PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator I, Quality Improvement
DATE: June 12, 2024
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

The California Public Health Emergency has ended and Q/UAC has now returned to in-person meetings per Brown Act guidelines.
Meeting locations (and call-in information for PHC staff only) are below and also listed on the agenda.
Please use your personal electronic device for reviewing the packet during the meeting. Hard copies will not be provided.

Meeting Date: Wednesday, June 19, 2024
Meeting Time: 7:30 – 8:55 a.m.
Meeting Locations: Partnership HealthPlan of California

- **4665 Business Center Drive, Fairfield, CA 94534 |** Napa/Solano Conference Room
- **2525 Airpark Drive, Redding, CA 96002 |** Trinity Alps Conference Room
- **495 Tesconi Circle, Santa Rosa, CA 95401 |** Santa Rosa Huddle Room

Other Locations: 13219 Pebble Court, Auburn, 95603
Open Door Community Health Center, 3770 Janes Road, Arcata, CA 95519
Kaiser Permanente No Cal Offices, 1950 Franklin St., Oakland, CA 94612

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
PHC Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx https://partnershiphp.webex.com/meet/quac | 809114256 (Note: If you need assistance please contact IT a minimum of one (1) day prior to the meeting so that they can provide instructions and testing.)

Voting Members:
Choudhry, Sara, MD
Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Lane, Brandy, PHC Consumer Member
Montenegro, Brian, MD
Mulligan, Meagan, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Manager, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Associate Medical Director
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director, Southwest
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Central
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, North
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Bjork, Sonja, JD, Chief Executive Officer
Booth, Garnet, Manager of PR Representatives (NR)
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, Quality Improvement
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Escobar, Nicole, Senior Manager of Behavioral Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Manager of Performance Improvement, QI (SR)
Harrell, Bria, Configuration Specialist, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Nakatani, Stephanie, Manager of Provider Relations Representatives
O'Leary, Hannah, Manager of Population Health, Population Health
Payumo, Desiree, Supervisor of Inpatient Nurses, UN (Fairfield)
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Rouse, Amber, LVN, Lead Nurse Coordinator, UM
Scuri, Lynn, MPH, Regional Director, Southwest
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, East
Williams, Joanie, RN, Supervisor of Inpatient Nurses, UM (Redding)

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

Date: June 19, 2024 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room

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PHC Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

PHC Staff only may join by Telephone:
1-844-621-3956 Access Code: 809 114 256

This Brown Act meeting may be recorded. Any audio or video tape 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 / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Approval/Acceptance of Minutes**			
1	*Approval of* Quality/Utilization Advisory Committee (Q/UAC) Minutes of May 15, 2024	Robert Moore, MD	7:30	5 – 25
2	*Acknowledgment and acceptance of draft minutes of the* • May 8, 2024 Internal Quality Improvement (IQI) Committee • May 21, 2024 Quality Improvement Health Equity Committee (QIHEC) • May 2, 2024 Population Needs Assessment (PNA) Committee • April 29, 2024 Over/Under Utilization Workgroup			26 – 66
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:34	67 – 78
2	HealthPlan Update	Robert Moore, MD	7:38	--
III.	**Old Business –**			
	Synopsis of Changes			79 – 80
1	MCUP3028 – Mental Health Services – *returning from May 15 Q/UAC for discussion of "closed loop referral"*	Jeffrey Devido, MD	7:43	81 – 89
2	MCUP3114 – Physical, Occupational and Speech Therapies – *returning post May 15 Q/UAC for TAR changes; CLEAN copy begins on p. 99*	Robert Moore, MD	7:49	91 – 104
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:55	105
	PULSE Report – Issue 13 – June 2024			107 – 115
	Quality Improvement			
	MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			117 – 147

	Item	Lead	Time	Page #
	MPXG5009 – Lactation Clinical Practice Guidelines			149 – 153
	Utilization Management			
	MCUP3041-A – TAR Requirements – *policy was approved in May; only a revised attachment is coming back to map to MCUP3114 on today's agenda under Old Business*			155 – 162
	MCUP3013 – Durable Medical Equipment (DME) Authorization			163 – 177
	MCUP3042 – Technology Assessment			179 – 186
	MCUP3053 – Acute Inpatient Administrative Days			187 – 188
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components			189 – 200
	MCUP3138 – External Independent Medical Review			201 – 204
	MCUP3139 – Criteria and Guidelines for Utilization Management			205 – 208
	MCUP3141 – Delegation of Inpatient Utilization Management			209 – 214
	MPUP3006 – Appropriate Service & Coverage Policy			215 – 218
	Provider Relations			
	MPNET101 – Wellness and Recovery Access Standards and Monitoring			219 – 221
	MPPRGR210 – Provider Grievance			223 – 225
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			227 – 232
	Care Coordination			
	MCCP2014 – Continuity of Care (Medi-Cal)	Shannon Boyle, RN	8:00	233 – 260
	Utilization Management			
	MCUP3052 – Medical Nutrition Services	Tony Hightower, CPhT	8:05	261 – 269
	Population Health Management			
	MCND9001 – PHM Strategy and Program Description – *CLEAN copy begins on p. 325*	Hannah O'Leary, MPH	8:10	271 – 370
VI.	**Presentations**			
1	Annual Review of UM/InterQual Criteria® - *Demonstration paper is not included in this packet*	UM Team	8:20	371 – 407
2	Population Health Management Grand Analysis – *PowerPoint presentation begins on p. 409*	Hannah O'Leary, MPH	8:35	409 – 438
	• Population Health Management 2023 Program Impact Analysis			439 – 475
	• Population Segmentation			477 – 482
3	Annual Grievance & Appeals Report	Kory Watkins, MBA-HM	8:50	483 – 496
VI.	**FYI:** 2024/2025 Population Health Management Work Plan – *direct any questions to Hannah O'Leary*			497 – 500
	Adjournment scheduled for 8:55 a.m. – Q/UAC WILL NOT MEET IN JULY; Q/UAC next meets 7:30 a.m. Wednesday, Aug. 21, 2024			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, May 15, 2024 / 7:30 a.m. – 9:33 a.m. Napa/Solano Room, 1st Floor

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

Voting Members Present

Sara Choudhry, MD
Emma Hackett, MD, FACOG
Brian Montenegro, MD
Meagan Mulligan, FNP-BC
John Murphy, MD
Robert Quon, MD, FACP
Chris Swales, MD
Randolph Thomas, MD
Jennifer Wilson, MD

Voting Members Absent: Steven Gwiazdowski, MD, FAAP; Brandy Lane, PHC Consumer Member; Michael Strain, PHC Consumer Member

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cox, Bradley, DO, Associate Medical Director
Devido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director (Southwest)Leung,
Stan, Pharm.D, Director of Pharmacy Services
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Scuri, Lynn, MPH, Regional Director (Southwest)
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Watkins, Kory, MBA-HM, Director, Grievance and Appeals

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bontrager, Mark, Sr. Director of Behavioral Health, Administration
Cotter, James, MD, Associate Medical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Kerlin, Mary, Senior Director of Provider Relations
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Northern Regional Medical Director
Ruffin, DeLorean, DrPH, Director of Population Health

Guests:

Booth, Garnet, Manager of Provider Relations Representatives, PR
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, QI
Brunkal, Monika, RPh, Assoc. Director of Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Devan, James, Manager of Performance Improvement (NR)
Erickson, Leslie, Program Coordinator I, QI (scribe)
Escobar, Nicole, Senior Manager of Behavioral Health
James, Jayme, Manager of Mental Health Programs, Behavioral Health
Jarrett-Lee, Kevin, Associate Director of Utilization Management
Matthews, Doug, MD, Regional Medical Director (East)
McCune, Amy, Manager of Quality Incentive Programs, QI
Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Representative
O'Leary, Hannah, Senior Health Educator, Population Health
Rodriguez, Cindy, Project Coordinator II, Member Safety – Quality Investigations

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Approval of Minutes	Vice Chair Mark Netherda, MD, called the meeting to order at 7:30 a.m. in the absence of Chair Robert Moore, MD, MPH, MBA. The April 17, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft minutes of the* • April 9, 2024 Internal Quality Improvement (IQI) Committee meeting • Jan. 25, 2024 Substance Use Internal Quality Improvement (SUIQI) Committee meeting	Unanimous Approval of Q/UAC Minutes: Robert Quon, MD Second: Meagan Mulligan, FNP Unanimous Acceptance of other Minutes: Robert Quon, MD Second: John Murphy, MD
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Senior Director of Quality & Performance Improvement*	• We issued payment on the Primary Care and Long-Term Care Quality Improvement Programs at the end of April. The LTC is sunsetting and will transition to the Department of Health Care Services (DHCS) QIP offering, emphasizing quality as a health plan going forward with these facilities. • Updates for the 2024 Partnership Quality Dashboard have officially gone live. A present tense view of the gap lists on the current measurement year are now accessible to our primary care providers. • Last month, I talked about the joint venture that DHCS initiated with the Institute for Healthcare Improvement (IHI) in the Medi-Cal Child Health Equity Collaborative running March 2024 through March 2025. Officially, Partnership has started a new collaborative with some counties on behavioral health. Partnership is working closely with Nevada County, focusing on two Health Effectiveness Date Information Set (HEDIS®) measures, one of which is the follow-up within 30 days after an Emergency department visit for mental health. This is an interesting collaborative that will involve some fast tracking of interventions. • Partnership's ongoing adolescent immunization work in Shasta County has expanded to involve Evergreen Elementary School District. The big change this year is actual school settings, rather than the local health center, are now acting as hosts. Four clinic dates have been planned. The April 18 event was successful largely due to the involvement of school nurses. • The Change Healthcare cyberattack has had a ripple effect on us in Quality. The National Committee for Quality Assurance (NCQA) gave us extra time to submit HEDIS® MY2023. The two-week extension gives us an opportunity for administrative data to flow through: we'll have more later this summer to share on the results.	For information only: no formal action required. There were no questions for Nancy.
2. HealthPlan Update *Mark Netherda, MD, Medical Director for Quality read out CMO Dr. Robert Moore's report*	• The State's May budget revision, if approved, would make the following cuts to healthcare: ○ The second round of the Equity Practice Transformation Directed Payments is being cancelled. It appears first round awardee payments are still intact; however, we await confirmation. ○ Much of the managed care organization (MCO) tax will be redirected to help close the deficit. This will affect all sorts of programs that were scheduled to start in January 2025, including specialist payment increases. The increases from January 2024 will be unaffected (for PCPs, Perinatal providers and Mental Health Professionals). A ballot initiative in November would reinstate the	For information only: no formal action required. *Meeting Postscript: Dr. Moore's May Medical Directors Newsletter was emailed to Q/UAC physicians May 30*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	proposed budget changes, and make permanent the allocation of MCO tax to support Medi-Cal rates and programs. o Will eliminate $350 million in state and local public health funding o Will make cuts in Youth and Behavioral health initiative ($400 million) o Will make cuts to a number of workforce development activities from the Department of Health Care Access and Information (HCAI), ranging from programs supporting community health worker (CHW) training to Family Physician training ($800 million) o A State hiring freeze: would leave thousands of unfilled positions, impacting timeliness and effectiveness of state initiatives. • Negotiations with Dignity to come to terms on a new contract are ongoing. All patients who were assigned to Dignity PCPs prior to April 1 have been reassigned to other PCPs. Partnership is working with local Dignity staff to ensure contractually required and state mandated Continuity of Care activities are provided to eligible patients. • The regional medical directors meetings are completed; the detailed notes are on our website on the CMO page. The detailed notes have a link to the County-level Annual Data Reports that are found on our website. • Several county medical society boards and California Medical Association Districts X and XI representing much of our region are advocating to the CMA that a major topic in the 2024 House of Delegates meeting by on Rural Health Equity. It is important for rural physicians to be members of their local medical societies and to be active, attending meetings and serving on committees, as well. • Partnership congratulates the following top performers in the MY 2023 PCP QIP: $38 million is awarded to 252 primary care sites, range of scores 0 to 99 points. o Community Medical Center in Dixon: 99 points o Communicare+Ole in St. Helena: 98 points o Petaluma Health Center, Petaluma: 98 points o Winters Healthcare Foundation: 95 points o Communicare+Ole in Davis: 92 points o Open Door CHC in Eureka: 91 points o Sonoma Plaza Pediatrics: 91 points o Communicare+Ole on Pear Tree Lane (Napa): 90 points	
III. Old Business –*returning from March approval with two items outstanding*		
Policy Owner: Quality Improvement –*Presenter: Mark Netherda, MD, Medical Director for Quality*		
MCQG1015 – Pediatric Preventive Health Guidelines	This came before the Committee (in March) and everything was approved but for two items: the definition of parent. After much internal discussion, "parent" is now stated as "For our purposes, a 'parent' is the designated legal guardian for the pediatric member." We tried to keep it as simple as we could and stay within the direction of DHCS and the policy. Secondly, we are adding back the definition of the Child Health and Disability Prevention (CHDP) program as this program does not sunset until July 1.	No comments. Motion to approve: Chris Swales, MD Second: Robert Quon, MD *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Consent (Committee Members as Applicable)		
Consent Calendar	***Health Services Policies*** Quality Improvement MCQP1021 – Initial Health Appointment – *coming back from February Q/UAC to address CHDP July 1, 2024 sunset* MCQP1047 – Advance Directives MCQP1052 – Physical Accessibility Review Survey SR Part C MPQP1055 – Provider Preventable Condition (PPC) Reporting MPXG5003 – Major Depression in Adults Clinical Practice Guidelines Care Coordination MCCP2025 – Pediatric Quality Committee Policy MCCP2026 – Diabetes Prevention Program – *added language describes Partnership's Medical Distribution Services (PMEDS) program* Utilization Management MCUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults MCUG3134 – Hospital Bed / Specialty Mattress Guidelines MCUP3136 – Fecal Microbiota Transplant (FMT) MCUP3144 – Residential Substance Use Disorder Treatment Authorization ***Provider Relations Policy*** MPNET100 – Access Standards and Monitoring	No policy was pulled for discussion. Motion to approve as presented: Robert Quon, MD Second: Emma Hackett, MD *Approved unanimously* Next Steps: June 12 Physician's Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Member Safety – Clinical Compliance*		
MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	**Related Policies: Added** MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline. **III. Definitions C.** Expansion counties Nevada and Placer are added to the list of Partnership counties that have their own Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, over which Partnership has no regulatory oversight responsibilities. **III. D&E Definitions added:** . Non- Physician Medical Practitioners (NPMP) are defined as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNM) and licensed midwives (LM). See MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines. . Licensed Practitioner of the Healing Arts (LPHA) includes physicians, NPs, PAs, registered nurses (RNs), registered pharmacists, licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor, licensed marriage and family therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. See MCUP3144 - Residential Substance Use Disorder Treatment Authorization.	There were no questions. Motion to approve as presented: Robert Quon, MD Second: Randy Thomas, MD *Approved unanimously* Next Steps: June 12 (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	IV. Attachments: The former Attachment A is split into Attachments A and B, respectively renamed SUD FSR Tool and SUD FSR Guidelines. **V.B.** DMC-ODS and Substance Abuse Block Grant (SABG) monitoring language is eliminated from the Purpose Statement. **VI.B.1-2.** The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by Partnership personnel. At a minimum, Partnership's Site Review team will consist of one of the following staff: a physician, a registered nurse (RN), or other Non-Physician Medical Practitioner (NPMP). Licensed physicians, RNs, NPMPs, and Certified Counselors, are eligible to act as Site Reviewers and may perform a site review (SR) independently and sign off on the FSR and MRR tools. Partnership will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. **Reviews of survey elements will be completed by the appropriate category of reviewer, as noted by survey labels (e.g., LPHA or RN/Physician/NPMP only).** **VI.C.1-2.** now outlines the 10 sections of both the SUD FSR Tool and the Guidelines (new Attachments A & B), as well as the new nine sections of the SUD MRR (re-lettered Attachment C). **VI.D.2:** An initial SUD MRR must now be completed within **11** months of the SUD FSR assuming services have been rendered. This may be deferred on claims. **New References G & H** supersede earlier Behavioral Health Information Notices (BHINs). Rachel began by thanking Nicole Escobar, Wendy Millis and the rest of her team for working on this policy. Site reviewers heretofore had gone to facilities to look at a site's policies and education but now, in addition, must obtain copies of same, either through ShareFile or other software.	
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		
MPQP1016 – Potential Quality Issue Investigation and Resolution	Staff titles are changed throughout the document as appropriate: "Quality Investigator" replaces "Performance Improvement Clinical Specialty (PICS)" and "Manager, Member Safety – Quality Investigations" replaces "Manager, Quality Assurance and Patient Safety." **VI.B.3.a revised**: Cases occurring more than two years before reporting involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee. **VI.C.1.c.i added**: Notification that another Peer Review Organization (PRO) is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process. **VI.C.2.b added**: Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions. **VI.C.2.f added:** Upon determination that a PQI case is out of Partnership's jurisdiction (e.g., serious mental health cases) the case will be referred to the appropriate oversight body (e.g., County Mental Health). **VI.C.3. Tertiary Review**: the Peer Review Committee's specific responsibilities are outlined in greater detail. **Section VI.C.3.b added**: "The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any letters to and responses from POCs	Motion to approve **as presented with an amended Attachment A**: Robert Quon, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: June 12 (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	and all other relevant documentation and correspondence related to the case. i. Following review and discussion of the case, the PRC may uphold the original scoring determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review. ii. If a score is leveled, the PRC will direct the Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid." **VI.C.3.d.iv is added:** For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the Provider of Concern (POC) to verify that the deployed corrective action is effective and eliminates the noted deficiencies. **VI.C.7.** on reporting per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities clarifies that "a similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency." **Attachment A:** The Practitioner Performance and Systems Scores Grid clarifies discrete practitioner score (P) and system score (S) definitions and actions/follow-ups. • P2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • P3 – Action/Follow-up strengthened: ASAP communication to provider of concern requesting a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentials Committee with recommendations from the PRC. • PUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated. • S2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • S3 – Action/Follow-up strengthened: ASAP communication to FOC/POC requiring a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentials Committee with recommendations for PRC. • SUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to the PRO of the FOC or the system of concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated. Dr. Netherda noted that many of the changes were made in response to DHCS feedback in our last audit. The added VI.C.3.d.iv means that if we have a Corrective Action Plan for a provider, and say 'you need to be …,' we can periodically investigate whether implementation has occurred and is continuing. VI.C.7 was augmented because Partnership credentials other providers, in addition to those whose actions might be subject to the California Medical Board, whose actions could be reported to other boards and agencies.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	A long conversation about the revised Attachment A occurred between Dr. Netherda and Q/UAC physician members Robert Quon, John Murphy, Jennifer Wilson, and Chris Swales. Dr. Quon thought that even **"minor opportunities" for improvement should result in a letter,** else a provider may never be made aware that there was that possibility to improve care. "My only concern is basically individual loop closure, being on the regulatory end, then there's assumptions that are happening in other venues. It could be a letter that says 'we understand you have already been notified.' It's loop closure for the Quality department to say 'we've already addressed this directly in some way, and this provider knows.'" **Delete the word 'informal' from the description of this letter.** Dr. Murphy agreed, adding that the minor opportunity (i.e., P1 / S1) letter could be a recap of 'we understand that the changes in your practice will be x, y, z. We suggest x, y, z, and a.' Dr. Netherda added that Partnership didn't use to send 'thank you, this case is now closed' letters but now we do. Dr. Wilson said that snail mail doesn't always get delivered to the correct addressee, particularly in multi-provider practices, and **suggested secure email be added as an option to each level** in the Attachment A grid. Dr. Murphy concurred, saying that both letter and email should be used together as the latter would not work when a provider has left the practice. Dr. Swales was concerned that even secure emails may be a violation of HIPPA: "I get all my mail, and my medical system opens it, so that may be a systems issue" to be addressed. Dr. Netherda noted that Partnership's secure emails carry big bold disclaimers in the subject line.	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance*		
MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Changes made to Policy based on APL 23-023 ICF/DD Language **Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities **Definitions added:** B. California Children's Services F. ICF/DD G. ICF/DD-H H. ICF/DD-N O. Whole Child Model (WCM) **VI.R added:** Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) 1. For more information, refer to Partnership Policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities	There were no questions. Motion to approve as presented: John Murphy, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: June 12 (PAC)

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	VII. Reference added: DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care *(Revised 11/28/2023)* **IX.** Updated to Chief Health Services Officer	
MCCP2034 – Transitional Care Services (TCS) – **NEW POLICY**	This policy describes and defines Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings. Partnership members identified as 'high risk' must be offered TCS services beginning Jan. 1, 2023. Partnership must offer support for TCS for lower-risk transitioning members effective Jan. 1, 2024. This policy outlines that Partnership shall ensure TCS are provided to members transferring from one setting, or level of care, to another. TCS includes the following: 1. Ensuring collaboration and partnership with discharging facilities 2. Closed loop referrals 3. Ensuring medication reconciliation is conducted pre- and post-transition 4. Ensuring all necessary prior authorizations required are completed 5. Coordination to ensure appropriate post-discharge appointment attendance and follow ups 6. Follow up with member and/or guardian/caregiver/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met 7. Members may choose to have limited to no contact with the identified TCS care manager, in these cases TCS care manager must act as a liaison 8. Coordination and verification that the member is receiving all appropriate services regardless of setting 9. Ensuring collaboration, communication and coordination with the member, their caregiver(s)/guardian/authorized representatives and their care team 10. Care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member 11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy level-appropriate, and be shared with the member. After Shannon presented, Dr. Murphy commented that the policy is rather aspirational and perhaps un-resourced. Shannon noted that is why Dr. Moore on May 7 IQI discussion approved adding this second paragraph to the policy purpose statement: **This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS**	Motion to approve as presented: Robert Quon, MD Second: John Murphy, MD *Approved unanimously* Next Steps: June 12 (PAC)

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	provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities. Dr. Swales asked if Partnership would be doing TCS in addition to the TCS activities that may be done by organizations? Shannon replied that DHCS would like to prevent duplication of services before she deferred the question to Director of Care Coordination Brigid Gast, RN. The policy language matches the aspirational language from the Policy Guide, Brigid said. "There are specific responsibilities needed from the MCP, so any separate responsibilities to the health system delivery would be separate, and while we can coordinate and collaborate, and we're certainly looking at those relationships, different expectations and metrics on success, and does not replace DHCS' MCPs to execute." Dr. Swales expressed concerns that this would complicate matters for members. Brigid said she would be happy to discuss further offline with provider offices. Dr. Murphy reiterated his concerns: "You are in a Catch-22 because DHCS expects you to have something but it's not resourced. I just wanted to mention that before we encumber the Health Plan with something it is not resourced to do. It wouldn't be the first time but I wanted to name it."	
MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities	Changes made to Policy based on APL 23-023 ICF/DD language and Child Health and Disabilities Prevention (CHDP) program sunsetting July 1, 2024. **Section I. Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities MCUG3038- Review Guidelines for Member Placement in Long Term Care (LTC) Facilities MCCP2014- Continuity of Care MCCP2034- Transitional Care Services (TCS) MPCD2013- Care Coordination Program Description MCCP2007- Complex Case Management MCCP2032- CalAIM ECM **Section III. Definitions added:** C. ICF/DD D. ICF/DD-H E. ICF/DD-N F. Medicaid G. Medical Home H. School-linked services: behavioral health services offered either at a physical location associated with a school or services rendered elsewhere that are provided by school personnel or arranged by school personnel.	Motion to approve **as amended**: Robert Quon, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: June 12 (PAC) *Meeting Postscript: Pursuant to Dr. Brian Montenegro's comments on the Behavioral Health Overview, leadership and staff agreed to add a definition of "school-linked" services to the definitions list. See. III.H.*

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	VI.B.1.a-b added: a. In participating counties, Partnership members who have a CCS-eligible condition participate in the Whole Child Model (WCM). As part of this model, Partnership provides the case management and utilization management services for these members. For more information, refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS). b. Partnership members who have a CCS eligible condition and participate in the CCS Program, refer to policy MPCP2002- California Children's Services for more details. **VI.B.2 is revised and added:** High Risk Infant Follow-Up (HRIF) Services- Birth to age 3 years. a. In accordance with APL 23-034 California Children's Services Whole Child Model Program (12/27/2023), for members in counties that participate in the WCM program, Partnership is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services. b. For members who live in a county that participates in the State CCS Program, this would be the responsibility of the CCS offices and providers, Partnership may work in collaboration if necessary. **VI.B.3.c. added** under Medicaid per APL 23-010 revisions. **VI.B.5.a revised due to APL 23-010 and to reference BHT Policy:** a. Partnership is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, Partnership must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]). Please see Partnership policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details. **VI.B.6 added:** Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) A. Services are offered to members with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system B. Partnership ensures that members in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care C. TCS: High-risk individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability. D. CCM: Members may need extra support to avoid adverse outcomes but who are not in the highest risk group E. COC: MCPs must provide 12 months of continuity of care for the ICF/DD Home placement of any member who is mandatorily enrolled into Partnership after January 1, 2024. Members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care of Medi-Cal Beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal Fee-For Service, on or after January 1, 2023. F. ECM: If a member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the member must be assessed to determine need/eligibility for ECM services	

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	G. Utilization Review: Refer to Partnership policy MCUG3058 **VI.B.7.b added language CHDP superseding** 10) This supersedes any contradicting information found within CHDP Program guidelines, as the CHDP sunsets July 1, 2024. **References updated:** **A.** Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III, Section 4.3.9 D. DHCS All Plan Letter (APL) 23-034 – California Children's Services Whole Child Model Program (12/27/2023) F. National Committee for Quality Assurance (NCQA) Health Plan Standards 2024. Population Health Management 5 Complex Case Management **Reference added:** **H.** DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) Shannon went through the synopsis. Dr. Quon questioned the use of "Medicaid" rather than "Medi-Cal," and Anna Campbell noted that the term is used only as it relates to Behavioral Health Treatment services because DHCS recently used the phrase "medically necessary and covered under Medicaid" repeatedly in the revisions to APL 23-010 BHT services. **Q/UAC agreed to add to this policy the definition of Medicaid** found in MPUP3126 – BHT for Members Under the Age of 21: **a joint federal and state program that helps cover medical costs for some people with limited income and resources. Medi-Cal is California's Medicaid health care program, supported by federal and state taxes.**	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	The annual review of this policy includes updates made for the 2024 contract and the CalAIM PHM Policy Guide as well as APL 23-004. **I. Related Policies:** Add two Related Policies: MCUP3142 – CalAIM Community Supports MCCP2032 – CalAIM Enhanced Care Management (ECM) **IV. Attachments** Deleted Attachments A. "BedHold/ TAR Process flow chart" and Attachment B. "Admissions for Short Term Rehab or Short Term Skilled Nursing," as both of these attachments are better suited to be desktop procedures. Attachment C. "Bed Hold & Change of Status Report Form" is now Attachment A but there were no changes otherwise. **VI.A.2.** This statement was deleted in light of 2024 DHCS contract requirements and the CalAIM PHM Policy Guide requirements for Transitional Care Services: "Partnership assists with finding a facility for the appropriate level of care upon request although primary responsibility remains with the hospital discharge planning staff." **VI.C.2.a.** Added information regarding "the Preadmission Screening and Resident Review (PASRR) form" indicating appropriateness for placement.	Motion to approve as presented: Robert Quon, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: June 12 (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.j. Deleted paragraph on Kaiser Capitated Members. Clarified language for Medicare denial letters. **VI.F.4.** Updated COC APL from 18-008 to 22-032 **VI.G.** Updated description of process for referring potential quality of care issues that may be identified during routine case review to Partnership's Member Safety Quality Investigations team. **VI.K.3** Added new paragraph describing ECM and CS services for which members in a SNF or LTC setting may be eligible. **VII. References** C. Updated DHCS Contract sections H. Updated APL 22-018 to APL 23-004 I. Updated APL 18-008 to APL 23-002 **IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Tony went through the synopsis. There were no questions or comments.	
MCUP3041 – Treatment Authorization Request (TAR) Review Process	With the annual review of this policy, we include changes in TAR requirements as per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process. **VI.A.2.b.** We deleted the phone number and reference to Partnership's Eligibility and Interactive Voice Response (IVR) System as this system will cease to operate on 05/01/24. Instead, we refer the reader to Partnership's Online Services (OLS) portal to verify Member eligibility for services and PCP assignment. **VI.A.5.** Updated paragraph on storage of UM records to specify they are not archived electronically. **VI.B.1.b.** Added that we include a few HCPCS codes on our TAR Requirements list. **VI.C.4.** Clarified in two places that 90 days is 90 "calendar" days. **VI.D.3.b.** Specified that the Associate Director of UM Regulations is responsible for monitoring the UM activities of delegate entities (instead of the Senior Health Services Director.) **IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." **Attachment A:** The Partnership TAR Requirements list was updated as follows: **H: Diagnostic Studies** In this section a change was made to specify that certain CT scans and MRIs no longer require a TAR. For CT Scans: A TAR is required for chest, abdomen, and/or pelvis CT. No TAR is required for other CT scans of extremities, Head/Neck/Spine, CT colonogram - effective 7/1/2024. For MRI: A TAR is required for chest, abdomen, and/or pelvis, including Cardiac MRI 05561. No TAR is required for other MRI scans of extremities, Head/Neck/Spine, MRI Breast - effective 7/1/2024. **W: Medical Supplies** A change was made to clarify TAR requirements for Wound Care Supplies. An additional resource was added for the reader to find detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, by referencing the Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits. Information was also added in the Nutritional Supplements section at W.7. to update the name of Partnership's "Medical Drug List Navigator" instead of Partnership's "Covered Medical Drug List." **W: Medications Provided by a Pharmacy:**	Motion to approve **as amended:** Randy Thomas, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: June 12 (PAC)

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	The name "Magellan" was removed in this section and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan. **AA: Occupational Therapy, FF: Physical Therapy, and HH: Speech Therapy:** All of these sections were updated to match new TAR requirements in policy MCUP3114 Physical, Occupational and Speech Therapies. For both PT and OT, it was specified that Members under age 21 still require a TAR for services; however, no TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.) For speech therapy, it was specified that Members age 21 and over still require a TAR for services; no TAR is required for Members under age 21 for up to 12 visits (limit one visit per day) in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.) Before Tony went through the synopsis, Dr. Netherda noted that Tony would be reading into the record changes that were agreed upon at the May 14 CMO meeting. In the Attachment A document, which is the PHC TAR Requirements List: • Section H.1. and 2: For both CT Scans and MRIs, we have added the statement that "TARs are required for all CT scans (or MRIs) for Members under age 21 years." Additionally, we separated the phrase "Head/Neck/Spine" for both CT and MRIs to say instead, "head, neck, or spine" to make it clear that those scans may be considered separately. • Sections AA. and FF. have also modified the changes for both OT and PT to specify that no TAR is required for services for adults for up to 12 visits in "a rolling 12-month period" instead of "a rolling 3-month period" of time. Dr. Murphy asked why modifications to MRIs and CTs in the 18-to-21 age group: is that DHCS? Safety? Utilization? Dr. Netherda responded that it is a DHCS differentiation, and Dr. Townsend corroborated that DHCS defines the pediatric population as those less than 21 years of age. Dr. Swales asked if a TAR would be required for a new injury: if he sends a patient to PT for a shoulder, does he submit a new TAR if the hip needs attention? Dr. Netherda said yes, and elaborated further. It is 12 visits a year without a TAR. Medi-Cal is two visits per month, two visits of any kind collectively: if you have had one speech therapy and one physical therapy, you're done. So, this is an enhancement for us. Swales noted that his practice, when looking at UM, will start denying requests if the patient has had 12 visits, has not progressed and there is no documentation of improvement. Dr. Netherda confirmed that Partnership will do the same. Dr. Townsend added it should be the physical therapist who notes continued progress when submitting a TAR for extended services. **Dr. Townsend suggested also modifying Attachment A Section I on Doula Services** because the State regulation is not that the visits must happen all postpartum. If someone exhausts their eight visits in the first half of their pregnancy, and there is a medical need for more based on the TAR submitted by the clinical provider, those visits can happen either prenatally or postpartum. Q/UAC agreed with Dr. Townsend's suggestion. **Attachment A Section I now reads: while most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional**	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	visits (beyond eight) during the postpartum period.	
MCUP3114 – Physical, Occupational and Speech Therapies	Per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process, this policy was updated to adjust TAR requirements for certain PT, OT, and ST services. **VI.B. and B.1.** Heading of this section updated to reflect "General Guidelines for Authorization" of services instead of "Submission of TARS" and the information regarding no RAF required but written prescription required for PT/OT/ST services, was moved to the beginning of this section. **VI.B.2.** This section was updated to specify PT/OT/ST services that will now have No TAR requirement which includes PT and OT services for Members age 21 and over and ST services for Members under age 21. **VI.B.3.** This section was updated to specify PT/OT/ST services that continue to have a TAR requirement, which includes PT and OT services for Members under age 21, ST services for Members age 21 and over, any PT/OT/ST services prescribed by a non-contracted provider, and services provided through home health. **VI.B.4.e.4)** This section was moved up from below for continuity in explaining which services are generally not considered medically necessary or are not covered. **VI.C.** This section was rearranged to better explain ESPDT services as they relate to PT/OT/ST services. Some EPSDT details were deleted with a statement added to refer the reader to Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services instead. Tony pointed out that, as in MCUP3041 – Treatment Authorization Request (TAR) Review Process, this policy's sections VI.B.2.a. and b. have been modified to specify that no TAR is required for services for adults for up to 12 visits in "a rolling 12-month period" instead of "a rolling 3-month period" of time.	There were no questions. Motion to approve as presented: Robert Quon, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: June 12 (PAC)
Policy Owner: Utilization Management – *Presenter: Jeff Devido, MD, Behavioral Health Clinical Director*		
MCUP3028 – Mental Health Services	Policy reviewed for annual update. **III.A.** Partnership definition of "closed loop referral" was added. **III.F.** Definition of Medical Necessity for EPSDT services was updated to specify that California now refers to the EPSDT benefit as "Medi-Cal for Kids & Teens." **III.I.** Definition was added for Partnership's Wellness & Recovery Program. **VI.A.3.a.e)** Added that Members residing in participating Partnership Wellness & Recovery counties will be directed to Partnership for SUD assessment. **VI.A.4.d.** Specified that Carelon Behavioral Health is Partnership's delegate. **VI.A.4.d.4) and 5)** Added language to explain how a closed loop referral process will work when there is a need to refer a member between levels of care (SMHS and NSMHS). **VI.G.** Clarified that Partnership provides or arranges for NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network. **VI.G.2.** Clarified Medi-Cal Rx information. Removed the name "Magellan" and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan.	Motion to approve **as amended** Robert Quon, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: ~~June 12 (PAC~~) *Meeting Postscript:* *The policy will not be referred to June PAC per Dr. Moore. Internal discussions will continue to refine a closed loop referral definition, and an update will go through IQI /*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Dr. Devido read into the record this suggested definition: **Closed Loop Referral**: "A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required." Dr. Swales said this definition is suggesting that everything should be readily available to anyone who is in the chart, which seems counter to what we have done in the past to protect patients' behavioral health care. Dr. Devido replied that the closed loop referral does not necessarily mandate or dictate a specific medium for the communicating of information. Behavioral health is sequestered. SUD services is held to even a different degree of sequestration. But the idea is there has to be a mechanism by which there is an opportunity for communication between the referring provider and the one who would provide the service. It is not specifically dictating that all information must be readily available in the electronic health record. A long conversation then ensued between doctors Swales, Quon, Murphy, Netherda, Townsend, and Mark Katz, MD. Nicole Escobar and Anna Campbell also offered suggestions. Anna asked whether the closed loop referral definition might be rewritten to say bi-directional sharing to communicate requests *and to verify outcomes of the request*? "You only need to know that it happened, right?" Dr. Swales responded "for behavioral health services, that is true. For non-behavioral health services, we are required to get the note and put it in the chart so that it can be seen by the provider. If you want to define closed loop referral, the first two sentences are perfectly acceptable for all types of closed loop referrals. The norm for kidney services would be you get the note from the provider and it is in their chart, and everybody can see that patients have been seen. For behavioral health services, it may just be that they have been seen and scheduled." Anna added that DHCS has a workgroup trying to agree on the specifics of a closed loop referral process. In the meantime, Partnership is trying to define our process because both the term and expectation appears throughout our 2024 Contract. Anna wondered if the definition at III.A should be removed from this policy and instead, clarifying language added at VI.A.4.d.4) to describe the closed loop referral process for behavioral health. Nicole thought this would work but Dr. Quon felt it should be defined somewhere. He suggested, "You could either say 'as defined by DHCS' or you could also say 'as defined by DHCS, as well as following mental health privacy guidelines' because that would actually say 'we are following closed loop referrals with mental health policy guidelines.' Then leave the actual definition out. Let (the State) define it." **Q/UAC approved the policy, amending it to clarify adherence to privacy guidelines according to this discussion.**	*Q/UAC / PAC later this year. This policy was last passed at PAC in April so we remain in compliance with DHCS's annual review expectation.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MCUP3101 – Screening and Treatment for Substance Use Disorders *revised Attachment A is now a screening tool grid*	Policy reviewed for annual update. **IQI suggested May 7 that the accepted screening tools language be in large part eliminated from the policy itself and turned into a grid. That new grid is now included in a revised Attachment A.** **IV.E.** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders. **VI.A.3.a.** Medications for Addiction Treatment (MAT) was updated to include acamprosate and disulfiram for treatment of alcohol use disorder and naltrexone extended release injection for treatment of opioid use disorder (OUD). A statement was also added to specify that special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of OUD. **VI.C.3.c.** Statement added to say that PCPs may utilize Partnership's delegated managed behavioral health organization through the process described in Partnership policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines when there are barriers in the primary care setting to making Brief Behavioral Counseling Intervention possible. **VI.C.6.d.1)** Screening tools for Unhealthy Alcohol Use were updated. NIAAA SASQ replaces prior NIDA Quick Screen. **VI.C.6.d.2)c)** ASSIST was added as a USPSTF validated screening tool for Unhealthy Drug Use. **VI.C.6.d.3)** CAGE was removed as a recommended screening tool for Unhealthy Drug Use as advised by NIAAA and USPSTF because it does not identify all patients who could benefit from a brief intervention. **VI.C.6.e.1) and 2)** NIAAA SASQ replaces prior NIDA Quick Screen question and the Prenatal Risk Overview PRO was removed as a brief assessment tool because we can no longer locate this tool online. A statement was added to recommend other tools validated for pregnant members and recommended by ACOG as follows: The 4Ps Plus, NIDA Quick Screen (superseded by TAPS), or the CRAFFT **VII. References:** Updated as follows: **C.** Added reference for NIH Quick reference guide for screening for drug use in general medical settings **G.** Removed reference to Prenatal Risk Overview (PRO), which can no longer be accessed. Replaced with reference to CRAFFT instead. **O.** Added reference to APL 23-029 and the two MOU templates attached to the APL for Specialty Mental Health Services and SUD Treatment services. **Attachment A:** The revised attachment now contains a new grid outlining which tool is approved for what screening. **Attachment E:** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders. Dr. Devido said the major change here is the new Attachment A, and he thanked Anna Campbell for organizing it. This is complex, he said, because we "have an alphabet soup of agencies: NCQA, HEDIS, USPSTF, NIDA, and NIAAA. The new chart outlines how the screening tools fit into the bigger picture, who's recommending them, who's holding them; now you can see what tool is used for what." Dr. Murphy questioned whether VI.A.3.1.a) - Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder – was meant to be exhaustive. Dr. Devido said we	Motion to approve **as amended**: Chris Swales, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: June 12 (PAC)

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	could amend the language here, specifying that these are the three FDA-approved MATs for alcohol use disorder but that other evidence-based MATs can also be used depending on clinician experience. **Dr. Swales suggested the policy state 'primary care clinicians may prescribe the FDA-indicated MAT and then list those, or other evidence-based medications.' (Call out the FDA ones apart from gabapentin or others clinicians may favor.)** **Dr. Netherda thanked Dr. Swales for the suggestion and then said he would work with staff on such rewording and send it to Dr. Devido for approval. Q/UAC approved this plan of action to amend.**	
VI. Presentations		
Continuity and Coordination between Medical Care and Behavioral Healthcare *Nicole Escobar, Senior Manager of Behavioral Health*	We will cover five different factors in presenting our QI4 Grand Analysis today. The first three were not selected for intervention, so it will be high-level overview. • Factor 1 measures the communications between PCPs and behavioral health providers. Providers were surveyed in three different ways and results demonstrated that 33.3% of behavioral health providers feel that they receive verbal or written information from primary care. Consequently, PCPs indicated that mental health referrals were only addressed 25% of the time. This indicates the need to address closed-loop referrals. • Factor 2 measures the screening of alcohol use in primary care settings. Our goal is that PCPs will screen and identify excessive alcohol use in at least 15% of their adult patients. In 2021, more than 40% of those screened were determined to have excessive alcohol use. In 2022, further increase in excessive use was apparent, with 61% of those being screened requiring intervention. In 2023, the goal was met, with an additional 706 screenings than the previous year, and of the overall screenings, only 35% were positive for excessive use. So we are seeing a downward trend. • Factor 3 monitors the follow-up care for children prescribed ADHD medication, measuring specifically members aged 6 to 12 with a newly-prescribed and dispensed ADHD med with a follow-up visit specifically with a provider who has prescribing authority within the 30-day timeframe. Our goal was to have each of our four regions at or above the 50% of the national Medicaid benchmark for the ADHD initiation phase. The goal was not met; however, we did see improvement in MY2022 performance in comparison to both preceding measurement years. The SW Region showed a marked improvement, meeting the 50%ile. Factor 4 reviews the follow-up visits for SUD service. This was a new intervention factor this year. The analysis focused on data on the frequency and follow-up of members newly diagnosed with SUD. We did include some of the FUA data: although it is not specifically included in this particular factor, we opted to include as we track it very closely. Our goal was that at least 50% of the members with a co-occurring diagnosis will be connected to SUD treatment within 10 days. More importantly, at least 50% will remain in treatment for at least 30 days. We aligned six different interventions and fully implemented each, including partnering with local hospitals for discharge support, recruiting efforts to accommodate capacity needs, and developing processes for sharing of data through beneficiary access line to ensure that real time support while the member was engaged was provided. Of those individuals connected to treatment, 79 participated in treatment for a minimum of seven days, and 63 remained in treatment for at least 30 days. There was an average of 39.22 days in treatment amongst the three most common diagnoses (i.e., alcohol use and dependency, opioid use, and stimulant use and dependency), with a median of 14 treatment episodes monthly. Factor 5 was an intervention measuring the prevalence of eating disorders and follow-up treatment within 90 days. Our goal was that 90% of those (newly) diagnosed with an eating disorder in the last 12 months would have a follow-up within 90 days. Six different projects were leveraged, including collaborative meetings with other managed care plans, primary care, and behavioral health clinicians to discuss prevalence	

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	and approaches to eating disorders. We hosted trainings by leading experts in the field, which then posted to our website. Lastly, we modified referral pathways were opportunities presented themselves. Twenty-one (fewer) cases were diagnosed in 2023 than in 2022. Although still failing to reach the goal of 90%, we hit 89.07% following-up treatment within 90 days. While it is uncertain the cause of the decrease in number of cases identified in 2023, history has indicated that claims lag may influence the measure. Of the 421 individuals newly diagnosed with an eating disorder in 2023, only nine were diagnosed in an acute setting, with six receiving follow-up care within 90 days. Primary care and Carelon Mental Health Services resulted in similar follow-up outcomes, with 369 of the 412 receiving care within 90 days. Factor 6 of QI4 measures specialty mental health services, and PHC continues to pursue an n/a as in years past. There were no questions for Nicole.	
Behavioral Health Overview *Jeff Devido, MD* and *Nicole Escobar*	Nicole covered what has been happening with the Student Behavioral Health Incentive Program (SBHIP) and our Wellness & Recovery benefit before Dr. Devido spoke. Partnership is in the final year of our three-year SBHIP. The program has been foundational and Partnership has created connections and relationships with our schools. Partnership meets regularly with each of the County Offices of Education and has a monthly learning collaborative with all 24 COEs. These meetings have evolved over time from discussing SBHIP deliverables towards what is likely coming next, a state-wide fee schedule. DHCS allowed for 14 possible interventions from which schools could choose. The most commonly chosen have been wellness program where schools implemented social and emotional curriculum, not only for students but also for staff. Expanding workforce was another area schools leaned into by using the funding to hire clinicians. The coming multi-payer statewide fee schedule is mandated by AB133. It requires health plans, both Medi-Cal and commercial, to reimburse for the delivery of school-linked behavioral health services regardless of contract status. Co-pays and deductibles do not apply. Cohort 1 (i.e., Partnerships counties Butte, Humboldt, Nevada, Placer, Shasta, Solano, and Tehama) was chosen as a soft-launch in 2024, with the remainder of the state to go-live in 2025. DHCS is still awaiting the approval of the state plan amendment. There will be capacity grants to support infrastructure but there are some changes coming (per May budget revision). *Brian Montenegro, MD, interjected that the phrase "school-linked" is ambiguous and perhaps should be defined in appropriate policies, especially if such services tie to reimbursement. Nicole agreed, and staff post-Q/UAC settled on a definition provided by Senior Director of Behavioral Health Mark Bontrager, accordingly further amending Care Coordination's MPCP2006 (see p. 9 of these minutes).* Dr. Devido spoke on mental health utilization rates. The overall penetration rate of nearly 10% is inclusive of specialty mental health through the counties as well as Carelon non-specialty health network. Thirty-two percent of non-specialty mental health was conducted via Telehealth, a higher rate than pre-pandemic but lower than mid-pandemic. This probably represents the new norm. Nearly 70% of diagnoses treated within the non-specialty mental health system were anxiety and depressive disorders. This does not mean that conditions like schizophrenia or bipolar are not seen in the non-specialty mental health arena but this is the prominent diagnosis breakdown. In terms of race and ethnicity, one noteworthy thing to highlight is that within the Native American population, part of the reason we see better utilization in that population is because many of the providers in that network are providing co-occurring or integrated behavioral health services in conjunction with medical services, Dr. Devido noted. We can see the breakdown (in utilization) by preferred language, age and gender. We do not have great resolution on the gender data to the extent we want to have it, and we will continue to work on expanding that. Of the top providers by utilizing members, North American Mental Health Services is far and away the largest provider by volume.	

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	Partnership is closing down into the third year of the Mental Health QIP. This was intended to bring principles of measure-based care in incentive-based format to non-specialty mental health provider network. When looking at the measurement we used, we honed in on the PHQ-9, the GAT-7, and we did see some significant improvement on scores in these measurement-based tools. Bright Heart Health did much of the data analytics and helped get the platform implemented in the various clinics. The results reported here are preliminary. Utilization of eating disorder treatment services is reported here by county, looking at the three levels of care (residential, partial, and intensive outpatient, or IOP) of shared financial responsibility. Sonoma and Marin counties consistently tend to be on the higher end of utilization. Wellness & Recovery: we have seven counties that have opted into a Partnership-administered Drug Medi-Cal Organized Delivery System for the delivery of substance use services. The main thing to look at here is that when developing the DMC-ODS, the State model is to have each of the counties, or in our case, the regional model, develop a managed care program that has all of the different ASAM (American Society of Addiction Medicine) levels of care embedded and available within the program. OTP and NTP services are high in part because they reflect the daily dosing of methadone in many instances. Some of these levels of care, like residential, are not available under standard Medicaid. The DMC-ODS represents an expansion of being able to draw down federal funds for additional substance use services. The 1,360 patients accessing residential treatment at the 3.1 level would not have been able to access residential treatment absent the DMC-ODS. Ninety-three percent of episodes were addressed by the timeliness requirements. We have an increasing number of direct referrals – people going directly to the provider – which means that word is getting out, and non-substance use providers and communities are guiding people directly to SUD providers, which is great: another door! Transition of Care is another measure by which we the State judges us. We are doing well in terms of time of transition of care, either up or down. (e.g., residential needs to go into a higher level of residential or someone in residential needs to step down into intensive outpatient or outpatient treatment). We are falling fully within the State's metrics. There were no further questions for Nicole or Dr. Devido. Those who later have questions may contact Dr. Devido offline.	
2024 Inequity Analysis of HEDIS® / PCP QIP *Mohammed Jalloh, Pharm.D, Director of Heath Equity (Chief Health Equity Officer)*	Dr. Jalloh began by explaining the methodology behind collecting two sets of data – a sample of our 2022 health equity accreditation/Managed Care Accountability Set (MCAS), and 2023 data on our QIP measures – and then analyzing said data in March 2024 to put everything in context. The analysis calculated Partnership regions below the minimum performance level (MPL) and 25%ile of the national Medicaid benchmarks before stratifying disparities as strong, moderate or weak. In looking at the 2023 QIP data, analysis included geographic drivers and community profiles; lesser Covid effects than in 2022, and utilized the performance of White ethnicity as a benchmark. Dr. Murphy questioned the latter, noting that his La Clinica site has noted that White patients did not always do best. He asked whether this analysis looked at White patients in aggregate or by measure. He also wondered whether the analysis would work were the top performers – regardless of racial/ethnic category – considered the benchmark. Dr. Jalloh replied there hasn't been a gold standard. This has been something debated among health equity leaders and experts. One way we try to approach it was looking at in two ways where, one, we would actually compare all the race groups to the white community, and there were some cases where the white community actually performed the worst. So, then it made it was easier to say 'oh, we've got to address those disparities in the white community.' For example, lead screening, they were the worst when we looked at our data. But we didn't only look at that. We also looked at the MPL – that's what the State holds us to – the 50th percentile of the national Medicaid benchmark. We compared each race group to that national benchmark and, as a composite, we evaluated if there was a group that had a disparity or not. We looked at it on one level, where we compared each group to the White community, and then we compared everyone to that standard that we are being held to	

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	at the State level. When we combined those two, we could see where there were strong disparities, moderate or weak. If there was a disparity where you were maybe 20% different than the white community AND you were well below the MPL, that was a big, "strong" disparity, versus a "weak" level (i.e., a one to two percent difference and really close to the MPL.) While there are disparities between communities, we recognize there may be quality concerns where everyone was performing worse. In Well-Child visits, all the groups, whether they were white, Hispanic, etc., were not performing to the level we were hoping for, especially for the MPL. We tried to do an inequity analysis at the race level. Here's an example how we did the American Indian/Alaskan Native analysis. When we looked at the Health Plan accreditation sample, we compared how well that community did comparing against White community as well as MCAS sample, but then we looked at it at the MPL: we looked at communities below the 25th percentile as well as the 50th percentile. For controlling blood pressure, three of our regions were below the 25th percentile and, on average they were below what the State holds us to by 13.18%, so that's when we aid 'oh, that's a pretty strong disparity.' For our Native American community, we saw that blood pressure was a big concern, and we saw in our QIP data that this actually worsened as well. This made it easy for us to determine that we really want to prioritize on blood pressure control in this community because not only was it a big disparity in our 2022 data but then in 2023, it got worse. In some cases, we saw a little bit of improvement from 2022 to 2023: in immunizations by adolescents as well as child and adolescent well care visits but when we looked at well-child visits in the first 15 months and childhood immunization status, it actually worsened from 2022 to 2023. These could be other areas we want to target in the Native American community. In some cases, there was a clear disparity between the White and Native American community. It made us easy to stratify which ones we may want to prioritize first because there is such a big difference. (e.g., 19% difference in blood pressure control, 16% in blood sugar control, and 19% difference in well-child visits). We looked at some of these measures and tried to find out if it was a more specific clinic issue or is this across the board? We found that our tribal centers unfortunately were the lowest performers in some of these, pretty consistently so in blood pressure, childhood immunization status and diabetes. But then we saw that there were some who were doing well. This tells us both that we may want to work with those providers to see the good practices they use, and also that it may not be as much of a quality issue if they all are doing pretty poor. When we took a look at the African-American community, at the time we did the data analysis for our HEDIS® measures, we saw that prenatal care was a big issue, as well as postpartum care. The other data we looked at was follow-up for mental health within 30 days of an ER visit: three regions were below the 25th percentile and on average they were below the minimum we are held to be 23.19%, so this is a strong disparity. We saw diabetes retinal exams actually improve from last year to this year but one thing that actually decreased was colorectal screening. So, that may be an area we want to target for this community. Some of the sites had the highest African-Americans, and that's one of the reasons leading to them being the poorest performers. However, Community Medical Center actually performed well for their colorectal screenings. When we looked at the QIP data [for 11 measures], there were five measures with big disparities. We classified them as strong, moderate or weak to make it easier for us to prioritize. The ones we figured we want to prioritize for this community based on the QIP data we saw in March are follow-up for mental illness post ED visit, prenatal/postpartum care, and colorectal cancer screenings. Time ran out to allow for questions. Dr. Netherda encouraged all to take a good look at the report and contact Partnership with any questions. Dr. Murphy commented he appreciated the analysis, and he wonders if there could be a tie-in to the QIP in terms of a reduction in disparities. Dr. Jalloh said this is a good suggestion. Some health plans have full QIPs on reducing disparities. Luckily, Partnership does have a fund where we do give clinical sites money if they are doing equity work.	
VII. FYI	QI Initiative: Expanded Mobile Mammography Program – *direct questions to Areli Carrillo*	
VIII. Adjournment – Dr. Netherda took a straw poll of Q/UAC voters to see if these meetings may start at 7:00 a.m. A majority said to keep the start time at 7:30 a.m. Q/UAC adjourned at 9:33 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, June 19, 2024.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Respectfully submitted by: Leslie Erickson, Program Coordinator I, QI Signature of Approval: _____ Date: _____ Mark Netherda, MD Committee Vice Chair		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, May 7, 2024 / 1:30 – 3:20 PM

Members Present:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Bjork, Sonja, JD, Chief Executive Officer
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, Quality Improvement
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Health Services Policy Analyst, Utilization Management
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gast, Brigid, MSN, BS, RN, NEA-BC, Director of Care Coordination
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance, Administration
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – East
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Scuri, Lynn, MPH, Regional Director – Southwest
Sharp, Tim, Regional Director – Northeast
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:

Ayala, Priscila, Associate Director of Provider Relations
Davis, Wendi, Chief Operating Officer
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Manager – Northwest
Randhawa, Manleen, Senior Health Educator, Population Health
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Arrazola, Kelcie, Education Specialist, Provider Relations
Bikla, Dejene, Sr. Health Data Analyst II, Finance
Bontrager, Mark, Senior Director of Behavioral Health
Brito, Alex, Senior Health Data Analyst I, Finance
Chebolu, Radha, Senior Health Data Analyst II, Finance
Chishty, Shahrukh, Sr Manager of Foster Care Programs, Behavioral Health
Clark, Kristen, Supervisor of Quality & Training, Member Services
Coester, Kristina, Provider Relations Representative, PR
Cox, Bradley, DO, Associate Medical Director
Devan, James, Manager of Performance Improvement (NR), QI
Devido, Jeff, MD, Behavioral Health Clinical Director
Erickson, Leslie, Program Coordinator I, QI (scribe)
Escobar, Nicole, Senior Manager of Behavioral Health
Gaul, Kristine, Manager of Performance Improvement (SR), QI
Hanusiak, Kenzie, Manager of Governance & Compliance, Regulatory Affairs
Harris, Vander, Senior Health Data Analyst I, Finance
James, Jaymee, Manager of Mental Health Programs
Jarret-Lee, Kevin, RN, Associate Director of UM
Kung, Jen, Senior Health Data Analyst I, Finance
Lee, Donna, Manager of Claims, Claims
Millis, Wendy, Program Manager I, Behavioral Health
O'Leary, Hannah, Manager of Population Health
Power, Kathryn, Regional Manager, Communications
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Robertello, Kimberly, Senior Medicare QI Program Manager, QI
Roberts, Dorian, Improvement Advisor, QI
Rodekohr, Dianna, Project Manager I, Configuration
Salehi, Tiphanie, Senior Health Data Analyst I, Finance
Selig, Barb, Manager of Quality Improvement Programs, QI
Stark, Rebecca, Regional Director – East
Thomas, Penny, Senior Health Data Analyst I, Finance
Townsend, Colleen, MD, Regional Medical Director – Southeast
Trosky, Renee, Compliance program Manager II, Provider Relations
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Watkins, Kory, Director, Grievance & Appeals

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions – None Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA called the meeting to order at 1:30 p.m. Approval of April 9, 2024 IQI Minutes *Acknowledgement and Acceptance of draft minutes of the* • Jan. 25, 2024 Substance Use Internal Quality Improvement Committee (SUIQI)	Motion to approve IQI Minutes: Mark Netherda, MD Second: Marshall Kubota, MD Motion to accept draft SUIQI: Mark Netherda, MD Second: Mohamed Jalloh, Pharm.D
II. Old Business – *returning from March 20 Quality/Utilization Advisory Committee*		
MCQG1015 – Pediatric Preventive Health Guidelines	Q/UAC on March 20 approved most of the redline changes but directed Partnership staff to re-define 'Parent." After much internal discussion, "Parent" is now stated as: "For our purposes, a 'parent' is the designated legal guardian for the pediatric member." We are also adding back the definition of the Child Health and Disability Prevention (CHDP) program as it does not sunset until July 1, 2024. The Pediatric Quality Committee approved these changes on May 2.	Motion to **approve as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: May 15 Q/UAC June 12 PAC
III. New Business (Committee Members as applicable) – Consent Calendar Policies		
Health Services Policies Quality Improvement MCQP1021 – Initial Health Appointment – *came back from February approval to address CHDP July 1 sunset* MCQP1047 – Advance Directives MCQP1052 – Physical Accessibility Review Survey SR Part C MPXG5003 – Major Depression in Adults Clinical Practice Guidelines Care Coordination MCCP2025 – Pediatric Quality Committee Policy MCCP2026 – Diabetes Prevention Program – *added language describes Partnership's Medical Distribution Services (PMEDS) program* Utilization Management MCUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3136 – Fecal Microbiota Transplant (FMT) MCUP3144 – Residential Substance Use Disorder Treatment Authorization ***Provider Relations Policies*** MPNET100 – Access Standards and Monitoring MPPR207 – Annual Physician Satisfaction Survey MPPR208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information Anna Campbell **pulled MPPR208** to ask if VI.F.2 as stated is not incorrect for postpartum continuation of care: we cover all of pregnancy; do we not do all postpartum continuity of care? Tony Hightower looked at Health and Safety Codes, as Dr. Netherda and CEO Sonja Bjork, JD, discussed applicable National Committee on Quality Assurance (NCQA) standards.	The Consent Calendar minus the pulled MPPR208 was approved as presented: Marshall Kubota, MD Second: Mohammed Jalloh, Pharm.D MPPR208 was approved as revised in committee today: Colleen Townsend, MD Second: Mark Netherda, MD Next Steps: • Health Services policies and PR's MPNET100 go to May 15 Q/UAC and to June 12 Physician Advisory Committee (PAC) • PR's MPPR207 bypasses Q/UAC and goes to June 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	IQI agreed to amend VI.F as follows: If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner as follows: 1. Continuation of treatment through the current period of active treatment, for members with a chronic or acute medical condition. 2. **Continuation of care through the postpartum period for members who are pregnant. Postpartum care begins immediately after childbirth, miscarriage, stillbirth, or pregnancy termination** and extends for the period mandated by [Department of Health Care Services] DHCS. 3. **This addresses the NCQA Network Management Standards.**	• PR's MPPR208 goes to CEO Sonja Bjork, JD, for signature.
IV. New Business – Discussion Policies		
Quality Improvement: *Presenter: Rachel Newman, RN, Manager, Member Safety & Clinical Compliance*		
MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	**III. Definitions C.** Expansion counties Nevada and Placer are added to the list of PHC counties that have their own Drug Medi-Cal Organized Delivery System (DMC-ODS) programs, over which Partnership has no regulatory oversight responsibilities. **IV. Attachments:** The former Attachment A is split into Attachments A and B, respectively renamed SUD FSR Tool and SUD FSR Guidelines. **V.B.** DMC-ODS and Substance Abuse Block Grant (SABG) monitoring language is eliminated from the Purpose Statement. **VI.B.1.** At a minimum, PHC's Site Review team will consist of one of the following staff: a Registered Nurse (RN), a Non-Physician Medical Practitioner (NPMP), a Certified Counselor, or a Physician. **VI.C.1-2.** now outlines the 10 sections of both the SUD FSR Tool and the Guidelines (new Attachments A & B), as well as the new nine sections of the SUD MRR (re-lettered Attachment C). **VI.D.2:** An initial SUD MRR must now be completed within **11** months of the SUD FSR assuming services have been rendered. This may be deferred on claims. **New References G & H** supersede earlier Behavioral Health Information Notices (BHINs). Rachel began by reading out additional definitions to be added to this policy: the Non-Physician Medical Practitioner (NPMP) and the Licensed Practitioner of the Healing Arts (LPHA), and she pointed out the differences between the two. (An updated policy will be provided to May 15 Q/UAC.) The main update comes in the attachments: the old Attachment A is now divided into new attachments A and B: The Facility Site Review Tool is now separate from the FSR Standards. The Site Review team is now working on a plan to garner copying provider organizations' compliance with the Standards into FSR records in accordance with new State expectations.	Motion to **approve as presented**: Doug Matthews, MD Second: Marshall Kubota, MD Next Steps: May 15 Q/UAC June 12 PAC
Quality Improvement: *Presenter: Mark Netherda, MD, Medical Director for Quality*		
MPQP1016 – Potential Quality Issue Investigation and Resolution	Staff titles are changed throughout the document as appropriate: "Quality Investigator" replaces "Performance Improvement Clinical Specialty (PICS)" and "Manager, Member Safety – Quality Investigations" replaces "Manager, Quality Assurance and Patient Safety." **VI.B.3.a revised**: Cases occurring more than two years before reporting involving a potentially serious matter or egregious lapse in care may be reviewed on an ad-hoc basis upon the discretion of the CMO/physician designee. **VI.C.1.c.i added**: Notification that another Peer Review Organization (PRO) is reviewing a case does not prevent Partnership from investigating a case through the Partnership PQI and Peer Review process.	Motion to **approve as presented**: Katherine Barresi, RN Second: Doug Matthews. MD Next Steps: May 15 Q/UAC June 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.2.b added: Additional information such as licensing board information and Partnership's Grievance, Credentialing, and PQI history may be used to determine an appropriate score and/or actions. **VI.C.2.f added:** Upon determination that a PQI case is out of Partnership's jurisdiction (e.g., serious mental health cases) the case will be referred to the appropriate oversight body (e.g., County Mental Health). **VI.C.3. Tertiary Review**: the Peer Review Committee's specific responsibilities are outlined in greater detail. **Section VI.C.3.b added**: "The PRC reviews the worksheets developed by the Investigator and CMO/physician designee, the medical records related to the case, any letters to and responses from POCs and all other relevant documentation and correspondence related to the case. i. Following review and discussion of the case, the PRC may uphold the original scoring determination, may level a lower or higher score, or may direct the Investigator to obtain more information for further review. ii. If a score is leveled, the PRC will direct the Member Safety-Quality Investigations team in the next actions to take, as outlined in the Practitioner Performance and Systems Scores Grid." **VI.C.3.d.iv is added:** For appropriate quality concerns, the PRC may instruct the Member Safety team to conduct periodic reviews of the Provider of Concern (POC) to verify that the deployed corrective action is effective and eliminates the noted deficiencies. **VI.C.7.** on reporting per policy MPCR601 Fair Hearing and Appeal Process for Adverse Action and MPCR602 Reporting Actions to Authorities clarifies that "a similar approach is applied to all clinical professionals credentialed by Partnership with a report filed with the appropriate professional licensing agency." **Attachment A:** The Practitioner Performance and Systems Scores Grid clarifies discrete practitioner score (P) and system score (S) definitions and actions/follow-ups. • P2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • P3 – Action/Follow-up strengthened: ASAP communication to provider of concern requesting a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentialing Committee with recommendations from the PRC. • PUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to Peer Review Organization (PRO) of the Facility of Concern (FOC) or the Provider of Concern (POC). If none identified, may be through direct contact with management of the FOC or with oversight of the POC. Refer to the appropriate licensing entity, if indicated. • S2 – Action/ Follow-up: added "Certified" to clarify the type of letter sent, changed "Requesting" to "Requiring." • S3 – Action/Follow-up strengthened: ASAP communication to FOC/POC requesting a response. May be by certified letter, email or direct phone call. Require CAP and/or other interventions. May be referred to Credentials Committee with recommendations for PRC. SUTD is used whenever the PQI cannot be scored through the usual process. Action/Follow-up strengthened to: Referral to the PRO of the FOC or the system of concern (SOC). If none identified, may require direct contact with management of the FOC or with oversight of the SOC. Refer to the appropriate licensing entity, if indicated. Dr. Netherda noted the biggest changes come in Attachment A, which make more "stringent" the follow-up actions required of both the reviewer and the POC/FOC for each P and S scores. He noted that any case before the PRC may result in a P or S score or both. There were no questions.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Care Coordination: *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*		
MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Changes made to Policy based on APL 23-023 ICF/DD Language **Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities **Definitions added:** B. California Children's Services F. ICF/DD G. ICF/DD-H H. ICF/DD-N O. Whole Child Model (WCM) **VI.R added:** Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) Homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N) 1. For more information, refer to PHC Policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities **VII. Reference added:** DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) **IX.** Updated to Chief Health Services Officer Shannon went through the synopsis. IQI posed no questions.	Motion to **approve as presented**: Mark Netherda, MD Second: Isaac Brown Next Steps: May 15 Q/UAC June 12 PAC
MCCP2034 – Transitional Care Services (TCS) – **NEW POLICY**	This policy describes and defines Partnership HealthPlan of California (PHC's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between PHC's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings. PHC members identified as 'high risk' must be offered TCS services beginning Jan. 1, 2023. Partnership must offer support for TCS for lower-risk transitioning members effective Jan. 1, 2024. This policy outlines that Partnership shall ensure TCS are provided to members transferring from one setting, or level of care, to another. TCS includes the following: 1. Ensuring collaboration and partnership with discharging facilities 2. Closed loop referrals 3. Ensuring medication reconciliation is conducted pre- and post-transition 4. Ensuring all necessary prior authorizations required are completed 5. Coordination to ensure appropriate post-discharge appointment attendance and follow-up 6. Follow up with member and/or guardian/caregiver/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met 7. Members may choose to have limited to no contact with the identified TCS care manager, in these cases TCS care	Motion to **approve as amended**: Marshall Kubota, MD Second: Mark Netherda, MD Next Steps **with the post-meeting amendment as stated below**: May 15 Q/UAC June 12 PAC "This policy was written based on the request by DHCS as part of their Population Health Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides

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	manager must act as a liaison 8. Coordination and verification that the member is receiving all appropriate services regardless of setting 9. Ensuring collaboration, communication and coordination with the member, their caregiver(s)/guardian/authorized representatives and their care team 10. Care manager is to coordinate with discharging facilities to ensure the care manager fully understands the potential needs and the needed follow-up plans for the member 11. Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy level-appropriate, and be shared with the member. Shannon presented the synopsis of this new policy, which is driven by the State's Population Health Management (PHM) Policy Guide, and thanked those who helped with its crafting, including Health Services Policy Analyst Anna Campbell and Director of Care Coordination Brigid Gast, RN. I**QI agreed with Kory Watkins' suggestion that secondary references of "PHC" be changed to "Partnership,"** and Dr. Moore and CEO Sonja Bjork agreed that all policies should do so as they come up for renewal. IQI agreed with Chief Health Services Officer Katherine Barresi, RN, that it is likely to change several times during the course of this next year as the State attempts to operationalize their expectations across many managed care organizations. Marshall Kubota, MD wondered if Transportation needs are considered herein, and Shannon thought they might be: she pointed to section VI.B.5.c. Further, almost every member could be considered "high risk" as the policy is now written. Dr. Moore noted that at present this expensive process is now an unfunded mandate and Sonja noted that possibly making up for this with higher rates is under discussion. Both liked adding a second paragraph to the Purpose Statement that would hedge against clarification of funding. **IQI agreed to pass the policy with such an amendment to be written offline.**	finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities.""
MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities	Changes made to Policy based on APL 23-023 ICF/DD language and Child Health Disabilities Prevention (CHDP) Program sunsetting July 1, 2024. **Related Policies added:** MPCP2002- California Children's Services MCCP2035- Local Health Department (LHD) Coordination MCUG3058- Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities MCUG3038- Review Guidelines for Member Placement in Long Term Care (LTC) Facilities MCCP2014- Continuity of Care MCCP2034- Transitional Care Services (TCS) MPCD2013- Care Coordination Program Description MCCP2007- Complex Case Management MCCP2032- CalAIM ECM **Definitions added:**	Motion to **approve as presented**: Marshall Kubota, MD Second: Isaac Brown Next Steps: May 15 Q/UAC June 12 PAC

A. California Children's Services (CCS)
B. Direct Member
C. ICF/DD
D. ICF/DD-H
E. ICF/DD-N
F. Medical Home
G. Whole Child Model

VI.B.1 added:

a. In participating counties, PHC members who have a CCS-eligible condition participate in the Whole Child Model (WCM). As part of this model, PHC provides the case management and utilization management services for these members. For more information, refer to policy MCCP2024 Whole Child Model for California Children's Services (CCS).
b. PHC members who have a CCS eligible condition and participate in the CCS Program, refer to policy MPCP2002-California Children's Services for more details.

VI.B.2 is revised and added:

High Risk Infant Follow-Up (HRIF) Services- Birth to age 3 years

a. In accordance with APL 23-034 California Children's Services Whole Child Model Program (12/27/2023), for members in counties that participate in the WCM program, PHC is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.
b. For members who live in a county that participates in the State CCS Program, this would be the responsibility of the CCS offices and providers, PHC may work in collaboration if necessary.

VI.B.3.c. added under Medicaid per APL 23-010 revisions

VI.B.5.a revised due to APL 23-010 and to reference BHT Policy:

PHC is not contractually responsible for educationally necessary BHT services covered by a LEA and provided pursuant to a member's IFSP, IEP, or IHSP. However, if medically necessary and covered under Medicaid, PHC must provide supplementary BHT services, and must provide BHT services to address gaps in service caused when the LEA discontinues the provision of BHT services (e.g. during a Public Health Emergency [PHE]). Please see PHC policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21 for details.

VI.B.6 added:

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)

a. Services are offered to members with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system
b. PHC ensures that members in ICF/DD Homes have access to a comprehensive set of services based on their needs and preferences across the continuum of care
c. TCS: High-risk individuals in all LTSS services, including LTC, as well as individuals that have a behavioral health diagnosis or a developmental disability.
d. CCM: Members may need extra support to avoid adverse outcomes but who are not in the highest risk group
e. COC: MCPs must provide 12 months of continuity of care for the ICF/DD Home placement of any member who is mandatorily enrolled into PHC after January 1, 2024. Members or their authorized representatives may request an additional 12 months of continuity of care, pursuant to the process established by APL 23-022, Continuity of Care of

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	Medi-Cal Beneficiaries who newly enroll in Medi-Cal managed care from Medi-Cal Fee-For Service, on or after January 1, 2023. f. ECM: If a member will be transitioning out of an ICF/DD Home, the restriction of duplicative service is removed, and the member must be assessed to determine need/eligibility for ECM services g. Utilization Review: Refer to PHC policy MCUG3058 **VI.B.7.b added language CHDP superseding** 10) This supersedes any contradicting information found within CHDP Program guidelines, as the CHDP sunsets July 1, 2024. **References updated:** A. Department of Health Care Services (DHCS) Contract Exhibit A, Attachment III, Section 4.3.9 D. DHCS All Plan Letter (APL) 23-034 – California Children's Services Whole Child Model Program (12/27/2023) F. National Committee for Quality Assurance (NCQA) Health Plan Standards 2024. Population Health Management 5 Complex Case Management **Reference added:** H. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023) Shannon went through the synopsis. Dr. Kubota asked if the several references of "Medicaid" are appropriate in California. Dr. Moore replied this terminology is correct in reference to Centers for Medicare & Medicaid Services (CMS). Anna further clarified that this is specific to BHT.	
Utilization Management: *Presenter: Tony Hightower, CPHT, Associate Director, UM Regulations*		
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	The annual review of this policy includes updates made for the 2024 contract and the CalAIM PHM Policy Guide as well as APL 23-004. **Section I. Related Policies:** Add two Related Policies: B. MCUP3142 – CalAIM Community Supports C. MCCP2032 – CalAIM Enhanced Care Management (ECM) **Section IV. Attachments** Deleted Attachments A. "BedHold/ TAR Process flow chart" and Attachment B. "Admissions for Short Term Rehab or Short Term Skilled Nursing," as both of these attachments are better suited to be desktop procedures. Attachment C. "Bed Hold & Change of Status Report Form" is now Attachment A but there were no changes otherwise. **Section VI.A.2.** This statement was deleted in light of 2024 DHCS contract requirements and the CalAIM PHM Policy Guide requirements for Transitional Care Services: "PHC assists with finding a facility for the appropriate level of care upon request although primary responsibility remains with the hospital discharge planning staff." **Section VI.C.2.a.** Added information regarding "the Preadmission Screening and Resident Review (PASRR) form" indicating appropriateness for placement. **Section VI.C.j.** Deleted paragraph on Kaiser Capitated Members. Clarified language for Medicare denial letters. **Section VI.F.4.** Updated COC APL from 18-008 to 22-032 **Section VI.G.** Updated description of process for referring potential quality of care issues that may be identified during routine case review to PHC's Member Safety Quality Investigations team. **Section VI.K.3** Added new paragraph describing ECM and CS services for which members in a SNF or LTC setting may be eligible.	Motion to **approve as presented**: Mark Netherda, MD Second: Doug Matthews, MD Next Steps: May 15 Q/UAC June 12 PAC

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	Section VII. References C. Updated DHCS Contract sections H. Updated APL 22-018 to APL 23-004 I. Updated APL 18-008 to APL 23-002 **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Tony went through the synopsis, stating that some attachments are now deleted because they reflect more internal processes that do not always need to be shared with our external partners. IQI posed no questions.	
MCUP3041 – Treatment Authorization Request (TAR) Review Process	With the annual review of this policy, we include changes in TAR requirements as per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process. **Section VI.A.2.b.** We deleted the phone number and reference to PHC's Eligibility and Interactive Voice Response (IVR) System as this system will cease to operate on 05/01/24. Instead, we refer the reader to PHC's Online Services (OLS) portal to verify Member eligibility for services and PCP assignment. **Section VI.A.5.** Updated paragraph on storage of UM records to specify they are not archived electronically. **Section VI.B.1.b.** Added that we include a few HCPCS codes on our TAR Requirements list. **Section VI.C.4.** Clarified in two places that 90 days is 90 "calendar" days. **Section VI.D.3.b.** Specified that the Associate Director of UM Regulations is responsible for monitoring the UM activities of delegate entities (instead of the Senior Health Services Director.) **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." **Attachment A:** The PHC TAR Requirements list was updated as follows: **Section H: Diagnostic Studies** In this section a change was made to specify that certain CT scans and MRIs no longer require a TAR. For CT Scans: A TAR is required for chest, abdomen, and/or pelvis CT. No TAR is required for other CT scans of extremities, Head/Neck/Spine, CT colonogram - effective 7/1/2024. For MRI: A TAR is required for chest, abdomen, and/or pelvis, including Cardiac MRI 05561. No TAR is required for other MRI scans of extremities, Head/Neck/Spine, MRI Breast - effective 7/1/2024. **Section W: Medical Supplies** A change was made to clarify TAR requirements for Wound Care Supplies. An additional resource was added for the reader to find detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, by referencing the Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits. Information was also added in the Nutritional Supplements section at W.7. to update the name of PHC's "Medical Drug List Navigator" instead of PHC's "Covered Medical Drug List." **Section W: Medications Provided by a Pharmacy:** The name "Magellan" was removed in this section and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan. **Sections AA: Occupational Therapy, FF: Physical Therapy, and HH: Speech Therapy:** All of these sections were updated to match new TAR requirements in policy MCUP3114 Physical, Occupational and Speech Therapies. For both PT and OT, it was specified that Members under age 21 still require a TAR for services; however, no TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.) For speech therapy, it was specified that Members age 21 and over still	Motion to **approve as presented**: Colleen Townsend, MD Second: Mohamed Jalloh, Pharm.D Next Steps: May 15 Q/UAC June 12 PAC *Postscript:* Further changes to Attachment A occurred at the May 14 CMO/Medical Directors' meeting and were read into the record at the May 15 Q/UAC.

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	require a TAR for services; no TAR is required for Members under age 21 for up to 12 visits (limit one visit per day) in a rolling 3-month period. (A TAR will be required for services in excess of 12 visits.) Tony said the bulk of changes occur in Attachment A to streamline, promote efficiencies, and remove barriers. Dr. Moore said the Medical Directors weighed in on these changes after looking at what other MCPs do. Dr. Kubota expressed appreciation for differentiating between calendar and business days, adding that he believes all Partnership policies should. IQI posed no questions.	
MCUP3114 – Physical, Occupational and Speech Therapies	Per discussion at the CMO Meeting in April regarding TAR volume and efficiencies of the UM process, this policy was updated to adjust TAR requirements for certain PT, OT, and ST services. **Section VI.B. and B.1.** Heading of this section updated to reflect "General Guidelines for Authorization" of services instead of "Submission of TARS" and the information regarding no RAF required but written prescription required for PT/OT/ST services, was moved to the beginning of this section. **Section VI.B.2.** This section was updated to specify PT/OT/ST services that will now have No TAR requirement which includes PT and OT services for Members age 21 and over and ST services for Members under age 21. **Section VI.B.3.** This section was updated to specify PT/OT/ST services that continue to have a TAR requirement, which includes PT and OT services for Members under age 21, ST services for Members age 21 and over, any PT/OT/ST services prescribed by a non-contracted provider, and services provided through home health. **Section VI.B.4.e.4)** This section was moved up from below for continuity in explaining which services are generally not considered medically necessary or are not covered. **Section VI.C.** This section was rearranged to better explain ESPDT services as they relate to PT/OT/ST services. Some EPSDT details were deleted with a statement added to refer the reader to PHC policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services instead. Tony went through the synopsis, pointing out some differing requirements for members whether over or under the age of 21. Dr. Moore made some remarks. IQI posed no questions.	Motion to **approve as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: May 15 Q/UAC June 12 PAC
Utilization Management: *Presenters Mark Bontrager, Senior Director of Behavioral Health,* and *Jeffrey Devido, MD, Clinical Director for Behavioral Health*		
MCUP3028 – Mental Health Services	Policy Reviewed for Annual update. **Section III.A.** PHC definition of "closed loop referral" was added. **Section III.F.** Definition of Medical Necessity for EPSDT services was updated to specify that California now refers to the EPSDT benefit as "Medi-Cal for Kids & Teens." **Section III.I.** Definition was added for PHC's Wellness & Recovery Program. **Section VI.A.3.a.e)** Added that Members residing in participating PHC Wellness & Recovery counties will be directed to PHC for SUD assessment. **Section VI.A.4.d.** Specified that Carelon Behavioral Health is PHC's delegate. **Section VI.A.4.d.4)and 5)** Added language to explain how a closed loop referral process will work when there is a need to refer a member between levels of care (SMHS and NSMHS). **Section VI.G.** Clarified that PHC provides or arranges for NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network.	Motion to **approve as presented**: Isaac Brown Second: Doug Matthews, MD Next Steps: May 15 Q/UAC June 12 PAC

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	Section VI.G.2. Clarified Medi-Cal Rx information. Removed the name "Magellan" and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan. Dr. Devido stated that there were no significant changes but we do now define "closed loop referral." Dr. Moore noted that Partnership took months to construct this definition and suggested Partnership use it until such time that DHCS achieves unity on and communicates to us their definition. Dr. Moore explained that Partnership is trying to make clear that every community is "local": the method matters less than that the loop should be closed locally. IQI posed no questions.	
MCUP3101 – Screening and Treatment for Substance Use Disorders	Policy Reviewed for Annual update. **Section IV.E.** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders. **Section VI.A.3.a.** The section on Medications for Addiction Treatment (MAT) was updated to include acamprosate and disulfiram for treatment of alcohol use disorder and Vivitrol ® for treatment of opioid use disorder (OUD). A statement was also added to specify that special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of OUD. **Section VI.C.3.c.** Statement added to say that PCPs may utilize PHC's delegated managed behavioral health organization through the process described in PHC policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines when there are barriers in the primary care setting to making Brief Behavioral Counseling Intervention possible. **Section VI.C.6.d.1)** Screening tools for Unhealthy Alcohol Use were updated. NIAAA SASQ replaces prior NIDA Quick Screen. **Section VI.C.6.d.2)c)** ASSIST was added as a USPSTF validated screening tool for Unhealthy Drug Use. **Section VI.C.6.d.3)** CAGE was removed as a recommended screening tool for Unhealthy Drug Use as advised by NIAAA and USPSTF because it does not identify all patients who could benefit from a brief intervention. **Section VI.C.6.e.1) and 2)** NIAAA SASQ replaces prior NIDA Quick Screen question and the Prenatal Risk Overview PRO was removed as a brief assessment tool because we can no longer locate this tool online. A statement was added to recommend other tools validated for pregnant members and recommended by ACOG as follows: The 4Ps Plus, NIDA Quick Screen (superseded by TAPS), or the CRAFFT **Section VII. References:** Updated as follows: **C.** Added reference for NIH Quick reference guide for screening for drug use in general medical settings **G.** Removed reference to Prenatal Risk Overview (PRO), which can no longer be accessed. Replaced with reference to CRAFFT instead. **O.** Added reference to APL 23-029 and the two MOU templates attached to the APL for Specialty Mental Health Services and SUD Treatment services. **Attachment E:** A new attachment was added: Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders. Dr. Devido noted that policy updates include additional resources and an expansion of various MAT options. Unfortunately, clear synergy does not exist between NCQA, HEDIS® and other agencies as to what screening tools for what disorder and what specific population are recommended or accepted. For example, what the United States Preventive Services Task Force (USPSTF) recommends does not always align with NCQA expectations, Dr. Devido said. Further, despite Partnership efforts to "de-gender" language where possible, risk stratification is different according	Motion to **approve as amended**: Marshall Kubota, MD Second: Colleen Townsend, MD Next Steps: May 15 Q/UAC June 12 PAC *Postscript:* Anna Campbell was able to rewrite the Attachment A narrative of screening tools into a comparative grid to present to Q/UAC May 15.

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	to male and female physiology and so some gender-specific language is still used. Dr. Moore asked if it might be possible to construct a universal screening of drinks-per-day to avoid gender specifics but Dr. Kubota expressed concern that doing so may thereafter result in negatives being noted in a member's medical record when no problem actually exists. IQI took no action here. **IQI did agree with Dr. Kubota's proposed amendment of the last sentence of VI.A.3.a.2):** "Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection (~~Vivitrol®) is fully~~ is within the scope of primary care practice." **IQI also agreed with Dr. Moore that Anna Campbell might try before Q/UAC meets May 15 to create a grid that compares screening tools by specific population and specific agency.** Dr. Devido noted that Partnership does not recommend one tool over another.	
V. Presentations		

1. Quality and Performance Improvement Update
 	
Nancy Steffen, Senior Director of Quality and Performance Improvement
	Nancy kept her remarks brief to allow time for scheduled presentations, complimenting Nicole Escobar, Dr. Devido and others for their work aiding in the launch of the Institute for Healthcare Improvement/DHCS Behavioral Health Demonstration Collaborative:
	
	• This work will continue to June 2025 efforts begun by the California Advancing and Innovating Medi-Cal (CalAIM).
	• DHCS selected Partnership, in concert with the Nevada County Behavioral Health Department, to participate in this collaborative.
	• Behavioral Health Administrator Mark Bontrager will lead Partnership's team of quality, clinical practice, equity, and population health subject matter experts in working with Nevada County counterparts to form an MCP/BHP "dyad" to plan and implement interventions.
	• Quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
	  ○ % of Medi-Cal members with 30-day follow-up after Emergency Department visit for mental illness (FUM)
	  ○ % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA).
		Information only.
		
		There were no questions for Nancy.

2. Continuity and Coordination between Medical Care and Behavioral Healthcare *Nicole Escobar, Senior Manager of Behavioral Health*	This QI 4 Grand Analysis summarizes Partnership's work to analyze, advance, and build upon efforts to promote the continuity and coordination of medical and behavioral health care services, using established goals for the range of measures and applied interventions and evaluations of effectiveness to improve Plan performance for two of the measures. These two were Factor 4 – follow-up visits for SUD services (new this year), and Factor 5 – measuring the prevalence of eating disorder diagnoses and follow-up treatment within 90 days. <u>Factor 4</u>: The goal was that at least 50% of members with a co-occurring diagnosis (medical and SUD) would be connected to SUD treatment within 10 days, and at least 50% would remain in treatment for 30 days. Six interventions were implemented, including partnering with local hospitals for discharge support, recruiting efforts to accommodate capacity needs, and processes for sharing of data through our beneficiary access line to allow for real time support while the member is engaged. Forty-two percent of members with co-occurring diagnoses had a subsequent SUD encounter. Of the individuals who connected to treatment, • 79% participated in treatment for a minimum of 7 days; • 63% remained in treatment for at least 30 days, and • There was an average of 139.22 days in treatment amongst the three most common SUD diagnoses (i.e., alcohol, opioids and methamphetamines) with a median of 14.02 treatment episodes monthly.	

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	The report shows marked improvement in each of the four regions in Calendar Year 2023 from CY2022 and CY 2021 in the days elapsed from new diagnosis to first SUD encounter: each region averaged fewer than the 10 days specified in the goal. (Plan-wide, the wait time averaged 7.71 days.) Factor 5: The goal was that 90% of those diagnosed with an eating disorder for the first time in 12 months would have a follow-up visit within 90 days. In CY 2023, that goal was nearly met at 89.07% - marked improvements above CY2020. 2021, and 2022 – although new diagnoses fell by 21% in CY2023 from CY2022. (While the cause(s) of the decrease in the number of new cases identified in 2023 remain uncertain, history has indicated claims lag may influence the measure as Medi-Cal allow for billing up to 365 days post service.) Interventions included the leveraging of six different projects, among them collaborative meetings with other managed care plans, primary care, and behavioral health clinicians to discuss prevalence and approaches to eating disorders. Partnership hosted trainings by leading experts in the field of eating disorders: these trainings have been posted to our website. Lastly, Partnership modified referral pathways where opportunities presented themselves. • Of the 421 individuals newly diagnosed with an eating disorder in 2023, only nine were diagnosed in an acute setting, with six receiving follow-up care within 90 days. • Primary care and Carelon mental health services resulted in a larger quantity of diagnosis with similar follow-up outcomes: 369 of 412 total members identified received care within 90 days. After Nicole concluded her report, Dr. Moore remarked that, insofar as he is aware, NCQA has more interventions required here than for any other standard. The goal that each of Partnership's four regions would be at or above the 50th percentile of the National Medicaid Benchmark for the ADD-Initiation Phase HEDIS® measure indicator, although a Partnership factor focused on in the recent past, was not in 2023. (This was in part because of the transition of Pharmacy services from Partnership to the State's Medi-Cal Rx. Still, some of the impacts of some interventions that were put on hold until March 2023 may be more fully realized in Measurement Year 2024.) Dr. Moore asked for thoughts why the ADD measure remains low. Director of Pharmacy Services Stan Leung, Pharm.D, replied that one of his pharmacists is working on this. There appears to be a disconnect between providers saying they are doing things within 30 days and claims data being received. Also, some prescribers are not local providers. Dr. Moore said it would be advisable to relook at this in the next year, especially with the 10 new counties that joined Partnership as of Jan. 1, 2024.	
3. Behavioral Health Overview *Jeffrey Devido, MD, Behavioral Health Clinical Director* and *Mark Bontrager, Senior Director of Behavioral Health*	Mark spoke about the Student Behavioral Health Incentive Program (SBHIP). Partnership is now in its final year of a three-year collaboration with schools to improve various wellness projects, passing $22M through the 14 County Offices of Education and 86 partner school districts in our core counties. We have completed transition plans with exiting managed care plans in the 10 expansion counties, where we intend to spend $2.3M in 2024. In all, 11 different interventions have been employed across the counties, among them behavioral health wellness centers that look remarkably different across Butte, Colusa, Nevada, Yolo, Napa, Trinity and Del Norte counties, and an expanded behavioral health work force in Modoc, Marin, Napa, Solano, Sonoma, Butte, Colusa and Sutter counties. Kermit Jones, MD, asked why some interventions were applied in some counties but not in others. Mark replied this is in part because schools appreciate that if screening occurs some remedy or action may be compelled, and this opens up the question of liability. Further, interventions were chosen three years ago during the pandemic. Schools might choose differently if asked today, Mark said. The State has now mandated that all health plans will reimburse for "school-linked" behavioral services beginning in 2024. Deliverables begin this week for Partnership's Cohort 1 counties of Butte, Humboldt, Nevada, Placer, Shasta, Solano, and Tehama. The first claims may hit in July. Mark and Dr. Devido also presented on mental health utilization. Nearly 10% of Partnership's CY2023 membership accessed mental health services, splitting 79/21% between Carelon Healthcare Services and the county offices. This split is higher than normal and may be somewhat skewed as data delays	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	and changes in coding have occurred. Isaac Brown asked if a comparison of demand to referrals exist. Mark replied that theoretically we do not have wait lists: Partnership must provide mental health services to all members requiring such service. Forty-five percent of members utilizing services in our non-specialty system in CY 2023 presented with anxiety disorders; 25% presented with depressive disorders. Overall, utilizers averaged 10 visits. Thirty-two percent of these visits occurred via telehealth, a lower rate than during the pandemic but higher than in non-pandemic years, Dr. Devido noted. Dr. Devido went through utilization of mental health services by various demographics, including race and ethnicity, calling our Tribal Health partners a "right spot" in serving our Native American/Indian populations. Top providers by utilizing members include North American Mental Health Services, with nearly 66,600 members. We are now in year three of our Mental Health Quality Incentive Program. Contracted group practices were incentivized to get clients to complete screenings at each visit, and summaries of results have been provided to the treating providers to use with clients. Staff has been incentivized to participate in quarterly learning collaboratives. Dr. Devido noted, however, that provider inclusion of the results in treatment is difficult to track. Another challenge has been client friction regarding the number of screening tools and the time necessary to complete these tools. Dr. Devido said that over the course of six months of treatment, the measurement-based care (MBC) QIP indicates symptom reduction over multiple domains, including a 60% decrease in average days in pain. Dr. Jones asked if this has resulted in lower opioid use. Mark replied that Bright Health has limited access to our data and has not crunched this; however, we might be able to go back and look at the data. Dr. Devido also spoke of eating disorder treatment, saying our partnerships with the 14 core counties are going well. A few of our new counties are proving to be heavy utilizers. Eating disorder treatment is a shared financial responsibility with county mental health plans at certain treatment levels: residential, partial, and intensive outpatient. Partnership continues to offer educational programs and additional trainings where warranted. In CY 2023, 5,222 members accessed SUD services, a 9.2% increase above CY 2022. To date, 9,915 members have accessed treatment since the inception of the Wellness & Recovery program in 2020. The channel members use depend on their county of residence: some use "state plan," which has a narrow focus. Some counties use the DMC-ODS; however, some counties cannot opt in because they cannot offer all the expected services, Dr. Devido said. For example, Federally Qualified Health Centers (FQHCs) do not provide residential care. Looking at the seven levels of W&R care, the highest utilization categories are outpatient (1,992), opioid/narcotic treatment (1,907), and residential 3.1 (1,360). This "top three" have been consistent across Partnership's counties. Dr. Devido noted that members utilizing W&R for the most part enjoy timely access: care for 93% of episodes met our timeliness requirements, Direct referrals were up nine percent over the previous year, reflecting the members are going directly to providers rather than through Carelon. Dr. Devido said non-urgent timeframes averaging 2.4 days from a level of care screening to SUD treatment exceeds our expectations; however, transitioning between levels of care in counties where differing levels are available varies. In particular, Partnership is keeping our eye on Lassen and Modoc counties, were average days to transition exceed 10. Dr. Devido invited additional questions. There were none.	
Dr. Moore acknowledged that time did not permit a full hearing of Director of Health Equity Dr. Moe Jalloh's 2024 Inequity Analysis nor Areli Carrillo's Mobile Mammography Program Evaluation and invited those interested in hearing the reports to attend the May 8 Physician Advisory Committee meeting.		
VI. FYI and Adjournment		
FYI: Updated 2024 QI Committee Presentations Calendar – *direct questions to Leslie Erickson.*		
Dr. Moor adjourned the meeting at 3:20 p.m. IQI will next meet Tuesday, June 11, 2024.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Respectfully Submitted by Leslie Erickson, Program Coordinator I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD* *Chief Medical Officer and Committee Chair*		

MEETING Minutes

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

Date: 5/21/24 **Time**: 7:30 am to 9:00 am

Facilitator: Mohamed Jalloh, HEO

Coordinator: Vicquita Velazquez

Meeting Locations:

- 4665 Business Center Drive, Fairfield, CA 94534 (Napa Solano Conference Room)
- 2525 Airpark, Redding, CA 96002 (Castle Crag Conference Room)

Attendees:

Shannon Boyle, Issac Brown, Dana Codron, Dawn R. Cook, Noemi Doohan, Greg Allen Friedman, Brigid Gast, Nisha Gupta, Tony Hightower, Latrice Innes, Amanda Kim, Vicky Klakken, Marshall Kubota, Sue Lee, Robert Moore, Mark Netherda, Rachel Newman, Hannah O'Leary, Valerie Padilla, Arlene Pena, Jose Puga, Sue Quichocho, Manleen Randhawa, Kimberly Robertello, Leila Romero, DeLorean Ruffin, Lynn Scuri, Chishty Shahrukh, Rebecca Stark, Nancy Steffen, Tiffani Thomas, Hendry Ton, Edna Villasenor, Lisa Wada, Kory Watkins, Denise Whitsett.

Absent: Priscilla Ayala, Katherine Barresi, Sonja Bjork, Mark Bontrager, Monika Brunkal, Cathryn Couch, Nicole Curreri, Wendi Davis, Jeffrey DeVido, Eugene Durrah, Heather Esget, Rachel Joseph, Stan Leung, Rachel Newman, Jeremy Plumb, Katheryn Power, Dorian Roberts, Najia Shah, Amy Turnipseed, Liat Vaisenberg, W. Suzanne Edison Tom

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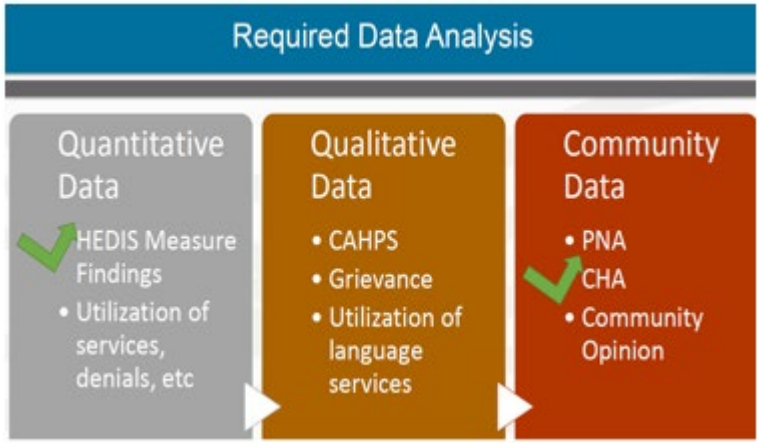
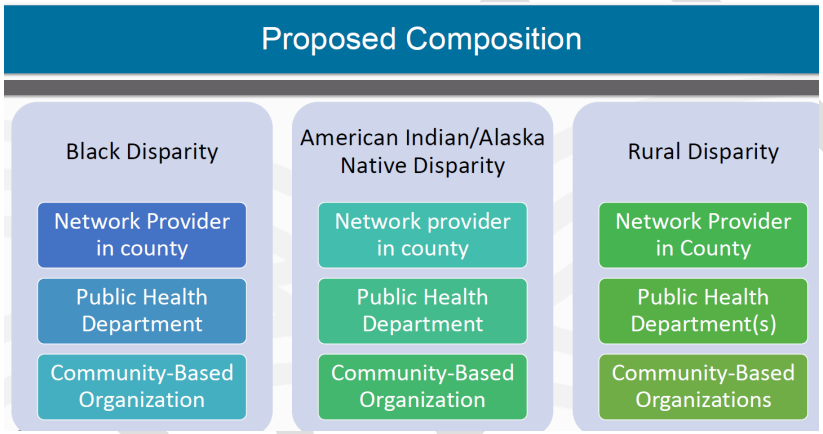
Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome & Introductions** **Time: 10 minutes** *Speaker: Dr. Mohamed Jalloh*	Introduction of attendees. The quorum was met. Dr. Noemi Doohan, a Public Health Officer from Lake County made a call out for advocacy related to health equity. She asks that the committee reach out to their legislators across the state to preserve public health funding. $300 million across the state. Dr. Jalloh says since the pandemic we understand how important public health is and the need to invest in the infrastructure around equity work.	
Agenda Item 2 **Key Health Plan Updates** **Format Review** *Speaker: Arlene Pena*	Arlene from Aliados Health: Aliados is a consortium of 17 community health centers that serve a six-county region of Napa, Solano, Yolo, Marin, Contra Costa, and Sonoma. They are working on how to advance equity amongst the community and patients they serve. In 2016 a social determinate of health (SDOH) workgroup was established to look at assessment tools the following year they worked with the National Association of Community Health Centers	

Agenda Topic	Notes	Action Item
	(NACHC) to pilot (PRAPARE) a Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences at two of the member healthcare centers which were: • Winters Healthcare Foundation • Marin Community Clinic From 2019 to the pandemic a look was given to the community information exchanged work and capacity to close the loop on referrals. Then the pandemic hit, and out of the challenges the pandemic posed the COs discussed ways to advance health equity so they decided to start the Health Equity Leadership Counsel at the end of 2021 to make recommendations to the COs for activities they can work on together. At the end of 2022, they re-convened the SDOH workgroup, where they have been doing a lot of work to improve data hygiene as it relates to demographic data collection, which includes looking at registration forms to ensure there is alignment in how information is collected and how it is entered into the electronic health record to get a better picture of where the disparities lie. They hoped that it would prompt them	

Agenda Topic	Notes	Action Item
	to know where to focus initiatives. They are currently building health equity dashboards for members to identify disparities. Also, various health centers have engaged in pilots to improve data collection and close the loop on referrals. One of the health care centers is in a pilot with Ochin Epic to communicate with CBO bi-directionally to close the loop on referrals. What infrastructure do others on the committee have in place to move this work forward? How do you engage others in your organization, specifically leadership? Dr. Doohan says she is interested in Ochin Epic and how that tool can be used within the public health department, as it is a costly product. How impactful was it to use that tool? Arlene replied they are currently transitioning most of the health centers to Ochin Epic. The goal is to have the same electronic health record to exchange information more easily. She would love to be able to take that information back to the team and get back to the committee.	• How can Ochin Epic be used in the Public Health realm? • How impactful was the tool to use in health equity?

Agenda Topic	Notes	Action Item
Agenda Item 3 **QIHEC Discussion:** *Speaker: ALL*	Dr. Jalloh mentions that DHCS wants the QIHEC TO be effective and look at the data with an equity lens. We will be looking at data points and stratifying based on race and language and other types of groups.  In our previous meeting, we reviewed our HEDIS, CHA/CHIP, PNA findings. Throughout the year we will look at other data such as our CAHPS, grievance, and utilization of language services. The QIHEC will be both internal members from the Partnership Health Plan and external members such	

Agenda Topic	Notes	Action Item
	as the hospital, tribal centers, and public health, even CEOs. We also want to address specific disparities:  During our meetings, we will evaluate the presented performance measures, consumer satisfaction surveys, community needs assessments, etc.	

