by Quarter for All Case Types

1Q20

2Q20

3Q20

4Q20

0 100 200 300 400

Claim

Discrimination

Referral

Service

TAR

Third Party

Transportation

Eligibility

0 0.2 0.4 0.6 0.8 1 1.2

Claim

Discrimination

Referral

Service

TAR

Third Party

Transportation

Eligibility

0 0.2 0.4 0.6 0.8 1 1.2

Claim

Discrimination

Referral

Service

TAR

Third Party

Transportation

Eligibility

0 0.2 0.4 0.6 0.8 1 1.2

Claim

Discrimination

Referral

Service

TAR

Third Party

Transportation

Eligibility

Eureka | Fairfield | Redding | Santa Rosa
REFERENCE
Top Issues within Trending RIs for 1Q20

**Service**

- Provider's Serv: 273
- Sched Appt: 80
- PHC Serv: 43
- PCP Enrollment: 26

**Transportation**

- Missed Ride: 57
- Mileage Reimb: 54
- MTM Serv: 31
- Denied Trip: 20
- Scheduling Issue: 23
- Taxi Co Preference: 17
- Mode of Transporation: 9

**TAR**

- Pain Meds: 37
- Durable Med Equipment: 15
- Diagnostic Tests: 13
- Member dislikes: 13
- Delay/Deny PRV: 10
- Delay/Deny Pharmacy: 5

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Eureka | Fairfield | Redding | Santa Rosa
**REFERENCE**

**1Q20 State Hearings**

<table>
<thead>
<tr>
<th>Cases Reviewed by Judge</th>
<th>Total</th>
<th>Withdrawn</th>
<th>Dismissed</th>
<th>Redirect</th>
<th>Upheld</th>
<th>Stipulated</th>
<th>Overturned</th>
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<tbody>
<tr>
<td># Cases</td>
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<td>13</td>
<td>12</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>% Cases</td>
<td>100%</td>
<td>33%</td>
<td>44%</td>
<td>8%</td>
<td>8%</td>
<td>6%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Trending Reasons for State Hearing Cases**

- **All Cases**
  - TAR-DME: 8
  - Claim-in PRV: 7
  - TAR-RX: 6
  - TAR-ANCILLARY: 3
  - TAR-OTHER: 3
  - SERVICE-PHC: 3
  - TAR-DIAGNOSTIC: 1
  - MTM-GMR: 1
  - DISCRIMINATION: 1
  - SERVICE-PRV: 1
  - KAISER: 1

- **Upheld, Stipulated, Overturned**
  - TAR-DME: 3
  - RAF-OON: 2
  - TAR-ANCILLARY: 1
  - TAR-MEDICATION: 1
  - SERVICE-PHC: 1

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Eureka | Fairfield | Redding | Santa Rosa
## 1Q20 Appeal Cases

### NCQA Category

<table>
<thead>
<tr>
<th>NCQA Category</th>
<th>1Q20 Appeals</th>
<th>1Q20 Case per 1,000 Members</th>
<th>2Q20 Appeals</th>
<th>2Q20 Case per 1,000 Members</th>
<th>3Q20 Appeals</th>
<th>3Q20 Case per 1,000 Members</th>
<th>4Q20 Appeals</th>
<th>4Q20 Case per 1,000 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Access</td>
<td>16</td>
<td>0.01</td>
<td>16</td>
<td>0.01</td>
<td>16</td>
<td>0.01</td>
<td>16</td>
<td>0.01</td>
</tr>
<tr>
<td>Attitude / Service</td>
<td>4</td>
<td>0.009</td>
<td>4</td>
<td>0.009</td>
<td>4</td>
<td>0.009</td>
<td>4</td>
<td>0.009</td>
</tr>
<tr>
<td>Billing / Financial</td>
<td>225</td>
<td>0.48</td>
<td>225</td>
<td>0.48</td>
<td>225</td>
<td>0.48</td>
<td>225</td>
<td>0.48</td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total / Number Per 1000:</strong></td>
<td><strong>245</strong></td>
<td><strong>0.5</strong></td>
<td><strong>179</strong></td>
<td><strong>0.39</strong></td>
<td><strong>179</strong></td>
<td><strong>0.39</strong></td>
<td><strong>179</strong></td>
<td><strong>0.39</strong></td>
</tr>
</tbody>
</table>

*Note: Appeals and Second Level Grievance (a.k.a., Appealed Grievances). Reported cases may be captured within multiple NCQA categories. Calculated by subtracting total PHC members minus KP assigned. 156 of 279*
**Highlights**

- Overturned TAR denial for Jardiance.
- Most common SH are pharmacy-related TARs.

**234 Cases**

**REFERENCE**

1Q20 Appeal Cases

**Trending RI Categories**

- TAR: 102
- Transportation: 50
- RAF: 12
- Service: 2

**Trending RI Sub-categories: TAR & Transportation**

- TAR-Rx: 68
- NMT-Mileage Reimb: 40
- TAR-DME: 17
- TAR-Diagnostic: 7

Approximately 28% related opioids.
REFERENCE
1Q20 Grievance Cases

<table>
<thead>
<tr>
<th>NCQA Category</th>
<th>1Q20</th>
<th>2Q20</th>
<th>3Q20</th>
<th>4Q20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care</td>
<td>1</td>
<td>470,043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>47</td>
<td>470,043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attitude / Service</td>
<td>500</td>
<td>470,043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Billing / Financial</td>
<td>29</td>
<td>470,043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of Practitioner Office Site</td>
<td>1</td>
<td>470,043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total / Number Per 1000:</td>
<td>578</td>
<td>470,043</td>
<td>179</td>
<td>0.39</td>
</tr>
</tbody>
</table>

*Note: Grievances only (Excludes Second Level Grievances). Reported cases may be captured within multiple NCQA categories. Calculated by subtracting total PHC members minus KP assigned.*
Trending RI Categories

- SERVICE: 288 cases
- TRANSPORTATION: 168 cases
- TAR: 36 cases
- DISCRIMINATION: 31 cases
- BEACON/KP/VSP: 23 cases
- RAF: 16 cases

Trending RI Subcategories: Service & Transportation

- 50 cases for SERV-Trmt Plan Dispute
- 46 cases for NMT-Missed Rides
- 33 cases for SERV-Sched Appt
- 31 cases for SERV-Communication
- 20 cases for SERV-Poor Attitude
- 14 cases for NMT-Taxi Co Pref
- 8 cases for NMT-Mode of Trans

45% of Scheduling Appointment issues are related to Long Wait Times.

Communication, Poor Attitude and Treatment Plan Dispute represent 66% of Service related cases. All 3 categories are typically found in one case.
REFERENCE
1Q20 Exempt Cases

Trending RI Categories

Top RI-Service Trends
- Communication (50)
- Long Wait Time (35)
- Treatment Plan Dispute (27)

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What is CCS?
California Children Services (CCS) offered through PHC Whole Child Model (WCM), eff 1/1/2019. Provides coverage for children under 21 years old with certain diseases, physical limitations, or chronic health problems. Offers improved coordination of care for CCS & non-CCS services. County determines CCS eligibility.
### # Expedited vs. Standard Cases

- **Expedited cases** represent 0.7% of all 1Q20 cases.
- **1,196 Standard Cases**
- **8 Expedited Cases**

### Types of Expedited Cases

- **Appeals** represent 75% of Expedited Cases.
- **6**
- **2** Grievances

- **162 of 279 Expedited cases**
Update on PHC Oversight, Provision and Coordination of Mental Health Services

Margaret Kisliuk, Behavioral Health Administrator
Jeff Devido, MD
Behavioral Health Clinical Director

May 2020
Presentation Overview

- Overview of Medi-Cal mental health benefit and services administered by PHC
- Status of PHC monitoring of delegated functions
- Summary of services delivered
- Care coordination across systems
- What’s next
## California Mental Health Delivery System for Medi-Cal:

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>Counties</th>
<th>Managed Care Plans</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific serious mental health diagnosis w/ significant impairment suited to tx</td>
<td>No diagnosis limitations</td>
<td>No listing of specific diagnoses for county or managed care plans</td>
<td></td>
</tr>
<tr>
<td>General modes of tx</td>
<td>Outpatient, medication mgt, crisis stabilization, residential/ inpatient</td>
<td>Outpatient, medication management, and testing</td>
<td>No specific changes proposed but may allow broader array to be addressed by MCPs</td>
</tr>
<tr>
<td>Typical service providers</td>
<td>County-run clinics; community based organizations; residential Institutions for Mental Disease (IMDs); acute psychiatric hospital units</td>
<td>Independent providers; community clinics; organizational providers</td>
<td>No changes</td>
</tr>
<tr>
<td>Workforce</td>
<td>Licensed mental health clinicians; interns</td>
<td>Licensed mental health clinicians; interns; primary care providers</td>
<td>No changes</td>
</tr>
</tbody>
</table>

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Medical Necessity for Outpatient Medi-Cal Mental Health Services

- **Medi-Cal Managed Care Plan**
  **Medi-Cal Necessity**

  A member is covered by the Managed Care Plan for services if he or she is:

  1. Diagnosed with a mental health disorder as defined by the current DSM
  2. Has mild to moderate distress or impairment of mental, emotional, or behavioral functioning resulting from the DSM diagnosis

- **Proposed**

  Relaxing medical necessity standards, primarily for counties, to encourage broader treatment and allow for co-occurring treatments of mental health and substance use disorders

- **County MHP Outpatient Medical Necessity**

  1. Has one of 18 included mental health diagnosis
  2. Has a significant impairment in an important area of life function, OR a reasonable probability of significant deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate;
  3. The focus of the proposed treatment is to address the impairment(s) in #2;
  4. The expectation that the proposed treatment will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning, and
  5. The condition would not be responsive to physical health care-based treatment

- **Coordination of care is governed by Memoranda of Understanding between PHC and each of the 14 county Mental Health Plans**

- **For children under 21 the criteria allow for a range of impairment levels and include treatment that allows the child to progress developmentally as individually appropriate**
Primary care providers were the largest source for prescriptions and other mental health services to PHC members.

Mental health professionals delivered the remainder of services through two delegated agreements:

- Kaiser provides mild/moderate mental health services to PHC members assigned to Kaiser for their primary care services, in Marin, Napa, Solano, Sonoma and Yolo Counties
- Beacon Health Options provides mild/moderate mental health services in all 14 counties to non-Kaiser members
PHC Oversight of Delegated Mental Health Services

- PHC Board of Commissioners
  - Quarterly reports on key metrics
  - Annual status report

- PHC Executive Leadership
  - Quarterly meetings with Beacon and PHC executives
  - Quarterly Delegation Oversight Meetings

- PHC Operational Leadership
  - Quarterly Kaiser Operations meetings
  - Monthly Beacon Operations meetings
  - Monthly PHC (internal) Leadership meetings
  - Ad hoc clinical reviews

- PHC Care Coordination / Health Services staff
  - Monthly “Integrated Health” rounds and ad hoc case conferences

PHC Board of Commissioners
PHC Executive Leadership
PHC Operational Leadership
PHC Care Coordination / Health Services staff
Bring behavioral health viewpoint to PHC activities such as general medical oversight or the monthly “Integrated Rounds” with Care Coordination staff (attended by Beacon clinicians), allowing the broad PHC viewpoint to inform delegation oversight.

Review of potential quality incidents.

Review of random sample of cases:
1. Kaiser: through annual audit and selection of representative sample of files.
2. Beacon: through quarterly review of UM files (approx. 5% each quarter).

Review of Quality Committee activities.

Outreach to providers and community agencies.
<table>
<thead>
<tr>
<th>Delegated Function</th>
<th>Beacon 2019 Performance</th>
<th>2019 Changes/Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider credentialing/recredentialing</td>
<td>Beacon credentialed/recredentialed nearly 116 individual providers and organizations.</td>
<td>Many mental health providers new to the non-county Medi-Cal system struggle with the credentialing requirements. There are complaints due to the time the credentialing process takes; there are also occasional problems because of staff changes at Beacon. In early 2020, Beacon instituted a new credentialing vendor; PHC is monitoring to track experience with and improvements in the credentialing process.</td>
</tr>
<tr>
<td>Provider screening, enrollment and validation</td>
<td>This remains a learning process for providers new to the system but is being handled appropriately by Beacon.</td>
<td></td>
</tr>
<tr>
<td>Network management</td>
<td>Concerns with meeting State network adequacy requirements in some areas for pediatric services; these are being addressed through telehealth.</td>
<td></td>
</tr>
<tr>
<td>Quality management and improvement</td>
<td>Continued to provide effective quality oversight.</td>
<td>PHC (Dr. Devido) reviewing sample of Beacon UM reviews each quarter.</td>
</tr>
<tr>
<td>Claims</td>
<td>100% of claims processed in 45 days, meeting all contract requirements</td>
<td></td>
</tr>
<tr>
<td>Customer services/call center</td>
<td>Abandonment rate less than 5%; over 80% of calls answered in 30 seconds, meeting all contract requirements</td>
<td>Call center services will be expanded to provide screening and facilitation of services for substance use services in the PHC regional model counties for Drug Medi-Cal</td>
</tr>
</tbody>
</table>
## Oversight of Delegated Services (cont’d)

<table>
<thead>
<tr>
<th>Delegated Function</th>
<th>Beacon 2019 Performance</th>
<th>2019 Changes/Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complaints/grievances/appeals</td>
<td>During PHC’s audit of Beacon, PHC found that Beacon was not providing PHC with data on all grievances submitted. The data were provided but changes in Beacon processes and approaches were requested for full compliance.</td>
<td>PHC issued a CAP on the reporting of grievances that was resolved during the CAP period.</td>
</tr>
<tr>
<td>Utilization management</td>
<td>No services were denied to eligible members in 2019; providers are asked for treatment plans to support high rates of utilization (e.g., more than 6 therapy claims in 30 days)</td>
<td></td>
</tr>
<tr>
<td>Encounter data reporting and financial reconciliation</td>
<td>This remains a major issue for Beacon and PHC; Beacon has been under a CAP to resolve these issues since November 2019.</td>
<td>Beacon remains under a CAP for the accuracy and timeliness of its encounter and financial data, but the issues appear to be near full resolution.</td>
</tr>
</tbody>
</table>

PHC, Partnership of California
Since 2019, additional providers have been added to the Solano Beacon network. A provider workgroup that includes Beacon and primary care providers, Beacon and PHC staff, and the County behavioral health division meet quarterly to address and work to improve mental health access for Solano County residents.
PHC’s goal is to ensure that all of our members’ mental health needs are effectively addressed. Our overall goal is to reach a “penetration rate” (number of unique individuals receiving services) of at least 7% with the remaining mental health needs addressed by primary care providers and the counties (for serious mental health issues).

It is difficult to set a fixed target for the level of mental health services that should be provided to children in order to adequately address their needs, due to: diagnostic challenges differentiating the wide range of normal developmental behaviors from pathological behaviors and the need to be judicious in making such determinations; provision of services to children through the Early Periodic Diagnosis Screening and Treatment (EPSDT) system; and additional services addressed outside of the Medi-Cal system (e.g., school-based systems). Overall, however, national research indicates that perhaps 1 in 10 children may experience a serious emotional disturbance that could benefit from treatment.
Service Delivery: 2019 - Adults (21+)

While PHC does not have an age-specific target penetration rate, it is estimated that 16 to 17% of the adult Medicaid population have mental health treatment needs, a little over half of these with serious mental illness.
## Service Delivery:
### 2019 - Children (Under 21)

<table>
<thead>
<tr>
<th>County</th>
<th>Beacon % Served</th>
<th>% w/ PCP Rx visit</th>
<th>County</th>
<th>Beacon % Served</th>
<th>% w/PCP Rx visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Del Norte</td>
<td>2.6%</td>
<td>3.7%</td>
<td>Lake</td>
<td>4.5%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Humboldt</td>
<td>4.5%</td>
<td>4.3%</td>
<td>Marin</td>
<td>8.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Lassen</td>
<td>3.7%</td>
<td>3.1%</td>
<td>Mendocino</td>
<td>4.4%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Modoc</td>
<td>1.9%</td>
<td>2.5%</td>
<td>Napa</td>
<td>5.6%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Shasta</td>
<td>8.8%</td>
<td>4.5%</td>
<td>Solano</td>
<td>4.7%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Siskiyou</td>
<td>8.1%</td>
<td>4.4%</td>
<td>Sonoma</td>
<td>8.4%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Trinity</td>
<td>4.7%</td>
<td>2.2%</td>
<td>Yolo</td>
<td>6.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>OVERALL</strong></td>
<td><strong>6.3%</strong></td>
<td><strong>3.5%</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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MOUs between PHC and each of the 14 County mental health plans outline shared responsibilities:

- Agreement of standard screening tools to determine the appropriate level of care
- Dispute resolution procedures
- Commitment to regular meetings and shared monitoring of data

Beacon’s Care Management staff work to address all issues and to facilitate the care of members by county.

Some Key challenges include:

- Individual therapy is generally not available in the county systems while Beacon/PHC case management services are sometimes insufficient
- Handling of eating disorders
- Insufficient workforce resources for both systems
Top diagnoses among those served by Beacon

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>2019</th>
<th>2020 (Q1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress and Trauma Related</td>
<td>41.2%</td>
<td>37.2%</td>
</tr>
<tr>
<td>Depression Disorder</td>
<td>35.0%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Anxiety disorders</td>
<td>27.5%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Bipolar and Related</td>
<td>9.0%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Neurodevelopmental disorders</td>
<td>7.0%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Schizophrenic spectrum</td>
<td>4.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Disruptive, impulse control</td>
<td>1.2%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>
Next Steps

- Continued work to enhance delegation oversight
- Work to improve performance on HEDIS/NCQA measures
- Address issues through pilot projects and special focus:
  - Increase overall access in selected counties
  - Build/enhance network resources to better address eating disorders, maternal mental health, etc.
  - Work with PCPs and behavioral health providers to promote integrated care within the community
  - Start to move focus more towards the quality/efficacy of services where possible
- Prepare for expected increase in needs projected post-Covid
Questions?
PHC QUAC Meeting

Summary of Beacon Services, and Partnership’s membership impact during COVID-19

May 20, 2020
Generally, call volume has remained lower since November 2019.

Within the months of March and April, call volume has dropped post-Safer At Home Order.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>1191</td>
<td>1160</td>
</tr>
<tr>
<td>March</td>
<td>1475</td>
<td>898</td>
</tr>
<tr>
<td>April</td>
<td>1342</td>
<td>680</td>
</tr>
</tbody>
</table>
## Medi-Cal Screenings & Outpatient Utilization

<table>
<thead>
<tr>
<th>Average Screening Per Month 2019</th>
<th>Total Screenings February 2020</th>
<th>Total Screenings March 2020</th>
<th>Total Screenings April 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>575</td>
<td>508</td>
<td>446</td>
<td>318</td>
</tr>
</tbody>
</table>

- Screenings have gone down for the month of March 12% drop from February to March, and additionally screenings and referrals decreased 28% from March to April for PHC members.
- March total screenings is an outlier to average screenings.
- OP utilization data is not available for March/April yet as there is a claims lag.
Telehealth

- Substantial increases in Telehealth services rendered with more increases expected.
- For the first time we saw therapy surpass medication management in number of visits.
We have seen a huge jump in members accessing Telehealth. Between Q4 2019 and Q1 2020 there has been over a 500% increase in unique utilizers.

We are continuing to onboard new providers and assist providers in network on rendering services via telehealth.

These numbers will likely continue to rise as members continue to access Telehealth.
Telehealth Visits by County

Total Visits by County Q1, 2020

- Shasta: 1528
- Sonoma: 1224
- Solano: 1215
- Mendocino: 854
- Humboldt: 209
- Del Norte: 786
- Marin: 308
- Lake: 141
- Siskiyou: 257
- Napa: 394
- Yolo: 147
- Shasta: 209
- Sonoma: 45
- Solano: 47

Q1, 2020
How do members access services?

- Call Member Services:
  - Phone: 1-855-765-9703 or TTY: 800-735-2929
- Beaconhealthoptions.com
  - Click FIND A PROVIDER
- PCP Referral
Beacon Resources

www.beaconhealthoptions.com/coronavirus/

Member Resources

Beacon Health Options is strongly committed to our members, clients and providers to ensure that mental health needs are being met during this stressful time.

We recognize that many of our members and providers are being encouraged or mandated to stay at home in order to prevent community spread of coronavirus. When clinically appropriate, telehealth can be an effective way for members to receive care through a mental health provider safely from their homes via phone, tablet or computer-enabled web cam.

During this national public health emergency Beacon will cover telehealth services including phone therapy, for most services. Additionally, in order to ensure access to care for our members we are waiving cost sharing for in-network and out-of-network providers.

GENERAL
› Coronavirus general & mental health FAQs
› What to do before and during a pandemic

MENTAL HEALTH
› Tips for housebound families
› Finding coronavirus media coverage overwhelming?
› Social distancing for the social animal
› How to navigate anxiety caused by coronavirus
› How to help children navigate anxiety caused by coronavirus
› Coping with stress during infectious outbreaks
› Children and COVID-19 — How to keep children healthy and happy (mp4)
› Living in uncertain times (mp4)
› Thinking traps (mp4)
› The intersection of uncertainty and parenting: COVID-19 (Coronavirus) (mp4)
› Conquering fear & anxiety (mp4)

PHYSICAL HEALTH
› Why, when and how to wash your hands (mp4)
› How to keep your family healthy (mp4)
› How to stay healthy (mp4)
Being social while physical distancing

- Anxiety
- Depression
- Job loss
- Working remotely
Recent Network Efforts

Provider Quality

• Identifying and surveying providers available to do telehealth, allowing all providers to render services via telehealth.
• Provider weekly webinar education series on telehealth and topics related to COVID-19.
• Conducting more quality audits in lieu of in person meetings with facilities/provider groups.

