PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator I, Quality Improvement
DATE: Sept. 11, 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 Partnership 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 Time/Date: 7:30 – 8:55 a.m., Wednesday, Sept. 18, 2024
Meeting Locations:

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

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
Kaiser Permanente, 5820 Owens Drive, Pleasanton, CA 94588
Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603

Staff and members only may join by Telephone: 1-844-621-3956 Access Code 809 114 256
Partnership Offices: Please use the QUAC Partnership HealthPlan's Personal Room in WebEx
https://partnershiphp.webex.com/meet/quac | 809114256 (Need assistance? Contact IT at least one (1) day prior to the meeting.)

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, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
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, Sr. Director of Care Management
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, Chico
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
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
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:
Andrews, Leigha, Regional Director, Santa Rosa
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
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
Harris, Vander, Senior Health Data Analyst, Finance
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
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, Manager of Population Health, Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico

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

Date: Sept. 18, 2024 **Time: 7:30 – 8:55 a.m.**

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

Other Locations:
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Kaiser Permanente, 5820 Owens Drive, Pleasanton, CA 94588
Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603

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

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

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

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Approval/Acceptance of Minutes**			
1	*Approval of* • Aug. 21 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD	7:30	5 - 18
2	*Acknowledgment and acceptance* of • Aug. 13 Internal Quality Improvement (IQI) Committee Meeting Minutes • Aug. 20 Quality Improvement Health Equity Committee (QIHEC) *draft* Meeting Minutes • Aug, 1 Population Needs Assessment Committee *draft* Meeting Minutes • Aug. 6 Over/Under Utilization Workgroup *draft* Meeting Minutes			19 - 66
II.				
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	67 - 81
2	HealthPlan Update	Robert Moore, MD	7:42	--
III.	**Old Business –** None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:50	83
	PULSE Report, Issue 14 – *direct any questions to Latrice Innes*			85 - 99
	Proposed 2025 ECM Measure Summary – *direct any questions to Deanna Watson*			101 - 103
	1st/2nd Qtr Pharmacy/UM IRR/Timeliness Report – *direct any questions to Andrea Ocampo, Pharm.D, and Anna Campbell*			105 - 116
	Utilization Management Policies			
	MCUG3022 – Incontinence Guidelines			117 - 125
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF-DD-N Facilities			126 - 131
	MCUP3003 – Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services			132 - 136
	MCUP3015 – Family Planning By-Pass Services			137 - 140
	MCUP3050 – Medication Abortion in the First Trimester			141 - 153

	Item	Lead	Time	Page #
	MCUP3115 – Community Based Adult Services			154 - 162
	MCUP3128 – Cardiac Rehabilitation			163 - 168
	MPUP3035 – Preoperative Day Review			169 - 172
	Care Coordination Policies [1]			
	MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			173 - 198
	MCCP2023 – New Member Needs Assessment			199 - 216
V.	**New Business – Discussion Policies**			
	Synopsis of Changes			217 - 218
	Care Coordination			
	MCCP2033 – Community Health Worker (CHW) Services Benefit	Lisa O'Connell	7:55	219 - 228
VI.	**Presentations**			
1	2024 3rd Next Available & Next Available Survey	Vander Harris	8:00	229 - 250
2	Summation of MY 2023 HEDIS® v. PCP QIP	Robert Moore, MD	8:12	251
3	Undercounting of American Indian Population	Robert Moore, MD	8:19	253 - 257
FYI	Tactical Plan Update for 5-Star Quality Strategy – *direct any questions to Nancy Steffen*			259 - 277
VI.	**Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Oct. 16, 2024**			

[1] Edits are mainly to the attachments in both CC policies, with acronyms spelled out to avoid any confusion.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Aug. 21, 2024 / 7:30 a.m. – 9:00 a.m. Napa/Solano Room, 1st Floor

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

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

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Cox, Bradley, DO, Regional Medical Director (Northeast)
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, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
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
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, Director of Population Health
Scuri, Lynn, MPH, Regional Director (Southwest)
Spiller, Bettina, MD, Associate Medical Director
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)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Kerlin, Mary, Senior Director of Provider Relations
Steffen, Nancy, Senior Director of Quality and Performance Improvement

Guests:

Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, QI
Campbell, Anna, Health Policy Analyst, Utilization Management
Chishty, Shahrukh, Sr. Mgr of Foster Care Programs, Behavioral Health
Erickson, Leslie, Program Coordinator I, QI (scribe)
Gual, Kristine, PMP, Manager of Performance Improvement, QI
Matthews, Doug, MD, Regional Medical Director ("No. Sacramento Valley")
Nakatani-Phipps, Stephanie, Manager of Provider Relations Representatives
O'Leary, Hannah, Manager of Population Health, Pop Health
Quichocho, Sue, Manager of Quality Measurement, QI
Rushing, Eric, Program Manager, Behavioral Health

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:32 a.m. The meeting began with Isaac Brown presenting the QI Update as quorum was not yet established. (Quorum was reached during Isaac's comment comments.) The June 19, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • June 11, 2024 Internal Quality Improvement (IQI) Committee • May 9, 2024 Substance Use Internal Quality Improvement (SUIQI) • May 23, 2024 Member Grievance Review Committee (MGRC)	Unanimous Approval of Q/UAC Minutes as presented: Robert Quon, MD Second: Randy Thomas, MD Unanimous Acceptance of other Minutes: Robert Quon, MD Second: Chris Swales, MD
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Director of Quality Management*	• Our provider outreach and onboarding for FY 2024-2025 have been going well. We are seeing 10 new organizations that are entering the Perinatal Quality Improvement Program (PQIP) this year; this is largely a result of expansion providers joining our program. The PQIP focuses on timely prenatal and postpartum care and includes depression screening, immunization status, and connection of data into the system. If you have specific questions about the PQIP, Dr. Colleen Townsend is a terrific resource. • Thank you to all who attended our Hospital Quality Symposium for our Hospital QIP. This year, we are introducing some new measures into the HQIP measure set: specifically, adding additional capacity to our hospitals to help with mammography, birthing through midwives. We are also looking at re-admissions. "Tiny" has been changed to "very small" in programmatic references to hospital size. • In the past year or so, we have been heavily engaged in the Department of Health Care Services' (DHCS) Equity and Practice Transformation Program. This is a statewide initiative to advance healthy equity and reduce disparity. This was an ambitious program with a $700M budget over five years; it is now a three-year program with $140M available because of the State's budget shortfalls. Each of our providers initially engaged in the program have elected to continue. The practices submitted an assessment that looked at the foundational readiness of each of the organizations. It was npt so measure focused. Those who completed their one-year phmCAT will still receive payments for that, though delayed. The EPT program was narrowed down from 108 milestones to 25 required across those three years. They will be focused mainly on empanelment and access, data, care delivery, and some key performance indicators. DHCS is redesigning this program. There will be several technical webinars for those who want to learn more about EPT, including one scheduled for Aug. 22. • We have been trying some pilots around the use of locums, some with groups that are really struggling with access, others who have the capacity to get work done if they have a little help. So, we developed this short term solution to provide access to clinicians with the goal of improving our Healthcare Effectiveness Data Information Set (HEDIS®) performance. We have found that giving	For information only: no formal action required.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	some of these organizations the money to pay for locums did not work as we had hoped: they had challenges and were not able to hire locums. We are working with these groups to fix their foundational problems. • We are in the midst of our Health Equity Accreditation Mock Survey. A consultant is now reviewing all of the evidence and findings and making recommendations. We will be closing out that Mock Survey later today. This is in preparation for our June 2025 First Survey.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• There are two articles of note in the forthcoming Medical Directors' Newsletter. One is a summary on DHCS' systematic undercounting of the Native American population. The second article is about the Managed Care Organization (MCO) tax that will be on the November ballot as Prop. 35. Perhaps the most important part is the specialty rate increase it promises. If Prop. 35 passes, those increases will occur in 2025. If not, the increases will be delayed under state legislation to 2026. This is going to be very important for the sustainability of our delivery system. • Chief Executive Officer Sonja Bjork, JD, is on a leave of absence for medical reasons. Chief Health Services Officer Katherine Barresi, RN, is acting CEO. • We will have some news in October about our Dual Special Needs Plan (D-SNP) when we talk about our forthcoming (Jan. 1, 2026) Medicare line of business.	For information only: no formal action required. *Meeting postscript:* Dr. Moore's Summer 2024 Medical Directors Newsletter was emailed to Q/UAC physicians on Aug. 29.
III. Old Business – *returning from May 15 Q/UAC*		
Policy Owner: Quality Improvement *–Presenter: Jeffrey Devido, MD, Behavioral Health Clinical Director*		
MPXG5003 – Major Depression in Adults Clinical Practice Guidelines *Returning to look at a new suggested clinical flow diagram (Attachment A)*	This is a major revision of the Adult Depression Treatment Flow Diagram (Attachment A) of this clinical practice guideline last approved in May QI committees. The prior version of this algorithm was based largely on the protocol used in the STAR*D study. In clinical practice, the basic protocol utilized in STAR*D existed before STAR*D and persists now afterwards, but since STAR*D itself is now dated, we endeavored to update our algorithm to reflect newer references. Furthermore, the previous Partnership algorithm has been condensed into one page, which, while crowded, aims to eliminate confusion in flipping between different pages. Two primary references are cited in the algorithm: 1) Pharmacology algorithms textbook, and Schatzberg's textbook on psychopharmacology. In addition, standard clinical practice experience was incorporated. The basic algorithm posits screening, making an accurate diagnosis and ruling out medical or other psychosocial factors, considering psychotherapy throughout, initiating lowest side effect antidepressant medications first (usually SSRI) through shared decision making model, and proposing augmentation/switching considerations. Furthermore, greater detail is provided in terms of factors to consider when selecting an antidepressant, reasons for poor response, and risk factors for recurrence. The algorithm is not intended to be comprehensive or definitive: it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care settings. **Provider Note:** Medi-Cal mental health treatment services are divided between county specialty mental health (SMH) and managed care plan non-specialty mental health (NSMH) programs. The differentiation is	Motion to approve **as amended:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Sept. 11 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	based on clinical severity, with higher severity patients being preferentially routed to SMH systems of care. See policy MCUP3028 – Mental Health Services. **Provider Note:** Depression pharmacotherapies are the responsibility of State Medi-Cal. If the pharmacotherapy is on the State Medi-Cal Covered Drug List (CDL), then no TAR is required. If the pharmacotherapy is not on the CDL then a TAR is required (submitted to Medi-Cal RX, not PHC). Dr. Devido went through the synopsis, adding that the revised Attachment A is not a mandated treatment but a suggested pathway. New "bubbles of information" address for considerations when adding antidepressants. Chris Swales, MD asked if the four SSRIs (selective serotonin reuptake inhibitors) listed are the only ones allowed, saying that "talopram has a very short half life; we tend not to use it because if you miss a dose, you are going to feel really terrible." Dr. Devido responded that the list is not mean to be exhaustive. At the bottom of the attachment readers are referred to the State Medi-Cal Drug List: the SSRIs are all covered in the Medi-Cal Rx formulary. Robert Quon, MD asked "if it wouldn't be better to instead say 'start with an adequate trial of a SSRI,' rather than listing the medications?" He cautioned that listing any specific drugs could be misinterpreted as Partnership promoting these drugs. Dr. Moore asked Dr. Devido **if such an amendment is acceptable, and Dr. Devido agreed. After the meeting he amended one box to say "**Consider trying an SSRI, such as: sertraline, escitalopram, citalopram or, fluoxetine];" and another, "Has the patient had an adequate trial of an SSRI such as sertraline, escitalopram, fluoxetine, or citalopram? 'Adequate trial' typically is 4-6 weeks (consistent dosing) at adequate dose." Dr. Swales also asked if two or three SSRIs needed to be tried before the physician could move to prescribe another class of medication. Dr. Devido said no, and reminded everyone that Partnership is no longer control of the formulary. "If you are trying to do a second or third line medication, it might require a TAR for some reason with the State," Dr. Devido said. "I was trying to back away from hard and fast rules that you have to trial this many. There are medications where the manufacturer has certain requirements. The short answer is bringing this back to more of clinician and patient centered conversation. An adequate trail, as (now re-defined) in the flow chart is typically 4-6 weeks at an adequate dose."	
IV. New Business – Introduction		
Phuong Luu, MD, MHS, FACP Partnership Board Commissioner	Dr. Luu is the Bi County (Yuba/Sutter) Health Officer. She has served as a Partnership commissioner since April 2024. "My interest in considering joining this committee is because, in terms of public health, there is much discussion to align with MCPs' work, including HEDIS® measures as promoted by DHCS and CDPH," Dr. Luu said. "I want to be situationally aware of what the clinical side is working on so we can align on the public health side." Dr. Luu graduated from University of Washington School of Medicine with honors in 2010 before serving her Internal Medicine Residency – Primary Care Track at George Washington University through 2013. She then had a General Internal Medicine Fellowship at Johns Hopkins University from 2013 to 2015. While at	Dr. Luu's Q/UAC candidacy will be voted on at the Sept. 11 PAC meeting. She would thereafter join Q/UAC in October; however, unlike Q/UAC clinicians, she will not serve on the Peer Review Committee.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Hopkins, she also obtained a Master of Health Sciences in Clinical Epidemiology. During that time, her research focused on transitions of care and end of life goals discussion. She later became the medical director of public health in the Commonwealth of Northern Mariana Islands, where she worked on a variety of public health issues, including emergency preparedness and recovery following a super typhoon in 2018. Dr. Luu holds an active California State Medical License. Dr. Moore welcomed Dr. Luu, saying today's meeting was the day to be present at Q/UAC to hear both our HEDIS® results and our QI Trilogy documents.	
IV. New Business – Introductions Consent (Committee Members as Applicable)		
Consent Calendar	PQI/PPC 1st and 2nd Qtrs 2024 and Data Analysis – *direct questions to Robert Bides, RN* ***Health Services Policies*** <u>Quality Improvement</u> MPQP1002 – Quality/Utilization Advisory Committee - *pulled* MPQP1004 – Internal Quality Improvement Committee - *pulled* MPQP1048 – Reporting Communicable Diseases <u>Utilization Management</u> MCUG3007 – Authorization of Ambulatory Procedures and Services MCUG3024 – Inpatient Utilization Management MCUP3012 – Discharge Planning (Non-capitated Members) MCUP3052 – Medical Nutrition Services – *passed in June IQI and Q/UAC, this is coming back for one addition* [1] MCUP3111 – Pulmonary Rehabilitation MCUP3119 – Sterilization Consent Protocol MCUP3130 – Osteopathic Manipulation Treatment MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21 MPUP3078 – Second Medical Opinions <u>Care Coordination</u> MCCP2007 – Complex Case Management [2] <u>Population Health Management</u> MCNP9004 – Regulatory Required Notices and Taglines	Motion to approve without the two pulled policies: Robert Quon, MD Second: Jennifer Wilson, MD *Approved unanimously* Motion to approve the two pulled policies **as amended**: Robert Quon, MD Second: Jennifer Wilson, MD *Approved unanimously* <u>Next Steps</u>: Sept. 11 PAC

[1] **Adding a sentence at VI.B.** to say "No accreditation of the provider's overall diabetes self-management training program is required."
Reasoning: Medicare requires that the American Diabetes Association (ADA) accredit the Diabetes Self-Management Training (DSMT) program to bill these codes, but that seems redundant and a barrier to having services provided. There is no such requirement for Medi-Cal, but the federal policies could be ambiguous, so it is best to clearly exclude this requirement from our standard. It will not require configuration changes.

[2] Per NCQA consultant recommendation, VI.C.5 is revised: "For any area of the assessment where the information below is considered inappropriate or not applicable to the Member, Partnership CC Staff will indicate an 'N/A' on the assessment next to that question followed by a clear reason or explanation why the assessment was marked N/A. If a Member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, Partnership CC Staff will notate applicable areas."

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Member Services Policies MP301 – Assisting Providers with Missed Appointments MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior Q/UAC scribe Leslie Erickson pulled both the IQI and Q/UAC policies to state that **Health Services leadership had decided to add the new position of Director of Enhanced Health Services to the internal staffing lists embedded in both policies.** As such, Lisa O'Connell will now be a voting member at IQI and an *ex-officio* (non-voting) member of Q/UAC. Dr. Moore welcomed Lisa, who was remotely present today.	
V. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*		
MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	**Policy edits due to CHDP Sun Setting July 1, 2024** **Related Policies added:** MCUP3102- Vision Care **Definitions added:** NCHCC: Northern California Hearing Coordination Center Newborn Hearing Screening Program (NHSP) **Definition revised:** EPSDT: Early and Periodic Screening, Diagnostic, and Treatment *(see also Medi-Cal for kids and Teens below)* Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s). **VI.C.2 added:** For more information, see Partnership policy MCUP3102 Vision Care **VI.J added:** For non-WCM counties, refer to Partnership policy MPCP2002 California Children's Services **VI.R. Newborn Hearing Screening Program (NHSP) added:** 1. Partnership is responsible for case management services related to EPSDT and collaborates with the PCP and/or Specialist to ensure follow-up for missed EPSDT-related appointments, which includes follow-up with the families of babies that miss their hearing screening or diagnostic appointments. Partnership's Care Coordination department will receive referrals from Northern California Hearing Coordination Center (NCHCC) to assist in case management services for access to care concerns and following up on missed hearing screening or diagnostic appointments. 2. Partnership providers can refer members who have missed or failed EPSDT-related appointments through the external referral form on the Partnership's website. Our Care Coordination staff may also reach out to the member once the referral is received to assist with care coordination services and identify barriers. Shannon went through the synopsis. There were no questions.	Motion to approve as presented**:** Robert Quon, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Sept. 11 PAC
Policy Owner: Utilization Management – *Presenter: Anna Campbell, Policy Analyst, UM*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MCUG3010 Chiropractic Services Guidelines	Policy updated per DHCS guidelines for chiropractic services for Members eligible for EPSDT services. **Section I.B.** Related Policy MCUP3042 Technology Assessment was removed and replaced by MCUP3041 TAR Review Process as chiropractic services for Members under age 21 will now require a TAR. **Section III.** Definition of EPSDT updated to include California's specific name for the program, "Medi-Cal for Kids & Teens." **Section VI.B.1.** Specified that Members age 21 and over who are capitated or assigned to a primary care provider require a RAF from their PCP for chiropractic services. **Section VI.B.2.** Specified that Members under age 21 require prior authorization with justification of medical necessity for chiropractic services. A TAR must be submitted and EPSDT criteria will be considered when evaluating the request. **Section VI.B.8.** Removed paragraph which previously stated that Partnership finds insufficient published evidence of any benefits of chiropractic manipulation in children under age 12 and therefore requests for chiropractic care in children under age 12 must be submitted as per policy MCUP3042 Technology Assessment which describes investigational services and interventions. (Instead, we now have the TAR requirement at VI.B.2.) Dr. Moore prefaced Anna's synopsis by noting that at one time the State did not cover chiropractic services but Partnership did as one means of safely managing pain. When the State later added the benefit, it did so under slightly different parameters. Partnership is now trying to better align our policy with that State benefit. Anna said the main difference now is to bring it into alignment with EPSDT for children. We are now saying it requires a TAR for children under the age of 21; for adults, it continues as it was: they need a RAF initially and then no TAR if it's two services or less per month. Dr. Swales noted that the codes listed in the policy are CPT codes, and not diagnostic codes, adding that language around "spinal" and "lumbar/spinal" seems to have been removed. "If people have low back pain and they want to see a chiropractor, and the chiropractor uses only these CPT codes, they can be seen?" he asked. "It used to be that 'you can't have it unless there is a specific thing seen on an x-ray.'" Northeast Regional Medical Director Jeff Ribordy, MD, clarified that no TAR is required for adults being seen no more than twice in one month, and that Partnership might not necessarily know why a member was seeing a chiropractor. Dr. Moore concurred, adding that we can audit on the back end if we suspect fraud. Discussion continued while Anna looked at the State Provider Manual. That page was last updated on September 2020 and contained approximately a dozen ICB 10 diagnostic codes. She asked if these codes should be listed in the policy but Dr. Moore instead suggested **an amendment to VI.A.1., adding a sentence that reads "see the Medi-Cal Provider Manual for covered diagnoses."**	Motion to approve **as amended:** Robert Quon, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: Sept. 11 Physician Advisory Committee (PAC)
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Southeast Regional Medical Director*		
MCUG3118 Prenatal and Perinatal Care	This policy was updated ahead of schedule to integrate changes in CPSP services, which allow programs that are not certified by the CDPH to provide these services and be reimbursed for Health Ed/Case	Motion to approve as presented: Robert Quon, MD Second: Brian Montenegro,

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Management, Nutrition, and Behavioral Health. The policy changes will allow programs to continue to be paid for these services for up to 12 months after delivery. **Section I.** The following were added as Related Policies: MCUP3124 – Referral to a Specialist MCUP3052 – Medical Nutrition Services MCCP2020 – Lactation Policy and Guidelines MCUP3113 – Telehealth Services MCQG1015 – Pediatric Preventive Health Guidelines **Section III.B**. The definition of the Comprehensive Perinatal Services Program (CPSP) was updated and a note was added to explain the relationship between CPSP and Partnership HealthPlan Perinatal Services (PHPS). **Section III.F**. A new definition was added for Partnership HealthPlan Perinatal Services (PHPS). **Section III.G**. A new definition was added for Perinatal Case Manager, which also describes a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program. **Section IV. Attachments** Three new attachments were added as follows: Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form Partnership Perinatal Case Management TAR Thresholds Applying for the CDPH CPSP program **Section VI.** Terminology was updated throughout the policy to differentiate between CPSP services and CPSP-like services. **Section VI.B.** This section was updated to describe Partnership HealthPlan Perinatal Services (PHPS) **Section VI.C.** This section was updated to describe PHPS Standards of Perinatal Case Management **Section VI.D.** This section was updated to describe CPSP/ Perinatal Services Case Management Responsibilities **Section VI.E.** This section was added to describe Perinatal Services Health Education Roles **Section VI.F.** This section was added to describe services for Diabetes Care in Pregnancy **Section VI.G.** This section was added to describe services for Lactation Counseling and Education **Section VI.H.** This section was updated to describe Referral Procedures. Mention of Kaiser and Woodland Health Care was removed. **Section VII.G.** A new Reference was added for the American Diabetes Association. **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Dr. Moore prefaced Dr. Townsend's presentation by saying that the State in February published an audit of its CPSP program, at which time, the State decided to turn the program over to the health plans and then audit them going forward. The State has yet to release clear policy documentation, Dr. Moore said; however, Partnership is anxious to move forward. Perhaps this Partnership policy may serve as the model for other managed care plans. Dr. Townsend said The Comprehensive Perinatal Services Program was developed probably 30 or 40 years ago and is now shifting from being completely administered by the CDPH and paid for by the health plans to being administered and paid for and oversight provided by the health plans. As originally conceived,	MD *Approved unanimously* Next Steps: Sept. 11 PAC Noon – 1 p.m. Sept. 11 webinar

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	CPSP could be provided either as a stand-alone practice with providing those allied health services in connection with the medical practice, or as in most programs, actually embedded in a prenatal medical practice. Most common in our network currently, they are provided by Federally Qualified Health Centers; however, there are a number of small practices that integrate these services into their program. This policy identifies that as Partnership takes over this benefit how we hope to build a program that is indeed comprehensive and allows the most flexibility for access across each of those services. The State continues to do certifications of CPSP programs at the level of CDPH and they have a whole process by which now programs can apply directly for certification to CDPH. Partnership will also allow individual practices or programs to apply directly to us, though we encourage practices to apply through the CDHP process. There have been some delays (in that certification application process). We want to know who are the programs and how are they structured in our network. In our program we do allow for an expansion of services that can be provided in each of those areas. Prenatal care is established by the American College of Obstetricians and Gynecologists (ACOG) but in our policy we have increased the volume of nutrition, health education, case management and behavioral health services and the number of codes that can be submitted for reimbursement. We also extended services to include the postpartum period for up to 12 months after delivery, which was not true for the CDHP program. We are allowing nutrition practices to contract as a CPSP provider because we want to extend nutrition to pregnant individuals. Dr. Moore added that the Partnership integrates what used to be known as the Sweet Success program, which was defunded by CDPH, as well as lactation counseling and education. Dr. Luu expressed appreciation for this policy and asked that a one or two-page breakdown of the program highlights be created and distributed to the 24 county health department personnel who answer provider calls. Dr. Townsend noted that immediately after PAC votes Sept. 11, Partnership will host a webinar. Meanwhile, information has been pushed to each of the perinatal service coordinators in Partnership's service area. Dr. Montenegro questioned VI.H.1.a. – "consultation during pregnancy with a non-Obstetrics specialist (Cardiology, Endocrinology) requires that a Referral Authorization Form (RAF) be submitted by the Primary Care Provider" – noting that many pregnant persons quit seeing their PCP during gestation. He advocated that OBs be allowed to make direct referrals to specialists to mitigate any risk of a patient not following through with a PCP. Doctors Townsend and Moore liked the suggestion but said current system constraints are prohibitive; such a change may be possible, however, once Health Rules Payor (HPR) comes online. Dr. Townsend added that the current system of referring via the PCP is not onerous, especially since most our network referrals move between referral coordinators. Jennifer Wilson, MD, clarified that if the issue is pregnancy related, the OB can refer directly to a specialist. Dr. Moore agreed but said "something like a thyroid issue is common during pregnancy and is within the scope of a family physicians; there is no need to jump to endocrinology." Dr. Swales "echoed" the worry that for systems that do not have OB included in them, delays in care may occur. "It's not just administrative," he said. "At some point it comes to me to sign off on."	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Policy Owner: Utilization Management – *Presenter: Eric Rushing, Program Manager, Behavioral Health*		
MCUP3145 Eating Disorder Management Policy	**Section IV. Attachments** Two new attachments were added as follows: Eating Disorder Process Flow Chart Eating Disorder Bidirectional Form **Section VI.A.2.b. and VI.3.** Language was updated to reflect that Eating Disorder guidance is part of the new DHCS MOU template for Specialty Mental Health Services **Section VI.3.a.** Statement added for division of financial responsibility. "In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the MHP for residential level treatment for eating disorders pursuant to APL 22-003." **Section VI.3.e.** Added language regarding exchange of information. "These procedures are either incorporated in the MOU or shared with the MHP as part of the related policies which further describe how the provisions on the MOU are carried out." **Section VII.F.** Updated reference for new DHCS MOU template for Specialty Mental Health Services **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Eric went through the synopsis. There were no questions. Dr. Moore noted that Partnership developed this policy after many years of discussions with the Counties. He commended Eric's management of the current program.	Motion to approve as presented: Robert Quon, MD Second: Chris Swales, MD *Approved unanimously*
VI. Presentations		
HEDIS® MY 2023 / RY 2024 Summary of Performance *Sue Quichocho, Manager of Quality Measurement*	HEDIS is important because there are real people behind this data, which reflects their personal health care outcomes. Additionally, DHCS is selecting measures called Quality Withhold Measures, starting with MY 2024, to drive the focus and prioritization with the healthcare delivery system. DHCS will be withholding .05% of Partnership's revenue stream, which we can only earn back through strong HEDIS® and CAHPS® performance. $17M is a rough estimate of what is at stake in year one. DHCS is expected to increase this percent of the withhold incrementally in the coming years. Finally, HEDIS® is important to Partnership's reputation: NCQA Health Plan Rating is publically reported and posted by NCQA and represents our standing as a Medicaid health plan on a national scale. DHCS in recent years has issued sanctions for below-average performance measures with corresponding press releases and public postings of sanctions issued. DHCS's Managed Care Accountability Set (MCAS) is generally defined in four distinct reporting regions generally reflecting prior expansions in Partnership's service area. This will be our last year reporting regionally. DHCS is moving Partnership to plan-wide reporting starting in MY 2024. MY2023 only reflects reporting for our 14 "legacy" counties. MY2024 will include both our legacy and expansion counties. Given the coming change, this year's summary of regional MCAS results is framed more from a plan-wide viewpoint. Details can be found in the MCAS Summary document included in this meeting packet. How do the measures sets compare between NCQA Health Plan Accreditation (HPA) and DHCS MCAS? There are limited overlaps and differences in the domains. MCAS has greater emphasis on the childhood and adolescent preventive care measures and other smaller domains, including cancer prevention, reproductive health, chronic disease and behavioral health. In contrast, NCQA HPA includes additional measures focused on adult immunizations, respiratory treatment, diabetes, heart diseases, and behavioral health. Each set varies in scope and types of measures included. This is addition to the Uniform Data Set (UDS) measures for which the FQHCs must	

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	report via federal Health Resources and Services Administration (HRSA) and are like cousins to the HEDIS® measures. The measures for which Tribal Health is responsible for reporting federally under the Government Performance and Results Act (GPRA) resemble distant cousins. The NCQA HPA Health Plan Rating (HPR) is much more favorable than our DHCS MCAS results. The HPR is assessed plan-wide using the measure set that NCQA has established for the Medicaid health plans. HPR is the weighted average of a plan's HEDIS and CAHPS measure ratings plus bonus points for plans with current accreditation status. The overall rating is calculated on a zero-to-five point scale to the nearest half point based on performance in three subcategories: patient experience (~ 1/3), rates for clinical measures in two domains – prevention and equity, and treatment (~2/3) – and, finally 0.5 bonus points are added to the overall rating before rounding to the nearest half point. MY2023 / RY 2024 represents the second year Partnership has been formally rated. Last year, Partnership's publically reported HPR was 3.5 Stars, which is considered just above average. The projected HPR for MY 2023 is 3.5 Stars. This is our best estimate based on available benchmarks. NCQA will use the updated benchmarks due for public release this month to finalize the HPR nationally. They will post publically in September. Our review of the DHCS MCAS results focuses on the 18 accountable measures vs. the 24 reporting-only measures. Why? The accountable measures must exceed the MPL, which is the 50th percentile of the national Medicaid benchmark. If the MCAS results are below average, Partnership is subject to enforcement actions that can include monetary sanctions. Last year, Partnership paid $184,000 in sanctions based on MY2022 performance in MCAS. There are five measure domains, totaling 18 accountable measures in MY 2023. The priority measures aligned with DHCS' comprehensive quality strategy and bold goals emphasising pediatric and preventive care. The MCAS accountable measures can vary year to year in terms or measures included and total measures, though MY2023 and MY2022 are very similar. All 15 measures from MY 2022 are included in MY2023, with the reinstatement of Asthma Medication Ratio (AMR). So, 16 of the 18 measures are included in the composite scoring. (2 new measures – Topical Fluoride if Children and Developmental Screening in 0-3 yrs – have no national benchmarks as yet available for scoring. These are Centers for Medicare & Medicaid Services (CMS) Core Measures, the first of their kind to be added as accountable measures.) We did not see greater performance improvement as we anticipated coming out of the global pandemic. The summary report in todau's packet provides a more detailed of drivers underlying the stagnant and declining rates. Reproductive health and chronic disease domains represent our strongest performance measures with 75% or more measures scoring at or above the MPL. Cancer prevention domains diverged across the Northern and Southern regions: the South exceeds the MPL whereas the North generally scores below the MPL. Activities focused on improving access, like mobile mammography clinics, are driving results. Partnership is also evaluating how to better collaborate with fixed imaging sites and PCPs to optimize capacity where possible. The Pediatric and Behavioral Health domains represent the largest plan-wide performance challenges. The majority of the measures in these domains are performing below the MPL. Please see the detail in the MCAS summary report in the packet. In the Pedes domain, aside from the very bright spot represented by 10 – 21% improvement in regional blood screening rates, drivers to low performance include rural regions with high rates of missing secondary immunizations doses in the vaccination series and parental refusal; access constraints; and data incompleteness due to gaps in newborn data. Partnership has identified significant gaps in the newborn data because early visits occur under a temporary ID before newborns are granted Medi-Cal and are enrolled. These visits are subsequently difficult to	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	link to the permanent ID when the member becomes eligible under the HEDIS® measure in the MY they turn 15 months old. We are working on new data solutions and process improvements with county and provider partners to expedite newborn enrollment. Where prescriptive coding is key to performance, we are seeing various provider coding practices: we are not seeing an accurate view of services delivered to our members. Challenges exist under oral health and developmental screening. In the Behavioral Health domain, DHCS has defined accountable measures because members are eligible for both medical and mental health benefits under Medi-Cal. Unlike other state Medicaid systems, which drive the national benchmarks, Medi-Cal divides mental health benefits from medical benefits, and then further divides these benefits between the managed care plans and the county mental health plans. The complicated dual delivery system limits Partnership's ability to capture through internal means all follow-up visits as it relies on reporting from the county mental health plans. The measure specs at present limit timely county follow-up visits if they do not have a diagnosis matching the ED visit. Partnership is pursuing new data agreement with more than 20 counties. … Partnership's composite scoring methodology is based on DHCS methodology applied annually to determine Quality Factor Scores. QSF includes aggregate scoring of MCAS performance across Medi-Cal health plans and ranks each MCP reporting unit. We are represented four times in this scoring. In composite scoring, points are awarded on a 10-point scale per measure per reporting region based on that measure's performance relative to national Medicaid benchmarks. We calculate an aggregate score across all four regions to assess overall health plan performance. While we have enjoyed strong improvement in recent years in the Southwest region, we saw a decline of almost 5% in MY2023 v MY2022. We also saw a marked decline in the Northeast. Only a small improvement occurred in the Southeast, with flat results v. prior year in the Northwest. We looked at how many measures scored above and below the MPL. Given the comparable measure sets in 2022 v 2023, the declines in composite scoring reflect no change. The number of measures meeting or exceeding the MPL grew in MY2023 by the same number of total measures dropping below the MPL. In MY2023, we see a downward trend: 53% of measures scored between the 25th and 75th percentiles. A contributor to the decline in the aggregate scoring trend is 67% of measures (43 of the total 64) demonstrated less than a 5% change in rate v. MY 2022. National benchmarks also are increasing. Next Steps: • NCQA will finalize HPR nationally and publically post the HPRs in September. • DHCS will report QSF later this year and thereafter assess mandated performance improvement activities and any sanctions. • Partnership will adapt QMSI strategies and tactics in 2024-2025 as noted. • Partnership will strengthen existing and add new supplemental data sources to improve data completeness. The impact on DHCS accountable measure performance is be analyzed in the Southeast and Southwest, where a delegated arrangement once existed between Kaiser and Partnership. Dr. Moore thanked Sue and said we were surprised to see a decline and that is why we did a deeper analysis. The full detail, including the county-level breakdown is in the packet.	
Close-out Summary of FY 2023-2024	Isaac encouraged Q/UAC members to pass these documents to the QI persons in each person's organization. Partnership's QI Work Plan is important from both NCQA and DHCS perspectives, and we are audited accordingly on it. In FY 2023-2024, we met 55 of our 62 goals. Six	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
QI Work Plan *Isaac Brown* ***Approval required***	goals were not met because they were tied to the delayed HPR system implementation. The seventh unmet goal was actually terminated because it duplicated with a Population Health department goal. Isaac encouraged Q/UAC members to review the Work Plan and reach out if there is an area that may or may not be listed by which provider organizations could use some help. The Q/UAC posed no questions. **Dr. Moore said approval would be by one motion at the end of the QI Trilogy presentation.**	
Summary of **QI Trilogy Documents** • 2023-2024 QI Evaluation • 2024-2025 QI Program Description • 2024-2025 QI Work Plan *Isaac Brown* ***Approval required***	Our QI Evaluation is designed to look at how well things went last year. Did the programs we put in place have the outcomes we hoped for? Did we want to continue those programs into the future? The Evaluation contains the FY 2023-2024 assessment of any activities that have been completed and many things that are on-going. We are looking at trending our performance over time. You may have had pilots in your organizations where you tried them out and you hoped that they would work well. We try to make sure that what we are working on has had the impacts that we were hoping form and if not, we need to change things up. Sometimes that requires us working with you all on this advisory committee to understand those new things that we could be doing to make a greater impact. If it didn't have the impact we expected, why? What are those barriers that are preventing us? Our Program Description is really looking at what are Quality department efforts are comprised of, who are the main players and pieces, and the different processes that we work. This document does not change much year to year because we follow a pretty consistent structure. That said, we have now started to include verbiage about our inclusion of D-SNP, our Dual Special Needs Plan anticipated to go-live Jan. 1, 2026. As we move toward having a Medicare line, you'll see Medicare inserted a little bit at a time in our goals and in our Work Plan. We've also added our work with Health Equity. There is one section that calls out the released All Plan Letter (APL) 24-004 on QI and Health Equity Transformation requirements. (Any time there is a change to policy or structure in an APL, we'll generally include that in the Program Description.) As our technology changes and our data needs change, we added different committees and different groups to help make sure that all of that is flowing properly. There was a formation of our Analytics Steering Committee to help us in our data efforts. Many of you may have looked at those HEDIS scores and thought "I felt I did better than that.' In many cases, we are finding that the data flowing in has some challenges. We are constantly working to improve how our data represents the good work that our providers are doing. Finally, we have our 2024-2025 Work Plan. This is where we are looking for ways to improve quality of care, safety of care, member experience. In there is timeframe, who is responsible for them. For those who use our Partnership Quality Dashboard (PQD) and eReports platforms, we have a member of our Process Improvement team that is going to be surveying you on the network to find out what tools you use, what you are not using, and what we need to add. Your feedback will allow us to choose the right interventions. We are trying to make sure our Work Plan aligns with our organizational goals and the goals of the State, and your goals. There were no questions for Isaac on the QI Trilogy, which Dr. Moore called "a rich document," developed over six or more months. **One motion to approve both the Close Out and the QI Trilogy: first: Robert Quon, MD; second: Brian Montenegro, MD. Approval was unanimous.** Medical Director for Quality Mark Netherda, MD, commented that he, Nancy and Isaac sit on the Local Health Plan of California's quality committee and that he was amazed to see on their Aug. 16 agenda the question "how do you get external physicians to sit on your quality	

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	committees?" (Most attend these committees virtually and they don't make any comments.) "I just want to say 'thank you so much for being here,'" Dr. Netherda said. "Thanks for understanding the importance of our work and participating."	
VIII. **Adjournment** – Q/UAC adjourned at 9:00 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Sept. 18, 2024.		

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

Signature of Approval: _____ Date: _____

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Aug. 13, 2024 / 1:30 – 3:15 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
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, Director of Quality Management, Quality Improvement
Campbell, Anna, 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
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Kerlin, Mary, Senior Director, Provider Relations
Klakken, Vicki, Regional Director – Northwest
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – Central
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
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:

Ayala, Priscila, Associate Director of Provider Relations
Bjork, Sonja, JD, Chief Executive Officer
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Davis, Wendi, Chief Operating Officer
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Sharp, Tim, Regional Director – Northeast
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Bikila, Dejene, Manager of Data Science, Finance
Bontrager, Mark, Senior Director of Behavioral Health
Booth, Garnet, Manager of Provider Relations Representatives (NR)
Brito, Alex, Senior Health Data Analyst I, Finance
Chishty, Shahrukh, Sr Manager of Foster Care Programs, Behavioral Health
Clark, Kristen, Manager of Quality & Training, Member Services
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)
Gual, Kristine, Manager of Performance Improvement, (SR) QI
Hanusiak, Kenzie, Manager of Governance & Regulation, Compliance
Harris, Vander, Senior Health Data Analyst I, Finance
Lee, Donna, Manager of Claims, Claims
Matthews, Richard "Doug," MD, Regional Medical Director, Central
O'Connell, Lisa, Director of Enhanced Health Services
O'Leary, Hannah, Manager of Population Health, Pop Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Rodekohr, Dianna, Project Manager I, Configuration
Rushing, Eric, Project Manager I, Behavioral Health
Townsend, Colleen, MD, Regional Medical Director – Southeast
Tryan, Tiffany, Improvement Advisor, QI
Vaisenberg, Liat, Associate Director of Health Analytics, Finance

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 1:32 p.m. Approval of June 11, 2024 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • May 9 Substance use Internal Quality Improvement (SUIQI) • May 23 Member grievance Review Committee (MGRC)	Motion to approve IQI Minutes: Isaac Brown Second: Colleen Townsend, MD Motion to accept other minutes: Mark Netherda, MD Second: Colleen Townsend, MD
II. Old Business – *returning from May 2024*		
Quality Improvement: *Presenter: Jeff Devido, MD, Behavioral Health Clinical Director*		
MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	**This is a major revision of the Adult Depression Treatment Flow Diagram (Attachment A)** of this clinical practice guideline last approved in May QI committees. The prior version of this algorithm was based largely on the protocol used in the STAR*D study, which is now dated for clinical practice. Two primary references are cited in the new algorithm: 1) Pharmacology algorithms textbook, and Schatzberg's textbook on psychopharmacology. In addition, standard clinical practice experience was incorporated. The basic algorithm posits screening, making an accurate diagnosis and ruling out medical or other psychosocial factors, considering psychotherapy throughout, initiating lowest side effect antidepressant medications first (usually SSRI) through shared decision making model, and proposing augmentation/switching considerations. Furthermore, greater detail is provided in terms of factors to consider when selecting an antidepressant, reasons for poor response, and risk factors for recurrence. The algorithm is not intended to be comprehensive or definitive: it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care settings. • **Provider Note:** Medi-Cal mental health treatment services are divided between county specialty mental health (SMH) and managed care plan non-specialty mental health (NSMH) programs. The differentiation is based on clinical severity, with higher severity patients being preferentially routed to SMH systems of care. See policy MCUP3028 – Mental Health Services. • **Provider Note:** Depression pharmacotherapies are the responsibility of State Medi-Cal. If the pharmacotherapy is on the State Medi-Cal Covered Drug List (CDL), then no TAR is required. If the pharmacotherapy is not on the CDL then a TAR is required (submitted to Medi-Cal RX, not Partnership). Dr. Devido went through the synopsis. There were no questions.	Motion to **approve as presented**: Mark Netherda, MD Second: Brigid Gast, RN Next Steps: Aug. 21 Quality/Utilization Advisory Committee (Q/UAC) Sept. 11 Physician Advisory Committee (PAC)
III. New Business (Committee Members as applicable) – Consent Calendar		
PQI/PPC 1st and 2nd Qtrs 2024 – *direct questions on this and the accompanying data analysis to Robert Bides, RN* ***Health Services Policies*** Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee MPQP1003 – Physician Advisory Committee (PAC) MPQP1004 – Internal Quality Improvement Committee MPQP1048 – Reporting Communicable Diseases		There were no questions. The Consent Calendar was **approved as presented:** Colleen Townsend, MD Second: Mark Netherda, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Utilization Management MCUG3007 – Authorization of Ambulatory Procedures and Services MCUG3024 – Inpatient Utilization Management MCUP3012 – Discharge Planning (Non-capitated Members) MCUP3052 – Medical Nutrition Services – *passed in June, this came back for one addition* MCUP3119 – Sterilization Consent Protocol MCUP3130 – Osteopathic Manipulation Treatment MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21 MPUP3078 – Second Medical Opinions Population Health Management MCNP9004 – Regulatory Required Notices and Taglines ***Member Services*** MC334 – American Indian *Rights and Protections* – **new title**; *attachments A & B are archived* MP301 – Assisting Providers with Missed Appointments MP316 – Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior ***Provider Relations' Credentialing Policies*** MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements	Next Steps: • Health Services policies will go to Aug. 21 Q/UAC and to Sept. 11 PAC • Member Services' policies MP301 and MP316 also go on to Q/UAC and PAC • Provider Relations' Credentialing policies passed the Credentials Committee on Aug. 14.
IV. New Business – Discussion Policies		
Care Coordination: *Presenter: Shannon Boyle, RN, Manager, Care Coordination Regulatory Performance*		
MCCP2007 – Complex Case Management	**Policy edits due to NCQA Consultant recommendation.** **Related Policies added:** MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities MPQP1038 - Physician Orders for Life-Sustaining Treatment (POLST) MCQP1047 - Advance Directives **Definition added:** Medical Home **Definition revised:** Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric Members with a CCS-eligible condition(s). **VI.C.5 revised:** For any area of the assessment where the information below is considered inappropriate or not applicable to the Member, Partnership CC Staff will indicate an 'N/A' on the assessment next to that question followed by a clear reason or explanation why the assessment was marked N/A. If a Member is unable to recall information on the assessment or refuses to answer a particular question on the assessment, Partnership CC Staff will notate applicable areas.	Motion to **approve as presented**: Mark Netherda, MD Second: Colleen Townsend, MD Next Steps: Aug. 21 Q/UAC consent calendar Sept. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.5.h. added: See Partnership policies MCQP1047 Advance Directives and MPQP1038 Physician Orders for Life-Sustaining Treatment for more details. **References updated:** National Committee for Quality Assurance (NCQA) Health Plan Standards 2024. Population Health Management 5 Complex Case Management Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032 Enhanced Care Management Requirements (12/22/2023) Shannon went through the synopsis and answered Dr. Netherda's question: Diane Williams is the NCQA consultant who suggested some changes. There were no other questions.	
MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	**Policy edits due to CHDP Sun Setting July 1, 2024** **Related Policies added:** MCUP3102- Vision Care **Definitions added:** NCHCC: Northern California Hearing Coordination Center Newborn Hearing Screening Program (NHSP) **Definition revised:** EPSDT: Early and Periodic Screening, Diagnostic, and Treatment *(see also Medi-Cal for kids and Teens below)* Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s). **VI.C.2 added:** For more information, see Partnership policy MCUP3102 Vision Care **VI.J added:** For non-WCM counties, refer to Partnership policy MPCP2002 California Children's Services **VI.R. Newborn Hearing Screening Program (NHSP) added:** 1. Partnership is responsible for case management services related to EPSDT and collaborates with the PCP and/or Specialist to ensure follow-up for missed EPSDT-related appointments, which includes follow-up with the families of babies that miss their hearing screening or diagnostic appointments. Partnership's Care Coordination department will receive referrals from Northern California Hearing Coordination Center (NCHCC) to assist in case management services for access to care concerns and following up on missed hearing screening or diagnostic appointments. 2. Partnership providers can refer members who have missed or failed EPSDT-related appointments through the external referral form on the Partnership's website. Our Care Coordination staff may also reach out to the member once the referral is received to assist with care coordination services and identify barriers. Shannon went through the synopsis. There were no questions.	Motion to **approve as presented**: Colleen Townsend, MD Second: Mark Netherda, MD Next Steps: Aug. 21 Q/UAC Sept. 11 PAC
Utilization Management: *Presenter: Anna Campbell, Policy Analyst, UM*		
MCUG3010 – Chiropractic Services Guidelines	Policy updated per DHCS guidelines for chiropractic services for Members eligible for EPSDT services. **Section I.B.** Related Policy MCUP3042 Technology Assessment was removed and replaced by MCUP3041 TAR Review Process as chiropractic services for Members under age 21 will now require a TAR. **Section III.** Definition of EPSDT updated to include California's specific name for the program, "Medi-Cal for Kids & Teens."	Motion to **approve as presented**: Doug Matthews, MD Second: Brigid Gast, RN Next Steps: Aug. 21 Q/UAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.B.1. Specified that Members age 21 and over who are capitated or assigned to a primary care provider require a RAF from their PCP for chiropractic services. **Section VI.B.2.** Specified that Members under age 21 require prior authorization with justification of medical necessity for chiropractic services. A TAR must be submitted and EPSDT criteria will be considered when evaluating the request. **Section VI.B.8.** Removed paragraph which previously stated that Partnership finds insufficient published evidence of any benefits of chiropractic manipulation in children under age 12 and therefore requests for chiropractic care in children under age 12 must be submitted as per policy MCUP3042 Technology Assessment which describes investigational services and interventions. (Instead, we now have the TAR requirement at VI.B.2.) Anna went through the synopsis. The policy was updated per DHCS guidelines for chiropractic services for Members eligible for EPSDT services. Partnership will require a Treatment Authorization Request for Members under age 21. There were no questions.	Sept. 11 PAC
Utilization Management: *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*		
MCUG3118 – Prenatal and Perinatal Care	This policy was updated ahead of schedule to integrate changes in CPSP services, which allow programs that are not certified by the CDPH to provide these services and be reimbursed for Health Ed/Case Management, Nutrition, and Behavioral Health. The policy changes will allow programs to continue to be paid for these services for up to 12 months after delivery. **Section I.** The following were added as Related Policies: G. MCUP3124 – Referral to a Specialist H. MCUP3052 – Medical Nutrition Services I. MCCP2020 – Lactation Policy and Guidelines J. MCUP3113 – Telehealth Services K. MCQG1015 – Pediatric Preventive Health Guidelines **Section III.B**. The definition of the Comprehensive Perinatal Services Program (CPSP) was updated and a note was added to explain the relationship between CPSP and Partnership HealthPlan Perinatal Services (PHPS). **Section III.F**. A new definition was added for Partnership HealthPlan Perinatal Services (PHPS). **Section III.G**. A new definition was added for Perinatal Case Manager, which also describes a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program. **Section IV. Attachments** Three new attachments were added as follows: A. Partnership HealthPlan Perinatal Services (PHPS) Application and Update Form B. Partnership Perinatal Case Management TAR Thresholds C. Applying for the CDPH CPSP program **Section VI.** Terminology was updated throughout the policy to differentiate between CPSP services and CPSP-like services. **Section VI.B.** This section was updated to describe Partnership HealthPlan Perinatal Services (PHPS) **Section VI.C.** This section was updated to describe PHPS Standards of Perinatal Case Management **Section VI.D.** This section was updated to describe CPSP/ Perinatal Services Case Management Responsibilities **Section VI.E.** This section was added to describe Perinatal Services Health Education Roles **Section VI.F.** This section was added to describe services for Diabetes Care in Pregnancy **Section VI.G.** This section was added to describe services for Lactation Counseling and Education	Motion to **approve as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: Aug. 21 Q/UAC Sept. 11 PAC **Note: Immediately after PAC ends Sept. 11, Partnership will hold a webinar for staff at noon.**