Agenda Topic	Notes	Action Item
	We will also be providing suggestions to address performance deficiencies and inequities with appropriate follow-ups such as: • Policy Recommendations • Clinical Intervention Recommendations • Community Event Recommendations • Ensuring appropriate follow-up of performance deficiencies • Soliciting feedback for completing health equity initiatives at their organization	

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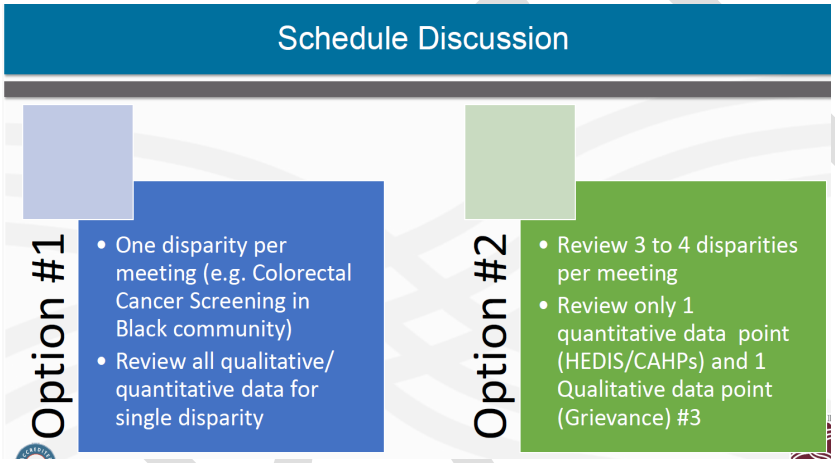
Agenda Topic	Notes	Action Item
Agenda Item 3	For upcoming meetings, the committee voted for Option 2 for scheduled discussions. 	
Agenda Item 4 **Review Organizational Goal:** **Alignment** *Speaker: Dr. Jalloh*	Health Equity Strategic Plan Update: In the coming year, we want to focus on internal and external organizational alignment. We recognize our health system is already working at full capacity. Key focal areas are related to priorities, culture, incentives, and what we are measuring.	

Agenda Topic	Notes	Action Item
	We are building organizational alignment and will be looking at other health plans and how health equity works to make it sustainable. One example is to approve metrics for health equity in line with the Institute of Healthcare Improvement. They have a self-assessment to measure how you are doing in the work for health equity. The organizations can range themselves on a scale of 1 to 5 and quantify how well they are doing and to implement goals for the future. It would be good to review this on a committee level. Every organization has a specific way of measuring disparities and we want to guide the health system so there is a uniform approach. For example, we want to use items such as race, language, and SOGI data to stratify the data. Then we would want the differences to be evaluated. Lastly, a comparison to an external benchmark.	

Agenda Topic	Notes	Action Item
	Questions from Dr. Jalloh: How has your organization approached measuring disparities? How can Partnership approach collaboration, to get uniformity? Response: Dr. Doohan responded the tribal nations should have a separate but equal way of measuring disparities. Dr. Tom says it is good that Partnership is engaging others to collaborate on the approach with bilateral dialogue. The challenge is what types of reference points we use to measure disparities, whether there are California-specific or national data. We have to keep in mind socio-economic in addition to geography. Dr. Jalloh agrees with integrating HDI information with how we identify and address disparities.	

Agenda Topic	Notes	Action Item
	Dr. Doohan says we should work on our language in using the word equity because, in some of our rural areas, the word can be seen as divisive. Dr. Jalloh comments some organizations are using the word "inclusion" and the terminology "inclusion work". Since we are responsible for DEI training we may be changing the name to Cultural Connection or Community Connection Training. We will use a strategic approach.	
Agenda Item: 5 **Quality Improvement Initiatives** *Speaker: Amanda Kim*		

Agenda Topic	Notes	Action Item
	This collaborative commits to health equity and focuses on intervention, delivery methods, equitable design, and building relationships. The focus is to improve the quality of pediatric well-child visits. The timeline for the measure is one year from March of 2024 to March of 2025. There are several phases of the framework with the implementation of interventions every 1-2 months. The managed care must have teams who meet weekly and participate in monthly collaborative calls twice a month. There is also a partnership with a provider who agrees to meet monthly with the managed care plan and identify interventions. Intervention 1 Summary (Thru May) • Engage in foundation-setting conversations on equity alongside other participants • Explore the current state of their pilot clinic's WCV data • Take at least one step towards improving and stratifying their data	

Agenda Topic	Notes	Action Item
	• Review data with their pilot clinic to agree on a shared priority population and aim for our work • Plan a "test" with their pilot clinic about a process for regularly updating and sharing data with them A new development on the share point lists the targeted population at 0 to 30 months and a second group of 15 to 18 years' population. This reduces the amount by 25% of the original "generic" population. **QUESTIONS:** Dr. Ton asks: What is the greatest barrier to improving well-child visits? Amanda responds: Access to providers in addition to education and knowledge about the importance of the visits. The focus on annual visits for older children is new and some parents may not know the new standard. There are also some parents who will only take the child in if there is some issue or problem. There is a lack of education or understanding. There is a lot to be discovered.	

Agenda Topic	Notes	Action Item
Agenda Item 6 **Population & Community Needs** **Speaker:** Hannah O'Leary	Dr. Ton says: It is good to review it from a person-centered community-centered perspective. We try to understand the baseline data and complement it with the experienced data. We found there were factors outside our frame of reference as providers that became important. Trust can also be built through the process of open communication. The CHA/CHIP is a new initiative that replaces our Population Needs Assessment. The SMART Goal Update is as follows: • 2 goals were approved • 6 counties have a priority area • 5 counties have goals • 11 counties have no goal One requirement is to share data with the counties Partnership has put together a data report that can be accessed on the external website. Partnership is leaning into in-kind staffing and what this looks like is stakeholder engagement activities, project management, and other administrative items.	

Agenda Topic	Notes	Action Item
	Some of the needs emerging from surveys: • Access to Care • Behavioral Health • Healthy Eating and Active Living • Tobacco Use • ACES • Transportation • Economic Instability • Harm Reduction/Suicide Prevention • Perinatal Care • Isolation • Chronic Disease Awareness • Awareness of Resources	

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Agenda Topic	Notes	Action Item
Agenda Item 7 **Policy Recommendations** Speaker: All	Dr. Jalloh Policy Recommendations: Should we create a policy for clinical sites to guide how to approach disparity quality improvement initiatives? • Removing Clinical Score Tools that Utilize Race (e.g. CrCl) • Creating protocols for evaluating biometrics that may be affected by skin tone (e.g. Pulse Oximeters) • Encouraging the use of culturally tailored care • Medical documentation of good practices for certain linguistic, and race groups • Stratify Clinical Measures by REAL (Race, Ethnicity, Age, Language) • Metrics to Measure Health Equity work	

Agenda Topic	Notes	Action Item
	Dr. Doohan approved the measure and asked that we add something to acknowledge tribal nations. Lake County uses the terms related to the tribes as sovereign nations and intragovernmental relations. Lake County has 7 sovereign nations. Dr. Tiffani Thomas seconded the motion. 9 voting members approved. No opposition…the policy will be proposed next year.	
Agenda Item 8	Dr. Jalloh says we will continue highlighting different tools to ensure we are using the best health equity tools available. Organizational Goal and Work Plan: Partnership is committed to health equity; we will be working on a strategic plan to achieve that goal. We also are working on our DEI by continuing to screen vendors so if anyone on the committee is interested in being part of that process you are welcome to join to	

Agenda Topic	Notes	Action Item
	participate in the screenings. We have three vendors currently. We are improving how we collect and share data.	
Agenda Item 9	The next meeting is August 20th, 2024 7:30 am to 9:00 am	

MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: May 2, 2024 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

Attendees: Christine Smith; DeLorean Ruffin, DrPH; Hannah O'Leary; Isaac Brown; Katherine Barresi, RN; Mohamed Jalloh, PharmD; Monika Brunkal, RPh

Virtual Attendees: Colleen Townsend, MD; Greg Allen Friedman; Jeff Ribordy, MD; Kathryn Power; Lisa O'Connell; Lynn Scuri; Mark Bontrager; Marshall Kubota, MD; Priscila Ayala; Rebecca Stark; Richard Matthews, MD; Robert Moore, MD; Tim Sharp; Vicky Klakken; William Kinder; Yolanda Latham

Absent: Matt Hintereder; Melissa McCartney; Nancy Steffen; Wendi Davis

Agenda Topic	Minutes	Action Items
1. Intros *Time: 5 minutes* *Speaker: Monika*	• Population Health's first Community Health Needs Liaison (CHNL) started recently. She is the first of an intended team of five, who will be spread across the county regional offices. If regional staff have recommendations for possible local hires, please send them to Hannah.	If regional staff have recommendations for possible local hires, please send them to Hannah.

2. CHA/CHIP updates
Time: 15 minutes
Speaker: Hannah
	• PowerPoint presentation *CHA CHIP Presentation 5.2.2024_FINAL* used during agenda items 2 and 3, attached. Terms: CHA (Community Health Assessment), CHIP (Community Health Improvement Plan).
	
	• SMART goal Status across our counties:
	  ○ 2 goals were approved by the counties and Partnership
	  ○ 5 counties have drafted goals
	  ○ 6 counties have a priority area for a goal
	  ○ 11 counties have no goal at this time	

Agenda Topic	Minutes	Action Items
	• DHCS's MCP-LHJ Worksheet was a tool to help guide our collaboration with counties. DHCS wants the worksheet completed by each county by 8/1/24. Current status: ○ 14 Counties have completed the worksheet ○ 8 Counties have a worksheet in progress ○ 2 Counties have no worksheet • Annual Data Reports are live on www.PartnershipHP.org/Community/Pages/Annual-Data-Reports.aspx ○ Update: as of 5/8/24, final 2024 reports are live. These versions include some minor word and font changes. The meaning of prose and the data have not been changed from previous versions. ○ These reports will be created annually from now on. ○ A data request form is available (found on the page hosting the reports) if counties want data not in the reports. We have not received any requests yet. If we see multiple requests for the same data in the future, it could be included in the next year's annual reports. • Resource Sharing: What can Partnership offer, now or in the future? ○ Counties are leaning towards in-kind staffing, but there are different ways to define it: 1. Project management: helping with surveys, focus groups in a county's CHA/CHIP process 2. Data analysis: helping counties analyze and understand data, perhaps using health analytics staff • Offering this could give counties the impression we are offering the help of a data epidemiologist. While we can give some help to a county with data if needed, Dr. Moore recommends leaving this off our official offering list. 3. Stakeholder engagement activities: offering facilities to host community stakeholder meetings • This is doable, with the exception of the Auburn and Chico offices, which aren't ready to host anyone at this time. 4. Other administrative help: miscellaneous help, like printing materials on behalf of a county	

Agenda Topic	Minutes	Action Items
	5. Supportive leadership for collective impact efforts: a regional lead, medical director, or other PHC staff take a leadership role with a CBO or other local group • Example: our participation with Hope Rising's coalition in Lake County. There are also opioid and breastfeeding coalitions. In Shasta, there's a children and youth behavioral health initiative. ○ The alternative to in-kind staffing would be funding (e.g. for a county to use to hire an employee). But if we'd prefer not to offer that, talking points are needed to explain why. ○ A more complete Partnership definition of in-kind staffing and talking points are needed so Partnership reps know what they can offer to counties. ○ Could we help counties distribute surveys? Communications may be able to help. ○ Some counties hire a consultant to do the CHA/CHIP process – a common request is for us to provide funding to pay that consultant. ▪ Partnership is not very interested in funding consultants. It's [not as effective for achieving real outcomes as other ways Partnership could be supporting the counties.] Additionally, the criteria for future funding will change in the future and we wouldn't be able to pay for consultants at that time. Best not to start something we can't continue doing. ▪ It's best to say that Partnership does not pay for the counties to do their CHAs/CHIPs (which would include consultants). ○ It's currently unclear whether a 2025 investment in the counties will get us credit in 2026.	Please send suggestions for in-kind staffing definitions and talking points to Hannah.
3. Draft Funding Request Form *Time: 10 minutes* *Speaker: Hannah*	• Kaiser Permanente reps have drafted a funding/staffing request form. ○ This form includes data infrastructure and a space for consultant funding, it's not appropriate for our needs. ▪ We need to inform Kaiser about what we're willing to do to avoid confusion with the counties. We can ask if they're open to collaborating on this form – "as is, we can't use it due to our internal committee recommendations." Otherwise, the counties with both us and Kaiser will need to fill out two forms. ○ Because Kaiser does community grants, their draft form is similar to what they would do there. But Partnership and Kaiser support different types of projects.	PHM staff will draft an in-house form and run it by Katherine. Hannah will show a draft form of our own at our next meeting with Kaiser on 5/20.

Agenda Topic	Minutes	Action Items

3. Open Discussion
Time: 15 minutes
Speaker: All
	• Who will carry out the SMART goals?
	  ○ If it's a shared goal, something that a team in Partnership is working on as well (e.g. childhood immunizations), we can discuss collaboration. It depends on the nature of the goal. Depending on the project, it could be a split responsibility.
	  ○ As long as the goal is in sync with and relevant to our activities, the relevant depts./teams/staff can be brought in as needed.
	  ▪ If the SMART goal is along the lines of a *supportive leadership for collective impact efforts* project, it would be certain Partnership leadership supporting it.
	
	• CHA/CHIP involvement with Community Advisory Committee (CAC) members
	  ○ An email was sent to the Partnership CAC organizers to get their ideas.
	  ○ CAC members live across our counties. In their respective communities, we could get their input.
	  ○ Comment: we could also involve people from the Board and other committees (like the Family Advisory Committee)
	  ○ This would be for things like the surveys counties do as part of their CHA/CHIP processes, or participation in virtual town halls. There may be an opportunity for a CAC member to join a county's CHA/CHIP meetings.
	  ○ Many of the health centers have their own CACs as well, which could also be leveraged.
	  ○ Counties often ask us to share their surveys with community members, but there are limits to how Partnership can help gather information from members. The Member Portal is not a good place for surveys, for example. These county asks can be shared with Communications.
		At the next CAC and FAC meetings, PHM will ask attending members about their interest in participating in CHA/CHIP-related activities.

4. Next steps *Time: 5 minutes* *Speaker: All*	• If attending a CHA/CHIP-relevant meeting, don't forget to send the CHA/CHIP team your notes! The email version of the meeting template has been updated with more current contacts, see this folder.	

Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

Objective of Meeting: Identify potential concerns for over/under utilization within the PHC network

Date: April 29th, 2024 **Time**: 3:00pm – 4:00pm

Location: HR Training Room **Coordinator**: Radha Chebolu (Health Analytics)

Attendees:		
Partnership Health Plan	Partnership Health Plan	Partnership Health Plan
☒ Robert Moore	☐ Ledra Guillory	☐ Annie Kufner
☐ James Cotter	☐ Melissa Perez	☐ Doreen Crume
☐ Debra McAllister	☐ Wendi West	☐ Sharon Hoffman-Spector
☐ Mary Kerlin	☐ Stan Leung	☐ Lisa Malvo
☒ Margarita Garcia-Hernandez	☒ Nancy Steffen	☒ Melanie Lam
☒ Dejene Bikila	☒ Shivani Sivasankar	☐ Cody West
☐ Liat Vaisenberg	☒ Radha Chebolu	☐ Angela Guevarra
☒ Kristine Gual	☒ Tiphanie Salehi	☐ Renee Trosky
☐ Amber Newell	☐ Kim Palfini	☒ Lisa O'Connell
☒ Athena Beltran-Nampraseut	☐ Mark Aguirre	☒ Jen Kung
☐ Garnet Booth	☒ Shell Swift	☐ James Devan
☐ Kim Fillette	☒ Stephanie Nakatani Phipps	☒ Isaac Brown
☒ Lindsey Bushey	☐ David Lopez	☐ Amy McCune
☐ Sarah Browning	☐ Candis Broadhead	☒ Katherine Barresi
☐ Emily Stoller	☐ Alex Brito	☐ Deanna Watson
☒ Monika Brunkal	☐ Ruth Hood	☐ Kristina Coester
☒ Penny Thomas	☐ Derick Stacy	☐ Rebecca Garcia
☐ Christopher Triolo	☐ Mark Bontrager	☒ David Lavine
☐ Jeffrey DeVido	☐ Greg Allen Friedman	☐ Elijah Allen
☒ Anthony Sackett	☐ Akshay Sharma	☒ Erin Hall
☐ Tim Sharp	☐ Dave Hosford	☐ Dominic Salido
☒ Rasitha Rathnayake	☐ Danielle Ogren	☐ Mohamed Jalloh
☒ Hanh Hoang	☒ DeLorean Ruffin	☐ Tim Sharp
		☒ Vander Harris

Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Robert Moore	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Robert Moore	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report *Speaker:* HA	Discuss Findings The overall PCP visit rate declined slightly by 1% from 2022 to 2023. The Northern region observed a slight increase from 2022 to 2023,

	while the Southern region's rate declined by 2% from 2022 to 2023. Lake, Modoc, and Solano Counties continue to have the lowest visit rates. Unlike 2022 rates, Marin had the highest rate in 2023. Amongst the Southern Counties, Mendocino, Marin, and Sonoma fared better than the others in 2023. Though the rates didn't reach the 2019 rates, they surpassed the target in most months. Del Norte is the only county that had rates in 2023 exceed those of 2019. Most Northern Counties' rates met the target and are closer to the 2019 rates. Northern Counties performed better than the Southern Counties. Solano County Health Services continues to underperform in 2023 and the visit rate declined further by 13.8% from 2022 to 2023. Marin Community, Woodland, and a few Kaiser Clinics have higher visit rates. In 2023, Lake County Tribal Health is one of the providers that had lowest visit rate. Some sites of Adventist Health Clearlake fared better than the others. There's marked decline in visit rates of Adventist Health Clearlake and Lake County Tribal Health from 2022 to 2023. There are more Adventist Health Clearlake sites that exceeded the target in 2022 than in 2023. Modoc Medical Clinic, Surprise Valley Medical Clinic, and Tulake Health Center are some of the clinics that saw a decrease in visit rates from 2022 to 2023. In 2023, females had higher visit rate than males. Amongst the 3 age groups, 65+ age group continues to have higher visit rate. Black and Asian/Pacific Islander races had the lowest visit rates. Overall, Telehealth visits stayed flat in 2023 except for slight increases in the months of March, May, and August. The Telehealth % of visits are higher in Southern Region than in the Northern Region. 21-64 age group had higher percentage of visits among the 3 age groups. Marin, Sonoma, and Solano Counties had higher percentage of Telehealth visits. Del Norte observed dramatic increase from 2023Q1 through Q3 and had a slight decrease from Q3 through Q4. Napa and Lake Counties observed higher increase in visit percentages. The Southern Regions' well care visit rates in 2023 tracked lower than those of 2019, while the Northern Region's rates were closer to the 2019 rates. Overall, Northern Region performed better than Southern Region. Marin, Mendocino, Trinity, Napa, and Del Norte had higher well care visit rates.
2) Maternal vaccinations *Speaker:* HA	Discuss Findings In 2023, the English population had the lowest prenatal flu vaccination rate (30%), while the Tagalog population decreased by 19% from 2022. White population had the lowest rate (21%) and the Asian/pacific islander population had the highest rate (46%) compared to other ethnic groups. In the northern counties, Modoc had decreased by 66% from 2022, while Trinity had increased by 181%. In the Southern counties, Sonoma had increased by 10%, while Yolo had decreased by 7% from 2022 to 2023 In 2023, the English population had the lowest prenatal Tdap vaccination rate (63%), while the Spanish population had the highest rate (80%). Native American population had the lowest rate (53%) and the Hispanic population had the highest rate (75%) compared to other ethnic groups. In the northern counties, Modoc had increased by 52% from 2022. In the Southern counties, Mendocino had increased by 9%, while Yolo and Solano had decreased by 4% from 2022 to 2023 Overall, the prenatal COVID vaccination rate had decreased by 74% from 2022 (31%) to 2023 (8%). In 2023, the English population had the lowest prenatal COVID vaccination rate (7%), while the Tagalog

	population had the highest rate (17%). White population had the lowest rate (5%) and the Hispanic population had the highest rate (10%) compared to other ethnic groups. In the northern counties, Humboldt had decreased by 79% from 2022. In the Southern counties, Marin had decreased by 67% from 2022 to 2023 In 2023, the overall prenatal RSV vaccination rate was 1.6% for 8131 members who delivered a baby. The English population had a higher rate compared to the Spanish population (2% vs 1%). The black population had the lowest rate (0.8%) while the Asian/pacific Islander population had the highest rate (4.7%). In the Northern counties, Siskiyou had the highest rate (5.7%) while Lassen and Modoc had no prenatal vaccines. In the Southern counties, Marin had the highest rate (20%), while Lake had the lowest rate (3%).
3) ACES screening *Speaker:* HA	Discuss Findings Adverse Childhood Experiences are traumatic events children between 0-18 may experience such as violence, drug abuse, self-harm, family abuse, and more. ACE screenings identify whether children are in unhealthy or unsafe environments and to seek ways to prevent and address the risks of the traumatic events. A large majority of ACEs are done for members 0-18. However, 13% of screenings are for members 19+. There was a decline in ACEs in 2023 compared to 2022 levels. Counties with the highest screenings rates are Yolo, Mendocino, and Sonoma. The top 3 ACEs providers by volume are West Sac Ped Medical Group, SRCH Pediatric Campus, and Community Medical Center in Vacaville. There were 19,021 ACEs for our members in 2022 and 11,519 ACEs in 2023, a 61% drop from 2022. The counties with the largest drop in the rate of ACE screenings per 1000 members are Marin from 210 to 4; and Sonoma from 155 to 71. Del Norte had the largest rise in the rate of ACE screenings per 1000 members from 0 to 63. Providers with the largest percentage drop in ACEs from 2022 to 2023 are: Marin Community Clinic (-99%), Rohnert Park Health Center (-85%), and Vista Family Health Center (-82%). In contrast, providers with the largest percentage increase in ACEs from 2022 to 2023 are: Lassen Medical Clinic (+74%), Eureka Community Health Center (+55%), and Baechtel Creek Medical Clinic (+53%).
4) Childhood Immunization Report Owner: QI *Speaker*	Information Only Measure Definition: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates. For measurement year 2023 (MY2023), Partnership HealthPlan of California's (Partnership's) performance on the HEDIS Childhood Immunization Status (CIS-10) measure relative to NCQA national Medicaid benchmarks is similar in all sub-regions performing at or below the 25th percentile, which is below the DHCS minimum performance level (MPL) which is the 50th national percentile. Scheduled vaccinations are an important strategy to ensure that children in our communities are protected, and Partnership strives to

	work with the provider network to ensure vaccinates are administered. Partnership has the following interventions to increase childhood immunization rates – • Media Campaigns • Child and Adolescent Workgroup • Addition of Flu UOS Measure to PCP QIP • Exploration of Mobile Pediatric Care • DHCS and CMS Well Child Affinity Workgroup • Provider Trainings • eReports Tools and Dashboards
Overutilization Analysis Discussion Topics	
1) TAR trend report *Speaker:* HA	Discuss Findings In 2023, Partnership received 479,076 authorizations which is a 14% increase from 2022; equivalent to a rate of almost 800 authorizations per 1,000 members, which is an 8% increase from 2022. Despite the system disruption in March 2022, which generates a biased increase for March 2023 rate, we do see an increase in the volume of authorizations processed from 2022 to 2023. For authorizations turned into paid claims, the total paid amount was more than 1 billion dollars in 2023, which is a 3.6% increase compared to 2022. In total paid amount per member per month, however, this represents a 2% decrease from 2022. Outpatient hospital is the specialty that generates the highest volume of authorizations and has increased by 12.6% compared to 2022. Hospital Referrals and Medical Transportation are some of the specialties with the highest increase in authorization rates compared to 2022, with a 20% and 26% increase respectively. In terms of cost (graph on the right) and total paid amount PMPM for authorizations turned into paid claims, the inpatient TAR class is the authorization class with the largest total paid amount in 2023. Both the hospital and SNF specialties have experienced a small decrease in cost compared to 2022.
Future Agenda Items	PCP visit rates will continued to be monitored
Next Meeting Date: TBD	

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

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• REMINDER: Final Statement Dashboard is available through Partnership Quality Dashboard (PQD) and sites are able to access three (3) years' worth of payment statements. This will remain in place until HRP implementation. As a good practice, we do recommend for providers to download and save their statements for future reference. • The PCP QIP team hosted a webinar on 05/09/2024 to introduce a supplemental QIP for providers who have agreed to take on member assignments formerly carried by Dignity sites. Monthly Supplemental QIP reporting will be distributed to providers through August 2024 so they can identify these newly assigned members and track their performance based on the specific member assignment. At the end of the Supplemental QIP timeframe, a preliminary period will be provided prior to final payment distribution in September 2024. • Measurement Year (MY) 2025 Measure Development: Starting in May 2024, the PCP QIP has begun their measurement development for the upcoming MY2025. Proposed ideas are being brought to the PCP QIP Technical Workgroup & Advisory Group meetings for discussion and consideration. This development will last throughout August 2024 so the proposed measure set can be finalized in September 2024 and presented in October's Physician Advisory Committee (PAC) meeting.
LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTC QIP)	• Payment processing for MY2023 of the LTC QIP has been completed and payment was distributed to 37 out of the 54 LTCs who participated. All facilities are transitioning this year to the new QIP offered state-wide through DHCS. • Quality Assurance Performance Improvement (QAPI) program development remains in progress, in response to DHCS' LTC benefit standardization and subsequent All-Plan Letters (APL) specifying new quality improvement and quality monitoring requirements. The team is focused on defining how the five required CMS elements of a QAPI will be addressed by Partnership, in contrast to the QAPI each LTC facility is required to have in place on an ongoing basis. At Partnership, this includes process development with stakeholders in Grievance & Appeals, Utilization Management, and Care Coordination. Further guidance from DHCS on QAPI and quality monitoring reporting is still expected to be released. Once this guidance is released, revisions to the initially developed QAPI program structure may be needed.
PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)	• The Palliative QIP is currently in payment processing for measure period II, representing July-December 2023. Preliminary reports were sent out on 05/21/2024. Palliative providers were given until 06/04/2024 to appeal their preliminary results and provide additional supporting data.

PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP)	• The Fiscal Year (FY) 2023-2024 audit was completed at the end of May, with results planned to be announced this month. • FY2024-2025 specifications are published on the Perinatal QIP webpage. • FY2024-2025 PQIP Kick-Off Webinar is scheduled for 06/27/2024. • FY2024-2025 onboarding meetings with perinatal providers in expansion counties are taking place this month. • Final details specific to the PQIP Enhanced Incentive offering will soon be shared with impacted perinatal providers in Partnership's legacy and expansion counties. This is a limited time offering that is designed to leverage our existing Perinatal QIP to help assure timely perinatal care for members displaced by the termination of the Dignity contract.
ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (ECM QIP)	• 1st Quarter 2024 incentive payment processing is underway, and final incentive payments are scheduled for distribution by the end of this month. • Measure development continues with proposed new measure, Timely Follow-up of ED/Admissions, set to be finalized in July-August. It will be presented to PAC for approval and addition to the measurement set in 4th Quarter 2024.
HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)	• Hospital Quality Symposium planning continues. Speaker agreements have been initiated for all invited speakers and a tentative agenda has been drafted. Registration links are live on Eventbrite: Redding Event on 08/05/2024, and Fairfield Event on 08/07/2024. • The proposed changes and additions to the 2024-2025 Measurement Set have been presented to all the quality committees (IQI, QUAC & PAC) for feedback and approval. Finalization of the measurement set continued throughout the month. • Troy Foster from the HQIP along with Dr. Moore, Dr. Spiller, and Eva Lopez attended the Coalition for Compassionate Care of California's Annual Conference in early April, which focused on delivering and promoting compassionate palliative care services to children and adults.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• No updates this month.
EREPORTS	• No updates this month.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	IHI / DHCS Medi-Cal Child Health Equity Collaborative • Partnership has launched participation in a new DHCS-mandated collaborative for all MCPs focused on child health equity, specifically for pediatric well-care visits. The collaborative will run through March 2025 and involves MCPs assembling an internal team to meet regularly, attend collaborative calls, and engage a single primary care organization to participate as a partner to test interventions.

Updates on progress will be provided as milestones are achieved. The interventions, or project phases for the collaborative will occur in this order:
  - Equity and Transparent, Stratified, and Actionable Data (*this is the current phase*)
  - Understand Provider and Patient/Caregiver Experiences
  - Reliable and Equitable Scheduling Processes
  - Asset Mapping and Community Partnerships
  - Partnering for Effective Education and Communication

IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative

- DHCS, in partnership with the Institute for Healthcare Improvement (IHI), has also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, in partnership with Nevada County Behavioral Health Department, was selected by DHCS to participate in this collaborative.
- This collaborative will run April 2024 through June 2025 and is just getting underway via an assembled interdisciplinary team led by Partnership's Behavioral Health Administrator. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
  - % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)
  - % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)

Enhanced Provider Engagement (EPE) & Modified PCP QIP Strategies

- All providers assigned to the Modified PCP QIP in 2024 have been assigned coaches and have begun initial steps of engagement for 2024.

Performance Improvement Projects (PIPs) Update

- As a contracted MCP, Partnership has been assigned two (2) Performance Improvement Projects (PIPs) by DHCS that will be completed over 2023–2026. Planning activities have begun on both PIP assignments:
  - Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County
  - Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit

QUALITY MEASURE SCORE IMPROVEMENT	• Partnership has completed one (1) round of Blood Lead testing grants for point-of-care (POC) devices for primary care providers and has closed its 2nd grant offering. The first round resulted in 10 POC device awardees along with 2 reimbursements for recently purchased POC devices. The second round is expecting to grant 10 POC devices along with 15 reimbursements for recently purchased POC devices, with MOU's currently in the review process. • As of the end of April, the Cervical Cancer Self Swab Pilot Project has distributed 26 out of 200 kits. There have been twenty-one (21) resulted and one high risk HPV positive was detected. The sites are working to expand to increase the use of kits. We are extending the pilot by 12 weeks to achieve maximum benefit from the pilot. • In April and May 2024, three School-Located Vaccine Events (SLVEs) have taken place in Shasta County for 6th graders at Enterprise Elementary School District, during the school day and with pre-authorization provided by guardians. Vaccinations offered were HPV, Tdap and Meningococcal. Prior to the events and forms being sent home for parents to complete, Partnership-supplied education about the available vaccines was delivered to the 6th grade classes which results in a much higher uptake in the non-mandated vaccines (HPV and Meningococcal). A total of 130 6th grade students were immunized across 3 schools in the district. • Practice Facilitation coaching has begun for 2024. At present, Southern Region practices are focusing on finalizing SMART Aims and planning initial interventions. East Region practices are engaged in optimizing the data tier for their QIP measures and planning a strategy for meeting benchmarks during their first year with Partnership. The following practices will be participating in Practice Facilitation in 2024: ○ Solano County Family Health Services (SE Region) ○ Consolidated Tribal Health Project (SW Region) ○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties (SW, NE, and East Region) ○ Ampla Health (East Region) ○ Northern Valley Indian Health (East Region) ○ Wellspace Health (East Region) ○ Western Sierra Medical Clinic (East Region)
IMPROVEMENT ACADEMY	• Final evaluations for both the Improving Measure Outcomes webinar series and the ABCs of Quality Improvement (QI) in-person events are being completed for the fiscal year. • Attendance for the Improving Member Outcomes webinars occurring in February through April ranged from 42 to 67 attendees, with each session representing 25 to 36 unique organizations. 100% of attendees who completed post-session evaluations for all six webinars selected "strongly agree" or "agree" when asked if the webinar was relevant and useful. • The ABCs of QI offered five in-person sessions this fiscal year, which encompassed all Partnership regions including the new Eastern Region. Attendance ranged from 23 to 79 attendees representing 8 to 26 unique organizations. Respondent rates

	for being "extremely satisfied" or "satisfied" with the course ranged from 93% to 100%.

JOINT LEADERSHIP INITIATIVE (JLI)	• Spring sessions are underway in the Northern and Southern Regions:
	  • Solano County Family Health Center 05/28/2024
	  • La Clinica 05/29/2024
	  • Adventist Health 06/05/2024
	  • Fairchild Medical Center 06/06/2024

REGIONAL IMPROVEMENT MEETINGS	• The Southeast Regional Provider meeting was held on 05/21/2024. Topics included a presentation by First 5 Yolo on their Welcome Baby home visitation program. • The Northwest and Northeast regional quality meetings were held on 05/02/2024 and 05/22/2024 respectively. Topics included year-over-year performance trends, acuity coding best practices for QIP, and soliciting feedback on Partnership's Improvement Academy trainings and overall QI services offered.

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE

STATE MANDATED WORK: *EQUITY AND PRACTICE TRANSFORMATION (EPT) PROGRAM*	• The DHCS Equity and Practice Transformation (EPT) Program is a one-time $700 million state-wide initiative. The goals of this initiative are focused on advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; $25M for the Initial Planning Incentives Payments (IPIP), $650M over five (5) years for the Provider Directed Payment Program (PDPP), and $25M over five (5) years for the Statewide Learning Collaborative (SLC).
	  ○ On 05/10/2024 Governor Newsom released the May Revision which will impact the EPT program.
	  ○ The revised budget proposal reduces the EPT program from $700 million over 5 years ($350M from CA General Fund and a $350M match from CMS), to $140 million ($70M from CA General Fund, $70M CMS match). If approved, it will reduce payments available to the 200+ EPT practices by about 80%. While the EPT program is not being eliminated, the reduction in funding, if it remains at the proposed levels, will significantly impact the program structure.
	  ○ Both the California Primary Care Association (CPCA) and the California Medical Association (CMA) are organizing efforts to work with the legislature to reduce the proposed cuts. MCPs have been encouraged to connect with these organizations and link efforts. They have prepared a summary for stakeholders to learn more at the link below.

	https://pophealthlearningcenter.org/wp-content/uploads/2024/05/PHLC-EPT-Budget-Revise-Impact-05-16-24.pdf • Partnership awarded $10,000 to twenty-three (23) qualifying provider organizations through the Initial Planning Incentive Payment (IPIP) program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the PDPP. Ten (10) of these provider organizations were already engaged under Partnership's Enhanced Provider Engagement (EPE) strategy in 2023. Two (2) provider organizations who did not initially qualify for the IPIP program have since been approved by DHCS to participate. ○ Partnership received $1,526,085.49 in IPIP funding. ○ The EPT strategy team continues to explore utilization for the IPIP funds. A subset of funds will be allocated to tribal health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continues to develop. • All twenty-seven (27) provider organizations who were invited to participate in the PDPP sent acceptance responses to DHCS by their 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. Based on the funding criteria of the program, there is a possible draw-down of $45M for Partnership's contracted provider organizations upon meeting the practice transformation activities over the program's five-year (5) timeline (01/01/2024 – 12/31/2028). ○ Milestone #1: As of 04/30/2024, all EPT practices have submitted their first EPT milestone deliverable. This deliverable requires completion of a Population Health Management Capabilities Assessment Tool (phmCAT) by 04/30/2024 to the Population Health Learning Center (PHLC) through an online platform at https://takethephmcat.com. ▪ The phmCAT is a self-administered survey assessment that is used to understand the current population health management capabilities of primary care practices. It can help organizations identify strengths and opportunities for improving population health management. ▪ Practices who submitted the Year 1 phmCAT will receive payment per the proposed payment cycle, estimated October 2024. ○ EPT practices who attested to completing any of the below required activities on their PDPP application were asked to complete an online form

	by 05/06/2024 or notify PHLC via e-mail at info@pophealthlc.org of their withdrawal to attestation. ▪ Empanelment & Access Activity ▪ Population Health & Quality Improvement Governance ▪ Dashboards & Business Intelligence ▪ Data & Quality Reporting Gaps ○ Only one practice, Lassen/Dignity, was identified as being eligible for attestation, however they withdrew their attestation prior to the deadline; the activities will return to their set of deliverables. ○ PHLC was notified that Lassen/Dignity is currently out of contract with Partnership and it was confirmed they will not be eligible for milestone payments until a contract is in place. • The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. • Partnership has a team of practice coaches dedicated to supporting EPT awardees and may draw on outside experts for specific transformation topics as needed. ○ PHLC and DHCS anticipate to share more information regarding the Technical Assistance and Coaching Pool aspect of the Statewide Learning Collaborative this month.
QUALITY MEASURE SCORE IMPROVEMENT MOBILE MAMMOGRAPHY PROGRAM	• Completed Mobile Mammography Events: ○ Between 01/01/2024 - 05/31/2024, Partnership sponsored a total of 16 event days, with eight (8) provider organizations in the following counties: Del Norte, Humboldt, Mendocino, Shasta, Sonoma and Trinity. • Upcoming Mobile Mammography events: ○ 13 event days are scheduled for June. ▪ Northwest Region: will include two (2) event days with two (2) provider organizations. ▪ Northeast Region: will include one (1) event day with one (1) provider organization. ▪ Southwest Region: will include three (3) event days with three (3) provider organization. ▪ Southeast Region: will include seven (7) event day with five (5) provider organizations. • Planning for Mobile Mammography event days for Q3 is underway for Northern, Southern and Eastern region provider organizations. Targeted providers include those who had Breast Cancer Screening HEDIS® rates below the 50th percentile benchmark in MY2023 and remain at risk of being below the benchmark in

	MY2024; for providers who are located in imaging center deserts with little or no access to local imaging services.
QI TRILOGY PROGRAM	• Updates for the FY 2024/25 QI Work Plan have been finalized. • Updates for the FY 2023/24 QI Evaluation are currently being compiled. • Goal submissions for the FY 2024/25 QI Work Plan are due 06/19/24. • All Trilogy documents (FY 2024/25 QI Program Description; FY 2023/24 QI Work Plan; FY 2023/24 QI Program Evaluation; and FY 2024/25 QI Work Plan) are on track to be submitted in July for formal Committee approval.
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM	• The CAHPS® regulated Measurement Year (MY) 2023 / Report Year (RY) 2024 survey has closed. • Preliminary survey respondent rate year-over-year comparisons are as follows: ▪ Adult Population ○ 2023-2024 - 15.2% (3375/506) ○ 2022-2023 - 14.3% (2700/388) ▪ Child Population ○ 2023-2024 - 16.1% (4125/658) ○ 2022-2023 - 14.9% (4125/610) • The National Committee for Quality Assurance (NCQA) provided final results reports and member files to Press Ganey, the plan's survey vendor, and HEDIS Team. Next steps for the HEDIS Team include: ○ Validating NCQA survey results ○ Performing preliminary analysis of QC Benchmarks and Health Plan Rating • The non-regulated Drill-Down survey closed on 05/29/2024. Results for this survey will be available in July 2024. • The completion of the NCQA Fiscal Year 2023-2024 ME 7: Member Experience Grand Analysis (MEGA) report is underway.
GEOGRAPHIC EXPANSION: QI PROGRESS	The Quality Improvement (QI) Project Plan to onboard the East Region Expansion Counties to QI functions and programs began in June 2023 and will continue over the course of 2024. Status updates include: • Resource planning to recruit, hire, and onboard staff dedicated to Expansion Counties is nearly complete. Two (2) Improvement Advisor positions remain in active recruitment. • Provider onboarding events in 2024 are underway with continued planning to build out further offerings, including: ○ PCP QIP focused communications and monthly office hours to assure providers have all the technical assistance needed to make a strong start in the PCP QIP. ▪ In the May office hour session, there were eleven (11) attendees representing seven (7) East Region organizations. ▪ There are twenty-six (26) registrants representing fourteen (14) East Region organizations for the June office hour session.

	○ Partnering with PCP organizations in Regional Performance Improvement initiatives and interventions, like Mobile Mammography. ○ The Perinatal QIP team began scheduling onboarding meetings in May and will continue through this month to prepare East Region participants to join this fiscal year program, starting 07/01/2024. ○ Providing in-depth Site Review trainings to address DHCS Site Review changes. ○ Orientation events expected later this year will align with an introduction to topics like: Member Experience Surveys (i.e. CAHPS/CG-CAHPS), participating in Annual HEDIS Medical Record Projects, and Member Safety oriented investigations (i.e. Potential Quality Issues and Peer Review).

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **04/27/2024 TO 05/30/2024**	• There were 20 PQI referrals received during this time period which were from Grievance and Appeals (18), and Other (2). • In total, 20 cases were processed and closed during this period. • There are 37 cases currently open. • Two new cases were presented to the Peer Review Committee on 05/15/2024. • An educational virtual meeting was provided for the Risk Management/Patient Safety manager at an inpatient acute hospital regarding Provider Preventable Conditions (PPC) and reporting requirements.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **04/29/2024 TO 05/30/2024**	• As of 05/30/2024, Partnership has a total of 466 PCP/OB/Mobile Sites (Previously 467). 5 Sites were termed and 4 sites were added. • The Site Review Team is starting to offer an updated version of training to providers to assist with FSR and MRR changes on the Site Review tool. There have been periodic updates throughout the last few years. • Currently waiting on DHCS approval for CHDP training PowerPoints in preparation for the CHDP transition as of 07/01/2024. **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
North	13	4	3	4
South	7	6	3	6
Expansion	2	1	1	1

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	The MY2023 (i.e. Reporting Year (RY) 2024) Annual Projects continue. Key updates include:
	• A final data refresh was completed on 05/24/2024 which included data received later than normal, as a result of the disruption of the Change Healthcare cyberattack.
	• Final rates were submitted on 05/31/2024, to assure our HEDIS auditors had adequate time to review/approve our rates and corresponding audit deliverables. Once approved, the auditors will permit formal rate submission to NCQA by the nationally designated deadline in June.
	• The Medical Record Review & Validation (MRRV) audits passed at 100% compliancy by both the DHCS/MCAS Audit and the HealthPlan Accreditation (HPA) Audit. Thank you to all providers who supported the medical record retrieval process.
	  • May 14: Approval received from Advent Advisory/HPA Audit
	  • May 22: Approval received from HSAG/MCAS Audit
	• The HEDIS MY2023 Annual Summary of Performance Reports are scheduled to be communicated to the various stakeholders beginning in July 2024 and will be publically published in late August 2024.

HEDIS® Program Overall	HRP: Conversion of PHC's core claims system from Amisys to HRP • Another round of testing is planned to begin in June 2024 to support the overall pending implementation of Health Rules Payer-Health Edge (HRP) Geographic Expansion: • The HEDIS team will be hosting Office Hours targeted to begin in July 2024, please look for a flyer that will soon be distributed with details.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE

NCQA Health Plan Accreditation (HPA)	• Partnership's next HPA Renewal Survey is scheduled for 09/22/2026. In preparation for the start of the 24-month look-back period, which begins September 2024, Business Owners (BOs) are asked to:
	  • Prepare screenshots of online materials and submit them to the NCQA Program Management Team by 08/08/2024.
	  • Ensure all documented processes are in compliance with the 2024 HPA Standards and Guidelines prior to the start of the look-back period (on or before August 2024).
	• A timeline for the 2026 HPA Renewal Survey has been developed that includes key milestones throughout the next three (3) year Renewal Survey period. For a copy

	of the timeline, please contact the NCQA Program Management Team at phc_ncqaaccreditation@partnershiphp.org.
	• The plan-wide NCQA-related HPA Department Goal for FY 23-24 focuses on sustaining key NCQA reporting requirements and maintaining up-to-date knowledge of the 2024 HPA Standards and Guidelines. There are three (3) milestones under the department goal.
	  • Milestones 1 and 2 are complete.
	  • Milestone 3 remains in progress and is on track for timely completion by 06/28/2024.
	  ▪ Departments that oversee file review requirements continue to maintain strict oversight by conducting file reviews:
	  • The last quarterly file review of the goal period is on track for completion.
	  • PR completed the 2024 annual delegation audits; all delegates met compliance on chart review and no findings were identified.
	  • The Rx team conducted quarterly monitoring for their one delegate through 03/31/2024. After this date, the delegate terminated their contact with Partnership; therefore, file monitoring is no longer required.
	  • UM monitors the UM hospital denials through the annual delegation audits; the audits are scheduled between April - July 2024. UM also confirmed the monitoring of the UM hospital denials takes place on a weekly basis and the team shares feedback with the delegates.
	  • In addition, applicable teams (PR, Rx and UM) participated in mock file reviews with our NCQA consultant.
	  ○ Recommendations were provided to the PR team tied to the 2024 HPA Standards and Guidelines updates. Feedback had been shared with the identified credentialing delegate as part of the follow-up. Subsequently, the credentialing delegate submitted the clarifying documentation and satisfied NCQA requirements.
	• Issues had been identified regarding Upheld Appeals managed by the Pharmacy and UM teams. Theses appeals were submitted by the treating practitioner on behalf of the member. Both teams were advised to follow-up with the G&A team for lesson learned and file review template to adopt. Additionally, the UM team was advised to follow-up with the CMO to address Same/Similar specialty reviews. The NCQA Program Management Team will also host a meeting with G&A, Pharmacy and UM teams to finalize a documented process that includes a unified approach describing Partnership's process of member appeals.
	• BOs continue to submit analysis reports for review and approval by our NCQA consultant based on due dates in the 2024-2026 HPA Report Schedules

NCQA Health Equity Accreditation (HEA)	• Partnership's HEA Mock Initial Survey with our NCQA consultant is scheduled for 08/19/2024 - 08/21/2024. BOs are currently in process of preparing and submitting their evidence to the NCQA Program Management Team. The NCQA Program Management Team will review all evidence, providing feedback as needed. All evidence is due by 06/28/2024. • The plan-wide NCQA-related HEA Department Goal, Focus Area 2, focuses on NCQA HEA compliance with requirements assigned to a BO within a department to ensure Partnership's readiness for accreditation. There are five (5) milestones under the HEA Focus Area 2 goal: ○ Milestones 1, 2, and 3 are completed. ○ Under Milestone 4, BOs are to achieve 80% compliance with their assigned HEA requirements. Milestone 4 is on track for timely completion by 06/28/2024. Activities by the BOs include: ▪ Submission of all draft reports as indicated in the HEA Report Schedule. ▪ Review their respective Action Items Tracker at least monthly. ▪ For departments below 80% compliance, a detailed strategic plan will be submitted to the NCQA Program Management Team to address the 20% or more non-compliant requirements by 06/14/2024. The NCQA Program Management Team distributed the Strategic Plan template to applicable teams on 05/17/2024. ○ Milestone 5 is in progress. This milestone is related to the submission of the annotated evidence for the HEA Mock Initial Survey, which began 04/30/2024 and will conclude on 06/28/2024. • The plan-wide NCQA-related HEA Department Goal, Focus Area 3, focuses on addressing compliance with Health Equity Standard HE 2, which is tied to Race/Ethnicity and Language (REaL) Data and Sexual Orientation and Gender Identity (SOGI) Data. The HE 2 Workgroup meets at least biweekly to develop the framework for compliance with HE 2 and includes the following activities: ○ The HE 2 Workgroup has drafted policies that describe the process of data collection for the future system, CSquare ("C2"). In addition, materials, including screenshots from C2, were planned as part of the survey submission. ○ Risks and proposed next steps were discussed at the May NCQA Steering Committee due to the delay with HRP implementation. ○ In addition, Partnership needs to develop policies and procedures to manage access of REaL and SOGI data. Partnership also needs to implement a process for communicating to individuals its permissible and impermissible use of the data. The HE 2 Core Workgroup has involved both Health Equity and Compliance in this discussion. • A RACI chart defining ownership by Elements and Factors will be finalized by 06/28/2024.

Old Business: Synopsis of Changes to
MCUP3028 – Mental Health Services and MCUP3114 – Physical, Occupational, Speech Therapies

These policies return from May 15 Quality/Utilization Advisory Committee (Q/UAC)
for refinement of "closed loop referral" definition and usage, and TAR requirements, respectively.

Policy and Page Numbers	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation
Policy Owner: Utilization Management – *Presenter: Jeffrey Devido, MD, Behavioral Health Clinical Director*		
MCUP3028 *pp. 81-89*	Policy Reviewed for Annual update. PHC updated to Partnership throughout. **Section III.A. Partnership definition of "closed loop referral" was added:** *Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.* **Section III.F.** Definition of Medical Necessity for EPSDT services was updated to specify that California now refers to the EPSDT benefit as "Medi-Cal for Kids & Teens." **Section III.I.** Definition was added for Partnership's Wellness & Recovery Program. **Section VI.A.3.a.e)** Added that Members residing in participating Partnership Wellness & Recovery counties will be directed to Partnership for SUD assessment. **Section VI.A.4.d.** Specified that Carelon Behavioral Health is Partnership's delegate. **Section VI.A.4.d.4)and 5)** Added language to explain how a closed loop referral process will work when there is a need to refer a member between levels of care (SMHS and NSMHS). **Section VI.G.** Clarified that Partnership provides or arranges for NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network. **Section VI.G.2.** Clarified Medi-Cal Rx information. Removed the name "Magellan" and replaced with "DHCS contracted pharmacy administrator" because the State is no longer contracted with Magellan.	Behavioral Health
Policy Owner: Utilization Management – *Presenter: Robert Moore, MD, Chief Medical Officer*		
MCUP3114 *pp. 91 – 104* *CLEAN copy begins on p. 97*	Per discussion at the CMO Meeting in April and discussion at May QUAC regarding TAR volume and efficiencies of the UM process, this policy was updated to adjust TAR requirements for certain PT, OT, and ST services. References to EPSDT services were removed to simplify requirements for all Members under 21 or ages 21 and over. **Section I.A.** Deleted policy MCCP2022 EPSDT Services as a Related Policy. **Section III.A. and B.** Deleted definition of Medical Necessity for Member under age 21 and provided the general definition of Medical Necessity instead. **Section VI.B. and B.1.** Heading of this section updated to reflect "General Guidelines for Authorization" of services instead of "Submission of TARS" and the information regarding no RAF required but written prescription required for PT/OT/ST services, was moved to the beginning of this section.	Provider Relations Provider Notification Member Services Configuration

Old Business: Synopsis of Changes to
MCUP3028 – Mental Health Services and MCUP3114 – Physical, Occupational, Speech Therapies

Policy and Page Numbers	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation
	Section VI.B.2. and 2.a. This section was updated to specify that PT/OT/ST services will now have No TAR requirement for Members age 21 and over for up to 12 visits (limit one visit per day) for PT or OT services in a rolling 12-month period of time. A TAR will be required for services in excess of 12 visits. **Section VI.B.3.** This section was updated to specify PT/OT/ST services will continue to have a TAR requirement for Members under age 21 and for any PT/OT/ST services prescribed by a non-contracted provider, and for all services provided through home health. **Section VI.B.4.e.4)** This section was moved up from below for continuity in explaining which services are generally not considered medically necessary or are not covered. **Section VI.C.** This section on ESPDT services was deleted. **Section VII. References:** References A. B. and E were deleted as they pertained to EPSDT.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3028 (previously UP100328)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Mental Health Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1995</td><td colspan="4">Next Review Date: ~~04/10/2025~~08/14/2025
Last Review Date: ~~04/10/2024~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~04/10/2024~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
B. ADM52 – Dispute Resolution Between ~~PHC~~Partnership and MHPs in Delivery of Mental Health Services
C. CMP36 – Delegation Oversight and Monitoring
D. MCUG3024 – Inpatient Utilization Management
E. MCUP3014 – Emergency Services
F. MCUP3101 – Screening and Treatment for Substance Use Disorders
G. MCUG3118 – Prenatal & Perinatal Care
H. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Behavioral Health

III. DEFINITIONS:

A. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

~~A.~~B. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's (~~PHC~~Partnership's) delegated managed behavioral healthcare organization is Carelon Behavioral Health.

~~B.~~C. (MCP) Managed Care Plan: Partnership HealthPlan of California (~~PHC~~Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.

~~C.~~D. (MHP) Mental Health Plan: A county Mental Health Plan in ~~PHC~~Partnerships' service area. MHPs are required to provide and cover all medically necessary SMHS in accordance with their contracts with DHCS.

~~D.~~E. Medical Necessity: Medically necessary services are 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.~~F. Medical Necessity for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services: (California refers to the EPSDT benefit as *Medi-Cal for Kids & Teens*.) For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services

~~F.~~G. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*

Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:

1. Mental health evaluation and treatment, including individual, group and family psychotherapy
2. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

~~G.~~H. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*

County Mental Health Plans (MHPs) are contractually required to provide or arrange for the provision of SMHS for ~~member~~Members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073.

I. Wellness & Recovery Program: Partnership's regional Drug Medi-Cal Organized Delivery System waivered program (substance use treatment services) in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. Adult Screening Tool
B. Youth Screening Tool
C. Transitions of Care Tool

V. PURPOSE:

To describe the means for providing mental health services to ~~member~~Members of Partnership HealthPlan of California (~~PHC~~Partnership).

VI. POLICY / PROCEDURE:

A. Mental health services for ~~member~~Members with Medi-Cal as their primary insurance are provided as follows:
   1. Members determined to require Non-Specialty Mental Health Services (NSMHS) are served by ~~PHC~~Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health at (855) 765-9703.
   2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County Mental Health Plan in the ~~member~~Member's county of residence. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.
   3. DHCS requires MCPs and MHPs to use the Screening and Transition of Care Tools (Attachments A, B & C) for ~~member~~Members under age 21 (youth) and for ~~member~~Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for ~~member~~Members

[1] As per APL 22-012 *Revised*, this does not include medications dispensed from pharmacies and covered under Medi-Cal Rx. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: *https://medi-calrx.dhcs.ca.gov/home/education/*

who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The contents, including the specific wording and order of fields in the Adult and Youth Screening Tools and Transition of Care Tool, must remain intact and unchanged

a. The Screening Tools (Attachments A & B) identify initial indicators of ~~member~~Member needs in order to make a determination for referral to either the ~~member~~Member's MCP (~~PHC~~Partnership) for a clinical assessment and medically necessary NSMHS or the MHP for a clinical assessment and medically necessary SMHS.
   1) The Adult Screening Tool includes screening questions that are intended to elicit information about the following topics:
      a) Safety: Information about whether the ~~member~~Member needs immediate attention and the reason(s) a ~~member~~Member is seeking services
      b) Clinical Experiences: Information about whether the ~~member~~Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
      c) Life Circumstances: Information about challenges the ~~member~~Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
      d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
      e) Questions related to substance use disorders (SUD): If a ~~member~~Member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan or ~~Carelon~~Partnership (for ~~member~~Members residing in one of the 7 counties participating in the Wellness and Recovery regional DMC-ODS program administered by ~~PHC~~Partnership) for SUD assessment. (*See also policy MCUP3101 Screening and Treatment for Substance Use Disorders*) The ~~member~~Member may decline this referral without impacting their mental health delivery system referral.
   2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
      a) Safety: Information about whether the ~~member~~Member needs immediate attention and the reason(s) a ~~member~~Member is seeking services
      b) System Involvement: Information about whether the ~~member~~Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
      c) Life Circumstances: Information about challenges the ~~member~~Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
      d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
      e) SMHS access and referral of other services

b. Adult and Youth Screening Tool questions must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the ~~member~~Member is able to respond.

c. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the ~~member~~Member must be referred to the MCP or the MHP for clinical assessment and medically necessary services.
   1) Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.
   2) MCPs must use the scoring methodology and follow the referral determination generated by the score.
      a) For all referrals, the ~~member~~Member must be engaged in the process and appropriate

consents must be obtained in accordance with accepted standards of clinical practice.

b) Referral coordination must include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the Member.

c) The MCP must coordinate ~~member~~Member referrals with MHPs or directly to MHP providers delivering SMHS. MCPs may only refer directly to an MHP provider of SMHS if policies and procedures have been established and MOUs are in place with the MHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the ~~member~~Member.

d. The Adult and Youth Screening Tools are administered by ~~PHC~~Partnership's MBHO, Carelon Behavioral Health, and may be administered in a variety of ways, including in person, by telephone, or by video conference.
   1) The Screening Tools can be administered by clinicians or non-clinicians.

e. The Screening Tools are not required or intended for use with ~~member~~Members who are currently receiving mental health services.

f. The Screening Tools are also not required for use with ~~member~~Members who contact mental health providers directly to seek mental health services. Contracted mental health providers who are contacted directly by ~~member~~Members seeking mental health services may begin the assessment process and provide services during the assessment period without using the Screening Tools.

g. The Adult and Youth Screening Tools do not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations and service recommendations.
   4) MCP requirements to provide EPSDT services.

h. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a ~~member~~Member is referred to the MCP or MHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.

i. During the assessment period for both youth and adult ~~member~~Members, provision of and payment for NSMHS remain the responsibility of ~~PHC~~Partnership, even if ~~member~~Member is found to meet criteria for SMHS.

4. MCPs are required to administer the Transition of Care Tool (Attachment C) to facilitate transitions of care to MHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change. When there is a need to refer a ~~member~~Member between levels of care (SMHS and NSMHS), the Transition of Care Tool shall be completed by the treating clinical provider and submitted as part of the referral.

   a. The Transition of Care Tool is used for both adults and youth and is intended to document the ~~member~~Member's information and provide information from the entity making the referral to the receiving delivery system to begin the ~~member~~Member's care transition.

   b. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure ~~member~~Members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.

   c. The Transition of Care Tool includes specific fields to document the following elements:
      1) Referring plan contact information and care team
      2) Member demographics and contact information
      3) Member behavioral health diagnosis, cultural and linguistic requests, presenting

behaviors/symptoms, environmental factors, behavioral health history, medical history, and medications
4) Requested services and plan contact information

d. Following the completion of the Transition of Care Tool, Partnership or its delegate, Carelon Behavioral Health, ~~MCPs~~ shall:
1) Refer the ~~member~~Member to the MHP, or directly to an MHP provider delivering SMHS if appropriate processes have been established in coordination with MHPs.
2) Coordinate ~~member~~Member care services with MHPs to facilitate care transitions or additions of services, including ensuring that the referral process has been completed, the ~~member~~Member has been connected with a provider in the new system, the new provider accepts the care of the ~~member~~Member, and medically necessary services have been made available to the ~~member~~Member.
3) All appropriate consents must be obtained in accordance with accepted standards of clinical practice.
4) When Closed Loop Referrals (see section III.A.) are made for mental health services between ~~(~~NSMHS and SMHS~~)~~, Partnership or its delegate, Carelon, will ensure that that there is an appointment in the other system of care, along with tracking the outcome of that appointment. At all times, parties involved will adhere to relevant privacy regulations for the sharing of mental health and SUD information. Obtaining appropriate releases of information (with appropriate member consent) is recommended~~in order~~ to ~~ensure~~allow ~~that~~ information exchange ~~has the member's consent is also another strategy~~ for facilitating exchange of pertinent clinical information.
5) Outcomes of referrals are monitored through monthly referral trackers between Partnership (and/or its delegate) and each MHP.

e. The determination to transition services to and/or add services from the MHP delivery system must be made by a clinician via a patient-centered, shared decision-making process in alignment with the plan's protocols?
1) Once a clinician has made the determination to transition care or refer for additional services, the Transition of Care Tool may be filled out by a clinician or a non-clinician.
2) Members must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice

f. The Transition of Care Tool is not considered an assessment and does not replace:
1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
2) MCP protocols that address clinically appropriate, timely, and equitable access to care
3) MCP clinical assessments, level of care determinations, and service recommendations
4) MCP requirements to provide EPSDT services

B. Members may self-refer for mental health services to an appropriate mental health provider. Members do not need a referral from their Primary Care Provider (PCP) to receive mental health services.

C. In an effort to coordinate medical and mental health care, providers should ask ~~member~~Members to sign a release of information so that the ~~member~~Member's providers can best coordinate care. However, the release of information is not a condition for services to be provided.

D. The County Mental Health Plan's (MHP's) role in providing mental health services:
1. County MHPs provide crisis assessments, SMHS and authorizations for acute in-patient psychiatric care for ~~member~~Members in their counties who meet access criteria as described in Behavioral Health Information Notice (BHIN) 21-073.
a. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider.
b. The County crisis stabilization service acts as a backup after hours and on weekends as well

as at other times of provider unavailability.

c. Members may call the County crisis line directly, without a referral.

d. Members eligible for mental health services from ~~PHC~~Partnership delegated managed behavioral health organizations will be re-directed to appropriate County crisis services as needed.

e. Should services be rendered concurrently in both the NSMHS and SMHS systems for both ~~member~~Members who are under the age of 21 and those 21 years and older, ~~PHC~~Partnership and County Mental Health Plans shall coordinate care as mutually agreed upon, while ensuring ~~member~~Member's choice is considered. This collaboration shall continue through transitions between systems of care.

E. The PCP's role in providing mental health services:

1. A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or ~~PHC~~Partnership's delegated managed behavioral health organization, Carelon Behavioral Health ~~(formerly Beacon Health Options)~~, for telephone consultation. For detailed screening, referral and consultation procedures, PCPs can refer to ~~PHC~~Partnership Policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines.

a. If a ~~member~~Member's screening is positive and indicates further assessment, the assessment may be performed either by the PCP or by referral to a network mental health provider.

b. If the ~~member~~Member's PCP cannot perform the mental health assessment, they must refer the ~~member~~Member to the appropriate provider and ensure referral to the appropriate delivery system for mental health services, either in the MCPs provider network or the county MHP's network

c. Members may then be treated by the PCP within the PCP's scope of practice; or

d. When the condition is beyond the PCP's scope of practice, the PCP must refer the ~~member~~Member to a mental health provider, first attempting to refer within the MCP network

e. At any time, ~~member~~Members can choose to seek and obtain a mental health assessment from a licensed mental health provider within the MCPs provider network.

F. Managed Care Plan's responsibility for providing NSMHS:

1. ~~PHC~~Partnership is responsible for the delivery of NSMHS (as defined in III.F.) for the following populations:

a. Members who are 21 year of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;

b. Members who are under the age of 21, to the extent they are eligible for services through the Medicaid EPSDT benefit, regardless of the level of distress or impairment, or the presence of a diagnosis;

c. Members who are under the age of 21, with specified risk factors or with persistent mental health symptoms in the absence of a mental health disorder, are subject to psychotherapy; and

d. Members of any age with potential mental health disorders not yet diagnosed.

2. NSMHS may be delivered~~,~~ by PCPs within their scope of practice, or through ~~PHC~~Partnership's provider network which shall provide a full range of covered NSMHS to its pediatric and adult ~~member~~Members.

3. In accordance with California Welfare and Institutions Code (WIC) sections 14059.5 and 14184.402, services that are "medically necessary" or a "medical necessity" (see III.F~~E~~.) to correct or ameliorate health conditions for ~~member~~Members under the age of 21 shall be in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS. These services are covered by ~~PHC~~Partnership as

Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services (per policy MCCP2022) regardless of whether the services are covered in the state's Medicaid State Plan.

a. Consistent with federal guidance from Centers for Medicare & Medicaid Services (CMS), behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

4. Consistent with W&I Code section 14184.402(f), clinically appropriate and covered NSMHS are covered by ~~PHC~~Partnership even when:
   a. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
   b. Services are not included in an individual treatment plan;
   c. The ~~member~~Member has a co-occurring mental health condition and substance use disorder (SUD); OR
   d. NSMHS and SMHS services are provided concurrently, if those services are coordinated and not duplicated.

G. ~~PHC~~Partnership provides or arranges for the provision of NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs as follows:
   1. ~~PHC~~Partnership covers physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions
   2. ~~PHC~~Partnership does not cover pharmacy benefits and services pursuant to APL 22-012 *Revised* ~~Executive Order N-01-19~~ and the Medi-Cal Rx program. ~~Medications covered under the Medi-Cal Rx Contract Drug List can be accessed at: https://medi-calrx.dhcs.ca.gov/home/cdl/.~~ All medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/~~Magellan~~ DHCS contracted pharmacy administrator instead of ~~PHC~~Partnership. Please refer to the State Medi-Cal Rx Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/

H. ~~PHC~~Partnership covers up to 20 individual and/or group counseling sessions for pregnant and postpartum ~~member~~Members with specified risk factors for perinatal depression when sessions are delivered during the prenatal period and/or during the 12 months following childbirth. (*see also policy MCUP3118 Prenatal & Perinatal Care*)

~~I.~~

~~J.~~I. ~~PHC~~Partnership provides medical case management and covers and pays for all medically necessary Medi-Cal- covered physical health care services, not otherwise excluded by contract, for ~~PHC~~Partnership beneficiaries receiving SMHS. ~~PHC~~Partnership coordinates care with the MHP, and is responsible for the appropriate management of a ~~member~~Member's mental and physical health which includes, but is not limited to, medication reconciliation and the coordination of all medically necessary, contractually required Medi- Cal covered services, including mental health services, both within and outside the MCPs provider network.

~~K.~~J. ~~PHC~~Partnership is responsible for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations (CCR). This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the ~~member~~Member. Emergency services include facility and professional services and facility charges claimed by emergency departments.

~~L.~~K. ~~PHC~~Partnership is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as

well as for emergency services necessary to stabilize the ~~member~~Member. *(see also policy MCUP3101 Screening and Treatment for Substance Use Disorders)*

~~M.~~L. Clinically appropriate and covered Drug Medi-Cal (DMC) services delivered by DMC providers whether delivered through the Drug Medi-Cal Organized Delivery System (DMC-ODS) model or the DMC State Plan model are covered by the counties respectively, whether or not the ~~member~~Member has a co- occurring mental health condition. *(~~S~~see also policy MCUP3101 Screening and Treatment for Substance Use Disorders.)*

~~N.~~M. The Parity in Mental Health and Substance Use Disorder Benefits requirements of Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR) stipulate that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Therefore, ~~PHC~~Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the ~~PHC~~Partnership provider network, and no referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

1. ~~PHC~~Partnership provides information regarding mental health services for ~~member~~Members in the ~~PHC~~Partnership Medi-Cal Member Handbook as well as through ~~PHC~~Partnership's website www.partnershiphp.org. Applicable ~~member~~Member informing materials state that referral and prior authorization are not required for a ~~member~~Member to seek an initial mental health assessment from a network mental health provider.
2. ~~PHC~~Partnership covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.

~~O.~~N. Dispute Resolution

1. If a dispute occurs between the local County Mental Health Plan (MHP) and Partnership HealthPlan of California (~~PHC~~Partnership) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the MHP and ~~PHC~~Partnership will participate in a dispute resolution process as defined in ~~PHC~~Partnership Policy ADM52 Dispute Resolution Between ~~PHC~~Partnership and MHPs in Delivery of Mental Health Services.
   a. ~~PHC~~Partnership does not delegate the responsibility of MCP and MHP dispute resolution to any Subcontractor.

~~P.~~O. Delegation Oversight and Monitoring

1. ~~PHC~~Partnership delegates the administration of certain mental health services to a managed behavioral health organization.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to ~~PHC~~Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 10, Section 10.8.D
B. Medi-Cal Provider Manual/ Guidelines: Non-Specialty Mental Health Services: Psychiatric and Psychological Services *(non spec mental)*
C. Title 9 of the California Code of Regulations (CCR) Chapter 11
D. Title 9 CCR Sections 1820.205, 1830.205, 1830.210, 1850.505, 1850.515, 1850.525, 1850.535
E. Title 22 CCR Section 53855
F. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)
G. Title 42 United States Code (USC) § 1396d(r)(5)

H. Welfare and Institutions Codes (WIC) § 14059.5, 14132.03, 14184.402 § 14189
I. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
   a. Specialty Mental Health Services Memorandum of Understanding Template
   b. Substance Use Disorder Treatment Services Memorandum of Understanding Template
J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (04/08/2022)
M. DHCS APL 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)
N. Behavioral Health Information Notice (BHIN) 21-073
O. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
P. County specific Mental Health Plan Memoranda of Understanding (MOUs)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 08/11/95; 10/10/97 (name change only); 06/21/00; 12/19/2001; 08/20/03, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 04/21/10; 03/16/11; 08/15/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 10/12/22; 06/14/23; 04/10/24; 08/14/24

*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:

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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~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3114</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Physical, Occupational and Speech Therapies</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/20/2012</td><td colspan="4">Next Review Date: ~~03/13/2025~~08/14/2025
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~03/13/2024~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

~~A. MCCP2022 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services~~
~~B.~~A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~C.~~B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
~~D.~~C. MPCP2002 – California Children's Services
~~E.~~D. MCUP3125 – Gender Dysphoria/ Surgical Treatment
~~F.~~E. MCUG3011 – Criteria for Home Health Services
~~G.~~F. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. 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).~~ Medical~~ly necessary~~ necessity 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.

~~B. 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)~~

~~C.~~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.

~~D.~~C. 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.

~~E.~~D. 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.

F.E. 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.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and PHCPartnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Submission of Treatment Authorization of Requests (TARs) for PT, OT and ST.
1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).
2. Partnership does *not* require Treatment Authorization Requests (TARs) fromfrom Partnership contracted providers for PT, OT, or ST for the following circumstances:for
   a. Members age 21 and over: No TAR required for up to 12 visits (limit one visit per day) in a rolling 123 month period of time.
      1) A TAR will be required for services in excess of 12 visits. in a rolling 3 month period of time.
      .
3. In addition, no RAF is required, but services must be ordered through a writer prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).Partnership *requires* a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21
      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. D. for that process.
   Members age 21 and over for ST services
   b. Non-contracted Providers:
   c. Home Health Services: A TAR is required for all ages for all PT, OT, or ST services provided

through a home health agency. Refer to policy MCUG3011 Criteria for Home Health Services. ~~for non-contracted providers.~~

~~1.~~4. ~~TAR~~Submission Guidelines ~~requirements: Here are the requirements,~~ W~~w~~hen a TAR is R~~r~~equired

a. ~~PHC~~Partnership members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner) for one consultation visit through written prescription of licensed practitioners acting within the scope of their practice.

b. No TAR or ~~Referral Authorization Form (~~RAF~~)~~ is required for the initial evaluation.

c. 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)

d. ~~PHC~~Partnership authorizes ancillary services on a case by case basis, provided that medical necessity has been demonstrated in the submitted documentation.

e. 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~~Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.
   1) Occupational and physical therapy may be considered medically necessary when:
      a) 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.
      b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
      c) The services are used to assess the existence or extent of impairment due to a medical condition.
      d) 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.
      e) 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.
   2) Speech Therapy services for members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the member and services meet the following criteria:
      a) 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.
      b) 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.

c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.

d) 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 referring provider.

e) 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.

f) A course 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.

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

a) 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.

b) 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.

c) 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.

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

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

f) 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

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

4) The following services are generally not considered "medically" necessary or are not covered:

a) Recreational therapy

b) Activities that provide diversion or general motivation

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

~~i)~~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:~~

i. 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.

~~For physical therapy, occupational therapy or speech therapy services provided through a home health agency, refer to policy MCUG3011 Criteria for Home Health Services.~~
~~Submission of Treatment Authorization Request (TAR)~~

f. ~~Any TAR submitted will state the number of treatment visits approved.~~ If therapy is required beyond the visits initially approved, a new TAR must be submitted.

g. 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~~Partnership.

~~1) The following services are generally not considered "medically" necessary or are not covered:~~

~~2)~~1)~~Recreational therapy~~

~~3)~~1)~~Activities that provide diversion or general motivation~~

~~4)~~1)~~Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking~~

~~5)~~1)~~Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health~~

~~6) 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.~~

~~7)~~1)Continued therapy will not be approved ~~When~~ once 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~~PT or OT in conjunction 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~~

~~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.~~

5. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:

~~General Guidelines~~

The medical condition of hearing loss is covered for hearing tests~~;~~, evaluations by audiologists, and~~;~~ medical evaluations by head and neck surgeons and physicians in other clinical specialties. ~~,~~ H~~h~~owever, 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~~CCS in the county of residence or the state where applicable, to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will either be provided by State CCS or by ~~PHC~~Partnership under the Whole Child Model program in participating counties. See policies MPCP2002 California Children's Services and MCCP2024 Whole Child Model for California Children's Services (CCS)[1].

~~a. 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.~~

~~b.~~a. 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.

~~c.~~ 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~~Partnership. If a member is receiving medically necessary services through the ~~Local Educational Agency (~~LEA~~)~~, ~~PHC~~Partnership 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~~Partnership 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)~~

~~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.~~

~~Requests for review under this program must state explicitly that the request is for EPSDT supplemental~~

[1] In ~~PHC~~Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in ~~PHC~~Partnership's service area are participants in the State's CCS program and are not participants in ~~PHC~~Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

~~services and must be accompanied by the following information:~~
~~The principal diagnosis and significant associated diagnoses~~
~~Prognosis~~
~~Date of onset of the illness or condition, and etiology if known~~
~~Clinical significance or functional impairment caused by the illness or condition~~
~~Specific types of services to be rendered by each discipline with physician's prescription when applicable~~
~~The therapeutic goals to be achieved by each discipline, and anticipated time for achievement of goals~~
~~The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care~~
~~Any other documentation available which may assist PHC in making the required determinations~~
~~The service to be provided must meet the following:~~
~~Are necessary to correct or ameliorate defects in physical and mental illnesses and conditions discovered by the screening services under EPSDT~~
~~The supplies, items or equipment to be provided are medical in nature~~
~~The services are not requested solely for the convenience of the beneficiary, family, physician or another provider of service~~
~~The services are not unsafe for the individual EPSDT eligible beneficiary, and are not experimental~~
~~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.~~
~~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.~~
~~Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the beneficiary~~
~~The predicted beneficial outcome of the services outweighs potential harmful effects.~~
~~The available scientific evidence demonstrates that the services improve overall health outcomes as much as, or more than, established alternatives.~~
~~Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.~~

~~e.~~b. ~~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.~~A. Social Security Act Section 1905(r)
~~D.~~B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; ~~(~~Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
~~E. Department of Health Care Services All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)~~
~~F.~~C. 2023 Consolidated Appropriations Act HR2617 Section 4113 Advancing Telehealth Beyond Covid-19

VIII. DISTRIBUTION:

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B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24

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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MPCP2002 – California Children's Services
D. MCUP3125 – Gender Dysphoria/ Surgical Treatment
E. MCUG3011 – Criteria for Home Health Services
F. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical necessity 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.
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. 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.
D. 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.

E. 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.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.
1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner).
2. Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for PT, OT, or ST for the following circumstances:
   a. Members age 21 and over: No TAR required for up to 12 visits (limit one visit per day) in a rolling 12-month period of time.
      1) A TAR will be required for services in excess of 12 visits.
3. Partnership *requires* a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21
   b. Non-contracted Providers:
   c. Home Health Services: A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MCUG3011 Criteria for Home Health Services.
4. Submission Guidelines When a TAR is Required
   a. Partnership members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, or Nurse Practitioner) for one consultation visit through written prescription of licensed practitioners acting within the scope of their practice.
   b. No TAR or RAF is required for the initial evaluation.
   c. 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)
   d. Partnership authorizes ancillary services on a case by case basis, provided that medical necessity

has been demonstrated in the submitted documentation.

e. 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 Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.
   1) Occupational and physical therapy may be considered medically necessary when:
      a) 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.
      b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
      c) The services are used to assess the existence or extent of impairment due to a medical condition.
      d) 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.
      e) 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.
   2) Speech Therapy services for members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the member and services meet the following criteria:
      a) 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.
      b) 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.
      c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
      d) 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 referring provider.
      e) 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.
      f) A course 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.
   3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
      a) 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.

b) 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.

c) 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.

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

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

f) 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

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

4) 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.

i. 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.

f. If therapy is required beyond the visits initially approved, a new TAR must be submitted.

g. 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 Partnership.

1) Continued therapy will not be approved once 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 PT or OT in conjunction with the patient's referring physician.

5. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
The medical condition of hearing loss is covered for hearing tests, evaluations by audiologists, and 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 CCS in the county of residence or the state where applicable, to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will either be provided by State CCS or by Partnership under the Whole Child Model program in participating counties. See policies MPCP2002 California Children's Services and MCCP2024 Whole Child Model for California Children's Services (CCS)[1].
   a. 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.
   b. A member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a member is receiving medically necessary services through the LEA, Partnership 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, Partnership will approve the additional two visits per week if criteria is met.

VII. REFERENCES:

A. Social Security Act Section 1905(r)
B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
C. 2023 Consolidated Appropriations Act HR2617 Section 4113 Advancing Telehealth Beyond Covid-19

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24

*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.

[1] In Partnership's service area, 14 counties participate in the Whole Child Model program (Del Norte, Humboldt, Lake, Lassen, Marin, Modoc, Mendocino, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, Yolo). As of January 1, 2024, the following 10 counties in Partnership's service area are participants in the State's CCS program and are not participants in Partnership's Whole Child Model program: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.

Policy/Procedure Number: MCUP3114		Lead Department: Health Services
Policy/Procedure Title: Physical, Occupational and Speech Therapies		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2012	**Next Review Date: 08/14/2025** **Last Review Date: 08/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO: N/A

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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 Partnership 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 Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT COMMITTEE

Consent Calendar

June 19, 2024

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

[1] The Partnership TAR Requirements List does triple duty as MCUP3041-A, MCUP3049-A, and MCUG3007-B. The List is today updated as follows:
Section W: Medical Supplies: In this section a change was made to clarify TAR requirements for Wound Care Supplies. An additional resource was added for the reader to find detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, by referencing the Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits.
Sections AA: Occupational Therapy, FF: Physical Therapy, and HH: Speech Therapy: All of these sections were updated to match new TAR requirements in policy MCUP3114 Physical, Occupational and Speech Therapies. For both PT, OT, and ST, it was specified that Members under age 21 still require a TAR for services but No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) in a rolling 12 -month period. (A TAR will be required for services in excess of 12 visits.) TARs are also required for all PT/OT/ST services provided as Home Health or by Non-contracted Providers.
Outpatient Surgical Procedures CPT Codes: For Corrections of Bunions, code 28291 was removed, and codes 28297, 28298 and 28299 were added. We also added code 28289 for Repair Hallux Rigidus

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GRIEVANCE & APPEALS
Pulse Report

Our Mission

To help our members, and the communities we serve, be healthy

G&A PULSE REPORT

INSIDE THIS ISSUE

ISSUE 13 | JUNE 2024

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings. The report contains data from the first quarter of 2024.

Partnership HealthPlan of California (Partnership) is committed to member satisfaction. When members understand their Partnership Medi-Cal benefits and how to access them, and the service they receive meets expectations, we believe members are likely to seek care and maintain their health. We invite all members to share their concerns or challenges.

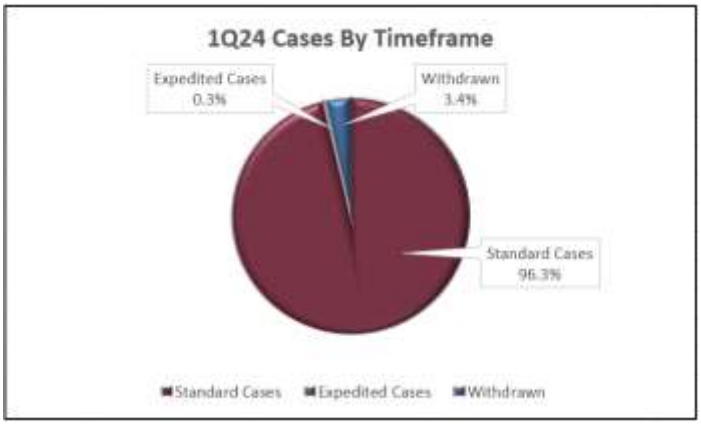
Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level.

1Q24 HIGHLIGHTS

OVERALL NUMBERS

In 1Q24, G&A investigated 1,641 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,306 cases subject to DHCS-mandated timeframes, 98.5% were closed on time, slightly below the 98.6% goal. Contributing factors included delays in receiving timely responses from providers, including responses to medical records requests, and delays in sending letters for translation.

1Q24 TOTAL # INVESTIGATED CASES		
Case Type	**# Cases**	**% Grand TTL**
Grievance	1172	71.4%
Exempt	299	18.2%
Appeal	123	7.5%
State Hearing	36	2.2%
Second Level Grievance	11	0.7%
Grand Total	**1,641**	**100.0%**



KEY POINTS & TRENDS

Transportation — Transportation related cases were the most frequently reported concern, making up 44.2% of the total concerns reported.

The most common issue was missed rides, which accounted for 21.3% of the transportation issues. Requests for specific transportation providers and dissatisfaction with transportation customer service were the next highest reported concerns, at 10.8% and 9.8%, respectively.

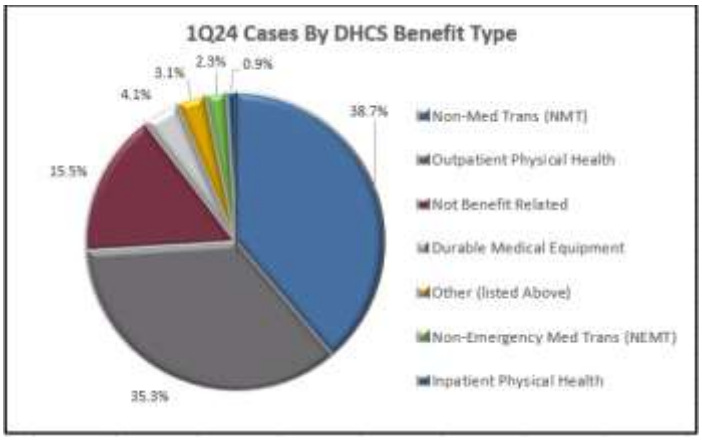
Lodging denials were the most commonly appealed, making up 31.8% of the transportation Appeal denials, followed by meal denials at 28.8%.

Provider Service – This category accounted for 42.5% of the total case concerns. The most common issue was Treatment Plan Disputes, followed by Poor Attitude/Service. Communication was the third most commonly reported concern within this category.

DHCS CATEGORIES

Non-Medical Transportation (NMT) is the most frequently reported Benefit Type, followed by Outpatient Physical Health services.

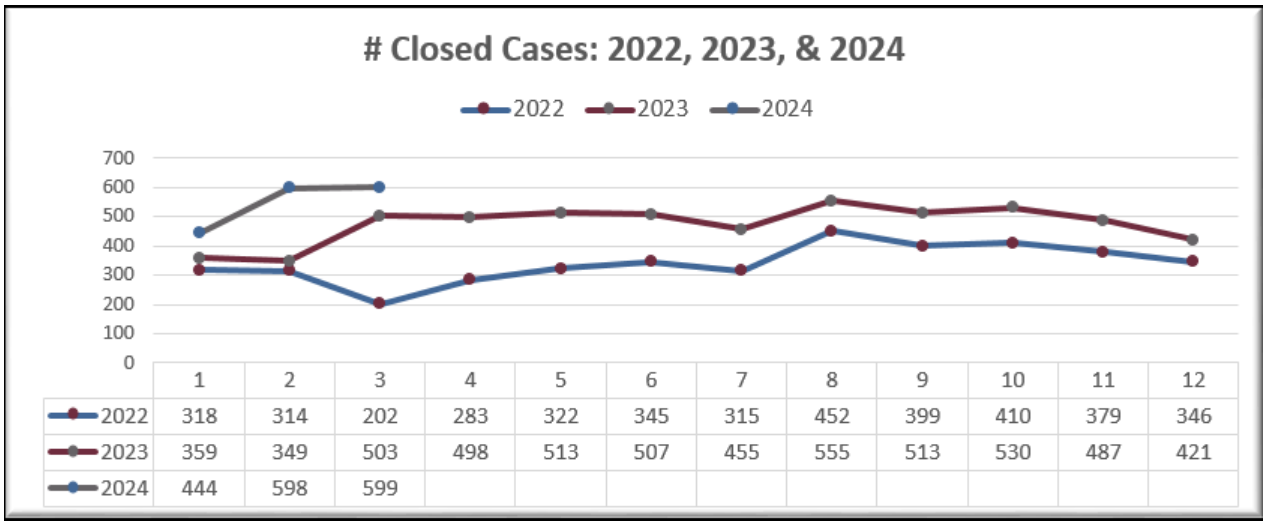
Non-Medical Transportation (NMT) represented 38.7% and Outpatient Physical Health services represented 35.3% of reported concerns. Not Benefit Related accounted for 15.5% of the DHCS Benefit Type categories.



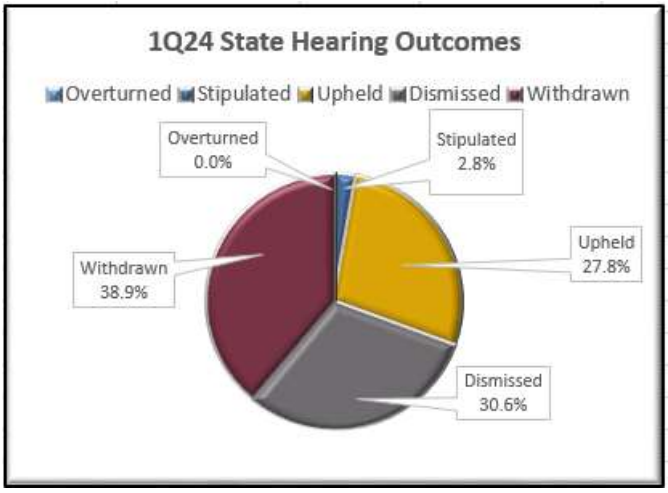
KEY STATISTICS

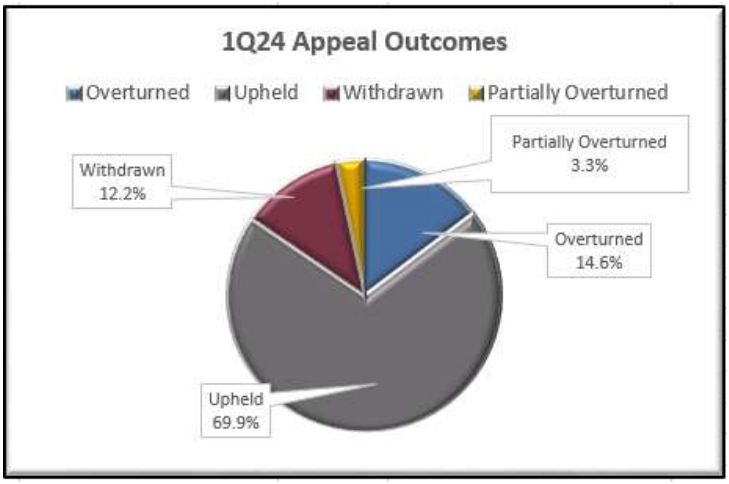
CHARTS OF KEY CASE TRENDS

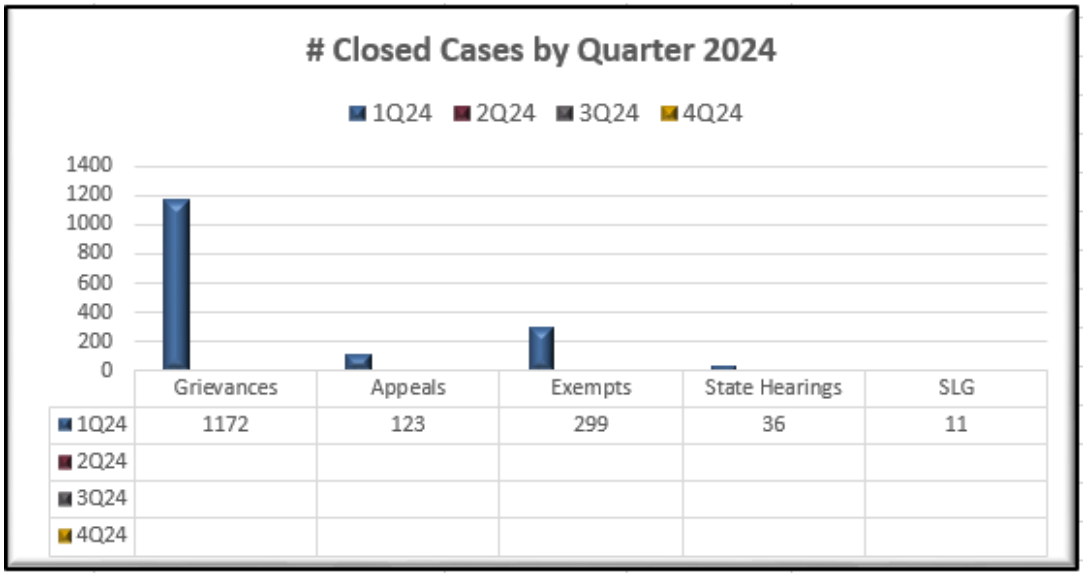
The following charts represent key data metrics used to track and trend Appeals, Grievances, Second Level Grievances, and State Hearings over time.



	1	2	3	4	5	6	7	8	9	10	11	12
2022	318	314	202	283	322	345	315	452	399	410	379	346
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599									







	Grievances	Appeals	Exempts	State Hearings	SLG
1Q24	1172	123	299	36	11
2Q24					
3Q24					
4Q24					

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, Second Level Grievance, or State Hearing during 1Q24.

1Q24 % CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	4.9%	18.5%
Age 11-19	3.9%	16.5%
Age 20-44	28.1%	35.2%
Age 45-64	45.3%	19.6%
Age 65+	17.7%	10.2%
Grand Total	100.0%	100.0%

1Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	54.6%	39.2%
Hispanic	11.2%	33.2%
Other	9.7%	5.9%
Black (African Ame	7.1%	3.5%
No Response	14.8%	13.4%
Native American	1.1%	1.8%
Asian Indian	0.5%	1.5%
Filipino	0.9%	1.1%
Vietnamese	0.1%	0.4%
Grand Total	100.0%	100.0%

1Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	91.3%	77.0%
Spanish	7.1%	19.8%
Other	1.0%	2.7%
Russian	0.3%	0.6%
Tagalog	0.2%	0.3%
Grand Total	100.0%	100.0%

1Q24 % CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	62.3%	52.6%
Male	37.7%	47.4%
Grand Total	100.0%	100.0%

"I had an appeal with you, Amanda, that you fought hard on my behalf and the denial was successfully overturned. I had the surgery and it changed my life. Thank you so much because you were a key person to make this all happen. I really appreciate you and want to offer you a very sincere thank you."

- Partnership Member

1Q24 % CASES BY COUNTY		
Member County	% Cases	% Membership
Solano	14.6%	11.3%
Shasta	11.2%	7.6%
Sonoma	11.2%	12.0%
Humboldt	10.1%	6.5%
Placer	8.1%	6.5%
Yolo	5.7%	6.0%
Butte	5.0%	9.4%
Lake	4.8%	3.8%
Marin	4.0%	5.1%
Siskiyou	3.9%	2.0%
Mendocino	3.5%	4.5%
Nevada	2.7%	3.1%
Del Norte	2.4%	1.4%
Napa	2.4%	3.0%
Tehama	2.1%	3.4%
Lassen	1.9%	0.9%
Yuba	1.8%	4.0%
Sutter	1.3%	4.8%
Trinity	0.8%	0.6%
Modoc	0.7%	0.4%
Plumas	0.7%	0.6%
Glenn	0.6%	1.5%
Colusa	0.5%	1.2%
Sierra	0.0%	0.1%
Grand Total	100.0%	100.0%

W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 1Q24. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.

1Q24 NUMBERS

There were five (5) W&R cases received in 1Q24, representing 0.3% of the total concerns reported this quarter.

TRENDING ISSUES

G&A received five (5) grievances and zero (0) appeals. All of the grievances received in 1Q24 were also resolved the same quarter.

After investigation of the cases, it was determined that the providers were not at-fault in four (4) of the cases. However, G&A was able to substantiate the one (1) remaining case.

In that case, a staff member at a Shasta County provider shared protected health information (PHI) with a patient's spouse. The spouse did not have the proper permissions on file to receive this information. The staff member received Ethics and Confidentiality Training from the facility. Our internal processes required us to report this breach of PHI to the Regulatory Affairs and Compliance (RAC) Department for research and tracking.

All of the grievances were related to provider care and/or case management. Three (3) of the five (5) grievances were also related to the member not following program rules.

Some of the program rules that were not followed included failing to provide the required medical release forms to continue treatment, refusing to attend group sessions, and leaving group sessions early without permission.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The next two tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. All the cases were closed within the 30-day DHCS regulatory timeframe.

1Q24 W&R Cases	
# of Grievance Received	5
# of Grievance Resolved	5
# of Appeal Received	0
# of Appeal Resolved	0

1Q24 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	2
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	3
Other	0

CCS RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to California Children's Services (CCS) and Whole Child Model (WCM) during 1Q24.

1Q24 STATISTICS

A total of 29 CCS-related cases were closed in 1Q24, representing 1.8% of the 1,641 reported concerns for this quarter. These cases are broken down into 26 Grievances and three (3) Appeals.

TRENDING ISSUES

The most commonly reported issues were related to transportation. There were 18 cases related to transportation issues or an individual transportation provider. These accounted for 62.1% of the 29 cases submitted. Among these cases, members most frequently had issues with the delay in getting reimbursement for gas mileage associated with CCS-related services. Other reported concerns include dissatisfaction with not having access to advanced funds and missed rides causing missed appointments.

Of the remaining cases unrelated to transportation, there were three (3) Appeals and eight (8) Grievances. All three (3) Appeals were upheld due to lack of medical necessity or because the requested services were not covered, as the members were over 21.

One provider was the subject of three (3) grievances regarding their treatment plan assessments. After our clinical staff reviewed their medical records and the provider's responses to the grievance, it was found that the care provided met the expected standards of care.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There were no cases of discrimination reported for CCS member during 1Q24.

ETHNICITY AND PREFERRED LANGUAGE

G&A provides ethnicity and language data specific to CCS members through charts below.

1Q24 CASES BY ETHNICITY		
Member Ethnicity	#Cases	% Cases
No Response	14	48.3%
Hispanic	8	27.6%
White	5	17.2%
Other	1	3.4%
Black (African American)	1	3.4%
Alaskan Native or American Indian	0	0.0%
Grand Total	29	100.0%

Members provide Partnership with their language preferences for communication. Below is a breakdown of the member's reported languages.

1Q24 CCS CASES BY LANGUAGE		
Member Language	# Cases	% Cases
English	22	75.9%
Spanish	7	24.1%
Grand Total	29	100.0%

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 1Q24.

1Q24 DISCRIMINATION STATISTICS

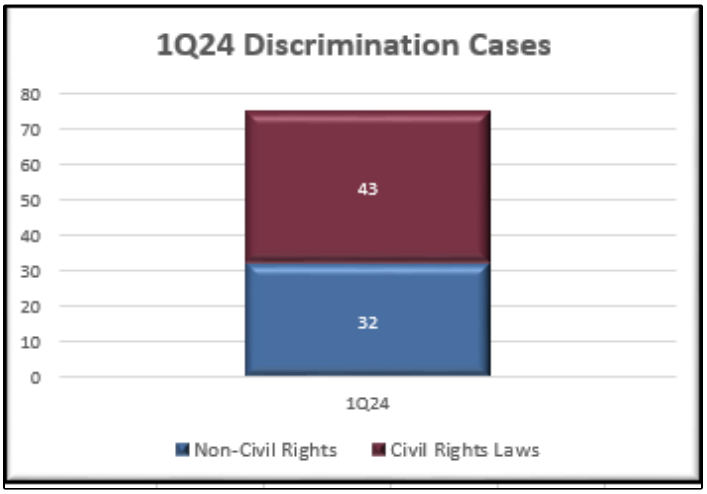
G&A investigated 75 cases related to discrimination allegations in 1Q24. This represented 4.6% of all cases closed. Of the 75 cases, 43 fell under an applicable federal or state civil rights law. Five (5) cases contained allegations that fell under multiple categories.

After investigation, it was determined discrimination likely occurred in two (2) cases.

In one case, the provider's office staff did not provide language assistance to the member when they appeared to be struggling to understand English. The office policy is to offer a tablet for the member to choose their preferred language. The staff member did not offer this option. The office leadership has committed to establishing a workflow to ensure proper adherence to their policy.

The other case, a member visited the emergency room and was not given pain medication. Witnesses heard the doctor tell a nurse that the member was a drug seeker, allegedly based on their appearance. This led to a loud altercation between the doctor and the member, witnessed by others. The hospital acknowledged the doctor's unprofessional behavior, and the incident was reported to the hospital's Emergency Room Director and Chief of Medicine. This case was also referred to our Quality department for review.

Discrimination allegations that do not fall under a civil rights law accounted for 32 of the 75 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having Medi-Cal, having a low income, having a service animal or being labeled a medication/drug seeker.



1Q24 DISCRIMINATION TRENDS

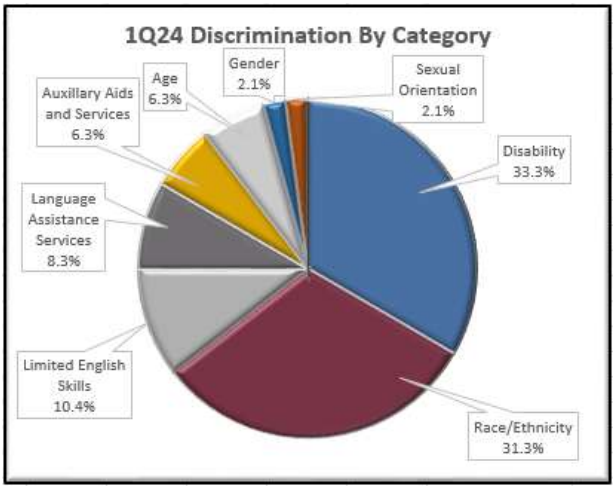
Overall, the number of discrimination allegations has increased in number, but they continue to remain under 5.0% of total cases filed. After investigation, the number of cases found to have indicated discrimination was likely remains low.

The increase in cases does not appear to be solely related to the county expansion as only six (6) cases from the new counties were reported for the whole 1Q24 timeframe.

1Q24 CASES BY CATEGORY

The chart below shows a breakdown of cases wherein discrimination was found to be likely by the reported civil rights law.

The most commonly reported allegation was Disability accounting for 33.3% cases followed by Race/Ethnicity accounting for 31.3% of the cases.



QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by Partnership's Grievance Registered Nurse team. A list of cases that were not previously reviewed by a Partnership Medical Director is forwarded to Partnership's Chief Medical Officer (CMO) or designated representative, of which a sample size is selected and evaluated. The Compliance Manager and Quality & Training Supervisor complete a subsequent comprehensive review to identify opportunities for operational improvements.

THE RESULTS

A sample size of 32 cases was evaluated for 1Q24 consisting of 31 Grievances and one (1) Second Level Grievance.

The G&A Nurse Specialists categorized all the cases evaluated by the Medical Director correctly and the solutions were satisfactory.

G&A leadership identified several opportunities for improvement. First, G&A staff need to correctly identify the provider involved. In Everest, the provider field is a free-form field and auto-populates with the word "provider." G&A staff must remember to update this field with the correct provider's name. Additionally, staff need to follow all the necessary steps for the expedited case process, which includes a specific list of actions to be completed when a member requests expedited handling. Finally, staff must include all criteria provided by the reviewer in the appeal decision letter to the member.

TIMELINESS

For 1Q24, 1,306 cases were subject to DHCS Turnaround Times (TAT).

The target timeliness goal for investigations is 98.6%, but we achieved 98.5%. This minor deviation was due to several factors. Twenty cases were processed late, primarily because of delayed responses from providers, late receipt of cases from other departments, and delays in receiving medical records.

There were 15 late acknowledgment letters (ack-letters), but the timeliness goal for this category was still met. Reasons for these delays included internal issues with sending letters to translation and system problems.

1Q24 DHCS Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.0%	20	98.5%	
Ack-Letters	98.0%	15	98.9%	

Partnership is a non-profit community based health care organization that contracts with the State to administer Medi-Cal benefits through local care providers to ensure Medi-Cal recipients have access to high-quality comprehensive cost-effective health care. Partnership is available to Medi-Cal-qualifying residents in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba.

