PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality
DATE: Improvement Nov. 14, 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, Nov. 20, 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
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata

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
Luu, Phuong, MD
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, MHA, 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, Southwest
Beltran-Nampraseut, Athena, Program Manager II, PCP/QIP
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, MHA/MBA, Director of Quality Management, QI
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, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, 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
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sackett, Anthony, Program Manager II, QI (MEGA)
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico
Trosky, Renee, Manager of Network Services Compliance

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

Date: Nov. 20, 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
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:

Open Door Community Health Center, 3770 Janes Road, Arcata

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

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

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

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Oct. 16 Quality/Utilization Advisory Committee (Q/UAC) Minutes		7: 30	5 - 19
2	*Acknowledgment and acceptance of draft* • Oct. 8 Internal Quality Improvement (IQI) Committee Meeting Minutes • Sept. 23 Quality Improvement Health Equity Committee (QIHEC) Minutes • Aug. 29 Member Grievance Review Committee (MGRC) Minutes • Oct. 3 Population Needs Assessment (PNA) Committee Minutes			21 - 59
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:33	61 - 75
2	HealthPlan Update *Q/UAC voters are asked to help with NCQA Health Equity Accreditation efforts by completing this survey:* https://www.surveymonkey.com/r/QUACDEI	Robert Moore, MD	7:38	--
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:43	77
	2023 PCP QIP Program Evaluation – *direct questions to Athena Beltran-Nampraseut*			79 - 102
	Grievance & Appeals PULSE Quarterly – *direct questions to Latrice Innes*			103 - 113
	UM Delegation to Capitated Hospitals – *direct questions to Tony Hightower, CPhT*			115
	Quality Improvement Policies			
	MCQG1015 – Pediatric Preventive Health Guidelines			117 - 130
	MCQP1021 – Initial Health Appointment			131 - 140
	MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline			141 - 149

	Item	Lead	Time	Page #
	Utilization Management Policies			
	MCUP3102 – Vision Care			151 - 153
	MCUP3106 – Waiver Programs			154 - 159
	MCUP3125 – Gender Dysphoria/Surgical Treatment			160 - 164
	MCUP3137 – Palliative Care Intensive Program (Adult)			165 - 172
	Transportation Policies			
	MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)			173 - 184
	MCCP2029 – Emergency Medical Transportation			185 - 187
	Member Services			
	MP300 – Member Notification of Provider Termination of Change in Location			189 - 192
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	193 - 199
	Health Equity			
	Health Equity: MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC) *CLEAN copy begins on p.206*	Mohamed Jalloh, Pharm.D	7:46	201 - 210
	Population Health			
	MCNP9006 – Doula Services Benefit	Hannah O'Leary, MPH	7:52	211 - 219
	Behavioral Health			
	MCUP3028 – Mental Health Services	Mark Bontrager	7:58	221 - 233
	MCUP3101 – Screening and Treatment for Substance Use Disorders		8:04	234 - 257
	Utilization Management			
	MCUP3131 – Genetic Screening & Diagnostics	Colleen Townsend, MD	8:10	258 - 391
VI.	**Presentations**			
1	Grand Analysis: Member Experience MY 2023 / RY 2024 *Consumer Assessment of Healthcare Providers & Services (CAHPS) NCQA ME 7 Report begins on p. 409*	Anthony Sackett, Kory Watkins, MBA	8:16	393 - 465
2	Grand Analysis: Network Access *Assessment of Network Adequacy NCQA NET 3, Elements A-B Report begins on p. 481*	Renee Trosky, BSRRT	8:35	467 - 515
VII. FYI	2025 QI Committees Meeting Schedule and Material Deadlines	*Direct issues and edits to Leslie Erickson*		517
	2025 QI Committees Presentations Calendar			518
	Health Services and Other External Policies before 2025 IQI/QUAC			519 - 523
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Jan. 15, 2025 – HAPPY HOLIDAYS!			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Introductions Approval of Minutes	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:32 a.m. He introduced • Partnership Commissioner and Bi-County Public Health Officer Phuong Luu, MD as Q/UAC's newest voting member. • Partnership Commissioner Andrew Miller, MD, who is considering joining Q/UAC. Dr. Miller is the Director of Community Health at Enloe Hospital in Chico. The Sept. 18, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Sept. 10 Internal Quality Improvement (IQI) Committee • July 25 Substance Use Internal Quality Improvement (SUIQI)	Unanimous Approval of Q/UAC Minutes as presented: John Murphy, MD Second: Jennifer Wilson, MD Unanimous Acceptance of other Minutes: Robert Quon, MD Second: John Murphy, MD *Meeting Postscript:* Dr. Miller will not join Q/UAC at this time but will look at other Partnership committees perhaps better aligned to his interests.
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Nancy Steffen, Sr. Dir. of Quality and Performance Improvement*	• Correction: the new date for payments on our Fiscal Year Quality Incentive Programs (Perinatal QIP and Hospital QIP) is Nov. 18. • As you know, we have a very robust Quality Measure Score Improvement series of workgroups by measure domain both to serve Department of Heal Care Services (DHCS) Measure Core Accountability Set (MCAS) as well as our National Committee on Quality Assurance (NCQA) Health Plan Accreditation (HPA) Measure Set. In our Blood Lead Screening measure, a particular focus of MCAS, we have had great improvement coupled with ongoing efforts to bring Point-of-Care devices to the primary care settings. We have up to 30 devices available for distribution as part of our third round review. • We continue to update the narrative around the Equity and Practice Transformation Program (QTP). This is a great opportunity to help some of our primary care providers develop capacity and infrastructure improvements. We had a total of 27 provider organizations who applied to this program last year. Our 27 provider organizations (POs) accepted last year into the ETP are still continuing with the program despite the 80% funding cut resulting from the May Revise of the State budget. These 27 include five expansion providers from the expansion counties, eight Tribal health POs and seven "legacy" county POs already engaged in ongoing enhanced provider engagement opportunities. We have a better sense now of what those practices need to contribute in terms of deliverables, beginning Nov. 1, 2024 through Oct. 31, 2025, things around empanelment and access: data to enable what they are calling a population health milestone, data governance, and full quality measurement capture under key preventive screening and chronic disease measures. POs are required to attend 80% of the learnings that have been constructed statewide: Partnership's participating POs are in the "Redwood Learning Community" collaboration.	For information only: no formal action required. There were no questions for Nancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature of Approval: _____ Date: _____

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Oct. 8, 2024 / 1:30 – 3:24 PM

Members Present:

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

Members Absent:

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

Guests:

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

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

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

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

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

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

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

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

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

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

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

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

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

Approval Signature: *Date:*

Robert Moore, MD
Chief Medical Officer and Committee Chair

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

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

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

Facilitator: Mohamed Jalloh, Health Equity Officer (Chair)

Coordinator: Vicquita Velazquez

Meeting Locations:

- WebEx

External Attendees:

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

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

Internal Attendees:

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

Absent Internal:

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

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

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

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

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

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

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

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

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

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

MEMBER GRIEVANCE REVIEW COMMITTEE
Meeting Minutes for August 29, 2024

The Member Grievance Review Committee (MGRC) represents a multi-disciplinary oversight forum with representatives across multiple Partnership HealthPlan departments to track and trend Grievances, Appeals, Exempt Grievances, and State Hearing cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Internal Quality Improvement (IQI) Meeting and/or Quality Utilization Advisory Committees (QUAC).

DATE:	*Thursday, August 29, 2024*
TIME:	*2:00 p.m. to 3:00 p.m.*
LOCATION:	***WebEx link in meeting invite**
	Fairfield West | *Board Room*
	Airpark | *Burney Falls Conference Room*
	Avtech | *Whiskeytown Conference Room*
	Mark Netherda, MD, Medical Director, Quality
FACILITATOR:	*Kory Watkins, Director, Grievance & Appeals*
	Latrice Innes, Compliance Manager, Grievance & Appeals

ATTENDEES			
☐	Aaron Maxwell, Transportation	☒	Mark Netherda, MD, Health Services
☐	Anthony Sackett, Quality	☐	Mary Kerlin, Provider Relations
☐	Amanda Bernal, Population Health	☒	Melissa Perez, Provider Relations
☐	Bettina Spiller, MD, Health Services	☒	Michelle Mootz, Transportation
☐	Danielle Biasotti, CPhT, Care Coordination	☒	Mori McLennan, Grievance & Appeals
☒	Edna Villasenor, Member Services	☒	Mohamed Jalloh, Pharm D, Health Equity
☐	Gary Robinson, Compliance	☐	Nicole Talley, Behavioral Health
☐	Hanh Hoang, Provider Relations	☒	Nicole Curreri, Population Heath
☐	Hannah O'Leary, Population Health	☐	Nikki Rotherham, Claims
☐	Heather Esget, Utilization Management	☒	Nisha Gupta, Population Health
☐	James Cotter, MD, Health Services	☒	Ramneek Kaur, Population Heath
☒	Jayne Cappello, Grievance & Appeals	☒	Rebecca Stark, Administration
☒	Katherine Barresi, RN, Care Coordination	☐	Renee Trosky, Provider Relations
☐	Kenzie Hanusiak, Compliance	☒	Robert Bides, RN, Quality
☐	Kermit Jones, MD, Medicare Services	☐	Robert Moore, MD, Health Services
☒	Kory Watkins, Grievance & Appeals	☐	Rosemenia Santos, RN, Quality
☒	Latrice Innes, Grievance & Appeals	☐	Stan Leung, Pharm.D., Pharmacy
☐	Ledra Guillory, Provider Relations	☒	Stephanie Nakatani-Phipps, Provider Relations
☐	Lisa Ooten, Pharm. D., Pharmacy	☐	Tim Sharp, Administration
☐	Lonni Hemphill, CPhT, Compliance	☐	Tony Hightower, Utilization Management
☒	Manleen Randhawa, Population Health	☒	Vivian Gill, RN, Grievance & Appeals
☐	Maria Cabrera, Member Services	☐	Wendi Davis, Administration
☒	Michela Englehart, Administration		

HANDOUTS			
1	Meeting Agenda	2	Meeting Minutes from May 23, 2024
3	Meeting PowerPoint Presentation		

I. WELCOME & INTRODUCTIONS

A. Meeting Minutes

Minutes from the MGRC meeting on May 23, 2023 will be motioned for approval at the November 21, 2024 meeting.

II. STANDING AGENDA

A. Department Updates

1. Department Updates

DHCS

- DHCS CAP response submitted 4/22/2024 regarding recommendation for the removal of the Second Level Grievance, when appropriate. DHCS rejected the proposal. In return, G&A reiterated the process would instead provide Appeal rights on Grievances that have an adverse determination.

- This process was initiated in 2019 to satisfy a NCQA requirement, which states the member must have the option to appeal an adverse decision of a grievance. DHCS called G&A out on this process stating there can be a Second Level Grievance however; every level of grievance must be completed consecutively within 30 days. With the Second Level Grievance process, G&A has 30 days for a grievance and 30 days for the second level grievance to be completed. G&A's response to the CAP is to remove the Second Level Grievance process.

- DHCS requested examples of our proposed changes by 9/1/2024. The examples will be provided to DHCS today, 8/29/24.

  Examples of grievances that result in an adverse benefit determination (ABD)

  - Gas Mileage Reimbursement Dispute: A member files a grievance because they disagree with the gas mileage reimbursement amount, they received. During investigation, we confirm that the correct reimbursement was issued according to our policy. In this case, the members would be informed of their right to appeal the reimbursement decision, and the grievance resolution would explicitly include this appeal right.
  - Transportation Policy Dissatisfaction: A member files a grievance because they are unhappy with PHC's policy that allows only one passenger to accompany the adult member during transportation. After investigation, we reiterate our policy, effectively denying the member's request to allow more than one passenger. The resolution of this grievance would include the member's right to appeal against the decision regarding the policy.

  Examples of grievances that do not result in an ABD

  - Service Quality: A member files a grievance about poor customer service from a plan representative. After investigation, the plan acknowledges the issue, apologizes, and takes steps to address the problem internally. Since there is no adverse decision regarding the member's benefits or services, there would be no right to appeal.

- Provider Directory Error: A member files a grievance because they found incorrect information in the provider directory. Upon investigation, the plan confirms the error and corrects the directory. Since this is not an adverse decision affecting the member's benefits, there is no appeal right associated with this resolution.

NCQA

- Every quarter G&A completes an Internal Quarterly File Review, which was completed 8/15/24. This report is similar to the NCQA audit where we review the first eight (8) cases if all eight cases pass then we are good. If any of the NCQA requirements are not met on the first eight (8) cases, then we have to review the remaining 22 cases, for a total of 30 cases, to ensure the requirements are met. G&A has passed with the first eight (8) cases - 100% accuracy achieved.

2. Staffing

As discussed in the previous meeting, we hired two (2) Grievance Nurse Specialists. One (1) is to back-fill an opening from a nurse who recently retired and the other position was an addition. Previously we had four (4) nurses but now we have five (5). We had a change in leadership; Malania previously in a Supervisor position has stepped into a new role as a Grievance Resolution Specialist. At this time we are recruiting for a Supervisor, we are almost ready to make an offer to someone. Currently we have two (2) vacant GCAs positions open; one (1) we made an offer on and the other we are getting ready to make an offer. We are currently waiting for approval on two (2) additional positions. G&A continues to grow in order to help handle the increase of cases.

B. Case Statistics

1. Case Statistics

There were 1,991 cases closed in 2Q24. Fifty-nine (59) cases were closed past 30-days, resulting in a 96.6% timeliness performance rate for the 2Q24. Members were notified their case was received within five (5) calendar days of receipt for all but 38 cases resulting in a 97.8% timeliness rate. There were two (2) lost State Hearings for the 2Q24.

In regards to the late cases/Ack letters, G&A will allow a case to stay open beyond the 30-day timeframe if we do not have the medical records or information needed to resolve a grievance or appeal. Late provider responses has also contributed to the tardiness as well. Also internally, we have multiple staff on Leave of Absence and an increased caseload due to the county expansion. Training sessions will be scheduled during our next all-staff meeting.

In regards to the two (2) lost State Hearings, we discussed one in the last MGRC. It was regarding reimbursement for a hearing aid purchased from Costco. The second case was for continuity of care (COC) for UCSF. Partnership extended for six months but the ALJ said to extend for one year.

In full transparency, we have been keeping a close eye on our numbers for July and August, which are not looking great. We have been struggling due to the increased caseload. For July and August, we will not have met our timeliness goal. There have been several measures put in place for September but at this point, we will not be meeting our timeliness for the third quarter.

G&A has closed 1,991 cases in 2Q24 compared to 1,518 cases closed in 2Q23. That is a 31.2% increase in cases. The trends appear to be flattening out at this time. In June and July, there was the same amount of cases closed each month.

The county expansion was estimated to account for a 30% increase in cases and for the second quarter G&A had a 31.2% increase in cases. The average amount of cases from July to December of 2023 was 500 cases per month. The first part of 2024 there was a 20-30% increase but for May, G&A received over 750 cases, which is over a 50% increase in May alone. Given those were cases received which in-turn means there will be a higher amount of closed cases for June and July. G&A reports on cases closed mainly and not cases received.

Q: Was the increase in cases in May due to the Dignity contract?
A: There was not many cases received concerning the Dignity contract. There was an increase in appeals in May since that was when denials started being issued after the initial 90 days.

There has been a large increase in inquiries from DHCS and DMHC, 1-2 inquiries per month in 2023 to 10-20 inquiries a month currently. The inquiries are not depicted in the slides as they are counted as inquiries, not a grievance or an appeal. Health Services has also received an increase of inquiries from DHCS and DMHC, not related to a grievance filed, from the State Ombudsman's Office. There is a new approach, "patient first member first" where DHCS and DMHC go straight to the department without any formal channels or working with the health plan. Which results in the department doing increased research had the inquiry just not originated with the health plan.

Case statistics for cases by Region will reflect the percentage per 1,000 members. The percentages provide a better comparison by the breakdown of regions per county, the number of cases in the county and the overall percentage for each region. The charts will be a new page included in the upcoming PULSE report. G&A measures the data in grievances meaning cases per 1,000 members, which is used as a benchmark in order to collaborate with other sister plans. Partnership typically has the lowest percentage or among the lowest, meaning our members are satisfied or are not filing a grievance.

C. Compliance & Strategy

1. Delegation Oversight

Carelon
The Annual File Review has started; we have requested 30 cases to be reviewed as well as Carelon's Policies.

Starting 2Q24 Carelon agreed to start submitting a supplemental report for the resolution of cases that were still open from the previous quarter. We have not received the report so at our meeting on Tuesday, August 27, 2024 we requested the report be sent. As of today, we have not received the report so we will be following up with Carelon.

Kaiser Permanente
G&A sent Kaiser an inquiry regarding quarterly reporting, for incident dates prior to January 1, 2024, since we had not received a report. Kaiser responded reporting 31 regular cases and 3 discrimination cases received for the quarter. Of note, there is no timeframe for a grievance to be filed so even though Kaiser is no longer a delegate the member can still file a grievance for incidents that happened prior to January 1, 2024 as long as they were an eligible Partnership member at the time of incident. Kaiser will continue to send reports of those

grievances.

VSP
VSP has started submitting quarterly reports as well since it is noted in their contract with Partnership.

2. **Inter-Rater Reliability (IRR) Findings**
IRR assesses the accuracy of clinical decisions made by GNS. The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides a clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 1Q24:

- The Grievance Nurse Specialist should have sent a case to be reviewed by a physician. We do not know what surgery was scheduled and then canceled. We might have sent it for PQI investigation, as more than the discrimination allegation is present. It is also concerning that this office did not send records when request. In the GNS meeting on August 28, 2024, they were provided additional training. This issue will be closed, as there is no further action needed.
- Several Grievance Case Analyst used the incorrect Reporting Interest Categories, outcomes and case types in their cases. There will be a Reporting training in an upcoming mandatory GCA meeting.

3. **The PULSE Report**
The 3Q24 PULSE Report will be released September 9, 2024. A highlight to look for:
- Statistics by region
- Transportation
- NCQA reports included

C. *Investigations*

Case Spotlight

Issue:
Member requested approval for transgender surgery, which was initially denied on the basis that it did not meet the plan's criteria for medical necessity.

Background:
A factor in the plan’s decision was the lack of specific photos that had been requested to substantiate the medical need for the surgery. The member challenged this decision, leading to a state fair hearing where the case was reviewed by an administrative law judge (ALJ). The core issue revolved around whether the health plan’s criterion for the medical necessity were appropriately applied, particularly in light of current clinical guidelines and standards of care for transgender individuals.

Learning Opportunity:
In resolving conflicts between the opinions of Partnership’s medical directors who have not observed or treated the member and the opinion of the member's treating providers and mental health clinician, who are employed to cure and have had the opportunity to observe the member, and know the patient as an individual, the opinions of the member’s treating providers are entitled to greater weight. Therefore, the ALJ deemed it insufficient to make a reasonable finding that Partnership correctly denied the request based on medical necessity.

FOLLOW-UP

Next Meeting: *Thursday, November 21, 2024 | 2 p.m. – 3 p.m.*

MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: October 3, 2024 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

Attendees: DeLorean Ruffin, DrPH; Greg Allen Friedman; Hannah O'Leary; Isaac Brown; Katherine Barresi, RN; Mohamed Jalloh, PharmD; Monika Brunkal, RPh
Virtual Attendees: Aaron Maxwell; Amanda Smith; Christine Smith; Denise Rivera; Jeff Ribordy, MD; Lilian Merino; Lisa O'Connell; Marshall Kubota, MD; Richard Matthews, MD; Vicky Klakken; William Kinder; Yolanda Latham
Absent: Colleen Townsend, MD; Kathryn Power; Mark Bontrager; Matt Hintereder; Nancy Steffen; Priscila Ayala; Rebecca Stark; Robert Moore, MD; Tim Sharp; Wendi Davis

Agenda Topic	Minutes	Action Items

1. CHA/CHIP updates
Time: 30 minutes
Speaker: Hannah
	Presentation given, see attached PowerPoint for more details.
	
	• Slide 2: MCP-LHJ Worksheet Status. Shasta and Humboldt refuse to sign, 5 counties still in progress.
	  ○ Shasta sees the worksheet as an MOU-like commitment. Humboldt wants a better understanding of Partnership's in-kind staffing process (e.g., what the Community Health Needs Liaisons (CHNLs) will and will not do for them, etc.). They're nervous about signing the form.
	  ○ At the 10/9 Board Meeting, there should be a larger discussion about community reinvestments, and representatives from these counties may attend. Partnership should have more talking points afterward.
	  ○ A webinar for Local Health Jurisdictions (LHJs) is planned later in the month of October, that should give them more info.
	  ▪ It would be good to distinguish funding sources, and the difference between an MOU and these worksheets. With in-kind staffing, counties have asked about whether they would get a full or part-time full time employee (FTE) assigned to them.
		• CHNLs will follow up with Shasta and Humboldt after the webinar to see if their

Agenda Topic	Minutes	Action Items
	• DHCS is having a listening tour on 10/15, and MOUs is one of the subjects. • Slide 3: Goal Status. Of 24 counties, 4 already have approved goals, 3 have goals pending approval, 9 have drafted goals, 3 have identified priority areas for a goal, and 5 have no goals. • Slide 4: Trinity County Goal. "Increase follow-up for SUD clients treated in the ED for SUD-related complaints." o After reviewing the goal, we'll remove the "8%" language to avoid confusion, and change the goal from 39.79% to 40%. o Should "Carelon" be removed from the goal? We don't believe they do this work. Trinity County Behavioral Health Services is the lead here. ▪ Before removing Carelon, we should check in with the Behavioral Health (BH) team to be sure it's fine to remove. Or does Strategy 1.1 and 2.1 align with Partnership's BH follow-up requirements? • Slide 5 and 6: Humboldt Resource Request. All categories of assistance were requested. o We'll plan to approve the categories from our request form. But there was also a funding request, for a total of $156,523. ▪ Nancy Stark from Humboldt is going to work with the county to modify the request with more doable asks. ▪ This committee can take the funding request to the executive team as a next step. Various factors make funding requests untenable for Partnership and other Medi-Cal plans at this time. o Does Humboldt have a SMART goal? ▪ Humboldt has a priority area identified, but no goal. As with the MCP-LHJ Worksheet, which they haven't signed, they want to know the extent of the resources available before they commit. • Having a goal from them would better justify the in-kind staffing support they're asking for. It would help to know what in-kind staff would be working on. We want to make sure the work is directed towards progressing the county's goal. o Do we have a standard way of handling funding requests? ▪ Being discussed at executive level. All Medi-Cal plans are leaning on in-kind staffing while they wait for more clarity from DHCS around funding of LHJs.	concerns have been addressed. • Hannah's team will run the updated goal by Trinity County. • Hannah's team will check in with BH about having Carelon in the goal.

Agenda Topic	Minutes	Action Items
	▪ Comparisons to Kaiser (which we share 8 counties with) aren't applicable. Kaiser has historically had a community health fund, funded with commercial money. As a Medi-Cal plan, Partnership can't do what Kaiser does. ○ What other funding requests have come in? ▪ There was one from Yuba, which we denied. ▪ Some counties have asked us to fund lunches • Slide 6: Five Part PHM Deliverable Update ○ Received the final template and forms from DHCS on 9/20. No significant change in content and questions. The original deadline of 10/31 has been extended to 11/22 (submission due to RAC on 11/21). [End of PowerPoint Presentation] • FYI for dept. leaders: the CHNL team will be reaching cross-departmentally to engage SMEs as needed to support CHA/CHIP work. This could include invitations to CHA/CHIP meetings with counties and/or local organizers. Managers and supervisors should be aware. ○ Staff joining CHA/CHIP meetings or activities should log their hours – the CHNL team will give them details. • CHNLs should be sure to get the specific asks from the counties before inviting other department SMEs to meetings. ○ Transportation is a topic of interest for many counties. ○ QI project managers could prepare a webinar for interested counties and CBOs, based on interest. They could go through the basics of getting groups and projects moving with LHJ reps, while not getting into the details of their particular projects. ▪ Right now, the CHNL team appears to be seen as the in-kind project managers by some LHJs. • CHNLs are welcome to engage with QI's QMSI workgroups, and for project management help, QI could help drive multiple similar projects along (i.e., multiple counties getting a VaxFacts website up and running) when opportunities arise. In that case, the QI project manager would gather all counties involved in a group setting.	• CHNLs will level-set that it is not in their scope to project manage a county's CHA/CHIP.

Agenda Topic	Minutes	Action Items

	Current County Request Forms:
	• The Resource Request form was updated to allow both the Public Health Officer or Director to sign. Shall we update the Data Request form to allow that as well?
	  ○ Yes, bring the Data Request form to parity with the Resource Request form re: signatures.
	• Received a data request marked as “urgent.” Are we prepared to fulfill urgent requests?
	  ○ Let’s remove the “urgent” option to avoid giving the perception that we offer urgent data reports.
		• Data Request Form signature and “urgent” box to be updated.

4. Next steps	• If attending a CHA/CHIP-relevant meeting, don’t forget to send the CHA/CHIP team your notes! • The next meeting is on December 3, 2024.	