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.H. This section was updated to describe Referral Procedures. Mention of Kaiser and Woodland Health Care was removed. **Section VII.G.** A new Reference was added for the American Diabetes Association. **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Dr. Townsend went through the synopsis. Our policy includes both clinical and "wrap-around" services once provided under CPSP. Partnership HealthPlan is now administering Perinatal Services to include program approval, oversight and reimbursement for the following services: clinical care, behavioral care, nutrition, health education and lactation support, and case management, under Partnership HealthPlan Perinatal Services (PHPS). We will not require any site to be CDPH certified, however certification by CDPH is encouraged. Further, a practice that may have been certified at just one site may operate perinatal services at all its practice sites. Dr. Kubota asked for clarity: a large organization like Adventist Health need only make one application? Doctors Moore and Townsend both said "yes," saying this should improve access to care. Dr. Moore noted that after this packet was put together, Attachment A was amended to say that a CPSP program can be run by a licensed midwife. The program's medical director will be referred to as the "clinical director." A contract addendum, which will affect the provider application, is now being drafted. Attachment B's codes were run by Claims. Benefits now extend to 12 months postpartum. Mark Bontrager asked if behavioral health claims will be billed through Carelon. Dr. Townsend said it depends. Dr. Moore said they will be billed on the medical side. Partnership will accept Carelon's certification of Perinatal Services Behavioral Health providers. Dr. Moore concluded this is a "great policy, one that other health plans may model."	
Utilization Management: *Presenter: Marshall Kubota, MD, Regional Medical Director (Southwest)*		
MCUP3111 – Pulmonary Rehabilitation	**Section VI.D.2.d.** Dr. Kubota would like to discuss the possible addition of "lung cancer" as another chronic condition, which may be eligible for pulmonary rehabilitation**.** **Section VIII. References** A. Reference article from the American Thoracic Society was updated. D. Reference article on post-acute COVID-19 Syndrome was updated. E. Reference article on Telehealth Pulmonary Rehabilitation was removed. **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." After Dr. Kubota's synopsis, Anna asked if this should still be considered an "enhanced benefit" if the State now covers pulmonary rehab, but Partnership provides additional benefits? Dr. Moore noted that when we cover something that the State does not, a TAR is required. On Dr. Moore's amendment, Anna will delete the word "enhanced" from any description of the benefit. **Subsequent to this meeting, two policy sections were amended**: v. The Purpose Statement now reads: "To define covered services and medical necessity criteria for pulmonary rehabilitation." x. The Revision Dates section now notes that DHCS added Pulmonary Rehabilitation as a benefit in 2018.	Motion to **approve as amended**: Mark Netherda, MD Second: Colleen Townsend, MD Next Steps: Aug. 21 Q/UAC Consent Calendar Sept. 11 PAC
Utilization Management: *Presenter: Eric Rushing, Project Manager, Behavioral Health*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MCUP3145 – Eating Disorder Management Policy	**Section IV. Attachments** Two new attachments were added as follows: A. Eating Disorder Process Flow Chart B. Eating Disorder Bidirectional Form **Section VI.A.2.b. and VI.3.** Language was updated to reflect that Eating Disorder guidance is part of the new DHCS MOU template for Specialty Mental Health Services **Section VI.3.a.** Statement added for division of financial responsibility. "In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the MHP for residential level treatment for eating disorders pursuant to APL 22-003." **Section VI.3.e.** Added language regarding exchange of information. "These procedures are either incorporated in the MOU or shared with the MHP as part of the related policies which further describe how the provisions on the MOU are carried out." **Section VII.F.** Updated reference for new DHCS MOU template for Specialty Mental Health Services **Section IX.** Updated Position Responsible for Implementing Procedure to "Chief Health Services Officer." Eric said that State policy is suggestive and not proscriptive. Partnership's Behavioral Health Clinical Director, in addition to the Chief Health Services Officer, will provide policy oversight. Partnership developed the Attachment A flow chart in long collaboration with all the legacy and expansion counties, a feat both doctors Moore and Netherda remarked upon. Dr. Moore noted that Partnership developed this policy in 2022 and it has been very helpful in reducing the amount of time it takes for our medical directors to approve treatment for eating disorders. This policy "is executed really well," Dr. Moore said.	Motion to **approve as presented**: Mark Netherda, MD Second: Jeff Devido, MD Next Steps: Aug. 21 Q/UAC Sept. 11 PAC
V. Presentations		
1. Quality and Performance Improvement Update *Nancy Steffen, Senior Director of Quality and Performance Improvement*	Dr. Moore prefaced Nancy's remarks by saying this is the first meeting at which we will reveal our MY2023 Health Effectiveness Date and Information Set (HEDIS®) performance. • Our fiscal year Perinatal Quality Improvement Program (PQIP) has done great outreach in our expansion counties. Ten perinatal providers are joining Partnership this month. This is timely given back-to-school and other access needs. FY 2023-2024 incentive payments are scheduled to be distributed by Oct. 31. • The State was late telling us about our measures. Quality Measure Score Improvement (QMSI) input into strategies is now being tracked. We will talk more about this in October. • The DHCS statewide Equity and Practice Transformation Program is reduced in scope and size because of budget constraints. The program is now $140M over three years. Partnership encourages our participating providers, who will receive their initial payments later this year, to keep on with the program, as there is no downside to doing so. We will talk more about funding in future meetings. • The QI Locum Pilot Initiative continues through 2024. Designed to help improve access in measures where we struggle (e.g., well-child), the pilot has offset some clinical needs too. Pilot grants have been awarded to four providers participating in the PCP Modified QIP: Hill Country Community Clinic, Pit River Health Service, Round Valley Indian Health, and Community Medical Center. • The Health Equity Accreditation Mock Survey is scheduled for Aug. 19-21. Some executives have been invited.	*Information only.* There were no questions for Nancy.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
2. HEDIS® MY 2023/ RY 2024 Summary of Performance *Nancy Steffen* and *Sue Quichocho, Manager of Quality Measurement*	HEDIS® shows there are real people behind the data. Outcomes can affect a health plan's reputation as below average results and related sanctions are publically disclosed. In MY 2024, Partnership risks approximately $17M based on HEDIS/CAHPS® (Consumer Assessment of Healthcare Providers and Systems), so we are focusing in part on improving our MCAS performance. In addition to our NCQA HPA Accreditation, we will be required to carry also NCQA HEA by 2026. MY2023 performance does not include the 10 expansion counties that came aboard Jan. 1, 2024, and is the last year DHCS will evaluate our performance based on our four legacy regions. In MY2024, our performance will be assessed plan-wide across all 24 member counties. This aligns with NCQA reporting. During MY 2023, Partnership membership increased by 5.8% and national Quality Compass benchmarks, though stabilizing, increased over the prior year. These are just two factors of many that resulted in a year that did not show marked performance improvement despite gaining distance from the pandemic. Anticipated improved platforms and better migration and integration of data should help improve MY 2024 results. Nancy congratulated the HEDIS team for qualifying data in this framework, a complex process as there were issues with the Health Information Exchange (HIE) known as SacValley Data Share. In MY2023, 15 MCAS measures continued from the previous year and three more were added, including two Centers for Medicare and Medicaid Services (CMS) Core Measures (i.e., developmental screening for children age 2-2 and dental screening) that as yet have no national benchmark available for scoring. DHCS requires us to perform above the Minimum Performance Level (MPL) (i.e., 50th percentile of the national Medicaid percentile) in each measure or financial withholds may result. Partnership bases its composite scoring methodology on that of DHCS to determine Quality Factor Scores (QFS). In composite scoring, points are awarded per measure per reporting region based on that measure's performance relative to the national benchmarks, so four reporting units X 16 scored measures = 64 total scores. Nancy noted of the 64 measures scored in MY2023, 31 reached or exceeded MPL while 33 measures remained at or declined below the MPL. Within those scoring at or above MPL, 24 continued from prior year, five improved from prior year, and two represented re-instated measures. Within those scoring below the MPL, 26 continued as such from prior year, five dropped below from prior year, and two represented re-instated measures. The stagnant change from MY 2022 can be explained in three ways: • Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes • Reported data showed gaps, decreasing confidence that reported rates accurately reflect performance • Measure specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure's purpose and clinical practice. Plan-wide, the four best performing measures (all of these will be considered Quality Withhold Measures starting in MY 2024) were: • Postpartum Care (PPC-Post) • Controlling High BP (CBP) • Hemoglobin A1c Poor Control (>9%) (HBD) • Timeliness of Prenatal Care (PPC-Pre)	More detail can be found in the Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) summaries of performance included in the packet.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Plan-wide, the most improved measure was Lead Screening in Children (LSC), perhaps because of efforts around provider education and increased practice access to lead Point of Care (POC) devices. Nancy thanked Associate Medical Director Teresa Frankovich, MD, for her work in this area. The HEDIS® report analyzed performance by region, diving into a closer look at stagnant rates in the Northeast and Northwest regions. Cervical Cancer Screening (CCS) was the only measure to improve to the MPL in the Northwest: Nancy gave a shout out to Open Door Community Health Centers for improving their PCP QIP rate by 46% in MY 2023. An ongoing pilot of self-swab test kits distributed to members by their PCPs could further improve this measure. The Asthma Medication Ratio (AMR) is once again a measure that will be addressed going forward in Partnership's Chronic Disease workgroup. It declined in both the Northwest and Northeast region, where access is a driver. Immunizations for Adolescents (IMA) improved in the Northwest, as did Breast Cancer Screening in both the Northwest and Northeast, although each remains below that MPL. There are no quick solutions to any withhold measures but one thing we may keep an eye on are those who miss their second flu vaccine, Nancy said. Child and Adolescent Well Care Visits (WCV) and Well Child Visits: 15-30 Months (W30+2) improved to the MPL in the Southwest region; however, well child measures taken together continue to face access challenges plan-wide. Further, these measures are "tricky" because many members do not perceive that a visit is necessary. Incomplete data is the largest driver to low Follow-up after ED visit for Mental Illness (FUM-30) and Follow-up after ED visit for Substance Use (FUA-30) rates. These measures are heavily reliant on DHCS providing data on behalf of the counties. Partnership will work on solutions through IT and Behavioral Health teams. More work on data completeness will also help us evaluate topical fluoride treatments. In the absence of national benchmarks, Partnership is assessing using the CMS FFY 2022 State Median as the DHCS designated MPL benchmark. Most PCPs refer members to dental clinics and we are not capturing those codes, nor do providers talk to Partnership about oral health, Nancy said. Out Site Review teams has been educating providers on the new MCAS measure, Developmental Screening in the First Three Years of Life (DEV). The Southeast region has performed well above the State Median but more work is still necessary to bring along the other regions. <u>Next Steps</u>: • The impact on accountable measures reported by Partnership is still being analyzed in the Southeast and Southwest regions, where a delegated arrangement once existed with Kaiser. • DHCS will report QFS later this year and assess mandated performance improvement activities and sanctions thereafter. • Final assessment of results is ongoing and being used to adapt QMSI strategies and tactics in 2024-2025. • The HEDIS® team continues to work with IT to strengthen existing and add new supplemental data sources to improve data completeness across MCAS. Sue concluded the presentation by going over a Venn diagram outlining the measure overlaps between DHCS MCAS and NCQA HPA. Partnership's focus has been more on DHCS's childhood and adolescent preventive care measures and less on NCQA HPA measures on adult immunizations, respiratory treatment, diabetes, heart disease, and behavioral health.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Partnership will be reporting our NCQA Health Plan Rating on our website at the end of August. Dr. Kubota asked if we got closer than before to a 4.0 Star rating. Nancy said we were very close to a 4.0. The HPA summary document in this meeting packet discusses that. Dr. Moore thanked both Nancy and Sue for their joint presentation.	
3. Closeout Summary of FY 2023-2024 QI Work Plan *Nancy Steffen*	The QI Work Plan is designed to track progress on key QI activities and initiatives throughout the year. Approved by our Board of Directors and quality committees, it includes progress updates on planned activities and objectives for improving quality of clinical care, safety of clinical care, quality of service and members' experience. The Work Plan is set on a fiscal year (FY) 2023-2024 schedule. This update includes progress on activities included in the FY 2023-2024 QI Work Plan from July 1, 2023 to June 30, 2024. Sixty-two goals were outlined in the QI Work Plan: 55 were met; six went unmet largely because of data system delivery delays, and one was terminated because it overlapped with Population Health programs. QMSI successfully engaged five measure-focused workgroups: Pediatric, Chronic Diseases, Medication Management, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities. Highlights include: • School-focused immunizations were expanded following previous year's successful pilot program. • A Cervical Cancer self-swab pilot launched in January. • Partnership members completed 1,528 mammograms through 67 mobile mammography days with 27 provider organizations at 41 geographical sites. The Southeast and Southwest regions reached the targeted PCP QIP Breast Cancer Screening 50th percentile benchmark. • The Perinatal QIP implemented a new "Depression Screening at First Prenatal Visit" measure. • Partnership's collaboration with Exact Sciences to distribute Cologuard kits continues to improve access to colorectal cancer screening. • The QIP Team developed and implemented a network-facing Disparity Analysis Dashboard, allowing the evaluation of member data by key demographic indicators including race and ethnicity. • The HQIP Team on-boarded six new Expansion County Hospitals into the HQIP, each participating in an individual orientation and receiving education on the new 6-month measure set developed specifically for them. • In addition to successful renewal of HPA, the program was expanded to prepare for Health Equity Accreditation (HEA) and the next HPA survey in 2025. The HPA goal ensured continuous compliance of HPA requirements and the HEA goal ensured readiness of all assigned HEA Standards and Guidelines for Initial Survey targeting for June 2025. The Work Plan Excel spreadsheet is included as FYI in today's packet. There were no questions for Nancy.	There were no questions for Nancy. **There was one collective motion to approve both the just closed QI work plan and the three documents of the 2024-2025 QI Trilogy**: Marshall Kubota, MD Second: Mark Netherda, MD
4. Summary of QI Trilogy Documents *Nancy Steffen*	Nancy thanked Isaac Brown and Barb Selig and her team who together serve with Nancy as the QI Trilogy team charged with preparing the QI Program Description, Program Evaluation, and Work Plan, keeping in mind regulatory and NCQA Accreditation requirements. Approval will be sought from the Board of Commissioners Oct. 9 and thereafter submitted to the State and shared with Partnership members via the website and upon request. The FY 2024-2025 Program Description is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The description contains the following components per the NCQA accreditation standards (QI 1A):	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• The QI program structure. • The behavioral healthcare aspects of the program. • Involvement of a designated physician in the QI program. • Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program. • Oversight of QI functions of the organization by the QI Committees. The FY 2023-2024 QI Evaluation is designed to assess performance on work outlined in the QI Program Description and the QI Work Plan. Per NCQA requirements (QI 1C), the evaluation must include the following: • A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service. • Trending of measures of performance in the quality and safety of clinical care and quality of service. • Evaluation of the overall effectiveness of the QI program and of its progress toward influencing network wide safe clinical practices. The FY 2024-2025 Work Plan outlines major activities for the QI Department and organization as a whole that advance quality and performance improvement. The Work Plan is designed to monitor and increase accountability per the NCQA technical specifications (QI 1B) via yearly planned QI activities and objectives for improving: • Quality of clinical care • Safety of clinical care • Quality of service • Members' experience	
5. QI Trilogy: Evaluation, PD, and Work Plan *Nancy Steffen*	In preparing the 2023-2024 Evaluation, the following items were given greater consideration. 1. Continued analysis of the QI program structure and how the roles defined within the QI department and senior leadership/physician roles fulfill it. 2. Enhanced trend analysis and implementation of interventions for measurements related to clinical quality, member safety, and member experience outcomes, reflecting the most recent 12-month period compared to the prior year 3. Continued assessment of barriers in quality improvement with corresponding health plan adaptations to member and provider engagement strategies and tactics Assessment of resources and organization of quality and performance improvement activities to accommodate the growing scope and complexity of quality measurement, and reporting under both DHCS and NCQA accreditation. In FY 2023-2024, of particular focus was the impact of Partnership's 10-county expansion, evaluation of achieving at least a 3.5 STAR health plan rating as an NCQA accredited health plan, and preparation for NCQA Health Equity Accreditation requirements. The 2024-2025 Program Description (MPQD1001) reflects revisions completed through interdepartmental review and collaboration, particularly in the following areas: 1. Updated policy language in the Approach to Quality and Performance Improvement section to clearly indicate how the QI Program fulfills recently released APL 24-004: QI and Health Equity Transformation Requirements. 2. Shifting from the IHI Triple Aim (population health, patient experience, and cost efficiency) to a Quintuple Aim. Partnership is committed to pursuing the fourth aim by supporting workforce well-being in an effort to ensure	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	providers across our network have adequate resources to provide high-quality care for our members. Partnership is committed to pursuing the fifth aim by striving to achieve equitable health for all of our members. 3. As a tool for evaluating meaningful improvements in DEI (Diversity, Equity, and Inclusion) and for preparing for NCQA Health Equity Accreditation (HEA), Partnership will distribute a DEI Survey on an annual basis to assess the diversity of key committees. The annual DEI Survey will allow committee members to provide feedback on improving the diversity, equity, and inclusion within their respective committee. 4. Formation of the Analytics Steering Committee that functions to promote and coordinate data analytics efforts to generate information, knowledge, and wisdom to improve health outcomes, enhance the member experience of care, and reduce or maintain the cost of care by optimizing utilization of data, technology and staff. 5. In preparation to acquire NCQA HEA, Partnership will conduct a full-scope Mock Initial Survey to identify and address gaps to assess readiness for Initial Survey in 2025. 6. Preparing to become a Medicare Medi-Cal Health plan by offering a Dual Eligible Special Needs Plan (D-SNP) by January 2026. 7. Partnership continues to devote coaching resources designed to align with the priorities and needs of organization performing below the minimum performance level (MPL) in an effort to build capacity for quality improvement work. The 2024-2025 Work Plan is enhanced over the previous year's document to identify whether a goal is new or continued to better track monitoring of previous conditions, which is an NCQA requirement. The Work Plan contains numerous deliverables, including: • 42 in measurement, analytics and reporting • 29 around value-based payment programs (QIPs) • 12 across clinical quality improvement projects • 3 around service and patient experience • 9 caring for members with complex needs • 22 around quality assurance and patient safety, and • 28 around QI training and coaching	
VI. FYI and Adjournment		
FYI: The final 2023-2024 QI Program Work Plan Excel document was included at the end of the packet – *direct any questions to Nancy Steffen*		
Dr. Moore adjourned the meeting at 3:15 p.m. IQI will next meet Tuesday, Sept. 10, 2024.		
Respectfully Submitted by Leslie Erickson, Program Coordinator I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD* *Chief Medical Officer and Committee Chair*		

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

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

Date: 8/20/24 **Time**: 7:30 am to 9:00 am

Facilitator: Mohamed Jalloh, Pharm.D, HEO

Coordinator: Vicquita Velazquez

Meeting Locations:

- WebEx teleconference
- 4665 Business Center Drive, Fairfield CA 94534 (Napa Solano Conference Room)
- 2525 Airpark, Redding, CA 96002 (Burney Falls Conference Room)

Internal Attendees:
Katherine Barresi, RN, BSN, PHN; Mark Bontrager; Shannon Boyle, RN; Isaac Brown; Monika Brunkal, RPh; Anna Campbell; Shahrukh Chishty; Nicole Curreri; Nicole Escobar; Heather Esget, RN; Greg Allen Friedman; Margarita Garcia-Hernandez, Ph.D.; Nisha Gupta; Jaymee James; Amanda Kim; Vicky Klakken; Marshall Kubota, MD; Yolanda Latham; John Lemoine; Stan Leung, Pharm.D; Lilian Merino; Robert Moore, MD; Mark Netherda, MD; Rachel Newman, RN; Hannah O'Leary; Katheryn Power; Sue Quichocho; Manleen Randhawa; Kimberly Robertello, Ph.D.; Dorian Roberts; DeLorean Ruffin, DrPH; Anthony Sackett; Tim Sharp; Amy Turnipseed; Edna Villasenor

External Attendees:

Eugene Durrah; Eva Julian; Arlene Pena, Rocio Rodriguez; Leila Romero; Saveena Sandhu; Candi Stockton, MD; Tiffani Thomas, EdD; Lisa Wada; Denise Whitsett

Absent:

Priscila Ayala; Robert Bides, RN; Sonja Bjork; Jason Cunningham; Dawn R. Cook; Cathryn Couch; Jeffrey DeVido, MD; Shandi Fuller, MD; Tony Hightower; Latrice Innes; Eva Julian; Kermit Jones, MD; Rachel Joseph, Mary Kerlin, Matthew Konar; Valerie Padilla; Jeremy Plumb; W. Suzanne Edison-Ton, MD; Hendry Ton, MD; Liat Vaisenberg; Harold Wallace; Kory Watkins

Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome & Introductions** Time: 5 minutes *Speaker:* *Robert Moore, MD* *Mohamed Jalloh, PharmD*	Introduction of attendees. The quorum was met by having 7 members present.	
Agenda Item 2 **Meeting Minutes** Time: 2 minutes *Speaker:* *Mohamed Jalloh, PharmD*	Dr. Jalloh brought the committee's attention to the last quarter meeting minutes and asked if anyone in attendance had any questions. There were no questions so the motion was made to approve the minutes. • **First motion:** Dr. Stockton • **Second motion:** Arlene Pena There were no opposed motions.	

4665 Business Center Drive
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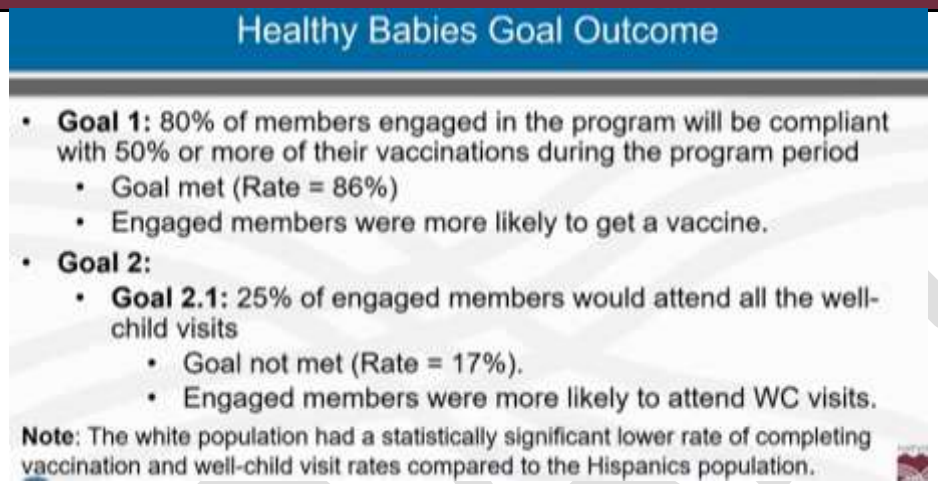
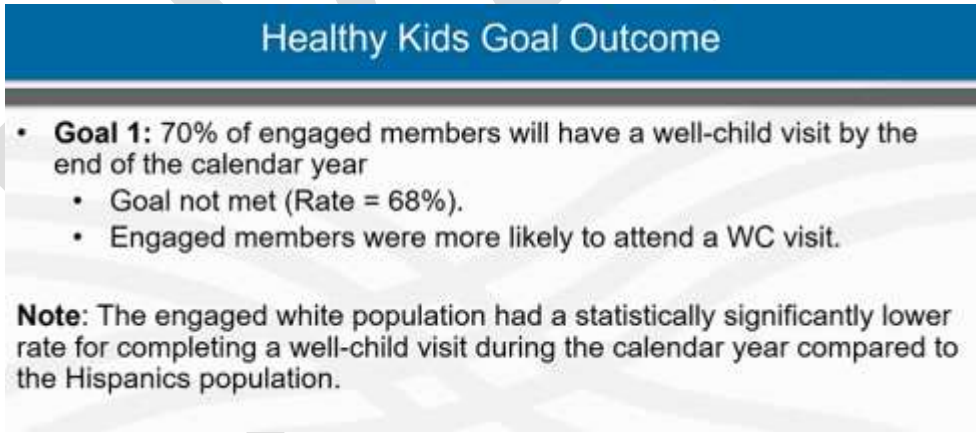
Agenda Topic	Notes	Action Item
Agenda Item 3 **Health Plan Updates** *Time: 10 minutes* *Speaker:* *Mohamed Jalloh, PharmD*	There is a new APL (All Plan Letter) from DHCS (Department of Health Care Services) related to transgender care. DHCS will be looking for draft comments on transgender care and requiring health plans to create training to train their internal staff. These trainings will be with the Diversity Equity and Inclusion (DEI) requirements. In addition, we will be updating our directory where the members can receive transgender care information. The Equity Transformation Grants (ETH) is looking for health plans to take over partial payments of the grants. We are currently working with a vendor to get the DEI training finalized. The state is reviewing the training submitted to them by the various health plans. The plans are waiting for feedback from the Department of Health Care Services (DHCS). The state did not have any guidance document on the way to review the training. This may mean we have flexibility on the training we can provide. Our health plan has 24 counties which is a big outreach. Katherine Barresi asked what is the time frame for submission of the DEI training. Dr. Jalloh says there are two phases with the first one being submitted by Oct. 15, 2024 to be reviewed. One health plan was granted an extension so that is something we can use if needed. The second phase is by December of 2025, the training is due to be distributed to all our external providers as well as internal employees. We will be doing a pilot with one of our external clinics the first 6 months of 2025 and subsequently, we will be rolling it out to all of our counties. We will be having a health equity strategic plan to create organizational alignment in addressing disparities.	

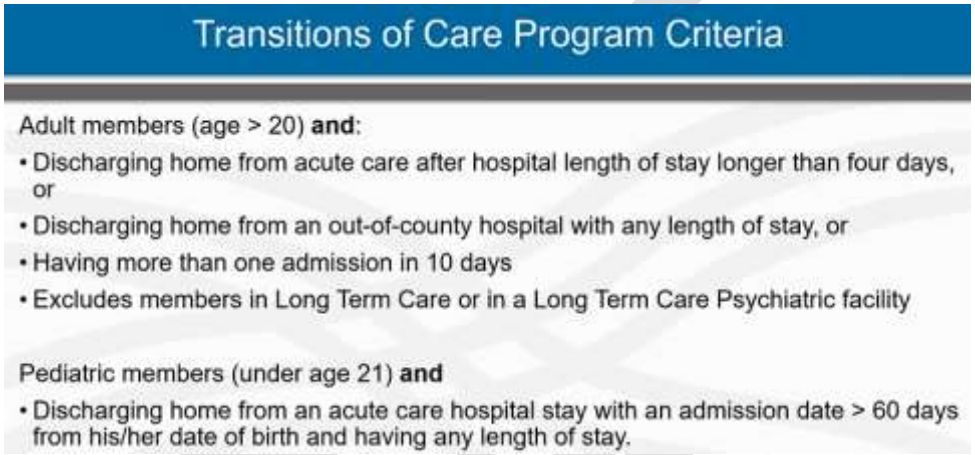
Agenda Topic	Notes	Action Item
	DHCS requires that QIHEC members review certain data points. Previously, we reviewed: • Population Needs Assessment (PNA) • Community Health Assessment (CNA) • HEDIS Measure Findings This meeting we will be considering: • Additional HEDIS Measures • CAHPS Measures • Population Health Strategy Activities • Utilization of Behavioral Health Services	
Agenda Item 4 **Population /Community Needs Assessment Updates (Population Health Update)** *Time: 10 minutes* *Speaker: Hannah O'Leary*	Hannah O'Leary gave us an overview of the Population Health Impact Analysis conducted earlier in 2024. The results represented in this review that shows significant differences in the population. Not all results are represented since not all the outcomes notes in the report were significantly different. While not all our goals were met we are continuously striving for improvement.	

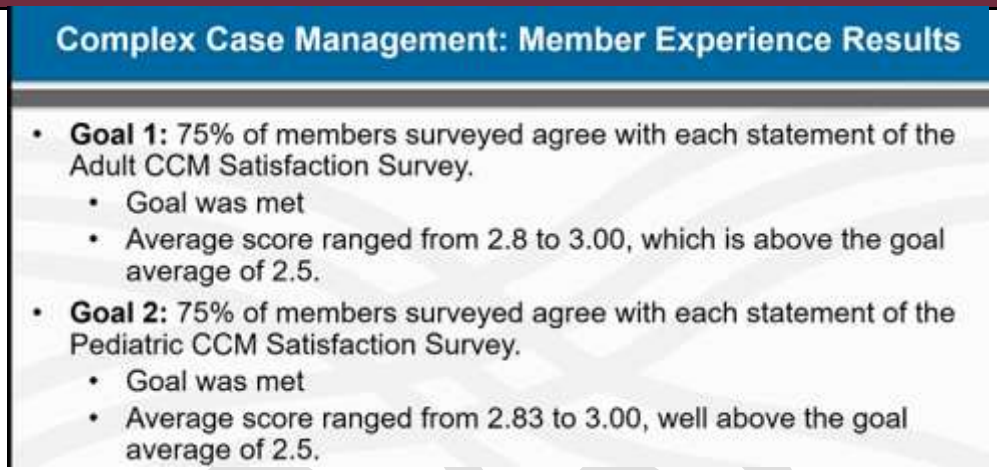
Agenda Topic	Notes	Action Item
	2023 Growing Together Program • Healthy Babies 0-30 months • Healthy Kids 3 years to 6 years • Healthy Moms Perinatal prenatal and postpartum period The engagement categories were: • Engaged (members who qualified were reached by phone and opted in) • Declined (members who qualified were reached by phone and opted not to participate) • Left Message (members who qualified were left a message, encouraging a specific behavior) • Unable to Reach (member who qualify for the program and were not able to be reached) • Not Referred (members who qualified for the program and were identified retrospectively and were identified prospectively for the campaign.	

Agenda Topic	Notes	Action Item

	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.
	
	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	

Agenda Topic	Notes	Action Item
	 	

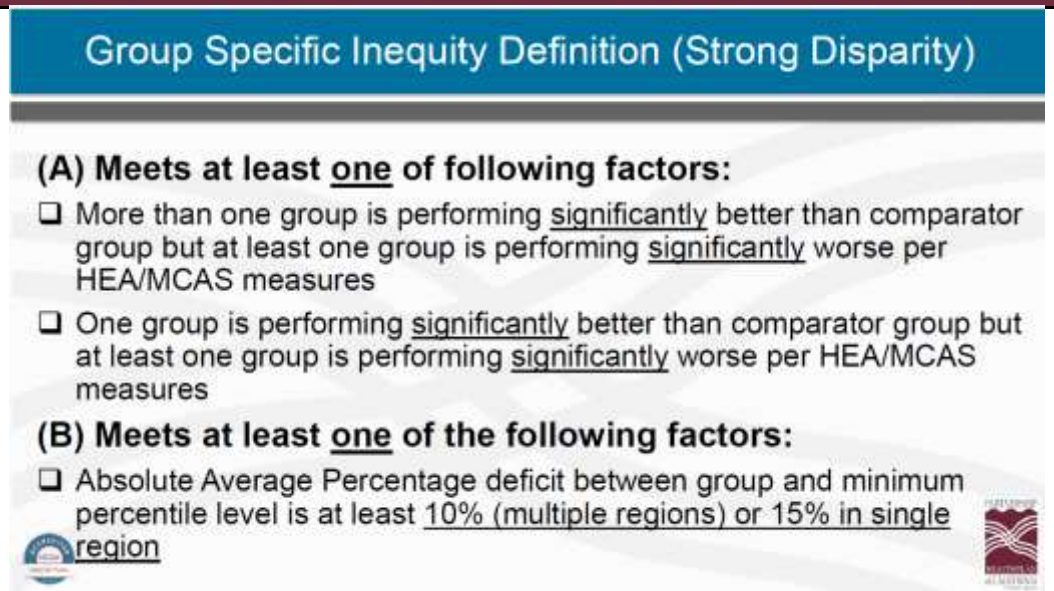
Agenda Topic	Notes	Action Item
	 Complex case management program criteria provide support for members who have: • Multiple chronic conditions • Social determinates of health barriers • Difficulty navigating the health system	

Agenda Topic	Notes	Action Item
	 Dr. Stockton said she would like to see what the difference was in the outcome measures. By comparing the actual statistics, we can learn if there are any clinical differences in terms of outcomes. **Question from Tim Sharp:** How do we define “engaged members”? **Response from Hannah O’Leary:** Members who are qualified for the program and were reached by phone and opted to participate in the program.	

Agenda Topic	Notes	Action Item
	The packet provided for the meeting compares campaign outcomes and shows more details. Dr. Kubota says we should consider looking at the statistics from a geographical perspective instead of only race and ethnicity. For instance: • White Rural versus White Urban • Hispanic Rural versus Hispanic Urban	

	Partnership has been tasked with working closely with the public health departments on their community health assessments (CHAs) and Community Health Improvement Plans (CHIPs)
	• This collaboration can be thought of as 4 main pillars
	  ○ 1) CHA/CHIP meeting attendance
	  ○ 2) Co-creating and implementing a shared SMART objective
	  ○ 3) Resource sharing in the form of in-kind staffing
	  ○ 4) Data sharing
	• We now have 4 SMART objectives that we are working towards implementing (Solano, Shasta, Modoc, and Yuba)
	• We also worked diligently to get as many of the MCP-LHJ worksheets signed by our counties as possible. As a reminder, these worksheets were a way for us and the public health departments to talk about what it looks like to meaningfully work together. We've had the opportunity to talk through the worksheet with all counties but we are still waiting for some counties to sign the worksheets.	

Agenda Topic	Notes	Action Item
	• We are starting to get asks from the county for in-kind staffing support for the CHA/CHIP work including project management, requests for support with admin tasks, and more. • We will be reporting out on our participation with each county's CHA/CHIP process in our PHM Strategy Deliverable to DHCS due in late October 2024.	
Agenda Item 5 **Health Equity Disparities Assessment Findings** **(Quantitative Evaluation)** *Time: 15 minutes* *Speaker:* *Mohamed Jalloh, PharmD*	We received HEDIS data on an annual base mid-July. Once received, it was submitted to the health analytics team to do a statistical analysis to verify if there were significant differences between the various HEDIS measures. After that, the QI team and I evaluated multiple angles. • We did statistical test comparing one group to another group and everyone was compared to that group. • Another way was looking at the Minimum Performance Level (MPL) that is the state standard and compared each group to the MPL. • We reviewed the 25% rate for measures and completed evaluations while we also stratified the data by race.	

Agenda Topic	Notes	Action Item
		

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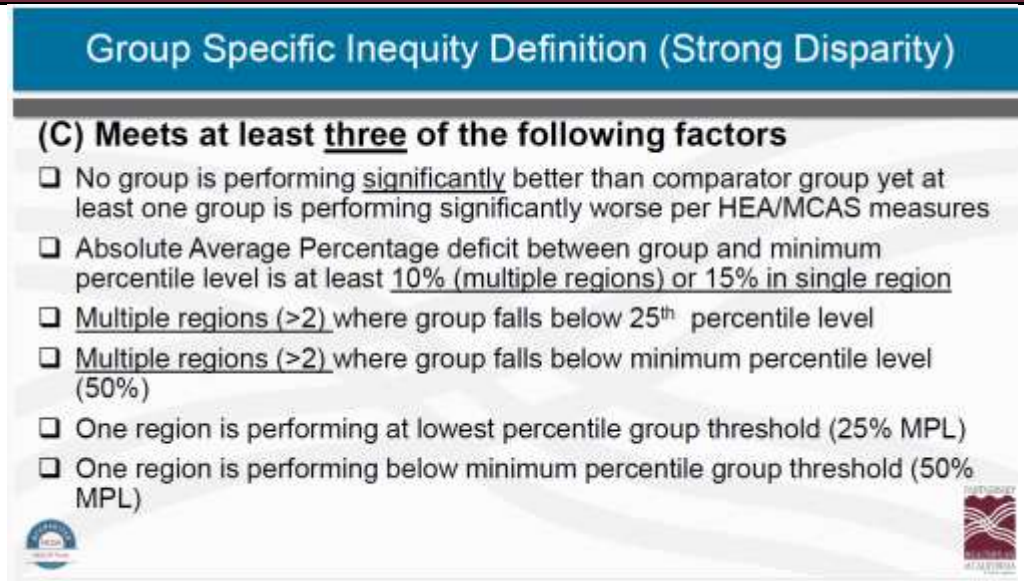
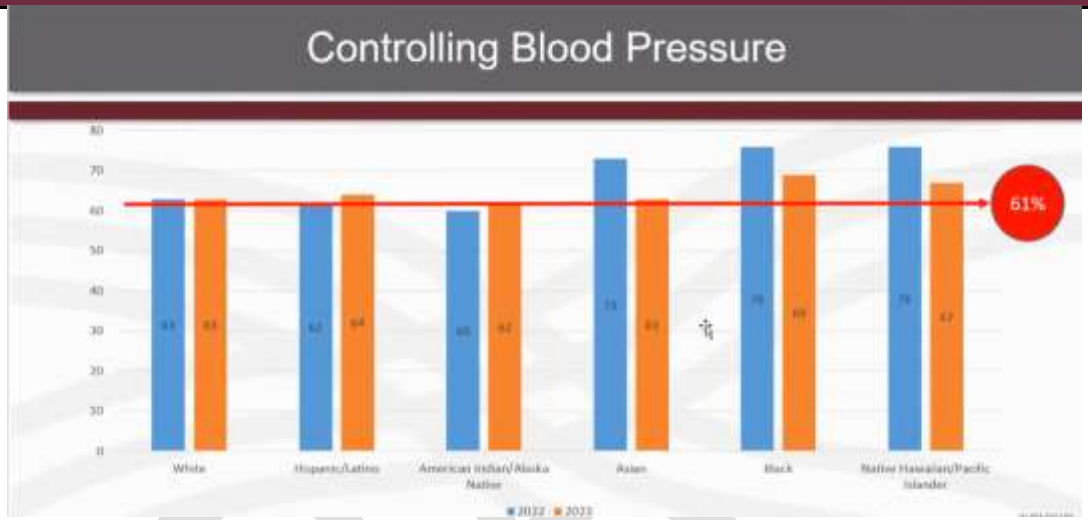
Agenda Topic	Notes	Action Item
		

Agenda Topic	Notes	Action Item
	 The 61% is the MPL state requirement. Every race/ethnic group met the MPL threshold of at least 61% control. There were improvements in Hispanic/Latino and American Indian/Alaska Native communities. Asian, Black and Native Hawaiian/Pacific Islander communities were trending downward.	

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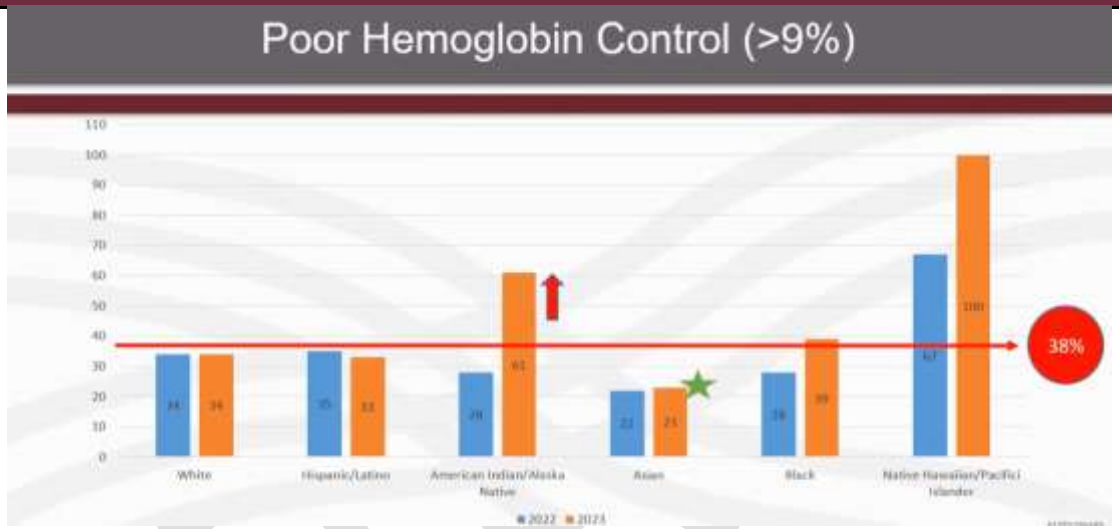
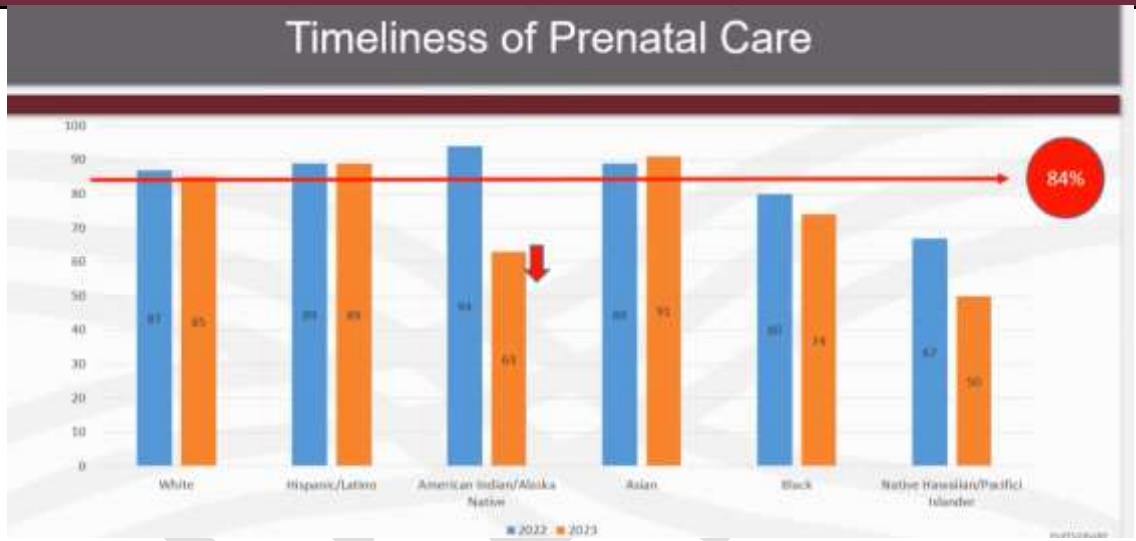
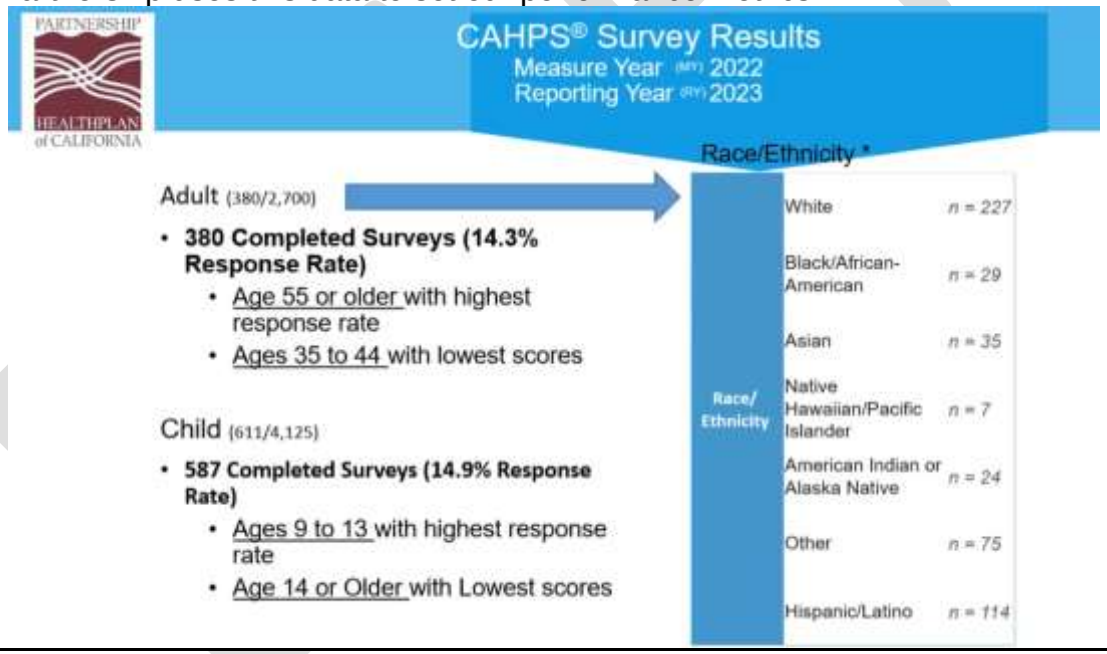
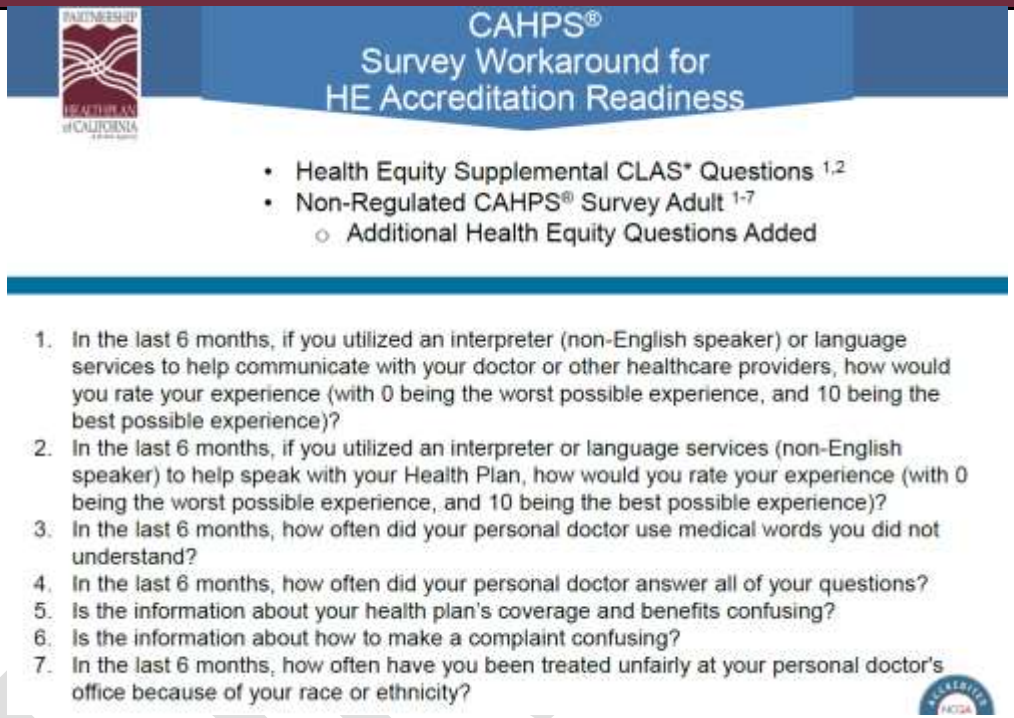
Agenda Topic	Notes	Action Item
	 The 38% is MPL state requirement. The lower the number the better. The star means there was a significantly better outcome in that region. The red arrow up is one group was doing significantly worse.	

Agenda Topic	Notes	Action Item
	 Some communities have met the 84% MPL. **American Indian/Alaska Native Prenatal Care:** • DHCS Bold Goal: Yes • MCAS Eligible Sanction: Yes • HEA Measure: Yes • Statistical Significant: Statistical Difference in SW Region • Clinical Significance: Yes • 3 Regions below 25th Percentile (NE, NW, SW) • Average % Below MPL: 21.78% • Potential Goal: Increase Prenatal Care Visit by 9% in NE region, 21% in NW region, and 34% SW region to have all regions achieve 50th percentile in 12 to 24 months.	

Agenda Topic	Notes	Action Item
	Black Prenatal Care: • DHCS Bold Goal: Yes • MCAS Eligible Sanction: Yes • HEA Measure: Yes • Statistical Significant: None • Clinical Significance: Yes • 2 regions below 25th Percentile (NE, NW) • Average % Below MPL = 30.1% • Potential Goal: Increase Prenatal Care Visit by 5% in NE region and 37% in NW region to have all regions achieve 50th percentile in 12 to 24 months. **American Indian/Alaska Native Post-Partum Care:** • DHCS Bold Goal: Yes • MCAS Eligible Sanction: Yes • HEA Measure: Yes • Statistical Significant: Statistical difference in NW Region • Clinical Significance: Yes • 1 region below 25th Percentile (NE) • 2 Regions below 50th Percentile (NW, SE) • Potential Goal: Increase Prenatal Care Visit by 25% in NE region and 5% in NW and SE regions in 24 months to have all regions achieve 50th percentile. **Well Care Visits:** • Hispanic/Latino performed significantly well in all regions • AI/AN performed significantly worse in the SW region o AI/AN performed above MPL in NE/NW regions	

Agenda Topic	Notes	Action Item
	SE Region • Black and Native Hawaiian/ Pacific Islanders performed significantly worse in the SE region. All others performed significantly or numerically better than the **White** community. **All Groups:** • Low in WCV across the majority of race groups American Indian/Alaska Native • Had 3 additional strong disparities in prenatal, postpartum, and poor hemoglobin control **Black/African American:** • Had additional strong disparity in prenatal care and poor hemoglobin control **White and Rural Community:** • Strong disparity in WCV measure Question from Dr. Stockton: Do we know if there was any discrepancy in the disparities noted in the Native American communities related to those who receive their care in tribal health care systems and United Indian Health Services (UIHS) versus other health care systems so we can identify if the work being done is paying off? Response from Dr. Jalloh: We did not do a deep dive; however, it was noted that the number of well-child visits in both tribal centers and external centers was low.	

Agenda Topic	Notes	Action Item
	Dr. Kubota does not think prenatal care is a Government Performance and Act (GRPA) measure.	
Agenda Item 6 **Member Experience in Disparities (Qualitative Evaluation)** *Time: 10 minutes* *Speaker: Anthony Sackett*	We will review the Consumer Assessment of Health Care Providers (CAHPS) survey as it pertains to health equity. This survey is an annual requirement from DHCS and NCQA. The population includes both adults and children. It aims to measure the patient experience as it relates to overall satisfaction. Partnership uses this data to set our performance metrics. 	

Agenda Topic	Notes	Action Item
	 Question from Dr. Kubota: Were the data points above and below the mean? Response from Anthony: Yes, that is correct. It was anything above or below 5 points.	

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Agenda Topic	Notes	Action Item
Agenda Item 7 **Non-Specialty Mental Health Member Outreach & Education Campaign (Behavioral Health Update)** *Time: 10 minutes* *Speaker: Mark Bontrager*	SB1019 Mandates that all managed care plans do the following every year: o Conduct an assessment of mental health utilization (NSMHS) o Consult with stakeholders: • Consumer Advisory Committee & QIHEC • Tribal Members • Racial and Ethnic Diverse stakeholders • Include input from the Population Needs Assessment o Create a Member Outreach & Education Plan • Plan must include multiple means of communication (examples: website, written materials, texts, etc.) • Use “stigma reduction” techniques • Meet cultural and linguistic standards We are doing this in the context of a draft APL with a deliverable date at the end of October in conjunction with the new member outreach and education campaign. The utilization mental assessment from 2023 is included in this report. Members Utilizing Services in our Non-Specialty System: • Overall average of 10 visits per utilizer • 32% Telehealth Visits • 88% Therapy • 12% Medication Management • Diagnoses: o 45% Anxiety Disorders o 25% Depressive Disorders	

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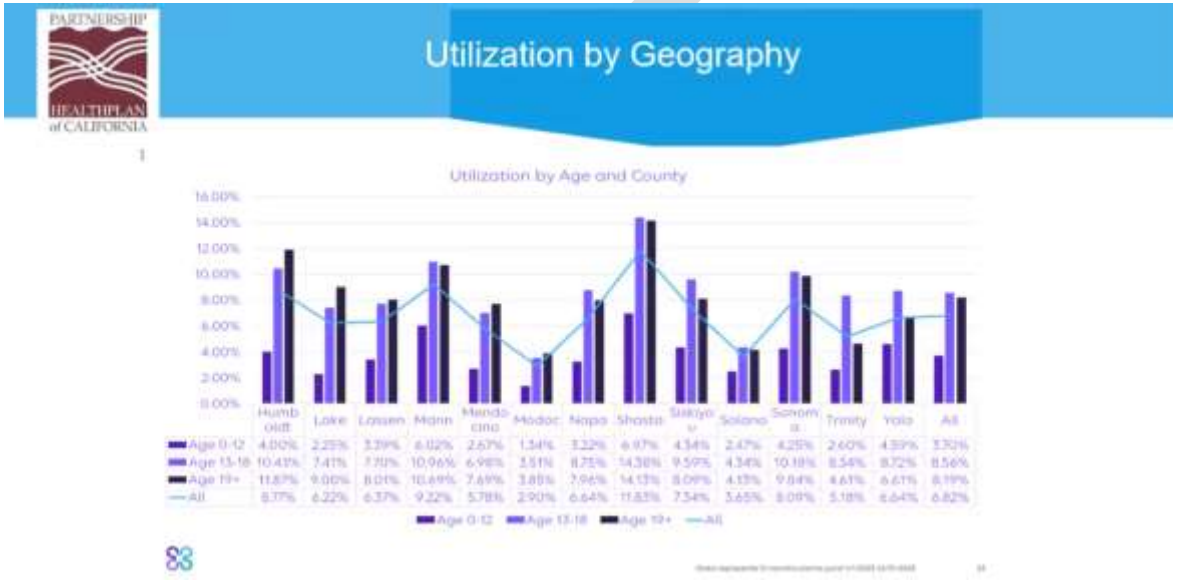
Agenda Topic	Notes	Action Item
	 There is a wide variety of utilization by geography. Shasta County has the highest rate, with Modoc having the lowest. There are many variables related to use. Our population health team is engaging members with low utilization rates by conducting in-person, telephone, and online surveys. We want to hear what the barriers are.	

Agenda Topic	Notes	Action Item
	Members being contacted within the next 30 to 60 days: • Tribal • African-American • Hispanic • Modoc Stigma Reduction Best Practices: • Education – provide education to combat myths or misunderstandings • Targeted - focus on specific groups for the highest impact and keep it local • Credible – people hear it best from others who are most like them • Continuous – the message needs to be repeated and in multiple ways for it to land	Send a survey to the QIHEC committee to find out are there ways that we can better engage our members and inform them about their mental health benefits. How might we reach them?

Agenda Topic	Notes	Action Item
Agenda Item 8 **Community Member Interview Feedback** *Time: 10 minutes* *Speaker: Vicquita Velazquez*	There is a maternal mortality crisis which disproportionality affects Black/African American women. According to the data from the CDC, black women are three times more likely to die from pregnancy-related causes than white women. 80% of these deaths are preventable. The pregnancy-related illness is also disproportionality high for black women. We had an intern over the summer and together we reached out to PHC members by phone and conducted interviews. We also wanted them to be uplifted and supported and have their voices heard. The driving focus of the interviews was: 1. What can we do to mobilize the stories and experiences being shared? 2. How can we help the holistic birthing process? The total sample size was 114 members. Notably, the birthing people interviewed were speaking for themselves, not the whole population. Their stories still carry significance and value. There is a scoring tool used for patient surveys called “PATIENT ACTIVATION” It involves a patient understanding their role in their healthcare and having the knowledge, skills, and confidence to manage it.	

Agenda Topic	Notes	Action Item
	While we did not use that methodology in our interviews the principle can still apply here and render positive results in healthcare delivery. Bringing their stories to the community's leaders like our QIHEC members is how we are making an impact, and their voices are heard. The Questions: 1. We received notice that at least one of your pregnancy-related appointments was missed, would you be comfortable letting me know why? • Do not remember • Transportation or health issue 2. Did the clinic/physician office make any errors in regards to your experience? • Lack of insurance clarity • Provider switched in various spots in pregnancy • Provider in attentive 3. Were there any mistakes made on Partnership HealthPlan's part in regards to your experience? • Transportation Service Issues • Clarity between PHC and providers 4. How can Partnership be your partner in health and make it easier for you to get the care you need? • Better access to resources	

Agenda Topic	Notes	Action Item
	5. Do you have any advice, specifically for Black women, that you think would be beneficial in regards to your experience? Self-advocacy • Personal research • Find an advocate • Ask questions to understand the care they are receiving **Now what?** - What can we do moving forward with this information? ○ Circling back to our driving questions ▪ What can we do to mobilize the stories and experiences being shared by black mothers? • Bringing them to you, people who work to understand these disparities • w/ new data, finding the true "why?" behind these missed appointments ▪ How can we help the holistic birthing process for black women? (prenatal postpartum & beyond) • Address the PHC-specific issues: obstacles of transportation, coverage clarity, etc.	

Agenda Topic	Notes	Action Item
	Question from Anna Campbell: Did the members say that the doula benefit helped them at all? Response from Vicquita: No one said the benefit helped them because the benefit was rolled out about the time these mothers were delivering so they did not know about it. In the future, we will be educating mothers on the county resources pages.	
Agenda Item 9 **Policy Recommendation Discussion** *Time: 5 minutes* *Speaker:* *Mohamed Jalloh, PharmD*	DHCS tasks the QIHEC committee with making policy recommendations. Attached to the meeting packet is a draft policy related to Diversity Equity and Inclusion (DEI) on page 122. The information listed is the training we will be providing, how we will provide the training and the timeline for the training. Our focus will be PHC contracted providers and anyone who receives a discrimination grievance. Some of the providers who do not have to do the training are those who do not have direct patient care such as some radiologists. In addition, some health systems already have high-quality training so we will allow them to submit their trainings to us for review and if the criteria are met we will give them our approval. If they are outside of our 24 counties we are not requiring contracted providers to do the training, only if they are seeing at least 1000 PHC members.	A work plan will be sent to the committee of the tasks we will be working on in the coming year.

Agenda Topic	Notes	Action Item
	Send recommendations to the Health Equity department email: HealthEquity@PartnershipHP.org The policy will be sent to the committee this coming fall. The disparities we will focus on are well-child visits and prenatal care.	
Agenda Item 10	The next meeting will be November 19, 2024, from 7:00 am to 9:30 am	

MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: August 1, 2024 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

Attendees: Greg Allen Friedman; Hannah O'Leary; Isaac Brown; Monika Brunkal, RPh

Virtual Attendees: Amanda Smith; Christine Smith; Colleen Townsend, MD; Denise Rivera; Katherine Barresi, RN; Kathryn Power; Lilian Merino; Mark Bontrager; Marshall Kubota, MD; Mohamed Jalloh, PharmD; Nancy Steffen; Rebecca Stark; Richard Matthews, MD; Robert Moore, MD; Tim Sharp; Wendi Davis; William Kinder; Yolanda Latham

Absent: Aaron Maxwell; DeLorean Ruffin, DrPH; Jeff Ribordy, MD; Lisa O'Connell; Matt Hintereder; Priscila Ayala; Vicky Klakken

Agenda Topic	Minutes	Action Items

1. Intros *Time: 5 minutes Speaker: Hannah*	• Introducing new regional Community Health Needs Liaisons (CHNLs)!
	  ○ Lilian Merino in Santa Rosa
	  ○ Amanda Smith in Redding
	  ○ Denise Rivera in Chico
	  ○ New hire starting August 19 in Eureka	

2. CHA/CHIP updates *Time: 20 minutes Speaker: Hannah*	This section's discussion took place during a PowerPoint presentation by Hannah, attached.
	
	• County SMART Goals for approval:
	  ○ Modoc: By December 31, 2025, increase the percentage of early entry into prenatal care for Modoc County residents (including Native American residents) by 25% from 38% to 47.5%
	  ▪ Approved by PNA Committee.	

Agenda Topic	Minutes	Action Items
	○ Yuba's general goal: By January 30, 2028, Yuba County residents will increase utilization of prevention visits by 20% compared with 2024 baselines. Partnership will help with specific sub-goal Strategy 2.1.2, "Increase percentage of adults completing age-appropriate colon cancer screening by 20% compared with 2024 baseline." ▪ Approved by PNA Committee. ▪ Comments: • With a completion date of 2028, we want to make sure there's steady progress on this goal. It would be great to have an intermediate goal(s) (like 5% improvement per year). • Any multi-year goal should have a monitoring strategy of some sort [to make sure the goal is on track]. • DHCS MCP/LHJ Work Sheet Updates ○ The due date to have these worksheets signed by the county was today, 8/1/24. However, we are not required to submit them to DHCS. ○ Of our 24 counties, 13 completed the worksheets, 8 are missing the final signature, and 3 decided not to sign right now. The 3 counties who chose not to sign are Humboldt, Yuba, and Sutter. ▪ There may be a fear that signing is "binding," though we understand it to only be an attestation. ○ A meeting is scheduled in mid-August to discuss with Yuba and Sutter. After that is resolved, we could come back to Humboldt [also in mid-August] and tell them they are the only county of our 24 that hasn't filled out the worksheet. ○ It is unknown whether we will be held accountable for a failure to complete the worksheets. We are documenting our communications with counties on this matter. • County Requests ○ Requests forms are starting to come in from counties, like Glenn, Solano, and Colusa. ○ Comment on a request for provider education in Solano: we are linking the county to activities Partnership is already doing there. Kathryn and Hannah can brainstorm opportunities to get people involved.	• Multi-year county SMART goals should specify a monitoring strategy going forward. • Katherine asks for an update after the Yuba/Sutter meeting. • Kathryn and Hannah to brainstorm Solano

Agenda Topic	Minutes	Action Items
	○ Comment: for counties asking for project management help, while we can't fund dedicated staffing, we could make project management trainings accessible to them. ○ We received some informal requests from other counties. ▪ Any counties requesting resources informally should be directed to the request form. ○ We are not approving requests for funding (including contractors or initiatives) at this time. ○ We received a suggestion that the form should also allow for a Public Health Director to sign. Sometimes the Public Health Officer is a different position, or under the Director. ▪ We'll update the form to allow for either. ○ On behalf of Trinity, Del Norte, and Lassen, Partnership shared county community surveys on social media. ○ Questions received around our community investment strategy. ▪ DHCS is preparing a draft APL on community investments which may be shared in August. Partnership will hold until DHCS's APL helps clarify the way forward. ○ Napa is requesting aggregate data combining Partnership and Kaiser's numbers. ▪ Partnership can't speak to the data Kaiser provides. We can tell Napa to ask Kaiser about getting aggregate data from them. ○ Can Partnership fund food as part of CHA/CHIP-related meetings? ▪ Info about the types of meetings Partnership would provide food for (planning, public facing, formally about CHA/CHIP or only informally, etc.) and recommendations can be sent to Katherine to discuss in an executive meeting. Execs can decide on principles for which meetings Partnership is willing to provide food for. • PHM Strategy Deliverable Template due to DHCS on October 31, 2024 ○ The Population Health (PHM) team developed a spreadsheet to prepare and track answers on the form. ○ Some info will need to be collected from all depts. with staff participating in the CHA/CHIP meetings and/or goals.	provider education solutions. • Informal county requests will be directed to the official request form. • The request form will be updated to allow for a Public Health Officer or Director to sign. (Completed 8/2/24) • Hannah will relay that Napa should inquire with Kaiser around aggregate data. • Hannah will gather food requests and types of meetings, send to Katherine.

Agenda Topic	Minutes	Action Items

3. Tobacco Cessation Discussion *Time: 10 minutes Speaker: Hannah / Monika*	• Making Tobacco Cessation an organizational priority
	  ○ There was recently a check-in with CalQuits, a UC Davis-based tobacco coalition that works with MCPs. They were interested in any initiatives Partnership is doing or planning around tobacco prevention. This topic was one of the top chronic conditions coming out of 2024's Population Needs Assessment (PNA).
	  ○ Population Health does some limited tobacco cessation education outreach currently, but a larger effort could have more effect. Adolescent vaping is a particular pain point.
	  ▪ There are a lot of incentive dollars for tribal health and others in this space. Public health often receives direct funding for it as well. There could be synergy [between Partnership and others] there.	

3. Open Discussion *Time: 10 minutes Speaker: All*	• Proposal to change meeting frequency from quarterly to every other month as this work ramps up. ○ Approved. Going forward, this meeting will now meet in the months of February, April, June, August, October, and December. The next meeting will be in October.	• The PNA Committee will now be scheduled bimonthly. (Completed)
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 at the CHA-CHIP Inbox!	