CONTACT US

Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, CA 94534

2525 Airpark Drive
Redding, CA 96001

www.partnershiphp.org

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)</td><td colspan="3">Lead Department:` Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 6/16/2004</td><td colspan="4">Next Review Date: ~~09/13/2024~~08/14/2025
Last Review Date: ~~09/13/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, M.D., MPH, MBA</td><td colspan="3">Approval Date: ~~09/13/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3049 – Pain Management Specialty Services
B. MCUP3101 – Screening and Treatment for Substance Use Disorders

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. Partnership Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines
B. Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines
C. Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines
D. Partnership Recommendations for Safe Use of Opioid Medications: Dental Prescribing Guidelines

V. PURPOSE:

The purpose of this guideline is to improve care for Partnership HealthPlan of California (Partnership) members with chronic pain by:

A. Clarifying the roles of primary care practitioners and specialists who care for members with chronic pain. The guideline is designed to help primary care practitioners make appropriate use of pain management specialists.
B. Summarizing best practices in opioid prescribing to create a series of recommendations for safe prescribing of opioid medications.

VI. GUIDELINE / PROCEDURE:

Partnership HealthPlan is the County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in ~~14~~ 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications. In addition, ~~PHC's~~ Partnership ~~14 counties have long supported~~supports Substance Use Disorder (SUD) treatment services through the Drug Medi-Cal (DMC)

program, including administration of the DMC-ODS (Organized Delivery System) program in ~~Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.~~several counties.

This guideline recognizes the services and responsibilities of primary care providers (PCPs), pain management and other specialists in caring for members with chronic pain. This guideline is highly dependent upon the individual clinical circumstances and the delivery system. Because of these circumstances, expectations may appropriately deviate from the guideline. The PCP is responsible for coordinating all services required by the patient except when precipitous circumstances preclude the PCP's role. 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~~ Partnership recognizes that differences in skill levels exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for specialty referral to a pain management specialist. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a telephone discussion with a specialist, e-consults, telehealth consultations and the referral of a patient to a specialist for services. When care by a specialist is required, it is the responsibility of the PCP and the specialist to coordinate all services.

PCPs and specialists may find guidance through various federal and state agencies, including the Medical Board of California, which has published its Guidelines for Controlled Substances for Pain. These guidelines are updated to provide a framework for clinician use while also encouraging the development of treatment plans customized for their patients.

A. The PCP should be responsible for providing the following basic pain management services:
   1. The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. Functional capacity should be evaluated and is the key target of any treatment. In addition, the PCP should assess for the presence of psychiatric disorders, substance use disorders and substance misuse. Assessment should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain should be considered. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.
   2. A thorough physical exam should be performed as clinically indicated.
   3. When medications with addictive/dependence potential are being used or being considered, the PCP should distinguish between physiologic dependence, tolerance, or addiction/substance use disorder.
   4. A pain management agreement is an important part of the scope of pain management. PCPs should consider a pain management agreement for all chronic pain patients who they are following.
   5. A referral to a pain management center should be considered when appropriate. Members should not be referred to a pain management specialist until treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists as indicated. All potential co-occurring psychiatric illnesses should be evaluated and under treatment when appropriate. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist. Referrals solely for purposes of reducing a PCP caseload of opioid-using patients should not be made.
   6. Consider referring a member with complex pain management as indicated under Pain Management Specialist referral or whenever the PCP feels the member would benefit from pain management evaluation based on his/her sound clinical judgment.
   7. For members who have been referred and evaluated by a pain management or other specialist, the

PCP should participate in the ongoing follow-up as jointly determined by the PCP and the specialist for members with these conditions who have reached a high degree of stability.

B. Specialist Referral

Referral to an appropriate specialist should be considered appropriate in the following situations:

1. Pain Management Specialist
   a. Complex pain management where the diagnosis is unclear or the condition is unresponsive to standard medication and non-pharmacologic therapy for a period of 3 to 6 months.
   b. Complex pain management compromised by severe functional impairment.
   c. Complex Regional Pain Syndrome (CRPS).
   d. Complex pain management complicated by mental health condition or substance use disorder unresponsive to usual therapy and treatment by an appropriate behavioral health specialist.
   e. For performance and/or supervision of procedures done by pain management specialists. (See MCUP3049 Attachment A – Pain Management Specialty Services.)
2. Refer to other specialists such as neurology, orthopedics, rheumatology, physical medicine and rehabilitation or behavioral health. Specific indications for referral to specialties other than pain management are beyond the scope of this guideline. The PCP should perform a careful evaluation of conditions with a known cause and initiate conservative therapy consistent with the PCP's skill and best judgment. Expert consultation should be considered in situations where the diagnosis is uncertain, the member has not responded to usual conservative therapy or specialty care is required based on the diagnosis.
3. After initial specialist consultation or a significant change in the patient status or when the specialist terminates care of patient, the specialist is responsible to send all relevant information back to the PCP.
4. Patients with suspected substance use disorder (SUD) should be assessed by the PCP or be referred for assessment. In many instances, opioid use disorder (OUD) and other SUDs can be evaluated and treated by the PCP, such as through the use of Medications for Addiction Treatment (MAT). ~~For instance, buprenorphine (sublingual or extended release injectable) or buprenorphine-naloxone, naltrexone and long-acting injectable naltrexone may be prescribed by PCPs for the treatment of opioid use disorder.~~Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice. Another MAT for OUD, methadone, is available for outpatient treatment only through certified narcotic treatment programs (NTP) with some exceptions for acute care hospitals and emergency department settings~~.~~ PCPs cannot prescribe methadone for the treatment of OUD under the guise of treating pain.~~,~~ However, sublingual buprenorphine products can be prescribed simultaneously for both pain and OUD. Naltrexone products should not be co-prescribed with any opioid medication, as naltrexone is an opioid receptor antagonist. In the event that referral is warranted, providers and patients can call Carelon Behavioral Health at (855) 765-9703 for referral information and options if the patient resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access departments. In addition, regardless of county of residence, for buprenorphine providers, patients and providers may visit the Partnership provider directory or the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator website (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator). It can be helpful for PCPs or staff at the PCP office to assist patients in securing a referral connection with an assessing provider, or a substance use disorder treatment provider. PCPs should also note that a specialized DEA waiver (known previously as the "X-Waiver") is no longer required for the prescribing of FDA-approved buprenorphine products for the treatment of opioid use disorder, and there are no longer any patient limits for prescribing under these circumstances. All

PCPs, therefore, with DEA certification to prescribe Schedule II-V controlled substances may now prescribe FDA-approved buprenorphine products for the treatment of opioid use disorder.

a. For facts about buprenorphine and important points to review with the patient, see the SAMHSA Buprenorphine Quick Start Guide at https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf.
b. Additional training materials and live mentoring can also be obtained through:
   1) The Provider's Clinical Support System (PCSS): https://pcssnow.org
   2) The University of California, San Francisco National Clinician Consultation Center warmline: https://nccc.ucsf.edu

C. Opioid Prescribing Guidelines For Physicians

1. Initial treatment considerations should include non-pharmacological therapies, including physical therapy, acupuncture, chiropractic treatment, activity modifications (rest, splinting), and mobility assistance (canes.)
2. Based on provider skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain.
   a. Initial pharmacologic treatment should rely on non-opioid analgesics, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDS).
   b. The use of opioids (tramadol, and opioids such as codeine, hydrocodone, methadone, oxycodone, morphine, and fentanyl) should be reserved for:
      1) Temporary use following trauma or surgery if non-opioid treatment is inadequate, with plan for discontinuation.
      2) For chronic use intermittently at the lowest doses in combination with other non-pharmacologic and non-opioid therapies.
      3) Severe functional disability, at the lowest doses in combination with other non-pharmacologic and non-opioid therapies (may involve ongoing regular doses.)
      4) Chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
   c. Before committing patients to long-term regular opioid treatment that may become lifelong, the patient's age should be taken into consideration and the risks of physiologic dependence and misuse potential should be discussed with patients.
   d. Opioids in the frail elderly may be contraindicated due to safety concerns.
   e. Offer to prescribe naloxone for any patient prescribed opioids. Intranasal naloxone is also available at pharmacies without a physician's prescription, although for Medi-Cal to cover it, a prescription is required.
3. Pain modulating agents should be considered when appropriate, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants, (gabapentin, pregabalin and carbamazepine.)
4. As a minimum standard, when starting opioid therapy for acute, subacute, or chronic pain – not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease – clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
   a. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs. Certain in-office toxicology screens are covered by ~~PHC~~ Partnership (See Important Provider Notice on ~~PHC~~ Partnership's website for details.) Consider a confirmatory urine test if the results of an in-office screen are unexpected, because false positive and negative screening results are common. If a patient is at higher risk for substance use disorder (SUD), diversion, or substance misuse, strongly consider more frequent toxicology screens. Ensure that the toxicology screen used can detect the relevant medications or substances of interest.

1) Validated screening tools for substance misuse or substance use disorder can be helpful, such as:
   a) Drug Abuse Screening Test (DAST): https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
   b) Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS-1)
      i. A self or clinician-administered tool available in online platform, TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component, TAPS-2 as described below.
      ii. After a positive screen on TAPS-1, TAPS-2 guides clinicians through brief substance-specific assessment questions to arrive at a risk level for that substance.

b. For pregnant individuals, consider using any of the validated tools recommended by the American College of Obstetricians and Gynecologists (ACOG): the 4Ps Plus (Parents, Partner, Past and Present), TAPs, or the CRAFFT (Driven in a **C**ar~~r~~ while high or with someone who was, use drugs or alcohol to **R**elax, ever use when **A**lone, ever **F**orget what you did while using, ever have **F**riends tell you to cut down, ever gotten into **T**rouble on account of use).

~~b.~~c. Consider a signed medication use agreement with the prescriber or prescribing office.

~~c.~~d. Provider to check California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.

~~d.~~e. Schedule at a minimum, three office visits yearly for chronic pain and monitoring opioid use.

~~e.~~f. Educate patients on proper safe storage of opioid medications to help prevent diversion (i.e., lock boxes).

~~f.~~g. Utilize CURES, pill counts, and urine drug screens to minimize the potential for diversion/resale or distribution of prescribed opioid medications.

4. Further Recommendations for PCPs and Specialists are found in Attachment A, Partnership Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines.

D. Community Pharmacy Guidelines

Community Pharmacies play a key role in helping prevent Opioid overdoses, Opioid induced hyperalgesia, Opioid diversion, and Opioid addiction, and have a legal responsibility to do so. ~~PHC~~ Partnership recommends that all community pharmacies develop policies and standards to fulfill this responsibility. For detailed recommendations, see Attachment B, ~~PHC~~ Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines.

E. Emergency Room Guidelines

The emergency department has two key roles in helping with community-wide efforts to control Opioid overuse: assuring acute pain is treated in a way that decreases the probability of future over-use of Opioids; working closely with primary care providers to ensure a coherent, safe approach to treating chronic pain. ~~PHC~~ Partnership recommendations are found in Attachment C, ~~PHC~~ Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines.

1. The emergency department (ED) can be a critical access point for members with SUD. ED personnel should consider screening for SUD and initiating medication-assisted treatment (MAT). See https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf

F. Dentist Guidelines

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications. ~~PHC~~ Partnership recommendations are found in Attachment D, ~~PHC~~ Partnership Recommendations for Safe Use of Opioid Medications: Dentist Prescribing Guidelines.

G. Indicators Monitored by ~~PHC~~Partnership
As part of retrospective DUR (Drug Utilization Review), ~~PHC~~ Partnership will monitor pharmacy claims and CURES data for high Morphine Equivalent Dose (MED) and use of multiple prescribers and pharmacies.

VII. REFERENCES:

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified May 13, 2024~~American Pain Society. Guideline for the Use of Chronic Opioid Therapy in Chronic Non-cancer Pain Evidence Review. Available at: Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain - The Journal of Pain (jpain.org) Accessibility verified on April 4, 2023~~

B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/ Accessibility verified on ~~April 4, 2023~~May 6, 2024

C. Centers for Disease Control. CDC Guideline for Prescribing Opioids for Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508. Accessibility verified ~~April 4, 2023~~May 6, 2024

D. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. Available at: http://www.cfp.ca/content/57/11/1257.full.pdf Accessibility verified on ~~April 4, 2023~~May 6, 2024

E. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf Accessibility verified on ~~April 4, 2023~~May 6, 2024

F. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August 2016, Available at https:/www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf. Accessibility verified on ~~April 4, 2023~~May 6, 2024

G. Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023, https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf. Accessibility verified May 6, 2024

H. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification. J Addict Med. 2011 Sep;5(3):221-6.

I. SAMHSA Buprenorphine Quick Start Guide: https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf.

J. The Provider's Clinical Support System (PCSS): https://pcssnow.org

~~G.~~K. The University of California, San Francisco National Clinician Consultation Center warmline: https://nccc.ucsf.edu

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Provider Manual
B. ~~PHC~~ Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/20/04; 03/15/06; 03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16; 04/19/17;

Guideline/Procedure Number: MPXG5008 (previously MPQG1029 & QG100129)		**Lead Department: Health Services**
Guideline/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing		☒ **External Policy** ☐ **Internal Policy**
Original Date: 6/16/2004	**Next Review Date: 09/13/202408/14/2025** **Last Review Date: 09/13/202308/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

*03/14/18; 04/10/19; 03/11/20; 04/14/21; 06/08/22; 09/13/23; 08/14/24

*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 MPXG5008 (Healthy Kids program ended 12/01/2016)
03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16 to 12/01/2016

PartnershipAdvantage:
MPXG5008 – 03/21/2007 to 01/01/2015

Healthy Families
MPXG5008 – 10/01/2010 to 03/01/2013

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Primary Care & Specialist Prescribing Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in ~~14~~ 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Based on their skill level, the primary care provider (PCP) should prescribe appropriate analgesics when indicated for the initial management of pain. In starting analgesics for new onset acute pain, the possibility the acute process will evolve into a chronic pain syndrome should be kept in mind. Chronic pain is defined as pain lasting longer than normally expected for the healing of an acute injury or tissue inflammation, usually in the range of 3-6 months. In this guideline, we are not addressing chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease, conditions in which treatment goals and needs are different.

Use of opioid pain medications for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related should be weighed carefully by any prescriber. Chronic use of opioids is associated with an increased risk of addiction, physiologic dependence, and tolerance. When combined with alcohol use or with other sedating medications such as benzodiazepines and muscle relaxants, opioid use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid-induced hyperalgesia, which ultimately generates increased pain and debility. Unlike acute pain or pain related to metastatic cancer or end-of-life care, the goal of opioid therapy in chronic non-cancer, non-terminal pain is *improved functioning*, not necessarily *elimination of pain*.

The following standards for opioid use in patients' pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease are suggested as a starting point from which each community in our ~~PHC~~ Partnership regions can develop their own standards, for the good of our members and the community. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.

Recommendations

For all opioid prescriptions, write as intended to be taken (i.e., 1 tablet q 6 hrs prn (this is a max of 4 per day); or 1-2 q 4-6 hrs but no more than 4 per day (also a max of 4 per day)

A. Acute pain. The main goal is to treat pain without creating opioid physiologic dependency, tolerance, or hyperalgesia.
   1. Preferentially use non-narcotics as first line therapy, especially acetaminophen or NSAIDS. Remember to be cautious with NSAIDs in seniors and persons with hypertension and azotemia.
   2. Restrict use of narcotic pain medications to situations with more severe pain, e.g., traumatic injuries, and if prescribed, limit their use to short periods.
   3. Discuss the risk of opioid dependence, tolerance, and hyperalgesia with patients being initiated on opioid treatment.
   4. According to the Centers for Disease Control (CDC), the lowest effective dose of fast-acting opioid prescriptions should be prescribed for 3 days or less; more than 7 days will rarely be needed. Per these recommendations, prescriptions for acute treatment of pain should not go beyond a few days without reevaluation.
   5. Before initiating opioid therapy for acute pain, assess for risk of substance use disorder/diversion using a standardized tool (e.g., DIRE, see Appendix A). If patient is at high risk, consider a baseline urine toxicology screen and focus on the use of non-opioid modalities to treat pain. Patients between 18 and 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.
   6. Advise patients that short-term opioid use can lead to unintended long-term opioid use and the importance of working toward planned discontinuation of opioid use as soon as feasible, including a plan to appropriately taper opioids as pain resolves if opioids have been used around the clock for more than a few days. Review communication mechanisms and protocols patients can use to inform clinicians of severe or uncontrolled pain and to arrange for timely reassessment and management. Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations at work, school, or home. Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase hydration and fiber intake and to maintain or increase physical activity as they are able. A cathartic (e.g., senna) with or without a stool softener or a laxative might be needed if opioids are used for more than a few days. To minimize withdrawal symptoms, clinicians should provide and discuss an opioid tapering plan when opioids will be used around the clock for more than a few days (see Recommendation 7). Limiting opioid use to the minimum needed to manage pain (e.g., taking the opioid only when needed if needed less frequently than every 4 hours and the prescription is written for every 4 hours as needed for pain) can help limit development of tolerance and therefore of withdrawal once opioids are discontinued.
   7. If formulations are prescribed that combine opioids with acetaminophen, advise patients of the risks of taking additional over-the-counter products containing acetaminophen. Acetaminophen can be hepatotoxic at dosages of >3–4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease (American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons, 2009). To help patients assess when a dose of opioids is needed, explain that the goal is to reduce pain to make it manageable rather than to eliminate pain. Discuss effects that opioids might have on ability to safely operate a vehicle or other machinery, particularly when opioids are initiated or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently. Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often. Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, non-prescribed or illicit drugs such as heroin, or other opioids. Discuss risks to

household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient, and that young children and pets are susceptible to unintentional ingestion. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (U.S. Food and Drug Administration, 2020a).

8. Discuss planned use of precautions to reduce risks, including naloxone for overdose reversal and clinician use of prescription drug monitoring program information.

B. Chronic pain in patients with a remote history of malignancy, but currently in remission, should be treated the same as those with chronic non-cancer pain. (See next section.)

C. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

1. Chronic pain not associated with the cancer or related to its treatment, end-of-life care palliative care, or sickle cell disease and not responding to non-opioid treatment modalities may benefit from chronic use of low dose opioid medications. This should be weighed against the risk of misuse and diversion. Use of a standardized Opioid Risk Tool should be considered.
2. According to the CDC 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.
3. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.
4. Other treatment modalities should be considered (if not previously utilized), including acupuncture, physical therapy, massage, exercise, counseling, chiropractic, activity modification, podiatric (for appropriate diagnoses), etc.
5. In neuropathic chronic pain, consideration should be given to the use of agents such as tricyclic antidepressants (e.g., amitriptyline or nortriptyline) and anticonvulsants (e.g., gabapentin, pregabalin or carbamazepine).
6. Emphasis should be placed on functional status as opposed to complete elimination of pain.
7. For patient safety, intramuscular and intravenous opioids should not be administered for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
8. In order to reduce the incidence and severity of neonatal abstinence syndrome (NAS) in pregnant individuals with chronic pain, consider consultation with obstetric specialists as well as targeting the lowest effective opioid dose and the use of appropriate non-opioid analgesics. Buprenorphine or similar classes of opioids may be helpful in addressing chronic pain in the setting of opioid dependence, and may carry less risk of severe NAS. For members of reproductive age on chronic opioids, consider discussing the pregnancy-specific risks of opioids, as well as contraception options.
9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.

D. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease already on opioid doses greater than 90 mg MED/day.

1. According to the CDC Guidelines, for patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue, such as warning signs of impending

overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages.

a. Substitution with buprenorphine ~~(Suboxone®)~~or buprenorphine-naloxone products by a prescriber ~~experienced~~ educated in the use of this medication. (Note: no longer does a prescriber require a DEA "X-Waiver" in order to prescribe buprenorphine products for the treatment of opioid use disorder.)
b. Combination of the above with involvement of a multidisciplinary team, including behavioral health and physical therapy, and non-opioid medication options. The goal is to optimize functional status as opposed to complete alleviation of pain as the latter is often not possible.
c. Reducing the opioid dose to a safer range can be time-consuming, and it requires both a discussion with the patient about the reasons why this reduction is needed and a clear, well-communicated plan for how this will happen. It is not advisable to allow the patient to decide whether to remain on an unsafe opioid doses.
d. In larger practices or in communities, consider establishing a "chronic pain review committee" to review cases where greater than 90 mg MED/day are requested, if other exceptions to the institutional policy are considered, and to review clinical management of difficult cases. This helps support clinicians with responding to challenging patient circumstances and gives good support for peer review, if a patient has an adverse outcome.
e. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. California law permits pharmacists to furnish naloxone without a physician's prescription and be reimbursed under AB 1114. If naloxone is furnished by a pharmacist outside of AB 1114 to a Medi-Cal patient, a presecription is required for the pharmacy to be reimbursed. (Note: naloxone is also now available over-the-counter without need of a prescription, but a prescription is required for Medi-Cal reimbursement.)

E. Routine monitoring of patients on chronic opioid therapy. The following monitoring standards for patients on opioid therapy should be used by all clinicians in ~~PHC~~ Partnership's regions.

1. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
2. ~~Require~~ Consider utilizing a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
3. Partnership recommends clinicians use best clinical judgment and seek consultation (when appropriate) when considering the risks of prescribing opioids to individuals who are using illicit substances, alcohol, marijuana(or derivatives thereof), and/or prescription medications.

F. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone maintenance dosing (e.g. daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

G. Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice. For facts about buprenorphine and important points to review with the patient, see the SAMHSA Buprenorphine Quick Start Guide at https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf. Further education and mentoring are also available through the Provider Clinical Support System (PCSS) at https://pcssnow.org, and the UCSF warmline at https://nccc.ucsf.edu

H. For patients presenting with acute pain who are on buprenorphine or naltrexone treatment for opioid use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals (e.g., CA Bridge Program: https://bridgetotreatment.org/addiction-treatment/ca-bridge/~~https://cabridge.org~~).

I. For all patients with identified **opioid use disorder**, offer initiation of medications for addiction treatment (MAT; e.g., buprenorphine-naloxone, methadone, naltrexone). Example protocols and strategies can be found through CA Bridge website: https://bridgetotreatment.org/addiction-treatment/ca-bridge/~~https://cabridge.org~~.

1. Linkages to community MAT providers can be facilitated through consulting the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment locator (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator), or for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact Carelon Behavioral Health for treatment options: (855) 765-9703. A DEA X-waiver is no longer required for the prescribing of FDA-approved buprenorphine products for the treatment of opioid use disorder, and there are no longer any patient limits associated with this treatment.
2. Patients with OUD commonly use other substances. MAT for OUD should not be withheld solely because the patient is using other substances (i.e., cannabis). Of course, reasonable care should be taken when prescribing buprenorphine, for example, and the patient is also misusing alcohol or sedative-hypnotics, but the co-occurring use of these substances should not preclude the prescribing of buprenorphine for OUD treatment. The FDA has listed these as relative contraindications, not absolute contraindications. (FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks | FDA)

~~I~~J. When opioids are prescribed for the treatment of pain, consider the following:

1. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur. While not mandatory, consider checking CURES even when prescribing Schedule V medications.
3. Schedule at least three office visits yearly for chronic pain patients using opioids.
4. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g., "must last 28 days".) Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply.)
5. Develop an office policy on breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication.
6. Develop an office policy for offering medications for addiction treatment (MAT), and referral for substance use disorder treatment, if appropriate.
7. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.
8. Offer to prescribe naloxone to patients at risk of overdose, or to family members or friends (with consent of the patient) of those who may be at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. Although, California law permits pharmacists to furnish naloxone without a physician's prescription, a prescription or standing order is required for dispensing to Medi-Cal patients in order for the pharmacy to be reimbursed by Medi-Cal. See http://prescribetoprevent.org/ for details.

Intranasal naloxone is available at a pharmacy without a physician's prescription, although Medi-Cal payment requires a prescription.

9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.
10. Medication lock boxes are available through Partnership's Medical Equipment Distribution Services (PMEDS) program.

Examples of a 90 Morphine Dose Equivalent (MED)
(Before use of any comparative dose data for patient use, please refer to listed reference below for dosing calculator)

Drug (Generic Name)	Mg	Low Cost Generic Available?	Brand Name Examples
Morphine (PO) Chronic	90	Yes	MS Contin, Avinza (Long Acting)
Codeine (PO)	600	Yes	
Fentanyl (Transdermal)	37.5mcg/hr	Yes	Duragesic (continuous release patch)
Hydrocodone (PO)	90	Yes	Vicodin, Norco (short acting only)
Hydromorphone (PO)	22.5	Yes	Dilaudid (short acting)
Levorphanol (PO) Chronic	7.5*	Yes	LevoDromoran
Methadone	20	Yes	
Oxycodone (PO)	60	Short Acting: Yes Long Acting: No	OxyContin (long acting)
Oxymorphone (PO)	30	No	Opana, Numorphan (short acting generic available but not low cost)
Tapentadol (PO)	225*	No	Nucynta

http://www.globalrph.com/narcotic.cgi

*https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Community Pharmacy Guidelines

Key Points from Other Guidelines

1. Emergency Departments should
   a. Check a CURES report on every patient who will receive an opioid prescription.
   b. Maximize the use of non-opioid analgesics, and limit the use of opioids in the treatment of acute pain. Exercise reasonable caution in the use of opioids in those individuals with evidence of substance misuse and in adults under the age of 25. Balance this caution, however, against the need to adequately treat pain.
   c. Limit opiate prescriptions to 4 days duration.
   d. Notify the PCP when an opioid is prescribed.
2. Dental Guidelines
   a. Preferentially use NSAIDs instead of opioids for dental pain (opioids are no better than placebo).
3. Community Pharmacies should
   a. Check a CURES report for all new opioid prescriptions.
   b. Notify the PCP if there is a prescription pattern suggesting misuse.
   c. Check the photo ID of any patient picking up an opioid prescription.

d. Counsel patients on the risk of tolerance, addiction, opiate-induced hyperalgesia, and drug overdose.

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The Provider's Clinical Support System (PCSS): https://pcssnow.org

The University of California, San Francisco National Clinician Consultation Center: https://nccc.ucsf.edu

Appendix A

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the right hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R = Total of P + C + R + S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

____ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles Belgrade, Fairview Pain & Palliative Care Center © 2005.

Functional Pain Scale

(developed by Kaiser Health Plan)

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Community Pharmacy Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in ~~14~~ 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community wide guidelines to promote safer use of opioid medications.

A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. Health & Safety Code Section 11153 (a) provides that the responsibility for the proper prescribing and dispensing of controlled substances is upon both the prescribing practitioner AND a corresponding responsibility rests with the pharmacist who fills the prescription.

Community pharmacies play a key role in helping prevent opioid overdoses, opioid-induced hyperalgesia, opioid diversion, and opioid dependence and addiction. They also have legal responsibility to do so. ~~PHC~~ Partnership recommends that all community pharmacies develop policies and standards to fulfill this responsibility. Here are recommended components of this policy:

Recommendations

A. Every pharmacist working at a community pharmacy should have an account to be able to check Controlled Substance Utilization Review and Evaluation System (CURES) reports.

B. Each pharmacy should define the circumstances for checking the CURES report of a patient. Options include:
   1. All patients with a prescription for a controlled drug
   2. New prescriptions for a controlled drug
   3. Patients with behavior suspicious for substance use disorder or diversion. Examples include:
      a. Patient is paying cash for a medication when they have active insurance coverage.
      b. Patient has no active filling history at this pharmacy, but presents a prescription for a controlled medication.
      c. Patient has multiple prescriptions, but only wants to pick up the narcotic.
      d. Patient has a prescription with an unusually high quantity of pain medications.
      e. Patient's doctor's office is not within reasonable distance of the pharmacy.
      f. Subject to professional judgment.
      g. Patient's home address is not within a reasonable distance from the pharmacy or the doctor's office.
      h. Patient looks nervous and tries to hurry the pharmacy staff.

i. Patient is unable to provide a valid ID.
j. Patient presents a story that sounds too suspicious to be true.
k. A significant number of customers appear with prescriptions from the same prescriber and for the same controlled medication.
l. Patient shows "unusual knowledge of controlled substances."

C. If finding in CURES report indicates potential inappropriate use, contact prescriber for appropriate actions. In situations where the prescriber is not the primary care physician (PCP), contact the PCP as well.

D. Pharmacists may have access to information that prescribers may not, and pharmacists should collaborate with prescribers when concerns arise. Consider notifying the patient's primary care clinician or primary prescriber when filling a controlled medication for a patient:
1. If the patient is picking up a prescription written by an Emergency Department clinician, a dental practice, or an out-of-area prescriber.
2. If the patient calls to request early refills.
3. If there are other concerns or questions.

E. Pharmacists should counsel patients picking up opioid prescriptions of the risk of tolerance, addiction, opioid induced hyperalgesia, and overdose.

F. Pharmacists should request photo ID for patients picking up controlled medications from the pharmacy.

G. Pharmacists should not allow cash payments for controlled medications; submit a Prior Authorization Request when indicated.

H. Pharmacy should establish and provide on-site medication disposal. Access to safe disposal of all medications at convenient locations help reduce the chance of accidental overdose or misuse in the community.

I. California law permits pharmacists to furnish naloxone without a physician's prescription and be reimbursed under AB 1114. If naloxone is furnished by a pharmacist outside of AB 1114 to a Medi-Cal patient, a presecription is required for the pharmacy to be reimbursed. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. Intranasal naloxone is available at a pharmacy without a prescription, although a prescription is required for Medi-Cal reimbursement~~payment requires a prescription~~.

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from Other Guidelines

1. According to the Centers for Disease Control (CDC) 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. Require a signed medication use agreement with the prescriber or prescribing office.

4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Schedule at least three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., "must last 28 days".) The 28-day refill, scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

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PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Emergency Department Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in ~~14~~ 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

The emergency department has two key roles in helping with community-wide efforts to control opioid overuse: (1) insuring acute pain is treated in a way that decreases the probability of future over-use of opioids and (2) working closely with primary care clinicians to ensure a coherent, safe approach to treating chronic pain. The emergency department can be a critical access point for members with Substance Use Disorder (SUD). ED personnel should consider screening for SUD and initiating medication-assisted treatment (MAT). See https:/www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf. ~~PHC~~ Partnership recommends the following to achieve these goals:

Recommendations

A. Check a Controlled Substance Utilization Review and Evaluation System (CURES) report on all patients who will receive opioid medications, and also those patients who will receive other Schedule I-IV controlled medications. If there is a discrepancy, consider contacting the relevant pharmacies to confirm information, as occasionally the CURES data is not accurate.

B. Limit opioid prescriptions for Acute Pain to no more than 4 days. Avoid opioids if pain is not severe, and consider non-opioid analgesic options preferentially. If there are risk factors for SUD (e.g., contextual or individual risk factors, such as history of abuse/trauma, personal history of SUD, family history of SUD, poverty, other mental health conditions, family rejection of sexual orientation or gender identity)~~including age 16-45)~~[JD1], carefully consider balancing the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. If opioids are prescribed, use low doses for short courses with all patients.

C. ~~Do not prescribe~~Avoid prescribing opioids for chronic pain not associated with the cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

D. ~~Do not prescribe~~Avoid prescribing opioids for poorly defined pain (e.g., pain not fitting any clinical syndrome after appropriate medical work up).

E. In patients with a suspected or documented history of substance misuse or SUD, take a careful history and after appropriate medical work up; if opioid analgesia is indicated, carefully balance the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. Potential indicators of substance misuse behaviors include:
   1. Patient goes to an emergency room outside of the community they live in (or multiple~~.~~) with suspected aim to secure opioid analgesic medications
   2. Patient paying cash for ED visit.
   3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.
   4. Patient reports that their medications were lost or stolen.
   5. CURES report reveals multiple controlled substance prescribers in multiple locations.
   6. Collateral sources indicate a history of maladaptive behaviors in relation to controlled substances.

F. Refer patient to primary care provider (PCP) instead of prescribing refills of existing opioid medications.

G. If the PCP cannot be contacted to do a refill, limit opioid refills to a 4-day supply maximum.

H. Notify PCP if an opioid prescription is given, especially if it is a refill.

I. Call pharmacy to verify medication history on intoxicated patients.

J. Perform a urine toxicology screen on a patient before prescribing a controlled medication, to be sure the result is consistent with the patient's medication history. Consider a confirmatory test if the results of a tox screen are unexpected, because false positive and negative screening results are common. Ensure that the urine toxicology screen adequately captures the substances of interest (e.g., often urine toxicology screens for "opiates" will not detect fully synthetic opioids such as methadone or fentanyl).

K. Prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)

L. If patients come to the emergency room for severe, breakthrough pain on any regular basis, develop an agreed-upon treatment plan with the Primary Care Physician or usual prescribing outpatient physician to avoid such visits.

M. For patient safety, intramuscular and intravenous opioids should not be administered for chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related pain.

N. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone maintenance dosing (e.g., daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

O. For patients presenting with acute pain who are on buprenorphine-containing products or naltrexone treatment for opioid use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals (e.g., CA Bridge Program: https://bridgetotreatment.org/addiction-treatment/ca-bridge/~~https://cabridge.org~~).

P. For all patients with identified opioid use disorder, offer initiation of medications for addiction treatment (MAT; e.g., buprenorphine-naloxone/buprenorphine, methadone, naltrexone). Example protocols and strategies can be found through CA Bridge website: https://bridgetotreatment.org/addiction-treatment/ca-bridge/~~https://cabridge.org~~.

1. Linkages to community MAT providers can be facilitated through consulting (Substance Abuse and Mental Health Services Administration) SAMHSA Treatment locator (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator), or for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact Carelon Behavioral Health for treatment options: (855) 765-9703. Members~~For patients~~ who reside in counties **other than** Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, or Modoc~~, patients~~ should be referred to their home county's behavioral health access number.

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

1. According to the Centers for Disease Control (CDC) 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. ~~Require~~ Consider a signed medication use agreement with the prescriber or prescribing office, renewed yearly.

4. Regularly check the CURES database in all patients being prescribed opioids at each time a prescription for a controlled substance (Schedule I-IV) is being authorized. Consider checking a CURES report when prescribing Schedule V controlled substances, as well. If a finding on the CURES report is not consistent with patient history, ~~PHC~~ Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Schedule at least three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., "must last 28 days".) The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

7. Offer to prescribe naloxone for all patients being offered opioid prescriptions, of any duration. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See http://prescribetoprevent.org/ for details. Intranasal naloxone is available at a pharmacy without a prescription, but a prescription is required to obtain Medi-Cal coverage for naloxone.

8. If present, consider offering prescribing naloxone for family members, friends, close contacts of those who are at high risk of opioid overdose (e.g., those with a history of opioid overdose.)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

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B. MPCR16 – Lactation Consultant Credentialing Policy
C. MCUG3118 – Prenatal and Perinatal Care
D. MCCP2021 - Women, Infant and Children (WIC) Supplemental Food Program
~~D.~~E. MCNP9006 – Doula Services Benefit

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~~ breastmilk feeding exclusively for about six 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. Partnership HealthPlan of California (PHC) and the American Academy of Pediatrics (AAP) acknowledge ~~breastfeeding~~ breast milk feeding as the preferred method of infant nutrition. Research has demonstrated numerous health benefits of breast milk feeding. Additional to health benefits, breast milk feeding also provides social, economic and environmental benefits for both mother and infant.

B. Promotion and Support of Breast Milk feeding

1. Lactation Education and Support Services: Each ~~PHC~~ Partnership county has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support and provision of breast pumps, for low income ~~women~~persons, including those with Medi-Cal. All pregnant and post partum members should be referred to WIC. Lactation support for ~~PHC~~

Partnership members is a shared goal and responsibility of WIC and the health delivery system provided through ~~PHC~~Partnership, by the following providers and support services:

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 and post partum ~~patients~~ members to ~~prenatal~~ breastfeeding breast milk feeding classes during and after pregnancy will ensure they have current evidence based information about breast milk feeding.

b. Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breast milk ~~f~~eeding 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 breast milk feeding should be ongoing. The pregnant members and their partners should be referred to a breast milk feeding class antenatally and have access to one on one breast milk feeding education prenatally and postnatally. This is especially important for members in their first pregnancy ~~who are first time mothers or~~ who have not breastfed in the past.

c. Comprehensive Perinatal Service Programs (CPSP) and Partnership Health Perinatal Serivces Programs: ~~PHC~~ Partnership strongly supports having all pregnant members receive support services provided though Perintatal Services ~~CPSP~~ providers, which provide comprehensive assessments as part of their total prenatal care. CPSP/Perinatal Services Providers ~~providers~~ may provide their own lactation support services or refer to other community resources to provide breast milk feeding promotion, education and counseling.

~~c.~~d. Doulas offer various types of support, including lactation support. For more details, refer to Partnership policy MCNP9006 Doula Services Benefit.

~~d.~~e. ~~PHC~~ Partnersip Population Health: Through specific programs and general case management support, Partnership Population Health supports breastfeeding in accordance with current guidelines and evidence-based practices. Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breast milk feeding when wanted.~~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.~~f. Postpartum follow-up calls are made to ~~PHC~~ Partnership members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation or newborn feeding assistance, support, education and information.

~~f.~~g. 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/documents/baby-friendly-hospital-initiative) 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~~ birthing person 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 breast milk feeding 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~~ Lactating persons 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 to manage common difficulties during the hospital stay.
5) Supplements such as water, glucose water or formula should not be given to breast milk feeding newborns unless there is an order from the Health Care Provider.
~~5)~~ Parents should be counseled on the risks associated with bottles and pacifiers.
6) Coordinate discharge to ensure parents and infants have access to ongoing breast milk feeding care and support.
~~6)~~ a.)Discharge planning includes ~~the assessment of the need~~ consideration of arrangements that include ~~for~~ follow-up with WIC, a peer counselor, the infant care office, an International Board of Lactation Consultant Examiner (IBCLC), or a home health or public health nurse visit specifically to assist the ~~mother~~ member with breast milk feeding. Whenever possible this should occur within 1-2 calendar days of discharge.
7) The Birth Facility should provide lactating ~~mother~~ patients ~~erson should leavees the hospital with a~~ list of resources for support and assistance with breast milk feeding, including ~~-~~information on how to tell if ~~her~~ the baby is getting enough milk, and referral to ~~a~~ breast milk feeding support resources. ~~group~~.

~~g.~~h. Infant care providers should encourage exclusive breast milk feeding per AAP recommendations. Infant care providers should consider referral to a lactation counselor / educator, certified ~~qualified~~ lactation consultant, doula, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of breast milk feeding ~~lactation~~. Providers need to consider the ~~mother's~~ lactating person's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the ~~mother~~ lactating parent may ~~need to~~ be provided with a breast pump and instructions on how to use it to ~~maintain her~~ milk supply.

~~h.~~i. 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~~parent-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 postpartum periods (from 84 calendar days to 365 calendar days post-delivery). Lactation visits independent of the standard postpartum visits are covered by ~~PHC~~Partnership.
3. Providers of Lactation support services:
   a. Basic Lactation support services may be provided in a provider office by a medical professional as follows: Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).
   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 e~~E~~ducators, lactation counselors, and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision

of a ~~PHC~~ Partnership contracted ~~Physician~~ licensed medical professional (Physician, NP, PA, CNM, LM) or ~~PHC~~ Partnership credentialed IBCLC.

d. Doulas may provide prenatal, peripartum and post partum education and support.

~~e.~~

4. Breast Pumps: When breastfeeding is interrupted or discontinued, the use of Breast Pumps and alternative feeding fluids may be necessary. If the lactating parent ~~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~~ Partnership 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:
   ACA http://www.investopedia.com/terms/a/affordable-care-act.asp (updated Sept. 23, 2022)
2. CPSP http://cchealth.org/services/perinatal/
3. FQHC https://www.cms.gov/mlnproducts/downloads/fqhcfactsheet.pdf (updated October 2022)
4. Bilitool www.bilitool.org
5. ~~Medications in Mothers Milk 2021, Hale, T, Hale Publishing, L.P.~~Hales's Medications & Mothers' Milk 2023, A Manual of Lactational Pharmacology, 20th Ed., Springer Publishing
6. Breastfeeding ANSWERS Made Simple – A Guide for Helping Mothers, Mohrbacher, N., ~~2012~~ 2020, Second Edition Hale Publishing, L.P. (PDF digital edition available)
7. Red Book: 2021-2024 Report of the Committee on Infectious Disease, 32nd Edition, American Academy of Pediatrics, January 2021

VII. REFERENCES:

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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_Breastfeedling_Toolkit_2012.pdf~~California Department of Public Health: Women, Infants & Children (WIC) 2023 Toolkit

E. Department of Health and Human Services/Center for Medicaid and CHIP Services
F. Medicaid Coverage of Lactation Services. CMS Bulletin
G. U.S. Preventive Services Task Force (USPSTF), Recommendation: Breastfeeding: ~~Primary Care~~ Interventions (~~Oct. 25, 2016~~July 7, 2022)
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions

VIII. DISTRIBUTION:
A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership 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; 08/11/21; 08/10/22; 08/09/23; 08/14/24

*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

PartnershipAdvantage
MPXG5009 – 01/15/2014 to 01/01/2015

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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~~e.~~f. Postpartum follow-up calls are made to ~~PHC~~ Partnership members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation or newborn feeding assistance, support, education and information.

~~f.~~g. 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/documents/baby-friendly-hospital-initiative) 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~~ birthing person 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 breast milk feeding 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~~ Lactating persons 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 to manage common difficulties during the hospital stay.
5) Supplements such as water, glucose water or formula should not be given to breast milk feeding newborns unless there is an order from the Health Care Provider.
~~5)~~ Parents should be counseled on the risks associated with bottles and pacifiers.
6) Coordinate discharge to ensure parents and infants have access to ongoing breast milk feeding care and support.
~~6)~~ a.)Discharge planning includes ~~the assessment of the need~~ consideration of arrangements that include ~~for~~ follow-up with WIC, a peer counselor, the infant care office, an International Board of Lactation Consultant Examiner (IBCLC), or a home health or public health nurse visit specifically to assist the ~~mother~~ member with breast milk feeding. Whenever possible this should occur within 1-2 calendar days of discharge.
7) The Birth Facility should provide lactating ~~mother~~ patients ~~erson should leavees the hospital with a~~ list of resources for support and assistance with breast milk feeding, including ~~-~~information on how to tell if ~~her~~ the baby is getting enough milk, and referral to ~~a~~ breast milk feeding support resources. ~~group~~.

~~g.~~h. Infant care providers should encourage exclusive breast milk feeding per AAP recommendations. Infant care providers should consider referral to a lactation counselor / educator, certified ~~qualified~~ lactation consultant, doula, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of breast milk feeding ~~lactation~~. Providers need to consider the ~~mother's~~ lactating person's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the ~~mother~~ lactating parent may ~~need to~~ be provided with a breast pump and instructions on how to use it to ~~maintain her~~ milk supply.

~~h.~~i. 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~~parent-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 postpartum periods (from 84 calendar days to 365 calendar days post-delivery). Lactation visits independent of the standard postpartum visits are covered by ~~PHC~~Partnership.
3. Providers of Lactation support services:
   a. Basic Lactation support services may be provided in a provider office by a medical professional as follows: Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).
   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 e~~E~~ducators, lactation counselors, and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision

of a ~~PHC~~ Partnership contracted ~~Physician~~ licensed medical professional (Physician, NP, PA, CNM, LM) or ~~PHC~~ Partnership credentialed IBCLC.

d. Doulas may provide prenatal, peripartum and post partum education and support.

~~e.~~

4. Breast Pumps: When breastfeeding is interrupted or discontinued, the use of Breast Pumps and alternative feeding fluids may be necessary. If the lactating parent ~~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~~ Partnership 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:
   ACA http://www.investopedia.com/terms/a/affordable-care-act.asp (updated Sept. 23, 2022)
2. CPSP http://cchealth.org/services/perinatal/
3. FQHC https://www.cms.gov/mlnproducts/downloads/fqhcfactsheet.pdf (updated October 2022)
4. Bilitool www.bilitool.org
5. ~~Medications in Mothers Milk 2021, Hale, T, Hale Publishing, L.P.~~Hales's Medications & Mothers' Milk 2023, A Manual of Lactational Pharmacology, 20th Ed., Springer Publishing
6. Breastfeeding ANSWERS Made Simple – A Guide for Helping Mothers, Mohrbacher, N., ~~2012~~ 2020, Second Edition Hale Publishing, L.P. (PDF digital edition available)
7. Red Book: 2021-2024 Report of the Committee on Infectious Disease, 32nd Edition, American Academy of Pediatrics, January 2021

VII. REFERENCES:

A. American Academy of Pediatrics, Clinical Practice Guideline. https://pediatrics.aappublications.org/content/pediatrics/129/3/3827.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. http://www.calwic.org/storage/documents/bf/2012/Ramping_up_for_Reform-~~

~~WIC_Breastfeedling_Toolkit_2012.pdf~~California Department of Public Health: Women, Infants & Children (WIC) 2023 Toolkit

E. Department of Health and Human Services/Center for Medicaid and CHIP Services
F. Medicaid Coverage of Lactation Services. CMS Bulletin
G. U.S. Preventive Services Task Force (USPSTF), Recommendation: Breastfeeding: ~~Primary Care~~ Interventions (~~Oct. 25, 2016~~July 7, 2022)
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breastfeeding-primary-care-interventions

VIII. DISTRIBUTION:
A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership 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; 08/11/21; 08/10/22; 08/09/23; 08/14/24

*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

PartnershipAdvantage
MPXG5009 – 01/15/2014 to 01/01/2015

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PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

A. **Acupuncture** *(see policy MCUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)

C. **Cardiac Rehabilitation** – Phase II and pediatric *(see policy MCUP3128 Cardiac Rehabilitation)*

D. **Chiropractic Services** *(see policy MCUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MCCP2033 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

G. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

H. **Diagnostic Studies**
1. CT Scans: TARs are required for all CT scans for Members under age 21 years. For adults age 21 years and older, TARs are required for CT scans of the chest, abdomen, and/or pelvis. *No TARs are required for other CT scans of the extremities, head, neck, or spine, or for screening CT colonograms - effective 7/1/2024*
2. MRI: TARs are required for all MRIs for Members under age 21 years. For adults age 21 years and older, TARs are required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis. *No TARs are required for other MRI scans of the extremities, head, neck, or spine, or for breast MRIs - effective 7/1/2024*
3. MRA (MR Angiogram)
4. MSI
5. MEG
6. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
7. Transcranial Doppler
8. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
9. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)
1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy*

MCUG3032 Orthotic and Prosthetic Appliances Guidelines)

2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MCUG3019 Hearing Aid Guidelines*)
4. 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)
5. Oxygen and related supplies - No TAR is required for CPAP supplies for a CPAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
6. 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)
7. 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.)
8. Purchase of any wheelchairs for Medi-Medi members
9. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MCUP3136 Fecal Microbiota Transplant)*

N. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

O. **Genetic Testing and Screening** – A TAR is required for certain genetic testing and screening as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

P. **Home Health Care** *(see policy MCUG3011 Criteria for Home Health Services)*

Q. **Home Infusion Therapy**

R. **Hysterectomy**

S. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

T. **Hospitalization**
1. The hospital must notify Partnership of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician prior to the admission.

U. **Hyperbaric Oxygen Pressurization**

V. **Long Term Care**
The LTC facilities must notify Partnership of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits/ hospice election.) *See policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities.*

W. **Medical Supplies***
1. Nebulizers – When the billed price including tax is $200 or more *(see policy MPUG3031 Nebulizer Guidelines*)
2. Ostomy Supplies+ (Note: NU modifier may not be used for "disposable" ostomy supplies)
3. Urological Supplies+ (Note: NU modifier may not be used for "disposable" urological supplies)
4. Tracheostomy Supplies+
5. Wound Care Supplies+ TAR requirements may vary.
6. Negative Pressure Wound Therapy Devices [*see policy MPUP3059 Negative Pressure Wound Therapy (NPWT) Device/Pump]*
~~6.~~7. Nutritional Supplements - *(see policy MCUP3052 Medical Nutrition Services*) Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership's medical benefit and is not included in Partnership's Medical Drug List (MDL) Navigator, or when the Partnership MDL indicates a prior authorization is required. Nutritional supplements provided by a Pharmacy must be submitted through Medi-Cal Rx TAR processes* when not on the Medi-Cal Rx Contract Drugs List (CDL). Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*
+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:** Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

Z. **Non-Emergency Medical Transportation:** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

AA. **Occupational ~~-~~Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership M~~m~~embers under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

~~AA.~~BB. **Outpatient Hemo / Peritoneal Dialysis** Initial authorization will be limited to 90 days and a lifetime authorization may be granted with annual certification, only after submission of Medicare determination.)

~~BB.~~CC. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 5)

~~CC.~~DD. **Pain Management** – see **Pain Management CPTs Requiring TAR** list (page 8) and policy *MCUP3049 Pain Management Specialty Services*

~~DD.~~EE. **Phototherapy** for dermatological condition

~~EE.~~FF. **Physical Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership M~~m~~embers under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

~~FF.~~GG. **Pulmonary Rehabilitation** *(see policy MCUP3111 Pulmonary Rehabilitation)*

HH. **Speech Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership members age 21 and over can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for ST services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

~~GG.~~II. **Transplants** (*see policy MCUP3104 Transplant Authorization Process)*

~~HH.~~JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
~~28291,~~ 28292, 28296, 28297, ~~2829~~28298, 28299,	Correction Of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC ‘s
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62290 thru 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685,	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
22510 thru 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy, percutaneous laser discectomy)
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62360 thru 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63661 thru 63664, 63685, 63688	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3013 (previously UP100313)</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Durable Medical Equipment (DME) Authorization</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="3">Next Review Date: ~~04/10/2025~~08/14/2025
Last Review Date: ~~04/10/2024~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~04/10/2024~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
D. MCUG3134 – Hospital Bed/ Specialty Mattress Guidelines
E. MCUP3039 – Direct Members

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the M~~m~~ember's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see ~~PHC~~Partnership network providers and/or ~~-~~certified Medi-Cal providers willing to bill ~~PHC~~Partnership for covered services. However, many specialists still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
B. DME: Durable Medical Equipment
C. Medical Necessity: 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.
D. MTU: Medical Therapy Unit - Outpatient clinics located in designated public schools where Medical Therapy Program (MTP) services are provided.
E. MTP: Medical Therapy Program – A special program within California Children's Services (CCS) that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. Services are provided at Medical Therapy Units (MTUs).
F. RAF: Referral Authorization Form
G. TAR: Treatment Authorization Request

IV. ATTACHMENTS:

A. DME Rental Only
B. DME Limited to Special Circumstances

C. Oxygen O_2 Request Verification Form
D. Certificate of Medical Necessity for all Durable Medical Equipment (DME)
E. MTU DME Review Process and Example Form

V. PURPOSE:

To describe the process of authorizing durable medical equipment (DME) for Partnership HealthPlan of California (~~PHC~~Partnership) Mmembers.

VI. POLICY / PROCEDURE:

A. ~~PHC~~Partnership covers certain durable medical equipment when prescribed by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist).
   1. ~~PHC~~Partnership will authorize items of DME in accordance with this policy and ~~PHC~~Partnership's MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process policy, as well as Title 22, Medi Cal Provider Bulletins and InterQual® Criteria to meet the M~~m~~ember's needs for medically necessary equipment. These needs are limited to services or devices necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain.
   2. ~~PHC~~Partnership covers durable medical equipment that is the lowest cost to meet the patient's medical needs.

B. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription for rental or purchase must clearly contain the following information:
   1. Full name, address and telephone number of the prescribing provider
   2. Date of prescription (must be current - written within one year of today's date)
   3. Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.
   4. Medical condition necessitating the particular DME item
   5. Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")

C. ~~PHC~~Partnership Health Services Department will refer to DHCS Medi-Cal Guidelines sections for Durable Medical Equipment including DME: Billing Codes *(dura cd)* and DME: Other DME Equipment (*dura other*) to determine which items may be rented and/or purchased. Attachment A summarizes "DME Rental Only" items.
   1. ~~PHC~~Partnership follows the guidelines as set forth in Title 22 Div 3 Sub 1 Chap 3 Article 3 51224.5 that when previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and NO FURTHER reimbursement to the provider shall be made for the beneficiary's use of the item UNLESS repair and maintenance is separately authorized.
   2. Ten months of rental is equal to purchase unless otherwise noted in DHCS guidelines/Attachment A.
   3. Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
   4. For codes that are available for both purchase and rental, if the rental costs exceed purchase, then the provider should be purchasing rather than renting

D. Refer to Attachment B "DME Limited to Special Circumstances" for a list of items that are authorized for specific categories of M~~m~~embers.

E. Modifications of Equipment – If a piece of equipment is provided to a M~~m~~ember whose medical condition has not changed since the time the equipment was provided, and the item does not meet the patient's needs when in actual use, then the provider is responsible for adjusting or modifying the equipment as necessary to meet the patient's medical needs.

F. DME for Disabled Parent - DME items may be covered to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian.
   1. The recipient's need for DME items must be reviewed annually by a physician.
   2. DME items cannot include common household items such as strollers, wraps, slings, or soft-structured carriers.
   3. A TAR is required for DME for a disabled parent, stepparent, foster parent, or legal guardian. The following documentation must be submitted with each TAR:
      a. A prescription from the physician for the specific DME item, and
      b. Documentation from the parent's/guardian's physician, nurse practitioner, clinical nurse specialist or physician assistant of the parent's/guardian's medical disability that justifies the need for the DME item.
   4. Claims for DME for a disabled parent, stepparent, foster parent, or legal guardian must be submitted using HCPCS code A9999, ICD-10 code Z73.6 (Limitation of activities due to disability) and modifier SC (medically necessary service/supply).

G. Specific Equipment Requirements
   1. Augmentative and Alternative Communication Devices – ~~PHC~~Partnership considers authorization for Augmentative and Alternative Communication (AAC) Devices as a benefit for eligible M~~m~~embers with speech, language and hearing disorders if the following conditions have been met:
      a. The request must be accompanied by an assessment acceptable to ~~PHC~~Partnership, conducted by a licensed speech and language pathologist.
      b. Additional assessments will be considered from other appropriately licensed providers, such as physical or occupational therapists, if the M~~m~~ember has physical limitations which could impact his/her ability to use the AAC device.
      c. A signed prescription from the M~~m~~ember's physician must accompany the request.
      d. The ~~PHC~~Partnership Chief Medical Officer or physician designee will apply current Medi-Cal criteria when making a determination.
   2. Bathroom Equipment must be ordered by the M~~m~~ember's PCP or specialist treating the M~~m~~ember through a referral from the PCP. For Direct Members, the bathroom equipment must be ordered by the physician currently managing the medical care for the M~~m~~ember.
      a. The following types of bathroom equipment are covered by ~~PHC~~Partnership provided that medical necessity has been demonstrated. (Note that DME items are covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability, but not necessarily to restore the M~~m~~ember to previous function.)
         1) Toilet rail or armrest
         2) Raised toilet seat
         3) Tub stool, bench or bath seat
         4) Bathtub safety rail or grab bars
         5) Transfer tub bench
         6) Commode (bedside)
      b. The TAR for bathroom equipment must include documentation of medical necessity for use of the device that includes the following information related to the condition:
         1) Length of time M~~m~~ember has been or will be needing the equipment
         2) Assessment of mental status
         3) Evaluation of functional abilities including assessment of body strength/mobility
         4) Information concerning the M~~m~~ember's ability to properly use the bathroom equipment
   3. Defibrillator Vests – ~~PHC~~Partnership reviews authorization requests for defibrillator vests on a case-by-case basis based on InterQual® criteria.
   4. Enuresis Alarm Pads – ~~PHC~~Partnership will cover one enuresis alarm pad per lifetime with no TAR requirement. Outside of this frequency, a TAR is required.

5. Home Oxygen Therapy – ~~PHC~~Partnership reviews authorization requests for home oxygen therapy based on the criteria as stated in Attachment C of this policy – "Oxygen (O_2) Request Verification Form." Please submit form with TAR.
6. Infant Monitor Guidelines
   a. The monitor must be ordered by the PCP or by a specialist who is treating the M~~m~~ember through a referral from the PCP. For Direct Members, the monitor must be ordered by the physician who is currently managing the medical care for the M~~m~~ember.
   b. A monitor can be ordered for a M~~m~~ember who has a history of bradycardia or apnea.
   c. The TAR must include documentation of medical necessity for use of the monitor that includes the following information related to the condition:
      1) Length of time M~~m~~ember needs the monitor
      2) Description of the history of the condition
   d. Infant monitors are generally authorized until the baby reaches 46 weeks post-conceptual age. Extension beyond this age requires submission of clinical justification.
   e. For all requests, the individual needs of the M~~m~~ember and the characteristics of the delivery system are considered in the authorization process. The general criteria for authorization of monitors are as follows:
      1) Documented apneic spells defined as a cessation of breathing for 20 seconds or longer or a shorter pause accompanied by bradycardia (<100 beats per minute), cyanosis, or pallor
      2) Significant apnea or bradycardia requiring infant stimulation
      3) Frequent periods of apnea and/or bradycardia
   f. The TAR for an infant monitor should include information concerning the caretaker's ability to properly use the monitor.
   g. TARs are typically authorized for rental only. If medical necessity is demonstrated, authorization for purchase may be approved.
7. Knee Scooters require a TAR and may be billed with code E0118 under the following guidelines:
   a. Knee scooters may be billed when a M~~m~~ember is expected to be non-weight bearing for 3 weeks or longer and one of the following criteria are met:
      1) Member has fracture, dislocation, tendon rupture or surgery which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. The M~~m~~ember is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      2) Member has an ulcer or infection which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      3) Member has a neurologic or musculoskeletal condition which makes him/her unable to effectively or safely bear weight on one foot. The knee scooter will greatly increase this person's ability to function independently.
   b. Wheelchairs will not be authorized in conjunction with knee scooters.
   c. The resale of the knee scooter is prohibited. ~~PHC~~Partnership recommends the equipment be donated to a charitable organization when no longer in use.
8. Pediatric Adaptive Equipment – Requests for pediatric adaptive equipment (e.g. specialty strollers, adaptive car seats, floor sitters/activity chairs, stair climbers, etc.) will be reviewed on a case by case basis using criteria described in CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) *08/08/2003*. For M~~m~~embers enrolled in the Medical Therapy Program, medical appropriateness of devices and/or equipment will be determined and recommended by the Medical Therapy Unit providing services. The MTU must submit a TAR with an MTU DME form and all required information as per the process described in Attachment E - MTU DME Review

Process and Example Form.

9. Portable ramps are a covered benefit under ~~PHC~~Partnership. Prior authorization is required.
   a. Portable ramps are those that meet the following conditions:
      1) Foldable or collapsible
      2) Not attached
      3) Suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations.
   b. Ramps are not considered portable when they are fixed or modular or in any way attached. Non-portable ramps are not a Medi-Cal benefit.
   c. Criteria for authorization are as follows:
      1) The M~~m~~ember utilizes a manual or power wheelchair for home and/or community access (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components).
      2) Access to variable height surfaces at home, to a vehicle, and in the community is needed.
      3) The weight of the M~~m~~ember and wheelchair does not exceed the manufacturer's recommended weight limit for the ramp.
      4) Caretaker / M~~m~~ember must demonstrate the ability to safely use the ramp.
      5) Based on the M~~m~~ember's needs, the portable ramp is safer and more efficacious than permanent structural modifications to the M~~m~~ember's residence.
         a) ~~PHC~~Partnership reimburses for a maximum of one vehicle ramp and one home access ramp. If the ramp is needed for employment, the benefit is to be provided through the Department of Rehabilitation.
   d. If the Treatment Authorization Request (TAR) includes all information required, the request is reviewed by a ~~PHC~~Partnership Nurse Coordinator (and the Chief Medical Officer or physician designee if needed.) If the medical necessity of the request is uncertain or questionable, all information is sent to an independent consultant with expertise in the area of the equipment requested. The consultant evaluates all information and may schedule an appointment with the M~~m~~ember, perform an independent evaluation of the request and submit a report to ~~PHC~~Partnership with recommendations as to the medical appropriateness of the request.
10. Tumor Treating Field Devices – ~~PHC~~Partnership reviews authorization requests for tumor treating field devices (electrical stimulation devices used for cancer treatment) on a case-by-case basis based on Medi-Cal criteria. Initial TARs are approved for 3 months rental. Re-authorization may be granted when all of the following criteria are met:
    a. A magnetic resonance imaging (MRI) scan has been performed not more than 2 months prior to date of renewal request and documents no evidence of disease progression, and
    b. The Karnofsky Performance Status score is 60 or higher, and
    c. The patient has been wearing the device at least 18 hours daily.
10. Ventilators – ~~PHC~~Partnership reviews authorization requests for non-invasive ventilators on a case-by-case basis based on InterQual criteria. Initial TARs are approved for 3 months rental. Reauthorizations can be approved in up to 12 month increments. Authorization requests for invasive ventilators are reviewed on a case by case basis based on Medi-Cal criteria.
11. Dynamic Splinting
    a. ~~PHC~~Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case by case basis. Authorizations may be approved as follows:
       1) Pre-operatively: As an adjunct to physical therapy for a M~~m~~ember having surgery to correct knee joint stillness or a contracture due to a previous injury or surgery to the knee.
       2) Post-operatively: As an adjunct to physical therapy if there is documentation of joint stiffness or contracture causing functional limitation of range of motion in the subacute post-operative period defined as > 3 weeks and up to 4 months after surgery.
    b. Dynamic splinting is not considered medically necessary for the following:

1) Pre-operative request unless the surgery is to correct knee joint stiffness or contraction due to previous injury or surgery
2) No evidence of knee contracture or stiffness in the subacute post-operative period
3) Chronic joint stiffness or fixed contractures
4) No significant improvement to the joint after 4 months of use

G. Reauthorization
1. All authorizations which may recur are subject to the following requirements:
   a. Assessment and demonstration of continued need for treatment/service
   b. Reevaluation of plan of treatment, appropriateness of level care and physician orders
   c. Documentation of patient compliance with treatment/service

H. Non Covered Items - The following DME items are not included as Medi-Cal or ~~PHC~~Partnership benefits:
1. Books or other items of a primarily educational nature
2. Air conditioners/air filters or heaters
3. Food blenders
4. Reading lamps or other lighting equipment
5. Bicycles, tricycles or other exercise equipment
6. Television sets
7. Orthopedic mattresses, recliners, recliners with lift system, rockers, seat lift chairs or other furniture items
8. Waterbeds
9. Household items
10. Modifications of automobile or other highway motor vehicles
11. Other items not used primarily for health care and which are regularly and primarily used by persons who do not have a specific medical need for them

I. Monitoring of DME Authorizations
1. A periodic random sample of authorization requests for DME may be audited by the Utilization Management (UM) staff or Chief Medical Officer or physician designee for appropriateness and accuracy. Medical record audits may also include survey for proper use and documentation of DME.

J. ~~PHC~~Partnership Medical Equipment Distribution Services (PMEDS) Program
1. Members may be able to obtain certain medical devices that do not require a TAR through the ~~PHC~~Partnership Medical Equipment Distribution Services (PMEDS) program when ~~they meet medical criteria and~~ their Provider submits a request form on their behalf. The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Form~~s~~ and information can be found on the ~~PHC~~Partnership website at ~~www.partnershiphp.org in the Provider Section. Keywords: Medical Equipment Distribution Services Request Form~~ https://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx

VII. REFERENCES:

A. Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME): Overview (*dura*), Billing Codes *(dura cd),* Billing Codes: Frequency Limits *(dura cd fre)*, Other DME Equipment (*dura other*) and Oxygen and Respiratory Equipment (*dura oxy*); Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Orthotics (*ortho auth ortho*)
B. DHCS All Plan Letter (APL) 15-018 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
C. Title 22 California Code of Regulations (CCR) Div 3 Sub 1 Chap 3 Article 3 51224.5
D. InterQual Criteria®

E. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
F. CCS Numbered Letter (N.L.) 02-0107 Authorization of Rental of Portable Home Ventilators (01/05/2007)

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 03/23/95; 10/10/97 (name change only); 02/09/00; 05/17/00; 09/19/01; 09/18/02; 10/15/03; 02/18/04; 10/20/04; 10/19/05; 08/16/06; 04/16/08; 07/15/09; 07/21/10; 06/20/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/12/18; 04/10/19; 05/13/20; 09/09/20; 08/11/21; 08/10/22; 01/11/23; 04/10/24; 08/14/24

*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:
MCUG3008 Bathroom Equipment Guidelines was Archived 01/11/2023
MCUG3023 Infant Monitor Guidelines was Archived 01/11/2023

****

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~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

DME RENTAL ONLY

Decubitus Care Equipment

E0202	Phototherapy (bilirubin) light with photometer (daily rental)

Oxygen and Related Equipment

E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask and tubing
E0431 *	Portable Gas Oxygen
E0433 *	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434 *	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439*	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0465 *	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
E0466 *	Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)
E0467*	Home ventilator; multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions.
E0481	Intrapulmonary percussive ventilation system and related accessories. This code is reimbursable only for repairs to patient-owned equipment
E0482	Cough stimulating device, alternating positive and negative airway pressure
E0483	High frequency chest wall oscillation air-pulse generator system, includes all accessories and supplies
E1390*	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1391*	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate
E1392*	Portable oxygen concentrator, rental
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing)

*Rental Only without a 10-month limit. (See MCUP3013 VI.C. for further information on DME rental limits)

DME RENTAL ONLY

Traction and Trapeze Equipment

E0935	Continuous passive motion exercise device for use on knee only (daily rental)
E0936	Continuous passive motion exercise device for use other than knee (daily rental)

Miscellaneous

E0604	Breast Pump, heavy duty, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.
E0720	TENS device, two lead, localized stimulation [+]
E0730	TENS device, four or more leads, for multiple nerve stimulation [+]
	[+]*Partnership does not require prior authorization for TENs units unless the request is outside of the allowable frequency limits per DHCS Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME) Billing Codes: Frequency Limits (dura cd fre)*
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type must be billed with modifier RR (rental) and KF
E2402	Negative pressure wound therapy electrical pump, stationary or portable (daily rental)
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0743	Suction pump, home model, portable, for use on wounds (modifier RR)

Rental Period

- Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
- Ten months rental is equal to purchase except as noted above by *.

DME LIMITED TO SPECIAL CIRCUMSTANCES

All lymphedema pumps/compression devices (codes as noted below) require authorization and evidence of meeting medical criteria as stated in the Durable Medical Equipment (DME): Other DME Equipment section of the DHCS Medi-Cal guidelines:

HCPCS codes E0650, E0651, E0652, E0655, E0656, ~~thru~~ E0657, E0660, E0665, E0666, E0667, E0668, ~~thru~~ E0669, E0670, E0671, E0672, ~~thru~~ E0673, E0675, E0676, E0678, E0679, E0680, E0681, ~~thru~~ E0682

Limited to recipients OVER age 12 (Any request for M~~m~~embers aged 12 and under will require review for medical necessity)

Cervical Traction Device

E0840	Traction frame, attached to headboard, cervical traction
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, free standing, cervical traction
E0860	Traction equipment, overdoor, cervical

Limited to CCS ONLY

A4606	Oximeter replacement probe
E0635	Electric patient lift
E0639	Movable patient lift

Limited to Recipients Who Are Disabled Parents, Stepparents, Foster Parents, or Legal Guardians

Please see section VI.F. of this policy MCUP3013 DME Authorization

Items Requiring Initial Rental Prior to ~~PHC~~Partnership's Consideration for Purchase

Hospital Beds
Manual Wheelchairs
Continuous Positive Airway Pressure (CPAP)
Bi-Level Positive Airway Pressure (Bi-PAP)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Oxygen (O_2) REQUEST VERIFICATION FORM

Please attach patient reports verifying this information and document activity level and/or sleep during the exam.

Member Name: _____ PHC ID Number (CIN):_____

Date of Birth: _____ Physician: _____

1. What is the diagnosis for which the Oxygen is requested? _____

2. Date of O_2 Saturation test: _____

3. Is the O_2 request

Continuous use? _____

Supplemental use with activity? _____

Nocturnal use? _____

	YES	NO
4. <u>For Continuous Requests:</u>		
Is the Oxygen Saturation <89% awake and at rest? (*Testing must show that this is the usual resting saturation for the patient*.)	____	____
5. <u>For Supplemental Requests:</u>		
Is the Oxygen Saturation <89% during the 6-minute walk test? (*Testing must show that the patient has an Oxygen Saturation over 89% at rest that drops to under this value with exercise*.)	____	____
6. <u>For Nocturnal Requests:</u>		
Is Oxygen Saturation <89% for at least 5 minutes during sleep? (*Testing must show that during sleep there is at least one continuous period of Oxygen Saturation <89% for at least 5 minutes. Cases where there are frequent drops of Oxygen Saturation to <89% but not in a continuous 5 minute period will be reviewed individually*.)	____	____

I have reviewed and concur with this information._____

Requesting Physician Signature/Please Also Print Name

State of California - Health and Human Services Agency

Department of Health Care Services

CERTIFICATE OF MEDICAL NECESSITY FOR ALL DURABLE MEDICAL EQUIPMENT (DME)

(EXCEPT WHEELCHAIRS AND SCOOTERS)

The provider must complete all applicable areas not completed by the clinician or therapist.

Dear Clinician/DME Provider: Cooperation in completing this form will ensure that the beneficiary receives full Medi-Cal consideration regarding the request for Durable Medical Equipment. Medi-Cal reimbursement is based on the least expensive medically appropriate equipment that meets the patient's medical need.

Incomplete information will result in a deferral, denial or delay in payment of the claim.

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

Clinician Name *(Print)* Last	First	Phone Number ( )	License Number

Address Street	City	State	ZIP

Clinician's description of the patient's current functional status and need for the requested equipment: _____

SECTION 2—Patient's Information: New Rx *(For Rx Renewal, please also complete 2A below)*

Patient Name *(Print)* Last	First	Phone Number ( )	Date of Birth mm / dd / yy	Medi-Cal Number

Address Street	City	State	ZIP

Date of last face-to-face visit with the beneficiary: _____

Is this beneficiary expected to be institutionalized within the next 10 months? Yes ❒ No ❒ Explain "Yes" answer: _____

Equipment required for:

❒ Less than 10 months *(code the TAR for a rental)*

❒ More than 10 months *(code the TAR for a purchase)*

SECTION 2A—For Renewal:

Verification of continued medical necessity and continued usage by the beneficiary must be done at each TAR renewal.

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

c) Replacing existing equiment? Yes ❒ No ❒ If yes, explain why: _____

d) Attach repair estimate if replacement with similar equipment is requested.

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

i) Other equipment currently in the home: Cane ❒ Walker ❒ Crutches ❒ Prosthesis ❒ Manual Wheelchair ❒ Power Wheelchair ❒ Hospital Bed ❒ Oxygen ❒ POV (scooter) ❒ Other: _____

j) Patient currently using the following equipment: _____

k) When/How often: _____

l) State specific reason for accessories requested: _____

SECTION 4—Diagnosis Information

Diagnoses: _____ Date of onset: _____

Prognosis: _____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

Beneficiary's height: _____ Beneficiary's weight: _____

a) Ambulation: Independent ❒ Walker/Cane ❒ Assisted ❒ Unassisted ❒ Unable ❒ Bed confined ❒
Recent fall(s) ❒ Dizziness/Vertigo ❒ Incoordination ❒ Ataxia ❒ Severe shortness of breath ❒

b) Transfer: Self ❒ Self, but with great dificulty ❒ Self with a transfer device ❒
Stand by assistant ❒ With assistance ❒ Mechanical or person lift ❒

c) Pertinent physical findings: Edema (location):
Pressure sore(s), state and location: Amputee ❒ Cast ❒ Ataxia ❒

Paralysis/weakness (location): _____ Sitting Posture/Deformity: _____

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

House/condominium ❒ Apartment ❒ Stairs ❒ Elevator ❒ Ramp ❒ Hills ❒ SNF ❒ ICF/DD ❒ B&C ❒

Other: _____

Living Assistance: Lives alone ❒ With other person(s) ❒ Alone most of the day ❒ Alone at night ❒

Attendant care: Live in attendant ❒ or _____ Hours/day Homemaker ❒ Hours _____

Transportation:

SECTION 8—Hospital Bed:

Document that this beneficiary requires positioning not feasible in an ordinary bed: _____

_____

Is frequent repositioning required throughout the day? Yes ❒ No ❒ Explain: _____

Is frequent repositioning required throughout the night? Yes ❒ No ❒

Can the beneficiary or caretaker use a "manual" bed? Yes ❒ No ❒

If no, explain why: _____

_____

For any anti-decubitus bed, please attach to the TAR, photos and explanation of previous therapies attempted, the nutritional status, and the latest hemoglobin and hematocrit of the beneficiary.

SECTION 9—DME provider/Therapist attestation and signature/date:

By my signature below, I certify to the best of my knowledge that the information contained in this Certificate of Medical Necessity is true, accurate and complete and I understand that any falsification, omission or concealment may subject me to criminal liability under the laws of the State of California.

Name of therapist answering these sections, if other than prescribing clinician or DME provider (please print):

Name: _____ *(Please print)* Title: _____ *(OT, PT, RESNA, etc.)* DME Provider Name: _____ *(Please print)*

✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____

✍ _____ *(Use Ink - A signature stamp is not acceptable)*

SECTION 10—Clinician attestation and signature/date:

I certify that I am the clinician identified in this document. I have reviewed this Certificate of Medical Necessity and I certify to the best of my knowledge that the medical information is true, accurate, current and complete, and I understand that any falsification, omission, or concealment may subject me to criminal liability under the laws of the State of California.

Clinician's Signature:

✍ _____ *(Use Ink - A signature stamp is not acceptable)* Date: _____

Medical Therapy Unit (MTU)/ Durable Medical Equipment (DME) Review Process

- Member is seen at the MTU
- MTU therapists and physicians agree on the need for DME
- Physician writes prescription for medically appropriate equipment or device(s)
- MTU staff reach out to DME provider/vendor to request quote

When quote is agreed upon,

- MTU therapists complete an MTU DME Request form (see example below)
- Rx and MTU DME Request form are forwarded to the DME provider/vendor
- DME provider/vendor submits a packet of information to PHC including the following:
  - Signed Rx
  - MTU DME Request form (*Specifying any items in quote that were not approved by the MTU*)
  - Treatment Authorization Request (TAR) – (may be submitted electronically)
  - Agreed upon quote
- TAR reviewed (*additional documentation may be required if packet submission was not complete*)

The spirit of this procedure is to allow the MTU and PHC to work seamlessly on DME approvals in replication of legacy CCS process and to minimize delays in care while avoiding unnecessary or unapproved DME from being ordered by another clinic without MTU knowledge.

Notes:

- Vendors are to submit the TAR.
- If the MTU DME Request form is used (see sample below), no "Certificate of Medical Necessity for DME" form 6181 is required.

Medical Therapy Unit (MTU)/ Durable Medical Equipment (DME) Request Form

Client Name		**CCS#**		**CIN#**	
DOB		**Program end date**			
Approved by		**Date of review**			

☐ 9K CCS ☒ MediCal ☒ Partnership ☐ 9N M/C ONLY ☐OTLICP ☐ MTP only ☐ HMO

Requested Item(s)				
Vendor				
Vendor Mailing address				
Vendor Physical address				
Vendor contact	**Phone**		**Fax**	
Provider Number				

☐ Signed prescription attached

☐ Therapist assessment complete

☐ CCS Numbered Letter 09-0703 or 09-0514 criteria reviewed and met

☐ Quote reviewed

☐ The following codes/items are not approved:

Vendor to submit this form along with TAR/eTAR, prescription and quote from DME provider (including CCS approved HCPCS codes) to Partnership HealthPlan of California for payment.

MTU Approval Date:

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3042 (previously UP100342)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Technology Assessment</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/14/1999</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/09/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPRP4001 – Pharmacy and Therapeutics (P&T) Committee
C. MPQP1003 – Physician Advisory Committee (PAC)
~~B.~~D. MPQP1002 – Quality/Utilization Advisory Committee
~~C.~~E. MCUP3138 – External Independent Medical Review

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment.
B. The following definitions apply to entirely new technologies or new applications of existing technologies

INTERVENTION	Lab or animal studies completed	Human studies completed	FDA or regulatory approval	State Medi-Cal benefit	~~PHC~~Partnership benefit

Experimental (preclinical trials)	No	No	No	No	No
Investigational (clinical trials in progress)	Yes	No	No	No	If all 6 criteria are met
New technology (clinical trial results available)	Yes	Yes	Yes or No	No	Case-by case review *OR* Consider addition as a ~~PHC~~Partnership benefit
New benefit	Yes	Yes	Yes	Yes	Yes

IV. ATTACHMENTS:

A. Review of New Medical Technology Form

V. PURPOSE:

To define the process utilized by Partnership HealthPlan of California (~~PHC~~Partnership) to evaluate new technologies/investigational services and interventions, including medical and behavioral health procedures, pharmaceuticals and devices as well as changes in the application of existing technologies or adding new benefits for M~~m~~embers.

VI. POLICY / PROCEDURE:

A. Investigational Interventions:
   1. Department of Health Care Services (DHCS) policy (Title 22, California Code of Regulations [CCR] Section 51303) for approval of investigational services (interventions) states that all six of the following criteria must be fully met:
      a. Conventional therapy will not adequately treat the intended patient's condition.
      b. Conventional therapy will not prevent progressive disability or premature death.
      c. The provider of the proposed service has a record of safety and success with the investigational service that is equivalent or superior to that of other providers.
      d. The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
      e. The service is not being performed as part of research study protocol.
      f. There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life and will maintain or restore a range of physical and social function suited to the activities of daily living.
   2. Investigational interventions will not be authorized in the inpatient setting if there is no indication for acute care treatment.
   3. After collection of all materials necessary to evaluate whether these criteria are met, the Chief Medical Officer (CMO) or Physician Designee will review the request. If all criteria are judged to be met, the investigational service will be approved.
   4. If criteria are not met, the case may be sent for independent medical review by a relevant specialist in the area of the intervention. If, in the opinion of the specialist, criteria have been met, the procedure will be approved.

B. Coverage for Cancer Clinical Trials follows Department of Health Care Services (DHCS) guidelines.
   1. ~~PHC~~Partnership covers routine patient care costs for eligible M~~m~~embers who are in any one of the

four clinical trial phases as long as the following are met:
   a. The treating physician recommends participation in the trial
   b. Participation in the trial MUST have meaningful potential to benefit the M~~m~~ember
   c. The trial must NOT exclusively be to test toxicity, but must have a therapeutic intent
   d. Trial will NOT occur in the inpatient setting if there is no indication for acute care treatment
2. Trials that qualify for approval include:
   a. Those involving a drug exempt under federal regulation from a new drug application OR
   b. The cancer clinical trial is approved by one of the following:
      1) The National Institute of Health
      2) The Food and Drug Administration (FDA) in the form of an investigational new drug application,
      3) The United States Department of Defense
      4) The United States Department of Veterans Affairs
3. Per Health and Safety Code (HSC) § 1370.6, ~~PHC~~Partnership does not limit, prohibit, or modify a M~~m~~ember's rights to cancer biomarker testing as part of an approved clinical trial and no prior authorization is required for either of the following*:
   a. Biomarker testing for a M~~m~~ember with advanced or metastatic stage 3 or 4 cancer
   b. Biomarker testing for cancer progression or recurrence in a M~~m~~ember with advanced or metastatic stage 3 or 4 cancer

   **If the biomarker test is not associated with an FDA-approved cancer therapy for advanced or metastatic stage 3 or 4 cancer, ~~PHC~~Partnership may still require prior authorization for such testing.*

C. New technologies physician request and authorization process
1. Case-by-case review: If ~~PHC~~Partnership receives a physician's request to provide benefits of a new intervention for a specific M~~m~~ember the process is as follows:
   a. A Treatment Authorization Request (TAR) must be submitted to ~~PHC~~Partnership describing the intervention and containing medical justification for its use. Pertinent patient medical records must be included.
   b. The CMO or P~~p~~hysician D~~d~~esignee will ask the provider for background information including copies of clinical studies regarding the intervention. ~~PHC~~Partnership staff will perform a literature search for peer reviewed studies or recommendations from professional societies regarding the use, efficacy, and safety of the proposed service. In addition, ~~PHC~~Partnership will consider determinations of regulatory authorities (e.g. Centers for Medicare and Medicaid Services [CMS] or US Food and Drug Administration [FDA]) concerning the intervention.
   c. The CMO or P~~p~~hysician D~~d~~esignee may request input from a relevant specialist prior to presenting the request to the various committees such as the Pharmacy & Therapeutics (P&T) Committee or Physician Advisory Committee (PAC). This specialist must have expertise in the technology under review.
   d. All behavioral health technologies will include input from an appropriate behavioral health specialist.
   e. When clinically indicated, a case may be sent for external review to a contracted independent medical review organization. (See policy MCUG3138 External Independent Medical Review.)
   f. Based on input from the Utilization Management Department, P&T Committee, PAC or relevant specialist, the CMO or Physician Designee renders a determination.
   g. All records concerning the review are retained by ~~PHC~~Partnership's Health Services department.
   h. Determination criteria used by the relevant specialist(s), P&T Committee, PAC, and the CMO or Physician Designee must include all six criteria specified in VI.A.1. a. – f. above when reviewers consider the following:

1) Sufficient objective information regarding the safety, efficacy, and indications for the intervention which support its use.
2) The proposed intervention is likely to lead to a better outcome than conventional interventions currently available.
3) The provider has a record of safety and success with the proposed service which is equivalent or superior to that of other providers of the intervention.
4) The practitioner proposing to provide the intervention is willing to accept the payment rate offered by ~~PHC~~Partnership.
5) The intervention is not provided as part of a research study protocol.

i. Evaluations of new and existing medications are managed by the process described in the Pharmacy & Therapeutics (P&T) Committee policy MPRP4001.

D. Addition of a new benefit:

1. A request to add a new ~~PHC~~Partnership benefit may be submitted by a provider, M~~m~~ember or ~~PHC~~Partnership staff. In such instance the following steps occur:
   a. The request is sent to the CMO or Physician Designee, which includes a statement explaining why the requested service should be added as a ~~PHC~~Partnership benefit, identification of the ~~PHC~~Partnership M~~m~~ember to benefit from the service, and all pertinent supporting clinical information. The ~~Senior Director of~~Chief Health Services Officer will also review the request and offer feedback.
   b. ~~PHC~~Partnership will perform a literature search regarding the use, efficacy and safety of the intervention and may also use the services of an external technology assessment organization such as ECRI Institute or others. As needed, materials collected relating to the request may be forwarded by the CMO or Physician Designee to an appropriate relevant specialist (or to an ad hoc physician committee) to review the material and to advise ~~PHC~~Partnership regarding the use of the new technology. The reviewer or review committee is asked to recommend whether the intervention be added as a ~~PHC~~Partnership benefit and to delineate criteria used to evaluate the use of the new technology. The CMO may also opt to bring the proposal to the Quality/Utilization Advisory Committee (QUAC) or PAC for feedback on the proposal.
   c. ~~PHC~~Partnership also has an operational workgroup for review of potential new benefits called the Benefit Review and Evaluation Workgroup (BREW). BREW is comprised of the Chief Medical Officer, the ~~Senior Director of~~Chief Health Services Officer, the Chief Operating Officer and representatives from these departments: Regulatory Affairs, Provider Relations, Member Services, Finance, Claims, and Information Technology. BREW investigates and considers the medical, financial and operational issues surrounding proposed benefit changes. BREW findings are summarized and presented to the ~~PHC~~Partnership Executive Committee which will determine next steps. All medical criteria changes follow the process described in VI.D.1.a. and b.~~c~~ above. The Executive Committee may refer a recommendation to the Board (~~PHC~~Partnership Commission) for addition of a new benefit class. The Executive Committee may also request input from the Physician Advisory Committee (PAC) prior to rendering a decision. The Executive Committee may approve coverage of single CPT codes ("minor changes") that it deems are within the general scope of medical services generally covered by ~~PHC~~Partnership. The Executive Committee will also determine operational changes required such as i~~I~~nformation t~~T~~echnology (IT) and claims configuration and/or financial considerations such as recommending Medi-Cal coverage of new technologies to the California Department of Health Care Services (DHCS).
2. Notification of New Benefit Addition: Once approved by the PAC and the Board (~~PHC~~Partnership Commission) ~~(~~as applicable~~)~~, information regarding the new benefit may be disseminated as necessary in the following manner:
   a. Primary Care Providers (PCPs) and relevant specialists are notified electronically by "Important

Provider Notice (IPN)."

b. Internal notification is sent to ~~PHC~~Partnership department leadership so that policies and procedures may be created and information gathered to inform utilization management determinations, benefit interpretations, care coordination decisions, and the design of health educational materials.

c. ~~PHC~~Partnership Members are notified of benefit additions via the Member Newsletter, updates to the Member Handbook and the ~~PHC~~Partnership website.

VII. REFERENCES:

A. Title 22, California Code of Regulations (CCR) Section 51303
B. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: An Overview (*chemo an over*)
C. DHCS All Plan Letter (APL) 22-010 Cancer Biomarker Testing (06/22/2022)
D. Health and Safety Code (HSC) § 1370.6
E. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1,~~2023~~ 2024) UM 10 Evaluation of New Technology Elements A & B

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual
C. Health Services Department Heads and Staff

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

X. REVISION DATES: 06/21/00; 12/19/01; 10/16/02, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 05/21/08; 07/15/09; 05/18/11; 02/20/13: 01/20/16; 10/19/16; 10/18/17; *06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24

*Through 2017, dates 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~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

Member Name: _____ **Date:** _____

Member ID# _____ **DOB** _____

Review Type ☐ **Reactive** ☐ **Proactive**

Requesting Practitioner: _____ **Phone #**_____

Proposed Treating Practitioner: _____

Proposed Procedure / Treatment / Medication: _____

_____

_____

Facility: _____ **Phone #** _____

Professional Cost: _____

Anticipated LOS: _____ **Facility Cost:** _____

1. **How long has treating practitioner been performing this procedure or treatment?**

   _____

2. **How many cases has he/she performed in the last two years?**

   _____

3. **Estimated Costs:**

Professional	**$**_____
Facility	**$**_____
Other	**$**_____
Total Estimated Cost:	**$**_____

4. **Is privileging or certification required to perform this procedure?**

   ☐ **Yes** ☐ **No**

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

5. Outcomes Review:

- **Mortality during global period?** _____
- **Mortality during 1 year out?** _____
- **Mortality during 5 years out?** _____
- **Other known complications / risks, actual and anticipated?**

_____

_____

_____

6. List other available treatment modalities:

_____

_____

_____

7. Medicare approved? _____

8. FDA approved? _____

9. Hayes Directory review? _____

10. Literature Search? _____

11. Review by Network Practitioners:

Name	**Specialty**
_____	_____
_____	_____
_____	_____
_____	_____

REVIEW OF NEW MEDICAL TECHNOLOGY FORM

12. Medical Director Review: _____

_____

_____

13. Other comments: _____

_____

_____

14. Send for External Review? Yes_____ No_____

15. Cover? Yes_____ No_____

16. Notify Benefits Coordination? Yes_____ No_____

17. Date Member notification sent _____

18. Date Provider notification sent _____

_____ _____

PHC Medical Director **Date**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3053 (previously UP100353)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Acute Inpatient Administrative Days</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/20/2001</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/09/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:
MCUG3024 - Inpatient Utilization Management

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

III. DEFINITIONS:
Acute administrative days - are those days approved at an acute inpatient facility, which provide a higher level of medical care than currently needed by the ~~member~~Member or when ~~member~~Members are awaiting placement in a transitional care setting such as a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Acute Rehabilitation Unit (ARU) or a Long Term Acute Care (LTAC) facility

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To define the circumstances under which Partnership HealthPlan of California (~~PHC~~Partnership) authorizes administrative days for inpatient hospitals when awaiting placement for a lower level of care.

VI. POLICY / PROCEDURE:
A. A ~~PHC~~Partnership ~~member~~Member may be approved for administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the ~~PHC~~Partnership Chief Medical Officer or physician designee that the Member's care no longer meets acute inpatient criteria, but does require lower level inpatient care such as long-term acute care (LTAC) or subacute care.
B. A ~~PHC~~Partnership ~~member~~Member may be approved for acute inpatient administrative days when, after review of information from the attending physician and the medical record, it is the professional judgment of the ~~PHC~~Partnership Chief Medical Officer or physician designee that the medical and nursing care required is at a level of care available in SNFs, ICFs, LTACs or ARUs in the community, but placement is not available at the present time
C. If the ~~member~~Member is pending placement at a level of care that is not ~~PHC~~Partnership's responsibility, administrative days do not apply. Examples include, but are not limited to, ~~member~~Members awaiting placement at a mental health facility, ~~member~~Members awaiting evaluation on a psychiatric hold, ~~member~~Members who are the responsibility of the criminal justice system or

~~member~~Members being discharged home or to a board and care facility.

D. As soon as it is identified that the ~~member~~Member will need placement, the acute inpatient facility must contact potential placement facilities within a 60 mile radius or further if needed. Outreach should be made frequently, as often as necessary to attempt to place any particular ~~member~~Member.
   1. The outreach made can cover more than one ~~member~~Member being placed provided that:
      a. The acute inpatient facility staff document in each ~~member~~Member record the attempted placement call/outreach effort.
      b. The post-acute facility can meet the special needs of a particular ~~member~~Member.
   2. The acute inpatient facility must continue placement efforts until placement occurs. The acute inpatient facility may be required to submit its documentation to the ~~PHC~~Partnership Nurse Coordinator.

VII. REFERENCES:
Medi-Cal Provider Manual/ Guidelines

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

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

X. REVISION DATES:
Medi-Cal
05/15/02; 05/21/03; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 05/18/11; 09/17/14; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 06/09/21; 06/08/22; 08/09/23; 08/14/24

*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

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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:

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- 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

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~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3133</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/18/2015</td><td colspan="4">Next Review Date: ~~06/14/2024~~08/14/2025
Last Review Date: ~~06/14/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/14/2023~~08/14/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Claims
D. Member Services

III. DEFINITIONS:

A. **Activities of Daily Living (ADL):** The activity of dressing/bathing, eating, ambulating (walking), toileting and hygiene.
B. **Custom Rehabilitation Equipment:** Any item, piece of equipment or product system, whether modified or customized, that is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of individuals with disabilities. Custom rehabilitation equipment includes, but is not limited to, non-standard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based upon patient height, weight and disability, specialized wheelchair electronics and cushions, custom bath equipment, standards, gait trainers and specialized strollers.
C. **Durable Medical Equipment (DME):** Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist)~~licensed practitioner~~ in the treatment of a specific medical condition and which have all of the following characteristics:
    1. Can withstand repeated use
    2. Is used to serve a medical purpose
    3. Is not useful to an individual in the absence of an illness, injury, functional impairment or congenital anomaly; and
    4. Is appropriate for use in or out of a patient's home.
D. **Instrumental Activities of Daily Living (IADL):** Activities that allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

E. **Licensed Practitioners:** Clinical professionals furnishing medical care, or any other type or remedial care recognized under State law within their scope of practice as defined by State Law.

F. **Medical Necessity:** For the purposes of this policy, a wheelchair is considered medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living, in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

G. **Power Mobility Device (PMD):** Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

H. **Power Operated Vehicle (POV):** Chair-like battery power fed mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

I. **Power Wheelchair (PWC):** Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, electronic steering, and four or more wheel non-highway construction.

J. **Qualified Healthcare Professional (QHP):** Licensed physical, occupational, or speech therapists with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the consumer's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.

K. **Qualified Rehabilitation Technical Professional (QRTP):** Individuals typically certified as Assistive Technology Professionals who are employed by the vendor providing assistive technology devices to PHC members. They may have an additional certification of a Certified Rehabilitation Specialist. The QRTP is responsible for ensuring the equipment provided meets the technical needs of the patient.

L. **SPC:** Seating and provisional components

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the policy and processes for review of wheelchairs (manual and electric powered) and Power Operated Vehicles (POV) in accordance with the Department of Health Care Services All Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Component issued July 9, 2015 as well as the California Children's Services (CCS) Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) issued August 8, 2003 and CCS N.L. 09-0514 Powered Mobility Devices (PMD) issued May 29, 2014.

VI. POLICY / PROCEDURE:

A. An authorization request for rental or purchase of a manual or powered mobility device (wheelchair, POV) requires a written request/prescription from a licensed professional and will be reviewed as follows:

1. Upon receipt of the Treatment Authorization Request (TAR) for custom rehabilitation equipment (as per III.B.) and/or powered mobility devices (as per III.G.), Partnership HealthPlan of California (PHC) will arrange for an assessment by an independent Qualified Healthcare Professional (QHP) who is not employed by or paid by a mobility device vendor. The purpose of the assessment is to evaluate the appropriateness of the request, document medical necessity for the mobility device, and identify the type of equipment best suited to meet the member's specific needs. The assessment must

be performed in the setting where the member will use the mobility device. The independent QHP's written summary of findings and recommendations is required to be submitted to PHC before a determination decision can be made for the mobility device authorization request. PHC does not offer incentives or compensation to independent consultants or health plan staff to deny medically appropriate services requested by members or providers.

2. A prescription for a wheelchair will not be denied on the grounds that it is for use only outside the home.
3. A TAR is required for all wheelchair requests when PHC is the secondary payer to Medicare.
4. The following sequential questions offer clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. These guiding principles will be used by PHC in making a benefit coverage determination.
    a. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
        1) Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
        2) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or
        3) Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame
    b. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?
        1) Some examples are impairment of cognition or judgment and/or vision.
        2) For these beneficiaries, the provision of a wheelchair and seating and provisional components (SPC) might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.
    c. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?
        1) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
        2) It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
    d. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
        1) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
        2) A history of unsafe behavior may be considered.
        3) Additional information may be requested from the member's treating medical providers.
    e. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?
        1) The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
        2) Assess the beneficiary's ability to safely use a cane, crutches or walker.
    f. Does the beneficiary's typical environment support the use of wheelchair and SPC?

1) Determine whether the beneficiary's environment will support the use of medically necessary types of wheel chair and SPC.
2) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.

g. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured (SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
1) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
2) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light-weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
4) Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.

h. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
1) A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC. Three-wheeled devices are not covered.
2) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.
3) Assess the beneficiary's ability to safely use a POV/scooter.

i. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADLs?
1) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
2) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
4) Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

4. When a manual or powered mobility device authorization is approved, it is the vendor's responsibility to have a Qualified Rehabilitation Technical Professional (QRTP) ensure the equipment provided meets the technical needs of the member. Any customized additions or added features that are not specifically covered under the approved authorization will require submission of another request (for a "custom wheelchair or device") to authorize these additions. Failure on the part of the vendor to do so before building and delivering the customized device could result in denial of requests for payment for the additional features.

B. Medical Necessity
1. Manual wheelchairs are medically necessary when:
a. Criteria 1), 2), 3), 4) and 5) below are met; and
b. Criterion 6) or 7) is met, and
c. Criteria is met for specific devices listed below.
1) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs, and

2) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, crutches or walker, and
3) The manual wheelchair supplied to the beneficiary for use in or out of the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
4) Use of a manual wheelchair will improve the beneficiary's ability to participate in ADLs or IADLs.
5) The beneficiary has expressed a willingness to use the manual wheelchair that is provided, and
6) The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
7) A standard wheelchair may be medically necessary
   a) When the beneficiary is able to self-propel the wheelchair, or
   b) Propel with assistance
8) A standard hemi-wheelchair may be medically necessary
   a) For disarticulation of one or both lower extremities, or
   b) Requires a lower seat height because of short stature, or
   c) To enable the beneficiary to place his/her feet on the ground for propulsion
9) A lightweight wheelchair may be medically necessary
   a) When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or
   b) For a beneficiary with marginal propulsion skills.
10) A high strength lightweight wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard or lightweight wheelchair, or
   b) The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
11) An ultra-lightweight multi-adjustable wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchairs, and
   b) The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
   c) The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
   d) The beneficiary's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (e.g., pediatric size and growth options)
12) A heavy duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 250 pounds, as documented in clinical notes within the past 12 months, or
   b) The beneficiary has severe spasticity, or
   c) Body measurements cannot be accommodated by standard sized wheelchairs.

13) An extra heavy duty wheelchair is medically necessary when
    a) The beneficiary weighs more than 300 pounds, as documented in clinical notes within the past 12 months, or
    b) Body measurements cannot be accommodated by a heavy duty wheelchair
14) Manual tilt-in-space wheelchairs are medically necessary when
    a) The beneficiary is dependent for transfers, and
    b) The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15) Pediatric sized folding adjustable wheelchairs with seating systems are covered as primary or back-up wheeled mobility when
    a) The beneficiary meets the criteria for wheeled mobility, and
    b) The wheelchair is an appropriate size for the beneficiary, and
    c) The beneficiary meets the criteria for recline and positioning options, and
    d) The wheelchair provides growth capability in width and length

2. Powered Mobility Devices are medically necessary when:
    a. Criteria 1), 2), and 3) below are met, and
    b. Criteria is met for specific devices listed below.
        1) The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more ADL or IADLs, and
        2) The beneficiary's mobility limitation cannot be safely resolved by the use of an appropriately fitted cane, crutches or walker, and
        3) The beneficiary does not have upper extremity function to self-propel an optimally-configured manual wheelchair to perform ADLs or IADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

A four wheeled Power Operated Vehicle (POV) is covered if all of the basic coverage criteria 1) - 3) have been met and if criteria 4) - 9) are also met.

4) The beneficiary is able to:
    a) Safely transfer to and from a POV, and
    b) Operate the tiller steering system, and
    c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids
5) The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in or out of the home, and
6) The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7) The beneficiary's weight, as documented in clinical notes within the past 12 months, is less than or equal to the weight capacity of the POV that is provided, and
8) Use of a POV will significantly improve the beneficiary's ability to participate in ADLs or IADLs, and
9) The beneficiary has expressed willingness to use a POV

A Power Wheelchair (PWC) is covered if all of the basic coverage criteria 1) – 3) have been met and

a) The beneficiary does not meet coverage criterion 4), 5), or 6) above for a POV; and
b) Criteria 10) – 13) below are met; and
c) Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.

10) The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11) The beneficiary's typical environment (in or out of the home) provides adequate access between rooms, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
12) The beneficiary has expressed willingness to use a power wheelchair.

Power Wheelchairs are segmented into the following groupings:

13) A Group 1 PWC (K0813-K0816) or a Group 2 (K0820-K0829) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
14) Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) The beneficiary requires a drive control interface other than a hand or chin- operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control), or
    b) The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair
15) A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
    a) The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
    b) The beneficiary uses a ventilator which is mounted on the wheelchair.
16) A Group 3 PWC with no power options (K0848-K0855) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
17) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
18) A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
    a) The Group 3 criteria [17)] are met, and
    b) The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the beneficiary engaging in frequent ADLs or IADLs cannot be performed in a Group 3 PWC.
19) A Group 4 PWC with Single Power Option (K0877-K0880) or with Multiple Power Options (K0884-K0886) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:

a) The Group 4 criteria [19)] are met, and
b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.

20) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met; and
   a) The beneficiary is expected to grow in height, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
21) A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met, and:
   a) The beneficiary has been self-propelling in a manual wheelchair for at least one year, and
   b) The beneficiary has a non-progressive disease, and
   c) The beneficiary has successfully completed a two-month trial period (reimbursable with prior approval as a rental).
22) SPC may be included with new wheelchair or billed separately under the following conditions:
   a) Refer to the SPC Coverage Criteria for information concerning coverage of general use, skin protection, positioning, powered and custom made components.
   b) A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
   c) If a beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
   d) A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.
23) If a beneficiary's weight, as documented in clinical notes within the past 12 months, combined with the weight of seating and positioning accessories can be accommodated by wheelchair with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.
24) A power mobility device (PMD) will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

3. Backup manual wheelchairs are medically necessary when
   a. The beneficiary meets the criteria for a powered mobility device, and
   b. The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
   c. The beneficiary is unable to complete ADLs or IADLs without a backup manual wheelchair, and
   d. The backup wheelchair accommodates the SPC on the primary wheelchair.