Provider Network

• Sending continuous letters to providers on COVID-19 billing updates and FAQs
• Centralized online resource bank on Beacon website
• Updating SOPs on telehealth options.
• May 6th, held a webinar on “How to effectively Manage a Remote Team.”
• Inviting all providers to attend webinar next week: “When Trauma is in Your Job Description: Reducing Impact Through Early Intervention”
• Weekly newsletter beginning last week: Caring through COVID Connection

Configuration

• Setting up system to pay claims for place of service code “02” for those not contracted for setting and to bypass codes that normally do not pair with setting?
Thank you

Contact Us

1-855-765-9703

www.beaconhealthoptions.com

Alison.French@beaconhealthoptions.com
resolution process as defined in PHC Policy MCUP3127 Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services.

**Triage and Referral for Mental Health**

PHC monitors the triage and referral protocols for the delegated behavioral health services provider to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinical evidence based and an accepted industry practice. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination and UM teams of the delegated Behavioral Health Services Provider which are co-located in the PHC offices with oversight by PHC’s Behavioral Health Clinical Director. Both work collaboratively with the designated County Mental Health Departments to ensure members receive care at the appropriate level in a timely manner.

**Substance Use Disorder Treatment Services/ Wellness & Recovery Program**

PHC works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Substance Use Disorder (SUD) treatment services offered through the state Drug Medi-Cal program are being greatly expanded in eight-seven of our counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano, and Trinity) through our new Wellness & Recovery Program, a benefit expected to become effective in the Spring of July 1, 2020. (Expanded SUD services are available in Napa, Marin, and Yolo counties, and are administered by the counties. A more limited benefit is administered by the remaining three-four counties — Del Norte, Lake, and Sonoma and Trinity)

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, nine-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MCCP2028 Residential Substance Use Disorder Treatment Authorization)
- Medically assisted treatment (methadone, buprenorphine, disulfiram, naloxone)
- Case management
- Recovery services (aftercare)

**Behavioral Health Treatment (BHT) for Members Under 21 Years of Age**

PHC has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014.

Effective July 1, 2018, PHC expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.
**PROVIDER AND MEMBER SATISFACTION**

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results as well as plans for corrective action are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless committee feels an expedited time frame needs to be implemented.

**ANNUAL PROGRAM EVALUATION**

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Senior Health Services Director
- Director of UM
- Director, Pharmacy Services
- Associate Director of UM
- UM Team Manager

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for PHC members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual UM Program Evaluation
- Develop and implement annual work plan
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of -UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC
- Complete all team Inter-Rater Reliability testing

Inter-Rater Reliability scoring, TAR timeliness, percentage of eRAFs vs. Manual RAFs, and Call Performance is compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program

*Services related to substance use services as outlined in the Regional Drug Medi-Cal Model are placeholders for when DHCS releases the benefit. Activity is not anticipated to be effective until late Spring on July 1, 2020.*
I. RELATED POLICIES:
A. MCCP2020 – Lactation Policy and Guidelines
B. MP PCR #16 – Lactation Consultant Credentialing Policy
C. MCUG3118 – Prenatal and Perinatal Care
D. MCCP2021 - Women, Infant and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:
N/A

III. DEFINITIONS:
Baby Friendly Hospital Initiative – A global initiative sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birth centers that offer an optimal level of care for infant feeding.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To support optimal nutrition in the healthy infant by appropriately supporting the mother’s efforts to initiate and sustain breastfeeding exclusively for 4-6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations. To support optimal nutrition in the healthy infant by appropriately supporting the mother’s efforts to initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.  

VI. GUIDELINE / PROCEDURE:
Lactation Guideline / Procedure
A. General Breastfeeding Guidelines
   Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by Partnership HealthPlan of California (PHC) and the American Academy of Pediatrics (AAP). Research has demonstrated numerous health benefits of breast feeding. Additional to breast feeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant.” Research has shown that breastfeeding decreases the incidence and/or severity of diarrhea, lower respiratory infection, otitis media, urinary tract infection, bacteremia, bacterial meningitis, botulism, and necrotizing enterocolitis. There is also a possible protection against sudden infant death syndrome, certain chronic diseases and childhood
Guideline/Procedure Number: MPXG5009

Guideline/Procedure Title: Lactation Clinical Practice Guidelines

Lead Department: Health Services

☐ External Policy
☐ Internal Policy

Original Date: 01/15/2014

Next Review Date: 05/08/2020

Last Review Date: 05/08/2020

Applies to: ☒ Medi-Cal

In addition to health benefits for the mother and infant, breastfeeding also provides social, economic and environmental benefits for both mother and infant.

B. Promotion and Support of Breastfeeding

1. Lactation Education and Support Services: Each county served by Partnership HealthPlan of California (PHC) has a local Women Infants and Children Nutrition Program (WIC) program that includes lactation education, support and provision of breast pumps, for low income women, including those with Medi-Cal. All pregnant members should be referred to WIC. Lactation support for PHC members is a shared goal and responsibility of WIC and the health delivery system provided through PHC, by the following providers:

   a. Primary care providers are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant patients to prenatal breastfeeding classes will ensure they have current evidence based information about breastfeeding.

   b. Prenatal care providers should specifically assess a pregnant member’s knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. The pregnant members and their partners should be referred to a breastfeeding class antenatally and have access to one on one breastfeeding education prenatally and postnatally. This is especially important for members who are first time mothers or have not breastfed in the past.

   c. Comprehensive Perinatal Service Programs (CPSP): PHC strongly supports having all pregnant members receive support services provided though CPSP providers, which provide comprehensive assessments as part of their total prenatal care. CPSP providers may provide their own lactation support services or refer to other community resources to provide breastfeeding promotion, education and counseling.

   d. PHC Care Coordination: Members who are planning to breastfeed need specific resources to call for assistance with breastfeeding when indicated. The Growing Together Program (GTP) at PHC (a part of the Care Coordination Department) will maintain and make accessible on the PHC website a list of all high quality lactation support resources available in PHC counties. In addition, GTP staff, who have received appropriate training, may provide telephonic support to members. Care coordination staff is available during regular business hours to help members and providers identify resources in the community. Through specific programs and general case management support, PHC Care Coordination supports breastfeeding in accordance with current guidelines and evidence-based practices.

   e. Postpartum follow-up calls are made to PHC members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.

   f. Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative (https://www.unicef.org/programme/breastfeeding/baby.htm) and will also include:

      1) The hospital should receive information on the member’s prenatal record stating the infant feeding plan. That plan should be confirmed when a woman is admitted for delivery.

      2) Family centered childbirth practices allowing for early mother-infant contact and breastfeeding within the first two hours as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.
3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Mothers can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infants feeding cues.

4) Members need access to qualified nursing staff to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.

5) Supplements such as water, glucose water or formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.

6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC or a home health or public health nurse visit specifically to assist the mother with breastfeeding. Whenever possible this should occur within 1-2 calendar days of discharge.

7) The lactating mother leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if her baby is getting enough milk, and referral to a breastfeeding support group.

g. Infant care providers should encourage exclusive breastfeeding for about at least four to six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant care providers should consider referral to a qualified lactation consultant, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the mother’s health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the mother may need to be provided with a breast pump and instructions on how to use it to maintain her milk supply.

h. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive home health nurse visits or public health nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first mother-baby home health visit by a home health nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public health nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

2. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate Postpartum (in the hospital), early postpartum (from hospital discharge to 84 calendar days after delivery), and late post-partum periods (from 84 to 365 calendar days post-delivery). From a Medi-Cal standpoint, care during the postpartum period includes a specifically defined postpartum visit between 21 to 56 calendar days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow up lactation visits should be encouraged, preferably in the first few days after discharge home. Some women also need lactation education and support after 56 calendar days post delivery. Lactation visits independent of the standard postpartum visits are covered by PHC.

3. Providers of Lactation support services:
   a. Basic Lactation support services may be provided by medical professionals: a Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, or a non-physician clinician, including Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse Midwife (CNM). No special certification is required.
   b. Certified Lactation Consultants provide more specialized lactation support. Most International Board Certified Lactation Consultants (IBCLCs) have an underlying health professional licensure (RN, RD, MD, DO, CNM, NP, PA) as well.
c. Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted Physician or PHC credentialed IBCLC.

4. **Breast Pumps:** When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If mother is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.

   — Electric breast pumps help infants with feeding problems where a mother must be separated from or is unable to nurse her baby. The use of an electric breast pump can help maintain adequate milk supply when a baby is not able to breastfeed.

   — Maternal/Infant Indications for Breast Pump Use. Breast pumps may be requested for:

   0) Medical conditions of the mother requiring temporary cessation of lactation, separation from her infant or issues with milk supply. (medical indication, covered benefit)

   0) Illness requiring hospitalization, surgery with or without hospitalization, moderate to severe skin disruption, infections or damage of the nipple complex, temporary or episodic use of medications contraindicated in breastfeeding, low milk supply and other unforeseen conditions that may cause a forced separation of the mother-baby dyad or render her temporarily unable to feed the baby at the breast.

   0) Conditions of the infant indicating support is necessary to successfully initiate and/or sustain breastfeeding (medical indication, covered benefit)

   0) Prematurity, sucking dysfunction, slow or poor weight gain, congenital anomalies, ankyloglossia, cleft lip and or palate, infant hospitalization for surgery or illness, neurological conditions of the infant, cardiac conditions of the infant and other conditions of the infant making it unable to fully or only partially able to feed at the breast.

11.5 **Supplementation:** When supplementation is necessary, consider supplementation in this order: Mother’s own expressed breast milk, pasteurized donor breast milk, standard infant formula, protein hydrolysate formula, consider AAP guidelines for breast milk supplementation.

6. **Banked Human Milk:** Banked human milk is currently not widely available, but may be helpful for specific conditions in the hospital setting. According to WIC, in their landmark publication Ramping up for Reform, “Banked human milk is provided by Medi-Cal and health insurance plans in order to provide infants, especially high-risk infants, the healthiest start in life and reduce costly health complications.”

1. Donor milk offers all the benefits of human milk for the infant including optimal nutrition, easy digestibility, and growth factors to promote maturation and the healing of tissues, immunologic protection, and infection fighting components. For some, banked human milk is the only source of nutrition that allows them to grow and develop without allergic symptoms.

7. **Active Management of Potentially Adverse Breastfeeding Situations**

   a. Active Management and Support of Breastfeeding should follow the guidelines set forth by the authorities listed in the reference section below. These guidelines change often as new research emerges, so providers are expected to stay informed of updated best practice guidelines.

   — Managing common maternal/newborn challenges that may impact feeding at the breast

   0) Jaundice: Distinguishing physiologic jaundice from breast milk jaundice and definition of pathologic jaundice. When a diagnosis of jaundice is made the accuracy of determining bilirubin levels is of great clinical importance and will establish the basis of an appropriate plan of care. Partnership HealthPlan suggests using an evidence-based tool such as the Biltool found at www.bilitool.org. This tool can be incorporated into the Electronic Medical Record (EMR) and it can be accessed through an APP on the clinician’s mobile device making it easy to use in the hospital or clinical setting.
Guideline/Procedure Number: MPXG5009  |  Lead Department: Health Services

Guideline/Procedure Title: Lactation Clinical Practice Guidelines

☑️ External Policy
☐ Internal Policy

Original Date: 01/15/2014  |  Next Review Date: 05/08/2020

Last Review Date: 06/10/2021

Applies to: ☒️ Medi-Cal
☐ Employees

Pathologic jaundice usually occurs on the first day of life and requires immediate evaluation. It is often associated with RH negative mothers.

Physiologic jaundice may be associated with inadequate breastfeeding. With physiologic jaundice, bilirubin levels peak shortly after the mother’s milk comes in when the breasts are engorged at 3-5 days.

Exacerbation of physiologic jaundice may be associated with inadequate breast milk intake and should be considered in the differential diagnosis.

The peak level of indirect bilirubin during physiologic jaundice may be higher in breast milk fed infants than in non-breast milk fed infants. This may be due, in part, to decreased breast milk intake by the infant.

Treatment should focus on observation of a feeding, assessment of the baby’s intake, including number of wet and soiled diapers, weight changes, and general behavior, (is baby sleeping and skipping feedings, or is baby awake, alert and feeding often?), teaching of breastfeeding techniques and routines and methods of increasing the mother’s milk supply.

Jaundice is an important sign that a baby may be underfed and needs help with breastfeeding.

Supplementing with water or dextrose water will not lower bilirubin levels in a normal, healthy, breastfeeding newborn.

If supplementation is necessary every effort should be to supplement with expressed breast milk.

Breast milk jaundice applies only to healthy, well-fed infants. Breast milk jaundice usually occurs after the first week of life and can last for many weeks. Breast milk jaundice is a normal prolongation of physiologic jaundice of the newborn, which results from an enzyme commonly found in human milk and affects 1-2% of breastfeeding infants.

Treatment is warranted when bilirubin levels reach clinically significant levels. Interrupting breastfeeding, only when necessary, for 1-2 calendar days the mother may need an electric pump and support to maintain her milk supply while formula is fed results in a rapid decline in the serum bilirubin concentration that does not increase significantly after breastfeeding is resumed.

Some of the problems associated can include difficulties in having the baby return to breastfeeding and risk of potential allergen. In either case an electric pump may need to be prescribed along with appropriate counseling on how to use the pump and continued follow up to insure return to breast for feedings.

With breast milk jaundice an electric pump could be used to maintain the milk supply if breastfeeding is interrupted for 24 hours, or more, to treat excessively high bilirubin levels. Expressed milk can be saved and used after jaundice resolves.

If phototherapy is required it may be possible for it to be provided in the home for infants with uncomplicated non-hemolytic jaundice.

If the baby needs to be hospitalized, arrangements for continued breastfeeding or breast pumping should be coordinated.

Inadequate milk supply: If the issue appears to be exacerbated by low milk supply possibly caused by slow or delayed onset of Lactogenesis II the case for active lactation management can be made. After assessment of feeding patterns and a review of the early days of initiation a proactive plan needs to be developed to increase the infant’s access to breast milk at the breast. An appropriate pump can be used after nursing to increase the milk supply. A trial of an effective galactogogue may be helpful. Appropriate education and follow-up maybe necessary with both breast pump and medication use. To measure effectiveness of any intervention allow 48-72 hours for the physiologic response to the intervention. Often low milk supply is a problem of perception. Expectations the mother and father have of the baby may be based on what friends and family tell them, or what they read. They might experience less frequent feedings and longer periods of sleep from their newborn. This group of women will benefit greatly with prenatal education and postpartum information and support. Childbirth education and prenatal Lactation classes cover breastfeeding expectations in great detail. WIC provides evidence based information and has universally adopted the Baby Behaviors program, developed at the UC Davis Center for Human Lactation, as a central part of their education to parents.
Cases of insufficient milk syndrome are rare. Generally speaking they are the result of a physiologic failure of Lactogenesis II. Careful physical assessment of the mother is helpful in making the determination. Two physical characteristics that are generally agreed upon in the literature are:

i. Widely spaced breasts approximately 4-5 fingerbreadths apart that are tubular in shape

ii. Little or no breast growth during pregnancy affecting milk glandular growth.

Some medical conditions may also affect the mother’s ability to produce enough milk.

- Advanced maternal age in a woman who may have experienced peri-menopausal symptoms before pregnancy.
- Women over 40 who used assisted reproductive technology techniques to achieve pregnancy.
- Women with Poly Cystic Ovarian Syndrome or women with other metabolic disorders.

Slow infant weight gain: Slow weight gain in the neonate is a complex and dynamic situation. Etiologies are varied. Multiple strategies and supportive interventions may be necessary to insure the growth and development of the infant in a safe and healthy manner. Useful strategies include:

- Utilizing AAP guidelines and documentation tools: See AAP Breastfeeding Toolkit
- Working collaboratively with a trained lactation professional to identify etiologies and develop strategies for resolution
- Early and frequent follow-up of the infant.
- Strong evidence based support for the mother
- Providing breast pump and equipment with appropriate education for use.
- Planned, effective communication with infant care provider, lactation professional and the family.
- When supplementation is necessary using pumped breast milk whenever possible.
- Use of the WHO growth charts for breastfed babies.
- Consistent follow up until evidence of established breastfeeding and acceptable weight gain is established.
- Realistic alternative plan should the need be evident.

Ankyloglossia – Tongue Tie and or Maxillary (Fraenum) Lip Tie:

On occasion infants present with perplexing breastfeeding challenges. One of the most perplexing conditions may be a tongue or lip tie. The presentation is not always clear and treatment recommendations may vary dramatically and may be viewed as controversial by some.

As breastfeeding rates increase it is expected that more cases will be identified. With a national history of two or more bottle fed generations the diagnosis and identification may have been masked making it poorly understood. Recent additions to the literature may reverse the trend.

This is a medically managed condition with close collaboration by an experienced lactation professional. Often dental specialists and ENTs are leading the developments in treatment.

From a maternal-infant perspective this condition(s) may mean the cessation of breastfeeding as it is often associated with great difficulty getting the infant to the breast and with significant maternal pain. With that in mind it is imperative that the needs are addressed in a timely manner regardless of the ultimate treatment plan chosen.

Maternal complaints may include: unusual persistent soreness, pain throughout the breastfeeding, possible low milk supply, something “not right” with the latch although it may sometimes appear normal. In a mother who has previously breastfed successfully she will be insistent that there is something quite different about this experience.

Infant presentation may include: frequent short feeds, slow or poor weight gain, reflux unrelied by treatment, unable to sustain an adequate latch and milk transfer during the feeding, clicking and other noise making throughout the feeding, and a possible early diagnosis of “colic”. Other symptoms may also be present.

The presentation for either may be easily confused with other challenges and conditions.

If feeding at the breast must be temporarily interrupted or the infant supplemented with pumped breast
Guideline/Procedure Number: MPXG5009  |  Lead Department: Health Services
Guideline/Procedure Title: Lactation Clinical Practice Guidelines

Original Date: 01/15/2014  |  Next Review Date: 05/08/2020

Applies to: ☒ Medi-Cal  |  ☐ Employees

milk the provision of an electric breast pump, with double pumping capabilities, could be provided in a timely fashion while the diagnosis and treatment plan is determined.

- It is essential that the medical provider and an experienced lactation professional collaborate on the plan of care.
- A detailed family history needs to be taken specific to oral anomalies, speech problems, or other family members identified with either condition.
- Tongue-tie will be identified more frequently.
- Assessment, identification and referral to a trained lactation professional in a timely fashion is essential.
- Keep in mind when assessing “flat/pseudo flat” nipples that there may be a correlation with the amount of IV fluids a woman received in labor and a temporary fullness in her breasts that may result in the appearance of “flat nipples”.
- Multiple follow-up visits may be necessary to establish successful breastfeeding.
- Assessment during a breastfeeding session is recommended to evaluate the infant’s ability to latch and transfer adequate milk.
- If it is determined that if feeding at the breast is not possible the timely provision of an electric breast pump with double pumping capabilities may be necessary to ensure the infant continues to receive breast milk.
- Shared access to the documented plan of care is essential.

- Damaged Nipples:
  - Assessment of the mother-baby dyad during a feeding by a trained lactation professional to evaluate proper latch and milk transfer is recommended.
  - Based on findings further individual assessments of the mother or baby or both may be indicated.
  - If it is determined that the mother needs medical management, e.g. infection or deep abrasions of nipple tissue, referral to licensed Health Care Provider for appropriate treatment is recommended.
  - After treatment plan is established referral back to trained lactation professional for follow-up is appropriate.
  - If feeding at the breast must be temporarily interrupted to facilitate the healing process the provision of an electric breast pump, with double pumping capabilities, may be provided in a timely fashion.
  - It is recommended that a shared plan of care be developed.

- Thrush:
  - The diagnosis of thrush in the baby, mother or both indicates the need to receive simultaneous treatment.
  - Any experienced lactation professional should be able to identify this condition.
  - With identification a referral will be made to the appropriate medical professional for further evaluation and pharmacologic treatment. Separate referrals may be needed for treatment of the mother and treatment of the baby.
  - An appropriate medical professional is defined as: MD, DO, Family Medicine or Pediatrics, OB/GYN, CNM, NP, or PA.
  - Mother and baby will need concurrent treatment.
  - Continued collaboration with a lactation professional during treatment and for follow-up is appropriate.
  - Shared documentation is indicated.
  - It is unusual with a diagnosis of simple or early thrush for feeding at the breast to be even temporarily interrupted. Should this occur, appropriate provision of a breast pump and education may be provided to the mother.
  - Additionally, education concerning personal hygiene, safe use of medications, signs and symptoms of worsening condition and when to call the health care provider will be given.

- Infant with cleft lip and or palate:
The pediatric care physician is defined as: MD/DO Pediatrician or Family Practice Medical Doctor.

The pediatric care physician shall determine the extent or degree of the cleft lip, palate or both.

The Pediatric physician will determine the medical/surgical treatment plan.

In determining the feeding plan of care it is appropriate to collaborate with a trained lactation professional with experience in this diagnosis.

Close collaboration is essential with the MD/DO as the lead clinician.

The feeding plan may include the need for specialized feeding devices and breast pumps. Close follow up is necessary to ensure adequate intake and weight gain in the infant.

Specialized education and anticipatory guidance will be provided.

Appropriate modification of the plan of care will occur as the treatment plan progresses.

It is possible the infant may not initially be fed at the breast. However, the infant will benefit from breast milk feeding. The mother may need to be provided with the necessary equipment and education to be successful in this situation.

Clear communication and documentation are essential.

Infant with a developmental or neurological condition:

The pediatric care physician shall determine the extent of the condition.

The Pediatric care physician is defined as: MD/DO Pediatrician or Family Practice Medical Doctor.

The Pediatric physician will determine the treatment plan.

In determining the feeding plan of care it is appropriate to collaborate with a trained lactation professional with experience in this type of diagnosis.

Close collaboration is essential with the MD/DO as the lead clinician.