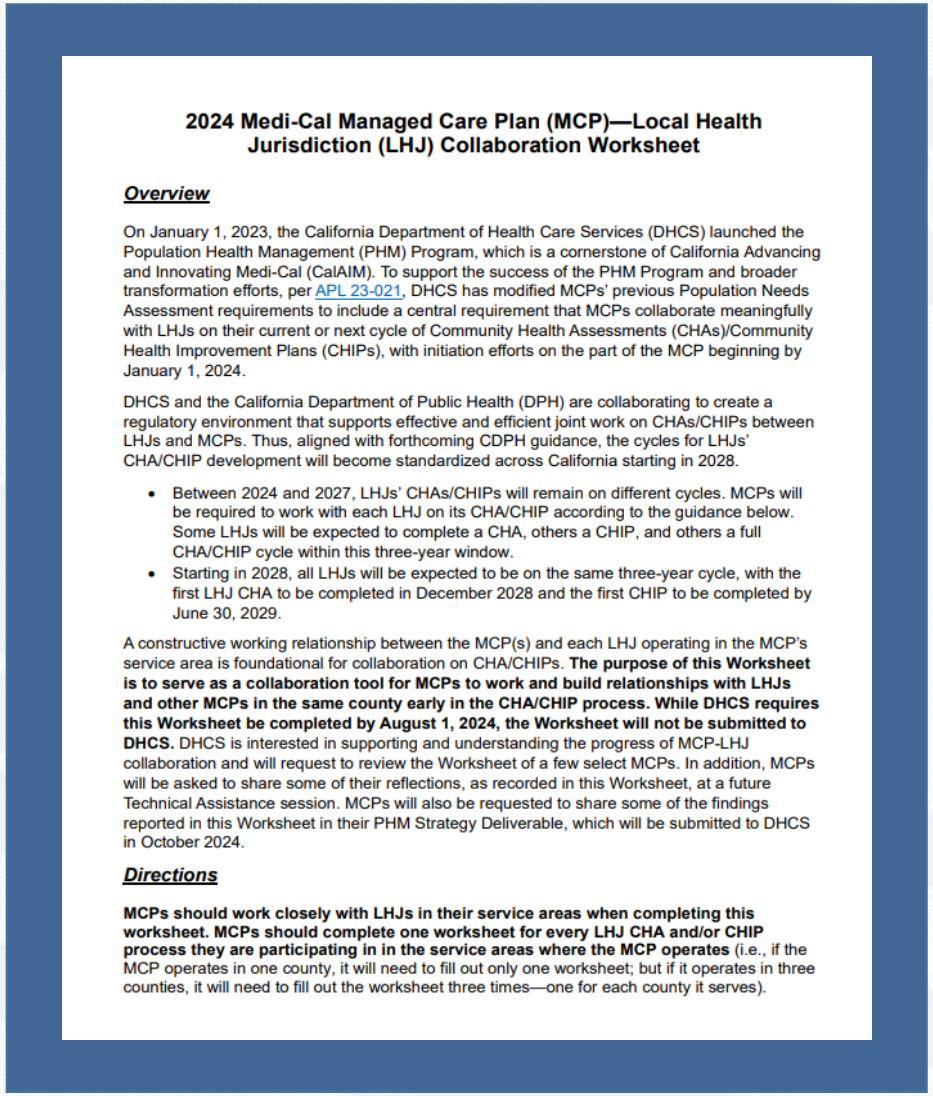
CHA/CHIP Updates

Hannah O’Leary, MPH, CHES

October 3, 2024

MCP-LHJ Worksheet Status

- 2 counties refused to sign
- 5 counties are in progress



2024 Medi-Cal Managed Care Plan (MCP)—Local Health Jurisdiction (LHJ) Collaboration Worksheet

Overview

On January 1, 2023, the California Department of Health Care Services (DHCS) launched the Population Health Management (PHM) Program, which is a cornerstone of California Advancing and Innovating Medi-Cal (CalAIM). To support the success of the PHM Program and broader transformation efforts, per APL 23-021, DHCS has modified MCPs' previous Population Needs Assessment requirements to include a central requirement that MCPs collaborate meaningfully with LHJs on their current or next cycle of Community Health Assessments (CHAs)/Community Health Improvement Plans (CHIPs), with initiation efforts on the part of the MCP beginning by January 1, 2024.

DHCS and the California Department of Public Health (DPH) are collaborating to create a regulatory environment that supports effective and efficient joint work on CHAs/CHIPs between LHJs and MCPs. Thus, aligned with forthcoming CDPH guidance, the cycles for LHJs' CHA/CHIP development will become standardized across California starting in 2028.

- Between 2024 and 2027, LHJs' CHAs/CHIPs will remain on different cycles. MCPs will be required to work with each LHJ on its CHA/CHIP according to the guidance below. Some LHJs will be expected to complete a CHA, others a CHIP, and others a full CHA/CHIP cycle within this three-year window.
- Starting in 2028, all LHJs will be expected to be on the same three-year cycle, with the first LHJ CHA to be completed in December 2028 and the first CHIP to be completed by June 30, 2029.

A constructive working relationship between the MCP(s) and each LHJ operating in the MCP's service area is foundational for collaboration on CHA/CHIPs. **The purpose of this Worksheet is to serve as a collaboration tool for MCPs to work and build relationships with LHJs and other MCPs in the same county early in the CHA/CHIP process. While DHCS requires this Worksheet be completed by August 1, 2024, the Worksheet will not be submitted to DHCS.** DHCS is interested in supporting and understanding the progress of MCP-LHJ collaboration and will request to review the Worksheet of a few select MCPs. In addition, MCPs will be asked to share some of their reflections, as recorded in this Worksheet, at a future Technical Assistance session. MCPs will also be requested to share some of the findings reported in this Worksheet in their PHM Strategy Deliverable, which will be submitted to DHCS in October 2024.

Directions

MCPs should work closely with LHJs in their service areas when completing this worksheet. MCPs should complete one worksheet for every LHJ CHA and/or CHIP process they are participating in in the service areas where the MCP operates (i.e., if the MCP operates in one county, it will need to fill out only one worksheet; but if it operates in three counties, it will need to fill out the worksheet three times—one for each county it serves).

Goal Status


Three Goals are pending approval
Nine goals are drafted
Goal Updates
Five have no goals
Three identified priority areas

Trinity County Goal

Goal: Increase follow up for SUD clients treated in the ED for SUD related complaints.

By December 31, 2025, increase follow-up care for individuals with substance use disorders (SUD) who present to the emergency department with SUD-related issues, such as overdose and withdrawal, by 8% of the baseline of 36.84% to 39.79%.

Strategy 1.1 Opioid Workgroup – Develop and implement a comprehensive referral system from the emergency department (ED) to County Behavioral Health or Carelon. This system should streamline the process of referring patients with SUD diagnoses from the ED, ensuring timely and effective connections to appropriate care services.

Strategy 2.1 Outreach Initiatives – Expand outreach efforts to increase awareness about available SUD care services and wrap around services through dissemination of outreach materials to individuals and community partners about the availability of SUD programs, Trinity County Behavioral Health Services, PHC- Carelon self-referral and transportation benefit options.

Humboldt Resource Request

- CHA/CHIP meetings
- Project management
- Supportive leadership
- Stakeholder engagement
- Other administrative tasks
- Other: funding

Humboldt Resource Request

Request for funding

- $41,523 - Live Well Humboldt Dashboard
- $65,000 - Live Well Humboldt Steering Committee
- $50,000 - Community Health Assessment Survey

Total ask: $156,523

Five Part PHM Deliverable Update

Shared Goal/SMART Objective

PHC/LHC meaningful participation

CHW Monitoring KPIs

MCP Bold goal projects

NCQA information

QI Department Update
November 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)	• Measurement Year (MY) 2025 proposed measure set was approved at the October Physician Advisory Committee (PAC) meeting. • MY2024 CG CAHPS data has been received, providers will be notified in early November with results. • The MY2023 PCP QIP Evaluation will be presented this month in all quality committee meetings.
Long Term Care Quality Improvement Program (LTC QIP)	• Quality Assurance Performance Improvement (QAPI) program attestations continue to be received from contracted LTC and Skilled Nursing Facilities (SNFs). These requests were made by Partnership in response to DHCS' LTC benefit standardization and subsequent All-Plan Letters (APL) specifying new quality improvement and quality monitoring requirements.
Palliative Care Quality Improvement Program (Palliative Care QIP)	• Payments for January – June 2024 performance will distribute this month. • The MY2025 proposed measure set was approved at October PAC.
Perinatal Quality Improvement Program (PQIP)	• Fiscal Year (FY) 2023-2024 incentive payments are scheduled for distribution later this month. • Supplemental QIP payment for reassigned Dignity Health members will also distribute this month.
Enhanced Care Management quality improvement program (ECM QIP)	• No updates
Hospital Quality Improvement Program (HQIP)	• FY 2023-2024 incentive payments are scheduled for distribution later this month.

Quality Data Tools

TOOL	UPDATE
Partnership Quality Dashboard (PQD)	• N/A
eReports	• MY2025 eReports development has begun with the annual Business Requirements Document (BRD) nearly finalized. • First stage User Acceptance Testing (UAT) will begin next month.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*Institute for Healthcare Improvement (IHI) / DHCS Medi-Cal Child Health Equity Collaborative*
	• This collaborative is focused on improving child health equity, specifically for pediatric well-care visits.
	• Partnership and Stallant Health and Wellness in Del Norte County are collaborating in a project. The populations of focus are Native American / Alaskan Native and Hispanic populations. Defined Aims for targeted populations are as follows:
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase the annual well-care visit completion rates for the Native American/Alaskan Native population who are 3-17 years of age from 8% to 25% by March 2025.
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase their annual well-care visit completion rates for the Hispanic population who are 3-17 years of age from 20% to 40% by March 2025.
	• The 3rd phase of this collaborative began on 08/22/2024 and focuses on conducting a Plan-Do-Study-Act (PDSA) cycle.
	  ○ Through additional discovery, it was determined that a vast majority of the patients assigned to Stallant who are Native American/Alaskan Native are seeking care at another local contracted primary care provider. Efforts are currently underway to initiate member re-assignment to accurately represent where each member is seeking care, and therefore has shifted the focus of this PDSA to only the Hispanic population.
	  ○ Stallant has launched a PDSA focusing on additional touch points prior to scheduled pediatric well care visits. The goals are to better ensure the parent/guardian is educated on the reasons for and importance of well-care visits, as well as ensuring access to necessary pre-appointment paperwork in advance of the appointment. This includes making sure the paperwork is available in Spanish, where needed.
	IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative
	• DHCS and IHI have also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, along with the Nevada County Behavioral Health Department, were selected by DHCS to participate in this collaborative.
	• The Partnership/Nevada County DBP team is currently selecting an initial intervention to pilot in fall 2024.
	• This collaborative will run April 2024 through June 2025. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:

	○ % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM) ○ % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA) *Performance Improvement Projects (PIPs) Update* As a contracted managed care plan (MCP), DHCS assigned two (2) PIPs to Partnership that will be completed over 2023–2026. Annual submissions for both PIPs were submitted to DHCS on 09/11/2024. • Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County: ○ Partnership piloted an intervention with newborns born at NorthBay Medical Center, the only hospital in Solano County that is open to Medi-Cal members. The intervention will pilot the use of navigators. The pilot focuses on assisting these families in enrolling in the Growing Together Program, completing the Newborn PCP Selection Form, and ensuring that they have begun the Medi-Cal enrollment process for their newborns. ○ Cycle 1 of the pilot is complete. Cycle 2 will continue the intervention with newborns born at NorthBay as part of Population Health's post-partum follow-up outreach, and also explore opportunities to add additional L&D's in proximity to Solano County to the pilot. • Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit. ○ Partnership is piloting an intervention with a provider organization (PO) to increase rates for follow-up visits for members with a recent ED visit with a mental health diagnosis. ○ Partnership and the Provider Organization began work on Cycle 1 in September 2024. The Provider Organization will use ED alerts that they receive via their Epic OCHIN EMR to track, schedule, and complete follow up visits with members. Partnership will verify that the visit coding results in closed care gaps for the FUM measure. Best practices from Cycle 1 have potential to be spread to other provider organizations using Epic. *DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Based on MY2022 HEDIS performance, DHCS has assigned Partnership additional accountability work around the Behavioral Health, Children's Health, and Reproductive Health and Cancer Prevention measure domains. This work, called the Comprehensive Quality Improvement and Health Equity Process, will require Partnership to complete strategies and action plans for 2024 activities meant to improve HEDIS rates in the included domains. • Partnership submitted progress reports to DHCS on strategies and action items to improve HEDIS measure performance on 10/25/2024.

	• 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	• A new internal committee was formed and conducted an initial kick-off meeting to develop an organization-wide strategy to address lagging measure performance under pediatric well-care visits (i.e. 6 visits within the first 15 months of life). The goal of this new committee is to develop a strategic approach that brings together all current efforts, as well as: ○ Initiate additional efforts needed to improve performance ○ Raise awareness and leverage operational expertise of all staff and departments within Partnership ○ Inform providers and engage members • 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. Providers participating in Practice Facilitation in 2024 include: ○ Solano County Family Health Services (Fairfield Region) ○ Community Medical Center (Fairfield Region) ○ Consolidated Tribal Health Project (Eureka Region)

	○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties (Eureka, Redding, and Chico Regions) ○ Adventist Health Ukiah Valley – Mendocino County (Eureka Region) ○ Ampla Health (Chico Region) ○ Northern Valley Indian Health (Chico and Fairfield Region) ○ Wellspace Health (Auburn Region) ○ Western Sierra Medical Clinic (Auburn Region)
Improvement Academy	• The ABCs of Quality Improvement training will happen on 11/07/24 in Fairfield. Promotion for the 01/30/2025 session in Ukiah is underway.
Joint Leadership Initiative (JLI)	• Fall Sessions are underway. Ampla's first JLI was held on 10/14/2024. Remaining sites are scheduled and include: ○ Shasta Community Health Center – 11/18/2024 ○ Fairchild Medical Center – 12/12/2024 ○ Solano County Family Health Services – 12/17/2024
Regional Improvement Meetings	• The 4th quarter Redding and Eureka Regional Improvement (quarterly) meetings are scheduled: ○ Northeast focus: 11/18/2024 ○ Northwest focus: 11/26/2024 • The Santa Rosa Region (Marin and Sonoma Counties) held a Regional Quality meeting on 10/17/2024. The meeting featured presentations on 2024 QIP "sprint" activities and a provider presentation on promising practices in assigning priority rankings to pediatric members with screenings approaching due dates. • The Solano QIP Improvement (SQIP-I) Regional Bi-Monthly meeting was held on 10/03/2024. The meeting featured an update on the W15 Disparity PIP interventions in Solano County.

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

QI Program & Project Management

ACTIVITY	UPDATE
State Mandated Work: Equity and Practice transformation (EPT) Program	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). • Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding. ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). ○ The EPT strategy team continues to explore utilization for the remaining IPIP funds. A subset of funds will be allocated to tribal health

	organizations to support improvement efforts. More information will follow as plans for the allocation of funds continue to develop. • All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by the 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS is recalculating the final award amounts, due to the budget revisions. ○ EPT practices were required to submit Key Performance Indicator (KPI) reports on 11/01/2024 by 11:59 p.m. ▪ Required Key Performance Indicator (KPI) Reporting on empanelment and access administrative metrics; Empanelment, Continuity, and Third Next Available Appointment. ○ EPT practices have as early as 11/01/2024 and up until 11/01/2025 to submit the below milestone deliverables: ▪ Empanelment and Access Milestone 1: Empanelment Assessment ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure. ○ EPT milestone deliverable templates to guide practices on their submissions are available on Population Health Learning Center's website: https://pophealthlearningcenter.org/milestones-and-deliverables/ ○ PHLC will have until 11/30/24 to review the milestone deliverable submissions and will send Managed Care Plans (MCPs) a report of all milestone deliverables EPT practices have and have not submitted later this month. ○ DHCS will operationalize EPT payments from December 2024 – February 2025. ○ MCPs should receive EPT payment from DHCS by March 2025, which they will send to EPT practices by April 2025. • 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) hosts bi-monthly "All MCP EPT Meetings" to share updates, on behalf of DHCS, related to EPT technical assistance and the program as a whole. ○ In the last “All MCP EPT Meeting” it was announced that MCPs will be reporting on the Assigned and Seen Improvement, one (1) of the four (4) administrative measures within the Key Performance Indicator (KPI) milestone deliverables. ○ PHLC is soliciting feedback from MCPs and working with DHCS to develop the KPI measure specifications. ○ Claims data will be used to get the most accurate picture of how practices are doing, however, the type of claims data required is still being determined. ○ If data will not be pulled from HEDIS software, there is concern about creating a new software/project to pull data from with limited resources. ○ A subset of the EPT strategy team met with PHLC’s Director of Analytics and Impact to voice their data concerns. ○ PHLC is hosting Data Workgroup sessions to discuss the specifications for practice-level data reporting on HEDIS-like measures. More information to come as PHLC finalizes these specifications.
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. ○ The second and final installment of CEG funding totaled $1,441,857.50. ○ Each CEG Awardee received a portion of the total funding based on their newly assigned membership on 10/24/2024.
LOCUM PILOT INITIATIVE	The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited Grant Program, whereby participating Provider Organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period. • A total budget of $250,000 was approved; participating Providers receive up to: ○ $45,000 when hiring a Physician; or ○ $31,600 when hiring an Advanced Practicing Clinician. • The Grant is paid in two installments: ○ 1st installment upon signing the Agreement, 50% of eligible funds ○ 2nd installment upon completing the 4-week assignment and post-program survey, remaining 50% • The initial cohort of providers was selected from those participating in the PCP Modified QIP. ○ Six (6) offers to apply were made and four applications were received.

- All four (4) applications were reviewed and accepted into the pilot program.

- Locum assignment periods will be carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment.
- Locum Providers are alleviating a backlog of well-child and adolescent visits.
- Locum Providers are covering urgent care which allows patients to schedule visits with their preferred physician.
- Hill Country Community Clinic initially hired a locum who was unable to fulfill the requirements of the position. A new locum contract has been executed with an anticipated start date of 11/04/2024, beginning with three (3) days of onboarding.
- Round Valley Indian Health is developing a plan to utilize two (2) retired clinicians, a medical doctor and a nurse practitioner, to complete the grant activities before the end of the calendar year. Knowledge of the practice and experience with their EMR will speed up the onboarding process.
- Community Medical Center completed the initial grant activities and has been awarded an extension; their locum will be funded through the end of 2024 to continue focusing on well-child visits, including up to 120 Direct Members in the surrounding area.
- Pit River Health Service is utilizing an existing locum, blocking time periodically for scheduled well-child visits and cervical cancer screenings. Grant activities will be completed through the end of 2024.
- Recipients of the Capacity Enhancements Grant who utilized Locum Tenens as short-term interventions are being surveyed for their experience and best practices to bolster pilot data.
- A round-table style debrief was held on 10/09/2024, a total of 24 people came together in discussion, including 14 provider staff (representing all 4 practices participating in the pilot), 4 Partnership Improvement Advisors and the QI Program & Project Management Team. Topics included: Managing a Grant, Recruiting and Onboarding, Program Impact on the Practice and Patients, and overall Program Review. Feedback captured during the session will be included in a comprehensive evaluation towards the completion of the first phase of the program.

Provider Organization	Total Award	Locum Assignment and Status
Hill Country Community Clinic	$31,600	Locum is in contract, anticipated start date November 4.
Pit River Health Service	$31,600	Focus: Well Child Visits and Cervical Cancer Screenings. Visits are being scheduled and tracked through the end of the year.
Round Valley Indian Health	$45,000	Developing plan: Retired MD and NP will work part-time to address Well Child Visits &

			Cervical Cancer Screenings through the remainder of 2024.
	Community Medical Center	$31,600	Focus: Child/Adolescent Well Care & Immunizations Initial program complete; an extension to the contract has been granted through December 2024.

Quality Measure Score Improvement
Mobile Mammography Program

- Between 07/01/2024 to 10/31/2024, Partnership sponsored 28 Mobile Mammography event days with 19 provider organizations at 27 provider sites.

Completed Event Days 07/01/2024 – 10/31/2024				
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**	**# of Completed Partnership Screenings**
ER	3	5	5	68
NE	7	8	9	163
NW	2	7	7	145
SE	2	2	2	43
SW	5	5	5	99
Plan Wide	**19**	**27**	**28**	**518**

- 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.
- One (1) event day in the Eastern Region was held at a Tribal Health Center in Tehama County.
- Upcoming Mobile Mammography events in November and December include:

Upcoming Event Days 11/01/2024 – 12/31/2024			
Legacy Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
ER	3	6	6
NE	1	1	1
NW	1	1	1
SE	1	1	1
SW	2	2	2
Plan Wide	**8**	**11**	**11**

- In response to several inquiries on upcoming events, the following list is included to detail participating provider organizations with completed and upcoming event days:

Northwest Region	
8/20/2024	K'ima:w Medical Center
8/28/2024	Open Door Community Health Centers (Willow Creek Community Health Center)
9/24/2024	Open Door Community Health Centers (Del Norte Community Health Center)
9/25/2024	Open Door Community Health Centers (McKinleyville Community Health Center)
9/26/2024	Open Door Community Health Centers (Arcata Community Health Center)
9/27/2024	Open Door Community Health Centers (Eureka Community Health Center)
9/28/2024	Open Door Community Health Centers (Redwood Community Health Center)
11/11/2024	K'ima:w Medical Center

Northeast Region	
7/24/2025	Shasta Community Health Centers (Shasta Community Health Center)
7/24/2025	Shasta Community Health Centers (Shasta Community Health Center)
8/19/2024	Churn Creek Healthcare - Redding Rancheria (Redding Rancheria Trinity Health Center)
8/21/2024	Hill Country Community Clinic Inc, (Churn Creek)
8/22/2024	Mountain Valley Health Centers (Butte Valley Health Center)
8/23/2024	Anderson Walk in Medical (Anderson Walk in Medical Clinic)
8/29/2024	Hill Country Community Clinic Inc, (Round Mountain)
10/24/2024	Shingletown Medical Center
10/25/2024	Surprise Valley Medical Clinic
11/12/2024	Shasta Community Health Centers (Shasta Community Health Center)

Southwest Region	
9/4/2024	Alexander Valley Regional Medical Center (Alexander Valley Healthcare)
9/11/2024	Long Valley Health Center
9/12/2024	West County Health Centers (Russian River Health and Wellness Center)
9/13/2024	Alliance Medical Centers (Healdsburg Clinic)
10/21/2024	Ritter Health Center
11/14/2024	Marin City Health & Wellness Center
11/21/2024	Consolidated Tribal Health Center

Southeast Region	
9/5/2024	Community Medical Centers (Community Medical Center Dixon)
9/6/2024	Elica Health Centers (Elica Health Centers - Halyard)
11/15/2024	Community Medical Centers (Community Medical Center Vacaville)

Eastern Region	
7/26/2024	Ampla Health (Ampla Health Chico Medical)
7/27/2024	Ampla Health (Ampla Health Orvoville Medical)
8/30/2024	Ampla Health (Ampla Health Richland Medical)
10/22/2024	PeachTree Healthcare (Peach Tree Health)
10/23/2024	Greenville Rancheria (Greenville Rancheria - Red Bluff)
11/13/2024	Sierra Family Health Center
11/18/2024	Ampla Health (Ampla Health Richland Medical)
11/19/2024	Rolling Hills (Rolling Hills Clinic - Red Bluff)
11/20/2024	Rolling Hills (Rolling Hills Clinic - Corning)
12/13/2024	Ampla Health (Ampla Health Lindhurst Medical)
12/14/2024	Ampla Health (Ampla Health Chico Medical)

- The Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 50th percentile benchmark has been met in the Southeast and Southwest Regions for the 2024 measure year.

QI Trilogy Program	• The following QI Trilogy Documents received formal Board approval in October and were submitted by the Regulatory Affairs and Compliance Department to the Department of Healthcare Services (DHCS). ○ FY 2024/25 QI Program Description ○ FY 2023/24 QI Work Plan (Final Updates) ○ FY 2023/24 QI Program Evaluation ○ FY 2024/25 QI Work Plan (Goal Submissions)
Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program	• The (MY 2023|RY 2024) Annual Member Experience (ME 7) analysis will be presented formally at Committee (IQI and Q/UAC) in November. • The CAHPS program is preparing for the next survey cycle (MY 2024|RY 2025) including development of supplemental questions and decision as to which formal population (Adult or Child) survey results will be submitted to NCQA for Patient Experience Rating and overall Healthplan Star Rating. • The strategic planning/implementation of the non-regulated (drill down) CAHPS® survey revealed key findings relative to member dissatisfaction. Goal activities over the past two fiscal years helped shape drill down questions to identify barriers related to common benefit questions and/or benefit confusion. Survey results and analysis offered insights for leadership to target improving member benefit literacy through additional actions related to assessment, staff engagement, and continued member engagement. • Fiscal Year (FY) 2024-25 Organization Goal #4 - Access to Care and Member Experience Improvement: Multiple departments are actively collaborating on eight goal milestones. The designated goal lead submitted FY Q1 goal update providing a summary of five goal champions within the following departments: Communication, HR/ Work Force Development, Member Services, and Quality Improvement. ○ Goal percentage complete as of FY Q1: 29.88% • All goals are expected to be MET by the end of the FY 24-25 goal period.
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. An additional HEDIS Analyst and Program Coordinator are planned for posting in early 24/25. ○ The Perinatal QIP is underway and began offering incentives under the ECDS measure for East Region Providers that contract with DataLink. ○ The last session of the HEDIS focused monthly office hours was held on 11/13/2024. The goal of these office hours has been to strengthen providers' understanding of how quality is measured by Partnership under its Annual HEDIS projects. ○ In-depth Site Review trainings to address DHCS Site Review tool changes are ongoing with new sessions being scheduled, as needed.