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: August 6th, 2024

Time: 2:00pm – 3:00pm

Location: Board Room

Owner : Dr. Moore

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
☐ Mary Kerlin	☐ Wendi West	☐ Sharon Hoffman-Spector
☒ Margarita Garcia-Hernandez	☐ Stan Leung	☐ Lisa Malvo
☒ Dejene Bikila	☒ Nancy Steffen	☐ Melanie Lam
☒ Liat Vaisenberg	☒ Brian Spiker	☐ Cody West
☒ Kristine Gual	☒ Shivani Sivasankar	☐ Angela Guevarra
☐ Amber Newell	☒ Radha Chebolu	☐ Renee Trosky
☒ Athena Beltran-Nampraseut	☒ Tiphanie Salehi	☐ Lisa O'Connell
☐ Garnet Booth	☒ Kim Palfini	☐ Jen Kung
☐ Kim Fillette	☐ Mark Aguirre	☒ James Devan
☐ Lindsey Bushey	☒ Shell Swift	☒ Isaac Brown
☐ Sarah Browning	☐ Stephanie Nakatani Phipps	☐ Amy McCune
☐ Emily Stoller	☐ David Lopez	☐ Katherine Barresi
☐ Monika Brunkal	☒ Candis Broadhead	☐ Deanna Watson
☒ Penny Thomas	☒ Alex Brito	☐ Kristina Coester
☐ Christopher Triolo	☐ Ruth Hood	☐ Rebecca Garcia
☐ Jeffrey DeVido	☐ Derick Stacy	☐ David Lavine
☐ Anthony Sackett	☐ Mark Bontrager	☐ Elijah Allen
☐ Tim Sharp	☐ Greg Allen Friedman	☐ Erin Hall
☒ Rasitha Rathnayake	☒ Akshay Sharma	☐ Dominic Salido
☐ DeLorean Ruffin	☐ Dave Hosford	☐ Mohamed Jalloh
☒ Vander Harris	☐ Danielle Ogren	☐ Tim Sharp
☐ Michelle Rodriguez	☒ Hanh Hoang	☒ Florentina Torres
☐ Cheng Saechao	☒ Amber Acosta	☒ Qi Yao
☒ Tasha Krongard	☒ Heather Esget	☒ Kevin Jarrett-Lee
☒ Zoey Ying		

Action Items	Presenter	Due	Revise / Approve Date
Approve Minutes from 04/29/2024		08/06/2024	

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 methodology for summarizing the PCP visits data was revised and the PCP visits dashboards were updated. The revised PCP visits report was presented in the over/under utilization meeting to review the revised report of the 2023 year-end review. Initially, Lake County was reported to have the lowest visit rate. However, after revision, it was found to have surpassed the benchmark. According to the updated report, Lassen, Napa, and Solano Counties now have the lowest visits rates, falling short of the benchmark. Lake County saw a remarkable increase in visit rates based on the revised report.
2) Lead screening in children Owner: QI	Discuss Findings Measure Definition: The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. For measurement year 2023 (MY2023), Partnership HealthPlan of California's (Partnership's) performance on the HEDIS Lead Screening in Children (LSC) 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. It is important to note that this is based on December 2023 HEDIS monthly data so final rates are subject to change. Lead screening is an important aspect of childhood development and can prevent developmental delays in children if identified and remedied. The four sub regions have seen a 5-16% increase between MY2022 and MY2023 with three sub regions increasing above the 25th percentile. PHC also observed that the LSC national benchmarks decreased from -MY2022 to MY2023, which contributed to sub regions and counties increasing percentiles. Partnership has the following interventions to increase lead screening rates : - Child and Adolescent Workgroup - Recovery from Supply Recall - Provider Education - Grant Funding for POC Devices - PCP QIP Change from Unit of Service to Clinical
3) Vasectomy Utilization *Speaker :* HA	Discuss Findings In 2023, 253 members had vasectomy and the utilization rate was 7.7 per 10K members. Overall, the Vasectomy rates per 10K members rose slightly from 2022 to 2023. In 2023, Modoc, followed by Humboldt and Lassen

	observed higher Vasectomy rates. White members had higher Vasectomy rates amongst all the ethnicities. Utilization rates were higher in the age group 35-39. Kaiser Santa Rose, Redwood Comm Health Center, and Eureka Comm Health Center were amongst the top assigned PCPs whose members were the higher utilizers in 2023, while Solano County Health Svc, Woodland Clinic, and Marin Comm Clinic San Rafael were amongst the assigned PCPs whose members had lower utilization rates.
4) Acute Inpatient Discharges *Speaker:* HA	Discuss Findings In 2023, Non-Capitated facilities had 29,717 discharges with discharge rate at 28 per 1000 members and average LOS 6 days. Capitated facilities had 6,693 discharges and the discharge rate was 40 per 1000 members and 4 days of average LOS. The discharge rate for Non-Capitated facilities in 2023 is on par with 2022 and average LOS dropped by 5% from 2022 to 2023. Marin Health had higher discharge rate in 2023, amongst the capitated hospitals. Except Kaiser, facilities such as Adventist, Marin Health, Queen of the Valley, and Woodland had increase in discharge rates from 2022 to 2023 between 9% and 19%. Kaiser had higher average LOS in 2023 compared to the other capitated facilities and it dropped by 3%. In 2023, the overall discharge rate per 1000 members is 48 with 32,963 discharges, 6 days of average LOS and $571.1M paid amount. Average LOS dropped slightly from 2022 to 2023. The top 3 Primary Diagnoses with higher number of admissions are – Sepsis, Unspecified Organism, Hypertensive Health Disease With Heart Failure, and HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY. Mercy Medical Center Redding, Providence SR Memorial Hospital, and Northbay Medical Center had higher admit counts in 2023 and UC Davis Medical Center had highest average LOS in 2023 and it saw an increase of 9% from 2022 to 2023. Plan wide adjusted readmission rates are on par between 2022 and 2023, while the observed readmission rate dropped slightly by 0.1 percentage points. The observed readmission rate is lower the HEDIS risk adjusted readmission rate for all years from 2020 – 2023, plan-wide. Sepsis, unspecified organism, Acute kidney failure, unspecified, Hypertension heart disease with heart failure are the top primary diagnoses that have higher observed readmissions in 2023. In 2023, Trinity had the lowest observed readmission rate, while the adjusted readmission rate was 7.3%. Modoc had higher observed readmission rate of 8.7% which is much higher than the

	previous years' rates of 4% and was higher than the adjusted readmission rate. Center Redding Mercy Medical had highest hospital readmissions with ACR rate of 6.2% and adjusted readmission rate of 7.44% in 2023. In 2023, RENOWN REG MEDICAL CENTER, GENERAL HOSP ZUCKERBURG SF, and HOSPITAL OROVILLE all had lower ACR readmission rates with ACR rate higher than the adjusted readmission rate. For the 3 aforementioned facilities, the ACR rate is higher in 2023 than the previous years.
Overutilization Analysis Discussion Topics	
1) Emergency Room utilization *Speaker:* HA	Discuss Findings The overall, visit rate dropped by 2.4% from 2022 to 2024. The PMPM increased by 4% for FFS members from 2022 to 2023. Modoc had highest visit rate in 2023, followed by Del Norte and Lake counties, and Yolo had the lowest visit rate. Trinity, Marin, and Shasta are the only counties that experienced an increase in visit rates from 2022 to 2023. Utilization increased slightly for 5-12 and 60+ age groups. Russian and Tagalog members saw an increase in visit rates from 2022 to 2023. Most races' visit rates stayed flat from 2022 to 2023. Ole Health, Solano County Health Services, and Adventist Health Clearlake are some of the facilities that had higher visit rates compared to the national benchmark of 625 in 2023. Woodland Clinic, Petaluma Health Center and Marin Comm San Rafael are amongst those that had lower visit rates compared to the benchmark. The overall ED utilization by homeless has gone up by 22% from 2022 to 2023. Humboldt, Shasta, and Siskiyou had higher utilization than the other counties. Native Americans had higher utilization compared to other races in 2023. 31-45 and 46-59 age groups saw higher utilization than the other age groups. Periapical abscess, Chest pain and Unspecified abdominal pain are the top reasons for the homeless to visit ER in 2023.
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
September 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)	• The 2024 Electronic Clinical Data Systems (ECDS) Unit of Service measure specifications have been finalized, as announced at a kick-off webinar on 09/04/2024. As outlined in this webinar, the PCP QIP specifications are being updated with required steps, including providers contracting with data aggregator, DataLink, by the end of September. • The Provider Public Comment Period started on 09/02/2024 and will be open for two weeks (09/02/2024 – 09/13/2024). All feedback collected over the comment period will be reviewed and considered in September's PCP QIP Technical Workgroup on 09/18/2024 to finalize the measure set for Measurement Year (MY) 2025 in October. • The proposed measure set changes for MY2025 are: 1) Add Chlamydia Screening in Women (CHL) as a monitoring measure for Family Practice and a core measure in Pediatrics 2) Add Well Child Visits for 15-30 month olds (W30+2) as a monitoring measure for Family Practice and a core measure in Pediatrics 3) Replace the current non-clinical Risk Adjusted Readmission (RAR) measure with RAR, 7-day follow-up 4) Add a monitoring Breast Cancer Screening (BCS) measure for ages 40-49 years 5) Add a monitoring Topical Fluoride in Children (TFL-CH) measure 6) Update the age range for the current Dental Fluoride Varnish unit of service measure to 1-4 years of age with 2 required applications during the MY 7) Update Peer Led unit of service measure to also include pediatric group visit for the ages 15mos-30mos.
Long Term Care Quality Improvement Program (LTC QIP)	• No updates for this program
Palliative Care Quality Improvement Program (Palliative Care QIP)	• No updates for this program
Perinatal Quality Improvement Program (PQIP)	• FY 2024-2025 provider outreach and onboarding meetings were completed last month. • FY 2023-2024 incentive payments remain on track to be distributed by 10/31/2024. • The PQIP Enhanced Incentive opportunity for perinatal providers caring for displaced Dignity members earlier this year ended as of 07/31/2024. Incentive payments will be distributed by 10/31/2024, separate from FY 2023-2024 incentive payments.
Enhanced Care Management quality	• 2nd quarter 2024 measure scoring and payment processing is underway, with incentive payments scheduled for distribution by 09/30/2024.

IMPROVEMENT PROGRAM (ECM QIP)	• Proposed new measure, Timely Review of ED/Admissions in PointClickCare, will be presented to quality committees this month for approval. If approved, this measure will be added to the 4th Quarter 2024 and 2025 measurement sets.
HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)	• The 2024 Hospital Quality Symposium occurred on 08/05/2024 and 08/07/2024 in Redding and Fairfield, respectively. Ninety-three people attended, which included representatives from 28 hospitals, a variety of speakers, and PHC employees. Attendees noted they especially enjoyed Arianna Campbell's presentation about reducing Overdoses in the ED, and others were greatly impacted by the final speaker of the day, who shared personal and professional experience dealing with understanding and caring for individuals with mental health illness. • The 2023-24 HQIP measurement year ended on 06/30/2024, with final submissions from hospitals due in August. Final submissions sere reviewed, as received, in August and preliminary scoring begins in September.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• N/A
EREPORTS	• MY2025 eReports scoping and development will begin at the end of September.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	Institute for Healthcare Improvement (IHI) / DHCS Medi-Cal Child Health Equity Collaborative
	• This collaborative is focused on improving child health equity, specifically for pediatric well-care visits.
	• Partnership and Stallant Health and Wellness in Del Norte County are collaborating in a project. The populations of focus are Native American / Alaskan Native and Hispanic populations. Defined Aims for targeted populations are as follows:
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase the annual well-care visit completion rates for the Native American/Alaskan Native population who are 3-17 years of age from 8% to 25% by March 2025.
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase their annual well-care visit completion rates for the Hispanic population who are 3-17 years of age from 20% to 40% by March 2025.
	• The 2nd phase of the project was recently completed. In this phase, the team focused on learning more about provider and patient experiences through conducting interviews with both populations. Primary learnings from interviews include lessons learned on needs of Native American and Spanish-speaking members and barriers faced by all Medi-Cal members to completing services.

- The 3rd phase of this collaborative began on 08/22/2024 and focuses on conducting a Plan-Do-Study-Act (PDSA) cycle

IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative

- DHCS and IHI have also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, along with the Nevada County Behavioral Health Department, were selected by DHCS to participate in this collaborative.
- The Partnership/Nevada County DBP team is currently selecting an initial intervention to pilot in fall 2024.
- This collaborative will run April 2024 through June 2025. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
    - % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)
    - % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)

Performance Improvement Projects (PIPs) Update

As a contracted managed care plan (MCP), DHCS assigned two (2) PIPs to Partnership that will be completed over 2023–2026. Planning activities are progressing 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:
    - Partnership will pilot an intervention with newborns born at Northbay Medical Center, the only hospital in Solano County that is open to Medi-Cal members. The intervention will pilot the use of navigators to expedite Medi-Cal enrollment and Primary Care Provider (PCP) assignment, as well as help families work through barriers to completing newborn and postpartum medical visits.
    - Cycle 1 of the pilot began on 08/19/2024 and relies on Population Health Department Wellness Navigators for member outreach.
- Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit
    - Partnership will pilot an intervention with a provider organization (PO) to increase rates for follow-up visits for members with a recent ED visit with a mental health diagnosis. Cycle 1 of the pilot will send the provider organization daily ADT notifications for members assigned to their practice; the organization will receive technical assistance and coaching support on scheduling and completing follow-up visits for the members and coding the visits correctly. Cycle 1 will launch in September 2024.

	DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process • Based on MY2022 HEDIS performance, DHCS has assigned Partnership additional accountability work around the Behavioral Health, Children's Health, and Reproductive Health and Cancer Prevention measure domains. This work, called the Comprehensive Quality Improvement and Health Equity Process, will require Partnership to complete strategies and action plans for 2024 activities meant to improve HEDIS rates in the included domains. • In July 2024, Partnership submitted strategies and associated action plans meant to impact selected barriers to success within each of the three measure domains. The strategies and action plans will begin implementation in 2024, with a progress report due to DHCS in October 2024. • An overview of strategies planned to improve performance on each measure domain include: Children's Health: ○ Development of data reporting that will be reviewed with providers highlighting missed opportunities (i.e. episodes where patients were seen via an office visit, but preventative services were not completed) to capture pediatric services such as well child visits. ○ Analysis of the issue of delayed newborn Medi-Cal enrollment's impact on claims capture for the Well Child Visit Birth – 15 Months measure and design of interventions to expedite newborn Medi-Cal enrollment. Behavioral Health Domain: ○ Collection of County Department of Public Health data around Follow-Up Visits for ED Visits with a Mental Health Diagnosis using the Sacramento Valley MedShare Health Information exchange to improve real-time visibility of ED visits, specialty mental health encounters, and outpatient visits. ○ Piloting the use of embedded Community Health Workers in several EDs within Partnership's network to complete referrals for Partnership members presenting with a mental health or substance use diagnosis. Reproductive Health and Cancer Prevention Domain: ○ Improving breast cancer screening rates in imaging center deserts, using mobile mammography events and interventions with imaging centers with significant access challenges. ○ Piloting the use of chlamydia home screening kits with a partner provider(s).
QUALITY MEASURE SCORE IMPROVEMENT	• Practice Facilitation coaching continues with nine (9) provider organizations throughout the provider network. At present, most practices are focusing on implementing interventions to impact SMART Aims. Expansion (i.e. Chico and Auburn) Region practices are engaged in optimizing the data tier for their QIP measures and planning a strategy for meeting benchmarks during their first year with Partnership. The following practices will be participating in Practice Facilitation in 2024: ○ Solano County Family Health Services (Fairfield Region) ○ Community Medical Center (Fairfield Region)

	○ Consolidated Tribal Health Project (Eureka Region) ○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties (Eureka, Redding, and Chico Regions) ○ Adventist Health Ukiah Valley – Mendocino County (Eureka Region) ○ Ampla Health (Chico Region) ○ Northern Valley Indian Health (Chico and Fairfield Region) ○ Wellspace Health (Auburn Region) ○ Western Sierra Medical Clinic (Auburn Region) • As part of Partnership's NCQA Health Equity Accreditation work, the Performance Improvement team has partnered with Partnership's Health Equity Officer to author a Grand Analysis that identifies statistically significant disparities in selected HEDIS measure rates, and identifies interventions meant to reduce or eliminate the identified disparities. The Grand Analysis has been completed using MY2023 HEDIS data and was included in the Health Equity Accreditation Mock Initial Survey that was completed 08/21/2024. The Quality Measure Score Improvement (QMSI) Workgroups will lead the effort to plan and implement interventions to address the disparities identified in the Grand Analysis. Each Workgroup will include an equity intervention as one of its annual deliverables for the 2024-2025 workgroup cycle. Workgroups are currently being briefed on the disparities identified and the requirements of the equity interventions to meet NCQA accreditation standards. • The Cervical Cancer Self-Swab Pilot Cycle 1 is winding down. Unused kits are being redistributed to Pilot sites that are able to use more than they were allotted from sites that were not able to use the original allotment. Some swab kits are being used at Mobile Mammography event days in the Northwest in September. Lessons learned from Cycle 1 will inform planning for future cycles of this pilot. • Anderson RX conducted a free community immunization clinic on 07/24/2024. This clinic focused on adolescents and early school entry (i.e. Kindergarteners and T-K students), in cooperation with Partnership, who also volunteered for this event. Partnership provides funding for event administration and non-covered vaccine costs. A total of 46 children were vaccinated at this event. • Enterprise Elementary School District, Anderson RX and Partnership conducted a free back to school immunization event on 08/03/2024. This event was offered to school-entry children and entering 7th graders. A total of 50 children were vaccinated, and built upon the over 100 children vaccinated at school during the school day during April and May of this year. • The Pediatric-focused QMSI workgroup recently conducted an assessment of outcomes across all pediatric-focused measures and have determined the following measures of focus for the 2024-2025 fiscal year: ○ W30 + 6 - Well-Child Visits in the First 15 Months of Life ○ WCV - Child and Adolescent Well-Care Visit ○ CIS-10 - Childhood Immunization Status: Combination 10 ○ IMA-2 - Immunizations for Adolescents: Combination 2 ○ W30 +2 - Well-Child Visits for age 15 – 30 months ○ LSC - Lead Screening in Children W30

	○ DEV - Developmental Screening in the First Three Years of Life ○ TFL- CH: Topical fluoride application for Children • 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 ten (10) POC device awardees along with two (2) reimbursements for recently purchased POC devices. ○ The second round has recently finalized with eleven (11) POC device awardees along with fifteen (15) reimbursements for recently purchased POC devices. Second round devices were recently delivered to sites. ○ A third round is set to launch 09/03/2024 with up to 30 devices available to distribute.
Improvement Academy	• For Fiscal Year 2024-25, the Improvement Academy will host three (3) ABCs of QI in- person trainings. ○ 11/07/2024 – Fairfield ○ 01/30/2025 – Ukiah ○ Spring 2025 – Redding • The Improving Measure Outcomes webinar series focused on targeted Managed Care Accountability Set (MCAS) measures will take place February – April 2025.
Joint Leadership Initiative (JLI)	• Fall JLIs are currently in the planning phase and will include Ampla as a new Parent Organization. There are a total of 9 participating organizations representing all regions. • September JLI meetings include: ○ Solano County Family Health Services, 09/04/2024
Regional Improvement Meetings	• Scheduling for the Northern Region quarterly regional meetings is currently underway for the 4th quarter in November. • The Southeast Regional Quarterly meeting is scheduled for 09/17/2024.

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

QI Program & Project Management

ACTIVITY	UPDATE
State Mandated Work: *Equity and Practice transformation (EPT) Program*	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). ○ On 05/10/2024, Governor Newsom released the May Budget Revision which has greatly impacted the EPT program. ○ The revised budget proposal reduced the EPT program funding by 80%, 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).

	• The EPT Program timeline has changed from a five (5) year program to a three (3) year program (01/2024 – 12/2026).
	• Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding.
	  ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP).
	  ○ The EPT strategy team continues to explore utilization for the remaining IPIP funds. A subset of funds will be allocated to tribal health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continue to develop.
	• All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by their 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS is recalculating the final award amounts, due to the budget revisions.
	  ○ Practices who submitted the Year 1 phmCAT will receive payment. The payments were anticipated to be released in October 2024 per the payment cycle, but are now delayed until March 2025
	  ○ The EPT milestones have been narrowed down to 108 milestones, with 25 required milestones in the following categories: PhmCAT (3 years), Empanelment & Access, and Data to Enable PHM, Care Delivery Model, Value-Based Payment, and Key Performance Indicators.
	  ○ DHCS is redesigned the EPT program and gave EPT practices the option to opt out of the program by 08/09/2024. All twenty-seven (27) practices have not opted out and are continuing with the EPT program.
	• The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP.
	  ○ To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance.
	  ○ Population Health Learning Center (PHLC), the EPT Program Officer, released the Practice Track and Learning Community assignments.
	  ▪ All Tribal Health Organizations are in the same Practice Track, facilitated by Indigenous Pact.

	▪ Eastern Plumas Health Care is joining a Practice Track facilitated by the California Medical Association with other practices outside of Partnership's provider network. All other EPT practices sponsored by Partnership will be in one of two Practice Tracks; "Lupine" or "Lilac", both facilitated by the California Primary Care Association. ○ PopHealth+, an eLearning Hub, launched this month to provide video tutorials on the PHM Building Blocks for EPT practices to complete. ○ All milestone deliverables will be submitted online in the PopHealth+ eLearning hub. ○ Partnership will not provide financial support to practices interested in PHLC's Optional Practice Coaching. The Performance Improvement team will provide practice coaching to their assigned EPT practices. ▪ PHLC will provide ad-hoc office hour sessions through Expert Consultation. Practices will be able to attend and ask questions related to the content learned in PopHealth+, Practice Track meetings, and Learning Community sessions.
CAPACITY ENHANCEMENT GRANTS	• For the first time in Partnership's 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health's contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health. ○ Partnership hosted an informational webinar for providers who were eligible for the CEG on 04/26/2024. There were thirty-seven (37) attendees representing seventeen (17) organizations. ○ Seventeen (17) out of the nineteen (19) eligible Provider Organizations applied for the CEG and were awarded funding based on the number of Dignity members they would be absorbing. ○ The first installment of CEG funding was distributed on 06/12/2024. ○ Partnership and Dignity Health reached a new agreement in June, retroactive to 06/01/2024. The new contract negotiation did not impact CEG funding, CEG providers were notified the program, activities, and funding opportunity will continue. ○ CEG Providers are required to submit a Progress Report Template on 09/13/2024 in order to receive the second and final installment of CEG funding. • Two (2) of seventeen (17) Progress Report Templates have been received, the Project Management Team anticipates receiving all templates by the due date.
LOCUM PILOT INITIATIVE	• The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited Grant Program, whereby participating Provider Organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period.

  - A total budget of $250,000 was approved; participating Providers receive up to:
    - $45,000 when hiring a Physician; or
    - $31,600 when hiring an Advanced Practicing Clinician.
  - The Grant is paid in two installments:
    - 1st installment upon signing the Agreement, 50% of eligible funds
    - 2nd installment upon completing the 4-week assignment and post-program survey, remaining 50%
- The initial cohort of providers was selected from those participating in the PCP Modified QIP. Six (6) offers to apply were made and four applications were received. All four (4) applications were reviewed and accepted into the pilot program.
- Locum assignment periods will be carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment.
  - 1st Installment has been issued to Providers
  - Two providers have a Locum Provider in place and are reporting visit details as well as successes and challenges.
  - Locum Providers are alleviating a backlog of well-child and adolescent visits.
  - Locum Providers are also covering urgent care which allows patients to schedule visits with their preferred physician.
- Two providers continue to recruit for Locum candidates and are experiencing limited opportunities due to a short assignment period, spanning less than 3 months. Alternative approaches are being explored.

Provider Organization	Total Grant	Locum Assignment and Status
Hill Country Community Clinic	$31,600	To be determined
Pit River Health Service	$31,600	Focus: Well Child Visits & Immunizations 07/29/2024 – 08/16/2024 (Part-time) other dates TBD
Round Valley Indian Health	$45,000	To be determined
Community Medical Center	$31,600	Focus: Child/Adolescent Well Care & Immunizations Assignment completed 08/16/2024 Program evaluation underway.

Quality Measure Score Improvement Mobile Mammography Program	• Between 07/01/2024 to 09/30/2024, Partnership sponsored 23 Mobile Mammography event days with 14 provider organizations at 22 provider sites.
	  ○ Northwest Region: seven (7) event days with two (2) provider organizations at seven (7) provide sites.
	  ○ Northeast Region: seven (7) event days with five (5) provider organizations at six (6) provider sites.
	  ○ Southwest Region: four (4) event days with four (4) provider organization at four (4) provider sites.
	  ○ Southeast Region: two (2) event days with two (2) provider organizations at two (2) event sites.
	  ○ Eastern Region: three (3) event days with one (1) provider organization at three (3) provider site.
	• One (1) event day in the Northwest Region was held at a Tribal Health Center in Humboldt County.
	• One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
	• Planning for Mobile Mammography event days for FY Q2 is underway for Northern, Southern and Eastern Region provider organizations. Targeted providers include those who have Breast Cancer Screening Primary Care Provider Quality Incentive Program (BCS PCP QIP) rates below the 50th percentile benchmark and are located in imaging center deserts with little or no access to local imaging services.

QI Trilogy Program	• The following documents were completed and are currently making their way through the Committee process for approval:
	  ○ FY 2024/25 QI Program Description
	  ○ FY 2023/24 QI Work Plan (Final Updates)
	  ○ FY 2023/24 QI Program Evaluation
	  ○ FY 2024/25 QI Work Plan (Goal Submissions)

Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program	• Partnership's survey vendor, Press Ganey, presented the regulated CAHPS® survey results for Measurement Year (MY) 2023 / Report Year (RY) 2024 (Adult and Child) to internal stakeholders. ○ Subsequent follow-up meetings with key internal stakeholders to further discuss findings and solicit/identify potential improvement opportunities were scheduled. • The MY 2023 / RY 2024 Adult CAHPS® Survey was formally submitted as part of NCQA's accreditation process to determine Health Plan Rating (HPR). The projected HPR for MY 2023 is 3.5 Stars, which met the organization's 23/24 aim of maintaining Partnership's current HPR. • Results for the CAHPS® non-regulated Drill Down Survey are currently being analyzed. • The Member Experience Grand Analysis (ME 7) is under review by Partnership's NCQA consultant and key QI leadership. The analysis will begin the formal Committee approval process in November.

	• Fiscal Year 2024-25 Organization Goal #4: Access to Care and Member Experience Improvement: ○ Progress is being made on the eight milestones outlined for both the Access Workgroup and Member Experience Workgroup. Assigned tasks are on track. • The CAHPS® Team continues to be an active participant in the second year of the ACAP CAHPS® Collaborative, which includes nine other plans. The Collaborative recently surveyed participating plans about the business processes within their organization that affect member experience. Input from external departments such as Member Services, Population Health Management, and Care Coordination was detailed in Partnership's survey submission. The Collaborative will prepare a detailed analysis for Partnership as well as sharing high-level responses from participating plans.

GEOGRAPHIC EXPANSION: QI PROGRESS	The Quality Improvement (QI) Project Plan to onboard the East Region Expansion Counties to QI functions and programs began in June 2023 and will continue over the course of 2024. Status updates include:
	• Resource planning to recruit, hire, and onboard staff dedicated to Expansion Counties is nearly complete. One (1) Improvement Advisor position is planned later in 2024. An additional HEDIS Analyst and Program Coordinator are also planned for posting in early 24/25.
	• 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.
	  ▪ Twenty-one (21) external Expansion Region invitees representing ten (10) Expansion organizations attended the August office hour session.
	  ▪ Twenty-one (21) external Expansion Region invitees representing ten (10) Expansion organizations have accepted to attend the September office hour session.
	  ○ Perinatal QIP focused communications and orientations to assure all providers have all the support needed to participate in the Perinatal QIP.
	  ▪ Onboarding meetings and Letters of Agreement (LOAs) are almost complete from the following participating East Region providers:
	  • Peach Tree
	  • Northern Valley Indian Health
	  • Ampla Health
	  • Chapa-De Indian Health
	  • Samuel Van Kirk, MD
	  • Tahoe Forest Hospital – (Perinatal QIP status pending)
	  • Well-Space Health – (Perinatal QIP status pending)
	  • Enloe Health – (Perinatal QIP status pending)
	  ○ HEDIS focused communications and monthly office hours to strengthen the provider's understanding of how quality is measured.

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

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **07/31/2024 TO 08/26/2024**	• 28 PQI referrals were received during this time. 23 of which were from Grievance and Appeals. • 11 cases were processed and closed during this period. • 65 cases are currently open. • Two new cases were presented and scored in the Peer Review Committee on 08/21/2024. • One focus review is pending receipt of medical records.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **07/29/2024 TO 08/23/2024**	• As of 8/27/2024, we have a total of 455 PCP and OB sites with an additional 27 reviews required due to multiple locations for patient check-ins (totaling 482 reviews). • We are currently offering CHDP training to providers prior to their next required Site Review, through WebEx with our Clinical Compliance Coordinator. This is a required training with the transition of CHDP to Partnership as of 7/1/2024. Training is also available on our website. We will continue to offer 1:1 training through WebEx, allowing providers the chance to choose what training option works best for them. **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
North	9	7	1	2
South	4	3	0	3
Expansion	1	8	1	3

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• The Annual MY2023 Summary of Performance Reports for the DHCS Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) are

<table>
<tr><td></td><td>posted on the Partnership website, under Providers → Quality Improvement → HEDIS.
• The final MY2023 Summary of Performance Reports were presented at the following stakeholder meetings:
○ Board Quality Advisory Committee
○ IQI
○ PAC
○ QUAC
○ Board of Commissioners
○ Upcoming in September: Clinic Consortia meetings
• The PHC HPA projected Star Rating for MY2023 is 3.5. NCQA communicated that their score for the Star Rating is projected to be 3.5. NCQA will formally publish the results of all health plans in the September timeframe.</td></tr>
<tr><td>HEDIS® Program Overall</td><td>HRP: Conversion of PHC's core claims system from Amisys to HRP
• Another round of testing started in August 2024 to support the overall pending implementation of Health Rules Payer-Health Edge (HRP)
Geographic Expansion:
• The HEDIS team began hosting Office Hours in July 2024, and will conclude in November 2024. Thank you to those who have participated in July, we look forward to meeting with you in the upcoming sessions, click on the links below to register:
<table><tr><td>09/18/2024</td><td>Topic TBD</td></tr><tr><td>10/30/2024</td><td>MY2023 Annual Summary of Performance
• HPA (Health Plan Accreditation)
• Managed Care Accountability Set (MCAS)</td></tr><tr><td>11/13/2024</td><td>Hybrid Measure Overview
• Blood Pressure Diabetes • Controlling Blood Pressure • Cervical Cancer Screening • Childhood Immunization Status • Eye Exam for Patients with Diabetes • Hemoglobin A1c Control for Patients With Diabetes • Immunizations for Adolescents • Lead Screening Children • Prenatal and Postpartum Care • Weight Assessment and Counseling on Nutrition and Physical Activity for Children and Adolescents – Body Mass Index</td></tr></table>CMS D-SNP Preparation:
• Planning is underway to prepare for baseline data capture & integration to support the DSNP implementation planned for January 2026.</td></tr>
</table>

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• NCQA released the new 2025 HPA Standards and Guidelines on 08/30/2024. Every year, NCQA makes adjustments to its accreditation standards to respond to feedback received from health plans, policy makers, providers, and patients during the Public Comment period.

	○ Although Partnership will follow the 2026 HPA Standards and Guidelines for the Renewal Survey, it is critical to align our practices with the 2025 HPA Standards and Guidelines for updates and changes. NCQA will assess Partnership based on the look-back period, measured from the point of the survey submission date, September 2026. For newly introduced standards, NCQA uses a glidepath approach, and may extend the look-back period gradually under the 2026 HPA Standards and Guidelines. ○ The NCQA Program Management Team prepared a summary of changes, which includes a crosswalk between the 2024 and 2025 HPA Standards and Guidelines; this summary has been shared with Business Owners. Business Owners are asked to review the changes to the standards assigned to them and advise the NCQA Program Management Team by 10/04/2024 if clarifications are needed. • As part of the HPA Key Activities for FY 24-25, Milestone 2 requires that all Business Owners review, and update as needed, the annual HPA Workbook which consists of the HPA Work Plan and Evidence Submission Library. The annual HPA Workbook will be shared with Business Owners by 09/20/2024. Business Owners are asked to submit their completed HPA Workbooks by 10/18/2024. • The 24-month look-back period for our next HPA Renewal Survey begins September 2024. Unless otherwise noted in the NCQA Standards and Guidelines, Partnership must meet requirements throughout the look-back period. Any changes made to evidence during the look-back period must be reviewed and approved by our NCQA consultant prior to finalizing the changes. The NCQA Program Management Team will review detailed information about meeting the look-back period in the September Business Owner Check-in Meetings.
NCQA Health Equity Accreditation (HEA)	• The HEA Mock Initial Survey was held 08/19-21/2024 with our NCQA Consultant and was successful with many key documents being in compliance; however, some opportunities for improvement were identified and discussed with Business Owners during the mock survey. Our consultant prepared an extensive report, which identified both strengths and opportunities for improvement, along with scoring for each standard. This report was shared with Business Owners in early September 2024. ○ Based on scoring from our NCQA consultant, overall HEA compliance was at 85.19%, with Partnership receiving 23 points out of the 27 total applicable points available. Partnership's estimated accreditation status is considered "Accredited", as the minimum 80% point threshold was met. ○ On 09/09/2024 the NCQA Program Management Team distributed a Corrective Action Plan (CAP) to Business Owners, as applicable, to address improvement recommendations. Business Owners are asked to indicate the actions or activities that will take place to address the findings to bring evidence into compliance. CAP submissions are due by 09/20/2024. The submission of the completed CAP will complete Milestone 1 of the FY 24-25 HEA Key Activities. • There were no new HEA Standards and Guidelines released for 2025. Organizations will continue to use the 2024 HEA Standards and Guidelines, which

	will be the standards and guidelines Partnership will follow for the HEA Initial Survey in June 2025. • As part of the HEA Key Activities for FY 24-25, Milestone 2 requires that all Business Owners review, and update as needed, the annual HEA Workbook which consists of the HEA Work Plan and Evidence Submission Library. The annual HEA Workbook will be shared with Business Owners by 09/27/2024. Business Owners are asked to submit their completed HEA Workbooks by 10/25/2024.

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

Consent Calendar

Sept. 18, 2024

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

[1] Edits are mainly to the attachments in both Care Coordination policies, with acronyms spelled out to avoid any confusion.

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Our Mission

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

GRIEVANCE & APPEALS
Pulse Report

G&A PULSE REPORT

ISSUE 14 | SEPTEMBER 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 second 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.

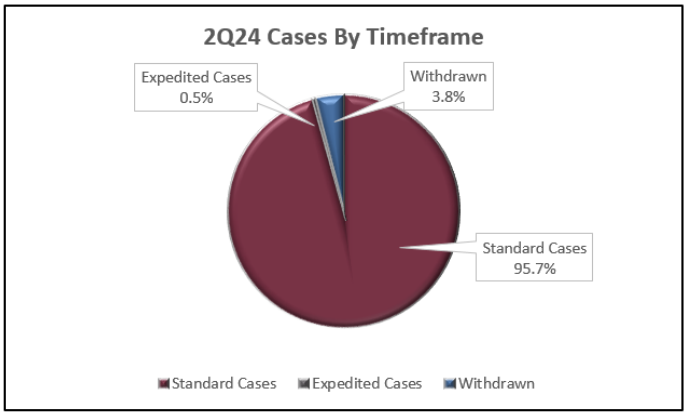
INSIDE THIS ISSUE

2Q24 HIGHLIGHTS

OVERALL NUMBERS

In 2Q24, G&A investigated 1,991 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,715 cases subject to DHCS-mandated timeframes, 96.6% were closed on time. This is below the 98.6% goal. Contributing factors included multiple staff on leave, an increased caseload due to the expansion, delays in receiving timely responses from providers, including responses to medical records requests, and delays in sending letters for translation.

2Q24 TOTAL # INVESTIGATED CASES		
Case Type	**# Cases**	**% Grand TTL**
Grievance	1528	76.7%
Exempt	224	11.3%
Appeal	187	9.4%
State Hearing	52	2.6%
Grand Total	**1,991**	**100.0%**



KEY POINTS & TRENDS

Transportation **—** Transportation related cases were the most frequently reported concern, making up 48.7% of the total concerns reported. The most common transportation related issue was missed rides, which accounted for 21.3% of the reported concerns. Requests for specific transportation providers and dissatisfaction with transportation customer service were the next highest reported concerns, at 11.6% and 7.8%, respectively.

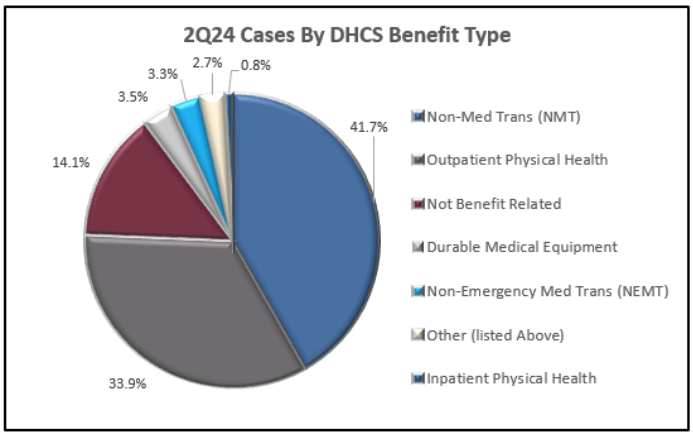
Appeals account for 13.5% of all transportation concerns reported. Meal denials were the most commonly appealed, making up 52.2% of the transportation Appeal denials, followed by lodging denials at 34.8%.

Provider Service – This category accounted for 37.5% of the total case concerns. The most common issue was Poor Attitude/Service, followed by Communication. Long Wait Time 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.

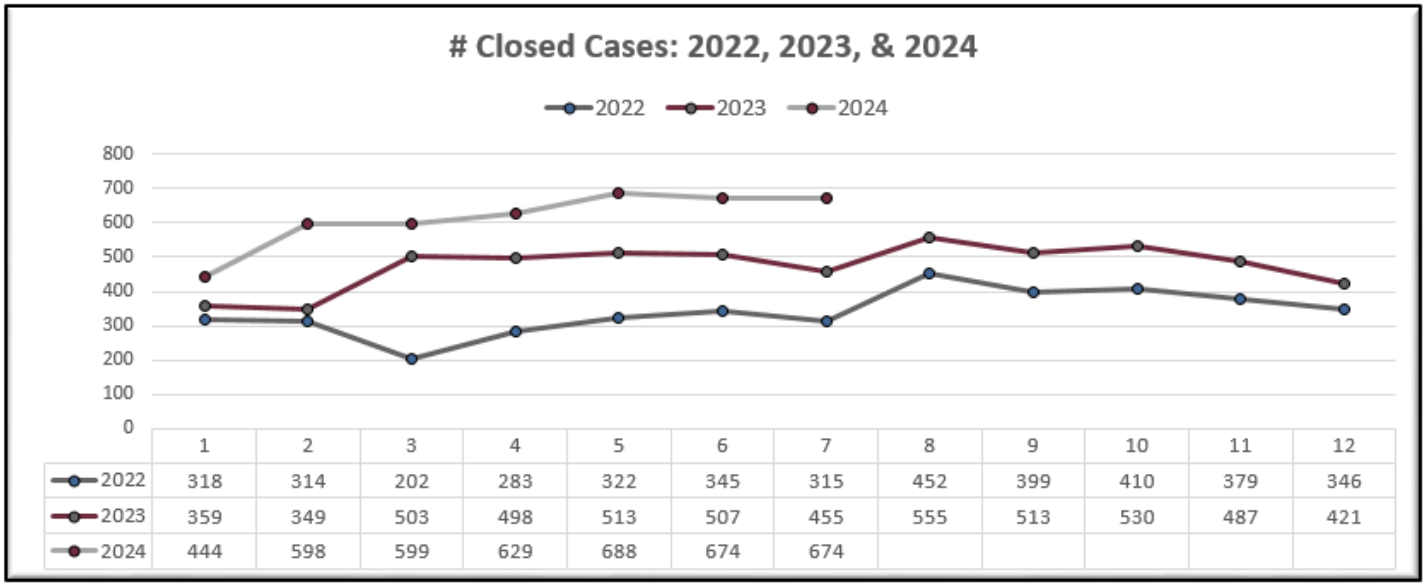
Non-Medical Transportation (NMT) represented 41.7% and Outpatient Physical Health services represented 33.9% of reported concerns. Not Benefit Related accounted for 14.1% of the DHCS Benefit Type categories.



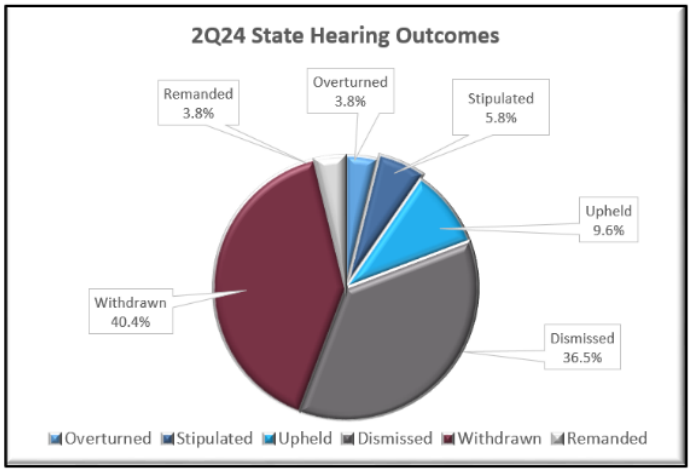
KEY STATISTICS

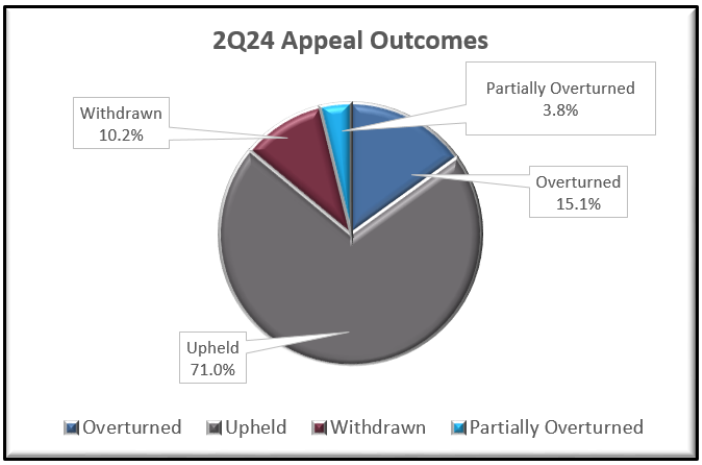
CHARTS OF KEY CASE TRENDS

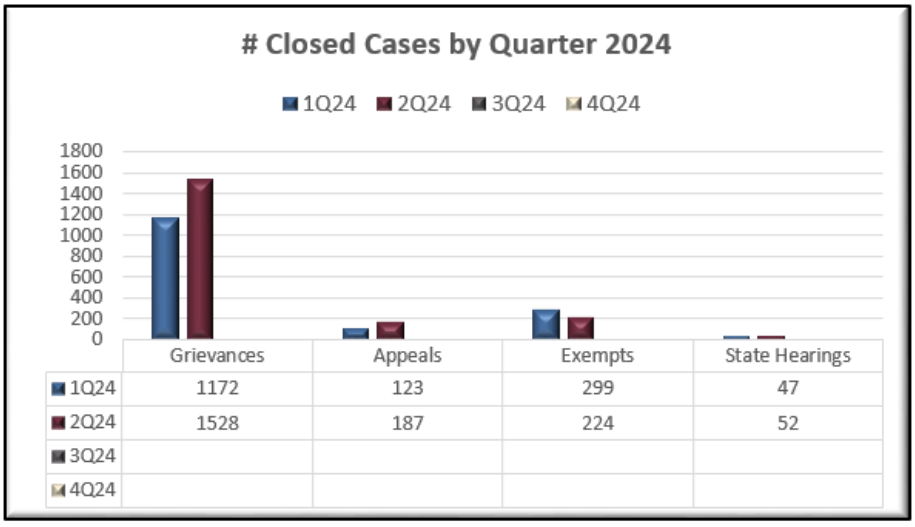
The following charts represent key data metrics used to track and trend Appeals, Grievances, Second Level Grievances, and State Hearings over time.



	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	629	688	674	674					







	Grievances	Appeals	Exempts	State Hearings
1Q24	1172	123	299	47
2Q24	1528	187	224	52
3Q24				
4Q24				

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases, the percentage of overall cases received, and the corresponding membership percentage per 1,000 members.

> "We had a hearing this morning with Robert. He was so collaborative and supportive and went over and beyond to give me information and help me navigate some systems and alternatives. I just wanted to make sure he received a thank you for that. It is nice to run across people within the system who are so compassionate and supportive. So thank you I hope we meet again someday."
>
> - *Partnership Member*

2Q24 % CASES BY REGION			
AUBURN			
Member County	# Cases	% Cases	% Membership
Nevada	69	3.5%	3.1%
Placer	210	10.5%	6.6%
Plumas	10	0.5%	0.7%
Sierra	2	0.1%	0.1%
Total	291	14.6%	10.5%

2Q24 % CASES BY REGION			
CHICO			
Member County	# Cases	% Cases	% Membership
Butte	116	2.6%	9.4%
Colusa	24	1.2%	1.1%
Glenn	15	5.8%	1.5%
Sutter	57	2.9%	4.8%
Yuba	52	0.8%	4.0%
Total	264	13.3%	20.8%

2Q24 % CASES BY REGION			
REDDING			
Member County	# Cases	% Cases	% Membership
Lassen	41	10.4%	1.0%
Modoc	14	0.7%	0.4%
Shasta	207	0.6%	7.6%
Siskiyou	67	3.0%	2.0%
Tehama	60	3.4%	3.4%
Trinity	12	2.1%	0.6%
Total	401	20.1%	14.9%

2Q24 % CASES BY REGION			
EUREKA			
Member County	# Cases	% Cases	% Membership
Del Norte	43	2.2%	1.4%
Humboldt	205	10.3%	6.5%
Lake	81	4.1%	3.8%
Mendocino	63	3.2%	4.6%
Total	392	19.7%	16.2%

2Q24 % CASES BY REGION			
SANTA ROSA			
Member County	# Cases	% Cases	% Membership
Marin	79	8.1%	5.2%
Sonoma	161	4.0%	12.2%
Total	240	12.1%	17.3%

2Q24 % CASES BY REGION			
FAIRFIELD			
Member County	# Cases	% Cases	% Membership
Napa	47	2.4%	3.0%
Solano	246	12.4%	11.3%
Yolo	110	5.5%	6.0%
Total	403	20.2%	20.3%

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 2Q24.

2Q24 % CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	6.0%	18.5%
Age 11-19	4.4%	16.5%
Age 20-44	29.0%	34.8%
Age 45-64	42.5%	19.7%
Age 65+	18.1%	10.4%
Grand Total	100.0%	100.0%

2Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	57.9%	39.1%
Hispanic	17.3%	33.4%
Other/Unknown	6.0%	17.7%
Black (African Amer	1.9%	3.5%
Native American	14.6%	1.8%
Asian Indian	0.6%	1.6%
Asian/Pacific Island	0.8%	1.4%
Filipino	0.8%	1.1%
Vietnamese	0.2%	0.4%
Grand Total	100.0%	100.0%

2Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	91.8%	76.4%
Spanish	6.6%	20.3%
Other	1.1%	2.5%
Russian	0.5%	0.6%
Tagalog	0.1%	0.3%
Grand Total	100.0%	100.0%

2Q24 % CASES BY COUNTY		
Member County	% Cases	% Membership
Sonoma	8.1%	12.2%
Solano	12.4%	11.3%
Butte	5.8%	9.4%
Shasta	10.4%	7.5%
Placer	10.5%	6.6%
Humboldt	10.3%	6.5%
Yolo	5.5%	5.9%
Marin	4.0%	5.2%
Sutter	2.9%	4.8%
Mendocino	3.2%	4.6%
Yuba	2.6%	3.9%
Lake	4.1%	3.8%
Tehama	3.0%	3.3%
Nevada	3.5%	3.1%
Napa	2.4%	3.0%
Siskiyou	3.4%	2.0%
Glenn	0.8%	1.5%
Del Norte	2.2%	1.4%
Colusa	1.2%	1.1%
Lassen	2.1%	1.0%
Plumas	0.5%	0.7%
Trinity	0.6%	0.6%
Modoc	0.7%	0.4%
Sierra	0.1%	0.1%
Grand Total	100.0%	100.0%

2Q24 % CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	64.0%	52.2%
Male	36.0%	47.8%
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 2Q24. 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.

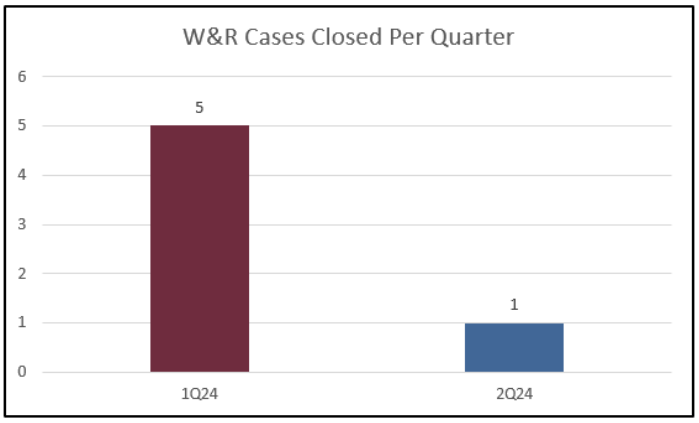
2Q24 NUMBERS

One (1) W&R case was received and closed in 2Q24.

TRENDING ISSUES

The number of grievances declined from five (5) in 1Q24 to one (1) in 2Q24. There were zero appeals reported in the first half of the year.

The grievance reported was thoroughly investigated and resolved within the same quarter. The case centered around a member's dissatisfaction with a facility's decision that it could not provide the necessary level of medical care the member needed. The investigation concluded that the provider was not at fault. The member was successfully transferred to a more appropriately equipped facility following the completion of their 60-day program.



Overall, the first half of 2024 has shown that grievances predominately revolve around issues related to provider care and case management.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The below two tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. The case received in 2Q24 was closed within the 30-day DHCS regulatory timeframe.

2Q24 W&R Cases	
# of Grievance Received	1
# of Appeal Received	0
# of Grievance Resolutions	1
# of Appeal Resolutions	0

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

2Q24 STATISTICS

During 2Q24, a total of 33 CCS-related cases were closed, representing 1.7% of the 1,991 reported cases for this quarter. These cases are divided into 15 Grievances and 18 Appeals.

TRENDING ISSUES

The predominant issue reported this quarter was transportation-related with 26 cases (15 appeals and 11 grievances) accounting for 78.8% of the total CCS related cases.

All 15 appeals were related to reimbursement for meals lodging, or flights. Of these, four (4) denials were overturned.

Notably, one (1) case involving a denied flight reimbursement was reversed after a thorough investigation. The reversal was based on a one-time exception granted because a Transportation Specialist offered flight reimbursement during a call with the member, despite the flight being pre-booked. This case highlights the importance of clear communication between the Transportation Specialist and members regarding coverage eligibility.

Grievances regarding transportation primarily concerned delays in receiving gas mileage reimbursement and issues with missed rides.

Of the remaining cases, unrelated to transportation, there were two (2) appeals and four (4) grievances. The appeals involved requests for a standing frame and home nursing hours. The grievances addressed issues related to a dislike for the Treatment Authorization Request (TAR) process, quality of service and a billing discrepancy.

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 members during 2Q24.

ETHNICITY AND PREFERRED LANGUAGE

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

2Q24 CASES BY ETHNICITY		
Member Ethnicity	#Cases	% Cases
No Response	9	27.3%
White	11	33.3%
Other	3	9.1%
Hispanic	6	18.2%
Black (African American)	3	9.1%
Alaskan Native or American Indian	1	3.0%
Grand Total	33	100.0%

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

2Q24 CCS CASES BY LANGUAGE		
Member Language	# Cases	% Cases
English	30	90.9%
Spanish	3	9.1%
Grand Total	33	100.0%

DISCRIMINATION

REPORTING PERIOD

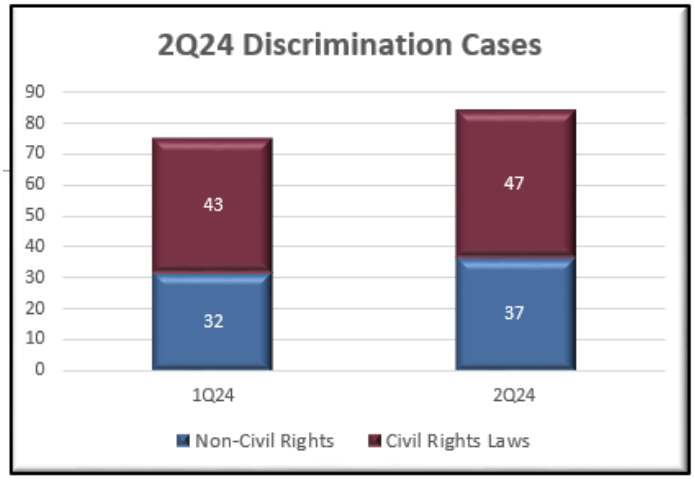
This section covers quarterly statistics and trends in cases related to discrimination during 2Q24.

2Q24 DISCRIMINATION STATISTICS

G&A investigated 84 cases related to discrimination allegations in 2Q24. This represented 4.2% of all cases closed. Of the 84 cases, 47 fell under an applicable federal or state civil rights law.

After investigation, it was determined discrimination likely occurred in five (5) cases. Four (4) cases were regarding race or ethnicity. The other case was regarding limited English skills. Three (3) of the five (5) cases were transportation-related. Lyft and Divine Right drivers were involved.

Discrimination allegations that do not fall under a civil rights law accounted for 37 of the 84 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having Medi-Cal or being labeled a medication/drug seeker.



2Q24 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.

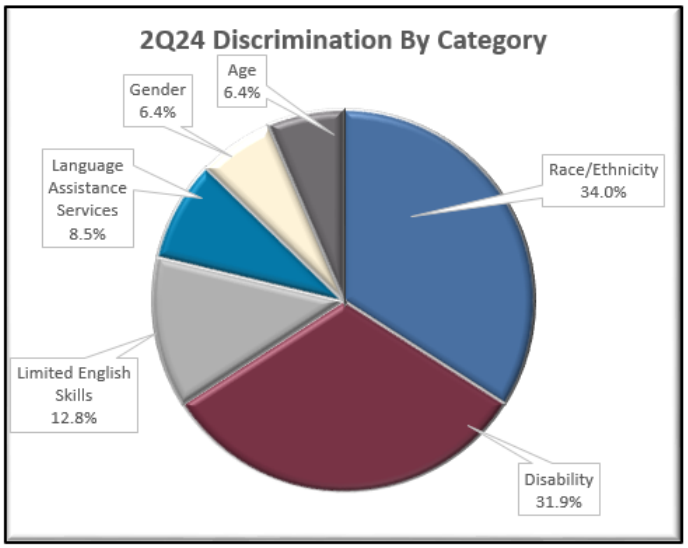
Discrimination cases saw a slight increase from the first to second quarter. Notably, in the expansion counties, the number of discrimination grievances rose from six (6) cases to 19 cases. The most commonly reported concern across the expansion counties was related to language issues.

2Q24 CASES BY CATEGORY

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

DISCRIMINATION FOUND LIKELY	
Civil Rights Category	# of Cases
Gender	1
Race or Ethnicity	4
Total	5

The most commonly reported allegation was Race/Ethnicity accounting for 34.0% of cases followed by Disability accounting for 31.9% of the cases filed.



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

Twenty-eight (28) Grievances were evaluated for the 2Q24 IRR review.

The Medical Director suggested one of the cases could have been reviewed by a physician. The case may have been sent for a review for a potential quality issue investigation and there was a concern that the provider's office did not submit the medical records that were requested.

G&A leadership identified several opportunities for improvement. First, G&A staff need to correctly identify the provider involved. In the program used for case processing, 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 send referrals correctly to internal departments. A summary of the issue along with proper questions that will assist in resolving the member's concerns should be sent to the proper department.

TIMELINESS

The target timeliness goal for investigations and ack letters is 98.6%. For 2Q24, 1,715 cases were subject to DHCS Turnaround Times (TAT). We achieved 96.6% timeliness for investigations. This deviation was due to increased caseload due to the expansion, as well as G&A having multiple staff on leave of absence. The 59 cases were processed late because of delays in responses from providers, delays in requesting additional information from providers, delays in receiving medical records and late case inductions.

There were 38 late acknowledgment letters (ack-letters), achieving 97.8% timeliness. Delays included internal issues in sending letters to translation and system issues.

2Q24 DHCS Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.0%	59	96.6%	
Ack-Letters	98.0%	38	97.8%	

TRANSPORTATION

HISTORY

The Medical Transportation Management (MTM) contract expired on March 31, 2023 for Non-Medical Transportation Services (NMT). Partnership decided to discontinue the use of their services. Partnership thereafter established a new Transportation Services department to manage all transportation needs for our members.

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 2Q24.

2Q24 STATISTICS

Transportation cases in 2Q24 accounted for 48.7% of the total cases closed.

The most reported issues were missed rides, requests for specific transportation providers, and driver behavior.

The counties with the most issues reported were Humboldt, Shasta and Solano.

TRENDING ISSUES

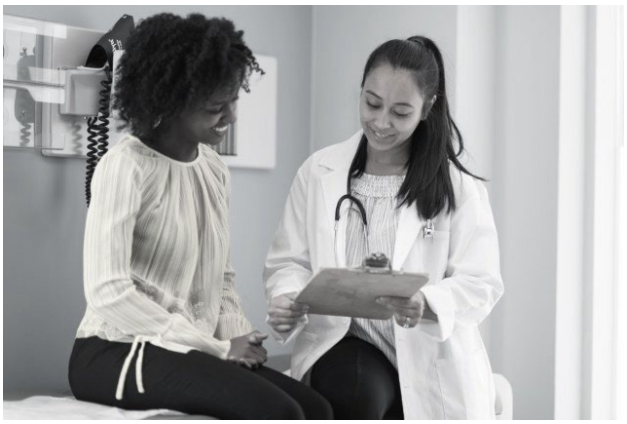
NorthBay Transit, Lyft, and Budget Friendly had issues including missed rides, rider preferences for or against certain providers, and drivers arriving late. G&A identified multiple complaints against Transportation Services department. Their complaints consists of scheduling issues and disliking the timeframe associated with gas mile reimbursement.

There has been progress in addressing some of these concerns. Notably, Budget Friendly, which experienced a high volume of complaints during 1Q24, took proactive steps to address these issues after provider education was administered. Their improvements have reduced their complaints by half compared to 1Q24.

MEMBER EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports member dissatisfaction reported in the first half of calendar 2024 compared to all of calendar year 2023. For more details, please reference the attached NCQA ME.7 Member Experience Threshold Report.



OVERVIEW

There were 2,905 Grievances, Second Level Grievances, and Appeals closed in 1Q24 and 2Q24, compared to 4,261 in the entire year of 2023. These cases are broken into two groups. Grievances accounted for 2,610, and Appeals and Second Level Grievances accounted for 295.

Although our membership increased by 34.7% from 678,546 to 913,703, the total number of cases filed per 1,000 members decreased from 5.26 to 2.86.

G&A met the threshold for all categories of Appeals and Second Level Grievances for the first half of 2024. For Grievances, all categories were met with the exception of Quality of Provider Office concerns. Four (4) Grievances were reported for the first half of 2024, which already exceeds the threshold.

GRIEVANCES

Access issues and Attitude/Service issues were the most frequently reported concerns, with 1,269 and 1,182 cases respectively.