The feeding plan may include the need for specialized feeding devices and breast pumps. Close follow up is necessary to ensure adequate intake and weight gain in the infant.

Specialized education and anticipatory guidance will be provided.

Appropriate modification of the plan of care will occur as the treatment plan progresses.

It is possible the infant may not initially be fed at the breast. However, the infant will benefit from breast milk feeding. The mother may need to be provided with the necessary equipment and education to be successful in this situation.

Detailed documentation of the plan of care is essential.

Use of “Lactation Aids”: Nipple Shields, Breast Milk Cups, and Supplemental Nursing system aka SNS, hand and electric pump, etc.

Use of Lactation Aids is a complex and dynamic situation created by numerous issues. Multiple strategies and supportive interventions may be necessary to insure the growth and development of the infant in a safe and healthy manner. Useful strategies include:

2. Make sure the right device is being used for the specific situation.
3. Working collaboratively with a trained lactation professional to identify etiologies and develop strategies for resolution.
4. Early and frequent follow up of the infant.
5. Strong evidence based support for the mother.
6. Providing breast pump and equipment with appropriate education for use.
7. Planned, effective communication with infant care provider, lactation professional and the family.
8. When supplementation is necessary using pumped breast milk whenever possible.
9. Consistent follow up until evidence of successful breastfeeding is established.
10. A realistic alternative plan should be developed.
11. Emotional status of the woman during the postpartum period:
If there is any indication the mother is experiencing an alteration in mood in the postpartum period, assessment and intervention may be needed.

It is suggested that an appropriate screening tool be used for the initial screening and follow up as appropriate when following the mother. For example, the Edinburgh Postnatal Depression Screening, PHQ-9, or GAD-7 tools.

Any alteration in mood, from mild to clinically significant depression, can impact the breastfeeding experience.

Identification and referral to the appropriate mental health professional is essential.

Medical consultation and management is indicated when medications are necessary or when depression is severe or psychosis is present/diagnosed.

Involvement of a Public Health Nurse may be helpful for follow-up. Lactation support from a lactation professional or trained counselor is appropriate to assist with maintaining lactation.

Many conditions may necessitate the use of medications in the breastfeeding woman. For example: initiation of contraception, postpartum mood disorders and treatment for mastitis among others should take into account lactation status. It is rarely necessary to discontinue breastfeeding or “pump and dump”. Excellent resources are available for help in the determination of a medications use and safety.

Call for information about the safety of using drugs, over-the-counter drugs, herbal products, chemical, vaccines, and other substances in pregnant and breastfeeding mothers. Thomas Hale, PhD, Professor of Pediatrics at Texas Tech University School of Medicine is the Founding Executive Director of the Infant Risk Center. The Infant Risk Center Phone Counselors are trained professionals using Dr. Hale’s most current data on the use of medications in pregnant and breastfeeding mothers.

Information about the safety of using drugs, over-the-counter drugs, herbal products, chemical, vaccines, and other substances in pregnant and breastfeeding mothers are also available at the above number.

The American Academy of Pediatrics has publications that address the use and safety of medications during breastfeeding. www.aap.org

Important Note:
In all the previous conditions, it is helpful if the health care provider caring for the mother or baby recognizes the important transition the dyad is experiencing. The initiation of breastfeeding and becoming a parent can present challenges to the family that is unprepared for. If this transitional process is recognized and supported temporarily by offering assistance, education and understanding the mother/baby/family may feel validated in their struggle and thus move more easily through the process. This is temporary and time intensive.

Infant Milk Transfer:
Essential to each clinical assessment of the infant at the breast; milk transfer must be confirmed. After the first day or two, as the mother’s milk volume increases, milk transfer is more easily identified.

Contraindications

1. AAP Guidelines should be utilized to identify additional conditions that are contraindicated
   a. Medications that may require temporary interruption of breastfeeding may be found utilizing AAP Guidelines; or for additional information call the Infant Risk Center at 806-352-2519.

Education Materials for PHC Members

The following educational materials may be helpful for parents. They are readily available through your local WIC office.

Useful Resources

1. Sources of simplified definitions:
   2. CPSP http://cchealth.org/services/perinatal/
USEFUL RESOURCES:

Sources of simplified definitions:
- CPSP http://cchealth.org/services/perinatal/
- Bilitool www.bilitool.org
- Medications in Mothers Milk 2019, Hale, T, Hale Publishing, L.P.

VII. REFERENCES:
B. Affordable Care Act, Section 4106a, Women’s Health Preventive Services, 
C. infant Risk Center: Call 806-352-2519
E. Department of Health and Human Services/Center for Medicaid and CHIP Services
F. Medicaid Coverage of Lactation Services. CMS Bulletin
G. Sources of simplified definitions:
   - CPSP http://cchealth.org/services/perinatal/
   - Bilitool www.bilitool.org
   - Medications in Mothers Milk 2012, Hale, T, Hale Publishing, L.P.

VIII. DISTRIBUTION:
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
GUIDELINE/PROCEDURE

Guideline/Procedure Number: MPXG5009
Lead Department: Health Services

Guideline/Procedure Title: Lactation Clinical Practice Guidelines

☒ External Policy
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Original Date: 01/15/2014
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Applies to:
☒ Medi-Cal
☐ Employees

Reviewing Entities:
☒ IQI
☐ P & T
☒ QUAC
☐ OPERATIONS
☐ EXECUTIVE
☐ COMPLIANCE
☐ DEPARTMENT

Approving Entities:
☐ BOARD
☐ COMPLIANCE
☐ FINANCE
☒ PAC
☐ CEO
☐ COO
☐ CREDENTIALING
☐ DEPT. DIRECTOR/OFFICER

Approval Signature: Robert Moore, M.D., MPH, MBA
Approval Date: 06/10/2020

I. RELATED POLICIES:
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II. IMPACTED DEPTS:
N/A

III. DEFINITIONS:
Baby Friendly Hospital Initiative – A global initiative sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birth centers that offer an optimal level of care for infant feeding.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To support optimal nutrition in the healthy infant by appropriately supporting the mother’s efforts to initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations.

VI. GUIDELINE / PROCEDURE:
Lactation Guideline / Procedure
A. General Breastfeeding Guidelines
   Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by Partnership HealthPlan of California (PHC) and the American Academy of Pediatrics (AAP). Research has demonstrated numerous health benefits of breast feeding. Additional to health benefits, breastfeeding also provides social, economic and environmental benefits for both mother and infant.
B. Promotion and Support of Breastfeeding
   1. Lactation Education and Support Services: Each county served by Partnership HealthPlan of California (PHC) has a local Women Infants and Children Nutrition Program (WIC) program that includes lactation education, support and provision of breast pumps, for low income women, including those with Medi-Cal. All pregnant members should be referred to WIC. Lactation
support for PHC members is a shared goal and responsibility of WIC and the health delivery system provided through PHC, by the following providers:

a. **Primary care providers** are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant patients to prenatal breastfeeding classes will ensure they have current evidence-based information about breastfeeding.

b. **Prenatal care providers** should specifically assess a pregnant member’s knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. The pregnant members and their partners should be referred to a breastfeeding class antenatally and have access to one on one breastfeeding education prenatally and postnatally. This is especially important for members who are first-time mothers or have not breastfed in the past.

c. **Comprehensive Perinatal Service Programs (CPSP):** PHC strongly supports having all pregnant members receive support services provided through CPSP providers, which provide comprehensive assessments as part of their total prenatal care. CPSP providers may provide their own lactation support services or refer to other community resources to provide breastfeeding promotion, education, and counseling.

d. **PHC Care Coordination:** Members who are planning to breastfeed need specific resources to call for assistance with breastfeeding when indicated. Through specific programs and general case management support, PHC Care Coordination supports breastfeeding in accordance with current guidelines and evidence-based practices.

e. **Postpartum follow-up** calls are made to PHC members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education, and information.

f. **Hospitals providing obstetrical care** play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative ([https://www.unicef.org/programme/breastfeeding/baby.htm](https://www.unicef.org/programme/breastfeeding/baby.htm)) and will also include:

1) The hospital should receive information on the member’s prenatal record stating the infant feeding plan. That plan should be confirmed when a woman is admitted for delivery.

2) Family-centered childbirth practices allowing for early mother-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.

3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Mothers can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infants feeding cues.

4) Members need access to qualified nursing staff to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.

5) Supplements such as water, glucose water or formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.

6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC or a home health or public health nurse visit specifically to assist the mother with breastfeeding. Whenever possible this should occur within 1-2 calendar days of discharge.
7) The lactating mother leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if her baby is getting enough milk, and referral to a breastfeeding support group.

g. Infant care providers should encourage exclusive breastfeeding per AAP recommendations. Infant care providers should consider referral to a qualified lactation consultant, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the mother’s health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the mother may need to be provided with a breast pump and instructions on how to use it to maintain her milk supply.

h. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive home health nurse visits or public health nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first mother-baby home health visit by a home health nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public health nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.

2. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate Postpartum (in the hospital), early postpartum (from hospital discharge to 84 calendar days after delivery), and late post-partum periods (from 84 calendar days to 365 calendar days post-delivery). Lactation visits independent of the standard postpartum visits are covered by PHC.

3. Providers of Lactation support services:
   a. Basic Lactation support services may be provided by medical professionals: a Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, or a non-physician clinician, including Nurse Practitioner (NP), Physician Assistants (PA), or Certified Nurse Midwife (CNM). No special certification is required.
   b. Certified Lactation Consultants provide more specialized lactation support. Most International Board Certified Lactation Consultants (IBCLCs) have an underlying health professional licensure (RN, RD, MD, DO, CNM, NP, PA) as well.
   c. Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a PHC contracted Physician or PHC credentialed IBCLC.

4. Breast Pumps: When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If mother is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.

5. Supplementation: When supplementation is necessary, consider AAP guidelines for breast milk supplementation.

6. Banked Human Milk: Banked human milk is currently not widely available, but may be helpful for specific conditions in the hospital setting. According to WIC, in their landmark publication Ramping up for Reform, “Banked human milk is provided by Medi-Cal and health insurance plans in order to provide infants, especially high-risk infants, the healthiest start in life and reduce costly health complications.”

7. Active Management of Potentially Adverse Breastfeeding Situations
   a. Active Management and Support of Breastfeeding should follow the guidelines set forth by the authorities listed in the reference section below.
      1) These guidelines change often as new research emerges, so providers are expected to stay informed of updated best practice guidelines.
C. Contraindications
   1. AAP Guidelines should be utilized to identify additional conditions that are contraindicated
      a. Medications that may require temporary interruption of breastfeeding may be found utilizing
         AAP Guidelines; or for additional information call the Infant Risk Center at 806-352-2519.

D. Education Materials for PHC Members
   Educational materials may be helpful for parents. They are readily available through your local WIC
   office.

E. Useful Resources
   1. Sources of simplified definitions:
      2. CPSP http://cchealth.org/services/perinatal/
      4. Bilitool www.bilitool.org
         Hale Publishing, L.P.
         Pediatrics, 2018

VII. REFERENCES:
   A. American Academy of Pediatrics, Clinical Practice Guideline.
   B. Affordable Care Act, Section 4106a, Women’s Health Preventive Services,
   C. Infant Risk Center: Call 806-352-2519
   D. CA WIC Association: Ramping up for Reform-Quality Breastfeeding Support in Preventive Care.
      http://www.calwic.org/storage/documents/bf/2012/Ramping_up_for_Reform-
      WIC_Breastfeeding_Toolkit_2012.pdf
   E. Department of Health and Human Services/Center for Medicaid and CHIP Services
   F. Medicaid Coverage of Lactation Services. CMS Bulletin

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
   Medi-Cal
   02/17/16; 04/19/17; *03/14/18; 05/08/19; 06/10/20

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

PREVIOUSLY APPLIED TO:
   HealthyKids MPXG5009 (Healthy Kids program ended 12/01/2016)
   02/17/16 to 12/01/2016

   Partnership Advantage
   MPXG5009 – 01/15/2014 to 01/01/2015
# Meeting Minutes

**Meeting Name:** Provider Advisory Group  
**Date:** May 15, 2020  
**Time:** 12:00 pm to 1:00 pm  
**Locations:** Fairfield Office, Santa Rosa Office, PHC  
**Attendees (via video):** Liz Gibboney; Robert Moore, MD MPH; Alison French; Colleen Townsend, MD; Jeff Ribordy, MD; William Kinder; Jamie Wilborn; Ledra Guillory; Kris Devan; Melissa Stewart; Erika Robinson; Anthony Sackett; Andrew Torge; Lisa O’Connell; Carol Parker; Dani Carpenter; Bianca Veneracion; Rebecca Garcia; Mark Aguirre; Cody Wade; Namita Vij; Kyli Sinner; Tina Yarcia; Chloe Shafer; Shiavona Johnson; Kristy Woolworth; Kristina Coester; James Devan; Melissa Perez; Gloria Turner; Becky Hohe-Baker; Kim Bergeron-Palfini  
**Guests (via video):** Elaine Ellis; Angela Morrissey; Mary Jane Guajardo; Alejandra Garcia; Athena Barber; Jolene Kingsley; Barbra Barbeau; Elizabeth Lastra; Sandra Jones; Erica Baumker; Sheila O’Donnell; Yolanda Smaldino; Adele French; Sheila Allen; Shalamar Ivey; Carrie Watkins; Ellie Popdic; Carma Scott; Kerin Mase; Jeff McGee; Laura Fierce; Hailee Anderson; Anne Frunk; Marilynn Johnson; Elva Gallegos; Judy Jacoby; Dorina Potter; Jennifer Edwards; Mia Houlberg; Aide Padilla; Peggy Townsend; San Jungwirth; Krystal Rivera; Elizabeth Coudright

<table>
<thead>
<tr>
<th>Agenda Topic</th>
<th>Minutes</th>
<th>Action Items</th>
</tr>
</thead>
</table>
| Welcome/Review of Minutes/Review of Agenda   | 1.1 Welcome and Introductions: Facilitator Gloria Turner, PHC Provider Representative, Lake County  
1.2 Review of Minutes from previous meeting  
1.3 Review of Agenda                         | None                                                                   |
| Partnership HealthPlan Updates              | 2.1 PHC Update: Liz Gibboney, CEO                                       |              |
| 2.1 PHC Update                              | • PHC is doing our best to support our network in response to the COVID-19 outbreak. We are collaborating to help provide virtual and telephonic options for appointments, as well as making available accelerated payments to hospitals and grants to our primary care network.  
• We are performing member outreach to over 60,000 of our higher risk members to ensure that they are aware of the resources available to assist them.  
• The May Revision of the California State Budget includes significant cuts to health plans, hospitals, and providers including CBAS, optometry and dental benefits. |              |
### 2.2 Report from CMO

- It will require much creativity and effort over the next months and years for the State and PHC to recover from the economic fallout of the COVID-19 pandemic.

**2.2 Report from PHC Medical Director: Robert Moore, MD, MPH Chief Medical Director**

- There is a second virtual Medical Directors Meeting scheduled for May 22.
- Following guidelines from the California Medical Association (CMA) and American medical Association (AMA), and in alignment with State orders to re-open essential businesses, PHC is collaborating with our network to resume and increase outpatient services and coordinate the availability of Personal Protective Equipment (PPE).

### Presentation

**3.1 How to Cope with Stress and Anxiety Related to COVID-19. Alison French, Director of Partnerships, Beacon Health Strategies**

- COVID-19 is impacting all aspects of our life, and things are changing quickly.
- Social distancing, school and business closures, loss of income, and changing needs are all very stressful.
- Beacon has seen a tremendous uptick in the need for emotional help during this crisis. Increased anxiety, mental health concerns, disruption in daily routine and the potential difficulty in accessing care all contribute to an increase in stress levels and need for emotional support.
- PHC and Beacon have increased efforts to provide access to telehealth including identifying providers available to do telehealth, provider education, and claims system configuration.
<table>
<thead>
<tr>
<th>Old Business</th>
<th>4.1 None</th>
<th>None</th>
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<tbody>
<tr>
<td><strong>New Business:</strong></td>
<td></td>
<td>None</td>
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<tr>
<td><strong>5.1 Report from Claims</strong></td>
<td>5.1 Report from Claims Department. Jamie Wilborn, Claims Resolution Coordinator presented information on billing for telehealth visits. Due to statewide public health “Stay at Home,” order, video and telephone visits are encouraged when medically appropriate. PHC has established billing guidelines for providers to allow members to obtain health care via telehealth.</td>
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<tr>
<td><strong>5.2 Report from Provider Education</strong></td>
<td>5.2 Report from Provider Education. Lisa O’Connell, Senior Manager of Network Education &amp; Credentialing. The April 29 Telehealth Provider Webinar was recorded and posted on the PHC Website. A bulletin regarding provider changes was sent May 14. A flyer on lab testing billing is upcoming.</td>
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<td><strong>5.3 Update from Provider relations</strong></td>
<td>5.3 Report from Provider Relations. Melissa Perez, Senior PR Representative, Mendocino County. The Physician Satisfaction Survey is ending: if providers have not yet responded to the survey, they are encouraged to do so today.</td>
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<td><strong>5.4 Telehealth Update</strong></td>
<td>5.4 Telehealth Update. William Kinder. PHC is partnering with UC Davis on a pilot telehealth program that involves 7 sites and includes video consultation services for cardiology, dermatology, endocrinology, gastroenterology, immunology, infectious disease, nephrology, neurology, and pulmonology. Telemed2U goals include the creation of a global clinic and virtual waiting room. The advantages include greater access, less no-shows, and quicker utilization of services.</td>
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5.5 Report from Quality Department

5.5 Report from Quality Department. Anthony Sackett
- The HEDIS Measures for 2020 include proposed changes in response to COVID-19
- The 2020 PCP QIP Timeline suggests payments will be distributed in April 2021

Provider Topics of Interest
**Speaker: All**

| 6.1 None | None |

Next Meeting

<p>| <strong>August 21, 2020</strong> | None |</p>
<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>DISCUSSION / CONCLUSIONS</th>
<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
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<tr>
<td>I. Meeting called to order.</td>
<td>I. PHC Regional Medical Director Marshall Kubota, MD called the meeting to order at 7:04 AM. Dr. Kubota reminded everyone that all items discussed are confidential.</td>
<td></td>
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<td>4/8/2020</td>
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<tr>
<td></td>
<td>a. Voting member reminder.</td>
<td>a. Marshall Kubota, MD, Regional Medical Director, reminded The Committee of who the voting members are, and voting is restricted to non-PHC staff.</td>
<td></td>
<td>4/8/2020</td>
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<td>b. Dr. Kubota welcomed new committee member Dr. Madeleine Ramos of St. Joseph Health Medical Group Eureka. Dr. Ramos introduced herself as an Allergist who has worked for Humboldt County for 13 years.</td>
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<td>4/8/2020</td>
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<td>c. Dr. Kubota then welcomed Susan Foster FNP of Hill Country Community Clinic. Ms. Foster is considering becoming a member of the Committee and is observing this meeting. Susan Foster introduced herself as being a FNP for 8.5 years and is serving as the CMO at Hill Country for the last 3.5 years. She oversees the Family practice Round Mountain location as well as the 2 satellite locations in Redding.</td>
<td></td>
<td>4/8/2020</td>
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<td>II. Review and approval of March 11, 2020 Credentialing Meeting Minutes.</td>
<td>II. The Credentialing Committee meeting minutes for March 11, 2020 were reviewed by the Committee. No changes were made.</td>
<td>II. Minutes were reviewed with no revisions. A motion for approval of the minutes was made by: Jeffrey Gaborko, MD, and seconded by: Bradley Sandler, MD. Meeting minutes were unanimously approved without changes.</td>
<td></td>
<td>4/8/2020</td>
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<td>AGENDA ITEM</td>
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<td>RECOMMENDATIONS / ACTION</td>
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<td>b. Exceptions.</td>
<td>b. Dr. Kubota called the Committee’s attention to pages 13-14 of the packet and asked the committee to read over the document regarding an exception for a provider. PHC staff has made the recommendation to approve continued credentialing.</td>
<td>b. There was detailed discussion by committee. A vote for approval of continued credentialing for Practitioner: Motion to Approve by Jeffrey Gaborko, MD, and seconded by: Bradley Sandler, MD. Vote to approve, David Gorchoff, MD, Bradley Sandler, MD, Madeleine Ramos, MD. Objection and motion not to approve by Steve Gwiazdowski, MD. Majority approved motion for continued credentialing.</td>
<td>4/8/2020</td>
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<td>c. Review of MPCR200 Clean/Routine Practitioners and Ancillaries Practitioners approved, Pre-Committee Meeting.</td>
<td>c. Dr Kubota called the Committee’s attention to Page 15. The MPCR 200 Clean/Routine Practitioners and Ancillaries Practitioners approved, Pre-Committee Meeting. Information Only.</td>
<td>c. Informational only.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>d. Review and Approval of Revised Policies</td>
<td>d. Dr. Kubota called the attention of the Committee to the review and approval of revised policies on pages 16-21, MP CR 301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. Heather Brandeburg noted that a law had passed January 1, 2020 that mid-level practitioners provide a Practice Agreement versus a Supervising Physician’s Agreement. Dr. Kubota made a recommendation to approve the list of revised policies.</td>
<td>d. Committee members reviewed revised policies. A motion for the approval of revised policies was made by: David Gorchoff, MD and seconded by: Bradley Sandler, MD and was unanimously approved.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>e. Dignity Health Medical Foundation.</td>
<td>e. Dr Kubota directed the Committee’s attention to the following four delegated audit reports beginning with, Dignity Health Medical Foundation: Report of Credentialing/Re-credentialing Delegation Oversight Audit, including review and approval of the delegate’s</td>
<td>e. A motion to approve the continued delegation of credentialing and re-credentialing activities for Dignity Health Medical Foundation dba Mercy Medical Group, Woodland Clinic and Dignity Health Medical Group North State was made by: Jeffrey Gaborko, MD and was</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>AGENDA ITEM</td>
<td>DISCUSSION / CONCLUSIONS</td>
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<td>f. Lucile Packard Children’s Hospital Medical Group.</td>
<td>credentialing policies and procedures. File review resulted in 2 findings. A corrective action plan was requested. Page 22.</td>
<td>seconded by: Bradley Sandler, MD and was unanimously approved. PR Staff will report back to Committee once CAP is completed by delegate.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>g. Sutter Valley Medical Foundation dba Sutter Medical Foundation</td>
<td>f. Lucile Packard Children’s Hospital Medical Group: Report of Credentialing/Re-credentialing Delegation Oversight Audit, including review and approval of the delegate’s credentialing policies and procedures. File review resulted in 2 findings. A corrective action plan was requested. Page 23.</td>
<td>f. A motion to approve the continued delegation of credentialing and re-credentialing activities for Lucile Packard Children’s Hospital Medical Group was made by: Jeffrey Gaborko, MD and was seconded by: Bradley Sandler, MD and was unanimously approved. PR Staff will report back to Committee once CAP is completed by delegate.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>h. University of California Davis</td>
<td>g. Sutter Valley Medical Foundation: Report of Credentialing/Re-credentialing Delegation Oversight Audit, including review and approval of the delegate’s credentialing policies and procedures. Page 24.</td>
<td>g. A motion to approve the continued delegation of credentialing and re-credentialing activities for Sutter Valley Medical Foundation dba Sutter Medical Foundation was made by: Jeffrey Gaborko, MD and was seconded by: Bradley Sandler, MD and was unanimously approved.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
</tr>
<tr>
<td>a. Review and Approval of Ongoing Monitoring of Sanctions Report.</td>
<td>h. University of California Davis Report of Credentialing/Re-credentialing Delegation Oversight Audit, including review and approval of the delegate’s credentialing policies and procedures. File review resulted in 1 findings. A corrective action plan was requested. Page 25.</td>
<td>h. A motion to approve the continued delegation of credentialing and re-credentialing activities for University of California Davis was made by: Jeffrey Gaborko, MD and was seconded by: Bradley Sandler, MD and was unanimously approved. PR Staff will report back to Committee once CAP is completed by delegate.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<tr>
<td>b. Practitioner Monitoring List.</td>
<td>V. Review and Approval of Ongoing Monitoring of Sanctions Report.</td>
<td>a. Committee members reviewed the reports. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by: David Gorchoff, MD and seconded by: Bradley Sandler, MD and was unanimously approved.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<tr>
<td></td>
<td>a. The Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report page 26. Dr. Kubota mentioned the terming of Provider as informational only.</td>
<td>b. Practitioner Monitoring List. Informational Only</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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<td>AGENDA ITEM</td>
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<tr>
<td>VI. Review and Approval of Consent Calendar Items.</td>
<td>VI. Review and Approval of Consent Calendar Items.</td>
<td>a. Committee members reviewed the consent calendar items. A motion for approval of Consent Calendar items was made by Jeffrey Gaborko, MD and seconded by: Bradley Sandler, MD. Consent calendar items unanimously approved by the Credentialing Committee.</td>
<td>4/8/2020</td>
<td>4/8/2020</td>
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### AGENDA ITEM