	○ East Region providers have been engaged in many Regional Collaborative events focused on PCP QIP needs such as: ▪ Monthly "How to Succeed in the PCP QIP" sessions. ▪ Operations meetings where Performance Improvement (PI) and Quality Incentive Program (QIP) teams attend to support East Region provider's QIP performance. ▪ Annual Tribal Health Convening with Partnership • Chapa-De, Feather River, Greenville Rancheria, and Rolling Hills attended the 10/07/24 event. ○ East Region participation in 2024 Joint Leadership Initiative (JLI) meetings have been identified with the following Provider Organizations (POs): ▪ Ampla Health ▪ Adventist Health (East Region sites will be included with their established JLI)
BLOOD LEAD SCREENING INITIATIVE	• Partnership has completed two (2) rounds of Blood Lead testing grants for point-of-care (POC) devices for primary care providers and has closed its 3rd grant offering. ○ The first round resulted in ten (10) POC device awardees along with two (2) reimbursements for recently purchased POC devices. ○ The second round has resulted in eleven (11) POC device awardees along with fifteen (15) reimbursements for recently purchased POC devices. Second round devices were recently delivered to participating sites. ○ The third round launched closed on 09/30/2024 with four (4) POC device awardees. • The program is transitioning from a round-based application process to an ongoing, continuous application period. This means applicants will no longer need to wait for specific rounds to apply. Instead, they can submit applications at any time. We are currently updating all materials to reflect this new approach and developing a targeted promotional strategy aimed at reaching low-performing participants who have not applied before.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **10/01/2024 TO 10/31/2024**	• PQI referrals received during this period: 27. Out of 27, 21 cases were referred from Grievance and Appeals, 1 from a Regional Medical Director, 1 from Utilization Management, 1 from Care Coordination and 3 from other sources. • PQI cases reviewed at the Peer Review Committee: 1 case • Cases processed and closed to completion: 19 cases • Focused Review: 1 case is being currently reviewed • PQI cases that are currently open: 89 cases

FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **09/30/2024 TO 10/25/2024**	• As of 10/29/2024, Partnership is responsible for conducting site reviews across a total of 451 PCP and OB sites, with an additional 29 reviews required due to multiple patient check-ins within larger sites. In total, this requires managing a total of 480 periodic site reviews. **Primary Care and OB Reviews – for the most recent reporting period:**

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

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	MY2024 Annual Audits:
	• Planning is underway for the MY2024 Annual Audits:
	  ○ DHCS Managed Care Accountability Set (MCAS) – Kickoff Date targeted to occur in November 2024
	  ○ NCQA Health Plan Accreditation (HPA) – Readiness Assessment scheduled in November 2024
	• The Non-Clinical team has started outreach to the provider network to confirm contact information, EHR for client collected and new providers. Thank you to those who have responded to our outreach.

HEDIS® Program Overall	• New Supplemental Data Source being assessed: ○ Efforts are underway to validate and integrate a new supplemental data resource through one of NCQA's approved data aggregators. This data source is anticipated to provide additional supplemental data to support several HEDIS measures. Primary focus will begin with the depression screening measures along with the W30 measure. • A W30 medical record review (MRR) will be conducted as a special project to identify compliant supplemental medical record documentation, via the PCP QIP, that will support HEDIS administrative rate for MY2024. This review will be performed along with the annual MRR set to launch February 2025. • Partnership's HEDIS Week was conducted 10/21/2024 – 10/25/2024. We received positive feedback from staff. The HEDIS team received the survey results from T&D, which they will use to plan for next year. HRP: Conversion of PHC's core claims system from Amisys to HRP • A final round of testing is planned to begin in November 2024 to support the overall pending implementation of Health Rules Payer-Health Edge (HRP)

	Geographic Expansion: • Continued preparation is underway to begin plan-wide reporting as required by DHCS (MCAS) and NQCA (HPA) reporting. • Additional County-Level Oversampling will be conducted for all 24 counties, as proposed and accepted by DHCS. D-SNP Preparation: • Efforts are in progress to prepare for baseline data capture & integration to support the D-SNP implementation planned for January 2026. • A Program Manager I has been hired to support the business requirements needed to support the development and implementation of Partnership's D-SNP based on integration of Medicare's specific requirements.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• The NCQA Program Management Team met with our NCQA consultant to assess the changes made to the 2025 HPA Standards and Guidelines and obtained clarification, as needed. This included focused discussion around the changes made to the former System Controls, now known as Information Integrity and the new QI 3 standard. Information learned from our NCQA consultant will be shared with Business Owners, as applicable. The NCQA Program Management Team will work with Business Owners to address the new requirements or any modification of the existing requirements, so Partnership can continue to maintain HPA compliance based on NCQA's look-back period, timelines, and/or expectations. • HPA Key Activities for FY 24-25: ○ All Business Owners (BOs) submitted the annual HPA Work Plan for Milestone 2, and the 2024-2026 HPA Report Schedule for Milestone 3, by the 10/18/2024 due date, with the exception of one department. The NCQA Program Management Team continues to work with the BOs based on edits made under the annual HPA Workbook, and clarify the list of evidence in alignment with NCQA's look-back period, timelines, and/or expectations. Additionally, all annual reports remain on track for timely submissions and review by the NCQA Consultant. Risks associated with the untimely submission of the Workbook and Report Schedule will be escalated to the NCQA Steering Committee. • Milestone 4 is in progress, with the next quarterly file review audits being due in November and December 2024. To date, no issues have been reported.
NCQA Health Equity Accreditation (HEA)	• The six-month look-back period for the HEA Initial Survey will begin in December 2024. The NCQA Program Management team continues to work closely with all Business Owners to ensure all documented processes are in compliance and necessary screenshots have been captured prior to the start of the look-back period.

	• HEA Key Activities for FY 24-25: ○ Milestone 2 required Business Owners to review, and update as needed, the HEA Workbook, which consists of the HEA Work Plan and Evidence Submission Library. The HEA Workbooks have been submitted, with the exception of one department. The NCQA Program Management Team will work with Business Owners to obtain clarifications, as needed. Risks associated with the untimely submission of the Workbook will be escalated to the NCQA Steering Committee. ○ Milestone 3 remains in progress. There are three (3) components to this milestone: ▪ Documented Processes: Business Owners provided their acknowledgement that documented processes meet the scope of review by the 10/25/2024 due date, with the exception of one department. ▪ Materials: In progress. Business Owners are to submit all applicable screenshots by 11/15/2024. On track for timely completion. ▪ Analysis Reports: In progress. Analysis Reports remain on track for timely completion and review by our NCQA Consultant.

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

Consent Calendar

Nov. 20, 2024

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

	Page #
2023 PCP QIP Program Evaluation – *direct questions to Athena Beltran-Nampraseut*	79 - 102
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UM Delegation to Capitated Hospitals – *direct questions to Tony Hightower, CPhT*	115
Quality Improvement Policies	
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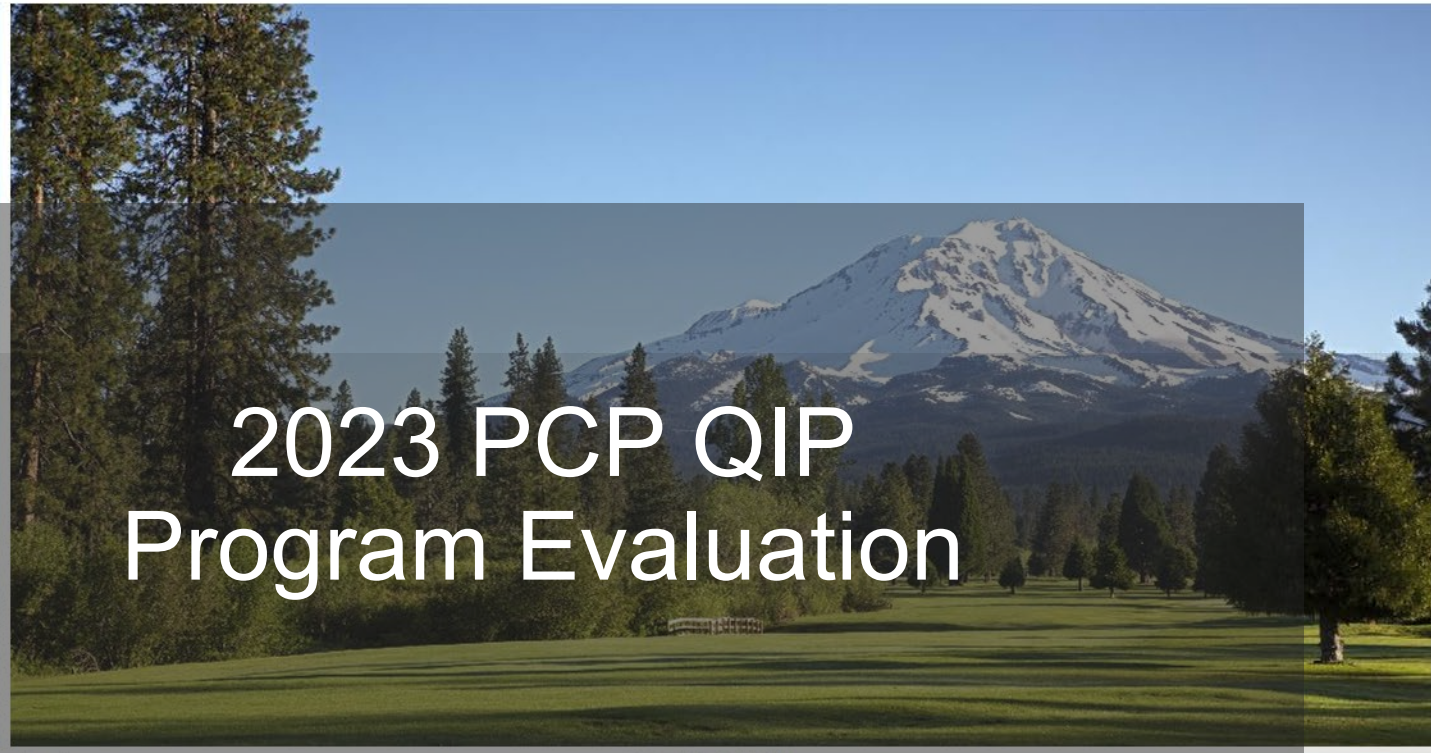
[1] Immunization language updated per DHCS's recently approved APL 24-008.

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency



2023 PCP QIP Program Evaluation

ACCREDITED NCQA HEALTH PLAN

Prepared by:
Athena Beltran-Nampraseut
November 2024

Contents


2023 Program Overview


2023 Program Adjustments and Changes


2023 PCP Program Performance


2023 Payout Overview


2023 Summary

2023 PCP Program Overview

Clinical Core Measurement Set

PCP QIP is a Calendar Year program: January 1 – December 31

CLINICAL DOMAIN										
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	AGE RANGE	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FULL 75th	PARTIAL 50th	FAMILY	INTERNAL	PEDS
✓	✓	✓	Asthma Medication Ratio	CHRONIC DISEASE MANAGEMENT	5 - 64 YRS	69.67%	64.26%	6 / 4	8 / 6	13 / 10
✓	✓		Comprehensive Diabetic Care - HbA1c Control		18 - 75 YRS	64.48%	60.10%	6 / 4	11 / 8	--
✓	✓		Comprehensive Diabetic Care - Retinal Eye Exams		18 - 75 YRS	56.51%	51.09%	5 / 3	5 / 3	--
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	65.10%	59.85%	6 / 4	10 / 8	--
✓		✓	Immunization for Adolescents - Combination 2	PREVENTATIVE SCREENING	13 YRS	41.12%	35.04%	6 / 5	--	16 / 12
✓	✓		Breast Cancer Screening		50 - 74 YRS	56.52%	50.95%	6 / 5	12 / 9	--
✓	✓		Cervical Cancer Screening		21 - 64 YRS	62.53%	57.64%	6 / 4	12 / 9	--
✓		✓	Childhood Immunization Status - Combination 10		2 YRS	42.09%	34.79%	6 / 5	--	16 / 12
✓	✓		Colorectal Cancer Screening		45 - 75 YRS	40.23%	32.80%	5 / 4	12 / 9	--
✓		✓	Child and Adolescent Well Care Visit	PEDIATRIC ACCESS	3 - 17 YRS	57.44%	48.93%	9 / 7	--	16 / 12
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	61.19%	55.72%	9 / 7	--	16 / 12

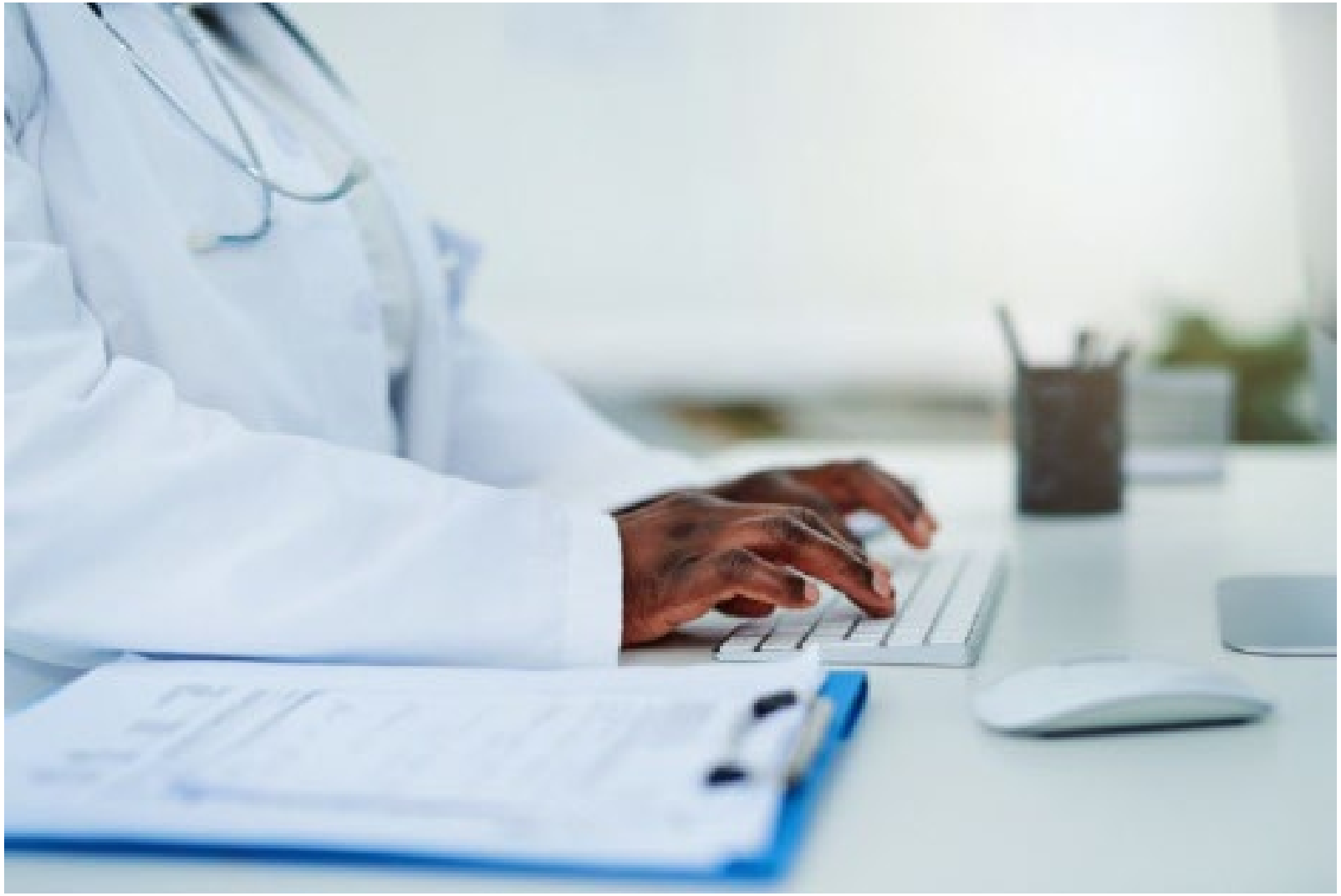
Non-Clinical & Patient Experience Measurement Sets

PRACTICE TYPE			NON-CLINICAL			FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FAMILY	INTERNAL	PEDS
APPROPRIATE USE OF RESOURCES								
✓	✓		Ambulatory Care Sensitive Admissions	FULL POINT TARGET 8.21 (60th Percentile)	PARTIAL POINT TARGET 10.61 (70th Percentile)	5 / 4	5 / 4	--
✓	✓		Risk Adjusted Readmission Rate	FULL POINT TARGET **SCORE <1.0**	PARTIAL POINT TARGET **≥1.0 - 1.2**	5 / 4	5 / 4	--
ACCESS AND OPERATIONS								
✓	✓	✓	Avoidable ED Visits	FULL POINT TARGET 6.57 60th Percentile	PARTIAL POINT TARGET 8.25 70th Percentile	5 / 4	5 / 4	7 / 5
✓	✓	✓	PCP Office Visits	FULL POINT TARGET Greater than 1.8 visits per member per year on average	PARTIAL POINT TARGET Between 1.5 and 1.8 visits per member per year on average	5 / 3	5 / 3	6 / 4
PATIENT EXPERIENCE								
✓	✓	✓	Patient Experience	**CAHPS**	**ACCESS**	**COMMUNICATIONS**	10 / 8	10 / 8	10 / 8
					FULL POINTS 50TH Percentile (45.19%)	FULL POINTS 50TH Percentile (69.69%)			
					PARTIAL POINTS 25TH Percentile (37.86%)	PARTIAL POINTS 25TH Percentile (66.34%)			
				SURVEY OPTION	**FULL POINTS**	**PARTIAL POINTS**			
					PARTS 1 AND 2	PARTS 1 OR 2			

Unit of Service

UNIT-OF-SERVICE
MEASURE
Advance Care Planning Attestations
Extended Office Hours
PCMH Certification
Peer-led Self-Management Support Groups (both new and existing)
Health Information Exchange
Health Equity
Blood Lead Screening
Dental Fluoride Varnish
Tobacco Screening
Electronic Clinical Data Systems (ECDS)

2023 PCP Program Adjustments/Changes



Core Measurement Sets Adjustment 2022 ➡ 2023

2022 Core Measurement Set
Clinical Measures
Asthma Medication Ratio
Breast Cancer Screening
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Control
Controlling High Blood Pressure
Counseling for Nutrition for Children/Adolescents
Counseling for Physical Activity for Children/Adolescents
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
Risk Adjusted Readmissions
Aviodable ED Visits/1000 member per year
Patient Experience
Monitoring Measures
Diabetes Management: Eye Exams
PCP Office Visits

2023 Core Measurement Set
Clinical Measures
Asthma Medication Ratio
Breast Cancer Screening
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Control
Comprehensive Diabetes Care: Retinal Eye Exams
~~Counseling for Nutrition for Children/Adolescents~~
~~Counseling for Physical Activity for Children/Adolescents~~
Controlling High Blood Pressure
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
Risk Adjusted Readmissions
Aviodable ED Visits/1000 member per year
Patient Experience
PCP Office Visits
Monitoring Measures

Key: Monitoring Measure, New Measure & ~~Removed Measure~~

UOS Measurement Sets Adjustment 2022 ➡2023

2022 Incentivized Measures
Clinical Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led Self-Management Support Groups
Alcohol Misuse Screening & Counseling
Health Information Exchange
Initial Health Assessment
Health Equity
Blood Lead Screening
Dental Fluoride Varnish
Tobacco Screening
Electronic Clinical Data Systems (ECDS)

2023 Incentivized Measures
Clinical Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led Self-Management Support Groups
~~Alcohol Misuse Screening & Counseling~~
Health Information Exchange
~~Initial Health Assessment~~
Health Equity
Blood Lead Screening
Dental Fluoride Varnish
Tobacco Screening
Electronic Clinical Data Systems (ECDS)

Key: ~~Removed Measure~~

Payment Methodology – Equity Adjustment

Equity adjustment is intended to make the PCP QIP payment fairer, while not reducing motivation to strive for high quality

- Gateway
  - Must have at least 100 assigned members as of December 1st of the current measurement year
- Core Adjustments
  - Acuity of patient panel
  - Socio-demographic risk, at patient level, rolled up to PCP site level
  - Site difficulty in recruiting PCP physicians
  - Lower than average baseline per visit resources available to PCP
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year
- Pediatric Access Adjustment
  - Adjustments for Family Practices and Pediatric Practices in certain FQHCs, RHCs, and Tribal Health Centers who agreed to have CHDP visits removed from capitation

Core Adjustments	
Percentage Weight	Equity Adjustment Factor
40%	Acuity Adjustment (2 components
20%	Socio-demographic risk factors
20%	Difficulty in Recruiting PCPs (2 components)
20%	Below Average Resources

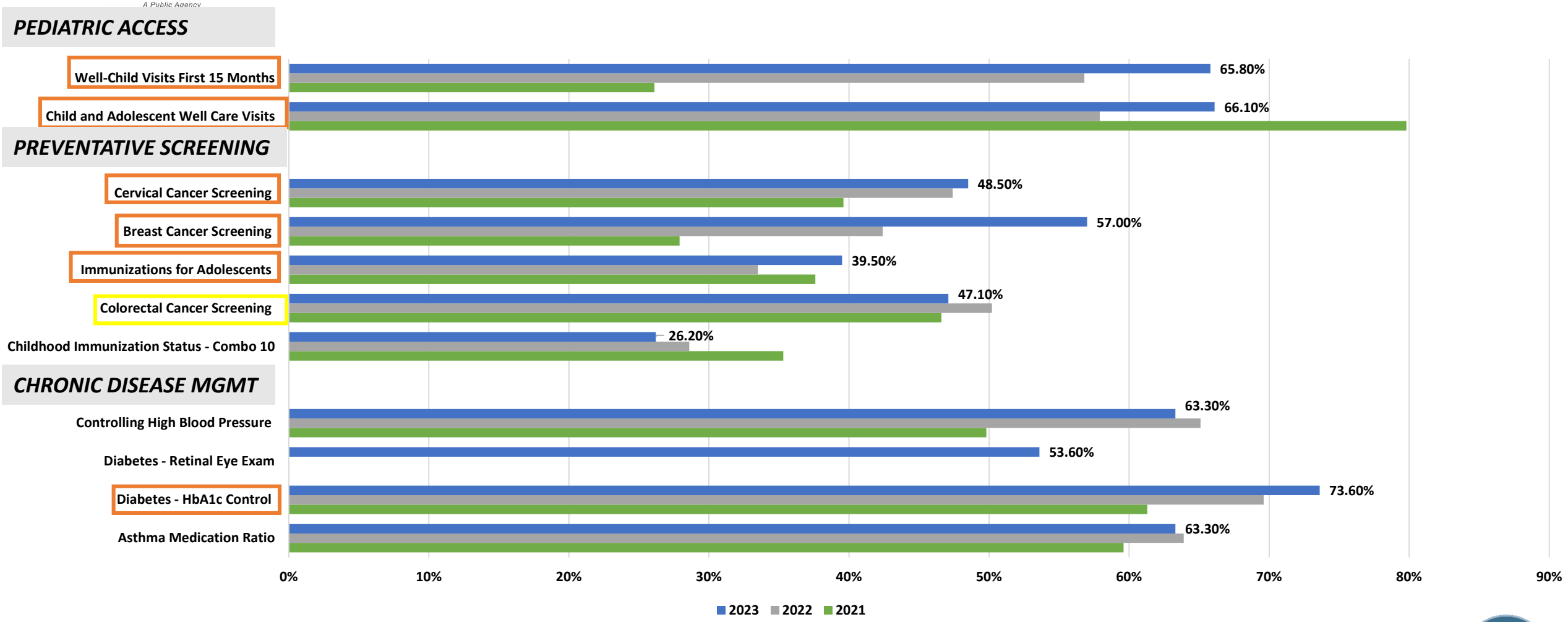
2023 PCP Program Performance

Plan-wide Performance
Clinical Domain YoY

PLANWIDE				
Clinical Core Measurement Set	2021	2022	2023	22-23 Relative Change
Asthma Medication Ratio	62.93%	70.62%	71.00%	0.54%
Breast Cancer Screening	49.51%	52.73%	54.87%	4.06%
Cervical Cancer Screening	57.92%	57.74%	56.96%	-1.35%
Child and Adolescent Well Care Visits	50.45%	51.30%	53.37%	4.04%
Childhood Immunization Combo 10	31.29%	30.35%	28.60%	-5.77%
Colorectal Cancer Screening (51-75 yrs.)	40.01%	39.93%	38.66%	-3.18%
Controlling High Blood Pressure (18-85 yrs.)	63.63%	65.78%	66.72%	1.43%
Diabetes - HbA1c Good Control (<=9.0%)	65.23%	65.98%	69.93%	5.99%
Diabetes - Retinal Eye Exam	N/A	N/A	56.67%	N/A
Immunizations for Adolescents	34.96%	37.06%	39.71%	7.15%
Well-Child Visits (1st 15 Months)	53.35%	61.54%	63.95%	3.92%
Counseling for Nutrition for Children/Adolescents	70.48%	67.82%	N/A	N/A
Counseling for Physical Activity for Children/Adolescents	67.81%	66.09%	N/A	N/A