Nearly half of the reported concerns were concerning NMT. These disruptions include missed rides and drivers arriving late. These disruptions not only inconvenience members but also directly affect their ability to receive timely care, making interruptions to care the next most significant concern following Attitude/Service.

The threshold was exceeded in the Quality of Provider Office category. The number of cases increased from two (2) to four (4) cases. Members complained of overflowing trashcans, dirty exam rooms, and insect infestations.

APPEALS & SECOND LEVEL GRIEVANCES

G&A met the threshold for all categories of Appeals and Second Level Grievances for the first half of 2024.

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the authorization or referral process in the first half of 2024 compared to 2023. For more details, please reference the attached NCQA UM 1B: Member Experience-UM Threshold Report.

OVERVIEW

There were 120 reported concerns regarding the UM process in the first half of 2024 compared to 205 for the full year 2023. We have met the threshold in all categories of the UM1B report. If there are no significant changes in the second half of 2024, we are projected to meet the thresholds for the 2024 year compared to the 2023 year. In the first half of 2024, there continues to be communication issues between members and their providers regarding referrals. This resulted in providers delaying or refusing to submit TARs or Referral Authorization Forms (RAFs).

DISSATISFACTION WITH RAF PROCESS

Of the 120 UM concerns, 84 of them were related to the RAF process. Of those, 51 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, thus, causing delays in getting appointments with specialists.

RAF Process	
# of Reported Concerns	
Delayed by Provider	51
Refused by Provider	9
Other	9
Delayed by Partnership	8
Member dislikes overall	7
Total	84

DISSATISFACTION WITH TAR PROCESS

Member's concerns related to the prior authorization process account for 36 of the 84 cases reported. The largest driver was

TAR Process	
# of Reported Concerns	
Delayed by Provider	21
Delayed by Partnership	6
Member dislikes overall	5
Other	4
Total	36

members alleging their provider delayed submission of their TAR to Partnership.

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2024 through June 30, 2024.

APPOINTMENTS

The Partnership Medi-Cal Handbook defines timely access to care as the following:

Urgent Care	48 hours
Non-urgent: w/PCP	10 Business Days
Non-urgent: w/Specialist	15 Business Days
Non-urgent: w/Mental Health	10 Business Days
Non-urgent: w/Ancillary Service	15 Business Days
Telephone Wait Times	10 minutes

G&A regularly reviews member concerns regarding timely access to care. Typically, members are not aware of these timeframes until educated during the Grievance process.

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – Members reported 72 concerns against their primary care provider (PCP) or office staff regarding access to appointments in person or by phone during this reporting period. Members expressed concerns about long wait times for appointments, being unable to speak with staff when calling, not receiving calls back from providers, or providers refusing to see them.

Specialists – Partnership approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists,

orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure timely appointments are available for our members. There were nine (9) cases reported, all of which were regarding appointment availability as members had difficulty scheduling timely appointments. Four (4) of the nine (9) reported cases were involving a high impact provider.

MEETING CULTURAL & LINGUISTIC NEEDS

Partnership monitors our provider network to ensure it meets the cultural, ethnic, racial, gender, and linguistic needs of our diverse membership. There were three (3) reported cases filed against medical groups or individual doctors. Two (2) of those cases were filed against providers in the Redding Region and one (1) provider in the Chico Region. Members reported they experienced barriers related to their race or ethnicity and language assistance services.

AGAINST PROVIDERS

REPORTING PERIOD

This NCQA Spotlight highlights trends discovered from January 1, 2024, through June 30, 2024. For more details, see corresponding CR5 Report included.

SEVERITY LEVELS

G&A tracks when members report a concern against a provider. These Grievances are assessed and given a Severity Rating 1 through 4. The severity levels are described as follows:

- *Level 1: General Service* – such as rudeness, attitude, problems scheduling appointments
- *Level 2:* Refusal or Barrier to Care – such as delayed/refused TAR or RAF, refused to see member
- *Level 3:* Potential Legal Risk – such as discrimination, HIPAA violation, alleged abuse, or fraud, waste, abuse (FWA)
- *Level 4:* Potential Quality Issue (PQI) – such as a missed diagnosis or treatment that did not follow standard of care

INDIVIDUAL PROVIDERS & OFFICE STAFF

NCQA requires specific oversight of individual providers and office staff. In this reporting period, 31 Grievances were filed against individual providers. The most commonly reported concern was Attitude/Service. A Severity Rating of 1 was the most common rating given, which accounted for 45.2% of all cases reported.

There were 30 cases filed against office staff and other non-MD clinical staff. The most common concern reported was Attitude/Service.

MEDICAL GROUP

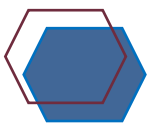
G&A reviews cases filed against medical groups to ensure Partnership's standard for quality of care is met. There were 206 cases filed against medical groups during this reporting period.

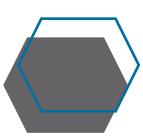
Access issues made up 81 cases, which equated to 39.3% of the reported concerns, and included concerns such as untimely access to appointments and providers not accepting new patients. There were 79 concerns reported that fell into the Attitude and service category, accounting for 38.3% of the concerns. The most frequent complaint reported was rude staff. There were 43 cases identified as PQI, accounting for 20.9%. There were three (3) concerns related to Billing/Financial.

Solano County Family Health & Social Services is the outlying provider as they have 14 grievances reported against them. Their concerns include access, quality of care, and attitude/service.

HOSPITALS

There were 20 cases reported against hospitals during this reporting period. The most common reported concerns were related quality of care, which represented 60.0% of the hospital concerns. Attitude and service cases accounted for 30.0% of the reported concerns with a count of six (6) cases. There were seven (7) cases reporting alleged discrimination against a hospital. Two (2) fell under an applicable federal or state civil rights law. After investigation of all the cases, it was determined that discrimination was not likely in any case.





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

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PROPOSAL
4th Quarter 2024 ECM QIP Measure Changes / 2025 ECM QIP Measurement Set

Total dollars available are $100 per member per month. **The Timely Reporting gateway measure** determines the number of dollars placed in an incentive pool. Providers can earn up to 100% of incentive pool by meeting the other measures.

Current: 2024 ECM QIP Measurement Set	Proposed Q4 2024 Measurement Set Change Proposed MY 2025 Measurement Set
Gateway Measure: Timely Reporting Measurement Period: January 1, 2024 – December 31, 2024 Description: Providers are required to submit three (3) monthly reports (Return Transmission File - RTF, Initial Outreach Tracker File - IOT, and Provider Capacity Survey) on or before their due date. Incentive: $100 per member per month Dollars earned are placed into an incentive pool. • 100% incentive will be placed in incentive pool if all reports are received on or before the due date. • 50% incentive will be placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date. • Reports received after five (5) business days will not be eligible for an incentive pool or participation in other program measures.	No changes
Measure 1: Care Plan and Release of Information (ROI) Forms Upload into PointClickCare within 60 Days Measurement Period: January 1, 2024 – December 31, 2024 Description: Providers must upload Care Plans and the ROI forms for ECM enrolled members into PointClickCare within 60 days of TAR request date. Incentive pool allotment: 30% Targets: • Full credit: ≥ 80% • Partial credit: 70% - 79% Reporting: PHC will audit PointClickCare for evidence of uploaded documents.	Change: Incentive pool allotment change from 30% to 25% for this measure

Measure 2: PHQ9 Depression Screening Measurement Period: January 1, 2024 – December 31, 2024 Description: Depression screening should be completed with ECM enrolled members as part of initial assessment and development of Care Plan. Incentive pool allotment: 35% Targets: • Full credit: ≥ 90% • Partial credit: 80% - 89% Reporting: Providers will submit a screening template quarterly with member names, CIN, DOB, and PHQ-9 screening date and score.	Change: Incentive pool allotment change from 35% to 25% for this measure
Measure 3: Blood Pressure Screening Measurement Period: January 1, 2024 – December 31, 2024 Description: Blood pressure screening must be completed by an in-person visit by ECM staff, a clinic visit, or patient use of PHC approved home blood pressure kit for enrolled ECM members (regardless of prior diagnosis of hypertension). Incentive pool allotment: 35% Target: • Full credit: ≥ 80% • Partial credit: 70% - 79% Reporting: Providers will submit a screening template quarterly with member names, CIN, DOB, and PHQ-9 screening date and score.	Change: Incentive pool allotment change from 30% to 25% for this measure

NEW **Measure 4: Timely Review of ED/ Admissions Notification Alerts in PointClickCare**

Part 1: PointClickCare Notification Alerts Set-up

Measurement Period:
October 1, 2024 – December 31, 2024

Description: As a prerequisite for participation in Part 2 of the Timely Review of ED/Admissions Notification Alerts in PointClickCare measure, providers are required to set up the Notification Alerts function in PointClickCare properly.

Incentive Amount: 25%

Reporting Requirements: No reporting is required from providers. PHC will monitor PointClickCare and confirm the alert function is working properly.

NOTE: New ECM providers are eligible to participate in the ECM QIP throughout the measurement year, and will be required to complete Part 1 of this measure during their first quarter in the program.

NEW **Measure 4: Timely Review of ED/ Admissions Notification Alerts in PointClickCare**

Part 2: Timely Review of ED / Admissions Notification Alerts in PointClickCare

Measurement Period:
January 1, 2025 – December 31, 2025

Description: Providers receive notification alerts in PointClickCare when an ECM member visits the ED and/or is admitted to the hospital. Providers are required to review the notification alerts within 72 hours of receiving the alert.

Incentive Pool Allotment: 25%

Targets:

- Full credit: ≥ 80% of notification alerts reviewed in PointClickCare within 72 hours
- Partial credit: 50%-79.9% of notification alerts reviewed in PointClickCare within 72 hours

Reporting Requirements: No reporting is required by providers. PHC will audit provider performance based on ED/Admissions report results obtained from PointClickCare.

NOTE: Incentive pool allotment or targets are subject to change for provider with 5 or less members.

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Pharmacy
Q1 & Q2 2024

Pharmacy Treatment Authorization Request (TAR) Timeliness Report
Physician Administered Drugs
(January 1, 2024 through June 30, 2024)

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity review

Urgent Pre-Service *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	122	108	230	
Total # of requests (denominator)	136	115	251	
% compliant	**89.71%**	**93.91%**	**91.63%**	95% (No)

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	95% (N/A)

Non-Urgent Pre-service *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	299	237	536	
Total # of requests (denominator)	299	237	536	
% compliant	**100%**	**100%**	**100%**	95% (yes)

Post-Service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	45	17	62	
Total # of requests (denominator)	45	17	62	
% compliant	**100%**	**100%**	**100%**	95% (yes)

Pharmacy
Q1 & Q2 2024

Pharmacy Inter-Rater Reliability (IRR) Results
(January 1, 2024 through June 30, 2024)

Pharmacy Technician IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	76/78	97%	90%	Yes
Q2	101/106	95%	90%	Yes
Total	**177/184**	**96%**	**90%**	**Yes**

Pharmacist IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	57/59	96%	90%	Yes
Q2	64/65	98%	90%	Yes
Total	**121/124**	**98%**	**90%**	**Yes**

Pharmacy TAR Volume & Staffing
(January 1, 2024 through June 30, 2024)

All Regions	January	February	March	April	May	June
Total TARs	1,065	994	877	879	865	848
Working Days	21	20	21	22	22	20
Pharmacy Technician FTE	4	7	7	7	7	7
TARs per tech per day	13	7	6	6	6	6
Pharmacist FTE	5	5	5	5	5	5
TARs per pharmacist per day	10	10	8	8	8	8

Pharmacy
Q1 & Q2 2024

Pharmacy TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		TOTAL	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	426	625	342	600	502	544	432	562	456	516	476	512	2,634	3,359
Approved as Modified	26	68	29	51	19	47	16	24	28	37	15	32	133	259
Medical Necessity Not Justified	74	119	79	112	77	86	64	95	62	98	63	83	419	593
Member Not Eligible	0	0	0	0	0	0	1	0	0	0	0	0	1	0
Other Health Insurance	13	23	10	29	19	39	11	18	22	29	14	29	89	167
Admin Denial*	93	206	99	165	84	123	70	147	61	157	60	162	467	960
Void	21	24	23	37	39	38	19	33	20	28	21	30	143	190
Total TARs	**653**	**1065**	**582**	**994**	**740**	**877**	**613**	**879**	**649**	**865**	**649**	**848**	**3,886**	**5,528**

* Duplicate TAR or No TAR Required

Utilization Management (UM)
Q1 & Q2 2024

UM Treatment Authorization Request (TAR) Timeliness Report
Non-Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

Urgent Preservice *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	36	49	85	
Total # of requests (denominator)	40	73	113	
% compliant	**90.0%**	**67.2%**	**75.2%**	95% **(No)**

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	117	210	327	
Total # of requests (denominator)	133	295	428	
% compliant	**88.0%**	**71.2%**	**76.4%**	95% **(No)**

Nonurgent Preservice *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	571	423	994	
Total # of requests (denominator)	1092	1299	2391	
% compliant	**52.3%**	**32.6%**	**41.6%**	95% **(No)**

Post-service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	5	8	13	
Total # of requests (denominator)	8	10	18	
% compliant	**63.0%**	**80.0%**	**72.2%**	95% **(No)**

Utilization Management (UM)
Q1 & Q2 2024

UM Inter-Rater Reliability (IRR) Results
Non-Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

INPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	183/191	95.81%	90%	Yes
Q2	211/220	95.91%	90%	Yes
Total	**394/411**	**95.86%**	**90%**	**Yes**

OUTPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	318/331	96.07%	90%	Yes
Q2	383/400	95.75%	90%	Yes
Total	**701/731**	**95.90%**	**90%**	**Yes**

LTC - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	50/51	98.04%	90%	Yes
Q2	84/88	95.45%	90%	Yes
Total	**134/139**	**96.40%**	**90%**	**Yes**

Physician UM IRR Results: *(Note: No Pharmacy TARs included in these two quarters)*

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	161/164	98.17%	90%	Yes
Q2	164/166	98.80%	90%	Yes
Total	**325/330**	**98.48%**	**90%**	**Yes**

Utilization Management (UM)
Q1 & Q2 2024

UM TAR Volume & Staffing
Non-Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

Report includes data for all TARs

INPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Inpatient	11	13	15	15	14	16	**14**
Total TARs	5994	5302	5255	5387	5429	5225	**32592**
Working Days	21	20	21	22	22	20	**126**
TARs per Nurse per day	25.9	20.4	16.7	16.3	17.6	16.3	**18.48**

OUTPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Outpatient	23	23	24	24	27	30	**25.17**
Total TARs	27117	23062	23240	23776	22744	21679	**141618**
Working Days	21	20	21	22	22	20	**126**
TARs per Nurse per day	56.1	50.1	46.1	45.0	38.3	36.1	**44.66**

LTC TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - LTC	4	3	4	5	6	9	**5.17**
Total TARs	2779	1766	1739	1568	1521	2202	**11575**
Working Days	21	20	21	22	22	20	**126**
TARs per Nurse per day	33.1	29.4	20.7	14.3	11.5	12.2	**17.77**

(FTE: *Full-Time Equivalent***)**

Utilization Management (UM)
Q1 & Q2 2024

UM Treatment Authorization Request (TAR) Timeliness Report
Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity review

Urgent Preservice *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	0	0	0	
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	95% **(N/A)**

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	95% **(N/A)**

Nonurgent Preservice *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	1	1	
Total # of requests (denominator)	0	1	1	
% compliant	**N/A**	**100%**	**100%**	95% (**Yes**)

Post-service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	95% **(N/A)**

Utilization Management (UM)
Q1 & Q2 2024

UM Inter-Rater Reliability (IRR) Results
Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

Behavioral Health Wellness & Recovery - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	30/30	100.00%	90%	Yes
Q2	30/30	100.00%	90%	Yes
Total	**60/60**	**100.00%**	**90%**	Yes

UM TAR Volume & Staffing
Behavioral Healthcare Decisions
January 1, 2024 through June 30, 2024

Report includes data for all TARs

Behavioral Health Wellness & Recovery TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE (ASAM training)	2	2	2	2	2	2	**2**
Total TARs	154	130	180	171	161	146	**942**
Working Days	21	20	21	22	22	20	**126**
TARs per Nurse per day	3.7	3.3	4.3	3.9	3.7	3.7	**3.8**

(FTE: *Full-Time Equivalent***)**

INPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		TOTAL	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	3,072	4,912	2,779	4,649	2,974	4,481	2,821	4,814	3,074	4,841	2,704	4,591	2,955		3,079		2,857		2,985		2,936		2,732		34,968	28,288
EB Approved	3	20	2	6	6	17	7	14	1	8	5	6	6		6		4		3		2		2		47	71
IB Approved	6	12	11	35	49	61	9	10	30	19	135	70	4		6		35		6		25		119		435	207
CTC / Capped Review	1	3	6	9	44	31	2	0	5	0	87	15	0		3		14		0		6		14		182	58
Correction Received	0	0	0	1	0	3	0	1	1	2	0	1	0		0		0		0		0		1		2	8
Modified per Correction Request	1	3	2	0	2	3	0	3	2	4	1	4	1		4		4		4		4		4		29	17
TOTAL (APPROVED)	**3,083**	**4,950**	**2,800**	**4,700**	**3,075**	**4,596**	2,839	**4,842**	**3,113**	**4,874**	**2,932**	**4,687**	**2,966**	**0**	**3,098**	**0**	**2,914**	**0**	**2,998**	**0**	**2,973**	**0**	**2,872**	**0**	**35,663**	**28,649**
Approve as Modified	**23**	**34**	**18**	**39**	**24**	**45**	**25**	**40**	**17**	**49**	**25**	**52**	**17**		**20**		**31**		**18**		**30**		**29**		**277**	**259**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
Med Nec Not Justified	34	64	39	66	44	73	30	75	44	80	29	94	18		37		37		43		38		46		**439**	**452**
Denied by Cap Hospital	5	3	3	3	3	5	7	6	8	5	5	8	9		3		0		3		2		4		**52**	**30**
Member not Eligible	10	17	7	10	9	12	7	8	9	10	6	8	5		7		7		8		7		7		**89**	**65**
Not Timely	0	0	1	0	0	0	0	0	0	0	0	1	0		0		0		0		2		0		**3**	**1**
Other Insurance	46	190	42	110	41	129	49	126	44	119	55	118	38		39		48		97		74		96		**669**	**792**
TOTAL (MED NEC DENIALS)	**95**	**274**	**92**	**189**	**97**	**219**	**93**	**215**	**105**	**214**	**95**	**229**	**70**	**0**	**86**	**0**	**92**	**0**	**151**	**0**	**123**	**0**	**153**	**0**	**1,252**	**1,340**
Admin Denial (Duplicate TAR)	74	110	38	63	48	63	32	69	36	72	37	63	33		34		47		44		45		43		**511**	**440**
Admin Denial (No Auth Required)	53	96	52	144	67	108	40	86	82	88	58	79	54		53		60		64		81		56		**720**	**601**
Admin Denial (Void)	116	512	85	161	99	222	77	114	111	114	81	109	105		94		119		120		136		122		**1,265**	**1,232**
TOTAL (ADMIN DENIALS)	243	718	175	368	214	393	149	269	229	274	176	251	192	0	181	0	226	0	228	0	262	0	221	0	**2,496**	2,273
TOTAL (DENIALS)	**338**	**992**	**267**	**557**	**311**	**612**	**242**	**484**	**334**	**488**	**271**	**480**	**262**	**0**	**267**	**0**	**318**	**0**	**379**	**0**	**385**	**0**	**374**	**0**	**3,748**	**3,613**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		1		0		1	0
Overturned by Appeal	1	1	0	1	0	0	1	2	0	1	0	0	0		0		0		0		1		0		3	5
Appeal Partially Overturned	2	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		2	0
Appeal Upheld	16	17	5	5	3	2	7	19	5	17	1	6	13		2		0		4		3		0		59	66
TOTAL TARs	**3,463**	**5,994**	**3,090**	**5,302**	**3,413**	**5,255**	**3,114**	**5,387**	**3,469**	**5,429**	**3,229**	**5,225**	**3,258**	**0**	**3,387**	**0**	**3,263**	**0**	**3,399**	**0**	**3,393**	**0**	**3,275**	**0**	**39,753**	**32,592**
IP Nurse FTE	**13**	**11**	**13**	**13**	**14**	**15**	**14**	**15**	**14**	**14**	**14**	**16**	**13**		**11**		**10**		**12.00**		**14.00**		**15.00**			
Working Days	**20**	**21**	**19**	**20**	**23**	**21**	**20**	**22**	**22**	**22**	**22**	**20**	**20**	**22**	**23**	**22**	**20**	**20**	**22**	**23**	**20**	**19**	**19**	**20**		
TARs per Nurse per Day	13.32	25.95	12.51	20.39	10.60	16.68	11.12	16.32	11.26	17.63	10.48	16.33	12.53	#DIV/0!	13.39	#DIV/0!	16.32	#DIV/0!	12.88	#DIV/0!	12.12	#DIV/0!	11.49	#DIV/0!		

OUTPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	10,338	20,105	10,097	17,394	12,139	17,474	10,395	17,182	12,479	17,000	11,872	15,412	10,834		12,694		11,004		11,859		11,211		10,471		135,393	104,567
EB Approved	1,107	921	1,208	788	1,543	756	753	651	804	651	811	845	746		1,148		896		1,142		929		875		11,962	4,612
CTC / Capped Review	0	0	0	1	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	1
Correction Received	12	70	19	74	27	103	20	62	25	96	73	78	23		31		43		77		78		105		533	483
Modified per Correction Request	795	1,427	605	898	478	579	644	1,252	613	920	280	556	707		656		369		764		512		324		6,747	5,632
TOTAL (APPROVED)	12,252	22,523	11,929	19,155	14,187	18,912	11,812	19,147	13,921	18,667	13,036	16,891	12,310	0	14,529	0	12,312	0	13,842	0	12,730	0	11,775	0	154,635	115,295
Approve as Modified	84	71	104	70	101	74	106	94	97	74	64	70	58		114		103		94		94		90		1,109	453
Admin Modification	237	149	276	158	278	179	278	177	329	133	270	156	219		231		258		235		210		211		3,032	952
Med Nec Not Justified	493	258	428	226	548	313	594	426	694	255	458	239	696		770		596		685		537		438		6,937	1,717
Denied by Cap Hospital	0	1	3	0	1	2	2	0	0	2	2	2	3		2		1		1		0		2		17	7
Member not Eligible	12	27	11	13	22	23	11	29	14	23	18	26	18		17		25		8		12		16		184	141
Not Timely	0	1	0	3	0	2	0	1	0	0	1	1	0		0		5		1		3		1		11	8
Other Insurance	223	418	148	369	197	371	161	351	171	379	200	366	193		219		190		241		197		217		2,357	2,254
TOTAL (MED NEC DENIALS)	728	705	590	611	768	711	768	807	879	659	679	634	910	0	1,008	0	817	0	936	0	749	0	674	0	9,506	4,127
Admin Denial (Duplicate TAR)	511	801	488	627	651	739	542	792	691	863	616	848	579		605		508		613		556		538		6,898	4,670
Admin Denial (No Auth Required)	909	2,255	883	1,994	990	2,230	863	2,251	995	1,988	900	2,666	844		956		883		974		845		848		10,890	13,384
Admin Denial (Void)	328	605	304	435	354	388	350	478	366	351	319	412	388		392		338		433		377		331		4,280	2,669
TOTAL (ADMIN DENIALS)	1,748	3,661	1,675	3,056	1,995	3,357	1,755	3,521	2,052	3,202	1,835	3,926	1,811	0	1,953	0	1,729	0	2,020	0	1,778	0	1,717	0	22,068	20,723
TOTAL (DENIALS)	2,476	4,366	2,265	3,667	2,763	4,068	2,523	4,328	2,931	3,861	2,514	4,560	2,721	0	2,961	0	2,546	0	2,956	0	2,527	0	2,391	0	31,574	24,850
Grievance Overturned	4	4	3	3	2	1	5	2	3	1	1	0	9		2		0		4		2		0		35	11
Overturned by Appeal	8	0	2	2	1	4	3	8	3	3	0	1	5		3		3		5		1		1		35	18
Appeal Partially Overturned	1	0	0	1	0	0	0	0	0	0	0	0	0		0		0		0		0		0		1	1
Appeal Upheld	7	4	5	6	4	2	2	20	3	5	0	1	4		12		3		8		4		0		52	38
TOTAL TARs	15,069	27,117	14,584	23,062	17,336	23,240	14,729	23,776	17,287	22,744	15,885	21,679	15,326	0	17,852	0	15,225	0	17,144	0	15,568	0	14,468	0	190,473	141,618
OP Nurse FTE	24	23	24	23	23	24	23	24	23	27	23	30	22		23		23		24.00		27.00		27.00			
Working Days	20	21	19	20	23	21	20	22	22	22	22	20	20	22	23	22	20	20	22	23	20	19	19	20		
TARs per Nurse per Day	31.39	56.14	31.98	50.13	32.77	46.11	32.02	45.03	34.16	38.29	31.39	36.13	34.83	#DIV/0!	33.75	#DIV/0!	33.10	#DIV/0!	32.47	#DIV/0!	28.83	#DIV/0!	28.20	#DIV/0!		

LTC TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	1,192	2,098	907	1,321	1,043	1,210	803	1,133	1,018	1,083	914	1,765	816		986		831		879		806		781		10,976	8,610
EB / IB Approved	128	239	146	187	133	209	126	190	133	219	118	195	146		134		151		169		133		104		1,621	1,239
Correction Received	11	25	9	18	20	66	10	3	28	16	72	28	12		18		22		17		28		47		294	156
Modified per Correction Request	0	13	0	9	0	12	0	22	0	19	0	7	0		0		0		14		19		21		54	82
TOTAL (APPROVED)	**1,331**	**2,375**	**1,062**	**1,535**	**1,196**	**1,497**	939	**1,348**	**1,179**	**1,337**	**1,104**	**1,995**	**974**	**0**	**1,138**	**0**	**1,004**	**0**	**1,079**	**0**	**986**	**0**	**953**	**0**	**12,945**	**10,087**
Approve as Modified	**5**	**4**	**3**	**2**	**5**	**9**	**1**	**5**	**3**	**7**	**2**	**7**	**4**		**2**		**0**		**7**		**5**		**1**		**38**	**34**
Admin Modification	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**1**	**0**	**0**	**1**	**1**	**0**		**0**		**0**		**1**		**0**		**4**		**8**	**2**
Med Nec Not Justified	5	10	4	6	5	24	11	20	7	31	8	29	8		7		9		9		9		6		**88**	**120**
Member not Eligible	2	7	2	3	4	4	2	3	1	3	1	4	4		0		4		2		1		4		**27**	**24**
Not Timely	0	0	0	1	0	0	0	3	0	1	0	1	0		0		0		0		0		2		**2**	**6**
Other Insurance	3	7	5	9	5	17	6	25	12	5	18	6	3		8		6		4		8		2		**80**	**69**
TOTAL (MED NEC DENIALS)	**10**	**24**	**11**	**19**	**14**	**45**	**21**	**51**	**20**	**40**	**27**	**40**	**15**	**0**	**15**	**0**	**19**	**0**	**15**	**0**	**18**	**0**	**14**	**0**	**197**	**219**
Admin Denial (Duplicate TAR)	42	79	34	95	51	105	39	94	60	81	54	75	52		53		35		43		30		41		**534**	**529**
Admin Denial (No Auth Required)	0	1	0	0	1	1	0	0	0	1	0	0	0		0		2		0		0		0		**3**	**3**
Admin Denial (Void)	62	294	74	112	79	82	58	67	61	55	57	84	63		83		59		85		52		63		**796**	**694**
TOTAL (ADMIN DENIALS)	104	374	108	207	131	188	97	161	121	137	111	159	115	0	136	0	96	0	128	0	82	0	104	0	**1,333**	1,226
TOTAL (DENIALS)	**114**	**398**	**119**	**226**	**145**	**233**	**118**	**212**	**141**	**177**	**138**	**199**	**130**	**0**	**151**	**0**	**115**	**0**	**143**	**0**	**100**	**0**	**118**	**0**	**1,530**	**1,445**
Grievance Overturned	0	1	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	1
Overturned by Appeal	0	0	0	2	0	0	0	1	0	0	0	0	0		0		0		0		0		0		0	3
Appeal Partially Overturned	0	0	0	0	0	0	1	0	0	0	0	0	0		0		0		1		1		0		3	0
Appeal Upheld	0	1	0	1	0	0	0	1	1	0	0	0	1		0		0		0		0		0		2	3
TOTAL TARs	**1,450**	**2,779**	**1,185**	**1,766**	**1,346**	**1,739**	**1,060**	**1,568**	**1,324**	**1,521**	**1,245**	**2,202**	**1,109**	**0**	**1,291**	**0**	**1,119**	**0**	**1,231**	**0**	**1,092**	**0**	**1,076**	**0**	**14,526**	**11,575**
LTSS Nurse FTE	**7**	**4**	**7**	**3**	**7**	**4**	**7**	**5**	**7**	**6**	**6**	**9**	**5**		**6**		**4**		**5.00**		**5.00**		**6.00**			
Working Days	**20**	**21**	**19**	**20**	**23**	**21**	**20**	**22**	**22**	**22**	**22**	**20**	**20**	**22**	**23**	**22**	**20**	**20**	**22**	**23**	**20**	**19**	**19**	**20**		
TARs per Nurse per Day	10.36	33.08	8.91	29.43	8.36	20.70	7.57	14.25	8.60	11.52	9.43	12.23	11.09	#DIV/0!	9.36	#DIV/0!	13.99	#DIV/0!	11.19	#DIV/0!	10.92	#DIV/0!	9.44	#DIV/0!		

Wellness & Recovery (BH) TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Approved	94	125	72	91	30	73	73	137	58	90	30	44	103		66		50		113		64		26		779	560
EB Approved	0	0	0	0	0	0	0	0	0	0	0	0	0		0		1		0		0		0		1	0
IB Approved	16	20	35	22	82	84	27	20	55	60	89	78	32		72		64		35		61		88		656	284
Correction Received	0	5	0	11	0	17	0	8	0	8	0	19	0		0		0		0		0		0		0	68
Modified per Correction Request	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL (APPROVED)	**110**	**150**	**107**	**124**	**112**	**174**	100	**165**	**113**	**158**	**119**	**141**	**135**	**0**	**138**	**0**	**115**	**0**	**148**	**0**	**125**	**0**	**114**	**0**	**1,436**	**912**
Approve as Modified	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
TOTAL (MED NEC DENIALS)	1	**0**	1	**0**	0	**0**	0	**0**	0	**0**	0	**0**	0		0		0		0		0		0		**2**	**0**
Admin Denial (Duplicate TAR)	1	3	1	5	3	4	0	4	0	1	1	4	4		3		3		2		4		4		**26**	**21**
Admin Denial (No Auth Required)	0	0	1	0	0	0	0	0	0	0	1	0	1		0		0		0		0		0		**3**	**0**
Admin Denial (Void)	2	1	0	1	0	2	0	2	2	2	2	0	6		0		0		0		1		3		**16**	**8**
TOTAL (ADMIN DENIALS)	3	4	2	6	3	6	0	6	2	3	4	4	11	0	3	0	3	0	2	0	5	0	7	0	**45**	29
TOTAL (DENIALS)	**4**	**4**	**3**	**6**	**3**	**6**	**0**	**6**	**2**	**3**	**4**	**4**	**11**	**0**	**3**	**0**	**3**	**0**	**2**	**0**	**5**	**0**	**7**	**0**	**47**	**29**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Overturned by Appeal	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Upheld	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL TARs	**114**	**154**	**110**	**130**	**115**	**180**	**100**	**171**	**115**	**161**	**123**	**145**	**146**	**0**	**141**	**0**	**118**	**0**	**150**	**0**	**130**	**0**	**121**	**0**	**1,483**	**941**
SUD Nurse FTE	**2**	**2**	**2**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**2**		**2**		**2**		**2**		**2.00**		**2.00**		**2.00**			
Working Days	**20**	**21**	**19**	**20**	**23**	**21**	**20**	**22**	**22**	**22**	**22**	**20**	**20**	**22**	**23**	**22**	**20**	**20**	**22**	**23**	**20**	**19**	**19**	**20**		
TARs per Nurse per Day	2.85	3.67	2.89	3.25	5.00	4.29	5.00	3.89	2.61	3.66	3.73	#DIV/0!	3.65	#DIV/0!	3.07	#DIV/0!	3.93	#DIV/0!	3.41	#DIV/0!	3.25	#DIV/0!	3.18	#DIV/0!		

Total All TAR Types	246,235	186,726
	2023	2024 (Q1&Q2)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3022 (previously UG100322)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Incontinence Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/24/1994</td><td colspan="4">Next Review Date: ~~09/13/2024~~10/09/2025
Last Review Date: ~~09/13/2023~~10/09/2024</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>☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO ☐ 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~~10/09/2024</td></tr>
</table>

I. RELATED POLICIES:

MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Medical Practitioner: For the purposes of this policy, the medical practitioner is a physician, nurse practitioner or physician assistant.
B. CMN Form: Incontinence Supplies Medical Necessity Certification Form *DHCS 6187*

IV. ATTACHMENTS:

A. ~~PHC~~Partnership Maximum/ Average Benefit Incontinence Guidelines
B. Incontinence Supplies Medical Necessity Certification form (DHCS 6187)

V. PURPOSE:

Incontinence supplies are a Medi-Cal benefit that must be prescribed by the physician, nurse practitioner, or physician assistant (medical practitioner) who is currently responsible for the care of the ~~member~~Member and has evaluated the ~~member~~Member's bladder and bowel incontinence within the past year. All ~~member~~Members with a diagnosis of incontinence should be evaluated by the current medical practitioner to determine whether consultation with a specialist is indicated.

VI. GUIDELINE / PROCEDURE:

A. TREATMENT AUTHORIZATION REQUEST (TAR) PROCESS
   1. A TAR is required for all incontinence supplies*. The TAR must contain documentation regarding the ~~member~~Member's history of incontinence, along with information regarding the medical necessity for the supplies ordered.
   2. For incontinence supplies over $165 per month (including sales tax), a state mandated Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (Attachment B) must accompany the TAR and will include the following information:
      a. Medical condition / diagnosis causing bowel and bladder incontinence
      b. Type of urinary / bowel incontinence

*See VI.A.3 for two code exceptions.

c. Evaluation and treatments attempted and outcomes (including urologist assessment or reports)
d. Documentation of the reasons why other options (pharmacologic, drugs, behavioral techniques or surgical interventions) are not appropriate to decrease or eliminate incontinence
e. Prognosis for controlling incontinence
f. Brief summary of the incontinence therapeutic intervention plan
g. Explanation if medical practitioner orders supplies in **excess** of the thresholds listed in Attachment A and information regarding medical necessity for the additional use

3. Codes A4335 and A6250 for skin wash and skin cream do not require a TAR unless they are ordered above normal supply limit. (See Attachment A for supply limits.) However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be ~~good~~ valid 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.
4. The requested item must be the lowest cost item to meet the ~~member~~Member's medical needs.
5. If the ~~member~~Member has chronic, non-treatable incontinence as confirmed by the primary care practitioner or a urologist, the TAR can be approved up to one (1) year.
6. If the approval is granted for an interval greater than 30 days, the provider of service has the responsibility to verify that the ~~member~~Member remains eligible with Partnership HealthPlan of California (~~PHC~~Partnership) on a monthly basis and in NO instance will ~~PHC~~Partnership reimburse for supplies in excess of a 60 day supply dispensed at any one time. (For Example: If ~~PHC~~Partnership approves supplies for a one year time frame, the provider will NOT be reimbursed for the entire year at one time. Billings are to occur incrementally on a monthly basis as the ~~member~~Member's eligibility status may change.) See Attachment A for supply limits.
7. Incontinence supplies such as diapers, liners, chux, etc. over $165 per month (including sales tax) require a completed Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (CMN form) (see Attachment B) submitted with the TAR.
8. Incontinence supplies $165 per month or less require a TAR with the prescription attached, but do not require the CMN form.
9. Note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.

B. Incontinence supplies for ~~member~~Members in a skilled nursing facility (SNF) and Intermediate Care Facility (ICF)/Developmentally Disabled (DD) or ICF are part of the facility per diem rate and are not billable separately to ~~PHC~~Partnership. Incontinence supplies for ~~member~~Members in ICF/DD-Habilitative (H) or ICF/DD- Nursing (N) are not part of the facility per diem and are separately billable to ~~PHC~~Partnership. Incontinence supplies for ~~member~~Members in ICF/DD-H or ICF/DD-N can be approved for up to one (1) year. The same requirements as per VI.A.7 apply.

C. Incontinence supplies for ~~member~~Members under age five may be covered under the Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services benefit (now referred to as Medi-Cal for Kids and Teens) where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence.

D. The CMN form (Attachment B) must be dated within 12 months of the date of service on the claim and must be signed by the ~~member~~Member's current medical practitioner.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines:~~–~~ Incontinence Medical Supplies *(incont)*
~~A.~~B. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 11-1223 Authorization for Purchase of Incontinence Medical Supplies (12/19/2023)
~~B.~~C. Welfare & Institutions Code, Section 14125.4

Guideline/Procedure Number: MCUG3022 (previously UG100322)		**Lead Department: Health Services**
Guideline/Procedure Title: Incontinence Guidelines		**☒External Policy** **☐Internal Policy**
Original Date: 07/24/1994	**Next Review Date: ~~09/13/2024~~10/09/2025** **Last Review Date: ~~09/13/2023~~10/09/2024**	
Applies to:	**☒ Medi-Cal**	**☐ Employees**

VIII. DISTRIBUTION:

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

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

X. REVISION DATES: 01/01/96; 04/28/00; 06/20/01; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 11/18/09; 07/21/10; 06/20/12; 08/20/14; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 02/12/20; 06/10/20; 09/09/20; 02/10/21; 05/12/21; 08/11/21; 08/10/22; 09/13/23; 10/09/24

*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.

****

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
4665 Business Center Drive
Fairfield, California 94534

PHC MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

DESCRIPTION OF PRODUCTS	HCPCS	MCL QTY
DISPOSABLE INCONTINENCE PRODUCTS (BRIEFS/ DIAPERS):	***See Note 1 below***	
Adult Sizes:		
Small	T4521	200/Month
Medium/ Regular	T4522	192/Month
Large	T4523	216/Month
Extra-Large (XL) and XXL	T4524	192/Month
Bariatric XXXL or above	T4543	200/Month
Youth Size:	T4533	200/Month
Pediatric Sizes:		
Small/Medium	T4529	200/Month
Large	T4530	200/Month
DISPOSABLE INCONTINENCE PRODUCTS (PROTECTIVE UNDERWEAR/ PULL-ONS):	***See Note 1 below***	
Adult Sizes:		
Small	T4525	120/Month
Medium	T4526	120/Month
Large	T4527	120/Month
Extra-Large (XL) and XXL	T4528	120/Month
Bariatric XXXL or above	T4544	120/Month
Youth Size:	T4534	200/Month
Pediatric Sizes:		
Small/Medium	T4531	200/Month
Large	T4532	200/Month
Note 1: Quantity limits for Disposable Incontinence Products **(Briefs/ Diapers)** and Disposable Incontinence Products **(Protective Underwear/ Pull-Ons)** cannot be combined without medical justification (which must be stated in Section C, field 12. on the DHCS form 6187 Incontinence Supplies Medical Necessity Certification which is Attachment B to this policy). If justification is provided, Briefs/ Diapers and Disposable Incontinence Products (Protective Underwear/ Pull-Ons) may be mixed and matched as long the combined total does not exceed 300 units. Also note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.		
DISPOSABLE LINERS/ SHIELDS/ PADS/ UNDERGARMENTS:	***See Note 2 below***	
Disposable Liners/ Shields	T4535	180/Month
Disposable Pads	T4535	180/Month
Beltless Undergarments	T4535	180/Month
Belted Undergarments	T4535	180/Month
Note 2: Specific qty. limits apply to each product type. In this section, liners/shields, pads & undergarments may be mixed and matched as long as no single product type exceeds 180 units AND the combined total does not exceed 300 units of these items. Also note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.		

Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, California 94534

PHC MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

DESCRIPTION OF PRODUCTS		HCPCS	MCL QTY
Disposable Underpads:			
Large Underpad		T4541	120/Month
Small Underpad		T4542	120/Month
Incontinent Reusable Pants (Any Size):		T4536	2/Month
Reusable Waterproof Sheeting:		T4537	2/Year
Incontinence Skin Care:			
Skin Cream	***See Note 3 below***	A6250	540 gm/ Month
Skin Wash	***See Note 3 below***	A4335	960 ml/ Month
Enter in the system in cc's (8 oz. tube = 270 cc)			
Note 3: Skin Cream and Skin Wash Codes A4335 and A6250 do not require a TAR unless they are ordered above normal frequency limit. 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.			
Gloves:			
Non-Sterile Gloves	***See Note 4 below***	A4927	200/Month
Note 4: These are not routinely approved, and there must be a clear need for the item. Diagnoses of quad/paraplegia, AIDS, hepatitis, etc., are considered appropriate reasons for gloves. PHC will also consider approval if the caregiver of an adult is not a family member.			

Notes:

(Applies to All): Kimberly-Clark Products are not a Medi-Cal Benefit

Enuresis Alarm Pads are a covered benefit as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization

State of California - Health of Human Services Agency | Department of Health Care Services

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION

SECTION A: Incontinence Provider Information

1. Contact Person	2. Contact Telephone Number	3. Contact Fax Number

SECTION B: Patient Information

4. Patient Name– Last, First, Middle (as appears on card)

5. Medi-Cal ID Number	6. Gender	7. Date of Birth (mm/dd/yy)	8. Age
	Male ☐ Female ☐		

9. Type of Residence
☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N ☐ Other _____

SECTION C: Documentation Supporting Medical Necessity

Note: If necessary, include supporting documentation on an attachment

10. Does the patient **meet the Code 1 Restriction**? Yes ☐ No ☐
If yes, indicate the primary and secondary diagnosis name and ICD-10-CM codes.

_____

_____

_____

If no, provide clinical evidence and describe in detail the medical conditions and/or extenuating circumstances to support the medical necessity.

_____

_____

_____

_____

11. Have any **previous treatments** (for example, drug therapy, behavioral techniques, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? Yes ☐ No ☐
If yes, describe treatment(s), treatment results, and patient's responsiveness.

_____

_____

_____

_____

If no, explain reasons why other treatments are not appropriate to decrease or eliminate incontinence.

_____

_____

_____

_____

SECTION C: Documentation Supporting Medical Necessity (Continued)

12. Is this patient **prescribed multiple absorbent product types** to be used during the same time period? Yes ☐ No ☐
If yes, explain in detail the need for multiple varieties of supplies.

13. Does this request include a billing code that **requires prior authorization?** Yes ☐ No ☐
If yes, list billing code(s) and supporting documentation of medical need.

14. Does the patient require a quantity that **exceeds the quantity limits** for any of the supplies needed? Yes ☐ No ☐
If yes, list billing code(s), provide clinical evidence and describe in detail the acute medical condition and/or extenuating circumstances for increased need for additional quantities.

15. Does the patient require supplies (except creams and washes) that **exceed the $165 per month allowable**? Yes ☐ No ☐
If yes, provide a detailed explanation to support the need for supplies exceeding $165 per month.

16. Does this request have an attachment for additional supporting documentation? Yes ☐ No ☐

NOTE: Medical justification must be complete and thorough to process this request. If necessary, provide the supporting documentation and any additional information on an attachment.

SECTION D: List All Prescribed Product Types (For example, briefs, protective underwear, etc.)

17. Complete the table below for the supplies prescribed. Enter the last date of service (DOS) if previously billed.

Billing Code	Product Type	Last DOS	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units

18. This prescription is valid for _____ months. **NOTE:** The maximum allowed is 12 months. The physician's signature date below must be within 12 months of the date of service on the claim.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

By my signature below, I verify that I have physically examined the patient within the last 12 months and certify to the best of my knowledge that the information contained in this form is true, accurate and complete. I have prescribed the items on this form and will maintain a copy of this prescription in the beneficiary's medical record to meet Medi-Cal documentation requirements.

19. Physician's Name	20. Physician's National Provider Identifier

21. Physician's Business Address (number, street)	City	ZIP Code

22. Physician Telephone Number	23. Physician's Signature	24. Date

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION INSTRUCTIONS

SUBMISSION REQUIREMENTS: This form must accompany each Treatment Authorization Request (TAR) and must contain <u>all</u> supplies needed for the time period, not just supplies needing a TAR.

SECTION A: Incontinence Provider Information

1. Enter the name of the individual to contact for TAR questions.
2. Enter the phone number where the contact person can be reached.
3. Enter the fax number to receive information.

SECTION B: Patient Information

4. Enter the patient's last name, first name and middle initial.
5. Enter the Medi-Cal Identification Number.
6. Check the appropriate box.
7. Enter the complete date as 2-digit month, 2-digit day, and 2-digit year.
8. Enter the patient's current age.
9. Check the appropriate box.

SECTION C: Documentation Supporting Medical Necessity

10. – 15. An answer to each question is required. Depending on the response further explanation to support medical justification is required and if needed may be included on an attachment.
    NOTE: Medical justification must be complete and thorough in order to process the request.
16. Indicate if an attachment is included with this form.

SECTION D: List All Prescribed Product Types

17. This table must include **<u>all</u> supplies prescribed** for this patient's use during the number of months covered by this prescription.
    - Billing Code - Enter the HCPCS billing code for each supply item. Refer to the *List of Incontinence Medical Supplies Billing Codes*
    - Product Type – For each billing code enter the corresponding product type name (for example, cream, wash, disposable brief, protective underwear, pad, liner and underpad). Do not list brand name.
    - Last DOS – Enter the last date of service if product type was previously billed.
    - Daily Usage – Enter the estimated number of units the patient will use daily
    - Monthly Usage – Enter the estimated number of units the patient will use monthly.
    - Monthly Cost – Enter the estimated monthly cost for this supply, including markup and sales tax (unit cost multiplied by the monthly usage plus markup and sales tax)
    - Total units – Enter the total number of units for each supply item prescribed (monthly usage multiplied by the total number of months covered by this prescription).
18. Enter the number of months covered by this prescription. The maximum allowed is twelve (12) months.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

NOTE: This section must be completed by the attending physician. The physician's personal signature in ink and date of signature is required. Signatures stamped, printed or initials are not acceptable.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3058 (previously UG100358)			**Lead Department: Health Services**	
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/19/2003		**Next Review Date:** ~~09/13/2024~~10/09/2025 **Last Review Date:** ~~09/13/2023~~10/09/2024		
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:** ~~09/13/2023~~10/09/2024	

I. RELATED POLICIES:

A. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
B. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
~~A.~~C. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled. The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system.
~~B.~~D. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
~~C.~~E. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
~~D.~~F. Form HS 231: State of California Department of Health Care Services form entitled "Certification for Special Treatment Program Services"
~~E.~~G. LOA: Leave of Absence
~~F.~~H. NF-A: Nursing Facility Level A Freestanding nursing facilities
~~G.~~I. NF-B: Nursing Facility Level B The facilities comprising this category are distinct parts of acute care hospitals
J. BH: Bed Hold

IV. ATTACHMENTS:

A. Bed hold/TAR Process

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in an ICF/DD for Partnership HealthPlan of California ~~(PHC)~~ members.

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services**
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 09/13/202410/09/2025** **Last Review Date: 09/13/202310/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. GUIDELINE / PROCEDURE:

A. Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities

1. Federal regulations require California to provide a program of independent professional review of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD-N) that provide services to Medi-Cal recipients. This process is referred to as utilization review. Its purpose is to control unnecessary utilization of services by evaluating patient needs and the appropriateness, quality and timeliness of service delivery.
2. Patient Placement Requirements
   a. Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures "as needed" are not appropriate for ICF/DD-H and ICF/DD-N placement.
   ~~a.~~b. Please refer to policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
3. Federal Requirements for monitoring utilization and quality of care include:
   a. A review of the recipient's plan of care every 90 calendar days by the facility's interdisciplinary team.
   b. A comprehensive medical and social evaluation of the recipient within 12 months prior to admission
   c. A requirement that the recipient be seen by the attending physician at least every 60 calendar days.
4. Per Diem Services
   a. Services covered under the daily rate of an ICF/DD, ICF/DD-H and ICF/DD-N include:
      1) Services of the direct care staff
      2) Services of the facility's interdisciplinary team
      3) Services of qualified intellectual disabilities professional
      4) Case conference reviews
      5) Development of service plans
      6) In-service training of direct care staff and consultation on individual recipient needs
      7) Transportation services
      8) Equipment and supplies necessary to provide appropriate care
      9) Room and Board
5. ICF/DD-H/DD-N
   a. Submitting with a Treatment Authorization Request (TAR):
      1) Submit form HS 231 with initial and reauthorization TARs within 15 business days from date of service.
   b. Certification Period:
      1) For the ICF/DD-H or ICF/DD-N level of care, form HS 231 must be certified by the Regional Center director or designee.
      2) Certification may be granted for a period of twelve months at a time.
      3) The Regional Center director or designee assesses new patients within a reasonable amount of time.
      4) When the certified period expires, the member must be re-assessed and a new form HS 231 must be filled out and signed by the Regional Center director or designee.
6. Readmission and New Certification:
   a. ICF/DD-H or ICF/DD-N member who is discharged and subsequently readmitted must be

re-assessed. A new form HS 231 must be filled out and submitted with a new TAR.

B. Leave of Absence ~~and Bed Hold (Applies to ICF/DD-N Only)~~
~~1. This section includes leave of absence and bed hold policies pertaining to facilities~~
~~2. Acute Hospitalization~~
~~3.~~1. Leave of Absence Qualifications
a. A leave of absence (LOA) may be granted to a recipient in an ~~a Nursing Facility Level A (NF-A) or Nursing Facility Level B (NF-B), swing bed facility, Intermediate Care Facility for the Developmentally Disabled-Nursing (~~ICF/DD-N~~),~~ or ~~and Intermediate Care Facility for the Developmentally Disabled-Habilitative (~~ICF/DD-H~~)~~ in accordance with the recipient's individual plan of care and for the specific reasons outlined below~~:. Leaves of absence may be granted for the following reasons:~~
1) A visit with relatives or friends
2) Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons

~~4.~~2. Leave of Absence Maximum Time Period
a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
1) Eighteen days per calendar year for non-developmentally disabled recipients. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:
a) The request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.
b) At least five days of LTC inpatient care must be provided between each approved LOA.
2) Developmentally disabled recipients can receive a leave of absence for relatives/friend visits or summer camp for up to seventy-three (73) days per calendar year.
3) These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the patient's bed (bed hold) as described below.

C. Bed H~~h~~old (BH) Qualifications
1. When a recipient residing in a ICF/DD ~~nursing~~ facility is admitted to an acute care hospital, providers must bill bed hold (BH) days. Reimbursement for bed hold days is limited to a maximum of seven days per hospitalization, subject to the following:
1) The attending physician must order the acute hospitalization.
2) The facility must hold a bed vacant when requested during the entire hold period, maximum of 7 days for each bed hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
2. General Leave of Absence and Bed Hold Requirements
a. General requirements for LOA and BH are outlined below:
1) Day of departure is counted as one day of LOA/BH, and the day of return is counted as one day of inpatient care.
2) Facility holds the bed vacant during LOA/BH
3) LOA or BH (hospitalization) is ordered by a licensed physician
4) Recipient's return from LOA/BH must not be followed by discharge within 24 hours
5) LOA/BH must terminate on a recipient's day of death
6) Facility claims must identify the inclusive dates of leave
3. Additional Leave of Absence Requirements
a. Requirements specific to LOA are listed below:

1) Provisions for LOAs are part of the patient care plan for recipients in an NF-A or NF-B.
2) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H, or ICF/DD-N.
3) Re-admission TAR's are not necessary for recipients returning from a leave of absence if a valid TAR covering the return date exists.
4) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
5) Recipient's records maintained in an NF-A, NF-B, ICF/DD, ICF/DD-H, or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
6) For all NF-A and NF-B recipients, including the mentally disabled, the provider is paid the appropriate NF-A and NF-B rate(s) minus the raw food cost established by Department of Health Care Services (DHCS) LOA/BH days.

b. Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
c. At the time of admission, if a recipient has not been an inpatient in any long term care (LTC) facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations.

4. Patient Failure to Return from Leave of Absence
   a. If recipients have used their total leave days, they may still be allowed a leave of absence during the same calendar year. However, the facility will not receive reimbursement for those authorized leave days.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Sections 483.400 – 483.480
B. Title 22 California Code of Regulations (CCR) Section 51535
C. California Department of Developmental Services (DDS) Guidelines
D. Medi-Cal Provider Manual/Guidelines: Leave of Absence, Bed Hold, and Room and Board *(leave)*
E. Lanterman Developmental Disabilities Services Act
~~D.~~F. DHCS APL 23-023 *Revised* Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023)

VIII. DISTRIBUTION:

A. PHC Department Directors
B. PHC Provider Manual

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

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

*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

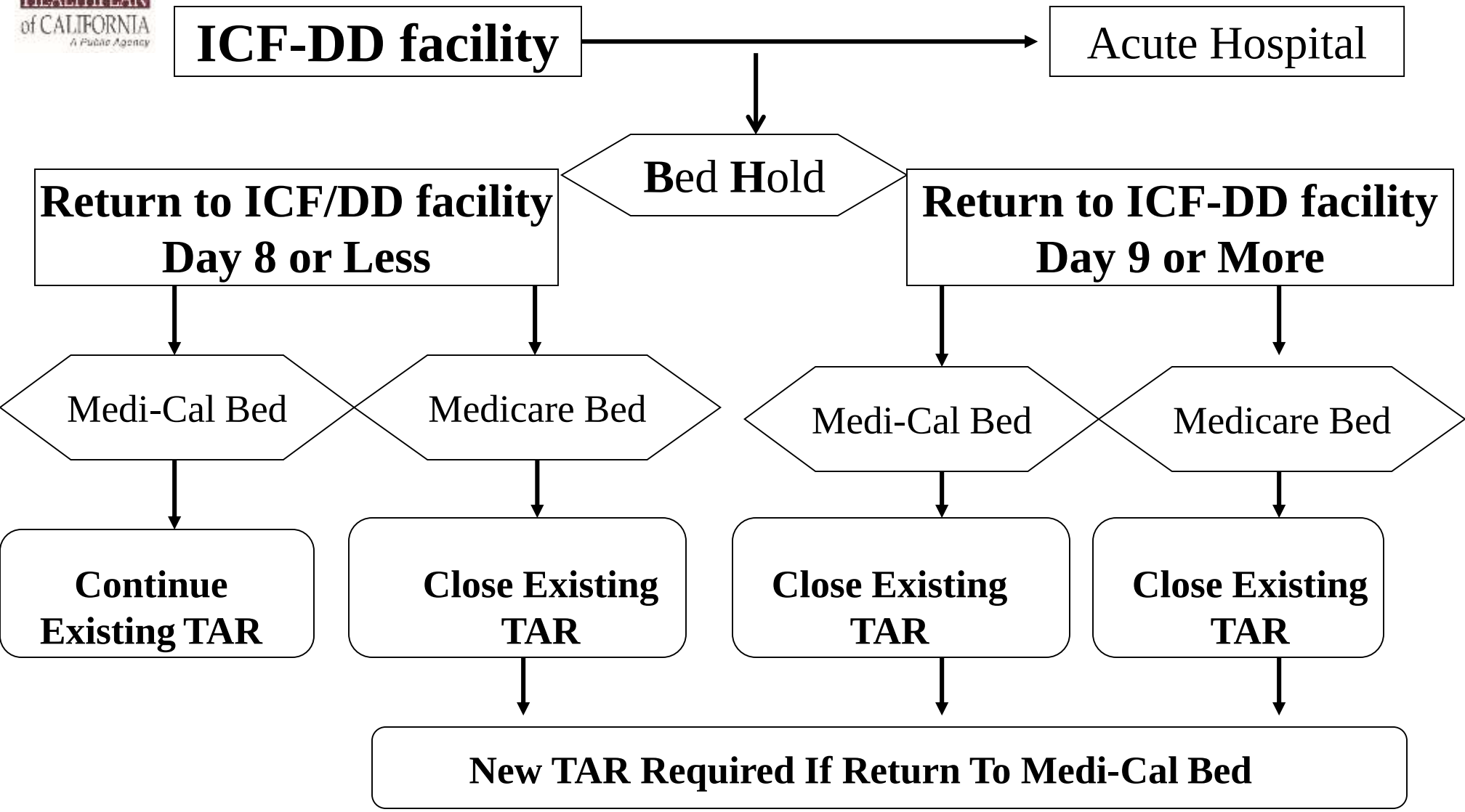
involvement from actively practicing health care providers and meets these provisions:

- 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 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.

Bed Hold / TAR Process After Acute Hospitalization



PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3003 (previously UP100303)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services</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: ~~10/11/2024~~10/09/2025
Last Review Date: ~~10/11/2023~~10/09/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ 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>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/11/2023~~10/09/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
C. MCUG3024 - Inpatient Utilization Management
D. MCUG3011 - Criteria for Home Health Services
E. MCUP3114 - Physical, Occupational and Speech Therapies

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. UM Nurse Coordinator – This is the Partnership HealthPlan of California ~~(PHC)~~ nurse in the Utilization Management department who is assigned to a case and who performs reviews for medical necessity and coordinates services covered by ~~PHC~~Partnership within the health plan and with the staff at the treating facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for review of rehabilitation facility admissions and define the criteria for authorization of rehabilitation services at either a long-term care (LTC) facility or an acute care facility to ensure that services that are delivered are medically appropriate and consistent with diagnosis and level of care required for each individual.

VI. POLICY / PROCEDURE:

A. Overview
   1. Acute rehabilitation is an interdisciplinary process under the direction of a physician skilled in rehabilitation medicine. It is intended to help the physically or cognitively impaired M~~m~~ember achieve or regain maximum functional potential for mobility, self-care, and independent living. Certification for inpatient or long-term care (LTC) acute rehabilitation services is contingent upon

the presence of one or more major physical impairments which significantly interfere with function and which require complex therapeutic interventions to restore function.