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<th>RECOMMENDATIONS / ACTION</th>
<th>TARGET DATE</th>
<th>DATE RESOLVED</th>
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<tbody>
<tr>
<td>VI. Meeting Adjourned.</td>
<td>VII. Meeting adjourned at 7:28 AM.</td>
<td></td>
<td>4/8/2020</td>
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*Credentialing Meeting Summary for April 8, 2020 respectfully prepared and submitted by Erika Roach Credentialing Specialist I.*

*Chairman Signature of Approval*

Marshall Kubota, M.D., PHC Credentialing Chairman
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<th>Full Name</th>
<th>Type Code</th>
<th>Name/Street</th>
<th>County Name</th>
<th>Specialty Description</th>
<th>Board Name</th>
<th>Initial Cert Date</th>
<th>Board Certification</th>
<th>Hospital Name</th>
<th>Staff Cat</th>
<th>Specialty Order</th>
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<tr>
<td>I</td>
<td>Aguilar, Rosaura L, BCBA</td>
<td>BHP</td>
<td>Behavior Matters California, LLC</td>
<td>Solano</td>
<td>Behavioral Health</td>
<td>Behavior Analyst Certification Board</td>
<td>02/10/2020</td>
<td>Yes</td>
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<td>I</td>
<td>Alexander, Laura L, SUDCC</td>
<td>W&amp;R</td>
<td>Ford Street Project</td>
<td>Mendocino</td>
<td>Wellness and Recovery</td>
<td>California Association of DUI Treatment</td>
<td>03/20/2018</td>
<td>Yes</td>
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<td>I</td>
<td>Anderson, Grant W, RAC</td>
<td>W&amp;R</td>
<td>Humboldt Recovery Center</td>
<td>Humboldt</td>
<td>Wellness and Recovery</td>
<td>California Association for Drug / Alcohol</td>
<td>10/01/2019</td>
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<td>I</td>
<td>Aron, Anthony E, MD</td>
<td>PCP</td>
<td>Sutter Coast Community Clinic (PCP/SPEC)</td>
<td>Del Norte</td>
<td>Family Medicine</td>
<td>ABMS of Family Medicine</td>
<td>07/09/2011</td>
<td>Yes</td>
<td>Admitting Agreement</td>
<td>Specialty Primary</td>
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<tr>
<td>I</td>
<td>Awamleh, Claudia FNP</td>
<td>PCP</td>
<td>McCloud Healthcare Clinic</td>
<td>Siskiyou</td>
<td>Family Nurse Practitioner</td>
<td>American Academy of Nurse Practitioners Certification Board</td>
<td>10/26/2018</td>
<td>Yes</td>
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<tr>
<td>R</td>
<td>Baltins, Alidis MD</td>
<td>SPEC</td>
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<td>Beirne, Joshua P, MD</td>
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<td>10/27/1973</td>
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<td>Plastic &amp; Reconstructive Surgery</td>
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<td>Primary Specialty</td>
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<td>R</td>
<td>Werra, Robert J.,MD</td>
<td>PCP</td>
<td>Adventist Health Ukiah Valley</td>
<td>Mendocino</td>
<td>Family Medicine</td>
<td>Board Meets MPCR#17, Previously Board Certified in FM, IM, or PEDs</td>
<td>03/01/1970</td>
<td>No</td>
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<td>R</td>
<td>Young, Darcy RADT</td>
<td>W&amp;R</td>
<td>Caminar - Healthy Partnerships</td>
<td>Solano</td>
<td>Wellness and Recovery</td>
<td>California Consortium of Addiction Programs Professionals</td>
<td>11/30/2018</td>
<td>Yes</td>
<td>Santa Rosa Memorial Active</td>
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<td>R</td>
<td>Young, Michael T.,DO</td>
<td>SPEC</td>
<td>Adventist Health Ukiah Valley</td>
<td>Mendocino</td>
<td>Pain Management &amp; Rehabilitation</td>
<td>ABMS of Orthopaedic Surgery</td>
<td>07/11/2003</td>
<td>Yes</td>
<td>Enloe Medical Center Active</td>
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<tr>
<td>R</td>
<td>Zane, Linda J.,FNP</td>
<td>PCP</td>
<td>Hill Country Comm Clinic-Round Mtn</td>
<td>Shasta</td>
<td>Family Nurse Practitioner</td>
<td>American Academy of Nurse Practitioners Certification Board None</td>
<td>02/06/2014</td>
<td>Yes</td>
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<tr>
<td>R</td>
<td>Zittel, Scott R.,DO</td>
<td>SPEC</td>
<td>Knapp &amp; Zittel, A Med Corp DBA Physicians Wound Center</td>
<td>Shasta</td>
<td>Wound Care</td>
<td>None</td>
<td>No</td>
<td>No</td>
<td>Specialty Primary</td>
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## Meeting Minutes

**Meeting Name:** Pediatric Quality Committee (PQC) Meeting  

**Date:** May 6, 2020  

**Time:** 1:00 to 3:00 PM  

**Location:** To comply with social distancing measures due to COVID-19, Partnership HealthPlan of California conducted this meeting virtually through WebEx. There were no in-person meeting locations. Calendar invitations were sent with WebEx link. Call-in number for the meeting was 844-621-3956  

Meeting ID: 800 165 113  

Videoconference Password: PQC0506  

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### Advising Members Present:  
Carol Miller, MD, Marin CCS  
Caryl Greenwood, MN, PHN, Shasta County  
Cheryl Losado, RN, PHN, Napa County CCS  
George Monteverdi, MD, Napa CCS  
Irene Jimenez, PHN Solano County  
Kristine Reyes, DO Pediatrics, Kaiser Permanente  
Lauren Burchfield, BSN, RN, PHN Humboldt County CCS  
Pam Sakamoto, BSN, PHN, Solano County CCS  
Paulomi Shah, MD, Sonoma CCS  
Sheka Jones Espy, MPH, PHN, RN, Solano County CCS  
Steven Gwiazdowski, MD, NorthBay Neonatology Associates  

### Advising Members Absent:  
Brenda Harris, RN, PHN Siskiyou County  
Chris McSorley, RN, PHN, CIC Lake County CCS  
David Bergman, MD Lucile Packard  
Duane Carter, MD, Shasta Community Health Center  
Gena Lee Lewis, MD CHO  
Helen May, RN, Lassen County  
R. Jennifer Olson, MD, CHO  
Lael Lambert, RN Marin County  
Lorna Boland, RN, Modoc County  
Marcie Jo Cudzio, RN, PHN, MPA - Trinity County HHS  
Mary Ann Limbos, MD, Yolo County CCS and Deputy Health Officer  
Melody Cannon-Cutts, Public Health Program Manager, Del Norte County  
Shandi Fuller, MD, Solano CCS  
Sharon Convery, PHN - CCS Administrator for Mendocino County  

### Other Members Present:  
Carlene Bramlett, Trinity County  
Jaime Ordonez, Yolo County CCS  
Jennifer Hathaway, LVN – Siskiyou County  
Meredith Wolfe, Humboldt County CCS  

### Other Members Absent:  
Cynthia Raschein, Public Health Director, Lassen County  
Naomi Underwood, Trinity County  
Peg Walden, MPH, Health Program Manager, Sonoma  
Tara Dikeman, Sonoma County  

### Required PHC Staff Present:  
Jeff Ribordy, MD, MPH – Committee Chair/ Medical Director, WCM  
Peggy Hoover, RN - Senior Director, Health Services  

### Required PHC Staff Absent:  
Robert L. Moore, MD, MPH, MBA – Vice Chair/Chief Medical Officer  
Stan Leung, Pharm.D, Director of Pharmacy Services  

### Other PHC Staff Present:  
Anna Campbell, Administrative Assistant II  
Doreen Crume, RN Case Management Supervisor  
Katherine Barresi, RN, PHN, CCM Associate Director Care Coordination  
Lisa O’Connell, Manager of Provider Education  
Ron Klinger, RN, MSN, CNL Team Manager, Care Coordination
### Agenda Item #1
**Introductions and Objective of Meeting**

All attendees joined the meeting virtually through WebEx due to COVID 19 social distancing requirements. Roll call was taken of all attendees logged into the virtual meeting.

Dr. Ribordy announced that advising member, Constance Caldwell, MD, passed away in November 2019 after our last meeting.

Dr. Ribordy announced changes in PHC positions. Katherine Barresi, RN, BSN, PHN CCM is now the Director of Care Coordination and will continue attending PQC meetings. Rebecca Boyd Anderson, MSN, PHN, CCM, is now the Director of a new PHC department, Population Health, and will no longer be attending PQC on a regular basis.

**Action Items**

Committee quorum requirements met.

### Agenda Item #2
**Approval of minutes from last meeting**

The Committee Chair presented the meeting minutes from November 6, 2019 for approval. No corrections were found to be necessary.

**MOTION**: Steven Gwiazdowski, MD moved to approve Agenda Item [2.] as presented, seconded by George Monteverdi, MD.


### Agenda Item #3
**Annual review of policy MCCP2025 Pediatric Quality Committee Policy**

Policy MCCP2025 Pediatric Quality Committee Policy was reviewed and no changes were found to be necessary.

**MOTION**: Dr. Gwiazdowski moved to approve policy MCCP2025 Pediatric Quality Committee Policy as presented, seconded by Pam Sakamoto, BSN, PHN.


### Agenda Item #4
**Annual review of policy MCQG1015 Pediatric Preventive Health Guidelines**

Policy MCQG1015 Pediatric Preventive Health Guidelines was reviewed.

**At VI.J**: Section was added for Developmental Screening per DHCS requirements for ACEs and Developmental screening incentives.

**At VI.K**: Section was added for Trauma Screening per DHCS requirements for ACEs and Developmental screening incentives.

**MOTION**: Dr. Gwiazdowski moved to approve changes to policy MCQG1015 Pediatric Preventive Health Guidelines as presented, seconded by Caryl Greenwood, MN, PHN.

### Agenda Item #5
Minutes presented from previous Family Advisory Committee Meetings:
*November 20, 2019*  
*January 15, 2020*

Katherine Barresi summarized PHC’s Family Advisory Committee (FAC) meetings of November 20, 2019 and January 15, 2020.

The next FAC meeting will be May 20 from 12 – 1:30 pm.

Dr. Miller asked if there are still openings on FAC for more parents to join? Yes, Katherine said 14 of 28 spaces are open and interested parties can inquire through email to FAC@partnershiphhp.org

**MOTION:** Dr. Gwiazdowski moved to approve Agenda Item [5.] as presented, seconded by Pam Sakamoto, BSN, PHN.  
**ACTION SUMMARY:** [11] yes, [0] no, [0] abstentions.  
Motion carried.

### Agenda Item #6
CCS Advisory Group Update


Meredith Wolfe, Humboldt County CCS, shared that DHCS also released a memo directly to CCS offices on April 28 which was written to classic CCS counties regarding Telehealth and HIPAA.

The MTP guidance letter provided MTU specific info such as what services are allowed to continue and in what modality. That information will not have a specific impact on PHC, but PHC will be supporting our MTUs.

The CCS guidance letter explained that the Annual visit may be waived or it could occur virtually. Katherine does not think they intend to get rid of the requirement for annual visits. CCS NL 01-0108 is referenced but that discusses the annual team conference, not the annual visit. Dr. Miller agreed with Katherine. She thinks they intend that the annual visit requirement remains but they will allow all options such as a delay up to 3 months or conducting the visit virtually.

Katherine said the CCS Advisory Group was not comfortable recommending that we allow certain conditions, like hemophilia, to be grandfathered in right now. She is not certain if a decision was made after April 19.

The time frame to request a State Fair Hearing was extended – it was doubled. PHC has been working to update this info on all member letters.
Specific guidance was given to providers regarding prior auths during COVID. Normally they need a SAR first. But current guidance allows them to provide treatment and submit retro auths as long as they state “COVID” in the TAR. DHCS states that this is for treatment across the board, not just CCS conditions.

Re: DME – PHC is working with families to be sure all DME needs are met.

CCS paneling is being fast tracked.

Well child visits are very important and we encourage them to continue to prevent new outbreaks of other diseases. PHC recommends providers continue to follow AAP guidelines.

Meredith Wolfe shared HRIF info. It normally cuts off at age 3. But they have extended it up to 42 months because appointments are delayed and we don’t want any children to miss their last visit.

CCS Pharmacy Flexibility – We are not putting any restrictions on WCM kids for refills or frequency. We are leaving it open as much as possible. There should be no medication barriers for families.

Dr. Miller asked about eligibility. Will families who may have challenges meeting deadlines for renewal have any leeway? Katherine said DHCS is taking 2 separate approaches. The Governor issued an order to halt annual Medi-Cal renewals. For people with aid codes that require annual proof documents, those requirements are paused for 90 days. On June 1 they will just stay, unless there is another executive order. Historically, CCS kids do not have an aid code that requires annual Medi-Cal renewal. Instead they have CCS program renewal requirements. When we have families open to case management, we continue to follow them even if their eligibility expires. We check in and encourage them to renew paperwork even though they are not PHC members as we do not think it is responsible to drop them.

Peggy Hoover advised that it looks like members who drop off of Medi-Cal and PHC right now will have to apply to the State and not to PHC to come back. So for a month or two, they could belong to State Medi-Cal and not to PHC.

Caryl Greenwood asked: According to the executive order, how many days do we need to keep them open? Katherine advised it would be 90 days back from June 1 (when
### Agenda Item #7

**COVID 19 Provider/Member Issues**

Newsom issued order to County Staff) but not everyone even needs an annual redetermination. 
Also, it is PHC standard process that when a PHC WCM child appears to lose eligibility, we investigate why. We will continue to follow the member for at least 60 days and try to contact the family by phone and mail. We would not close out a member until after at least 60 days of no contact. Caryl said that is very helpful to Shasta County because they are a hybrid and they have to do SARS.

According to DHCS mandate re: COVID-19, PHC is reach out to certain populations, including CCS. On April 13th we began reaching out to 7400 CCS families. Some had outdated contact info and we could not reach them. But as of Friday last week, we’ve made 5300 calls and reached 2400 families. Families have expressed that they are overwhelmed and they are grateful we are reaching out. Concerns stated include issues with large vendors, vendors hoarding oxygen tanks, families being told to reuse ventilator equipment, and shift nursing nurses not showing up. Families are also overwhelmed with non-health care issues – income, food supply, childcare and school. In our efforts to reach out, we have accidentally discovered and resolved some other issues during this campaign such as prescription management issues. Dr Shah expressed appreciation that PHC is conducting this calling campaign and reaching out to families because Sonoma county staff was already limited before COVID and now it is reduced to disaster management. She wanted to know what kinds of questions PHC asks. We ask “How are you?” and “How is this affecting your health and your family?” We also remind members of resources available to them in their area and, if they are having issues, we open them up to case management.

### Agenda Item #8

**COVID 19 DHCS Call campaign**

See discussion above. Question was asked, will there be follow up calls for COVID calling campaign? So far PHC has done an initial round of calls, largely organized by our Population Health department, to meet state mandates. PHC has trained staff from all health services departments to assist in making these calls. Dr. Miller asked if we are able to track the concerns we discover and share them? Katherine said she will report outcomes of our next debrief meeting to Dr. Ribordy and we can share at next PQC.

Ron Klinger explained that an unexpected side effect of Shelter In Place is that Members are more receptive to taking our calls and speaking with us. In fact, we have received quite a variety of praise from Members for reaching out and we have been happy to accidentally discover other non-COVID issues that we can help resolve.

Katherine Barresi will provide Dr. Ribordy with a report on concerns we discover during our COVID-19 call campaign to CCS families. We will share that info at the next PQC meeting.
<table>
<thead>
<tr>
<th>Agenda Item #9</th>
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<tbody>
<tr>
<td><strong>HBCS Waiver</strong></td>
<td>Katherine, Ron and Doreen Crume would like to know if any PQC members have worked with CCS children who also applied for the Home and Community Based Alternatives Waiver. At PHC, we have always thought you could not be on CCS and also apply for this waiver. We had people wait until age 20 and then start applying for it because it took a year. But now we are learning we may have been wrong. We had a provider ask us recently because they had a child “on the waiver” and wanted to know where to send bill. Can children under 21 get shift nursing through the waiver? Which payor takes precedence? Do any PQC members know of any CCS kids who have been enrolled in the waiver program? Lauren Burchfield and Dr. Miller report they have not heard of it. Caryl Greenwood (Shasta County) said Eileen, who just retired a week ago, is their historian and she will ask her about it. Katherine reached out yesterday to our managed care counterparts to ask as well. We need to find guidance to support it because agencies providing are continuing to bill PHC. Ron said we are aware of two kids on it right now - approval of hours on assessment are different so we are trying to decide what to do. Doreen has a situation now where a Member was again out of WCM on May 10 and a home health agency has been providing shift nursing services. The Mom asked what happens at 21? PHC reached out to the agency and they brought up the waiver. They reached out to company in Chico. They get the application, they go into home and do and intake on member. (virtual right now) Once determined that the member qualifies, they stay on the waiver indefinitely. They supply case management and approve TARS for the benefit. PHC verified they got the application for this member and we are following to see if it goes through. PHC does not provided shift nursing for over 21. That is the purpose of the waiver.</td>
</tr>
<tr>
<td>a.HCBA PL 19-01</td>
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<th>Agenda Item #10</th>
<th>No new information to present on this topic.</th>
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<td><strong>CCS Transition</strong></td>
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<td>Coding and Billing</td>
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**Agenda Item #11**
**Questions and New Topics**

Caryl Greenwood (Shasta County) is noticing a decrease in CCS referrals. They assume it is COVID. They had only 13 referrals last month from one clinic in Fortuna for cardiac care. Otherwise nothing. But they did get recommendations for restarting care.

**Discussion:** Primary care visits and ED visits are all down. Children are not as sick because they have been out of school and daycare. Accident rates are down, even for children. Also, many issues are being handled at home via telehealth instead of going into an ED.

**Discussion:** We have wanted to increase telehealth for a long time. Now the question is whether it will continue after COVID. Dr. Miller said she likes it better for certain types of visits (e.g. it has worked very well for breastfeeding support groups). In rural counties, travel to a provider can be an hour or more each way. From Shasta County it can be 4 hours to get to UCSF and the visit may only be 10 minutes. Those situations can be very frustrating for CCS children and families and telehealth could be more effective.

Dr. Shah thinks there is definite benefit to telehealth but for high risk populations, she worries about not being able to pick up on signs of domestic abuse and other issues. She is also concerned that when a second wave of COVID hits, they may not be able to determine what is actually going on by telehealth. We don’t want the pendulum to swing too far – you can’t do a full well child exam entirely by telehealth.

Caryl Greenwood said they had a transfer from a non-WCM county to Shasta county that was very streamlined and went well. They received all info very smoothly from the ombudsman.