GREEN – Increased Relative Change
RED – Decreased Relative Change
YELLOW – Not Applicable (No data to show Relative Change)

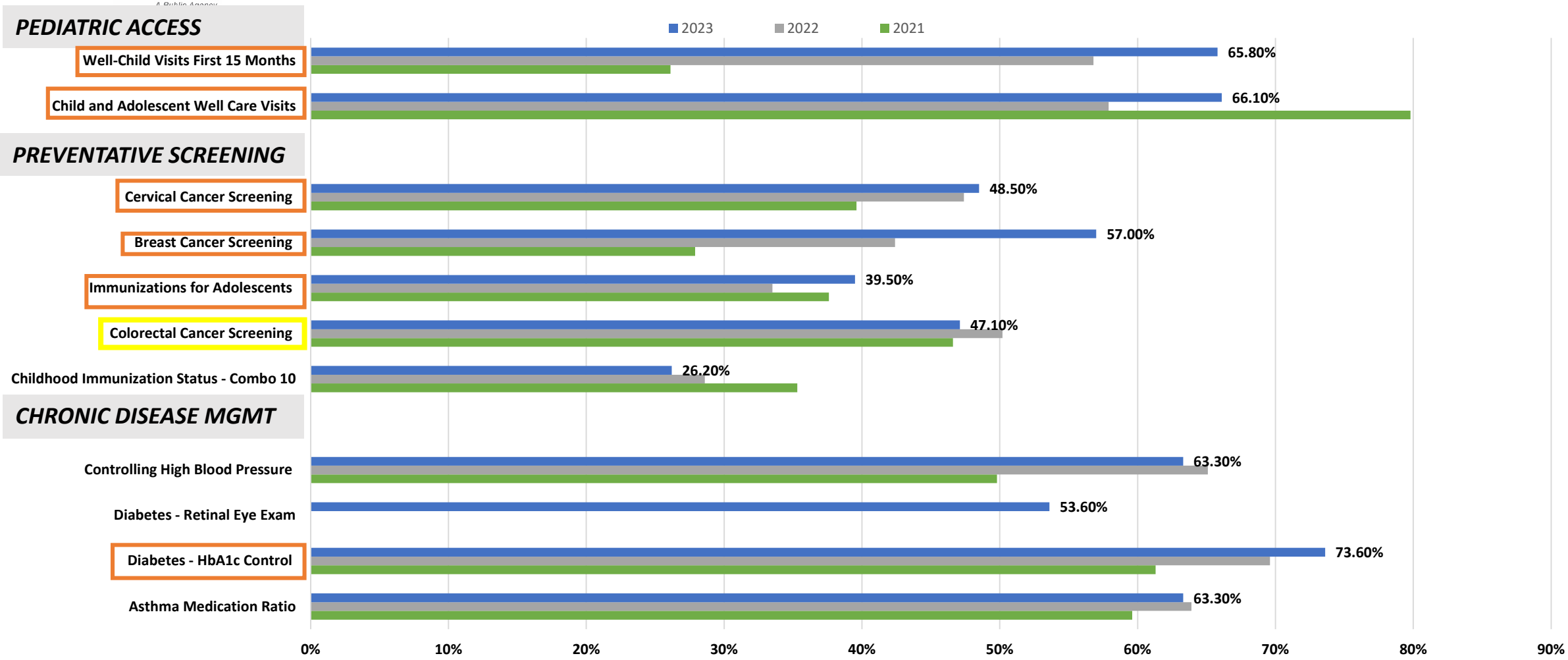
Percentage Providers Meeting Partial Points (50th Percentile) – Clinical Domain (Plan-wide)



Partial Points Target Set at the 25th Percentile

Indicates measure where provider point earnings outperformed prior measurement year

Percentage of Providers Meeting Full Points (75th Percentile) – Clinical Domain (Plan-wide)



Partial Points Target Set at the 50th Percentile

Indicates measure where provider point earnings outperformed prior measurement year

Relative Improvement (RI)

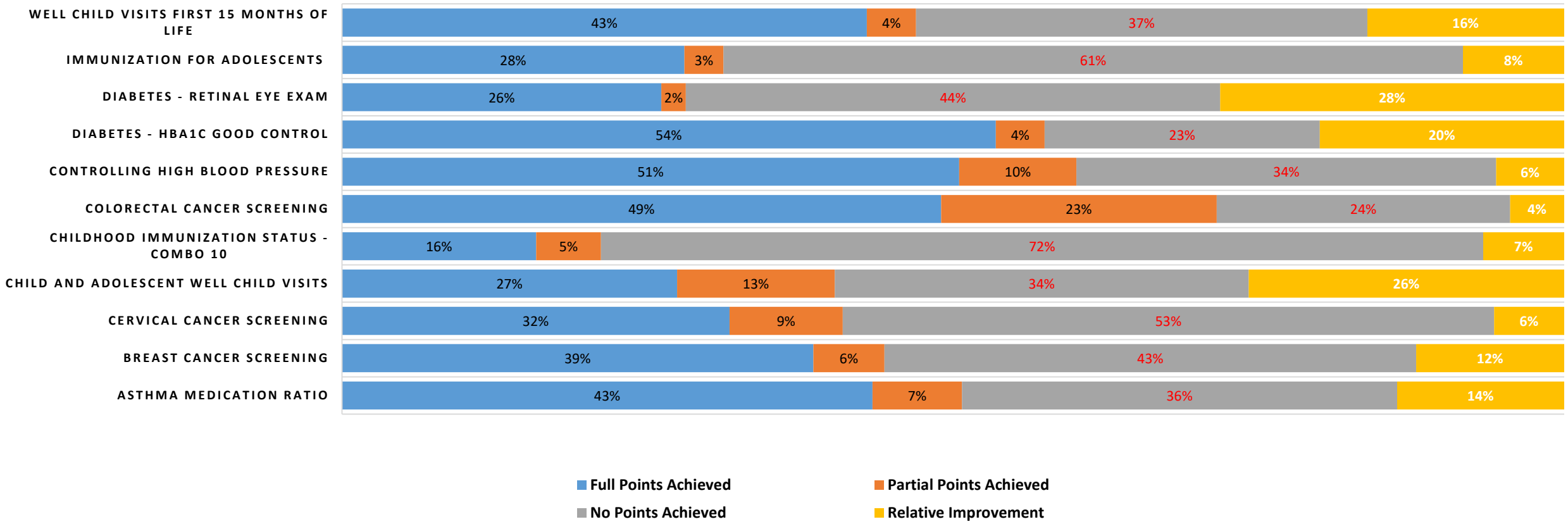
- Available for most existing clinical measures where a provider site was eligible for scoring/payment in the previous measurement year
- A site's performance on an existing clinical measure must:
  - Meet the ***50th percentile target***
    AND
  - Achieve an ***RI score of 10%*** or higher

  Thereby achieving performance equal to or exceeding the 50th percentile and not exceeding the 75th percentile, **to earn full points**

$$\frac{\text{(Current year performance)} - \text{(previous year performance)}}{\text{(100} - \text{Previous year performance)}}$$

- This method of calculating RI is based on a Journal of the American Medical Association article authored by Jencks et al in 2003. It is widely used by the Integrated Healthcare Association's commercial P4P program and CMS.

Points Earning Distribution for Clinical Measures (Plan-wide)

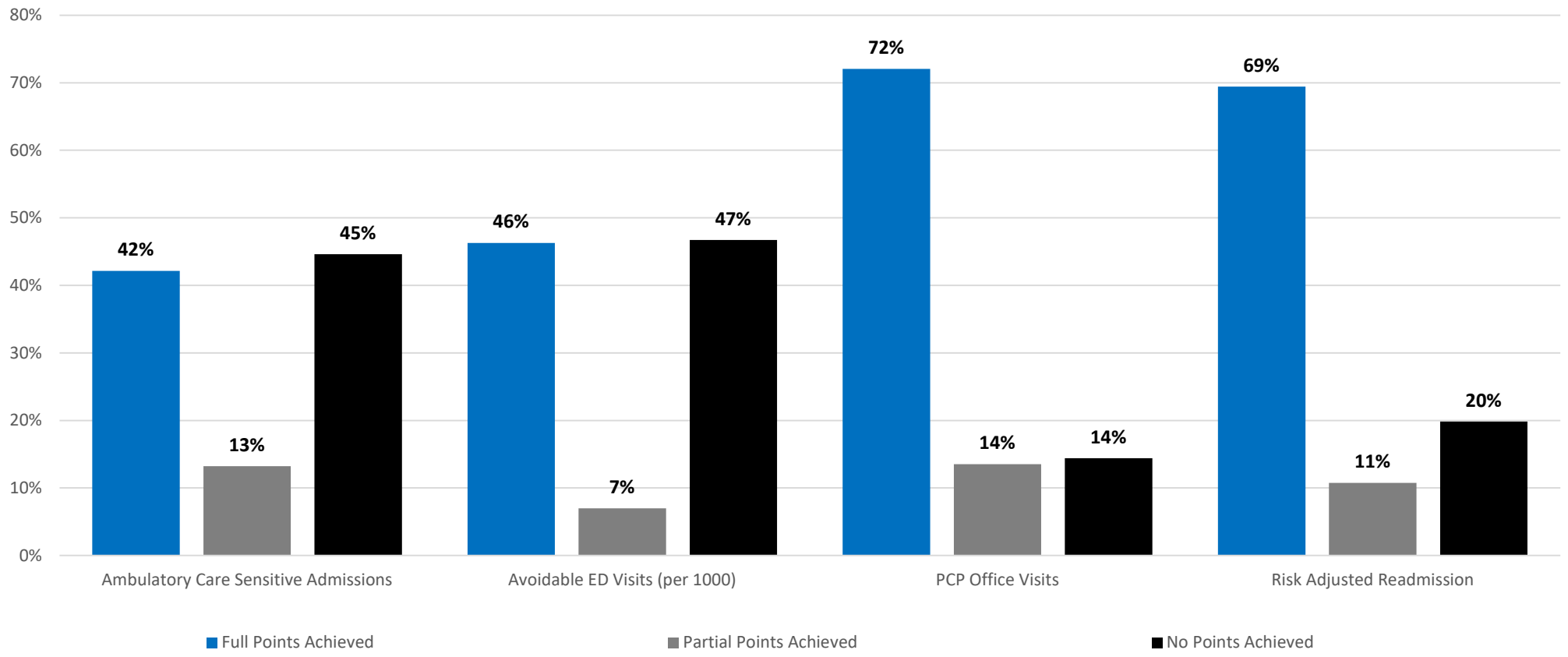


Plan-wide Performance
Non-Clinical Domain YoY

PLANWIDE				
Non Clinical Core Measurement Set	**2021**	**2022**	**2023**	**22-23 Relative Change**
Avoidable ED Visits (per 1000)	6.94%	8.33%	10.87%	30.49%
Risk Adjusted Readmission	0.95%	0.75%	0.80%	6.67%

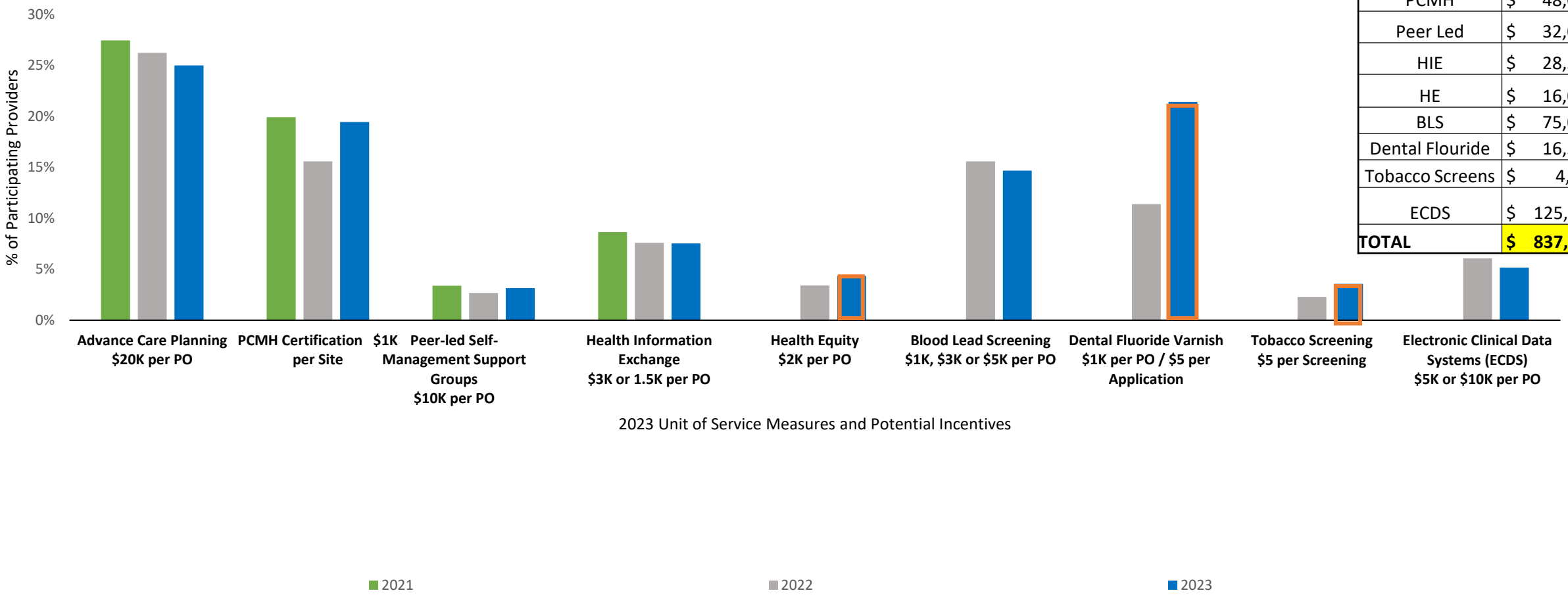
RED - Increased Rate, Declined Performance

Points Earning Distribution for Non-Clinical Measures (Plan-wide)



Unit of Service Participation

UOS Measures	Total Payout
ACP	$ 492,100.00
PCMH	$ 48,000.00
Peer Led	$ 32,000.00
HIE	$ 28,500.00
HE	$ 16,000.00
BLS	$ 75,000.00
Dental Flouride	$ 16,510.00
Tobacco Screens	$ 4,580.00
ECDS	$ 125,000.00
TOTAL	**$ 837,690.00**



2023 Unit of Service Measures and Potential Incentives

Indicates higher participation over prior Measurement Year 2022

2023 PCP Payout Overview

County Payout Y-o-Y Breakdown

- 2023 Incentive Payout: $38.5M
- 2023 Weighted Average Earned PMPM Rate: $7.08

	PMPM Ranges	# of Providers
Base PMPM	$4.00	52
	$4 - $9.25	51
	$9.26 - $12	74
	$12.01 - $13	63
	$14 - $16	11
	$17	1
Highest PMPM Earned	$ 17.58	

Higher Payout from the prior year

County Payout Breakdown 2022 to 2023

PCP QIP CY 2022		
COUNTY	NUMBER OF PROVIDERS	TOTAL INCENTIVE DOLLARS
DEL NORTE	7	645,415.24
HUMBOLDT	29	4,320,257.20
LAKE	16	1,532,727.46
LASSEN	5	298,878.22
MARIN	25	3,362,018.23
MENDOCINO	23	2,781,244.21
MODOC	4	109,458.23
NAPA	15	2,111,529.52
SHASTA	24	4,228,775.19
SISKIYOU	18	1,115,244.53
SOLANO	29	6,548,988.90
SONOMA	42	6,999,146.31
TRINITY	4	283,991.65
YOLO	23	3,983,501.11
TOTAL:	264	**38,321,176.00**

PCP QIP CY 2023		
COUNTY	NUMBER OF PROVIDERS	TOTAL INCENTIVE DOLLARS
DEL NORTE	7	$ 727,360.55
HUMBOLDT	26	$ 5,221,220.68
LAKE	16	$ 2,386,042.04
LASSEN	4	$ 381,109.15
MARIN	24	$ 2,652,207.81
MENDOCINO	22	$ 2,922,355.85
MODOC	4	$ 74,536.90
NAPA	15	$ 2,673,804.52
SHASTA	24	$ 4,549,685.54
SISKIYOU	17	$ 1,024,014.49
SOLANO	28	$ 6,372,341.14
SONOMA	39	$ 5,746,716.95
TRINITY	4	$ 343,331.90
YOLO	22	$ 3,429,175.25
TOTAL:	252	**$ 38,503,902.77**

COUNTY	
NET DIFFERENCE **2022-2023**	
$	81,945.31
$	900,963.48
$	853,314.58
$	82,230.93
$	(709,810.42)
$	141,111.64
$	(34,921.33)
$	562,275.00
$	320,910.35
$	(91,230.04)
$	(176,647.76)
$	(1,252,429.36)
$	59,340.25
$	(554,325.86)
$	**182,726.77**

2023 Summary

PCP QIP Summary

Programmatic Changes	• Added 1 new Clinical measure: Diabetes - Retinal Eye Exams & 1 Non-Clinical measure: PCP Office Visits • Removed 2 UOS measures: 1) Alcohol Misuse Screening & Counseling & 2) Initial Health Assessment • Equity Adjustment
Program Performance	• Increased QIP performance in 7 of 11 Clinical measures from the prior year • 4 Clinical measures ended above the 50th HEDIS Benchmark • 2 Clinical measures ended above the 75th HEDIS Benchmark • 2 Clinical measures ended under the 50th HEDIS Benchmark
2025 Program Recommendations	• Expand Breast Cancer Screening age range from 50-75yo to 40-75yo • Add new Clinical measures: Chlamydia Screening, Well Child Visits in the First 15-30 Months of Life, Topical Fluoride in Children & Reduction of Inequity Adjustment (Participation is optional) **AND** new UOS measure, Academic Detailing • Replace Non-Clinical Risk Adjusted Readmission with Follow-up within 7 days after Hospital Discharge measure • Update the Peer-Led & Pediatric Group Visit UOS measure • Raise Thresholds back to 75th for Partial Points & 90th for Full Points

Our Mission

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

GRIEVANCE & APPEALS Pulse Report

G&A PULSE REPORT

ISSUE 15 | NOVEMBER 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 third 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

PG. 4
Statistics Broken Down by Region

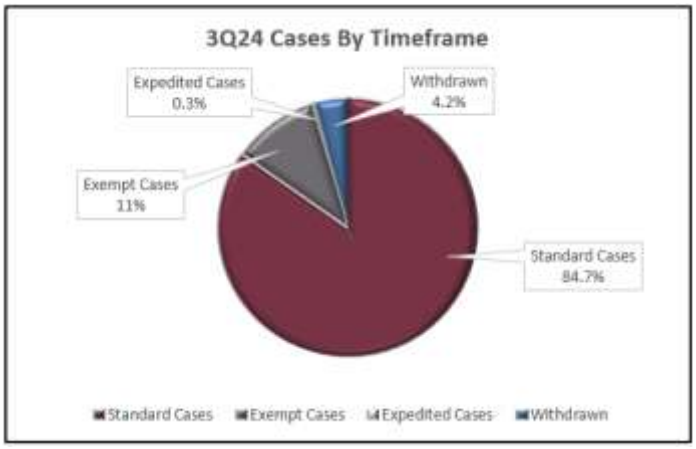
PG. 10
Increase in Transportation State Hearings

3Q24 HIGHLIGHTS

OVERALL NUMBERS

In 3Q24, G&A investigated 2,008 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,747 cases subject to DHCS-mandated timeframes, 97.4% were closed on time. This is below the 98.0% goal. G&A timeliness was impacted by delayed referrals and records requests from underperforming staff, along with an increase in non-threshold language translation requests. G&A has brought underperforming staff back into the office to enhance oversight and efficiency.

3Q24 TOTAL # INVESTIGATED CASES		
Case Type	# Cases	% Grand TTL
Grievance	1562	77.8%
Exempt	217	10.8%
Appeal	185	9.2%
State Hearing	44	2.2%
Grand Total	2,008	100.0%



KEY POINTS & TRENDS

Transportation — Transportation related cases were the most frequently reported concern, making up 44.1% of the total concerns reported. The most common transportation related issue was missed rides, which accounted for 22.7% of the reported concerns. Requests for specific transportation providers and drivers arriving late for pick-ups were the next highest reported concerns, at 13.1% and 10.1%, respectively.

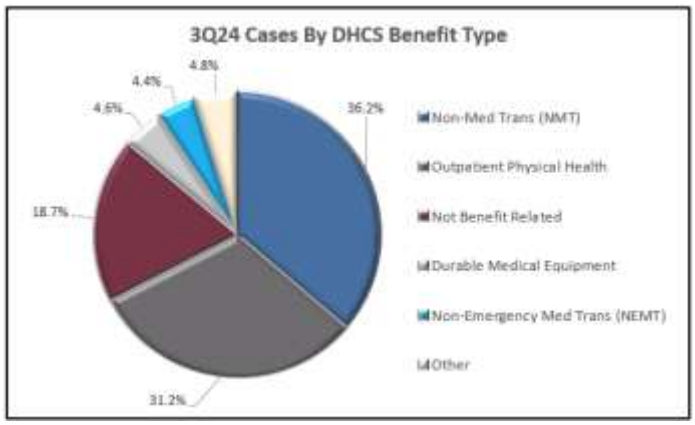
Appeals accounted for 6.5% of all transportation concerns reported. Meal denials were the most commonly appealed, making up 39.4% of the transportation Appeal denials, followed by lodging denials at 35.1%.

Provider Service – This category accounted for 39.9% of the total case concerns. The most common issue was Communication, followed by Attitude/Service. Treatment Plan Disputes 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.

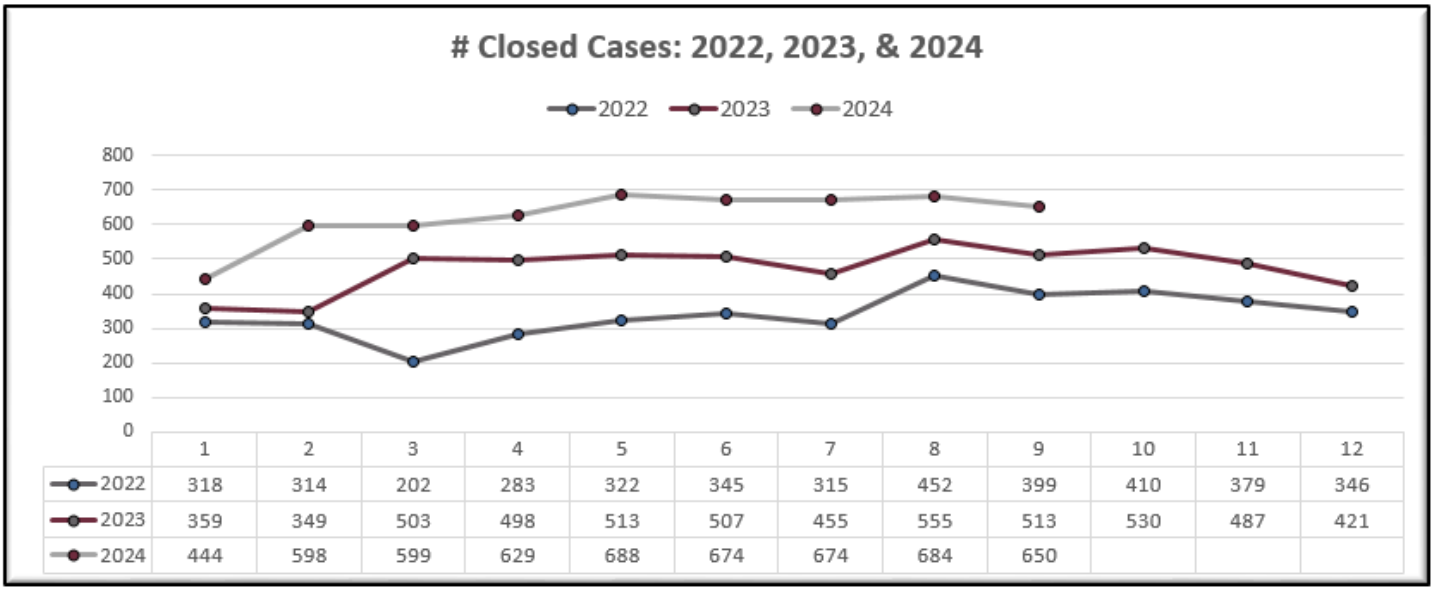
Non-Medical Transportation (NMT) represented 36.2% and Outpatient Physical Health services represented 31.2% of reported concerns. Not Benefit Related accounted for 18.7% of the DHCS Benefit Type categories.