2. Rehabilitative services for the physically and/or cognitively impaired Mmember are covered in the following circumstances:
   a. Immediately post hospitalization for acute trauma or other disease resulting in impairment.
   b. Maintenance therapy for chronically impaired Mmembers is expected to be provided in lLong-tTerm care facilities or subacute hospitals and is included in the facility's per diem rate
   c. In-home care for home-bound Mmembers.
3. The Mmember must demonstrate a need for an interdisciplinary therapeutic program to reach the goals established by the initial evaluation. A severe functional deficiency must be present in one or more of the following areas:
   a. Self-care skills - including drinking, feeding, dressing, hygiene, grooming, bathing, perineal care, and/or use of upper or lower extremity prosthesis or orthosis. (Activities of Daily Living or ADLs)
   b. Mobility skills - including dependence upon an assistant or supervision in transferring to and from chair, toilet, tub or shower, upright ambulation and/or use of wheelchair
   c. Bladder control and management - needing assistance in urination and in developing and/or maintaining a bladder program due to lack of bladder control
   d. Bowel control and management - needing assistance in excretion and in developing and/or maintaining a bowel program due to lack of bowel control
   e. Pain management - pain so severe as to markedly limit functional performance
   f. Safety - needing instruction because of impaired judgment, impulsive behavior, or physical deficits in the proper and safe management of self-care and/or avoidance of complications such as contractures, decubiti or urinary tract infections
   g. Cognitive functioning - needing speech and /or language therapy in association with another primary problem listed above
   h. Communication - needing speech and/or language therapy in association with another primary problem listed above
4. Members are not eligible for rehabilitative services unless the Mmember's other medical problems are stable and will not interfere substantially with the rehabilitation program. The Mmember must also demonstrate a cognitive ability to understand the program and the motivation to participate in all aspects of the program. The Mmember must have adequate endurance to actually participate in the program. The degree of endurance required will vary depending on the therapeutic setting.
5. The attending physician must refer the Mmember to the rehabilitation program for an initial evaluation. For Mmembers not currently inpatient, either the Mmember's primary care provider (PCP) must make the referral, or concur with the physician who made the referral. After the rehabilitation program has completed the initial evaluation, a treatment plan must be developed in consultation with the referring physician as indicated.
6. A Treatment Authorization Request (TAR) must be submitted by the rehabilitation program indicating the services requested, a description of medical need, level of rehabilitation services, and a copy of the treatment plan. The referring physician must sign the treatment plan. In order to expedite care, Partnership ~~HealthPlan of California (PHC)~~ will accept the TAR with an unsigned treatment plan, however; the rehabilitation program must obtain the physical signature as soon as possible.
7. The written treatment plan must include the following:
   a. Date of onset of the illness
   b. Medical diagnosis necessitating the service, with severity and duration of condition
   c. Related medical conditions
   d. Impairments necessitating an inpatient or LTC admission for rehabilitation services

e. Functional limitations including cognitive abilities, mobility and self-care limitations, emotional problems, and communication difficulties
f. History and results of previous rehabilitation services and outcomes of treatment
g. Prognosis
h. Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
i. Types of services to be rendered by each discipline related to the problem
j. Description of plan to instruct household members or other caregivers to provide needed care after discharge from the rehabilitation program.
k. Documentation that the M~~m~~ember has sufficient strength and endurance to actively participate in the proposed treatment.

8. The UM Nurse Coordinator reviews the TAR for medical necessity and consults with the referring physician or rehabilitation staff as indicated. Definition of "medical necessity" states that necessary health care services are those needed to protect life and to prevent significant illness or significant disability, or to alleviate pain. The Chief Medical Officer or physician designee is the only individual who can deny TARs for inpatient or LTC rehabilitation services.
9. If additional days are needed beyond the initial TAR, a progress report must be submitted to ~~PHC~~Partnership documenting that significant improvement has occurred with the initial therapy and that continued therapy will further improve the M~~m~~ember's function, although not necessarily restoration of full capacity. The progress report must indicate plans for discharge and measured progress in each problem area being treated. In addition, the report must detail the M~~m~~ember's active participation in therapy and that the M~~m~~ember still requires close supervision in an inpatient or LTC setting.
10. Requests for extension of inpatient rehabilitation services are denied for medical necessity for the following reasons:
    a. Therapeutic goals have been attained or the prospect of further incremental improvement is so small that an additional expense is not justified
    b. Lack of progress toward attaining goals, with further progress unlikely
    c. Inability or unwillingness of M~~m~~ember or family to cooperate with the M~~m~~ember's program
    d. Goals can be achieved at a lower level of care

B. Admission Criteria

All statements in Section VI.B.1. Patient Selection and Section VI.B.2. Admission below must apply to the patient (Partnership Member).

1. Patient Selection
    a. The patient must have a physical disability of which the medical condition and functional performance can be realistically improved through intensive, accepted rehabilitation measures.
    b. The patient must have the potential to be medically and emotionally stable for management on a rehabilitation nursing service and be capable of active participation in a rehabilitation program.
    c. The patient must be in need of close daily medical supervision by a physician with specialized training or experience in rehabilitation and must require 24-hour rehabilitation nursing or other rehabilitation services.
    d. Primary admitting diagnosis must include one of the following:
        1) Stroke
        2) Spinal cord injury
        3) Amputation
        4) Major multiple trauma
        5) Fracture of femur (hip)
        6) Brain injury
        7) Polyarthritis - including rheumatoid arthritis
        8) Neurological disorder, including multiple sclerosis, motor neuron diseases, polyneuropathy,

muscular dystrophy, and Parkinson's Syndrome
9) Burns
10) Other conditions requiring intensive rehabilitative care

2. Admission
   a. Skilled rehabilitation services, as ordered by a physician, must be required and provided on a daily basis. Daily may be defined to be at least five (5) days a week. A break of a day or two in service where rehabilitation services are not furnished and discharge is not indicated is also permissible.
   b. The medical director of the rehabilitation unit or the physician designee must perform patient evaluation and final determination regarding transfer of the patient to the rehabilitation service.
   c. Admission medical record (admission physical examination) must include all of the following:
      1) Treatment goals - what functional improvements might be realistically expected from rehabilitation
      2) Potential - what is the realistic possibility of achieving above stated goals - excellent, good, fair, guarded
      3) Treatment plan - how will treatment goals be achieved. Specifically what therapies will be utilized - Physical Therapy, Occupational Therapy, Speech, Psychology, Social Service
      4) Duration of stay - realistic estimate of time required to achieve stated goals

C. CONTINUED STAY CRITERIA
(These criteria will only be applied up to the limit of rehabilitation coverage.)
1. A treatment plan, as outlined on admission physical examination, must be reviewed and revised as needed, at least weekly, in consultation with rehabilitation nursing, all involved therapies and social services.
2. The patient must be receiving basic therapeutic and training services at least twice daily from at least two therapies in addition to rehabilitation nursing.
3. There must be documented, weekly continued improvement in one or more functional abilities in at least one therapy.
4. If there is development of a complicating medical or emotional problem which requires temporary suspension of rehabilitation therapies, but which is of such a nature as to expect a return to an active rehabilitation program within one week (seven days), then rehabilitation services may be continued.

D. DISCHARGE CRITERIA
1. Must meet either a., b., c., or d. below:
   a. The patient has met the goals established at, and subsequent to, the time of admission.
   b. The patient no longer requires rehabilitative nursing and is receiving treatment in only one therapy area, i.e., occupational therapy, physical therapy, speech therapy, psychology, neuropsychology.
   c. There is no evidence of progress toward documented goals.
   d. There are intercurrent medical conditions that require~~s~~ acute care and suspension of rehabilitative services.
2. A weekend pass may be given the week prior to planned discharge to determine problems or issues that might exist that would need to be addressed before patient is sent home.

E. CASE REVIEW CONFERENCES
~~PHC~~Partnership M~~m~~embers in acute rehabilitation facilities are reviewed in case review conferences.
1. Weekly review conferences are held to discuss select hospitalized M~~m~~embers.
2. Participants include, but are not limited to, Nurse Coordinators, Care Coordination staff, UM Team Manager, Chief Medical Officer and/or Regional Medical Director and the Associate Director of UM.
3. The purpose of the meeting is to collaborate and facilitate timely medical services and transition to the next level of care.

4. UM Nurse Coordinators may also attend conferences at assigned hospitals upon request.
5. UM Nurse Coordinators are expected to follow the review guidelines outlined in policy MCUG3024 Inpatient Utilization Management, ~~Procedure~~ including, but not limited to, admission review and concurrent review.

NOTE: The above criteria are neither mutually inclusive nor exclusive. The final judgment must be reached using professional nursing judgment of the variety of the care needs and the availability of other care alternatives to determine the need for rehabilitation level of care.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines~~criteria for Inpatient and Outpatient care~~
B. California Code of Regulations (CCR) Title 22 Health Care Services

VIII. DISTRIBUTION:

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

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

X. REVISION DATES: 03/23/95; 08/98; 06/21/00; 04/18/01; 01/16/02; 08/20/03; 09/15/04; 10/19/05; 08/20/08; 05/19/10; 11/28/12; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 08/14/19; 08/12/20; 08/11/21; 10/12/22; 10/11/23; 10/09/24

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3015 (previously UP100315)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Family Planning Bypass Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/08/1995</td><td colspan="4">Next Review Date: ~~10/11/2024~~10/09/2025
Last Review Date: ~~10/11/2023~~10/09/2024</td></tr>
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</table>

I. RELATED POLICIES:
MCUP3050 - Medication Abortion~~s~~ in the First Trimester

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

III. DEFINITIONS:
A. Bypass Services: Members may receive services from any family planning provider, including those not contracted with ~~PHC~~Partnership, without prior authorization.
B. Medi-Cal Minor Consent Program: The Minor Consent program provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To describe and define “family planning bypass” services as implemented and managed by Partnership HealthPlan of California ~~(PHC)~~.

VI. POLICY / PROCEDURE:
A. ~~PHC~~Partnership provides ~~member~~Members with direct access to the full range of family planning services and providers without prior authorization.
B. Federal law, Title 42 U.S. Code Section 1396a(a)23(B), states that "enrollment of an individual eligible for medical assistance in a primary care case-management system [described in section 1396n(b)(1)], a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such services under Section 1396d(a)(4)(C) of this title.” ~~PHC~~Partnership must allow ~~member~~Members the freedom of choice with family planning providers. Members may receive services from any family planning provider, including those not contracted with ~~PHC~~Partnership, without prior authorization.
C. ~~PHC~~Partnership notifies its ~~member~~Members regarding the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a

qualified family planning provider. Members are encouraged to use their primary care provider (PCP) for family planning services, when appropriate.

D. Family planning services are defined as:
   1. Health education and counseling necessary to understand contraceptive methods and make informed choices
   2. History and physical examination as indicated
   3. Laboratory tests, if medically indicated, as part of decision making process for choice of contraceptive methods. This includes cervical cancer screening methods recommended by the United States Preventative Services Task Force (USPSTF): For ages 21 – 29 cervical cytology every 3 years and for ages 30 to 65 years old cervical cytology every 3 years OR high risk human papillomavirus (HPV) testing every 5 years, OR high risk HPV testing in combination with cytology every 5 years. For ~~member~~Members under 21 years, cervical cancer screening is not recommended.
   4. Diagnosis and treatment of sexually transmitted infections (STIs) when medically necessary.
   5. Screening, testing and counseling of individuals at risk for human immunodeficiency virus (HIV) and referral for treatment
   6. Provision of contraceptive pills/devices/supplies
   7. Tubal ligation
   8. Vasectomy
   9. Pregnancy testing and counseling

E. Abortion-related services are available to ~~member~~Members from the provider of their choice without prior authorization.
   1. ~~PHC~~Partnership covers all medical services and supplies incidental or preliminary to an abortion, as per requirements stated in Medi-Cal Provider Guidelines: Abortions ~~https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/abort.pdf~~
   2. ~~PHC~~Partnership is prohibited from imposing annual or lifetime limits on coverage of outpatient abortion services.
   3. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.

F. The following services are NOT included under family planning bypass services:
   1. Routine infertility studies or procedures
   2. Reversal of voluntary sterilization
   3. Hysterectomy for sterilization purposes only
   4. Evaluation and treatment of gynecological problems
   5. Evaluation and treatment of breast problems

G. To be reimbursed for services, the family planning provider must meet the following requirements:
   1. The provider is qualified to provide family planning services based on his/her scope of practice.
   2. The provider must submit claims on the appropriate billing form.
   3. The provider must maintain medical records that contain information regarding the eligible services rendered. ~~PHC~~Partnership reserves the right to request copies of records prior to paying a claim or for quality improvement audits.
   4. The provider must obtain appropriate consent for contraceptive methods including voluntary sterilization, consistent with the requirements of Title 22 CCR, Sections 51305.1 and 51305.3.
   5. The bypass provider should coordinate services with the PCP, by requesting the ~~member~~Member's consent to share information and sending a copy of pertinent medical records to the PCP.
   6. The provider should refer the ~~member~~Member to return to the PCP for all non- family planning related services.

H. Access to Services to Which Contractor or Subcontractor Has a Moral Objection:
Unless prohibited by law, ~~PHC~~Partnership providers shall arrange for the timely referral and coordination of covered services including abortion services and family planning bypass services when

the ~~to which the~~ hospital, clinic or other provider ~~within PHCPartnership's network~~ may have religious or ethical objections to the request~~-~~/ required service(s)~~.perform~~. The provider shall support and shall demonstrate ability to arrange, coordinate and ensure provision of abortion and family planning bypass services. If the provider is unwilling to arrange for or coordinate the provision of such services, the provider ~~should~~ must refer the ~~member~~Member to ~~PHC~~Partnership Member Services d~~D~~epartment for assistance.

VII. REFERENCES:

A. United States Preventive Services Task Force: https://uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening
B. Title 42 U.S. Code Sections 1396a(a)23(B), 1396n(b)(1), 1396d(a)(4)(C)
C. Title 22 California Code of Regulations (CCR) Sections 51305.1 and 51305.3
D. Medi-Cal Provider Manual/ Guidelines: Abortions *(abort)*, Minor Consent Program *(minor)*
E. Department of Health Care Services (DHCS) All Plan Letter (-APL) ~~22-022~~24-003 Abortion Services (~~10/28/2022~~03/28/2024) *supersedes* APL 22-022

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Medi-Cal
10/10/97 (name change only); 06/14/00, 10/17/01; 8/20/03; 10/20/04; 10/19/05, 08/20/08; 11/19/08; 11/18/09; 08/15/12; 01/21/15; 01/20/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

+Policy/Procedure Number: MCUP3050 (previously UP100350)			**Lead Department: Health Services**	
Policy/Procedure Title: Medication Abortion in the First Trimester			☒**External Policy** ☐ **Internal Policy**	
Original Date: 01/17/2001		**Next Review Date:** ~~10/11/2024~~10/09/2025 **Last Review Date:** ~~10/11/2023~~10/09/2024		
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:** ~~10/11/2023~~10/09/2024	

I. RELATED POLICIES:

A. MCUG3024 - Inpatient Utilization Management
B. MCUP3015 - Family Planning Bypass Services
C. MPQP1016 - Potential Quality Issue Investigation and Resolution

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Mifepristone REMS Program: The U.S. Food and Drug Administration (FDA) risk evaluation and mitigation strategy (REMS) for mifepristone for reproductive health indications. On January 3, 2023, the FDA permanently removed the in-person dispensing requirement and added a new pharmacy certification process, which will enable retail pharmacies that meet certain qualifications to dispense mifepristone directly to patients, in-person or by mail, who have a prescription from a certified prescriber. All other previous mifepristone REMS requirements remain in effect, including the need for prescriber certification and completion of Prescriber and Patient Agreement Forms.

IV. ATTACHMENTS:

A. Mifepristone Patient Agreement Form for Danco Laboratories
~~A.~~B. Mifepristone Patient Agreement Form for GenBioPro Inc.
~~B.~~C. Mifepristone Prescriber Agreement Form for Danco Laboratories
D. Mifepristone Prescriber Agreement Form for GenBioPro Inc.
~~C.~~E. Mifepristone Pharmacy Agreement Form for Danco Laboratories
~~D.~~F. Mifepristone Pharmacy Agreement Form for GenBioPro Inc.

V. PURPOSE:

To define the guidelines for appropriate management of medication abortions using mifepristone and/or misoprostol for first trimester medication abortions.

VI. POLICY / PROCEDURE:

A. Medication Regimens:
This policy describes Provider and~~,~~ Member ~~, and Partnership HealthPlan of California (PHC)~~ considerations with regard to the medical management of abortion using mifepristone and/or

misoprostol.

1. 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* "Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx," and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. Please refer to the State Medi-Cal Rx webpage which is found at https://medi-calrx.dhcs.ca.gov/home/

~~1.~~2. Mifepristone, an antiprogestin, has been approved by the U.S. Food and Drug Administration (FDA) for termination of intrauterine pregnancies through 70 days gestation. It is generally used with misoprostol, an E1 prostaglandin analog.
   a. The usual dose is oral mifepristone 200 mg followed by misoprostol 800 mcg buccal 24 to 48 hours later. This leads to complete abortion in 94% to 98% of patients up to 63 days gestation and in 93% of patients between days 64 – 70 gestation.
   b. For patients 9 to 11 weeks gestation, a second dose of misoprostol should be self-administered after 3 to 6 hours (see Reference VII.DE. It is noted that the FDA approval does not include usage after 10 weeks gestation or a second dose.
   c. The primary complications are vaginal bleeding and crampy abdominal pain, which may be severe. Curettage may be needed to control bleeding or, after treatment failure, to terminate the pregnancy.

~~2.~~3. Misoprostol alone is endorsed by the World Health Organization (WHO), the American College of Obstetrics and Gynecology (ACOG) and the Society of Family Planning for medical abortions at < 11 weeks gestational age.
   a. Dosing regimens include sublingual 800 mcg every 3 hours for 2-3 doses OR intravaginal or buccal 800 mcg every 3-12 hours 2-3 doses
   b. Complications that may need follow up include heavy bleeding, pain or fever.
   c. Primary side effects include nausea, vomiting, diarrhea and fever.

B. Provider Requirements
   1. Under Federal law, the FDA Mifepristone REMS Program requirements were updated on January 3, 2023 as follows:
      a. Mifepristone must be prescribed by a health care provider who meets certain qualifications and is certified under the Mifepristone REMS Program (see III.A. above).
      b. In order to become certified to prescribe mifepristone, health care providers must complete a Prescriber Agreement Form. (see Attachments B and C)
      c. The Patient Agreement Form (Attachment A) must be reviewed with, and signed by, the patient and the health care provider, and the risks of the mifepristone treatment regimen must be fully explained to the patient before mifepristone is prescribed.
      d. The Patient must be provided with a copy of the Patient Agreement Form (Attachment A) and Mifepristone Medication Guide (FDA approved information for patients.
      e. Mifepristone may only be dispensed by, or under the supervision of, a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber.
      f. To become certified to dispense mifepristone, pharmacies must complete a Pharmacy Agreement Form. (see Attachments D and E)
      g. Certified pharmacies must be able to ship mifepristone using a shipping service that provides tracking information.
      h. Certified pharmacies must ensure mifepristone is dispensed to the patient in a timely manner.
   2. The following provider requirements must also be met for all medical abortions:
      a. The prescriber must have the ability to assess the duration of pregnancy accurately.
      b. The prescriber must have the ability to diagnose ectopic pregnancies.

c. The prescriber must be able to provide surgical intervention in cases of incomplete abortion or severe bleeding, or has made arrangements to provide such care through other appropriately trained and credentialed practitioners, and is able to assure patient access to medical facilities equipped to provide blood transfusion and resuscitation, if necessary.
d. When using Mifepristone, the prescriber has read and understood the prescribing information. Prescribing information is available on the manufacturers' websites as cited in VII.B and C. below.

3. Providers of medication abortions must be available to patients receiving this care for consultation after office hours and must have arrangements with a suitable facility for emergency surgical intervention when necessary, including after office hours.
4. The prescriber must provide each patient with a Mifepristone Medication Guide. The prescriber must fully explain the procedure to each patient, provide the patient with a copy of the Mifepristone Medication Guide and Patient Agreement form (see Attachment A), give the patient an opportunity to read and discuss, obtain the patient's signature on the Patient Agreement form, and the prescriber must sign it.
5. The prescriber should educate the patient on the importance of follow-up between 5 to 14 days after use of mifepristone to confirm that a complete termination of pregnancy has occurred and to address any complications. The prescriber must ensure there is access to schedule a follow up appointment after initiating treatment.
   a. Telephonic follow up at 5 to 14 days for evaluation of patient experience and infection symptoms (cramping, vaginal bleeding, passage of tissue, fever or discharge) in combination with an in- home pregnancy test at 4 weeks can be considered adequate.
   b. The prescriber must notify the manufacturer in writing as discussed in the Package Insert under the heading Dosage and Administration in the event of an on-going pregnancy which is not terminated subsequent to the conclusion of the treatment procedure.
   c. While serious adverse events associated with the use of mifepristone are rare, the prescriber must report any hospitalization, transfusion, or other serious event to the manufacturer, identifying the patient solely by package serial number to ensure patient confidentiality.
6. The provider must keep on file a signed Mifepristone Patient Agreement Form (Attachment A).

C. Patient Requirements
1. The patient must read carefully and understand the Mifepristone Medication Guide, which will help in understanding how the treatment works.
2. The patient must sign the Patient Agreement Form.
3. The patient should agree to see their provider between day 7 and day 14 after receiving the medication.

D. Partnership Requirements
1. Partnership will reimburse Medi-Cal providers for the service.
2. Partnership does not require prior authorization or medical justification for medication abortion services, but does require authorization for inpatient hospital services for complications arising from medication abortions when such services are medically necessary (in agreement with Partnership policy MCUG3024 Inpatient Utilization Management).
3. Abortions are considered sensitive services and as such are provided to Partnership Members in a timely manner through the Member's primary care provider (if appropriately qualified), obstetrics/gynecology (OB/GYN) specialist, or providers of family planning bypass services.

E. Partnership monitors the quality of medical abortion services ~~provided by physicians who are Plan providers~~ through the Member grievance and appeals process~~issues~~ or through the Plan's Potential Quality Issue (PQI) process (see MPQP1016 Potential Quality Issue Investigation and Resolution policy).

Policy/Procedure Number: MCUP3050 (previously UP100350)		Lead Department: Health Services
Policy/Procedure Title: Medication Abortion in the First Trimester		☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/17/2001	**Next Review Date: 10/11/202410/09/2025** **Last Review Date: 10/11/202310/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. U.S. Food and Drug Administration (FDA) "Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation" website content updated 03/23/2023
B. Danco Mifeprex (mifepristone) manufacturer's website, "For Health Professionals" tab: https://www.earlyoptionpill.com/for-health-professionals/
C. GenBioPro Inc. Mifepristone manufacturer's website, "Prescriber Resources" tab: https://genbiopro.com/resources-prescriber/
D. UpToDate: "Medication Abortion"
E. UpToDate: Bartz D, Blumenthal P. First-trimester pregnancy termination: Medication abortion published online 27 June 2022
F. American College of Obstetrics and Gynecology (ACOG), "Medication Abortion Up to 70 Days of Gestation" Practice Bulletin #225 Volume 136, No. 4, October 2020. https://www.acog.org/-/media/project/acog/acogorg/clinical/files/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-gestation.pdf
G. Medi-Cal Provider Manual/ Guidelines: Abortions *(abort)*
H. World Health Organization (WHO) 2022 Abortion Care Guideline: https://apps.who.int/iris/handle/10665/349316
I. International Federation of Gynecology and Obstetrics: Morris JL, Winikoff B, Dabash R, et al. FIGO's updated recommendations for misoprostol used alone in gynecology and obstetrics. Int J Gynaecol Obstet 2017; 138:363.
J. Department of Health Care Services (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)
~~I.~~K. DHCS All Plan Letter APL 24-003 Abortion Services (03/28/2024)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. OB/GYN Providers
C. Partnership Department Directors

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

X. REVISION DATES:

02/14/01 (Physician Advisory Committee); 09/19/01; 10/16/02, 10/20/04; 10/19/05, 10/18/06, 08/20/08; 11/28/12; 02/18/15; 02/17/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24

*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

PATIENT AGREEMENT FORM

Mifepristone
Tablets, 200 mg

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must provide a written or electronic signature on this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my healthcare provider's advice about when to take each drug and what to do in an emergency.

2. I understand:
- **a.** I will take mifepristone on Day 1.
- **b.** I will take the misoprostol tablets 24 to 48 hours after I take mifepristone.

3. My healthcare provider has talked with me about the risks, including:
- heavy bleeding
- infection

4. I will contact the clinic/office/provider right away if in the days after treatment I have:
- a fever of 100.4°F or higher that lasts for more than four hours
- heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
- severe stomach area (abdominal) pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol — these symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).

My healthcare provider has told me that these symptoms could require emergency care. If I cannot reach the clinic or office right away my healthcare provider has told me who to call and what to do.

5. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.

6. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.

7. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.

8. I have the MEDICATION GUIDE for mifepristone.

9. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name (print):** _____ **Date:** _____

Provider Signature: _____ **Provider Name (print):** _____ **Date:** _____

Patient Agreement Forms may be provided, completed, signed, and transmitted in paper or electronically.

1/2023

DANCO

PATIENT AGREEMENT FORM **Mifepristone Tablets, 200 mg**

Healthcare Providers: *Counsel the patient on the risks of mifepristone. Both you and the patient must provide a written or electronic signature on this form.*

Patient Agreement:

1. I have decided to take mifepristone and misoprostol to end my pregnancy and will follow my healthcare provider's advice about when to take each drug and what to do in an emergency.
2. I understand:
   a. I will take mifepristone on Day 1.
   b. I will take the misoprostol tablets 24 to 48 hours after I take mifepristone.
3. My healthcare provider has talked with me about the risks, including:
   - heavy bleeding
   - infection
4. I will contact the clinic/office/provider right away if in the days after treatment I have:
   - a fever of 100.4°F or higher that lasts for more than four hours
   - heavy bleeding (soaking through two thick full-size sanitary pads per hour for two hours in a row)
   - severe stomach area (abdominal) pain or discomfort, or I am "feeling sick," including weakness, nausea, vomiting, or diarrhea, more than 24 hours after taking misoprostol – these symptoms may be a sign of a serious infection or another problem (including an ectopic pregnancy, a pregnancy outside the womb).

   My healthcare provider has told me that these symptoms listed above could require emergency care. If I cannot reach the clinic/office/provider right away, my healthcare provider has told me who to call and what to do.
5. I should follow up with my healthcare provider about 7 to 14 days after I take mifepristone to be sure that my pregnancy has ended and that I am well.
6. I know that, in some cases, the treatment will not work. This happens in about 2 to 7 out of 100 women who use this treatment. If my pregnancy continues after treatment with mifepristone and misoprostol, I will talk with my provider about a surgical procedure to end my pregnancy.
7. If I need a surgical procedure because the medicines did not end my pregnancy or to stop heavy bleeding, my healthcare provider has told me whether they will do the procedure or refer me to another healthcare provider who will.
8. I have the MEDICATION GUIDE for mifepristone.
9. My healthcare provider has answered all my questions.

Patient Signature: _____ **Patient Name (print):** _____ **Date:** _____

Provider Signature: _____ **Provider Name (print):** _____ **Date:** _____

Patient Agreement Forms may be provided, completed, signed, and transmitted in paper or electronically.

GenBioPro
PUTTING ACCESS INTO PRACTICE

GenBioPro, Inc. - PO Box 32011 - Las Vegas, NV 89103
1-855-MIFE-INFO (1-855-643-3463) - www.MifeInfo.com

Mifeprex® (Mifepristone) Tablets, 200 mg

PRESCRIBER AGREEMENT FORM

Mifeprex* (Mifepristone) Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

TO *BECOME A CERTIFIED PRESCRIBER*, YOU MUST:

If you submit Mifeprex prescriptions for dispensing from certified pharmacies:

- Submit this form to each certified pharmacy to which you intend to submit Mifeprex prescriptions. The form must be received by the certified pharmacy before any prescriptions are dispensed by that pharmacy.

If you order Mifeprex for dispensing by you or healthcare providers under your supervision:

- Submit this form to the distributor. This form must be received by the distributor before the first order will be shipped to the healthcare setting.
- Healthcare settings, such as medical offices, clinics, and hospitals, where Mifeprex will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

Prescriber Agreement: By signing this form, you agree that you meet the qualifications below and will follow the guidelines for use. You are responsible for overseeing implementation and compliance with the Mifepristone REMS Program. You also understand that if the guidelines below are not followed, the distributor may stop shipping mifepristone to the locations that you identify and certified pharmacies may stop accepting your mifepristone prescriptions.

Mifepristone must be provided by or under the supervision of a certified prescriber who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-877-4 Early Option (1-877-432-7596), or by visiting **www.earlyoptionpill.com**.

In addition to having these qualifications, you also agree to follow these guidelines for use:

- Ensure that the *Patient Agreement Form* is reviewed with the patient and the risks of the mifepristone treatment regimen are fully explained. Ensure any questions the patient may have prior to receiving mifepristone are answered.
- Ensure the healthcare provider and patient sign the *Patient Agreement Form*.
- Ensure that the patient is provided with a copy of the *Patient Agreement Form* and Medication Guide.
- Ensure that the signed *Patient Agreement Form* is placed in the patient's medical record.
- Ensure that any deaths of patients who received Mifeprex are reported to Danco Laboratories, LLC, identifying the patient by a non-identifiable reference and including the NDC and lot number from the package of Mifeprex that was dispensed to the patient.

Ensure that healthcare providers under your supervision follow the guidelines listed above.

If Mifeprex will be dispensed through a certified pharmacy:

- Assess appropriateness of dispensing Mifeprex when contacted by a certified pharmacy about patients who will receive Mifeprex more than 4 calendar days after the prescription was received by the certified pharmacy.
- Obtain the NDC and lot number of the package of Mifeprex the patient received in the event the prescriber becomes aware of the death of a patient.

If Mifeprex will be dispensed by you or by healthcare providers under your supervision:

- Ensure the NDC and lot number from each package of Mifeprex are recorded in the patient's record.

I understand that a certified pharmacy may dispense mifepristone made by a different manufacturer than that stated on this Prescriber Agreement Form.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Medical License # _____ State _____

NPI # _____

Practice Name(s): _____

Practice Setting Address: _____

Email: _____ Phone: _____ Preferred ☐ email ☐ phone

Return completed form to: Mifeprex@dancodistributor.com or fax to 1-866-227-3343.

Mifeprex® (Mifepristone) Tablets, 200 mg

THE ORIGINAL EARLY OPTION PILL.

DANCO
Support ● Progress ● Options

P.O. BOX 4816 · NEW YORK, NY 10185 1-877-4-EARLY-OPTION · (1-877-432-7596)
WWW.EARLYOPTIONPILL.COM

Approved 03/2023

PRESCRIBER AGREEMENT FORM **Mifepristone Tablets, 200 mg**

Mifepristone Tablets, 200 mg, is indicated, in a regimen with misoprostol, for the medical termination of intrauterine pregnancy through 70 days gestation. Please see Prescribing Information and Medication Guide for complete safety information.

To *become a certified prescriber*, you must:

- If you submit mifepristone prescriptions for dispensing from certified pharmacies:
    - Submit this form to each certified pharmacy to which you intend to submit mifepristone prescriptions. The form must be received by the certified pharmacy before any prescriptions are dispensed by that pharmacy.
- If you order mifepristone for dispensing by you or healthcare providers under your supervision:
    - Submit this form to the distributor. This form must be received by the distributor before the first order will be shipped to the healthcare setting.
    - Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

Prescriber Agreement: By signing this form, you agree that you meet the qualifications below and will follow the guidelines for use. You are responsible for overseeing implementation and compliance with the Mifepristone REMS Program. You also understand that if the guidelines below are not followed, the distributor may stop shipping mifepristone to the locations that you identify and certified pharmacies may stop accepting your mifepristone prescriptions.

Mifepristone must be provided by or under the supervision of a certified prescriber who meets the following qualifications:

- Ability to assess the duration of pregnancy accurately.
- Ability to diagnose ectopic pregnancies.
- Ability to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.
- Has read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-855-MIFE-INFO (1-855-643-3463 toll-free), or by visiting www.MifeInfo.com.

In addition to meeting these qualifications, you also agree to follow these guidelines for use:

- Ensure that the *Patient Agreement Form* is reviewed with the patient and the risks of the mifepristone treatment regimen are fully explained. Ensure any questions the patient may have prior to receiving mifepristone are answered.
- Ensure the healthcare provider and patient sign the *Patient Agreement Form*.
- Ensure that the patient is provided with a copy of the *Patient Agreement Form* and Medication Guide.
- Ensure that the signed *Patient Agreement Form* is placed in the patient's medical record.
- Ensure that any deaths of patients who received mifepristone are reported to GenBioPro, Inc., identifying the patient by a non-identifiable reference and including the NDC and lot number from the package of mifepristone that was dispensed to the patient.

Ensure that healthcare providers under your supervision follow the guidelines listed above.

- If mifepristone will be dispensed through a certified pharmacy:
    - Assess appropriateness of dispensing mifepristone when contacted by a certified pharmacy about patients who will receive mifepristone more than 4 calendar days after the prescription was received by the certified pharmacy.

- Obtain the NDC and lot number of the package of mifepristone the patient received in the event the prescriber becomes aware of the death of a patient.

- If mifepristone will be dispensed by you or by healthcare providers under your supervision:
  - Ensure the NDC and lot number from each package of mifepristone are recorded in the patient's record.

I understand that a certified pharmacy may dispense mifepristone made by a different manufacturer than that stated on this Prescriber Agreement Form.

Print Name: _____ Title: _____

Signature: _____ Date: _____

Medical License #: _____ State: _____

NPI #: _____

Practice Name(s): _____

Practice Setting Address: _____

_____

Email: _____ Phone _____ Preferred: ☐ Email ☐ Phone

Return completed form to RxAgreements@GenBioPro.com or fax to 1-877-239-8036.

PHARMACY AGREEMENT FORM

Mifeprex® (Mifepristone) Tablets, 200 mg

Pharmacies must designate an authorized representative to carry out the certification process and oversee implementation and compliance with the Mifepristone REMS Program on behalf of the pharmacy.

Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

BY SIGNING THIS FORM, AS THE AUTHORIZED REPRESENTATIVE I CERTIFY THAT:

- Each location of my pharmacy that will dispense Mifeprex is able to receive *Prescriber Agreement Forms* by email and fax.
- Each location of my pharmacy that will dispense Mifeprex is able to ship Mifeprex using a shipping service that provides tracking information.
- I have read and understood the Prescribing Information for Mifeprex. The Prescribing Information is available by calling 1-877-4 EARLY OPTION (1-877-432-7596 toll-free) or online at www.earlyoptionpill.com; and **each location of my pharmacy that will dispense Mifeprex will put processes and procedures in place to ensure the following requirements are completed.** I also understand that if my pharmacy does not complete these requirements, the distributor may stop accepting Mifeprex orders.
    - Verify that the prescriber is certified in the Mifepristone REMS Program by confirming their completed *Prescriber Agreement Form* was received with the prescription or is on file with your pharmacy.
    - Dispense Mifeprex such that it is delivered to the patient within 4 calendar days of the date the pharmacy receives the prescription, except as provided in the following bullet.
    - Confirm with the prescriber the appropriateness of dispensing Mifeprex for patients who will receive the drug more than 4 calendar days after the date the pharmacy receives the prescription and document the prescriber's decision.
    - Record in the patient's record the NDC and lot number from each package of Mifeprex dispensed.
    - Track and verify receipt of each shipment of Mifeprex.
    - Dispense mifepristone in its package as supplied by Danco Laboratories, LLC.
    - Report any patient deaths to the prescriber, including the NDC and lot number from the package of Mifeprex dispensed to the patient, and remind the prescriber of their obligation to report the deaths to Danco Laboratories, LLC. Notify Danco that your pharmacy submitted a report of death to the prescriber, including the name and contact information for the prescriber and the NDC and lot number of the dispensed product.
    - Not distribute, transfer, loan or sell mifepristone except to certified prescribers or other locations of the pharmacy.

- Maintain records of *Prescriber Agreement Forms*, dispensing and shipping, and all processes and procedures including compliance with those processes and procedures.
- Maintain the identity of Mifeprex patients and prescribers as confidential and protected from disclosure except to the extent necessary for dispensing under this REMS or as necessary for payment and/or insurance.
- Train all relevant staff on the Mifepristone REMS Program requirements.
- Comply with audits carried out by the Mifepristone Sponsors or a third party acting on behalf of the Mifepristone Sponsors to ensure that all processes and procedures are in place and are being followed.

Any new authorized representative must complete and submit the Pharmacy Agreement Form.

Authorized Representative Name: _____ Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____ Preferred ☐ email ☐ phone

Pharmacy Name: _____

Pharmacy Address: _____

Return completed form to Mifeprex@dancodistributor.com or fax to 1-866-227-3343.

Mifeprex®
(Mifepristone) Tablets, 200 mg
THE ORIGINAL EARLY OPTION PILL

DANCO

Danco Laboratories, LLC • P.O. Box 4816 • New York, NY 10185
1-877-4 Early Option (1-877-432-7596) • www.earlyoptionpill.com

PHARMACY AGREEMENT FORM **Mifepristone Tablets, 200 mg**

Pharmacies must designate an authorized representative to carry out the certification process and oversee implementation and compliance with the Mifepristone REMS Program on behalf of the pharmacy.

Healthcare settings, such as medical offices, clinics, and hospitals, where mifepristone will be dispensed by or under the supervision of a certified prescriber in the Mifepristone REMS Program do not require pharmacy certification.

By signing this form, as the Authorized Representative I certify that:

- Each location of my pharmacy that will dispense mifepristone is able to receive *Prescriber Agreement Forms* by email and fax;
- Each location of my pharmacy that will dispense mifepristone is able to ship mifepristone using a shipping service that provides tracking information;
- I have read and understood the Prescribing Information for mifepristone. The Prescribing Information is available by calling 1-855-MIFE-INFO (1-855-643-3463 toll-free) or online at www.MifeInfo.com; and
- Each location of my pharmacy that will dispense mifepristone will put processes and procedures in place to ensure the following requirements are completed. I also understand that if my pharmacy does not complete these requirements, the distributor may stop accepting mifepristone orders.
  - Verify that the prescriber is certified in the Mifepristone REMS Program by confirming their completed *Prescriber Agreement Form* was received with the prescription or is on file with your pharmacy.
  - Dispense mifepristone such that it is delivered to the patient within 4 calendar days of the date the pharmacy receives the prescription, except as provided in the following bullet.
  - Confirm with the prescriber the appropriateness of dispensing mifepristone for patients who will receive the drug more than 4 calendar days after the date the pharmacy receives the prescription and document the prescriber's decision.
  - Record in the patient's record the NDC and lot number from each package of mifepristone dispensed.
  - Track and verify receipt of each shipment of mifepristone.
  - Dispense mifepristone in its package as supplied by GenBioPro, Inc.
  - Report any patient deaths to the prescriber, including the NDC and lot number from the package of mifepristone dispensed to the patient, and remind the prescriber of their obligation to report the deaths to GenBioPro, Inc. Notify GenBioPro that your pharmacy submitted a report of death to the prescriber, including the name and contact information for the prescriber and the NDC and lot number of the dispensed product.
  - Not distribute, transfer, loan or sell mifepristone except to certified prescribers or other locations of the pharmacy.
  - Maintain records of *Prescriber Agreement Forms*, dispensing and shipping, all processes and procedures including compliance with those processes and procedures.
  - Maintain the identity of mifepristone patients and prescribers as confidential and protected from disclosure except to the extent necessary for dispensing under this REMS or as necessary for payment and/or insurance purposes.
  - Train all relevant staff on the Mifepristone REMS Program requirements.
  - Comply with audits carried out by the Mifepristone Sponsors or a third party acting on behalf of the Mifepristone Sponsors to ensure that all processes and procedures are in place and are being followed.

Any new authorized representative must complete and submit the Pharmacy Agreement Form.

Authorized Representative Name: _____ Title: _____

Signature: _____ Date: _____

Email: _____ Phone: _____ Preferred __ email __ phone

Pharmacy Name: _____

Pharmacy Address: _____

Return completed form to RxAgreements@GenBioPro.com or fax to 1-877-239-8036.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3115</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Community Based Adult Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/17/2012
(Effective 07/01/2012)</td><td colspan="4">Next Review Date: ~~10/11/2024~~10/09/2025
Last Review Date: ~~10/11/2023~~10/09/2024</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: ~~10/11/2023~~10/09/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~B.~~C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
~~C.~~D. CGA024 – Medi-Cal Member Grievance System
~~D.~~E. MPCR700 – Assessment of Organizational Providers
~~E.~~F. MPCR500 – Ongoing Monitoring and Interventions

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Community Based Adult Services (CBAS): An outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services and transportation to qualified beneficiaries.
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. Emergency Remote Services (ERS): Temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth to allow for immediate response to a M~~m~~ember's need when an emergency restricts or prevents them from receiving services at their CBAS center.
D. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
~~B.~~E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

IV. ATTACHMENTS:

A. CBAS Individual Plan of Care (IPC) Form (DHCS 0020)

Policy/Procedure Number: MCUP3115		Lead Department: Health Services
Policy/Procedure Title: Community Based Adult Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/17/2012	**Next Review Date: 10/11/202410/09/2025** **Last Review Date: 10/11/202310/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

Effective ~~Date~~ July 1, 2012, Partnership HealthPlan of California~~PHC~~ assume~~d~~s responsibility to provide benefits for the services provided at Community Based Adult Service (CBAS) agencies. Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses ADHC centers and CDA certifies them for participation in the Medi-Cal Program. ~~This benefit was formerly administered by the California Department of Health Care Services (DHCS).~~ The purpose of this policy is to define the process required to access CBAS services.

VI. POLICY / PROCEDURE:

A. CBAS Objectives
   1. The primary objectives of the CBAS program are to:
      a. Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
      b. Delay or prevent inappropriate or personally undesirable institutionalization
      c. The program stresses partnership with the participant, the family and/or caregiver, the primary care provider (PCP), and the community in working toward maintaining personal independence.

B. Eligibility Criteria
   1. To be eligible for CBAS services through Partnership HealthPlan of California, the person must be at least 18 years of age. They must be an eligible M~~m~~ember of ~~PHC~~Partnership's Medi-Cal program.
   2. The M~~m~~ember must also meet all the following criteria:
      a. Must have one or more chronic or post-acute medical, cognitive, or mental health conditions.
      b. A physician, physician assistant, nurse practitioner or other health care provider has, within his/her scope of practice, requested CBAS services for the person.
      c. The person requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health provider to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive or mental health condition.
      d. The person requires CBAS services that are individualized and planned to support the individual and his or her family or caregiver in the living arrangement of his/her choice and to avoid or delay the use of institutional services, including but not limited to, hospital services, inpatient mental health services or placement in a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
      e. Any person who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS care services if that resident has disabilities and a level of functioning that are of such a nature that without supplemental intervention through CBAS care, placement to a more costly institutional level of care would likely occur.
   3. Medical Necessity Criteria
      a. Except for participants residing in an ICF/DD-H, authorization or reauthorization of a CBAS Treatment Authorization Request (TAR) shall be approved only if the participant meets all of the following medical criteria:
         1) The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization:
            a) Monitoring
            b) Treatment
            c) Intervention

2) The participant's network of daytime health care support is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
   a) Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
   b) Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant
   c) Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
   d) A high potential exists for the deterioration of the Participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
3) The M~~m~~ember meets the criteria for Emergency Remote Services (ERS) as defined in Section VI.F below.

C. CBAS Authorization Process
1. Initial Request: A request for initiation of CBAS services may come from one of the following sources:
   a. Community Based Adult Services Center
   b. Physician, physician assistant, nurse practitioner or other health care provider within scope of practice
   c. Nursing Facility
   d. Hospital
   e. Individual M~~m~~ember
   f. Family member
   g. Community Based Organization
   h. ~~PHC~~Partnership's internal report with CBAS indicator
   i. ~~PHC~~Partnership's Care Coordination staff
2. To recommend a M~~m~~ember for CBAS services, all other requesting entities besides the CBAS center itself must refer to the CBAS center. This inquiry may be done verbally or in writing. The following information should be included at the time of the request:
   a. Member's Name
   b. Identification Number
   c. Date of Birth
   d. Contact Information of M~~m~~ember, caregiver and referring agent. (Name, address, phone number)
   e. Reason the M~~m~~ember needs CBAS services
   (Specific information may vary by the requesting entity)

D. TAR Submission
1. The CBAS agency will begin their Multidisciplinary Team assessment process and complete the Individualized Plan of Care (IPC), (see Attachment A). When the evaluation and IPC is complete and CBAS staff determines the M~~m~~ember to be appropriate for services, the CBAS agency must electronically submit a TAR to ~~PHC~~Partnership. The TAR must include the codes and description of the services to be provided and a copy of the IPC, with anticipated level of service, as well as any other clinical documentation available (i.e. History and Physical).
2. An initial face-to-face review is not required when ~~PHC~~Partnership or DHCS or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. ~~PHC~~Partnership determines that a M~~m~~ember is eligible to receive CBAS, and that the receipt of CBAS is clinically appropriate, based

on review of the IPC and clinical information submitted with the TAR.

a. If ~~PHC~~Partnership or DHCS or its contractor(s) cannot determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses, then the initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by DHCS.

3. ~~PHC~~Partnership will approve, modify or deny the requested CBAS services within five (5) business days of receipt of the TAR, in accordance with Health and Safety Code 1367.01. Decisions for requests on behalf of M~~m~~embers in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who are at high risk for admission to a hospital or SNF will be made within 72 hours of receipt of the TAR, in accordance with CMS Letter Number 11-W100193/9 (CalAIM) Special Terms and Conditions (STCs). If the TAR is approved, the facility will be notified via copy of the authorization.
4. If the TAR is modified or denied, a Notice of Action (NOA) letter will be sent to the M~~m~~ember and CBAS provider.
5. If the plan does not have sufficient information to make a determination, ~~PHC~~Partnership will extend the time frame one time by up to 14 calendar days. The M~~m~~ember and the CBAS provider are notified immediately in writing of the extension and what additional information is required to complete the review. If no additional requested information is received, the TAR may be denied via the NOA letter. The letter will include appeal rights and responsibilities.
6. CBAS providers can contact ~~PHC~~Partnership at (800) 863-4155 with all inquiries related to CBAS eligibility determinations, authorization requests, and care planning. The call will be triaged to the appropriate department, where the appropriate assigned Case Manager/Care Team will be identified and notified for follow-up. ~~PHC~~Partnership will coordinate with CBAS providers for the timely exchange of coordination of care information, including but not limited to:
   a. Updates to M~~m~~ember's IPC and/or discharge plan
   b. Reports of incidents that threaten the welfare, health, and safety of the M~~m~~ember
   c. Significant changes in the M~~m~~ember's condition

E. Reassessment and Reauthorization

1. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by ~~PHC~~Partnership to be clinically appropriate.
2. A CBAS center requests reassessment and submits a request to begin the CBAS reassessment process.
   a. Examples:
      1) Prior authorization end date is approaching
      2) Due to a change in level of service
3. A TAR is created and sent to ~~PHC~~Partnership with an IPC and a Level of Service recommendation.
4. ~~PHC~~Partnership receives the prior authorization request from the CBAS center, which includes a completed IPC and level of service recommendation. ~~PHC~~Partnership will handle the recommendation through existing TAR process which includes:
   a. ~~PHC~~Partnership will approve, modify or deny prior authorization request within five (5) business days, in accordance with Health and Safety Code 1367.01.
   b. If ~~PHC~~Partnership cannot make a decision within five (5) business days, a 14-day pend letter will be sent to the M~~m~~ember and center.
   c. ~~PHC~~Partnership notifies the center within 24 hours of the decision. The plan notifies the M~~m~~ember within 48 hours of the decision.
5. Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by ~~PHC~~Partnership requires a face-to-face review.
   a. Process must be completed in accordance with the Health and Safety Code 1367.01 and ensure

timelines are met.

6. CBAS services continue.

F. Emergency Remote Services (ERS)

~~1. Effective September 30, 2022, CBAS Temporary Alternative Services (TAS) related to the COVID-19 pandemic have ended. During this period of transition, PHC shall work collaboratively with each contracted CBAS provider to ensure that each member's needs continue to be met, whether through in-person services provided at the CBAS center or through ERS, and that the member's needs are documented appropriately.~~

~~. PHC health services staff shall outreach to the contracted CBAS providers and obtain a list of members for whom ERS services are still needed.~~

~~0) If transitioning members are identified, the CBAS provider(s) is to update the member's IPC and submit a TAR request for ERS services pursuant to section VI. F. 7. below.~~

~~. CBAS providers are to update the member's IPC and submit a TAR request for ERS pursuant to section VI.F.7. below.~~

~~5.~~1. Pursuant to the CalAIM 1115 waiver authorized by Centers for Medicare and Medicaid Services (CMS) in January of 2022, CBAS Emergency Remote Services (ERS) are available to M~~m~~embers who are approved and participate in services delivered by a CBAS center.

a. ERS are defined as the temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, to allow for immediate response to a M~~m~~ember's needs when an emergency restricts or prevents them from receiving services at their CBAS center.

~~6.~~2. Prior to delivery or approval of ERS services, CBAS centers are required to complete the necessary two-step process for obtaining approval from the California Department of Aging (CDA).

a. Prior to authorizing CBAS ERS services, ~~PHC~~Partnership shall track and ensure contracted CBAS providers have completed the approval process as required.

b. ~~PHC~~Partnership shall regularly check the CDA website for updated CBAS and ERS letters.

~~7.~~3. Effective October 1, 2022, CBAS providers are required to provide ERS when M~~m~~embers experience emergencies as defined below:

a. Public Emergency: The CBAS center is located in a region that is impacted by state or local disaster(s), regardless of whether formally declared. These may include, but are not limited to: earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc., and/or

b. Personal Emergency: The M~~m~~ember is experiencing serious illness or injury, crises or care transition, which affects their ability to safely and appropriately participate in services at the CBAS center. For the purposes of ERS, DHCS has defined this as:

1) Serious illness or injury that prevents the M~~m~~ember from receiving CBAS services within the facility and that providing medically necessary services/supports to the M~~m~~ember would protect life, address or prevent significant illness or disability, and/or alleviate pain.

2) Crises means that the M~~m~~ember is experiencing or threatened with intense difficulty, trouble or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.

3) Care transitions occur when the M~~m~~ember is moving to or from care settings such as returning to home or another community setting after a hospital or nursing facility stay.

~~8.~~4. Members who are hospitalized or admitted to a skilled nursing facility (SNF) are not eligible for ERS services while they are admitted or in those facilities.

~~9.~~5. ERS provided during a care transition shall address service gaps and M~~m~~ember/caregiver needs but should not duplicate responsibilities assigned to intake or discharging entities.

~~10.~~6. To request ERS services:

a. The Registered Nurse and Social Worker at the CBAS center must first assess the emergency and make updates to the M~~m~~ember's IPC above (Attachment A).

b. If there is no active TAR on file for CBAS services, the CBAS provider must submit a new TAR to ~~PHC~~Partnership requesting ERS services along with:
   1) A copy of the M~~m~~ember's IPC
   2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
   3) Anticipated time/duration of ERS services

c. If there is already an active TAR on file for CBAS services, the CBAS provider must submit a TAR modification request to ~~PHC~~Partnership requesting ERS services along with:
   1) An updated copy of the M~~m~~ember's IPC
   2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
   3) Anticipated time/duration of the ERS services

d. During the TAR review process for ERS services, ~~PHC~~Partnership staff shall work collaboratively with contracted CBAS providers regarding the method of ERS services.

~~11.~~7. ERS services are time-limited and may be authorized for up to three (3) consecutive months for M~~m~~embers who are experiencing a public or personal emergency.

a. Members may choose to cease ERS services at any time.

b. For ~~member~~Members who may require ERS beyond the initial three (3) consecutive months:
   1) The CBAS center shall complete a new assessment documenting the continued need for remote/telehealth delivery of CBAS services and supports at least every three (3) months. A TAR modification request shall be submitted to ~~PHC~~Partnership requesting a continuation of ERS along with the ~~member~~Member's updated IPC for review.

~~12.~~8. Through the TAR review process for ERS services, ~~PHC~~Partnership shall coordinate with the CBAS center(s) to ensure that ~~member~~Members have their service and support needs met throughout the duration of ERS services.

G. CBAS Facility Selection

1. The ~~member~~Member may choose any CBAS Center as long as it is within the selected facility's time and distance criteria for transportation.

H. Reduction in Services or Discharge from CBAS Services

1. If a ~~member~~Member is going to experience a reduction in CBAS or ERS services, the CBAS center must submit an updated IPC to ~~PHC~~Partnership.
2. If the ~~member~~Member will be discharged from a CBAS center, the CBAS center must update the ~~member~~Member's IPC and/or complete a discharge plan for the ~~member~~Member. A copy of the revised IPC and/or discharge plan must be submitted to ~~PHC~~Partnership for review. The discharge plan must include the following:
   a. The ~~member~~Member's name and ID number
   b. The name(s) of the ~~member~~Member's physician(s)
   c. If applicable, the date the NOA denying authorization for CBAS was issued
   d. If applicable, the date the CBAS benefit will be terminated
   e. Specific information about the ~~member~~Member's current medical condition, treatments, and medications
   f. Potential referrals for medically necessary services and other services or community resources that the ~~member~~Member may need upon discharge
   g. Contact information for the ~~member~~Member's case manager
   h. A space for the ~~member~~Member or the ~~member~~Member's representative to sign and date the discharge plan or IPC
3. If a ~~member~~Member has already been discharged, the CBAS center must submit the updated IPC and/or discharge plan to ~~PHC~~Partnership within 30 days.
4. ~~PHC~~Partnership shall review the IPC and/or discharge plan to determine if the ~~member~~Member has additional needs.
   a. For ~~member~~Members that possess additional needs, ~~PHC~~Partnership shall make a referral to appropriate care coordination or case management services.

b. Members who are discharged from a CBAS program involuntarily may file a grievance with ~~PHC~~Partnership or request a fair state hearing or independent medical review.
   1) A ~~member~~Member who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
   2) A CBAS participant may file a grievance with ~~PHC~~Partnership as a written or oral complaint as described in ~~PHC~~Partnership policy CGA024 Medi-Cal Member Grievance System. The ~~member~~Member or their authorized representative may file a grievance at any time that they experience dissatisfaction with the services or quality of care provided to them.

I. Unbundled Services
   1. If a ~~member~~Member is determined to be eligible for CBAS services but there is no CBAS facility in the ~~member~~Member's service area, the ~~member~~Member may choose to attend a CBAS facility of their choice. If there is no CBAS facility available, ~~PHC~~Partnership will assist in arranging for those individual services that are ~~PHC~~Partnership benefits and make appropriate referrals to other agencies for the unbundled services that are not ~~PHC~~Partnership benefits.
   2. Unbundled CBAS covered services are limited to the following:
      a. Professional Nursing Services
      b. Nutrition
      c. Physical Therapy
      d. Occupational Therapy
      e. Speech and Language Pathology Services
      f. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and
      g. Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are covered s~~S~~ervices

J. Quality and Monitoring
   1. Licensing & Program Oversight: Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDA certifies licensed Adult Day Health Care (ADHC) centers as Medi-Cal CBAS providers. CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers, certification renewal, providing on-going training and technical assistance to centers, and initiating adverse certification actions against centers that are substantially out of compliance with program requirements.
      a. ~~PHC~~Partnership's Provider Relations department shall review All Center Letters (ACL) issued by the CDA and ensure that contracted CBAS providers are meeting all requirements issued in those letters.
   2. Credentialing: ~~PHC~~Partnership's Provider Relations department is responsible for ensuring that all CBAS providers are licensed pursuant to CDA and DHCS regulations, and verifying center credentials (see policy MPCR700 Assessment of Organizational Providers). Pursuant to ~~PHC~~Partnership policy MPCR500 Ongoing Monitoring and Interventions, ~~PHC~~Partnership's CBAS providers shall be monitored monthly to ensure they remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license.
      a. In addition, ~~PHC~~Partnership's Provider Relations department shall review and monitor the CDA website for updates to contracted CBAS providers licensing and/or ERS approval status.
      b. ~~PHC~~Partnership's Provider Relations department shall update ~~PHC~~Partnership Health Services staff when or if a CBAS provider loses their license(s) or ERS approval(s).
      c. ~~PHC~~Partnership Provider Relations and Health Services departments will be responsible for providing written notification and training (if necessary) when substantive updates to CBAS-related policies and procedures are made.
   3. In collaboration with Health Services (HS) staff, ~~PHC~~Partnership's Provider Relations

department shall monitor the documentation and reporting requirements of CBAS providers, including but not limited to IPCs, discharge plans, on-going assessments, progress notes, discharge plans, timely completion of the CBAS Emergency Remote Services Initiation Form (CEIF or CDA 4000), etc.

4. Reporting: CBAS centers shall remit to ~~PHC~~Partnership all DHCS and/or CDA required reporting pursuant to the templates and frequencies requested by ~~PHC~~Partnership.
5. In addition to DHCS Quarterly reporting, ~~PHC~~Partnership Health Services staff shall monitor and track available performance and/or quality measures made available on the on the CDA website, such as the CBAS dashboard, to track, trend and/or evaluate CBAS provider performance and outcomes.

K. Darling vs. Douglas Settlement
1. Members who were considered ~~member~~Members under the DHCS Darling vs Douglas litigation and were determined not to be eligible for CBAS services will continue to receive these services as stipulated in the settlement agreement.