**Dr. Miller** noted that timeliness is improving for receiving necessary records for annual reviews.

AAP has made recommendations for immunizations for under 2. Our providers need PPE for those visits.

**Next Meeting**

Please email Anna Campbell with agenda topics for the next meeting.

[ACampbell@partnershiphp.org](mailto:ACampbell@partnershiphp.org)

Meeting adjourned at 2:15 pm

*The next PQC meeting will be August 5, 2020 from 1:00 – 3:00 p.m.*
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

Policy/Procedure Number: MCCP2025
Lead Department: Health Services

Policy/Procedure Title: Pediatric Quality Committee Policy

Original Date: 04/10/2019
Next Review Date: 04/10/2020
Last Review Date: 04/10/2020

Applies to: ☑ Medi-Cal
☐ P & T
☐ Internal Policy

Reviewing Entities:
☒ IQI
☐ Operations
☐ Executive
☐ Compliance
☒ PQC

Approving Entities:
☐ CEO
☐ COO
☐ Credentialing
☐ Department
☒ PAC

Approval Signature: Robert Moore, MD MPH MBA
Approval Date: 04/10/2020

I. RELATED POLICIES:
A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1002 – Quality/Utilization Advisory Committee
C. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
D. ADM21 – Members on PHC Committees

II. IMPACTED DEPTS:
Health Services

III. DEFINITIONS:
A. California Children’s Services (CCS): The CCS program is a program of the State of California, established under the Health and Safety Code, Section 123800 et seq. which is administered by the Department of Health Care Services (DHCS). It provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions.
B. Whole Child Model (WCM): A program of the California Department of Health Care Services (DHCS) established under the authority of Senate Bill (SB) 586 (Hernandez, Chapter 625, Statutes of 2016), which allowed designated County Organized Health Systems (COHS) or Regional Health Authority Counties to incorporate CCS-covered services into Medi-Cal managed care for CCS-eligible members.

IV. ATTACHMENTS:
A. NA

V. PURPOSE:
The Partnership HealthPlan of California (PHC) Pediatric Quality Committee (PQC) was established by the Chief Medical Officer (CMO) to provide PHC with advice on clinical issues related to CCS conditions. It reports its findings to the PHC Physician Advisory Committee (PAC) and the Family Advisory Committee (FAC). The PAC has the ultimate authority over clinical policies for PHC, so recommendations of the PQC are subject to the approval of PAC.

VI. POLICY / PROCEDURE:
A. COMMITTEE STRUCTURE
1. Membership:
   a. The PQC is comprised of the PHC Chief Medical Officer, the PHC Whole Child Model Medical Director, the Senior Director of Health Services, the Pharmacy Director, at least four CCS-
paneled clinician providers, the CCS Medical Directors designated by each PHC county, and
the Nurse Director/Manager designated by each County CCS program.
b. Other health plan staff and outside experts may make special or periodic reports to the
committee or may attend selected meetings by invitation from the committee chair or designee.

2. Minutes: Minutes of all meetings are maintained.
3. Chair: The PHC Whole Child Model Medical Director chairs the committee; the PHC Chief Medical
Officer is the vice chair.
4. Meetings: The Committee meets at least four (4) times a year, with the option to add additional
meetings if needed. The meeting agenda will be sent out at least one week prior to meeting date.
5. Advisory Recommendations: Only non-PHC clinical members (physicians and nurses) may reach a
consensus on recommendations to be submitted to the PAC. The committee chair may lead and
participate in the discussion and serves in a tie breaking capacity as necessary. A quorum needed to
recommend action items shall be at least 4 non-PHC members. Any action items pass with a simple
majority of members present.
6. Compensation: Physician members who are not PHC staff are eligible to receive a financial stipend
for each meeting attended (unless otherwise compensated by their county CCS agency for
attendance at PQC or by PHC for management responsibilities). This stipend may be in addition to
other compensation when the member serves as a clinical consultant/physician adviser. (Please see
policy ADM21 – Members on PHC Committees for stipend form and instructions.)

B. COMMITTEE RESPONSIBILITIES
1. Discuss clinical issues relating to CCS conditions, as brought to the committee by committee
members, by PHC staff or by referral from the Family Advisory Committee.
2. Make recommendations to the PAC on CCS/WCM related clinical policies. These
recommendations may first flow through the Internal Quality Improvement (IQI)/ Quality
Utilization Advisory Committee (QUAC) policy flow, if applicable, before going to the PAC.
3. Upon approval by the committee, an ad hoc subcommittee may be formed as needed.

VII. REFERENCES:
DHCS All Plan Letter (APL) 18-023 California Children’s Services Whole Child Model Program (dated
12/23/2018)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 05/13/20

PREVIOUSLY APPLIED TO:
N/A
I. RELATED POLICIES:
A. MCQP1021 - Initial Health Assessment and Behavioral Risk Assessment
B. MPQP1022 - Site Review Requirements and Guidelines

II. IMPACTED DEPTS:
A. Health Services
B. Provider Relations

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. AAP Recommendations for Preventive Pediatric Health Care

V. PURPOSE:
To specify Partnership HealthPlan of California (PHC) policy for periodic health screening and preventive health services for members through 20 years of age provided by primary care providers. The California Department of Health Services requires that all Medi-Cal managed care health plans, including PHC; utilize the current Child Health and Disability Program (CHDP) and American Academy of Pediatrics (AAP) preventive health care recommendations, as well as the Advisory Committee on Immunization Practices (ACIP)/AAP immunization schedule, in formulating plan specific standards and guidelines. Since all PHC primary care providers who care for children are expected to be enrolled as CHDP providers, all other CHDP policies related to the provision of pediatric preventive services are applicable as well.

VI. GUIDELINE / PROCEDURE:
A. The following standards and guidelines address periodic health screening and preventive services for low risk, asymptomatic children and adolescents. Individuals identified as being at high risk for a given condition may require screening at more frequent intervals or the performance of additional screening tests specific to the condition. High risk individuals are defined as those whose risk behaviors, family history, socioeconomic status, lifestyle or disease or genetic condition is associated with a higher tendency to the development of a specific condition or disease.
B. Where the AAP periodicity exam schedule is the same as the Child Health and Disability Prevention (CHDP) periodicity examination schedule, the AAP scheduled assessment must include all components required by the CHDP program for the lower age nearest to the current age of the child. A physical examination is completed according to CHDP/AAP periodicity exam schedule and each health
assessment will include:
1. Anthropometric measurements of weight, length/height and head circumference of infants up to age 24 months.
2. Physical examination/body inspection, including screen for sexually transmitted infection (STI)/human immunodeficiency virus (HIV) on sexually active adolescents.
3. Follow up care or referral is provided for identified physical and behavioral health problems as appropriate.

C. Primary Care Providers (PCPs) must complete an Initial Health Assessment (IHA) on all new members within 120 days of enrollment to PHC. Since the Initial Health Assessment includes the provision of an Individual Health Education Behavioral Assessment (IHEBA), also known as Staying Healthy Assessment (SHA), it must also be completed during this timeframe. If the member was already enrolled in the PCP’s practice and only the insurance coverage changed, then any physical, containing all the elements that were done within the previous 12 months, may be counted.

D. Immunizations must be provided according to the General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP), AAP, and the American Academy of Family Physicians (AAFP). Specific to APL 18-004: Providers must ensure timely provision of immunizations to members in accordance with the most recent schedule and recommendations published by ACIP, regardless of a member’s age, sex, or medical condition, including pregnancy. Providers must document each member’s need for ACIP recommended immunizations as part of all regular health visits.
   1. When immunizations are provided at sites other than the PCP’s office, the provider should notify the PCP’s office of the immunization given and the date.
   2. If this is not possible, the member or parent/guardian of the member must be advised to provide this information to the PCP at the next visit.
   3. PCP office should be requesting previous medical record(s) to show a complete history.

E. Unless the member has received a periodic health screening visit within the periodicity schedule in reference B, the member, or the member’s parent/guardian, must be informed at the time of each non-emergency primary care visit of the availability of services through the PCP’s practice. If the needed exam qualifies for services through the CHDP program, the member’s parent/guardian should be informed that services are available at the PCP’s practice, or at another site offering CHDP services.
   1. This requirement may be met through the provision of the PHC document Recommendations for Preventive Adolescent/Pediatric Care in reference A, or by providing a document of equivalent content.
   2. Should the member not receive periodic health screening services according to the attached schedule, either:
      a. The voluntary refusal of the member (or the parent/guardian) regarding the use of CHDP services should be documented in the member’s medical record, or:
      b. There should be documentation of an outbound phone call or written communication from the provider to the member advising of the need to schedule a periodic health screening appointment.
   3. In the case where a child scheduled for a periodic health screening visit is not seen as scheduled, the PCP’s staff should contact the member (or parent/guardian) to reschedule the visit, and document same in the medical record.

F. Diagnosis and treatment of any medical conditions identified through the periodic health screening (CHDP) process, either by the PCP or through referral to a specialist, must be initiated within 60 days of identification. Justification for delays beyond 60 days must be entered into the member’s medical record.
G. Providers must enter their findings in the member’s medical record.
H. Parents of children found to have conditions which could constitute eligibility for the California Children’s Services (CCS) Program must be informed. The PCP’s staff should initiate a referral to the county CCS office for eligibility determination.

I. Monitoring and Quality management
   1. Timeliness and appropriateness of pediatric preventive health will be monitored annually by completing designated HEDIS measures (Childhood Immunization, Adolescent Immunization, Well Child Visits in the third, fourth, fifth and sixth years of life, Adolescent Well Care Visits and Well Child Visits in the First 15 months).
   2. Documentation of children’s/adolescent preventive services will be reviewed periodically as a component of the Site Review.

J. Developmental Screening
   1. Before age 3, comprehensive developmental screening must be performed at least annually, using one of the standardized instruments listed below.
      a. Ages and Stages Questionnaire (ASQ) - 2 months to age 5
      b. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
      c. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
      d. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
      e. Brigance Screens-II - Birth to 90 months
      f. Child Development Inventory (CDI) - 18 months to age 6
      g. Infant Development Inventory - Birth to 18 months
      h. Parents’ Evaluation of Developmental Status (PEDS) - Birth to age 8
      i. Parents’ Evaluation of Developmental Status - Developmental Milestones (Peds-Dm)
   2. Comprehensive developmental screening using one of the instruments above must be billed using the CPT code 96110 without a modifier.
   3. Additional screening tests, such as focused screening for autism using the Modified Checklist for Autism in Toddlers (M-CHAT) or screening for social and emotional development using the ASQ-SE, may be performed before age 3, but must be billed using the added KX modifier: 96110.KX.
   4. Developmental screening may also be performed for children over age 3, and billed with 96110 if one of the standardized instruments in section VI.I.1 is used, or 96110.KX if another standardized tool is used.
   5. Up to one 96110 without a modifier is payable per year. Additionally, up to one 96110.KX is payable per year.
   6. Use of the correct tools will be audited by the Patient Safety team as part of the site review process. Use of the correct billing codes will be audited with intermittent spot audits, performed by the Patient Safety team.

K. Trauma Screening
   1. Starting on January 1, 2020, primary care clinicians may screen children annually up to age 19 for traumatic life events using the Pediatric ACEs and Related Life-events Screener (PEARLS), which includes screening for several social determinants of health.
   2. Coding results of screening will depend on the result of the screening.
      a. G9919: Screening performed and positive and provisions of recommendations (4 and greater)
      b. G9920: Screening performed and negative (0 to 3)
   3. The California Department of Health Care Services (DHCS) is developing recommendations for stratifying the risk, based on the screening, and tailoring interventions to this risk stratification. These recommendations are based on consensus of experts and have not yet been studied.
systematically. DHCS will have on-line training available in early 2020 for clinicians to learn more.

4. At this time, trauma screening for children is recommended, but not required for primary care providers caring for children.

5. Attestation of completion of DHCS-approved training will be through DHCS. After July 1, 2020, DHCS has stated that payment for billing trauma screening services will depend on completion of this attestation.

2.6. Audit: The use of the PEARLS in association with use of the billing codes above will be audited intermittently by the Patient Safety team in the quality department.

VII. REFERENCES:
B. CHDP Bright Futures Schedule for Health Assessment by Age Group https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-other/CHDP/Forms/periodbright_e01.pdf
C. General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and CDC Recommended Childhood and Adolescent Immunization and Catch-Up Schedule, access current version from link found at: http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
D. American Academy of Family Physicians (AAFP) on immunization can also be found at: http://www.aafp.org/immunization
E. United States Preventive Services-Task Force (USPSTF) current recommendations, American Academy of Pediatrics (AAP) current recommendations, Center for Disease Control (CDC) 2011 Immunization Schedule. Information can also be found at: https://www.aafp.org/patient-care/public-health/immunizations/schedules.html
G. AAP publications on Health Supervision for Children with (disease/genetic condition) https://www.aappublications.org/search/policy/%20subject_collection_code%3A100 (Search should be done under the Policy tab)
H. CDC Immunization Schedules: https://www.cdc.gov/vaccines/schedules/index.html

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

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

X. REVISION DATES:
Medi-Cal
10/13/95; 10/10/97 (name change only); 03/11/98; 5/17/00; 02/20/02; 10/30/02 vs. 10/16/02; 10/20/04; 04/20/05; 10/19/05; 06/21/06; 09/19/07; 03/18/09; 02/17/10; 03/16/11; 10/17/12; 10/16/13; 11/19/14; 11/18/15; 10/19/16; 09/20/17; *06/13/18; 06/12/19; 02/12/20
### Recommendations for Preventive Pediatric Health Care

**Bright Futures/American Academy of Pediatrics**

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the Bright Futures Guidelines (Hagan JF, Shaw J, Duncan PM, eds. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. 4th ed. Elk Grove Village, IL, American Academy of Pediatrics, 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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<tr>
<th>EARLY CHILDHOOD</th>
<th>MIDDLE CHILDHOOD</th>
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<td><strong>AGE</strong></td>
<td><strong>HISTORY Initial Evaluation</strong></td>
<td><strong>MEASUREMENTS</strong></td>
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<td>Newborn*</td>
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<td><strong>Fluoride Varnish</strong></td>
<td><strong>Fluoride Supplementation</strong></td>
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<td><strong>Blood Mass Index</strong></td>
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<td><strong>Diabetes Screening</strong></td>
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**Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC Toolkit**

See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/134/6/1814).

**1.** A provider should screen for depression among all children and adolescents aged 10 years and older. A child who is 8-9 years old may be included if there is a high risk of depression. This is consistent with the recommendation for adults. Use a depression screening tool that has been validated for children this age.

**2.** A provider should screen for alcohol or drug use among children aged 10 years and older. A child who is 8-9 years old may be included if there is a high risk of alcohol or drug use. Use a screening tool that has been validated for children this age.

**3.** A provider should screen for tobacco use among children aged 10 years and older. A child who is 8-9 years old may be included if there is a high risk of tobacco use. Use a screening tool that has been validated for children this age.

**4.** A provider should discuss sexual risk behaviors with children aged 11 years and older. A child who is 10 years old may be included if there is a high risk of sexual risk behavior.

**5.** A provider should screen for sexual abuse among children aged 11 years and older. A child who is 10 years old may be included if there is a high risk of sexual abuse.

**6.** Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (http://pediatrics.aappublications.org/content/137/4/e20160339).

**7.** Measurement in infants and children with specific risk conditions should be performed at visits before age 3 years. Importantly, measurement in children with intellectual disability or autism spectrum disorder should be performed in the appropriate age range based on the child’s developmental age.

**8.** Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery should be evaluated within 48 hours of discharge per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/127/Supplement_A/1).

**9.** A provider should screen all children for violence. Use the following tools:

- **The Modified Conflict Tactics Scale (MCTS)** (http://www.casa-index.org/software/modif ppt/toolkit)
- **The Severe Violence Questionnaire (SVQ)** (http://www.jahonline.org/article/S1054-139X(16)30001-0/fulltext)
- **The Conflict Behavior Scale**

**10.** A provider should screen for child abuse and neglect. Use a screening tool that has been validated for children this age.

**11.** A provider should screen children for developmental delay at age 3 years and then at ages 4, 5, 6, and 7 years to identify children with developmental delay that might benefit from additional evaluation and follow-up.

**12.** A provider should screen for childhood apraxia of speech at age 4 years. Use a screening tool that has been validated for children this age.

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**Continued**
Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2018 and published in March 2019. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

CHANGES MADE IN DECEMBER 2018

BLOOD PRESSURE

- Footnote 6 has been updated to read as follows: “Screening should occur per Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents” (http://pediatrics.aappublications.org/content/140/3/e20171904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.”

ANEMIA

- Footnote 24 has been updated to read as follows: “Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP Pediatric Nutrition: Policy of the American Academy of Pediatrics (Iron chapter).”

LEAD

- Footnote 25 has been updated to read as follows: “For children at risk of lead exposure, see “Prevention of Childhood Lead Toxicity” (http://pediatrics.aappublications.org/content/134/3/626) and “Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention” (https://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).”
# Meeting Minutes

**Meeting Name:** Family Advisory Committee Meeting  
**Date:** January 15th, 2020  
**Time:** 12:00 p.m. – 1:30 p.m.  
**Location:** Partnership HealthPlan of California - Fairfield, Santa Rosa, Eureka, and Redding offices

|-----------------------------|--------------------------------|-----------------------------|---------------------------|
| Samantha Coburn – Parent – Napa - Yes  
Robert Pewitt – Parent – Solano – Yes  
Tamara DeBarssi – Solano (County CCS – Phone) | James Peila – Parent – Santa Rosa - Yes  
Taryn Larson – Parent – Lake – Yes | Ginger Moyles – Parent – Siskiyou (Phone) - Yes  
Shonda Smith – Lassen (County CCS – Phone)  
Eileen Rodgers – Shasta (County CCS – Phone)  
Carlene Bramlett – Trinity (County CCS – Phone) | Diane Larson – Del Norte (Phone) - Yes |

<table>
<thead>
<tr>
<th>Members Absent:</th>
<th>PHC Staff Present: Fairfield Office:</th>
<th>PHC Staff Present: Santa Rosa Office:</th>
<th>PHC Staff Present: Redding Office:</th>
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</table>
| Araceli Gonzalez Aguilar – Napa  
Christa Poe – Solano  
Lasonja Porter - Yolo  
Karolyn Poppin – Marin | Peggy Hoover, RN - Senior Director, Health Services - Yes  
Ron Klinger, RN, MSN, CNL, Care Coordination Manager - Yes  
Wendy Stewart, Administrative Assistant, Care Coordination – Yes  
Catherine Thomas, Sr. Health Educator, Care Coordination – Yes  
Amanda Bernal, Health Educator, Care Coordination - Yes  
Patty Hayes, Communications - Yes | Suzanne Cervantes – Care Coordination (VC) - Yes  
Jay Navarrete – IT (VC) - Yes | Bre Williams – Care Coordination (VC) |
| | | | Eureka Office: |
| | | | Dr. Jeff Ribordy – (VC) |

*Note: via Video Conference (VC), via Teleconference (TC)*
**Agenda Item #1**
*Introductions & Objective of Meeting*

**Speaker:** Ron Klinger, RN
Care Coordination Manager

Introductions were made from the various locations in Fairfield, Eureka, Redding, and Santa Rosa.

Introductions:

**Phone:**
- Diane Larson – Parent – Del Norte County
- Shonda Smith – Lassen County CCS
- Carlene Bramlett – Trinity County CCS
- Eileen Rodgers – Shasta County CCS
- Tammy DeBarssi – Solano County CCS

**Eureka:**
- Dr. Ribordy

**Redding (Airpark):**
- Pat (County CCS)
- Bre Williams – Care Coordination

**Santa Rosa:**
- Sue Cervantes – Care Coordination
- James Peila – Parent – Santa Rosa
- Taryn Larson – Parent – Lake County
- Jay – IT (PHC)

**Fairfield:**
- Peggy Hoover – Health Services
- Ron Klinger – Care Coordination
- Samantha Coburn – Chair – Parent
- Robert Pewitt – Vice Chair – Parent
- Catherine Thomas – Care Coordination (Health Education)
- Amanda Bernal – Care Coordination (Health Education)
- Patty Hayes – Administration
- Wendy Stewart – Care Coordination

**Meeting Purpose:** The Family Advisory Committee is here to leverage the Whole Child Model, and how families experience care.
Ron: First off, we’ve provided the meeting minutes from the prior meeting (November 20th, 2019). If you haven’t had a chance, look those over, and let us know if you have any adjustments or changes to prior minutes. If not, Samantha can suggest a motion to approve them.

As you might know, we are still looking for membership for the committee. We hope to get 2 participants from each of our 14 counties – we would like to have broad participation, and each unique county represented well. We might just open membership up to anyone who is interested regardless of the county, in order to have sufficient participation. If you get word of any family who might be interested, please pass that on to myself or Katherine Barresi (who was unable to be here today due to a meeting conflict).

Samantha: To the parents on the phone and at the other offices, maybe between friends you know or on social media, you can take an opportunity to seek out like-minded people through our groups. It’s always so much better to have more parents at the table to have a good hearty discussion, to figure out our needs for ourselves and for everyone.

Carlene (Trinity): What would you suggest would be the best way to reach out to parents? We are a small county, and parents don’t have good cell phone coverage to use email – should we send a letter to parents to ask them to participate?

Patty: A letter coming from you suggesting that to the parents wouldn’t be a bad idea at all.