C. Wheelchairs are NOT covered when:
1. Not medically necessary
2. Not used by the beneficiary
3. Used as a convenience item
4. Used to replace private or public transportation such as an automobile, bus or taxi

5. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them
6. Used in a facility that is expected to provide such items to the beneficiary
7. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of the Code of Regulation section 51321(h)
8. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, by a licensed practitioner after evaluation by a QHP.

D. Seating and Positioning Component Coverage Criteria
SPC are covered when criteria 1. 2. and 3., at least one of 4. – 9., and 10. – 19. (if applicable) are met:
1. The beneficiary has met the criteria for wheelchair, and
2. The SPC meets the quality standards and coding definitions specified in the APL 15-018. The Medicaid program reserves the right to review any and all coding assignments by vendors and the Medicare Pricing, Data Analysis and Coding (MPDAC) web site based on submitted and published product specifications and other relevant information.
3. The primary and back-up wheelchair bases accommodate the SPC.
4. A general use seat cushion and a general use back cushion are covered when 1., 2. and 3. are met.
5. A skin protection seat cushion or decubitus wheelchair pad is covered when 1., 2. and 3. are met and that beneficiary has one of the following:
   a. A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   c. Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn, cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   d. Confined to their wheelchair for more than four (4) continuous hours on a daily basis
   e. A well-documented history (as well as current status) of malnutrition.
6. A positioning seat cushion or positioning back cushion, is covered when 1., 2. and 3. are met and the beneficiary has one of the following:
   a. Significant postural asymmetries that are due to but not limited to one of the diagnoses listed in criterion "5." above; or
   b. One of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.
7. A positioning accessory is covered when criteria 1., 2., 3. and 6. are met and specifically:
   a. A headrest or headrest extension (sling support for the head) is covered when the recipient has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
   b. An upper extremity support system (UESS) is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or

potential seating or wheelchair features. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). UESS and related accessories are not covered when used solely for activities of daily living.

c. UESS padding and positioning blocks are covered in addition to a UESS when there is a medical need for stabilization of the UESS due to strong spasticity or exaggerated muscle activity.

d. Foot-Ankle Padded Positioning Straps (e.g., "ankle huggers") are covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.

8. A combination skin protection and positioning seat cushion is covered when 1., 2., 3., 5. and 6. are met, i.e., the criteria for both a skin protection seat cushion and a positioning seat cushion are met.
9. A custom fabricated seat cushion is covered if the criteria for 8. are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer), which clearly explains why a standard seating system is not sufficient to meet the beneficiary's seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)
10. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual recipient, the cushion must be billed as a customized cushion, not custom fabricated.
11. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
12. Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item.
13. The swing away, multi-positioning or removable mounting hardware upgrade code may only be billed in addition to the codes for a headrest, lateral trunk, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back cushions, or with PWCs with swing away, fixed or retractable joysticks.
14. A manual tilt in space option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary is dependent for transfers, and
    c. The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15. A power tilt in space option for a PWC is covered when:
    a. Criteria 1. – 3. and 14. above are met, and
    b. The beneficiary has the mental and physical capabilities to safely and independently operate the power tilt in space that is provided.
16. A manual recline option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or
    d. The beneficiary's postural control requires a recline feature.

17. A power recline option for a PWC is covered when:
    a. Criteria 1. – 3. and 16. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
18. A combination manual tilt in space and recline option is covered when criteria 14. and 16. are met and if provided alone will not meet the seating and positioning needs.
19. A combination power tilt in space and recline option is covered when criteria 15. and 17. are met and if provided alone will not meet the seating and positioning needs.

E. Portable Ramps
1. For PHC's policy on portable ramps, please see policy MCUP3013 DME Authorization section VI.~~E.~~G.9.

F. Loaner Rental During Repair
1. Back-up or loaner rental power wheelchairs are not a Medi-Cal covered benefit.
    a. On a case by cases basis, a~~A~~ one ~~-~~month rental of a wheelchair may be considered medically necessary if a member-owned wheelchair requires an extended repair. Payment for the rental is based on the type of replacement device that is provided. Requests for loaner powered mobility device rentals will require documentation of medical necessity to be reviewed by the Chief Medical ~~Director~~ Officer or Physician Designee.

VII. REFERENCES:

A. Title 22, CCR Sections 52260, 51321
B. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (*dura wheel guide*) and Bill for Wheelchairs and Wheelchair Accessories (*dura bil wheel*)
C. Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
D. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
E. CCS Numbered Letter (N.L.) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)
F. Senate Bill No.717 Complex Needs Patient Act, California Legislature 2021-2022 Regular Session, Amended in Senate May 20, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB717

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

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

X. REVISION DATES: 08/17/16; 08/16/17; *09/12/18; 11/13/19; 11/11/20; 11/10/21; 05/11/22; 06/14/23; 08/14/24

*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.

Policy/Procedure Number: MCUP3133		**Lead Department: Health Services**
Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components		☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2015	**Next Review Date: 06/14/202408/14/2025** **Last Review Date: 06/14/202308/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:

MCUP3083 - Wheelchair and Power Operated Vehicle Authorization was archived 11/18/2015
Original Date: 04/16/2008
Revision Dates: 07/15/09; 05/18/11

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3138</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: External Independent Medical Review</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/13/2018</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
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</table>

I. RELATED POLICIES:

A. MCUP3042 – Technology Assessment
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~C.~~D. MCRP4068 – Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Independent Medical Review process: Process in which an expert independent medical professional is selected to review a specific health service request and provide a fair and objective opinion based on his/her designated specialty.
B. Independent Medical Review Organization (IMRO): A third-party medical review resource which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.
C. Life Threatening: Defined as a disease or condition where the likelihood of death is high unless the course of the disease is interrupted OR diseases or conditions with potentially fatal outcomes where the end point of the clinical intervention is survival.
D. Seriously Debilitating: Defined as diseases or conditions causing major irreversible morbidity.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the process used by Partnership HealthPlan of California (~~PHC~~Partnership) to provide a comprehensive and fair evaluation of health service requests. The external independent medical review process may be applied in circumstances for which nationally recognized evidenced-based criteria or ~~PHC~~ Partnership medical policy does not provide ample guidance or where the Chief Medical Officer (CMO) or Physician Designee desires an additional opinion from an actively practicing board certified physician of like or similar specialty.

VI. POLICY / PROCEDURE:

Policy/Procedure Number: MCUP3138		Lead Department: Health Services
Policy/Procedure Title: External Independent Medical Review		☒External Policy ☐Internal Policy
Original Date: 06/13/2018	**Next Review Date: ~~08/09/2024~~08/14/2025** **Last Review Date: ~~08/09/2023~~08/14/2024**	
Applies to:	☒ Medi-Cal	☐ Employees

A. Partnership~~PHC~~ contracts with an Independent Medical Review Organization (IMRO) to ensure qualified case-matched independent specialists are available to review health service requests as expeditiously as possible in deference to the M~~m~~ember's health condition. In addition to the IMRO, Partnership~~PHC~~ may also use qualified case-matched independent specialists to review on a case by case basis.

B. An IMRO or qualified case-matched independent specialist may be used at the discretion of ~~the Chief Medical Officer~~ CMO or Physician Designee for circumstances including, but not limited to the following:
   1. Assessment of health treatment efficacy and/or scope of application
   2. Service requests deemed Experimental or Investigational
   3. In the instance of an appeal
   4. Denial of an Experimental or Investigational therapy when a M~~m~~ember has a life threatening or seriously debilitating condition.
   5. Denial, modification or delay of health care services based in whole or part on the determination that the service requested is not medically necessary. The M~~m~~ember's contracted treating physician must certify that the condition has not responded to standard therapies AND must make written recommendation that another drug, device, procedure or therapy would be MORE beneficial than those that are standard.
   6. Existing technology/pharmacology used differently

C. With the exception of Experimental or Investigational Therapy, determinations to deny, delay or modify health care services based on a benefit exclusion, are not eligible for an independent medical review.

D. Partnership~~PHC~~ does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for Utilization Management (UM) decision makers to deny care, and Partnership ~~PHC~~ does not encourage decisions which would result in underutilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.

E. The IMRO conducting the independent medical review is contracted directly by Partnership~~PHC~~. The cost of the independent medical review is the responsibility of the health plan. The M~~m~~ember or P~~p~~rovider requesting an independent medical review on the M~~m~~ember's behalf shall NOT be charged an application or processing fee.

F. Process for Referral to Independent Medical Review
   1. ~~The~~ Partnership's CMO or Physician Designee ~~Medical Director~~ will work with the Utilization Management (UM) Department to assemble and submit all necessary information to the contracted IMRO or qualified case-matched independent specialist.
   2. The UM staff will submit a completed~~-~~ file for review by the Independent Medical Reviewer which will include, but is not limited to:
      a. Internal patient identifier for the purpose of the review
      b. Requested service/procedure to include specific CPT/HCPCS code(s)
      c. Member diagnosis (Using current ICD Code sets)
      d. All information provided relevant to the service requested
      e. All information submitted by the practitioner in support of the requested service
      f. Pertinent medical history
      g. Treatment or clinical data
      h. Date response needed
      i. Specific questions concerning treatment requiring clarification
   3. The UM staff maintain contact with the IMRO and ensure timely resolution of the submitted case.
   4. Upon receipt of the independent review, ~~the~~ Partnership's CMO or Physician Designee ~~Medical Director~~ will determine coverage of the requested service.
   5. After the coverage decision has been reached and all parties notified, ~~the~~ Partnership's CMO or Physician Designee ~~Medical Director~~ will submit a copy of the case, including the final resolution,

to UM department staff.

6. UM department staff uploads a summary of the case and all supporting documentation into the UM Department documentation system as an attachment to the M~~m~~ember's Treatment Authorization Request (TAR) file for which the review was completed.
7. UM staff maintain tracking/monitoring of all cases submitted to the IMRO.
8. IMRO information is ~~reported~~ available to the Partnership Quality/Utilization Advisory Committee (Q/UAC) upon request~~bi-annually~~.
9. The ~~Chief Medical Officer~~CMO or Physician Designee is responsible for ensuring the timely processing and final resolution of the requested service. When independent medical review is sought, it must also occur in this time frame.

G. Time Frames
1. Standard Review: The IMRO shall review all relevant information and make a written determination within five (5) business days of receipt of the request in order to allow for timely resolution of non-urgent requests.
2. Expedited Review:
   a. An expedited independent medical review is initiated under the following conditions:
      1) The ~~Chief Medical Officer~~CMO or Physician D~~d~~esignee, or treating physician determines there is an imminent and serious threat to the health of the M~~m~~ember including, but not limited to, severe pain, the potential loss of life, limb or major bodily function, and or the immediate and serious deterioration of the health of the M~~m~~ember.
      2) The M~~m~~ember's physician has determined that the proposed therapy would be significantly less effective if not promptly initiated.
   b. The IMRO shall make their determination within 24 hours of the receipt of the request and provide supporting documentation to allow for a timely appeal resolution within seventy-two (72) hours of date of receipt at ~~PHC~~Partnership. Partnership~~PHC~~ may extend the IMRO's determination deadline for an additional 24 hours in extraordinary circumstances or for good cause, which is in the best interest of the M~~m~~ember and still allows for a timely appeal resolution within seventy-two (72) hours of date of receipt.
3. Retrospective Review: In the case of a retrospective review, the IMRO shall review all relevant information and make a written determination within five (5) to seven (7) business days of receipt of the request to allow for timely appeal decision within 30 business days of the date of receipt at Partnership~~PHC~~.
4. In all cases, Partnership will provide the Member and the Member's treating practitioner with the analysis and determination as well as a description of the qualifications of the medical professionals who reviewed the case. As part of the grievance process, Partnership provides a Member with a written determination to uphold a denial, delay or modification based on either medical necessity or the experimental or investigational nature of the request, and advises the Member of appeal rights and process.

VII. REFERENCES:

A. California Health and Safety Code Section 1374.30 -.36
B. Title 28, Division 1, Chapter 2, Article 8 Section 1300.70.4 and 1300.74.30
C. In compliance with the California Department of Health Care Services (DHCS) contract
D. Title 22 California Code of Regulations (CCR)
E. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, ~~2023~~2024) UM 4 Appropriate Professionals Element F and UM 10 Evaluation of New Technology Elements A & B

VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Provider Manual

B. Partnership~~PHC~~ Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: ~~Senior Director,~~Chief Health Services Officer, Chief Medical Officer or Physician Designee

X. REVISION DATES:
08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24

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
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- 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 Partnership 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 Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3139</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Criteria and Guidelines for Utilization Management</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/12/2020</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
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I. RELATED POLICIES:

A. MPQP1002 – Quality/ Utilization Advisory Committee
B. MPRP4001 – Pharmacy & Therapeutics (P&T) Committee

II. IMPACTED DEPTS:

A. Health Services
B. Compliance
C. Provider Relations

III. DEFINITIONS:

Standard of Care: The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstance.

IV. ATTACHMENTS:

A. Table of Approved Criteria and Guidelines Referenced for Utilization Management

V. PURPOSE:

To establish an approved list of Utilization Management criteria and guidelines for reviewing Treatment Authorization Requests (TARs) and hospitalizations. (Note: The process for review and approval of criteria for pharmacy services can be found in policy MPRP4001 Pharmacy & Therapeutics [P&T] Committee.)

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (Partnership ~~PHC~~) is responsible for reviewing requests for services submitted by network providers. A key element of these reviews is the use of criteria and guidelines to assist in making decisions to approve, modify or deny service authorization requests. It is important that the criteria and guidelines used in this process be known and accessible and reflective of well accepted standards of care. This policy will establish the process of Criteria and Guideline review and approval for use by the Partnership ~~PHC~~ network of providers.
B. Process of Review and Approval:
    1. On an annual basis, the Quality/ Utilization Advisory Committee (Q/UAC) will review a list of criteria and guidelines to be used by Partnership~~PHC~~ Utilization Management staff and Partnership ~~PHC~~ medical directors in performing reviews of treatment authorization requests (TARs).
        a. This list will be evaluated during the Chief Medical Officer (CMO)/Medical Director (MD) meeting the month prior to presentation to Q/UAC.

b. To be included in this list, a criteria set or guideline must be developed by a nationally recognized entity or a Partnership ~~PHC~~ policy that has been approved through the standard committee process.
c. These guidelines and criteria sets should be utilized by managed care organizations throughout the country or region. (This would mean that the criteria and guidelines reflect the generally accepted standard of care.)
d. Guidelines and criteria sets should be supported by clinical literature and peer review.
e. A specific guideline or criteria can be submitted for potential inclusion in the approved list by any provider within the Partnership ~~PHC~~ network or by Partnership ~~PHC~~ staff.
   1) This recommendation will be submitted to the Office of the CMO.
   2) The CMO will assign the suggested criteria or guideline to a specific medical director for evaluation. This medical director will present the review at the next CMO/MD meeting.
   3) After the medical directors have completed their evaluation of the guideline or criteria set, they will decide to either forward the document to Q/UAC with a recommendation for approval, or decide that the guideline or criteria should not be used by Partnership~~PHC~~ for performing reviews.

2. Hierarchy of Guidelines and Criteria Sets:
   a. The guidelines and criteria can be grouped into the following groups:
      1) Required standards as set forth by the State of California (Department of Health Care Services [DHCS] or other agencies) where Partnership ~~PHC~~ is contractually and legally obligated to follow the guidelines.
      2) Industry accepted guidelines that are used by a variety of other managed care organizations (e.g. InterQual® and National Comprehensive Cancer Network [NCCN]).
      3) Guidelines developed through government agencies (e.g. Center for Disease Control [CDC] or Agency for Healthcare Research and Quality [AHRQ]).
      4) Policies developed by Partnership~~PHC~~.
   b. There should be few circumstances where these groups of guidelines conflict. In situations where there is a conflict, the use of the guidelines should favor the patient first.
   c. The guidelines that are required by statute or contract should be followed at all times, as long as the patient's safety is not compromised.
   d. Partnership ~~PHC~~ policies should be followed as long as there is no conflict with legally required or contractually required services.

C. See Attachment A for Table of Approved Criteria and Guidelines Referenced for Utilization Management.

VII. REFERENCES:
National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, ~~2023~~2024) UM 2 Clinical Criteria for UM Decisions Elements A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 08/11/21; 08/10/22; 08/09/23; 08/14/24

PREVIOUSLY APPLIED TO: N/A

APPROVED CRITERIA AND GUIDELINES REFERENCED FOR UTILIZATION MANAGEMENT

Criteria/ Guideline	Citation Style for Policy Reference	Abbreviation
Medi-Cal Provider Manual / Guidelines	Medi-Cal Guidelines then subsection used and abbreviation *Example:* Medi-Cal Guidelines Pathology: Molecular Pathology (*path molec)*	_ _
InterQual® Criteria	InterQual® Criteria including version year and then subset used *Example*: InterQual® ~~2020~~ 2024 DME Criteria – Insulin Pump, Ambulatory	IQ
All Plan Letters from DHCS	Department of Health Care Services (DHCS) All Plan Letter (APL) (2 digit year)-(number) Title (Date) *with hyperlink* *Example:* Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)	APL (xx)-(xxx)
CCS Numbered Letters	California Children's Services (CCS) Numbered Letter (NL) (2 digit year)-(number) Title (Date) *with hyperlink* *Example:* California Children's Services (CCS) Numbered Letter (NL) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)	CCS NL (xx)-(xxxx)
Agency for Healthcare Research and Quality	Agency for Healthcare Research and Quality: then guideline used *with hyperlink*	AHRQ
Centers for Disease Control and Prevention	Centers for Disease Control and Prevention (CDC): then guideline or article used *with hyperlink* *Example:* Centers for Disease Control and Prevention (CDC): Epigenetics, Health, and Disease~~Genomics & Precision Health~~	CDC
National Comprehensive Cancer Network	National Comprehensive Cancer Network (NCCN): then guideline used *with hyperlink* *Example*: National Comprehensive Cancer Network (NCCN): NCCN Guidelines for Treatment of Cancer by Site	NCCN
United States Preventive Services Taskforce	United States Preventive Services Taskforce (USPSTF) guidelines: then guideline used *with hyperlink* *Example*: United States Preventive Services Taskforce (USPSTF): Cervical Cancer: Screening	USPSTF
Up-To-Date	UpToDate: Author(s), Article Title, publishing date *with hyperlink* or UpToDate: Search Term or Title of Article *Example:* UpToDate: D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults; published online 9 August 2019. or UpToDate: Obstructive Sleep Apnea	UTD
Other government or specialty society guidelines	Varies	_ _

as noted in PHC policies		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3141</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Delegation of Inpatient Utilization Management</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/09/2021</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
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I. RELATED POLICIES:

A. MCUG3024 - Inpatient Utilization Management
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. MCUP3014 - Emergency Services
D. MCUP3039 - Direct Members
E. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
F. CGA024 - Medi-Cal Member Grievance System
G. CMP36 - Delegation Oversight and Monitoring
H. CMP02 - Risk Assessment, Audits and Monitoring
I. CMP38 - Escalation and Corrective Action
J. ADM47 - Administrative and Financial Sanctions

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations
C. Finance
D. Regulatory Affairs/Compliance

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD) - The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. ~~Partnership~~Partnership HealthPlan of California):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the M~~m~~ember's request to obtain services outside the network.
   7. The denial of a M~~m~~ember's request to dispute financial liability.

B. Assigned Risk: In accordance with the Division of Financial Responsibility (DOFR), a determination made by ~~Partnership~~Partnership HealthPlan of California (~~PHC~~Partnership) concerning which entity,

PartnershipPHC or the Delegated Entity, will be financially responsible for the inpatient hospital services rendered to the Mmember under the capitation agreement and applied in accordance with the written understanding between PartnershipPHC and the Delegated Entity.

C. Capitated Hospital Admission: Admission of an assigned Mmember to a capitated hospital within a Delegated Entity's contracted network.

D. Capitation: Refers to a form of reimbursement between PartnershipPHC and the Delegated Entity of a fixed amount per member per month.

E. Delegated Entity(ies): The hospital that has assumed certain financial responsibilities including Utilization Management (UM), and who has entered into a capitated contractual arrangement with PHCPartnership to perform services specifically related to fulfilling PHCPartnership's obligations to the Department of Health Care Services (DHCS) under the terms of the DHCS/Medi-Cal contract or those duties PHCPartnership would otherwise perform as defined by the National Committee for Quality Assurance (NCQA).

F. Delegation Oversight: The process whereby PHCPartnership monitors a Delegated Entity's delegated activities to ensure their compliance with statutes, regulations, policies and contractual obligations, including the Delegation Agreement and/or NCQA standards and DHCS requirements.

G. Delegation Agreement: A written agreement between PHCPartnership and the Delegated Entity that defines the obligations and responsibilities of the Delegated Entity.

H. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment ~~inclusion in the PHC capitation system~~ would be inappropriate. Assignment to Direct Member status ~~may be~~is based on the Mmember's aid code, ~~medical condition,~~ primeary insurance, demographics, or administrative approval based on qualified circumstances.~~eligibility status.~~ A Referral Authorization Form (RAF) is not required for Direct Members to see PHC network providers and/or certified Medi-Cal providers willing to bill PHC for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

I. Division of Financial Responsibility (DOFR): DOFR shall be defined as the written understanding between PHCPartnership and the Delegated Entity regarding Assigned Risk.

J. Emergency Medical Condition: Per DHCS County Organized Health System (COHS) contract Exhibit ~~E~~A, Attachment 1 Definitions, a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in one or more of the following:

1. Placing the health of the individual (or, the case of a pregnant member, the health of the Mmember or Mmember's unborn child) in serious jeopardy
2. Serious impairment to bodily functions~~, or~~
3. Serious dysfunction of any bodily organs or part, ~~s~~or

~~3.~~4. Death

K. InterQual® Criteria: Nationally recognized medical criteria guidelines, developed and approved by appropriate board certified specialists. InterQual® Criteria are used to assist in making a determination of medical necessity for services proposed or rendered to a PHCPartnership Mmember.

L. Out-of-Area Admission (OOA): An inpatient hospital admission that occurs at a facility that is not in the Delegated Entity's service area as defined by the contractual agreement between PHCPartnership and the Delegated Entity.

K. Utilization Management (UM): The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

IV. ATTACHMENTS:

A. N/A

Policy/Procedure Number: MCUP3141		Lead Department: Health Services
Policy/Procedure Title: Delegation of Inpatient Utilization Management		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/09/2021	**Next Review Date: 08/09/202408/14/2025** **Last Review Date: 08/09/202308/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

To define processes, procedures and respective responsibilities that apply when ~~Partnership~~Partnership HealthPlan of California (~~PHC~~Partnership) delegates inpatient utilization management functions to hospitals.

VI. POLICY / PROCEDURE:

A. Delegated Entity(ies):
   1. Adventist Health (*Clear Lake, Howard Memorial, Mendocino Coast, St. Helena and Ukiah Valley*)
   ~~2. Dignity Health/ Woodland Memorial Hospital~~
   ~~3.~~2. MarinHealth Medical Center
   ~~4.~~3. NorthBay Medical Center/ VacaValley Hospital
   ~~5.~~4. Providence (aka St. Joseph Health) Queen of the Valley Medical Center

B. Preauthorization Process for Elective Admissions to the Delegated Entity
   1. ~~PHC~~ Partnership performs prior authorization review to determine if the proposed services meet medical necessity criteria. ~~PHC~~Partnership notifies the requesting provider of the determination in writing.

C. Preauthorization Process for Elective Admissions outside of the Delegated Entity's Contracted Service Area
   1. ~~PHC~~Partnership receives the Provider's request and forwards it to the Delegated Entity's UM Designee for their review within one (1) business day of receipt.
   2. The Delegated Entity is responsible for the following actions:
      a. Reviewing the medical necessity of the requested elective services
         1) The Delegated Entity's Medical Director, or physician designee, must review any case in which medical necessity is in question (based on the nurse reviewer's assessment), utilizing nationally recognized inpatient medical criteria approved by ~~PHC~~Partnership.
         2) In a denial or modification of medical necessity (adverse benefit determination), the Delegated Entity will notify the requesting provider in writing or electronically (using the appropriate NCQA/DHCS approved letter template) at the time of the decision, but no later than 24 hours from the date of decision. The Delegated Entity shall send a copy of the notification letter to ~~PHC~~Partnership. The letter must include the medical rationale for the denial or modified determination. ~~PHC~~Partnership will mail the notification to the M~~m~~ember on behalf of the Delegated Entity.
      b. Determining if the elective procedure(s) can be provided (and redirected) within the Delegated Entity's network or whether they will allow the M~~m~~ember to receive services out of network.
      c. Complying with the following NCQA review and timeliness standards:
         1) Rendering a decision within five (5) business days from receipt of standard request; or
         2) 72 hours from receipt of an urgent request

D. Concurrent Review at Delegated Hospitals
   1. Admission: The Delegated Entity notifies ~~PHC~~Partnership of any admission to their hospital within one (1) business day.
      a. Admission notification may be made using ~~PHC~~Partnership's secure O~~o~~nline Services (OLS)~~Provider~~ Portal https://provider.partnershiphp.org/UI/Login.aspx or by submission of a patient demographic "face sheet" via fax to (707) 863- 4118.
      b. Upon submission, a Treatment Authorization Request (TAR) number is generated in ~~PHC~~Partnership's electronic system.
   2. The Delegated Entity is responsible for concurrent review throughout the inpatient stay.
   3. Discharge
      a. The Delegated Entity must notify ~~PHC~~Partnership of the M~~m~~ember's discharge within one (1) business day and provide the following information:
         1) Discharge Date
         2) Dates of service with specified level of care approved or denied (e.g. Med/Surg, ICU, etc.)

b. Once all authorization information is completed, ~~PHC~~Partnership forwards the UM review determination electronically to the provider of service.
   1) Delegated Entities who are accessing ~~PHC~~Partnership's electronic system may populate the discharge information directly to generate the status print of the UM review determination.
   2) Delegated Entities not using ~~PHC~~Partnership's electronic system must notify ~~PHC~~Partnership by phone or fax and then ~~PHC~~Partnership will generate the status print of the UM review determination.

E. Emergency Admissions at Hospitals Outside of the Delegated Entity's Contracted Service Area
1. When ~~PHC~~Partnership is notified that a capitated M~~m~~ember has been admitted emergently to an out-of-area hospital, ~~PHC~~Partnership notifies the Delegated Entity of the M~~m~~ember's admission within one (1) business day.
2. The case is assigned to a ~~PHC~~Partnership Concurrent Review Nurse to perform an initial clinical review.
3. ~~PHC~~Partnership performs concurrent review during the hospital stay or until the Delegated Entity is determined to be financially responsible for the hospital stay. This occurs when ~~PHC~~Partnership's Chief Medical Officer, or physician designee, determines that the M~~m~~ember is medically stable for transfer to the Delegated Entity's hospital. Upon determination, the Delegated Entity is notified and becomes financially responsible for the continued hospital stay on the next calendar day or in accordance with their contractual agreement with ~~PHC~~Partnership.
4. The Delegated Entity may choose to allow continued hospitalization at the current hospital or make arrangements to repatriate the M~~m~~ember to their hospital; however, the financial risk remains with the Delegated Entity. The Delegated Entity must verbally notify ~~PHC~~Partnership's Nurse Coordinator of the decision.
5. In the event the out-of-area hospital fails to notify ~~PHC~~Partnership in a timely manner (that is after the M~~m~~ember becomes medically stable for transfer to the Delegated Entity's hospital), ~~PHC~~Partnership's Chief Medical Officer, or physician designee, reviews the clinical documentation and determines the date of medical stability. ~~PHC~~Partnership then notifies the Delegated Entity of the effective date of the determination.
   a. If ~~PHC~~Partnership and the Delegated Entity do not agree on the effective date of the Delegated Entity's financial responsibility, both parties agree to negotiate in good faith to resolve the issue or as defined by the contractual arrangement between ~~PHC~~Partnership and the Delegated Entity.

F. Other Services/Considerations
1. Provider Education
   a. Although ~~PHC~~Partnership will assist the Delegated Entity with ~~PHC~~Partnership network resources, it is the Delegated Entity's responsibility to keep their network physicians and/or staff informed of the services that are available within the Delegated Entity's network.
   b. Collaborating with network providers increases the opportunity to keep referrals within the network.
2. Referrals
   a. If a ~~PHC~~Partnership M~~m~~ember is referred by their Primary Care Provider (who is linked with the Delegated Entity) to an out-of-area specialist for ongoing specialty care and as a result, the M~~m~~ember is hospitalized on either an elective or an emergency basis in an out-of-area hospital by the out-of-area specialist, ~~PHC~~Partnership will assign the financial risk to the Delegated Entity at the time of the hospital admission.
3. If a M~~m~~ember is transported by ambulance from the Delegated Entity's hospital to an out-of-area hospital because the service is not routinely provided by the Delegated Entity's hospital, the Delegated Entity maintains the financial responsibility.
4. In the event that an emergency occurs in the Delegated Entity's service area, but the M~~m~~ember is transported to an out-of-area hospital, the financial responsibility remains with the Delegated Entity.
5. If the Delegated Entity's hospital emergency department is on diversion status (unable to accept

patients) and the Mmember is transported to another hospital, the financial responsibility remains with the Delegated Entity.

G. Member Removal from Capitation
   1. Certain PHCPartnership Mmembers may be removed from capitation status based on special service needs e.g. Mmember's medical condition, prime insurance, demographics or administrative eligibility status.
   2. In order for PHCPartnership to consider a Mmember's removal from capitation, the Delegated Entity must securely submit a request with supporting clinical documentation and a detailed description of the circumstances that necessitate removal. Reference should be made to PHCPartnership's policy MCUP3039 Direct Members to determine under what Direct Member status category the request for removal from capitation status is being made and that specific status should be indicated in the letter of request. Requests may be addressed to the Senior Director of Health Services and the Associate Director, UM Regulations at PHCPartnership.
   3. The Mmember will remain under the Delegate's capitation agreement pending written outcome of the review determination.
   4. The request and clinical documentation will be reviewed by a PHCPartnership Medical Director and the requesting Delegate will be notified of the determination in writing.
   5. If it is determined by PHCPartnership's Medical Director that the Mmember should be placed in a Direct Member status, the effective date of the Direct Member status will be the date the decision was made by the Medical Director.

H. Provider/Member Appeals and Member Complaints/Grievances
   1. PHCPartnership assumes responsibility for processing all Provider and Member appeals, complaints and grievances o. n behalf of the delegated entities. They are not delegated.
   2. Delegated Entities must comply with the Appeal/Complaint/Grievance processes by providing all written relevant clinical documentation, review determination rationale and any other available documents pertinent to the subject of the dispute in accordance with regulatory requirements.
   3. If the Appeal/ Complaint/ Grievance review results in the overturning of the Delegated Entity's previous determination, the Delegated Entity must abide by PHCPartnership's determination and remains financially responsible for the disputed services.

I. Regulatory Compliance and Oversight
   1. Delegated Entities are required to meet UM standards as set forth by the National Committee for Quality Assurance (NCQA) and the California Department of Health Care Services (DHCS).
   2. Delegated Entities must comply with all oversight activities, which may include, but not be limited to, the following:
      a. Monthly reporting of all inpatient acute admissions to the Delegated Entity's network hospitals. (If the Delegated Entity is using PHCPartnership's electronic system, this report can be generated by PHCPartnership.)
      b. Participation in a Compliance audit at least annually to include (at a minimum) PHCPartnership review of the Delegated Entity's UM policies, procedures, and Mmember medical record reviews.
   3. Delegated Entity agrees to comply with all requirements set forth in the Delegation Agreement.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III Section 2.35 Utilization Management Program and Exhibit A, Attachment 1, Definitions
B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20232024) UM Standards

VIII. DISTRIBUTION:

A. PHCPartnership Department Directors

B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES: 06/08/22; 08/09/23; 08/14/24

PREVIOUSLY APPLIED TO:
Medi-Cal (UP100333; MCUP3033: 01/10/1995 to 06/09/2021)
01/10/95; 10/10/97 (name change only); 12/15/99; 03/22/00 by Commission; 12/20/00; 09/19/01; 10/16/02; 06/16/04; 09/21/05; 10/19/05, 10/18/06; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 08/12/20; ARCHIVED 06/09/2021

*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.

****

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~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3006 (previously UP100306)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Appropriate Service and Coverage Policy</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/21/2000</td><td colspan="4">Next Review Date: ~~08/09/2024~~08/14/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/09/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1002 – Quality/ Utilization Advisory Committee
B. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to define the method by which Partnership Health Plan of California (~~PHC~~Partnership) facilitates the delivery of appropriate care, and to identify mechanisms to detect and correct potential under and over-utilization of services.

VI. POLICY / PROCEDURE:

A. Over/Under Utilization Workgroup Composition & Function
   1. The Over/Under Utilization Workgroup (O/U UW) meets on a regular basis and at least three (3) times per year. The Workgroup is composed of, but not limited to, the Chief Medical Officer, the Director of Quality and Performance Improvement, the ~~Senior Director of~~ Chief Health Services Officer, the Utilization Management Director and Associate Director(s), the Manager of Health Analytics, representatives from the Behavioral Health team, ~~the Manager of Health Analytics~~, the Quality Improvement ~~Coordinator~~team~~, and representatives from, the Management Information Systems Department,~~ the Provider Relations Department, and the Claims Department. The purpose of the O/U UW is to monitor utilization data for the organization as a whole to detect potential under and over-utilization. The committee monitors data across practices and provider sites for primary care providers (PCPs), substance use treatment providers, and high-volume specialists. The O/U UW analyzes the data collected and recommends appropriate interventions whenever it identifies under or over-utilization. The O/U UW reports all analysis to the Internal Quality Improvement Committee (IQI) and then to the Quality/ Utilization Advisory Committee (Q/UAC).

B. Quality/Utilization Advisory Committee Role
   1. The Q/UAC reviews the analysis and recommendations from the O/U UW and implements appropriate interventions whenever it identifies possible under or over-utilization. The Q/UAC directs the O/U UW to measure whether the interventions have been effective at an appropriate interval and then implement strategies to achieve appropriate utilization.

C. Monitoring
   1. ~~PHC~~ Partnership routinely monitors, tracks and analyzes both non-behavioral and behavioral health services as well as substance use treatment services.
   2. The O/U UW may monitor several additional types of data when looking for potential under- or over-utilization problems. It may monitor the following:
      a. HEDIS® measures
      b. Physician practice profiles from Utilization Management (UM) data
      c. Data from M~~m~~ember complaints and PCP change requests
      d. Information on referrals to specialists
      e. Data on inpatient days and discharges
      f. Pharmacy utilization
      g. Data on outpatient visits
      h. Emergency Room visits
      i. Admission and length of stay in acute rehabilitation units
      j. Compliance with Preventive Care Guidelines are routinely assessed by practice site to detect over and under-utilization
      k. Top 10 diagnoses for inpatient, outpatient and the Emergency Department settings
      l. Top 25 M~~m~~embers based on utilization and/or cost
      m. Selected procedures performed by high volume specialists are monitored and compared to other organization's rates or national data to detect under or over-utilization.
      n. Services performed by substance use treatment providers are monitored to detect over-use, under-use, and misuse of services.
      o. The workgroup monitors the accuracy, timeliness, and completeness of data submitted by providers to Partnership~~PHC~~.

D. Access to All Covered Services
   1. Unless prohibited by law, ~~PHC~~ Partnership or its subcontractor will arrange for the timely referral and coordination of any Covered Services to which Partnership~~PHC~~ or its subcontractor has religious or ethical objections to perform or otherwise support and will arrange, coordinate and ensure provision of services.
   2. Providers who are unwilling to perform, provide or otherwise support a covered service are obligated to notify Partnership~~PHC~~'s Care Coordination Department. Once notified, a Partnership~~PHC~~ Case Manager will assist the M~~m~~ember in obtaining timely access to the covered service.

E. Triage and Referral for Behavioral Health and Substance Use Disorder Services
   1. Partnership~~PHC~~ monitors the triage and referral protocols for its delegated behavioral health care provider~~s~~ to assure that they are appropriately implemented, monitored and professionally managed. Protocols utilized by delegates must be based on sound clinical evidence and be accepted industry practice. They must define the level of urgency and appropriateness of the care setting.
   2. Triage and referral decisions not requiring clinical judgment are made by staff with relevant knowledge, skills and professional experience.
   3. Triage and referral decisions requiring clinical judgment are made by a licensed behavioral health care practitioner with appropriate qualified experience.
   4. Supervision of triage and referral staff is ~~done~~ by a licensed behavioral health care practitioner with a minimum of a master's degree and five years of post-master's clinical experience.

5. Oversight of triage and referral decisions is ~~done~~ by a licensed psychiatrist or an appropriately licensed doctoral level psychologist experienced in clinical risk management.

F. Decisions Made on Medical Appropriateness
1. On an annual basis, Partnership~~PHC~~ distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service. Furthermore, Partnership~~PHC~~ does not reward practitioners, or other individuals conducting utilization reviews, for issuing denials of coverage. There are no financial incentives for UM decision makers to deny care; and Partnership~~PHC~~ does not encourage decisions which would result in under-utilization, but rather, bases decisions solely on the appropriateness of care or service and the existence of coverage.

G. Delegation Oversight and Monitoring
1. Partnership~~PHC~~ delegates the administration of certain mental health services to a managed behavioral health organization~~(s) and contracted globally capitated health plan(s)~~.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to Partnership~~PHC~~'s Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) contract, Exhibit A, Attachment ~~4~~III, 2.3.3
B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, ~~2023~~2024)
UM 1 Program Structure Element A Written Program Description Factors 3 and 4 Involvement of a Designated Senior Level Physician and a Designated Behavioral Healthcare Practitioner;
Front Matter: Policies and Procedures –Section 2
C. ~~Department of Health Care Services (~~DHCS~~)~~ Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Department Directors
B. ~~PHC~~ Partnership Q/UAC members
C. ~~PHC~~ Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
05/16/01; 05/15/02; 10/16/02; 10/20/04; 10/19/05; 10/18/06; 08/20/08; 06/17/09; 07/21/10; 10/01/10; 05/16/12; 08/20/14; 06/17/15; 04/20/16; 04/19/17; *06/13/18; 04/10/19; 11/13/19; 09/09/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24

*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.

Policy/Procedure Number: MPUP3006 (previously UP100306)		**Lead Department: Health Services**
Policy/Procedure Title: Appropriate Service and Coverage Policy		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/21/2000	**Next Review Date: 08/09/202408/14/2025** **Last Review Date: 08/09/202308/14/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:
Healthy Kids - MPUP3006 (Healthy Kids program ended 12/01/2016)
10/18/06; 08/20/08; 06/17/09; 07/21/10; 10/01/10; 05/16/12; 08/20/14; 06/17/15; 04/20/16 to 12/01/2016

PartnershipAdvantage:
PA UM302 - 06/21/2006 to 08/20/2014
MPUP3006 – 08/20/2014 to 01/01/2015

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~~PHC's~~ Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPNET101</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Wellness and Recovery Access Standards and Monitoring</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/12/20</td><td colspan="4">Next Review Date: ~~08/08/2024~~08/15/2025
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~08/09/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:
A. MPNET100 – Access Standards and Monitoring

II. IMPACTED DEPTS:
A. Member Services
B. Provider Relations
C. Health Services
D. Finance
E. Compliance
F. Behavioral Health

III. DEFINITIONS:
A. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards), includes Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity counties.
B. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards), includes Lake, Napa, and Yolo counties.
C. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards), includes Marin, Solano, and Sonoma counties.
D. Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

IV. ATTACHMENTS:
N/A

V. PURPOSE:
To define access standards for substance use disorder treatment through the ~~PHC~~Partnership HealthPlan of California (Partnership) Wellness and Recovery Program.

VI. POLICY / PROCEDURE:
~~Partnership HealthPlan of California~~Partnership is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. ~~PHC~~Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone availability. ~~PHC~~Partnership monitors provider

availability and accessibility on an annual basis.

A. Access to Providers
   1. Established measureable standards for the geographic distribution of each type of wellness and recovery program.

GEOGRAPHIC DISTRIBUTION OF WELLNESS AND RECOVERY PROVIDERS		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Outpatient Services	• Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 60 miles or 90 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%
Opioid Treatment Programs	• Programs Rural Counties: 60 miles or 90 minutes from the beneficiary's residence • Small Counties: 45 miles or 75 minutes from the beneficiary's residence • Medium Counties: 30 miles or 60 minutes from the beneficiary's residence • Large Counties: 15 miles or 30 minutes from the beneficiary's residence	≥ 80%

   2. Established measureable standards for timely access of each type of wellness and recovery program.

TIMELY ACCESS STANDARD		
Provider Type	**Standard**	**Performance Goal**
Outpatient Services	Within 10 business days from request to appointment	≥ 80%
Opioid Treatment	Within 3 business days from request to appointment	≥ 80%

B. Communication
   1. ~~PHC~~Partnership communicates access standards to:
      a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
      b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VII. REFERENCES:

A. Master Agreement between ~~PHC~~Partnership and Wellness and Recovery Counties BHIN (Behavioral Health Information Notice) 21-023 2021 Federal Network Certification Requirements for County Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery Systems (DMC-ODS). (May 24, 2021)

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors

B. ~~PHC~~Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Senior Director, Provider Relations

X. REVISION DATES: 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024

PREVIOUSLY APPLIED TO:
N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPPRGR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Provider Grievance</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~08/08/2024~~08/13/2025
Last Review Date: ~~08/09/2023~~08/14/2024</td></tr>
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<tr><td colspan="4">Approval Signature: Steven Gwiazdowski, MD</td><td colspan="3">Approval Date: ~~08/09/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services

III. DEFINITIONS:

Provider Grievance: For the purposes of this policy, a Provider Grievance is defined as an expression of dissatisfaction from a provider that, after exhausting all Plan appeal processes, requests to have their complaint, appeal or dispute submitted to the Provider Grievance Review Committee for final review of the medical or pharmacy decision or how the Plan implemented a regulatory requirement.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the process for resolving provider grievances related to determinations of medical or pharmacy decisions made by Partnership HealthPlan of California, the Plan's implementation of DHCS Regulatory or other State and Federal requirements, or contractual disputes between the Health Plan and providers. The provider grievance process is not applicable to provider appeals filed on behalf of members and as such, is separate and distinct from the member grievance and appeal process. A provider may request a grievance after all applicable ~~PHC~~Partnership appeal processes have been exhausted.

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California~~,~~ (~~PHC~~Partnership) Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the ~~PHC~~Partnership Chief Medical Officer, Senior Director of Health Services and Senior Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.
B. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.

1. Informal grievances may be registered by the provider, by telephone, letter or visit to the ~~PHC~~Partnership office. The provider should contact the Provider Relations department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.
2. Formal grievance is filed in writing at the ~~PHC~~Partnership offices or by mail within 45 working days of the determination or action that is the subject of the grievance. There is a fifteen (15) working-day resolution period during which time the ~~PHC~~Partnership staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing a Provider Grievance Review Committee (PGRC) hearing.
3. The PGRC will meet within forty-five (45) working days of receipt of the written provider request for a meeting. PGRC decisions are binding unless reversed by ~~PHC~~Partnership's Board of Commissioners.

C. The Provider Grievance Review Committee (PGRC) has been established to provide a formal grievance mechanism.

1. The PGRC consists of the members of the Peer Review Committee (PRC) who are not ~~PHC~~Partnership medical directors, excluding any members of the PRC who have a potential conflict of interest. Potential conflict of interest for provider grievances includes being a member of the active medical staff on a hospital if the hospital is the grieving party and otherwise working for a hospital or institution if the grieving party is a physician on the active medical staff of that hospital or institution. PGRC will meet on the same date as the Peer Review Committee.
2. The Committee's meeting is documented in minutes. The provider and ~~PHC~~Partnership are advised in writing of the Committee's decision within ten (10) working days of the meeting.

D. Providers appealing utilization management or pharmacy decisions on behalf of members must follow the procedure outlined in Health Services policy MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a PGRC hearing.

E. Providers retrospectively appealing a decision to deny or limit payment for a service based on application of UM criteria, for which the member is not financially responsible, should first submit an appeal (which is not on behalf of a member, but on behalf of the billing provider), with additional documentation responding to the reason for the initial denial or limitation. A provider grievance may not be filed until an initial appeal has been completed, which the provider disagrees with.

F. If during the review process, the PGRC determines that a provider may be deficient in rendering or managing care, or problem areas are discovered, this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI); see MPQP1016 - Potential Quality Issue Investigation and Resolution.

G. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a contracted provider grievance or a non-contracted provider grievance.

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (Aug. 31, 2021 supersedes APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2023) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process and Element I, Written Notification of Pharmacy Appeal Rights/Process

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Provider Manual

B. ~~PHC~~Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Senior Director of Provider Relations

X. REVISION DATES:
08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024

PREVIOUSLY APPLIED TO:
N/A

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the June 19, 2024 Quality/Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*				
MCCP2014	Continuity of Care	233 – 260	**Policy Edits due to 2024 MCP Transition Policy Guide and revisions made for APL 23-022, APL 23-031** **Related Policies added (and referenced in the body of the policy):** MCUP3143- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) MCUP3142- CalAIM Community Supports (CS) MCCP2016- Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) MCUP3104 – Transplant Authorization Process **Definitions added:** A. Adult Expansion Population 1. New Enrollee Population 2. Transition Population J. Special Populations **Attachments added:** **A.** Continuity of Care Data Sharing Information **B.** Continuity of Care (CoC) Data Template – 1) Data Elements for All Members **C.** Continuity of Care (CoC) Data Template – 2a) Special Populations Specifications **D.** Continuity of Care (CoC) Data Template – 2b) Special Population Member File **E.** Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data *Note: Attachment A in its entirety and only the data dictionaries of attachments B-E are included in the Q/UAC packet.* **Purpose added:** I. Members transitioning to new MCPs on January 1, 2024 (Partnership will ensure that transitioning members are able to access assistance from Partnership's call center starting November 1, 2023 and will be offering the same level of support	Health Services Member Services Claims Administration Provider Relations

			for transitioning members who seek assistance before January 1, 2024 while not enrolled in Partnership) J. Members classified as Adult Expansion Population, which includes New Enrollee and Transition Populations **VI. Policy/Procedure updated:** If the member has one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96) **VI. Policy/Procedure Added:** 4. Partnership must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024 by January 1, 2024 or within 30 calendar days of receiving data for Special Populations. To minimize the risk of harm for disruptions in care, Partnership will focus their attention, resources, and provide continuity of care for transitioning members in the following Special Populations 5. Enhanced protections for members accessing the Transplant benefit **VI.D. Continuity of care protections extend to primary care providers (PCPs) Added**: ECM providers, CS Providers, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), Community-Based Adult Services (CBAS) providers, including dialysis centers, mental health providers, doulas, and community health workers (CHW). **They do not extend to all other ancillary providers Added:** non-emergency medical transportation (F), non-medical transportation (NMT) **VI.E. Partnership will provide continuity of care with an out-of-network provider when the following criteria are met: Added:** 2. The provider is providing a service that is eligible for COC, and **VI.F. Added** 1. Partnership must accept COC requests made over the telephone, electronically, or in writing, according to the requester's preference **VI.K. Added** Adult Expansion Population Members: 1. For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, Partnership is required to maintain that assignment. Adult Expansion Population Members are not required to request COC to maintain their PCP assignment with PCPs that are in Partnership's Network. If the PCP is out-of-Network, Partnership is not expected to maintain that assignment; however, Partnership must adhere to all Continuity of Care requirements in accordance with APL 23-022. **VI.L.1 Updated**: section VI.A-K **VI.L. Added:** 2. For members that have one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section	

			1373.96), once Partnership has established a COC for Providers agreement with an eligible provider, Partnership must reimburse the provider for covered services for the appropriate duration (as defined above) and as agreed upon with the provider. 3. For members under the Special Population (as defined above), Partnership will initiate the COC process within 30 calendar days from receipt of the Special Populations data. 4. If the COC request is made in advance of January 1, 2024, Partnership will provide the same level of support and will process the request by January 1, 2024 or according to the timeframes in VI.K.1, whichever is later. **VI.L.7 added:** Specifically, for ECM and CS Providers, if Partnership does not come to an agreement, Partnership must explain in writing to DHCS why Partnership and the ECM Provider could not execute a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship. Refer to policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and MCUP3142 CalAIM Community Supports (CS) for more details. **VI.L.10.a Updated:** Section VI.L.1 **VI.L.10.d.1) added**: Partnership will engage with the member and provider, including the transferring of the member's record **VI.L.10.d.2) Added:** For members falling under the transition as outline in V.I, the notification timeframe is 60 days prior to the expiration of the COC approval **VI.M.1-7 Revised: 90 days to 6 months** **VI.M.1. Added**: Utilization data of Special Populations will be examined to identify active courses of treatment and the MCP will contract providers as needed to establish any necessary prior authorizations **VI.M.3 Added**: Reassessments for clinical necessity for members to continue accessing the transplant benefit will start no sooner than six months after the transition date **VII. References updated:** A. DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023 (08/15/2023) D. Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96) **VII. References added:** F. DHCS APL 23-018: Managed Care Health Plan Transition Policy Guide (6/23/23) G. DHCS APL 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition (12/20/2023)	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director*				
MCUP3052	Medical Nutrition Services	261 – 269	This policy was update to add Pregnancy Related conditions and codes.	Provider Relations Provider Notification

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			Section VI.C.4. Updated description of code 99539 to include Telehealth **Section VI.C.8.** Added Z codes as follows: Z6200, Z6202, Z6204 - Medical nutrition therapy ante-partum/post-partum, individual, provided in a Perinatal Services Program based on perinatal services program guidelines **Section VI.C.9.** Added Z codes as follows: Z6206, Z6208 - Medical Nutrition Therapy antepartum, group, recommendations/ limits based on Perinatal Services Program allowances **Section VI.D.3.** Deleted language regarding nutritional evaluation claims submitted as pharmacy benefits because that would now fall under Medi-Cal Rx. **Attachment A and B.** Two both Attachment A (Children/Adolescents) and B (Adults) the following ICD-10 codes were added for Pregnancy Related Conditions: O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34. We specified that "All pregnant individuals with these diagnoses are eligible for MNT" and the frequency is "See Perinatal Services visit recommendations OR 1-2 visits per month up to 12 months after delivery."	Member Services Configuration
Policy Owner: Population Health Management – *Presenter: Hannah O'Leary, MPH, Manager of Population Health*				
MCND9001	PHM Strategy and Program Description	271 – 370 *CLEAN copy begins p. 325*	Annual Update includes revisions to further align the document with the most recent version of the 2024 contract, the PHM policy guide, APL 23-029, were updates from Pop Health departmental changes, or other various departments on their processes (QI, Health Analytics, BH, and Care Coordination). **P. 6-8 under program purpose, introduction, and data analysis and strategy**: Minor changes adding language about the CHA CHIP work. More minor changes adding language about the CHA CHIP work and associated deliverables and how findings are used to draft other related reports such as PHMSD due every Oct., the PHM strategy/program description, and various related work plans. **P. 9 under Data Analysis and Strategy**: added a paragraph describing the PNA committee. **P. 10 under Data Analysis and Strategy**: updated the graphic to reflect the PNA committee, added a paragraph about how QIHEC fits into Pop Health. **P. 11 under Population Needs and Community Needs Assessments**: added language about the written PNA for NCQA and the different committees it goes to (i.e. CAC, FAC, IQI, PAC, QUAC, PNA committee, QIHEC and board of directors, as well as provider newsletter and fax blast for visibility).	Grievance Member Services Pharmacy Utilization Management Communications

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			P. 12 under Population Needs and Community Needs Assessments: added more language about how the CHA CHIP work with the counties replaces DHCS' mandate for a written PNA, the various external stakeholders involved in the process, the deliverables due to DHCS to fulfill the new mandate, the various committees involved in hearing CHA CHIP updates and deliverables, and how findings from the CHA CHIP work guides health education initiates around mental health strategies, C&L strategies, and wellness/prevention initiatives. Also added that the PNA committee, CAC/FAC and QIHEC, as well as providers through the PR newsletter and fax blast, receive CHA CHIP updates. **P. 13-19 under Social Drivers of Health and Community Needs, and Population Risk Stratification & Segmentation, and Future Risk Stratification and Segmentation and Risk Tiering:** Health analytics provided technical updates on the SDoH section, and on the Population Risk Stratification and Segmentation section as well as how PHC's segmentation and risk scoring processes avoids racial bias. Redefined serious and persistent mental health to align with NCQA definitions. There were also other edits to the Future Risk Stratification and Segmentation and Risk Tiering section. **P. 20-22 under Basic Population Health Management and Wellness and Prevention Programs:** added DHCS contract language on BPHM and Wellness/prevention programs. Also added language to clarify IHA processes. **P. 25 under Organizational Support for PHM:** removed a program about a program that is no longer in operation. **P. 29 under Material Development:** added language indicating that the CHA CHIP findings and other regulatory requirements play a role in Health Ed material development. **P. 30 under Member Incentives:** added language to indicate that member incentives are also used to garner feedback on member experiences **P. 31 under Member Incentives and Point of Service Education:** clarified that Member incentives can also be used for surveys and focus groups. Also added language to clarify IHA processes. **P. 32 under Practitioner Education and Training:** we updated the section to include language that states that provider trainings are informed by CHA CHIP finings and may include BPHM program requirements **P. 33 under Health Education Interventions** – added language that health education interventions are informed by CHA CHIP findings and other regulatory requirements	

Synopsis of Changes to Discussion Policies

Policy Number	Policy Name	Page Number	Summary of Revisions (Please include why the change was made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
			and are included in the C&L work plan as appropriate. Also added language that mentions the C&L evaluation and how it evaluates the health education interventions. **P. 35 under Informing Members About Available PHM Programs:** updated the web link, added more language about the CHA CHIP work, removed language about COVID-19. **P. 36 under Community Engagement and Coordination of PHM Programs:** added language that emphasizes that community relationship building is an ongoing effort. Added language about the new case-management software that will be implemented later in 2024. **P. 37-38 under Community Engagement and Coordination of PHM Programs:** added language about the MOUs to be executed in 2024 and 2025 with third party entities. **P. 39-40 under Program Evaluation:** Replaced PHM&HE committee with QIHEC. **P. 41 under sharing data:** added a brief sentence about the annual data reports we share with each county. **P. 43 under Population Health and Health Education Delegation Oversight and Monitoring:** added language that Partnership also delegates C&L activities. **P. 44 under Team Roles and Responsibilities:** Changed title from Senior Director of Health Services to Chief Health Services Officer. **P. 44 under Team Roles and Responsibilities:** added language about CHA CHIP activities to the Manager of Pop. Health job description. **P. 45 under Team Roles and Responsibilities:** Added a description of the CHNL (Community Health Needs Liaison). Modified the Sr. Health educator's position to say that they assist with the writing and implementation of the PNA (instead of leading). **P. 46 under Team Roles and Responsibilities:** removed the Community Outreach representative job description as this position was eliminated. Modified the Wellness Guide job description to clarify that they also share DHCS approved health education materials with members. **P. 47 under references:** added a reference to the PHM Policy Guide. **P. 49-54 under appendix A and B:** updated Appendix A and B to better reflect current processes.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2014			**Lead Department: HS Department**	
Policy/Procedure Title: Continuity of Care (Medi-Cal)			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/19/2015 **Effective Date:** 12/29/2014 per DHCS		**Next Review Date:** ~~10~~09/~~12~~3/~~2024~~08/14/2025 **Last Review Date:** ~~10~~09/12~~3/2023~~08/14/2024		
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, MD, MPH, MBA*			**Approval Date:** 08/14/2024~~09/13/2023~~	

I. RELATED POLICIES:

A. MCUP3039 – Direct Members
B. MPUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21
C. MCCP2007 – Complex Case Management
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCUP3028 – Mental Health Services
F. CGA024 – Medi-Cal Member Grievance System
G. MCCP2032 – CalAIM Enhanced Care Management (ECM)
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~H.~~ MCUP3143 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
I.
J. MCUP3142 – CalAIM Community Supports (CS)
K. MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
L. MCUP3104 - Transplant Authorization Process

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims
D. Administration
E. Provider Relations

III. DEFINITIONS:

A. **Adult Expansion Population:** Senate Bill (SB) 184 (Chapter 47, Statutes of 2022) amended Welfare and Institutions Code (W&I) section 14007.8 to expand eligibility for full scope Medi-Cal to individuals who are 26 through 49 years of age, and who do not have satisfactory immigration status (SIS) as required by W&I section 14011.2. SB 184 took effect on January 1, 2024. Impacted populations include:
   1. **New Enrollee Population**: The new enrollee population consists of individuals who are 26 through 49 years of age in January 2024, who are not currently enrolled in full scope or restricted scope Medi-Cal, but who may apply for Medi-Cal after implementation of the Age 26-49 Adult Expansion and meet all eligibility criteria for full scope Medi-Cal, under any eligibility group, including Modified Adjusted Gross Income (MAGI) and Non-MAGI, except for SIS.
   2. **Transition Population**: The transition population consists of individuals who are 26 through 49 years of age and are currently enrolled in restricted scope Medi-Cal because they do not have SIS or

are unable to establish SIS for full scope Medi-Cal under any eligibility group, including MAGI and Non-MAGI, before implementation of this expansion.

~~A.~~B. **Behavioral Health Treatment (BHT):** BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are based on reliable evidence and are not experimental. BHT services include a variety of behavioral interventions that have been identified as evidenced-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence and are designed to be delivered primarily in the home and in other community settings.

~~B.~~C. **California Children's Services (CCS):** A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.

~~C.~~D. **Existing Relationship with Provider (for services other than Behavioral Health Treatment [BHT]):** is defined as the situation where a member has seen an out of network Primary Care Provider (PCP) or specialist at least once during the 12 months prior to the date of their initial enrollment into Partnership HealthPlan of California (Partnership~~PHC~~) for a non-emergency visit.

~~D.~~E. **Existing Relationship with Provider (for individuals receiving BHT):** is defined as the situation where a member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of responsibility for BHT services from the Regional Center to Partnership~~PHC~~, or the date of the member's initial enrollment with Partnership~~PHC~~ if enrollment occurred on, or after, July 1, 2018.

~~E.~~F. **Managed Care Plan (MCP):** Partnership HealthPlan of California (Partnership~~PHC~~) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services

~~F.~~G. **Medical Exemption Request (MER):** A request for a Medi-Cal beneficiary to be temporarily exempt from mandatory enrollment into an MCP, and to instead remain in fee for service (FFS) Medi-Cal. This allows the beneficiary to maintain access to providers who are not enrolled as network providers with the MCP until the member's medical condition has stabilized to a level that would enable the member to transfer to a network provider of the same specialty without deleterious medical effects.

~~G.~~H. **Medical Necessity for EPSDT Services**: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by screening services.

I. **Risk of Harm:** An imminent and serious threat to the health of the member.

~~H.~~J. **Special Populations:** Members most at risk for harm from disruptions in care or who are least able to access COC protections by request and who are identifiable in DHCS data or Previous MCP data.

~~I.~~K. **Whole Child Model (WCM):** A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric member insured by Partnership~~PHC~~.

IV. ATTACHMENTS:

A. ~~N/A~~Continuity of Care Data Sharing Information
B. Continuity of Care (CoC) Data Template ~~– 1)~~ 1) Data Elements for All Members
C. Continuity of Care (CoC) Data Template ~~– 2a)~~ 2a) Special Populations Specifications
D. Continuity of Care (CoC) Data Template ~~– 2b)~~ 2b) Special Population Member File
~~A.~~E. Continuity of Care (CoC) Data Template – 2c) ~~– 2c)~~ Special Populations Accompanying Data

Policy/Procedure Number: MCCP2014		Lead Department: Health Services
Policy/Procedure Title: Continuity of Care (Medi-Cal)		☒External Policy ☐Internal Policy
Original Date: 08/19/2015 **Effective Date:** 12/29/2014 per DHCS	**Next Review Date:** 08/14/2025~~10~~09/12~~3~~/2024 **Last Review Date:** 08/14/2024~~10~~09/12~~13~~/2023	
Applies to:	☒ Medi-Cal	☐ Employees

V. PURPOSE:

The purpose of this guideline is to define the process by which a member may request to be allowed to continue to receive services by an out-of-network provider in the event that the member has an established relationship with the provider who is providing ongoing care to the member prior to their enrollment or re-enrollment into Partnership HealthPlan of California (Partnership~~PHC~~). This policy applies to the following populations:

A. Medi-Cal members assigned a mandatory aid code that transitions them from Medi-Cal fee-for-service into a Medi-Cal managed care plan (Partnership~~PHC~~), i.e. Covered California to Partnership~~PHC~~
B. Members newly enrolled directly into Partnership~~PHC~~
C. Members from MCPs with contracts expiring or terminating into Partnership~~PHC~~ on or after January 1, 2023
D. Members newly enrolled and eligible for the Seniors and Persons with Disabilities aid code
E. Members receiving BHT services
F. Members with CCS-eligible conditions transitioning into WCM
G. Members receiving non-specialty (mild-to-moderate) mental health services
H. Members who have been denied for a Medical Exemption Request (MER)
I. Members transitioning to new MCPs on January 1, 2024 (Partnership~~PHC~~ will ensure that transitioning members are able to access assistance from Partnership~~PHC~~'s call center starting November 1, 2023 and will be offering the same level of support for transitioning members who seek assistance before January 1, 2024 while not enrolled in Partnership~~PHC~~)
J. Members classified as Adult Expansion Population, which includes New Enrollee and Transition Populations

~~VII.~~VI. POLICY/ PROCEDURE:

A. Medi-Cal members assigned a mandatory aid code who are transitioning into a Medi-Cal managed care plan (MCP) have the right to request continuity of care in accordance with federal and California law and managed care ~~plan contracts~~plan contracts with some exceptions.
   1. Consistent with federal law, members must:
      a. Have access to services consistent with the access they previously had
      b. Be permitted to have continued access to services during a transition from FFS to Partnership~~PHC~~, or a transition from a different MCP to Partnership~~PHC~~
      c. Be permitted to retain their current provider for a period of time if that provider is not in Partnership~~PHC~~'s network when the member, in the absence of continued services, would suffer serious detriment to health or be at risk of hospitalization or institutionalization.
   2. All Partnership~~PHC~~ members with verifiable pre-existing provider relationships who make a continuity of care request to Partnership~~PHC~~ must be given the opportunity to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.
   3. At the member's request, Partnership~~PHC~~ will provide continuity of care for the completion of treatment by a terminated provider or by a non-participating provider, if the member has one of the following conditions listed under Knox-Keene Health Care Service Plan Act (~~in~~California Health and Safety Code (H&S) section 1373.96):
      a. An acute condition – a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention that has a limited duration.
         1) Completion of covered services shall be provided for the duration of the acute condition
      b. A serious chronic condition – a medical condition due to a disease, illness, or other medical

problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration

1) Completion of the covered services shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for newly covered member.

c. A pregnancy – the three trimesters of pregnancy and the immediate postpartum period (which is 12 months)

1) Completion of covered services shall be provided for the duration relating to the pregnancy

d. A terminal illness – an incurable or irreversible condition that has high probability of causing death within one year or less

1) Completion of covered services shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date of 12 months from effective date of coverage for a new member.

e. The care of a newborn between birth and age 36 months.

1) Completion of covered services under this paragraph shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly covered member.

f. Performance of a surgery or other procedure that is authorized by the MCP as part of a documented course of treatment and has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered member.

4. Partnership~~PHC~~ must review all available data to identify eligible providers that provided services to Special Populations during the 12 months preceding January 1, 2024 by January 1, 2024 or within 30 calendar days of receiving data for Special Populations. To minimize the risk of h~~a~~arm for disruptions in care, Partnership~~PHC~~ will focus their attention, ~~and~~resources, and provide continuity of care for transitioning members in the following Special Populations that include:

a. Adults and children with authorizations to receive ECM service
b. Adults and children with authorizations to receive CS
c. Adults and children receiving CCM
d. Enrolled in 1915(c) wavier programs
e. Receiving In-Home Supportive Services (IHSS)
f. Children and youth enrolled in CCS/CCS Whole Child Model
g. Children and youth receiving foster care, and former foster youth through age 25
h. In active treatment for the following chronic communicable diseases: HIV/AIDS, Tuberculosis, Hepatitis B and C
i. Taking immunosuppressive medications, immunomodulators, and biologics
j. Receiving treatment for end-stage renal disease (ESRD)
k. Living with an intellectual or developmental disability (I/DD) diagnosis
l. Living with a dementia diagnosis
m. In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months
n. Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
o. Receiving specialty mental health services (adults, youth, and children)
p. Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
q. Receiving hospice care (for duration of the terminal illness)
r. Receiving home health

s. Residing in Skilled Nursing Facilities (SNF)
t. Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
u. Receiving hospital inpatient care (for duration of the acute condition)
v. Post-discharge from inpatient hospital, SNF or sub-acute facility on or after December 1, 2023
w. Newly prescribed DME (within 30 days of January 1, 2024)
x. Members receiving Community-Based Adult Services

5. Enhanced protections for members accessing the Transplant benefit

~~f.~~ ~~a.~~ If the MCP is unable to bring a Transplant Program in Network, the Receiving MCP must make a good ~~-~~faith effort to:

a.

1) ~~1)~~ Enter into a CoC for Providers agreement with the hospital at which a Transplant Program is located as described in Section V.C and according to the following terms:
   a) Make explicit the existing statutory requirement that Receiving MCPs are to pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code
   b) Permit the CoC for Providers agreement to continue for the duration of the member's access to the transplant benefit.

~~1)~~ If the MCP is unable to enter into a CoC for Providers agreement, the MCP must:

2)
   a) Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
   b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement, per guidance in the Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.

~~(a) Make explicit the existing statutory requirement that Receiving MCPs are to pay, and transplant providers are to accept, FFS rates (section 14184.201(d)(2) of the Welfare and Institutions Code)~~

~~b) (b) Permit the CoC for Providers agreement to continue for the duration of the member's access to the transplant benefit.~~

~~2) If the MCP is unable to enter into a CoC for Providers agreement, the MCP must: (a) Arrange for the hospital at which the Transplant Program is located to continue to deliver services to a member as an OON provider, in accordance with the timeline in 2024 Medi-Cal Managed Care Plan Transition Policy Guide.~~

~~(b) Explain in writing to DHCS why the provider and the MCP could not execute a CoC for Provider agreement, per guidance in the Transition Monitoring and Related Reporting Requirements, of the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.~~

~~D.~~B. For members with written documentation of being diagnosed with a maternal mental health condition from the treating health care provider, completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

~~E.~~C. Partnership~~PHC~~ is not required to provide continuity of care for services that are not covered by Medi-Cal.

~~F.~~D. Continuity of care protections extend to primary care providers (PCPs), specialists, ECM providers, CS Providers, Skilled Nursing Facilities (SNFs), Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF/DD), Community-Based Adult Services (CBAS) providers, and select ancillary providers, including dialysis centers, physical therapist~~y~~, occupational therapists~~y~~, respiratory

therapists~~y~~, mental health providers, behavioral health treatment (BHT) providers, ~~and~~ speech therapy providers, doulas, and community health workers (CHW). They do not extend to all other ancillary providers such as radiology, laboratory, non-emergency medical transportation (~~NEMT~~NEMT), non-medical transportation (NMT), ~~dialysis centers,~~ and non-enrolled or carved-out service providers.

~~G.~~E. Partnership~~PHC~~ will provide continuity of care with an out-of-network provider when the following criteria are met:

1. Partnership~~PHC~~ is able to determine that the member has an ongoing relationship with the provider (defined as at least one non-emergency visit during the 12 months preceding January 1, 2024).
   a. Self-attestation is not sufficient to provide proof of an established relationship with a provider.
2. The provider is providing a service that is eligible for COC, and
~~2.~~3. The provider is willing to accept the higher of Partnership~~PHC~~'s contract rates or Medi-Cal Fee For Service (FFS) rates, and
~~3.~~4. The provider meets Partnership~~PHC~~'s applicable professional standards and has no disqualifying quality of care issues and,
~~4.~~5. The provider is a California State Plan approved provider, and
~~5.~~6. The provider supplies Partnership~~PHC~~ with all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

~~H.~~F. If a member changes managed care plans by choice following the initial enrollment into Partnership~~PHC~~, or if a member loses and then later regains Partnership~~PHC~~ eligibility, the 12-month continuity of care period may start over one time. If the member changes managed care plans or loses and regains Partnership~~PHC~~ eligibility a second time or more, the continuity of care (COC) period does not start over and the member does not have the right to a new 12-month period of continuity of care. ~~-~~If the member returns to Medi-Cal fee-for-service and later re-enrolls in Partnership~~PHC~~, the COC period does not start over.

1. Partnership~~PHC~~ must accept COC requests made over the telephone, electronically, or in writing, according to the requester's preference.
~~1.~~2. Partnership~~PHC~~ informs members of their continuity of care protections through the member welcome packet and the Partnership~~PHC~~ provider website. ~~–~~This information includes how the member, member's authorized representative, and/or provider may initiate continuity of care requests with Partnership~~PHC~~. ~~–~~All information provided is made available in threshold languages and alternative formats upon request.
~~2.~~3. Partnership~~PHC~~ also provides on-going training regarding continuity of care to both the Care Coordination and Member Services staff who interact regularly with members and/or providers.

~~I.~~G. Behavioral Health Treatment

1. For members under 21 years of age transitioning from a Regional Center (RC), Partnership~~PHC~~ must automatically generate a continuity of care request. Members do not have to independently request continuity of care from Partnership~~PHC~~. The State of California Department of Health Care Services (DHCS) will provide Partnership~~PHC~~ with a list of transitioning members whose services will transfer from the Regional Center to Partnership~~PHC~~. Partnership ~~PHC~~ will make a good faith effort to proactively contact the current treating provider(s) to begin the continuity of care process. For all members assigned to Partnership~~PHC~~ on or after July 1, 2018, who were not receiving BHT services from a Regional Center, Partnership~~PHC~~ will offer the same continuity of care as outlined below.
2. Continuity of Care for an out-of-network BHT provider can be granted for a member for up to 12 months when all of the following DHCS criteria is met:
   a. The member has an existing relationship with a qualified provider of BHT services. An existing relationship means the member has seen the out-of-network BHT provider at least one time during the six months prior to either the transition of services from the RC to Partnership~~PHC~~ or

the date of the member's initial enrollment with Partnership~~PHC~~ if enrollment occurred on or after July 1, 2018.

b. The provider and Partnership~~PHC~~ can agree to a rate, with the minimum rate offered by Partnership~~PHC~~ being the established Medi-Cal FFS rate for the applicable BHT service.
c. The provider does not have any documented quality of care concerns that would cause him/her to be excluded from the Partnership~~PHC~~'s network.
d. The provider is a California State Plan approved provider.
e. The BHT provider supplies Partnership~~PHC~~ with relevant treatment information for the purpose of determining medical necessity, as well as current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

3. If Partnership~~PHC~~ and the existing member's provider are unable to reach a continuity of care agreement by the date of transition to Partnership~~PHC~~, Partnership~~PHC~~ will reach out to the member to transition through a warm handoff to an in-network BHT provider to ensure no gaps in services will apply.
4. Additionally, if a member has an existing relationship (as defined above) with an in-network BHT service provider, Partnership~~PHC~~ will allow the member to continue BHT services with that provider.
5. BHT services will not be discontinued or changed during the continuity of care period until a new behavioral treatment plan has been completed and approved by Partnership~~PHC~~, regardless of whether the services are provided by the RC provider under continuity of care or a new, in-network Partnership~~PHC~~ provider.
6. Retroactive requests for BHT service continuity of care reimbursement are limited to services that were provided after a member's transition date to Partnership~~PHC~~, or the date of the member's enrollment into Partnership~~PHC~~, if the enrollment date occurred after the transition.

~~J.~~H. Specialty Mental Health Services to Non-Specialty Mental Health Services Transition:

1. Partnership~~PHC~~ provides outpatient non-specialty mental health services for members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health condition as defined by the current Diagnostic and Statistical Manual.
2. County Mental Health Plans (MHPs) are required to provide specialty mental health services (SMHS) for members who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health Information Notice (BHIN) 21-073. These criteria are less stringent for members under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit so children with a lower level of impairment may meet medical necessity criteria for SMHS services (see III.G. above).
3. Partnership~~PHC~~ will provide continuity of care with an out-of-network SMHS provider in instances where a member's mental health condition has stabilized such that the member no longer qualifies for SMHS service from the county MHP. Continuity of Care for SMHS services applies only to psychiatrists and/or mental health provider types permitted though California's Medicaid State Plan to provide outpatient non-specialty mental health services.
4. Continuity of care requests for non-specialty mental health services must meet all criteria outlined in section VI.A-F.
5. If the member later requires additional SMHS services from the county MHP to treat a serious mental illness and subsequently experiences sufficient improvement to be referred back to Partnership~~PHC~~ for non-specialty mental health services, the 12 month continuity of care period may start over one time.
6. If the member requires subsequent SMHS services from the county MHP after the continuity of care period has ended, the continuity of care period does not start over when the member returns to Partnership~~PHC~~ or changes managed care plans (i.e., the member does not have the right to a new

12 months of continuity of care).

~~K.~~I. WCM and CCS Members:

1. Please see policy MCCP2024 Whole Child Model for California Children's Services for continuity of care guidelines.

~~L.~~J. Pregnancy and Post-Partum Members:

1. Pregnant and post-partum Medi-Cal members who are assigned a mandatory aid code and who are transitioning from Medi-Cal FFS into Partnership~~PHC~~ or from MCPs with contracts expiring or terminating to Partnership~~PHC~~ on or after January 1, 2023 have the right to request continuity of care per criteria outlined ~~in VI.A.~~in VI.A.3. These requirements will apply for pregnant and postpartum members and newborn children who transition from Covered California to Medi-Cal due to eligibility requirements.

K. Adult Expansion Population Members:

1. For Adult Expansion Population Members with an existing PCP that is in-Network with the receiving MCP, Partnership~~HC~~ is required to maintain that assignment. Adult Expansion Population Members are not required to request COC to maintain their PCP assignment with PCPs that are in Partnership~~HC~~'s Network. If the PCP is out-of-Network, Partnership~~HC~~ is not expected to maintain that assignment; however, ~~the MC~~Partnership~~HC~~ must adhere to all Continuity of Care requirements in accordance with APL 23-022.

~~M.~~L. Continuity of Care (COC) Process:

1. Members, their authorized representative, or their provider may make a direct request to Partnership~~PHC~~ for continuity of care. Partnership ~~PHC~~ will begin to process the request within five (5) business days of receipt of the request. The COC process begins when Partnership~~PHC~~ starts to determine if the member meets the criteria outlined in section VI.A-K.~~J~~ and has a pre-existing relationship with the provider. Partnership~~HC~~ will complete non-urgent ~~the~~ request within 30 calendar days from the date Partnership~~HC~~ receives the request, or 15 calendar days if an immediate request or if the member's medical condition requires more immediate action such as upcoming appointments or other pressing care needs, or three (3) calendar days if this is an urgent request or if there is risk of harm to the member (as defined above).

~~1.~~ For members that have one of the following conditions listed under Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96)

2. , once Partnership~~PHC~~ has established a COC for Providers agreement with an eligible provider, Partnership~~HC~~ must reimburse the provider for covered services for the appropriate duration (as defined above) and as agreed upon with the provider.

3. For members under the Special Population (as defined above), Partnership~~HC~~ will initiate the COC process within 30 calendar days from receipt of the Special Populations data.

~~2.~~ If the COC request is made in advance of January 1, 2024, Partnership~~PHC~~ will provide the same level of support and will process the request by January 1, 2024 or according to the timeframes in VI.K.1, whichever is later.

4.

~~3.~~ Partnership~~PHC~~ will accept requests for COC over the telephone, electronically, or in writing, according to the requester's preference and will not require that the requester complete and/or submit paper or computer form if the requester prefers to make the request by telephone. Partnership~~PHC~~ will collect any necessary information from the requester over the telephone. Partnership ~~PHC~~ will consider any Medical Exception Request (MER) that has been denied as an automatic COC request.

5.

~~4.~~6. Partnership~~PHC~~ will utilize the following criteria to determine if a relationship exists:

a. FFS utilization data provided by DHCS, or

b. FFS utilization or claims data from an MCP with its contract expiring or terminating, or
c. Documentation from the member and/or provider which demonstrates a pre-existing relationship, or
d. Partnership~~PHC~~ claims data

~~5.~~7. If a pre-existing relationship has been established with an out-of-network provider, Partnership~~PHC~~ will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the member. Specifically, for ECM and CS Providers, if Partnership~~PHC~~ does not come to an agreement, Partnership~~PHC~~ must explain in writing to DHCS why Partnership~~PHC~~ and the ECM Provider could not execute a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship. Refer to policy MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) and MCUP3142 CalAIM Community Supports (CS) for more details.

~~6. If a pre-existing relationship has been established with an out-of-network provider, PHC will contact the provider and make a good faith effort to enter into a contract, letter of agreement, single-case agreement, or other form of relationship to establish a COC relationship for the member.~~

~~7.~~8. Partnership~~PHC~~ will accept and review retroactive COC requests for services that were already provided if the request meets all of the COC requirements in VI.A.- J. and the services that are subject to the request meet the following requirements:

a. Have dates of service that occur after the member's assignment to Partnership~~PHC~~ or dates of service that occur after 7/1/2018
b. Have dates of services within 30 calendar days of the first date of service for which the provider is requesting, or the date from which they have previously requested COC retroactive reimbursement, and
c. Are submitted to Partnership~~PHC~~ within 30 calendar days of the first date of service for which retroactive continuity of care is being requested

~~8.~~9. Each COC request is considered complete when the member is notified of the COC decision via member's preferred method of communication or by telephone. A written notice will also be mailed to the member within seven calendar days of the COC decision when:

a. Partnership~~HC~~ and the out-of-network FFS or prior MCP provider are unable to agree to a rate
b. Partnership~~HC~~ has documented quality of care issues; or
c. Partnership~~HC~~ makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days

~~9.~~10. Member Notifications

a. Partnership~~PHC~~ will provide acknowledgment of the COC request within the time frames specified below, advising the member that the COC request has been received, the date of receipt, whether the request was considered urgent, immediate, or non-urgent (as defined in Section VI.L~~K~~.1.), and the estimated timeframe of resolution. Partnership ~~PHC~~ will notify the member using the member's known preference of communication or by using one of these methods in the following order: telephone call, email and then notice by mail.
    1) For non-urgent, immediate ~~requests~~, and Special Population requests, acknowledgment of the COC request will be provided within seven calendar days of the decision.
    2) For urgent requests, acknowledgment of the COC request will be provided within the shortest applicable timeframe that is appropriate for the member's condition, but no longer than three calendar days of the decision.

~~b.~~

~~c.~~b. Member Notification of Denial

1) When a COC request is denied, the member will be offered an in-network alternative. If the member does not make an alternate choice, the member will be referred or assigned to an

in-network provider. When a COC request is denied and/or a member disagrees with the result of the process, a notice by mail will be sent within seven calendar days of the COC decision to include the following information:

a) A statement of Partnership~~PHC~~'s decision
b) A clear and concise explanation of the reason for denial
c) The member's right to pursue a grievance and/or appeal (please see policy CGA024 – Medi-Cal Member Grievance System).

~~d.~~c. Member Notification of Approval

1) If a provider meets all the necessary requirements, including agreeing to a letter of agreement or contract with Partnership~~HC~~, Partnership~~HC~~ will grant the COC request to allow access to that provider for the length of the continuity of care period unless the provider is only willing to work with Partnership~~PHC~~ for a shorter time frame. Upon approval, a notice by mail will be sent within seven calendar days of the COC decision including the following information:
   a) A statement of Partnership~~HC~~'s decision
   b) The duration of the COC agreement
   c) The process that will occur to transition the member's care at the end of the continuity of care period and
   d) The member's right to choose a different provider from Partnership~~PHC~~'s provider network
2) When the COC agreement has been established, Partnership~~PHC~~ will work with the provider to establish a plan of care for member.
3) At any time, members may change their provider to a network provider regardless of whether or not a COC relationship has been established.

~~e.~~d. Member Notification Prior to End of COC Period

1) 30 ~~630~~ days prior to the expiration of the COC approval, Partnership~~PHC~~ will notify the member using member's preferred method of communication about the process that will occur to transition the member to a network provider at the end of the COC period. Partnership~~PHC~~ will engage with the member and provider, including the transferring of the member's record, before the COC period ends to ensure continuity of services through the transition to a new provider. This serves as the notification that continuity of care will not be extended past the expiration date unless the member reaches out to Partnership~~PHC~~ prior to the date on the COC approval letter.
   ~~a.~~ Any request for extension of a COC request may be subject to Medical Director Review.
   a.
   ~~b.~~ Although not required by DHCS, Partnership~~PHC~~ may continue to work with the member's out-of-network provider past the 12 month COC period.
   b.
2) For members falling under the transition as outline in V.I, the notification timeframe is 60 days prior to the expiration of the COC approval.

~~10.~~11. Referrals

a. An approved out-of-network provider must work with Partnership~~PHC~~ and its contracted network and cannot refer the member to another out-of-network provider without authorization from Partnership~~PHC~~. In such cases, Partnership~~PHC~~ will make the referral if it the request meets medically necessity criteria and Partnership~~PHC~~ does not have an appropriate provider within its network.
b. At the request of the member, the member's authorized representative, or the provider, Partnership~~PHC~~ will allow transitioning members to keep authorized and scheduled specialist

appointments with out-of-network providers when COC has been established and the appointments occur during the COC period.

1) If a member, their authorized representative, or their provider contacts Partnership~~PHC~~ to request to keep an authorized and scheduled specialist appointment with an out-of-network provider that the member has not seen in the previous 12 months and there is no established relationship, Partnership~~PHC~~ may arrange for the member to keep the appointment or may schedule an appointment with a network provider on or before the member's scheduled appointment with the out-of-network provider.
2) If Partnership~~PHC~~ is unable to arrange a specialist appointment with a network provider on or before the member's scheduled appointment with the out-of-network provider, Partnership~~PHC~~ will make a good faith effort to allow the member to keep their appointment; however, since the appointment occurs after the transition into Partnership~~PHC~~, it does not meet criteria for a pre-existing relationship to request COC.

~~N.~~M. Continuity of Covered Services and Prior Treatment Authorizations:

1. Active prior treatment authorizations for services remain in effect for ~~90 days~~6 months and must be honored without a request by the member, member's authorized representative, or provider. Partnership~~PHC~~ will arrange for services authorized under the active prior treatment authorization with a network provider, or if there is no network provider to provide the service, with an out-of-network provider. Utilization data of Special Populations will be examined to identify active courses of treatment and the MCP will contact providers as needed to establish any necessary prior authorizations.
2. After 6~~90~~ months~~days~~, the active treatment authorization remains in effect for the duration of the treatment authorization or until new assessment is completed, whichever is shorter.
3. If a new assessment is not completed, the active treatment authorization remains in effect and after 6~~90~~ months~~days~~, the prior treatment authorization may be reassessed at any time. Reassessments for clinical necessity for members to continue accessing the transplant benefit will start no sooner than six months after the transition date. A new assessment is considered complete if the member has been seen in-person and/or via synchronous telehealth by a network provider who has reviewed the member's current condition and completed a new treatment plan that includes assessment of the services specified by the pre-transition active prior treatment authorization.
4. If reassessing Enhanced Care Management (ECM) authorizations after 6 month~~90 day~~s, the reassessment must be against ECM discontinuation criteria and not the ECM Population of Focus eligibility criteria. Please refer to policy MCCP2032 – CalAIM Enhanced Care Management (ECM~~)~~), MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and MCUP3142 CalAIM Community Supports (CS) for more details.
5. Durable Medical Equipment (DME): Partnership~~PHC~~ will allow transitioning members to keep their existing DME rentals and medical supplies from their existing provider under the criteria above (VI.L.1- 3). Additionally, if the DME or medical supplies have been arranged for a transitioning member but the equipment or supplies have not been delivered, Partnership~~PHC~~ will allow the delivery and for the member to keep the equipment or supplies for a minimum of 6 month~~90 day~~s following Partnership~~PHC~~ enrollment and until reassessed.
6. Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT): Partnership~~PHC~~ will allow members to keep the modality of transportation under the previous prior authorization with a network provider until member's continued transportation needs are reassessed. Refer to policy MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) for details.
7. Treatment Authorization Request (TAR) data or prior authorization data will be used to identify prior treatment authorizations, including authorized procedures and surgeries, and existing authorizations for DME and medical supplies. Partnership~~PHC~~ will pay claims for prior

authorizations or existing authorizations when data is incomplete.

~~O.~~N. Reporting

1. Partnership~~PHC~~ will report metrics related to COC provisions to DHCS. DHCS may request additional reporting on COC at any time and in a manner determined by DHCS.

~~IX.~~VII. REFERENCES:

A. DHCS All Plan Letter 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023~~Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, and for Medi-Cal Members Who Transition Into a New Medi-Cal Managed Care Health Plan on or after January 1, 2023~~ (08~~12~~/15~~27~~/2023~~2~~)

B. DHCS All Plan Letter 23-010 *Revised*: Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21 (11~~05~~/22~~04~~/2023)

C. Welfare and Institutions Code Sections 14132.03 and 14189

D. Knox-Keene Health Care Service Plan Act (California Health and Safety Code (H&S) section 1373.96)

~~D. Health and Safety (H&S) Code §1373.96~~

E. DHCS All Plan Letter 23-03~~41-005 *Revised*~~: California Children's Services Whole Child Model Program (12/27~~10~~/2023~~1~~)

F. DHCS All Plan Letter 23-018: Managed Care Health Plan Transition Policy Guide (06/23/2023)

~~E.~~G. DHCS All Plan Letter 23-031: Medi-Cal Managed Care Plan Implementation of Primary Care Provider Assignment for the Age 26-49 Adult Expansion Transition (12/20/2023)

~~X.~~VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Department Directors

B. Partnership~~PHC~~ Provider Manual

~~XI.~~IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer~~Senior Director~~, Health Services

~~XII.~~X. REVISION DATES: 8/19/15 effective 12/29/14 per DHCS; 11/18/15; 08/17/16; 08/16/17; *06/13/18; 11/14/18; 11/13/19; 09/09/20, 09/08/21; 09/14/22; 09/13/23; 08/14/24

*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

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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 Partnership~~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 Partnership~~PHC~~.

Partnership~~PHC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

MCCP2014 – A Continuity of Care Data Sharing Information: Successful data sharing among DHCS, Previous MCPs, and Receiving MCPs, will be critical to effectuate 2024 MCP Transition. Receiving MCPs must have access to ingestible, complete, accurate, and timely data from Previous MCPs and DHCS. Receiving MCPs must receive confirmation from Previous MCP to ensure that they completed all data transfer sharing activities. DHCS will require Previous MCPs to transmit utilization data, authorization data, member information, including preferred form of communication, supplemental accompanying data for Special Populations, and any additional data elements identified by DHCS for data transfer directly to Receiving MCPs.

I. DHCS Provided Data Files

Partnership HealthPlan of California (Partnership) must utilize information provided in the standard monthly Plan Data Feed to implement COC protections. DHCS will share the data outlined below which represents a subset of all Special Populations that can be identified by DHCS held data in eligibility and claims/encounters data.

Figure A: Summary of DHCS Provided Data Files

File	Description	Data Recipient	Refresh Frequency	Data Elements
Plan Transfer Status Report	Pending MCP enrollment for transitioning members.	Previous MCPs	Weekly, Beginning October 20, 2023	Refer to Figure 1: Plan Transfer Status Report Data Elements

Figure A.1: Plan Transfer Status Report Data Elements

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member Date of Birth	MM/DD/YYYY, Date
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Choice Plan	Alpha-Numeric, Text
Default Plan	Alpha-Numeric, Text

Figure B: Member Level Data

File	Description	Data Recipient	Refresh Frequency
Member Level Data	For transitioning members in November 2023: 1. Plan Data Feed historical utilization data 2. Treatment Authorization Request (TAR) data	Receiving MCPs	One-Time in November

Figure C: Plan Data Feed

File	Description	Data Recipient	Refresh Frequency
Plan Data Feed	Utilization information for all enrolled members	Receiving MCPs	Monthly (First of Each Month)

Figure D: Special Populations Member File

File	Description	Data Recipient	Refresh Frequency
Special Populations Member File	Member-level information, specifically CINs for transitioning members who meet Special Populations criteria (see MCCP2014 Continuity of Care (Medi-Cal) Policy for details),	Receiving MCPs must use both the DHCS-provided Special Populations Member File and the Previous MCP-provided Transitioning Member Special Population Information Data file to	Monthly for All Special Population Members from November 2023 through March 2024

	indicating the members' Special Population group(s)	identify Special Populations members' providers and begin outreach, a key tenet of the COC policies for Special Populations.	

II. Previous MCP Provided Data Files

DHCS is requiring Previous MCPs to share data with Receiving MCPs to ensure access to the most timely, accurate, and comprehensive member-level information to effectuate COC protections. The Previous MCP must complete all data sharing requirements outlined below (Figure E) that reflects a standardized set of "minimum necessary" data elements for data shared from the Previous MCP to Receiving MCPs, as well as standard file formats, transmission methods, and transmission frequencies.

Figure E: Summary of MCP Provided Data Files

File	Description	Data Recipient	Refresh Frequency
Transitioning Member Identifying Data	Identifying information (e.g., name, date of birth) and contact information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Utilization Data	Claims and encounter information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Authorization Data	Prior authorization information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	Scheduled transportation information for transitioning members	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Transitioning Member Special Populations Information Data	Transitioning members who meet Special Populations criteria and relevant accompanying data elements	Receiving MCPs and DHCS	Initial transfer November 2, weekly refreshes beginning in December
Special Populations Member Supportive Information Data	Transitioning member screening and assessment findings, and member Care Management Plans	Receiving MCPs and DHCS	Within 15 days of member changing to a new Care Manager or by January 1, 2024, whichever is later

Figure F: Accompanying Excel Attachments for Previous MCP Provided Data

DHCS has compiled the outlined data elements into four accompanying Excel workbooks for Previous MCPs to prepare data files to transmit to Receiving MCPs to enable implementation of Continuity of Care policies. Refer to Figure F table for details. Refer to policy MCCP2014 – Continuity of Care (Medi-Cal) for attachment details.

Excel Attachment File	Description
Continuity of Care (CoC) Data Template - 1) Data Elements for All Members	Previous MCPs must use this template to prepare member level data files for transitioning members outlined in Figures G-J
Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications	Previous MCPs must use these specifications to identify relevant members and prepare Transitioning Member Special Populations Data files

Continuity of Care (CoC) Data Template – 2b) Special Population Member File	Previous MCPs must use this template to prepare a file identifying members that meet the outlines criteria
Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data	Previous MCPs must use this template to prepare Special Populations accompanying data for certain Special Population groups for transmittal to Receiving MCPs

Figure G: Transitioning Member Identifying Data
Previous MCPs will share Transitioning Member Identifying Data files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined below in Figure G.1 and G.2.

Figure G.1: Transitioning Member Identifying Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Member First Name	Alpha-Numeric, Text
Member Last Name	Alpha-Numeric, Text
Member Date of Birth	MM/DD/YYYY, Date
Member Gender Code	Numeric 3-digit, Text
Member Homelessness Indicator	Numeric, 1 digit, Text
Member Residential Address	Alpha-numeric, Text
Member Residential City	Alpha-numeric, Text
Member Residential Zip Code	Alpha-numeric, Text
Member Mailing Address	Alpha-numeric, Text
Member Mailing City	Alpha-numeric, Text
Member Mailing Zip Code	Numeric, 5-digit
Member Phone Number	Numeric, 10-digit
Member Email Address	Alpha-Numeric, Text
Member's Preferred Form of Contact	Alpha-Numeric, Text
Description of Member's Selected Alternative Format	Alpha-Numeric, Text
Member's Preferred Language (Spoken)	Alpha-Numeric, Text
Member's Preferred Language (Written)	Alpha-Numeric, Text

Figure G.2: Transitioning Member Primary Care Provider Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Primary Care Provider/Name (Assigned PCP)	Alpha-numeric, Text
Primary Care Provider/National Provider Identifier (NPI)	Numeric, 10-digit, Text
Primary Care Provider/Phone Number	Numeric, 10-digit
Primary Care Facility Name	Alpha-numeric, Text
Primary Care Facility NPI	Numeric, 10-digit, Text
Primary Care Facility Phone Number	Numeric, 10-digit
Primary Care Facility Address	Alpha-numeric, Text
Medical Group	Alpha-numeric, Text
Medical Group TIN	Numeric, 9-digit
Last Visit Date	MM/DD/YYYY, Date

Figure H: Transitioning Member Utilization Data
Previous MCPs must share Transitioning Member Utilization Data files directly with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined in Section I (A-D) and Section II (E-F). Previous MCPs must share Transitioning Member Utilization Data files with Receiving MCPs and DHCS in accordance with the

required data elements and format outlined in the transitioning member claims/encounter information outlined below in Figure H.1.

Figure H.1: Transitioning Member Claims / Encounter Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Detail Service Date	MM/DD/YYYY, Date
Procedure Code	Alpha-Numeric, Text
HCPCS Modifier	Alpha-Numeric, Text
Revenue Code	Numeric, 4-digit, Text
Place of Service	Numeric, 2-digit, Text
Bill Type	Alpha-Numeric, Text
Billed Units	Numeric, 6-digit, Text
Tax Identification Number	Numeric, 9-digit, Text
Billing Provider NPI	Numeric, 10-digit, Text
Billing Provider First Name	Alpha-Numeric, Text
Billing Provider Last Name	Alpha-Numeric, Text
Billing Provider Phone Number	Numeric, 10-digit
Rendering Provider Taxonomy Code	Alpha-Numeric 9-digit, Text
Rendering Provider NPI	Alpha-Numeric, Text
Rendering Provider First Name	Alpha-Numeric, Text
Rendering Provider Last Name	Numeric, 10-digit
Rendering Provider Phone Number	Alpha-Numeric, Text
Rendering Provider Specialty Type	Alpha-Numeric, Text
Admittance Low Service Date	MM/DD/YYYY, Date
Discharge High Service Date	MM/DD/YYYY, Date
Diagnosis Code 1	Alpha-Numeric, Text
Diagnosis Code 2	Alpha-Numeric, Text
Diagnosis Code 3	Alpha-Numeric, Text
Diagnosis Code 4	Alpha-Numeric, Text

Figure I: Transitioning Member Authorization Data

Previous MCPs will share Transitioning Member Authorization Data files with Receiving MCPs and DHCS in accordance with the required transmission method and frequency outlined below in Figure I.1.

Figure I.1: Transitioning Member Authorization Information

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Requesting Provider Name	Alpha-numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number	Numeric, 10-digit
Requesting Facility Name	Alpha-numeric, Text
Requesting Facility NPI	Numeric, 10-digit, Text
Requesting Facility Phone Number	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit
Rendering Facility Name	Alpha-numeric, Text
Rendering Facility NPI	Numeric, 10-digit, Text
Rendering Facility Phone Number	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Units (as applicable)	Numeric 7-digit, Text

Service Code	Alpha-Numeric, 5-digit, Text
Service Code Description	Alpha-Numeric, Text
Diagnosis Code	Alpha-Numeric, Text
Diagnosis Description	Alpha-Numeric, Text
Authorization Status	Alpha-Numeric, Text
Authorization Type	Alpha, 2-digit, Text
Previous MCP Authorization Number	Alpha-Numeric, Text
Discharge Status	Alpha-Numeric, Text

Figure J: Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data
Receiving MCPs must identify scheduled NEMT/NMT services for which there is no provider scheduled or the provider is OON and either schedule a Network provider or an OON provider to transport the member. See policy MCCP2014 – Continuity of Care (Medi-Cal) for details and refer to Figure J.1 and J.2 for outlined data elements and format.

Figure J.1: Transitioning Member NEMT/NMT Schedule Data

Data Element	Format
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Level Of Transportation Service	Numeric, 1 digit, Text
Date of Scheduled Transportation Service	MM/DD/YYYY, Date
Time of Scheduled Transportation Service	hh:mm:ss, Time
Recurring Transportation Service Indicator	Numeric, 1 digit, Text
Member Phone Number	Numeric, 10-digit
Pickup Location	Alpha-Numeric, Text
Pickup Address	Alpha-Numeric, Text
LTC/SNF Phone Number	Numeric, 10-digit
Mode of Transport	Alpha-Numeric, Text
Transportation Provider Name	Alpha-Numeric, Text
Transportation Provider Phone Number	Numeric, 10-digit
Dropoff Provider Name	Alpha-Numeric, Text
Dropoff Provider Address	Alpha-Numeric, Text
Dropoff Provider Phone Number	Numeric, 10-digit
Current NMT/NEMT Vendor	Alpha-Numeric, Text
Transportation Notes	Alpha-Numeric, Text

Figure J.2: Transitioning Member PCS Information

Data Element	Format
Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text
Level Of Service	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Start Date of Standing Order	MM/DD/YYYY, Date
Mode of Transportation	Alpha-Numeric, Text
Requesting Provider Name	Alpha-Numeric, Text
Requesting Provider NPI	Numeric, 10-digit, Text
Requesting Provider Phone Number	Numeric, 10-digit
Rendering Provider Name	Alpha-numeric, Text
Rendering Provider NPI	Numeric, 10-digit, Text
Rendering Provider Phone Number	Numeric, 10-digit
PCS Notes	Alpha-numeric, Text

Figure K: Transitioning Member Special Populations Information Data
Previous MCPs must share Transitioning Member Special Populations Information Data files with Receiving MCPs in accordance with the required transmission method and frequency outlined in Section I (A-D) and Section II (E-F). Previous

MCPs must also share a copy of this data to DHCS to facilitate DHCS' oversight of the transition. For transitioning members not captured in the subset of members included in the *Special Populations Member File* provided by DHCS, including transitions involving subcontracted MCP terminations, the MCP and its subcontracted MCP are required to identify **both** Figure K.1 and Figure K.2 members and share all data elements outlined in this section.