VII. REFERENCES:

A. Welfare and Institutions Code, Sections 14525 and 14526.1
B. California Health and Safety Code Section 1367.01
C. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) #19-02 Implementation of New CBAS Individual Plan of Care (IPC) (*Amended* 03/19/2019)
D. Medi-Cal Provider Manual/ Guidelines: Community-Based Adult Services (CBAS) *(community)*
~~D.~~E. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~19-004~~22-013 *Revised* Provider Credentialing / Re-C~~c~~redentialing and Screening / Enrollment (06/12/2019)
~~E.~~F. DHCS APL 22-020 *Revised* Community-Based Adult Services Emergency Remote Services (11/02/2022)
~~F.~~G. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-04 *Revised* Launch of New CBAS Emergency Remote Services (ERS) (~~08/08/2022~~10/03/2023)
~~G.~~H. Centers for Medicare and Medicaid Services (CMS) Letter Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) (*Amended* 11/28/2014)

VIII. DISTRIBUTION:

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

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

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

*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 ~~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

~~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">3EPolicy/Procedure Number: MCUP3128</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Cardiac Rehabilitation</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/18/2015
Effective Date: 08/01/2015</td><td colspan="3">Next Review Date: ~~10/11/2024~~10/09/2025
Last Review Date: ~~10/11/2023~~10/09/2024</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: ~~10/11/2023~~10/09/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3052 – Medical Nutrition Services
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Cardiac rehabilitation is a medically supervised program that helps improve the health and well-being of people who have heart problems.
   1. Phase I cardiac rehabilitation takes place during the acute hospitalization or in an acute rehabilitation setting, of the index diagnosis.
   2. Phase II cardiac rehabilitation takes place in a monitored, supervised outpatient setting.
   3. Phase III cardiac rehab takes place in an outpatient setting, in a supervised environment without cardiac monitoring, including organized group classes.
   4. Phase IV cardiac rehab is a lifetime maintenance of physical conditioning, fitness and wellness, either at home, or other community-based setting.
B. Cardiac rehabilitation programs provide cardiac rehabilitation, including exercise training, education on heart healthy living, and counseling to reduce stress and help ~~member~~Members return to an active life.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy defines covered services and medical necessity criteria for cardiac rehabilitation services. Cardiac rehabilitation services have been found to reduce morbidity and mortality from cardiovascular disease.

VI. POLICY / PROCEDURE:

A. Eligibility
   1. Appropriately identified adults with full-scope Medi-Cal are eligible for Phase II Cardiac Rehabilitation services, with the following diagnoses:
      a. Myocardial infarction within the past 12 months
      b. Coronary artery bypass surgery in the past 12 months

c. Current stable angina pectoris
d. Heart valve repair or replacement in the past 12 months
e. Coronary angioplasty performed or coronary stent placed in the last 12 months
f. A heart or heart-lung transplant in the last 12 months
g. Intermittent claudication due to atherosclerotic disease, with current symptoms.
h. Stable chronic heart failure with an ejection fraction of less than 35% and New York Heart Association (NYHA) class II to IV symptoms in spite of optimal therapy for at least 6 weeks.
i. Other cardiac or major pulmonary surgery, in the past 12 months
j. Sustained Ventricular Tachycardia, Ventricular Fibrillation or survivor of sudden cardiac death.

2. ~~PHC~~Partnership HealthPlan of California considers cardiac rehabilitation experimental and investigational for all other indications including:
   a. Atrial Fibrillation (other than post Maze procedure)
   b. Atrial Fibrillation with ablation (other than post Maze procedure)
   c. Takotsubo (stress) Cardiomyopathy
   d. Uncompensated congestive heart failure
   e. Uncontrolled arrhythmias (other than PVCs and PACs)
3. Phase II services are only covered when ordered by a licensed physician and when performed in a facility/program meeting Medicare's standards for cardiac rehabilitation programs. These standards include:
   a. The facility meets the definition of a hospital outpatient department or a physician-directed facility.
   b. The facility has available for immediate use all the necessary cardio-pulmonary emergency and therapeutic life-saving equipment to perform defibrillation, administer oxygen and perform cardiopulmonary resuscitation.
   c. The program is conducted in an area set aside for the exclusive use of the program while it is in session.
   d. The program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
   e. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area or immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself, provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible. The examples below are for illustration purposes only. They are not meant to limit the discretion of the contractor to make determinations in this regard.
   f. The non-physician personnel are employees of either the physician, hospital, or facility conducting the program and their services are "incident-to" a physician's professional services.
4. Prior to referral for Phase II cardiac rehabilitation services, a cardiologist or primary care physician with experience and training in evaluation and assessment of cardiovascular disease must complete a diagnostic evaluation of the prospected cardiac rehabilitation participant. This will include:
   a. Evaluation of chest pain and atypical chest pain. This may include performance of a cardiac stress test or review of a recent stress test
   b. Pre or post-operative evaluation of cardiac operations (if applicable)
   c. Review and reconciliation of all medications
   d. Review of medical history, including social history, medical history, surgical history
   e. Specific recommendations for the exercise regimen to be used in the cardiac rehabilitation program. This can lead to either a prescription or a referral to cardiac rehabilitation.

Partnership ~~HealthPlan of California (PHC)~~ does not require submission of a Referral Authorization Form (RAF), but Phase II cardiac rehabilitation services do require a TAR as detailed in VI.A.5. below. ~~PHC~~Partnership may audit the clinical documents to ensure the criteria required in a. – e. have been met.

5. Requests for pediatric cardiac rehabilitation are reviewed on a case by case basis in accordance with our Treatment Authorization Request (TAR) Review Process described in policy MCUP3041. Pediatric cases require consultation with an appropriate specialist (e.g. pediatric cardiologist) and must take place at an appropriate facility for pediatric rehabilitation.
6. **A Treatment Authorization Request (TAR) is required for Phase II cardiac rehabilitation services.**
   a. Current Procedural Terminology (CPT)-4 codes 93797 and 93798 may not be reimbursed in the same calendar month as Healthcare Common Procedure Coding System (HCPCS) codes G0422 and G0423, for any provider. Similarly, HCPCS codes G0422 and G0423 may not be reimbursed in the same calendar month as CPT-4 codes 93797 and 93798, for any provider.
   b. Modifiers SA, U7, 24, 25 and 99 are all allowable for CPT-4 codes 93797 and 93798, as well as HCPCS codes G0422 and G0423.
   c. Qualified Practitioners
      1) Licensed practitioners who are eligible for reimbursement of CPT-4 codes 93797 and 93798 include physicians, physician assistants, nurse practitioners and physical therapists.
      2) Licensed practitioners who are eligible for reimbursement of HCPCS codes G0422 and G0423 include physicians, physician assistants, nurse practitioners, psychologists, licensed clinical social workers, marriage and family therapists and physical therapists.
7. For all other indications (individuals who are too debilitated to exercise, and secondary prevention after transient ischemic attack or mild, non-disabling stroke), because of insufficient evidence in the peer-reviewed information, ~~PHC~~Partnership considers cardiac rehabilitation experimental and investigational and therefore not a benefit.

B. Covered Services
1. Phase I cardiac rehabilitation services are performed while the ~~PHC~~Partnership ~~member~~Member is in the acute hospital or acute rehab setting. They are integral to the inpatient care provided to ~~PHC~~Partnership ~~member~~Members for appropriate indications.
2. Phase II cardiac rehabilitation services are performed in an outpatient setting. Services may include:
   a. medically-supervised exercise program
   b. nutritional counseling
   c. stress management
   d. smoking cessation counseling and support services
3. Phases III and IV cardiac rehabilitation, by themselves, are not covered.
4. Phase II cardiac rehabilitation services do not include the diagnostic evaluation that is required prior to referral to cardiac rehabilitation, which is covered separately.
5. The medically necessary frequency and duration of cardiac rehabilitation is determined by the ~~member~~Member's level of cardiac risk stratification:
   a. High-risk ~~member~~Members have any of the following:
      1) Decrease in systolic blood pressure of 15 mm Hg or more with exercise; or
      2) Exercise test limited to less than or equal to 5 metabolic equivalents (METS); or
      3) Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more ST depression by electrocardiography (ECG); or
      4) Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure; or
      5) Resting complex ventricular arrhythmia; or
      6) Severely depressed left ventricular function (ejection fraction less than 30 %); or

7) Survivor of sudden cardiac arrest; or
8) Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.

b. Program Description for High-Risk Members:
1) 36 one-hour sessions (e.g., 3 times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring
2) Create an individual out-patient exercise program that can be self-monitored and maintained
3) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.
4) If no clinically significant arrhythmia is documented during the first 3 weeks of the program, the provider may have the ~~member~~Member complete the remaining portion without telemetry monitoring.

c. Intermediate-risk ~~member~~Members have any of the following:
1) Exercise test limited to 6-9 METS; or
2) Ischemic ECG response to exercise of less than 2 mm of ST depression

d. Program Description for Intermediate-Risk Members:
1) 24 one-hour sessions or less of exercise training with or without continuous ECG monitoring
2) Geared to define an ongoing exercise program that is "self-administered."
3) Educational program for risk factor/stress reduction; classes listed below in VI.B.6. c. – f. covered for up to 3 months.

e. Low-risk ~~member~~Members have exercise test limited to greater than 9 METS

f. Program Description for Low-Risk Members:
1) Six 1-hour sessions involving risk factor reduction education and supervised exercise to show safety and define a home program (e.g., 3 times per week for a total of 2 weeks or 2 sessions per week for 3 weeks).
2) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.

g. Intensive Cardiac Rehabilitation (ICR)
1) ICR is a Centers for Medicare & Medicaid Services (CMS) designation (through the National Coverage Determination [NCD] process) for certain programs demonstrated to have:
a) Accomplished one or more of the following for its patients:
i. Positively affected the progression of coronary heart disease
ii. Reduced the need for coronary bypass surgery, OR
iii. Reduced the need for percutaneous coronary interventions; AND
b) Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services:
i. Low density lipoprotein
ii. Triglycerides
iii. Body mass index
iv. Systolic blood pressure
v. Diastolic blood pressure
vi. The need for cholesterol, blood pressure, and diabetes medications
2) Proof of CMS designation should accompany the TAR
3) ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

6. Procedure codes covered:
a. 93797 – Physician or other qualified health care professional services for outpatient cardiac

rehabilitation; without continuous ECG Monitoring (For intermediate-risk and low-risk ~~member~~Members)

b. 93798 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG Monitoring (for high-risk ~~member~~Members)
c. G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session (This code will only be paid to programs approved by CMS, as described above).
d. G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session (This code will only be paid to programs approved by CMS, as described above.)
e. S9449 – Weight management classes, non-physician provider, per session
f. S9451 – Exercise classes, non-physician provider, per session
g. S9453 – Smoking cessation classes, non-physician provider, per session
h. S9454 – Stress management, non-physician provider, per session
i. Nutrition Therapy services are also covered, as defined in policy MCUP3052 Medical Nutrition Services.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Rehabilitative Services *(rehab)*
~~A.~~B. Up-To-Date: Lynne T Braun, PhD, RN, CNP, Nanette K Wenger, MD, Robert S Rosenson, MD, "Cardiac Rehabilitation Programs" updated 5/15/2024.
~~B. Department of Health Care Services (DHCS) Operating Instruction Letters (OILs) 029-18 (01/12/2018) and 029a-18 (03/16/2018)~~

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: 06/17/15; 05/18/16; 05/17/17; *08/08/18; 09/11/19; 09/09/20; 09/08/21; 09/14/22; 10/11/23; 10/09/24

*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

Policy/Procedure Number: MCUP3128		Lead Department: Health Services
Policy/Procedure Title: Cardiac Rehabilitation		☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/18/2015 Effective Date: 08/01/2015	**Next Review Date: 10/11/202410/09/2025** **Last Review Date: 10/11/202310/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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="4">Policy/Procedure Number: MPUP3035 (previously UP100335)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Preoperative Day Review</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/28/1999</td><td colspan="4">Next Review Date: ~~10/11/2024~~10/09/2025
Last Review Date: ~~10/11/2023~~10/09/2024</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>☐ 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: ~~10/11/2023~~10/09/2024</td></tr>
</table>

I. RELATED POLICIES:
MCUP3041 – Treatment Authorization Request (TAR) Review Process

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

III. DEFINITIONS:
Preoperative Day – The planned admission of a member to the acute hospital one or more days prior to a scheduled (elective) procedure.
1. As part of the precertification review process, patients are identified for Preoperative Day Review when the reasons for and the timing of admissions are submitted by the provider of service.
2. Preoperative Day Review is initiated for patients who must be admitted on the day prior to the planned procedure. If the admitting physician requests that the patient be admitted the day before surgery, all patient information is compared to InterQual® criteria for an elective admission and to the anesthesia staging criteria. If necessary, the clinical information is referred to the Utilization Management (UM) leadership team or to the Chief Medical Officer or Physician Designee.

IV. ATTACHMENTS:
APPENDIX
A. Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System

V. PURPOSE:
To identify elective surgical cases that may be admitted to the hospital the day prior to surgery rather than the day of surgery.

VI. POLICY / PROCEDURE:
A. Objective
1. To determine the appropriateness of a patient's admission to the hospital prior to the day of surgery. Whenever possible, early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, special certification consideration by the Chief Medical Officer, Physician Designee or UM leadership team may be given through the prior authorization process.

B. Procedure
1. Admissions for elective surgical procedures are identified during the precertification review process.
2. If the admitting physician requests the patient be admitted the day prior to surgery, all pertinent clinical information is compared to InterQual® criteria and to the anesthesia staging criteria. The authorization request must clearly explain the medical necessity of the requested preoperative day.
3. If any one of the criteria elements for anesthesia staging criteria class IV-V is met (see Appendix A), the Nurse Coordinator approves the admission for the day prior to the planned procedure.
4. If none of the criteria elements are met, or the medical need for the request is not clear, the case is referred to the UM leadership team or to the Chief Medical Officer or Physician Designee.
5. Chief Medical Officer or Physician Designee is the only individual who can deny a request based on lack of medical justification.

VII. REFERENCES:
A. American Society of Anesthesiologists (ASA) Standards and Guidelines
B. InterQual® criteria

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

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

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

*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 - MPUP3035 (Healthy Kids program ended 12/01/2016)
10/18/06; 08/20/08; 11/18/09; 10/01/10; 05/16/12; 08/20/14; 01/20/16; 09/21/16 to 12/01/2016
PartnershipAdvantage:
MPUP3035 - 10/18/2006 to 01/01/2015
Healthy Families:
MPUP3035 - 10/01/2010 to 03/01/2013

****

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

Policy/Procedure Number: MPUP3035 (previously UP100335)		**Lead Department: Health Services**
Policy/Procedure Title: Preoperative Day Review		☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/28/1999	**Next Review Date: 10/11/202410/09/2025** **Last Review Date: 10/11/202310/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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.

APPENDIX

Preoperative Day Review

AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA) PATIENT CLASSIFICATION SYSTEM

CLASS I - The patient has no organic, physiologic, biochemical, or psychiatric disturbance. The pathologic process for which the surgery is to be performed is localized and does not entail a systemic disturbance.
Examples - A fit patient with an inguinal hernia; fibroid uterus in an otherwise healthy person.

CLASS II - Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.
Examples - Non- or only slightly limiting organic heart disease, mild diabetes, essential hypertension, or anemia. Some might choose to list the extremes of age here, either the neonate or the octogenarian, even though no discernible systemic disease is present. Extreme obesity and chronic bronchitis may be included in this category. Normal pregnancy may also be included. (Although pregnancy is not a disease, the parturient' s physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA 2 for a woman with uncomplicated pregnancy).

CLASS III - Severe systemic disturbance or disease from whatever cause even though it may not be possible to define the degree of disability with finality.
Examples - Severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris, or healed myocardial infarction.

CLASS IV - Indicative of the patient with severe systemic disorders that are already life threatening, not always correctable by surgery.
Examples - Patients with organic heart disease showing marked signs of cardiac insufficiency, persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency.

CLASS V - The moribund patient who has little chance of survival but is submitted to surgery in desperation.
Examples - The burst abdominal aneurysm with profound shock, major cerebral trauma with rapidly increasing intracranial pressure, massive pulmonary embolus. Most of these patients require surgery as a resuscitative measure with little if any anesthesia.

CLASS VI - A declared brain-dead patient whose organs are being removed for donor purposes.

Emergency Operation (E) - Any patient in one of the classes listed previously who is operated upon as an emergency is considered to be in poorer physical condition. The letter "E" is placed beside the numerical classification. Thus, the patient with a hitherto uncomplicated hernia now incarcerated and associated with nausea and vomiting is

classified "I. E".

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2019 (previously MCUP3117)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)</td><td colspan="4">Next Review Date: ~~11/08/2024~~10/09/2025
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</table>

I. RELATED POLICIES:

A. MCUP3012 – Discharge Planning (Non-capitated Members)
B. MCUP3039 – Direct Members
C. MCCP2007 – Complex Case Management
D. MCCP2023 – New Member Needs Assessment
E. MCCP2024 – Whole Child Model for California Children's Services (CCS)
F. MPCD2013 – Care Coordination Program Description
G. MCCP2032 - CalAIM Enhanced Care Management (ECM)
H. MCUP3143 - CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
I. MCCP2014 – Continuity of Care (Medi-Cal)
~~I.~~J. MPCP2002 - California Children's Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

~~A. Nurse Case Manager (NCM): A registered nurse in Care Coordination who works with the multidisciplinary team in order to facilitate coordination of the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes.~~

~~B.~~A. ~~CCM:~~ Complex Case Management (CCM): The process of applying evidence-based practices to individual members to assist them with the coordination of their care and promote their well-being.

~~C.~~B. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

~~D.~~C. Health Care Guide (HCG): A non-clinical Care Coordination staff member who provides support and guidance to members, families, providers community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting members to available internal and external resources.

~~E.~~D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

E. Individualized Care Plan (ICP): A member-focused care plan designed to optimize the member's health, function, and well-being.

F. Nurse Case Manager (NCM): A registered nurse in Care Coordination who works with the multidisciplinary team in order to facilitate coordination of the comprehensive medical, behavioral, and psychosocial needs of the member while promoting quality and cost-effective outcomes.

G. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

H. Social Worker (SW)/Medical Social Worker (MSW): A social worker in Care Coordination who provides members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

IV. ATTACHMENTS:

A. HRA
B. PHRA
~~C.~~ HRA Stratification Matrix
C.
D. PHRA Stratification Matrix

V. PURPOSE:

~~This policy describes the process Partnership Health Plan of California (PHC) will follow to assess new enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS members at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.~~This policy describes the process Partnership Health Plan of California (Partnership) will follow to assess new enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS members at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.

VI. POLICY / PROCEDURE:

A. Member Risk Stratification
Partnership~~HC~~ considers all newly enrolled SPD/CCS members as higher risk and therefore they are comprehensively assessed via the Health Risk Assessment (HRA) or Pediatric Health Risk Assessment (PHRA) form to determine their current health risk.

B. HRA/PHRA Process
1. All newly enrolled members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment A) or PHRA (Attachment B) via mail within 10 calendar days of enrollment into the plan.
2. The HRA/PHRA forms are reviewed by the Chief Medical Officer, the ~~Health Services (HS)~~ Health Educator, and by the Consumer or Family Advisory Committee prior to implementation by the health plan, as are any and all revisions to the HRA/PHRA.
3. All newly enrolled SPD/CCS members are contacted telephonically within 45 days of enrollment in order to encourage the member to return the HRA/PHRA.
4. All questions on the HRA/PHRA forms are sent to each SPD/CCS beneficiary according to age upon enrollment. -In no instance are any questions in the HRA/PHRA forms sent to a subset of the

SPD/CCS population.

5. For those HRA/PHRAs completed, the member's responses will be captured and evaluated as follows:
   a. Adult member responses will be captured and evaluated utilizing the HRA Stratification Matrix (Attachment C) for adult members. Adult members will be placed in low or high risk categories.
      1) Low Risk – members will benefit from basic case management; or
      2) High Risk – member requires complex ~~care~~ case management through an individualized care plan (ICP) to prevent adverse health outcomes.
   b. All pediatric members who complete a PHRA are treated as high risk according to policy MCCP2024 Whole Child Model for California Children's Services (CCS) and MPCP2002 California Children's Services.

C. Care Coordination
   1. Low Risk Members
      a. Adult members who are stratified as low risk based on their responses to the HRA will be contacted by a Health Care Guide (HCG) within 30 calendar days of the returned HRA.
      b. The role of the HCG is to identify barriers to care and safety and to carry out non-clinical interventions to eliminate those barriers. Examples include, but are not limited to:
         1) Work with the primary care provider and/or specialist's offices to coordinate appointments
         2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
         3) Work with community-based organizations to assist member with access to psychosocial services
         4) Arrange transportation as appropriate
         5) Resolve any claims issues
         6) Provide support and encouragement to the member and caregiver
         7) Evaluate the member for need for additional case management services available through the health plan.
         8) Facilitate referrals for Long Term Support Services (LTSS) needs identified
      c. The HCG, Nurse Case Manager (NCM), and Social Worker (SW) work together. Any clinical issues will be the responsibility of a licensed clinician.
   2. High Risk Members
      a. Adult Members stratified as high risk, as well as all pediatric members who complete a PHRA, will be contacted by a NCM or SW within 14 days of the returned HRA/PHRA, and the member will be offered enrollment into Complex Case Management (CCM~~)~~() (see policy MCCP2007 Complex Case Management.) The NCM/SW collaborates with a member's interdisciplinary care team and is responsible for the development of the individualized care plan (ICP) for a member stratified as high risk. ~~He/she is~~They are also responsible for providing education and clinical support, facilitating appropriate communication among the interdisciplinary care team, and working closely with outside agencies and available community resources.
      b. The NCM/SW will discuss the HRA/PHRA results with the member and develop an ICP with interventions tailored to the particular needs of the member. The care plan will include, but is not limited to, needs such as:
         1) The member's identified medical care needs
         2) Access to primary and/or specialty care
         3) DME and/or medications
         4) Assessment of member's current use of community resources as well as provision of

referrals to appropriate resources and/or services outside of the Plan's benefits (i.e. mental health and behavioral health services, personal care, housing, meal delivery programs, energy assistance programs and services for individuals with intellectual and developmental disabilities)

5) Identification of the member's caregiver(s) and need for ~~his/her~~their involvement in the care plan
6) Identification of an action plan to assist the member with other activities or services needed to optimize ~~his/her~~their health status, including:
   a) Process/Plan for coordination of care across all settings, including those outside the provider network
   b) Process/Plan for referrals to resolve any physical or cognitive barriers to access care
   c) Process/Plan for helping to facilitate communication among the member's health care providers
   d) Process/Plan for identifying a member's need for other activities/services that would optimize ~~his or her~~their health status (e.g. self-management skills, health education classes, etc.)
   e) For the member in a facility, a plan to ensure discharge planning and coordination is implemented
   f) Designated date of follow-up and reassessment as often as necessary, but not less than annually
   g) Referrals to LTSS services where applicable

c. For adult and pediatric members stratified as high risk, Partnership~~HC~~ shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership~~HC~~. Refer to policies MCCP2032 CalAIM Enhanced Care Management (ECM) and ~~-~~MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

D. Assessment and Reassessment
   1. Populations required to receive an assessment as referenced in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" (11/28/2022) and the latest version of the DHCS CalAIM: Population Health Management (PHM) Policy Guide include:
      a. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
      b. Those entering CCM, refer to policy MCCP2007 Complex Case Management.
      c. Those entering ECM, refer to policy MCCP2032 CalAIM Enhanced Care Management (ECM)
      d. Children with Special Health Care Needs (CSHCN)
      e. Pregnant Individuals
      f. Seniors and persons with disabilities who meet the definition of "high risk" as established in existing APL requirements, namely:
         1) Members who have been authorized to receive:
            a) IHSS greater than, or equal to, 195 hours per month;
            b) Community-Based Adult Services (CBAS), and/or
            c) Multipurpose Senior Services Program (MSSP) Services
         2) Members who:
            a) Have been on oxygen within the past 90 days;
            b) Are residing in an acute hospital setting;

c) Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
d) Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
g) Have cancer and are currently being treated;
h) Are pregnant;
i) Have been prescribed antipsychotic medication within the past 90 days;
j) Have been prescribed 15 or more prescriptions in the past 90 days;
k) Have a self-report of a deteriorating condition; and
l) Have other conditions as determined by the Partnership~~HC~~, based on local resources.

2. Each month, Partnership~~HC~~ leverages age-based algorithms to capture emerging risk in the entire population including, but not limited to SPD~~s~~ or CCS members, to promote timely reassessment for member~~'~~s whose risk level demonstrates need for intervention.
   a. The Monthly Utilization Report analyzes claims data and other predictive modeling factors for members based upon age – adults (ages 21 and over) and pediatrics (under age 21).
   b. Any member who shows as high risk on one of these reports will be contacted by Partnership~~HC~~ Care Coordination staff for telephonic reassessment, unless the member is currently enrolled in care coordination. Members recently closed to care coordination will be reassessed if their case was closed more than 30 calendar days prior to new risk identification for pediatric members, and 90 days prior to new risk identification for adult members.
   c. In addition, if the Monthly Utilization Report reveals a potential CCS condition in a pediatric member, that case will be referred to the CCS County program for CCS eligibility determination according to policy MCCP2024 Whole Child Model for California Children's Services (CCS) and MPCP2002 California Children's Services.

E. Extended Continuity of Care (COC)
1. Newly enrolled SPD/CCS members who request continued access to a provider who is not part of Partnership~~HC~~'s network will be permitted to remain with that provider for up to 12 months as long as certain criteria are met. Partnership~~HC~~ will begin processing requests for extended COC and will follow the COC process as described in policy MCCP2014 Continuity of Care (Medi-Cal).

F. Diversity Equity and Inclusion Training
1. Partnership~~HC~~ provides Partnership-developed sensitivity, diversity, cultural competency and cultural humility, and health equity trainings to Partnership~~HC~~ staff; providers and provider staff, and~~,~~ delegated entities and delegate's staff.
2. Partnership~~HC~~ also provides the training to each aforementioned party who serves seniors and individuals living with disabilities. ~~-~~This training is done via webinar.
3. Documentation of trainings is maintained and is available upon request.

VII. REFERENCES:

A. Welfare and Institutions Code Section 14182
B. DHCS ~~APL 22-024 "Population Health Management Program Guide"~~All Plan Letter 22-024: Population Health Management Program Guide (~~dated~~ 11/28/2022)

~~C.~~ DHCS CalAIM: Population Health Management (PHM) Policy Guide (May 2024~~August 2023~~)
C. https://www.dhcs.ca.gov/CalAIM/Documents/PHM-Policy-Guide.pdf~~————~~
D. DHCS ~~APL 21-005 *Revised* "California Children's Services Whole Child Model Program"~~All Plan Letter 23-034: California Children's Services Whole Child Model Program ~~(dated~~ 12/27/2023~~)~~
E. DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements ~~(dated~~ 09/14/2023~~)~~
F. DHCS Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2022-2023

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

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

X. REVISION DATES:
MCCP2019 (effective 02/15/17)
10/18/17; *11/14/18; 11/13/19; 09/09/20, 09/08/21; 10/12/22; 11/08/23; 10/09/24

*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:
MCUP3117 (04/11/2013 to 02/15/2017)
05/20/15; 04/20/16 to 02/15/17

****

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~~HC~~ 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~~HC~~.

Partnership~~HC~~'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
Health Risk Assessment Form
Seniors and Persons with Disabilities (SPD)

This form will help Partnership HealthPlan of CaliforniaA (PHC) learn about your health and wellness needs and find ways we can help you. Please take a few minutes to fill out this form and send it back as soon as possible.

If you think you need to see a doctor before PartnershipHC calls you, you should go to the doctor or hospital at that time.

If you have questions, please call PartnershipPHC at **(800) 809-1350**,
Monday – through Friday,
between 8 a.m. to– 5 p.m.
TDD/TTY users can callshould dial:
(800) 735-2929.

Please return your completed form in the (green) envelope.
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA -94534

Filling out this form is voluntary.
We will not deny your care because of how you respond.

Name of PartnershipHC Member: _____

Date of Birth: _____ **Medi-Cal ID Number:** _____

1. What is your preferred language?
   ☐ English ☐ Spanish ☐ Russian ☐ Mandarin ☐ Tagalog ☐ Other

2. What was your gender at birth?
   ☐ Male ☐ Female ☐ Other

3. What do you like to be called?
   ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other

4. Do you have trouble communicating due to hearing, vision, or speech problems?
   _____ ☐Yes ☐No
   If yes, do you need special materials/equipment? _____ ☐Yes ☐No

5. Do you have a regular doctor? ☐Yes ☐No

6. Do you see a specialistSpecialist (a doctor who specializes in health problems, like heart, kidney, cancer or other health problems)? _____ ☐Yes ☐No

7. Do you feel your doctor(s) understand your medical needs?
☐ Yes ☐ No

8. Do you need to see a doctor in the next 60 days? ☐ Yes ☐ No
If yes, do you have the appointment scheduled? ☐ Yes ☐ No

9. Do you get services or care from a Regional Center that cares for people with developmental disabilities? ☐ Yes ☐ No

10. Are you pregnant? ☐ Yes ☐ No

11. Have you been to the emergency room 2 or more times in the last 12 months?
☐ Yes ☐ No

12. Have you been admitted to the hospital in the last 12 months?
☐ Yes ☐ No

13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags? ☐ Yes ☐ No
If yes, do you need help getting more supplies? ☐ Yes ☐ No

14. Do you smoke or use tobacco products? ☐ Yes ☐ No
If yes, would you like help quitting? ☐ Yes ☐ No

15. Do you use home oxygen? ☐ Yes ☐ No

16. How many prescription medicines do you take each day?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

17. Have you ever been told you have any of these health problems?
(check yes or no for each of the problems below)

California Children's Services (CCS) condition	☐ Yes	☐ No
Asthma/Lung problems	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV or AIDS	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Medical Therapy Program or Unit (MTP/MTU) condition	☐ Yes	☐ No

If yes to any, do you see a doctor or specialist for any of these problems?
☐ Yes ☐ No

If yes to any, have you ever had any surgeries for these problems?
☐ Yes ☐ No

Do you need help finding a doctor to help you with these problems?
☐ Yes ☐ No

18. Have you ever been told you have a mental or behavioral health problem such as depression, bipolar disorder, or schizophrenia? ☐ Yes ☐ No
If yes, do you need help finding a doctor to help you with a mental or behavioral health problem?
☐ Yes ☐ No

19. Would like more information about how to improve your health or stay healthy?
☐ Yes ☐ No

20. Do you need help with any of these actions? (**Yes** or **No** to each individual action, choose **N/A** if this is something you have never done)

Taking a bath or shower	☐ Yes	☐ No	☐ N/A
Going up stairs	☐ Yes	☐ No	☐ N/A
Eating	☐ Yes	☐ No	☐ N/A
Getting dressed	☐ Yes	☐ No	☐ N/A
Brushing teeth, brushing hair, shaving	☐ Yes	☐ No	☐ N/A
Making meals or cooking	☐ Yes	☐ No	☐ N/A
Getting out of a bed or a chair	☐ Yes	☐ No	☐ N/A
Shopping and getting food	☐ Yes	☐ No	☐ N/A
Using the toilet	☐ Yes	☐ No	☐ N/A
Making it to the toilet on time/without an "accident"	☐ Yes	☐ No	☐ N/A
Walking	☐ Yes	☐ No	☐ N/A
Washing dishes or clothes	☐ Yes	☐ No	☐ N/A
Writing checks or keeping track of money	☐ Yes	☐ No	☐ N/A
Getting a ride to the doctor or to see your friends	☐ Yes	☐ No	☐ N/A
Doing house or yard work	☐ Yes	☐ No	☐ N/A
Going out to visit family or friends	☐ Yes	☐ No	☐ N/A
Using the phone	☐ Yes	☐ No	☐ N/A
Keeping track of appointments	☐ Yes	☐ No	☐ N/A

If yes, are you getting all the help you need with these actions?
☐ Yes ☐ No ☐ N/A

21. Can you live safely and move easily around your home?
☐ Yes ☐ No ☐ N/A

*If **no***, does the place where you live have:
(Yes, No, or N/A to each individual item)

Good lighting	☐ Yes	☐ No	☐ N/A
Good heating	☐ Yes	☐ No	☐ N/A
Good cooling	☐ Yes	☐ No	☐ N/A
Rails for any stairs or ramps	☐ Yes	☐ No	☐ N/A
Hot water	☐ Yes	☐ No	☐ N/A
Indoor toilet	☐ Yes	☐ No	☐ N/A
A door to the outside that locks	☐ Yes	☐ No	☐ N/A

Stairs to get into your home or stairs inside your home
☐ Yes ☐ No ☐ N/A
Elevator ☐ Yes ☐ No ☐ N/A
Space to use a wheelchair ☐ Yes ☐ No ☐ N/A
Clear ways to exit your home ☐ Yes ☐ No ☐ N/A

22. I would like to ask you about how you think you are managing your health conditions
Do you need help taking your medications? ☐ Yes ☐ No ☐ N/A
Do you need help filling out health forms? ☐ Yes ☐ No ☐ N/A
Do you need help answering questions during a doctor's visit?
☐ Yes ☐ No
☐ N/A

23. Which of the following answers best describes how you feel with your medical needs? (check all that apply)
☐ I sometimes forget what I am supposed to do for my health
☐ I can't afford all of things I need to take care of myself
☐ It's hard to read or understand directions at times
☐ I'm confused about what I really need to do for my health
☐ I don't think it is necessary to do what my doctor says all of the time
☐ I don't understand my medical needs
☐ I feel confident that I know how to take care of what I need

24. Do you have family members or others willing and able to help you when you need it?
☐ Yes ☐ No
☐ N/A

25. Do you ever think your caregiver has a hard time giving you all the help you need?
☐ Yes ☐ No
☐ N/A

26. Are you afraid of anyone or is anyone hurting you?
☐ Yes ☐ No
☐ N/A

27. Is anyone using your money without your ok? ☐ Yes ☐ No
☐ N/A

28. Have you had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No ☐ N/A

29. Have you fallen in the last month? ☐ Yes ☐ No
☐ N/A
Are you afraid of falling? ☐ Yes ☐ No
☐ N/A

30. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
☐ Yes ☐ No ☐ N/A

31. Over the past month (30 days), how many days have you felt lonely?
☐ None – I never feel lonely
☐ Less than 5 days
☐ More than half the days (more than 15)
☐ Most days – I always feel lonely

32. In general, would you say that your health is
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Signature of person filling out the form:

Date Signed: _____

If not signed by member, what is your relationship to the member:
Parent/ Guardian/ Other Representative

Thank you for your time filling out this form.
CONFIDENTIAL

Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

Please take a few minutes to complete this form to help us learn about your child's health and wellness needs. We want to use these answers to help you get the right care as soon as possible.

If you think you need to see a doctor before PartnershipHC calls you, you should go to the doctor or hospital at that time.

Filling out this form is voluntary. We will not deny your care because of how you respond.

If you have questions, please call PartnershipHC at: **(800) 809-1350** Monday – through Friday, between 8 a.m. – 5 p.m. TDD/TTY users should dial can call: **(800) 735-2929**.

Please return this completed form in the (green) envelope

To: Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership CCS Member: _____

Date of Birth: _____ **Medi Medi-Cal ID Number:** _____

1. Who is answering the questions on this survey?
   ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Self
   ☐ Other Family Member: _____ ☐ Other: _____

2. What is your preferred language?
   ☐ English ☐ Spanish ☐ Tagalog ☐ Russian ☐ Other: _____

3. Does your child have difficulty with any of the following? (Choose **N/A** if you would not expect other children of this age to be able to do this on his/her own)

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐ Yes	☐ No	☐ N/A
Taking a bath or shower (bathing)	☐ Yes	☐ No	☐ N/A
Getting dressed (dressing)	☐ Yes	☐ No	☐ N/A
Going to the toilet (toileting)	☐ Yes	☐ No	☐ N/A
Making it to the toilet on time/without an "accident" (continence)	☐ Yes	☐ No	☐ N/A
Being active, like:			
Walking (mobility)	☐ Yes	☐ No	☐ N/A
Getting out of a bed or a chair (transferring)	☐ Yes	☐ No	☐ N/A
Going up or down stairs	☐ Yes	☐ No	☐ N/A

Showing independence by:

Going out to visit family or friends	☐ Yes	☐ No	☐ N/A
Going to school or work	☐ Yes	☐ No	☐ N/A
Making doctor or dentist appointments	☐ Yes	☐ No	☐ N/A
Using the phone, tablet, or computer	☐ Yes	☐ No	☐ N/A
Other _____	☐ Yes	☐ No	☐ N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐ Yes ☐ No ☐ Not sure

   What is the name of the center where you go?_____

5. Does your child receive any of the following services? (Check all that apply)

   ☐ Speech Therapy
   Where is this received? ☐ Home ☐ School ☐ Medical Therapy Program (MTP) or Medical Therapy Unit (MTU) ☐ Other _____

   ☐ Physical Therapy
   Where is this received? ☐ Home ☐ School ☐ MTP/MTU ☐ Other _____

   ☐ Occupational Therapy
   Where is this received? ☐ Home ☐ School ☐ MTP/MTU ☐ Other _____

   ☐ Respiratory Therapy
   Where is this received? ☐ Home ☐ School ☐ Other _____

   ☐ Nursing Services
   Where is this received? ☐ Home ☐ School Hours/days per week? _____ ☐ Other _____

   ☐ Mental or Behavioral Therapy
   Where is this received? ☐ Home ☐ School ☐ Other _____

   ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
   Which one(s)? ☐ IEP ☐ 504 ☐ School Name _____

   ☐ Other supportive services (Respite Care, Palliative Care, etc.)
   Please explain _____
   Where is this received? ☐ Home ☐ School ☐ Other _____

6. In general, would you say that your child's health is
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

7. Does your child have any allergies?
   ☐ Food(s) (please specify) _____
   Environmental (seasonal, dust, pollution, etc.)
   (please specify) _____
   ☐ Medication(s) (please specify) _____
   ☐ No Known Allergies

8. Does your child use durable medical equipment (DME) ~~medical equipment (DME)~~ or supplies that were ordered for your child's specific needs?
   ☐ Yes (check all that apply)
   ☐ Glasses
   ☐ Hearing Aids
   ☐ Cochlear Implant
   ☐ Wheelchair
   ☐ Brace
   ☐ Orthotics
   ☐ Walker
   ☐ Car Seat
   ☐ Bed
   ☐ Ventilator/breathing machine
   ☐ Oxygen
   ☐ Percussion Vest
   ☐ Insulin Pump/Continuous Glucose Monitor~~CGM~~
   ☐ Intravenous~~IV~~ -pump/Infusion device
   ☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)~~GT/JT/GJT~~
   ☐ Other (please specify) _____

   Who ordered it? _____

   Date of last order _____

   Who was the vendor? _____

   Vendor Phone:_____

9. What is your child's current:
   Height _____ Weight _____

10. Has your child ever had surgery?
    ☐ Yes ☐ No ☐ Don't Know

Please list each surgery	Date or Year
☐ **More than can fit here**	

11. Has your child been to the emergency room (ER) in the last 6 months?
    ☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now
    i. How many times?_____
    ii. When?_____

12. Has your child been in the hospital overnight in the last 6 months?
    ☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now
    i. How many times?_____
    ii. When?_____

13. What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. **Start with the medications your child is taking now, and then add medications your child has taken in the past**.

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
☐ **More than can fit here**	☐	☐

14. Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past.

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Muscular Dystrophy	☐	☐

	Current	Past
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Ostomy/G Tube ~~G-tube~~/Colostomy/Urostomy	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI) ~~GI~~/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐

	Current	Past
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
      - ☐ Which condition(s) _____
    - ☐ No – my child already has provider(s) for all his/her needs
      - ☐ Name/Specialty _____
      - ☐ Name/Specialty _____
      - ☐ Name/Specialty _____
    - ☐ No – my child does not need a specialist for his/her condition

16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
      - ☐ Next Appointment: Date:_____
    - ◊ Specialty Care Center
      - ☐ N/A
      - ☐ Facility Name: _____
      - ☐ Facility Phone: _____
      - ☐ Last Appointment: Date:_____
      - ☐ Next Appointment: Date:_____
    - ◊ Regular Dental Care
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
    - ◊ Regular Vision Care
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
    - ◊ Ongoing care from Mental or Behavioral Health Specialist
      - ☐ N/A
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____

☐ Condition(s) being treated for:
_____

☐ My child does not get regular care from any provider
◊ Do you need help choosing a provider for your child?
☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now

17. Have your child's medical conditions caused him/her to miss activities, work, or school in the past year? If yes, please describe:
_____
_____
_____

18. What is the best time of day (Monday to Friday, 7:30 a.m. to 5:30 p.m.) to call you to discuss your child's needs in more detail?
_____

Signature of Person
Filling Out the Form: _____ Date ~~Signed~~:_____

Thank you for your time filling out this form.
CONFIDENTIAL

Adult Health Risk Assessment (HRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MCCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(1) What is your preferred language?	English		
	Spanish		
	Russian		
	Mandarin		
	Tagalog		
	Other		
(2) What was your gender at birth?	Male		
	Female		
	Other		
(3) What do you prefer to be called	he/him/his	(if different)	
	she/her/hers	(if different)	
	they/them/theirs	(if different)	
	other		
(4) Do you ever have trouble communicating due to hearing, vision, or speech problems?	Yes		
	No		
If yes, do you need special materials/equipment?	Yes		X
	No		
(5) Do you have a regular doctor?	No		
	Yes		
(6) Do you see a Specialist (a doctor that specializes in certain health conditions, like a cardiologist, nephrologist, oncologist, or other doctor)?	No	X	X
	Yes		
(7) Do you feel your doctor(s) understand(s) your overall medical needs?	No		
	Yes		

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(8) Do you need to see a doctor within the next 60 days?	No		
If yes, do you already have an appointment scheduled?	Yes		X
	Yes		
	No		X
(9) Do you get services or care from a Regional Center?	No		
	Yes	X	
(10) If you are **female**, are you pregnant?	No		
	Yes		X
(11) Have you been to the emergency room two (2) or more times in the last twelve (12) months?	No		
	Yes		X
(12) Have you been admitted to the hospital in the last twelve (12) months?	No		
	Yes		X
(13) Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags?	No		
	Yes		
If yes, do you need help obtaining more supplies?	No		
	Yes		X
(14) Do you smoke or use tobacco products?	No		
	Yes		
If yes, would you like help quitting?	No		
	Yes	X	
(15) Do you use home oxygen?	No		
	Yes		X
(16) How many prescription medications do you take each day?	> 8		X
(17) Have you ever been diagnosed with any of the following health conditions? (check yes or no for each of the conditions below)			
California Children's Services (CCS) condition	Yes		X
	No		
Asthma/Lung Problems	Yes		
	No		
Heart Problems	Yes		
	No		
Diabetes	Yes		
	No		
HIV or AIDs	Yes		
	No		
Kidney Disease	Yes		
	No		

(Question #)	Response	High Risk (MSW)	High Risk (CM)
Seizures	Yes		
	No		
Cancer	Yes		
	No		
Medical Therapy Program or Unit (MTP/MTU)	Yes		X
	No		
If yes to any, do you see a doctor or specialist or any of the condition(s) above?	No		
	Yes		
If yes to any, have you ever had any surgeries for these conditions?	Yes		X
	No		
Do you need help finding a doctor to help you with any of the condition(s) above?	Yes		X
	No		
(18) Have you ever been told you have a mental or behavioral health condition such as depression, bipolar disorder, or schizophrenia?	No		
	Yes	X	X
Do you need help finding a doctor to help you with a mental or behavioral health condition?	No		
	Yes	X	X
(19) Would like more information about how to improve your health or stay healthy?	No		
	Yes		X
(20) Do you need help with any of these Actions? (list follows)	No		
	Yes		
If yes, are you getting all the help you need?	No	X	
	Yes		
(21) Can you live safely and move easily around your home? (list follows)	No to any	X	X
	Yes		
(22) I would like to ask you about how you think you are managing your health conditions	No	X	
	Yes to any	X	
Do you need help taking your medications	No		
	Yes		X
Do you need help filling out health forms?	No		
	Yes	X	
Do you need help answering questions during a doctor's visit?	No		
	Yes		X
(23) Which of the following answers best describes how you feel with your medical needs? (check all that apply)	No		
I sometimes forget what I am supposed to do for my health			
I can't afford all of the things I need to take care of myself	Yes		X
It's hard to read or understand directions at times	Yes	X	
I'm confused about what I really need to do for my health	Yes		X
I don't think it is necessary to do what my doctor says all of the time	Yes		X
I don't understand my medical needs	Yes		X
I feel confident that I know how to take care of what I need	Yes		X

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(24) Do you have family members or others willing and able to help you when you need it?	Yes		X
	No		
(26) Do you ever think your caregiver has a hard time giving you all the help you need?	No	X	
	Yes	X	
(26) Are you afraid of anyone or is anyone hurting you?	No		
	Yes	X	
(27) Is anyone using your money without your okay?	No		
	Yes	X	
(28) Have you had any changes in thinking, remembering, or making decisions?	No		
	Yes	X	X
(29) Have you fallen in the last month?	No		
	Yes		X
Are you afraid of falling?	No		
	Yes	X	X
(30) Do you sometimes run out of money to pay for food, rent, bills, and medicine?	No		
	Yes	X	
(31) Over the past month (30 days), how many days have you felt lonely?	No		
None – I never feel lonely			
Less than 5 days			
More than half the days (more than 15)			
Most days – I always feel lonely		X	
(32) In general, would you say that your health is?		X	
	Excellent		
	Very Good		
	Good		X
	Fair		X
	Poor		X

Pediatric Health Risk Assessment (PHRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MCCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
(1) Who is answering the questions on this survey?	Self		
	Other		
(2) What is your preferred language?	English		
	Spanish		
	Russian		
	Mandarin		
	Tagalog		
	Other		
(3) Does your child have difficulty with any of the following? (Choose N/A if you would not expect other children at this age to be able to this this on their own)	Yes		
	No		
If yes to any of the above, does your child get all the help they need?	Yes		
	No		X
(4) Does your child get services from a Regional Center that provides care for people with developmental disabilities?	Yes	X	
	No		
	Not Sure	X	
(5) Does your child receive any of the following services?			
Speech Therapy	Yes		X
Physical Therapy	Yes		X
Occupational Therapy	Yes		X
Respiratory Therapy	Yes		X
Nursing Services	Yes		X
Mental or Behavioral Therapy	Yes	X	
Individualized Education Plan (IEP) or 504 Plan or other learning support	Yes		X
Other supportive services			X

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
(6) In general, would you say that your child's health is	Excellent		
	Very Good		
	Good		X
	Fair		X
	Poor		X
(7) Does your child have any allergies? (list follows)	Yes		X
	No		
(8) Does your child use medical equipment (DME) or supplies that were ordered for your child's specific needs? (list follows)	Yes		X
	No		
(9) What is your child's current height/weight?			
(10) Has your child ever had surgery?	Yes		X
	No		
	Don't Know	X	
(11) Have you been to the emergency room (ER) in the last 6 months?	Yes		X
	No		
	Don't know	X	
(12) Has your child been in the hospital overnight in the past 6 months?	Yes		X
	No		
	Don't know	X	
(13) What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. Start with the medications your child is taking now, and then add medications your child has taken in the past.	Medications Listed		X
	No Medications Listed		
(14) Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past. (check yes for any conditions marked)	Yes		X
	No		
(15) Does your child need a specialist to provide care for any of these conditions?	Yes		X
	No – has a provider		
	No – Specialist Not Needed		
(16) Who are your child's medical providers?			
Primary Care Provider			
Specialty Care Center			

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
Regular Dental Care			
Regular Vision Care			
Ongoing care from Mental or Behavioral Health Specialist			
My child does not get regular care from any provider – do you need help choosing a provider for your child?	Yes		X
	No		
	Don't Know		X
(17) Have your child's medical conditions caused him/her to miss activities, work, or school in the past year?	Yes	X	
	No		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCCP2023				**Lead Department: Health Services**	
Policy/Procedure Title: New Member Needs Assessment				☒**External Policy** ☐ **Internal Policy**	
Original Date: 08/16/2017			**Next Review Date:** ~~10/11/2024~~10/09/2025 **Last Review Date:** ~~10/11/2023~~10/09/2024		
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:** ~~10/11/2023~~10/09/2024	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description

B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services

C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

~~C.~~D. MPCP2002 - California Children's Services

II. IMPACTED DEPTS:

A. Health Services

B. Information Technology

C. Member Services

III. DEFINITIONS:

~~A.~~ 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.

~~Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled members to identify members needing expedited care.~~

A.

~~B. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).~~

~~C. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).~~

B. Care Coordination (CC) Staff: P~~artnership~~HC's CC staff members have either experience in health care fields (e.g., Medical Assistant, Emergency Medical Technician, etc.) or are licensed and possess the appropriate skills and training to assist members. All staff are trained in care coordination and motivational interviewing.

C. Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled members to identify members needing expedited care.

D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

E. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric members (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes

and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

~~D.~~F. Whole Child Model (WCM): In participating counties, this program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. HIF Form
B. HRA Form
C. PHRA Form

V. PURPOSE:

~~This policy describes the process Partnership HealthPlan of California (PHC) will follow to assess new plan enrollees in order to identify those members who may need expedited services.~~This policy describes the process Partnership HealthPlan of California (Partnership) will follow to assess new plan enrollees in order to identify those members who may need expedited services.

VI. POLICY / PROCEDURE:

A. New Member Outreach Process
   1. All newly enrolled members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment B) or PHRA (Attachment C) via mail within 10 calendar days of enrollment into the plan along with a postage-paid envelope for response. The HRA includes both questions from the HIF tool as well as additional questions appropriate for assessing the need for expedited services for high-risk members. (See policy MCCP2019 for the full process of screening of Seniors and Persons with Disabilities and/or California Children's Services beneficiaries, and risk assignment process.)
   2. For more information on the assessment, outreach and case management activities for CCS members, please see Partnership~~HC~~ policy MCCP2024 Whole Child Model for California Children's Services and MPCP2002 California Children's Services.
   3. All newly enrolled members who are designated with neither an SPD aid code nor a CCS identifier are sent the HIF/MET form (Attachment A) via mail within 10 days of enrollment into the plan along with a postage-paid envelope for response.
   4. Each new member will also receive up to two telephone calls reminding them to review and return the assessment form. This telephonic outreach can be made to head of household for members under the care of parents or other authorized representatives. At least two attempts will be made to contact the member or their authorized representative within 45 days of enrollment.

B. Initial Screening
   1. Returned forms will be reviewed to determine if the member requires expedited care within 30 days of receipt of a completed HRA form for SPD/CCS members, or within 90 days of return of the HIF/MET for all other newly enrolled members. If the member is found to require expedited care, a CC staff member will contact the member or member's authorized representative.
      a. The role of CC staff member in the HRA or HIF/MET process is to expedite access to care for new members. Examples include, but are not limited to:
         1) Facilitate referrals for Long Term Services and Supports (LTSS) needs identified
         2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
         3) Work with the primary care provider and/or specialists' offices to coordinate appointments
         4) Arrange transportation as appropriate
         5) Provide support and encouragement to the member and caregiver

6) Identify members who may benefit from mental health services and refer to appropriate agencies for services
7) Work with member to identify any psychosocial needs and refer to community-based organizations as appropriate
8) Assist with facilitating referrals to appropriate resources and/ or services outside of the Plan's benefits (i.e., personal care, and/or energy assistance programs)
9) Screen and refer new members who may benefit from Basic Care Management or Complex Case Management Services

C. Disenrollment
1. Upon disenrollment from Partnership~~HC~~ and when requested, Partnership~~HC~~ will make the results of the HRA or HIF/MET assessment available to the new Medi-Cal Managed Care Health Plan.

VII. REFERENCES:
Title 42 Code of Federal Regulations (CFR) 438.208(b)

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

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

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

Health Information Form

You are receiving this form because you are newly assigned to Partnership HealthPlan of California ~~(PHC)~~. Partnership~~HC~~ will use this form to make sure you get the care that you ~~may~~ need.

Please circle each answer that applies to you. Complete one form for each person in your family who is newly assigned to Partnership~~HC~~.

If you have questions, please call Partnership~~HC~~ at ~~: 1 (~~**800**~~) -~~**863-4155** Monday ~~–~~ ~~through~~ Friday, ~~between~~ 8 ~~:00~~a.m. ~~–~~ 5 ~~:00~~p.m. ~~TDD/~~TTY users ~~should dial:~~ can call ~~(1~~**800**~~) -~~**735-2929**.

Please return this completed form in the (yellow) envelope provided or mail ~~separately~~ t~~T~~o:
Q&A Research Inc
#357, 22052 W 66th Street
Shawnee KAS 66226-9905

Filling out this form is voluntary. You will not be denied care based on your confidential answers.

Name of Partnership Member:_____

Date of Birth: _____ **Medi-Cal ID Number:**_____

1. Do you need to see a doctor within the next 60 days?	YES	NO
2. Do you take 3 or more prescription medications each day?	YES	NO
3. Do you see a doctor regularly for a mental health condition such as depression, bipolar disorder, or schizophrenia?	YES	NO
4. Have you been to the emergency room two (2) or more times in the last twelve (12) months?	YES	NO
5. Have you been admitted to the hospital in the last twelve (12) months?	YES	NO
6. Have you needed help with personal care such as bathing, getting dressed, or changing bandages in the last six (6) months?	YES	NO
7. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, oxygen or ostomy bags?	YES	NO
8. Do you have a condition that limits your activities or what you can do?	YES	NO
9. Are you pregnant?	YES	NO
9a. *If yes, are you currently seeing a doctor for this pregnancy*?	YES	NO
10. Do you see a doctor for a chronic medical condition?	YES	NO

If yes, circle all that apply:

a. Asthma / Lung Problems b. Heart Problems c. Diabetes
d. HIV or AIDS e. Kidney Disease f. Seizures
g. Other _____

These answers will be sent to PartnershipHC. If you think you need to see a doctor before PartnershipHC contacts you, you should go to the doctor or hospital at that time.

Please note, if you change to another health plan and we get a request, PartnershipHC will share this health information form with your new plan.

~~Signature of Person~~

~~Filling Out the Form~~Signature:_____ Date ~~Signed~~:
_____

If not signed by memberbeneficiary, specify relationship: : Parent/ Guardian/ Other Representative

CONFIDENTIAL

Partnership HealthPlan of California
Health Risk Assessment Form
Seniors and Persons with Disabilities (SPD)

This form will help Partnership HealthPlan of CaliforniaA (PHC) learn about your health and wellness needs and find ways we can help you. Please take a few minutes to fill out this form and send it back as soon as possible.

If you think you need to see a doctor before PartnershipHC calls you, you should go to the doctor or hospital at that time.

If you have questions, please call PartnershipPHC at **(800) 809-1350**,
Monday – through Friday,
between 8 a.m. to– 5 p.m.
TDD/TTY users can callshould dial:
(800) 735-2929.

Please return your completed form in the (green) envelope.
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary.
We will not deny your care because of how you respond.