Peggy: We have put announcements in member newsletters and provider newsletters – it’s a challenge to get ahold of some of the people who have been recommended to us, but we are continuing to try. At this point we won’t be limiting it by county at all – we want a robust committee, to best serve the majority of the members. We’ll take applications no matter which county the family is in. Any county willing to help us would be great. We have more participants than those who come to the meeting – they said they would, filled out their applications, but they’re not coming – we’ll need to reach out to them as well.
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<td>Catherine: I attended a Solano Health to School meeting, which had a presentation from CCS moms in schools. How open are we to collaborating with schools and getting those moms on board as well?</td>
<td>Peggy: I think that’s an excellent resource – go back to the next meeting and promote it.</td>
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<td>Samantha: If there are parents who are unsure and want to talk to another parent about what the FAC is about, I am willing to speak to them – my email or phone number can go out.</td>
<td>Diane: What is involved in the FAC committee – for Katherine to give us information about what PHC is doing?</td>
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<td>Peggy: The FAC committee is designed to be a little of both – it gives us an opportunity to share what PHC is doing, new initiatives and activities that might be involved – we also want participants to let us know what’s going on in their community, and the challenges that are being faced by committee members and their special needs children. If we can grow the size of the committee to get more ideas of what you want on this committee – the purpose is to give the opportunity for CCS parents to have input on how we do what we do. It is a forum for sharing info amongst each other, as well as recommendations – minutes are kept, and they do go through our physician advisory committee for review. Something came up a while back about diapers, and Medi-Cal had made the wrong choice for switching to a different brand. It was resolved before we did this, but the intent was to ask a vendor to explain the difference in diapers, and whether or not PHC should make an exception and cover something in Medi-Cal. That is an example of what the FAC committee can accomplish.</td>
<td>FAC Member: My daughter is 22 with special needs – with her being an adult, would I be outside of the qualifications to help on the committee? I don’t have the resources or a person to go to help with those questions.</td>
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<td>Peggy: MTM is on the agenda today – we’ll be talking about it a little bit – as far as your daughter aging out, we really haven’t addressed that issue, but we are willing to have you participate and give your perspective.</td>
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<td>Ron:</td>
<td>I would like to remind everyone that you can attend these meetings even if you’re not a committee member – family members can join just to check us out. You don’t necessarily have to join the committee to participate in these conversations.</td>
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<td>Robert:</td>
<td>I’ve made efforts in reaching out and asking people to participate as committee members – should I send invites just to participate? If you made a call that it is an open meeting – have you made a formal attempt to make those invitations?</td>
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<td>Patty:</td>
<td>We haven’t as far as on our website or Facebook posts, but that would be fairly easy to do.</td>
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<td>Ron:</td>
<td>My staff can use a refresher on that – in the course of Case Management, I have a sense that over time, that might have slipped. We are talking to folks we can mention it to.</td>
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<td>Shonda (Lassen):</td>
<td>I think having the counties mention it during conversations about annual eligibility would be good – touch point with parents, letting them know when meetings are.</td>
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<td>Robert:</td>
<td>We have a number of committee members, and I’m curious about what was their entry into being a committee member, how were they invited, how did they hear about it? Is there a pattern of the 14 or 18 members we have, and among those people, a pattern in how they were contacted, so we can identify the best way that’s been successful for us – maybe there’s a common element, and we can enhance it, or continue in a better way.</td>
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<td>Ron:</td>
<td>Another good suggestion.</td>
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<td>Peggy:</td>
<td>Question for any members participating in today’s meeting, how did you end up here?</td>
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<td>Robert:</td>
<td>I was asked to participate by the people at MTU in Solano County.</td>
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<td>Samantha:</td>
<td>Same thing – I was reached out to by the people at MTU in Napa County and asked to step forward.</td>
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<td>Peggy: We are meeting with the counties tomorrow – I will discuss this with them as well – representatives from MTU.</td>
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<td>Diane: I was asked to step forward when renewing my membership with Partnership.</td>
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<td>Taryn and James: MTU as well.</td>
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<td>Samantha: It makes me think maybe – if there are parents at clinics, we could check in with those parents and talk to them, that might be an option too.</td>
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<td><strong>Agenda Item #3</strong></td>
<td><strong>2020 Family Voices of California Health Summit and Legislative Day &amp; Youth Track – March 15th – 17th</strong></td>
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<td>Speaker: Ron Klinger, RN Care Coordination Manager</td>
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<td>Ron: We would like to take the opportunity to remind everyone of the Family Voices Health Summit coming up in March this year – it will take place in Sacramento, from March 15th to the 17th – all three days are available to families and members. We wanted to give a little plug to anyone in case they weren’t aware of it, and invite everyone to participate.</td>
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<td>Peggy: We will share the flyer out.</td>
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<td>Samantha: Scholarships are offered for lodging, travel, etc. Sometimes working on a committee can be hard, but it’s good to understand different avenues. This is a fun opportunity.</td>
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<td>Address: 300 J Street – Holiday Inn.</td>
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<td><strong>Agenda Item #4</strong></td>
<td><strong>MTM Problems and Possible Resolutions for Gas Reimbursements</strong></td>
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<td>Speaker: Robert Pewitt</td>
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<td>FAC Member: I started asking questions about MTM problems, and there are some things I learned. The paperwork has to be perfect, and you can’t write over the date or have any scribbles. I looked over it 6 times before I attempted to use the benefit, and almost every time had a measure of frustration attached – at a particular point, I looked back and said I could have done a better job in providing information that was required in the process, but there were issues that caused me to make a complaint. It may have been anomaly, and hasn’t been experienced by another user of the program. To summarize, on the reimbursement form it suggests that if the reimbursement check hasn’t been received within 3 weeks, to call MTM. To give an example: if the last day of the 3rd week falls on a Friday, 21 days have been used up. If you call them on a Tuesday, 4 more days have been used up. I learned there was a problem in my</td>
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<td>paperwork,</td>
<td>by Thursday or Friday I was able to provide the correct paperwork, submit, wait 3 weeks, on original submit, there was not one error but two. I was only informed of one, and once I got to the second problem, I found out that beyond the 60 days, they are not obligated to give me a reimbursement, which didn’t sit well with me. The system does work, but one must be very attentive to what they’re doing with paperwork. A helpful suggestion – if I had been able to check in and inquire about reimbursement long before the 3 weeks was up, that would have helped me – it takes time, and it would have been good to know it takes 3 weeks. I would have been ahead of it by 10 days.</td>
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<td>Peggy:</td>
<td>To put it into perspective, we are providing thousands of rides for our members, but we are not excusing them. If they are not processing things in a timely manner, we want to know. For members filing complaints with our grievance department, we are tracking how often it happens. We meet regularly with MTM to inform them of issues coming up, and help them re-evaluate their processes. Unfortunately, consumers do have to stay on top of the paperwork. They are very tuned into fraud waste and abuse, that’s why they’re looking so carefully at forms and making sure there are no errors. They have to be processed correctly.</td>
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<td>FAC Member:</td>
<td>I’m glad to hear you’re able to measure some of these difficulties by looking at the grievances. There are problems MTM is posing to membership and to Partnership – I was hoping there would be a way to measure or to take a tally of complaints or problems that perhaps don’t get to the grievance level. I have had excellent service when contacting the transportation department, and I assume they are fielding a lot of these issues large and small, so I was wondering whether or not there was way to categorize the many complaints or problems within the program.</td>
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<td>Peggy:</td>
<td>We can assure you that is being done on a couple of different levels – at MTM and at PHC. It is an interesting benefit, and a very costly benefit. We are glad we’re able to get people to their appointments. We don’t have a representative from grievances here today so we can’t give you a number of complaints, but we take vendor’s services very seriously. People talk about drivers not showing up and when we last checked, yes there weren’t drivers showing up, but sometimes it’s a member not being in the right place. We work continuously with MTM to collect statistics. We encourage anyone who does have a problem with MTM to contact our grievance department and file a grievance.</td>
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**Meeting Minutes for**  
**Family Advisory Committee Meeting**  
**January 15th, 2020**

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| FAC Member: I’ve been having problems with MTM, but our last trip to Sacramento was very pleasant. The driver double-checked with me to make sure I had everything in order – they were the first person who double-checked the trip number, explained what needed to be done, told me to have the doctor sign it, etc. I turned it in, and there were no problems. If there is a problem, MTM should put an alert out if they can to the person.  
**Question:**  
A friend of mine just had a trip, and said MTM would not pay for lodging for those over the age of 21 – only for mileage – can you confirm for me?  
**Answer:**  
It depends on the circumstances – if it’s for a child under the age of 21 who was transported by a parent or guardian, PHC will pay for lodging – not strictly by an age limit. However, if the child is over 21, we do not pay for lodging. Lodging is not a benefit over the age of 21 unless they are accompanying a child under 21 who is on the WCM benefit. | | |
| Agenda Item #5 | An FAC Member spoke about issues with MTUs for parents in the Northern Counties.  
**MTUs**  
**Question:**  
If we have benefit services provided by the MTU program, are those benefits being delivered to those who have a need? When it comes to concerns or questions for lesser populated counties and services that CCS members are eligible for, are there services that are private to MTU?  
There are several Northern County workers who are on the phone – would one of you or all of you like to comment on how your MTU provides services and how you operate?  
**Answers:**  
Shonda (Lassen): I think that every county is unique in the Northern Counties. Dependent counties (county that depends on the State to make any medical eligibility determinations) do not have MTUs, only certain ones do. We have a member clinic in October and another in April, with a full clinic in a conference room – pediatrician, medical equipment, and PT person, along with an adaptive PE and OT person who gives consult with the doctor.  
Eileen (Shasta): We also have a medical therapy clinic that we hold monthly.  
Carlene (Trinity): Our MTU goes through the county, in Redding. | | |
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</table>
| **Question:** With it being every 6 months, if something happens with their child, do they have a contact to call for over the phone help?  
**Answers:**  
Shonda (Lassen): A pediatrician normally writes out prescriptions to cover modifications, repairs, or anything new, then the family can refer back to their specialist to write prescriptions.  
Eileen (Shasta): We have an occupational pediatrician in-house to help families with equipment, speak directly w/therapist, write prescriptions, and help families get prescriptions – whatever their needs might be.  
Sam: It would be cool if CCS parents had a better way to get ahold of each other – another parent to talk to if they have a kid in AFOs, strap broke, cobble old braces, etc., parents could contact each other through CCS.  
Eileen (Shasta): Shasta County used to have Facebook page, but it lapsed when our parent liaison retired. This makes me want to go back and work on the Facebook page again – I’m glad you brought it up.  
Sue: Both parents here said we need a Facebook page to connect us all.  
Robert: It would be great for every chair on our committee to be filled, so folks who attend the meetings can ask questions and receive good answers for these questions. I hear what I consider a possibility of many concerns and suggestions – Sam and I are supposed to be the ones comparing and suggesting agenda items, but our contact with the community is limited, and when we talk about things we don’t always have a clear resolution. We need input on what interests our community, and with so few seats filled, it makes this process difficult. As of now, Sam comes up with an agenda item or I do – anyone can drop a note to her with suggestions or concerns – we need to find folks who are the silent voices.  
Ginger: When trying to get ahold of people to find out what they need, there can be problems with trying to contact them. We need someone from the inside to get contact with the county – unless I have close proximity to other CCS parents, I don’t know who to contact to find out what their concerns are. | |
<table>
<thead>
<tr>
<th>Agenda Topic</th>
<th>Minutes</th>
<th>Action Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam: If you know one or two other CCS parents – I know parents who are not in Napa, and they are on social media or talking in private groups. If there was a Facebook page, and you know one person, you could let them know about it, and they could go into that forum. I work on CAC in Napa, and it’s hard to get voices to come to the table. If we can bring people into communication on Facebook, if we as parents have a community of parents – a place where we can go to each other – we will be stronger if we have that avenue.</td>
<td>Ginger: That would be a great way to make contact. I would be more than willing to help with that. Patty: I don’t think PHC is comfortable facilitating it. We have no objection to it being out there, or parents creating their own private Facebook. It would foster more involvement in the committee itself. Sam: I have no problem creating things – I relish being able to talk to more CCS parents and having those rich conversations. I’m assuming PHC’s name shouldn’t be mentioned? Peggy: PHC can’t sponsor or in any way monitor a Facebook page, and questions would have to be brought here in this forum. It is more of a legal issue than anything else, but we support parents forming their own group, and hopefully ideas would be brought back here and we could discuss them – we can certainly take that under advisement, but we would not be able to form it, design it, or advertise it. Ron: Or participate in it. Sam: It would streamline things and help us know what’s going on and what we need to bring back. I can give my email to anyone and talk to anyone who wants to work on this with me. Ginger: I am more than willing to work on this for Siskiyou county.</td>
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<tr>
<td>Agenda Item #6</td>
<td>Ron: Any other concerns anyone here would like to discuss?</td>
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<td>---------------</td>
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</table>
| **Open Forum / Next Steps** | **Question:** Is there a solution for online access to the portal for adopted children or foster children yet? My child has been adopted for 8 years, and I still don’t have access to the portal because she has her own number.  
**Answer:** We have no answer for that today. There is a way, we designed it so some of it could happen, but we need to go to IT dept. or whoever is running the website. Patty can you help with this? We will look into it, and someone will give you a call. |
| **Speaker:** Group | **PHC:** Do you have any topics you specifically want to discuss at the next meeting, and are you interested in any education session, or speakers? What would you like to see at the next meeting?  
**Question:** FAC Member: I would like to know if there’s a phone number we can give to people to get information they need if they can’t get it from their doctors. If there’s a particular department a parent can contact, if for example, they’re at the doctor and they’re denied. Is there a particular doctor they could see, or a website where they can find out what other doctors take their insurance. The dermatologist said they took our insurance, and we found out after appointment that they did not take our insurance.  
**Answer:** We have an online insurance portal with a provider directory that lists everyone we’re contracting with. They will call and say “Do you take Medi-Cal?” if you ask if PHC, they sometimes say yes, they don’t necessarily equate one to the other. There is a provider directory, but if you’d like assistance, I’m sure we can have one of our case manager’s reach out to you. We will have someone from Care Coordination in the Northern Region reach out to you.  
FAC Member: I would like to understand transitioning out of the CCS program.  
**Question:** FAC Member: I have a question about power of attorney. I found out that I cannot access my daughter’s medical records even though I have power of attorney, but PHC
Meeting Minutes for
Family Advisory Committee Meeting
January 15th, 2020

<table>
<thead>
<tr>
<th>Agenda Topic</th>
<th>Minutes</th>
<th>Action Items</th>
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<tr>
<td></td>
<td>does not have a record of it. I want to make sure that once a person turns 21, parents can go about making sure that’s on file with PHC?</td>
<td><strong>Answer:</strong> PHC cannot offer legal advice, but we can look into having a speaker here to help you with that.</td>
</tr>
<tr>
<td></td>
<td><strong>Question:</strong> How does she go about getting paperwork to you guys?</td>
<td><strong>Answer:</strong> Paperwork goes through our Member Services department – they keep those records on file. We can facilitate that process when Heather’s team reaches out, and we’ll have someone reach out by the end of tomorrow.</td>
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<td></td>
<td>Samantha called the meeting to a close.</td>
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</table>

**Next Meeting**
Meeting adjourned at 1:30 pm.

*The next FAC meeting will be March 18th, 2020 from 12:00 p.m. – 1:30 p.m.*

**Post Meeting Note:** The meeting of 03/18/2020 was cancelled due to COVID-19 shelter in place issues.

April 28, 2020

The purpose of this guidance is to provide temporary direction to County California Children’s Services (CCS) and Special Care Centers (SCC) during the COVID-19 public health emergency and to ensure that CCS clients are able to access, without delay, medically necessary essential services.

In light of both the federal Health and Human Services (HHS) Secretary’s January 31, 2020, public health emergency declaration, as well as the President’s March 13, 2020, national emergency declaration, the Department of Health Care Services (DHCS) has issued policy guidance pertaining to provision of Medi-Cal covered benefits and services during the public health emergency. These policy letters are posted on the DHCS COVID-19 Response page. As DHCS continues to closely monitor the COVID-19 situation, DHCS will provide updated guidance to CCS counties.

Policies issued by DHCS pertaining to Medi-Cal services are applicable to CCS, when Medi-Cal beneficiaries are seeking services from CCS paneled providers. In addition, federal and state flexibilities during this time support the safe provision of CCS services, including the option to offer services through telehealth whenever possible. These flexibilities apply to all CCS clients, whether they participate in both CCS and Medi-Cal, or only CCS. They also apply, as applicable, to CCS clients enrolled in Whole Child Model (WCM) counties.

Provision of CCS Services via Telehealth

DHCS has issued guidance regarding the use of telehealth as an alternate means of providing critical, medically necessary services during the public health emergency. All telehealth policies issued by DHCS pertaining to Medi-Cal services are applicable to the CCS Program, including the CCS annual medical review, when CCS clients are seeking services from CCS providers. These policies are described in the Medi-Cal Provider Manual, Telehealth services section, and in the following guidance: FFS and Managed Care Telehealth and Virtual Communication Guidance. For CCS clients receiving care in a Rural Health Clinic or Federally Qualified Health Center (FQHC), additional
telehealth flexibility and options are described in the following guidance: Providing Care in Alternative Settings, Hospital Capacity, and Blanket 1135 Waiver Flexibilities.

Medically necessary services can be delivered by CCS providers and SCCs via an in-person visit or via telehealth, as deemed appropriate by the CCS provider or SCC. CCS providers and SCCs should seek to implement telehealth methods that provide remote consultation as an alternate means of providing critical, medically necessary services during the public health emergency.

DHCS recognizes that in addition to traditional telehealth/telemedicine modalities (i.e., synchronous two-way interactive, audio-visual communication, and/or asynchronous store and forward/e-consults), as outlined in existing Medi-Cal coverage policy (links above), there are extraordinary circumstances under which both face-to-face visits as well as traditional telehealth modalities are not an option. Under these limited and extraordinary instances (i.e., COVID-19), DHCS recognizes the need for Medi-Cal providers – including but not limited to physicians, nurses, mental health practitioners, substance use disorder practitioners, genetic counselors, FQHCs, RHCs, and Tribal 638 Clinics – to utilize other methods such as telehealth and virtual/telephonic communication to provide medically necessary health care services.

DHCS and Medi-Cal Managed Care Plans (MCPs), unless otherwise agreed to by the MCP and CCS provider, must reimburse CCS providers at the same CCS rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider’s description of the service on the claim. DHCS and MCPs must provide the same amount of reimbursement for a service rendered via telephone or virtual communication, as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the CCS client. For more information, please refer to Section III in the document FFS and Managed Care Telehealth and Virtual Communication Guidance.

Discretion in Enforcement of Compliance with Health Insurance Portability and Accountability Act (HIPAA) Regulations

On March 17, 2020, the U.S. Department of HHS issued a limited waiver of certain HIPAA sanctions to improve data sharing and patient care during the pandemic. Similarly, on March 18, 2020, HHS’ Office for Civil Rights announced it would not impose penalties for noncompliance with HIPAA regulations against providers leveraging telehealth platforms that may not comply with the privacy rule during the COVID-19 pandemic. DHCS recommends that providers review that guidance relative to providing services via telehealth and virtual/telephonic communications during the COVID-19 pandemic. Additional information is available at the following link: U.S. Department of Health & Human Services Health Information Privacy.
CCS Medical Therapy Unit (MTU) Services

DHCS has issued guidance regarding flexibilities in the delivery of CCS MTU services during the COVID-19 public health emergency, to support the ability of MTU clients to access physical and occupational services delivered through the MTUs.

SCC Annual Team Conferences

Current CCS Policy (CCS Numbered Letter 01-0108) requires each CCS client followed at an SCC to have an Annual Team Conference (ATC) consisting of a multidisciplinary, multispecialty evaluation performed by core team members including physicians, nurses, social workers, and dieticians as a best practice in the management of complex patients. During the current public health emergency, many components of the ATC can be delivered via telehealth technology, as described above under “Provision of CCS Services via Telehealth.” Therefore, the in-person ATC requirement for SCCs is temporarily suspended for the duration of the public health emergency. In addition, DHCS is waiving the requirement for an ATC as a pre-cursor for authorization of other medically necessary new or re-authorized services for CCS clients. This flexibility will extend for a 6 month period after the end of the COVID emergency declaration to allow SCCs adequate time to reschedule ATCs that could not be accommodated using telehealth services during the time of the COVID emergency declaration timeframe.

CCS State Fair Hearings Conducted via Phone or Video Conference

Pursuant to Executive Order N-55-20, CCS State Fair Hearings may be conducted by phone or video conference. DHCS will include information about this process in each CCS Notice of Hearing.

Prior Authorization

On March 23, 2020, DHCS received approval under federal Section 1135 authority to waive or modify prior authorization requirements for the duration of the public health emergency. As a result, for all Medi-Cal covered benefit categories in the State Plan which are currently subject to prior authorization, DHCS is temporarily suspending prior authorization requirements. Please note that Treatment Authorization Requests (TARs) and Service Authorization Requests (SARs) are still required, but may be submitted after the date of service. Providers are instructed to incorporate the statement, “Patient impacted by COVID-19” within the Miscellaneous Information field on the TAR and the Freeform Message Text field on the SAR. TARs/SARs with this designation may be submitted after services have been rendered for an expedited adjudication. Providers must still submit supporting documentation to justify the need or medical necessity and maintain documentation of medical necessity in the client’s medical file. For additional information, please see DHCS’ guidance Medi-Cal Fee-For-Service Prior Authorization Section 1135 Waiver Flexibilities.
Durable Medical Equipment (DME)

The telehealth and prior authorization provisions described above are applicable to DME. Telehealth may be used in place of a face-to-face visit related to a physician’s order for DME, including repairs and supplies. Also, the need for a TAR/SAR should not negatively affect providing the covered benefit to the CCS client, as the TAR/SAR can be submitted retrospectively. As noted above, providers and suppliers must still provide and maintain documentation indicating the need for the benefit and in the instance of DME, indicate why the equipment must be replaced and whether the equipment was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.

Provider Enrollment and CCS Paneling

DHCS established an Emergency Medi-Cal Provider Enrollment process, effective March 23, 2020, with a retroactive date to March 1, 2020. For additional information, see Requirements and Procedures for Emergency Medi-Cal Provider Enrollment. This includes the temporary enrollment of providers who are enrolled in Medicare or as Medicaid Providers in other states.