Figure K.1: Special Populations for which DHCS Data is Primary Source of Information

Members Who Are:
• Children and youth receiving foster care and former foster youth through age 25
• Children and youth enrolled in CCS/CCS Whole Child Model
• Enrolled in Assisted Living Waiver
• Enrolled in HIV/AIDS waiver
• Enrolled in Home and Community-Based Services (HCBS) Waiver for Developmental Disabilities (DD)
• Enrolled in in Home and Community-Based Alternatives (HCBA) Waiver
• Enrolled in Multipurpose Senior Services Program MSSP
• Enrolled in Self-determination program for intellectual and DD
• Receiving In Home Supportive Services (IHSS)
• Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
• Receiving Community-Based Adult Services

Figure K.2: Special Populations for which Previous MCP Data is Primary Source of Information

Members Who Are:
• In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
• Living with an Intellectual or Developmental Disability (I/DD) diagnosis
• Newly prescribed DME (within 3 months prior to January 1, 2024)
• Accessing the transplant benefit
• Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
• Receiving hospital inpatient care
• Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or risk of mortality
• Taking immunosuppressive medications, immunomodulators and biologics
• Adults and children with authorizations to receive Enhanced Care Management services
• Adults and children with authorizations to receive Community Supports
• Living with a dementia diagnosis
• Pregnant or post-partum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
• Receiving home health
• Receiving hospice care
• Receiving Specialty Mental Health Services (adults, youth, and children)
• Receiving treatment for End Stage Renal Disease (ESRD)
• Residing in Skilled Nursing Facilities (SNF)
• Adults and children receiving Complex Care Management

Figure K.3: Previous MCP-Provided Special Population Accompanying Data Elements

Data Element	Format
Adults and children receiving Complex Care Management	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Reason for Care Management or Program type	Alpha-Numeric, Text
Care Management Open Date	MM/DD/YYYY, Date
Plan Contact Name	Alpha-Numeric, Text
Plan Contact Phone Number	Numeric, 10-digit
Assessment Completion Date	MM/DD/YYYY, Date
Care Plan Date	MM/DD/YYYY, Date
Members accessing the transplant benefit	
Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text
Transplant Stage	Alpha-Numeric, Text
Eligibility Plan Code	Alpha-Numeric, Text
Organ	Alpha-Numeric, Text

Transplant Date	MM/DD/YYYY, Date
Request Type	Alpha-Numeric, Text
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Transplant Waitlisting Date	MM/DD/YYYY, Date
Transplant Evaluation Date	MM/DD/YYYY, Date
Transplant Date	MM/DD/YYYY, Date
Request Type	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit
Living Donor Indicator	Numeric, 1 digit, Text
Transplant SAR Number	Numeric, 10 digit
Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis	Alpha-Numeric, Text
Discharge Date	MM/DD/YYYY, Date
Discharge Disposition	Numeric, 2 digit, Text
Facility Name	Alpha-Numeric, Text
Facility Type	Numeric, 1 digit, Text
Facility NPI	Numeric, 10 digit, Text
Facility Phone Number	Numeric, 10 digit
Receiving hospital inpatient care	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Admission Date	MM/DD/YYYY, Date
Admission Diagnosis	Alpha-Numeric, Text
Authorization Determination	Alpha-Numeric, Text
Authorization Status	Alpha-Numeric, Text
Bed Type Code	Alpha-Numeric, Text
Level of Care	Alpha-Numeric, Text
Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit
Adults and children with authorizations to receive Community Supports	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Servicing CS Provider Name	Alpha-Numeric, Text
Member's Servicing CS Provider NPI	Numeric, 10-digit, Text
Member's Servicing CS Provider Phone Number	Numeric, 10-digit
Authorization Begin Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date
Member received Community Supports	Numeric, 1 digit, Text
Community Supports approved: **Housing Transition/Navigation Services**	Numeric, 1 digit, Text
Community Supports approved: **Housing Deposits**	Numeric, 1 digit, Text
Community Supports approved**: Housing Tenancy and Sustaining Services**	Numeric, 1 digit, Text
Community Supports approved**: Short-Term Post-Hospitalization Housing**	Numeric, 1 digit, Text
Community Supports approved**: Recuperative Care (Medical Respite)**	Numeric, 1 digit, Text
Community Supports approved: **Respite Services**	Numeric, 1 digit, Text

Community Supports approved: **Day Habilitation Programs**	Numeric, 1 digit, Text
Community Supports approved: **Nursing Facility Transition/Diversion to Assisted Living Facilities**	Numeric, 1 digit, Text
Community Supports approved: **Nursing Facility Transition to a Home**	Numeric, 1 digit, Text
Community Supports: **Personal Care and Homemaker Services**	Numeric, 1 digit, Text
Community Supports: **Environmental Accessibility Adaptations**	Numeric, 1 digit, Text
Community Supports approved: **Medically Supportive Food/Meals/Medically Tailored Meals**	Numeric, 1 digit, Text
Community Supports approved: **Asthma Remediation**	Numeric, 1 digit, Text
Community Supports approved: **Other**	Numeric, 1 digit, Text
Adults and children with authorizations to receive Enhanced Care Management services	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text
Member's Assigned ECM Provider Name	Alpha-Numeric, Text
Member's Assigned ECM Provider NPI	Numeric, 10-digit, Text
Member's Assigned ECM Provider Phone Number	Numeric, 10-digit
Member's Servicing ECM Provider Name	Alpha-Numeric, Text
Member's Servicing ECM Provider NPI	Numeric, 10-digit, Text
Member's Servicing ECM Provider Phone	Numeric, 10-digit
ECM Population of Focus: Individuals Experiencing Homelessness: Adults without Dependent Children/Youth Living with Them Experiencing Homelessness	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Experiencing Homelessness: Homeless Families or Unaccompanied Children/Youth Experiencing Homelessness	Numeric, 1 digit, Text
ECM Population of Focus: Individuals At Risk for Avoidable Hospital or ED Utilization	Numeric, 1 digit, Text
ECM Population of Focus: Individuals with Serious Mental Health and/or SUD Needs	Numeric, 1 digit, Text
ECM Population of Focus: Individuals Transitioning from Incarceration	Numeric, 1 digit, Text
ECM Population of Focus: Adults Living in the Community and At Risk for LTC Institutionalization	Numeric, 1 digit, Text
ECM Population of Focus: Adult Nursing Facility Residents Transitioning to the Community	Numeric, 1 digit, Text
ECM Population of Focus: Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition	Numeric, 1 digit, Text
ECM Population of Focus: Children and Youth Involved in Child Welfare	Numeric, 1 digit, Text
ECM Population of Focus: Birth Equity Population of Focus	Numeric, 1 digit, Text
ECM Benefit Date Assessed/Approved	MM/DD/YYYY, Date
ECM Benefit Start Date	MM/DD/YYYY, Date
Residing in Skilled Nursing Facilities (SNF)	
Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text

Facility Name	Alpha-Numeric, Text
Facility NPI	Numeric, 10-digit, Text
Facility Phone Number	Numeric, 10-digit, Text
Level of Care	Alpha-Numeric, Text
Authorization Start Date	MM/DD/YYYY, Date
Authorization End Date	MM/DD/YYYY, Date

III. Continuity of Care Coordination and Management Information

Transitioning members in Special Populations who are receiving care management services from their Previous MCP will change to a new Care Manager on January 1, 2024, upon transitioning to Receiving MCPs. The Previous MCP must transfer supportive information that includes, but is not limited to, results of available member screening and assessment findings, and member Care Management Plans. Transitioning members receiving CCM services are expected to continue receiving these services from Receiving MCPs. To facilitate the sharing of supportive information important for members' care coordination and management for these transitioning members, the Previous MCP shall designate key staff with appropriate training and experience to serve as the plan-level contact(s). The Previous MCP must provide to Receiving MCPs, by November 2, 2023, contact information for plan-level staff and for the Care Managers (program level contact information) who served transitioning members. Receiving MCPs must proactively contact the Previous MCP's point of contact(s) for Care Managers in order to obtain information to mitigate gaps in members' care. Previous MCPs must share supportive data for these members before January 1, 2024 or within 15 calendar days of the member changing to a new Care Manager, whichever is later.

Figure L:

Members in Inpatient Hospital Care	Members Accessing the Transplant Benefit
The Previous MCP must inform the Receiving MCP of members known to be receiving inpatient care by December 22, 2023, and must refresh that information daily through January 9, 2024, including holidays and weekends. It is possible that Previous MCPs may stop receiving ADT feeds after December 31, 2023. MCP must also contact inpatient member's Primary Care Physician responsible for the member's care while they are admitted. Refer to MCCP2014 Continuity of Care (Medi-Cal) Policy for more details.	For members accessing the transplant benefit on January 1, 2024, Receiving MCPs are responsible for ensuring coordination of care between all providers, organ donation entities, and Transplant Programs. Receiving MCPs must ensure that members accessing the transplant benefit are provided services and/or treatments as expeditiously as possible.

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Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. MCPs must use this template to prepare member level data files for **all** transitioning members in accordance with requirements outlined in Sections VIII of the Policy Guide. Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V. of the Policy Guide.

File	Data Elements	Required Naming Convention	Field Description	Format	Notes
Transitioning Member Identifying Data	Transitioning Member Identifying Data	C01_INFO	Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text	
			Member First Name	Alpha-Numeric, Text	
			Member Last Name	Alpha-Numeric, Text	
			Member Date of Birth	MM/DD/YYYY, Date	
			Member Gender Code	Numeric 3-digit, Text	This will be limited to the Medi-Cal 834 file acceptable values.
			Member Homelessness Indicator	Numeric, 1 digit, Text	Identifier for if the member is experiencing "homelessness," as defined in the ECM Policy Guide (pgs. 11-12). If "homeless," enter "2", if not, enter "1", if unknown, enter "0".
			Member Residential Address	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Residential City	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and Residential City is not available.
			Member Residential Zip Code	Alpha-numeric, Text	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Mailing Address	Alpha-numeric, Text	MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.
			Member Mailing City	Alpha-numeric, Text	MCPs may complete field as "HOMELESS" if the member is identified as homeless by the "Member Homelessness Indicator" and another address is not available.
			Member Mailing Zip Code	Numeric, 5-digit	MCPs may complete data element as "99999" if the member is identified as homeless by the "Member Homelessness Indicator" and another zip code is not available.
			Member Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Member Email Address	Alpha-Numeric, Text	
			Member's Preferred Form of Contact	Alpha-Numeric, Text	Member's Preferred Form of Contact, as known by MCP (e.g., "CALL", "TEXT", "EMAIL", "MAIL"). If not known, MCP may report "UNKNOWN".
			Description of Member's Selected Alternative Format	Alpha-Numeric, Text	If applicable, member's selected alternative format, as known by MCP (e.g., "LARGE PRINT", "AUDIO CD", "DATA CD", "BRAILLE"). If not known, MCP may report "UNKNOWN".
Transitioning Member Identifying Data	Primary Care Provider Information	C02_PCP	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Primary Care Provider/Clinic Name (Assigned PCP)	Alpha-numeric, Text	
			Primary Care Provider/Clinic National Provider Identifier (NPI)	Numeric, 10-digit, Text	
			Primary Care Provider/Clinic Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Medical Group	Alpha-numeric, Text	
			Medical Group TIN	Numeric, 9-digit	
			Last Visit Date	MM/DD/YYYY, Date	As known by the MCP; if no visits on record, MCP should enter "00/00/0000".
			Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Detail Service Date	MM/DD/YYYY, Date	
			Procedure Code and Description	Alpha-Numeric, Text	
			HCPCS Modifier	Alpha-Numeric, Text	
			Revenue Code and Description	Alpha-Numeric, Text	
			Place of Service	Numeric, 2-digit, Text	
			Bill Type	Alpha-Numeric, Text	

File	Data Elements	Required Naming Convention	Field Description	Format	Notes
Transitioning Member Utilization Data	Transitioning Member Claims / Encounter Information	C03_CLAIMS	Billed Units	Numeric, 6-digit, Text	
			Tax Identification Number	Numeric, 9-digit, Text	
			National Provider Identifier (NPI)	Numeric, 10-digit, Text	
			Provider First Name	Alpha-Numeric, Text	
			Provider Last Name	Alpha-Numeric, Text	
			Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Provider Specialty Type	Alpha-Numeric, Text	
			Admittance Low Service Date	MM/DD/YYYY, Date	
			Discharge High Service Date	MM/DD/YYYY, Date	
			Diagnosis Code 1	Alpha-Numeric, Text	
			Diagnosis Code 2	Alpha-Numeric, Text	
			Diagnosis Code 3	Alpha-Numeric, Text	
			Diagnosis Code 4	Alpha-Numeric, Text	
Transitioning Member Authorization Data	Transitioning Member Authorization Information	C04_PA	Medi-Cal Member CIN	Alpha-Numeric 9-digit,	
			Referring Provider Name	Alpha-numeric, Text	
			Referring Provider NPI	Numeric, 10-digit, Text	
			Referring Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Authorization Begin Date	MM/DD/YYYY, Date	
			Authorization End Date	MM/DD/YYYY, Date	
			Units (as applicable)	Numeric 7-digit, Text	
			Level of Service	Alpha-Numeric, Text	
			Service Code	Alpha-Numeric, 5-digit,	
			Service Code Description	Alpha-Numeric, Text	
			Diagnosis Code	Alpha-Numeric, Text	
			Diagnosis Description	Alpha-Numeric, Text	
			Prior Authorization Status	Alpha-Numeric, Text	
			Authorization Type	Alpha, 2-digit, Text	
Transitioning Member NEMT/NMT Schedule and Physician Certification Statement Data	NEMT/NMT Schedule Data	C05_NEMTNMT	Medi-Cal Member CIN	Alpha-Numeric 9-digit,	
			Level Of Service	Alpha-Numeric, Text	
			Days of Week of Scheduled Service	Alpha-Numeric, Text	
			Time of Scheduled Service	Alpha-Numeric, Text	
			Member Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Pickup Location	Alpha-Numeric, Text	Indicates NEMT/NMT pickup locations (e.g., "MEMBER HOME", "SNF", "LTC").
			Pickup Address	Alpha-Numeric, Text	
			LTC/SNF Phone Number	Numeric, 10-digit	If applicable. Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Mode of Transport	Alpha-Numeric, Text	Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").
			Transportation Provider Name	Alpha-Numeric, Text	
			Transportation Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Dropoff Provider Name	Alpha-Numeric, Text	
			Dropoff Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
			Current NMT/NEMT Vendor	Alpha-Numeric, Text	
			Transportation Notes	Alpha-Numeric, Text	
Transitioning Member NEMT/NMT Schedule			Medi-Cal Member Client Index Number (CIN)	Alpha-Numeric 9-digit, Text	
			Level Of Service	Alpha-Numeric, Text	
			Authorization Begin Date	MM/DD/YYYY, Date	
			Authorization End Date	MM/DD/YYYY, Date	
			Standing Orders	Alpha-Numeric, Text	

File	Data Elements	Required Naming Convention	Field Description	Format	Notes
NEMT/NMT Schedule Data and Physician Certification Statement Data	Physician Certification Statement (PCS) Data	C06_PCS	Mode of Transportation	Alpha-Numeric, Text	Member's Mode of Transportation, as known by MCP (e.g., "AMBULANCE", "ADVANCED LIFE SUPPORT AMBULANCE", "BASIC SUPPORT AMBULANCE", "GURNEY VAN/LITTER VAN", "WHEELCHAIR VAN", "AIR TRANSPORT").
			Requesting Provider Name	Alpha-Numeric, Text	
			Requesting Provider NPI	Numeric, 10-digit, Text	
			Requesting Provider Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".

Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications

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Version: 1.0

This workbook is an attachment to the 2024 Managed Care Transition Policy Guide. MCPs must use this identification strategy to identify relevant members in accordance with requirements outlined in Section VIII of the Policy Guide and prepare *Transitioning Member Special Populations Information* data files inclusive of required data elements in the *Continuity of Care (CoC) Data Template – 2b) Special Population Member File* and *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data* templates for sharing with Receiving MCPs. Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V. of the Policy Guide.

Population	Tab Name	Look-back Period
Adults and children receiving Complex Care Management	M01_CCM	12 months
In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C	M02_CHRONIC_DX	90 days
Living with an intellectual or developmental disability (I/DD) diagnosis	M03_IDD	12 months
Newly Prescribed DME (within 30 days of January 1, 2024)	M04_NEW_DME	30 days
In the transplant evaluation process, or any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	M05_TP	12 months
Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023	M06_DIS_IP_HOSP, M07_DIS_IP_LTC	30 days
Receiving hospital inpatient care	M08_IP	Point in Time
Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality	M09_TX_WITH_MORT	90 days
Taking immunosuppressive medications, immunomodulators, and biologics	M10_TX_IMMUNE_BIO	90 days
Adults and children with authorizations to receive Community Supports	M11_CS	12 months
Adults and children with authorizations to receive Enhanced Care Management services	M12_ECM	12 months
Living with a dementia diagnosis	M13_DEM_DX	12 months
Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)	M14_MAT_MH, M15_PRE_POST	12 months
Receiving home health	M16_HH	30 days
Receiving hospice care	M17_HOSPICE	30 days
Receiving specialty mental health services (adults, youth, and children)	M18_SMHS	12 months
Receiving treatment for end-stage renal disease (ESRD)	M19_END_STAGE_RENAL	90 days
Residing in Skilled Nursing Facilities (SNF)	M20_SNF	90 days

Last Updated: 8/7/2023
Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. Previous MCPs must use this template to identify transitioning members who meet Special Populations criteria outlined in *Continuity of Care (CoC) Data Template - 2a) Special Populations Specifications*. For certain populations, Previous MCPs must also provide accompanying data elements using the *Continuity of Care (CoC) Data Template – 2c) Special Populations Accompanying Data.* Receiving MCPs will utilize the resulting member level data to implement Continuity of Care policies in Section V. of the Policy Guide.

Required Naming Convention	Data Type	Field Name	Field Description	Format	Notes
B01_MEM	*Member Special Populations Information*	Medi-Cal Member CIN	Medi-Cal Member CIN	Alpha-Numeric 9 digit, Text	
		CCM	Adults and children receiving Complex Care Management	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		CHRONIC_DX	In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		IDD	Living with an intellectual or developmental disability (I/DD) diagnosis	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		NEW_DME	Newly Prescribed DME (within 30 days of January 1, 2024)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TP	In the transplant evaluation process, or any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		DIS	Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		IP	Receiving hospital inpatient care	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TX_WITH_MORT	Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		TX_IMMUNE_BIO	Taking immunosuppressive medications, immunomodulators, and biologics	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		CS	Adults and children with authorizations to receive Community Supports	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		ECM	Adults and children with authorizations to receive Enhanced Care Management services	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		DEM_DX	Living with a dementia diagnosis	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		MAT_MH_PRE_POST	Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		HH	Receiving home health	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		HOSPICE	Receiving hospice care	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		SMHS	Receiving specialty mental health services (adults, youth, and children)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		END_STAGE_RENAL	Receiving treatment for end-stage renal disease (ESRD)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"
		SNF	Residing in Skilled Nursing Facilities (SNF)	Numeric, 1 digit, Text	Identifier for if the member meets Special Populations criteria. If "yes," enter "1", if no enter "0"

Last Updated: 8/7/2023
Version: 1

This template is an attachment to the 2024 Managed Care Transition Policy Guide. MCPs must use this template in conjunction with the template *2a) Special Populations Specifications* to prepare the accompanying data elements listed below to share with Receiving MCPs, in accordance with requirements outlined in Section VIII of the Policy Guide. Receiving MCPs will utilize the resulting member level Special Populations data to implement Continuity of Care policies in Section V. of the Policy Guide.

File	Required Naming Convention	Special Population	Field Description	Format	Notes
Transitioning Member Special Populations Information	M01_CCM	Adults and children receiving Complex Care Management	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Reason for Care Management or Program type	Alpha-Numeric, Text	
			Care Management Open Date	MM/DD/YYYY, Date	
			Plan Contact Name	Alpha-Numeric, Text	
			Plan Phone Number	Numeric, 10-digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M02_TP	In the transplant evaluation process, or any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Transplant Stage	Alpha-Numeric, Text	Indicates which phase of the transplant process the member is in ("CONSULTATION/PRE-SCREEN", "EVALUATION", " PRE-TRANSPLANT/WAITLIST", "TRANSPLANT EPISODE", "POST TRANSPLANT", or "UNKNOWN").
			Eligibility Plan Code	Alpha-Numeric, Text	
			Organ	Alpha-Numeric, Text	
			Transplant Date	MM/DD/YYYY, Date	
			Request Type (Outpatient, Inpatient)	Alpha-Numeric, Text	
			Facility Notify Date	MM/DD/YYYY, Date	
			Facility Name	Alpha-Numeric, Text	
			Facility NPI	Numeric, 10 digit, Text	
			Facility Phone Number	Numeric, 10 digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M03_DIS	Post-discharge from inpatient hospital, SNF, ICF/DD, or sub-acute facility on or after December 1, 2023	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Facility Name	Alpha-Numeric, Text	
			Facility Type	Numeric, 1 digit, Text	Indicates member facility type, ("INPATIENT", "SNF", "SUB-ACUTE").
			Facility NPI	Numeric, 10 digit, Text	
			Facility Phone Number	Numeric, 10 digit	Numbers only, no dashes, character limit of ten. If number not available to the MCP, MCP may report "0000000000".
Transitioning Member Special Populations Information	M04_IP	Receiving hospital inpatient care	Medi-Cal Member CIN	Alpha-Numeric 9-digit, Text	
			Facility Name	Alpha-Numeric, Text	
			Facility NPI	Numeric, 10 digit, Text	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3052 (previously UP100352)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Medical Nutrition Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 05/16/2001</td><td colspan="4">Next Review Date: ~~09/13/2024~~08/14/2025
Last Review Date: ~~09/13/2023~~08/14/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/13/2023~~08/14/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3113 - Telehealth Services
B. MCCP2026 - Diabetes Prevention Program
C. MCUP3145 - Eating Disorder Management Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Nutrition Therapy (MNT): An evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/ re-assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. [Academy of Nutrition and Dietetics (see latest edition)]
B. Registered Dietician (RD): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)
C. Certified Diabetes Educator (CDE®): A health professional who possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention, and management. The CDE® educates and supports people affected by diabetes to understand and manage the condition. A CDE® promotes self-management to achieve individualized behavioral and treatment goals that optimize health outcomes. The Certification Examination for Diabetes Educators (Examination) is designed and intended for health professionals who have responsibilities that include the direct provision of diabetes self-management education (DSME), as defined by National Certification Board for Diabetes Educators.

IV. ATTACHMENTS:

A. Referral Guidelines for Children/Adolescents
B. Referral Guidelines for Adults
C. Adult Body Mass Index

Policy/Procedure Number: MCUP3052 (previously UP100352)		Lead Department: Health Services
Policy/Procedure Title: Medical Nutrition Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/16/2001	**Next Review Date:** ~~09/13/2024~~08/14/2025 **Last Review Date:** ~~09/13/2023~~08/14/2024	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

V. PURPOSE:

To define the criteria for medically necessary referrals and continuing services for medical nutrition therapy (MNT) and Diabetes education services for children and adults.

The Patient Protection and Affordable Care Act of 2010 requires all United States Preventive Services Task Force (USPSTF) recommendations with class A or B be covered. The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. Grade: B Recommendation. Children are also covered under this policy, as an enhanced benefit.

VI. POLICY / PROCEDURE:

A. Medical nutrition therapy (MNT) must be provided by a Registered Dietitian (RD) or Certified Diabetes Educator (CDE®). The RD or CDE may either be working for a provider contracted with Partnership HealthPlan of California (~~PHC~~Partnership) (including primary care, specialist, hospital, home health agency, or hospice) or may be an unaffiliated RD or CDE contracted individually with Partnership~~PHC~~. In either case, the RD and/or CDE® documentation must be on file with the Provider Relations department of Partnership~~PHC~~ for claims to be paid.

B. MNT Services must meet state and federal standards of medical necessity. Diagnoses that are covered are listed in Attachments A and B. The frequency of services in Attachments A and B are guidelines, not maximum requirements. No Referral Authorization Form (RAF) nor Treatment Authorization Request (TAR) is required.

C. The following codes should be used as applicable when submitting a claim for MNT services.

1. 97802 - Initial Visit - Medical Nutritional Therapy (outpatient initial assessment, is limited to one initial visit per year per diagnosis grouping listed in the attached criteria. No RAF is required, although a clinician referral (Physician or Non-Physician Clinician) must be documented in the medical record.
2. 97803 - Medical Nutrition Therapy- Individual follow-up outpatient nutritional counseling education
3. 97804 - Medical Nutrition Therapy- Group reassessment and intervention. Must have an individual assessment prior to first group appointment.
4. 99539 ~~–~~ Home/Telehealth Medical Nutrition Therapy – Nutritional Counseling/Education/Assessments
5. 98970 thru 98972 - Monitoring Meal Plan Journals virtually between sessions. Registered Dieticians may bill Partnership~~PHC~~ for these codes when treating a ~~member~~Member who has been diagnosed with an eating disorder. No TAR is required when the ~~member~~Member has an eating disorder diagnosis code on record (as defined in Attachments A and B.)
6. G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes. Partnership~~PHC~~ allows up to 8 hours to be billed without a TAR in a rolling 12-month period. *(code may not be billed on same date of service as CPT codes 97802 thru 97804)*
7. G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes. *(may not be billed on same date of service as CPT codes 97802 thru 97804)*
8. Z6200, Z6202, Z6204 - Medical nutrition therapy ante-partum/post-partum, individual, provided in a Perinatal Services Program based on perinatal services program guidelines

~~7.~~9. Z6206, Z6208 - Medical Nutrition Therapy antepartum, group, recommendations/ limits based on Perinatal Services Program allowances

D. Nutrition supplements

1. Physician administered nutritional supplements~~-~~ require a TAR to be submitted to Partnership~~PHC~~ when the item is billed to Partnership~~PHC~~'s medical benefit and is not on Partnership~~PHC~~'s Medical Drug List (MDL), or when the MDL~~PHC Medical Drug List~~ indicates a prior authorization is required.

2. Nutritional supplements provided by a Pharmacy must be submitted through the Medi-Cal Rx TAR process* when not on the Medi-Cal Rx Contract Drugs List (CDL).
3. Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

~~The Pharmacy Department may request a nutritional evaluation. Nutritional evaluation claims should be submitted using code 97803.~~
~~Claims for nutritional supplement prescriptions must be submitted through the pharmacy benefit.~~
*__NOTE__: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised, "Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx." Please refer to the State Medi-Cal Rx webpage ~~Contract Drugs List (CDL),~~ which is found ~~in both the Medical and Pharmacy provider manual sections of the website~~ at https://medi-calrx.dhcs.ca.gov/home/

VII. REFERENCES:

A. United States Preventive Services Task Force (USPSTF) recommendations
B. Medi-Cal Provider Manual/ Guidelines: Medicine *(medne)*
C. DHCS All Plan Letter (APL) 22-012 *Revised* – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)

VIII. DISTRIBUTION:

A. Partnership~~PHC~~ Department Directors
B. Partnership~~PHC~~ Provider Manual

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

X. REVISION DATES:

05/15/02, 08/20/03; 11/17/04; 11/16/05; 10/18/06; 08/15/07, 08/20/08; 07/21/10; 01/18/12; 08/21/13; 01/15/14; 02/18/15; 03/16/16; 03/15/17; *06/13/18; 06/12/19; 06/10/20; 01/13/21; 01/12/22; 08/10/22; 09/13/23; 08/14/24

*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 Partnership~~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 Partnership~~PHC~~.

Partnership~~PHC~~'s authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES FOR CHILDREN / ADOLESCENTS

Nutrition Criteria/ ICD-10 Codes	Definition of Child/Adolescent Criteria	Recommended Number of Visits
Diabetes E10.10 – E11.9	Type 1 & Type 2	4 visits over 6 months
Eating disorders F50.00 - F50.02 F50.2, F50.8 – F50.9	Anorexia nervosa, bulimia or other feeding or eating disorder	4 visits over 2 months
Lead poisoning T56.0X1A – T56.0X4S	Blood Lead Level	4 visits over 6 months
Obesity and Overweight E66.9, E66.3	Ages 2 – 19 years: > 85th percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS)	8 visits over 1 year
Pre-diabetes (impaired glucose tolerance) R73.01 – R73.09	Impaired fasting glucose of ≥ 100 mg/dl, but <125 mg/dl. **and/or** impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of ≥ 140 mg/dl, but less than 200 mg/dl	2 visits over 6 months
Pregnancy Related Conditions O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34	All pregnant individuals with these diagnoses are eligible for MNT	see Perinatal Services visit recommendations OR 1-2 visits per month up to 12 months after delivery
Severe anemia D50.0 – D50.9 D53.9	Has received a trial of iron therapy for 2 months and **who still has a** Hemoglobin less than or equal to 9.0gm/dl **and a** hemoglobin electrophoresis which does not indicate hemoglobinopathy	3 visits over 6 months
Severe food hypersensitivity L27.2	Diagnosed food hypersensitivity to casein, gluten, or soy	2 visits over 6 months
Short Stature R62.0 R62.50 – R62.52	Measurement below the 5th percentile height for age using the appropriate growth chart for age (NCHS)	3 visits over 6 months
Under weight, and/or failure to thrive R62.0 R62.50 – R62.52	Measurement below the 5th percentile weight for height using the appropriate growth chart (NCHS) **or** Dramatic drop on the growth curve from previous visit by two percentiles	3 visits over 6 months

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES ~~REFERRAL GUIDELINES~~ FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Cardiovascular disease/or risk of **E78.0 – E78.3, E78.5** **I70.0 – I70.249** **I70.261 – I70.299** **I70.401 – I70.419** **I70.501 – I70.519** **I70.8 – I70.92, I10 – I11.9**	Hypertension, hyperlipidemia **and/or** coronary artery disease	3 visits over 3 months
Decubitus ulcer **L89.90 – L89.95** **L89.000 – L89.029** **L89.110 – L89.149 L89.200 – L89.329 L89.500 – L89.819**	Increased nutritional need due to wound	1 visit
Pre-diabetes (impaired glucose tolerance) **R73.01 – R73.09**	Impaired fasting glucose of ≥ 100 mg/dl, but <125 mg/dl. **and/or** impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of ≥ 140 mg/dl, but less than 200 mg/dl	2 visits over 6 months
Diabetes **E10.10 – E11.9**	Type 1 & Type 2	4 visits over 6 months
Eating disorder **F50.00 – F50.02** **F50.2, F50.8 – F50.9**	Anorexia nervosa, bulimia or other feeding or eating disorder	4 visits over 2 months
Gastrointestinal disease: **Crohn's Disease** **K50.00, K50.10, K50.80, K50.90** **·Ulcerative colitis** **K51.00, , K51.20, K51.30, K51.40, K51.50, K51.80, K51.90 K52.9** **· Irritable bowel syndrome** **K58.9** **·Malabsorption, s/p GI surgery** **K90.0 – K90.3** **K90.81 – K90.9**	Need for dietary manipulation due to gastrointestinal condition	2 visits over 2 months
HIV/AIDS **B20**	Nutritional problems related to HIV/AIDS	4 visits over 3 months

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES
~~REFERRAL GUIDELINES~~ FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Liver disease **K70.0 – K70.31** **K72.91, K73.0, K73.2, K73.9, K74.5 – K75.1, K75.4, K75.9, K76.3, K76.6 – K77**	Need for dietary manipulation due to declining liver function	2 visits over 2 months
Obesity **E66.9, E66.2**	BMI ≥ 30 Kg/m² **and** at medical risk with concurrent medical problem(s) **or** BMI ≥ 27 Kg/m² with CVD complications	2 individual appointments and group weight management program over 6 months
Overweight **E66.3**	BMI between 25 and 29.9 Kg/m², **and** Waist to Hip Ratio ≥ .95 in men and ≥ .85 in women	Group weight management program over 6 months
Pre-End Stage Renal and/or Chronic Kidney Disease **N01.0, N03.1 – N03.2, N03.5, N03.8 – N03.9, N04.0 – N04.2, N04.5, N04.8 - N04.9, N05.1 – N05.2, N05.5, N05.8 – N05.9, N08, N17.0 – N17.2, N17.8 – N17.9, N18.1 – N19**	Need for dietary manipulation due to declining renal function (pre-dialysis)	2 visits over 2 months
Pregnancy Related Conditions **O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34**	All pregnant individuals with these diagnoses are eligible for MNT	see Perinatal Services visit recommendations OR 1-2 visits per month up to 12 months after delivery
Substance abuse **Z79, ~~-~~F10.10, F11.10, F11.20 – F11.21, F12.10, F12.20 – F12.21, F13.10, F13.20 – F13.21, F14.10, F14.20 – F14.21, F15.10, F15.20 – F15.21, F16.10, F16.20 – F16.21, F17.200, F18.20 – F18.21, F19.10, F19.20 – F19.21**	Nutritional problems related to substance abuse	4 visits over 4 months

MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES ~~REFERRAL GUIDELINES~~ FOR ADULTS

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
Undernutrition or risk of related to dietary deficiency: **E40 – E41, E43 – E51.12, E51.8, E52 – E56.1, E56.9, E58, E63.8 – E63.9, E64.3** **Poor dentition, poor appetite, unexplained weight loss** **R63.0, R63.3 - R63.6** **Cachexia** **R64**	Poor nutritional status related to a variety of medical problems, including cancer, cancer treatment, frail elder, etc.	2 visits over 2 months

ADULT BODY MASS INDEX

Body weight in lb (kg)/height (m)²

Height in inches (cm)	BMI 25	BMI 27	BMI 30
58 (147.32)	119 (53.98)	129 (58.51)	143 (64.86)
59 (149.86)	124 (56.25)	133 (60.33)	148 (67.13)
60 (152.40)	128 (58.06)	138 (62.60)	153 (69.40)
61 (154.94)	132 (59.87)	143 (64.86)	158 (71.67)
62 (157.48)	136 (61.69)	147 (66.68)	164 (74.39)
63 (160.02)	141 (63.96)	152 (68.95)	169 (76.66)
64 (162.56)	145 (65.77)	157 (71.21)	174 (78.93)
65 (165.10)	150 (68.04)	162 (73.48)	180 (81.65)
66 (167.64)	155 (70.31)	167 (75.75)	186 (84.37)
67 (170.18)	159 (72.12)	172 (78.02)	191 (86.64)
68 (172.72)	164 (74.39)	177 (80.29)	197 (89.36)
69 (175.26)	169 (76.66)	182 (82.56)	203 (92.08)
70 (177.80)	174 (78.93)	188 (85.28)	207 (93.89)
71 (180.34)	179 (81.19)	193 (87.54)	215 (97.52)
72 (182.88)	184 (83.46)	199 (90.27)	221 (100.25)
73 (185.42)	189 (85.73)	204 (92.53)	227 (102.97)
74 (187.96)	194 (88.00)	210 (95.26)	233 (105.69)
75 (190.50)	200 (90.72)	216 (97.98)	240 (108.86)
76 (193.04)	205 (92.99)	221 (100.25)	246 (111.58)

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Population Health Management Strategy & Program Description

MCND9001
(previously MCCD2027)

~~June 2023~~~~January~~June 2024~~4~~

Original Date: 11/13/2019~~11/13/2019~~11/13/2019
Previously Applied to MCCD2027 11/13/19 to 04/08/20
Revision Dates: MCND9001 04/08/20; 08/11/21; 08/10/22; 0~~8~~6/09~~1~~4/23: 6/2024

Table of Contents

Program Purpose

To identify the strategy and organizational structure Partnership HealthPlan of California (Partnership) utilizes to assess, segment, and act in order to meet the needs of its member population and subpopulations within the context of the various communities in which Partnership's members live.

Introduction

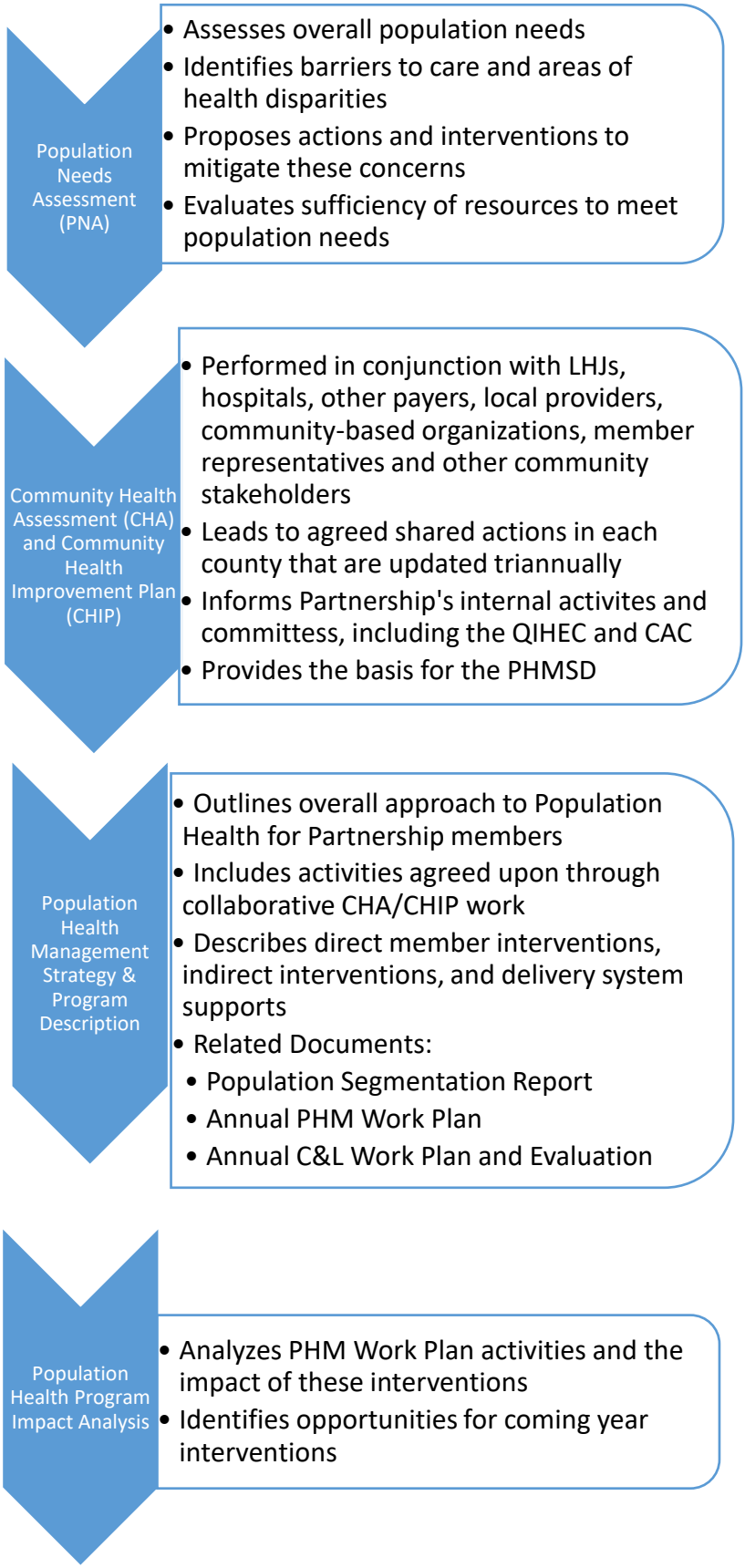
Partnership's Population Health Management (PHM) Strategy & Program Description outlines a cohesive plan of action for addressing Partnership's member needs across the continuum of care engaging not only the Population Health department, but also multiple departments within the organization. The unique characteristics and needs of Partnership's member population determine the programs and services designed to help individual members and subpopulation groups, in alignment with California's Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) requirements. This document also highlights Partnership-sponsored delivery system supports designed to enhance population health management within our provider network, describes the process for annual assessment of member needs, and the effectiveness of our population health strategy in meeting those needs. As part of Partnership's Population Health strategy, Partnership is committed to identifying root causes of health disparities for its members and collaborating across the organization, with providers, and with other community agencies to ~~eradicate~~ reduce inequities for the members we serve and to address Social Drivers of Health.~~.~~

As part of NCQA requirements, Partnership performs an~~'s~~ annual Population Needs Assessment (PNA~~) which~~), which identifies factors leading to health disparities for Partnership subpopulations, and outlines a plan for addressing and mitigating these disparities. In addition, as part of DCHS' updated PNA requirement, Partnership collaborates with ~~Local Health Districts~~Local Health Jurisdictions (~~LHDs~~LHJs), ~~-~~and Public Hospitals as appropriate, on their Community ~~Needs~~Health Assessments (CH~~N~~As) and Community Health Improvement Plans (CHIPs), documenting the shared work ~~every three years~~ in accordance with each of the LHJ~~D~~ reporting cadences in all ~~of~~ Partnership's~~'~~ counties of operation.~~.~~

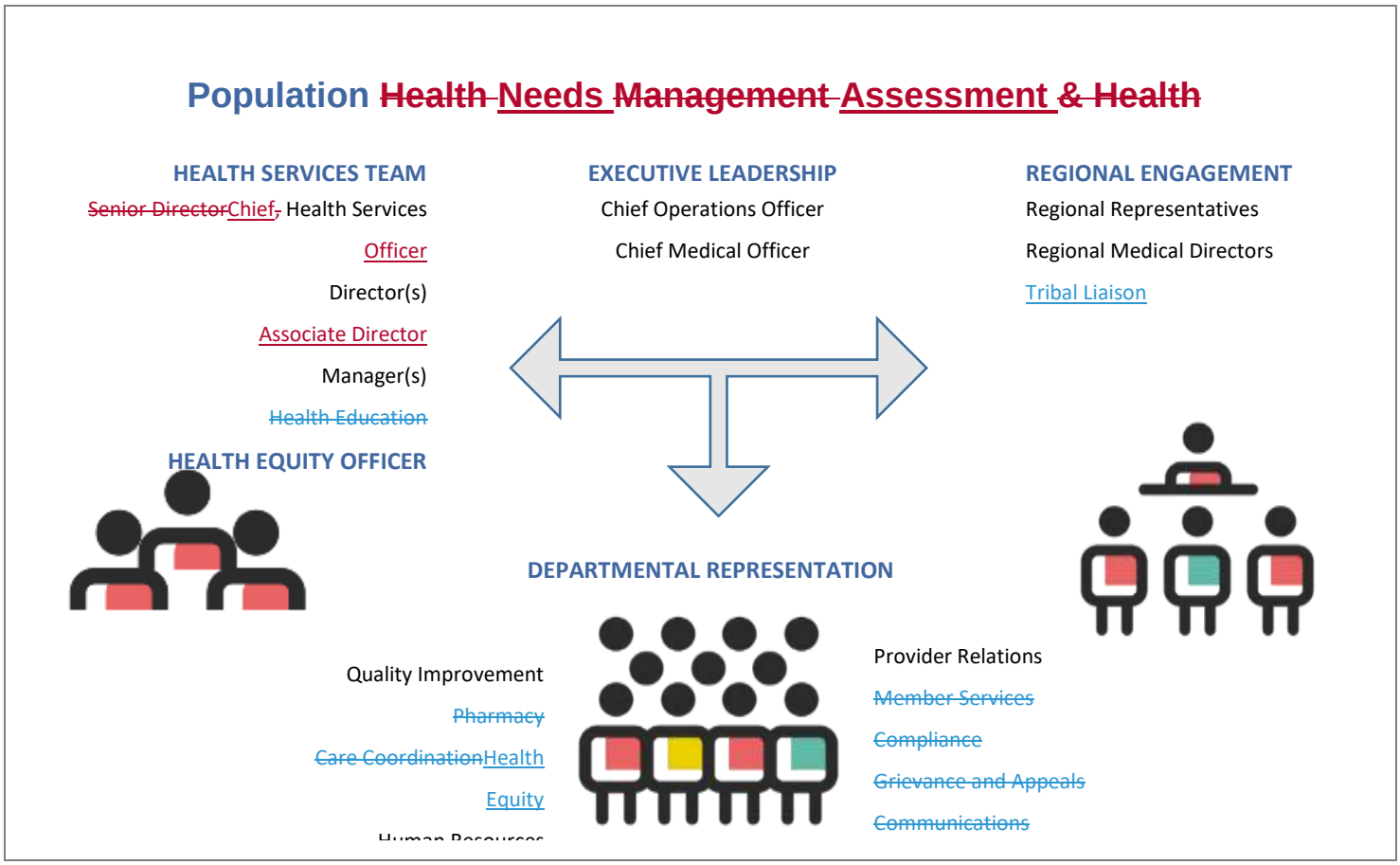
Data Analysis and Strategy

Partnership uses several methods to identify member needs, and to strategize the means best to meet them. ~~The~~ Both the annual PNA and county ~~the shared work of the~~ CH~~N~~As/CHIPs ~~s~~ describe~~s~~ the overall health, social, health education, and cultural and linguistic needs of Partnership's membership, including members who are less than 21

years of age, by analyzing service utilization patterns, disease burden, and gaps in care for our members, taking into account their risk level, geographic location, and age groups and recommends interventions to address barriers and disparities. The PNA identifies community resources to integrate in program offerings (including Partnership's Community Resource pages), and describes Partnership's collaboration with network providers, LHJDs, and community leaders in support of the population. The PNA and county CHNA/CHIP activitiesfindings informs Partnership's overall PHM strategiesy and is are electronically submitted to the appropriate governing bodies in June of every yearper their respective reporting timelines. Key stakeholders within Partnership review the PNA and /CHNA/CHIP findings and, from there, develop the annual Population Health Management (PHM) Work Plan, the DHCS PHM Sstrategy Deliverable (PHMSD) (PHMS)) for NCQA and DHCS, the Segmentation Report, the annual Cultural & Linguistics (C&L) Work Plan, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description as appropriate. T Tthese work plans outline specific interventions to mitigate health disparities both on a member and system level. The PHM Strategy & Program Description (MCND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The PHM Work Plan provides details on specific member-facing interventions, staff who will perform the interventions, method of contact, and outcome measures Partnership will implement during the year. Similarly, the C&L Work Plan identifies specific health equity concerns and provides a strategy for how Partnership will address them through annual activities. The PHM Impact Analysis report evaluates Partnership's programs and services to determine if the benefits offered are adequate to meet our member needs and identifies opportunities for further intervention. The PHM Segmentation Report categorizes Partnership's subpopulations into the appropriate categories on the continuum of risk as defined by DHCS and NCQA and as described under "Organizational Support for PHM". The following diagram shows the relationship of these activities:


Population Needs Assessment (PNA)
• Assesses overall population needs
• Identifies barriers to care and areas of health disparities
• Proposes actions and interventions to mitigate these concerns
• Evaluates sufficiency of resources to meet population needs
Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)
• Performed in conjunction with LHJs, hospitals, other payers, local providers, community-based organizations, member representatives and other community stakeholders
• Leads to agreed shared actions in each county that are updated triannually
• Informs Partnership's internal activites and committess, including the QIHEC and CAC
• Provides the basis for the PHMSD
Population Health Management Strategy & Program Description
• Outlines overall approach to Population Health for Partnership members
• Includes activities agreed upon through collaborative CHA/CHIP work
• Describes direct member interventions, indirect interventions, and delivery system supports
• Related Documents:
• Population Segmentation Report
• Annual PHM Work Plan
• Annual C&L Work Plan and Evaluation
Population Health Program Impact Analysis
• Analyzes PHM Work Plan activities and the impact of these interventions
• Identifies opportunities for coming year interventions

In late 20233, Partnership ~~created~~ replaced the Population Health Management and Health Equity Committee with the internal Population Needs Assessment (PNA) Committee~~Population Health Management & Health Equity (PHM&HE) Committee~~. The PNA Committee is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PNA Committee Meetings occur on a quarterly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the implementation of the shared SMART goals between Partnership and each of the LHJs in Partnerships service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Quality Improvement and Health Equity Committee (QIHEC), Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners. ~~, which meets quarterly to align interdepartmental efforts towards health equity~~around PNA development and county collaboration, and deliberate on ~~through member-facing and systemic interventions outlined in the PNA Action Plan/ (see figure that follows). In conjunction with the Quality Improvement and Health Equity Committee (QIHEC), t~~The ~~internal PHM&HE Committee ensures Partnership is meeting DHCS and NCQA requirements. and individual member needs for health equity, culturally and linguistically appropriate services (including appropriate language access services at all points of contact), health education, and Basic Population Health Management (BPHM) interventions. It also reviews new state and community initiatives to ensure Partnership programs meet these objectives without duplicating interventions from other sectors. This forum provides the platform to review and implement organizational initiatives, and to revise existing programs and services, if needed, to ensure continuous process improvement and program evolution in accordance with the needs of the population. Multidisciplinary workgroups convene several times per year to analyze the results of Partnership's interventions, and to develop and refine program offerings.~~



Quality Improvement and Health Equity Committee (QIHEC)

Following each PNA PHM&HE committee meeting, the proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are forwarded to Partnership's QIHEC for deliberation and approval. The QIHEC consists of a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as PHCPartnership members. The committee further identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. This committeeIt is also responsible tofor reviewing the annual Population Health Management Strategy and Program Description, the PNA, CHA/CHIP updates, and other reports and data that represent Partnership's activity to promote the quality and equity of program offerings. The committee further identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. For more information, (sSee Policy MCMCEP6002 XXXXX Quality Improvement and Health Equity Committee (QIHEC)).

Population Needs and Community Needs Assessments

Partnership routinely collects data regarding cultural, ethnic, racial, linguistic, health education and environmental needs of its members, and conducts a quantitative and qualitative evaluation to determine unmet needs and areas of health disparities. Data sources may include, but are not limited to, US census and enrollment data, member surveys, member grievances, and other published health statistics, as well as data provided by Health Plan sponsors or other sources such as local community needs assessments. Partnership's Health Analytics and Health Education teams analyze the data collected no less than annually with the goal of ensuring Partnership and its providers deliver services that equitably meet the needs of our culturally and linguistically diverse member population.

~~The Health Education~~ Population Health staff~~unit~~ prepare~~s~~ an annual Population Needs Assessment (PNA) for NCQA that describes our membership and region, including Partnership's demographics, community-identified needs and resources, health education, and cultural and linguistic needs, health inequities, ~~and~~ social and structural barriers to care, and more. The PNA proposes actions to address identified disparities and promote health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, ~~use of interpreters~~ (if available), traditional health beliefs, and beliefs about health and health care utilization.

The ~~Senior Health Educator~~Manager of Population Health provides a summary report of the NCQA PNA findings for discussion with the Consumer Advisory Committee (CAC) session and the Family Advisory Committees (FAC). Members of both committees are given an opportunity to provide input and advice on selecting Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs. The NCQA PNA and its proposed actions also undergo review by Partnership's~~the~~ PNA Committee, the ~~Quality Improvement Health Equity Committee~~QIHEC, ~~Partnership's~~ Internal Quality Improvement Committee, ~~Partnership's~~ Quality/~~-~~Utilization Advisory Committee, ~~Partnership's~~ Physician Advisory Committee, and by the~~Partnership's~~ Board of Directors before submission to NCQA and DHCS per regulatory requirements. PNA findings are also sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

~~The Senior Health Educator provides a summary report of PNA findings for discussion with the Consumer~~ommunity Advisory Committee (CAC) session and the Family Advisory Committees (FAC). Members of both committees are given an opportunity to provide input and advice on selecting Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs. The PNA and its proposed actions undergo review by the PHM&HE Committee, Partnership's Internal Quality

~~Improvement Committee, Partnership's Quality Utilization Advisory Committee, Partnership's Physician Advisory Committee, and by Partnership's Board of Directors before submission to NCQA and DHCS per regulatory requirements.~~

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide[1] and 2024 C~~c~~ontract, Partnership works collaboratively with ~~LHD~~LHJs, ~~LHDs,~~ hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CH~~N~~A ~~,~~ and CHIP report. This collaborative work has replaced DHCS's historically mandated PNA. ~~and provide a summary of each CNA on the Partnership website, along with a description of Partnership's collaboration on the report.~~ The county CH~~N~~As/CHIPs represent the overall community needs and priorities, and provide an opportunity for health plans to work with ~~LHD~~LHJs, local hospitals, and other community stakeholders to prioritize local needs and agree upon a shared plan of action. The PNA committee, CAC, FAC, and QIHEC receive regular updates on the CHA/CHIP collaborative work and are provided an opportunity to give feedback. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

Each county has its own schedule for CH~~N~~A/ ~~and~~ CHIP work, and Partnership will align its reporting with each county ~~schedule~~as needed until timelines are standardized in 2028. The shared action plans and findings from ~~this collaborative~~county collaborations lead to development of Partnership's annual PHM Strategy Deliverable (PHMSD) ~~-~~that demonstrates commitment to the implementation of prioritized actions and responses to community needs. ~~-~~The PHM ~~Strategy~~SD ~~-~~is submitted to DHCS annually, along with an NCQA-approved ~~PHM strategy~~version of this document and the annual NCQA-approved PNA. Findings from these~~is~~ collaboratives are also used to guide the following efforts:

- Targeted health education materials for members, and the creation of member-facing outreach materials for any identified gaps in services and resources, including but not limited to, Non-Specialty Mental Health Services;
- Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
- Wellness and prevention programs

[1] 2024 PHM Policy Guide

Partnership also publishes the CHAs/ ~~and~~ CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of Partnership's collaboration on the report.

Similar to the PNA review described above, the annual PHM ~~Strategy~~SD will be shared with members (through CAC and FAC sessions as well as through key informant interviews), with the ~~PHM&HE~~PNA Committee, the Quality Improvement Health Equity Committee (QIHEC), Partnership's Internal Quality Improvement Committee (IQI), Partnership's Quality Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Directors. These documents will be posted on Partnership's external website as they are updated, and provider newsletters will prompt providers when new versions are available.

Social Drivers of Health and Community Needs

Partnership's Health Analytics department estimates the impact of Social Drivers of Health (SDOH) for the region and membership through proxy data sources. One such source is the California Healthy Places Index (HPI) data produced by the Public Health Alliance of Southern California (healthyplacesindex.org). This freely available data set ranks California census tracts on a composite score of health disadvantage by incorporating data on 25 individual indicators organized in eight domains: economy, education, healthcare access, housing, neighborhoods, clean environment, transportation, and social environment. In every census tract, each indicator is shown on standardized scales (Z-scores) of increasing disadvantage, and averaged for each domain. The overall score is calculated as the weighted sum of domain scores. The HPI data set also includes the percentiles of each domain and individual indicator, as well as the overall composite values ranking each census tract.

Using the residential addresses of members found in the Membership data files received from DHCS, Partnership's Health Analytics team determines the geographic coordinate of each member's valid address and finds the corresponding census tract ~~that corresponds to~~. The calculated census tract for each member is then ~~used to~~ joined ~~Partnership's data~~ with the HPI ~~data set~~scores (https://healthyplacesindex.org/about/). These ~~rankings~~ HPI scores are used in combination with the rest of the SDOH data to estimate the SDOH risks for each of Partnership's members.

Member-specific sources for SDOH data include location, distance from providers, and non-medical transportation claims that demonstrate member needs for services; demographic attributes found in membership data; specific social risk factors identified from diagnosis codes; and homelessness data derived from members' addresses and diagnosis coding. Members who are new to Partnership and having either a Senior or

Person with Disability (SPD) aid code, or identified as California Children's Services (CCS) beneficiaries complete a detailed assessment of their social supports, barriers to care, food security, and financial resources, as well as their medical history and current care needs.

Members who have serious mental illness or serious emotional disturbance ~~serious and persistent mental illness~~ (S~~P~~MI/SED) receive care for those conditions through county-administered Mental Health Managed Care, which is carved out of Partnership's benefit package and assigned to the county in which the member lives (see All Plan Letter 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services).

~~-~~In July 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. Partnership works together with our providers and partners in seven Partnership counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) to provide integrated physical health and SUD services for the Medi-Cal population.

~~-~~In addition, Partnership's disease registry flags members with ~~several~~ SMI/SED ~~SPMI~~ conditions, such as schizophrenia or major depression. Partnership uses prescription data for anti-psychotic and specific anti-manic medications as a means of identifying members who may have any SMI/SED~~SPMI~~, and leverages this data to ensure members with SMI/SED ~~SPMI~~ receive care for comorbid medical conditions.

Population Risk Stratification & Segmentation

Currently, Partnership analyzes and segments the entire population by need and appropriate intervention(s), as described in the Population Segmentation Report. Once DHCS has ~~implemented~~launched the PHM Service and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data points and methods to~~for~~ further stratify~~ing the~~ populations for intervention. Partnership's RSS and Risk Tiering approach is available upon DHCS request.

Partnership has developed a proprietary method currently in use for assigning members to a risk level, which ~~that is currently in use and~~ will be used until DHCS launches the PHM Service's Risk Stratification and Segmentation and Risk Tiering Tool (RSST).

Partnership's Risk Stratification Process

~~PHC~~Partnership's Health Analytics team has developed a risk score model ~~A~~ that predicts member's risk for becoming a high-utilizer ~~is~~ at individual level ~~calculated using a~~

~~Generalized Linear Mixed Model (GLMM)~~ by applying the following data sources: ~~longitudinal data of Partnership's membership~~member demographic data, ~~(including race/ethnicity, age, gender, language, disability aid codes),~~ claims (behavioral, medical, and pharmacy), case management enrollment, and external data (California's health index and census tract). This risk score model forecasts the likelihood of a member becoming a high utilizer within the next six months. A member will be classified as a high utilizer if they meet any of these four criteria within a six-month period~~a high utilizer~~ : (a) five or more ED visits, (b) one or more acute hospital admission, (c) fifteen or more distinct drug prescriptions, or (d) total paid claims of more than $50,000 for medical cost (hospital and pharmacy). During the development of the risk score model, the health utilization of the entire Partnership population was included in the study to avoid any sampling bias and also ensured no bias from other factors like race and ethnicity. ~~(i.e., utilization of >=5 ED Visits, >=15 Distinct Drugs, >=1 hospital inpatient admission or >=$50,000 medical and pharmacy claims) in the next six months.~~The risk score model adjusts for social determinants, demographics, ~~and disease or disability burden~~member's aid category, chronic disease conditions (up to 19 chronic conditions as defined through HEDIS or CMS protocols), as well as the member's eligibility criteria under the CCS program or SPD aid codes. ~~–~~ In the realm of social determinants, the risk score adjust~~ments made~~ for homelessness, non-emergency transportation usage, and the Healthy Places Index. Similarly, in the demographic category, the adjustments include~~made for~~ gender, age, and race/ethnicity. ~~Within social determinants, we adjust for homelessness, non-emergency transportation usage, and Healthy Places Index. In the demographic category, PHC adjusts the risk score by gender, age, race/ethnicity, and language. Finally, PHC adjusts for disease burden using our chronic disease registry, which identifies members having up to 19 chronic conditions as defined through HEDIS and/or CMS protocols, as well as the member's eligibility criteria under the CCS program or SPD aid codes.~~

~~PHC's Health Analytics team has evaluated t~~The relative significance of these factors on the member's overall risk score ~~such that members with similar diagnoses but variations in race/ethnicity, or social determinants~~ is ~~will have diverse risk scores assigned~~estimated using the odds ratio. The highe~~r~~st the odds ratio, the highe~~r~~st the contribution of that factor to the risk score. ~~-~~The bar chart~~,~~ below~~,~~ shows the odds ratios of all the factors that have a statistical significant contribution to the risk score. For example, members who use non-medical transportation benefit~~s~~ are 3.09 times more likely to become high utilizers compared to those who do not use this benefit~~. Similarly, the odds of a member with a particular chronic condition becoming a high utilizer, compared to a member without that condition, are provided. For instance~~, holding all other conditions constant~~, a member with Asthma is 2.51 times more likely to become a high utilizer than a member without~~

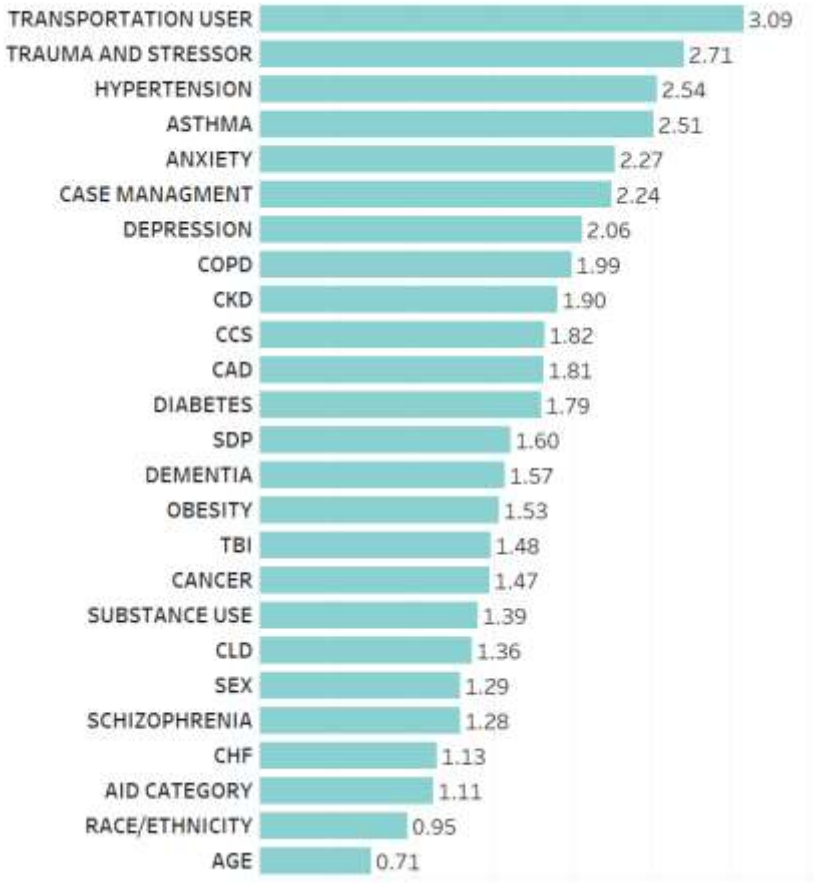
~~Asthma.~~. Similarly, considering the race and ethnicity factor, the white population (with an odd ratio of 0.95) is slightly less likely to experience the risk comparing to other race and ethnicity groups.

~~The odds ratio estimates derived from the family of exponential form, with a log likelihood function and logit link function where the response variable assumed to possess Bernoulli distribution. Accordingly, for significant covariates, the standard error and p-value are as follows:~~

~~*Factor*~~	~~Standard Error~~	~~P-Value~~
~~*Age*~~	~~0.04616~~	~~<.0001~~
~~*Sex*~~	~~0.03699~~	~~<.0001~~
~~*Aid Category*~~	~~0.01733~~	~~<.0001~~
~~*Race/Ethnicity*~~	~~0.008272~~	~~<.0001~~
~~*SPD*~~	~~0.06776~~	~~<.0001~~
~~*Case Management*~~	~~0.04223~~	~~<.0001~~
~~*CCS*~~	~~0.1249~~	~~<.0001~~
~~*Transportation User*~~	~~0.09318~~	~~<.0001~~
~~*Asthma*~~	~~0.05462~~	~~<.0001~~
~~*Obesity*~~	~~0.03945~~	~~<.0001~~
~~*Diabetes*~~	~~0.04118~~	~~<.0001~~
~~*Hypertension*~~	~~0.04418~~	~~<.0001~~
~~*Chronic Kidney Disease*~~	~~0.04147~~	~~<.0001~~
~~*Chronic Obstructive Pulmonary Disease*~~	~~0.04917~~	~~<.0001~~
~~*Congestive Heart Failure*~~	~~0.04966~~	~~0.0109~~
~~*Coronary Artery Disease*~~	~~0.08542~~	~~<.0001~~
~~*Chronic Lung Disease*~~	~~0.05601~~	~~<.0001~~
~~*Traumatic Brain Injury*~~	~~0.1505~~	~~0.0093~~
~~*Substance Use*~~		~~<.0001~~
~~*Dementia*~~		~~<.0001~~
~~*Cancer*~~		~~<.0001~~
~~*Depression*~~		~~<.0001~~
~~*Schizophrenia*~~	~~0.05167~~	~~<.0001~~
~~*Trauma And Stressor*~~	~~0.05265~~	~~<.0001~~
~~*Anxiety*~~	~~0.04154~~	~~<.0001~~

~~The higher the number, the higher the influence of the factor as a predictor of utilization. Where a number is less than 1.0, the factor has a protective influence.~~

The influence of isolated factors on a member becoming a high utilizer



The risk score generated from this model ~~is defined as the probability that a member will become a high utilizer (i.e., utilization of >=5 ED Visits, >=15 Distinct Drugs, >=1 hospital inpatient admission or >=$50,000 medical and pharmacy claims) in the next six months. Risk scores have~~has values ranging between zero and one, going up to 5 decimal places. In addition, the entire Partnership ~~PHC~~ membership is segmented into ~~the risk score values are segmented into~~ four risk tiers by defining risk score ranges that delineate ~~the risk levels within~~ homogenous risk groupss ~~The Risk Level groups are determined. by stratifying the entire Partnership population. using cluster analysis.~~

Accordingly, the ~~R~~risk ~~l~~tiers~~L evels~~ ~~Groupings~~ are assigned as follow~~s~~s:

No Risk:	Risk score is less than 0.02004
Low Risk:	Risk score is between 0.02004 and 0.0742
Medium Risk:	Risk score is between 0.0742 and 0.20038
High Risk:	Risk score is above 0.20038

Within every risk tier, we evaluated the distribution of race and ethnicity and ensured that there were no significant biases due to the risk segmentation.

Risk scores prove valuable in assigning members to risk-tiered programs for individuals whose health and well-being require the support of intensive interventions.

Partnership's Health Analytics team runs the risk stratification report every month so that members who have a significant change in health status are captured and offered appropriate interventions to support their health and wellbeing. In ~~addition,~~

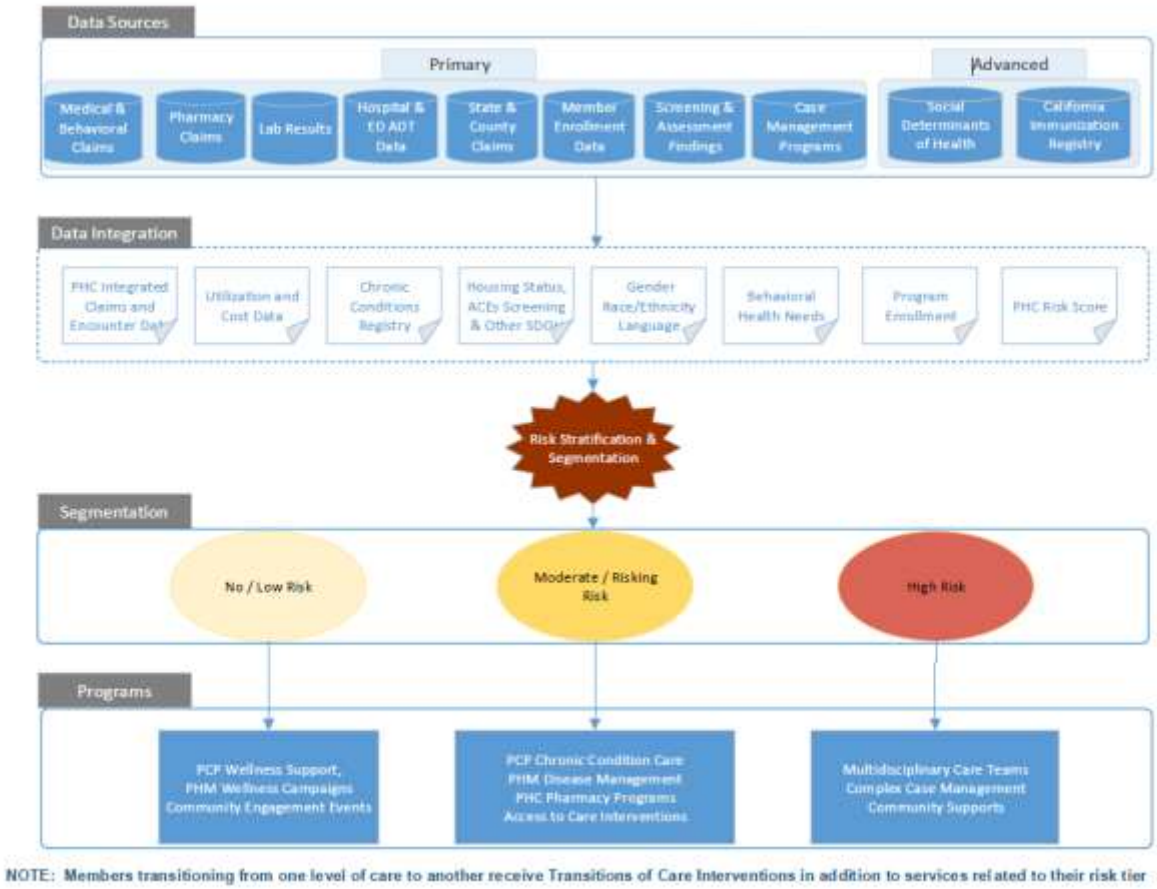
~~Partnership's~~addition, Partnership's Quality team uses HEDIS data to evaluate Population Health interventions. Partnership analyzes HEDIS performance by race/ethnicity and language to identify statistically significant disparities that drive development of interventions to promote health equity within its membership.

HEDIS measures provide insight on members having gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. Partnership's Population Health team uses monthly care gap reports to perform outreach to members, explaining their benefits and connecting them with providers.

The PNA describes how Partnership analyzes HEDIS Measure results in aggregate, by race/ethnicity, and by language, and examines individual measures for evidence of subpopulations experiencing disparities that warrant intervention. Census, Healthy Places Index, and County Health Rankings data provide insight into the challenges faced by communities and racial groups that lead to health disparities, such as food insecurity, housing problems, tobacco use, and other concerns. ~~Census, Healthy Places Index, and County Health Rankings data provide insight into the challenges faced by communities and racial groups that lead to health disparities, such as food insecurity, housing problems, tobacco use, and other concerns.~~ Data provided by our providers and community partners also helps identify opportunities and interventions for members with low risk scores, insufficient data to assign a risk score, or members who may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the impact of racial bias that could result from risk stratification based solely on utilization patterns by evaluating the entire population through multiple lenses (including race, language, housing status, and other social factors) for enrollment into a wide variety of programs that meet subpopulation needs according to shared identifiers. Partnership will continuously reassess the effectiveness of the RSS methodologies and tools.

Partnership works in ~~partnership~~ collaboration with local providers and community resources to analyze, develop, and implement interventions that support the health and well-being of the entire population (see diagram).

Partnership's Risk Stratification and Segmentation Process



NOTE: Members transitioning from one level of care to another receive Transitions of Care Interventions in addition to services related to their risk tier

Future Risk Stratification and Segmentation and Risk Tiering

After the release of the DHCS~~'s~~ PHM Service's RSST methodologies, Partnership will assign member risk first based ~~up~~on the DHCS methodology, and will ensure members who are identified as high-risk are assessed for appropriate intervention, including care management programs, BPHM, and Transitional Care Services.- Partnership will also evaluate members through its proprietary methodology to cull members not identified through the DHCS RSST methodology, who may benefit from Partnership interventions, programs, and services. Partnership will perform the RSST process no less than annually and/or upon each member's enrollment, ~~upon~~ a significant change in health status/level of care, and upon ~~the~~an occurrence of events or when new information arises that ~~may~~ potentially changes a member's needs.

Programs and Services

Partnership leverages committees and multidisciplinary workgroups to design and implement programs and services. Using the risk stratification and segmentation

method described above, the Population Health department maintains a PHM Work Plan that describes the interventions offered to members along the continuum of risk. These interventions represent Partnership's basic population health management and case management service offerings to improve the health of our members and to promote health equity within the communities we serve. Beyond the interventions described in the PHM Work Plan, Partnership ~~work~~ collaborates with providers, specialty groups, community based organizations (CBOs), public health agencies, local education agencies, justice programs, and other agencies to support the health and well-being of the members and communities we serve.

Basic Population Health Management

Partnership's ~~Basic PHM (~~BPHM~~)~~ is for all members. BPHM includes services such as having an ongoing source of care, Care Coordination, and sharing resources and education to improve the health of members.

Each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs. Partnership also works to ensure members are engaged with their assigned PCP, and receive all needed preventive services. Member utilization reports are reviewed to identify members not using primary care.~~-~~ At minimum, r~~R~~eports are stratified ~~at minimum,~~ by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services. Strategies are then developed to address differences in utilization to promote health equity for all members.

Partnership works to ensure the member's PCP plays a key role in the member's c~~C~~are c~~C~~oordination. Members receiving care from out-of-n~~N~~etwork p~~P~~roviders will maintain efficient c~~C~~are c~~C~~oordination and continuity of care. Members have access to needed services including:

- Care c~~C~~oordination
- Navigation and referrals to services that address a members' developmental, physical, mental health, s~~S~~ubstance u~~U~~se d~~D~~isorder, dementia, long-term services and supports~~LTSS~~, palliative care, and oral health needs~~.~~
- Help with making appointments~~,~~
- Help with arranging transportation~~, and~~
- Health education on the importance of Primary Care when disengaged with their Primary Care Provider, especially among members less than 21 years of age

To address members' needs, health and social services are coordinated between settings of care, across other Medi-Cal ~~managed care health plans~~MCPs, delivery

systems, and programs (e.g., Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services. Referrals are coordinated to ensure Care Coordination with public benefits programs. Members, and members' parents, family members, legal guardians, authorized representatives (ARs), caregivers, or authorized support persons can receive assistance with navigating the health delivery systems in order to access care and services that may benefit the member. All care coordination provided to a member is communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons as appropriate. Partnership maintains processes to ensure there isare no duplication of services.

Members are further provided with resources and education about how to access the various programs and services offered by organizations with whom Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed MOU. Members are also provided with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that promotes hHealth eEquity for all mMembers.

Providers serving Partnership members must maintain and share, as appropriate, the members' Medical Records, and any necessary member information, in accordance with professional standards and State and federal privacy laws and regulations.

Wellness and Prevention Programs

Partnership provides wellness and prevention programs that strive to align with NCQA PHM standards and DHCS requirements, including provision ofaccess to evidence-based self-management tools , available through our member portal. All members also have access to culturally and linguistically appropriate health education materials.

Partnership provides wellness and prevention programs to improve the health outcomes of all members. Eligible members have access to evidence-based disease management and improvement programs that incorporate health education interventions, target Members for engagement, and/or seek to close care gaps for participating members that include, but are not limited to:

- Diabetes,
- Cardiovascular disease
- Asthma

- Depression
- Improving access to preventative health visits, developmental screenings, and services for members less than 21 years of age
- Improving pregnancy outcomes for women, including through 12 months post-partum~~, and~~
- Ensuring adults have access to Preventive Care
- Programs aimed at helping Members set and achieve wellness goals.

Partnership works to ensure there is a process for monitoring the provision of wellness and preventive services by PCPs as part of its c~~C~~ontractor's s~~S~~ite r~~R~~eview process. Partnership also submits its wellness and prevention programs to DHCS for review and approval as appropriate, and strives to align its wellness and prevention programs with the DHCS Comprehensive Quality Strategy.

On an annual basis, Partnership's DHCS ~~reports through the DHCS Population Health Management~~PHM ~~Strategy~~ SD report~~s~~s~~(PHM~~e ~~on~~ how community-specific information and stakeholder input from the CHA/CHIP collaborations~~ve~~ are~~is~~ used to design and implement evidence-based wellness and prevention strategies.~~;~~ F~~f~~indings from the NCQA Population Needs Assessment are also incorporated into the design and implementation process of wellness and prevention strategies.

Organizational Support for PHM

As an organization, Partnership is engaged in promoting the health and well-being of members. Various departments address particular segments of the population, per NCQA's four area of focus and DHCS's three levels of risk. For example, Member Services, Quality Improvement, the Population Health department with the Health Education Unit, all provide outreach to members with no identified risk or low risk to Keep Members Healthy, offer BPHM interventions, and promote health equity where there are barriers to health. Population Health and its Health Education Unit, Quality Improvement, Pharmacy, and Care Coordination collaborate to identify and support Members with Emerging Risk, including racial or language groups with health disparities. Care Coordination collaborates with Utilization Review and Member Services to assist members with their Outcomes Across Settings and to bolster provider communication along the continuum of care. Care Coordination's clinical and social work teams provide highly skilled support to assist members who are Managing Multiple Chronic Conditions.

Members may move ~~along~~ up and down the acuity continuum as their needs change, and services are matched to the member's evolving level of need. A member may have few identified risks, but might have difficulty navigating the healthcare system and

require an intensive level of intervention through Partnership's Complex Case Management (CCM), or through other member benefits such as Community Health Worker (CHW) support or Enhanced Case Management (ECM). Conversely, a member with multiple chronic conditions may have well-established support systems and not require assistance from the Care Coordination team in order to access care. The information in the following table outlines Partnership's approach to population health management. The PHM Work Plan and supporting desktop procedures provide details about each service and the associated goals for member segments.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
No/Low Risk: Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	*Keeping Members Healthy*	*Member Needs:* To understand benefits and how to access them; identify and access providers for primary care; help with prescriptions or DME; access to non-Partnership services (Denti-Cal, In Home Support Services, etc.). *Population Health Interventions:* Member outreach campaigns to promote well-child visits or other wellness care. Collaborate with local agencies to identify community events for underserved communities (immigrant populations, homeless members, rural and frontier communities, etc.) to promote Partnership services and benefits. *Health Education Interventions*: Develop and distribute member newsletters and benefits information. Create educational materials on various health topics in threshold language groups and racial groups that have outcome data revealing inequities. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		Quality Interventions: Provide HEDIS-based gap reports to providers, showing which members are missing well care visits, timely immunizations, and cancer prevention screenings; evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and the quality of care members receive.
Moderate / Rising Risk Pregnant members, or members that that have risk of disease/ disease exacerbation, or a newly diagnosed chronic illness. Racial groups with inequitable access to health care, e.g., American Indian access to mammograms.	*Managing Emerging Risk*	*Member Needs:* Access to specialty care and/or behavioral health providers to manage emerging or stable chronic conditions; resources/education supporting lifestyle management to maximize health and wellness, and mitigating effects of chronic disease; education on managing new diagnoses. *Population Health Interventions*: Offer BPHM services to engage members to understand barriers to care; provide member coaching on how to manage chronic illnesses. Outreach to members who are homebound or vulnerable to poor air quality to encourage them to prepare for disasters and wildfires. Schedule mobile mammography clinic days in conjunction with Tribal Health clinics. *Care Coordination Interventions:* Outreach to CCS members who have not had an annual well-child visit to encourage them to maintain program eligibility; coordinate care for members

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		who identify (or whose provider identified) a care gap or equipment gap, who need basic case management support. *Grievance Interventions:* Streamlined grievance process and produced educational videos in multiple languages to educate non-English speaking or LEP members on how to report dissatisfaction. Conduct ongoing grievance process improvement efforts. *Health Education Interventions:* Develop and distribute educational member materials on staying healthy, common conditions, and their management, aligning with member age, sex, education, culture, and at a 6th-grade reading level. ~~*Pharmacy Interventions:* Educate pregnant members on the importance of prenatal and well-baby immunizations, perform outreach to members who show interest in smoking cessation, and educate diabetic members on the importance of statin therapy.~~ *Quality Interventions:* Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. Member Services uses these reports to remind members of these care gaps during member calls. Evaluate interventions conducted in the provider setting where members are

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and member-level outcomes
Transitions of Care: Members going through transitions in their care.	*Outcomes Across Settings*	*Member Needs:* Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home. *Member Services Interventions:* Support members discharged after hospitalization who may need to establish care with a PCP. *Utilization Management Interventions:* Collaborate with facility discharge planners to approve post-acute care needs. *Care Coordination Interventions:* Review and implement of hospital discharge plan; coordinate services; assess member's need for ongoing case management; help schedule follow-up appointments; ensure transportation is available to attend appointments; collaborate with the PCP office to ensure a full transition of care.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
High Risk: Members with multiple chronic conditions, unmanaged conditions like asthma or diabetes, medically fragile, frequent visits to emergency department and/or inpatient admissions; may also have poor social supports or other psychosocial issues.	*Managing Members with Multiple Chronic Conditions*	*Member Needs:* Coordination of medically complex care needs. Members may have multiple chronic conditions or unmanaged chronic conditions or may be complex due to other factors such as disorganized care delivery, cognitive or developmental impairment, behavioral health challenges, or lack a wellness support structure. *Care Coordination Interventions:* Complex case management support; personalized assessments; individualized care plans; motivational interviewing; medication reconciliation; education/support for disease(s); coordination of services; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts; may include face-to-face interactions.

Health Education

The Health Education team is integrated into the Population Health department and works closely with all Partnership departments to assess member needs, to evaluate and improve established programs/activities, and to develop and implement new programs/activities/materials to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver evidence-based health education programs, services, and education materials directly to members (including members under age 21), and through members' health care providers according to members' health education and cultural and linguistic needs and preferences.

The Health Education team uses general health education, health promotion, and patient education methods to help Partnership's members prevent sickness and

disease; improve their health; manage their illnesses; effectively use health care services; and ensure that members who have not had a recent visit with their assigned medical home or PCP receive health education on the importance of primary care (including members under age 21). Partnership also provides health education opportunities to members directly through resources offered on the Partnership Member Portal and via select subcontracted providers who are skilled in delivering health education services and whose performance is monitored. Select written Health Education materials are available on Partnership's website for members, providers, and the community at large. Partnership members can also call in or email Population Health to request additional health education materials or resources. Finally, Partnership promotes health education information and Population Health programs through the member newsletter, the provider newsletter, the Partnership website and social media, and through targeted outreach.

Partnership's Health Education system promotes member health through 3 categories of educational interventions:

- Effective use of managed health care services: Partnership provides written information (at a 6th grade reading level) to help members effectively use the services of their managed care plan. This includes accessing preventive and primary health care services, obstetrical care, appropriate use of complementary and alternative care, dental and vision care, and health education services.
- Evidence-based Risk-Reduction as well as Wellness & Prevention programs: Partnership connects members to educational interventions designed to modify health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes. Programs can include: smoking and tobacco cessation; managing stress; injury prevention; prevention of sexually transmitted diseases and; nutrition/healthy eating, weight maintenance, physical activity; avoiding risky drinking; and identifying depressive symptoms. These interventions are available on Partnership's Member Portal as Healthy Living Tools.
- Evidence-based Healthy Lifestyle, Self-Care, and Management of Health Conditions: Partnership provides or connects members to health educational interventions that can help members learn about and follow self-care management for existing chronic diseases or health conditions like obesity, pregnancy, depression, asthma, diabetes, and hypertension.

This collection of health education strategies forms the health education system. The health education system is maintained and monitored to ensure equal access to all Partnership programs for all members, including accessibility for Limited English

Proficient (LEP) members; to ensure appropriate allocation of health education resources; and to conduct appropriate levels of program evaluation. All programs and materials are available to members at no charge. Programs will not discriminate against Partnership members for any reason.

The Senior Health Educator participates in Partnership's internal committees, addressing ~~es~~ quality and compliance with Partnership's programs. The Senior Health Educator ensures that all health education programs and materials are appropriate for members of varying demographics, including but not limited to: language, age, race, ethnicity, national origin, disability, sex and gender ~~[~~per Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557)~~]~~.

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other departments, the Health Education team develops targeted health education materials to help members modify health behaviors, achieve healthy lifestyles, and promote health equity (See Appendix A). Data from the PNA, CHA/CHIP collaboratives, ~~and~~ other resources, and regulatory requirements also guide~~s~~ decisions regarding the availability of health educational materials and resources for specific member populations. Furthermore, the health education team assesses member health care needs and barriers to care by consulting regularly with the Consumer Advisory Committee (CAC), the Family Advisory Committee (FAC), community organizations, Partnership~~PHC~~'s Chief Medical Officer, and also through community outreach such as through CHA CHIP efforts, use of Healthy Living Tools~~, key informant interviews~~, and analysis of Partnership~~PHC~~'s data. Materials are available to members through direct mail, their network provider's office, community events, on the Partnership website and Member Portal, and via email by request.

The Senior Health Educator assesses written, member facing materials for readability and suitability according to state and national guidelines, which ensures that member facing materials are written at the sixth grade reading level using a readability formula that is most appropriate and reliable for the type of materials and target audience. The Senior Health Educator also ensures that health education materials are culturally and linguistically appropriate for the intended audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up-to-date. Health education materials are made available in Partnership's threshold languages, large font, and in any of California's top 18 non-English languages upon the request of the member. Partnership's qualified ~~-~~Health Educator(s) can approve written member health education materials as long as the following conditions are met:

- Materials purchased to distribute for member health education are from a DHCS approved company. The Health Education team will maintain a list of approved companies as these are updated by DHCS throughout each year.
- Materials are field-tested to ensure written health education materials are understood by the target audience. The qualified Senior Health Educator will provide oversight of the field-testing of all materials. Field-testing is designed to garner feedback from the targeted audience for the materials and may include community focus groups, key informant interviews, simple review and surveys by community member, and/or review during Consumer Advisory Committee and Family Advisory Committee meetings. The health education team will review the results and adapt materials as needed and as appropriate.
- Health Education materials are assessed using the Readability and Suitability Checklist (per DHCS website requirements). They are approved when:
    - A majority of the Readability and Suitability Checklist provisions are met.
    - When some of the Readability and Suitability Checklist provisions are somewhat met and/or not met, so long as the qualified Health Educator provides justification, and keeps the justification on file with the Suitability Checklist.
- The signed/approved Readability and Suitability Checklist, along with the approved health education material, must be kept (electronic file or hard copy) by the health plan and made available to DHCS for auditing/monitoring purpose upon request.
- The assessment and approval process must be conducted by a qualified health educator/health education specialist with the equivalent training and background required by DHCS per APL 18-016.

Health education staff who do not meet the definition of a “qualified health educator” as listed above will not approve health education materials for Partnership. If Partnership does not have a qualified health educator on staff to assess and approve health education materials, Partnership will submit health education materials to the Managed Care Quality and Monitoring Division (MCQMD) of DHCS for review and prior approval, along with a completed Readability and Suitability Checklist.

Member Incentives

Non-monetary member incentives (MI) may be used in conjunction with, or as a component of, Partnership education programs and Basic Population Health Management programs to motivate members to adopt heathy behaviors, ~~and~~ enhance health education activities, including participation in focus groups, or to gain feedback on member experiences. Member incentives must meet DHCS guidelines and follow

Partnership's approval process for Member, Survey and Focus Groups (see Appendix B). MI program components include, but are not limited to:

- Increasing member participation, learning, and motivation to effectively use health care services including preventive and primary care services.
- Appropriate health care utilization that includes, but is not limited to:
  - Timely prenatal and post-partum care
  - Timely immunizations
  - Timely well child visits
  - Timely screenings (i.e., mammograms, colorectal screening)
  - Regular monitoring tests for chronic diseases
- Non-monetary member incentives that may range in value depending on the components and complexity of the health education program.
- A Member Incentive Request, ~~or~~ Focus Group Request, or Survey Request form (per APL 16-005) that includes:
  - Completion of the MI request form by a qualified Health Educator
  - Review by Partnership~~PHC~~'s Regulatory Affairs and Compliance Coordinator
  - Submission to DHCS Health Education Consultants for final review and approval at least two weeks prior to implementing new MI programs or focus groups.
- Annual Member Incentive, Focus Group, and Survey Incentive Evaluation forms are required to be submitted to the DHCS Health Education Consultant thirteen (13) months after the planned program start date, covering the prior 12 months. If the program has ended, a Member Incentive Evaluation form must be submitted to the DHCS Health Education Consultant within 45 days from the date the program ended. Focus group and survey incentive program evaluation forms are due 60 days after the due date for completed surveys.

Point of Service Education

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership~~PHC~~) or within ~~120~~ 90 days of a member's assignment to a PCP (whichever is most recent). Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process. The IHA must include the member's physical and behavioral health history, identification of risks, an identification process of any needs for preventive screens or services, referrals to health education where appropriate, physical examination, and if applicable, the diagnosis and treatment plan for any diseases.

Primary Care Providers (PCPs) are responsible for the screening and identification of members with specific health educational needs. PCPs are also responsible for providing appropriate health education information or referring the member and/or the caregiver to Partnership's Population Health department for assessment of appropriate health education activities or materials, and for following up on referrals (including providing anticipatory guidance).

Members can also identify their own needs for health education. Partnership makes educational materials, resource information, and other tools (such as training, and programs) available to help network providers provide health education services. Select Health Education materials are available on Partnership's website or upon request.

Partnership Health Education materials and resource topics are also available on Partnership's Member Portal and include, but are not limited to:

- Age-Specific Anticipatory Guidance
- Alcohol and drug use
- Asthma
- COPD
- Chronic Disease Management
- Diabetes Management
- Family Planning (contraception)
- Heart Disease & Prevention
- HIV/STD Prevention
- Immunizations
- Injury Prevention
- Living Well with a Disability
- Medication Management
- Nutrition
- Parenting
- Perinatal/Breastfeeding
- Physical Activity
- Preventive Screening
- Senior Services
- Stress Management
- Tobacco Prevention & Cessation
- Weight Management & Exercise

Practitioner Education and Training

Partnership's Health Education team supports network providers through trainings on the unique cultural needs of Partnership's member populations. The PNA and CHA/CHIP collaborative ~~is one of the tools that~~ serves~~s~~ as guidance for provider trainings highlighting Partnership members' beliefs about illness and health, their cultural health behaviors, and their preferences for interacting with providers and the health care system. The trainings are designed to support network providers and their staff in providing effective health education in a manner that respects the cultural and linguistic diversity of patients and promotes health equity.

Starting in 2025~~No less than annually~~, ~~PHC~~ Partnership ~~offers~~ will offer trainings to providers in its network on topics of health equity, including cultural competency, bias, diversity or inclusion ~~.~~ training. Some of the trainings will include information about

relevant health inequities and identified cultural groups in the Partnership's service area. T ~~t~~opics may include, but are not limited to: s~~S~~eniors and p~~P~~ersons with d~~D~~isabilities awareness and sensitivity, preventive health care for children, a~~A~~lcohol m~~M~~isuse s~~S~~creening and c~~C~~ounseling, and other concerns as appropriate for the population. Other trainings may also include ~~Population Health Management~~B~~BPHM~~ program requirements, including referrals, health education resources, and p~~P~~rovider and m~~M~~ember incentive programs. Trainings may be delivered in person, virtually, and made available on the external website.

Health Education Interventions

The CHA/CHIP efforts, PNA, and other regulatory requirements serve~~s~~ as ~~the~~ vehicles for setting the Health Education Program goals, which ~~that~~ are documented in the Quality Improvement and Health Equity Transformation Program (QIHETP)/Cultural & Linguistic (C&L) Work Plan as appropriate. The annual QIHETP/C&L Work Plan and C&L ~~Work Plan~~Evaluation report ~~also~~ describes the methodology for evaluating intervention outcomes to ensure Partnership is effective in delivering high-quality health education and culturally and linguistically appropriate interventions for our members to promote health equity and reduce disparities. The PNA and conclusions drawn from CHA/CHIP efforts evaluate ~~s~~ and make~~s~~ recommendations for appropriate allocation of health education resources based on needs assessment findings, provider training results, Partnership staff training results, intervention evaluation results, and other data. The departments responsible for each specific intervention monitor their outcomes to ensure program objectives are being met. Performance improvement plans are implemented as necessary to improve Partnership and provider performance in delivering programs and services to our members.

Other Activities – Interventions that Indirectly Affect Members

There are many opportunities to collaborate through joint action with providers, county initiatives, and local care management programs to meet the needs of individual members. The following table describes the strategies used to promote population wellness through partnerships with community resources and organizations.

Initiative Type	Definition
Partnership Provider Population Reports	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. Supports providers in conducting direct outreach to close gaps in preventive care.

Initiative Type	Definition
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services.
Poster Campaign, School Engagement	Educational events where students create art projects that amplify a health topic (e.g., immunizations, tobacco prevention); engagements with screening sessions at school clinics.
Provider Newsletters	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations department (Provider Newsletter) with dedicated space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
Provider Education	Coaching, consultation, measure review, and in-depth guidance for providers on HEDIS/Quality Improvement Program (QIP) measures as part of the Partnership value-based payment program, improving communication between providers, and promoting appropriate specialty referrals. Annual training on health equity.
Provider Fax Blast (email or fax)	Communication to all network providers for important updates (e.g., a fax blast on new standards for using combined long acting beta agonist/corticosteroid combinations in treating asthma).
Partnership Website	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
Point of Service Interaction	Inform pharmacies of important clinical issues (such as drug class duplication) through point of service notices.
Media Campaign	Social media campaign(s) and county-level websites focused on improving member education and influencing member decision-making in preventive services/screenings. Websites include

Initiative Type	Definition
	Public Service Announcements from local providers and community-based organizations.

Informing Members ~~About~~About Available PHM Programs

Partnership shares information on programs and services available to the communities it serves in multiple ways, including Partnership's website (P~~www.p~~artnershipHP~~hp~~.org), the Partnership Member Portal, member newsletters, program introductory letters, and telephonically through Partnership's Care Coordination, Population Health, and Member Services departments. When a member requires a referral ~~in~~to a Population Health or Care Coordination program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

Community Engagement and Coordination of PHM Programs

Partnership has committed to being an active partner in each of the communities it serves, through local presence, local knowledge, and consciously building productive and strong working relationships. The new emphasis on Population Health is an exciting opportunity to expand community engagement activities and build on the strong partnerships developed over many years, and in some cases, decades.

Partnership is divided into ~~four~~ five distinct geographic areas, with regional offices strategically located in each area. Regional offices and the regional staff are responsible for working closely with local providers of health care to Partnership members, county health and social services departments, local health improvement coalitions and a variety of community~~-~~-based organizations addressing the social, economic and health needs of Plan members. Regional staff live and work in these communities and share their knowledge of the managed care program with the community, and just as importantly, share their knowledge of the community with Partnership.

Regional staff meet regularly with county health and social service leaders to share information and collaborate on projects with aligned goals, such as childhood immunization campaigns, ~~COVID-19 vaccine outreach, and~~ local disaster response management or planning, CHA/CHIP~~p~~ activities, and more. These staff attend a variety of community organization meetings and collaboratives, and they participate in local initiatives aimed at improving health and quality of life for Partnership members and others in the community. All communities (including Partnership) came together ~~Partnership~~ to respond to the devastating wildfires in Northern California, forming strong

working relationships. Regional staff were able to build on these working relationships as the COVID pandemic emerged to share information, communicate consistently, and build cohesive strategies in each community. Partnership seeks to continue this type of collaboration for years to come.

Partnership has many different member programs/initiatives concurrently planned and executed. In order to prevent duplication of effort, any department planning or implementing programs affecting our members has read-only access to Essette, Partnership's case-management software system. A move to a new system is planned after mid-2024. Member-facing campaigns are logged in a Campaign Tracker and shared with the entire organization, ensuring staff are aware of current interventions. Monthly check-in meetings include all member-facing departments, and provide updates on new initiatives and outreach campaigns. Population Health department staff communicate with providers, multidisciplinary health agencies, community resources, community-based organizations, and workgroups to share and gather information about member-facing programs. This process facilitates identification, planning, and support of healthy initiatives in the community, and identifies community programs and resources that can improve member health and wellness.

Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may be of benefit to Partnership's members and share these resources with the organization to promote integration into program offerings and meet member needs. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms, along with the cloud-based Collective Medical Platform to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCCP2032). This allows members of Care Coordination or other member-facing teams to collaborate with community

partners and external case management leads without duplicating services. In addition, Partnership has appropriate agreements in place with each lead entity to ensure HIPAA mandates are followed and member data is not shared inappropriately.

Per DHCS's California Advancing and Innovating Medi-Cal (CalAIM) effective January 1, 2022, members with exceptional clinical and non-clinical needs have access to a community-based benefit called Enhanced Case Management (ECM). ECM provides coordination of services and comprehensive care management through an interdisciplinary, high-touch, person-centered care plan. Members who ~~quality~~ qualify for ECM services are tracked through a shared data platform to promote communication between providers and reduce duplication of effort.

Partnership also executes Memorandums of Understanding (MOUs) with the following Third Party Entities~~community organizations~~ to ensure the delivery of services to Partnership members:

- County In-Home Supportive Services to coordinate between county and managed care plan (MCP) for members who may be eligible for and/or are receiving IHSS
- Regional Centers for the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center, including Intermediate Care Facilities for Developmentally Disabled Services
- Mental Health Plans (MHPs) to coordinate between MCP and MHP for Non-specialty and specialty Mental Health Services
- Substance Use Disorder Treatment Services to coordinate covered substance abuse services between DMC-ODS and MCPs
- ~~cmanaged care plan ()m~~Local Health Jurisdictions/Local Health Departments to coordinate between LHJ/LHD and MCP for the delivery of care and services for Members who reside in LHJ's jurisdiction and may be eligible for one or more services provided, made available, or arranged for by LHJ including:
    - California Children's Services (CCS);
    - Maternal and Child and Adolescent Health; and
    - Tuberculosis Direct Observed Therapy;
- ~~(MHPs)~~County Social Services for Child Welfare to coordinate between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services~~.~~
- Women, Infant, and Children (WIC) to coordinate services between WIC Agencies and MCP to ensure provision and delivery of MCP's Covered Services and WIC Services to Members

- Local Government Agency (LGA) County-Based Targeted Case Management (TCM) Program to coordinate services between LGA TCM Programs and the MCP to ensure the delivery of care and services for eligible Members.
- ~~Local Government Agency (~~County Behavioral Health Departments to coordinate services around Substance Use Disorder Treatment Services in Drug Medi-Cal State Plan Counties
-

Other MOUs with the following organizations will be effective on~~starting in~~ January 1, 2025:

- HCBS Waiver Agencies and Programs
- LGA/Jails, Juvenile Facilities and Probation Departments
- Continuum of Care
- First 5 Programs
- Area Agencies on Aging
- California Caregiver Resource Centers
- Local Education Agencies (LEAs)
- Indian Health Services/Tribal Entities
-

By January 1, 2025, Partnership must also have a process to implement DHCS guidance regarding Closed Loop Referrals to applicable C~~c~~ommunity Supports, ECM benefits, and/or community-based resources. Partnership must also work to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner. ~~appropriate manner.~~

Informing Members on Interactive Content

Many of Partnership's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances, members have the ability to opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction – this preference is documented for each campaign or intervention. The PHM Work Plan details the interactive services offered, how members qualify for programs, and how to opt out of programs.

Program Evaluation

The Population Health department analyzes the impact of PHM programs annually through clinical, utilization, and member experience measures, in accordance with the PHM efforts of the year. Partnership's Health Analytics department takes the lead in performing quantitative analyses to monitor the cost of services and programs, utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis includes advanced data sets described previously, as well as annual medical/behavioral and pharmacy claims data, transportation claims data, health appraisal results, HEDIS data, and data specific to internal programs such as case management, pilot programs, and/or provider performance improvement activities, as appropriate. The ~~PHM&HE~~PNAQIHEC ~~Committee~~ reviews reports of PHM activities for potential areas of concern, opportunities for improvement, and evaluates the impact of existing programs. This allows Partnership's leadership to review and update PHM activities to meet the needs of the members, as well as identify staffing, education, system, and infrastructure changes/requirements needed to support the delivery of those services. Partnership's Quality Improvement and Performance Improvement programs use HEDIS monthly and annual reporting and analysis to monitor the impact of the programs and select opportunities for future interventions. The PHM Work Plan tracks the progress of interventions according to the measures identified at the beginning of the year, while the Population Health Management Impact Analysis reports on select clinical and utilization measures, as well as member experiences with the population health interventions.

In addition, Partnership hosts quarterly committees to encourage members to engage directly with Partnership. One such committee is the Consumer Advisory Committee (CAC), made up of member representatives from each of the regions in which Partnership operates. This committee meets to review Partnership's programs and provide feedback on how Partnership is meeting the needs of its members and of its ~~the~~ communities~~y~~. A separate Family Advisory Committee (FAC) is comprised of members whose children have special needs. The Pediatric Quality Committee consists of public and private sector physicians who care for Partnership members; the committee provides insight into challenges members may have in getting the care they need from a provider perspective.

The Grievances & Appeals department gathers and analyzes trends in member-reported complaints to identify areas for program improvement in the coming year. Partnership also has a process for identifying and intervening where there may be Potential Quality Issues (PQIs) related to a provider or provider organization. Finally, Partnership participates in two NCQA-approved Consumer Assessment of Healthcare

Providers and Systems (CAHPS) surveys; one assesses factors under Health Plan influence, the other focuses on factors managed by Primary Care sites.

Identifying Opportunities for Improvement

No less than annually, the ~~PHM&HE~~QIHEC~~PNA Committee~~ evaluates the impact of PHM's programs, identifies opportunities for improvement, and selects at least one improvement opportunity to address in the coming year.