Name of PartnershipHC Member: _____

Date of Birth: _____ **Medi-Cal ID Number:** _____

1. What is your preferred language?
   ☐ English ☐ Spanish ☐ Russian ☐ Mandarin ☐ Tagalog ☐ Other

2. What was your gender at birth?
   ☐ Male ☐ Female ☐ Other

3. What do you like to be called?
   ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other

4. Do you have trouble communicating due to hearing, vision, or speech problems?
   _____ ☐ Yes ☐ No
   If yes, do you need special materials/equipment? _____ ☐ Yes ☐ No

5. Do you have a regular doctor? ☐ Yes ☐ No

6. Do you see a specialistSpecialist (a doctor who specializes in health problems, like heart, kidney, cancer or other health problems)? _____ ☐ Yes ☐ No

7. Do you feel your doctor(s) understand your medical needs? ☐ Yes ☐ No

8. Do you need to see a doctor in the next 60 days? ☐ Yes ☐ No
If yes, do you have the appointment scheduled? ☐ Yes ☐ No

9. Do you get services or care from a Regional Center that cares for people with developmental disabilities? ☐ Yes ☐ No

10. Are you pregnant? ☐ Yes ☐ No

11. Have you been to the emergency room 2 or more times in the last 12 months? ☐ Yes ☐ No

12. Have you been admitted to the hospital in the last 12 months? ☐ Yes ☐ No

13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags? ☐ Yes ☐ No
If yes, do you need help getting more supplies? ☐ Yes ☐ No

14. Do you smoke or use tobacco products? ☐ Yes ☐ No
If yes, would you like help quitting? ☐ Yes ☐ No

15. Do you use home oxygen? ☐ Yes ☐ No

16. How many prescription medicines do you take each day?
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

17. Have you ever been told you have any of these health problems?
(check yes or no for each of the problems below)

California Children's Services (CCS) condition	☐ Yes	☐ No
Asthma/Lung problems	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV or AIDS	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Medical Therapy Program or Unit (MTP/MTU) condition	☐ Yes	☐ No

If yes to any, do you see a doctor or specialist for any of these problems? ☐ Yes ☐ No

If yes to any, have you ever had any surgeries for these problems? ☐ Yes ☐ No

Do you need help finding a doctor to help you with these problems?
☐ Yes ☐ No

18. Have you ever been told you have a mental or behavioral health problem such as depression, bipolar disorder, or schizophrenia? ☐ Yes ☐ No
If yes, do you need help finding a doctor to help you with a mental or behavioral health problem?
☐ Yes ☐ No

19. Would like more information about how to improve your health or stay healthy?
☐ Yes ☐ No

20. Do you need help with any of these actions? (**Yes** or **No** to each individual action, choose **N/A** if this is something you have never done)

Taking a bath or shower	☐ Yes	☐ No	☐ N/A
Going up stairs	☐ Yes	☐ No	☐ N/A
Eating	☐ Yes	☐ No	☐ N/A
Getting dressed	☐ Yes	☐ No	☐ N/A
Brushing teeth, brushing hair, shaving	☐ Yes	☐ No	☐ N/A
Making meals or cooking	☐ Yes	☐ No	☐ N/A
Getting out of a bed or a chair	☐ Yes	☐ No	☐ N/A
Shopping and getting food	☐ Yes	☐ No	☐ N/A
Using the toilet	☐ Yes	☐ No	☐ N/A
Making it to the toilet on time/without an "accident"	☐ Yes	☐ No	☐ N/A
Walking	☐ Yes	☐ No	☐ N/A
Washing dishes or clothes	☐ Yes	☐ No	☐ N/A
Writing checks or keeping track of money	☐ Yes	☐ No	☐ N/A
Getting a ride to the doctor or to see your friends	☐ Yes	☐ No	☐ N/A
Doing house or yard work	☐ Yes	☐ No	☐ N/A
Going out to visit family or friends	☐ Yes	☐ No	☐ N/A
Using the phone	☐ Yes	☐ No	☐ N/A
Keeping track of appointments	☐ Yes	☐ No	☐ N/A

If yes, are you getting all the help you need with these actions?
☐ Yes ☐ No ☐ N/A

21. Can you live safely and move easily around your home?
☐ Yes ☐ No ☐ N/A

*If **no***, does the place where you live have:
(Yes, No, or N/A to each individual item)

Good lighting	☐ Yes	☐ No	☐ N/A
Good heating	☐ Yes	☐ No	☐ N/A
Good cooling	☐ Yes	☐ No	☐ N/A
Rails for any stairs or ramps	☐ Yes	☐ No	☐ N/A
Hot water	☐ Yes	☐ No	☐ N/A
Indoor toilet	☐ Yes	☐ No	☐ N/A
A door to the outside that locks	☐ Yes	☐ No	☐ N/A

Stairs to get into your home or stairs inside your home
☐Yes ☐No ☐N/A
Elevator ☐Yes ☐No ☐N/A
Space to use a wheelchair ☐Yes ☐No ☐N/A
Clear ways to exit your home ☐Yes ☐No ☐N/A

22. I would like to ask you about how you think you are managing your health conditions
Do you need help taking your medications? ☐Yes ☐No ☐N/A
Do you need help filling out health forms? ☐Yes ☐No ☐N/A
Do you need help answering questions during a doctor's visit?
☐Yes ☐No
☐N/A

23. Which of the following answers best describes how you feel with your medical needs? (check all that apply)
☐ I sometimes forget what I am supposed to do for my health
☐ I can't afford all of things I need to take care of myself
☐ It's hard to read or understand directions at times
☐ I'm confused about what I really need to do for my health
☐ I don't think it is necessary to do what my doctor says all of the time
☐ I don't understand my medical needs
☐ I feel confident that I know how to take care of what I need

24. Do you have family members or others willing and able to help you when you need it?
☐Yes ☐No
☐N/A

25. Do you ever think your caregiver has a hard time giving you all the help you need?
☐Yes ☐No
☐N/A

26. Are you afraid of anyone or is anyone hurting you?
☐Yes ☐No
☐N/A

27. Is anyone using your money without your ok? ☐Yes ☐No
☐N/A

28. Have you had any changes in thinking, remembering, or making decisions? ☐Yes ☐No ☐N/A

29. Have you fallen in the last month? ☐Yes ☐No
☐N/A
Are you afraid of falling? ☐Yes ☐No
☐N/A

30. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
☐ Yes ☐ No ☐ N/A

31. Over the past month (30 days), how many days have you felt lonely?
☐ None – I never feel lonely
☐ Less than 5 days
☐ More than half the days (more than 15)
☐ Most days – I always feel lonely

32. In general, would you say that your health is
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Signature of person filling out the form:

_____

Date Signed: _____

If not signed by member, what is your relationship to the member:
Parent/ Guardian/ Other Representative

Thank you for your time filling out this form.
CONFIDENTIAL

Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

Please take a few minutes to complete this form to help us learn about your child's health and wellness needs. We want to use these answers to help you get the right care as soon as possible.

If you think you need to see a doctor before PartnershipHC calls you, you should go to the doctor or hospital at that time.

Filling out this form is voluntary. We will not deny your care because of how you respond.

If you have questions, please call PartnershipHC at: **(800) 809-1350** Monday – through Friday, between 8 a.m. – 5 p.m. TDD/TTY users should dial can call: **(800) 735-2929**.

Please return this completed form in the (green) envelope

To: Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership CCS Member: _____

Date of Birth: _____ **Medi Medi-Cal ID Number:** _____

1. Who is answering the questions on this survey?
   ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Self
   ☐ Other Family Member: _____ ☐ Other: _____

2. What is your preferred language?
   ☐ English ☐ Spanish ☐ Tagalog ☐ Russian ☐ Other: _____

3. Does your child have difficulty with any of the following? (Choose **N/A** if you would not expect other children of this age to be able to do this on his/her own)

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐ Yes	☐ No	☐ N/A
Taking a bath or shower (bathing)	☐ Yes	☐ No	☐ N/A
Getting dressed (dressing)	☐ Yes	☐ No	☐ N/A
Going to the toilet (toileting)	☐ Yes	☐ No	☐ N/A
Making it to the toilet on time/without an "accident" (continence)	☐ Yes	☐ No	☐ N/A
Being active, like:			
Walking (mobility)	☐ Yes	☐ No	☐ N/A
Getting out of a bed or a chair (transferring)	☐ Yes	☐ No	☐ N/A
Going up or down stairs	☐ Yes	☐ No	☐ N/A

Showing independence by:

Going out to visit family or friends	☐ Yes	☐ No	☐ N/A
Going to school or work	☐ Yes	☐ No	☐ N/A
Making doctor or dentist appointments	☐ Yes	☐ No	☐ N/A
Using the phone, tablet, or computer	☐ Yes	☐ No	☐ N/A
Other _____	☐ Yes	☐ No	☐ N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐ Yes ☐ No ☐ Not sure

   What is the name of the center where you go?_____

5. Does your child receive any of the following services? (Check all that apply)

   ☐ Speech Therapy
   Where is this received? ☐ Home ☐ School ☐ Medical Therapy Program (MTP) or Medical Therapy Unit (MTU) ~~MTP/MTU~~
   ☐ Other _____

   ☐ Physical Therapy
   Where is this received? ☐ Home ☐ School ☐ MTP/MTU ~~MTP/MTU~~
   ☐ Other _____

   ☐ Occupational Therapy
   Where is this received? ☐ Home ☐ School ☐ MTP/MTU ~~MTP/MTU~~
   ☐ Other _____

   ☐ Respiratory Therapy
   Where is this received? ☐ Home ☐ School
   ☐ Other _____

   ☐ Nursing Services
   Where is this received? ☐ Home ☐ School Hours/days per week? _____
   ☐ Other _____

   ☐ Mental or Behavioral Therapy
   Where is this received? ☐ Home ☐ School
   ☐ Other _____

   ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
   Which one(s)? ☐ IEP ☐ 504
   ☐ School Name _____

   ☐ Other supportive services (Respite Care, Palliative Care, etc.)
   Please explain _____
   Where is this received? ☐ Home ☐ School
   ☐ Other _____

6. In general, would you say that your child's health is
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

7. Does your child have any allergies?
   ☐ Food(s) (please specify) _____
   Environmental (seasonal, dust, pollution, etc.)
   (please specify) _____
   ☐ Medication(s) (please specify) _____
   ☐ No Known Allergies

8. Does your child use durable medical equipment (DME) ~~medical equipment (DME)~~ or supplies that were ordered for your child's specific needs?
   ☐ Yes (check all that apply)
   ☐ Glasses
   ☐ Hearing Aids
   ☐ Cochlear Implant
   ☐ Wheelchair
   ☐ Brace
   ☐ Orthotics
   ☐ Walker
   ☐ Car Seat
   ☐ Bed
   ☐ Ventilator/breathing machine
   ☐ Oxygen
   ☐ Percussion Vest
   ☐ Insulin Pump/Continuous Glucose Monitor~~CGM~~
   ☐ Intravenous~~IV~~ -pump/Infusion device
   ☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)~~GT/JT/GJT~~
   ☐ Other (please specify) _____

   Who ordered it? _____

   Date of last order _____

   Who was the vendor? _____

   Vendor Phone:_____

9. What is your child's current:
   Height _____ Weight _____

10. Has your child ever had surgery?
    ☐ Yes ☐ No ☐ Don't Know

Please list each surgery	Date or Year
☐ **More than can fit here**	

11. Has your child been to the emergency room (ER) in the last 6 months?
    ☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now
    i. How many times?_____
    ii. When?_____

12. Has your child been in the hospital overnight in the last 6 months?
    ☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now
    i. How many times?_____
    ii. When?_____

13. What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. **Start with the medications your child is taking now, and then add medications your child has taken in the past**.

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
☐ **More than can fit here**	☐	☐

14. Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past.

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Muscular Dystrophy	☐	☐

	Current	Past
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Ostomy/G Tube ~~G-tube~~/Colostomy/Urostomy	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI) ~~GI~~/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐

	Current	Past
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
      - ☐ Which condition(s) _____
    - ☐ No – my child already has provider(s) for all his/her needs
      - ☐ Name/Specialty _____
      - ☐ Name/Specialty _____
      - ☐ Name/Specialty _____
    - ☐ No – my child does not need a specialist for his/her condition

16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
      - ☐ Next Appointment: Date:_____
    - ◊ Specialty Care Center
      - ☐ N/A
      - ☐ Facility Name: _____
      - ☐ Facility Phone: _____
      - ☐ Last Appointment: Date:_____
      - ☐ Next Appointment: Date:_____
    - ◊ Regular Dental Care
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
    - ◊ Regular Vision Care
      - ☐ Do not have one
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____
      - ☐ Last Appointment: Date:_____
    - ◊ Ongoing care from Mental or Behavioral Health Specialist
      - ☐ N/A
      - ☐ Provider Name: _____
      - ☐ Provider Phone: _____

☐ Condition(s) being treated for:
_____

☐ My child does not get regular care from any provider
- ◊ Do you need help choosing a provider for your child?
  ☐ Yes ☐ No ☐ ~~☐~~ Don't k~~K~~now

17. Have your child's medical conditions caused him/her to miss activities, work, or school in the past year? If yes, please describe:
_____
_____
_____

18. What is the best time of day (Monday to Friday, 7:30 a.m. to 5:30 p.m.) to call you to discuss your child's needs in more detail?
_____

Signature of Person
Filling Out the Form: _____ Date ~~Signed~~:_____

Thank you for your time filling out this form.
CONFIDENTIAL

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Sept. 18, 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 & Name	**Page #**	**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: Lisa O'Connell, Director, Enhanced Health Services*			
MCCP2033 - Community Health Worker (CHW) Benefit	219 - 228	**Policy edits due to APL 24-006** **Definitions added:** Closed loop referral Managed Care Plan (MCP) **VI.B.3 revised** to state Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area. **VI.C.2 added** The Supervising Provider does not need to have a licensed provider on staff in order to contract with Partnership to provide CHW services **VI.G.1 replaced** require a referral with require a written recommendation per APL **V1.G.1.b added** to indicate for CHW services rendered in the ED **VI.G.1.c added** the required recommendation can be provided by a written recommendation placed in the Member's record **V1.H.1 added** data on health risks and clinical core gaps as data sources to identify member needs for CHW services **VI.J.1 added** Partnership does not require prior authorization for CHW services as preventive care for the first 12 units **with a limit of four (4) units a day**. **VI.J.2.a added** Documentation to be provided **with the TAR** includes **the original written recommendation**, **(with the exception of services provided in the ED)** **VI.L.2 added** If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session. **VI.M.1.l replaced** Coordinating and assisting with transportation to **Transporting members** **VI.O.2 added** Claims processes must adhere to contractual requirements related to claims processing and encounter data submission including use of approved codes pursuant to the Med-Cal Provider Manual for CHW Preventative Services **VI.O.6 revised** to state Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. **VI.O.8 section added** in Pursuant to Welfare and Institutions Code (WIC) 14087.325 (d) **References updated:** Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) *supersedes APL 22-016*	Health Services Claims Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	**Page #**	**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)
		DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) *supersedes APL 22-023* **References added:** Welfare and Institutions Code (WIC) 14087.325(d)	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2033</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Community Health Worker (CHW) Services Benefit</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/08/2023
Effective Date: 07/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: ~~02/14/2025~~10/09/2025
Last Review Date: ~~02/14/2024~~10/09/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ 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="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date:
~~02/14/2024~~10/09/2024~~TBD~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
B. MCCP2032 – CalAIM Enhanced Care Management (ECM)
C. MCUP3142 – CalAIM Community Supports (CS)
D. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
E. MCUP3041 – Treatment Authorization Request (TAR) Review Process
F. MCUP3113 – Telehealth Services
G. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
H. MCUP3146 – Street Medicine

II. IMPACTED DEPTS:

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

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. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.

~~B.~~C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

~~C.~~D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health

conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

~~D.~~E. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.51532).

~~E.~~F. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM

~~F.~~G. Licensed Practitioner of the Healing Arts (LPHA): For the purposes of this policy, an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment.

H. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).

~~G.~~I. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

~~H.~~J. Supervising Providers: The organizations with which Partnership HealthPlan of California (~~PHC~~Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL ~~22-016~~24-006 ~~*Revised*~~, oversees CHWs and the services delivered to ~~PHC~~Partnership- Members, and submits claims for services provided by CHWs.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the Community Health Worker (CHW) Medi-Cal benefit (effective July 1, 2022) including categories of service and pathways to CHW certification.

VI. POLICY / PROCEDURE:

A. ~~PHC~~Partnership recognizes the CHW benefit as a means to ensure that members have improved access to culturally competent services that link health and social resources with the intent to improve the overall quality of health and wellbeing of the member population. CHW services may be provided through multiple entities including contracted primary care providers (PCPs), community-based organizations (CBOs), as well as via health plan staff trained to perform services normally provided by CHWs

B. CHW Qualifications

1. Per APL ~~22-016~~24-006 Community Health Worker Services Benefit ~~*Revised*~~, CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other

groups in the community for which the CHW is providing services.

2. CHWs must demonstrate, and Supervising providers must maintain evidence of, minimum qualifications that may be met through one of the following means:
   a. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
      1) CHW Certificate: A CHW Certificate allows a CHW to provide all covered CHW services including violence prevention services. It must be a valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas as determined by the Supervising Provider:
         a) communication
         b) interpersonal and relationship building
         c) service coordination and navigation
         d) capacity building
         e) advocacy
         f) education and facilitation
         g) individual and community assessment
         h) professional skills and conduct
         i) outreach
         j) evaluation and research, and
         k) basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider.
         l) Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL ~~22-016~~24-006 ~~*Revised*~~, including violence prevention services.
      2) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.
         a) A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or completion of a general CHW Certificate.
   b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
      1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.
3. Supervising Providers will maintain evidence of CHWs ~~must complete~~completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area.~~.~~

C. Supervising Provider Responsibilities
1. The Supervising Provider ensures that CHWs meet all required qualifications, maintains evidence of the CHW's experience (as mentioned in section VI.B.2.) and training, and oversees CHWs and the services delivered to ~~PHC~~Partnership Members.
2. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, nor do they need to have a licensed provider on staff in order to contract with Partnership to provide CHW services.
3. Supervising Providers do not need to be physically present at the location when CHWs provide

services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.

4. Supervising Providers must provide direct or indirect oversight to CHWs.
   a. Supervising providers (or their Subcontractors contracting with or employing CHWs to provide covered CHW services to the MCP's Members) must ensure CHWs have adequate supervision and training.
   b. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of the care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
   c. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
5. See policy MPCR11 Credentialing of Community Health Worker (CHW) Supervising Providers for further information on credentialing requirements for Supervising Providers.

D. ~~PHC~~Partnership CHW Workforce Initiative
1. ~~PHC~~Partnership actively supports local partnerships and CHW training across our network, including funding by the Health Resources and Services Administration (HRSA).
2. ~~PHC~~Partnership encourages providers to integrate CHWs into basic Population Health Management (PHM) and preventive care, and to give anticipatory guidance in support of the primary care team, Enhanced Care Management (ECM) teams, and perinatal care teams.
3. ~~PHC~~Partnership surveys our provider network periodically to get an understanding of how many CHWs are providing services, what area of focus/training the CHWs have, and if they have capacity for referrals from outside agencies.
4. ~~PHC~~Partnership is actively building a mechanism for ~~PHC~~Partnership staff and outside providers to search for organizations with CHW capacity for outside referrals, so they can make referrals to CHWs matched to the needs of individual members.

E. Informing providers about the CHW benefit
1. ~~PHC~~Partnership publicizes our current understanding of the regulatory framework for CHWs with our provider network and community based organizations in community meetings, provider meetings, and in provider newsletters.
2. ~~PHC~~Partnership's Provider Relations department educates providers on CHW services through the Medical Director's newsletter, Provider quarterly newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

F. Informing members about the CHW benefit
1. ~~PHC~~Partnership's Health Education team crafts communications that are culturally and linguistically appropriate and explain CHW services to our members. Details of the CHW benefit and services are outlined in ~~PHC~~Partnership's Evidence of Coverage (EOC), which is distributed annually to ~~PHC~~Partnership members by Member Services.
2. ~~PHC~~Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the member newsletter and that the ~~PHC~~Partnership webpage is updated with these new services.
3. CHW can provide qualifying members with specific support and offer tailored communication about how these services can support their health and wellbeing. Members referred to these services can be provided with materials explaining the services and are given the option to opt out of CHW services.

G. Member Eligibility for CHW services
1. CHW services require a ~~referral~~ written recommendation submitted to ~~PHC~~Partnership by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law.

a. Partnership accepts recommendations for CHW Services from other licensed practitioners, whether they are in the Network or Out-of-Network Providers, within their scope of practice. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

~~a.~~b. ~~-~~For CHW services rendered in the ED, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation~~ed~~ in the Member's medical record of the ED visit.

c. The required recommendation can be provided by a written recommendation placed in the Member's record.~~: Community Health Worker (CHW) Preventive Services (chw prev) .~~

2. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider, whom does not need to be Medi-Cal enrolled, must determine whether a Member meets eligibility criteria based on the presence of one or more of the following before recommending CHW services:
   a. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
   c. Any stressful life event presented via the Adverse Childhood Events (ACEs) screening.
   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
   f. One or more visits to a hospital emergency department (ED) within the previous six months.
   g. One or more hospital visits or hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
   h. One or more stays at a detox facility within the previous year.
   i. Two or more missed medical appointments within the previous six months.
   j. Member expressed need for support in health system navigation or resource coordination services.
   k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.
3. CHW violence prevention services are specific to community violence (e.g. gang violence) and are available to Members who meet any of the following circumstances as determined by a licensed practitioner:
   a. The Member has been violently injured as a result of community violence.
   b. The Member is at significant risk of experiencing violent injury as a result of community violence.
   c. The Member has experienced chronic exposure to community violence.
4. CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

H. Assessing and Identifying Member Needs for CHW Services

1. In addition to recommending that Providers identify member needs for CHW services, ~~PHC~~Partnership also assesses member needs for services and determines priority populations using a data driven approach. ~~PHC~~Partnership attempts outreach to identified members and their Providers and offers to connect the qualifying Members to needed CHW services. Data sources may include, but are not limited to, using past and current Member utilization/encounters, ~~PHC~~Partnership's proprietary risk score model, risk stratification and segmentation methodology, utilization reports showing member hospitalizations and ED visits, data on health risks and clinical core gaps, demographic and SDOH data, referrals from the community (including Provider referrals) for services, member self-referral to identify members who may benefit from CHW services, and needs assessments.
2. Populations of special focus include:
   a. Children who need preventive care
   b. Members who under-utilize primary care
   c. Pregnant or newly delivered members
   d. Members who have behavioral health needs, substance use disorders (SUD), or conditions requiring integration of physical and behavioral health.
   e. Members newly released from incarceration.

I. Documentation Requirements
1. CHWs are required to document the dates and time/duration of services provided to Members, which should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
2. Documentation must be accessible to the Supervising Provider upon their request.
3. Documentation should be integrated into the Member's medical record and available for encounter data reporting. ~~CHW's National Provider Identifier (NPI) number should be included in documentation when available upon certification.~~

J. Authorization for CHW Services and Care Plans
1. ~~PHC~~Partnership does not require prior authorization for CHW services as preventive care for the first 12 units with a limit of four (4) units a day.
2. For Members who need multiple CHW services or continued CHW services in excess of 12 units, a prior authorization request (TAR) is required (see ~~PHC~~Partnership Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for requirements and procedures).
   a. Documentation to be provided with the TAR includes the original written recommendation, a written care plan that must be written by one or more individual licensed providers~~,~~ (with the exception of services provided in the ED)~~,~~ ~~(~~which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider~~)~~.
      1) The care plan must state the following:
         a) Specify the condition that the service is being ordered for and be relevant to the condition
         b) Include a list of other health care professionals providing treatment for the condition or barrier
         c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
         d) List the specific services required for meeting the written objectives
         e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives
      2) The Provider submitting the care plan does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
      3) CHWs may participate in the development of the care plan and may take a lead role in drafting the care plan if done in collaboration with the Member's care team and/or other

Providers which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.

4) The plan of care may not exceed a period of one year.
5) The care plan must state the following:
   a) Specify the condition that the service is being ordered for and be relevant to the condition
   b) Include a list of other health care professionals providing treatment for the condition or barrier
   c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
   d) List the specific services required for meeting the written objectives; and
   e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives.
6) A licensed Provider must review the member's care plan at least every six months from the effective date of the initial care plan. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.
   a) TARs will be authorized for 6 months and reauthorization will be contingent upon submission of a reviewed/updated care plan.
   b) If there is a significant change in the member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

K. ~~PHC~~Partnership's CHW Program Standards
1. ~~PHC~~Partnership will not establish unreasonable or arbitrary barriers for accessing coverage.
2. ~~PHC~~Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste and abuse of CHW services through committees that review for over and under-utilization of services.
3. ~~PHC~~Partnership uses CHWs to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. ~~PHC~~Partnership encourages providers to integrate CHWs into basic population health management and preventive care activities. This may include:
   a. Referrals for families with children requiring preventive care
   b. Referrals for vulnerable pregnant members who may benefit from added support through pregnancy and the first year of a child's life
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits.
5. ~~PHC~~Partnership will encourage recruitment of CHWs who have lived experience with incarceration, behavioral health concerns, homelessness, and other vulnerable populations to provide CHW services to members facing these challenges.
6. ~~PHC~~Partnership will track quality indicators for those members who use CHW services compared to a matched sample of members who do not agree to CHW services. For example:
   a. HEDIS compliance with well-child visits for families requiring preventive care
   b. HEDIS compliance with prenatal, post-partum, and well-baby visits for pregnant mothers
   c. Member satisfaction post benefit-utilization for a representative sample of those using the CHW benefit.
7. ~~PHC~~Partnership will assess the CHW workforce through several means:
   a. Surveying providers known to be using CHWs to determine the number of CHWs engaged by provider, the particular population of focus for each CHW, and a percentage of population covered calculated by provider and by county.
   b. Tracking utilization rates using the DHCS-designated CPT/HCPCS billing codes for CHW

services that are not billed under global services (such as ECM or perinatal services).

L. CHW Services Provided
   1. CHW services can be provided as individual or group sessions, and can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services may also be provided via telehealth (see policy MCUP3113 Telehealth Services). There are no service location limits.
   2. Services may be provided to a parent or legal guardian of Members under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. Services for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session. Covered services do not require a license.
   3. CHWs may render street medicine and the Supervising Provider would bill ~~PHC~~Partnership for any appropriate and applicable services within the~~ir~~ scope of the CHW benefit~~service~~. (Street Medicine services are defined by DHCS in APL ~~22-023~~24-001 *Street Medicine Provider: Definitions and Participation In Managed Care* dated ~~11/08/2022~~01/12/2024)
   4. Covered CHW services do not include any service that requires a license.
   5. CHW Services include:
      a. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
      b. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care, including, and communicating cultural and language preferences to providers. Health navigation includes connecting Members to community resources necessary to promote health; addressing barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
         1) Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
         2) Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
         3) Help a Member enroll or maintain enrollment in government or other assistance programs related to improving their health, if such navigation services are provided pursuant to a plan of care.
      c. Screening and Assessment: Providing screening and assessment services that do not require a license, and assisting Members with connecting to appropriate services to improve their health, including connecting individuals and families with community-based resources.
      d. Individual Support or Advocacy: Assisting Members in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative or other covered benefits.

M. Non-Covered CHW Services
   1. Non-covered CHW services include, but are not limited to:
      a. Clinical case management/care management that requires a license
      b. Child care
      c. Chore services, including shopping and cooking meals
      d. Companion services
      e. Employment services
      f. Helping a Member enroll in government or other assistance programs that are not related to

improving their health as part of a plan of care
   g. Delivery of medication, medical equipment, or medical supply
   h. Personal care services/Homemaker services
   i. Respite care
   j. Services that duplicate another covered Medi-Cal service already being provided to a Member
   k. Socialization
   l. ~~Coordinating and assisting with transportation~~Transporting members
   m. Services provided to individuals not enrolled in Medi-Cal, except as noted above
   n. Services that require a license
   o. Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. (CHW services are distinct and separate from Peer Support Services.)

N. ~~PHC~~Partnership is actively working towards establishing closed loop referrals for services provided by CHWs, peer counselors (peer support not duplicative of other covered Medi-Cal benefits), and local community organizations, as defined at III.A. above. ~~to be implemented no later than January 1, 2024.~~ Closed loop referrals are currently accomplished through:
   1. Tracking member referrals through ~~PHC~~Partnership's case management system and sharing access to this system with providers.
   2. Leveraging Community Information Exchanges (CIEs) to allow community-based organizations and their staff to have insight into services and referrals made on behalf of shared members/clients.
   3. Establishing protocols for documenting and sharing referral data in shared systems.

O. Billing, Claims, and Payments
   1. CHW services will be reimbursed through a CHW Supervising Provider in accordance with its Provider contract~~., unless reimbursed directly through PHC if the CHW is Medi-Cal enrolled provider~~.
   ~~1.~~2. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Med-Cal Provider Manual for CHW Preventative Services.
   ~~2.~~3. Claims for CHW services will be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined in the Medi-Cal Provider Manual at Community Health Worker (CHW) Preventive Services (*chw prev*).
   ~~3.~~4. ~~PHC~~Partnership does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the care plan as described in section VI.J.2.
   ~~4.~~5. Encounter data
      a. ~~PHC~~Partnership shall submit all CHW encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
      b. ~~PHC~~Partnership shall be responsible for submitting to DHCS all CHW encounter data, including encounter data for CHW generated under subcontracting arrangements.
      c. In the event the CHW Supervising Provider is unable to submit CHW encounters to ~~PHC~~Partnership using the national standard specifications and code sets to be defined by DHCS, ~~PHC~~Partnership shall be responsible for converting CHW Supervising Providers' invoice data into the national standard specifications and code sets for submission to DHCS.
   ~~5.~~6. ~~Providers who use CHWs to provide the Enhanced Care Management (ECM) benefit may not bill for both CHW and ECM.~~ Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. Through ~~PHC~~Partnership's ~~Utilization Management and TAR~~Claims process~~es~~, ~~PHC~~Partnership shall ensure that members shall not receive duplicative services through CHW and/or ECM. Please see ~~PHC~~Partnership policies MCCP2032 CalAIM Enhanced Care Management and MCUP3143 CalAIM Service Authorization Process for Enhanced

Care Management (ECM) and/or Community Supports (CS).

7. Tribal clinics may bill ~~PHC~~Partnership for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Medi-Cal Provider Manual.

~~6.~~8. Pursuant to Welfare and Institutions Code (WIC) 14087.325(d)~~21~~, Partnership is required to reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that Partnership would make for the same scope of services if the services were furnished by another provider type that is not an FQHC or RHC.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~22-016~~24-006 ~~*Revised*~~ Community Health Worker Services Benefit (05/13/2024~~09/18/2023~~) supersedes APL 22-016

B. State Plan Amendment (SPA) 22-0001

C. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)

~~C.~~D. Welfare and Institutions Code (WIC) 14087.325(d)

~~D.~~E. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)

~~E.~~F. DHCS APL ~~22-023~~24-001 Street Medicine Provider: Definitions and Participation in Managed Care (~~11/08/2022~~01/12/2024) supersedes APL 22-023

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: 02/14/24; 10/09/24~~09/11/24~~

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
- 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 ~~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.

2024 3rd Next Available & Next Available Survey

Provider Relations & Health Analytics

September 2024

Overview - 3rd Next Available & Next Available Survey

The survey is used to assess Partnership's compliance with the Accessibility standards annually

- The survey monitors appointment availability, telephone access and appointment wait time among primary care providers and high volume specialists

Standards are set forth by the Department of Health Care Services (DHCS), to ensure access to and availability of services for our members

Survey Objectives:

- Assess compliance with Partnership access standards
- Review trends and identify opportunities to improve
- Assist providers to ensure standards are met

Methodology

The survey is administered by Partnership's Provider relations staff (cross-sectional; one-time call to provider offices to request access data; some surveys taken in-person)

Surveyed providers: Primary Care Providers (Family Practice, Internal Medicine and Pediatrics) and High-Volume Specialists

Telephonic survey: Telephonic survey during business hours in March 2024, asking specific appointment availability using the "third next available appointment" methodology

Data Entry: Sugar Database with fields constructed to align with the survey questions which allows uniformity of data entry across interviewers.

Data Validation and Analysis: Completed by Analytics using Tableau

3rd Next Available/ Next Available Surveyed Sites

Primary Care Access
- ✓Surveyed **357** Sites
  - ✓94 – North
  - ✓153 – South
  - ✓110 - East

Specialty Providers
- ✓Surveyed **428** Sites
  - ✓88 – North
  - ✓223– South
  - ✓117 - East

Prenatal Providers
- ✓Surveyed **140** Sites
  - ✓37 – North
  - ✓71 – South
  - ✓32 - East

Previous Year 2023

Primary Care Access
- ✓Surveyed **248** Sites
  - ✓86 – North
  - ✓162 – South

Specialty Providers
- ✓Surveyed **329** Sites
  - ✓85 – North
  - ✓244– South

Prenatal Providers
- ✓Surveyed **120** Sites
  - ✓32 – North
  - ✓88 - South

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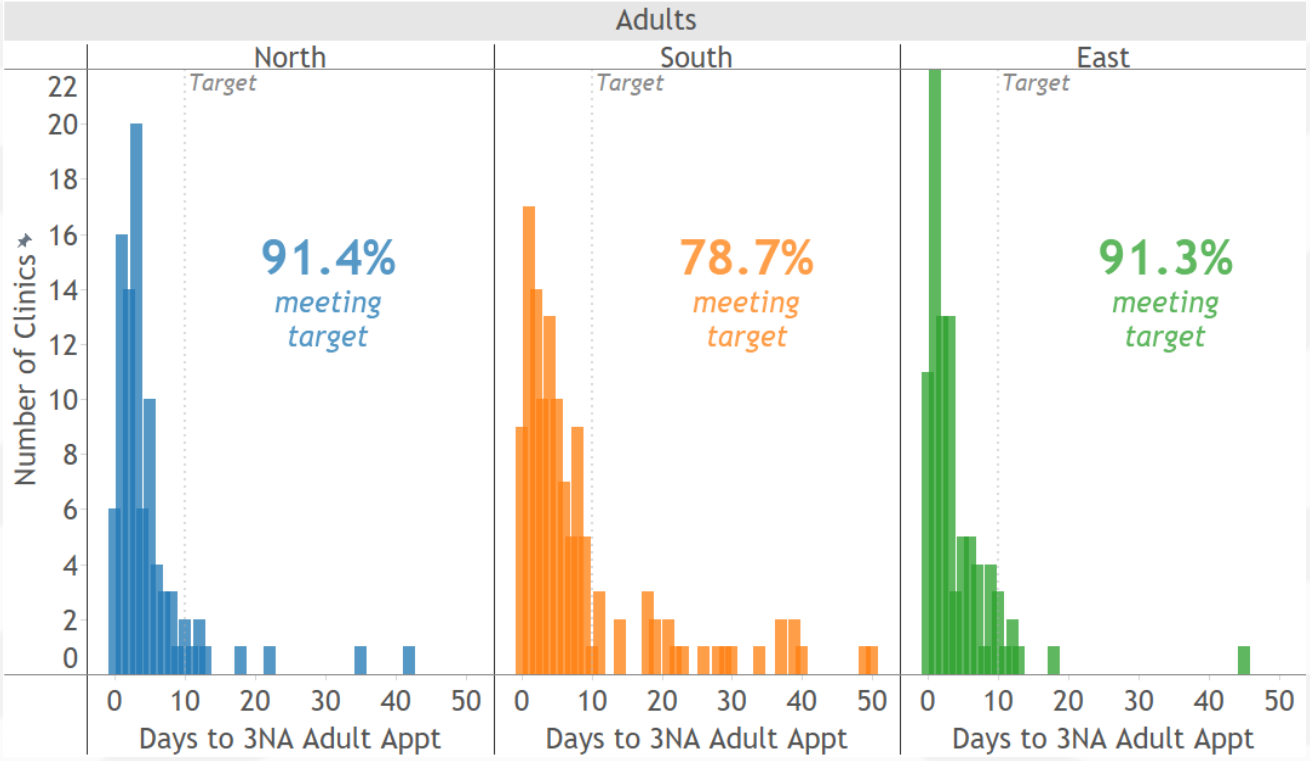
Criteria/Targets

ALL REGIONS PRIMARY CARE PROVIDERS	Standard
Days to 3NA Adult Appt	<= 10 business days
Days to 3NA Pediatric Appt	<= 10 business days
Time to Next Available Newborn Appt	<= 48 Hours
Time to Next Available Urgent Appt	<= 48 Hours
HIGH-VOLUME SPECIALISTS	**Standard**
Days to 3NA Specialty appt	<=15 business days
Time to Next Available Urgent Appt	<= 48 Hours
PRENATAL CARE	**Standard**
Days to 3NA Prenatal Care (PCP & Specialists)	<= 10 days

PCP Appointments

Adult PCP Appointments

Distribution of Clinics by Days to 3rd Next Available Appointment for Adults



Target for Adult Appointments:
<= 10 days

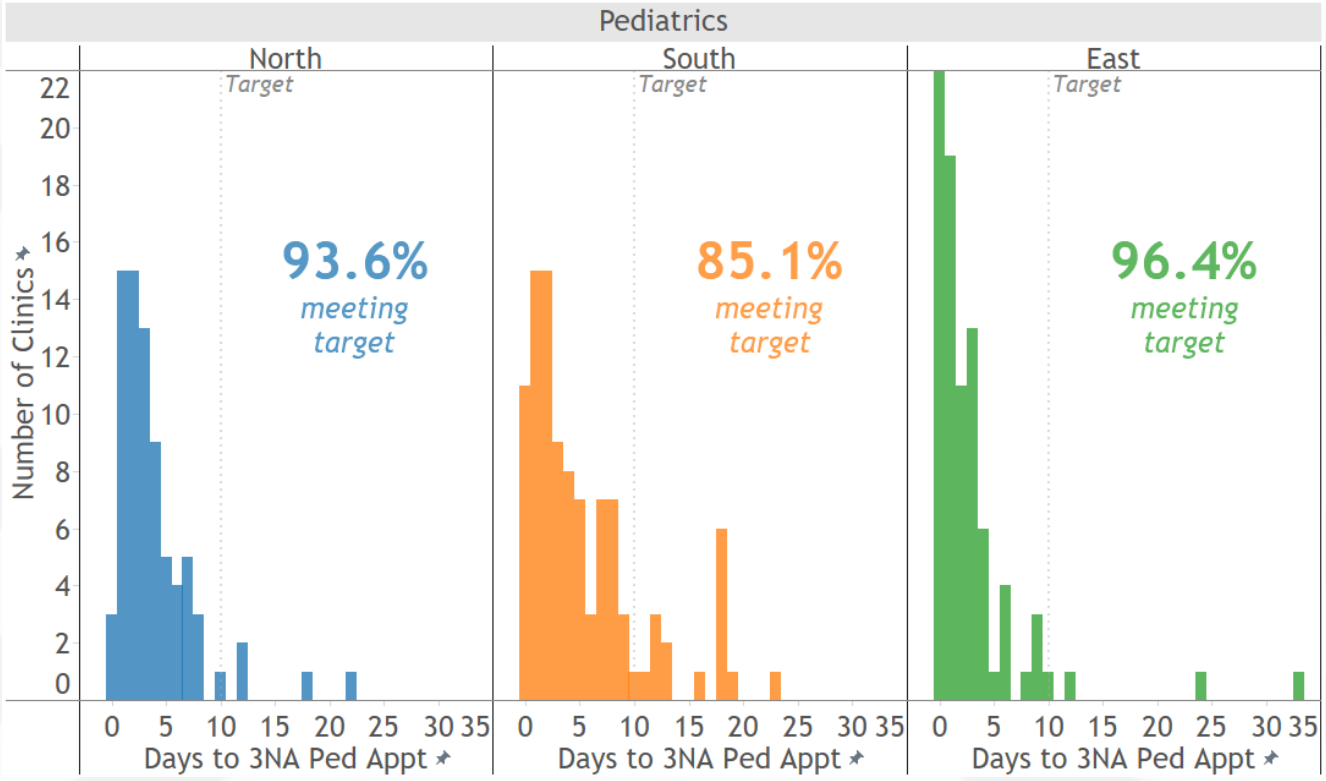
Previous Year:

- 94.0% (-2.6%) met target in Northern Region
- 91.7% (-13.0%) met target in Southern Region

Targets
3NA Appointment / Next Available
Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

Pediatric PCP Appointments

Distribution of Clinics by Days to 3rd Next Available Pediatric Appointment



Target for Pediatric Appointments:
<= 10 days

Previous Year:

- 94.4% (-0.8%) met target in Northern Region
- 90.4% (-5.3%) met target in Southern Region

Targets:
3NA Appointment / Next Available
Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

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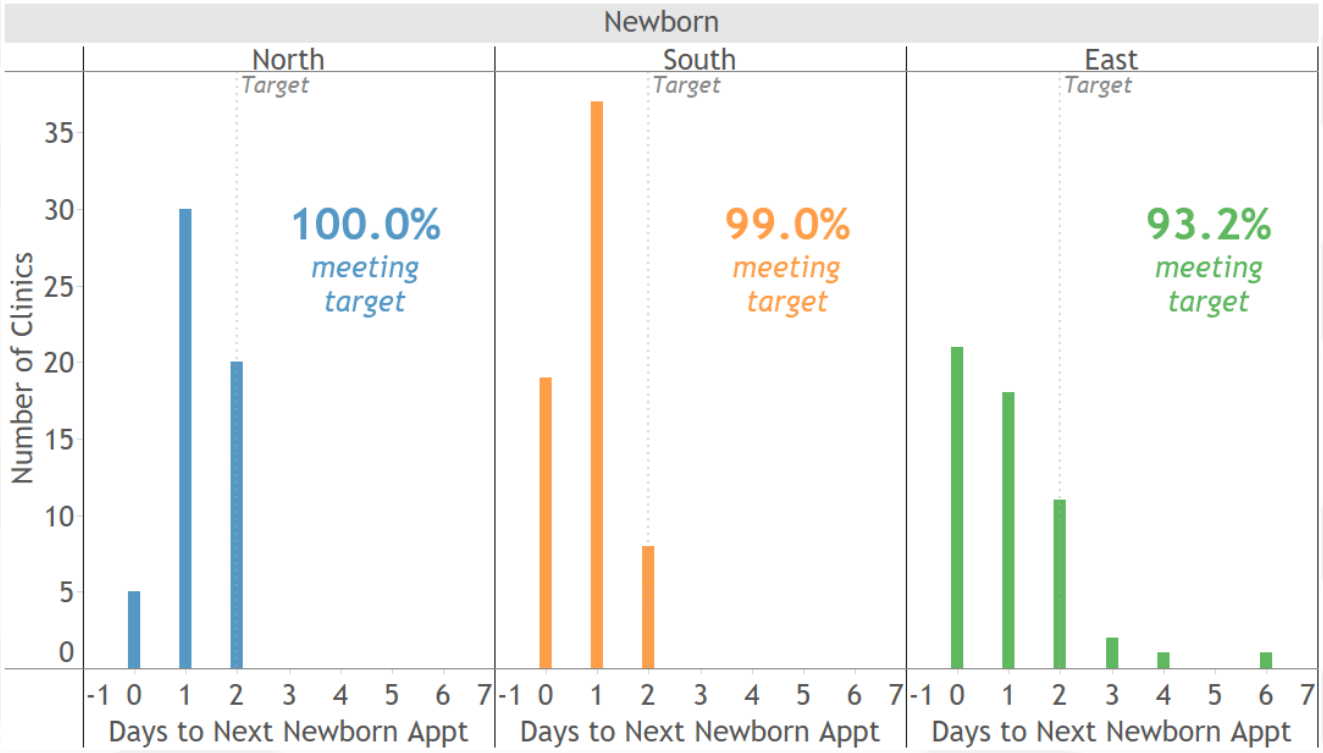
Newborn PCP Appointments

Distribution of Clinics by Days to Next Available Appointment for Newborns



Target for Newborn Appointments:
<= 48 hours

Previous Year:

- 96.9% (+3.1%) met target in Northern Region
- 100.0% (-1.0%) met target in Southern Region

Targets:
3NA Appointment / Next Available
Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

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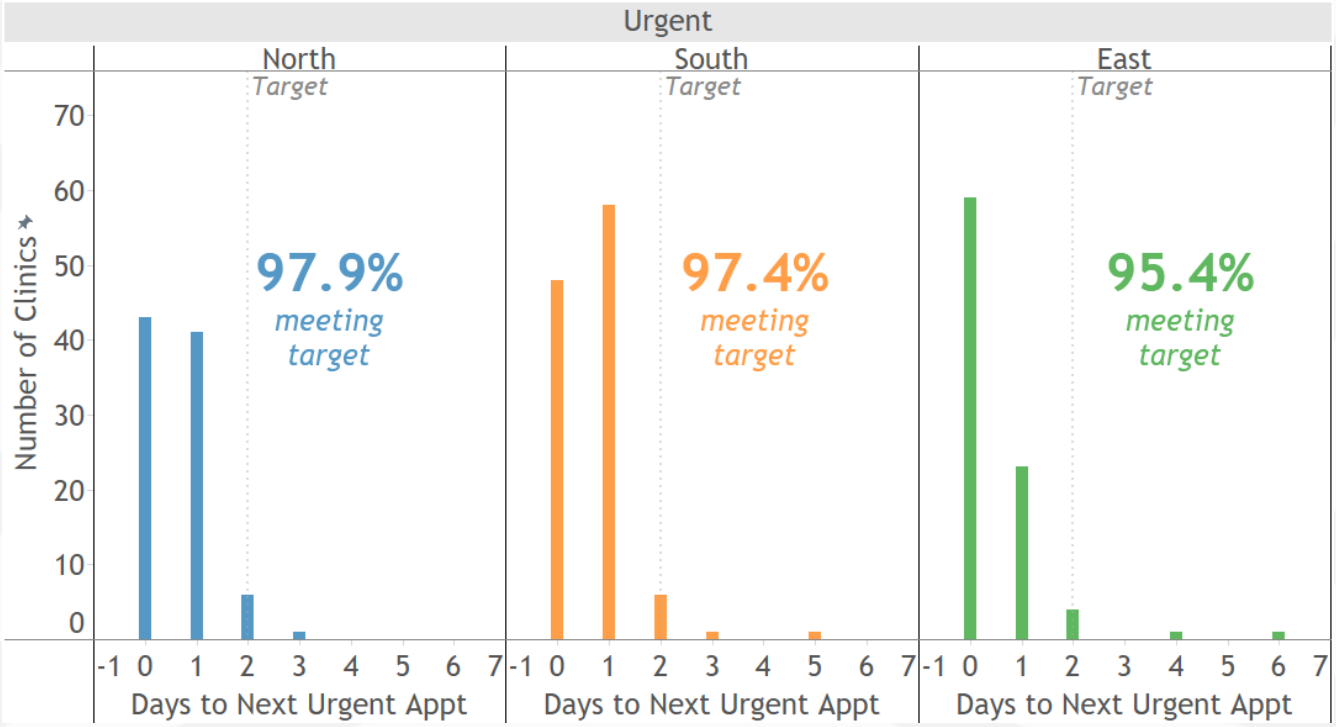
Urgent PCP Appointments

Distribution of Clinics by Days to Next Available Urgent Appointment



Target for Urgent Appointments:
<= 48 hours

Previous Year:

- 95.3% (+2.6%) met target in Northern Region
- 96.9% (-0.5%) met target in Southern Region

Targets:
3NA Appointment / Next Available
Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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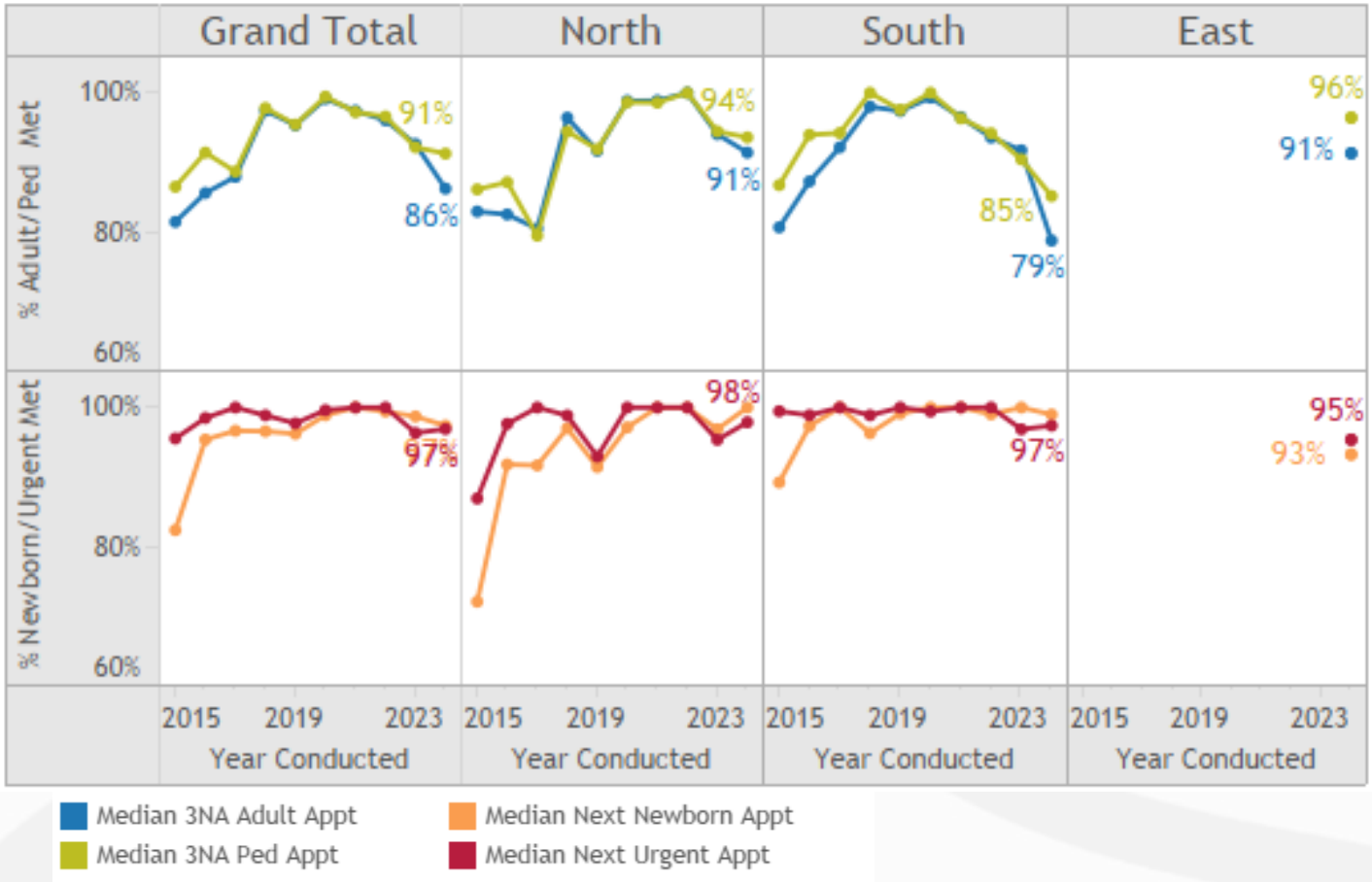
Trends for PCP Appointments Meeting Targets

Share of Clinics Meeting Targets by Year and Appointment Type



- Overall downward trends across Adult, Pedi and Newborn PCP appts
- Upward trend for Urgent PCP appts across regions
- Eastern Region >90% for all PCP appts

Targets:
3NA Appointment / Next Available
Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

PCP Appointments Meeting Targets by County

% of Clinics Meeting PCP Standards by County

		% Meeting Target - Adult	% Meeting Target - Peds	% Meeting Target - Newborn	% Meeting Target - Urgent	# Clinics
North	Humboldt	92%	95%	100%	100%	25
	Shasta	96%	100%	100%	96%	23
	Siskiyou	88%	93%	100%	100%	16
	Tehama	100%	100%	100%	100%	11
	Del Norte	100%	100%	100%	100%	7
	Trinity	75%	75%	100%	100%	4
	Modoc	100%	100%	100%	100%	4
	Lassen	50%	50%	100%	75%	4
South	Sonoma	97%	100%	100%	100%	37
	Solano	65%	67%	100%	100%	24
	Yolo	84%	89%	100%	95%	22
	Marin	65%	91%	100%	91%	22
	Mendocino	57%	60%	93%	94%	17
	Lake	93%	100%	100%	100%	16
	Napa	82%	86%	100%	100%	14
East	Placer	100%	100%	100%	100%	25
	Sutter	78%	93%	83%	90%	21
	Butte	81%	92%	100%	95%	21
	Yuba	89%	90%	63%	89%	10
	Nevada	100%	100%	100%	100%	10
	Glenn	100%	100%	100%	100%	9
	Colusa	100%	100%	100%	86%	7
	Plumas	100%	100%	100%	100%	5
	Sierra	100%	100%	100%	100%	2

Summary

- Majority of Southern counties have low share of clinics meeting Adult and Pedi targets
- Eastern counties Sutter and Yuba have low share meeting Newborn and Urgent targets
- Eastern Region has highest rates for 100% of clinics meeting targets
- Generally, counties have the same or lower share of clinics meeting targets compared to last year
  - Napa +29% for Pedi appts

Targets:
3NA Appointment / Next Available

Adult: <= 10 days
Pediatric: <= 10 days
New Born: <= 48 hours
Urgent Care: <=48 hours

Clinics not Meeting Targets for PCP Appointments

# Clinics Not Meeting a Target Northern Region	# Clinics Not Meeting a Target Southern Region	# Clinics Not Meeting a Target Eastern Region
42	98	67

Region	Clinic Location	3NA Adult Appt	3NA Ped Appt	Next Urgent Appt	Next Newborn Appt
East	Harmony Health Medical Clinic and Family Reso..	45	10	45	10
	Oroville Family Practice-Ste 9	85		4	
	Peach Tree Healthcare- 5730 Packard Ave	68	24	11	2
North	Anderson Medical Associates	26	25	0	25
	Anderson Walk In Medical Clinic	22		22	
	Dignity Health Pine Street Clinic	29	29	21	5
	Hill Country Community Clinic	18	18	0	22
	Hill Country Health and Wellness Center-Gold S..	27	65	17	16
	McKinleyville Community Health Center	2	4	1	44
	Mercy Community Clinic Mount Shasta	43	10	1	2
	Mercy Lake Shastina Community Clinic	88	66	5	15
	Northeastern Rural Health Clinic	45	39	0	2
	Redwood Community Health Center	43		1	
	Shasta Lake Family Health	39	61	0	3
	Shasta Regional Medical Group-Redding PCP	42		18	
South	Lakeview Health Center	46	13	1	2
	Marin Community Clinics-Campus Clinic	52	7	1	1
	Matthew Tracy Johnson, MD - Fairfield	150		1	
	Matthew Tracy Johnson, MD - Vacaville	162		2	
	North Bay Pediatrics-Vallejo		64	0	
	OLE Health-Calistoga	65	28	1	15
	Richard Andolsen, MD	15	15	0	15
	Ruth Wilson, MD	24		23	
	SCFH&SS - Fairfield-2101 Courage		60	1	1
	SCFH&SS - Fairfield-2201 Courage	50		1	

Summary

- 58.0% of clinics missed at least one PCP next appointment target
- Maximum waits for next appt. are exceedingly long

Targets:
Adult & Pediatric
<= 10 days

New Born & Urgent
<= 48 hours

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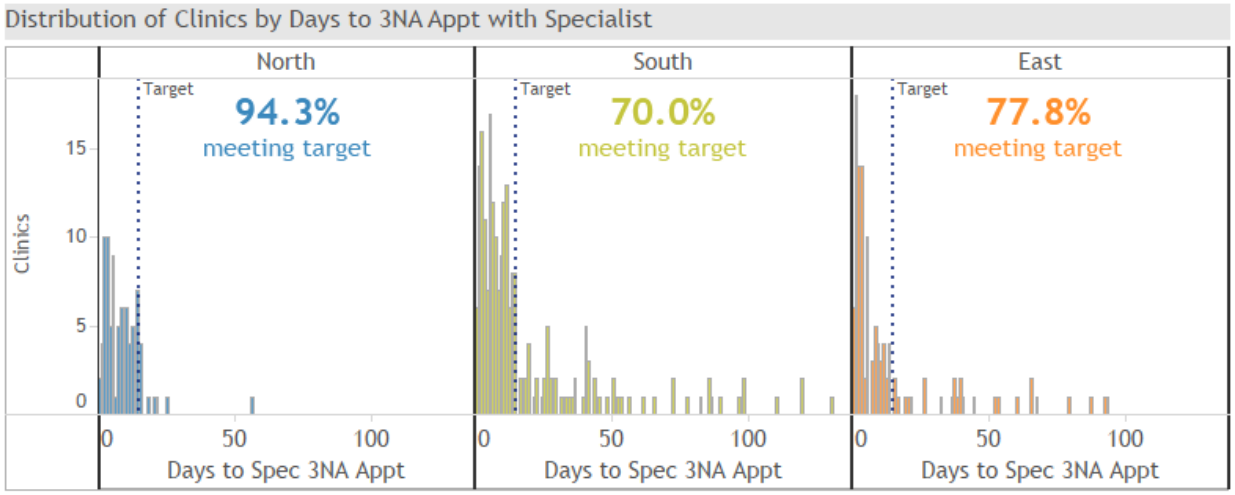
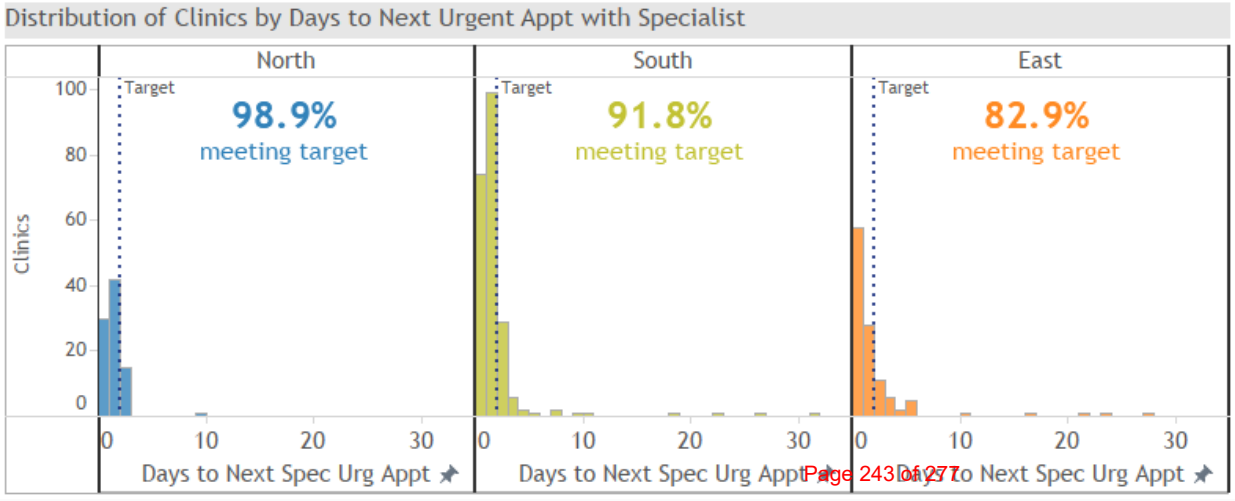
Specialty Appointments

Specialty Appointments

Distribution of Specialty Clinics by Days to 3rd Next Available Appointment





Target for 3NA Specialty Appointments:
<= 15 days

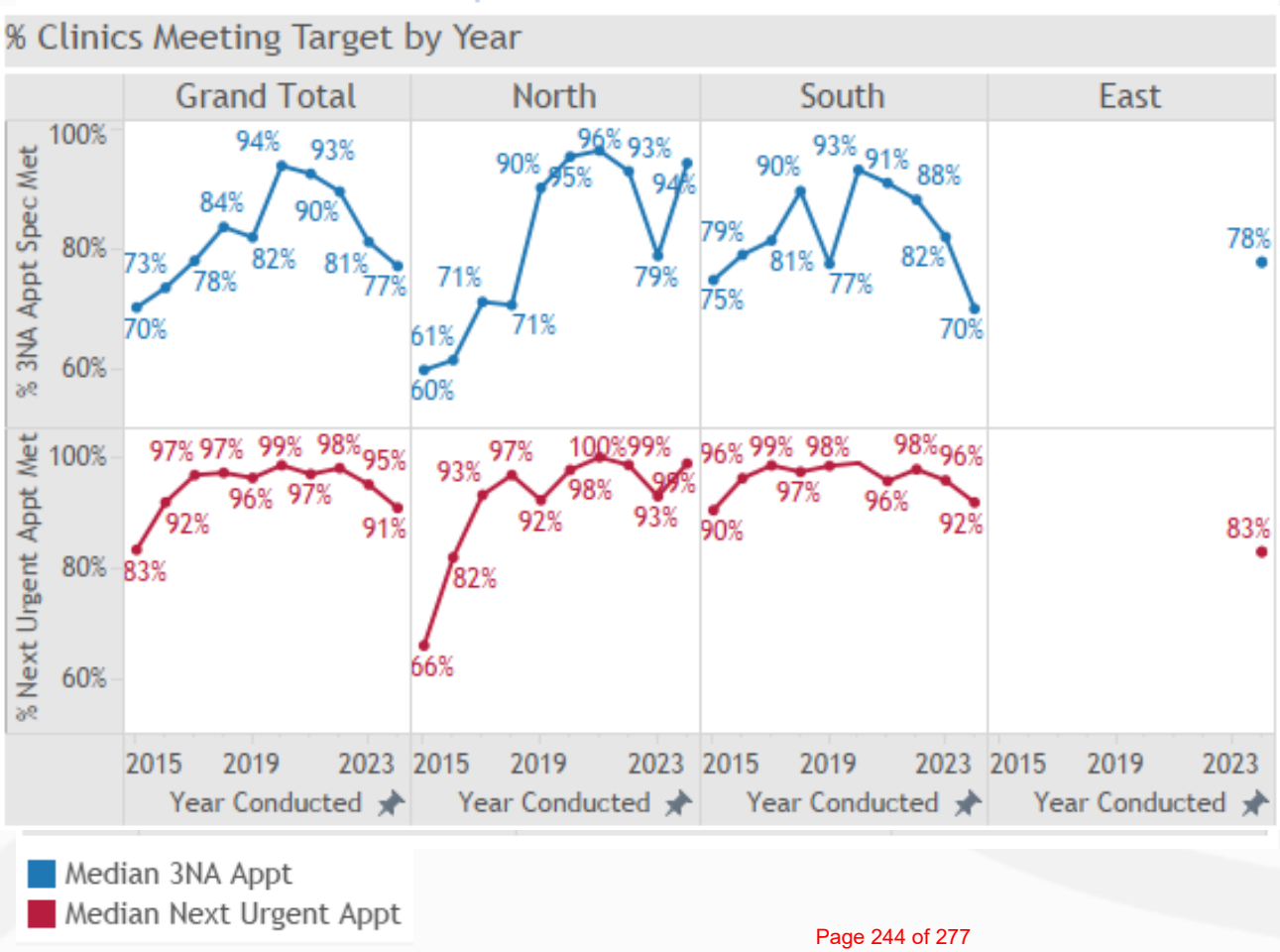
Previous Year
- 78.8% (+15.5%) meeting target in Northern Region
- 88.0% (-18.0%) meeting target in Southern Region

Target Urgent Appointments
<= 48 hours:

Previous Year
- 92.9% (+6.0%) meeting target in Northern Region
- 95.8% (-4.0%) meeting target in Southern Region

Trends for Specialty Appointments Meeting Targets

Share of Clinics Meeting Targets by Year and Appointment Type



- Southern Region continued decline in clinics meeting target for specialist non-urgent and urgent appts
- Northern Region returned to high rates of clinics meeting specialist targets
- Eastern Region at ~80% clinics meeting specialist targets

Target
3NA Appointment / Next Available
Specialty <= 15 days
Urgent Care: <=48 hrs

Share of Clinics Meeting Targets by Specialty

% of Clinics Meeting Standards by Specialty, 2024

	North	South	East	Grand T..
CARDIOVASCULAR DISEASE	89%	71%	86%	80%
DERMATOLOGY	100%	33%	75%	57%
ENDOCRINOLOGY	50%	86%	0%	64%
GASTROENTEROLOGY	83%	40%	50%	50%
GENERAL SURGERY	100%	95%	83%	95%
INFECTIOUS DISEASES	100%	100%		100%
NEPHROLOGY	100%	88%	60%	80%
NEUROLOGY	100%	18%	57%	48%
OBSTETRICS/ GYNECOLOGY	100%	61%	67%	71%
ONCOLOGY/HEMATOLOGY			75%	75%
OPHTHALMOLOGY	83%	85%	85%	85%
ORTHOPAEDIC SURGERY	100%	90%	80%	90%
OTOLARYNGOLOGY	100%	60%	88%	83%
PHYSICAL MEDICINE AND REHABILITATION	100%	67%	100%	88%
PULMONARY DISEASE	100%	85%	100%	90%

*Gastroenterology was added in 2023 survey

Summary

- The Northern Region has lowest rates of clinics meeting targets for: ***Endocrinology, Gastroenterology,*** *and* ***Ophthalmology.***
- The Southern Region has lowest rates of clinics meeting targets for: ***Neurology, Dermatology,*** *and* ***Gastroenterology***.
- The Eastern Region has lowest rates of clinics meeting targets for: ***Endocrinology,*** **Gastroenterology**, *and* ***Neurology***.