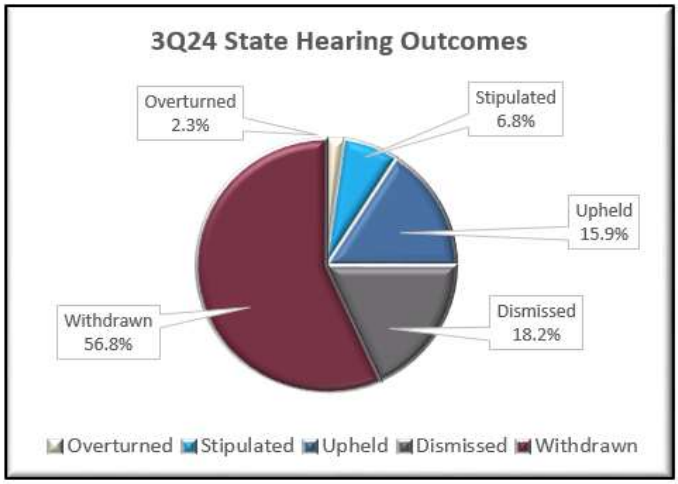
KEY STATISTICS

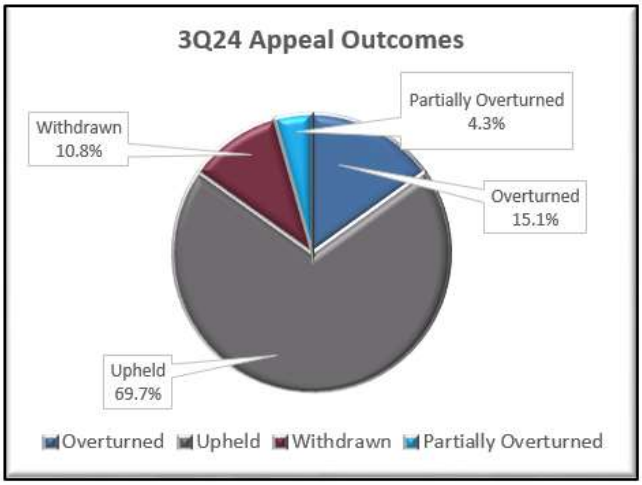
CHARTS OF KEY CASE TRENDS

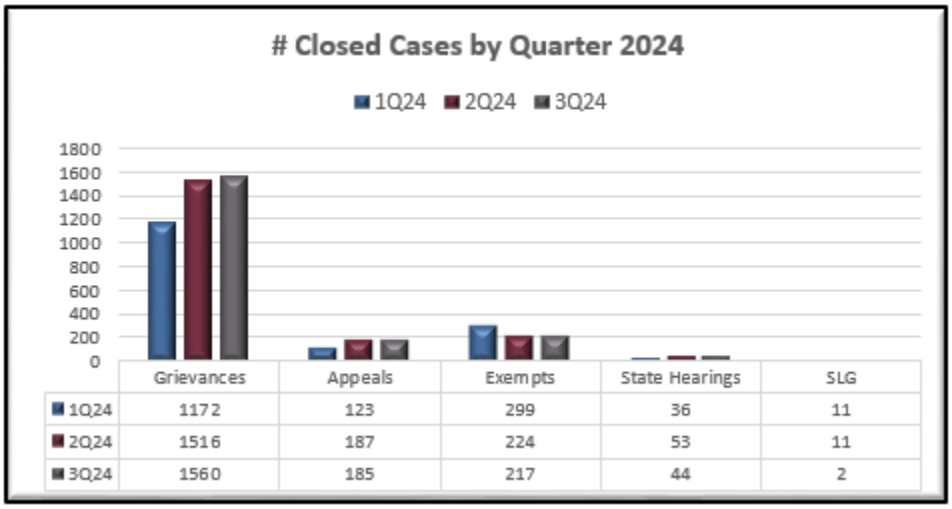
The following charts represent key data metrics used to track and trend Appeals, Grievances, Second Level Grievances, and State Hearings over time.



	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	684	650			







	Grievances	Appeals	Exempts	State Hearings	SLG
1Q24	1172	123	299	36	11
2Q24	1516	187	224	53	11
3Q24	1560	185	217	44	2

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.

"I'm very grateful. You [Amanda] went above and beyond and I'm very grateful for this. I know [the member] will be very grateful as well. You took this by the horns and drove it home. Thank you! I can't thank you enough." - Michelle at Provider's Office

3Q24 % CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	76	898,027	0.08
Placer	190		0.21
Plumas	6		0.01
Sierra	0		0.00
Grand Total	272		0.30

3Q24 % CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	252	898,027	0.28
Napa	54		0.06
Yolo	129		0.14
Grand Total	435		0.48

3Q24 % CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	152	898,027	0.17
Colusa	16		0.02
Glenn	20		0.02
Sutter	44		0.05
Yuba	53		0.06
Grand Total	285		0.32

3Q24 % CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	252	898,027	0.28
Marin	73		0.08
Grand Total	325		0.36

3Q24 % CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	50	898,027	0.06
Humboldt	164		0.18
Lake	61		0.07
Mendocino	69		0.08
Grand Total	344		0.38

3Q24 % CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	36	898,027	0.04
Modoc	23		0.03
Shasta	211		0.23
Siskiyou	76		0.08
Tehama	65		0.07
Trinity	15		0.02
Grand Total	426		0.47

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 3Q24.

3Q24 % CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	6.0%	18.5%
Age 11-19	3.7%	16.5%
Age 20-44	26.8%	34.6%
Age 45-64	44.0%	19.8%
Age 65+	19.5%	10.7%
Grand Total	100.0%	100.0%

3Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.0%	38.9%
Hispanic	19.6%	33.6%
Other/Unknown	5.2%	17.9%
Black (African Amer	0.4%	3.5%
Asian	15.8%	2.5%
Native American	19.6%	1.8%
Asian Indian	0.7%	1.6%
Native Hawaiian or	0.1%	0.2%
Grand Total	100.0%	100.0%

3Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	90.6%	76.2%
Spanish	8.0%	20.5%
Other	1.1%	2.0%
Russian	0.0%	0.6%
Punjabi	0.1%	0.5%
Tagalog	0.1%	0.3%
Grand Total	100.0%	100.0%

3Q24 % CASES BY COUNTY		
Member County	% Cases	% Membership
Sonoma	8.6%	12.3%
Solano	12.5%	11.3%
Butte	7.6%	9.5%
Shasta	10.5%	7.5%
Placer	9.5%	6.6%
Humboldt	8.2%	6.5%
Yolo	6.4%	5.8%
Marin	3.6%	5.2%
Sutter	2.2%	4.8%
Mendocino	3.4%	4.6%
Yuba	2.6%	3.9%
Lake	3.0%	3.8%
Tehama	3.2%	3.4%
Nevada	3.8%	3.2%
Napa	2.7%	2.9%
Siskiyou	3.8%	2.0%
Glenn	1.0%	1.5%
Del Norte	2.5%	1.4%
Colusa	0.8%	1.1%
Lassen	1.8%	1.0%
Plumas	0.3%	0.7%
Trinity	0.7%	0.6%
Modoc	1.1%	0.4%
Sierra	0.0%	0.1%
Grand Total	100.0%	100.0%

3Q24 % CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	63.3%	52.1%
Male	36.7%	47.9%
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 3Q24. 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.

3Q24 NUMBERS

Four (4) W&R case were received and closed in 3Q24.

TRENDING ISSUES

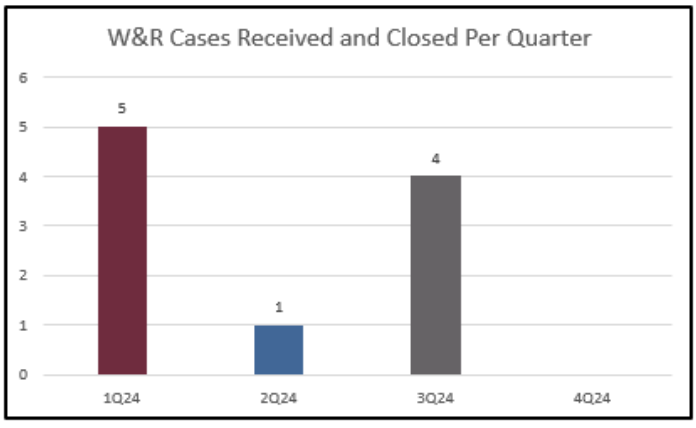
The number of grievances increased from one (1) in 2Q24 to four (4) in 3Q24. There were zero appeals reported in this timeframe.

Three (3) grievances were reported that fell into the Interpersonal Relationship Issues category.

One (1) case was regarding Program Requirements. The member requested an expedited review. A physician reviewer determined the member's request involved a medical condition with immediate risk to life, limb, mental health, or ability to regain maximal function if reviewed through the standard process. The member was advised they could no longer have services at MedMark Treatment Center. After investigation, it was found that the member did not follow their treatment plan and became aggressive towards staff. The director felt it was no longer safe for the member to be treated at that facility. Their care was transferred to another facility appropriately.

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. All cases received in 3Q24 were closed within the 30-day DHCS regulatory timeframe.



3Q24 W&R Cases	
# of Grievance Received	4
# of Grievance Resolutions	4
# of Appeal Received	0
# of Appeal Resolutions	0

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

CCS RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to California Children's Services (CCS) and Whole Child Model (WCM) during 3Q24.

3Q24 STATISTICS

During 3Q24, a total of 14 CCS-related cases were closed, representing 0.01% of the 2,008 reported cases for this quarter. These cases are divided into 12 Grievances and two (2) Appeals.

TRENDING ISSUES

The predominant issue reported this quarter was transportation-related with nine (9) cases (two (2) appeals and seven (7) grievances) accounting for 64.3% of the total CCS related cases.

Both of the appeals were related to reimbursement for meals and lodging. One case was for an additional night of lodging and an additional meal the day after the member's appointment. The other case was regarding an additional night of lodging and additional meal, two (2) days before the member's appointment. They took a flight to the appointment that was scheduled to arrive two (2) days before the appointment. These denials were upheld as there was no appointments on the additional dates requested.

Of the remaining cases, unrelated to transportation, there were three (3) grievances regarding timely access to see providers involving no appointment availability and two (2) cancelled appointments. One (1) grievance was regarding a delay of a Treatment Authorization Request (TAR) for incontinence supplies. The supplier can only allow orders every 30 days. The member did receive their supplies.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There was one (1) case of discrimination reported for CCS members during 3Q24. The member's authorized representative accused the medical assistant of discrimination due to the member's disability. The medical assistant suggested the member be seen by the Pediatrics Department as that office did not have the resources to treat a patient with autism. Discrimination was found to be unlikely. The provider referred these concerns to their Quality Review Process.

ETHNICITY AND PREFERRED LANGUAGE

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

3Q24 CASES BY ETHNICITY		
Member Ethnicity	#Cases	% Cases
Hispanic	3	21.4%
White	4	28.6%
No Response	2	14.3%
Other	4	28.6%
Black (African American)	1	7.1%
Grand Total	14	100.0%

3Q24 CCS CASES BY LANGUAGE		
Member Language	# Cases	% Cases
English	10	71.4%
Spanish	4	28.6%
Grand Total	14	100.0%

DISCRIMINATION

REPORTING PERIOD

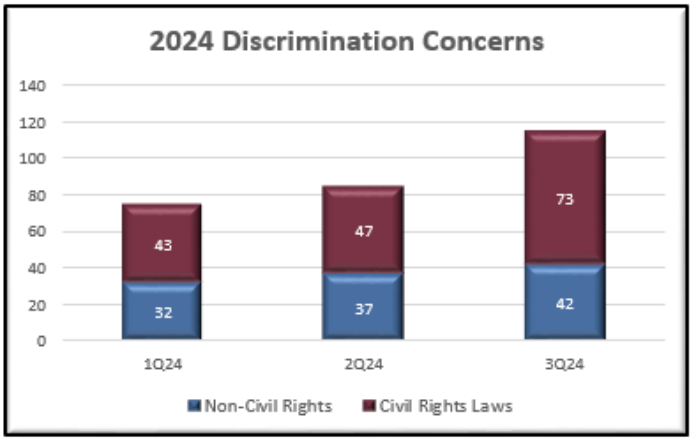
This section covers quarterly statistics and trends in cases related to discrimination during 3Q24.

3Q24 DISCRIMINATION STATISTICS

G&A investigated 115 cases related to discrimination allegations in 3Q24. This represented 5.7% of all cases closed. Of the 115 cases, 73 fell under an applicable federal or state civil rights law.

After investigation, it was determined discrimination likely occurred in eight (8) cases. Two (2) cases were regarding language assistance services and two (2) cases were regarding limited English skills. The other cases were concerning auxiliary aids and services, disability, race or ethnicity, and sexual orientation.

Discrimination allegations that do not fall under a civil rights law accounted for 42 of the 115 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having Medi-Cal or being labeled a medication/drug seeker.



3Q24 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations has increased in number and surpassed 5% of total cases filed. It is important to note that after investigation, the number of cases found to have indicated discrimination was likely remains low, around 11%.

Notably, in the expansion counties, the number of discrimination grievances decreased from 19 cases to nine (9) cases. The most commonly reported concerns across the expansion counties were related to race or ethnicity, and language.

3Q24 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
Language Assistance Services	2
Limited English Skills	2
Auxillary Aids and Services	1
Disability	1
Race or Ethnicity	1
Sexual Orientation	1
Total	8

The most commonly reported allegation was Race/Ethnicity accounting for 31.5% of cases followed by Disability accounting for 27.4% of the cases filed.

Civil Rights Category	# of Cases	% of Cases
Race or Ethnicity	23	31.5%
Disability	20	27.4%
Language Assistance Services	7	9.6%
Age	5	6.8%
Gender	5	6.8%
Limited English Skills	4	5.5%
Sexual Orientation	3	4.1%
Auxillary Aids and Services	2	2.7%
Religion	2	2.7%
Gender Identity	1	1.4%
Sex Stereotypes	1	1.4%
Totals	73	100.0%

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-four (24) Grievances were evaluated for cases closed in 1Q24 for the 2Q24 IRR review.

The Medical Director suggested one of the cases could have been reviewed by a physician as the case involves timed dialysis care. The late transportation provider directly affected the care of the member by infringing on the time the member could have been dialyzed. Records from the Dialysis center could confirm if late transportation had occurred more than once for this member.

G&A leadership identified several opportunities for improvement for cases during this period. All G&A staff must ensure all communication emails and documents are attached to each case, and these attachments must be in PDF format. Additionally, staff should verify that documentation is thorough, particularly for provider referrals. When information is received back from the provider, if it arrives as a separate attachment, that information must be documented within the case.

TIMELINESS

The target timeliness goal for investigations and ack letters is 98.0%.

For 3Q24, 1,747 cases were subject to DHCS Turnaround Times (TAT). We achieved 97.4% timeliness for investigations. The timeliness was impacted by delayed referrals and records requests from underperforming staff, along with an increase in non-threshold language translation requests. G&A has brought underperforming staff back into the office to enhance oversight and efficiency.

There were 30 late acknowledgment letters (ack-letters), achieving 98.3% timeliness. This is an improvement from the 38 late acknowledgement letters last quarter.

3Q24 DHCS Timeliness Performance				
	Performance			
Performance Category	Goal	# Late	Performance Result	Status
Investigations	98.0%	45	97.4%	
Ack-Letters	98.0%	30	98.3%	

TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 3Q24.

3Q24 STATISTICS

Transportation cases in 3Q24 accounted for 810 cases of the total 2,008 cases closed. This represented of 40.3% of all the cases closed in 3Q24. There were 53 Appeals, 748 Grievances (Exempt and Standard), and nine (9) State Hearings.

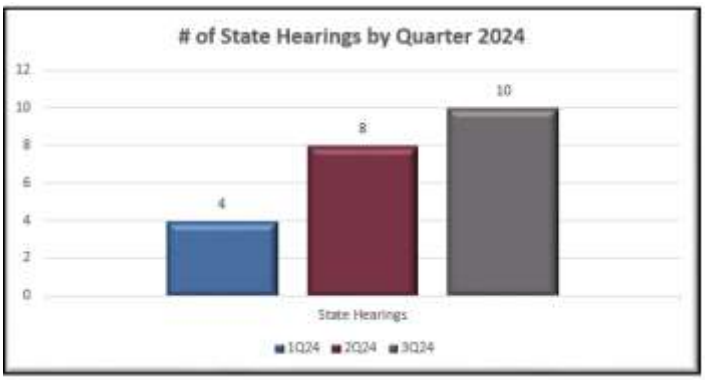
TRENDING ISSUES

Northbay Transit, Lyft, Redline Transit, Budget Friendly and Easy Day Rides are the top five providers in 3Q24. Members had issues such as missed rides, rider preferences for or against certain providers and drivers arriving late.

G&A identified multiple complaints against Transportation Services department. The top three complaints against Transportation Department for 3Q24 includes scheduling issues, disliking the timeframe associated with gas mileage reimbursement and Meals/Lodging.

There has been a steady increase in State Hearings involving transportation since 1Q24.

A total of 10 State Hearings were closed in 3Q24. Of these cases, six (6) were withdrawn by the members. The remaining cases resulted in various outcomes: two (2) were stipulated by the court, another was dismissed due to a lack of denial, and the final case was upheld.



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 the counties of 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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UM Delegation to Capitated Hospitals
November 2024

Partnership HealthPlan of California currently delegates UM responsibilities to four (4) hospital groups with locations in Lake, Marin, Mendocino, Napa, and Solano Counties.

- **Adventist Health** (Adventist Clearlake, Adventist St. Helena, Adventist Ukiah Valley, Adventist Mendocino Coast, Howard Memorial)
    - Delegation Agreement current as of 10/1/2022.
    - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
    - CY2023 annual audit completed 5/14/2024. Adventist team had zero (0) identified deficiencies for program and file review audits. Partnership UM continues to monitor Adventist denials on a weekly basis for compliance and sustainability.

- **NorthBay Medical Center/ VacaValley Hospital**
    - Delegation Agreement current as of 10/1/2022.
    - Not currently operating on the Essette platform for prior authorizations, with no immediate plans to migrate. This poses a risk for DHCS and NCQA compliance for UM reviews and denials.
    - CY2023 annual audit completed 5/30/2024. NorthBay team had zero (0) identified deficiencies for program and file review audits. Partnership UM continues to monitor NorthBay denials on a weekly basis for compliance and sustainability.

- **Queen of the Valley Medical Center (QVMC)**
    - Delegation Agreement current as of 10/1/2022.
    - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
    - CY2023 annual audit completed 5/13/2024. QVMC team had zero (0) identified deficiencies for program and file review audits. Partnership UM continues to monitor QVMC denials on a weekly basis for compliance and sustainability.

- **MarinHealth Medical Center (MHMC)**
    - Delegation Agreement current as of 10/1/2022.
    - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
    - CY2023 annual audit completed on 5/30/2024. Areas of improvement in the documentation of UM processes addressed through the preliminary CAP process. Partnership UM continues to monitor MHMC denials on a weekly basis for compliance and sustainability.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Pediatric Preventive Health Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~06/12/2025~~01/08/2026
Last Review Date: ~~06/12/2024~~01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td><td>☒ PQC</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: ~~06/12/2024~~01/08/2025</td></tr>
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I. RELATED POLICIES:

A. MCQP1021 - Initial Health Appointment
B. MCUP3047 – Tuberculosis Related Treatment
C. MPQP1022 - Site Review Requirements and Guidelines
D. MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
F. MCCP2024 – Whole Child Model for California Children's Services (CCS)
G. MCUP3101 – Screening and Treatment for Substance Use Disorders
~~H. MPCP2002 – California Children's Services~~
~~I.~~H. CMP-20 Records Retention and Access Requirements

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Adolescent: The American Academy of Pediatrics (AAP) defines adolescents as persons aged 11 up to 21 years of age.
B. Parent: For our purposes, a "parent" is the designated legal guardian for the pediatric member.
C. CHDP: The Child Health and Disability Prevention (CHDP) was~~is~~ a preventive program that delivered~~s~~ periodic health assessments and services to low income children and youth in California. CHDP provide~~ds~~ care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. CHDP sunsetted~~s~~ July 1, 2024, consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.~~and the managed care plans are now providing these services.~~

IV. ATTACHMENTS:

A. AAP Recommendations for Preventive Pediatric Health Care
B. TB Screening Recommendations (Flow Charts)
C. Blood Lead Testing Refusal Form

D. Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger

V. PURPOSE:

To specify Partnership HealthPlan of California (Partnership) policy for periodic health screening and preventive health services for members up to 21 years of age provided by primary care providers (PCPs). The California Department of Health Care Services (DHCS) requires that all Medi-Cal managed care health plans, including Partnership, utilize the American Academy of Pediatrics (AAP) preventive health care recommendations, as well as the Advisory Committee on Immunization Practices (ACIP)/AAP immunization schedule, in formulating plan specific standards and guidelines. Since all Partnership primary care providers who care for children are expected to be enrolled as CHDP providers, all other CHDP policies related to the provision of pediatric preventive services are applicable as well.

VI. GUIDELINE / PROCEDURE:

A. The following standards and guidelines address periodic health screening and preventive services for low-risk, asymptomatic children and adolescents. Pediatric preventive care is also addressed in Partnership's policy MCCP2022 - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services.
   1. Individuals identified as being at high risk for a given condition may require screening at more frequent intervals or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those whose risk behaviors, family history, socioeconomic status, life style or disease or genetic condition is associated with a higher tendency to the development of a specific condition or disease.
   2. The AAP scheduled assessment must include all components required for the lower age nearest to the current age of the child. A physical examination is completed according to AAP periodicity exam schedule and each health assessment will include:
      a. Anthropometric measurements of weight, length/height and head circumference of infants up to age 24 months.
      b. Physical examination/body inspection, including screen for sexually transmitted infection (STI)/ human immunodeficiency virus (HIV) on sexually active adolescents.
      c. Follow up care or referral for identified physical and behavioral health problems as appropriate.
      d. Pediatric preventive care visits may take place on a more frequent basis than the AAP periodicity recommendations, when medically necessary. Partnership recommends a 14-day minimum interval between well-child visits.

B. Primary Care Providers (PCPs) must complete an Initial Health Appointment (IHA) on all new Members within 120 days of enrollment to Partnership or assignment to a PCP, or within 12 months prior to Plan enrollment. (See policy MCQP1021.) The IHA must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases (Reference A, CalAIM Population Health Management Guide (~~October 2023~~May 2024). PCP office should request and review previous medical record(s) to show a complete history.

C. PCPs must provide immunizations according to the *General Recommendations on Immunization: Recommendations of the ~~Advisory Committee on Immunization Practices (~~*ACIP~~)~~, AAP, the American Academy of Family Physicians (AAFP) and the Centers for Disease Control and Prevention (CDC).
   1. Specific to DHCS All Plan Letter ~~(APL) 18-004~~(APL) 24-008, providers must ensure timely provision of immunizations to Members in accordance with the most recent schedule and recommendations published by ACIP, regardless of age, sex, or medical condition, including pregnancy [as clinically appropriate]. This policy ensures coverage of all U.S. Food and Drug Administration (FDA) approved vaccines recommended by the ACIP and their administration,

without cost sharing.

~~1.~~2. Providers must document each Member's need for ACIP recommended immunizations as part of all regular health visits. All provided immunizations must be reported within 14 calendar days to ~~and enter such into~~ the California Immunization Registry (CAIR2).

~~1.~~3. When immunizations are provided at sites other than the PCP's office, that provider should enter the immunizations into CAIR2, according to the provisions of AB1797.

D. Screening for alcohol or drug or tobacco use and/or substance use disorders is considered part of the standard of primary care of Members aged 11 up to age 21. APL 21-014 stipulates that, consistent with United States Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, MCPs are required to provide SABIRT (Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment) for all Members aged 11 and older. PCPs must screen via validated screening tools. For more details, see MCUP3101 - Screening and Treatment for Substance Use Disorders.

E. Unless the Member has received a health screening visit within the periodicity schedule (Attachment A), the Member, or the Member's parent, must be informed at the time of **each** non-emergency primary care visit of the availability of services through the PCP's practice. If the Member is not seen as scheduled, the PCP's staff should contact the Member (or parent to reschedule the visit and document that they have done so. Any voluntary refusal by the Member (or parent) to visit their PCP as recommended should be documented in the medical record.

F. Diagnosis and treatment of any medical conditions identified through the periodic health screening either by the PCP or through referral to a specialist, must be initiated as soon as possible but no later than 60 days from identification. Justification for delays beyond 60 days must be entered into the Member's medical record.

G. If the PCP determines the Member has a condition making them eligible for the California Children's Services (CCS) Program, the PCP or their staff should inform the parent and initiate a referral to the county CCS office for eligibility determination. (See policies MCCP2024 ~~and MPCP2002~~.)

H. Monitoring and Quality Management
   1. Timeliness and appropriateness of pediatric preventive health will be monitored annually by Healthcare Effectiveness Data and Information Set (HEDIS®) measures (including but not limited to Childhood Immunization, Adolescent Immunization, Well Child Visits in the third, fourth, fifth and sixth years of life, Adolescent Well Care Visits and Well Child Visits in the First 15 months.
   2. Partnership's Site Review team will periodically review PCPs' documentation of pediatric preventive services. (See MPQP1022.)