Delivery-System Supports for Population Health Management

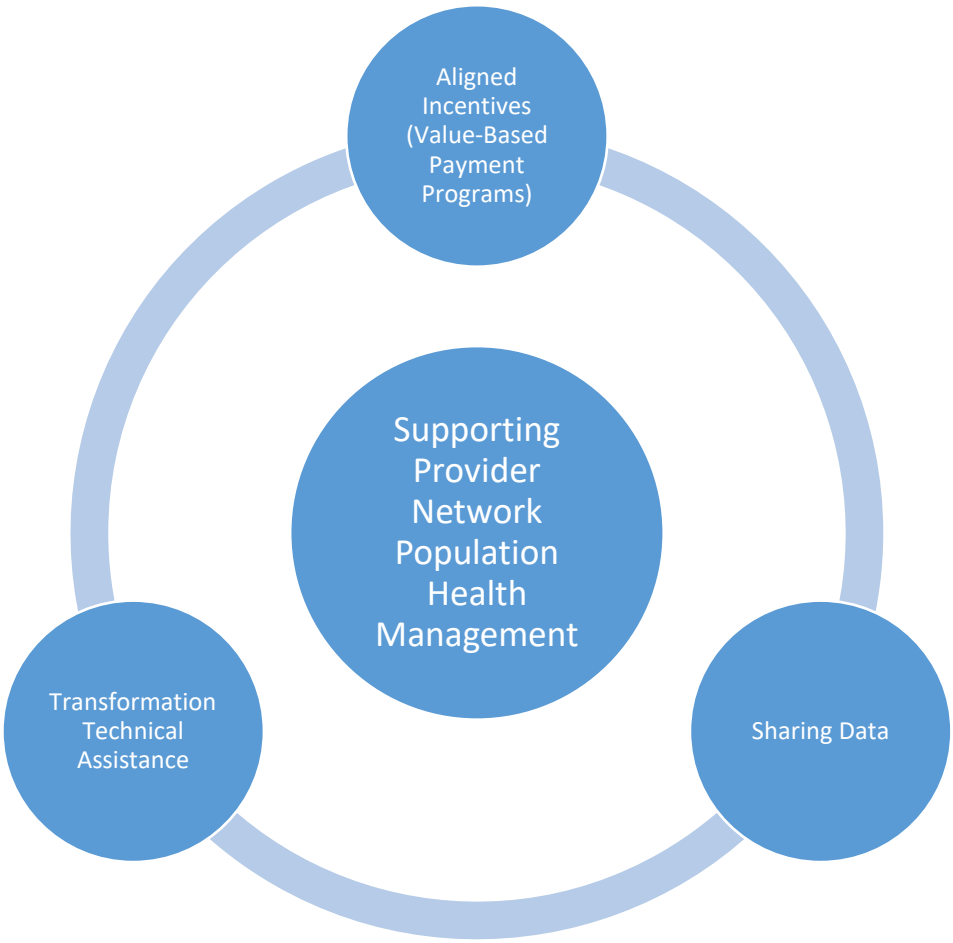
Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description (See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.

Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial bonus for quality-related performance. There are separate incentive programs for primary care providers, hospitals, pharmacies, perinatal providers, behavioral health, palliative care, and other specialty providers. Partnership's Primary Care Provider Quality Improvement Program (PCP-QIP) is Partnership's value-based payment program for primary care providers. The PCP-QIP is largely focused on improving the quality of care members receive through a measure set reflecting Partnership's HEDIS measure score improvement priorities.

Incentivizing Patient-Centered Medical Home (PCMH) Recognition

Through our PC~~P~~H-QIP, Partnership incentivizes contracted primary care practices to achieve and maintain Patient-Centered Medical Home recognition. This program is designed as an annual incentive, intended to encourage and recognize those provider practices that achieve excellent levels of service, care integration, and panel management, as recognized by established quality organizations.



Sharing Data

Partnership shares a variety of member data with our provider network in an effort to facilitate coordination of care and population health management. The two main systems for data sharing are eReports and the Partnership Quality Dashboard (PQD). Partnership also shares an annual data report with County Public Health Departments in alignment with DHCS' PHM requirements.[2]

eReports

eReports is a web-based platform that supports measurement and reporting for the clinical care domain of the Core Measurement set in Partnership's PCP-QIP. These preventive care and chronic disease management measures reflect DHCS's priority quality measures and are developed in-house by Partnership. The Core Measurement set is reviewed, modified, and approved annually by Partnership's Physician Advisory

[2] DHCS Population Health Management Policy Guide, 2024

Committee (PAC) after considerable input from an internal technical workgroup, an external provider advisory group, and an open comment period involving all participating providers. eReports gives providers member-level data showing member eligibility and compliance for each clinical measure leveraging claims, lab, pharmacy, and immunization registry data. Providers may also upload medical record data to substantiate member compliance where representative administrative data is unavailable. eReports data are refreshed twice per week, giving providers nearly real-time visibility to their measure-specific performance relative to performance targets. It also offers the ability to drill down into member lists by measure and view measure performance by site or organizational level (i.e. if multi-site provider).

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

Measure-Specific Data	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
Trended Data	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
Comparative Data	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Note: While the most currently available data for QIP Clinical measures is available on eReports, PQD serves as a visualization tool. PQD does not allow for any data entry. Instead, all clinical rates are calculated in eReports, and PQD takes the output of eReports, presenting the data longitudinally and comparatively. While eReports displays performance at a given point in time, PQD shows performance data trending. In addition, the eReports interface compares performance against pre-defined thresholds, whereas PQD has multiple means of comparison including averages at regional, sub-regional, and county levels. PQD also includes data for non-clinical measures (e.g., readmissions, PCP Office Visits).

Transformation Technical Assistance

In addition to aligned incentives and data sharing, Partnership supports quality improvement and care delivery transformation in our network via the Partnership

Improvement Academy and its component offerings. These opportunities are designed to prepare providers to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. The Academy offerings include the ABCs of QI (QI basic methodology for the model for improvement) and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership delegates activities for both Population Health, ~~and~~ Health Education, and Cultural and Linguistics functions. A formal agreement is maintained and inclusive of all delegated functions. Partnership conducts an audit of all delegated entities no less than annually to ensure the appropriate policies and procedures are in place. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval, as needed.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy, identifying the health disparities and wellness needs of Partnership's members, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, promote collaboration of effort, and reduce duplication of services.

Team Roles and Responsibilities

~~Senior Director~~Chief Health Services Officer ~~of Health Services~~:

P~~At the senior level, p~~rovides overall direction to the Heath Services (HS) Care Coordination/Population Health/Utilization Management Leadership Team. This position has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location.

Director of Health Equity (Health Equity Officer)

In collaboration with other Partnership leaders, develops and drives forward the key strategies helping Partnership be a diverse, equitable, and inclusive organization. Works to raise awareness of health inequities within Partnership's staff, providers, and membership, and creates concrete plans for addressing them. Works closely with the Senior Director of Health Services, Quality, Human Resources, Provider Relations and Population Health departments toward shared goals, and with other internal and external Partnership stakeholders to ensure high standards of equitability.

Director of Population Health

Provides oversight of the Population Health strategy, programs and services to improve the health of Partnership members. Works with the Chief Medical Officer, ~~Senior~~ Chief Health Services Officer~~Director of Health Services~~, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership~~PHC~~'s population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables.

Manager of Population Health

The Manager of Population Health gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, CHA/CHIP activities, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisors,

manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit.

Supervisor of Population Health

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Community Health Needs Liaison

Supports the coordination and implementation of Partnership's Population Needs Assessment (CHA/CHIP) activities through active and meaningful engagement in identified community workgroup and initiatives. On behalf of the health plan, identifies and supports key strategic activities and interventions that support alignment of collective agency efforts that promote and support efforts to encourage member health outcomes. ~~emenAssists in pinging or trainingspresented to, and training~~Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate as needed. Makes these resources available on Partnership's external website.

Senior Health Educator

A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. ~~Collaborates~~ Supports ~~on~~ the creation of trainings for contracted providers and internal Partnership staff to promote cultural competency, health equity, and member wellness. ~~Responsible for~~Assists with preparation and implementation of the PNA ~~and the C&L Work Plan~~. Monitors and provides administrative oversight of all regulatory requirements related to Health Education and the Cultural & Linguistics programs. Provides assistance with regulatory requirements as needed.

Health Educator

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on assigned member education projects, monitors health education materials, performs literacy reviews to ensure appropriate readability and suitability levels, and evaluates

member discrimination grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials.

Healthy Living Coach

Engages Partnership members to identify barriers to care, member concerns, and resources needed. Leads member wellness ~~courses~~ campaigns and supports members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learning with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

~~Community Outreach Representative~~

~~Identifies and participates in provider and member educational opportunities for internal departments, external agencies/community-based organizations, community advisory groups, and trainings. Provides hands-on support to the internal team, and Partnership providers, community partners, and members. Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate. Makes these resources available on Partnership's external website.~~

Wellness Guide

Performs outbound call campaigns to members based on identified member needs (e.g., pregnant members, members impacted by natural disasters, etc.) using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved database/tracking system, per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved~~,~~ health education materials.

Project Manager

Responsible for managing timelines and deliverables in department projects. Develops agendas and leads meetings to advance departmental objectives. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables.

Project Coordinator

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with

designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

Coordinator

Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.

Note: Staffing and staff job descriptions are~~is~~ subject to change based upon program needs and organizational growth.

References

DHCS APL 18-016 Readability and Suitability of Written Health Education Materials (10/05/2018)

Document A (APL 18-016): Review and Approval Guidance for Written Health Education and Member Information Materials

Document B (APL 18-016): Readability and Suitability Checklist for Written Health Education materials

DHCS APL 16-005 *Revised* Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys (11/23/2016)

DHCS 2024 Contract

DHCS Population Health Management Policy Guide, 2024

NCQA. (2018). *Population Health Management / Resource Guide.* www.ncqa.org.

Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557)

Snyder, A. M., Willey, C., McKenna, M., Foley, P., & Coleman, R. (2005). Development of a Risk Assessment Tool for Predicting Pediatric Health Services Utilization. *Journal of Clinical Outcomes Management*, 451-458.

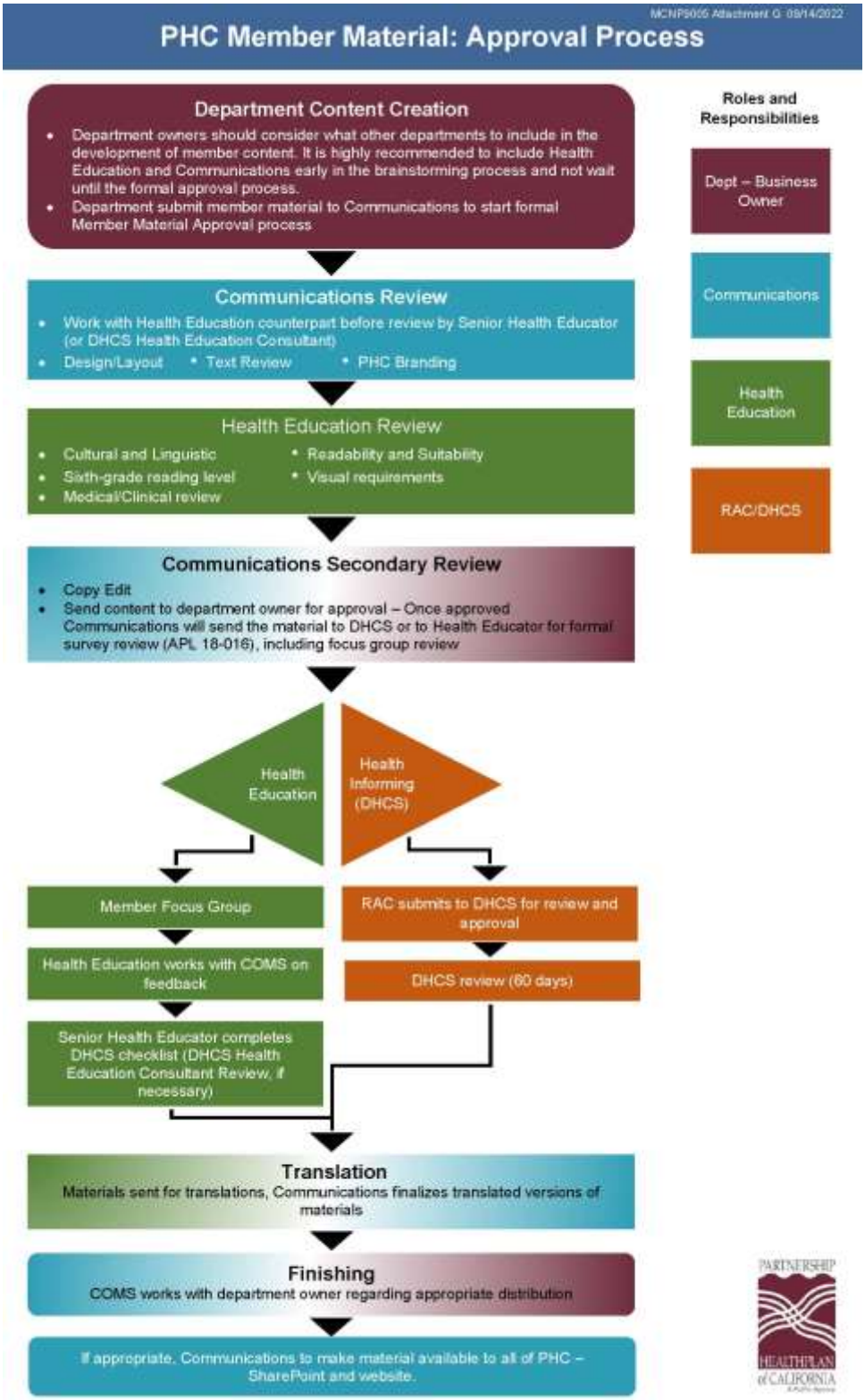
Population Health Management Strategy & Program Description Approval

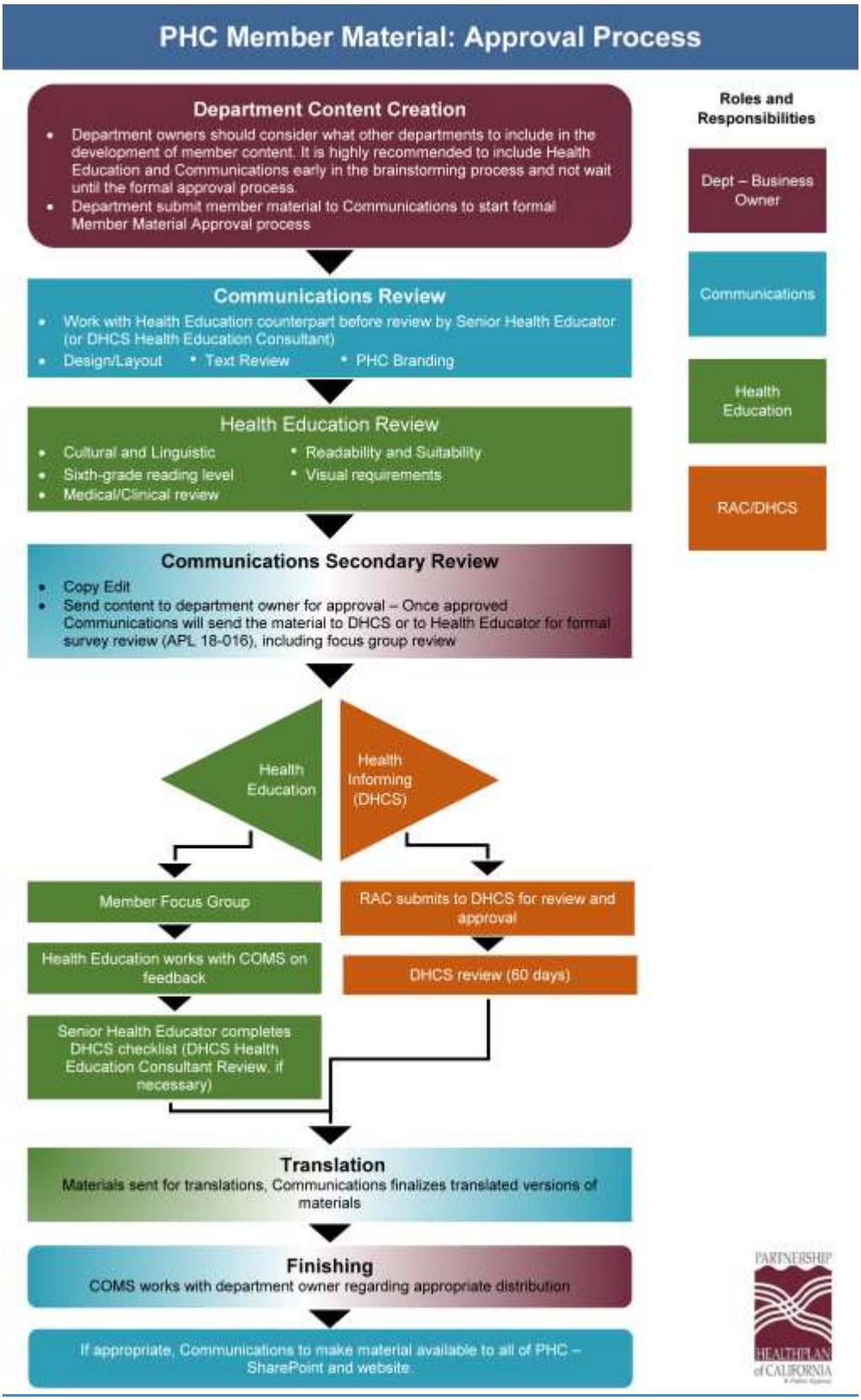
Robert Moore, MD, MPH, MBA *Quality/Utilization Advisory Committee Chairperson*	*Date Approved*

Steve Gwiazdowski, M.D. *Physician Advisory Committee Chairperson*	*Date Approved*

~~*Alicia Hardy*~~*Kim Tangermann*~~*, LCSW*~~ ~~———~~*Date Approved* *Board of Commissioners Chairperson*	_____

Appendix A


MCNPS005 Attachment G 09/14/2022
PHC Member Material: Approval Process
Department Content Creation
Department owners should consider what other departments to include in the development of member content. It is highly recommended to include Health Education and Communications early in the brainstorming process and not wait until the formal approval process.
Department submit member material to Communications to start formal Member Material Approval process
Communications Review
Work with Health Education counterpart before review by Senior Health Educator (or DHCS Health Education Consultant)
Design/Layout
Text Review
PHC Branding
Health Education Review
Cultural and Linguistic
Sixth-grade reading level
Medical/Clinical review
Readability and Suitability
Visual requirements
Communications Secondary Review
Copy Edit
Send content to department owner for approval – Once approved Communications will send the material to DHCS or to Health Educator for formal survey review (APL 18-016), including focus group review
Health Education
Health Informing (DHCS)
Member Focus Group
Health Education works with COMS on feedback
Senior Health Educator completes DHCS checklist (DHCS Health Education Consultant Review, if necessary)
RAC submits to DHCS for review and approval
DHCS review (60 days)
Translation
Materials sent for translations, Communications finalizes translated versions of materials
Finishing
COMS works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of PHC – SharePoint and website.
Roles and Responsibilities
Dept – Business Owner
Communications
Health Education
RAC/DHCS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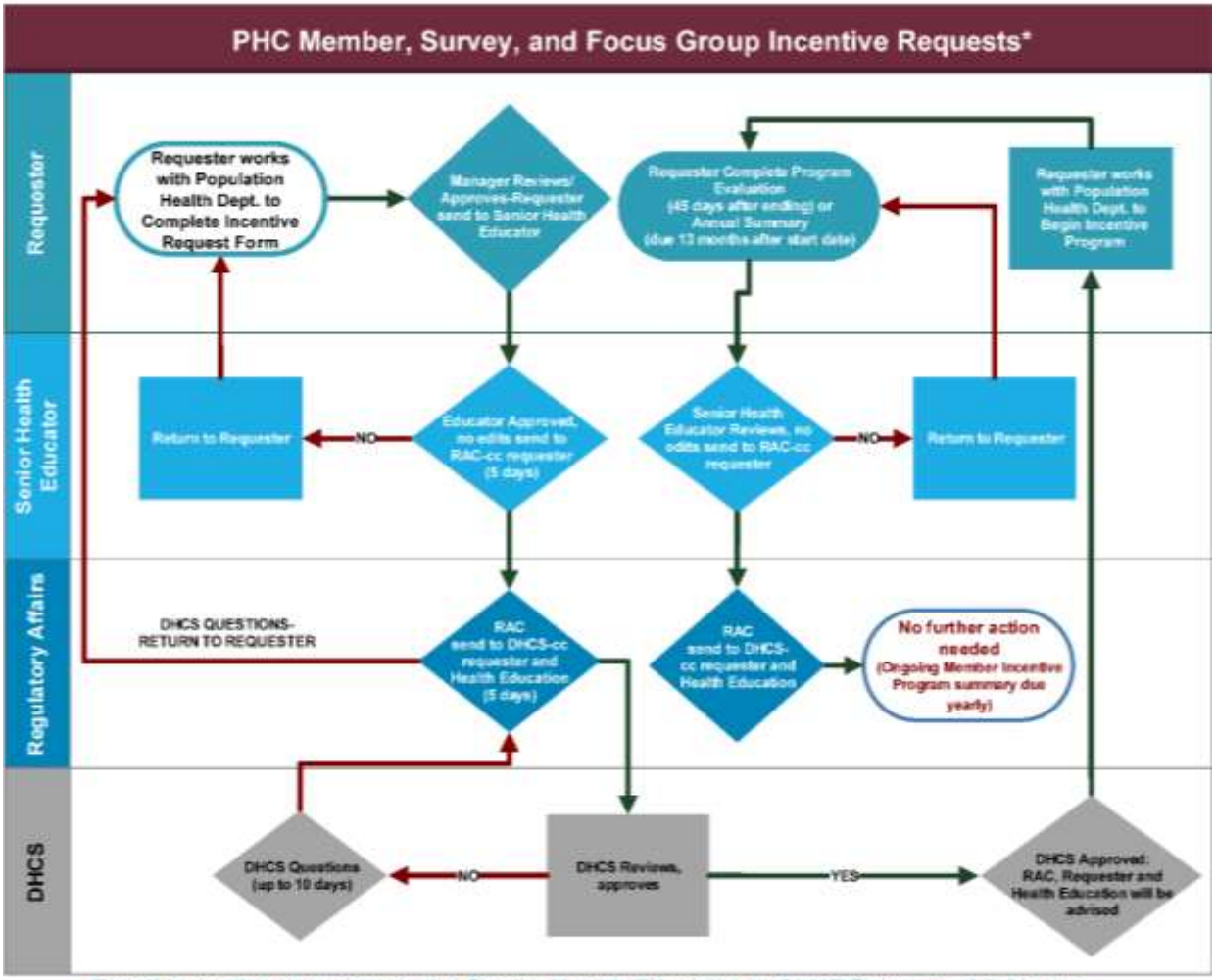
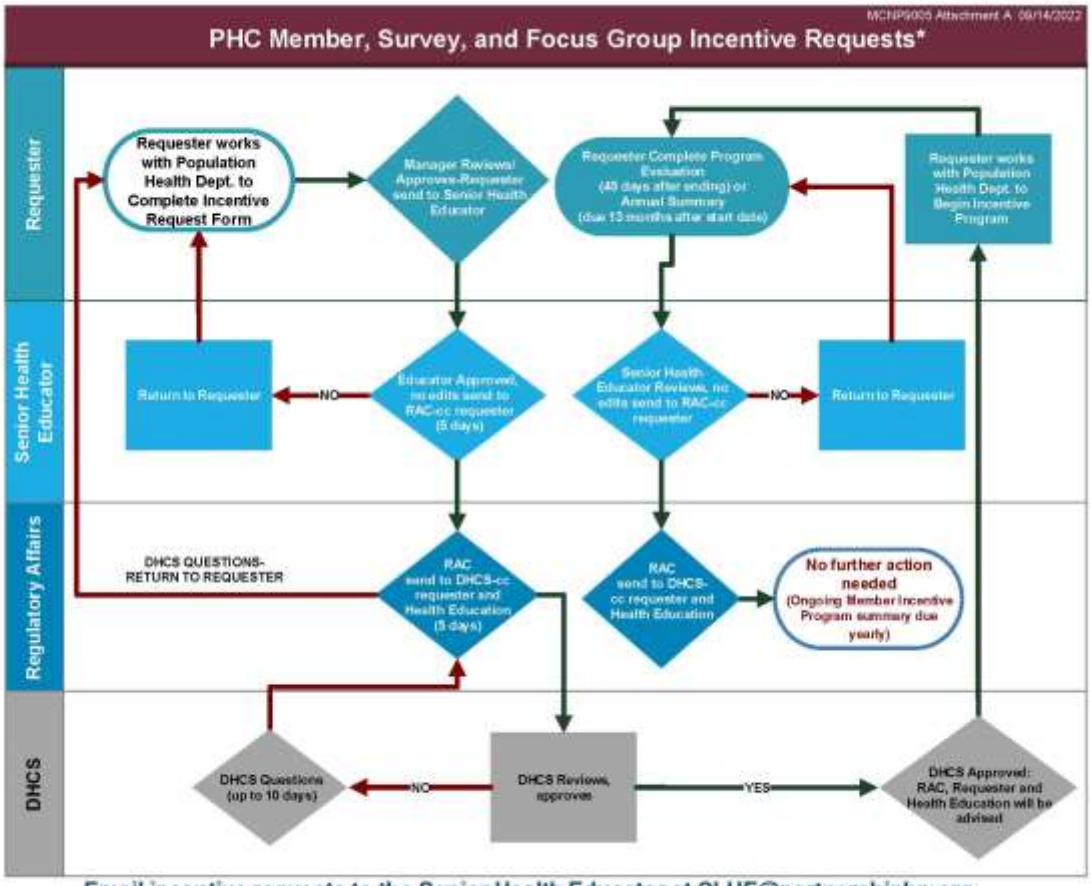
PARTNERSHIP HEALTHPLAN of CALIFORNIA

Appendix B



Email incentive requests to the Senior Health Educator at CLHE@partnershiphp.org

*As referenced by MMCD All Plan Letter (APL) 16-005 Revised



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*As referenced by MMCD All Plan Letter (APL) 16-005 Revised

Population Health Management Strategy & Program Description

MCND9001
(previously MCCD2027)

June 2024

Original Date: 11/13/201911/13/201911/13/2019
Previously Applied to MCCD2027 11/13/19 to 04/08/20
Revision Dates: MCND9001 04/08/20; 08/11/21; 08/10/22; 08/09/23: 6/2024

Table of Contents

Program Purpose

To identify the strategy and organizational structure Partnership HealthPlan of California (Partnership) utilizes to assess, segment, and act in order to meet the needs of its member population and subpopulations within the context of the various communities in which Partnership's members live.

Introduction

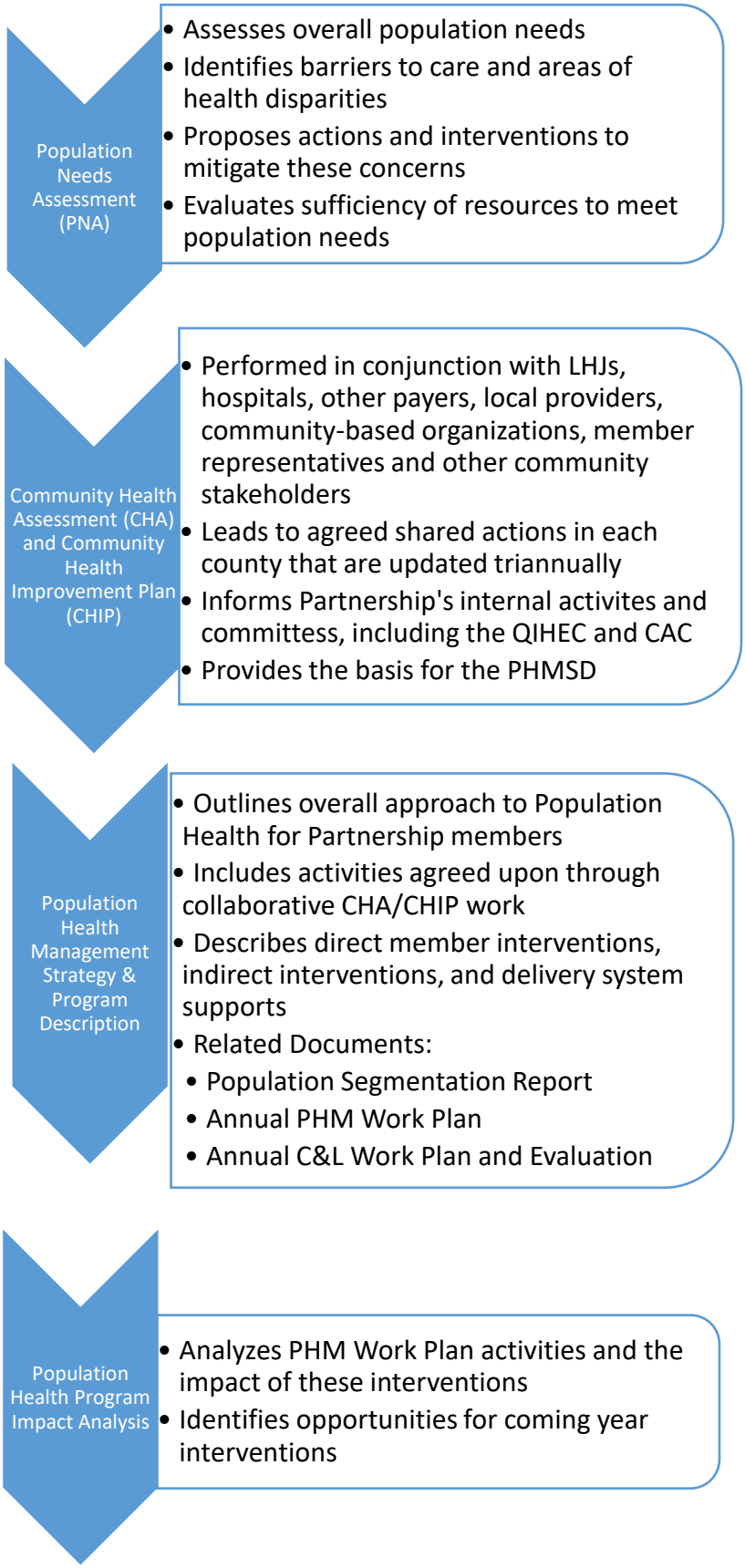
Partnership's Population Health Management (PHM) Strategy & Program Description outlines a cohesive plan of action for addressing Partnership's member needs across the continuum of care engaging not only the Population Health department, but also multiple departments within the organization. The unique characteristics and needs of Partnership's member population determine the programs and services designed to help individual members and subpopulation groups, in alignment with California's Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA) requirements. This document also highlights Partnership-sponsored delivery system supports designed to enhance population health management within our provider network, describes the process for annual assessment of member needs, and the effectiveness of our population health strategy in meeting those needs. As part of Partnership's Population Health strategy, Partnership is committed to identifying root causes of health disparities for its members and collaborating across the organization, with providers, and with other community agencies to reduce inequities for the members we serve and to address Social Drivers of Health.

As part of NCQA requirements, Partnership performs an annual Population Needs Assessment (PNA), which identifies factors leading to health disparities for Partnership subpopulations, and outlines a plan for addressing and mitigating these disparities. In addition, as part of DCHS' updated PNA requirement, Partnership collaborates with Local Health Jurisdictions (LHJs), and Public Hospitals as appropriate, on their Community Health Assessments (CHAs) and Community Health Improvement Plans (CHIPs), documenting the shared work in accordance with each of the LHJ reporting cadences in all Partnership's counties of operation.

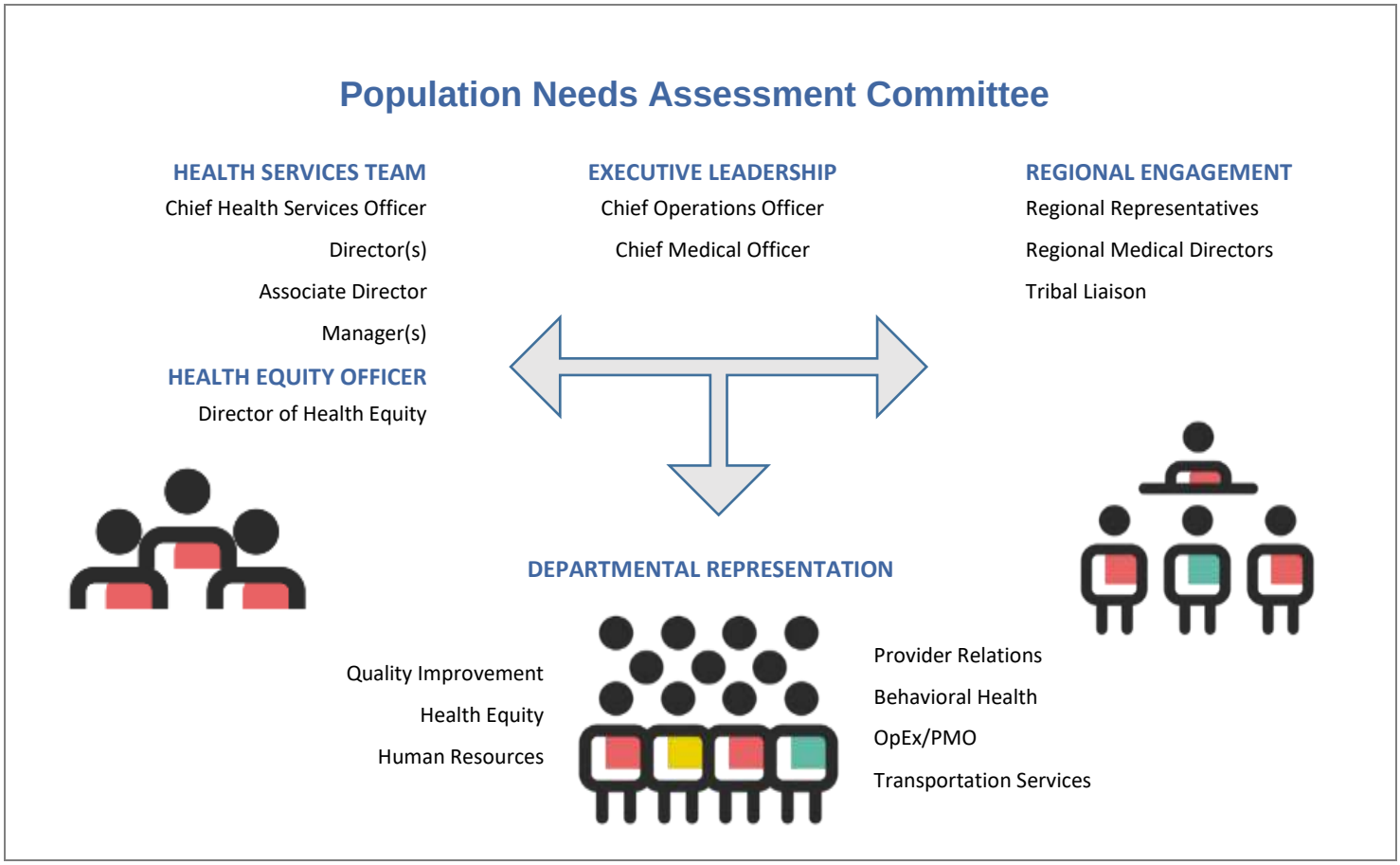
Data Analysis and Strategy

Partnership uses several methods to identify member needs, and to strategize the means best to meet them. Both the annual PNA and county CHAs/CHIPs describe the overall health, social, health education, and cultural and linguistic needs of Partnership's membership, including members who are less than 21 years of age, by analyzing service utilization patterns, disease burden, and gaps in care for our members, taking

into account their risk level, geographic location, and age groups and recommends interventions to address barriers and disparities. The PNA identifies community resources to integrate in program offerings (including Partnership's Community Resource pages), and describes Partnership's collaboration with network providers, LHJs, and community leaders in support of the population. The PNA and county CHA/CHIP findings inform Partnership's overall PHM strategies and are electronically submitted to the appropriate governing bodies per their respective reporting timelines. Key stakeholders within Partnership review the PNA and CHA/CHIP findings and from there, develop the annual PHM Work Plan, DHCS PHM Strategy Deliverable (PHMSD), Segmentation Report, Cultural & Linguistics (C&L) Work Plan, and appropriate health education and shared community interventions; findings may also be used to update Partnership's Strategy and Program description as appropriate. These work plans outline specific interventions to mitigate health disparities both on a member and system level. The PHM Strategy & Program Description (MCND9001) provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population we serve. The PHM Work Plan provides details on specific member-facing interventions, staff who will perform the interventions, method of contact, and outcome measures Partnership will implement during the year. Similarly, the C&L Work Plan identifies specific health equity concerns and provides a strategy for how Partnership will address them through annual activities. The PHM Impact Analysis report evaluates Partnership's programs and services to determine if the benefits offered are adequate to meet our member needs and identifies opportunities for further intervention. The PHM Segmentation Report categorizes Partnership's subpopulations into the appropriate categories on the continuum of risk as defined by DHCS and NCQA and as described under "Organizational Support for PHM". The following diagram shows the relationship of these activities:


Population Needs Assessment (PNA)
• Assesses overall population needs
• Identifies barriers to care and areas of health disparities
• Proposes actions and interventions to mitigate these concerns
• Evaluates sufficiency of resources to meet population needs
Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP)
• Performed in conjunction with LHJs, hospitals, other payers, local providers, community-based organizations, member representatives and other community stakeholders
• Leads to agreed shared actions in each county that are updated triannually
• Informs Partnership's internal activites and committess, including the QIHEC and CAC
• Provides the basis for the PHMSD
Population Health Management Strategy & Program Description
• Outlines overall approach to Population Health for Partnership members
• Includes activities agreed upon through collaborative CHA/CHIP work
• Describes direct member interventions, indirect interventions, and delivery system supports
• Related Documents:
• Population Segmentation Report
• Annual PHM Work Plan
• Annual C&L Work Plan and Evaluation
Population Health Program Impact Analysis
• Analyzes PHM Work Plan activities and the impact of these interventions
• Identifies opportunities for coming year interventions

In late 2023, Partnership replaced the Population Health Management and Health Equity Committee with the internal Population Needs Assessment (PNA) Committee. The PNA Committee is an internal committee serving as a multi-departmental decision-making body whose goal is to carry out the DHCS mandate to meaningfully participate in each Local Health Jurisdiction's (LHJs) Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP). PNA Committee Meetings occur on a quarterly basis to review requests from the counties, and general progress towards shared work on the CHA/CHIP collaborative in Partnership's service areas, including the implementation of the shared SMART goals between Partnership and each of the LHJs in Partnerships service. This committee also meets annually to review and make recommendations for the Population Needs Assessment (PNA) used to fulfill NCQA requirements. The PNA Committee activities and recommendations will be shared with the Quality Improvement and Health Equity Committee (QIHEC), Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.



Quality Improvement and Health Equity Committee (QIHEC)

Following each PNA committee meeting, the proceedings and recommendations from the written PNA, and/or updates from the CHA/CHIP efforts, are forwarded to Partnership's QIHEC for deliberation and approval. The QIHEC consists of a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership members. The committee identifies, reviews, and recommends actions and/or activities designed to promote health equity for Partnership members in their communities. It is also responsible for reviewing the PNA, CHA/CHIP updates, and other reports and data that represent Partnership's activity to promote the quality and equity of program offerings. For more information, see Policy MCEP6002 Quality Improvement and Health Equity Committee (QIHEC).

Population Needs and Community Needs Assessments

Partnership routinely collects data regarding cultural, ethnic, racial, linguistic, health education and environmental needs of its members, and conducts a quantitative and qualitative evaluation to determine unmet needs and areas of health disparities. Data sources may include, but are not limited to, US census and enrollment data, member surveys, member grievances, and other published health statistics, as well as data provided by Health Plan sponsors or other sources such as local community needs assessments. Partnership's Health Analytics and Health Education teams analyze the data collected no less than annually with the goal of ensuring Partnership and its providers deliver services that equitably meet the needs of our culturally and linguistically diverse member population.

Population Health staff prepare an annual Population Needs Assessment (PNA) for NCQA that describes our membership and region, including Partnership's demographics, community-identified needs and resources, health education, and cultural and linguistic needs, health inequities, social and structural barriers to care, and more. The PNA proposes actions to address identified disparities and promote health equity. The PNA also analyzes language preferences (including limited English proficiency [LEP]), reported ethnicity, traditional health beliefs, and beliefs about health and health care utilization.

The Manager of Population Health provides a summary report of the NCQA PNA findings for discussion with the Consumer Advisory Committee (CAC) session and the Family Advisory Committees (FAC). Members of both committees are given an opportunity to provide input and advice on selecting Partnership's targeted, priority health education, and cultural and linguistic strategies and outreach programs. The

NCQA PNA and its proposed actions also undergo review by Partnership's PNA Committee, the QIHEC, Internal Quality Improvement Committee, Quality/Utilization Advisory Committee, Physician Advisory Committee, and by the Board of Directors before submission to NCQA and DHCS per regulatory requirements. PNA findings are also sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

In addition to the annual PNA, and in alignment with DCHS's Population Health Management Policy Guide[1] and 2024 Contract, Partnership works collaboratively with LHJs, hospitals, community providers, other payers, community-based organizations, member representatives, and other community stakeholders on each county's CHA and CHIP report. This collaborative work has replaced DHCS's historically mandated PNA. The county CHAs/CHIPs represent the overall community needs and priorities, and provide an opportunity for health plans to work with LHJs, local hospitals, and other community stakeholders to prioritize local needs and agree upon a shared plan of action. The PNA committee, CAC, FAC, and QIHEC receive regular updates on the CHA/CHIP collaborative work and are provided an opportunity to give feedback. CHA/CHIP updates are sent to providers via Partnership's quarterly provider newsletter and corresponding fax blast notice.

Each county has its own schedule for CHA/CHIP work, and Partnership will align its reporting with each county as needed until timelines are standardized in 2028. The shared action plans and findings from county collaborations lead to development of Partnership's annual PHM Strategy Deliverable (PHMSD) that demonstrates commitment to the implementation of prioritized actions and responses to community needs. The PHMSD is submitted to DHCS annually, along with an NCQA-approved version of this document and the annual NCQA-approved PNA. Findings from these collaboratives are also used to guide the following efforts:

- Targeted health education materials for members, and the creation of member-facing outreach materials for any identified gaps in services and resources, including but not limited to, Non-Specialty Mental Health Services;
- Cultural and linguistic and quality improvement strategies to address identified population-level health and social needs; and
- Wellness and prevention programs

[1] 2024 PHM Policy Guide

Partnership also publishes the CHAs/CHIPs of all LHJ's in its Service Area on Partnership's website, along with a description of Partnership's collaboration on the report.

Similar to the PNA review described above, the annual PHMSD will be shared with members (through CAC and FAC sessions as well as through key informant interviews), with the PNA Committee, the Quality Improvement Health Equity Committee (QIHEC), Partnership's Internal Quality Improvement Committee (IQI), Partnership's Quality Utilization Advisory Committee (Q/UAC), Partnership's Physician Advisory Committee (PAC), and by Partnership's Board of Directors. These documents will be posted on Partnership's external website as they are updated, and provider newsletters will prompt providers when new versions are available.

Social Drivers of Health and Community Needs

Partnership's Health Analytics department estimates the impact of Social Drivers of Health (SDOH) for the region and membership through proxy data sources. One such source is the California Healthy Places Index (HPI) data produced by the Public Health Alliance of Southern California (healthyplacesindex.org). This freely available data set ranks California census tracts on a composite score of health disadvantage by incorporating data on 25 individual indicators organized in eight domains: economy, education, healthcare access, housing, neighborhoods, clean environment, transportation, and social environment. In every census tract, each indicator is shown on standardized scales (Z-scores) of increasing disadvantage, and averaged for each domain. The overall score is calculated as the weighted sum of domain scores. The HPI data set also includes the percentiles of each domain and individual indicator, as well as the overall composite values ranking each census tract.

Using the residential addresses of members found in the Membership data files received from DHCS, Partnership's Health Analytics team determines the geographic coordinate of each member's valid address and finds the corresponding census tract. The calculated census tract for each member is then joined with the HPI scores (https://healthyplacesindex.org/about/). These HPI scores are used in combination with the rest of the SDOH data to estimate the SDOH risks for each of Partnership's members.

Member-specific sources for SDOH data include location, distance from providers, and non-medical transportation claims that demonstrate member needs for services; demographic attributes found in membership data; specific social risk factors identified from diagnosis codes; and homelessness data derived from members' addresses and diagnosis coding. Members who are new to Partnership and having either a Senior or

Person with Disability (SPD) aid code, or identified as California Children's Services (CCS) beneficiaries complete a detailed assessment of their social supports, barriers to care, food security, and financial resources, as well as their medical history and current care needs.

Members who have serious mental illness or serious emotional disturbance (SMI/SED) receive care for those conditions through county-administered Mental Health Managed Care, which is carved out of Partnership's benefit package and assigned to the county in which the member lives (see All Plan Letter 17-018: Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services).

In July 2020, Partnership began administering the Drug Medi-Cal Organized Delivery System (DMC ODS) substance use treatment services on behalf of participating counties. Partnership works together with our providers and partners in seven Partnership counties (Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano) to provide integrated physical health and SUD services for the Medi-Cal population.

In addition, Partnership's disease registry flags members with SMI/SED conditions, such as schizophrenia or major depression. Partnership uses prescription data for anti-psychotic and specific anti-manic medications as a means of identifying members who may have any SMI/SED, and leverages this data to ensure members with SMI/SED receive care for comorbid medical conditions.

Population Risk Stratification & Segmentation

Currently, Partnership analyzes and segments the entire population by need and appropriate intervention(s), as described in the Population Segmentation Report. Once DHCS has launched the PHM Service and associated Risk Stratification and Segmentation methodology, Partnership will incorporate those data points and methods to further stratify populations for intervention. Partnership's RSS and Risk Tiering approach is available upon DHCS request.

Partnership has developed a proprietary method currently in use for assigning members to a risk level, which will be used until DHCS launches the PHM Service's Risk Stratification and Segmentation and Risk Tiering Tool (RSST).

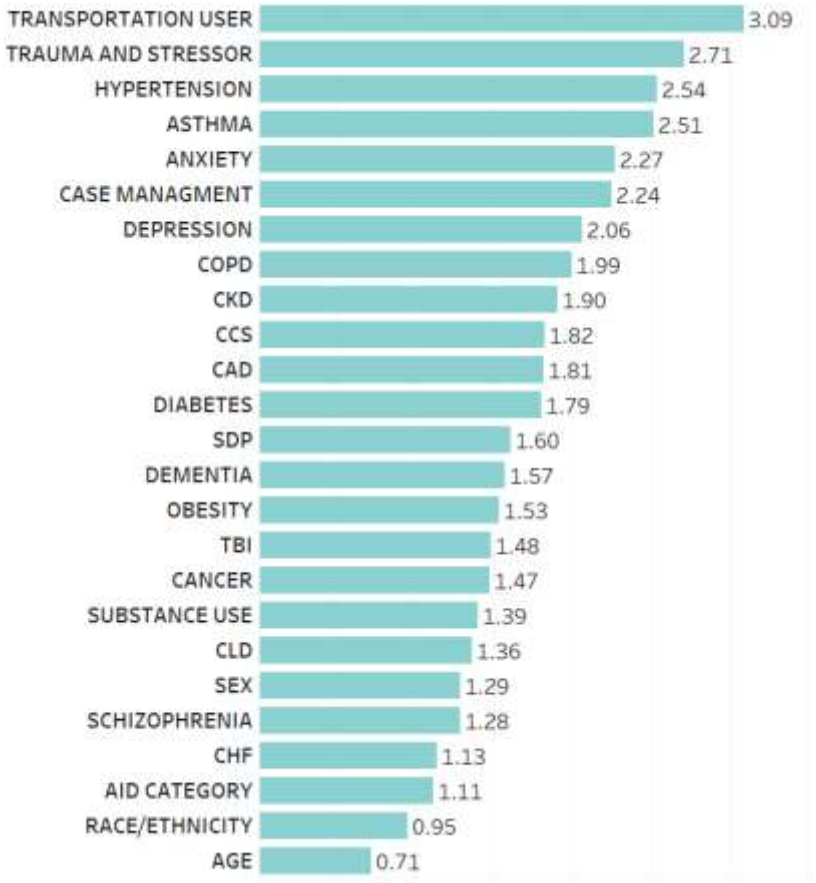
Partnership's Risk Stratification Process

Partnership's Health Analytics team has developed a risk score model that predicts member's risk for becoming a high-utilizer at individual level by applying the following data sources: member demographic data, claims (behavioral, medical, and pharmacy),

case management enrollment, and external data (California's health index and census tract). This risk score model forecasts the likelihood of a member becoming a high utilizer within the next six months. A member will be classified as a high utilizer if they meet any of these four criteria within a six-month period: (a) five or more ED visits, (b) one or more acute hospital admission, (c) fifteen or more distinct drug prescriptions, or (d) total paid claims of more than $50,000 for medical cost (hospital and pharmacy). During the development of the risk score model, the health utilization of the entire Partnership population was included in the study to avoid any sampling bias and also ensured no bias from other factors like race and ethnicity. The risk score model adjusts for social determinants, demographics, member's aid category, chronic disease conditions (up to 19 chronic conditions as defined through HEDIS or CMS protocols), as well as the member's eligibility criteria under the CCS program or SPD aid codes. In the realm of social determinants, the risk score adjust for homelessness, non-emergency transportation usage, and the Healthy Places Index. Similarly, in the demographic category, the adjustments include gender, age, and race/ethnicity.

The relative significance of these factors on the member's overall risk score is estimated using the odds ratio. The higher the odds ratio, the higher the contribution of that factor to the risk score. The bar chart below shows the odds ratios of all the factors that have a statistical significant contribution to the risk score. For example, members who use non-medical transportation benefit are 3.09 times more likely to become high utilizers compared to those who do not use this benefit, holding all other conditions constant. Similarly, considering the race and ethnicity factor, the white population (with an odd ratio of 0.95) is slightly less likely to experience the risk comparing to other race and ethnicity groups.

The influence of isolated factors on a member becoming a high utilizer



The risk score generated from this model has values ranging between zero and one, going up to 5 decimal places. In addition, the entire Partnership membership is segmented into four risk tiers by defining risk score ranges that delineate homogenous risk groups.

Accordingly, the risk tiers are assigned as follows:

No Risk:	Risk score is less than 0.02004
Low Risk:	Risk score is between 0.02004 and 0.0742
Medium Risk:	Risk score is between 0.0742 and 0.20038
High Risk:	Risk score is above 0.20038

Within every risk tier, we evaluated the distribution of race and ethnicity and ensured that there were no significant biases due to the risk segmentation.

Risk scores prove valuable in assigning members to risk-tiered programs for individuals whose health and well-being require the support of intensive interventions.

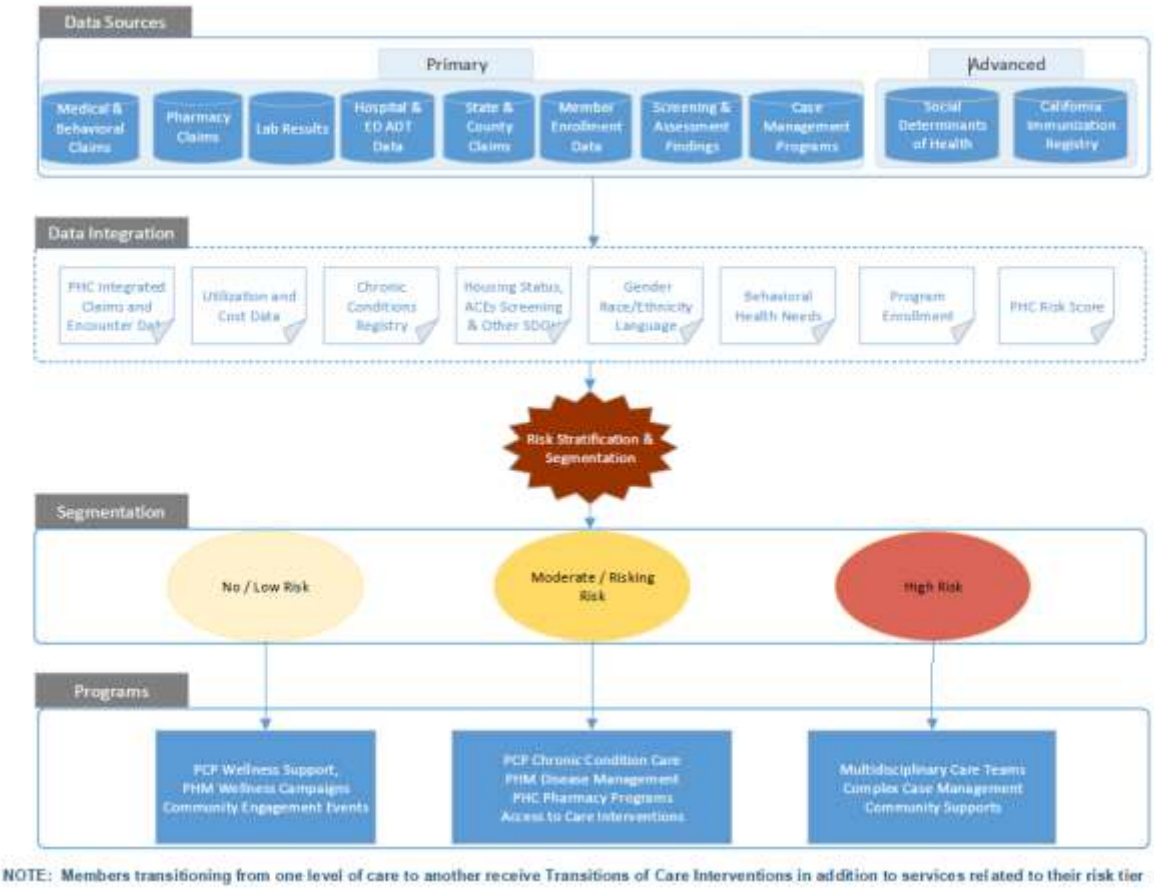
Partnership's Health Analytics team runs the risk stratification report every month so that members who have a significant change in health status are captured and offered appropriate interventions to support their health and wellbeing. In addition, Partnership's Quality team uses HEDIS data to evaluate Population Health interventions. Partnership analyzes HEDIS performance by race/ethnicity and language to identify statistically significant disparities that drive development of interventions to promote health equity within its membership.

HEDIS measures provide insight on members having gaps in care, and this information is shared with providers to help members obtain preventive and chronic care. Partnership's Population Health team uses monthly care gap reports to perform outreach to members, explaining their benefits and connecting them with providers.

The PNA describes how Partnership analyzes HEDIS Measure results in aggregate, by race/ethnicity, and by language, and examines individual measures for evidence of subpopulations experiencing disparities that warrant intervention. Census, Healthy Places Index, and County Health Rankings data provide insight into the challenges faced by communities and racial groups that lead to health disparities, such as food insecurity, housing problems, tobacco use, and other concerns. Data provided by our providers and community partners also helps identify opportunities and interventions for members with low risk scores, insufficient data to assign a risk score, or members who may benefit from intervention regardless of risk score. Partnership recognizes that cost and utilization data is insufficient to identify the needs of all racial, language, and gender groups. Therefore, Partnership mitigates the impact of racial bias that could result from risk stratification based solely on utilization patterns by evaluating the entire population through multiple lenses (including race, language, housing status, and other social factors) for enrollment into a wide variety of programs that meet subpopulation needs according to shared identifiers. Partnership will continuously reassess the effectiveness of the RSS methodologies and tools.

Partnership works in collaboration with local providers and community resources to analyze, develop, and implement interventions that support the health and well-being of the entire population (see diagram).

Partnership's Risk Stratification and Segmentation Process



NOTE: Members transitioning from one level of care to another receive Transitions of Care Interventions in addition to services related to their risk tier

Future Risk Stratification and Segmentation and Risk Tiering

After the release of the DHCS PHM Service's RSST methodologies, Partnership will assign member risk first based on the DHCS methodology, and will ensure members who are identified as high-risk are assessed for appropriate intervention, including care management programs, BPHM, and Transitional Care Services. Partnership will also evaluate members through its proprietary methodology to cull members not identified through the DHCS RSST methodology, who may benefit from Partnership interventions, programs, and services. Partnership will perform the RSST process no less than annually and/or upon each member's enrollment, a significant change in health status/level of care, and upon an occurrence of events or when new information arises that potentially changes a member's needs.

Programs and Services

Partnership leverages committees and multidisciplinary workgroups to design and implement programs and services. Using the risk stratification and segmentation

method described above, the Population Health department maintains a PHM Work Plan that describes the interventions offered to members along the continuum of risk. These interventions represent Partnership's basic population health management and case management service offerings to improve the health of our members and to promote health equity within the communities we serve. Beyond the interventions described in the PHM Work Plan, Partnership collaborates with providers, specialty groups, community based organizations (CBOs), public health agencies, local education agencies, justice programs, and other agencies to support the health and well-being of the members and communities we serve.

Basic Population Health Management

Partnership's BPHM is for all members. BPHM includes services such as having an ongoing source of care, Care Coordination, and sharing resources and education to improve the health of members.

Each member has an ongoing source of care that is appropriate, ongoing, and timely to meet the member's needs. Partnership also works to ensure members are engaged with their assigned PCP, and receive all needed preventive services. Member utilization reports are reviewed to identify members not using primary care. At minimum, reports are stratified by race and ethnicity to identify health disparities that result from differences in utilization of outpatient and preventive services. Strategies are then developed to address differences in utilization to promote health equity for all members.

Partnership works to ensure the member's PCP plays a key role in the member's care coordination. Members receiving care from out-of-network providers will maintain efficient care coordination and continuity of care. Members have access to needed services including:

- Care coordination
- Navigation and referrals to services that address a members' developmental, physical, mental health, substance use disorder, dementia, long-term services and supports, palliative care, and oral health needs
- Help with making appointments
- Help with arranging transportation
- Health education on the importance of Primary Care when disengaged with their Primary Care Provider, especially among members less than 21 years of age

To address members' needs, health and social services are coordinated between settings of care, across other Medi-Cal MCPs, delivery systems, and programs (e.g.,

Targeted Case Management, Specialty Mental Health Services), with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services. Referrals are coordinated to ensure Care Coordination with public benefits programs. Members, and members' parents, family members, legal guardians, authorized representatives (ARs), caregivers, or authorized support persons can receive assistance with navigating the health delivery systems in order to access care and services that may benefit the member. All care coordination provided to a member is communicated to the members' parents, family members, legal guardians, ARs, caregivers, or authorized support persons as appropriate. Partnership maintains processes to ensure there is no duplication of services.

Members are further provided with resources and education about how to access the various programs and services offered by organizations Partnership has established relationships with or by agencies and third-party entities with whom Partnership has or will have an executed MOU. Members are also provided with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes. All services are delivered in a culturally and linguistically competent manner that promotes health equity for all members.

Providers serving Partnership members must maintain and share, as appropriate, the members' Medical Records, and any necessary member information, in accordance with professional standards and State and federal privacy laws and regulations.

Wellness and Prevention Programs

Partnership provides wellness and prevention programs that strive to align with NCQA PHM standards and DHCS requirements, including access to evidence-based self-management tools through our member portal. All members also have access to culturally and linguistically appropriate health education materials.

Partnership provides wellness and prevention programs to improve the health outcomes of all members. Eligible members have access to evidence-based disease management and improvement programs that incorporate health education interventions, target Members for engagement, and/or seek to close care gaps for participating members that include, but are not limited to:

- Diabetes
- Cardiovascular disease
- Asthma
- Depression

- Improving access to preventative health visits, developmental screenings, and services for members less than 21 years of age
- Improving pregnancy outcomes for women, including through 12 months post-partum
- Ensuring adults have access to Preventive Care
- Programs aimed at helping Members set and achieve wellness goals.

Partnership works to ensure there is a process for monitoring the provision of wellness and preventive services by PCPs as part of its contractor's site review process. Partnership also submits its wellness and prevention programs to DHCS for review and approval as appropriate, and strives to align its wellness and prevention programs with the DHCS Comprehensive Quality Strategy.

On an annual basis, Partnership's DHCS PHMSD reports how community-specific information and stakeholder input from the CHA/CHIP collaborations are used to design and implement evidence-based wellness and prevention strategies. Findings from the NCQA Population Needs Assessment are also incorporated into the design and implementation process of wellness and prevention strategies.

Organizational Support for PHM

As an organization, Partnership is engaged in promoting the health and well-being of members. Various departments address particular segments of the population, per NCQA's four area of focus and DHCS's three levels of risk. For example, Member Services, Quality Improvement, the Population Health department with the Health Education Unit, all provide outreach to members with no identified risk or low risk to Keep Members Healthy, offer BPHM interventions, and promote health equity where there are barriers to health. Population Health and its Health Education Unit, Quality Improvement, Pharmacy, and Care Coordination collaborate to identify and support Members with Emerging Risk, including racial or language groups with health disparities. Care Coordination collaborates with Utilization Review and Member Services to assist members with their Outcomes Across Settings and to bolster provider communication along the continuum of care. Care Coordination's clinical and social work teams provide highly skilled support to assist members who are Managing Multiple Chronic Conditions.

Members may move up and down the acuity continuum as their needs change, and services are matched to the member's evolving level of need. A member may have few identified risks, but might have difficulty navigating the healthcare system and require an intensive level of intervention through Partnership's Complex Case Management (CCM), or through other member benefits such as Community Health Worker (CHW)

support or Enhanced Case Management (ECM). Conversely, a member with multiple chronic conditions may have well-established support systems and not require assistance from the Care Coordination team in order to access care. The information in the following table outlines Partnership's approach to population health management. The PHM Work Plan and supporting desktop procedures provide details about each service and the associated goals for member segments.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
No/Low Risk: Members with no known risk of disease or for whom we have no claims data; focus on supporting wellness.	*Keeping Members Healthy*	*Member Needs:* To understand benefits and how to access them; identify and access providers for primary care; help with prescriptions or DME; access to non-Partnership services (Denti-Cal, In Home Support Services, etc.). *Population Health Interventions:* Member outreach campaigns to promote well-child visits or other wellness care. Collaborate with local agencies to identify community events for underserved communities (immigrant populations, homeless members, rural and frontier communities, etc.) to promote Partnership services and benefits. *Health Education Interventions*: Develop and distribute member newsletters and benefits information. Create educational materials on various health topics in threshold language groups and racial groups that have outcome data revealing inequities. *Member Services Interventions:* Explain benefits and how they may be accessed; connect members to providers. *Quality Interventions:* Provide HEDIS-based gap reports to providers, showing

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		which members are missing well care visits, timely immunizations, and cancer prevention screenings; evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and the quality of care members receive.
Moderate / Rising Risk Pregnant members, or members that that have risk of disease/ disease exacerbation, or a newly diagnosed chronic illness. Racial groups with inequitable access to health care, e.g., American Indian access to mammograms.	*Managing Emerging Risk*	*Member Needs:* Access to specialty care and/or behavioral health providers to manage emerging or stable chronic conditions; resources/education supporting lifestyle management to maximize health and wellness, and mitigating effects of chronic disease; education on managing new diagnoses. *Population Health Interventions*: Offer BPHM services to engage members to understand barriers to care; provide member coaching on how to manage chronic illnesses. Outreach to members who are homebound or vulnerable to poor air quality to encourage them to prepare for disasters and wildfires. Schedule mobile mammography clinic days in conjunction with Tribal Health clinics. *Care Coordination Interventions:* Outreach to CCS members who have not had an annual well-child visit to encourage them to maintain program eligibility; coordinate care for members who identify (or whose provider identified) a care gap or equipment gap,

DHCS Risk Segment	NCQA Program/Services	Organizational Support
		who need basic case management support. *Grievance Interventions:* Streamlined grievance process and produced educational videos in multiple languages to educate non-English speaking or LEP members on how to report dissatisfaction. Conduct ongoing grievance process improvement efforts. *Health Education Interventions:* Develop and distribute educational member materials on staying healthy, common conditions, and their management, aligning with member age, sex, education, culture, and at a 6th-grade reading level. *Quality Interventions:* Develop reports that identify members with chronic conditions showing gaps in HEDIS measures specific to monitoring chronic disease management. Member Services uses these reports to remind members of these care gaps during member calls. Evaluate interventions conducted in the provider setting where members are directly engaged and receive services; share resulting best practices for improving HEDIS measure performance and member-level outcomes
Transitions of Care: Members going through	*Outcomes Across Settings*	*Member Needs:* Assistance with transitions between settings, such as acute care to home or skilled nursing facility to home.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
transitions in their care.		*Member Services Interventions:* Support members discharged after hospitalization who may need to establish care with a PCP. *Utilization Management Interventions:* Collaborate with facility discharge planners to approve post-acute care needs. *Care Coordination Interventions:* Review and implement of hospital discharge plan; coordinate services; assess member's need for ongoing case management; help schedule follow-up appointments; ensure transportation is available to attend appointments; collaborate with the PCP office to ensure a full transition of care.

DHCS Risk Segment	NCQA Program/Services	Organizational Support
High Risk: Members with multiple chronic conditions, unmanaged conditions like asthma or diabetes, medically fragile, frequent visits to emergency department and/or inpatient admissions; may also have poor social supports or other psychosocial issues.	*Managing Members with Multiple Chronic Conditions*	*Member Needs:* Coordination of medically complex care needs. Members may have multiple chronic conditions or unmanaged chronic conditions or may be complex due to other factors such as disorganized care delivery, cognitive or developmental impairment, behavioral health challenges, or lack a wellness support structure. *Care Coordination Interventions:* Complex case management support; personalized assessments; individualized care plans; motivational interviewing; medication reconciliation; education/support for disease(s); coordination of services; assistance accessing social and community supports; interagency coordination to reduce duplication of efforts; may include face-to-face interactions.

Health Education

The Health Education team is integrated into the Population Health department and works closely with all Partnership departments to assess member needs, to evaluate and improve established programs/activities, and to develop and implement new programs/activities/materials to help members improve their health. The Health Education Team promotes a variety of strategies and methods to deliver evidence-based health education programs, services, and education materials directly to members (including members under age 21), and through members' health care providers according to members' health education and cultural and linguistic needs and preferences.

The Health Education team uses general health education, health promotion, and patient education methods to help Partnership's members prevent sickness and

disease; improve their health; manage their illnesses; effectively use health care services; and ensure that members who have not had a recent visit with their assigned medical home or PCP receive health education on the importance of primary care (including members under age 21). Partnership also provides health education opportunities to members directly through resources offered on the Partnership Member Portal and via select subcontracted providers who are skilled in delivering health education services and whose performance is monitored. Select written Health Education materials are available on Partnership's website for members, providers, and the community at large. Partnership members can also call in or email Population Health to request additional health education materials or resources. Finally, Partnership promotes health education information and Population Health programs through the member newsletter, the provider newsletter, the Partnership website and social media, and through targeted outreach.

Partnership's Health Education system promotes member health through 3 categories of educational interventions:

- Effective use of managed health care services: Partnership provides written information (at a 6th grade reading level) to help members effectively use the services of their managed care plan. This includes accessing preventive and primary health care services, obstetrical care, appropriate use of complementary and alternative care, dental and vision care, and health education services.
- Evidence-based Risk-Reduction as well as Wellness & Prevention programs: Partnership connects members to educational interventions designed to modify health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes. Programs can include: smoking and tobacco cessation; managing stress; injury prevention; prevention of sexually transmitted diseases and; nutrition/healthy eating, weight maintenance, physical activity; avoiding risky drinking; and identifying depressive symptoms. These interventions are available on Partnership's Member Portal as Healthy Living Tools.
- Evidence-based Healthy Lifestyle, Self-Care, and Management of Health Conditions: Partnership provides or connects members to health educational interventions that can help members learn about and follow self-care management for existing chronic diseases or health conditions like obesity, pregnancy, depression, asthma, diabetes, and hypertension.

This collection of health education strategies forms the health education system. The health education system is maintained and monitored to ensure equal access to all Partnership programs for all members, including accessibility for Limited English

Proficient (LEP) members; to ensure appropriate allocation of health education resources; and to conduct appropriate levels of program evaluation. All programs and materials are available to members at no charge. Programs will not discriminate against Partnership members for any reason.

The Senior Health Educator participates in Partnership's internal committees, addressing quality and compliance with Partnership's programs. The Senior Health Educator ensures that all health education programs and materials are appropriate for members of varying demographics, including but not limited to: language, age, race, ethnicity, national origin, disability, sex and gender per Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557).

Material Development

In collaboration with Population Health, Care Coordination, Communications, Pharmacy, Quality Improvement, and other departments, the Health Education team develops targeted health education materials to help members modify health behaviors, achieve healthy lifestyles, and promote health equity (See Appendix A). Data from the PNA, CHA/CHIP collaboratives, other resources, and regulatory requirements also guide decisions regarding the availability of health educational materials and resources for specific member populations. Furthermore, the health education team assesses member health care needs and barriers to care by consulting regularly with the Consumer Advisory Committee (CAC), the Family Advisory Committee (FAC), community organizations, Partnership's Chief Medical Officer, and also through community outreach such as through CHA CHIP efforts, use of Healthy Living Tools, and analysis of Partnership's data. Materials are available to members through direct mail, their network provider's office, community events, on the Partnership website and Member Portal, and via email by request.

The Senior Health Educator assesses written, member facing materials for readability and suitability according to state and national guidelines, which ensures that member facing materials are written at the sixth grade reading level using a readability formula that is most appropriate and reliable for the type of materials and target audience. The Senior Health Educator also ensures that health education materials are culturally and linguistically appropriate for the intended audience with special attention to concept, density, tone, key messages, including format, page design and graphics, and that documents are up-to-date. Health education materials are made available in Partnership's threshold languages, large font, and in any of California's top 18 non-English languages upon the request of the member. Partnership's qualified Health Educator(s) can approve written member health education materials as long as the following conditions are met:

- Materials purchased to distribute for member health education are from a DHCS approved company. The Health Education team will maintain a list of approved companies as these are updated by DHCS throughout each year.
- Materials are field-tested to ensure written health education materials are understood by the target audience. The qualified Senior Health Educator will provide oversight of the field-testing of all materials. Field-testing is designed to garner feedback from the targeted audience for the materials and may include community focus groups, key informant interviews, simple review and surveys by community member, and/or review during Consumer Advisory Committee and Family Advisory Committee meetings. The health education team will review the results and adapt materials as needed and as appropriate.
- Health Education materials are assessed using the Readability and Suitability Checklist (per DHCS website requirements). They are approved when:
    - A majority of the Readability and Suitability Checklist provisions are met.
    - When some of the Readability and Suitability Checklist provisions are somewhat met and/or not met, so long as the qualified Health Educator provides justification, and keeps the justification on file with the Suitability Checklist.
- The signed/approved Readability and Suitability Checklist, along with the approved health education material, must be kept (electronic file or hard copy) by the health plan and made available to DHCS for auditing/monitoring purpose upon request.
- The assessment and approval process must be conducted by a qualified health educator/health education specialist with the equivalent training and background required by DHCS per APL 18-016.

Health education staff who do not meet the definition of a “qualified health educator” as listed above will not approve health education materials for Partnership. If Partnership does not have a qualified health educator on staff to assess and approve health education materials, Partnership will submit health education materials to the Managed Care Quality and Monitoring Division (MCQMD) of DHCS for review and prior approval, along with a completed Readability and Suitability Checklist.

Member Incentives

Non-monetary member incentives (MI) may be used in conjunction with, or as a component of, Partnership education programs and Basic Population Health Management programs to motivate members to adopt heathy behaviors, enhance health education activities, including participation in focus groups, or to gain feedback on member experiences. Member incentives must meet DHCS guidelines and follow

Partnership's approval process for Member, Survey and Focus Groups (see Appendix B). MI program components include, but are not limited to:

- Increasing member participation, learning, and motivation to effectively use health care services including preventive and primary care services.
- Appropriate health care utilization that includes, but is not limited to:
    - Timely prenatal and post-partum care
    - Timely immunizations
    - Timely well child visits
    - Timely screenings (i.e., mammograms, colorectal screening)
    - Regular monitoring tests for chronic diseases
- Non-monetary member incentives that may range in value depending on the components and complexity of the health education program.
- A Member Incentive Request, Focus Group Request, or Survey Request form (per APL 16-005) that includes:
    - Completion of the MI request form by a qualified Health Educator
    - Review by Partnership's Regulatory Affairs and Compliance Coordinator
    - Submission to DHCS Health Education Consultants for final review and approval at least two weeks prior to implementing new MI programs or focus groups.
- Annual Member Incentive, Focus Group, and Survey Incentive Evaluation forms are required to be submitted to the DHCS Health Education Consultant thirteen (13) months after the planned program start date, covering the prior 12 months. If the program has ended, a Member Incentive Evaluation form must be submitted to the DHCS Health Education Consultant within 45 days from the date the program ended. Focus group and survey incentive program evaluation forms are due 60 days after the due date for completed surveys.

Point of Service Education

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 90 days of a member's assignment to a PCP (whichever is most recent). Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process. The IHA must include the member's physical and behavioral health history, identification of risks, an identification process of any needs for preventive screens or services, referrals to health education where appropriate, physical examination, and if applicable, the diagnosis and treatment plan for any diseases.

Primary Care Providers (PCPs) are responsible for the screening and identification of members with specific health educational needs. PCPs are also responsible for

providing appropriate health education information or referring the member and/or the caregiver to Partnership's Population Health department for assessment of appropriate health education activities or materials, and for following up on referrals (including providing anticipatory guidance).

Members can also identify their own needs for health education. Partnership makes educational materials, resource information, and other tools (such as training, and programs) available to help network providers provide health education services. Select Health Education materials are available on Partnership's website or upon request.

Partnership Health Education materials and resource topics are also available on Partnership's Member Portal and include, but are not limited to:

- Age-Specific Anticipatory Guidance
- Alcohol and drug use
- Asthma
- COPD
- Chronic Disease Management
- Diabetes Management
- Family Planning (contraception)
- Heart Disease & Prevention
- HIV/STD Prevention
- Immunizations
- Injury Prevention
- Living Well with a Disability
- Medication Management
- Nutrition
- Parenting
- Perinatal/Breastfeeding
- Physical Activity
- Preventive Screening
- Senior Services
- Stress Management
- Tobacco Prevention & Cessation
- Weight Management & Exercise

Practitioner Education and Training

Partnership's Health Education team supports network providers through trainings on the unique cultural needs of Partnership's member populations. The PNA and CHA/CHIP collaborative serves as guidance for provider trainings highlighting Partnership members' beliefs about illness and health, their cultural health behaviors, and their preferences for interacting with providers and the health care system. The trainings are designed to support network providers and their staff in providing effective health education in a manner that respects the cultural and linguistic diversity of patients and promotes health equity.

Starting in 2025, Partnership will offer trainings to providers in its network on topics of health equity, including cultural competency, bias, diversity or inclusion training. Some of the trainings will include information about relevant health inequities and identified cultural groups in the Partnership's service area. Topics may include, but are not limited to: seniors and persons with disabilities awareness and sensitivity, preventive health

care for children, alcohol misuse screening and counseling, and other concerns as appropriate for the population. Other trainings may also include PHM program requirements, including referrals, health education resources, and provider and member incentive programs. Trainings may be delivered in person, virtually, and made available on the external website.

Health Education Interventions

The CHA/CHIP efforts, PNA, and other regulatory requirements serve as vehicles for setting the Health Education Program goals, which are documented in the Quality Improvement and Health Equity Transformation Program (QIHETP)/Cultural & Linguistic (C&L) Work Plan as appropriate. The annual QIHETP/C&L Work Plan and C&L Evaluation report describes the methodology for evaluating intervention outcomes to ensure Partnership is effective in delivering high-quality health education and culturally and linguistically appropriate interventions for our members to promote health equity and reduce disparities. The PNA and conclusions drawn from CHA/CHIP efforts evaluate and make recommendations for appropriate allocation of health education resources based on needs assessment findings, provider training results, Partnership staff training results, intervention evaluation results, and other data. The departments responsible for each specific intervention monitor their outcomes to ensure program objectives are being met. Performance improvement plans are implemented as necessary to improve Partnership and provider performance in delivering programs and services to our members.

Other Activities – Interventions that Indirectly Affect Members

There are many opportunities to collaborate through joint action with providers, county initiatives, and local care management programs to meet the needs of individual members. The following table describes the strategies used to promote population wellness through partnerships with community resources and organizations.

Initiative Type	Definition
Partnership Provider Population Reports	An automated list of members with missing services supplied to providers that are specific to low-performing HEDIS measures and immunization status updates. Supports providers in conducting direct outreach to close gaps in preventive care.
Outreach/ Scheduling Calls	Based on the list of care gaps provided by Partnership, provider offices call members to remind them about scheduling needed services.

Initiative Type	Definition
Scheduling Block	Clinic days at provider sites or health centers where blocks of appointment time are scheduled for Partnership members to receive missing services.
Poster Campaign, School Engagement	Educational events where students create art projects that amplify a health topic (e.g., immunizations, tobacco prevention); engagements with screening sessions at school clinics.
Provider Newsletters	Monthly Medical Director Newsletter to Primary Clinician Leaders, as well as a quarterly publication by the Provider Relations department (Provider Newsletter) with dedicated space for Quality Improvement and Member Engagement articles for providers to consider applying to their patients.
Provider Education	Coaching, consultation, measure review, and in-depth guidance for providers on HEDIS/Quality Improvement Program (QIP) measures as part of the Partnership value-based payment program, improving communication between providers, and promoting appropriate specialty referrals. Annual training on health equity.
Provider Fax Blast (email or fax)	Communication to all network providers for important updates (e.g., a fax blast on new standards for using combined long acting beta agonist/corticosteroid combinations in treating asthma).
Partnership Website	Changing banners to communicate health information to providers, community-based organizations, as well as to members.
Point of Service Interaction	Inform pharmacies of important clinical issues (such as drug class duplication) through point of service notices.
Media Campaign	Social media campaign(s) and county-level websites focused on improving member education and influencing member decision-making in preventive services/screenings. Websites include Public Service Announcements from local providers and community-based organizations.

Informing Members About Available PHM Programs

Partnership shares information on programs and services available to the communities it serves in multiple ways, including Partnership's website (PartnershipHP.org), the Partnership Member Portal, member newsletters, program introductory letters, and telephonically through Partnership's Care Coordination, Population Health, and Member Services departments. When a member requires a referral to a Population Health or Care Coordination program, the member is directed to the appropriate staff for assistance with enrollment to the program best matching the member's level of need.

Community Engagement and Coordination of PHM Programs

Partnership has committed to being an active partner in each of the communities it serves, through local presence, local knowledge, and consciously building productive and strong working relationships. The new emphasis on Population Health is an exciting opportunity to expand community engagement activities and build on the strong partnerships developed over many years, and in some cases, decades.

Partnership is divided into five distinct geographic areas, with regional offices strategically located in each area. Regional offices and the regional staff are responsible for working closely with local providers of health care to Partnership members, county health and social services departments, local health improvement coalitions and a variety of community-based organizations addressing the social, economic and health needs of Plan members. Regional staff live and work in these communities and share their knowledge of the managed care program with the community, and just as importantly, share their knowledge of the community with Partnership.

Regional staff meet regularly with county health and social service leaders to share information and collaborate on projects with aligned goals, such as childhood immunization campaigns, local disaster response management or planning, CHA/CHIP activities, and more. These staff attend a variety of community organization meetings and collaboratives, and they participate in local initiatives aimed at improving health and quality of life for Partnership members and others in the community. All communities (including Partnership) came together to respond to the devastating wildfires in Northern California, forming strong working relationships. Regional staff were able to build on these working relationships as the COVID pandemic emerged to share information, communicate consistently, and build cohesive strategies in each community. Partnership seeks to continue this type of collaboration for years to come.

Partnership has many different member programs/initiatives concurrently planned and executed. In order to prevent duplication of effort, any department planning or

implementing programs affecting our members has read-only access to Essette, Partnership's case-management software system. A move to a new system is planned after mid-2024. Member-facing campaigns are logged in a Campaign Tracker and shared with the entire organization, ensuring staff are aware of current interventions. Monthly check-in meetings include all member-facing departments, and provide updates on new initiatives and outreach campaigns. Population Health department staff communicate with providers, multidisciplinary health agencies, community resources, community-based organizations, and workgroups to share and gather information about member-facing programs. This process facilitates identification, planning, and support of healthy initiatives in the community, and identifies community programs and resources that can improve member health and wellness.

Partnership's regional liaisons and leaders in various departments actively participate in both internal and external workgroups to share information and reduce duplication of effort. Through collaborative meetings, these staff members identify community resources that may be of benefit to Partnership's members and share these resources with the organization to promote integration into program offerings and meet member needs. Programs within the community or offered through providers may include:

- Enhanced Case Management (ECM)
- Community Supports
- Regional Center participation
- Behavioral Health and Wellness & Recovery services
- Eating Disorder treatment
- Outpatient palliative care
- Other community programs such as WIC, support groups, community collaboratives, etc.

Partnership members enrolled in the above programs are tracked through Partnership's internal data platforms, along with the cloud-based Collective Medical Platform to facilitate real-time data sharing between Partnership and ECM or other community providers of services (see Partnership Policy MCCP2032). This allows members of Care Coordination or other member-facing teams to collaborate with community partners and external case management leads without duplicating services. In addition, Partnership has appropriate agreements in place with each lead entity to ensure HIPAA mandates are followed and member data is not shared inappropriately.

Per DHCS's California Advancing and Innovating Medi-Cal (CalAIM) effective January 1, 2022, members with exceptional clinical and non-clinical needs have access to a community-based benefit called Enhanced Case Management (ECM). ECM provides

coordination of services and comprehensive care management through an interdisciplinary, high-touch, person-centered care plan. Members who qualify for ECM services are tracked through a shared data platform to promote communication between providers and reduce duplication of effort.

Partnership also executes Memorandums of Understanding (MOUs) with the following Third Party Entities to ensure the delivery of services to Partnership members:

- County In-Home Supportive Services to coordinate between county and managed care plan (MCP) for members who may be eligible for and/or are receiving IHSS
- Regional Centers for the coordination of services between Regional Center and MCP for Members who are or may be served by Regional Center, including Intermediate Care Facilities for Developmentally Disabled Services
- Mental Health Plans (MHPs) to coordinate between MCP and MHP for Non-specialty and specialty Mental Health Services
- Substance Use Disorder Treatment Services to coordinate covered substance abuse services between DMC-ODS and MCPs
- Local Health Jurisdictions/Local Health Departments to coordinate between LHJ/LHD and MCP for the delivery of care and services for Members who reside in LHJ's jurisdiction and may be eligible for one or more services provided, made available, or arranged for by LHJ including:
    - California Children's Services (CCS);
    - Maternal and Child and Adolescent Health; and
    - Tuberculosis Direct Observed Therapy;
- County Social Services for Child Welfare to coordinate between County and MCP for the delivery of care and services for Members who are receiving County Child Welfare Services
- Women, Infant, and Children (WIC) to coordinate services between WIC Agencies and MCP to ensure provision and delivery of MCP's Covered Services and WIC Services to Members
- Local Government Agency (LGA) County-Based Targeted Case Management (TCM) Program to coordinate services between LGA TCM Programs and the MCP to ensure the delivery of care and services for eligible Members.
- County Behavioral Health Departments to coordinate services around Substance Use Disorder Treatment Services in Drug Medi-Cal State Plan Counties

Other MOUs with the following organizations will be effective on January 1, 2025:

- HCBS Waiver Agencies and Programs
- LGA/Jails, Juvenile Facilities and Probation Departments
- Continuum of Care
- First 5 Programs
- Area Agencies on Aging
- California Caregiver Resource Centers
- Local Education Agencies (LEAs)
- Indian Health Services/Tribal Entities

By January 1, 2025, Partnership must also have a process to implement DHCS guidance regarding Closed Loop Referrals to applicable Community Supports, ECM benefits, and/or community-based resources. Partnership must also work to ensure services carried out by third party entities are delivered in a culturally and linguistically appropriate manner.

Informing Members on Interactive Content

Many of Partnership's programs and services are designed to be interactive, allowing members to select the extent to which they wish to engage in these opportunities. In all instances, members have the ability to opt out of the program. Should the member express this wish – in writing, in a telephonic conversation, or through a face-to-face interaction – this preference is documented for each campaign or intervention. The PHM Work Plan details the interactive services offered, how members qualify for programs, and how to opt out of programs.

Program Evaluation

The Population Health department analyzes the impact of PHM programs annually through clinical, utilization, and member experience measures, in accordance with the PHM efforts of the year. Partnership's Health Analytics department takes the lead in performing quantitative analyses to monitor the cost of services and programs, utilization results in aggregate and by subpopulation, and data supporting the tracking measures identified in specific initiatives. Data gathered to perform this analysis includes advanced data sets described previously, as well as annual medical/behavioral and pharmacy claims data, transportation claims data, health appraisal results, HEDIS data, and data specific to internal programs such as case management, pilot programs, and/or provider performance improvement activities, as appropriate. The QIHEC reviews reports of PHM activities for potential areas of concern, opportunities for improvement, and evaluates the impact of existing programs. This allows Partnership's leadership to review and update PHM activities to meet the needs of the members, as

well as identify staffing, education, system, and infrastructure changes/requirements needed to support the delivery of those services. Partnership's Quality Improvement and Performance Improvement programs use HEDIS monthly and annual reporting and analysis to monitor the impact of the programs and select opportunities for future interventions. The PHM Work Plan tracks the progress of interventions according to the measures identified at the beginning of the year, while the Population Health Management Impact Analysis reports on select clinical and utilization measures, as well as member experiences with the population health interventions.

In addition, Partnership hosts quarterly committees to encourage members to engage directly with Partnership. One such committee is the Consumer Advisory Committee (CAC), made up of member representatives from each of the regions in which Partnership operates. This committee meets to review Partnership's programs and provide feedback on how Partnership is meeting the needs of its members and of its communities. A separate Family Advisory Committee (FAC) is comprised of members whose children have special needs. The Pediatric Quality Committee consists of public and private sector physicians who care for Partnership members; the committee provides insight into challenges members may have in getting the care they need from a provider perspective.

The Grievances & Appeals department gathers and analyzes trends in member-reported complaints to identify areas for program improvement in the coming year. Partnership also has a process for identifying and intervening where there may be Potential Quality Issues (PQIs) related to a provider or provider organization. Finally, Partnership participates in two NCQA-approved Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; one assesses factors under Health Plan influence, the other focuses on factors managed by Primary Care sites.

Identifying Opportunities for Improvement

No less than annually, the QIHEC evaluates the impact of PHM's programs, identifies opportunities for improvement, and selects at least one improvement opportunity to address in the coming year.

Delivery-System Supports for Population Health Management

Through PHM, Partnership acts to support providers by working intentionally and collaboratively with the provider community. The Quality Improvement department outlines strategies for the coming year in the Quality Improvement Program Description

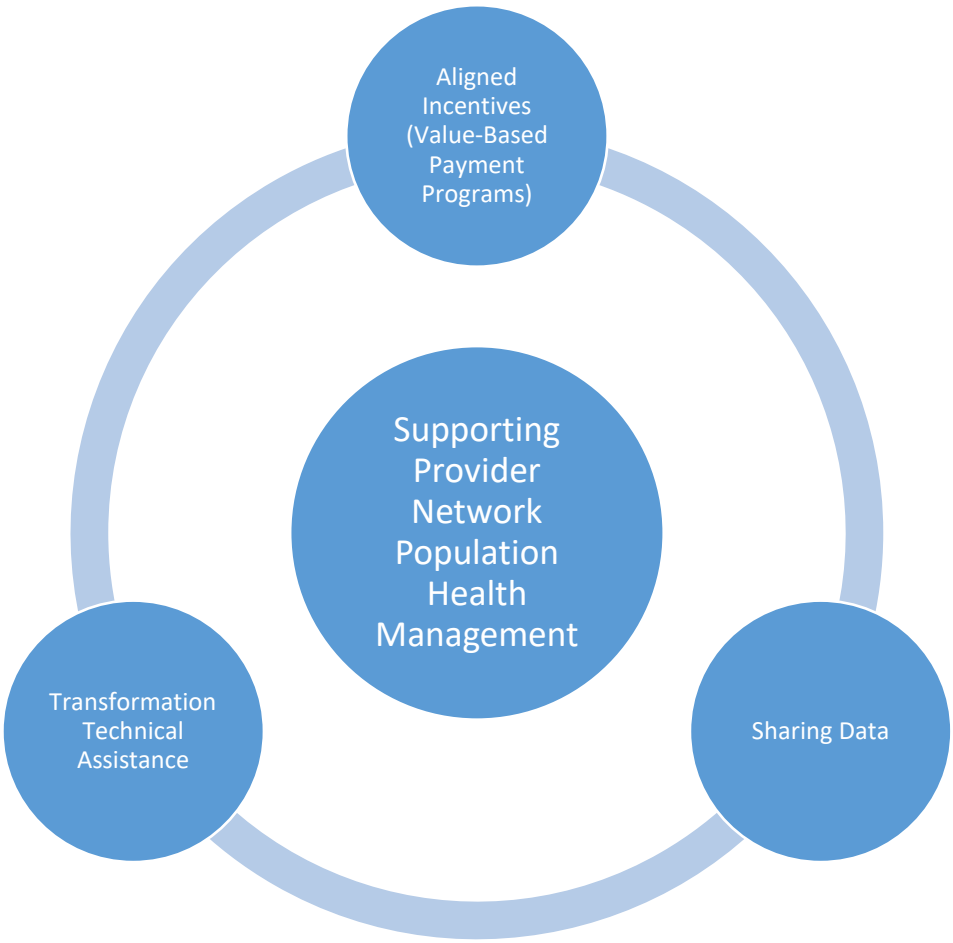
(See Policy MPQD1001) and annual Work Plan, addressing how providers will be made aware of population needs, and how they will be supported in addressing them.

Value-Based Payment Programs

Partnership has a number of value-based payment programs through which contracted provider organizations can qualify for a financial bonus for quality-related performance. There are separate incentive programs for primary care providers, hospitals, pharmacies, perinatal providers, behavioral health, palliative care, and other specialty providers. Partnership's Primary Care Provider Quality Improvement Program (PCP-QIP) is Partnership's value-based payment program for primary care providers. The PCP-QIP is largely focused on improving the quality of care members receive through a measure set reflecting Partnership's HEDIS measure score improvement priorities.

Incentivizing Patient-Centered Medical Home (PCMH) Recognition

Through our PCP-QIP, Partnership incentivizes contracted primary care practices to achieve and maintain Patient-Centered Medical Home recognition. This program is designed as an annual incentive, intended to encourage and recognize those provider practices that achieve excellent levels of service, care integration, and panel management, as recognized by established quality organizations.



Sharing Data

Partnership shares a variety of member data with our provider network in an effort to facilitate coordination of care and population health management. The two main systems for data sharing are eReports and the Partnership Quality Dashboard (PQD). Partnership also shares an annual data report with County Public Health Departments in alignment with DHCS' PHM requirements.[2]

eReports

eReports is a web-based platform that supports measurement and reporting for the clinical care domain of the Core Measurement set in Partnership's PCP-QIP. These preventive care and chronic disease management measures reflect DHCS's priority quality measures and are developed in-house by Partnership. The Core Measurement set is reviewed, modified, and approved annually by Partnership's Physician Advisory

[2] DHCS Population Health Management Policy Guide, 2024

Committee (PAC) after considerable input from an internal technical workgroup, an external provider advisory group, and an open comment period involving all participating providers. eReports gives providers member-level data showing member eligibility and compliance for each clinical measure leveraging claims, lab, pharmacy, and immunization registry data. Providers may also upload medical record data to substantiate member compliance where representative administrative data is unavailable. eReports data are refreshed twice per week, giving providers nearly real-time visibility to their measure-specific performance relative to performance targets. It also offers the ability to drill down into member lists by measure and view measure performance by site or organizational level (i.e. if multi-site provider).

Partnership Quality Dashboard (PQD)

This secure, online platform makes provider-site-level quality data available across quality improvement programs to help inform, prioritize, and evaluate quality improvement efforts. Specifically, PQD functionality includes:

Measure-Specific Data	PQD tracks provider performance on all Primary Care Provider Quality Improvement Program and HEDIS measures relevant to targets.
Trended Data	Providers can track their performance on the measures throughout the measurement periods (i.e. monthly rates).
Comparative Data	PQD allows providers to compare their performance to blinded data of peer providers, including local averages and national benchmarks

Note: While the most currently available data for QIP Clinical measures is available on eReports, PQD serves as a visualization tool. PQD does not allow for any data entry. Instead, all clinical rates are calculated in eReports, and PQD takes the output of eReports, presenting the data longitudinally and comparatively. While eReports displays performance at a given point in time, PQD shows performance data trending. In addition, the eReports interface compares performance against pre-defined thresholds, whereas PQD has multiple means of comparison including averages at regional, sub-regional, and county levels. PQD also includes data for non-clinical measures (e.g., readmissions, PCP Office Visits).

Transformation Technical Assistance

In addition to aligned incentives and data sharing, Partnership supports quality improvement and care delivery transformation in our network via the Partnership

Improvement Academy and its component offerings. These opportunities are designed to prepare providers to optimize population health, enhance their patients' experiences of care, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. The Academy offerings include the ABCs of QI (QI basic methodology for the model for improvement) and personalized services through Quality's Improvement Advisors, who work directly with provider sites to provide support, guidance, and tailored recommendations in support of practice transformation and the development of quality improvement subject matter expertise.

Population Health and Health Education Delegation Oversight and Monitoring

Partnership delegates activities for both Population Health, Health Education, and Cultural and Linguistics functions. A formal agreement is maintained and inclusive of all delegated functions. Partnership conducts an audit of all delegated entities no less than annually to ensure the appropriate policies and procedures are in place. Results from Oversight and Monitoring activities are presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval, as needed.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff. Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy, identifying the health disparities and wellness needs of Partnership's members, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, promote collaboration of effort, and reduce duplication of services.

Team Roles and Responsibilities

Chief Health Services Officer:

Provides overall direction to the Heath Services (HS) Care Coordination/Population Health/Utilization Management Leadership Team. This position has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location.

Director of Health Equity (Health Equity Officer)

In collaboration with other Partnership leaders, develops and drives forward the key strategies helping Partnership be a diverse, equitable, and inclusive organization. Works to raise awareness of health inequities within Partnership's staff, providers, and membership, and creates concrete plans for addressing them. Works closely with the Senior Director of Health Services, Quality, Human Resources, Provider Relations and Population Health departments toward shared goals, and with other internal and external Partnership stakeholders to ensure high standards of equitability.

Director of Population Health

Provides oversight of the Population Health strategy, programs and services to improve the health of Partnership members. Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Director of Health Equity, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables.

Manager of Population Health

The Manager of Population Health gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, CHA/CHIP activities, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisors,

manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit.

Supervisor of Population Health

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff. Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics.

Community Health Needs Liaison

Supports the coordination and implementation of Partnership’s Population Needs Assessment (CHA/CHIP) activities through active and meaningful engagement in identified community workgroup and initiatives. On behalf of the health plan, identifies and supports key strategic activities and interventions that support alignment of collective agency efforts that promote and support efforts to encourage member health outcomes. Identifies community service programs available within our counties, outlining resources that are culturally and linguistically appropriate as needed. Makes these resources available on Partnership’s external website.

Senior Health Educator

A masters-prepared (or MCHES-certified) professional who ensures the delivery of health education resources for both members and primary care providers. Supports the creation of trainings for contracted providers and internal Partnership staff to promote cultural competency, health equity, and member wellness. Assists with preparation and implementation of the PNA. Monitors and provides administrative oversight of all regulatory requirements related to Health Education and the Cultural & Linguistics programs. Provides assistance with regulatory requirements as needed.

Health Educator

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on assigned member education projects, monitors health education materials, performs literacy reviews to ensure appropriate readability and suitability levels, and evaluates member discrimination grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials.

Healthy Living Coach

Engages Partnership members to identify barriers to care, member concerns, and resources needed. Leads member wellness campaigns and supports members using Partnership's Healthy Living Tools. Participates in health fairs and other activities where Partnership members congregate; shares learning with other Partnership departments who promote member engagement and wellness. When applicable, refers to culturally and linguistically appropriate community services.

Wellness Guide

Performs outbound call campaigns to members based on identified member needs (e.g., pregnant members, members impacted by natural disasters, etc.) using appropriate scripts. Administers post-campaign surveys. Helps members identify and access resources for their health and social support needs. Tracks outreach efforts in approved database/tracking system, per prescribed protocols. When applicable, refers members to culturally and linguistically appropriate community services, and DHCS-approved health education materials.

Project Manager

Responsible for managing timelines and deliverables in department projects. Develops agendas and leads meetings to advance departmental objectives. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables.

Project Coordinator

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

Coordinator

Provides coordination and administrative support to their manager and assigned unit. Performs a variety of general clerical duties, including data entry, help desk management, referral tracking, the distribution of non-monetary member incentives to members participating in incentive programs, organizing member packets and gifts, etc.

Note: Staffing and staff job descriptions are subject to change based upon program needs and organizational growth.

References

DHCS APL 18-016 Readability and Suitability of Written Health Education Materials (10/05/2018)

Document A (APL 18-016): Review and Approval Guidance for Written Health Education and Member Information Materials

Document B (APL 18-016): Readability and Suitability Checklist for Written Health Education materials

DHCS APL 16-005 *Revised* Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys (11/23/2016)

DHCS 2024 Contract

DHCS Population Health Management Policy Guide, 2024

NCQA. (2018). *Population Health Management / Resource Guide.* www.ncqa.org.

Section 1557 of the Patient Protection and Affordable Care Act (ACA 1557)

Snyder, A. M., Willey, C., McKenna, M., Foley, P., & Coleman, R. (2005). Development of a Risk Assessment Tool for Predicting Pediatric Health Services Utilization. *Journal of Clinical Outcomes Management*, 451-458.