Target
3NA Appointment / Next Available
Specialty <= 15 days
Urgent Care: <=48 hrs

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Clinics not Meeting Targets for Specialty Appointments

22.9% of Surveyed Clinics do not meet the 3NA Specialist Appointment Target

# Clinics Not Meeting Target Northern Region	# Clinics Not Meeting Target Southern Region	# Clinics Not Meeting Target Eastern Region
5	67	26

Northern Region Specialty Providers

Specialty Group	Provider Name	
CARDIOVASCUL..	Dignity Health Medical Group N..	25
ENDOCRINOLOGY	Dignity Health Medical Group N..	20
GASTROENTERO..	Providence Medical Group, Hum..	18
OPHTHALMOLO..	Northridge Eye Care	56
	Robert C. Fox MD, Inc	21

Southern Region Specialty Providers

Specialty Group	Provider Name	
CARDIOVASCULAR DISEASE	Adventist Health Clearlake-152..	19
	Adventist Health Physicians Net..	25
	Adventist Health Physicians Net..	40
	Adventist Health Ukiah Valley-..	41
	Enloe Cardiology Services & Str..	20
	Northstate Cardiology Consulta..	44
	Providence Medical Group, Son..	65
	Providence Medical Group, Son..	19
	Sutter Medical Group Solano-27..	27
	Sutter Medical Group Yolo-2030..	86
DERMATOLOGY	Jiva Health, Inc-Vacaville	26
	Loftis, Brent, DO	28
	MarinHealth Medical Network D..	56
	Oroville Dermatology	37
	Redwood Family Dermatology-S..	35
	Solano Dermatology Associates-..	18
	Sutter Medical Group Solano-27..	96
	Sutter Medical Group Yolo-2030..	130
	Woodland Clinic-2440 W Covell ..	45
ENDOCRINOLO..	Dove's Landing Multi Specialty ..	65
	Providence Medical Group, Son..	77
	Sutter North Medical Group-Endo	87
GASTROENTER..	Adventist Health Physicians Net..	22
	Adventist Health Physicians Net..	18
	Enloe Digestive Diseases Clinic	67
	NorthBay Healthcare Group-Fai..	55
	NorthBay Healthcare Group-Fai..	36
	NorthBay Healthcare Group-Ga..	51

Eastern Region Specialty Providers

Specialty Group	Provider Name	
CARDIOVASCULAR DISEASE	Adventist Health Physicians Net..	40
	Enloe Cardiology Services & Stru..	20
	Northstate Cardiology Consultants	44
DERMATOLOGY	Oroville Dermatology	37
ENDOCRINOLO..	Dove's Landing Multi Specialty Pr..	65
	Sutter North Medical Group-Endo	87
GASTROENTER..	Enloe Digestive Diseases Clinic	67
	Oroville Gastroenterology	52
	Sutter North Medical Group-Gastro	65
GENERAL SUR..	Oroville Surgical Specialists	26
NEPHROLOGY	Jon Ferguson DO Corp	39
	Mona Sarbu MD	93
NEUROLOGY	Oroville Neurology	79
	Sutter Medical Group Placer-2 M..	16
	Tahoe Forest MultiSpecialty Clini..	21
OBSTETRICS/ GYNECOLOGY	Adventist Health Physicians Net..	60
	Enloe Women's Services - North	36
	Oroville Women's Health-Midwife..	39
	Sutter North Medical Group-969 ..	37
ONCOLOGY/HE..	Oroville Cancer Center	32
OPHTHALMOL..	Kirstiane Ransbarger MD	92
	Oroville Premier Health Center	38
ORTHOPAEDIC SURGERY	Adventist Health Physicians Net..	53
	Sutter Medical Group Placer-3 M..	19
OTOLARYNGO..	Oroville Comprehensive Health P..	26

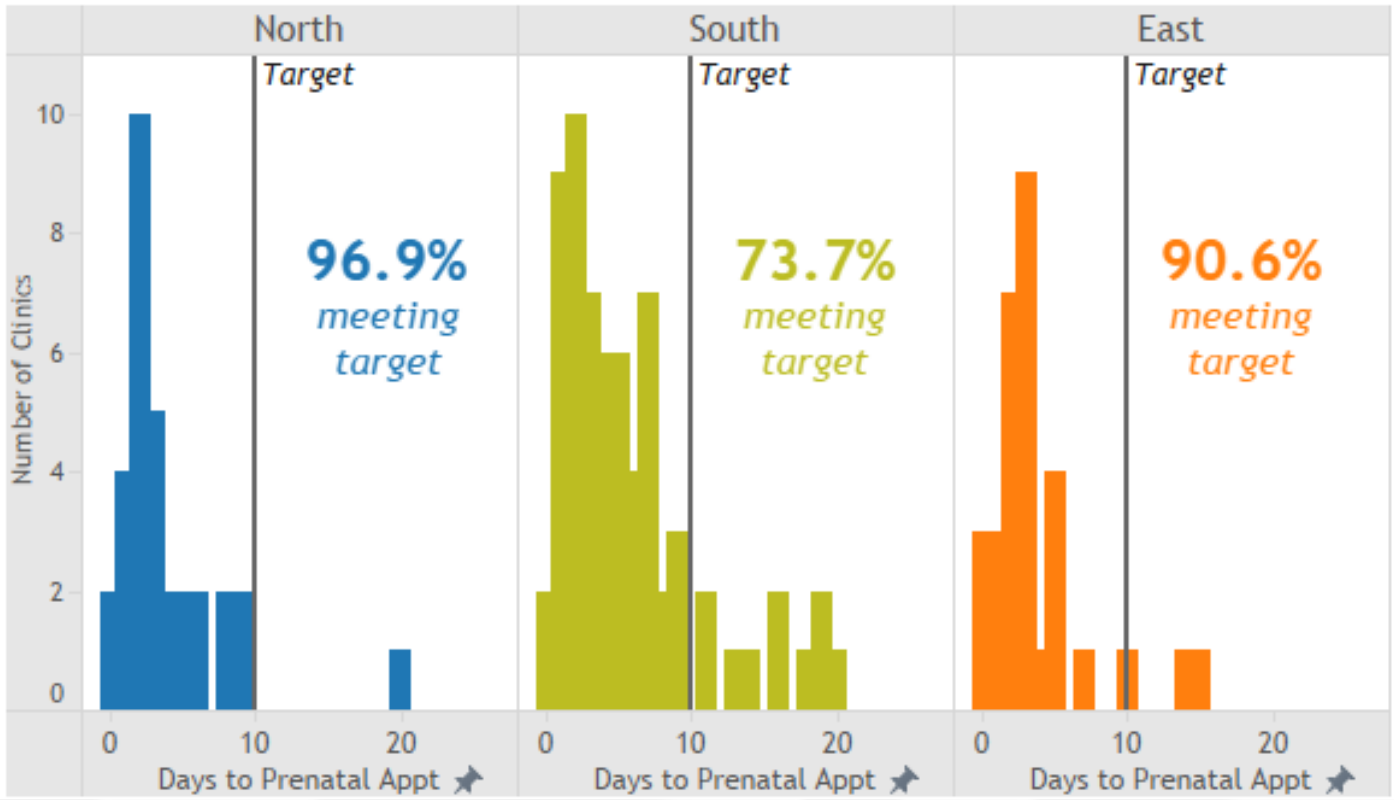
Target
3NA Appointment / Next Available
Specialty <= 15 days
Urgent Care: <=48 hrs

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Prenatal Appointments

Prenatal Appointments Meeting Targets

Distribution of Clinics by Days to Next Prenatal Appt



Target for Prenatal Appointments:
<= 10 days

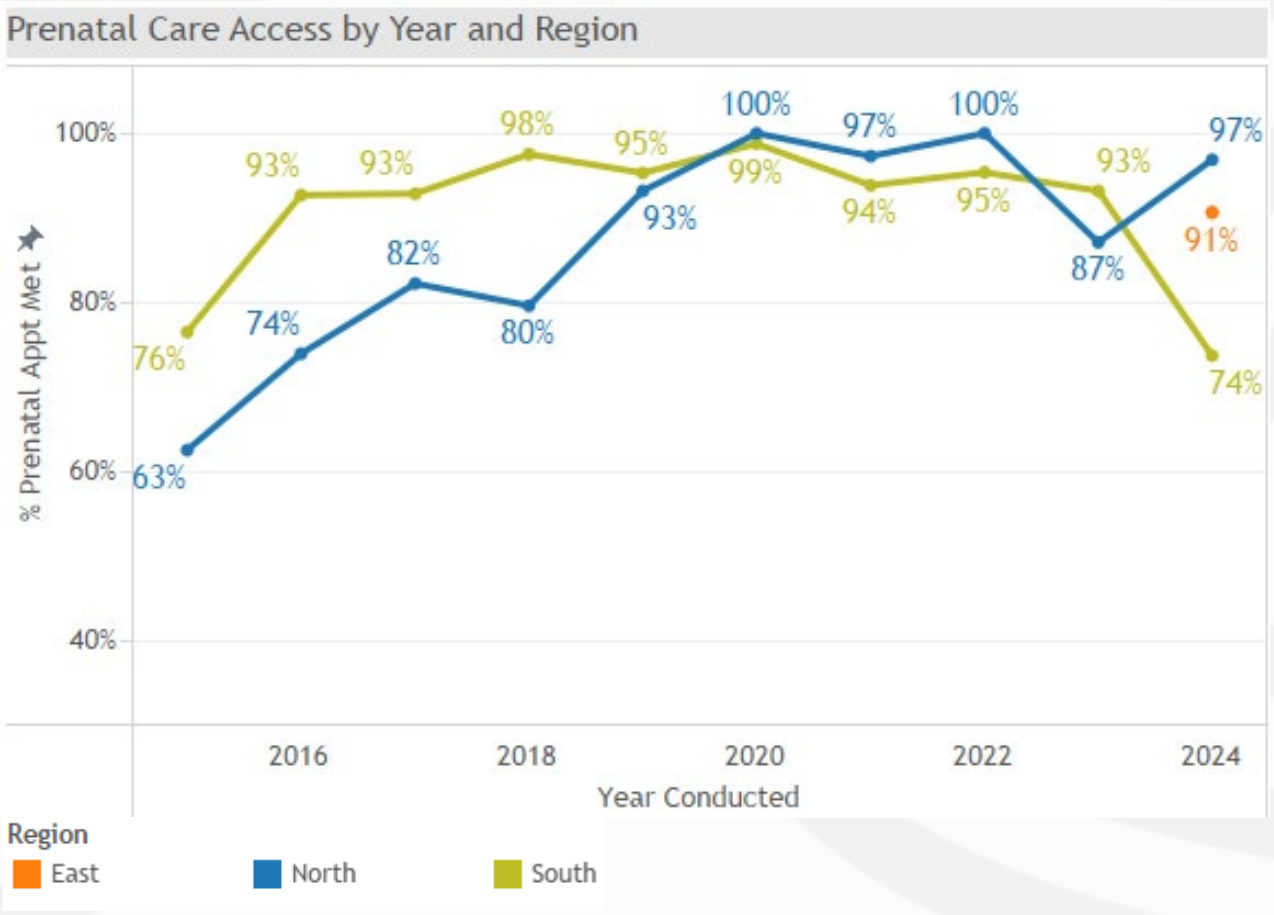
Previous Year:

- 87.1% (+9.8%) met target in Northern Region
- 93.2% (-19.5%) met target in Southern Region

Target
3NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days

Prenatal Appointments Meeting Targets

Trends for Days to Prenatal Appts and Meeting Target



- Southern Region precipitous decline in clinics meeting target for prenatal appts
- Northern Region return to high rates of clinics meeting prenatal targets
- Eastern Region at ~90% clinics meeting specialist targets

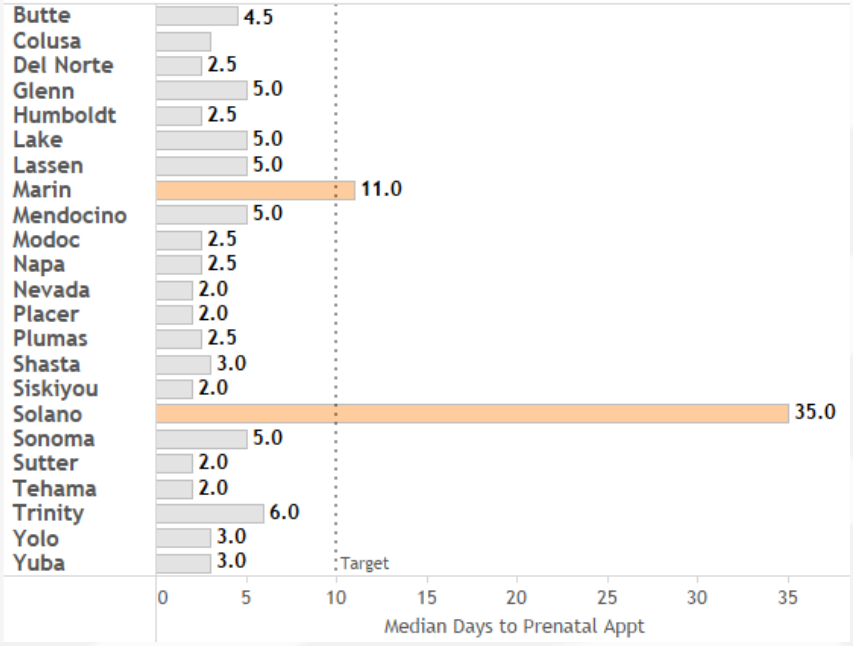
Target
3NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Prenatal Appointments Meeting Targets

Marin and Solano contained the most clinics with high 3NA Prenatal Appointment Target waits

Days to Prenatal Appts by County



Clinics that Missed Prenatal Target

Region	County	Location	
East	Butte	Enloe Women's Services - Esplanade	15
		Oroville Women's Health-Midwifery	14
	Yuba	Peach Tree Healthcare- 5730 Packard Ave	37
North	Humboldt	UIHS-Potawot Health Village	20
South	Lake	Adventist Health Clearlake-21337 Bush St	19
	Marin	Marin Community Clinics-Campus Clinic	11
	Mendoci..	Adventist Health Ukiah Valley	37
		Adventist Health Ukiah Valley-1050 N State	18
		Hillside Health Center	13
		Little Lake Health Center	16
		Point Arena Community Health Center	19
	Solano	Center for Primary Care-Vacaville	37
		Community Medical Centers-Vacaville Ste 310	14
		NorthBay Women's Health - Fairfield	43
	Yolo	Sutter Medical Group Yolo-2020 Sutter Pl Ste 203	20
		Woodland Clinic-1321 Cottonwood St Flr 3 OB/GYN	16

Target
3NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Max Possible MCAS= 150
HEDIS Scores MY2023/RY2024
Significant Change from 2022 to 2023
QIP Scores 2023 – Clinical Only
Weighted Average for Parent Organizations
HEDIS MCAS = 150
Kaiser (MediCal) San Diego = TBD
Kaiser (MediCal) Sacramento = TBD
SFHP = TBD
CCAH Monterey/Santa Cruz = TBD
Kaiser in PHC region (130 pt)
HEDIS MCAS = 120
Marin County (114 pt)
Napa County (115 pt)
CHG San Diego = TBD
Yolo County (101 pt)
Sonoma County (101 pt)
PHC SW Region 134 (97 without Kaiser)
PHC SE Region 129 (95 without Kaiser)
HEDIS MCAS = 90
Mendocino County (88 pt)
PHC weighted score = 87
CA Health and Wellness Region 1 = TBD
Anthem Region 1 = TBD
Humboldt County (83 pt)
Solano County (78 pt)
PHC NW Region 73
Lake County (67 pt)
CA Health and Wellness Region 2 = TBD
HEDIS MCAS = 60
Modoc County (60 pt)
Siskiyou County (60 pt)
Trinity County (56 pt)
Shasta County (55 pt)
PHC NE Region 52
Health Net San Joaquin = TBD
Lassen County (44 pt)
Del Norte County (38 pt)
HEDIS MCAS = 30
QIP = 100% of Clinical Points
La Clinica QIP 95%
Santa Rosa CHC QIP 93%
Petaluma HC QIP 92%
Marin CC QIP 90%
Ole Health DBA CommuniCare Ole 89%
Sonoma Valley CHC QIP 84%
Community MC QIP 75%
QIP = 75% of Clinical Points
West County HC QIP 73%
Weighted Average PCP Clinical Score 71%
Open Door CHC QIP 69%
Mendocino CHC QIP 69%
Shasta CHC QIP 59%
Fairchild Medical QIP 52%
QIP = 50% of Clinical Points
Adventist Health QIP 47%
Mountain Valley HC QIP 44%
Solano County HSS QIP 37%
QIP = 25% of Clinical Points
QIP = 0% of Clinical Points

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Undercounting of American Indian Population

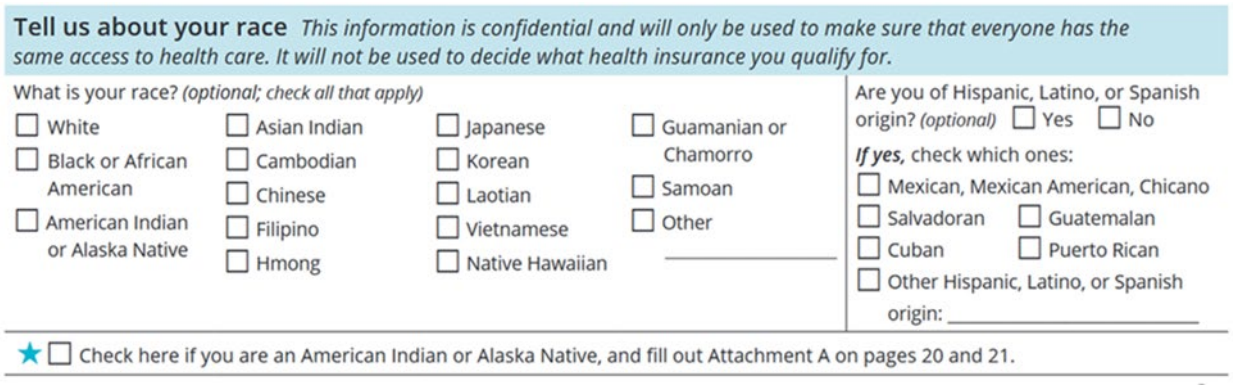
By Dr. Robert Moore, Chief Medical Officer

Two years ago, Partnership first stratified Quality Outcome data based on the race/ethnicity we received from DHCS. As noted in prior newsletters, this data showed that outcomes were much worse for the self-identified American Indian/Alaska Native (AI/AN) population than for any other racial group. This prompted Partnership to launch a Tribal Engagement Strategy to build relationships with the 21 Tribal Health Centers and their associated 51 individual tribes, so that we can work together on improving health and wellness for our Tribal communities.

Two months ago, while preparing a presentation for the Medi-Cal Managed Care Advisory Group about Partnership's Tribal Health Liaison Yolanda Latham, I was looking through race/ethnicity data on our members, and comparing it to the official California Census data, and discovered something very concerning: The number of AI/AN members enrolled in Partnership seemed very low. After a little digging (details below), I discovered that the magnitude of the undercounting is somewhere between 213% and 900%, and may be even higher.

The reason for this is the way DHCS takes the race/ethnicity/tribal affiliation data from the official Medi-Cal application and uses an algorithm to assign a single race. The Medi-Cal application encourages individuals to choose all races that apply, in accordance with federal recommendations going back to 2000.

Page 4 of the Medi-Cal application:



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

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

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

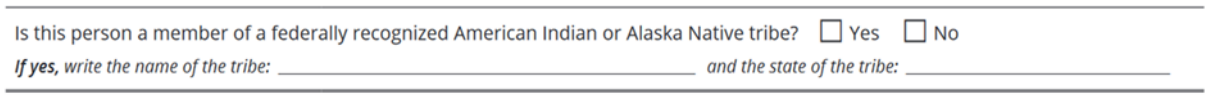
Are you of Hispanic, Latino, or Spanish origin? *(optional)* ☐ Yes ☐ No

If yes, check which ones:

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

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

Page 20 of the Medi-Cal application:



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

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

The mechanism that DHCS uses to convey membership information to Partnership and other Medi-Cal managed care plans is a file called the 834 file or membership file. This file lists just one single race-ethnicity category per enrollee. DHCS uses an algorithm to translate the application race and ethnicity responses to this single category.

While the exact algorithm is not publicly posted, it seems likely that if an AI/AN member also identifies as Hispanic or Latino, this trumped their AI/AN status and they were assigned a Latino ethnicity. Additionally, if an enrollee identified as both AI/AN and any other racial status, they were classified as "other" or "mixed race," a category with poor outcomes similar to the AI/AN population, but as it is mixed with all other mixed-race individuals is completely non-actionable.

Here are three mechanisms used to estimate the scope of this undercounting:

1. Census Data

One way to estimate the scope of undercounting is to compare the proportion the Medi-Cal enrolled population identified as AI/AN compared to California census data on AI/AN ethnicity.

Official Medi-Cal statistics show a total of 55,302 **(only 0.4% of all beneficiaries)** AI/AN individuals enrolled in Medi-Cal as of July 2023. (Medi-Cal Fast Facts).

In contrast, in the 2020 census, 1.6% of the California population identified as American Indian and Alaska Native race alone and an additional 2% of the population identified as American Indian or Alaska Native in combination with some other race, for a total of 3.6% of the population categorized at AI/AN alone or in combination. Even if we assume that the proportion of the AI/AN population of California with Medi-Cal is the same as the non-Medi-Cal population (a highly unlikely assumption), **Medi-Cal is undercounting the AI/AN population by as much as nine-fold**. Put another way, the true number is 900% higher.

Extrapolating the scope of the undercounting based on census data, as many as 495,000 Medi-Cal beneficiaries would be categorized as AI/AN alone or in combination, instead of just 55,302.

2. American Community Survey

An analysis of the 2018 American Community Survey conducted by the National Indian Health Board estimated the California Medi-Cal population to be 242,813. An updated estimate from 2021 put the number at 330,959, or 600% higher than the official state data.

3. Tribal Health Centers

Confirmatory evidence of racial mis-categorization comes from the subset of Tribal health centers, which **only** allow enrolled Tribally-affiliated members to be served. Of those Medi-Cal members served at these Tribal health centers, 53% were categorized by Medi-Cal 834 data as **not** being AI/AN. Meaning that the true number is 213% greater than the identified AI/AN at Native-run health centers.

Extrapolating this underestimate would mean that the actual number of AI/AN members receiving Medi-Cal is about 118,000 individuals.

Why such a broad range?

Undercounting of American Indian Population

The range of undercounting (from 213% to 900%) is so large, partly because the U.S. Census groups together indigenous populations from Central America (such as the Maya and Aztec), South America and Canada into its totals. Of these groups, those who identify as indigenous from Central America are large and growing, resulting in a shift from the Latino category to the indigenous/AI/AN category. In contrast, indigenous persons from outside of the United States are not generally eligible to receive care at Tribal health centers that are limited to Tribal members.

The American Community Survey assesses race and ethnicity differently, in a way that likely does not include indigenous individuals from Central America in the AI/AN count, which lowers that count relative to the census estimate.

Impact of Undercounting

Official methods of categorizing race have a centuries-long history of being built on racist assumptions and bias. While I would like to think that the algorithm decisions that led to the undercounting of the AI/AN population in Medi-Cal were not intended to harm the AI/AN population, such large-scale undercounting has several important impacts.

First, it reinforces the perception that American Indians are no longer present in California; “erasure” is the term used by American Indian scholars and activists. In fact, in the past century, erasure was an official U.S. government policy, as tribes were “terminated” in the 1950s and 1960s, children kidnapped and taken away to boarding schools to indoctrinate them into American culture. The residual evidence of erasure reflects a lack of acknowledgement and sensitivity of this historical trauma.

Second, such profoundly faulty data leads to faulty analysis of health inequities. If the racial data used to calculate rates of quality indicators is biased and faulty, then the inferences drawn by stratifying data by race are hints of the underlying reality, but any sanctions or penalties tied to reducing such inequities by any specified quantity are statistically invalid.

Lastly, such significant undercounting impacts public health prioritization based on population affected, and thus potentially impacts funding allocated proportional to the AI/AN population affected.

What should be done?

Major Tribal organizations representing health and public health policy issues have raised the problematic nature of categorization of AI/AN persons in multiple settings and give input into the newly updated 2024 OMB standards.

National organizations, especially the National Indian Health Board have raised the issue of data incompleteness and undercounting. Some shorthand terms for the lack of sharing of accurate data about the AI/AN population is “data sovereignty” and the need to “decolonize data systems.” The National Council on Urban Indian Health issued an analysis of undercounting among Urban Indians. Other organizations that have weighed in on undercounting of AI/AN population data include the 12

regional Tribal Epidemiology Centers, and the state Tribal health organizations like the California Rural Indian Health Board.

Major changes in the new U.S. Office of Management and Budget (OMB) Standards

The Updated 2024 OMB Standards for categorizing race/ethnicity move Latino/Hispanic to be a co-equal race/ethnicity category, instead of a carved-out ethnicity category. The Middle-eastern/north African population was carved out of the White category, so there will now be 7 major race/ethnicity categories. One of which is American Indian or Alaska Native, with a box to fill in details with the following language: “Enter, for example Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya etc.”

The most concerning aspect of the new OMB standard is the list of options for handling individuals who identify more than one race/ethnicity category. The three options identified are (see page 22195):

- The “alone or in combination” approach mentioned earlier related to census data. There is some complexity to using this approach, but it substantially resolves the undercounting of the AI/AN population and should be the starting point of data sharing and equity analysis. A key feature of this approach is that the total of all categories is greater than 100%, as one individual may be two or more categories; this requires special statistical methods to avoid errors.
- The “most frequent multiple responses” approach, in which the top combined categories are each presented with individual data. For example, in addition to each race ethnicity category alone, each combination is listed with the number of individuals. Some may be simple two-race categories (like Black-Asian) but more complex combinations are possible (like Latino-Black-White). This allows the most granular data analysis, and the numbers can be folded into the “alone or in combination” category. The sum of all individuals in all categories will total 100%.
- The “multiracial” approach in which any individual who chooses more than one race/ethnicity category is categorized as either “other” or “mixed.” This grouped category is impossible to analyze, so the “pure” race/ethnicity categories end up being the only way to look for health disparities. This appears to be the method currently used by DHCS, and it should be abandoned as soon as possible.

What Can DHCS Do Now?

First and foremost, DCHS should share the current detailed enrollment race/ethnicity/tribal affiliation data with all Medi-Cal Managed Care plans so they can better analyze and understand the inequities faced by their members. This could be done with a separate monthly report from DHCS and it could also be integrated into the new Medi-Cal Connect platform that DHCS is building to feed assorted supplemental data to health plans. In addition, if DHCS has separate member-level internal flags

indicating Tribal affiliation or AI/AN status, from other sources, this should also be conveyed to the plans with the more complete enrollment demographic data.

This granular race/ethnicity/Tribal affiliation data will allow managed care plans to re-run our disparity analyses and release an analysis of our findings. In addition, we can pass on this information to primary care practices to give them the complete and accurate data they need to identify and address health inequities.

As DHCS plans its implementation of the new OMB race-ethnicity standards, they should convene a workgroup with representatives from the California Tribal Epidemiology Center, the California Department of Public Health, the California Rural Indian Board, the California Consortium of Urban Indian Health, and Region IX of US HHS to review the options for categorization of data, strongly considering either the “alone or in combination” approach or the “most frequent multiple responses” approach, which can be combined to create “alone or in combination” groups. These two approaches would stop the undercounting of the AI/AN population.

Finally, to stop presenting incomplete and inaccurate data about the AI/AN population, DHCS should create an internal team to review all presentations of data that is stratified by race/ethnicity to identify, correct and/or put into context the data as it relates to American Indian population. This team should be empowered to raise concerns anonymously to the DHCS Chief Health Equity officer if their concerns are not addressed.

As unintentional as it may be, the DHCS racial categorization algorithm is an example of structural racism that deserves to be addressed. With the increased emphasis on Health Equity at DHCS and CDPH, there should be a heightened sense of urgency to definitively address this issue. DHCS alignment with the OMB’s updated race and ethnicity data standards creates an opportunity to correct an issue that obscures Tribal communities and other small populations from the data.

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Tactical Plan Update for 5-Star Quality Strategy

Status Update:

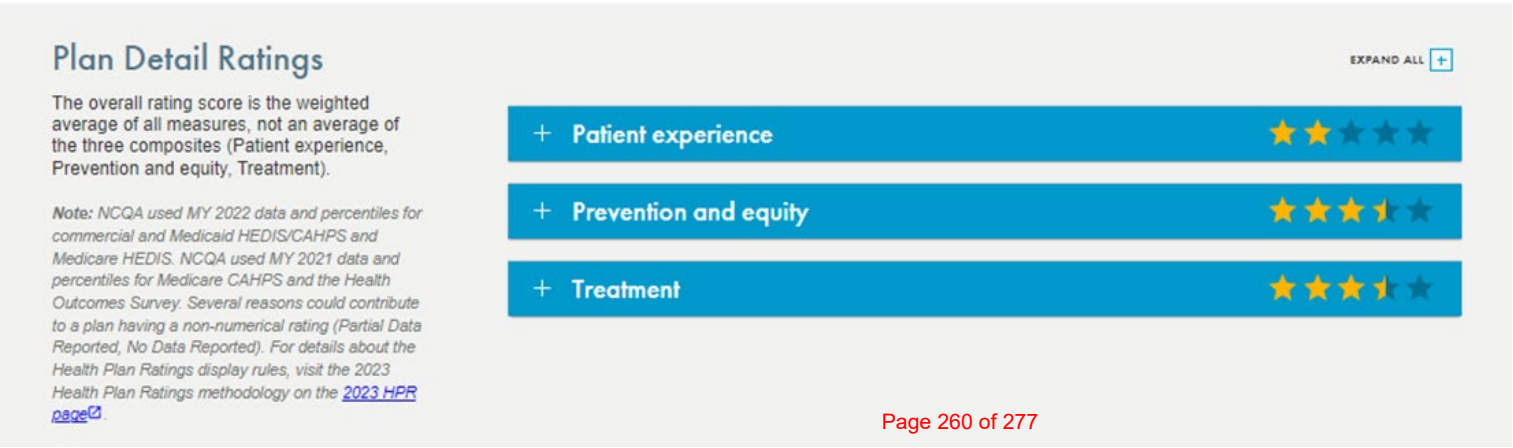
Close of Q4 FY2023/2024

Nancy Steffen

Reported to IQI/QUAC in September 2024

2023 Health Plan Rating

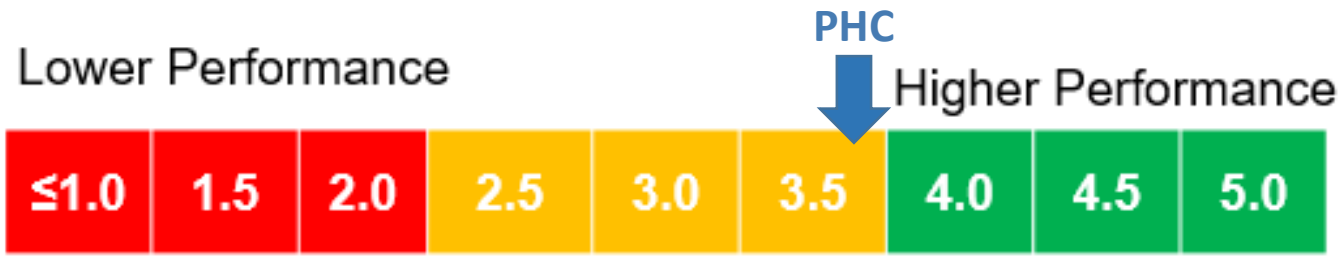
- Successful Renewal Survey in 4Q2023
- Very close to achieving a 4.0 Rating



NCQA HEALTH INSURANCE PLAN RATINGS

2023 NCQA Health Plan Ratings

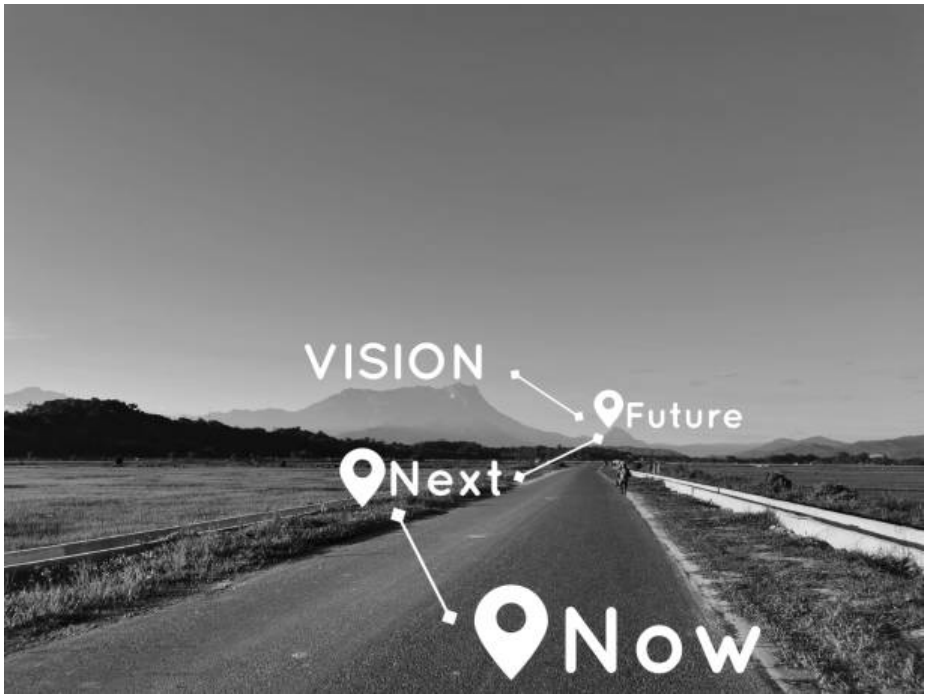
- Full NCQA rating assigns score of 0 to 5
- 5-star is the highest possible score (0/285 plans nationally)
- Score of 4-star or greater is above average (54/285 plans).
  - 4-star California plans: Contra Costa, San Mateo, Alameda Alliance, Community Health Group, SF HealthPlan, CalOptima
- Only 9 accredited California plans, including Partnership, achieved a 3.5 star rating!



5-Star Quality Strategy

- Partnership aims to become an NCQA 5-Star rated health plan, while balancing increasing oversight and external pressures.

- Partnership's 5-Star Quality Strategy & Tactical Plan serve as the roadmap.



- In 2023-2024, Partnership continued its journey in becoming a highly rated health plan with a stated goal of maintaining **or exceeding** a 3.5 Star rating in 2024.

Projected 2024 Health Plan Rating

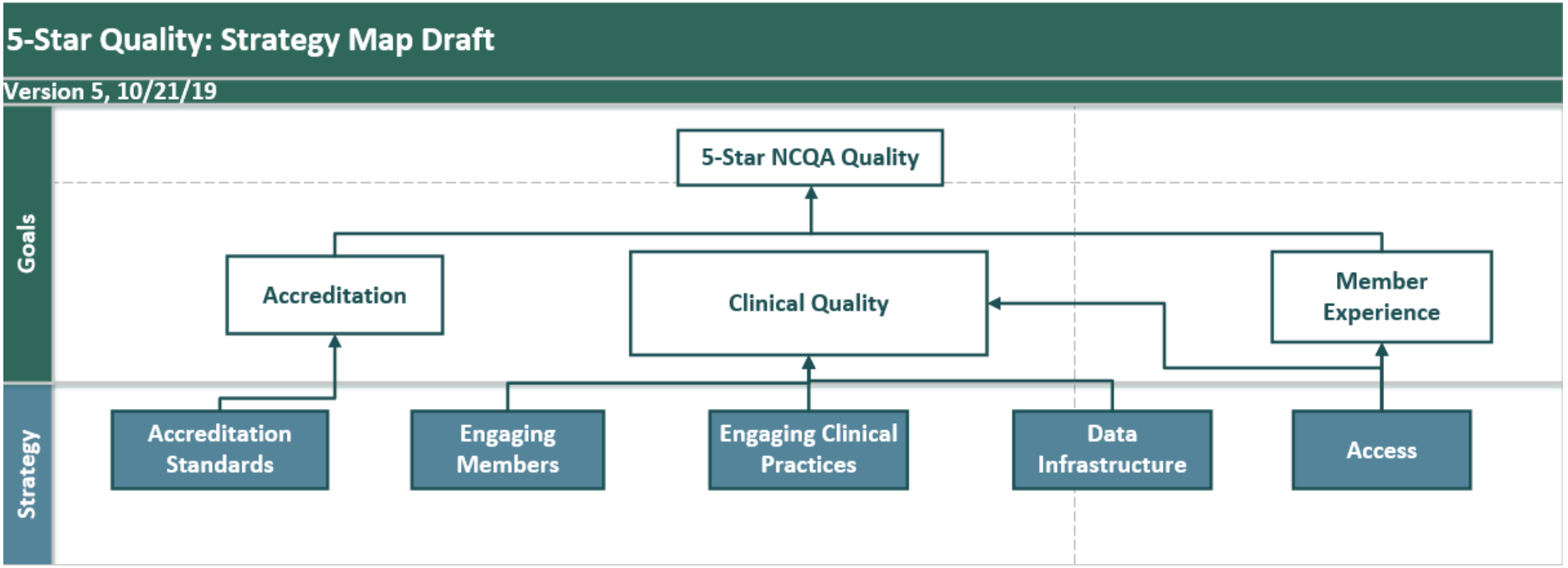
- The *projected* HPR for MY2023 is **3.5 Stars** is our *best estimate* using available benchmarks, pending NCQA publishing final ratings later this fall.
- This *projected* HPR reflects our decision to submit Adult CAHPS vs. Child CAHPS.

	2023 Final, Used Child CAHPS	2024 Projected, Used Adult CAHPS	2024* FYI - If we had Used Child CAHPS
Patient Experience (CAHPS)	2.0	1.5	2.0
Prevention and Equity (HEDIS domain)	3.5	3.5	3.5
Treatment (HEDIS domain)	3.5	3.5	3.5
Bonus for Accreditation	0.5	0.5	0.5
Overall HPR	3.5	3.5	4.0

*For reference only

- Similar to last year, the projected HPR is *only* 0.043 pts. from rounding up to a 4.0 Star Rating!

HEDIS Quality to 5-Star Quality



73 Tactics

HEDIS = Health Effectiveness Data and Information Set®
NCQA = National Committee for Quality Assurance

Performance Priorities in 2023-2024

- Enhance provider engagement in measure improvement initiatives with focus on
  - Lowest performing PCP orgs in PCP QIP
  - Advancing health equity & practice transformation
- Invest further to improve Patient Experience
- Continue adapting Access tactics
- Engage new providers and community partners in expansion region and integrate with 5-Star Quality Strategy & Tactics

Tactical Plan: Focus Areas

Engaging Clinical Practices	Engaging Members	Data Infrastructure	Accreditation	Access
Supply Actionable Care Gap Data to PCPs	Supply Care Gap Data to PHC Staff, Providers and Members	Provide Actionable Care Gap Data	Pass "Must Pass" Elements	Recruitment
Technical Assistance to Support Provider QI Capacity	Increase PHC Member Engagement Capacity	Data Quality, Access, Completeness	Maintain Grand Analyses	Retention
Pay for Performance Programs	Specific Member Engagement Activities	Supportive Analytics	Prepare for Health Equity Accreditation	Alternative Access
Work with Community Partners to Improve Quality		Pathway to Excellence	Prepare for Medicare	Learning about Optimizing Access

Engaging Clinical Practices

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
1.A	Supply Actionable Care Gap Data to PCPs	1.A.1	eReports	*Optimize*	*Optimize*	Some Risk
		1.A.2	PQD	*Optimize*	*Optimize*	Some Risk
		1.A.3	ePrompts logic integration into Provider Online Services	*Promote*	*Promote*	Established
		1.A.4	Unblinded quality data reporting	*Optimize*	*Sustain*	Established
		1.A.5	EMR workflow optimization	*Update*	*Update*	Established
		1.A.6	ECDS measures	*Optimize*	*Optimize*	Early pilots
1.B	Technical Assistance to Support Provider QI Capacity	1.B.1	Leverage other quality mandates: State mandated PDSAs, PIPs, Site Reviews, Prop 56	*Optimize*	*Optimize*	On Time
		1.B.2	Execute Tribal Health engagement strategy and tactical plan	*Optimize*	*Optimize*	On going
		1.B.3	Execute a plan-wide ***Enhanced Provider Engagement Strategy*** for provider organizations to increase capacity for QI work	*Optimize*	*Optimize*	In progress
		1.B.4	General QI Training (ABCs of QI)	*Sustain*	*Sustain*	Established
		1.B.5	Measure-specific trainings and webinars	*Optimize*	*Optimize*	Established
		1.B.6	PCP Organization Leadership Development	*Adapt*	*Adapt*	Planning in
		1.B.7	Delivering diversity, equity and inclusion (DEI) training to promote Health Equity	*Adapt*	*Adapt*	In Development
		1.B.8	JLI activities	*Optimize*	*Optimize*	Established
1.C	Pay for Performance Programs	1.C.1	PCP QIP	*Optimize*	*Optimize*	Established
		1.C.2	Modified PCP QIP for low performing PO's	*Optimize*	*Optimize*	In progress
		1.C.3	Perinatal QIP	*Optimize*	*Optimize*	Established
		1.C.4	Hospital QIP	*Optimize*	*Optimize*	Established
		1.C.5	New incentive for focused quality work			Early pilots
1.D	Work with Community Partners to Improve Quality	1.D.1	Support CHA and CHIP within counties	*Optimize*	*Refine*	In Development

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

ACCREDITED NCQA HEALTH PLAN

Engaging Clinical Practices

PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Key Changes in Tactical Activity Status or New Tactics:

- 1 Tactic (1.B.2) updated from **In Development** → **Ongoing**
  - Tribal Engagement Strategy has been developed and shared with stakeholders for review and feedback. A corresponding tactical plan is on track for completion by the end of 2024.

- 1 Tactic (1.B.3) updated from **Initial Work Needed** → **In Progress**
- 1 Tactic (1.C.2) updated from **In Development** → **In Progress**
  - Enhanced Provider Engagement Strategy (1.B.3) coupled with Modified PCP QIP (1.C.2) are well into second year of implementation and yielding good engagement and initial outcomes. Resulted in new pilot activities:
    - Select Year 1-Modified PCP QIP providers invited to participate in Locum Grant program. At present, 2 of 4 practices have engaged locums with good outcomes thus far. Remaining 2 struggling to recruit locums
    - Select Year 2-Modified PCP QIP providers invited to apply for upfront funding of up to 25% of potential estimated QIP funds to aid in focused improvement efforts

ACCREDITED NCQA HEALTH PLAN

Engaging Members

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
2.A	Supply Care Gap Data to PHC Staff, Providers and Members	2.A.1	Call Center ePrompts	*Optimize*	*Optimize*	Established
		2.A.2	Member Portal ePrompts	*Optimize*	*Optimize*	Early pilots
2.B	Increase PHC Member Engagement Capacity	2.B.1	Member Outreach Activities and Campaigns	*Expand*	*Expand*	In progress
		2.B.2	Member Services Reminders (on hold messaging)	*Optimize*	*Optimize*	On hold
		2.B.3	Train PHC staff on targeted quality metrics	*Adapt*	*Sustain*	Established
		2.B.4	Member Incentive Programs	*Adapt*	*Adapt*	In progress
		2.B.5	Monitor Member Input in QI Engagements in Coordination with Population Health	*Adapt*	*Optimize*	Early pilots
		2.B.6	Member media campaigns	*Expand*	*Expand*	In progress
2.C	Specific Member Engagement Activities	2.C.1	Leverage new CHW benefit to support Quality strategies/goals	*Adapt*	*Expand*	Early pilots
		2.C.2	Engagement in ED and Inpatient settings	*Adapt*	*Adapt*	Implementation On Time
		2.C.3	Outreach to unestablished members	*Adapt*	*Operationalize*	On hold
		2.C.4	Sponsorship of Mobile Mammography events	*Expand*	*Expand*	On going
		2.C.5	Increase Members having In Home Monitoring Devices (integrated)	*Optimize*	*Optimize*	On hold

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
Red	Orange	Light Green	Dark Green	Blue

Engaging Members

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Key Changes in Tactical Activity Status

- 1 Tactic (2.B.2) changed from **Established** → **On Hold**
  - Due to the impact of geographic expansion and Dignity contracting issues, Member Services focused on addressing significant increases in call volumes and service levels. Q1 goal is to re-establish on hold messaging with priority measure-focus messaging.
- 1 Tactic (2.C.1) updated from **In Development** → **Early Pilots**
  - Enhanced Health Services leadership implementing CHW strategy, presently focused on operationalizing and capturing billing/use in serving members. Future integration with QI activities pending.
- 1 Tactic (2.C.2) updated from **Early Pilots** → **Implementation On time**
  - BH team overseeing implementation of BRIDGE Program, which embeds CHWs in various Emergency Dept. across Partnership service region
- 1 Tactic (2.C.4) updated from **Implementation On time** → **On Going**
  - Partnership's Mobile Mammography Program is now well-established, resulting in positive and measurable outcomes

ACCREDITED NCQA HEALTH PLAN

Data Infrastructure

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
3.A	Provide Actionable Care Gap Data	3.A.1	Improve member Contact Information (Unestablished Members; Moved Member-work with County; Mass reassignment)	*Optimize*	*Optimize*	On hold
		3.A.2	Health Education tools aligned with quality measures	*Adapt*	*Adapt*	Established
3.B	Data Quality, Accuracy Completeness	3.B.1	New core claims system	*Optimize*	*Optimize*	Some Risk
		3.B.2	Master Provider Data Management	*Optimize*	*Optimize*	In progress
		3.B.3	Data Dictionaries	*Optimize*	*Optimize*	In progress
		3.B.4	Data Stewardship Program	*Optimize*	*Optimize*	In progress
		3.B.5	Meaningful Use of HIE Across Systems	*Optimize*	*Optimize*	Optimize
		3.B.6	PHC Data Governance Structure	*Optimize*	*Optimize*	In progress
		3.B.7	Data Quality Monitoring and Expanding via the Data Quality Dashboard	*Optimize*	*Optimize*	Established
3.C	Supportive Analytics	3.C.1	Data Marts	*Optimize*	*Optimize*	In progress
		3.C.2	Analysis and Presentation of Annual quality measurement results	*Optimize*	*Optimize*	Established
		3.C.3	Monthly HEDIS data	*Optimize*	*Optimize*	Established
		3.C.4	Equity Analysis and related improvement activities	*Optimize*	*Optimize*	In progress
3.D	Pathway to Excellence	3.D.1	Knowledge Management Infrastructure	*Optimize*	*Optimize*	In progress
		3.D.2	Standardized scientific approach to small tests of change	*Optimize*	*Optimize*	On going
		3.D.4	Optimize data validation in all settings			In Development
		3.D.3	Standardized approach to scaling up/implementation	*Operationalize*	*Operationalize*	On going
		3.D.4	Nurture PHC Values around Quality	*Adapt*	*Adapt*	Established

Status Legend:

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ACCREDITED NCQA HEALTH PLAN

Data Infrastructure

Key ***Highlights**** on Tactical Activity Status:

**No major status changes since last update in February 2024.*

- 1 Tactic (3.A.1) remains **Needs Attention**
  - Due to redetermination, 18-20% of our members are not actually our members.
  - Once redetermination is complete, the completeness and accuracy of member contact information can be assessed and better addressed through local efforts.
- 1 Tactic (3.B.1) remains **Some Risk**
  - HRP (i.e., new core claims system) Go-Live date is late Q1 2025.
  - Validation activities for QI systems are ongoing.
- 1 Tactic (3.D.2) updated from **In Development** → **On Going**
  - Finalized framework defining Partnership's standardized scientific approach to small tests of change. Now focusing on optimizing methods and quality controls key to reliable data validation.

NCQA Accreditation & D-SNP Prep

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
4.A	Pass "Must Pass" Elements	4.A.1	Internal File Review; Delegated file review; Delegation oversight to NCQA standards	*Optimize*	*Sustain*	Established
		4.A.2	Organization Wide Goals and Department goals related to NCQA	*Optimize*	*Sustain*	Stable
4.B	Maintain Grand Analyses	4.B.1	Ensure comprehensive and timely submission of grand analyses, including: UM, Member Experience, Network Adequacy/Availability, PHM/C&L, Continuity and Coordination of Care, and Behavioral Health	*Optimize*	*Sustain*	Stable
4.C	Prepare for Health Equity Accreditation	4.C.1	Conduct Gap Analysis, review resulting findings, and propose target HEA survey timeline	*Operationalize*	*Operationalize*	In progress
4.D	Prepare for Medicare	4.D.1	Baseline HEDIS measure collection	*Optimize*	*Optimize*	In progress
		4.D.2	Address Medicare HEDIS gaps	*Operationalize*	*Operationalize*	In progress
		4.D.3	MediCare Incentive Programs for Members and Providers	*Operationalize*	*Operationalize*	In progress
		4.D.4	Overall quality oversight	*Operationalize*	*Operationalize*	In progress

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
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ACCREDITED NCQA HEALTH PLAN

Key Changes in Tactical Activity Status:

- 1 Tactic (4.D.1) updated from **On Target** → **In Progress**
  - Medicare specific HEDIS® measures and specs are being evaluated as part of early quality strategy development under CMS Medicare STARS program. Baseline data collection and analysis are next steps.
- 1 Tactic (4.D.3) updated from **Initial Work Needed** → **In Progress**
  - Medicare specific provider incentive program (i.e., D-SNP PCP QIP) is in active development for 2026 launch.
- 1 Tactic (4.D.4) updated from **Initial Work Needed** → **In Progress**
  - Plan-wide collaboration is actively underway to finalize Partnership's Model of Care by end of 2024. In parallel, Partnership is developing infrastructure, collaborative workgroups, and quality committee structure to implement CMS Medicare STARS program.

Access

Goal #	Goal Description	Objective #	Objective Description	Anticipated Action in 2024-2025	Anticipated Action in 2025-2026	Status
5.A	Recruitment	5.A.1	Marketing to PCP Residents (PHC Regions, CA and Out of State)	*Promote*	*Optimize*	Deferred Prioritization
		5.A.2	Support J-1 Visa process	*Expand*	*Expand*	Deferred Prioritization
		5.A.3	Support the development, spread and quality of NP/PA residencies/fellowships in our region	*Operationalize*	*Operationalize*	In progress
		5.A.4	PHC Recruitment Program	*Optimize*	*Optimize*	Established
		5.A.5	Contingency Firm Use Pilot Program	*Operationalize*	*Optimize*	In progress
		5.A.6	Convene Regional Physician Residency Programs	*Operationalize*	*Operationalize*	Established
5.B	Retention	5.B.1	Provider Retention Initiative (PRI)	*Expand*	*Optimize*	In progress
		5.B.2	Support local applicants with existing loan repayment programs	*Expand*	*Optimize*	Deferred Prioritization
		5.B.3	Recruitment difficulty factor adjustment for QIP	*Adapt*	*Adapt*	In Development
		5.B.4	Virtual provider recruitment networking/mentoring	*Expand*	*Expand*	Deferred Prioritization
5.C	Alternative Access	5.C.1	Phone/Video visits in lieu of in person	*Optimize*	*Optimize*	Stable
		5.C.2	Advanced Access methodology	*Promote*	*Promote*	Some Risk
5.D	Learning about Optimizing Access	5.D.1	Clinician Entry/Exit interviews	*Expand*	*Expand*	Deferred Prioritization
		5.D.2	Capture best practices	*Expand*	*Expand*	In progress

Status Legend:

Problems	Needs Attention	Planning/Development	Progressing	Stable/Maintenance
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Access

Key Changes in Tactical Activity Status or New Tactics:

- The Partnership Workforce Development team continues to work on new tactics and have deferred specific existing tactics to accommodate growing workload and priorities
- 5 Tactics flagged as **Deferred Prioritization**
  - 5.A.1: Marketing to PCP Residents (In/Out of State)
  - 5.A.2: Support J-1 Visa process
  - 5.B.2: Support applicants with existing loan repayment programs
  - 5.B.4: Virtual provider recruitment networking / mentoring – ***newly deferred as of June***
  - 5.D.1: Clinician Entry/Exit interviews
- 1 Tactic (5.A.3) updated from **Pending Launch** → **In progress**
  - Development/spread of PA/NP residencies/fellowships in our service region is being supported through Partnership's awarding of planning grants totaling $200k over the next 2 years. California Health Care Foundation (CHCF) is providing additional $950k in grant funding.
- 1 Tactic (5.B.4) updated from **Initial Work Needed** → **Deferred Prioritization**
  - Deferred to better focus on establishing a provider mentorship program with initial strategy framework by end of 2024
- 1 Tactic (5.C.2) updated from **Stable** → **Some Risk**
  - Prior Advanced Access cohort's collateral and recorded training sessions posted on Partnership's public website. With 80% reduction in state funding of Equity and Practice Transformation (EPT) program, significantly less provider investment in advanced access strategies is expected. Partnership will promote via improvement advising.

Summary

- Partnership's 5-Star Quality Strategy was last updated in 2020 to align with our NCQA Accreditation goals.
  - Stretch goal: Being named a 5-Star NCQA Accredited plan by 2025
- Since the last 5-Star Strategy and Tactical Plan update in February 2024:
  - Continued developing new tactics focused in enhanced community partnering and improving access
  - Consolidated or deferred existing tactics to better reflect ongoing work and to make space for promising new tactics
  - Invested more time and resources to prepare for Medicare (D-SNP)
  - Actively assessing progress and risks, adapting resource allocations
- Partnership continues to make progress under our 5-Star Quality Strategy/Tactical Plan in our continued journey to becoming a highly rated health plan.