I. Developmental Screening
   1. Before age 3, comprehensive developmental screening must be performed at least annually in accordance with the APP/Bright Futures periodicity schedule, using one of the standardized instruments listed below.
      a. Ages and Stages Questionnaire (ASQ) - 2 months to age 5
      b. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
      c. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
      d. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
      e. Brigance Screens-II - Birth to 90 months
      f. Child Development Inventory (CDI) - 18 months to age 6
      g. Infant Development Inventory - Birth to 18 months
      h. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
      i. Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
      j. Or a standardized tool that follows CMS criteria per APL 23-016:

1) Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
2) Established Reliability: Reliability scores of approximately 0.70 or above.
3) Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

i. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above (Reference: APL 23-016, Pg. 4)

3. Comprehensive developmental screening using one of the instruments above must be billed using the Current Procedural Terminology (CPT) code 96110 without a modifier.
4. Additional screening tests, such as focused screening for autism using the Modified Checklist for Autism in Toddlers (M-CHAT) or screening for social and emotional development using the ASQ-SE, may be performed before age 3, but must be billed using the added KX modifier: 96110.KX.
5. Developmental screening may also be performed for children over age 3, and billed with 96110 if one of the standardized instruments in section VI.I.1 is used, or 96110.KX if another standardized tool is used.
   a. Up to one 96110 without a modifier is payable per year. Additionally, up to one 96110.KX is payable per year.
6. Providers will be audited for correct use of developmental screening instruments as part of the site review process.
7. Providers must document the following:
   a. The tool that was used.
   b. That the completed screen was reviewed.
   c. The results of the screen.
   d. The interpretation of the results.
   e. Any discussions with the Member and/or family; and any appropriate actions taken.
      1) Note, this documentation must remain in the Member's medical record and be available upon request by the Member and/or Member's parent.
   f. Completion of the developmental screening with CPT code 96110 without the modifier KX.
   g. Any additional developmental screenings done when medically necessary due to risk identified on developmental surveillance are also eligible for directed payment if completed with standardized developmental screening tools and documented with CPT code 96110 without the modifier KX (Reference: APL 23-016, Pg. 4 & 5).

J. Trauma Screening – Adverse Childhood Experiences (ACEs) APL 23-017
1. PCPs may screen children annually up to age 19 for traumatic life events using the Pediatric ACEs and Related Life-events Screener (PEARLS), which includes screening for several social determinants of health.
   a. Coding results of screening will depend on the result of the screening. Codes will not be reported for non-qualifying ACE screening services or other services. Providers must calculate the Member's ACE screening score using the questions on the 10 original categories of ACE.
      1) G9919: Screening performed and positive and provisions of recommendations (4 and greater)
      2) G9920: Screening performed and negative (0 to 3)
2. DHCS develops recommendations for stratifying the risk, based on the screening, and tailoring interventions to this risk stratification. These recommendations are based on consensus of experts and have not yet been studied systematically. DHCS maintains provider resources for administering

trauma screenings and provision of trauma informed care. More information is available on the DHCS website. See also ACESaware.org.

3. Providers must document the following in the Member's medical record and be available upon request by the Member and/or Member's parent in compliance with all relevant state and federal privacy requirements:
   - The tool that was used.
   - The completed screen was reviewed.
   - Results of the screen.
   - The interpretation of results.
   - What was discussed with the Member and/or parent.
   - Any appropriate actions that were taken.
   - (References: APL 23-017, Page 7-8)
4. Provider attestation of completion of DHCS-approved training (accessible through the ACESaware.org website) by individual clinicians performing the screening is required for payment for billing of trauma screening services.
5 Auditing: Use of an approved ACE Screening Tool will be audited Partnership through the site review process.

K. Blood Lead Level (BLL) Testing

1. DHCS APL 20-016 requires that during each well-child visit, providers shall ensure the provision of oral or written anticipatory guidance to the parent of children between six months and six years of age that, at a minimum, includes:
   a. Information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning.
2. As per state and federal law, California Department of Public Health's Childhood Lead Poisoning Prevention Branch (CLPPB) guidance and Centers for Disease Control and Prevention (CDC) recommendations, , all children should be should be tested and as applicable, treated for elevated blood lead levels (BLL) at intervals as follows:
   a. Ages 12 and 24 months;
   b. For children up to 72 months in age:
      1) Upon identification of missing/undocumented screening;
      2) Upon change in circumstance that may put the child at risk; or
      3) As requested by parent/guardian; and/or
      4) Post-arrival screening of refugees consistent with CLPPB guidance
   c. If parent refuses BLL testing, they must sign a refusal form, which the provider will document in the Member's ~~-~~medical record. (See Attachment C.)
   d. If a parent, guardian or legal representative refuses to sign the refusal form, the provider must note this refusal and reason in the Member's medical record.
3. Communication to Providers
   a. Effective January 1, 2021, MCPs must identify, at least quarterly and report to respective network providers, all Members under the age of 6 years who do not have a recorded BLL test result~~-~~.
      1) This list will be shared with the PCP site, which is expected to conduct outreach to arrange for BLL test.
   b. Partnership will train providers and laboratories as appropriate, regarding Partnership testing requirements and related claims procedures. This includes use of correct billing codes, claims forms, and reporting to Partnership and to the CLPPB as required.
5. Record Retention and Reporting
   a. Data, documentation, and information related to the processes described under this policy shall be maintained in compliance with Partnership policy CMP-30.

6. Claims and Validation
   a. Claims shall be submitted to Partnership using appropriate and current claims forms/format (CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I)).
   b. Consistent with DHCS APLs 14-019 and 17-005 and the current DHCS Companion Guide for X12 Standard File Format, capitated encounters shall be validated, by Partnership, for completeness, accuracy, reasonableness, and timeliness when making payment and/or submission to DHCS.

VII. REFERENCES:

A. CalAIM Population Health Management Policy Guide, ~~October 2023~~ (May 2024)
B. American Academy of Pediatrics (AAP) ~~Practice Management, Preventive Care/Periodicity Schedule Summary of Changes to the 2023 Recommendations:~~ Recommendations for Preventive Pediatric Health Care Bright Futures/AAP (updated June 2024)
C. AAP. Bright Futures Guidelines and Pocket Guide, 4th Edition. ~~https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/~~ (April 26, 2022)
D. United State Preventive Services Task Force (USPSTF) A & B Recommendations
E. Centers for Disease Control and Prevention (CDC). 2024 Immunization Schedules ~~at~~ (Aug. 9, 2024) ~~https://www.cc.gov/vaccines/index.html and https://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-child-combined-schedule.pdf~~
F. American Academy of Family Physicians (AAFP) Birth through Age 18 Immunization Schedules~~:~~ ~~http:www.aafp.org/immunization~~ (June 27, 2024)
~~F.~~G. Advisory Committee on Immunization Practices (ACIP) Child and Adolescent Immunization Schedule by Age (June 27, 2024)
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008 Immunization Requirements (June 21, 2024 supersedes APL 18-004)
~~F.~~**C.** AAP publications on Health Supervision for Children with (disease/genetic condition) https://www.aappublications.org/search/policy/%20subject_collection_code%3A100 (Search should be done under the Policy tab)
~~G.~~**D.** DHCS APL 23-017 Directed Payments for Adverse Childhood Experiences Screening Services (June 13, 2023 supersedes APL 19-018)
~~H.~~**E.** DHCS APL 23-016 Directed Payments for Developmental Screening Services (June 9, 2023 supersedes APL 19-016)
~~I.~~**F.** DHCS APL 22-030 Initial Health Appointment (Dec. 27, 2022 supersedes APL 13-017)
~~J.~~**G.** DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)
~~K.~~**H.** DHCS APL 20-016 *Revised:* Blood Lead Screening of Young Children (Nov. 2, 2020 supersedes APL 18-017)
~~L.~~**I.** DHCS APL 17-005 Reminder Regarding Requirement to Submit Specialty Referrals Report (July 28, 2017)
~~M.~~**J.** DHCS APL 14-019 Encounter Data Submission Requirements (Dec. 19, 2014 supersedes APL 13-006)
~~N.~~**K.** DHCS Child Health and Disability Prevention Program (CHDP) Transition Plan (March 2024)
~~O.~~**L.** Title 17 CCR section 37100
~~P.~~**M.** California Assembly Bill 1797 Immunization Registry (March 27, 2022)
~~Q.~~**N.** CHDP Provider Notice 23-04 Child Health and Disability Prevention Program Activities in Fiscal Year 2023-2024 (Dec. 13, 2023)

Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)		**Lead Department: Health Services**
Guideline/Procedure Title: Pediatric Preventive Health Guidelines		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date:** ~~06/12/2025~~01/08/2026 **Last Review Date:** ~~06/12/2024~~01/08/2025	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

VII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

IX: REVISION DATES:

Medi-Cal
10/13/95; 10/10/97 (name change only); 03/11/98; 5/17/00; 02/20/02; 10/30/02 vs. 10/16/02; 10/20/04; 04/20/05; 10/19/05; 06/21/06; 09/19/07; 03/18/09; 02/17/10; 03/16/11; 10/17/12; 10/16/13; 11/19/14; 11/18/15; 10/19/16; 09/20/17; *06/13/18; 06/12/19; 02/12/20; 02/10/21; 05/12/21; 02/09/22; 03/08/23; 06/12/24; 01/08/25

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee (Q/UAC) meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee (PAC) meeting date.

PREVIOUSLY APPLIED TO:

PartnershipAdvantage:
MPQG1015 - 09/19/2007 to 10/16/2013

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

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

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

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

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures™ prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving nurturing parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require more frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest concerns.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

The Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care are updated annually.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal[2]**	**Newborn[3]**	**3-5 d[4]**	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9] →	→	→	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←	←	●[10]	→	←	●	→	←	←	●	→
DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH																																
Maternal Depression Screening[11]				●	●	●	●																									
Developmental Screening[12]								●			●		●																			
Autism Spectrum Disorder Screening[13]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Behavioral/Social/Emotional Screening[14]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[15]																						★	★	★	★	★	★	★	★	★	★	★
Depression and Suicide Risk Screening[16]																							●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20] →	→	→																											
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	●	→	★	★	★	★	★	←	←	←	●	→
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	● →	→	→	→	→	→	→
Hepatitis B Virus Infection[31]		★ →	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→
Hepatitis C Virus Infection[32]																													● →	→	→	→
Sudden Cardiac Arrest/Death[33]																						★ →	→	→	→	→	→	→	→	→	→	→
Cervical Dysplasia[34]																																●
ORAL HEALTH[35]							●[36]	●[36]	★		★	★	★	★	★	★	★															
Fluoride Varnish[37]							←	←	←	←	●	→	→	→	→	→																
Fluoride Supplementation[38]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (https://doi.org/10.1542/peds.2018-1218).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Policy Statement: Breastfeeding and the Use of Human Milk" (https://doi.org/10.1542/peds.2022-057988). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborn Infants" (https://doi.org/10.1542/peds.2015-0699).
5. Screen, per "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity" (https://doi.org/10.1542/peds.2022-060640).
6. Screening should occur per "Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents" (https://doi.org/10.1542/peds.2017-1904). Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://doi.org/10.1542/peds.2015-3596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (https://doi.org/10.1542/peds.2015-3597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (https://doi.org/10.1542/peds.2007-2333).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (https://www.sciencedirect.com/science/article/abs/pii/S1054139X16000483).
11. Screening should occur per "Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice" (https://doi.org/10.1542/peds.2018-3259).
12. Screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening" (https://doi.org/10.1542/peds.2019-3449).
13. Screening should occur per "Identification, Evaluation, and Management of Children With Autism Spectrum Disorder" (https://doi.org/10.1542/peds.2019-3447).

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ←— ★ or ● —→ = range during which a service may be provided

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(continued)

14. Screen for behavioral and social-emotional problems per "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (https://doi.org/10.1542/peds.2014-3716), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders" (https://pubmed.ncbi.nlm.nih.gov/32439401), "Screening for Anxiety in Adolescent and Adult Women: A Recommendation From the Women's Preventive Services Initiative" (https://pubmed.ncbi.nlm.nih.gov/32510990), and "Anxiety in Children and Adolescents: Screening" (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents). The screening should be family centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. See "Poverty and Child Health in the United States" (https://doi.org/10.1542/peds.2016-0339), "The Impact of Racism on Child and Adolescent Health" (https://doi.org/10.1542/peds.2019-1765), and "Preventing Childhood Toxic Stress: Partnering With Families and Communities to Promote Relational Health" (https://doi.org/10.1542/peds.2021-052582).
15. A recommended tool to assess use of alcohol, tobacco and nicotine, marijuana, and other substances, including opioids is available at http://crafft.org. If there is a concern for substance or opioid use, providers should consider recommending or prescribing Naloxone (see https://www.cdc.gov/ore/search/pages/2018-evidence-based-strategies.html and https://nida.nih.gov/publications/drugfacts/naloxone).
16. Screen adolescents for depression and suicide risk, making every effort to preserve confidentiality of the adolescent. See "Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management" (https://doi.org/10.1542/peds.2017-4081), "Mental Health Competencies for Pediatric Practice" (https://doi.org/10.1542/peds.2019-2757), "Suicide and Suicide Attempts in Adolescents" (https://doi.org/10.1542/peds.2016-1420), and "The 21st Century Cures Act & Adolescent Confidentiality" (https://adolescenthealth.org/press_release/naspag-sahm-statement-the-21st-century-cures-act-adolescent-confidentiality/).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (https://doi.org/10.1542/peds.2011-0322).
18. These may be modified, depending on entry point into schedule and individual need.
19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Screening Panel (https://www.hrsa.gov/advisory-committees/heritable-disorders/rusp/index.html), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (https://www.babysfirsttest.org/) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation" (https://doi.org/10.1542/peds.2022-058859).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (https://doi.org/10.1542/peds.2011-3211).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at https://publications.aap.org/redbook/pages/immunization-schedules. Every visit should be an opportunity to update and complete a child's immunizations.
24. Perform risk assessment or screening, as appropriate, per recommendations in the current edition of the AAP *Pediatric Nutrition: Policy of the American Academy of Pediatrics* (Iron chapter).
25. For children at risk of lead exposure, see "Prevention of Childhood Lead Toxicity" (https://doi.org/10.1542/peds.2016-1493) and "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (https://stacks.cdc.gov/view/cdc/11859).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.* Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per "Human Immunodeficiency Virus (HIV) Infection: Screening" (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per "Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis" (https://doi.org/10.1542/peds.2021-055207).
31. Perform a risk assessment for hepatitis B virus (HBV) infection according to recommendations per the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-b-virus-infection-screening) and in the 2021–2024 edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*, making every effort to preserve confidentiality of the patient.
32. All individuals should be screened for hepatitis C virus (HCV) infection according to the USPSTF (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hepatitis-c-screening) and Centers for Disease Control and Prevention (CDC) recommendations (https://www.cdc.gov/mmwr/volumes/69/rr/rr6902a1.htm) at least once between the ages of 18 and 79. Those at increased risk of HCV infection, including those who are persons with past or current injection drug use, should be tested for HCV infection and reassessed annually.
33. Perform a risk assessment, as appropriate, per "Sudden Death in the Young: Information for the Primary Care Provider" (https://doi.org/10.1542/peds.2021-052044).
34. See USPSTF recommendations (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (https://doi.org/10.1542/peds.2010-1564).
35. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2022-060417).
36. Perform a risk assessment (https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/). See "Maintaining and Improving the Oral Health of Young Children" (https://doi.org/10.1542/peds.2022-060417).
37. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prevention-of-dental-caries-in-children-younger-than-age-5-years-screening-and-interventions1). Once teeth are present, apply fluoride varnish to all children every 3 to 6 months in the primary care or dental office based on caries risk. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).
38. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (https://doi.org/10.1542/peds.2020-034637).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in December 2023 and published in June 2024. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

FOOTNOTE CHANGES MADE IN DECEMBER 2023

- **3-5 DAY VISIT**
  (Footnote 4)
  This footnote reflects the AAP "Policy Statement: Breastfeeding and the Use of Human Milk", published June 2022.
- **BODY MASS INDEX**
  (Footnote 5)
  This footnote reflects the AAP "Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents with Obesity", published January 2023.
- **BEHAVIORAL/SOCIAL/EMOTIONAL SCREENING**
  (Footnote 14)
  This footnote reflects the USPSTF "Anxiety in Children and Adolescents: Screening" recommendations, published October 2022.
- **TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT**
  (Footnote 15)
  This footnote reflects the Centers for Disease Control (CDC) and National Institute of Drug Abuse (NIDA) guidance related to recommending and prescribing Naloxone.
- **NEWBORN BILIRUBIN SCREENING**
  (Footnote 21)
  This footnote reflects the AAP "Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 or More Weeks of Gestation", published August 2022.
- **ORAL HEALTH**
  (Footnotes 35 and 36)
  These footnotes reflect the AAP clinical report, "Maintaining and Improving the Oral Health of Young Children", published December 2022.

CHANGES MADE IN DECEMBER 2022

HIV

The HIV screening recommendation has been updated to extend the upper age limit from 18 to 21 years (to account for the range in which the screening can take place) to align with recommendations of the US Preventive Services Task Force and AAP policy ("Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis").

- Footnote 30 has been updated to read as follows: "Screen adolescents for HIV at least once between the ages of 15 and 21, making every effort to preserve confidentiality of the adolescent, as per 'Human Immunodeficiency Virus (HIV) Infection: Screening' (https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/human-immunodeficiency-virus-hiv-infection-screening); after initial screening, youth at increased risk of HIV infection should be retested annually or more frequently, as per 'Adolescents and Young Adults: The Pediatrician's Role in HIV Testing and Pre- and Postexposure HIV Prophylaxis' (https://doi.org/10.1542/peds.2021-055207)"

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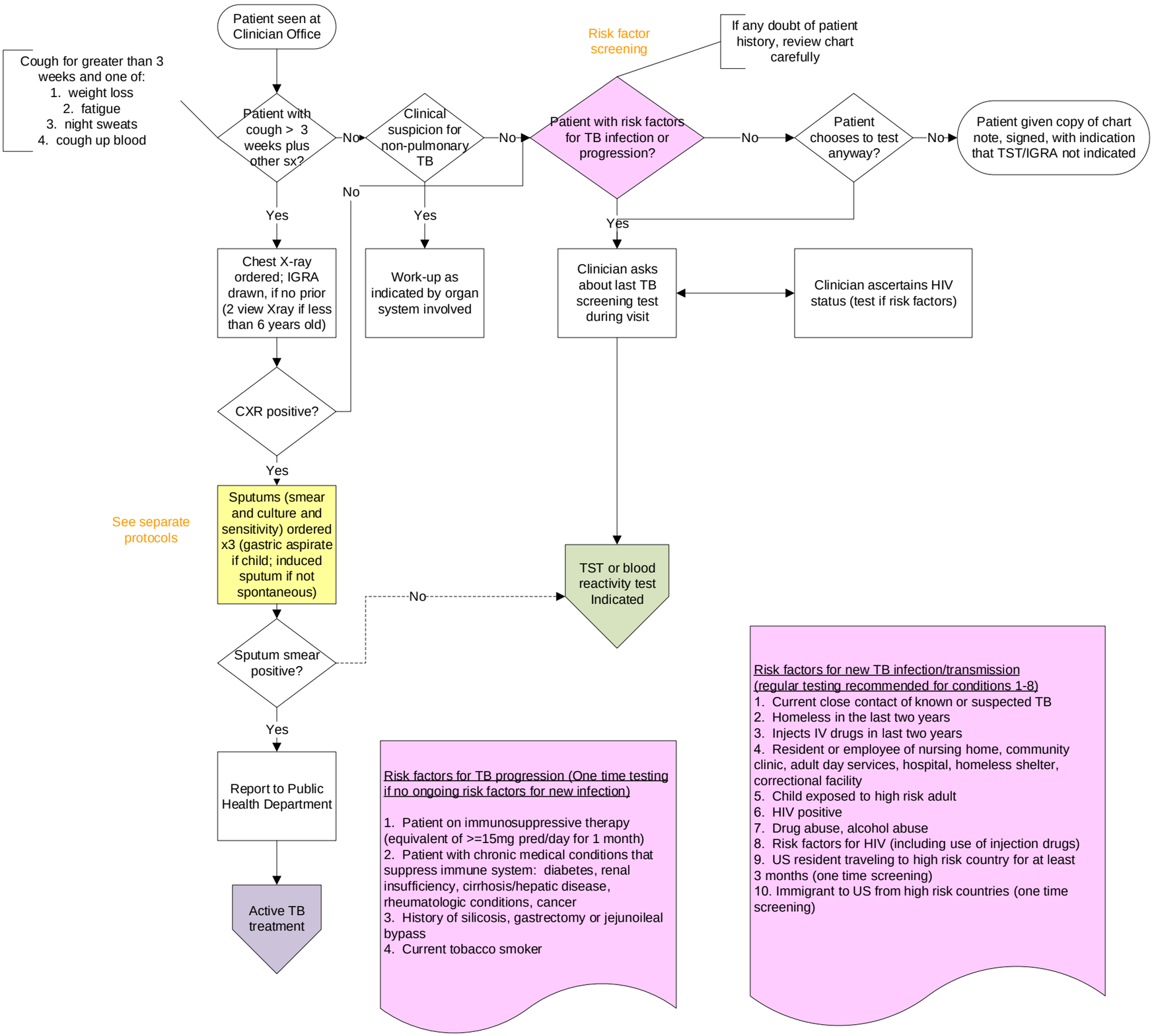
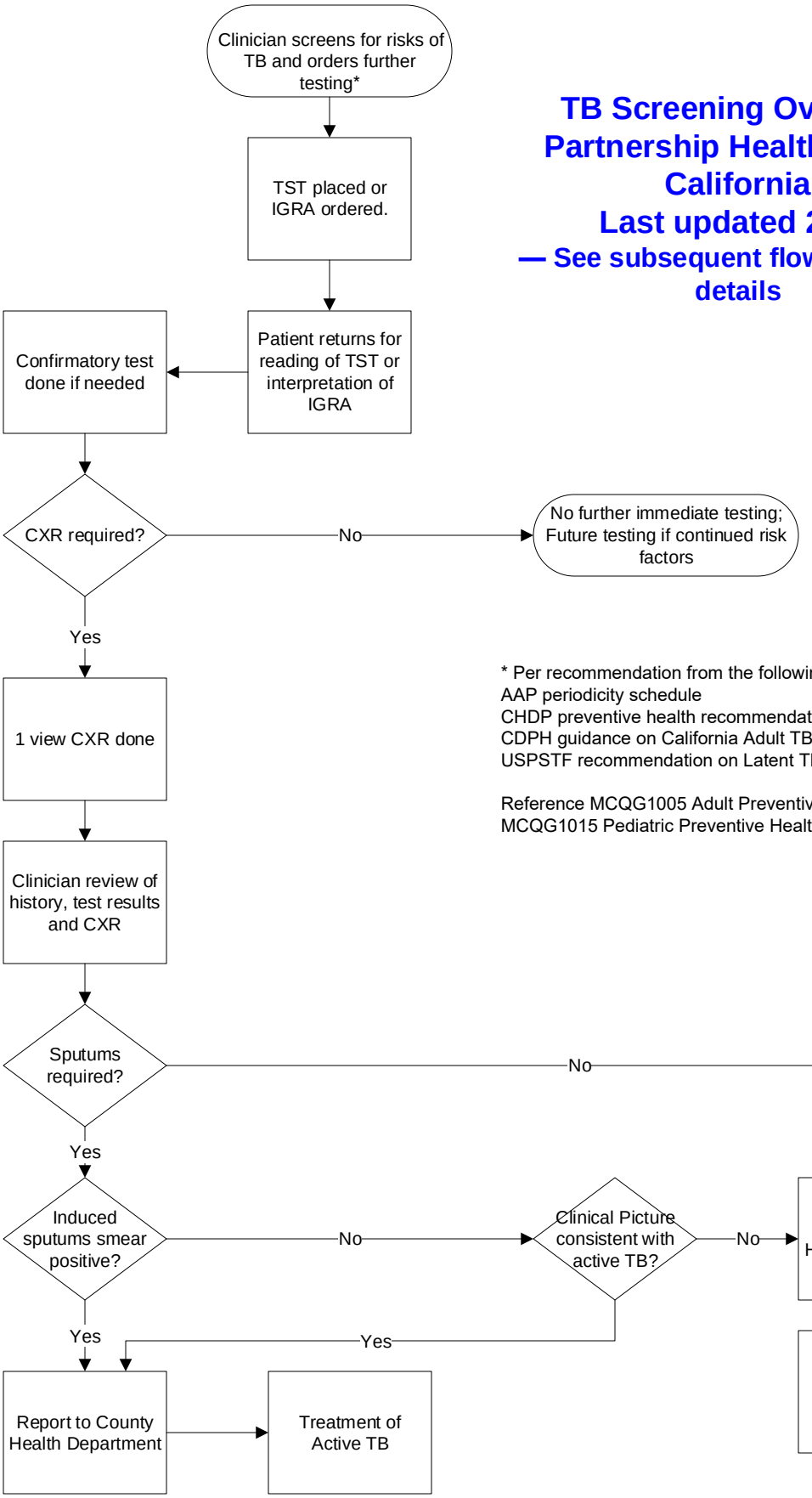
TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2024



TB Screening Overview Partnership HealthPlan of California Last updated 2023 — See subsequent flow charts for details



* Per recommendation from the following agencies:
AAP periodicity schedule
CHDP preventive health recommendations
CDPH guidance on California Adult TB Risk Assessment
USPSTF recommendation on Latent TB infection screening

Reference MCQG1005 Adult Preventive Health Guidelines and MCQG1015 Pediatric Preventive Health Guidelines

Blood Lead Testing Refusal

Patient/Child Name: _____ **Patient Date of Birth:** _____

Patient Medical Record Number: _____

My child's doctor has told me why it is important to test my child for lead and the risks of not testing.