CCS paneling will be expedited in conformance with the Emergency Medi-Cal Provider Enrollment process. Please note, the provider’s National Provider Identifier (NPI) must be registered with Medi-Cal via the Provider Application and Validation for Enrollment (PAVE) database for expedited CCS paneling to occur. Submit your CCS paneling application electronically via the CCS Provider Paneling portal. Please notify the CCS Program’s paneling team that expedited paneling is being requested, or if any submission errors occur, via e-mail at: Providerpaneling@dhcs.ca.gov and indicate in the subject line that the request is related to “Expedited COVID-19 CCS Paneling.”

Well-Child Visits During COVID-19 Pandemic

On April 24, 2020, DHCS released guidance on conducting well-child visits and regular checkups during the COVID-19 pandemic, reflecting the American Academy of Pediatrics (AAP) guidance on the provision of pediatric ambulatory services via telehealth during the pandemic. SCCs should consider this guidance for CCS clients.

High Risk Infant Follow-up (HRIF) Services

HRIF Numbered Letter N.L. 05-1016 and Program Letter P.L. 01-1016 provide guidelines for this program, which identifies infants who might develop CCS-eligible conditions after discharge from a CCS Neonatal Intensive Care Unit (NICU). DHCS is providing flexibility to HRIF clinics for individual approaches to follow-up services, in consultation with infection control staff and following CDC and local public health guidance. The age-out limit for HRIF is extended so that the third and final standard visit may be performed up to 42 months of age.
CCS Pharmacy Flexibility

DHCS Medi-Cal (including CCS) now allows up to a 100-day supply per dispensing of any covered drug, medical supplies, or prescription formulas and covered enteral supplements. Utilization limits on quantity, frequency, and duration of medications dispensed to CCS clients may be waived by means of an approved SAR if there is a documented medical necessity to do so. Pharmacies are advised to incorporate the statement “Patient impacted by COVID-19” within the Special Instructions section of the SAR. For more details, see the article titled “Fee-for-Service Pharmacy Benefit Reminders and Clarifications” posted to the NewsFlash area of the Medi-Cal website on March 12, 2020.

Procedures for Face-to-Face Visits

CCS providers and SCCs that see clients face-to-face during the state of emergency must follow all necessary infection control protocols established by the Centers for Disease Control and Prevention (CDC) and their county health department, including having all necessary preventative supplies. Current social distancing guidelines must be followed. For more information, the California Department of Public Health’s COVID-19 website has detailed guidance for protecting yourself and others from the risk of contracting and transmitting COVID-19.

For any questions regarding this guidance, please contact the DHCS CCS Medical Policy team at ISCD-MedicalPolicy@dhcs.ca.gov.

Additional Resources

For additional COVID-19 information and resources, we encourage you to review the following resources:

- Latest news from California Department of Public Health (CDPH) about COVID-19 | En Español
- CDPH COVID-19 guidance
- Centers for Disease Control and Prevention (CDC) COVID-19 response | En Español
California Children’s Services (CCS) Medical Therapy Programs (MTP) Guidance Relative to the 2019-Novel Coronavirus (COVID-19)

April 29, 2020 - Revised

The purpose of this guidance is to provide temporary direction to County California Children’s Services (CCS) Medical Therapy Programs (MTPs). In light of both the federal Health and Human Services (HHS) Secretary’s January 31, 2020, public health emergency declaration, as well as the President’s March 13, 2020, national emergency declaration, the Department of Health Care Services (DHCS) began exploring options to temporarily waive and/or modify certain requirements of the programs DHCS oversees, including Medi-Cal Fee-for-Service (FFS) and the CCS program. In response to the 2019 Novel Coronavirus known as COVID-19, DHCS has issued several policy letters pertaining to the provision of services during the public health emergency. These policy letters are posted on the DHCS website. As DHCS continues to closely monitor the emerging 2019 Novel Coronavirus (COVID-19) situation, DHCS will provide updated guidance to CCS counties.

On March 19, 2020, Governor Newsom issued a stay-at-home Executive Order to protect the health and well-being of all Californians and to establish consistency across the state in order to slow the spread of COVID-19. On April 23, 2020, Governor Newsom issued an Executive Order to temporarily suspend Health and Safety Code sections 123950 and 123870(b) and California Code of Regulation, Title 2, section 60330 to allow MTPs to offer physical and occupational therapy services in non-school settings.

Guidance

For the duration of this public health emergency, CCS MTPs may provide physical and occupational therapy services in non-school settings. DHCS encourages CCS MTPs to stay in contact with families to provide alternative options for routine therapy appointments due to the school and Medical Therapy Unit (MTU) closures. County CCS
MTPs should seek to implement telehealth methods that would allow therapists to provide remote consultation and treatment for routine therapy and equipment needs. MTP therapists must use their clinical and professional judgement to determine if services can be appropriately and effectively provided using telehealth. DHCS issued guidance regarding the use of telehealth as an alternate means of providing critical, medically necessary services.

Typically, physical therapy and occupational therapy require prior authorization; however, DHCS has federal Section 1135 authority to waive prior authorization requirements for the duration of the public health emergency. Prior authorization requirements are temporarily suspended for physical therapy and occupational therapy. However, treatment authorization requests (TARs) and service authorization requests (SARs) are still required. Providers are instructed to incorporate the statement, “Patient impacted by COVID-19” within the Miscellaneous Information field on the TAR and the Freeform Message Text field on the SAR. TARs/SARs with this designation may be submitted after services have been rendered for an expedited adjudication. Providers must still submit supporting documentation to justify the need or medical necessity and maintain documentation of medical necessity in the patient’s medical file. For additional information, please see DHCS’ guidance Medi-Cal Fee-For-Service Prior Authorization Section 1135 Waiver Flexibilities.

MTUs that see clients face-to-face during the state of emergency must follow all necessary infection control protocols established by the Centers for Disease Control and Prevention (CDC) and their county health department, including having all necessary preventative supplies. MTU staff must follow current social distancing guidelines. For more information, the California Department of Public Health’s website has detailed guidance for protecting yourself and others from the risk of contracting and transmitting COVID-19. If the MTU remains open, and the county health department permits it with all proper precautions for the clients’ safety, clients that are critical (post-surgical/procedural) may be brought in for services at the MTU. If the MTU is not open, county MTPs should authorize clients to receive these services in a hospital setting with CCS paneled providers.

Medical Therapy Conferences (MTCs) should be held remotely in lieu of face-to-face conferences. Prescriptions for therapy and Durable Medical Equipment (DME) that expire during the state of emergency can be extended without a face to face encounter with the physician. Please see DHCS’ guidance addressing Medi-Cal Fee-For-Service Prior Authorization Flexibilities for additional information about flexibilities regarding DME authorizations and requirements related to treatment authorization requests and service authorization requests.
In addition, County MTPs should inform MTP families that if their CCS-approved supplies or medications are running low, they should contact the vendor, pharmacy, or prescribing specialist. If they need help with this, please have them contact your CCS Case Manager.

DHCS encourages County MTPs to remind staff or clients who show any signs of illness to stay home and to contact their primary care physician. If either clients or MTP staff become diagnosed with COVID-19, they should immediately notify their county health department and the CCS administrative office.

If you have any questions regarding these instructions, please contact the MTPCentral mailbox at MTPCentral@dhcs.ca.gov

**Additional Resources**

Medicare Telemedicine Health Care Provider Fact Sheet

Section 1135 Flexibilities

COVID-19 Emergency Declaration Health Care Providers Fact Sheet
Date: June 7, 2019
To: Home and Community-Based Alternatives Waiver Agencies
Subject: Prioritization of Intake Screening for Children / Youth under 21-Years of Age Who Have Applied for Enrollment into the Home and Community-Based Alternatives Waiver

POLICY EFFECTIVE ON JUNE 7, 2019

PURPOSE

The purpose of this Policy Letter (PL) is to clarify and make more specific the Home and Community-Based Alternatives (HCBA) Waiver Agency Contract terms regarding the prioritization of eligible children and youth under the age of 21 for intake screening and enrollment into the HCBA Waiver to ensure they are not added to the waitlist. The intent of this PL is to ensure children and youth with nursing level of care (LOC) medical need(s) receive comprehensive care management and have access to medically-necessary Medi-Cal services in the community setting of their choice and avoid institutionalization.

AUTHORITY

Federal Authority

- U.S. Social Security Act (Public Law 74-171) – The Medicaid Program is authorized in Title XIX and the HCBS Waivers are authorized under 42 U.S.C. section 1396n(c).
- 42 CFR §430 et. seq., including sections 441.720, 441.725, and 441.540

State Authority

- WIC, Division 9, Part 3, Chapter 7, Article 4
  - Medical Necessity is defined in §14059.5
Authority for the HCBA Waiver is included in §14132.99. Provides the Department of Health Care Services (DHCS) the authority to delegate Waiver administration and comprehensive care management to contracted organizations §14132.991; and to implement, interpret, or make specific the Waiver operations in whole or in part, by means of policy letters.

Contract Authority

- HCBA Waiver Agency Contract, Exhibit E Additional Provisions, Provision 1 Additional Incorporated Exhibits, Subparagraph D.

BACKGROUND

In administering the current HCBA Waiver, DHCS processes enrollment as follows:

1. Participant enrollment is based on a “first come, first served” process unless the applicant:
   a. Meets reserve capacity criteria, which includes the following subpopulations:
      i. Medi-Cal eligible individuals who have been residing in a facility for more than 90 days and wish to transition to a home or home-like setting in the community and receive long-term services and supports they require to maintain their health and wellbeing outside of an institution, or
      ii. Current Medi-Cal members who will turn 21 years of age during the current waiver year AND who were authorized to receive private duty nursing services for at least six months prior to his/her 21st birthday, as provided under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, or the California Children’s Services (CCS) program; or
   b. Is under the age of 21 with full scope Medi-Cal, or requires institutional deeming to be eligible to receive Medi-Cal services or eliminate his or her share of cost.

Institutional Deeming

Under institutional deeming, only the income and resources of the child are considered when determining Medi-Cal eligibility. Similarly, children who are currently eligible for Medi-Cal with a share of cost based on their Medi-Cal Family Budget Unit determination may also be eligible for institutional deeming to waive their share of cost.

*Note:* People residing in a nursing home under a limited state-only Aid Code and people who do not have satisfactory immigration status are not eligible for institutional deeming.
To qualify for institutional deeming, a child must:

- Be under the age of 18 (upon turning 18-years old, applicants should apply for Medi-Cal directly),
- have a valid Social Security Number,
- be ineligible for Medi-Cal because of his or her family’s income (or other source of income), and
- be eligible for Medi-Cal if he or she was in an institution and/or meets the LOC criteria for the HCBA Waiver.

The institutional deeming process begins when an applicant receives a face-to-face comprehensive assessment and an Intake Medical Summary (IMS) has been completed and approved.

1. Once the IMS is approved, a letter is sent to the California Department of Social Services (CDSS) and to the applicant/responsible party to notify him or her that the applicant is medically eligible for the HCBA Waiver.

2. CDSS mails the applicant a Medi-Cal application.

3. Timely submission of completed Medi-Cal application is essential for being approved for Medi-Cal.

POLICY

Children and youth under the age of 21 who meet HCBA Waiver LOC eligibility requirements are prioritized for intake screening and enrollment onto the Waiver.

PRIORITY ENROLLMENT PROCESS

Follow the steps outlined below to review HCBA applications for priority enrollment / intake processing:

1. Upon receipt of an HCBA application, Waiver Agency staff shall immediately identify if the applicant is under the age of 21.
   a. Waiver Agency staff will also review to identify if an applicant under the age of 18 may require and/or qualify for institutional deeming.

2. Applicants under the age of 21 cannot be placed on the waitlist, and must be routed for priority enrollment / intake processing.

3. Once an applicant under the age of 21 is assigned to a Care Management Team (CMT), comprised of a Registered Nurse and a Masters of Social Work, the
CMT must schedule a face-to-face visit with the applicant within 60 calendar days of receipt of a qualified application.

4. The CMT must ensure that an IMS case report is completed and uploaded in MedCompass within one week after the face-to-face visit.

5. In developing the person-centered Plan of Treatment (POT) with the applicant, his or her legal guardian, and/or circle of support, the CMT shall provide the applicant, and their legal guardian with information on the EPSDT benefit, CCS, or similar services and supports for which the individual may qualify.

6. The CMT shall then complete the enrollment process and submit the packet to DHCS for final approval.

7. DHCS shall have 30 calendar days to review a completed enrollment packet. Incomplete enrollment packets will be returned to the Waiver Agency for completion. When an enrollment packet is completed and resubmitted to DHCS, the Department shall have an additional 30 days to review the completed enrollment packet. Upon approval by DHCS, the date of an applicant’s enrollment into the Waiver shall be the date upon which a complete and approvable enrollment packet was uploaded in MedCompass and the applicant’s status was switched from “Intake Assess” to “Pending Enrollment Review”.

8. Once enrolled, the CMT shall provide on-going comprehensive care management to the HCBA Waiver participant.

QUESTIONS

For further information about this PL, please contact your assigned Contract Manager or submit a question to the HCBA email inbox at: HCBAAlternatives@dhcs.ca.gov.

(Original Signed by)

Evelyn Schaeffer, Chief
Integrated Systems of Care Division
Department Of Health Care Services
## 2019-20 Hospital Measures/Requirements

<table>
<thead>
<tr>
<th>GATEWAY MEASURE</th>
<th>Proposed 2020-21 Hospital Measures/Requirements</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIE and EDIE Interface</td>
<td>HIE and EDIE Interface</td>
<td>No Change</td>
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</table>

All hospitals.

By the end of the measurement year, both of the following:

1. Live with Emergency Department Interface Exchange (EDIE) including a mechanism for the EDIE data to be pushed to ED physicians for patients who are seen
2. ADT interface with a community HIE

If not met, entire incentive amount will be withheld.

## GATEWAY MEASURE

Delegation Reporting

All capitated hospitals

Capitated hospitals must submit timely and accurate delegation deliverables, according to deadlines outlined in the hospital’s delegation agreement.

Deliverables include:
1) Utilization Program Structure, and
2) Delegation reporting requirements

Impact:
- Timely submitting > 90.0% of requirements results in 100% incentive.
- Timely submitting > 75.0% and < 90.0% of requirements results in 10% cut from incentive.
- Timely submitting < 75.0% of requirements results in a 20% cut from incentive.
<table>
<thead>
<tr>
<th>2019-20 Hospital Measures/Requirements</th>
<th>Proposed 2020-21 Hospital Measures/Requirements</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Plan All-Cause Readmissions Rate</td>
<td>1. Plan All-Cause Readmissions Rate</td>
<td>No Change</td>
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<tr>
<td>Plan All Cause Readmissions based on an Observed/Expected Ratio as defined by NCQA/HEDIS specification</td>
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<tr>
<td>• Full Points: Ratio &lt;1.30</td>
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<tr>
<td>• Partial Points: Ratio ≥1.30-1.90</td>
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<tr>
<td>2. Palliative Care Capacity</td>
<td>2. Palliative Care Capacity</td>
<td>COVID-19 Related Change for hospitals ≥ 50 beds:</td>
</tr>
<tr>
<td>1) Hospitals &lt; 50 beds, evidence of a structured team including: Trained Physician, LCSW, RN, NP or PA.</td>
<td></td>
<td>• Lowered threshold – from 50% to 40% for Full Points</td>
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<tr>
<td>2) Hospitals ≥ 50 beds, PCQN enrollment, monthly reporting includes: Consults, completed ADs and POLSTS.</td>
<td></td>
<td>• Lowered number of patients from 20 to 10 patients for Full Points</td>
</tr>
<tr>
<td>1) Hospitals &lt;50 beds: Participation in one Safe Table Forum. Submission of 50 patient safety events to CHPSO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Hospitals ≥ 50 beds: Participation in four Safe Table Forums. Submission of 100 patient safety events to CHPSO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. QI Capacity</td>
<td>4. QI Capacity</td>
<td>Change to 5 points for both Large and Small hospitals for attending the Hospital Quality Symposium in 2021.</td>
</tr>
<tr>
<td>Hospitals with &lt; 50 beds only:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Summary of one QI training attended during the 2019-20 measurement.</td>
<td></td>
<td></td>
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<tr>
<td>• Summary of one QI project executed in the hospital.</td>
<td></td>
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</tr>
<tr>
<td>2019-20 Hospital Measures/Requirements</td>
<td>Proposed 2020-21 Hospital Measures/Requirements</td>
<td>Considerations</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td>5. CAIR Utilization</td>
<td>5. CAIR Utilization</td>
<td></td>
</tr>
<tr>
<td>- CAIR reporting of Hep B Newborn Vaccines for Maternity Hospitals.</td>
<td></td>
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<tr>
<td>- Non-Maternity hospitals report other vaccines into CAIR (i.e., Tdap, Pneumococcal, etc.)</td>
<td></td>
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<tr>
<td>6. Elective Delivery before 39 weeks</td>
<td>6. Elective Delivery before 39 weeks</td>
<td></td>
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<tr>
<td>Percent of patients with newborn deliveries at ≥ 37 to &lt; 39 weeks gestation completed, where the delivery was elective.</td>
<td></td>
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<tr>
<td>Hospitals submit data to California Maternal Quality Care Collaborative (CMQCC), and PHC will work directly with CMQCC for reports.</td>
<td></td>
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</tr>
<tr>
<td>7. Exclusive Breast Milk Feeding</td>
<td>7. Exclusive Breast Milk Feeding</td>
<td></td>
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<tr>
<td>Hospitals submit data to California Maternal Quality Care Collaborative (CMQCC), and PHC will work directly with CMQCC for reports.</td>
<td></td>
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<tr>
<td>8. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate</td>
<td>8. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate</td>
<td></td>
</tr>
<tr>
<td>Hospitals submit data to California Maternal Quality Care Collaborative (CMQCC), and PHC will work directly with CMQCC for reports.</td>
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<tr>
<td>9. Substance Abuse Bundle</td>
<td>9. Substance Abuse Bundle</td>
<td></td>
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<tr>
<td><strong>Overall Target:</strong></td>
<td><strong>Overall Target:</strong></td>
<td></td>
</tr>
<tr>
<td>o Hospitals &lt; 50 beds:</td>
<td><strong>Voluntary Inpatient Detox (VID)</strong></td>
<td>Eliminate</td>
</tr>
<tr>
<td>Full points - 2 components met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial points - 1 component met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Hospitals &gt; 50 beds:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full points - 3 components met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partial points - 2 components met</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Voluntary Inpatient Detox (VID)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital patients (all payers) admitted for VID</td>
<td></td>
<td></td>
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<tr>
<td>• Hospitals &lt; 50 beds: &gt; 2 PHC Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospitals &gt; 50 beds: &gt; 5 PHC Members</td>
<td></td>
<td></td>
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<tr>
<td>Naloxone fill/distribution</td>
<td>Eliminate: Challenges surrounding other community naloxone distribution sources</td>
<td></td>
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<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>50% of PHC Members presenting in ED with opioid overdose/intoxication have prescription filled for Naloxone within 6 months of discharge or visit.</td>
<td></td>
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<tr>
<td></td>
<td></td>
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</tr>
<tr>
<td>Medication Assisted Treatment (MAT) in ED</td>
<td>No Change</td>
<td></td>
</tr>
<tr>
<td>PHC Members started on MAT in the ED setting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitals &lt; 50 beds: ≥ 2 PHC Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitals ≥ 50 beds: ≥ 5 PHC Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT) in inpatient setting</td>
<td>eliminate</td>
<td></td>
</tr>
<tr>
<td>PHC Members started on MAT in the ED setting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitals &lt; 50 beds: ≥ 2 PHC Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Hospitals ≥ 50 beds: ≥ 5 PHC Members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support for Hospital Opioid Use Treatment (SHOUT)</td>
<td>Eliminate</td>
<td></td>
</tr>
<tr>
<td>Hospital adopts SHOUT program protocols in the ED/Inpatient setting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019-20 Hospital Measures/Requirements</td>
<td>Proposed 2020-21 Hospital Measures/Requirements</td>
<td>Considerations</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>-----------------------------------------------</td>
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</tr>
<tr>
<td><strong>2. Cal Hospital Compare – Patient Experience</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All hospitals already are required to conduct patient experience surveys.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• This will be the first patient experience measure for HQIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target: Add up the subcategory scores. Compare to sum of average score for California hospitals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If [individual hospital composite score] is greater than [{Average California Hospital score}* 0.9], then they get full credit.</td>
<td></td>
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<tr>
<td>The idea is that, for year 1 of this measure, all hospitals would get credit except those far below the state average.</td>
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<tr>
<td><strong>3. Health Equity</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Submission based measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospitals will submit their plan (best practices) for addressing health equity</td>
<td></td>
<td></td>
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<tr>
<td><strong>4. Sexual Orientation / Gender Identity (SO/GI) in the EHR</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Submission of implementation plan over a 12-month period, or screenshot of existing SO/GI in EHR.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Organizations can discuss options with their EHR vendor prior to starting the implementation process to see if the vendor has created SO/GI customizations before. In some cases, a vendor may have an updated version that includes SO/GI data fields such as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What is your legal name?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What is your preferred name?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What sex were you assigned at birth?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What is your legal sex? (we will use gender on ID card)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What is your gender identity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o What pronouns do you use?</td>
<td></td>
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</tr>
</tbody>
</table>
Introduction

In 2017, Partnership HealthPlan of California (PHC) created a HEDIS measure score improvement strategic plan, directed at dramatically improving HEDIS scores by sub-region. Two imperatives have led us to a major revision of this plan. First, the HEDIS score improvement strategic plan did not address the link between the member experience and overall quality. Second, PHC is on the road to NCQA accreditation, which includes a number of standards outside the patient experience and clinical quality scores and defines many activities throughout the organization that impact both.