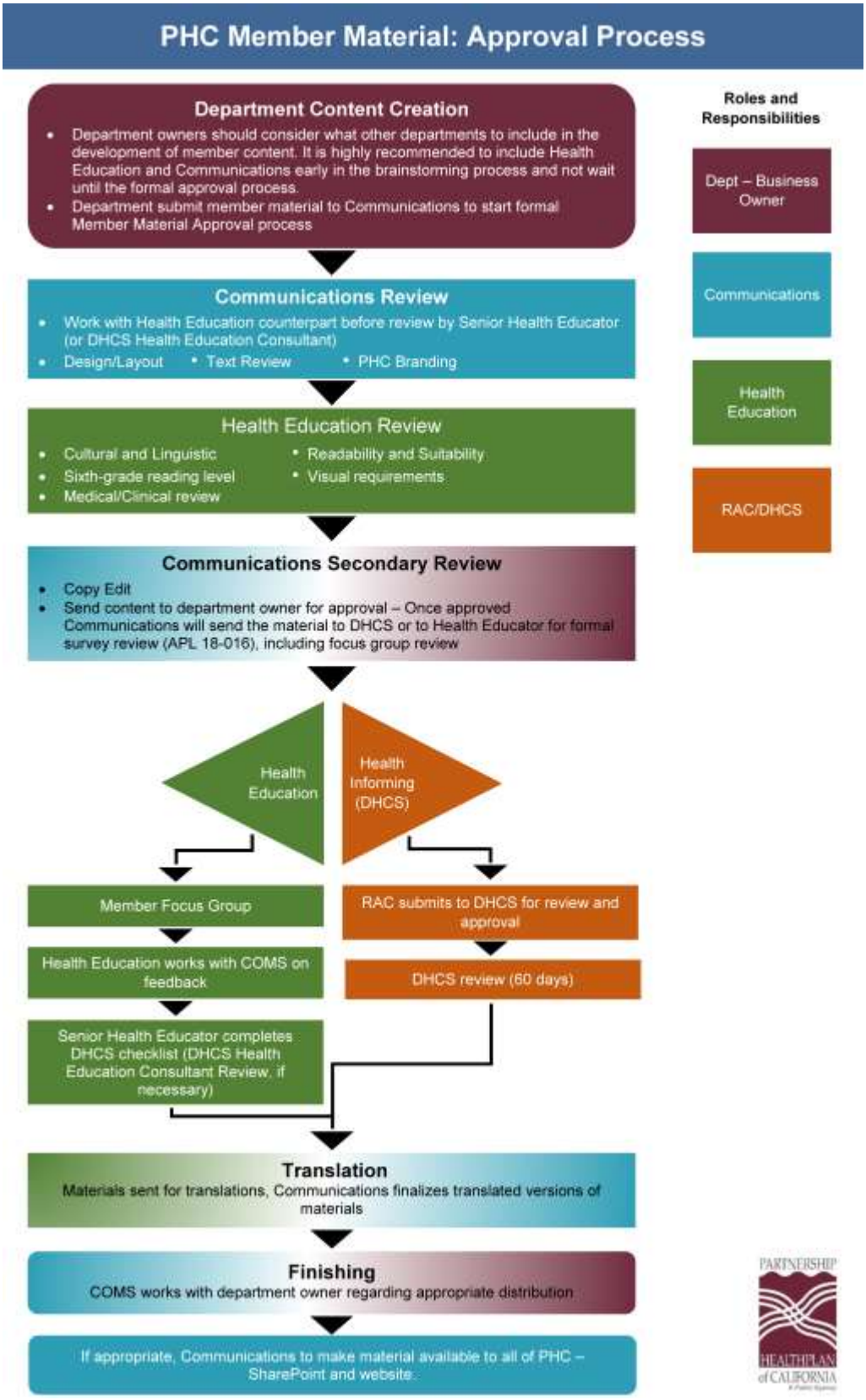
Population Health Management Strategy & Program Description Approval

Robert Moore, MD, MPH, MBA *Quality/Utilization Advisory Committee Chairperson*	*Date Approved*

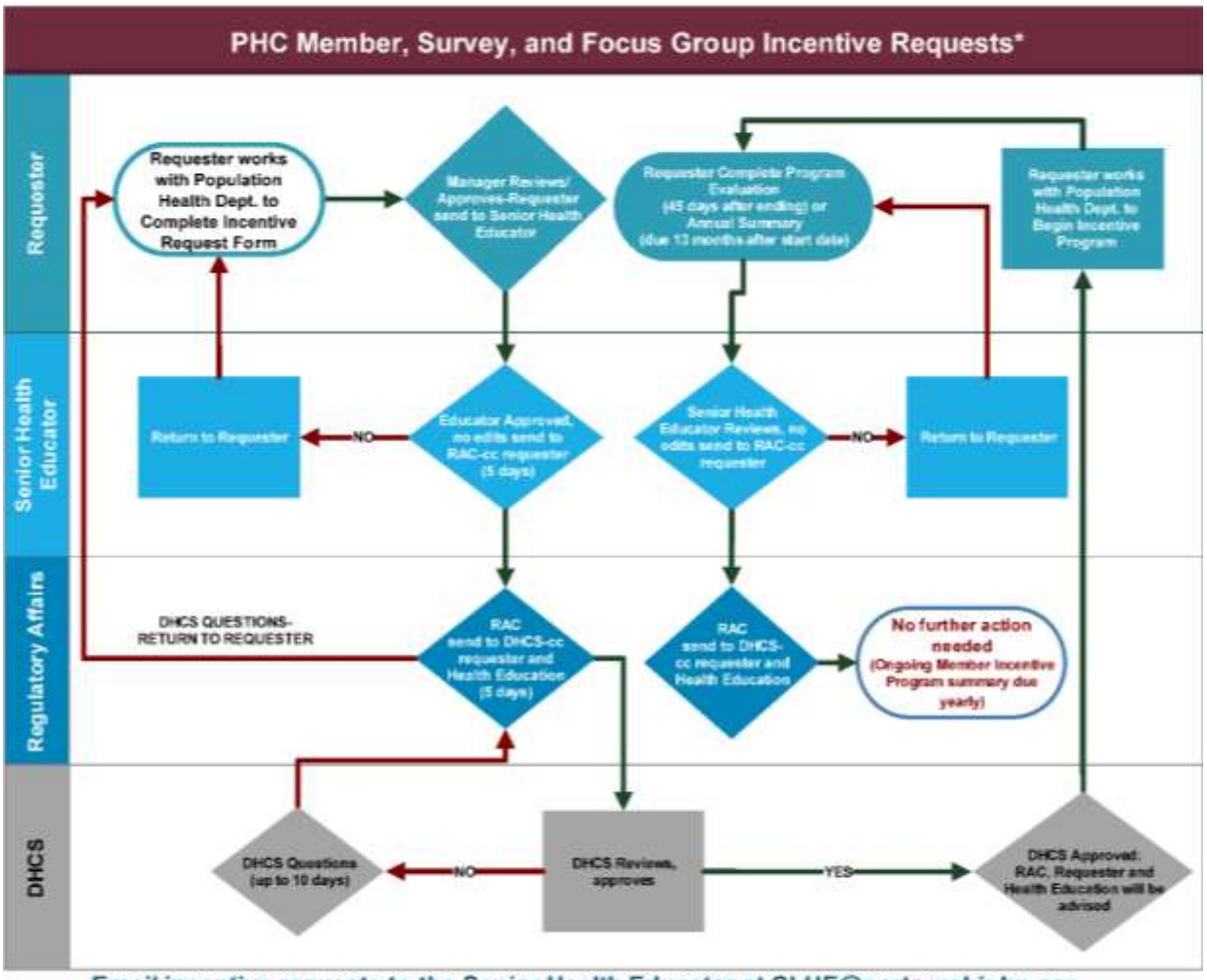
Steve Gwiazdowski, M.D. *Physician Advisory Committee Chairperson*	*Date Approved*

Kim Tangermann *Board of Commissioners Chairperson*	*Date Approved*

Appendix A


PHC Member Material: Approval Process
Department Content Creation
Department owners should consider what other departments to include in the development of member content. It is highly recommended to include Health Education and Communications early in the brainstorming process and not wait until the formal approval process.
Department submit member material to Communications to start formal Member Material Approval process
Communications Review
Work with Health Education counterpart before review by Senior Health Educator (or DHCS Health Education Consultant)
Design/Layout
Text Review
PHC Branding
Health Education Review
Cultural and Linguistic
Sixth-grade reading level
Medical/Clinical review
Readability and Suitability
Visual requirements
Communications Secondary Review
Copy Edit
Send content to department owner for approval – Once approved Communications will send the material to DHCS or to Health Educator for formal survey review (APL 18-016), including focus group review
Health Education
Health Informing (DHCS)
Member Focus Group
Health Education works with COMS on feedback
Senior Health Educator completes DHCS checklist (DHCS Health Education Consultant Review, if necessary)
RAC submits to DHCS for review and approval
DHCS review (60 days)
Translation
Materials sent for translations, Communications finalizes translated versions of materials
Finishing
COMS works with department owner regarding appropriate distribution
If appropriate, Communications to make material available to all of PHC – SharePoint and website
Roles and Responsibilities
Dept – Business Owner
Communications
Health Education
RAC/DHCS
PARTNERSHIP HEALTHPLAN of CALIFORNIA

Appendix B



Email incentive requests to the Senior Health Educator at CLHE@partnershiphp.org

*As referenced by MMCD All Plan Letter (APL) 16-005 Revised

UM 2A CLINICAL CRITERIA FOR UM DECISIONS FACTORS 4 AND 5

Annual Review of UM and InterQual® Criteria

Partnership HealthPlan of California (Partership) utilizes InterQual® criteria in its utilization management (UM) decision making process as well as policies and procedures developed for specific situations. Partnership's UM policies are developed by Partnership Medical Directors and subject matter expert specialists. Specific UM policies may be created when the following situations apply:

1. InterQual® does not have criteria available for a particular service/procedure
2. The most current clinical information in recent nationally recognized literature conflicts with InterQual® criteria
3. The California Department of Health Care Services (DHCS) Provider Manuals or "All Plan Letter" directives require development of a policy to provide additional information to Providers

All Partnership UM policies are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists.

Partnership HealthPlan of California utilizes the following InterQual® criteria modules in its UM decision making process. A summary of content for each module is provided in this document. Arrangements can be made to provide further criteria for review upon request. (*Please send request by email to UMHelpDeskSR@partnershiphp.org*)

InterQual® Clinical Content

Optum

InterQual®

Clinical Development Process 2024

InterQual Integrity Charter

Thousands of people in hospitals, health plans, and government agencies trust InterQual® evidence-based clinical decision support content to provide recommendations about the appropriateness and management of care and resource use including helping to facilitate equitable access to care. During the last four decades, InterQual has helped define and advance the disciplines of utilization and care management, providing medical directors, utilization management leaders, and other hospital and health plan professionals support in making the type of objective, evidence-based decisions that define top-quality, safe, equitable, and efficient care. This leads to greater transparency and collaboration between payers and providers.

The InterQual suite has expanded to 30 modules providing industry-leading objective clinical evidence and expert technology to help payers and providers collaborate for better healthcare outcomes at lower cost. While individual solutions meet key needs in a time of rapid industry change, the breadth of our portfolio allows healthcare organizations to combine our solutions in innovative ways to turn challenge into opportunity.

Our history of growth and innovation highlights our commitment to enhance InterQual through unbiased clinical content development and technology solutions. As our team is a part of Optum, we have access to a wealth of data and technologists. Aggregated data and literature search technologies are instrumental to the future of content curation. Our data can help us understand current practices and provide benchmarks, which are not intended to serve as treatment limits or substitute for clinical judgment, but can help medical directors, utilization leaders, and other hospital and health plan professionals understand normal ranges for current practice.

With over 4,000 InterQual customers relying on the guidance that InterQual provides, we take our responsibility to provide accurate, objective, evidence-based content very seriously. For over 40 years, our commitment is reflected in our rigorous evidence-based development process, designed to protect against bias.

InterQual development process

InterQual is produced using a rigorous development process based on the principles of evidence-based medicine (EBM). InterQual clinical content is created by the Optum research and content development staff of over 55 research and clinical decision support specialists including physicians, registered nurses, physician assistant, nurse practitioners, social workers, physical and occupational therapists, and other healthcare professionals, including a medical librarian. The physicians' backgrounds include experience or specialization in internal medicine, neurology, psychiatry, substance use disorders, hospital medicine, pulmonary medicine, and critical care medicine. Most of the clinical staff hold advanced degrees (e.g., MD, DO, Masters, Ph.D.), certifications (e.g., nurse practitioner, physician assistant), and/or case management certification. All InterQual research and content development staff receive comprehensive,

ongoing training at least quarterly in the concepts and methods of EBM and value-based clinical improvement to ensure that InterQual uses the best available evidence to support improved clinical decision-making, outcomes, quality, and value. New content staff receive comprehensive training in the principles of evidence-based medicine including the completion of 9 modules. Additionally, all staff participate in annual refresher training regarding mental health parity to reinforce that the processes, strategies, factors, and evidentiary standards are applied consistently and no more stringently between the development of our medical/surgical content and behavioral health content. The InterQual clinical content development process relies on, and is generally consistent with, the following:

- AHRQ Methods Guides, the Cochrane Handbook, and the NICE guideline development manual for literature searching, critical appraisal, and combining results of studies
- GRADE methodology for compiling evidence and determining recommendations

Although InterQual Criteria are not clinical practice guidelines, their development process is closely aligned with the AGREE-II and National Academy of Medicine (formerly IOM) standards for high-quality, trustworthy clinical practice guidelines.

Optum uses a multi-step standardized development process across our medical/surgical (physical medicine), care management, and mental health/substance use disorders content that synthesizes the best quality relevant scientific evidence and standards of care to ensure that the content reflects unmatched clinical rigor and integrity. The process is the same across all areas of medical and behavioral health literature. (Figure 1.)

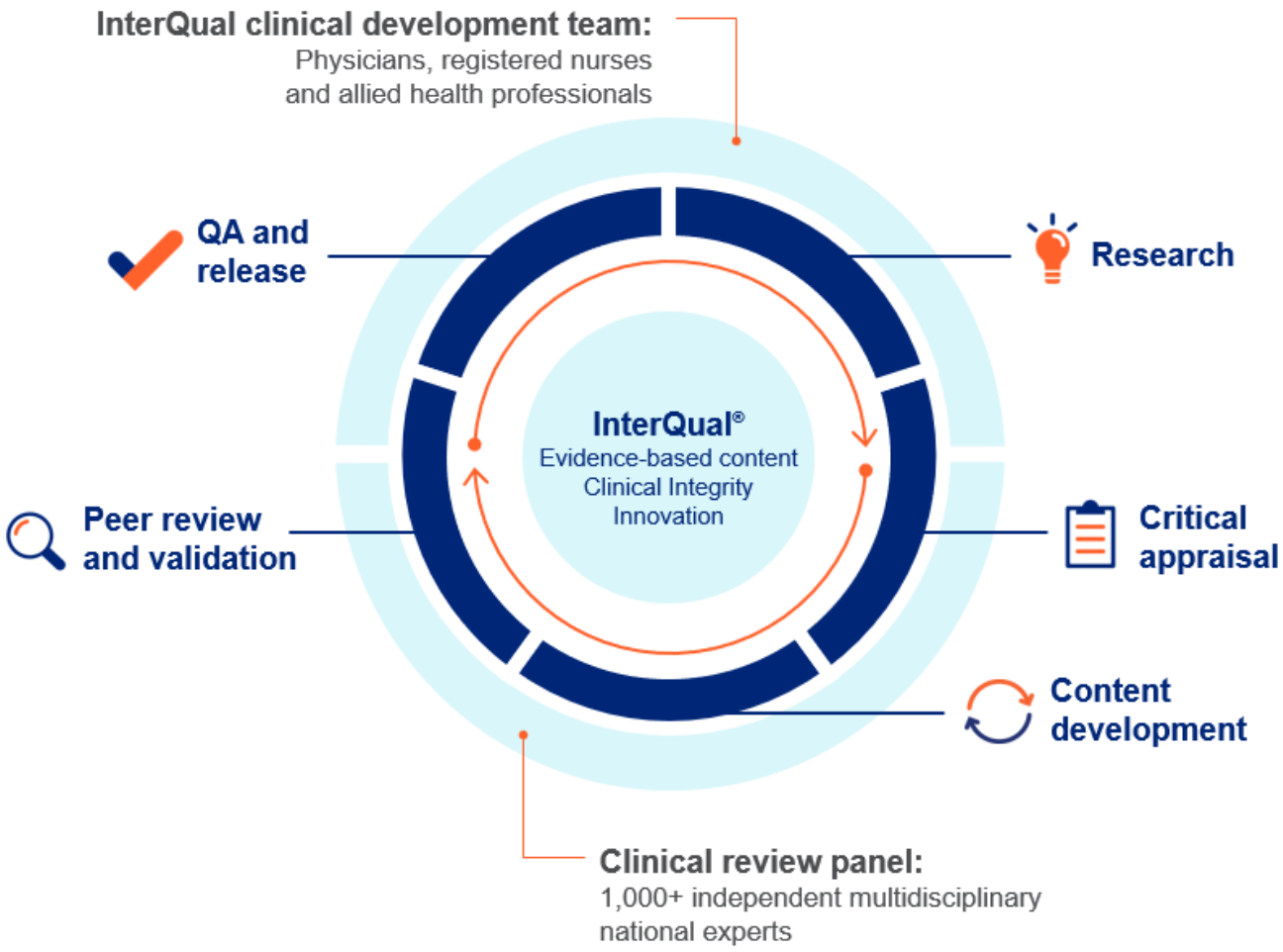


Figure 1. InterQual evidence-based content is reviewed at least annually and updated as necessary through a rigorous and comprehensive development cycle.

Step 1: Research

Optum observes a planned schedule for reviewing and updating every InterQual subset and module it produces. Our automated literature surveillance processes ensure that, when a critical publication emerges that may necessitate an interim update, our staff are immediately alerted.

The InterQual research and content development team uses a systematic and continuous review of the published medical and behavioral health literature, combined with customer and external peer review panel feedback, to identify content that needs revision and additional content that must be developed as both physical and behavioral health medicine advances. These teams are physician-led and the mix of internal staff and external peer review panel members include those who have licensure and expertise specific to the specialty area of the services being reviewed. In addition to their professional and academic experiences, all research and content development staff undergo extensive training in the principles and application of evidence-based medicine and critical appraisal upon hire and year-round education sessions led by members of our Evidence Based Medicine Committee. Content is reviewed and updated as needed, at least annually, with the capability to release updates as frequently as every month for critical and regulatory updates in the evidence base. Peer-reviewed journals are monitored, and our proprietary automated surveillance system monitors thousands of key sites and topical areas for newly published literature and guidelines. Additionally, we review customer feedback received through our toll-free number (800-CRITERIA), email (mailto:interqualsupport@changehealthcare.com), and our customer website (https://customercare.changehealthcare.com), Additionally, there is proactive outreach for voice of the customer sessions, and at least annual customer surveys. Additionally, we monitor state and federal regulation and legislation that can impact our content. Our internal staff annually reviews thousands of articles across the InterQual suite of products. We also subscribe to a proprietary, web-based medical literature service (Clinical Key) and the Cochrane Library.

Content research and development staff formulate key research questions. This helps focus the literature search on information that is needed to determine appropriate care, such as clinical effectiveness, potential harms, or diagnostic accuracy. Scoping reviews of the literature and healthcare-related news sites, customer feedback, input from internal medical directors and other clinical staff, and guidance from our medical librarian help the developer to create and refine the key research questions. Searches are designed based on the population and interventions to be included, critical and important clinical outcomes, and relevant comparators; key concepts and terminology are noted in related content. A search is initiated using a combination of search engines that are public (e.g., PubMed,) and proprietary (e.g., Cochrane Library). For specific topics, focused databases such as the Physiotherapy Evidence Database (PEDro) and PsycNet may be used. Developers also review the bibliographies of relevant articles and consult with practicing experts about any soon-to-be published research. The search looks for recent systematic reviews and meta-analyses, randomized controlled trials, society guidelines, and additional publication types as needed. For example, RCTs are not the most appropriate study design for certain types of questions. For questions of risk factors and prognosis, prospective cohort studies are best. For questions of diagnostic test accuracy, cohort or cross-sectional studies are used. Epidemiologic studies may also be important for addressing clinical utility (e.g., screening for a rare disease).

InterQual is supported by tens of thousands of citations; sources include but are not limited to:

- **General databases:** PubMed
- **Specialty guidelines:** American Academy of Family Physicians, American Academy of Orthopedic Surgeons, American College of Cardiology, American Academy of Pediatrics, Society of Critical Care Medicine, American College of Medical Genetics and Genomics, American College of Obstetrics and Gynecology, American College of Radiology, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Psychological Association, American Association of Community Psychiatrists, Association For Ambulatory Behavioral Healthcare, American Thoracic Society, National Comprehensive Cancer Network, Infectious Diseases Society of America, Surviving Sepsis Campaign
- AHRQ-contracted Evidence-based Practice Centers (EPCs) and Cochrane Review Groups

- **Accreditation organizations' standards:** URAC, NCQA, The Joint Commission, and CARF
- **National guidelines:** Centers for Disease Control and Prevention (CDC), National Institutes of Health (NIH), U.K.'s National Institute for Health and Care Excellence (NICE), Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Medicare and Medicaid Services (CMS) Coverage Determinations, U.S. Food and Drug Administration

Step 2: Critical appraisal

The research and content development team conducts a critical appraisal of the search results to identify studies that include best available, peer reviewed evidence. The certainty of each primary research study is assessed using critical appraisal from tools such as the Agency for Healthcare Research and Quality (AHRQ) Methods Guide for Effectiveness and Comparative Effectiveness Reviews, the Cochrane Handbook for Systematic Reviews Chapter 8, the AHRQ Methods Guide for Medical Test Reviews, the Cochrane Handbook for DTA Reviews Chapter 9, NICE Methodology Checklists, and QUADAS-2. Principles found in the Cochrane Handbook for Systematic Reviews and methods promoted by the GRADE Working Group are used to combine findings from multiple primary studies so that the overall certainty of evidence is evident for each clinically relevant outcome. Landmark studies are acknowledged when applicable. The quality of each systematic review and health technology assessment, including those embedded in clinical practice guidelines, is assessed using tools such as the Cochrane Handbook for Systematic Reviews, AHRQ Methods Guide, and AMSTAR.

Evidence is classified to help user understanding. The classifications, which are not intended to be hierarchical, are as follows:

Classification	Type of Evidence
Class I	Meta-analysis, technology assessment, or systematic review
Class II	Randomized controlled clinical trial
Class III	Observational or epidemiologic study
Class IV	Evidence-based guideline
Class V	Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series

Assessing the certainty of the evidence

Utilizing an extensive library of critical appraisal tools and guided by the InterQual policies and procedures and training, staff apply their expertise to complete their assessment of the current body of knowledge. When developing clinical recommendations, InterQual staff and external expert peer review panelists consider the likely effectiveness of each intervention, based on a synthesis of the best available evidence. The certainty of that evidence is used to determine whether we can have sufficient confidence in our estimate of the intervention's effectiveness to support a particular recommendation. In determining the certainty of the evidence, sourced through the critically appraised research described in Step 1, the following key factors are taken into consideration across the body of evidence as a whole:

- Supporting research studies
- Study designs and sample sizes
- Risk of bias across the best available studies
- Consistency of findings between different studies

- Directness
- Precision of the estimated effect after combining all studies
- Size of the effect
- Whether there appears to be a dose-response relationship
- Potential impact of plausible confounders
- Likelihood of publication bias

To summarize the certainty of evidence, Optum adopted the following categories:

Category	Definition
High	Additional research is considered very unlikely to change our confidence in the estimate of effect
Medium	Further research is likely to have an important impact on the estimate of effect
Low	Further research is very likely to change the estimate of effect
Very Low	Our estimate of effect is very uncertain

Step 3: Content development

Based on the outcome of the critical appraisal phase, content drafts are updated accordingly, noting the evidence base. Each multidisciplinary content development team is physician-led and includes members with licensure and expertise specific to the services being reviewed. Initial drafts of the InterQual content are created by Optum's clinical staff, based on the exhaustive review and critical appraisal of external guidelines, medical and behavioral literature, and extensive internal peer review.

The following factors are considered:

- Clinically relevant benefits (e.g., related to disease progression, mortality, and quality of life)
- Risk of harms (e.g., serious adverse events)
- Certainty of the research evidence
- Relative resource utilization between comparably effective interventions
- Potential impact of patient preferences on compliance
- Whether the optimal intervention or treatment setting is widely available

Recommendations from key medical specialty societies, FDA approval status (when applicable), government regulations, accreditation standards, and standards of care are also taken into consideration. Clinical utility (i.e., whether the result of the service(s) will impact patient management and improve outcomes) and, when appropriate, diagnostic accuracy are also taken into consideration. The drafts reflect the analysis and synthesis of all information collected.

Recommendations are intended to optimize clinical outcomes while avoiding invasive, costly, or potentially harmful interventions that are not necessary or appropriate. When an intervention or treatment setting is fully recommended, that should be considered a "strong" recommendation; the intervention should be applied in most cases.

When a recommendation is designated as "Limited Evidence (secondary review required)," this indicates a weak recommendation. Recommendations are designated as "Limited Evidence" based on one or more of the following:

- Research to date has not demonstrated this intervention's equivalence or superiority to the current standard of care
- The balance of benefits and harms does not clearly favor this intervention
- The clinical utility of this intervention has not been clearly established
- The evidence is mixed, unclear, or of low quality
- This intervention is not standard of care
- New technology is still being investigated

Notes attached to these recommendations indicate whether it is a weak recommendation in favor of the intervention or against it. "Limited Evidence" is used when the intervention may be appropriate for many individuals, but reviewers should consider each situation individually.

When an intervention (or treatment setting) is not included in the recommendations or "Evidence does not support [the intervention]" appears, that can be considered a strong recommendation against that intervention in the given situation. In these cases, most patients should not receive the intervention under that set of circumstances.

Table 6.1. Implications of strong and weak recommendations for different users of guidelines[1]

	Strong Recommendation	Weak Recommendation
For patients	Most individuals in this situation would want the recommended course of action and only a small proportion would not.	The majority of individuals in this situation would want the suggested course of action, but many would not.
For clinicians	Most individuals should receive the recommended course of action. Adherence to this recommendation according to the guideline could be used as a quality criterion or performance indicator. Formal decision aids are not likely to be needed to help individuals make decisions consistent with their values and preferences.	Recognize that different choices will be appropriate for different patients, and that you must help each patient arrive at a management decision consistent with her or his values and preferences. Decision aids may well be useful helping individuals making decisions consistent with their values and preferences. Clinicians should expect to spend more time with patients when working towards a decision.
For policy makers	The recommendation can be adapted as policy in most situations including for the use as performance indicators.	Policy making will require substantial debates and involvement of many stakeholders. Policies are also more likely to vary between regions. Performance indicators would have to focus on the fact that adequate deliberation about the management options has taken place.

[1] Schünemann H et al., Handbook for grading the quality of evidence and the strength of recommendations using the GRADE approach. Updated October 2013. Available from: https://gdt.gradepro.org/app/handbook/handbook.html. Accessed Jan 22, 2024.

Detailed notes and literature references provide the clinical basis for decisions. Less commonly, there are key clinical questions where evidence is limited or lacks consensus and may reflect topics which are not conducive to formal study. In these situations, standards of care are used to support the development of criteria which reflect the highest quality available literature and best practice. Identification and validation of standards of care is the product of an external peer review process involving multiple practicing clinicians with diverse expertise in varied relevant practice and geographic settings who assist with the translation of current standards of care.

Step 4: External peer review

Once a subset or module is created or updated, it is sent for external peer review by a group of independent experts drawn from the Optum external clinical review panel. This multidisciplinary panel is comprised of over 1,100 board-certified, practicing clinicians (two thirds of whom are MDs or DOs), all of whom have been screened for conflicts of interest and are credentialed every two years. Clinicians are widely dispersed geographically and practice in various settings, including academic and community-based practices. These experts serve two purposes: first, to ensure that the interpretation of the literature is correct and that they are not aware of any other practice-changing new literature about to be published, and to validate the application of evidence underpinning the standard of care into best practice medical appropriateness criteria. The number of external clinicians assembled is in inverse correlation to the strength of the evidence for the topic. For cases that do not lend themselves to formalized study, larger geographically dispersed groups of clinical experts are used to better establish the standard of care. When clinically meaningful changes are made during the external review process and/or there is a lack of consensus among the panel members, the content is vetted again, and additional external peer reviewers are added when necessary to ensure accuracy.

Step 5: Quality assurance and release

Quality is central throughout the development process to help ensure effectiveness and the correct interpretation and application of the evidence. Prior to release, certified medical coders work with the team to help ensure appropriate codes are applied to the relevant areas of content and the team conducts a final quality assurance check. The content is reviewed for clinical accuracy, consistency and completeness across products and approved content is prepared for distribution. A physician medical director provides oversight throughout the development process and helps to ensure clinical accuracy of the content. Extensive clinical revision documents accompany each release outlining the changes made and their rationale along with extensive bibliographies. Releases occur at least annually in the spring for all content modules and as often as monthly to reflect key changes in the literature or regulatory content for any module affected.

Summary

We are proud of our objective process, our large external expert peer review panel, and the quality that we incorporate into every InterQual clinical content set we develop. These processes, based on the principles of evidence-based medicine (EBM), continue to drive value and confidence for our customers, as they have for over 40 years.

Optum

InterQual® Level of Care Criteria

Acute Adult Criteria 2024

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Adult	InterQual 2024
Acute Coronary Syndrome (ACS)	LOC:Acute Adult	InterQual 2024
Acute Kidney Injury	LOC:Acute Adult	InterQual 2024
Anemia	LOC:Acute Adult	InterQual 2024
Antepartum	LOC:Acute Adult	InterQual 2024
Arrhythmia, Atrial	LOC:Acute Adult	InterQual 2024
Arrhythmia, Blocks	LOC:Acute Adult	InterQual 2024
Arrhythmia, Ventricular or Abnormal ECG Finding	LOC:Acute Adult	InterQual 2024
Asthma	LOC:Acute Adult	InterQual 2024
Bowel Obstruction	LOC:Acute Adult	InterQual 2024
Carbon Monoxide Poisoning	LOC:Acute Adult	InterQual 2024
COPD	LOC:Acute Adult	InterQual 2024
Cystic Fibrosis	LOC:Acute Adult	InterQual 2024
Deep Vein Thrombosis	LOC:Acute Adult	InterQual 2024
Dehydration or Gastroenteritis	LOC:Acute Adult	InterQual 2024
Diabetes Mellitus	LOC:Acute Adult	InterQual 2024
Diabetic Ketoacidosis	LOC:Acute Adult	InterQual 2024
Electrolyte or Mineral Imbalance	LOC:Acute Adult	InterQual 2024
Epilepsy	LOC:Acute Adult	InterQual 2024
Extended Stay	LOC:Acute Adult	InterQual 2024
Gallbladder Disorders	LOC:Acute Adult	InterQual 2024
Gastrointestinal (GI) Bleeding	LOC:Acute Adult	InterQual 2024
General Medical	LOC:Acute Adult	InterQual 2024
General Surgical	LOC:Acute Adult	InterQual 2024
General Trauma	LOC:Acute Adult	InterQual 2024

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InterQual® Level of Care Criteria 2024 Acute Adult

Subset	Product	Version
Heart Failure	LOC:Acute Adult	InterQual 2024
Hematology/Oncology: Complications or Disease Progres	LOC:Acute Adult	InterQual 2024
Hematology/Oncology: Hemolytic Uremic Syndrome	LOC:Acute Adult	InterQual 2024
Hematology/Oncology: Treatments	LOC:Acute Adult	InterQual 2024
Hospital in the Home	LOC:Acute Adult	InterQual 2024
Hyperosmolar Hyperglycemic State	LOC:Acute Adult	InterQual 2024
Hypertension	LOC:Acute Adult	InterQual 2024
Hypertensive Disorders of Pregnancy	LOC:Acute Adult	InterQual 2024
Hypoglycemia	LOC:Acute Adult	InterQual 2024
Infection: Cellulitis	LOC:Acute Adult	InterQual 2024
Infection: CNS	LOC:Acute Adult	InterQual 2024
Infection: COVID-19	LOC:Acute Adult	InterQual 2024
Infection: Endocarditis	LOC:Acute Adult	InterQual 2024
Infection: General	LOC:Acute Adult	InterQual 2024
Infection: GI/GYN	LOC:Acute Adult	InterQual 2024
Infection: Musculoskeletal	LOC:Acute Adult	InterQual 2024
Infection: Pneumonia	LOC:Acute Adult	InterQual 2024
Infection: Pyelonephritis or Complex UTI	LOC:Acute Adult	InterQual 2024
Infection: Sepsis	LOC:Acute Adult	InterQual 2024
Infection: Skin	LOC:Acute Adult	InterQual 2024
Inflammatory Bowel Disease	LOC:Acute Adult	InterQual 2024
Labor and Delivery	LOC:Acute Adult	InterQual 2024
Non-Traumatic Bleeding	LOC:Acute Adult	InterQual 2024
Pancreatitis	LOC:Acute Adult	InterQual 2024
Postpartum Complication After Discharge	LOC:Acute Adult	InterQual 2024
Pulmonary Embolism	LOC:Acute Adult	InterQual 2024
Rhabdomyolysis or Crush Syndrome	LOC:Acute Adult	InterQual 2024
Sickle Cell Disease	LOC:Acute Adult	InterQual 2024

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InterQual® Level of Care Criteria 2024 Acute Adult

Subset	Product	Version
Stroke	LOC:Acute Adult	InterQual 2024
Syncope	LOC:Acute Adult	InterQual 2024
TIA	LOC:Acute Adult	InterQual 2024
Transition Plan	LOC:Acute Adult	InterQual 2024
Withdrawal Syndrome	LOC:Acute Adult	InterQual 2024

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InterQual® Level of Care Criteria

Acute Pediatric Criteria 2024

Subset	Product	Version
Acetaminophen Overdose	LOC:Acute Pediatric	InterQual 2024
Acute Kidney Injury	LOC:Acute Pediatric	InterQual 2024
Anemia	LOC:Acute Pediatric	InterQual 2024
Antepartum	LOC:Acute Pediatric	InterQual 2024
Asthma	LOC:Acute Pediatric	InterQual 2024
Bone Marrow Transplant/Stem Cell Transplant (BMT/SCT)	LOC:Acute Pediatric	InterQual 2024
Bowel Obstruction	LOC:Acute Pediatric	InterQual 2024
Brief Resolved Unexplained Event (BRUE)	LOC:Acute Pediatric	InterQual 2024
Bronchiolitis	LOC:Acute Pediatric	InterQual 2024
Carbon Monoxide Poisoning	LOC:Acute Pediatric	InterQual 2024
Croup	LOC:Acute Pediatric	InterQual 2024
Cystic Fibrosis	LOC:Acute Pediatric	InterQual 2024
Dehydration or Gastroenteritis	LOC:Acute Pediatric	InterQual 2024
Diabetes Mellitus	LOC:Acute Pediatric	InterQual 2024
Diabetic Ketoacidosis	LOC:Acute Pediatric	InterQual 2024
Electrolyte or Mineral Imbalance	LOC:Acute Pediatric	InterQual 2024
Epilepsy	LOC:Acute Pediatric	InterQual 2024
Extended Stay	LOC:Acute Pediatric	InterQual 2024
Failure to Thrive	LOC:Acute Pediatric	InterQual 2024
Gastrointestinal (GI) Bleeding	LOC:Acute Pediatric	InterQual 2024
General Medical	LOC:Acute Pediatric	InterQual 2024
General Surgical	LOC:Acute Pediatric	InterQual 2024
General Trauma	LOC:Acute Pediatric	InterQual 2024

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InterQual® Level of Care Criteria 2024 Acute Pediatric

Subset	Product	Version
Hematology/Oncology: Acute Leukemia or Lymphoma	LOC:Acute Pediatric	InterQual 2024
Hematology/Oncology: Brain Malignancy or Metastasis	LOC:Acute Pediatric	InterQual 2024
Hematology/Oncology: Chemotherapy	LOC:Acute Pediatric	InterQual 2024
Hematology/Oncology: Hemolytic Uremic Syndrome	LOC:Acute Pediatric	InterQual 2024
Hematology/Oncology: Malignant Disease	LOC:Acute Pediatric	InterQual 2024
Hematology/Oncology: Tumor Lysis Syndrome	LOC:Acute Pediatric	InterQual 2024
Hyperbilirubinemia	LOC:Acute Pediatric	InterQual 2024
Hypertension	LOC:Acute Pediatric	InterQual 2024
Hypertensive Disorders of Pregnancy	LOC:Acute Pediatric	InterQual 2024
Hypoglycemia	LOC:Acute Pediatric	InterQual 2024
Infection: Cellulitis	LOC:Acute Pediatric	InterQual 2024
Infection: CNS	LOC:Acute Pediatric	InterQual 2024
Infection: COVID-19	LOC:Acute Pediatric	InterQual 2024
Infection: Endocarditis	LOC:Acute Pediatric	InterQual 2024
Infection: General	LOC:Acute Pediatric	InterQual 2024
Infection: GI/GYN	LOC:Acute Pediatric	InterQual 2024
Infection: Meningitis	LOC:Acute Pediatric	InterQual 2024
Infection: Musculoskeletal	LOC:Acute Pediatric	InterQual 2024
Infection: Pneumonia	LOC:Acute Pediatric	InterQual 2024
Infection: Pyelonephritis	LOC:Acute Pediatric	InterQual 2024
Infection: Sepsis	LOC:Acute Pediatric	InterQual 2024
Infection: Skin	LOC:Acute Pediatric	InterQual 2024
Labor and Delivery	LOC:Acute Pediatric	InterQual 2024
Non-Traumatic Bleeding	LOC:Acute Pediatric	InterQual 2024
Nursery	LOC:Acute Pediatric	InterQual 2024
Pancreatitis	LOC:Acute Pediatric	InterQual 2024
Postpartum Complication After Discharge	LOC:Acute Pediatric	InterQual 2024
Rhabdomyolysis or Crush Syndrome	LOC:Acute Pediatric	InterQual 2024
Sickle Cell Disease	LOC:Acute Pediatric	InterQual 2024
Transition Plan	LOC:Acute Pediatric	InterQual 2024
Withdrawal Syndrome	LOC:Acute Pediatric	InterQual 2024

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InterQual® Durable Medical Equipment Criteria 2024

Subset	Product	Version
Aerosol Delivery Devices	CP:Durable Medical Equipment	InterQual 2024
Airway or Secretion Clearance Devices	CP:Durable Medical Equipment	InterQual 2024
Bone Growth Stimulators, Noninvasive	CP:Durable Medical Equipment	InterQual 2024
Cardioverter Defibrillator, Wearable (WCD)	CP:Durable Medical Equipment	InterQual 2024
Continuous Glucose Monitors, Insulin Pumps, and Automated Insulin Delivery Technology	CP:Durable Medical Equipment	InterQual 2024
Continuous Passive Motion Device (CPM), Knee	CP:Durable Medical Equipment	InterQual 2024
Continuous Passive Motion Device (CPM), Upper Extremity	CP:Durable Medical Equipment	InterQual 2024
Enteral and Parenteral Nutrition Therapy	CP:Durable Medical Equipment	InterQual 2024
Hearing Aids	CP:Durable Medical Equipment	InterQual 2024
Home International Normalized Ratio (INR) Monitoring Device	CP:Durable Medical Equipment	InterQual 2024
Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction	CP:Durable Medical Equipment	InterQual 2024
Home Oxygen Therapy	CP:Durable Medical Equipment	InterQual 2024
Home Phototherapy for Neonatal Hyperbilirubinemia	CP:Durable Medical Equipment	InterQual 2024
Hospital Beds, Cribs, and Accessories	CP:Durable Medical Equipment	InterQual 2024
Negative Pressure Wound Therapy (NPWT) Devices	CP:Durable Medical Equipment	InterQual 2024
Noninvasive Airway Assistive Devices	CP:Durable Medical Equipment	InterQual 2024
Orthoses, Cranial Remodeling	CP:Durable Medical Equipment	InterQual 2024
Orthoses, Lower Extremity, Knee	CP:Durable Medical Equipment	InterQual 2024
Orthoses, Lower Extremity, Knee-Ankle-Foot (KAFO) and Ankle-Foot (AFO)	CP:Durable Medical Equipment	InterQual 2024
Orthoses, Thoracic, Lumbar, and Sacral Spine	CP:Durable Medical Equipment	InterQual 2024
Orthoses, Upper Extremity	CP:Durable Medical Equipment	InterQual 2024
Patient Lift System	CP:Durable Medical Equipment	InterQual 2024
Pediatric Gait Trainers	CP:Durable Medical Equipment	InterQual 2024
Pneumatic and other Powered Compression Devices	CP:Durable Medical Equipment	InterQual 2024
Power Operated Vehicles (POV)	CP:Durable Medical Equipment	InterQual 2024
Prosthetics, Lower Extremity	CP:Durable Medical Equipment	InterQual 2024
Prosthetics, Myoelectric, Upper Extremity	CP:Durable Medical Equipment	InterQual 2024

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InterQual® Durable Medical Equipment Criteria 2024

Subset	Product	Version
Seat Lift Mechanism	CP:Durable Medical Equipment	InterQual 2024
Speech Generating Devices (SGD)	CP:Durable Medical Equipment	InterQual 2024
Standing Frames	CP:Durable Medical Equipment	InterQual 2024
Support Surfaces	CP:Durable Medical Equipment	InterQual 2024
Therapeutic Shoes and Inserts for Persons with Diabetes	CP:Durable Medical Equipment	InterQual 2024
Transcutaneous Electrical Nerve Stimulation (TENS)	CP:Durable Medical Equipment	InterQual 2024
Trigeminal and Vagus Nerve Stimulator Devices, Noninvasive	CP:Durable Medical Equipment	InterQual 2024
Tumor Treatment Field Therapy (TTFT) Devices	CP:Durable Medical Equipment	InterQual 2024
Wheelchair Cushions or Seating System	CP:Durable Medical Equipment	InterQual 2024
Wheelchair Options and Accessories	CP:Durable Medical Equipment	InterQual 2024
Wheelchairs or Strollers, Pediatric	CP:Durable Medical Equipment	InterQual 2024
Wheelchairs, Manual	CP:Durable Medical Equipment	InterQual 2024
Wheelchairs, Power	CP:Durable Medical Equipment	InterQual 2024
Wheels or Wheelchairs, Power-Assist	CP:Durable Medical Equipment	InterQual 2024

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InterQual® Imaging Criteria 2024

Subset	Product	Version
Angiogram, Coronary +/- Left Heart Catheterization	CP:Imaging	InterQual 2024
Angiography, Spinal Cord	CP:Imaging	InterQual 2024
Cardiac Catheterization, Right Heart with Coronary Angiogram (Imaging)	CP:Imaging	InterQual 2024
Cardiac Imaging, Computed Tomography (CT) or Magnetic Resonance Imaging (MRI)	CP:Imaging	InterQual 2024
Echocardiogram, Transthoracic (TTE) or Transesophageal (TEE)	CP:Imaging	InterQual 2024
Hysterosalpingogram (HSG)	CP:Imaging	InterQual 2024
Imaging, Abdomen and Pelvis	CP:Imaging	InterQual 2024
Imaging, Ankle	CP:Imaging	InterQual 2024
Imaging, Bone Marrow	CP:Imaging	InterQual 2024
Imaging, Bone Mineral Density (BMD)	CP:Imaging	InterQual 2024
Imaging, Brain	CP:Imaging	InterQual 2024
Imaging, Breast	CP:Imaging	InterQual 2024
Imaging, Cardiac, Stress	CP:Imaging	InterQual 2024
Imaging, Carotid	CP:Imaging	InterQual 2024
Imaging, Chest, Noncardiac	CP:Imaging	InterQual 2024
Imaging, Elbow	CP:Imaging	InterQual 2024
Imaging, Extremity	CP:Imaging	InterQual 2024
Imaging, Face or Ear or Orbit or Sinonasal	CP:Imaging	InterQual 2024
Imaging, Foot	CP:Imaging	InterQual 2024
Imaging, Hip	CP:Imaging	InterQual 2024
Imaging, Knee	CP:Imaging	InterQual 2024
Imaging, Musculoskeletal Pelvis	CP:Imaging	InterQual 2024
Imaging, Neck	CP:Imaging	InterQual 2024
Imaging, Obstetrical	CP:Imaging	InterQual 2024

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InterQual® Imaging Criteria 2024

Subset	Product	Version
Imaging, Peripheral Vascular	CP:Imaging	InterQual 2024
Imaging, Pituitary	CP:Imaging	InterQual 2024
Imaging, Shoulder	CP:Imaging	InterQual 2024
Imaging, Spine, Cervical	CP:Imaging	InterQual 2024
Imaging, Spine, Lumbar	CP:Imaging	InterQual 2024
Imaging, Spine, Thoracic	CP:Imaging	InterQual 2024
Imaging, Temporomandibular Joint (TMJ)	CP:Imaging	InterQual 2024
Imaging, Wrist	CP:Imaging	InterQual 2024
Lymphoscintigraphy	CP:Imaging	InterQual 2024
Multi Gated Acquisition (MUGA) Scan, Resting	CP:Imaging	InterQual 2024
Musculoskeletal Nuclear Medicine Scan	CP:Imaging	InterQual 2024
Positron Emission Tomography (PET), Cardiac	CP:Imaging	InterQual 2024
Positron Emission Tomography (PET), Whole Body	CP:Imaging	InterQual 2024
Thyroid Scan, Whole Body	CP:Imaging	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Ablation or Excision, Endometriosis, Laparoscopic	CP:Procedures	InterQual 2024
Ablative or Transarterial Therapy, Liver	CP:Procedures	InterQual 2024
Achilles Tendon Repair	CP:Procedures	InterQual 2024
Adenoidectomy	CP:Procedures	InterQual 2024
Adenoidectomy (Pediatric)	CP:Procedures	InterQual 2024
Amputation of Digit or Extremity	CP:Procedures	InterQual 2024
Angiogram, Coronary +/- Left Heart Catheterization	CP:Procedures	InterQual 2024
Angioplasty and Stent, Carotid or Vertebral	CP:Procedures	InterQual 2024
Angioplasty, Renovascular	CP:Procedures	InterQual 2024
Antireflux Surgery or Hiatal Hernia Repair	CP:Procedures	InterQual 2024
Aortic Valve Replacement (AVR)	CP:Procedures	InterQual 2024
Aortic Valvuloplasty, Percutaneous Balloon	CP:Procedures	InterQual 2024
Appendectomy	CP:Procedures	InterQual 2024
Appendectomy (Pediatric)	CP:Procedures	InterQual 2024
Arthrodesis or Arthroplasty, Interphalangeal Joint, Second-Fifth Toes	CP:Procedures	InterQual 2024
Arthrodesis, Ankle (Talotibial Joint)	CP:Procedures	InterQual 2024
Arthrodesis, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2024
Arthrodesis, Hip	CP:Procedures	InterQual 2024
Arthrodesis, Knee	CP:Procedures	InterQual 2024
Arthrodesis, Triple	CP:Procedures	InterQual 2024
Arthroplasty, Carpometacarpal (CMC) Joint, Thumb	CP:Procedures	InterQual 2024
Arthroplasty, Metacarpophalangeal (MCP) Joint, Digits	CP:Procedures	InterQual 2024
Arthroplasty, Proximal Interphalangeal (PIP) Joint, Fingers	CP:Procedures	InterQual 2024
Arthroplasty, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2024
Arthroscopy or Arthroscopically Assisted Surgery, Knee	CP:Procedures	InterQual 2024
Arthroscopy or Arthroscopically Assisted Surgery, Knee (Pediatric)	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder	CP:Procedures	InterQual 2024
Arthroscopy or Arthroscopically Assisted Surgery, Shoulder (Adolescent)	CP:Procedures	InterQual 2024
Arthroscopy or Arthroscopically Assisted Surgery, Wrist	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Ankle	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Elbow	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Hip	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Knee	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Shoulder	CP:Procedures	InterQual 2024
Arthroscopy, Diagnostic, +/- Synovial Biopsy, Wrist	CP:Procedures	InterQual 2024
Arthroscopy, Surgical, Ankle	CP:Procedures	InterQual 2024
Arthroscopy, Surgical, Elbow	CP:Procedures	InterQual 2024
Arthroscopy, Surgical, Hip	CP:Procedures	InterQual 2024
Arthroscopy, Surgical, Hip (Pediatric)	CP:Procedures	InterQual 2024
Arthroscopy, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2024
Arthrotomy, Ankle	CP:Procedures	InterQual 2024
Arthrotomy, Elbow	CP:Procedures	InterQual 2024
Arthrotomy, Hip	CP:Procedures	InterQual 2024
Arthrotomy, Knee	CP:Procedures	InterQual 2024
Arthrotomy, Knee (Pediatric)	CP:Procedures	InterQual 2024
Arthrotomy, Shoulder	CP:Procedures	InterQual 2024
Arthrotomy, Wrist	CP:Procedures	InterQual 2024
Artificial Disc Replacement, Cervical	CP:Procedures	InterQual 2024
Artificial Disc Replacement, Lumbar	CP:Procedures	InterQual 2024
Atrial Septal Defect (ASD) Repair	CP:Procedures	InterQual 2024
Balloon Ostial Dilation	CP:Procedures	InterQual 2024
Bariatric or Metabolic Surgery	CP:Procedures	InterQual 2024
Bariatric or Metabolic Surgery (Adolescent)	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Biopsy, Adrenal Mass, Needle	CP:Procedures	InterQual 2024
Biopsy, Breast, Needle Core	CP:Procedures	InterQual 2024
Biopsy, Prostate, Needle	CP:Procedures	InterQual 2024
Biopsy, Sentinel Lymph Node	CP:Procedures	InterQual 2024
Bladder Neck Suspension/Sling, Female	CP:Procedures	InterQual 2024
Blepharoplasty	CP:Procedures	InterQual 2024
Bone Augmentation, Mandible	CP:Procedures	InterQual 2024
Bone Augmentation, Maxilla	CP:Procedures	InterQual 2024
Bone Graft and Implantable Stimulator, Fracture Nonunion	CP:Procedures	InterQual 2024
Brachytherapy, Prostate	CP:Procedures	InterQual 2024
Breast Implant Removal	CP:Procedures	InterQual 2024
Breast Reconstruction	CP:Procedures	InterQual 2024
Bronchoscopy	CP:Procedures	InterQual 2024
Bypass, Distal, Peripheral Artery	CP:Procedures	InterQual 2024
Bypass, Proximal, Peripheral Artery	CP:Procedures	InterQual 2024
Capsule Endoscopy	CP:Procedures	InterQual 2024
Capsule Endoscopy (Pediatric)	CP:Procedures	InterQual 2024
Capsulotomy	CP:Procedures	InterQual 2024
Cardiac Catheterization, Right Heart with Coronary Angiogram (Procedure)	CP:Procedures	InterQual 2024
Cataract Removal	CP:Procedures	InterQual 2024
Cesarean Section, During Labor	CP:Procedures	InterQual 2024
Cesarean Section, Prior to Onset of Labor	CP:Procedures	InterQual 2024
Cheilectomy, First Metatarsophalangeal (MTP) Joint	CP:Procedures	InterQual 2024
Cholangiogram, Intraoperative	CP:Procedures	InterQual 2024
Cholangiogram, Intraoperative (Pediatric)	CP:Procedures	InterQual 2024
Cholecystectomy, Laparoscopic	CP:Procedures	InterQual 2024
Cholecystectomy, Laparoscopic (Pediatric)	CP:Procedures	InterQual 2024
Cholecystectomy, Open	CP:Procedures	InterQual 2024
Circumcision	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Circumcision (Pediatric)	CP:Procedures	InterQual 2024
Cleft Lip or Palate Repair (Pediatric)	CP:Procedures	InterQual 2024
Cochlear Implantation	CP:Procedures	InterQual 2024
Cochlear Implantation (Pediatric)	CP:Procedures	InterQual 2024
Colectomy, Left	CP:Procedures	InterQual 2024
Colectomy, Right	CP:Procedures	InterQual 2024
Colonoscopy	CP:Procedures	InterQual 2024
Colonoscopy (Pediatric)	CP:Procedures	InterQual 2024
Coronary Artery Bypass Graft (CABG)	CP:Procedures	InterQual 2024
Craniotomy	CP:Procedures	InterQual 2024
Cryoablation, Prostate	CP:Procedures	InterQual 2024
Cutaneous Lipoma Excision	CP:Procedures	InterQual 2024
Cystolithotomy	CP:Procedures	InterQual 2024
Cystolithotomy (Pediatric)	CP:Procedures	InterQual 2024
Decompression +/- Fusion, Cervical	CP:Procedures	InterQual 2024
Decompression +/- Fusion, Lumbar	CP:Procedures	InterQual 2024
Decompression +/- Fusion, Thoracic	CP:Procedures	InterQual 2024
Dental Implant, Osseointegrated	CP:Procedures	InterQual 2024
Dilatation and Curettage (D & C)	CP:Procedures	InterQual 2024
Discectomy, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2024
Discography, Spine, Lumbar	CP:Procedures	InterQual 2024
Ectropion Repair	CP:Procedures	InterQual 2024
Electrocardiography, Ambulatory (AECG)	CP:Procedures	InterQual 2024
Electroconvulsive Therapy (ECT)	CP:Procedures	InterQual 2024
Electromyography (EMG) and Nerve Conduction Studies (NCS)	CP:Procedures	InterQual 2024
Electrophysiology (EP) Testing +/- Radiofrequency (RFA) or Cryothermal Ablation, Cardiac	CP:Procedures	InterQual 2024
Endarterectomy, Carotid or Vertebral	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Endoscopy, Upper Gastrointestinal (GI)	CP:Procedures	InterQual 2024
Endoscopy, Upper Gastrointestinal (GI) (Pediatric)	CP:Procedures	InterQual 2024
Endovascular Intervention, Intracranial	CP:Procedures	InterQual 2024
Endovascular Intervention, Peripheral Artery	CP:Procedures	InterQual 2024
Endovascular Repair, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2024
Endovascular Repair, Thoracic Aortic Aneurysm	CP:Procedures	InterQual 2024
Endovenous Ablation, Lower Extremity Superficial Truncal or Perforator Vein	CP:Procedures	InterQual 2024
Entropion Repair	CP:Procedures	InterQual 2024
Epicondyloplasty, Lateral, Elbow	CP:Procedures	InterQual 2024
Epicondyloplasty, Medial, Elbow	CP:Procedures	InterQual 2024
Epidural or Intrathecal Catheter Placement	CP:Procedures	InterQual 2024
Epidural Steroid Injection	CP:Procedures	InterQual 2024
Ethmoidectomy	CP:Procedures	InterQual 2024
Exercise Treadmill Testing (ETT)	CP:Procedures	InterQual 2024
Exostectomy, Fifth Metatarsal (MT) Head	CP:Procedures	InterQual 2024
Exostectomy, First Metatarsophalangeal (MTP) Joint (Bunionectomy)	CP:Procedures	InterQual 2024
Extraction, Third Molar	CP:Procedures	InterQual 2024
Eyelid Lesion Excision, +/- Reconstruction	CP:Procedures	InterQual 2024
Eyelid Reconstruction	CP:Procedures	InterQual 2024
Facet Joint Injection	CP:Procedures	InterQual 2024
Facial Nerve Repair	CP:Procedures	InterQual 2024
Fusion, Cervical Spine	CP:Procedures	InterQual 2024
Fusion, Lumbar Spine	CP:Procedures	InterQual 2024
Fusion, Thoracic Spine	CP:Procedures	InterQual 2024
Ganglion Cyst Excision	CP:Procedures	InterQual 2024
Gastric Stimulation	CP:Procedures	InterQual 2024
Gender Affirmation Surgery	CP:Procedures	InterQual 2024
Glossectomy, Partial or Hemiglossectomy	CP:Procedures	InterQual 2024
Hearing Device, Bone Anchored or Bone Conduction	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Hearing Device, Bone Anchored or Bone Conduction (Pediatric)	CP:Procedures	InterQual 2024
Hearing Device, Middle Ear	CP:Procedures	InterQual 2024
Hemiarthroplasty, Hip	CP:Procedures	InterQual 2024
Hemorrhoid Procedures, Minimally Invasive	CP:Procedures	InterQual 2024
Hemorrhoidectomy	CP:Procedures	InterQual 2024
Herniorrhaphy, Inguinal (Pediatric)	CP:Procedures	InterQual 2024
Herniorrhaphy, Inguinal or Femoral	CP:Procedures	InterQual 2024
Herniorrhaphy, Umbilical	CP:Procedures	InterQual 2024
Herniorrhaphy, Umbilical (Pediatric)	CP:Procedures	InterQual 2024
Herniorrhaphy, Ventral or Incisional or Epigastric	CP:Procedures	InterQual 2024
Herniorrhaphy, Ventral or Incisional or Epigastric (Pediatric)	CP:Procedures	InterQual 2024
High-Intensity Focused Ultrasound (HIFU)	CP:Procedures	InterQual 2024
Hydrocelectomy	CP:Procedures	InterQual 2024
Hydrocelectomy (Pediatric)	CP:Procedures	InterQual 2024
Hyperbaric Oxygen Therapy	CP:Procedures	InterQual 2024
Hyperbaric Oxygen Therapy (Pediatric)	CP:Procedures	InterQual 2024
Hysterectomy, +/- Bilateral Salpingo-Oophorectomy (BSO) or Bilateral Salpingectomy	CP:Procedures	InterQual 2024
Hysterectomy, Radical	CP:Procedures	InterQual 2024
Hysteroscopy, + Dilatation and Curettage (D & C), Diagnostic	CP:Procedures	InterQual 2024
Hysteroscopy, Operative	CP:Procedures	InterQual 2024
Implantable Cardioverter Defibrillator (ICD) Insertion	CP:Procedures	InterQual 2024
Interspinous Process Device with or without Open Decompression	CP:Procedures	InterQual 2024
Joint Replacement, Elbow	CP:Procedures	InterQual 2024
Joint Replacement, Shoulder	CP:Procedures	InterQual 2024
Joint Replacement, Wrist	CP:Procedures	InterQual 2024
Keloid Excision	CP:Procedures	InterQual 2024
Keratoplasty	CP:Procedures	InterQual 2024
Laparoscopy, Diagnostic (Abdomen)	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Laparoscopy, Diagnostic (Abdomen) (Pediatric)	CP:Procedures	InterQual 2024
Laparoscopy, Diagnostic (Pelvic)	CP:Procedures	InterQual 2024
Laparotomy or Exploratory Laparotomy	CP:Procedures	InterQual 2024
Laparotomy or Exploratory Laparotomy (Pediatric)	CP:Procedures	InterQual 2024
Left Atrial Appendage Closure, Percutaneous	CP:Procedures	InterQual 2024
Left Ventricular Assist Device (LVAD) Insertion	CP:Procedures	InterQual 2024
Ligation and Division +/- Stripping or Excision, Lower Extremity Superficial Vein	CP:Procedures	InterQual 2024
Lithotripsy, Extracorporeal Shock Wave (ESWL)	CP:Procedures	InterQual 2024
Lithotripsy, Extracorporeal Shock Wave (ESWL) (Pediatric)	CP:Procedures	InterQual 2024
Lobectomy	CP:Procedures	InterQual 2024
Lung Volume Reduction Surgery (LVRS)	CP:Procedures	InterQual 2024
Manipulation Under Anesthesia, Shoulder	CP:Procedures	InterQual 2024
Mastectomy, Modified Radical (MRM)	CP:Procedures	InterQual 2024
Mastectomy, Partial, +/- Axillary Dissection	CP:Procedures	InterQual 2024
Mastectomy, Prophylactic, Total or Simple	CP:Procedures	InterQual 2024
Mastectomy, Total or Simple	CP:Procedures	InterQual 2024
Maxillectomy	CP:Procedures	InterQual 2024
Maxillomandibular Advancement	CP:Procedures	InterQual 2024
Median Nerve Decompression, +/- Neurolysis, Wrist	CP:Procedures	InterQual 2024
Mitral Valve Replacement (MVR) or Repair	CP:Procedures	InterQual 2024
Mitral Valvuloplasty, Percutaneous Balloon	CP:Procedures	InterQual 2024
Morton's or Interdigital Neuroma Excision	CP:Procedures	InterQual 2024
Myomectomy	CP:Procedures	InterQual 2024
Myringotomy, +/- Tympanostomy Tube	CP:Procedures	InterQual 2024
Nephrectomy, Partial	CP:Procedures	InterQual 2024
Nephrectomy, Radical	CP:Procedures	InterQual 2024
Nephrectomy, Simple	CP:Procedures	InterQual 2024
Nephrolithotomy, Percutaneous	CP:Procedures	InterQual 2024
Nerve Graft, Hand or Digit	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Nerve Repair, Wrist or Hand or Digit	CP:Procedures	InterQual 2024
Neuroablation, Percutaneous	CP:Procedures	InterQual 2024
Neuropsychological and Developmental Testing	CP:Procedures	InterQual 2024
Orbitotomy	CP:Procedures	InterQual 2024
Orchiopexy (Pediatric)	CP:Procedures	InterQual 2024
Osteotomy, Anterior Segment, Mandible	CP:Procedures	InterQual 2024
Osteotomy, Anterior Segment, Maxilla	CP:Procedures	InterQual 2024
Osteotomy, Calcaneal	CP:Procedures	InterQual 2024
Osteotomy, Distal Transpositional, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2024
Osteotomy, High Tibial	CP:Procedures	InterQual 2024
Osteotomy, LeFort I	CP:Procedures	InterQual 2024
Osteotomy, Maxillary Buttress, +/- Mid Palatal Osteotomy	CP:Procedures	InterQual 2024
Osteotomy, Pelvic or Proximal Femur	CP:Procedures	InterQual 2024
Osteotomy, Proximal Phalanx, First Toe	CP:Procedures	InterQual 2024
Osteotomy, Proximal, First Metatarsal (MT) (Bunionectomy)	CP:Procedures	InterQual 2024
Osteotomy, Sagittal Split, Mandible Ramus	CP:Procedures	InterQual 2024
Osteotomy, Supracondylar Femur	CP:Procedures	InterQual 2024
Osteotomy, Transpositional, Distal or Proximal, Fifth Metatarsal (MT)	CP:Procedures	InterQual 2024
Pacemaker Insertion	CP:Procedures	InterQual 2024
Pacemaker Insertion, Biventricular	CP:Procedures	InterQual 2024
Pacemaker Insertion, Biventricular + Implantable Cardioverter Defibrillator (ICD) Insertion	CP:Procedures	InterQual 2024
Palmar Fasciectomy	CP:Procedures	InterQual 2024
Panniculectomy, Abdominal	CP:Procedures	InterQual 2024
Pectus Deformity Repair (Pediatric)	CP:Procedures	InterQual 2024
Penile Implant Insertion	CP:Procedures	InterQual 2024
Percutaneous Coronary Intervention (PCI)	CP:Procedures	InterQual 2024
Phlebectomy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2024
Photocoagulation, Focal Laser	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Photocoagulation, Grid Laser	CP:Procedures	InterQual 2024
Plantar Fascial Release	CP:Procedures	InterQual 2024
Plantar Fasciitis, Extracorporeal Shock Wave Therapy (ESWT)	CP:Procedures	InterQual 2024
Pneumonectomy	CP:Procedures	InterQual 2024
Polypectomy, Nasal	CP:Procedures	InterQual 2024
Prostatectomy, Open	CP:Procedures	InterQual 2024
Prostatectomy, Radical	CP:Procedures	InterQual 2024
Prostatectomy, Transurethral Ablation	CP:Procedures	InterQual 2024
Prostatectomy, Transurethral Resection	CP:Procedures	InterQual 2024
Proton Beam Radiotherapy (PBRT)	CP:Procedures	InterQual 2024
Proton Beam Radiotherapy (PBRT) (Pediatric)	CP:Procedures	InterQual 2024
Psychological Testing	CP:Procedures	InterQual 2024
Ptosis Repair	CP:Procedures	InterQual 2024
Pyloromyotomy (Pediatric)	CP:Procedures	InterQual 2024
Radiofrequency Ablation (RFA) or Cryoablation, Renal	CP:Procedures	InterQual 2024
Reconstruction, Temporomandibular Joint (TMJ)	CP:Procedures	InterQual 2024
Reduction and Fixation, Distal Radius +/- Ulna	CP:Procedures	InterQual 2024
Reduction and Fixation, Radius +/- Ulna Shaft	CP:Procedures	InterQual 2024
Reduction Mammaplasty, Female	CP:Procedures	InterQual 2024
Reduction Mammaplasty, Female (Adolescent)	CP:Procedures	InterQual 2024
Reduction Mammaplasty, Male	CP:Procedures	InterQual 2024
Reduction Mammaplasty, Male (Adolescent)	CP:Procedures	InterQual 2024
Reimplantation, Ureter (Pediatric)	CP:Procedures	InterQual 2024
Removal and Replacement, Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2024
Removal and Replacement, Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2024
Removal and Replacement, Total Joint Replacement (TJR), Shoulder	CP:Procedures	InterQual 2024
Removal or Revision, Arthroplasty, Elbow	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Removal or Revision, Arthroplasty, Wrist	CP:Procedures	InterQual 2024
Resection and Graft, Abdominal Aortic Aneurysm (AAA)	CP:Procedures	InterQual 2024
Resection and Graft, Thoracic or Thoracoabdominal Aortic Aneurysm	CP:Procedures	InterQual 2024
Rhinoplasty	CP:Procedures	InterQual 2024
Sacrocolpopexy	CP:Procedures	InterQual 2024
Sacroiliac (SI) Joint Injection	CP:Procedures	InterQual 2024
Salpingectomy	CP:Procedures	InterQual 2024
Salpingo-Oophorectomy, Bilateral or Oophorectomy, Bilateral	CP:Procedures	InterQual 2024
Salpingo-Oophorectomy, Unilateral or Oophorectomy, Unilateral	CP:Procedures	InterQual 2024
Salpingostomy	CP:Procedures	InterQual 2024
Scar Contracture Release	CP:Procedures	InterQual 2024
Scar Revision	CP:Procedures	InterQual 2024
Sclerotherapy, Lower Extremity Superficial Tributary Varicose Vein	CP:Procedures	InterQual 2024
Scoliosis or Kyphosis Surgery	CP:Procedures	InterQual 2024
Scoliosis or Kyphosis Surgery (Pediatric)	CP:Procedures	InterQual 2024
Septoplasty	CP:Procedures	InterQual 2024
Septoplasty (Adolescent)	CP:Procedures	InterQual 2024
Sigmoidoscopy	CP:Procedures	InterQual 2024
Sinusotomy, Frontal	CP:Procedures	InterQual 2024
Sinusotomy, Maxillary	CP:Procedures	InterQual 2024
Skin Graft	CP:Procedures	InterQual 2024
Skin Substitute Graft	CP:Procedures	InterQual 2024
Sleep Studies	CP:Procedures	InterQual 2024
Sleep Studies (Pediatric)	CP:Procedures	InterQual 2024
Small Bowel Resection	CP:Procedures	InterQual 2024
Spinal Cord Stimulator (SCS) Insertion	CP:Procedures	InterQual 2024
Stereotactic Introduction, Subcortical or Cortical Electrodes	CP:Procedures	InterQual 2024
Stereotactic Radiosurgery, Brain or Skull Base	CP:Procedures	InterQual 2024
Strabismus Repair (Pediatric)	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Subfascial Endoscopic Perforator Surgery (SEPS)	CP:Procedures	InterQual 2024
Sympathectomy	CP:Procedures	InterQual 2024
Sympathetic Blockade	CP:Procedures	InterQual 2024
Tendon Sheath Incision or Excision, Hand, Flexor	CP:Procedures	InterQual 2024
Tendon Transfer, Hand or Forearm	CP:Procedures	InterQual 2024
Thoracoscopy, Video Assisted (VAT)	CP:Procedures	InterQual 2024
Thrombolysis, Deep Vein Thrombosis (DVT)	CP:Procedures	InterQual 2024
Thyroidectomy, Partial or Total	CP:Procedures	InterQual 2024
Thyroidectomy, Partial or Total (Pediatric)	CP:Procedures	InterQual 2024
Tibial Nerve Decompression	CP:Procedures	InterQual 2024
Tissue Transfer (Flap)	CP:Procedures	InterQual 2024
Tonsillectomy	CP:Procedures	InterQual 2024
Tonsillectomy (Pediatric)	CP:Procedures	InterQual 2024
Total Joint Replacement (TJR), Ankle	CP:Procedures	InterQual 2024
Total Joint Replacement (TJR), Hip	CP:Procedures	InterQual 2024
Total Joint Replacement (TJR), Knee	CP:Procedures	InterQual 2024
Trabeculoplasty or Trabeculectomy	CP:Procedures	InterQual 2024
Transcatheter Aortic Valve Replacement (TAVR)	CP:Procedures	InterQual 2024
Transcatheter Mitral Valve Edge-to-Edge Repair (TEER)	CP:Procedures	InterQual 2024
Transcranial Magnetic Stimulation (TMS)	CP:Procedures	InterQual 2024
Transplantation, Allogeneic Stem Cell	CP:Procedures	InterQual 2024
Transplantation, Allogeneic Stem Cell (Pediatric)	CP:Procedures	InterQual 2024
Transplantation, Autologous Stem Cell	CP:Procedures	InterQual 2024
Transplantation, Autologous Stem Cell (Pediatric)	CP:Procedures	InterQual 2024
Transplantation, Cardiac	CP:Procedures	InterQual 2024
Transplantation, Liver	CP:Procedures	InterQual 2024
Transplantation, Renal	CP:Procedures	InterQual 2024
Transurethral Resection, Bladder Tumor (TURBT)	CP:Procedures	InterQual 2024

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InterQual® Procedures Criteria 2024

Subset	Product	Version
Tricuspid Valve Replacement (TVR) or Repair or Resection	CP:Procedures	InterQual 2024
Turbinectomy, Inferior, Partial	CP:Procedures	InterQual 2024
Tympanoplasty (Pediatric)	CP:Procedures	InterQual 2024
Tympanostomy Tube (Pediatric)	CP:Procedures	InterQual 2024
Ulnar Nerve Decompression or Transposition, Elbow	CP:Procedures	InterQual 2024
Ulnar Nerve Decompression, Wrist	CP:Procedures	InterQual 2024
Ultrasound, Endobronchial (EBUS) or Endoscopic (EUS)	CP:Procedures	InterQual 2024
Unicondylar or Patellofemoral Knee Replacement	CP:Procedures	InterQual 2024
Ureteroscopy	CP:Procedures	InterQual 2024
Ureteroscopy (Pediatric)	CP:Procedures	InterQual 2024
Urethral Sling, Male	CP:Procedures	InterQual 2024
Urethroplasty	CP:Procedures	InterQual 2024
Urine Drug Testing (UDT)	CP:Procedures	InterQual 2024
Uterine Artery Embolization (UAE)	CP:Procedures	InterQual 2024
Uvulopalatopharyngoplasty (UPPP)	CP:Procedures	InterQual 2024
Vaginal Delivery, Early Elective	CP:Procedures	InterQual 2024
Vagus Nerve Stimulation (VNS)	CP:Procedures	InterQual 2024
Vagus Nerve Stimulation (VNS) (Pediatric)	CP:Procedures	InterQual 2024
Vertebroplasty or Kyphoplasty	CP:Procedures	InterQual 2024
Video Electroencephalographic (EEG) Monitoring	CP:Procedures	InterQual 2024
Video Electroencephalographic (EEG) Monitoring (Pediatric)	CP:Procedures	InterQual 2024
Vitrectomy, Pars Plana	CP:Procedures	InterQual 2024
Wedge Resection or Segmentectomy, Lung	CP:Procedures	InterQual 2024

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InterQual® Molecular Diagnostics Criteria 2024

Subset	Product	Version
21-Hydroxylase-Deficient Congenital Adrenal Hyperplasia (CYP21A2)	CP:Molecular Diagnostics	InterQual 2024
Achondroplasia	CP:Molecular Diagnostics	InterQual 2024
Acute Myeloid Leukemia (AML)	CP:Molecular Diagnostics	InterQual 2024
Adenomatous Polyposis Coli (APC)-associated Polyposis Conditions	CP:Molecular Diagnostics	InterQual 2024
AlloMap®	CP:Molecular Diagnostics	InterQual 2024
Alpha Thalassemia	CP:Molecular Diagnostics	InterQual 2024
Alpha-1 Antitrypsin Deficiency (AATD)	CP:Molecular Diagnostics	InterQual 2024
Alzheimer's Disease	CP:Molecular Diagnostics	InterQual 2024
Angelman Syndrome (AS)	CP:Molecular Diagnostics	InterQual 2024
ARX-Related X-linked Disorders	CP:Molecular Diagnostics	InterQual 2024
Ataxia-Telangiectasia (A-T)	CP:Molecular Diagnostics	InterQual 2024
BCR::ABL1 Testing in Acute Lymphoblastic Leukemia (ALL)	CP:Molecular Diagnostics	InterQual 2024
BCR::ABL1 Testing in Chronic Myeloid Leukemia (CML)	CP:Molecular Diagnostics	InterQual 2024
Beckwith-Wiedemann Syndrome (BWS)	CP:Molecular Diagnostics	InterQual 2024
Beta globin (HBB) testing for Beta-thalassemia and Sickle Cell Disease	CP:Molecular Diagnostics	InterQual 2024
Bloom's Syndrome	CP:Molecular Diagnostics	InterQual 2024
BRAF Testing for Drug Response in Melanoma	CP:Molecular Diagnostics	InterQual 2024
BRCA1 and BRCA2 in Hereditary Cancer	CP:Molecular Diagnostics	InterQual 2024
Canavan Disease	CP:Molecular Diagnostics	InterQual 2024
Cancer Antigen 19-9 (CA 19-9) (CES only)	CP:Molecular Diagnostics	InterQual 2024
Cancer Antigen 72-4 (CA 72-4)	CP:Molecular Diagnostics	InterQual 2024
Cancer Antigens 27.29 and 15-3 (CA 27.29 and CA 15-3) (CES only)	CP:Molecular Diagnostics	InterQual 2024
Carrier Screening (Genetic) for General Population	CP:Molecular Diagnostics	InterQual 2024
Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts and Leukoencephalopathy (CADASIL)	CP:Molecular Diagnostics	InterQual 2024
Charcot-Marie-Tooth (CMT) Hereditary Neuropathy	CP:Molecular Diagnostics	InterQual 2024
Chimerism Analysis after Allogeneic Stem Cell Transplantation (SCT)	CP:Molecular Diagnostics	InterQual 2024
Chronic Lymphocytic Leukemia (CLL) Prognostic or Predictive Testing	CP:Molecular Diagnostics	InterQual 2024
clonoSEQ® and other Clonality Testing	CP:Molecular Diagnostics	InterQual 2024
Cologuard®	CP:Molecular Diagnostics	InterQual 2024
Comprehensive Genomic Profiling for Solid Tumor, Liquid Biopsy	CP:Molecular Diagnostics	InterQual 2024
Comprehensive Genomic Profiling, Tumor Tissue	CP:Molecular Diagnostics	InterQual 2024
ConfirmMDx® for Prostate Cancer	CP:Molecular Diagnostics	InterQual 2024
Congenital Factor XIII Deficiency	CP:Molecular Diagnostics	InterQual 2024
Congenital Von Willebrand Disease (VWD) testing	CP:Molecular Diagnostics	InterQual 2024
COVID-19 Testing	CP:Molecular Diagnostics	InterQual 2024
Craniofrontonasal Syndrome (EFNB1)	CP:Molecular Diagnostics	InterQual 2024
CYP450 Genotyping	CP:Molecular Diagnostics	InterQual 2024

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Subset	Product	Version
UGT1A1 Genotyping for Crigler-Najjar Syndrome	CP:Molecular Diagnostics	InterQual 2024
UGT1A1 Genotyping for Drug Response	CP:Molecular Diagnostics	InterQual 2024
UGT1A1 Genotyping for Gilbert Syndrome	CP:Molecular Diagnostics	InterQual 2024
Urea Cycle Disorder	CP:Molecular Diagnostics	InterQual 2024
UroVysion® for Bladder Cancer	CP:Molecular Diagnostics	InterQual 2024
VEGF and VEGFA Testing for Bevacizumab Response (CES only)	CP:Molecular Diagnostics	InterQual 2024
VeriStrat® (CES only)	CP:Molecular Diagnostics	InterQual 2024
Von Hippel-Lindau Syndrome (VHL)	CP:Molecular Diagnostics	InterQual 2024
Whole Genome Sequencing (WGS), Whole Exome Sequencing (WES), and Chromosomal Microarray (CMA) for Congenital or Hereditary Disorders	CP:Molecular Diagnostics	InterQual 2024
Whole-Genome Next-Generation Sequencing (WGS) for Oncology (CES only)	CP:Molecular Diagnostics	InterQual 2024
Wilson Disease	CP:Molecular Diagnostics	InterQual 2024

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InterQual® Behavioral Health Criteria 2024

Adult and Geriatric Psychiatry Criteria Review Process

Subset	Product	Version
Adult and Geriatric Psychiatry	BH:Adult and Geriatric Psychiatry	InterQual 2024
Transition Plan	BH:Adult and Geriatric Psychiatry	InterQual 2024

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InterQual® Behavioral Health Criteria 2024

Child and Adolescent Psychiatry Criteria Review Process

Subset	Product	Version
Child and Adolescent Psychiatry	BH:Child and Adolescent Psychiatry	InterQual 2024
Transition Plan	BH:Child and Adolescent Psychiatry	InterQual 2024

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InterQual® Behavioral Health Criteria 2024

Substance Use Disorders Criteria Review Process

Subset	Product	Version
Substance Use Disorders	BH:Substance Use Disorders	InterQual 2024
Transition Plan	BH:Substance Use Disorders	InterQual 2024

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InterQual® Behavioral Health Criteria 2024

Behavioral Health Services Criteria Review Process

Subset	Product	Version
Aducanumab-avwa (Aduhelm)	BH:Behavioral Health Services	InterQual 2024
Applied Behavior Analysis (ABA) Program	BH:Behavioral Health Services	InterQual 2024
Brexanolone (Zulresso)	BH:Behavioral Health Services	InterQual 2024
Electroconvulsive Therapy (ECT)	BH:Behavioral Health Services	InterQual 2024
Esketamine (Spravato)	BH:Behavioral Health Services	InterQual 2024
Lecanemab-irmb (Leqembi)	BH:Behavioral Health Services	InterQual 2024
Multi-Gene Panels for Autism Spectrum Disorder (ASD)	BH:Behavioral Health Services	InterQual 2024
Neuropsychological and Developmental Testing	BH:Behavioral Health Services	InterQual 2024
Outdoor Behavioral Healthcare (OBH) Residential Wilderness Program	BH:Behavioral Health Services	InterQual 2024
Paliperidone palmitate (Invega Hafyera)	BH:Behavioral Health Services	InterQual 2024
Paliperidone palmitate (Invega Sustenna)	BH:Behavioral Health Services	InterQual 2024
Paliperidone palmitate (Invega Trinza)	BH:Behavioral Health Services	InterQual 2024
Pharmacogenomic Testing for Psychotropic Medication Drug Response	BH:Behavioral Health Services	InterQual 2024
Psychological Testing	BH:Behavioral Health Services	InterQual 2024
Psychosocial Rehabilitation (PSR), Adult	BH:Behavioral Health Services	InterQual 2024
Stereotactic Introduction, Subcortical or Cortical Electrodes	BH:Behavioral Health Services	InterQual 2024
Transcranial Magnetic Stimulation (TMS)	BH:Behavioral Health Services	InterQual 2024
Urine Drug Testing (UDT)	BH:Behavioral Health Services	InterQual 2024
Vagus Nerve Stimulation (VNS)	BH:Behavioral Health Services	InterQual 2024

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Population Health Grand Analysis

Hannah O'Leary

June 2024

Engagement Categories

- Engaged
- Declined
- Left Message
- Unable to Reach
- Not Referred

Data Sources for Report

Data Type	Data Source
Member Demographics from Partnership data warehouse	Member demographics from Partnership data warehouse
Encounters from Partnership claims system	Encounters from Partnership claims system
Immunization data	California Immunization Registry (CAIR)
DHCS medical and pharmacy claims	DHCS claims data
Member Experience Survey results	Partnership case management system (Essette)
Member Delivery Report	Partnership Utilization Management system hospital ADT data authorization data
Case Management	Partnership case management system (Essette)

Growing Together Prenatal Program

Growing Together Prenatal Program Criteria

Measure Description:	Members who engaged in the Growing Together Prenatal Program would have a greater rate of TDap vaccination during their third trimester than those not engaged or declined engagement.
Denominator:	Partnership members who had at least one prenatal care visit in the 12 months prior to report run date and who delivered a baby at least 90 days prior to report run date
Numerator:	Of the denominator, those who had a vaccination in the 120 days prior to delivery.
Measurement Period:	January 2023, through March 2024. (Reporting period includes 90 days following last day of calendar year enrollment to allow for post-delivery follow up visits and claims).
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby

Prenatal Program Goal Outcome

- **Goal 1:** 75% of engaged members would have a Tdap vaccine within 120 days (4 months) of delivery
  - Goal met (rate = 75%)
  - Engaged members were more likely to get a Tdap vaccine.

Note: There was no statistically significant difference for this outcome measure when comparing the engaged white population with all the other ethnic groups.

Prenatal Program Engagement Results

Campaign Outcome	Members (% of Total)	Members who had TDAP vaccination in the 4 months before delivery (% of outcome)
Engaged	251(32%)	188(75%)
Declined	92(12%)	56(61%)*
Left message	302(39%)	215(71%)
Unable to reach	129(17%)	86(67%)
Total	774	545
Not Referred	4652	3102(67%)*

* Indicates statistically significant result

Growing Together Postpartum Program

Growing Together Postpartum Program Criteria

Measure Description:	**Members who engaged in the Growing Together Postpartum Program will attend a postpartum visit in the 60 days following delivery**
Denominator:	**Partnership members who delivered a baby during the 2023 calendar year**
Numerator:	**Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery**
Measurement Period:	January 2023 through March 2024. (Reporting period includes 60 days following last day of calendar year enrollment to allow for post-delivery follow up visits).
Exclusion Criteria:	Members who were not identified as pregnant prior to delivery; members identified as pregnant, but had not delivered a baby during 2023; members assigned to Kaiser

Postpartum Program Goal Outcome

- **Goal 1:** 80% of moms engaged in the program will attend a postpartum visit within 60 days of delivery
  - Goal not met (Rate = 73%)
  - Engaged members were more likely to attend a postpartum visit.

Note: The white population had a statistically significantly lower rate of members with postpartum visits when compared to Hispanics

Postpartum Program Engagement Results

Campaign Outcome	Members (% of Total)	Members who attended a post-partum visit within 60 days of delivery (% of outcome)
Engaged	1285(26%)	942(73%)
Declined	599(12%)	406(68%)*
Left Message	1644(34%)	1112(68%)*
Unable to Reach	1379(28%)	919(67%)*
Total	4907	3379
Engaged in Prenatal	217(4%)	159(73%)
Not Referred	1262	749(59%)*

* Indicates statistically significant result

Growing Together Healthy Babies Program

Growing Together Healthy Babies Program Criteria: Vaccines

Measure Description:	**Of the members who were reached and engaged for at least 12 months in the Healthy Babies Growing Together Program, those who had at least 50% of the recommended vaccinations completed.** • **Age at enrollment 0 - 6 months – 9+ vaccines** • **Age at enrollment 7 - 12 months – 4+ vaccines**
Denominator:	Members enrolled with Partnership at less than 12 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
Numerator:	Of denominator, those who completed immunizations by age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2022 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members enrolled less than 12 total months and members identified as California Children's Services (CCS)

Growing Together Healthy Babies Program Criteria: WC Visits

Measure Description:	**The percentage of members who were reached in the first twelve months of life, and engaged in the Growing Together Healthy Babies campaign, and who were enrolled for at least 12 months and completed all or half of the recommended well child visits for their enrollment time period.**
Denominator:	Members enrolled with Partnership and who had been enrolled for at least 12 months as of report run date
Numerator:	Of denominator, those who had completed all well-care visits by age at enrollment. • Age at enrollment 0 - 6 months – all (5+ visits) or some (3+ visits) • Age at enrollment 7 - 12 months – all (4+ visits) or some (2+ visits)
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2023 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members who enrolled less than 12 months during the reporting period; members identified as California Children's Services (CCS)

Healthy Babies Goal Outcome

- **Goal 1:** 80% of members engaged in the program will be compliant with 50% or more of their vaccinations during the program period
  - Goal met (Rate = 86%)
  - Engaged members were more likely to get a vaccine.
- **Goal 2:**
  - **Goal 2.1:** 25% of engaged members would attend all the well-child visits
    - Goal not met (Rate = 17%).
    - Engaged members were more likely to attend WC visits.

Note: The white population had a statistically significant lower rate of completing vaccination and well-child visit rates compared to the Hispanics population.

Healthy Babies Engagement Results: Vaccines

Campaign Outcome	Members (% of Total)	2023 Members who completed vaccines (% of outcome)
Engaged	601(23%)	514(86%)
Declined	528(21%)	405(77%)*
Left Message	927(36%)	699(75%)*
Unable to Reach	516(20%)	357(69%)*
Total	2572	1975
Not Referred	7518	3989(53%)*

* Indicates statistically significant result

Healthy Babies Engagement Results: WC Visits

Campaign Outcome	Members (% of Total)	Members who completed all recommended visits (% of outcome)
Engaged	601(23%)	105(17%)
Declined	528(21%)	60(11%)*
Left Message	927(36%)	93(10%)*
Unable to Reach	516(20%)	43(8%)*
Total	2572	301
Not Referred	7518	744(10%)*

* Indicates statistically significant result

Growing Together Healthy Kids Program

Growing Together Healthy Kids Program Criteria

Measure Description:	**The percentage of members who were engaged in the Growing Together Healthy Kids campaign who were between 3-6 years old at the time of enrollment and completed the recommended well-child visits for that age range.**
Denominator:	Partnership members between ages 3 and 6 years during reporting period, and enrolled with Partnership for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with Partnership.
Numerator:	Of denominator, those who completed a well-child visit during the: • 180 days after call • 90 days after call • The calendar year (January 2023-December 2024)
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2023 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members enrolled less than 12 total months and members identified as California Children's Services (CCS)

Healthy Kids Goal Outcome

- **Goal 1:** 70% of engaged members will have a well-child visit by the end of the calendar year
  - Goal not met (Rate = 68%).
  - Engaged members were more likely to attend a WC visit.

Note: The engaged white population had a statistically significantly lower rate for completing a well-child visit during the calendar year compared to the Hispanics population.

Healthy Kids Engagement Results

Campaign Outcome	Members (% of Total)	Members who completed a well-child visits during the calendar year (% of outcome)
Engaged	1952(23%)	1319(68%)
Declined	523(6%)	200(38%)*
Left Message	3363(40%)	1645(49%)*
Unable to Reach	2478(30%)	1020(41%)*
Total	8316	4184
Not referred	27213	16,720(61%)

Transitions of Care

Transitions of Care Program Criteria

Adult members (age > 20) **and**:

- Discharging home from acute care after hospital length of stay longer than four days, or
- Discharging home from an out-of-county hospital with any length of stay, or
- Having more than one admission in 10 days
- Excludes members in Long Term Care or in a Long Term Care Psychiatric facility

Pediatric members (under age 21) **and**

- Discharging home from an acute care hospital stay with an admission date > 60 days from his/her date of birth and having any length of stay.

Transitions of Care: Member Experience Results

- **Goal 1:** 75% of members surveyed agree with each statement of the Adult TOC Satisfaction Survey.
  - Goal was met
  - Average score ranged from 2.86 to 2.98, exceeding the goal average of 2.5
- **Goal 2:** 75% of members surveyed agree with each statement of the Pediatric TOC Satisfaction Survey.
  - Goal was met
  - Average score ranged from 2.85 to 2.98, exceeding the goal average of 2.5.

TOC Member Experience Results

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.86	Yes
My health has improved since working with my case management team.	2.94	Yes
I was able to safely transition between Providers with the help of my Care Team	2.64	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.87	Yes
I was provided the available equipment, medication and/or services that were needed.	2.92	Yes

Complex Case Management

Complex Case Management Program Criteria

- Provides support for members who have:
  - Multiple chronic conditions,
  - Social determinants of health barriers and/or
  - Difficulty navigating the healthcare system.

Complex Case Management: Member Experience Results

- **Goal 1:** 75% of members surveyed agree with each statement of the Adult CCM Satisfaction Survey.
  - Goal was met
  - Average score ranged from 2.8 to 3.00, which is above the goal average of 2.5.
- **Goal 2:** 75% of members surveyed agree with each statement of the Pediatric CCM Satisfaction Survey.
  - Goal was met
  - Average score ranged from 2.83 to 3.00, well above the goal average of 2.5.

CCM Member Experience Results

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my child's health care needs is better	2.96	Yes
My child's health has improved since working with our case management team	2.91	Yes
I was able to safely transition my child between providers with the help of my care team.	2.94	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.85	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.98	Yes

Summary of Findings

- Vaccination rate goals for healthy moms and babies were met
- Neither postpartum visit goals were met.
- Mixed results for well-child visit goals
  - all recommended visits = not met
  - attendance at some of the recommended visits = met
- Member experience goals for CCM and TOC were met.
- Hispanic members faired better than other races/ethnicities for
  - attendance at postpartum visits under the postpartum program
  - all well-child vaccinations in the first years of life
  - attendance at well-child visits in the first years of life, and
  - attendance at well child visits from ages 3-6 years old

Population Health Management 2023 Program Impact Analysis

June 2024

Production Date: June 13, 2024

Table of Contents

I. Objective

The purpose of this report is to evaluate the Population Health Management (PHM) interventions performed during 2023 through clinical, utilization, and member experience measures in accordance with the PHM efforts of the year.

II. Methodology

Partnership's Health Analytics team provided performance data related to clinical and utilization measures for individuals engaged in Population Health outreach campaigns. In addition, Partnership staff invited members to complete post-intervention satisfaction surveys for selected campaigns. Partnership uses the following data sources to evaluate the PHM programs:

Data Type	Data Source
Member Demographics from Partnership Data warehouse	Member Demographics from Partnership Data warehouse
Encounters from Partnership Claims System	Encounters from Partnership Claims System
Immunization Data	California Immunization Registry (CAIR)
DHCS Medical and Pharmacy Claims	DHCS Claims Data
Member Experience Survey Results	Partnership Case Management System (Essette)
Member Delivery Report	Partnership Utilization Management System Hospital ADT Data Authorization data
Case Management	Partnership Case Management System (Essette)

A. Statistical Significance

The statistical significance of association between contact outcome and the various measures were calculated using either the chi-square test for association when all expected cell frequencies were > 5 or the Fisher's exact test when any one of the expected cell frequencies were < 5. The association is found to be significant when the p-value is < 0.05.

The statistical significance of association in contact outcome, and the various measures were calculated using either the chi-square test for association when all expected cell frequencies were > 5 or the Fisher's exact test when any one of the expected cell frequencies were < 5. The association is found to be significant when the p-value is < 0.05. Race disparities are identified by comparing the white population with other ethnic groups.

III. Definitions and Explanations

A. Clinical Measures

Vaccinations are the primary intervention that keep individuals healthy and prevent them from disease and even death. There are multiple times in an individual's life where vaccinations are offered, including during pregnancy (to protect a newborn), during the first six years of life, and again in adolescence. The PHM Program clinical measures evaluated this year focused on campaigns that promoted vaccinations, specifically:

- Growing Together Prenatal Program
- Healthy Babies Growing Together

B. Utilization Measures

In alignment with California's Department of Health Care Services (DHCS) Bold Goals 2025, Partnership focused outreach campaigns on improving well-care visits for pregnant members and for children through adolescence. Early well-child visits allow providers to educate parents about their child's developmental milestones, and to teach parents how to build healthy habits with their children. Early visits also give providers the opportunity for early intervention when a child has developmental delays. Well care visits also establish a strong relationship between parents and providers that serves the child well in case of illness or injury. The programs that reinforce well-care visits in the PHM Work Plan include:

- Growing Together Prenatal Program
- Growing Together Postpartum Program
- Healthy Babies Growing Together
- Healthy Kids Growing Together

C. Member Experience/Satisfaction Measures

At the close of each campaign or service, a Partnership Coordinator contacts the members by phone to complete a Likert-scale member experience survey. Scores assigned are Agree (3 points) Neutral (2 points) Disagree (1) or No Response. In addition to weighted responses, members have an opportunity to provide comments. Partnership tallies and reviews these responses no less than annually to ensure the interventions are meeting member needs. For each satisfaction measure, the goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response.

The programs that emphasize and track member satisfaction in the PHM Work Plan include:

- Transitions of Care Services for Adult and Pediatric Members

- Complex Case Management for Adult and Pediatric Members

D. Reporting Categories

Partnership staff reached out to any member who met qualifying criteria (as defined below for each individual measure), and those who were successfully reached were given the opportunity to opt in or out of the campaign. Outcomes reflect the member's level of engagement with the campaign as follows:

- Engaged – members who qualified for the program, reached by phone, and opted in to program participation
- Declined – members who qualified for the program, reached by phone, and opted against program participation
- Left Message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior
- Unable to Reach – members who qualified for the program but were not able to be reached via phone
- Not Referred – members who qualified for the program retrospectively, but were not identified prospectively for campaign inclusion
- Completion - indicates that staff has completed all of the attempted outreach and the member is not being worked on by any staff member

IV. Growing Together Prenatal Program

Partnership offers a Growing Together Prenatal outreach campaign through which members known to be pregnant are enrolled for program outreach. PHM staff contact these members and offer engagement in a campaign that supports prenatal care, reinforces the importance of TDap vaccinations during pregnancy, and reminds them of the importance of post-partum care, along with well-child visits and vaccinations in the first months following delivery. (Note: while flu vaccinations are also recommended for pregnant members at certain seasons of the year, they are not included in this program analysis). There are incentives provided for members who reach program milestones, both before and after delivery.

A. Clinical Measure

1. Tdap Vaccination during third trimester

The goal for this intervention is that 75% of members engaged in the program during 2023 would have a higher percentage of Tdap vaccinations within 120 days (four months) prior to delivery compared to those who did not engage or who declined to participate in the program.

Methodology

Measure Description:	Members who engaged in the Growing Together Prenatal Program would have a greater rate of TDap vaccination during their third trimester than those not engaged or declined engagement.
Denominator:	Partnership members who had at least one prenatal care visit in the 12 months prior to report run date and who delivered a baby at least 90 days prior to report run date
Numerator:	Of the denominator, those who had a vaccination in the 120 days prior to delivery.
Measurement Period:	January 2023, through March 2024. (Reporting period includes 90 days following last day of calendar year enrollment to allow for post-delivery follow up visits and claims).
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby

Results

Campaign Outcome	*Members (% of Total)*	*Members who had Tdap vaccination in the 4 months before delivery (% of outcome)*
Engaged	251(32%)	188(75%)
Declined	92(12%)	56(61%)*
Left Message	302(39%)	215(71%)
Unable to Reach	129(17%)	86(67%)
Total	**774**	**545**
Not Referred	4652	3102(67%)*

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	6.4550	0.0111	Yes*
Engaged Vs Left Message	Chi-Square	0.9536	0.3288	No
Engaged Vs Unable to Reach	Chi-Square	2.8720	0.0901	No
Engaged Vs Not Referred	Chi-Square	7.2883	0.0069	Yes*

* Indicates statistically significant result

The goal for this intervention was for 75% of members engaged in the program in 2023 to have a higher percentage of Tdap vaccinations within 120 days (four months) prior to delivery. The goal was met (Rate = 75%). Engaged members had a statistically significantly higher rate of completing Tdap vaccination 4 months before delivery (Rate = 75%) compared to members who declined (Rate = 61%, Chi-square = 6.4550, p =0.0111) and members who were not referred (Rate =67%, Chi-square = 7.28, p =0.0069).

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Members with Tdap				
			N(%)	Test	Statistic	P-value	Sig
WHITE	215	64(30%)	47(73%)				
AMERICAN INDIAN	12	4(33%)	3(75%)	Fishers Exact	0.4332	1.0000	No
ASIAN	31	9(29%)	7(78%)	Fishers Exact	0.3119	1.0000	No
BLACK	31	12(39%)	7(58%)	Fishers Exact	0.1503	0.3125	No
HISPANIC	322	105(33%)	84(80%)	Chi-Square	0.9825	0.3216	No
UNKNOWN/ OTHER	159	57(36%)	40(70%)	Chi-Square	0.1588	0.6903	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	0(0%)	0(.%)	Chi-Square	1.8682	0.1717	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of Tdap vaccination completion 4 months before delivery between the engaged white population (Rate = 73%) and all the other ethnic groups. The results for other groups are displayed in the table above. This data shows our current campaign may not be making a measurable difference in the lives of our non-white populations. Further analysis may be warranted due to the small sample size for some groups.

B. Utilization Measures

1. Post-Partum Visits

The goal for this intervention is that 80% of moms engaged in the program will attend a post-partum visit within 60 days of delivery.

Methodology

Measure Description:	Members who engaged in the Growing Together Prenatal program will attend a post-partum visit in the 60 days following delivery
Denominator:	Partnership members who had at least one prenatal care visit in the 12 months prior to report run date and who delivered a baby at least 90 days prior to report run date
Numerator:	Of the denominator, those who attended a post-partum visit in the 60 days following delivery.
Measurement Period:	January 2023 through March 2024. (Reporting period includes 90 days following last day of calendar year enrollment to allow for post-delivery follow up visits and claims).
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby

Results

Campaign Outcome	*Members (% of Total)*	*Members who attended a post-partum visit within 60 days of delivery (% of outcome)*
Engaged	251(32%)	194(77%)
Declined	92(12%)	62(67%)
Left Message	302(39%)	214(71%)
Unable to Reach	129(17%)	94(73%)
Total	**774**	**564**
Not Referred	4652	3405(73%)

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	3.4852	0.0619	No
Engaged Vs Left Message	Chi-Square	2.9295	0.0870	No
Engaged Vs Unable to Reach	Chi-Square	0.9083	0.3406	No
Engaged Vs Not Referred	Chi-Square	2.0471	0.1525	No

* Indicates statistically significant result

The Growing Together Prenatal Program did not met the goal of 80% attendance at post-partum visits (Rate = 77%). While the engaged members had the best outcomes, there was no statistically significant difference in the rate of post-partum visit attendance within 60 days of delivery between the engaged members and all the other campaign outcomes.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members with postpartum visits*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	215	64(30%)	48(75%)				
AMERICAN INDIAN	12	4(33%)	4(100%)	Fishers Exact	0.3324	0.5658	No
ASIAN	31	9(29%)	8(89%)	Fishers Exact	0.2487	0.6751	No
BLACK	31	12(39%)	8(67%)	Fishers Exact	0.2219	0.7216	No
HISPANIC	322	105(33%)	85(81%)	Chi-Square	0.8404	0.3593	No
UNKNOWN/ OTHER	159	57(36%)	41(72%)	Chi-Square	0.1461	0.7023	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	0(0%)	0(.%)	Chi-Square	1.8682	0.1717	No

* Indicates statistically significant result

There was no statistically significant difference in the rate of attending a post-partum visit within 60 days of delivery between the engaged white population (Rate = 75%) and all the other ethnic groups. Results for other groups are as follows:

- American Indians (Rate = 100%, Fishers Exact = 0.3324, p = 0.5658);
- Asian (Rate = 89%, Fishers Exact = 0.2487, p = 0.6751);
- Black (Rate = 67%, Fishers Exact = 0.2219, p = 0.7216);
- Hispanics (Rate = 81%, Chi-Square = 0.8404, p = 0.3593);
- Unknown/other population (Rate = 72%, Chi-Square = 0.1461, p = 0.7023); and
- Native Hawaiian or Other Pacific Islander (Rate = 0%, Chi-Square = 1.8682, p = 0.1717).

This data shows our current campaign may not be making any measurable difference in the lives of our non-white population. Further analysis may be warranted due to the small sample size for some groups.

2. Linked Newborns Well-Child Visits

A secondary goal of this intervention is that 80% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth.

Methodology

Measure Description:	Newborns linked to members who engaged in the Growing Together Prenatal program will attend a well-baby visit in the 60 days following birth
Denominator:	Partnership members who had at least one prenatal care visit in the 12 months prior to report run date and who delivered a baby at least 90 days prior to report run date and baby is linked to birth mom
Numerator:	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth
Measurement Period:	January 2023 through March 2024. (Reporting period includes 90 days following last day of calendar year enrollment to allow for post-delivery follow up visits and claims).
Exclusion Criteria:	Individuals who were not Partnership members when they delivered a baby

Results

Campaign Outcome	*Members (% of Total)*	*Members who were linked to a Newborn (% of Outcome)*	*Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)*
Engaged	251(32%)	231(92%)	159(69%)
Declined	92(12%)	80(87%)	54(68%)
Left Message	302(39%)	289(96%)	201(70%)
Unable to Reach	129(17%)	116(90%)	81(70%)
Total	**774**	**716**	**495**
Not Referred	4652	4325	3050(71%)

Analysis of Newborns who attended a well-child visit within 60 day of birth

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	0.0488	0.8252	No
Engaged Vs Left Message	Chi-Square	0.0312	0.8599	No
Engaged Vs Unable to Reach	Chi-Square	0.0359	0.8496	No
Engaged Vs Not Referred	Chi-Square	0.2946	0.5873	No

The program goal that 80% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth was not met (Rate = 69%). In addition, there was no statistically significant difference in the rate of newborns attending a well-child visit within 60 days of birth between the engaged members and all the other campaign outcomes.