My child's doctor has explained the facts below from the California Department of Public Health:

- The only way to know if your child has lead poisoning is through a blood test.
- Lead can harm a child's brain. Most children who have lead poisoning do not look or act sick.
- Children should be tested at age 1 and age 2.
- Children between ages 2 and 6 also need lead testing if they have never been tested before or the test results are not known.

I still choose not to have my child tested for lead poisoning.

Reason(s):

Parent/Guardian Signature: Date:

Clinic Use Only

Reasons why parent/guardian is not able to sign Blood Lead Testing Refusal form:

Provider / clinic signature / stamp:

Please keep this form and include it in patient's medical record.

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2024

Vaccines and Other Immunizing Agents in the Child and Adolescent Immunization Schedule*

Monoclonal antibody	Abbreviation(s)	Trade name(s)
Respiratory syncytial virus monoclonal antibody (Nirsevimab)	**RSV-mAb**	Beyfortus™
Vaccine	**Abbreviation(s)**	**Trade name(s)**
COVID-19	**1vCOV-mRNA**	Comirnaty®/Pfizer-BioNTech COVID-19 Vaccine
		Spikevax®/Moderna COVID-19 Vaccine
	1vCOV-aPS	Novavax COVID-19 Vaccine
Dengue vaccine	**DEN4CYD**	Dengvaxia®
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Haemophilus influenzae type b vaccine	**Hib (PRP-T)**	ActHIB® Hiberix® PedvaxHIB®
	Hib (PRP-OMP)	
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV4**	Multiple
Influenza vaccine (live, attenuated)	**LAIV4**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II® Priorix®
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-CRM**	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	**MenB-4C**	Bexsero®
	MenB-FHbp	Trumenba®
Meningococcal serogroup A, B, C, W, Y vaccine	**MenACWY-TT/ MenB-FHbp**	Penbraya™
Mpox vaccine	**Mpox**	Jynneos®
Pneumococcal conjugate vaccine	**PCV15** **PCV20**	Vaxneuvance™ Prevnar 20®
Pneumococcal polysaccharide vaccine	**PPSV23**	Pneumovax 23®
Poliovirus vaccine (inactivated)	**IPV**	Ipol®
Respiratory syncytial virus vaccine	**RSV**	Abrysvo™
Rotavirus vaccine	**RV1** **RV5**	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel® Boostrix®
Tetanus and diphtheria vaccine	**Td**	Tenivac® Tdvax™
Varicella vaccine	**VAR**	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel®
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	**MMRV**	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child and adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

5 Review contraindications and precautions for vaccine types **(Appendix)**

6 Review new or updated ACIP guidance **(Addendum)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Associates (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Questions or comments

Contact www.cdc.gov/cdc-info or 800-CDC-INFO (800-232-4636), in English or Spanish, 8 a.m.–8 p.m. ET, Monday through Friday, excluding holidays

Download the CDC Vaccine Schedules app for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html

Helpful information

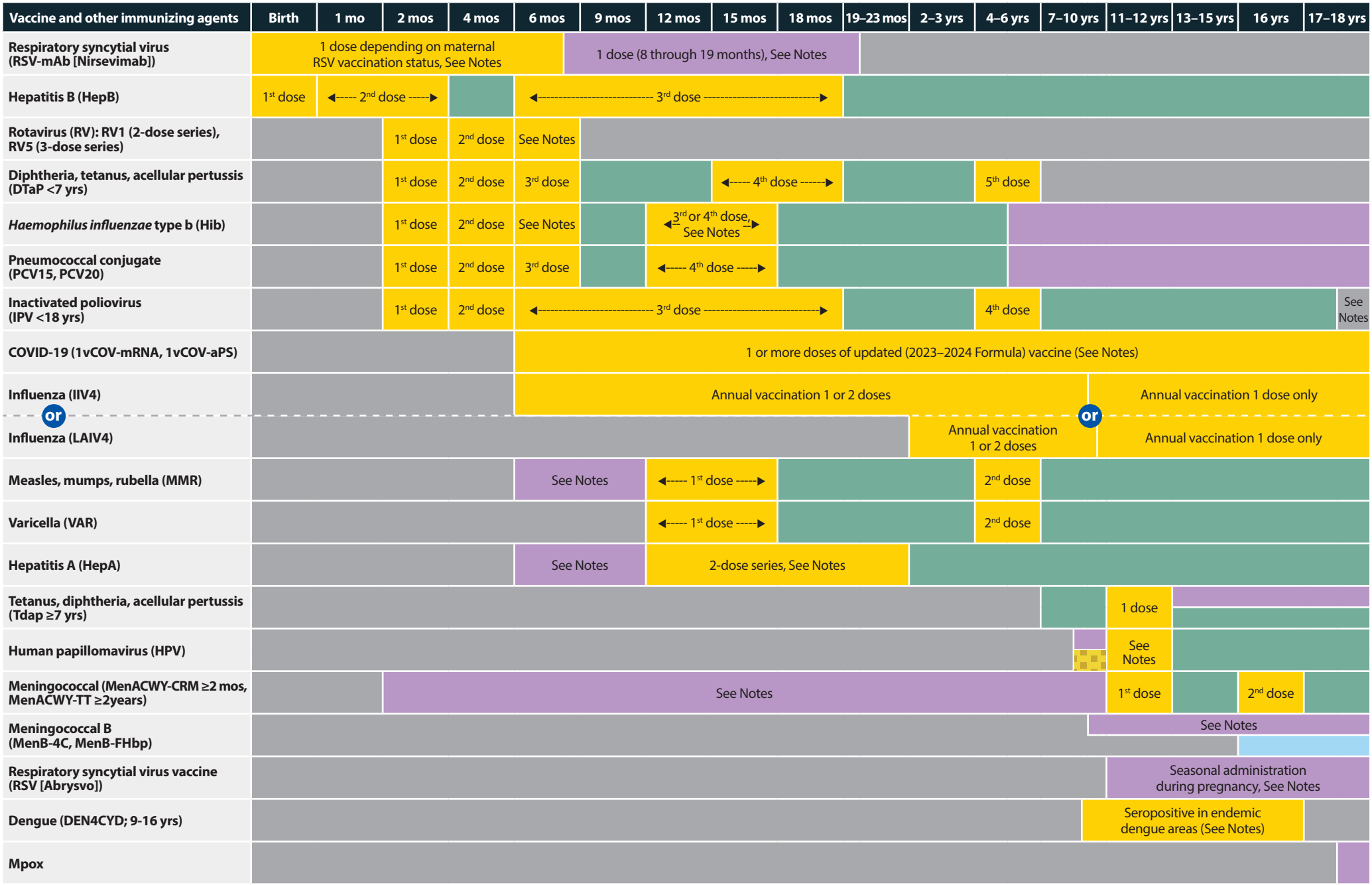
- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html
- *General Best Practice Guidelines for Immunization* (including contraindications and precautions): www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Vaccine information statements: www.cdc.gov/vaccines/hcp/vis/index.html
- Manual for the Surveillance of Vaccine-Preventable Diseases (including case identification and outbreak response): www.cdc.gov/vaccines/pubs/surv-manual

Scan QR code for access to online schedule

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2024

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).



Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups

Recommended vaccination can begin in this age group

Recommended vaccination based on shared clinical decision-making

No recommendation/ not applicable

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1021 (previously QP100121)				**Lead Department: Health Services**	
Policy/Procedure Title: Initial Health Appointment				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/18/2000			**Next Review Date:** ~~06/12/2025~~**01/08/2026** **Last Review Date:** ~~06/12/2024~~**01/08/2025**		
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:** ~~06/12/2024~~**01/08/2025**	

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MPQG1015 – Pediatric Preventive Health Guidelines
C. MCUP3101 – Screening and Treatment for Substance Use Disorders
D. MCUG3118 – Prenatal and Perinatal Care
E. MPQP1022 – Site Review Requirements and Guidelines
F. CMP36 – Delegation Oversight and Monitoring
G. MCUP3039 – Direct Members
H. MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. An Initial Health Appointment (IHA) is defined as a member's visit to his or her Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
B. Partnership HealthPlan of California (Partnership) defines newly assigned members as those individuals never before enrolled to the health plan or a previously enrolled member's first month back to the plan, who was not continuously enrolled for 120 days in the past eight months, prior to the new member month.
C. Direct Members are those whose service needs are such that PCP assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

IV. ATTACHMENTS:

A. PCP New Member Letter MC
B. IHA Applicable Visit Codes
C. Two- Attempt Outreach Tracker Template

Policy/Procedure Number: MCQP1021 (previously QP100121)		**Lead Department: Health Services**
Policy/Procedure Title: Initial Health Appointment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/18/2000	**Next Review Date:** ~~06/12/2025~~01/08/2026 **Last Review Date:** ~~06/12/2024~~01/08/2025	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

V. PURPOSE:

To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members.

VI. POLICY / PROCEDURE:

A. To meet the Department of Health Care Services (DHCS) contractual requirements, an IHA is to be performed:
   1. Within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 120 days of a member's assignment to a PCP (whichever is most recent).
      a. Refer to Medi-Cal Managed Care Division policy letter APL 22-030 (Dec. 22, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003).
      b. Exceptions to this requirement are specified in Section E of this policy.

B. An IHA must be performed by a Provider within the primary care medical setting and must be provided in a way that is culturally and linguistically appropriate for the member.

C. An IHA must include all of the following:
   1. A history of the member's physical and mental health;
      a. History of present illness
      b. Past medical history
      c. Social history
      d. Review of organ systems (ROS) including dental assessment
   2. An identification of risks;
   3. An assessment of need for preventive screens or services; see Section D
   4. Health education
      a. The provider should assure documentation, at initial and subsequent visits, of health education interventions including risk factors addressed, intervention codes, date and PCP's signature or initials. More extensive documentation in the progress notes is encouraged.
   5. The diagnosis and plan for treatment of any diseases.
   6. A M~~m~~ember Risk Assessment

D. Preventive Services
   1. The IHA must bring members up to date with all currently recommended preventive services, including immunizations, or arrange to have the member brought up-to-date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.
   2. The IHA shall follow the United States Preventive Services Task Force (USPSTF) / Advisory Committee on Immunization Practices (ACIP) immunization protocols as set forth in DHCS' APL 24-008.
      ~~1.~~a. If the Medi-Cal provider manual outlines less restrictive criteria than ACIP, immunizations are provided according to the less restrictive guidelines.
   ~~2.~~3. For members under the age of 21 years, the IHA shall follow these requirements:
      a. The IHA shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et seq., and Title 17, CCR, Sections 6l842 through l6852, except that the PCP shall follow the most recent periodicity schedule (*aka* Bright Futures Recommendations for Periodic Preventive Health Care) recommended by the American Academy of Pediatrics (AAP) as noted in Reference D of this document and in MPQG1015, the Pediatric Preventative Health Guidelines. ~~This supersedes any contradicting information found within the Child Health and Disability Prevention (CHDP) Program guidelines, as the CHDP sunsets July 1, 2024.~~
         1) All active CHDP providers as of June 30, 2024 ~~will be~~were automatically enrolled as CPE (Children's Presumptive Eligibility Program) providers on July 1, 2024.
      b. For asymptomatic members 21 years and older, the IHA shall follow these guidelines:

1) The IHA shall include a history and physical examination sufficient to assess and manage the acute, chronic, behavioral, and preventive health needs of the member.
2) The PCP shall provide the core set of preventive services for adult screening of asymptomatic health members over the age of 21years consistent with MCQG1005, Adult Preventive Health Guidelines and the Guide to Clinical Preventive Services of the U.S. Preventive Services Task Force (USPSTF).

~~3.~~4. Perinatal Services

a. Perinatal services for pregnant members will be provided according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG). Refer to the policy MCUG3118, Prenatal and Perinatal Care. For members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, an IHA must be performed by the member's PCP, or other provider of primary care services (i.e., OB/GYN). The pregnancy must be noted and the Initial Prenatal Assessment for pregnant women completed, or referral made to another Partnership provider for initiation of pregnancy-related services, including the required prenatal assessment. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.

b. Pregnant and breastfeeding members must be referred to the Women, Infants, and Children (WIC) program. Infant feeding plans should be documented during the prenatal period, and infant/breastfeeding status is documented during the postpartum period. See MCCP2021 – Women, Infants and Children (WIC) Supplemental Food Program.

~~4.~~5. Members with Chronic and/or Complex Conditions

a. For members who have been receiving services for chronic and/or complex conditions prior to enrollment in Partnership, the clinician conducting the IHA must ask specific questions to identify services being provided to members by Local Education Agencies, Regional Centers, early intervention programs, the Whole Child Model (WCM) and other special programs outside of the Partnership network, including those serving aged and/or disabled members, to allow the PCP and Partnership to most effectively accomplish necessary coordination, continuity of care and case management functions.

E. Excluded Members

1. Individual members may be excluded from the IHA requirement under the following circumstances:
   a. The medical records contain documentation of prior health assessments within the 12 months prior to enrollment, and which the member's primary care services provider determines meets the requirements for documentation of the IHA.
   ~~b. Members under 2 years of age upon enrollment generally require a periodic health examination in less than 120 days given AAP periodicity requirements and related contractual requirements.~~
   ~~c.~~b. Members who are not continuously enrolled in Partnership for 120 days.
   ~~d.~~c. Members, including emancipated minors, or a member's parent(s) or guardian, who refuses an IHA. ~~In this case, a statement signed by the member must~~ A declination should be documented in the member's medical record. ~~If the member or the party legally responsible for the member refuses to sign a refusal statement, the verbal refusal of services will be noted in the medical record.~~
   ~~e.~~d. Members with certain restricted aid codes, except pregnancy, which limit the services to which members are entitled, or to members who are share-of-cost (SOC) Medi-Cal beneficiaries are exempted from the IHA.
   ~~f.~~e. The member was dis-enrolled from the plan before an IHA could be performed.
   ~~g.~~f. The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation

must include at least two attempts to outreach to the member. ~~the following:~~
~~1) One attempt to contact member by phone~~
~~2) One attempt to contact member by letter or postcard~~
~~3) Partnership's good faith effort to update the member's contact information~~
~~4) Attempts to perform the IHA at subsequent member office visit(s)~~

F. IHA Training
   1. Site Review:
      a. Partnership will provide training for our network providers and staff during the Site Review (SR) and via the Providers' Newsletter on an annual basis. Information includes:
         1) Adequate documentation,
         2) Timelines for performing IHAs, and
         3) Procedures to assure the visit(s) for the IHA are scheduled and that members are contacted for missed IHA appointments.
   2. Provider Relations
      a. New member lists, with address labels, are distributed to providers. Providers may use these lists to document contact attempts. This documentation should be kept for three years.

G. Informing Members
   1. Members will be informed of IHA requirements via the Member's Newsletter and Partnership's website regarding:
      a. Instructions on arranging IHA appointments with appropriate timelines
      b. Importance of scheduling and keeping the IHA appointment

H. IHA Monitoring
   1. Partnership will monitor compliance to the timely provision of IHAs during the regularly scheduled Medical Record Review (MRR), as part of the Site Review. Reviewers provide PCPs with a list of members that claims data identifies as needing an IHA. Reviewers also provide templates for PCPs to document outreach attempts to bring members in for an IHA visit. PCPs or other providers of primary care services must document the performance of an IHA in the member's medical record or state that equivalent information is part of the medical record. All counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted during the IHA should be documented in the medical record. Exemptions from the IHA requirement must be appropriately documented in the medical record or on the PCP member list.
   2. On an annual basis, Partnership pulls claims and encounters with specific visit codes (Attachment B – IHA ~~Applicable~~ Applicable Visit Codes) for primary care providers to identify the potential percentage of their newly assigned members who had a visit within 120 days of being newly assigned. Due to limitations and the lack of a singular IHA billing code, this report is only able to show potential IHA's completed.

I. Direct Members: Since Direct Members are not generally assigned to a PCP, providers primarily responsible for their care should perform the IHA per the requirements outlined in this policy. For more information on Direct Members, see MCUP3039 – Direct Members.

J. Delegation of IHA monitoring functions
   1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at Partnership discretion, to perform IHA monitoring functions as part of the Site Review Process. An organization or groups will perform these functions under a formal delegation agreement.
   2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.
   3. Delegated entities will perform IHA monitoring functions for all Primary Care Physician (PCP) sites no less than every three years.

4. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
5. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008 Immunization Requirements (June 21, 2024) supersedes APL 18-004

~~A.~~B. ~~Department of Health Care Services (~~DHCS~~) All Plan Letter (~~APL~~)~~ 22-030 Initial Health Appointment (Dec. 22, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003)

~~B.~~C. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021)

~~C. DHCS APL 18-004 Immunization Requirements (Jan. 31, 2018)~~

D. American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (June 2024)

E. DHCS APL 23-005 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21 (March 16, 2023 supersedes 19-010)

F. DHCS CHDP Provider Notice 22-06 Child Health and Disability Prevention Program Discontinuance (Oct. 21, 2022)

~~F.~~G. DHCS CHDP Transition Plan (March 2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 05/15/02; 04/20/05; 06/21/06; 06/20/07; 07/16/08; 10/21/09 11/17/10; 10/16/13; 02/19/14; 02/17/16; 02/15/17; *03/14/18; 06/13/18; 06/12/19; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 03/13/24; 06/12/24; 01/08/25

*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

To: Primary Care Providers

From: Partnership HealthPlan of California
Provider Relations Department

RE: Mailing Labels/List of New Patients to your Practice

Attached is a list and address labels for members recently assigned to your practice. We are providing this information to assist you in welcoming new patients to your practice and to remind you of the importance of conducting an Initial Health Appointment (IHA) within 90 days of the member's enrollment into Partnership. If the member had a health history and physical exam completed by you or a previous provider within 1 year of joining Partnership, you do not have to complete another initial health appointment, provided that you have a copy in the member's chart. Conducting IHAs is a regulatory requirement by the Department of Healthcare Care Services (DHCS) and is therefore contractually required by Partnership.

The initial health appointment must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screenings or services, health education, and the diagnosis and treatment plan for any diseases. For children and youth (i.e., individuals under age 21) screenings should be conducted according to the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care: Bright Futures periodicity schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). For adults screenings should be conducted according to U.S. Preventive Services Task Force (USPSTF) guidelines.

We've attached sample letters in English, Spanish, Russian and Tagalog that you can use to welcome new members to your practice and to encourage them to make an appointment with you so that they can timely receive an IHA.

You should retain documentation of your efforts as Partnership will look for this documentation during your facility site review and sometimes, DHCS audits providers directly to ensure this requirement is met.

Please contact your Provider Relations Representative at (707) 863-4100 if you have any questions. We hope this information is helpful to your practice.

Thank you.

www.partnershiphp.org

SAMPLE WELCOME LETTER MEDI-CAL

Dear Partnership HealthPlan Member,

Welcome to our practice. As your primary care provider, I am looking forward to meeting you and would like to ask that you call the office to schedule a check-up. Both the Partnership HealthPlan and state Medi-Cal program ask that you have this visit within 3 months of becoming Medi-Cal eligible. During this check-up, we will review your past and current medical needs. I would also be happy to answer any questions that you have about your health.

Please take the time to schedule your appointment by calling (___) ___-____. Check-ups are a great way for you to know that you are in good health and also, a good time for your doctor to explain how you can prevent health problems.

Let's work together for your health.

Sincerely,

Estimado miembro del Partnership HealthPlan:

Bienvenido a nuestro consultorio. Como somos su proveedor medico principal, nos encantaría conocerle, y por eso le pedimos que nos llame para hacer una cita con su medico regular. Tanto el Partnership HealthPlan, como el Medi-Cal del Estado de California, requieren que usted haga cita con su médico antes de que pasen tres meses desde la fecha en que le dijeron que era elegible para Medi-Cal. Cuando venga a su cita para que le hagan un examen general, vamos a platicare de su cuidado medico del pasado, y del cuidado medico que necesita en estos momentos. También tendremos el gusto de darle respuesta a cualquier pregunta que tenga sobre su salud.

Por favor, llame al numero (___) ___-____ para hacer su cita para un examen general con el medico. Los exámenes generales son la mejor manera de saber si su salud es buena, y también es la mejor oportunidad de que su doctor le explique en que forma puede prevenir ciertos problemas médicos que pueda tener.

Vamos a colaborar juntos para mantenerlo sano.

Atentamente,

ОБРАЗЕЦ ПРИВЕТСТВЕННОГО ПИСЬМА MEDI-CAL

Уважаемый участник плана Partnership HealthPlan,

Добро пожаловать в нашу организацию. Как ваш основной поставщик медицинских услуг я жду знакомства с вами и прошу вас позвонить администратору, чтобы запланировать проверку здоровья. Правила плана Partnership HealthPlan и программы штата Medi-Cal требуют, чтобы вы посетили нас в течение 3 месяцев с момента получения права на Medi-Cal. Во время этой плановой проверки мы оценим ваши текущие и прошлые потребности в медицинском обслуживании. Я также с удовольствием отвечу на все ваши вопросы о вашем здоровье.

Запишитесь на прием по телефону (___) ___-____. Плановые проверки помогут установить состояние вашего здоровья и обсудить с врачом способы профилактики проблем со здоровьем.

Вместе мы сможем позаботиться о вашем здоровье.

С уважением,

HALIMBAWA NG WELCOME LETTER SA MEDI-CAL

Minamahal na Miyembro ng Partnership HealthPlan,

Welcome sa aming panunungkulan. Bilang inyong tagapagbigay ng pangunahing pangangalaga, inaabangan ko ang ating pagkikilala at gusto kong hilingin sa inyo na tawagan ang opisina para magtakda ng check-up. Hinihingi ng kapwa Partnership HealthPlan at programang Medi-Cal ng estado na pumunta kayo para sa pagbisitang ito sa loob ng 3 na buwan matapos maging kwalipikado para sa Medi-Cal. Sa check-up na ito, rerepasuhin namin ang inyong mga medikal na pangangailangan sa nakaraan at sa kasalukuyan. Ikagagalak ko ring sagutin ang anumang mga tanong ninyo tungkol sa inyong kalusugan.

Maglaan sana ng oras para itakda ang inyong appointment sa pamamagitan ng pagtawag sa (___) ___-____. Ang mga check-up ay magandang paraan para malaman ninyo na nasa mabuting kalusugan kayo at mabuti ring panahon para ipaliwanag ng doktor ninyo kung paano ninyo maiiwasan ang mga problema sa kalusugan.

Magtulungan tayo para sa inyong kalusugan.

Taos-pusong sumasainyo,

INITIAL HEALTH APPOINTMENT (IHA)

MCQP1021- Attachment B rev. 01/08/25~~06/12/24~~

BILLING CODES

New Patient Age	CPT Code
0-12 Months	99381
1-4 Years	99382
5-11 Years	99383
12-17 Years	99384
18+ Preventative Visit	99385
18-64 Office Visit	99386
65+ Office Visit	99387
Any Age During Pregnancy	59400, 59510, 59610, 59618

New Patient Visit Location	Visit Duration	CPT Code
Office Visit	30-44 Minutes	99203
Office Visit	45-59 Minutes	99204
Office Visit	60-74 Minutes	99205
Home Visit	30 Minutes	99342
Home Visit	60 Minutes	99344
Home Visit	75 Minutes	99345
SNF Visit	25 Minutes	99304
SNF Visit	35 Minutes	99305
SNF Visit	45 Minutes	99306

Established Patient Age	CPT Code
0-12 Months	99391
1-4 Years	99392
5-11 Years	99393
12-17 Years	99394
18+ Preventative Visit	99395
18-64 Office Visit	99396
65+ Office Visit	99397

Established Patient Location	Visit Duration	CPT Code
Office Visit	20-29 Minutes	99213
Office Visit	30-39 Minutes	99214
Office Visit	40-54 Minutes	99215
Home Visit	30 Minutes	99348
Home Visit	60 Minutes	99349
Home Visit	75 Minutes	99350

ICD-10 Description	ICD-10 Code
General medical without abnormal finding	Z00.00
General medical with abnormal finding	Z00.01
Child health exam with abnormal finding	Z00.121
Child health exam without abnormal finding	Z00.129
Potential organ donor	Z00.5
Examination as part of a clinical trial	Z00.6
Exam for period of delayed growth	Z00.70
General examination	Z00.8
Exam for admission to educational institute	Z02.0
Pre-employment examination	Z02.1
Admission to residential institute	Z02.2
Exam for driver's license	Z02.4
Exam for sports	Z02.5
Exam for insurance purposes	Z02.6
Pregnancy	Z1032
Other administrative examinations	Z02.89

EDUCATIONAL RESOURCE

The Initial Health Appointment replaced the Initial Health Assessment, effective Jan. 1, 2023. The Staying Healthy Assessment (SHA) is no longer required: all screenings once addressed by completing a SHA (ex: Alcohol, drugs, tobacco, etc.) need to be completed with an approved screening tool.

What is required to complete the Initial Health Appointment (IHA)?

- A history of the Member's physical and mental health;
- An identification of risks;
- An assessment of need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases.
- A Member Risk Assesssment

The Initial Health Appointment (IHA) is required to be completed within 120 days of Partnership enrollment and is:

- To be performed by a Provider within the primary care medical setting.
- Not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- To be provided in a way that is culturally and linguistically appropriate for the Member.
- To be documented in the Member's medical record.

What if I cannot get in contact with a newly assigned member?