The purpose of this strategic plan is to clearly articulate the long and short-term initiatives PHC will engage in over the next five years to achieve 5-star NCQA Health Insurance Plan Rating status. NCQA accreditation is the gold standard for measuring performance of health plans in the United States. Full accreditation by NCQA categorizes overall health plan performance from zero to five stars, analogous to the Medicare Stars rating system. A 5-star rating is the highest possible score achieved by just 2 of 171 Medicaid plans nationally in 2019; a score of 4-star or above is considered above average, achieved by 40 health plans nationally.

This document serves as a communication tool for PHC leadership and staff, Board members, providers and other stakeholders and lays a solid foundation from which an operational plan will be created.

This Five-Star Strategic Plan is an elaboration of the first focus area of PHC’s organizational Strategic Plan: to ensure high quality health care to all our members. This strategic plan also aligns with PHC’s vision - to be the most highly regarded Health Plan in California - and its mission, which transcends service to our members to include the greater community, “To help our members, and the communities we serve, be healthy.”

Improving quality not only has intrinsic benefits to our members, but it carries intangible benefits to the organization and the community. When quality improvement activities are aligned with the “quadruple aim” of better health, lower cost, better care and caring for the providers, it assists with making the overall health care system function more effectively and efficiently. A focus on quality also improves the reputation of PHC in the state, allowing further innovation and influence among state-wide stakeholders. Finally, the principles of quality improvement can influence the organization to more efficiently execute on operational priorities not directly related to quality.

Lastly, in 2019, DHCS moved aggressively towards the use of larger scale health plan sanctions for performance on measures that are below average performance. This places additional financial pressure on PHC to improve quality measure results within our network.
Organizational Values Supporting Quality

To achieve 5-star quality, PHC must have an organizational culture of quality which is nurtured by the executive leadership team and Board of Commissioners. Core to this culture are these organizational values (from our organizational strategic plan), with aphorisms reflecting these values.

- **Partnerships:** Fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes. “Putting our members first.”
- **Overall focus on Quality:** Focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners. “Doing the right thing right, the first time and every time.”
- **Integrity:** Set a standard of professionalism, integrity, and accountability. “Striving for perfection, but embracing the opportunity to learn from imperfection. Excellence is achievable!”
- **Innovation:** Striving to be innovative and seeking creative solutions. “Willingness to challenge the status quo, and insist on change when needed.”

In addition, the PHC leadership team has several conceptual frameworks focused on quality:

- **Balancing Compliance and Performance:** Balancing rigid attention to regulatory requirements with flexibility and innovation needed to drive improvement. “Not all change is improvement, but all improvement requires change.”
- **Promoting Health Equity:** Ensuring an organizational culture that recognizes the diverse backgrounds of our employees and supports the institution of practices that consider social determinants of health, the impacts of implicit bias and the provision of fair and judicious health care and services to meet the broad based needs of our members. “Everyone has a fair and just opportunity to be as healthy as possible.”
- **Becoming a Learning Health Plan:** “Making decisions based on rigorous data analysis whenever possible (instead of based on hope or wishful thinking).” “Creating an atmosphere where new ideas can be explored and where strong, independent teams can test these ideas.”

The term “Learning Health Plan” is new in this strategic plan, although many associated tactics are not new. More background and explanation is presented next.

Learning Health Plan

A common underlying theme in most Quality Improvement frameworks is that organizations and teams must embrace continuous learning to achieve their highest potential. Tom Nolan, one of the creators of the Model for Improvement, said “What are the necessary and sufficient conditions for improvement in large systems? **Will, ideas and execution!**”

Donald Berwick describes what will, ideas, and execution means:
“Providing **will** refers to the tasks of fostering discomfort with the status quo and attractiveness for the as-yet-unrealized future. Providing **ideas** means assuring access to alternative designs and ideas worth testing, as opposed to continuing legacy systems. And **execution** was his term for embedding **learning** activities and change in the day-to-day work of everyone, beginning with leaders.” –Milbank Quarterly, August, 2019

The PHC Executive Team and Board are committed to making a profound and deep link between the necessities of using a learning health plan framework to best serve our members and our communities.

The fundamental tenets of a Learning Health Plan are:

1. Using the scientific method to optimize implementation of quality improvement initiatives
   a. Building on prior research/experiences
   b. Rigorous and widespread testing of change on a small scale (using the model for improvement framework)
   c. Tracking of information gleaned from small tests of change so others can retrieve this information and build upon it.
   d. Use of control groups (where appropriate)
   e. Careful data and statistical analysis
   f. Using a combination of classic project management methodology with the Consolidated Framework for Advancing Implementation Science\(^1\) to have a systematic effective approach to program implementation and building internal expertise in these approaches.

2. Having the leadership and staff to support this approach
   a. Communicate effectively about quality and change, through a mixture of data and stories. “No data without a story, no story without data.”

A Learning Health Plan avoids widespread implementations of any unproven projects, without measurement of what the outcome is, performing weak or no evaluation of the project, and continuing the project without knowing if it is effective. While such projects are often related to regulatory mandates, gathering data on their effectiveness or lack thereof can provide valuable evidence for advocating policy change.

Without using the term “learning organization” or “learning health plan,” PHC has been building the infrastructure and leadership to include most of these elements. For example, creating a Project Management/Operational Excellence Department and Team, creating a Health Analytics Team, doing internal trainings through the Learning Management System and external trainings, conducting efficient but meaningful Return on Investment analyses of several programs, and developing a system of storing lessons learned in small tests of change in the quality department are all examples.

By identifying the elements of a strong learning health organization and standardizing our communication around the core principles, we will solidify the cultural values around being a Learning Health Plan.

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Process of Developing 5-Star Strategic Plan

Leaders in the Quality Improvement (QI) Department created this strategic plan with input from PHC leadership and staff via the HEDIS Score Improvement team and the Analytics, Care Coordination, Population Health, Information Technology (IT), Member Services, Pharmacy and QI departments.

The scope of this strategic plan is rooted in the emerging field of population health management. Population health management, in the context of a health plan, requires assessment and analysis of member needs, stratifying the population into risk tiers and defining segments for targeted interventions. Once population segments are identified, the health plan engages available resources to improve the health and wellbeing of the plan’s assigned membership on both an individual and aggregate level. This is distinct from approaching population health with a public health approach—which would encompass coordinated and multi-sector efforts to improve the quality of health for an entire community or communities—an approach which is beyond the scope of this strategic plan.

The Quality Improvement department will lead the implementation of this strategic plan, collaboratively and in partnership with other departments and providers, respecting capacities and competing priorities.

Evaluation

PHC is committed to testing new approaches and scaling up when new approaches are successful. The QI department will lead efforts to support processes and systems for learning and monitoring progress on the implementation of the NCQA 5-Star Strategic Initiative Plan, and sharing evaluations with PHC leaders and our community partners.
Environmental Factors

The following strengths and weaknesses within the organization and opportunities and threats external to the organization were taken into consideration when drafting this strategic plan.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NCQA Interim Accreditation status attained - many standards (notably the Population Health Management standards) directly support improved HEDIS scores.</td>
<td>• Competing priorities: major system implementations, multiple goal teams, efforts to comply with NCQA standards, new benefits, new regulatory mandates</td>
</tr>
<tr>
<td>• Significant programming and ability to offer technical assistance to bolster primary care capacity for quality and clinical improvement</td>
<td>• Many databases still not integrated or standardized</td>
</tr>
<tr>
<td>• Robust pay-for-performance program and commitment to value-based processes.</td>
<td>• Data governance processes not deeply institutionalized</td>
</tr>
<tr>
<td>• Supportive data systems including eReports and Partnership Quality Dashboard</td>
<td>• Preventive or coordination services PHC offers are not widely understood or utilized by members</td>
</tr>
<tr>
<td>• Increasing cross-department collaboration</td>
<td>• Member input not deeply integrated into member-facing improvement efforts</td>
</tr>
<tr>
<td>• Strong HEDIS Medical Record Review Project processes</td>
<td>• Limited PHC experience in outreaching to members to close HEDIS gaps</td>
</tr>
<tr>
<td>• New member portal building an infrastructure to outreach to members</td>
<td>• Collaboration across PHC departments sometimes not prioritized over core departmental work.</td>
</tr>
<tr>
<td>• Growing internal analytic capacity and standardized data sets support population health analysis</td>
<td>• Confined “single views” of member; gaps in care not visible across health plan data systems</td>
</tr>
<tr>
<td>• Recent assignment of largest special member categories to primary care providers so that PCP QIP applies</td>
<td>• Regional disparities in access and health risk factors</td>
</tr>
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<table>
<thead>
<tr>
<th>External Opportunities</th>
<th>External Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NCQA First Survey Accreditation (11/2020) – roadmap to becoming higher quality plan</td>
<td>• Judicial threats to the Affordable Care Act (risk aversion)</td>
</tr>
<tr>
<td>• Provider network and communities support improved clinical performance and are willing to partner (e.g., Joint Leadership Initiative)</td>
<td>• Lethargic CMS response to DHCS proposals impact scope and speed of DHCS policy changes</td>
</tr>
<tr>
<td>• Provider partner bright spots with best practices and excellent quality scores</td>
<td>• Changing regulatory environment with increasing risk of financial sanctions and other penalties</td>
</tr>
<tr>
<td>• Pilot programs to enable greater accuracy of member contact information.</td>
<td>• Proposed changes to public charge policy (decreased enrollment)</td>
</tr>
<tr>
<td>• Preparation for MediCare Duals Special Needs Plan (D-SNP)</td>
<td>• Primary care site staff turnover (providers, nurses, medical assistants)</td>
</tr>
<tr>
<td>• MCHC for all: Enhanced Care Management and In Lieu of Services proposals</td>
<td>• Member access to PCPs for care</td>
</tr>
<tr>
<td>• Aligned Proposition 56 incentive funding</td>
<td>• PCP capacity for outreach</td>
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<tr>
<td></td>
<td>• PPS providers (provider primary care for over 75% of members): PPS system reimburses based on volume, not services provided (removes some options for incentivizing quality activities)</td>
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<td></td>
<td>• Natural disasters and power outages</td>
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<td>• Pharmacy Carve Out</td>
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</table>
HEDIS Score Improvement Aim Statement

The PHC Five Star Quality Strategic Plan Aims to achieve the following:

1. A weighted average of all accountable DHCS MCAS measures >50th percentile (in year 1) with yearly improvement afterwards in three years, all individual measures performance will be above the 50th percentile.
2. ≥25th percentile in all adult and pediatric CAHPS measures year 1; with yearly improvement afterwards
3. 80% of applicable points earned in each standard category of NCQA accreditation standards, including Must Pass elements

These are ambitious goals and will require a significant amount of investment, collaboration, and focus. The Managed Care Accountability Set (MCAS) will grow from 19 measures for measurement year (MY) 2018 to 36 for MY 2020. With the new MCAS measures, the minimum performance level increased from the 25th to the 50th national Medicaid percentile.

Focus Areas, Goals and Objectives

This strategic plan is centered on five key focus areas: 1) Engaging Clinical Practices 2) Engaging Members 3) Data Infrastructure 4) Accreditation Standards and 5) Access. Specific activities, timelines, resources, and evaluation benchmarks will be developed in an operational plan. See Appendix A for a visual depiction (process map) of PHC’s Achieving Five-Star Quality focus areas and goals.
Focus Area 1: Primary Care Practice Ability to Deliver High Quality Health Care

PHC recognizes the critical role primary care providers (PCPs) play in improving clinical quality performance, as well as optimizing utilization, maximizing access to care and enhancing the patient experience. A central theme within this focus area is to better equip PCPs to provide recommended high quality care through provision of information, technical assistance, improvement tools and financial incentives.

<table>
<thead>
<tr>
<th>Focus Area 1: PCP Delivery of High Quality Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
</tr>
</tbody>
</table>
| A. Supply Actionable Care Gap Data to PCPs | • Optimize: eReports  
• Optimize: Partnership Quality Dashboard (PQD)  
• Study: Integrate ePrompts into Provider Online Services  
• Expand: Unblinded quality data sharing  
• Promote: Electronic Health Record (EHR) workflow optimization, including integration with CAIR |
| B. Technical Assistance to Support Provider QI Capacity | • Optimize: Mandated PDSA/PIPs/Site Reviews/Prop 56  
• Expand: Technical assistance offerings, provider education and coaching for large and medium sized practices  
• Sustain: General QI training: ABCs of QI  
• Adapt: Measure-specific trainings and webinars  
• Evaluate: PCP leadership development  
• Study: PHC leverage for promoting health equity through providers |
| C. Optimize Pay for Performance Programs | • Optimize: PCP QIP  
• Optimize: Perinatal QIP  
• Optimize: Hospital QIP |
Focus Area 2: PHC Engaging Members to Improve Quality Metrics

There is a significant opportunity for PHC to expand direct-to-member engagement activities to improve MCAS and HEDIS scores. The goals within this focus area will require PHC to take on new initiatives and/or expand current initiatives that provide actionable data to PHC staff, leverage contacts with members through in-reach and outreach, and increase PHC’s presence in communities. Direct health plan contact with members complements the outreach conducted by providers. PHC Network providers are diverse in size, staffing and resources and may be limited in outreach capabilities for a variety reasons, including competing priorities or absence of supportive technology or workflows. In other instances, members are not assigned to or directly managed by a PCP (e.g., special members) or the member may have considerable movement across PCPs during the HEDIS measurement year.

Focus Area 2: PHC Engaging Members to Improve Quality

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| A. Supply Actionable Care Gap Data to PHC Staff and Members | • Integrate: Prompts into Essette  
• Integrate: ePrompts into Call Center  
• Integrate: ePrompts into Member Portal |
| B. Increase PHC Member-Engagement Capacity | • Pilot: Reminders into Care Coordination workflow  
• Study: Integration of reminders into Member Services workflow  
• Expand: Train PHC staff on targeted quality measures  
• Study: New and updated member incentives  
• Increase: Member input into engagement process  
• Expand: PHC Outbound engagement activities  
• Develop: Digital Engagement Solutions |
| C. Other Strategies for Member Engagement | • Test: Leverage Community Health Workers/Care Managers on Quality Measures  
• Study: ED and inpatient settings  
• Test: Outreach to special members  
• Expand: Outreach through identification and participation in grassroots community activities |
Focus Area 3: Data, Analytics, and Knowledge Management

A critical element to improving MCAS and HEDIS quality scores lies in PHC’s ability to strengthen data and analytics infrastructure. Additionally, in order to function under the Learning Health Plan framework, foundational systems and processes need to be developed and established to strengthen how data and improvement study results are evaluated and used in decision-making to further optimize the rate of quality improvement. Four goals will help improve the organization’s infrastructure needed to support and assess primary care and member interventions.

### Focus Area 3: Data, Analytics, and Knowledge Management

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| **A. Actionable Care** | • Objectives in Focus Area 1, Goal 1  
• Objectives in Focus Area 2, Goal 2  
• Expand: Pilots on improving member contact information  
• Align: Health education tools on Member Portal with quality measures |
| **B. Data Quality, Timely Access and Completeness** | • Optimize: Configuration of new core claims system  
• Implement: Provider Master Data Management  
• Expand: Data Dictionaries  
• Operationalize: Data Stewardship Program  
• Expand: Health Information Exchange (HIE)  
• Expand: Clinical Data Repository (CDR)  
• Operationalize: PHC Data Governance structure |
| **C. Supportive Analytics** | • Expand: Well-constructed Data Marts  
• Build: Comprehensive member data (Member 360)  
• Optimize: Analysis and presentation of annual quality measure results  
• Optimize: Leverage rolling-year monthly HEDIS data  
• Integrate: Equity analysis with improvement activities |
| **D. Learning Health Plan Framework** | • Expand: Knowledge Management infrastructure  
• Develop: Standardized scientific approach to small tests of change  
• Study: Standardized approach to scaling up/implementation  
• Pilot: Nurture PHC cultural values around quality |
Focus Area 4: Achieving Health Plan NCQA Accreditation

The provision of high quality healthcare to our members is fundamental to PHC’s vision and mission. We want to be one of the highest quality health plans in California. NCQA Health Plan Accreditation supports this goal by:

- Providing a framework to guide our operational and quality improvement activities. (Many of the activities outlined in the standards are best practices that should be pursued regardless of our accreditation goals.)
- Providing a nationally-recognized standard and definition for a high quality health plan, performance against which will allow PHC to compare ourselves objectively against other high quality plans.
- Offering the only widely-available health plan assessment that bases results on clinical performance (HEDIS) and member experience (CAHPS).

In the summer of 2019, PHC received formal Interim Accreditation Status, receiving 50 out of 50 total possible points. Interim Accreditation ensures organizations have a basic structure in place to meet expectations for consumer protection and quality improvement. Interim Accreditation status indicates a strong position and readiness of an organization to move forward with formal First Survey Accreditation, which covers the full scope of the standards and requirements, including HEDIS and CAHPS reporting.

First Survey Accreditation is planned for late 2020-early 2021. As noted earlier, two years after that the HEDIS and CAHPS scores will be integrated to give a star rating from 0 to 5.

5-Star Scale

As part of the process for setting appropriate goals and areas of focus, the NCQA Project Management Team reviews the accreditation scoring methodology on an annual basis to appropriately apply updates, changes or modifications. Broadly, here are the categories in which we have extracted as areas of focus, which are resource intensive and have significant cross-departmental impact, expressed as goals:
### Focus Area 4: Achieving NCQA Accreditation

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| **A. Pass all "Must Pass" Elements** |  - Optimize: Internal file review  
  - Optimize: Delegated file review  
  - Optimize: Delegates following NCQA Standards  
  - Align: Department Goals |

| **B. Strengthen "Grand Analysis" Improvement Activities** |  - Optimize: Utilization Management  
  - Improve: Member Experience  
  - Optimize: Network Adequacy and Availability  
  - Implement: Population Health Management  
  - Implement: Continuity and Coordination of Care  
  - Non-Behavioral  
  - Behavioral |

| **C. Prepare for MediCare** |  - Measure: Baseline MediCare HEDIS Measures  
  - Address: MediCare HEDIS Gaps  
  - Evaluate: MediCare incentive program options for patients and providers  
  - Plan: Support for overall quality oversight |
Focus Area 5: Improving Member Experience through Improved PCP Access

Background: In the 2019 PHC CAHPS survey, the areas below the 25th percentile for adult and children were almost exclusively in the area of perceived access to services. Since the CAHPS survey will account for about one-third of our accreditation score and is also slated to become an MCAS measure, it is imperative that PHC explore additional activities to improve PCP access. While the access composite scores in CAHPS include questions related to specialty access, only PCP access will be included in Focus Area 5. Activities related to increasing specialty access will be covered in the Access and Availability Grand Analysis required as part of NCQA accreditation.

From July-October, 2019 multiple stakeholders\(^2\) were asked to give feedback and suggestions for increasing access to Primary Care Providers in the PHC service area.

The 54 ideas that were generated were categorized by the degree of control the Clinical Practice has over the factor, the degree of control the Health Plan has over the factor, as well as a categorization of the cost, effort and effectiveness of each suggestion.

Prioritization Process:
We eliminated those suggested interventions that were high cost (3-4) and low estimated effectiveness (1). Additional changes were made, based on feedback from Executive Committee. This leads to these 17 objectives, grouped into four goals.

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\(^2\) Nine Joint Leadership Initiatives, Physicians Advisory Committee, Strategic Planning Committee, Medical Directors of PHC, Board Advisory Group on Quality, Executive Committee at PHC, Operations Committee at PHC
Focus Area 5: Improving Member Experience through PCP Access

<table>
<thead>
<tr>
<th>Goals</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| A. Recruitment                             | • Implement: Marketing to Residents within PHC region  
• Implement: Marketing to Residents outside PHC region  
• Implement: Marketing to out-of-state primary care Residents originally from PHC counties  
• Explore: Support partner job search  
• Study: Support J-1 visa process          |
| B. Retention                               | • Test: Optimize HPSA scores in shortage areas  
• Implement: Support providers in completing application/process for loan repayment  
• Study: Increase PCP organization reimbursement for sites with greatest challenge via adjustment of PCP-QIP by recruitment difficulty factor  
• Study: Coordination among local agencies providing supplemental dollars for loan repayment, signing bonus, etc.  
• Implement: Advocacy for new and larger loan repayment programs by state/federal government.  
• Test: Vetted Locum Tenens providers to provide vacation coverage  
• Planning: Proposal for structure for providing social support to providers |
| C. Alternative Access Options              | • Implement: Promoting the leveraging Phone/Video visits to increase access  
• Implement: On demand video visits for urgent care  
• Promote: Advanced Access methodology     |
| D. Learning                                | • Implement: Exit Interviews of Clinicians leaving the region  
• Implement: Interview practices that are very successful in recruiting strong staff |
Conclusion

This PHC Strategic Plan for Achieving Five Star Quality provides a roadmap for using the overall structure and framework of NCQA, modified by requirements of DHCS, to substantially improve quality and ultimately achieve a 5-star rating by NCQA by 2025.
Appendix A

NCQA 5-Star Plan Strategy Map
Version 5, 02/05/2020

Focus Area 4
- Accreditation Standards
- Delegation Oversight
- Department Goals

Focus Area 5
- Access to care
- Recruitment and Retention Initiatives
- Specialty access (including telemedicine and e-consult)

Focus Area 2
- Engaging Members
- Call Center
- Digital Member Engagement
- Member Portal

Focus Area 1
- Engaging Clinical Practices
- QIP
- Technical Assistance
- Centrally locate data in EDW
- Learning Health Plan

Focus Area 3
- Data and informatics infrastructure
- Timely & accurate Data
- Health data exchange/sharing (e.g., HIE, CAIR)

5-Star NCQA Quality
- Clinical Quality
- NCQA accreditation

Member Experience
- Engagement
- Clinical Practices
- Data and informatics infrastructure
- Member outreach
- Member inreach

Access to care
- Recruitment initiatives
- Specialty access (including telemedicine and e-consult)

Tactics

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