Engaged members had no statistically significantly difference between the rate of newborns who attended a well-child visit within 60 days of birth when compared to members who declined (Rate =68%, Chi-Square = 0.0488, p= 0.8252) and members who were unable to be reached (Rate =70%, Chi-Square = 0.0359, p = 0.8496).

Analysis by Race and Ethnicity

	Members in		*Newborns with well-child visits*				
Ethnicity Group	*Campaign*	*Engaged*	*N (%)*	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	215	64(30%)	44(69%)				
AMERICAN INDIAN	12	4(33%)	2(50%)	Fishers Exact	0.2082	0.2510	No
ASIAN	31	9(29%)	4(44%)	Fishers Exact	0.0450	0.0547	No
BLACK	31	12(39%)	9(75%)	Fishers Exact	0.2815	1.0000	No
HISPANIC	322	105(33%)	66(63%)	Chi-Square	1.2617	0.2613	No
UNKNOWN/ OTHER	159	57(36%)	34(60%)	Chi-Square	2.2646	0.1324	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	4	0(0%)	0(.%)	Chi-Square	1.8682	0.1717	No

There was no statistically significant difference in the rate of newborns attending a well-child visit within 60 days of birth between the engaged white population (Rate = 69%) and all the other ethnic groups. Results for other groups are as follows:

- American Indian (Rate = 50%, Fishers Exact = 0.2082, p = 0.2510);
- Asian (Rate = 44%); Fishers Exact = 0.0450, p = 0.0547);
- Black (Rate = 75%, Fishers Exact = 0.2815, p = 1.0000);
- Hispanic (Rate = 63%), Chi-Square = 1.2617, p = 0.2613);
- Unknown/Other (Rate = 60%, Chi-Square = 2.2646, p = 0.1324);
- Native Hawaiian or Other Pacific Islander (Rate = 0%, Chi-Square = 1.8682, p = 0.1717)

This data shows our current campaign may not be making any measurable difference in the lives of our non-white population. Further analysis may be warranted due to the small sample size for some groups.

Year-Over-Year Analysis of the Prenatal Program

In 2023, the PHM team continued to identify an opportunity to increase the numbers of members offered enrollment in the prenatal program along with the percentage of members reached. A year over year analysis shows the following:

Campaign Outcome	*2023 Members (% of Total)*	*2023 Post-Partum Visits (% of outcome)*	*2022 Members (% of Total)*	*2022 Post-Partum Visits (% of outcome)*
Engaged	251(32%)	194(77%)	380 (36%)	283 (74%)
Declined	92(12%)	62(67%)	94 (9%)	69 (73%)
Left Message	302(39%)	214(71%)	364 (34%)	271 (74%)
Unable to Reach	129(17%)	94(73%)	223 (21%)	177 (79%)
Total	**774**	**564**	**1061**	**800**
Not Referred	4652	3405(73%)	4345	3140 (72%)

During 2023, Partnership sought additional means to engage more pregnant members in the Growing Together Prenatal Program. As a result, we refined our prenatal member identification algorithm. However, between 2022 and 2023, there was a decrease of members identified, from 1061 in 2022 to 774 in 2023. We anticipate increased identification of pregnant members in 2024.

In addition, we made improvements to the scripts and did further training to attempt to improve member-engagement skills in order to increase our overall percentage of members engaged in the program. While the overall percentage of members engaged actually

decreased between 2022 (36%) to 2023 (32%), the number of those who were categorized as unable to reach was 21% in 2022 but dropped to 17% in 2023, meaning that we were able to reach more people.

C. Opportunities

Partnership recognizes the importance of prenatal care to promote the health of the mother and to establish an important foundation for wellness behaviors for the mother and the baby. Because this program is the basis for other post-partum and well-baby interventions, Partnership will continue this intervention and continue to evaluate results of program engagement. However, given the dropping scores, there are opportunities to improve the impact of this program.

1. Improving postpartum visits and linked newborns

While the goal that a higher percentage of members engaged in the program would have a higher percentage of Tdap vaccinations within 120 days of delivery was met, Partnership did not meet its other goals for this program. The goal of having a higher percentage of members attend a post-partum visit within 60 days of delivery was not met. Partnership also did not meet the goal of increasing the percentage of attendance at well-child visits within 60 days of birth among newborns linked to members engaged in the program. Furthermore, there is no statistically significant variance by race to indicate that a certain race/ethnic group among Partnership's membership was more likely to vaccinate prior to delivery, attend postpartum visits 60 days after delivery, or attend well-child visits within 60 days of birth, when compared to other races/ethnicities.

Significant barriers to reaching this goal based on qualitative feedback from Partnership members are primarily concerns of long appointment wait times, and limited provider choices. Other barriers include certain eligibility requirements and logistical challenges in which a newborn's enrollment into Medi-Cal can be delayed. The prenatal program engagement rates for postpartum visits has decreased from 283 (74%) in 2022 to 194 (77%) in 2023. The prenatal program engagement for newborns linked to care has also decreased from 272 (78%) in 2022 to 159(69%) in 2023. Current efforts to improve program engagement rates for both programs includes assisting members with booking an appointment by directly calling the provider. They are also offered the option to switch to a new provider. If participants are still struggling to book an appointment, they are offered the option to file a grievance with Partnership's grievance department. The decline in results may be due in part to ineffective program efforts.

To help address logistical challenges program participants face, the Population Health Team has identified an opportunity to conduct additional outreach to parents of newborns. The goal

of this additional outreach is to ensure their child is signed up for Medi-Cal in order to improve the rate of well-child visits among newborns linked to members. There is also an opportunity to improve the percentage of members who attend a post-partum visit within 60 days of delivery by making providers, members, and internal staff more aware of our programs. Efforts include circulating program flyers to community partners and providers to raise programmatic awareness. Furthermore, the Population Health department is exploring opportunities to extend provider clinic hours and offer Partnership member-specific time blocks dedicated to well child and postpartum visits. While the goal for Tdap vaccine rates was met, members have expressed negative attitudes towards vaccines. Therefore there is an opportunity for Population Health staff to provide additional education to members on the importance of immunizations during the call campaigns. The results of these efforts will be reviewed in 2025.

On a systems level, Partnership has tried, and will continue to work on improving some of these barriers through ongoing efforts to expand our provider network in hopes of improving engagement rates. Provider network expansion efforts include offering the Provider Retention Initiative Pilot and Provider Recruitment program. These programs help our contracted network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

2. Identifying and referring high-risk pregnant members

As of 2023, Partnership will assign a high risk level to pregnant members based on new program efforts referred to as Transitions of Care (TOC) services. As a result, there is an opportunity to refer high-risk pregnant members to additional resources, such as referrals to Care Coordination or assignment to a Community Health Worker or a doula, in order to provide closer connection with these members during their pregnancy and post-partum period. These interventions serve as an opportunity to improve the percentage of members who attend a post-partum visit within 60 days of delivery.

V. Growing Together Post-Partum Program

In addition to Partnership's Growing Together Prenatal outreach campaign, Population Health offers a campaign for members after delivery to encourage them to attend post-partum care visits as well as start bringing their child to well-baby visits.

A. Utilization Measures

1. Post-Partum Visits

The goal for this measure is that 80% of moms engaged in the program will attend a post-partum visit within 60 days of delivery.

Methodology

Measure Description:	Members who engaged in the Growing Together Post-Partum Program will attend a post-partum visit in the 60 days following delivery
Denominator:	Partnership members who delivered a baby during the 2023 calendar year
Numerator:	Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery
Measurement Period:	January 2023 through March 2024. (Reporting period includes 60 days following last day of calendar year enrollment to allow for post-delivery follow up visits).
Exclusion Criteria:	Members who were not identified as pregnant prior to delivery; members identified as pregnant, but had not delivered a baby during 2023; members assigned to Kaiser

Results

Campaign Outcome	*Members (% of Total)*	*Members who attended a post-partum visit within 60 days of delivery (% of outcome)*
Engaged	1285(26%)	942(73%)
Declined	599(12%)	406(68%)*
Left Message	1644(34%)	1112(68%)*
Unable to Reach	1379(28%)	919(67%)*
Total	**4907**	**3379**
Engaged in Prenatal	217(4%)	159(73%)
Not Referred	1262	749(59%)*

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	6.1327	0.0133	Yes*
Engaged Vs Left Message	Chi-Square	11.0585	0.0009	Yes*
Engaged Vs Unable to Reach	Chi-Square	14.0322	0.0002	Yes*
Engaged Vs Not Engaged in Prenatal	Chi-Square	0.0639	0.8004	No
Engaged Vs Not Referred	Chi-Square	55.5863	<.0001	Yes*

* Indicates statistically significant result

This intervention did not meet the goal that 80% of moms engaged in the program will attend a post-partum visit within 60 days of delivery (Rate = 73%). Engaged members had a statistically significantly higher rate of attending a postpartum visit within 60 days of delivery (Rate = 73%) when compared to the following outcomes:

- Declined members (Rate =68%, Chi-square = 6.13, p =0.0133),
- Members who were left message (Rate =68%, Chi-square = 11.06, p =0.0009),

- Members who were unable to reach (Rate =67%, Chi-square = 14.03, p =0.0002) and
- Not referred members (Rate =59%, Chi-square = 55.59, p <.0001

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members with postpartum visits*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	1579	316 (20%)	215(68%)	N/A			
AMERICAN INDIAN	164	14 (9%)	11(79%)	Fishers Exact	0.1777	0.5610	No
ASIAN	159	42 (26%)	27(64%)	Chi-Square	0.2383	0.6254	No
BLACK	175	56 (32%)	36(64%)	Chi-Square	0.3052	0.5807	No
HISPANIC	2050	625 (30%)	484(77%)	Chi-Square	9.7120	0.0018	Yes*
UNKNOWN/OTHER	768	228 (30%)	166(73%)	Chi-Square	1.4354	0.2309	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	12	4 (33%)	3(75%)	Fishers Exact	0.4051	1.0000	No

* Indicates statistically significant result

The white population had a statistically significantly lower rate of members with postpartum visits (Rate = 68%) when compared to Hispanics (Rate = 77%, Chi-Square = 9.71, p =0.0018). Other race/ethnicities with lower postpartum visit rates include Asians (64%), and Black (64%).

2. Linked Newborn Well-Child Visits

A secondary goal for this intervention is that 85% of newborns linked to members engaged in the program will attend a well-child visit within 60 days of birth.

Methodology

Measure Description:	Babies born to members who engaged in the Growing Together Post-Partum program will attend a well-child visit in the 60 days following birth
Denominator:	Partnership members who delivered a baby during the 2023 calendar year and baby is linked to birth mom.
Numerator:	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth.
Measurement Period:	January 2023 through March 2024. (Reporting period includes 60 days following last day of calendar year enrollment to allow for post-delivery follow up visits).
Exclusion Criteria:	Members who were not identified as pregnant prior to delivery; members identified as pregnant, but had not delivered a baby during 2023; members assigned to Kaiser

Results

Campaign Outcome	*Members (% of Total)*	*Members who were linked to a New Born (% of Outcome)*	*Newborns who attended a well-child visit within 60 days of birth (% of linked Newborns)*
Engaged	1285(26%)	1201(93%)	815(68%)
Declined	599(12%)	548(91%)	387(71%)
Left Message	1644(34%)	1510(92%)	1056(70%)
Unable to Reach	1379(28%)	1274(92%)	881(69%)
Total	4907	4533	3139
Engaged in Prenatal	217(4%)	199(92%)	135(68%)
Not Referred	1262	1075	685(64%)*

* Indicates statistically significant result

Analysis of newborns who attended a well-child visit within 60 days of birth

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	1.3340	0.2481	No
Engaged Vs Left Message	Chi-Square	1.3452	0.2461	No
Engaged Vs Unable to Reach	Chi-Square	0.4786	0.4891	No
Engaged Vs Not Engaged in Prenatal	Chi-Square	1.7171	0.1901	No
Engaged Vs Not Referred	Chi-Square	4.3251	0.0376	Yes*

* Indicates statistically significant result

The percentage of newborns attending a well-child visit did not meet the goal of 85% (Rate = 68%). Engaged members had a statistically significantly higher rate of newborns attending a well-child visit within 60 days of delivery (Rate = 68%) when compared to not referred members (Rate =64%, Chi-square = 4.32, p =0.0376). This program will continue in 2024 with modifications.

Analysis by Race and Ethnicity

Ethnicity Group	Members in Campaign	Engaged	Newborns with well-child visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	1579	316(20%)	200(63%)				
AMERICAN INDIAN	164	14(9%)	5(36%)	Fishers Exact	0.0123	0.0185	Yes*
ASIAN	159	42(26%)	29(69%)	Chi-Square	0.6427	0.4227	No
BLACK	175	56(32%)	39(70%)	Chi-Square	0.6470	0.4212	No
HISPANIC	2050	625(30%)	398(64%)	Chi-Square	0.0052	0.9425	No
UNKNOWN/ OTHER	768	228(30%)	140(61%)	Chi-Square	0.3802	0.5375	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	12	4(33%)	4(100%)	Fishers Exact	0.2176	0.3120	No

* Indicates statistically significant result

The engaged white population had a statistically significantly higher rate of newborns with well child visits (Rate = 63%) when compared to American Indians (Rate = 36%, Fishers= 0.0123, p =0.0185)

B. Opportunities

Partnership recognizes the importance of postpartum care to promote the health of the mother and to establish an important foundation for wellness behaviors for the mother and the baby. Because this program is the basis for other well-baby and well-child interventions, Partnership will continue this intervention and will evaluate results of program engagement. However, there are opportunities to improve the impact of this program.

1. Improving Postpartum and Well Child Visit Rates

This program's outcome measures for increasing postpartum visit attendance and increasing the number of well child visits among newborns linked to engaged members showed statistical significance in the results compared to non-engaged members. However, Partnership did not meet the goal that 80% of moms engaged in the program will attend a post-partum visit within 60 days of delivery. Partnership also did not meet the goal that 85% of newborns will be linked to well child visits.

Significant barriers to reaching this goal based on qualitative feedback from Partnership members are primarily concerns of long appointment wait times, and limited provider choices. Other barriers include certain eligibility requirements and logistical challenges in which a newborn's enrollment into Medi-Cal can be delayed. The postpartum program engagement rates for postpartum visits has increased from 729 (74%) in 2022 to 942 (73%) in 2023. The postpartum program engagement rates for newborns linked to care has also increased from

728 (80%) in 2022 to 815(68%) in 2023. Current efforts to improve program engagement rates for both programs include helping participants book an appointment by directly calling the provider. They are also offered the option to switch to a new provider. If participants are still struggling to book an appointment, they are offered the option to file a grievance with Partnership's grievance department.

To help address logistical challenges program participants face, the Population Health Team has identified an opportunity to conduct additional outreach to parents of newborns. The goal of this additional outreach is to ensure their child is signed up for Medi-Cal in order to improve the rate of well-child visits among newborns linked to members. There is also an opportunity to improve the percentage of members who attend a post-partum visit within 60 days of delivery by making providers, members, and internal staff more aware of our programs. Efforts include circulating program flyers to community partners and providers to raise programmatic awareness. Furthermore, the Population Health department is exploring opportunities to extend provider clinic hours and offer Partnership member-specific time blocks dedicated to well child and postpartum visits. The results of these efforts will be reviewed in 2025.

On a systems level, Partnership has tried, and will continue to work on improving some of these barriers through ongoing efforts to expand our provider network in hopes of improving engagement rates. Provider network expansion efforts include offering the Provider Retention Initiative Pilot and Provider Recruitment program. These programs help our contracted network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

VI. Healthy Babies Growing Together Program

Population Health enrolls infants under 12 months of age in the Healthy Babies Growing Together Program the month they become Partnership members. The program includes education and reinforcement of well-child visits and the importance of timely vaccinations to build the child's lifetime of immunity; there are also incentives for completing well-care visits with immunizations throughout the program.

A. Clinical Measure

1. Well Child Vaccinations

Of the members who agreed to participate in the program, 80% of members engaged in the program would be compliant with 50% or more of their vaccinations during the program period.

Methodology

Measure Description:	Of the members who were reached and engaged for at least 12 months in the Healthy Babies Growing Together Program, those who had at least 50% of the recommended vaccinations completed. • Age at enrollment 0 - 6 months – 9+ vaccines • Age at enrollment 7 - 12 months – 4+ vaccines
Denominator:	Members enrolled with Partnership at less than 12 months of age and who were enrolled with Partnership for at least 12 months as of report run date.
Numerator:	Of denominator, those who completed immunizations by age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2022 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members enrolled less than 12 total months and members identified as California Children's Services (CCS)

Results

Members who completed vaccines by age at campaign enrollment and year over year comparison.

Campaign Outcome	*Members (% of Total)*	***2023** Members who completed vaccines (% of outcome)*	***2022** Members who completed vaccines (% of outcome)*
Engaged	601(23%)	514(86%)	283 (85%)
Declined	528(21%)	405(77%)*	234 (75%)*
Left Message	927(36%)	699(75%)*	561 (80%)*
Unable to Reach	516(20%)	357(69%)*	404 (79%)*
Total	**2572**	**1975**	**1482**
Not Referred	7518	3989(53%)*	3137 (80%)*

* Indicates statistically significant result

Analysis

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	14.4399	0.0001	Yes*
Engaged Vs Left Message	Chi-Square	22.8156	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	43.1545	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	237.4513	<.0001	Yes*

* Indicates statistically significant result

The goal for 80% of members engaged in the program to be compliant with 50% or more of their vaccinations during the program period was met (Rate = 86%). Engaged members had

a statistically significantly higher rate of completing 9+ or 4+ vaccines (Rate =86%) compared to the following outcomes:

- Declined members (Rate =77%, Chi-square = 14.439, p =0.0001),
- Members who were left message (Rate =75%, Chi-square = 22.816, p <0.0001),
- Members who were unable to reach (Rate = 69%, Chi-square = 43.154, p <0.0001) and
- Members who were not referred (Rate = 53%, Chi-square = 237.451, p <0.0001)

In addition, significantly more members completed vaccines in 2023 than in 2022 (514 compared to 283, respectively). This may be due in part to the fact that many organizations offered vaccination clinics to facilitate ready access to timely vaccines. Rates may also have improved due to the end of the COVID-19 public health emergency in 2023.

Analysis by Race and Ethnicity

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members completing recommended vaccinations*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	357	59(17%)	45(76%)				
AMERICAN INDIAN	24	2(8%)	2(100%)	Fishers Exact	0.5907	1.0000	No
ASIAN	54	15(28%)	12(80%)	Fishers Exact	0.2637	1.0000	No
BLACK	87	23(26%)	18(78%)	Chi-Square	0.0368	0.8479	No
HISPANIC	854	245(29%)	218(89%)*	Chi-Square	6.5816	0.0103	Yes*
UNKNOWN/ OTHER	1193	257(22%)	219(85%)	Chi-Square	2.7913	0.0948	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	3	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing 9+ or 4+ vaccines (Rate =76%) when compared to Hispanics (Rate =89%, Chi-square = 6.582, p =0.0103)

B. Utilization Measure

1. Well Child Visits

This program also had a secondary and tertiary goal. The secondary goal is that of the members who agreed to participate in the Healthy Babies Growing Together Program, 25% of members will be compliant with all recommended well-child visits (5+ visits for members enrolled between ages 0 – 6 months and 4+ visits for members enrolled between 7 – 12 months). The tertiary goal is that 65% of members engaged in the program will be compliant

with at least half of the recommended well-child visits (3+ visits for members enrolled between 0 – 6 months of age and 2+ visits for members enrolled between 7 – 12 months of age).

Methodology

Measure Description:	The percentage of members who were reached in the first twelve months of life, and engaged in the Growing Together Healthy Babies campaign, and who were enrolled for at least 12 months and completed all or half of the recommended well child visits for their enrollment time period.
Denominator:	Members enrolled with Partnership and who had been enrolled for at least 12 months as of report run date
Numerator:	Of denominator, those who had completed all well-care visits by age at enrollment. • Age at enrollment 0 - 6 months – all (5+ visits) or some (3+ visits) • Age at enrollment 7 - 12 months – all (4+ visits) or some (2+ visits)
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2023 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members who enrolled less than 12 months during the reporting period; members identified as California Children's Services (CCS);

Results

Members who completed all or some well-child visits by age at campaign enrollment.

Campaign Outcome	*Members (% of Total)*	*Members who completed **all** recommended visits (% of outcome)*	*Members who completed **some** of the recommended visits (% of outcome)*
Engaged	601(23%)	105(17%)	396(66%)
Declined	528(21%)	60(11%)*	286(54%)*
Left Message	927(36%)	93(10%)*	475(51%)*
Unable to Reach	516(20%)	43(8%)*	249(48%)*
Total	**2572**	**301**	**1406**
Not Referred	7518	744(10%)*	3090(41%)*

* Indicates statistically significant result

Analysis

Members who completed all the recommended well-child visits by age at campaign enrollment

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	8.4010	0.0038	Yes
Engaged Vs Left Message	Chi-Square	17.8868	<.0001	Yes
Engaged Vs Unable to Reach	Chi-Square	20.1675	<.0001	Yes
Engaged Vs Not Referred	Chi-Square	34.1005	<.0001	Yes

***** Indicates statistically significant result

These results indicate that the goal of 25% of engaged members would attend all the well-child visits was not met (Rate = 17%). Engaged members had a statistically significantly higher rate of completing 5+ or 4+ WC visits (Rate =17%) compared to the following outcomes:

- declined members (Rate = 11%, Chi-square = 8.401, p =0.0038),
- members who were left message (Rate = 10%, Chi-square = 17.887, p <0.0001),
- members who were unable to reach (Rate = 8%, Chi-square = 20.168, p <0.0001) and
- members who were not referred (Rate = 10%, Chi-square = 34.1, p <0.0001)

Members who completed some of the recommended well-child visits by age at campaign enrollment

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	16.1520	<.0001	Yes
Engaged Vs Left Message	Chi-Square	31.9262	<.0001	Yes
Engaged Vs Unable to Reach	Chi-Square	35.3831	<.0001	Yes
Engaged Vs Not Referred	Chi-Square	139.5731	<.0001	Yes

These results indicate that the goal of 65% of members engaged in the program will be compliant with at least half of the recommended well-child visits was met (Rate = 66%). Engaged members had a statistically significantly higher rate of completing 3+ or 2+ WC visits (Rate =66%) compared to the following outcomes:

- Declined members (Rate = 54%, Chi-square = 16.152, p <0.0001),
- Members who were left message (Rate =51%, Chi-square = 31.93, p <0.0001),
- Members who were unable to reach (Rate = 48%, Chi-square = 35.38 p <0.0001) and
- Members who were not referred (Rate = 41%, Chi-square = 139.57, p <0.0001)

Analysis by Race and Ethnicity
Members attending all recommended well-child visits

Ethnicity Group	Members in Campaign	Engaged	Members attending all recommended visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	357	59(17%)	6(10%)				
AMERICAN INDIAN	24	2(8%)	0(0%)	Fishers Exact	0.8115	1.0000	No
ASIAN	54	15(28%)	0(0%)	Fishers Exact	0.2432	0.3367	No
BLACK	87	23(26%)	3(13%)	Fishers Exact	0.2723	0.7055	No
HISPANIC	854	245(29%)	62(25%)*	Chi-Square	6.2738	0.0123	Yes*
UNKNOWN/ OTHER	1193	257(22%)	34(13%)	Chi-Square	0.4064	0.5238	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	3	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing: 5+ or 4+ WC visits (Rate = 10%) when compared to Hispanics (Rate =25%, Chi-square = 6.274, p =0.0123).

Analysis by Race and Ethnicity
Members attending some of the recommended visits

Ethnicity Group	Members in Campaign	Engaged	Members attending some of the recommended visits				
			N (%)	Test	Statistic	P-value	Sig
WHITE	357	59(17%)	33(56%)	N/A			
AMERICAN INDIAN	24	2(8%)	0(0%)	Fishers Exact	0.2066	0.2066	No
ASIAN	54	15(28%)	3(20%)*	Chi-Square	6.1810	0.0129	Yes
BLACK	87	23(26%)	11(48%)	Chi-Square	0.4373	0.5084	No
HISPANIC	854	245(29%)	176(72%)*	Chi-Square	5.5984	0.0180	Yes*
UNKNOWN/ OTHER	1193	257(22%)	173(67%)	Chi-Square	2.7398	0.0979	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	3	0(0%)	Insufficient Data				

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate of completing 3+ or 2+ WC visits (Rate= 56%) when compared to Hispanics (Rate =72%, Chi-square = 5.598, p =0.0180). The engaged white population also had a statistically significant higher rate of completing 3+ or 2+ WC visits (Rate= 56%) when compared to Asians (Rate =20%, Chi-square = 6.181, p =0.013).

C. Opportunity

The Healthy Babies Growing Together Program is key to helping babies, and their parents, establish wellness patterns and immunities that will protect them for life. Of 10,090 Partnership members ages 0 – 12 months in 2023, only 2,572 (~25%) members were identified as potential program participants. In 2024, the Population Health team will continue to send a letter to unable-to-reach members for the Healthy Babies Growing Together Program and invite them to contact Partnership to engage in the program in hopes of boosting the rate of members attending well-child visits and obtaining all recommended vaccinations. Of interest, member were more likely to be vaccinated in 2023 than they were in 2022 (514 compared to 283, respectively). However, the percentage of members attending all of their well-child visits in the first years of life was only 17% of engaged members and 10% of all members in that age group.

1. Improving Well Child Visit Rates

A significant barrier to reaching this goal is the ongoing national shortage of providers, particularly pediatric care specialists which is a common theme heard in Partnership's qualitative feedback. Members report inability to schedule timely well-child visits and having scheduled visits cancelled or pushed out for several months. The healthy babies program engagement rates for attending all well child visits has increased from 80 (25%) in 2022 to 105(17%) in 2023. These results may be due in part to additional efforts described in the next sentence. Current efforts to improve program engagement rates includes helping participants book an appointment by directly calling the provider. They are also offered the option to switch to a new provider. If participants are still struggling to book an appointment, they are offered the option to file a grievance with Partnership's grievance department.

While the goal for well child vaccine rates was met, members have expressed negative attitudes towards vaccines. Therefore there is also an opportunity for Population Health staff to continue to provide additional education to members on the importance of immunizations during the call campaigns. There is also an opportunity to continue to reinforce the importance of these vaccinations by providing an incentive to all members who receive this vaccination.

On a systems level, Partnership has and will continue to work on a multi-year collaborative approach to improve provider availability. Partnership staff will continue to collect data on specific member experiences with their providers to give insight into their access barriers in order to identify provider or location-specific actions to improve access. Furthermore Partnership will continue its efforts to expand our provider network in hopes of improving engagement rates. Provider network expansion efforts include offering the Provider Retention Initiative Pilot and Provider Recruitment program. These programs help our contracted

network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members. A multi-disciplinary team including Quality, Provider Relations, the Office of the Chief Medical Officer, and Population Health will evaluate the data in order to develop interventions to adopt in 2024/2025 to mitigate these concerns.

VII. Healthy Toddlers Growing Together

Prior to 2020, Partnership did not have Population Health Management programs for reaching out to members under three years of age. In 2020, along with adding the Healthy Babies (ages 0 to 12 months) program, Partnership expanded the Growing Together Program to include toddlers at the time of their enrollment into the health plan. Partnership had planned to reach out to children newly enrolled as Partnership members and who were between 12 and 36 months of age to engage in the Healthy Toddlers Growing Together campaign. The one-time call program included education and reinforcement of well-child visits to screen for health and developmental milestones, and the importance of timely vaccinations to build the child's lifetime of immunity.

A. Opportunity

In 2023, the Healthy Toddlers Growing Together program did not include an incentive for members to attend a well-child visit; nor did it seek to engage all children in this age range. Population Health proposed to expand this program in 2024 to engage all children ages 12 – 36 months who have not had a well-child visit, regardless of enrollment date with Partnership. Despite the planning efforts, this program was not implemented. Partnership will look for other opportunities to engage members 0-30 months and members 3-6 years of age.

VIII. Healthy Kids Growing Together

In 2022, Partnership recognized an opportunity to expand the programs reaching out to some members ages 3 – 6 years of age due to evidence of statistically significantly improved results for members who received flyers, calls, and incentives for attending well-child visits. The Population Health team worked through 2023 to transition away from the prior program structures to a new program.

In January 2023, Partnership transitioned away from the Healthy Kids Pilot programs to create a program designed to reach all children between ages 3 through 6, beginning with members in this age group who have never had a well-child visits. These members are offered an incentive to bring their child to annual well-child visits between their age at identification for the program until their 7th birthday. The evaluation of the impact of this program is detailed below.

A. Utilization Measure

The first goal for this intervention is for 50% of members engaged in the program to have a well-child visit within 90 days of the phone call outcome referred to as “Agreed to Participation.” The second goal for this intervention is for 70% of members engaged to have a well-child visit by the end of the calendar year.

Methodology

Measure Description:	The percentage of members who were engaged in the Growing Together Healthy Kids campaign who were between 3-6 years old at the time of enrollment and completed the recommended well-child visits for that age range.
Denominator:	Partnership members between ages 3 and 6 years during reporting period, and enrolled with Partnership for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with Partnership.
Numerator:	Of denominator, those who completed a well-child visit during the: • 180 days after call • 90 days after call • The calendar year (January 2023-December 2024)
Measurement Period:	January 2023 through March 2024. (Reporting period captures members enrolled in 2023 and extends for 3 months into new year to allow members to complete up to 12 months of visits after enrollment.)
Exclusion Criteria:	Members enrolled less than 12 total months and members identified as California Children's Services (CCS)

Results

Members who completed a well-child visits 180 days after the call

Campaign Outcome	*Members (% of Total)*	*Members who completed a well-child visits 180 days after the call (% of outcome)*
Engaged	1952(23%)	738(38%)
Declined	523(6%)	141(27%)*
Left Message	3363(40%)	1053(31%)*
Unable to Reach	2478(30%)	635(26%)*
Total	**8316**	**2567**
Not Referred	27213	N/A

* Indicates statistically significant result

Analysis

Members who completed a well-child visits 180 days after the call

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	21.1932	<.0001	Yes*

Engaged Vs Left Message	Chi-Square	23.3280	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	75.7612	<.0001	Yes*

* Indicates statistically significant result

There was no set goal for members who completed a well-child visit 180 days after the call. However, engaged members had a statistically significantly higher rate of completing WC visit 180 days after call (Rate =38%) when compared to the following outcomes:

- Declined members (Rate = 27%, Chi-square = 21.19, p <0.0001),
- Members who were left message (Rate = 31%, Chi-square = 23.32, p <0.0001),
- Members who were unable to reach (Rate = 26%, Chi-square = 75.76, p <0.0001)

Results

Members who completed a well-child visits 90 days after the call or by the end of the calendar year.

Campaign Outcome	*Members (% of Total)*	*Members who completed a well-child visits 90 days after the call (% of outcome)*	*Members who completed a well-child visits during the calendar year (% of outcome)*
Engaged	1952(23%)	598(31%)	1319(68%)
Declined	523(6%)	90(17%)*	200(38%)*
Left Message	3363(40%)	708(21%)*	1645(49%)*
Unable to Reach	2478(30%)	436(18%)*	1020(41%)*
Total	**8316**	**1832**	**4184**
Not referred	27213		16,720(61%)

* Indicates statistically significant result

Analysis

Members who completed a well-child visits 90 days after the call

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	37.0502	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	61.1926	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	103.7718	<.0001	Yes*

* Indicates statistically significant result

The goal that 50% of members engaged in the program will have a well-child visit within 90 days of the phone call outcome referred to as "Agreed to Participation" was not met (Rate = 31%). Engaged members had a statistically significantly higher rate of completing WC visit 90 days after call (Rate = 31%) when compared to the following outcomes:

- Declined members (Rate = 17%, Chi-square = 37.05, p <0.0001),
- Members who were left message (Rate = 21%, Chi-square = 61.2, p <0.0001),
- Members who were unable to reach (Rate = 18%, Chi-square = 103.77, p <0.0001)

Analysis

Members who completed a well-child visits during the calendar year

Measure	*Test*	*Statistic*	*P-value*	*Significance*
Engaged Vs Declined	Chi-Square	149.6887	<.0001	Yes*
Engaged Vs Left Message	Chi-Square	174.2873	<.0001	Yes*
Engaged Vs Unable to Reach	Chi-Square	305.5771	<.0001	Yes*
Engaged Vs Not Referred	Chi-Square	29.0107	<.0001	Yes*

* Indicates statistically significant result

The goal that 70% of engaged members will have a well-child visit by the end of the calendar year was not met (Rate = 68%). Engaged members had a statistically significantly higher rate of completing WC during the CY (Rate = 68%) when compared to the following outcomes:

- Declined members (Rate = 38%, Chi-square = 149.69, p <0.0001),
- Members who were left message (Rate = 49%, Chi-square = 174.29, p <0.0001),
- Members who were unable to reach (Rate = 41%, Chi-square = 305.58, p <0.0001), and members who were not referred (Rate = 61%, Chi-square =29.01, p <0.0001)

Analysis by Race and Ethnicity

Members who completed a well-child visits 180 days after the call

Ethnicity Group	*Members in Campaign*	*Engaged*	*Members attending a well-child visit 180 days after the call*				
			N (%)	*Test*	*Statistic*	*P-value*	*Sig*
WHITE	8066	366(5%)	114(31%)	N/A			
AMERICAN INDIAN	578	17(3%)	3(18%)	Insufficient data			
ASIAN	1095	59(5%)	26(44%)	Chi-Square	3.8396	0.0501	No
BLACK	1552	102(7%)	32(31%)	Chi-Square	0.0019	0.9654	No
HISPANIC	13719	882(6%)	378(43%)*	Chi-Square	14.8512	0.0001	Yes*
UNKNOWN/ OTHER	10440	521(5%)	183(35%)	Chi-Square	1.5268	0.2166	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	79	5(6%)	2(40%)	Insufficient data			

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate for completing a well-child visit 180 days after the call (Rate = 31%) when compared to Hispanics (Rate =43%, Chi-square = 14.85, p =0.0001);

Members who completed a well-child visits 90 days after the call

Ethnicity Group	Members in Campaign	Engaged	Members attending a well-child visit 90 days after the call				
			N (%)	Test	Statistic	P-value	Sig
WHITE	8066	366(5%)	81(22%)	N/A			
AMERICAN INDIAN	578	17(3%)	0(0%)	Insufficient data			
ASIAN	1095	59(5%)	23(39%)*	Chi-Square	7.8070	0.0052	Yes*
BLACK	1552	102(7%)	25(25%)	Chi-Square	0.2576	0.6118	No
HISPANIC	13719	882(6%)	317(36%)*	Chi-Square	22.7114	<.0001	Yes*
UNKNOWN/ OTHER	10440	521(5%)	150(29%)*	Chi-Square	4.9503	0.0261	Yes*
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	79	5(6%)	2(40%)	Insufficient data			

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate for completing a well child visit 90 days after the call (Rate= 22%) when compared to Asians (Rate =39%, Chi-square = 7.81, p =0.0052), Hispanics (Rate =36%, Chi-square = 22.71, p <0.0001), and the unknown population (Rate =29%, Chi-square = 4.95, p =0.0261).

Members who completed a well-child visits during the calendar year

Ethnicity Group	Members in Campaign	Engaged	Members attending a well-child visit during the calendar year				
			N (%)	Test	Statistic	P-value	Sig
WHITE	8066	366(5%)	220(60%)	N/A			
AMERICAN INDIAN	578	17(3%)	9(53%)	Chi-Square	0.3472	0.5557	No
ASIAN	1095	59(5%)	42(71%)	Chi-Square	2.6369	0.1044	No
BLACK	1552	102(7%)	53(52%)	Chi-Square	2.1791	0.1399	No
HISPANIC	13719	882(6%)	665(75%)*	Chi-Square	29.3082	<.0001	Yes*
UNKNOWN/ OTHER	10440	521(5%)	328(63%)	Chi-Square	0.7377	0.3904	No
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER	79	5(6%)	2(40%)	Insufficient data			

* Indicates statistically significant result

The engaged white population had a statistically significant lower rate for completing a well-child visit during the CY (Rate = 60%) compared to the Hispanics (Rate =75%, Chi-square = 29.70, p <0.0001).

B. Opportunity

The Healthy Kids Growing Together Program is key to helping kids, and their parents, establish wellness patterns and immunities that will protect them for life. Because this program is the basis for other well-child interventions, Partnership will continue this intervention and will evaluate results of program engagement. However, there are opportunities to improve the impact of this program. In 2024, the Population Health team will continue to send a mailer to members for the Healthy Kids Growing Together Program and invite them to contact Partnership to engage in the program in hopes of boosting the rate of members attending well-child visits.

1. Improve Well Child Visits

Significant barriers to reaching this goal based on qualitative feedback from Partnership members are primarily concerns of long appointment wait times, and limited provider choices. Partnership has tried, and will continue to work on improving some of these barriers through ongoing efforts to expand our provider network. The healthy kids program engagement rates for attending well child visits 90 days after receiving a call and within the calendar year is a new measure and therefore cannot be compared to 2022 results as data is not available. Comparisons will be drawn in 2025 when additional data becomes available. However, current efforts to improve program engagement rates includes helping participants book an appointment by directly calling the provider. They are also offered the option to switch to a new provider. If participants are still struggling to book an appointment, they are offered the option to file a grievance with Partnership's grievance department.

Partnership also has an opportunity to improve well-child visit rates by continuing to provide education and encouragement to members during outbound call campaigns on the importance of well-child visits. Results of this additional outreach will be evaluated in 2025. Furthermore, Partnership has ongoing efforts to expand its provider network. Provider network expansion efforts include the Provider Retention Initiative Pilot and Provider Recruitment program. These programs help our contracted network use incentives to recruit and retain high-quality health professionals in our region to improve access to care for Partnership members.

IX. Transitions of Care

Transitions of Care (TOC) services focus on members who are transitioning across settings or benefit structures. Partnership Care Coordination (CC) provides TOC to this vulnerable population to ensure implementation of the discharging facility's transition plan and connect members to medical care and community resources that support health and wellness following a transition of care. The criteria for the members identified include the following:

Adult members (age > 20) **and**:

- Discharging home from acute care after hospital length of stay longer than four days, or
- Discharging home from an out-of-county hospital with any length of stay, or
- Having more than one admission in 10 days
- Excludes members in Long Term Care or in a Long Term Care Psychiatric facility

Pediatric members (under age 21) **and**:

- Discharging home from an acute care hospital stay with an admission date > 60 days from his/her date of birth and having any length of stay.

A. Member Experience/Satisfaction Measures

At the close of TOC services, a Partnership Coordinator contacts the members by phone to complete a member-experience survey. Response options are Agree (3 points) Neutral (2 points) Disagree (1) or No Response. In addition to weighted responses, members have an opportunity to provide comments.

1. Adult Member Experience

There were 200 adult members who completed TOC services, and 185 completed Adult TOC Satisfaction Surveys between January 1 and December 31, 2023; a survey completion rate of 93%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. Average scores for each of the questions were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.98	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my healthcare needs is better.	2.86	Yes
My health has improved since working with my case management team.	2.94	Yes
I was able to safely transition between Providers with the help of my Care Team	2.64	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with my case management team.	2.87	Yes

I was provided the available equipment, medication and/or services that were needed.	2.92	Yes

Analysis

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Adult TOC Satisfaction Survey. The average score ranged from the lowest at 2.86 to the highest at 2.98, which exceeds the goal average of 2.5. The results of the Adult TOC surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Our adult members report good outcomes with this program and we will continue providing this benefit.

2. Pediatric Experience Member

There were 132 pediatric members who completed TOC interventions, and 98 of them provided responses for the Pediatric TOC Satisfaction Surveys between January 1 and December 31, 2023; a response rate of 74%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
I am satisfied with the case management program that has helped me manage my child's health issues.	2.98	Yes
I am confident in the abilities of the team members who contacted me; (the team could have included: health care guide, social worker, and/or nurse case manager).	2.99	Yes
My team referred me to medical and community resources that were valuable and helped me.	2.96	Yes
After working with the case management team, I feel my ability to manage my child's healthcare needs is better	2.96	Yes
My child's health has improved since working with our case management team	2.91	Yes
I was able to safely transition my child between Providers with the help of my Care Team.	2.94	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	2.85	Yes
My child and I were provided with the available equipment, medication and/or services that were needed.	2.98	Yes

Analysis

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric TOC Satisfaction Survey. The average score ranged from the lowest at 2.85 to the highest at 2.98; well above the goal average of 2.5. The results of the Pediatric TOC surveys and the many positive comments

left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members and we will continue providing this benefit.

X. Complex Case Management

Complex Case Management is a support for members who have multiple chronic conditions, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. Care Coordination licensed staff engage the member or caregiver to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her wellness goals. Individual goals are time-bound; however, a member may remain in complex case management for an extended period of time to ensure they receive appropriate care.

A. Member Experience/Satisfaction Measures

Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership Coordinator either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. Response options are Agree (3 points), Neutral (2 points), Disagree (1), or No Response. In addition to weighted responses, members have an opportunity to provide comments.

1. Adult Experience Measure

The number of Adult CCM Satisfaction Surveys completed was low because many of the adult members enrolled in the CCM program have cases that remain open, were closed after becoming unable to reach, or had insufficient time within the program per NCQA standards to qualify for a satisfaction survey in 2023.

There were 5 adult members assigned to the Adult CCM Survey intervention after completion of the program and those 5 members completed an Adult CCM Satisfaction Survey between January 1 and December 31, 2023; a response rate of 100%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my health issues.	3	Yes
I am happy with the number of calls I received from our case management team.	3	Yes

I am confident in the abilities of the team members who contacted me	3	Yes
My team referred me to medical and community resources that were valuable and helped me.	3	Yes
I feel my ability to manage my healthcare needs is better after working with CM.	2.8	Yes
I have a better understanding of my health conditions and/or diagnosis after working with CM.	3	Yes
I have a better understanding of my medications after working with CM.	3	Yes
My health has improved since working with our case management team.	3	Yes
The relationship that I have with the PCP and/or Specialist offices has improved since working with our case management team.	3	Yes
I feel like my providers and I work together better to help me since working with our case management team.	2.8	Yes
I have had more success reaching our health goals since working with our case management team.	2.8	Yes

Analysis

With five respondents, the average score for each satisfaction measure met the goal of at least 75% of members surveyed agreeing with each statement of the Adult CCM Satisfaction Survey. The average score ranged from the lowest at 2.8 and the rest at 3.00, which is above the goal average of 2.5. The number of members eligible to complete the survey is very low; nevertheless, Partnership will continue providing this benefit.

2. Pediatric Experience Measure

In addition to the above program criteria, Partnership's Clinical CC staff outreach to all newly identified CCS members and members currently eligible for CCS who develop an additional CCS condition to complete a comprehensive assessment, determine acuity, and to offer enrollment into CCM. The final activity upon completion of the program for these CCS members along with other enrolled Pediatric CCM cases is the satisfaction survey. For each satisfaction measure, the goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response.

Of 14 pediatric members assigned to the Pediatric CCM Survey intervention after completion of the program, there were 12 responses for a Pediatric CCM Satisfaction Survey completed between January 1 and December 31, 2023; a response rate of 86%. The goal is at least 75% of members surveyed agree with the statement, which translates to an average score of 2.5 or greater for each response. The average responses were as follows:

Survey Question	Average Response	Goal Met
The CM program helped me manage my child's health issues.	3	Yes
I am happy with the number of calls I received from our case management team	3	Yes
I am confident in the abilities of the team members who contacted me	3	Yes
My team referred me to medical and community resources that were valuable and helped me.	3	Yes
I feel my ability to manage my child's healthcare needs is better after working with CM	3	Yes
I have a better understanding of my child's health conditions and/or diagnosis after working with CM	2.92	Yes
I have a better understanding of my child's medications after working with CM.	2.83	Yes
My child's health has improved since working with our case management team.	3	Yes
The relationship that my child and I have with the PCP and/or Specialist offices has improved since working with our case management team.	3	Yes
I feel like my providers and I work together better to help my child since working with our case management team.	3	Yes
My child and I have had more success reaching our health goals since working with our case management team.	3	Yes

Analysis

The average score for each satisfaction measure exceeded the goal of at least 75% of members surveyed agreeing with each statement of the Pediatric CCM Satisfaction Survey. The average score ranged from the lowest at 2.83 to the highest at 3.00; well above the goal average of 2.5. The results of the Pediatric CCM surveys and the many positive comments left reveal a high satisfaction rate among the members surveyed. Families report good outcomes with this program for our Pediatric members and we will continue providing this benefit.

XI. Overall Program Effectiveness

During 2023, Partnership refined program offerings based on prior year successes and learnings. We have learned the most successful programs combine multiple modalities of reaching members, such as combining mailings with phone calls and with incentives. Thus, we are gradually building capacity to leverage this approach for all children from birth through age 7. Of the clinical measures, we met the goals for pregnant member Tdap vaccinations and for healthy baby vaccination rates. For utilization measures, we did not meet our post-partum visit goal for members enrolled in the prenatal program, nor did we meet the goal for those enrolled in the postpartum program. Other well-child visit goals also varied depending

on measuring attendance at all recommended visits (not met) compared to attendance at some of the recommended visits (met). A significant finding in 2023 is the feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider capacity to serve the member population in a timely manner. This finding in member and provider-level data shows the greatest areas of need for creative solutions and will guide multi-disciplinary efforts to support providers for this needed service. Our member experience measures demonstrated the significant value that Partnership's programs bring to members. During 2023, we have added member experience questions to more member interactions in order to gain insight into member barriers to care and to promote enhanced the experience our members have with Partnership.

During 2023, Partnership was able to perform analyses of program outcomes by race/ethnicity. An interesting finding is that Hispanic members had statistically significantly higher results than other races/ethnicities for attendance at postpartum visits under the postpartum program, all well-child vaccinations in the first years of life, attendance at well-child visits in the first years of life, and attendance at well child visits from ages 3-6 years old.

A. Summary

Overall, Partnership's members enrolled in Population Health interventions have improved outcomes compared to members not engaged or not referred to the programs. There are some opportunities to improve the design of PHM interventions along with larger scale opportunities addressing the environment of care. Partnership will explore means to leverage new benefits and resources offered through the CalAIM initiative to bolster member care and the overall health of the population.

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Population Segmentation

Production Date: June 2024

Eligible Members as of May 2024: 912,409

Data presented in this report reflects distinct members as of May 1, 2024; Activities are presented for 2024 / 2025 fiscal year.

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
Keeping Members Healthy				
Members new to PHC and less than 1 year old	• **PHC Member Enrollment Data** • **PHC Integrated Claims and Encounter Data**	**Healthy Babies Growing Together** Reminds parent/guardian to take baby for recommended well baby check-ups, immunizations, and blood lead testing; periodic assessments of child and family care needs, and provides incentives for attending well child visits	2,436	0.26%
PHC members between 3 and 6 years of age, enrolled with PHC for at least 12 months and have never had a well-child visit coded while enrolled with PHC	• **PHC Member Enrollment Data** • **PHC Integrated Claims and Encounter Data**	**Healthy Kids Growing Together** Reminds parent/guardian of the well-child visit benefit, reinforces the importance of immunizations, and make-up blood lead testing; periodic developmental screenings and assessments of child and family care needs, and offers an incentive for members who complete a well-care visit following outreach.	27,453	3.00%
PHC members ages 11 – 12	• **PHC Member Enrollment Data**	**Healthy Teens Growing Together** – Informational brochure to parents/ guardians of 11 & 12 year old PHC members about their changing relationship with their PCP, teen issues, and teen vaccinations. Option to call in for more information.	2,524	0.27%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
PHC members between 0 – 20 years old (up to 21st birthday)	• **PHC Member Enrollment Data**	**Medi-Cal for Kids and Teens (EPSDT) Awareness Campaign -** DHCS approved materials sent to parents/guardians of all PHC members under the age of 21 outlining their benefits and rights, and how to access care.	334,030	36.60%
All Member Households	• **PHC Member Enrollment Data**	**Routine Member Newsletters** which includes general preventive and wellness material and provides contact information for Member Services, Care Coordination, and a to PHC's website for more information about preventive health and chronic care services	337,786 households in February 2024	100.00%
PHC members seeking local resources available and accessible to Medi-Cal recipients	• **PHC Member Enrollment Data** • **PHC Community Resources Pages**	**Community Resource Connections** – Part of the outbound call service to provide resources for members, track resources provided, and perform follow-up (closed loop referrals) to ensure resource(s) met member needs	38	0.004%
PHC members living in areas lacking local imaging service providers	• **PHC Member Enrollment Data** • **PHC Integrated Claims & Encounter Data**	**Mobile Mammography Clinics – ~~40+~~** mobile mammography clinic days in locations known to have poor access to mammography services	272 (year to date)	0.029%
PHC members attending middle-school within PHC's region where a high percentage of PHC members are enrolled	• **PHC Member Enrollment Data** • **California Immunization Registry (CAIR) Data**	**School-Based Vaccination Education & Clinics –** PILOT in-classroom education about the importance of adolescent vaccinations, poster contest with awards, and vaccination clinic available during poster contest awards.	200 (estimate)	0.02%

Population Subset	Data Source(s) Used for Identification	Interventions for which Members are Eligible	Number of Qualifying Members	% of Membership
PHC members of any age attending events in their communities	• **PHC Member Enrollment Data** • **PHC Community Events Page**	**Community Outreach / Engagement Events -** Offer benefit education, resource referrals, and member surveys to gain insight into barriers and member priorities. Attend approximately 3 events per county per month during seasonable weather (150+ events per year).	300 (estimate)	0.03%

Managing Members with Emerging Risks				
PHC members who are pregnant	• **PHC Member Enrollment Data** • **Referral Data** • **Utilization Data** • **PHC Integrated Claims & Encounter Data** • **Collective Medical**	**Growing Together Prenatal Program** - welcome call when pregnancy is identified, reinforcement of prenatal care, educational materials, pre and post-partum depression screening, reminders for post-partum care and re-establishment with a PCP; incentives provided.	267	0.029%
PHC members who have delivered babies	• **PHC Member Enrollment Data** • **Referral Data** • **Utilization Data** • **ADT Data** • **PHC Integrated Claims & Encounter Data** • **Collective Medical**	**Growing Together Post-Partum Program** - Welcome call when member has delivered, educational materials, post-partum depression screening, reminders for post-partum care and re-establishment with a PCP, initiating well-child visits for their babies; incentives provided.	483	0.05%
Black/African American, Native or Pacific Islander PHC members ages 40 - 60	• **PHC Member Enrollment Data** • **PHC Integrated Claims & Encounter Data** • **Utilization Data**	**BPHM Hypertension Lifestyle Control Program –** Call members and offer Healthy Living Tools and lifestyle coaching to	166	0.018%

Managing Members with Emerging Risks

years old with a new diagnosis of hypertension.		promote wellness and disease management using the hypertension action plan		
Black/African American, Native or Pacific Islander PHC members between the ages of 30 - 40 who either have a new diagnosis of diabetes or an A1C of >8.0 and have not received an A1C test in the last year	• **PHC Member Enrollment Data** • **PHC Integrated Claims & Encounter Data** • **Laboratory Results**	**BPHM Diabetes Management Program –** Call members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the diabetes action plan	270	0.029%
Black/African American, Native or Pacific Islander PHC members that have had a recent diagnosis of stroke or myocardial infarction within the past 90 days and who may be experiencing symptoms of depression	• **PHC Member Enrollment Data** • **PHC Integrated Claims & Encounter Data** • **Utilization Data**	**BPHM Depression Management Program –** Call members and offer Healthy Living Tools and lifestyle coaching to promote wellness and lifestyle management using the depression management action plan	124	0.013%

Outcomes Across Settings				
PHC adult members over age 20 and discharging home from acute care after a hospital length of stay longer than 5 days or from a facility outside his/her county of residence; ***or*** a pediatric member under age 21 who has been hospitalized for reasons other than birth.	• **PHC Member Enrollment Data** • **PHC Case Management Flag(s)** • **ADT Data** • **PHC Utilization Data**	**Transitions of Care Intervention –** reinforcement of discharge plan, confirmation of filled prescriptions and home health, support attending follow-up PCP appointment	450	0.05%
Managing Multiple Chronic Conditions				
Members (adult or pediatric) with either multiple unmanaged chronic conditions or who have barriers to managing their care without the support of an individualized care plan	• **PHC Member Enrollment Data** • **ADT Data** • **PHC Utilization Data** • **PHC Integrated Claims & Encounter Data** • **PHC Risk Score Level** • **Screening and Assessment data** • **Social Needs data** • **Behavioral Health data**	**Complex Case Management –** coordination of multiple conditions and providers, support navigating the healthcare system, connections to community services, and support meeting personal health and wellness goals	2,413	0.26%

Grievance & Appeals Annual Report – CY 2023

Kory Watkins, MBA-HM
Director, Grievance & Appeals

June 2024

Agenda


Overview
The Numbers
The Members
The Reasons
Improvements

Purpose Overview

The Grievance & Appeals (G&A) department is responsible for resolving member complaints, grievances, and appeals. Our primary goal is to **ensure that our members' rights are protected, and that they have a fair process to address any concerns or disputes** they may have regarding their healthcare services.

The G&A department is an integral piece of the health plan because we:

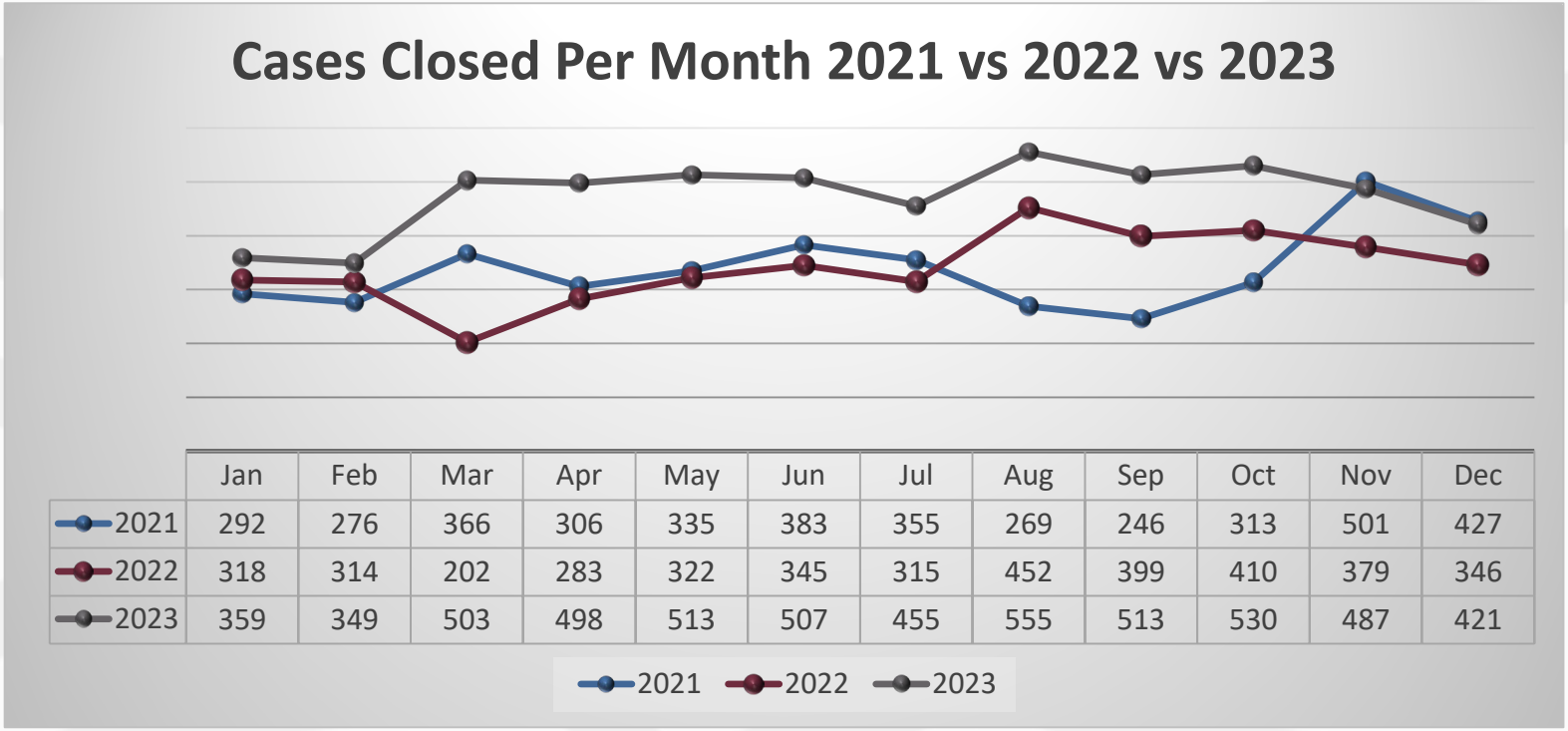
- Help members understand their benefits
- Improve how PHC delivers benefits
- Improve provider's service to members
- Solve conflicts between parties
- Identify new training opportunities

Process Overview

G&A processes 5 different case-types

- Appeal
- Grievance
- 2nd Grievance
- Exempt
- State Hearing

Annual Statistics By Year

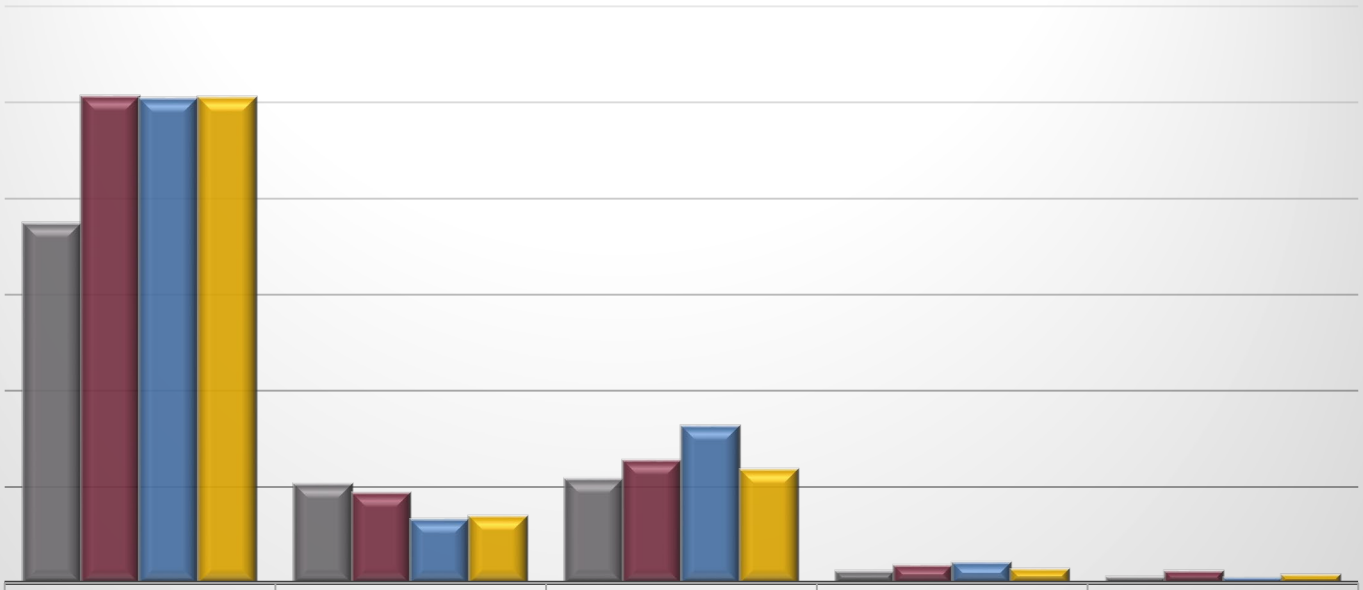


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2021	292	276	366	306	335	383	355	269	246	313	501	427
2022	318	314	202	283	322	345	315	452	399	410	379	346
2023	359	349	503	498	513	507	455	555	513	530	487	421

Total Annual Case Count
2023 – 5,690
2022 – 4,085
2021 – 4,069

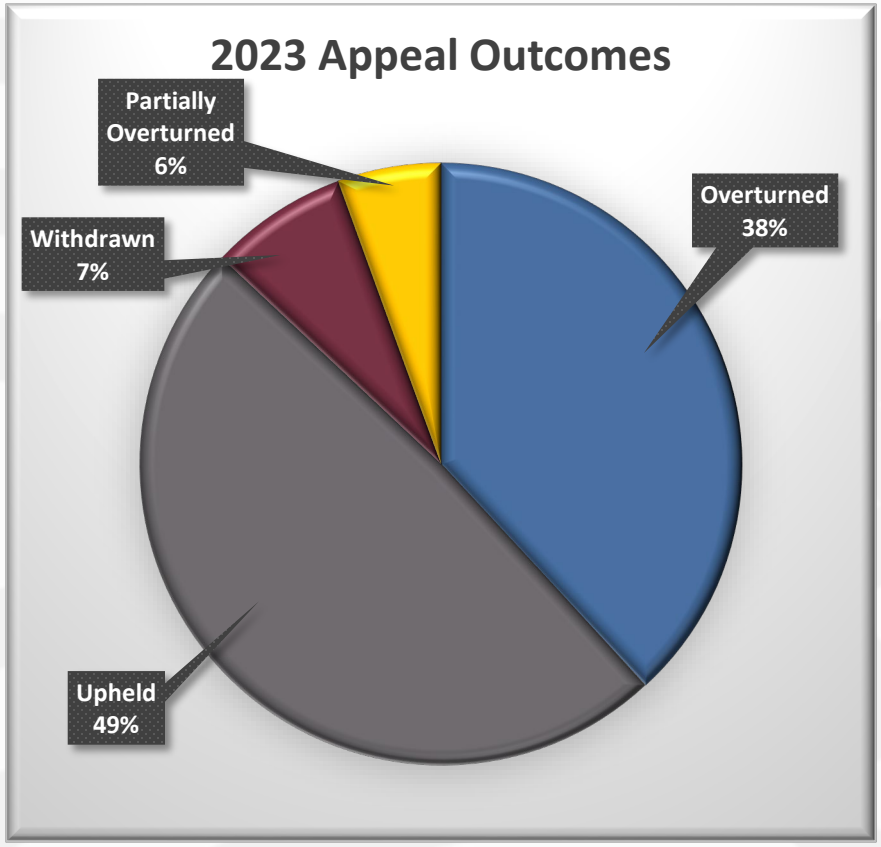
Annual Statistics By Quarter

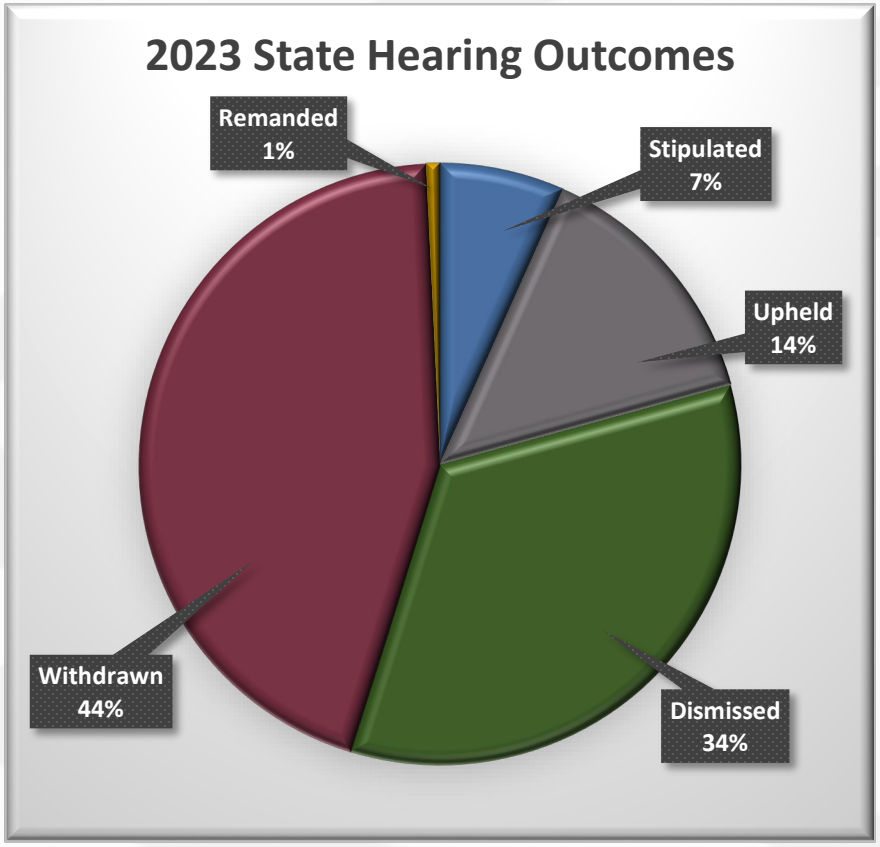
2023 Cases Closed By Case Type



	Grievances	Appeals	Exempts	State Hearings	SLG
1Q23	748	207	218	25	13
2Q23	1013	188	255	37	25
3Q23	1008	133	327	43	12
4Q23	1009	141	240	30	18

Case Outcomes





Timeliness

Performance Goals

Case Closure

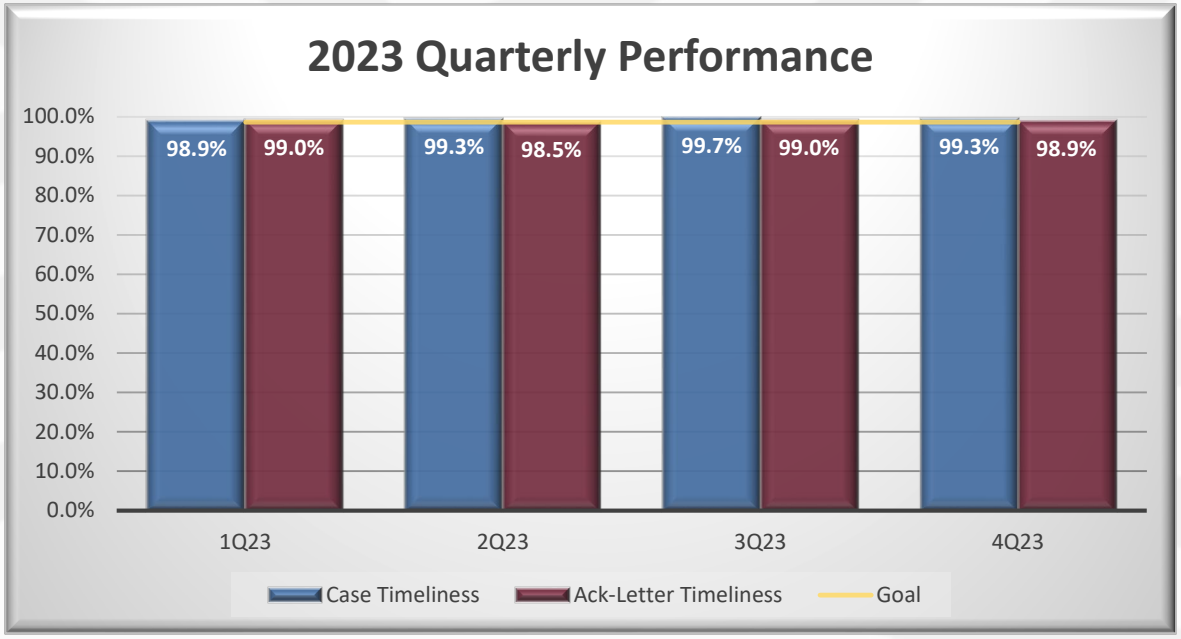
- Expedited cases – Investigate 98.6% of cases within 72 hours
- Standard Cases – Investigate 98.6% of cases within 30 days

Acknowledgment Letters

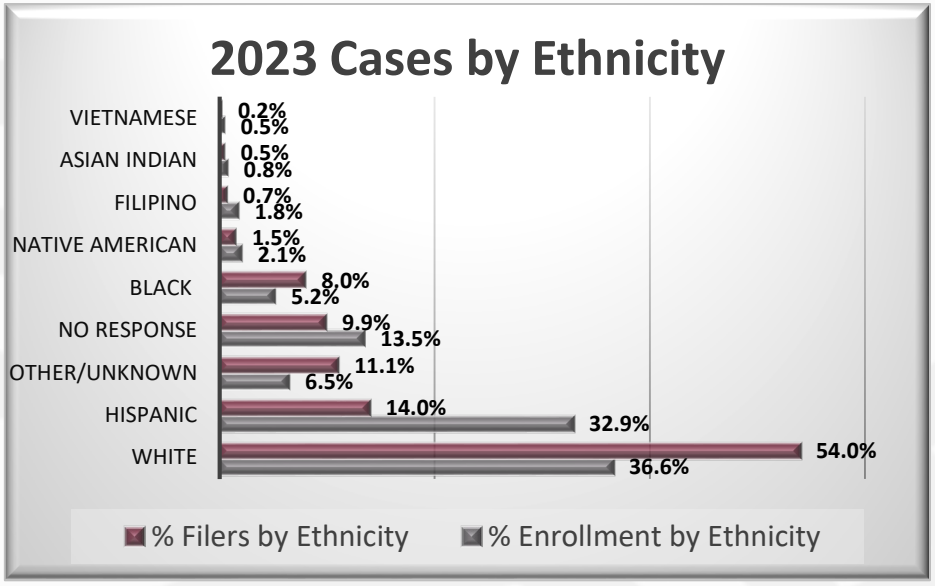
- Mail Acknowledgment Letters on or before the 5th calendar day after case received

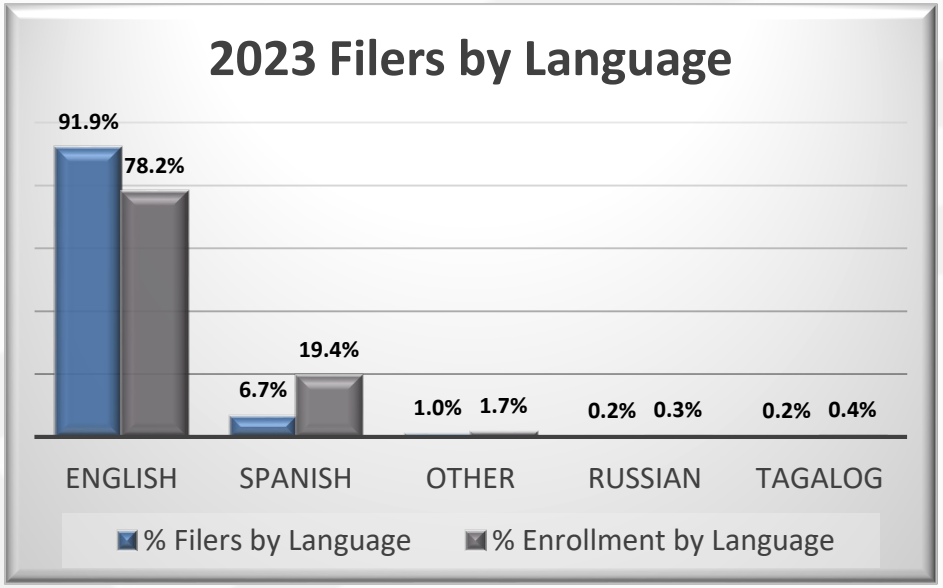
2023 Annual Performance

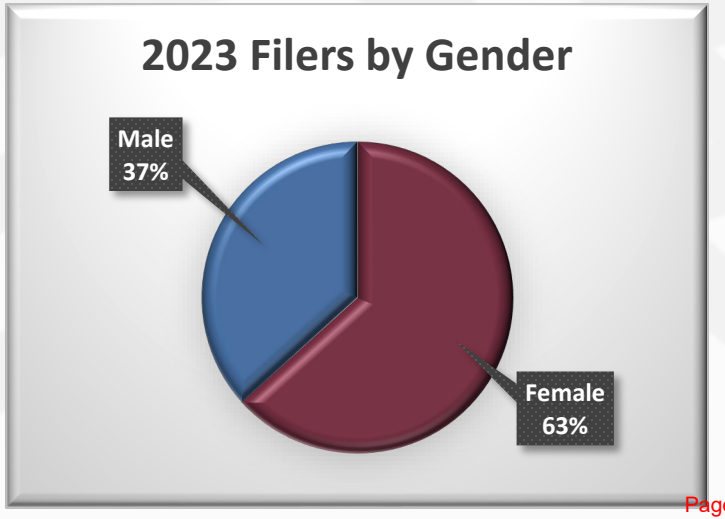
	Case Closure	Ack-Letters Mailed
# Cases Impacted by DHCS TAT	4,515	4,515
# Late	31	52
Goal	98.6%	98.6%
Actual Performance	99.3%	98.8%

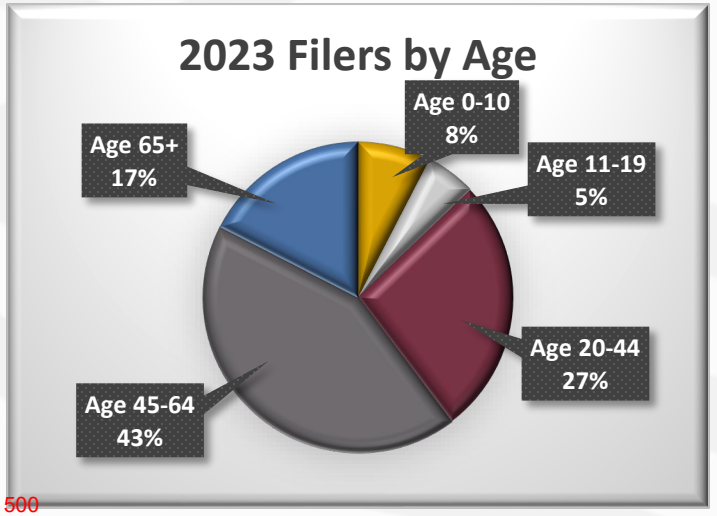


Member Demographics







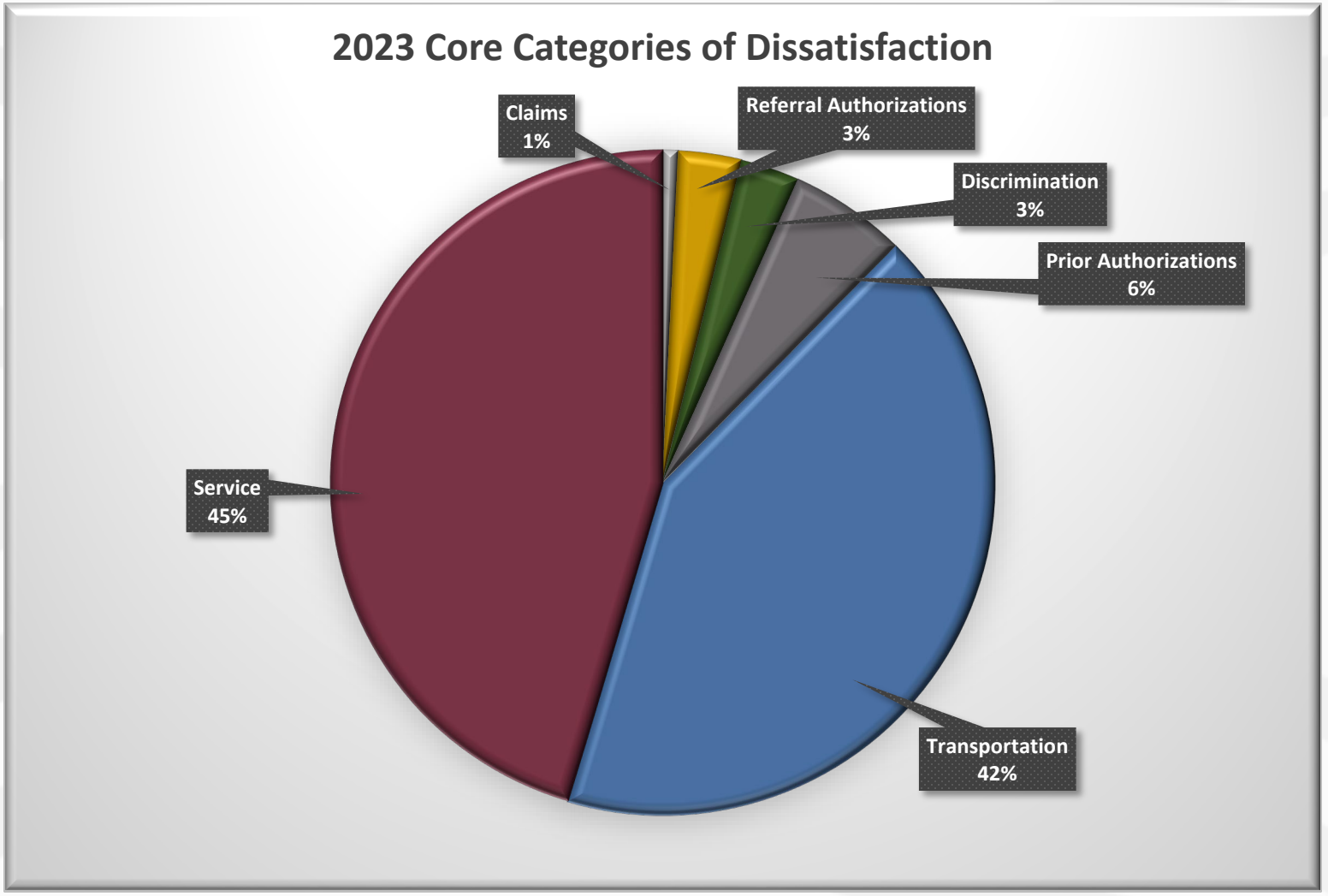


Member Demographics Cont.

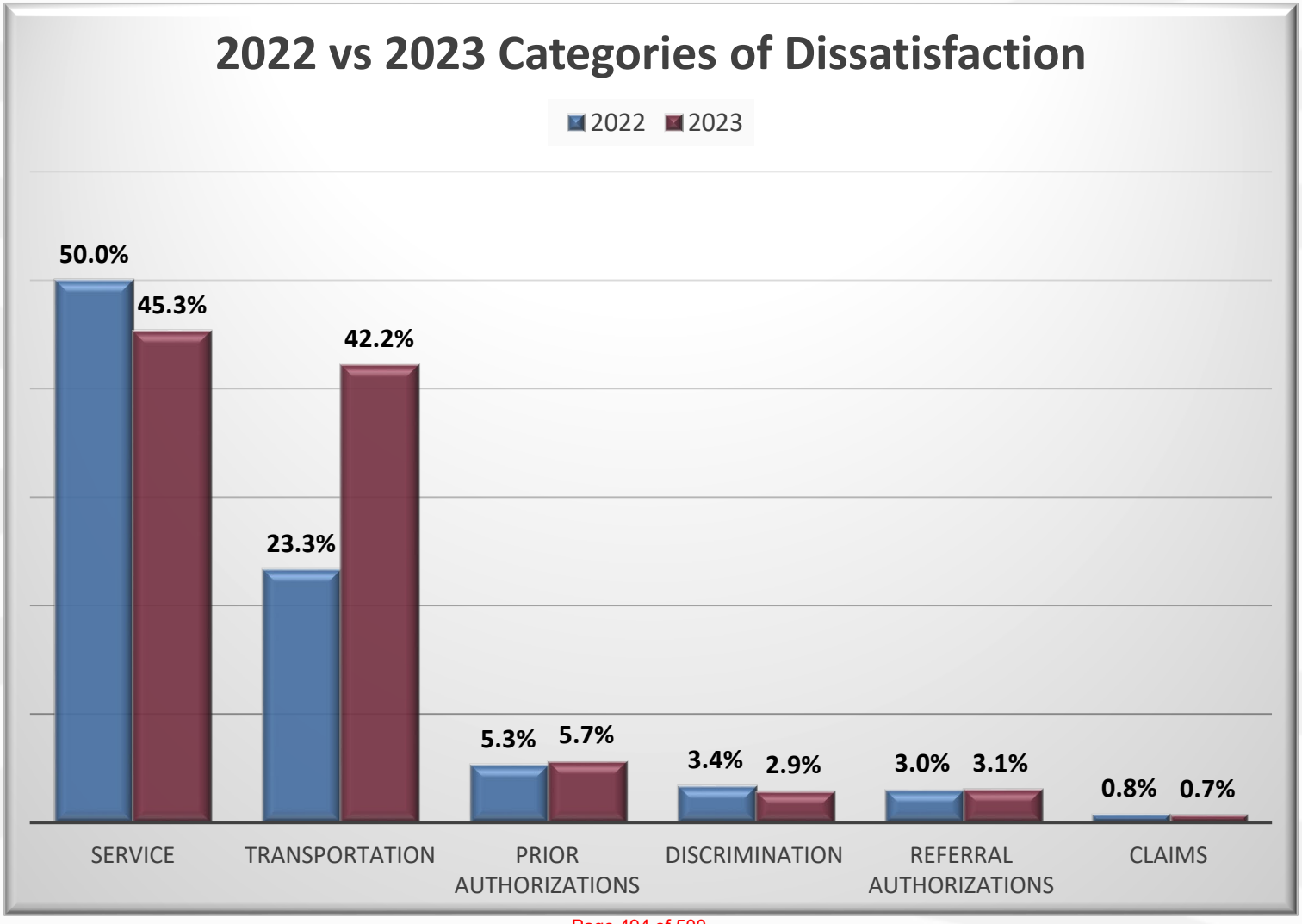
2023 Filers by County		
County	% Filers by County	% Eligibility by County
Solano	22.8%	20.5%
Sonoma	13.6%	19.4%
Shasta	12.4%	10.6%
Humboldt	12.0%	9.0%
Yolo	7.9%	9.1%
Marin	7.2%	7.5%
Mendocino	4.7%	6.1%
Lake	4.5%	5.2%
Napa	3.7%	5.1%
Lassen	3.1%	1.3%
Siskiyou	2.9%	2.9%
Del Norte	2.9%	1.9%
Trinity	1.4%	0.8%
Modoc	0.8%	0.6%

2023 Filers by Top 10 Cities		
City	# Cases	% Cases
Redding	421	7.4%
Vallejo	356	6.3%
Santa Rosa	346	6.1%
Fairfield	344	6.0%
Vacaville	246	4.3%
Eureka	242	4.3%
Crescent City	166	2.9%
Napa	151	2.7%
W. Sacramento	138	2.4%
Davis	119	2.1%

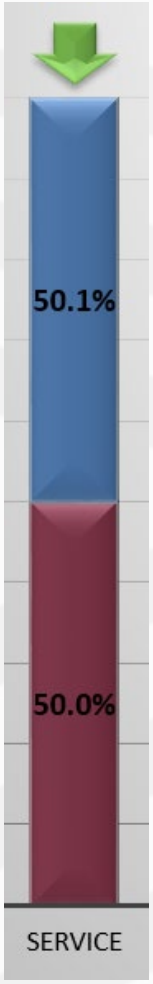
Categories of Dissatisfaction



The Reasons


2022 vs 2023 Categories of Dissatisfaction
2022
2023
50.0%
45.3%
23.3%
42.2%
5.3%
5.7%
3.4%
2.9%
3.0%
3.1%
0.8%
0.7%
SERVICE
TRANSPORTATION
PRIOR AUTHORIZATIONS
DISCRIMINATION
REFERRAL AUTHORIZATIONS
CLAIMS

Service Related Grievances



Breakdown of Service Issues

Provider Services account for 82.4% (3,427 concerns). The top four reported concerns related to Provider Services are:

- Treatment Plan Disputes (24.7%)
- Access/Scheduling Appointments (24.6%)
- Poor Provider Communication (16.5%)
- Poor Provider Attitude (14.8%)

Other Service Issues include:

- PHC Service Complaints (12.2%)
- PCP Enrollment (4.1%)
- PHC Staff Complaints (4.4%)

Discrimination

Discrimination cases can fall into more than one category

Discrimination Categories	# Reported Concerns
Race or Ethnicity	50
Disability	44
Limited English Skills	13
Age	11
Auxiliary Aids and Services	8
Language	3
Language Assistance Services	2
Gender	2
Nationality	2
Sexual Orientation	1
Religion	1

Definitions:
* **Engaged = Agreed to Participation**
* **Declined = Declined Participaton**
* **Not Engaged = Unable to Reach**
* **Not Referred = in campaign demographic but not referred to the campaign**

2024/2025 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**	**Service Description**	**Member Notification**	**Interactive (Y/N)**	**How to Opt Out**	**Measure Goals**	**Denominator**	**Numerator**	**Measurement Period**
Low Risk	**Healthy Babies Growing Together**	INCLUDE: * PHC members ***new to the plan*** AND < 12 months old at age of enrollment EXCLUDE: * members enrolled less than 6 (update 12) total months * Members identified as California Children's Services (CCS)	Reminds parent/guardian to take baby for recommended well baby check-ups, immunizations, and blood lead testing; periodic assessments of child and family care needs, and provides incentives for attending well child visits	Telephone, informational mailer, mailed incentives	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* **25%** of members **engaged** in the Healthy Babies GTP program will be compliant with well child visits within 12 months of engagement Target per age at enrollment: * 0 - 6 months - 5+ visits * 7 - 12 months - 4+ visits	Members enrolled with PHC at less than 12 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed well child visits by age at enrollment: * 0 - 6 months - 5+ visits * 7 - 12 months - 4+ visits	January 1, 2024 - December 31, 2024
							* **65%** of **members engaged** in the Healthy Babies GTP program will be compliant with well child visit scheduled within 12 months of engagement Target per age at enrollment: * 0 - 6 months - 3+ visits * 7 - 12 months - 2+ visits	Members enrolled with PHC at less than 12 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed well child visits by age at enrollment: * 0 - 6 months - 3+ visits * 7 - 12 months - 2+ visits	January 1, 2024 - December 31, 2024
							* **80%** of **members engaged** in the Healthy Babies GTP program will be compliant with 50% of recommended immunizations within 12 months of engagement Target per age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations	Members enrolled with PHC at less than 12 months of age and who were enrolled with PHC for at least 12 months as of report run date	Of denominator, those who completed immunizations by age at enrollment: * 0 - 6 months - 9+ vaccinations * 7 - 12 months - 4+ vaccinations	January 1, 2024 - December 31, 2024
Keeping Members Healthy / Low Risk	**Healthy Kids Growing Together**	INCLUDE: * PHC members between 3 years and 6 years of age (up to age 7) and * enrolled with PHC for at least 12 months and have never had a well-child visit coded while enrolled with PHC. EXCLUDE: * members enrolled less than 12 total months * members identified as California Children's Services (CCS)	Reminds parent/guardian of the well-child visit benefit, reinforces the importance of immunizations, and make-up blood lead testing; periodic developmental screenings and assessments of child and family care needs, and offers an incentive for members who complete a well-care visit following outreach	Telephone,informational mailer, mailed incentives	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* **50 %** of members **engaged** will have a well-child visit within 90 days of call outcome "Agreed to Participation"	PHC members between ages 3 and 6 years during reporting period, and enrolled with PHC for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with PHC	Of denominator, those who completed a well-child visit during the: 90 days after call	January 1, 2024 - December 31, 2024
							* **70%** of members **engaged** will have a well-child visit by the end of the calendar year	PHC members between ages 3 and 6 years during reporting period, and enrolled with PHC for at least 12 months as of report run date, and have never had a well-child visit coded while enrolled with PHC	Of denominator, those who completed a well-child visit during the calendar year	January 1, 2024 - December 31, 2024
Keeping Members Healthy / Low Risk	**Health Care Transitions**	* PHC members ages 11 & 12 years old	Informational brochure to parents/ guardians of 11 & 12 year old PHC members about their changing relationship with their PCP, teen issues, and teen vaccinations. Option to call in for more information.	informational mailer	N	N/A				January 1, 2024 - December 31, 2024
Keeping Members Healthy / Low Risk	**Medi-Cal for Kids and Teens (EPSDT) Awareness campaign**	* PHC members under the age of 21 and their families	DHCS approved materials sent to parents/guardians of all PHC members under the age of 21 outlining their benefits and rights, and how to access care.	mailed information packet / Member Newsletter / Partnership Website	N	N/A				**May 2023 and annually in June thereafter**

2024/2025 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**	**Service Description**	**Member Notification**	**Interactive (Y/N)**	**How to Opt Out**	**Measure Goals**	**Denominator**	**Numerator**	**Measurement Period**
Keeping Members Healthy / Low Risk	**Routine Member Newsletters**	* Any PHC member * Known mailing address	Includes general preventive and wellness material, benefit information, and provides contact information for Member Services, Care Coordination, and directs members to PHC's website for more information about preventive health and chronic care services.	USPS Mailing and email	N	N/A	Newsletters are sent out **2 times per year**.			January - December 2024
Keeping Members Healthy / Low Risk	**Community Resource Connections**	* PHC members seeking local resources available to Medi-Cal recipients	Provide members with resources, track resources provided, and perform follow up (closed loop referrals) to ensure resource(s) met member needs.		Y					**Ongoing**
Keeping Members Healthy / Low Risk / Equity	**Mobile Mammography Clinics**	* Community members living in areas lacking local imaging service providers for mammography screening	40+ clinic days in locations with poor access to mammography services		Y					**January 2024 - June 2024 (continuted participation beyond this is tentative)**
Keeping Members Healthy / Low Risk	**School-Based Vaccination Education & Clinics**	* Middle-school event(s) in at least one middle-school with a high percentage of PHC members enrolled	PILOT - In-classroom education about the importance of adolescent vaccinations, poster contest with awards, with some vaccination clinics offered during event.		Y					**June 2024 - December 2024**
Keeping Members Healthy / Low Risk	**Community Outreach / Engagement Events**	* Onsite presence at community events where PHC members are likely to gather.	Offer benefit education, resource referrals, and member surveys to gain insight into barriers and member priorities. Attendance at approximately 3 events per county per month during seasonable weather (300+ events per year).		Y					**January 2024 - December 2024**
Medium / Emerging Risk	**Moms Growing Together - Prenatal**	INCLUDE: * PHC members who have had a prenatal care visit in the past 12 months **and** * delivered a baby at least 90 days prior to report run date EXCLUDE: * Individuals who were not PHC members when they delivered a baby	Welcome call when pregnancy is identified, reinforcement of prenatal care, educational materials, pre and post-partum depression screening, reminders for post-partum care and re-establishment with a PCP; incentives provided. Modified to include: * reminders to attend all scheduled visits - if unable to attend, please work with provider to reschedule * build in referral pathways for High Risk (CCM) start in July 2023; CHWs (American Indian) or Doulas (Black) start in Q1 2024, if possible	Telephone, informational mailers, mailed incentives	Y	When member is called, they will be given the opportunity to Opt Out of further calls	* **75%** of members **engaged** in the program will have a Tdap vaccination in the 120 days prior to delivery	PHC members who had at least one prenatal care visit in the 12 months prior to report run date **and** who delivered a baby at least 90 days prior to report run date	Of denominator, those who had a Tdap vaccination in the 120 days prior to deliver	January 1, 2024 - December 31, 2024
							* **80%** of moms **engaged** in the program will attend a post-partum visit within 60 days of delivery	PHC members who had at least one prenatal care visit in the 12 months prior to report run date **and** who delivered a baby at least 90 days prior to report run date	Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery	January 1, 2024 - December 31, 2024
							* **70 %** of **babies linked to moms** engaged in the program will attend a well-child visit within 60 days of birth	PHC members who had at least one prenatal care visit in the 12 months prior to report run date **and** who delivered a baby at least 90 days prior to report run date **and** baby is linked to birth mom	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	January 1, 2024 - December 31, 2024
Medium / Emerging Risk	**Moms Growing Together - Post-Partum**	INCLUDE: *PHC members who delivered a baby in the 2024 Calendar year EXCLUDE: * Individuals who were not PHC members when they delivered a baby	Welcome call when member has delivered identified, educational materials, post-partum depression screening, reminders for post-partum care and re-establishment with a PCP, initiating well-child visits for their babies; incentives provided. Modified to include:	Telephone, informational mailers, mailed incentives	Y		* **35%** of members **referred** to the program will be **engaged** in the post-partum program	PHC members who delivered a baby during the 2024 calendar year	Of denominator, those were were engaged in the program	January 1, 2024 - March 31, 2025

2024/2025 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**	**Service Description**	**Member Notification**	**Interactive (Y/N)**	**How to Opt Out**	**Measure Goals**	**Denominator**	**Numerator**	**Measurement Period**
		~~when they delivered a baby~~	~~Modified to include:~~ * reminders to attend all scheduled visits - if unable to attend, please work with provider to reschedule			When member is called, they will be given the opportunity to Opt Out of further calls	* **75%** of moms **engaged** in the program will attend a post-partum visit within 60 days of delivery	PHC members who delivered a baby during the 2024 calendar year	Of denominator, the percentage of moms who attended a post-partum visit within 60 days of delivery	January 1, 2024 - March 31, 2025
							* **70%** of **babies linked to moms** engaged in the program will attend a well-child visit within 60 days of birth	PHC members who delivered a baby during the 2023 calendar year **and** baby is linked to birth mom	Of denominator, the percentage of linked babies who attended a well-child visit within 60 days of birth	January 1, 2024 - March 31, 2025
Medium / Emerging Risk	**Disaster Preparedness**	INCLUDE: * PHC Adult Members who are homebound or vulnerable to power shut off due to medical needs	Mailed booklet describing how to prepare for emergencies with local resources supporting the vulnerable community. Option to call in for further information and local links.	USPS information packet	N					**6/1/2024**
Medium / Emerging Risk	**BPHM - Asthma Control / Improvement Program**	* PHC members 5-65 who have a recent (<7 days) ED event with a primary diagnosis of asthma	If a member calls in after receiving the flyer, then a pharmacists will consult member/member's guardian on priorities of asthma self-management • educate member of different roles of asthma medications and inhaler technique • educate member to identify asthma triggers and how to avoid asthma flare ups • educate member to work with their PCP to develop an asthma action plan	mailed informational flyer packet	Y	Member opts out of the program by not responding to mailer	75% of members who complete a consultation with a Pharmacist and scored a 3 on a Likert scale on the chronic conditions survey in response to the following statement "After working with a PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members **engaged** in the Asthma Control program	Members who respond to post-intervention survey questions	June 1, 2024 - March 31, 2025
Medium / Emerging Risk	**BPHM - Hypertension Lifestyle Control Program**	* PHC members 18-85 with a new diagnosis of hypertension AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander	PHM staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the hypertension action plan	Telephone, mailed letter, mailed information packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program *and who stay engaged for at least 60 days and* complete a chronic disease survey will give a score of 3 on a Likert scale in response to the following statement "After working with a PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members **engaged** in the Hypertension Control program	Members who respond to post-intervention survey questions	June 1, 2024 - March 31, 2025
Medium / Emerging Risk	**BPHM - Diabetes Management Program**	* PHC members between the ages of 21-44 who either have a new diagnosis of diabetes or an A1C of >8.0 or who have not received an A1C test in the last year AND self-identify as African American and/or Native American/Alaskan Native and/or Pacific Islander	PHM staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and disease management using the diabetes action plan	Telephone, mailed letter, mailed information packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program *and who stay engaged for at least 90 days and* complete a chronic disease survey will give a score of 3 on a Likert scale in response to the following statement "After working with the PHC staff member, I have a better understanding of how to manage my condition (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members **engaged** in the Diabetes Management Program	Members who respond to post-intervention survey questions	June 1, 2024 - March 31, 2025
Medium / Emerging Risk	**BPHM Depression Management Program**	* PHC members ages 21 years and older that have had a recent diagnosis of stroke or myocardial infarction within the past 90 days and who may be experiencing symptoms of depression	PHM staff will reach out to members and offer Healthy Living Tools and lifestyle coaching to promote wellness and lifestyle management using the depression management action plan	Telephone, mailed letter, mailed information packet upon request	Y	When member is called, they will be given the opportunity to Opt Out of further calls	50% of members engaged in the program *and who stay engaged for at least 90 days and* complete a complete a chronic disease survey will give a score of 3 on a Likert scale in response to the following statement "After working with the PHC staff member, I have a better understanding of how to manage my condition" (1 = Disagree; 2 = Neutral; 3 = Agree) (average score of 2.75).	Members **engaged** in the Depression Management program	Members who respond to post-intervention survey questions	June 1, 2024 - March 31, 2025

2024/2025 Population Health Management Work Plan										
NCQA/DHCS Risk Tier	**Project/ Program**	**Target Population / Inclusion / Exclusion**	**Service Description**	**Member Notification**	**Interactive (Y/N)**	**How to Opt Out**	**Measure Goals**	**Denominator**	**Numerator**	**Measurement Period**
Outocmes Across Settings / Transitions of Care	**Transitions of Care**	* PHC members who are either: *Adult members (age > 20) and **discharging home from acute care after hospital length of stay longer than 4 days, or **discharging home from an out-of-county hospital with any length of stay, or **having more than 1 admission in 10 days. OR *Pediatric members under age 21 and **discharging home from a hospital with an admission date > 60 days from his/her date of birth and having any length of stay.	Care Coordination staff contact members discharging home after a hospital stay in order to: • ensure discharge planning services have been rendered, • ensure any new medications have been obtained, • coordinate referrals/authorizations for appropriate services/providers (including transitioning from non-capitated into captitated services), and • ensure member obtains and attends a follow-up appointment following discharge from hospital. Telephone and Letter by USPS	Telephone & USPS Letter	Y	After program purpose is explained, member may decline to participate, and this choice is documented in the case management system.	Adult member satisfaction with Transition of Care services per annual Transitions of Care satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.			Ongoing 1/1/2022
Multiple Chronic Conditions / High Risk	**Complex Case Management**	PHC Members of any age who meet one of the following criteria for enrollment: 1. having barriers to managing their care without the support of CCM, (e.g., poor support systems, fragmented care, health literacy barriers), **or** 2. having one (1) or more California Children's Services (CCS)-eligible conditions and requiring the support of an individualized care plan; **or** 3. high-risk members new to PHC who are identified as Seniors and Persons with Disability (SPD) , according to the parameters outlined in policy MCCP 2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services **or** 4. having two (2) or more chronic medical conditions (e.g. CKD, COPD, CHF, DM, HTN, hyperlipidemia), or an unmanaged chronic condition like asthma or diabetes, and requiring the support of an individualized care plan; **or** **5.** having at least one hospitalization and have a mental or behavioral health component that requires urgent stabilization and/or collaboration with County Mental Health Services to support the member's overall wellness. Examples include members who have eating disorders or substance use disorders	CC licensed staff engage member to perform a comprehensive assessment, clarify member/caregiver's goals and desired level of involvement, and develop an individualized care plan to overcome barriers to care and to support the member/caregiver in reaching his/her wellness goals. Individual goals are time-bound; however, a member may remain in complex case management for an extended period of time to ensure the member gets the care he/she needs. Telephone or USPS Letter	Telephone & USPS Letter	Y	After program purpose is explained, member may decline to participate, and this choice is documented in the case management system. CC staff may begin coordination of services for a member while he/she is hospitalized/ unable to participate in a full CCM assessment; however, once the member is stabilized, CC staff will contact the member to perform the assessment, and he/she will be given the option of participation in ongoing case management. The member may opt out at any time and this choice is documented in the case management system.	Pediatric member satisfaction with Complex Case Management services per annual Complex Case Management satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.			Ongoing 1/1/2022
							Adult member satisfaction with Complex Case Management services per annual Complex Case Management satisfaction survey summary will be at least **75% positive / average score of 2.5** on survey responses.			Ongoing 1/1/2022