If you are unable complete an IHA within 120 days of Partnership enrollment, make sure to document your two attempts of outreach. ~~We are looking for:~~

~~1. Written (mailed)~~

~~1. Verbal (phone call)~~

If you have any questions please feel free to contact the Member Safety Inspections team at fsr@partnershiphp.org

IHA Outreach

PCP ID	Patient Name:	CIN:	DOB:	Date of Enrollment	Date of Attempt 1: How was attempt made?	Date of Attempt 2: How was attempt made?

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Policy/Procedure Number: MPQG1011			**Lead Department: Health Services**	
Policy/Procedure Title: Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/31/1994		**Next Review Date:** ~~01/10/2025~~01/08/2026 **Last Review Date:** ~~01/10/2024~~01/08/2025		
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 L. Moore, MD, MPH, MBA*			**Approval Date:** ~~01/10/2024~~01/08/2025	

I. RELATED POLICIES:

A. MPQP1022 – Site Review Requirements and Guidelines
B. MPCR301 – Non-Physician Medical Practitioner Credentialing Criteria & Non-Physician Medical Practitioner Re-Credentialing Criteria

II. IMPACTED DEPTS.:

A. Provider Relations
B. Health Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP) are defined as nurse practitioners, physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM).
B. Nurse Practitioner (NP), by definition, shall be currently licensed as a registered nurse in California and be currently certified by a licensed Nurse Practitioner Program, which has met the requirements set forth and described in Title 16, Section H84 of the California Administrative Code.
C. Physician Assistant (PA) shall be currently licensed by the Physician Assistant Examining Committee/Medical Board of California.
D. Midwifery practice is the independent, comprehensive management of birthing individuals' health care in a variety of settings focusing particularly on pregnancy, childbirth, and the postpartum period.
   1. A Certified Nurse Midwife (CNM) is licensed by the California Board of Registered Nursing. CNMs are registered nurses who acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives (ACNM).
   2. A Licensed Midwife (LM) in an individual issued a license to practice midwifery by the Medical Board of California to attend cases of normal pregnancy and childbirth, and to provide prenatal, intrapartum and postpartum care, including family-planning care and immediate care (first 6 weeks) for the newborn.
E. Medical Assistants (MAs) are unlicensed persons who have received certificates indicating satisfactory completion of training requirements specified in Chapter 13, Title 16 of the California Code of Regulations.
F. "Protocols" refers to protocols that meet the requirements of the Physician Assistant Practice Act and Regulations of the Physician Assistant Examining Committee for Physician Assistants and standardized procedures for Nurse Practitioners and Certified Nurse Midwives.

IV. ATTACHMENTS:

A. Sample Non-Physician Medical Practitioners Agreement

Policy/Procedure Number: MPQG1011		Lead Department: Health Services
Policy/Procedure Title: Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines		☒External Policy ☐Internal Policy
Original Date: 10/31/1994	**Next Review Date:** ~~01/10/2025~~01/08/2026 **Last Review Date:** ~~01/10/2024~~01/08/2026	
Applies to:	☒ Medi-Cal	☐ Employees

V. PURPOSE:

To outline general guidelines describing the nature and scope of practice for non-physician medical practitioners (NPMP) and medical assistants.

VI. GUIDELINE / PROCEDURE:

A. Credentialing: See Provider Relation Policies MPCR301: Non-Physician Medical Practitioner Credentialing Criteria & Non-Physician Medical Practitioner Re-Credentialing Requirements

B. Supervision:

1. When required by state regulations, NPMP clinicians must practice under the supervision of a licensed physician, either directly, or using medical policies, procedures or agreements (e.g., protocols) established by the physician according to the category of the NPMP.
   a. Physicians may only supervise NPMPs practicing in the same medical field or specialty in which the supervising physician is trained to practice, as credentialed by Partnership HealthPlan of California.
   b. Any California-licensed physician except those who are expressly prohibited by the Medical Board from supervising a NPMP may supervise a NPMP.
2. Written standardized procedures or practice agreements, depending on the requirements for the category of NPMP being supervised, must be developed and maintained and agreed upon by the supervising physician and NPMP.
   a. These documents must be available for review at the time of site reviews performed by Partnership HealthPlan of California (~~PHC~~Partnership) Department of Health Care Services (DHCS) certified reviewers.
   b. These documents define the scope of services provided by ~~Physician Assistants (PA)~~NPMPs and Supervisory Guidelines that define the method of supervision by the supervising physician.
3. Review and co-signing of medical records involving care provided by the NPMP, while not required by law, will be completed by the supervising physician within the time frame and frequency dictated by practice protocols and agreements.
4. The supervising physician must be available for consultation with the NPMP clinician at all times when the NPMP is providing services, either by physical presence or by electronic communication.
   a. ~~PHC~~ Partnership will review compliance with this standard during site reviews.
5. An individual supervising physician may not supervise or oversee greater than the following full time equivalent NPMP ratios (each):
   a. Four (4) Nurse Practitioners (with furnishing licenses.)
      i. There is no limit on supervising NPs without furnishing licenses.
   b. Four (4) Physician Assistants
6. NPMP may participate in the after-hours call network, provided the supervising physician is available for consultation at all times that the NPMP is on call.

C. Scope of Practice:

1. Each physician and/or contracting medical group/affiliate will define the scope of practice for each NPMP working in the practice. The scope of practice may vary depending on the skills of the individual clinician, but in all cases shall comply with applicable State laws. Practitioners may substitute their protocols for scope of practice for the NPMP. These protocols must be made available to ~~PHC~~ Partnership for review and approval when requested to ensure they meet ~~PHC~~ Partnership and community standards.
2. Online or physical reference texts, or parts thereof, may be maintained by the practice and adapted for use as protocols by the physician and NPMP to be followed for each type of medical problem that might be encountered. Online protocols may also be used, but should be specified in office documentation of protocols. The supervising physician will determine and specify in writing, as required by protocols, which references, or parts thereof, are to be used by the NPMP.

3. Physician consultation should be obtained as soon as possible for conditions defined as requiring immediate physician consultation or as defined in the protocols.
4. For new NPs/PAs, for at least 6 months, consultation is recommended for specialty referral and ordering diagnostic procedures requiring a Treatment Authorization Request (TAR). The supervising physician may sign off on the accuracy and appropriateness of straightforward specialty referrals and diagnostic procedures submitted by a NPMP, such that they can order these without consultation.
5. Whenever necessary, the NPMP shall perform emergency care necessary to sustain life applying current standards of care. This includes, but is not limited to, basic first aid, establishment and maintenance of the airway, CPR, and administration of oxygen and emergency medications. Physician consultation shall be obtained as soon as possible and the NPMP shall comply with any applicable backup emergency procedures specified by protocols and professional scope of practice. The local Emergency Medical Services system shall be activated (i.e., ensure someone has called 911) when indicated.
6. The supervising physician may authorize and approve the NPMP to perform certain outpatient procedures without physician consultation, consistent with the NPMP's education, training and legal scope of practice.
7. The supervising physician may authorize the NPMP to diagnose and treat common medical problems according to accepted criteria and management as per the references utilized in the practice.
8. Inpatient Care: Consultation is required for referral for non-emergency hospitalization. NPMPs who have been granted hospital privileges may perform procedures consistent with their education, training and legal scope of practice for which they have been granted hospital privileges.

D. Physician/Clinician Agreement:
   1. Each physician/NPMP clinician team will sign an agreement stating that the NPMP will follow the protocols developed for practice by the supervising physician and in accordance with State laws governing the appropriate discipline, and based on the skills and area of specialty of each clinician. This agreement will be kept on file and will be available for review by ~~PHC~~ Partnership upon request. A sample agreement is attached. (See Attachment A)

E. Prescribing:
   1. The NPMP may furnish drugs and devices in accordance with Federal or State law, whichever is more restrictive.

F. Certified Nurse Midwife (CNM) and Licensed Midwife (LM) Guidelines:
   1. In California, CNMs have been allowed to practice without physician supervision since January, 2021; Licensed Midwives have been allowed to practice independently since 2013.
      a. CNMs and LMs may practice independently for low-risk pregnancies and births, prenatal, intrapartum, and postpartum care, family planning care, and immediate care of the newborn. At all times, nurse midwives are expected to practice under the standards used by the American Midwifery Certification Board (AMCB), which credentials midwives.
      b. CNMs and LMs also may care for patients who have higher risks if they have formal written collaboration and procedures with a physician obstetrician.
      c. CNMs and LMs who practice in out-of-hospital settings must report data on their birth outcomes.
   2. During the course of care, the midwife will consult with a physician when deviations from normal arise. If a condition requires frequent and/or continuing management by a physician, but certain aspects of care remain within the scope of midwifery management, a situation of collaborative management exists. Under collaborative management, all patients will be followed by both the physician and the midwife. The midwife may institute those midwifery protocols that do not conflict with the aspect of care under the physician's management. Thus, collaborative management

requires careful communication between the midwife and the physician, who assumes responsibility for overall provision of the patient's care.

3. When a patient develops a condition, which requires management by a physician, the patient's care must be transferred to a physician for management of antepartum, intrapartum, and/or postpartum care. When a complication develops during the intrapartum period, a transfer order then should be communicated directly to the obstetrician through the nurse in charge of the labor and delivery area. The nurse midwife may continue to provide supportive care.
4. If a collaborative agreement is in place (F.1.b above), the collaborating physician will be licensed in the State of California and will provide consultation when needed or requested by the midwife.
   a. The collaborating physician will assume active intrapartum management or co-management of those patients whose conditions are beyond the scope of midwifery practice.
   b. The collaborating physician will provide coverage when the midwife is unavailable.
   c. Consultation by the collaborating physician must be available at all times, either by physical presence or electronic communication.

G. Physician Assistant Guidelines:
   1. Physician Assistants must practice under the supervision of a physician according to a "Practice Agreement".
   2. When authorized to do so by the supervising physician, the physician assistant may perform patient-related activities within the scope of practice defined by Title 16 and in accordance with applicable Federal and State laws.
   3. The physician assistant may provide medical care that is either based upon direct consultation with the physician or contained within written protocols approved by the supervising physician.
   4. The physician assistant will seek physician consultation as soon as possible for the following situations, and any others perceived as appropriate:
      a. Any conditions which have failed to respond to appropriate management or any unusual symptom
      b. Unexplained physical finding
      c. Potentially serious or life threatening condition where prompt initiation of appropriate care has a substantial impact on outcome
      d. All emergencies arising after initial patient stabilization
      e. Any patient who desires physician consultation
      f. Before performing any invasive procedures, other than those outlined and agreed upon in established protocols.
   5. The supervising physician shall be a physician licensed by the State of California.
      a. Nothing in regulations requires that a physician review or countersign a medical record of a patient treated by a physician assistant, unless required by the Practice Agreement. The supervising physician will adhere to any such Practice Agreement requirements.
      b. The physician assistant will be responsible to communicate with the supervising physician regarding patient management and seek assistance or additional instructions in patient management as deemed necessary by the physician assistant, including unusual or non-routine cases.
      c. The supervising physician will be available for consultation or assistance at all times, either by physical presence or by electronic communications.
   6. A supervising physician shall not supervise more than four physician assistants at any one time. Per the Medical Board of California, the supervising physician is responsible for all medical services provided by the PA under their supervision and for following each patient's progress.

H. Nurse Practitioner Guidelines:
   1. In California, Nurse Practitioners are currently required to practice under the supervision of a

physician.

a. Assembly Bill 890 was signed into law and became effective January 1, 2023. This law authorizes Nurse Practitioners who meet certain education, experience and certification requirements to perform specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.
b. This creates two categories of NPs
   1) A "103 NP" - Works under the provisions outlined in Business and Profession Code Section 2837.103. This NP works in a group setting with at least one physician and surgeon within the population focus of their National Certification
   2) A "104 NP"- works under the provisions outlined in Business and Professions Code Section 2837.104. This NP may work independently within the population focus of their National Certification.
c. Assembly Bill 890 requires an NP to first work as a 103 NP in good standing for at least 3 years prior to becoming a 104 NP. Consequently, the Board is only able to certify 103 NPs at this time and will not be able to certify 104 NPs until 2026.

2. When authorized to do so by the supervising physician, the nurse practitioner may perform the patient-related activities within the scope of practice defined by Title 16 and applicable Federal and State laws.
3. The nurse practitioner may provide medical care which is either based upon direct consultation with the physician or contained within written medical policies and procedures (e.g., protocols) adapted by the supervising physician. The policies and procedures must be reviewed and approved by the supervising physician.
4. The nurse practitioner will seek physician consultation as soon as possible for the following situations, and any others perceived as appropriate:
   a. Any conditions which have failed to respond to appropriate management or any unusual symptom
   b. Unexplained physical finding
   c. Potentially serious or life threatening condition where prompt initiation of appropriate care has a substantial impact on outcome
   d. All emergencies after initial patient stabilization.
   e. Any patient who desires physician consultation
   f. Before performing any invasive procedures, other than those outlined and agreed upon in established protocols.
5. The supervising physician shall be a physician licensed by the State of California.
   a. The Nursing Practice Act (NPA) does not require physician countersignature of nurse practitioner charts. However, other statutes or regulations, such as those for third party reimbursement, may require the physician countersignature. Additionally, some malpractice insurance carriers require physicians to sign NP charts as a condition of participation. Standardized procedures may require physicians to countersign charts.
   b. The nurse practitioner will be responsible to communicate with the supervising physician regarding patient management and seek assistance or additional instructions in patient management as deemed necessary by the nurse practitioner including in unusual or non-routine cases.
   c. The supervising physician will be available for consultation or assistance at all times, either by physical presence or by electronic communications.
   d. A supervising physician shall not supervise more than four nurse practitioners with furnishing licenses at any one time. There is no limit to the number of supervised nurse practitioners without furnishing licenses.

i. A physician may be held liable for the care provided by a nurse practitioner under the physician's supervision.

I. Medical Assistant Guidelines:

1. In agreement with Title 16, CCR, Section 1366, a medical assistant may perform technical supportive services such as those specified in section IX.B. provided that all of the following conditions are met:
   a. The service is a usual and customary part of the medical practice where the medical assistant is employed.
   b. The supervising physician authorized the medical assistant to perform the service and assumed responsibility for the patient's treatment and care.
   c. The medical assistant has completed training in the services described in section III.E. and has demonstrated competence in the performance of the service, as ascertained by the supervising physician.
   d. Each technical supportive service performed by the medical assistant is documented in the patient's medical record, indicating the name, date and time, a description of the service performed, and the name of the physician who gave the medical assistant patient-specific authorization to perform the task or who authorized the task under a patient-specific standing order.
2. A medical assistant, in accord with the provisions in section IX.A, performs technical supportive services such as the following:
   a. Administer medication orally, sublingually, topically, vaginally or rectally, or by providing a single dose to a patient for immediate self-administration. A medical assistant may administer medication by inhalation if the medications are patient-specific and have been or will be routinely and repetitively administered to that patient. In every instance, prior to administration of medication by the medical assistant, a licensed physician or other person authorized by law to do so shall verify the correct medication and dosage. No anesthetic agent may be administered by a medical assistant.
   b. Perform electrocardiogram, electroencephalogram, or plethysmography tests, except full-body plethysmography. The medical assistant may not perform tests involving the penetration of human tissues, except for skin tests. The medical assistant may not interpret test findings or results.
   c. Apply and remove bandages and dressings; apply orthopedic appliances such as knee immobilizers, orthotics, and similar devices; remove casts, splints and other external devices; obtain impressions for orthotics and custom molded shoes; select and adjust crutches for the patient and instruct the patient in proper use of crutches.
   d. Perform automated visual field testing, tonometry, or other simple or automated ophthalmic testing not requiring interpretation in order to obtain test results.
   e. Remove sutures or staples from superficial incisions or lacerations.
   f. Perform ear lavage to remove impacted cerumen.
   g. Collect specimens for lab testing by utilizing non-invasive techniques, including urine, sputum, semen and stool.
   h. Draw blood for laboratory testing with proper phlebotomy training and certification.
   i. Administer injectable medications and vaccines with proper training, provided each dose of any medication or vaccine to be given is visually verified as appropriate by an authorized and licensed medical provider or nurse prior to administration.
   j. Assist patients with ambulation and transfers.
   k. Prepare patients for and assist the physician, physician assistant or registered nurse in examinations or procedures including positioning, draping, shaving and disinfecting treatment sites.

l. As authorized by the supervising physician, provide patient information and instruction.
m. Collect and record patient data including height, weight, temperature, pulse, respiration rate and blood pressure, and basic information about the presenting and previous conditions.
n. Perform simple laboratory and screening tests customarily performed in a medical office.
o. Cut the nails of otherwise healthy patients.
p. Administer first aid or cardiopulmonary resuscitation in an emergency.
q. A medical assistant may also fit prescription lenses or use any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

J. Patient Choice:
1. The patient must be informed that the provider is a NPMP, and be granted the opportunity to see a physician if they choose.

K. Monitoring Compliance:
1. ~~PHC~~ Partnership monitors compliance with this policy through the Site Review. A Corrective A~~a~~ction ~~plans~~ Plan~~s~~ (CAP) ~~are~~ may be required when deficiencies are identified and any uncorrected deficiencies may be reported to the Chief Medical Officer, Provider Relations department and Credentialing Committee for further action.

VII. REFERENCES:

A. California Senate Bill 697 (Caballero. Chapter 707, Statutes of 2018), effective date January 1, 2020 – Physician assistants: practice agreement: supervision.- amending Sections 3500, 3501, 3502, 3502.1, 3502.3, 3509, 3516, 3518, 3527, and 3528 of, and to repeal Sections 3516.5, 3521, and 3522 of, the Business and Professions Code, relating to healing arts.
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB697

B. California Assembly Bill 890 (Wood, Chapter 265, Statutes of 2020) Approved September 29, 2020. Nurse practitioners: scope of practice: practice without standarized procedures. - amending Sections 650.01, 805, and 805.5 of, and to add Article 8.5 (commencing with Section 2837.100) to Chapter 6 of Division 2 of, the Business and Professions Code, relating to healing arts.
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB890

C. California Assembly Bill 1308 (Bonilla, Chapter 665, Statutes of 2013) Chaptered October 10, 2013. Midwifery– amending Sections 2507, 2508, 2513, 2516, and 2519 of, and to add Section 2510 to, the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to professions and vocations. https://legiscan.com/CA/text/AB1308/2013

D. California Senate Bill 1237 (Dodd, Chapter 88 Statutes of 2020) Approved September 18, 2020 – Nurse-midwives: scope of practice- amending Sections 650.01, 2746.2, 2746.5, 2746.51, and 2746.52 of, and to add Sections 2746.54 and 2746.55 to, the Business and Professions Code, and to amend Sections 102415, 102426, and 102430 of the Health and Safety Code, relating to healing arts.
https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB1237

E. Medical Board of California website - Information pertaining to the practice of midwifery.
https://www.mbc.ca.gov/Licensing/Licensed-Midwives/Practice-Information/#:~:text=The%20law%20provides%20that%3A,immediate%20care%20for%20the%20newborn.

F. Medical Board of California website – Frequently Asked Questions – Physician Assistants
https://www.mbc.ca.gov/FAQs/?cat=Licensees&topic=Physician%20Assistants

G. University of California San Francisco. Sacramento Midwifery website. Scope of Practice. https://sacramentomidwifery.ucsf.edu/scope-practice#:~:text=Nurse%20Midwives%20in%20California%20have,immediate%20care%20of%20the%20newborn.

California Board of Registered Nursing website. Nursing Practice Act. https://rn.ca.gov/practice/npa.shtml#:~:text=The%20Nursing%20Practice%20Act%20(NPA,Code%20starting%20with%20Section%202700 .

VIII. DISTRIBUTION:

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/14/95; 05/17/00; 08/15/01; 09/18/02; 10/20/04; 04/20/05; 04/19/06; 06/20/07; 07/16/08; 07/15/09; 09/15/10; 01/16/13; 01/15/14; 01/21/15; 08/17/16; 08/16/17; *08/08/18; 09/11/19; 10/14/20; 10/13/21; 10/12/22; 01/10/24; 01/08/25

*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:

Partnership*Advantage*:
MPQG1011 - 06/20/2007 to 01/01/2015

Healthy Families:
MPQG1011 - 10/01/2010 to 03/01/2013

Healthy Kids (Program ended 12/01/2016)
06/20/07, 07/16/08, 07/15/09, 09/15/10, 01/16/13, 01/15/14, 01/21/15, 08/17/16 to 12/01/16

(S A M P L E)

Non-Physician Medical Practitioners Agreement

The following is an agreement between _____ and
(Clinician Name)

_____.
(Supervisory MD or Medical Director)

The undersigned Non-Physician Medical Practitioners (NPMP) acknowledges the following:

I agree to follow the protocols established by _____
(Name of Practice or Organization)
for NPMP practice.

I understand that failure to follow these protocols may result in disciplinary action.

I agree to consult with my supervising physician for all cases as outlined in the protocols and for any case if I am unsure about the diagnosis or management.

I understand that I must maintain my current state license and must participate in Continuing Medical Education relating to my specialty, in accordance with the license and certification requirements applicable to my specialty.

I understand that a supervising physician will be available either on-site or by electronic communication at all times while I am caring for patients.

I understand that I am expected to stabilize patients during life-threatening emergencies and to contact a physician as soon as possible and/or arrange for emergency transport to the nearest hospital.

I understand that my charts will be reviewed by the supervising physician who will discuss cases with me on a regular basis.

I understand that medications must be ordered pursuant to applicable provisions of applicable California and Federal laws relating to my specific certification or licensure.

I understand that _____ is the provider for purposes of delivering medical services,

determining fees, billing patients and setting office practices and procedures. I further agree that the salary or wages I receive from said provider constitutes payment in full to me for the services rendered to said provider's patients.

This agreement is effective until amended in writing or terminated by the supervising physician, and shall automatically terminate when the NPMP no longer provides services in the practice.

Name of NPMP (typed or printed)	Signature	Date
Name of Supervising Physician or Medical Director (typed or printed)	Signature	Date

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3102</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Vision Care</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~01/10/2025~~01/08/2026
Last Review Date: ~~01/10/2024~~01/08/2025</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: ~~01/10/2024~~01/08/2025</td></tr>
</table>

I. RELATED POLICIES:
CMP36 – Delegation Oversight and Monitoring

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

III. DEFINITIONS:
A. Optical Low Vision Aids: Low vision optical devices include a variety of devices, such as stand and handheld magnifiers, strong magnifying reading glasses, loupes, and small telescopes. Magnifying devices are generally either handheld or mounted on a stand, with zoom ranges from 2x to 10x.
B. Optometry Services: Services provided by optometrists acting within the scope of their practice under California law. Orthoptics and pleoptics may be part of optometry services but are not covered benefits.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To describe the means for providing vision care services to ~~member~~Members of Partnership HealthPlan of California~~PHC~~.

VI. POLICY / PROCEDURE:
A. Provision of Services
1. ~~PHC~~Partnership contracts with a vision care insurance organization, Vision Services Plan (VSP), for the provision of Medi-Cal vision care services to eligible ~~member~~Members. Members assigned to VSP must go to a VSP Medi-Cal participating provider for refraction services and eye glass frames.
2. Members not assigned to VSP are billed directly to ~~PHC~~Partnership.

B. Examination
1. Benefits include one eye examination with refraction every 24 months. A second eye examination with refraction will be covered if the ~~member~~Member has a sign or symptom indicating medical necessity. The reimbursement rates of optometric services shall not exceed charges made to the general public.

C. Eye Appliances
1. A written prescription is required.

2. The reimbursement rates for appliances shall not exceed charges made to the general public.
3. Lenses and frames are covered every 24 months. Lenses may be covered more often if medically necessary.
   a. Lost, stolen, broken or significantly damaged eye appliances may be replaced within 24 months if damage was beyond the recipient's control. Recipient must submit a signed statement describing the circumstances of replacement.
4. All fabrication of optical lenses is provided by the Prison Industry Authority (PIA) optical laboratories. The Department of Health Care Services (DHCS) is responsible for reimbursement for the fabrication of the ophthalmic lenses in accordance with the Interagency Agreement between DHCS and PIA.

5. Elective contact lenses are not a covered benefit.
   a. In certain cases, contact lenses may be covered if medically necessary. Prior authorization is required.

~~5.~~6. Optical low vision aids may be covered when medically necessary for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery and the subnormal vision interferes with the ~~member~~Member's ability to perform everyday activities. Prior authorization is required.

E. Delegation Oversight and Monitoring
1. ~~PHC~~Partnership delegates the administration of vision care services to a vision care insurance organization~~(s)~~.
2. A formal agreement is maintained and inclusive of all delegated functions.
3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
4. Results from the annual delegation oversight audit shall be presented to ~~PHC~~Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Title 22 California Code of Regulations (CCR) Sections 51306, 51317, 51518, 51519, 51519.1 and 51519.2
B. DHCS Contract Exhibit A, Attachment 10, 8 (C)
C. Medi-Cal Provider Manual/ Guidelines: Eye Appliances *(eye app)*; ~~and~~ Low Vision Aids *(low vision)*; TAR Completion for Vision Care (*tar comp vc*); PIA Optical Laboratories *(pia)*

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
03/21/12; 01/21/15 (effective 02/01/15); 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25

*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:

Policy/Procedure Number: MCUP3102		**Lead Department: Health Services**
Policy/Procedure Title: Vision Care		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/10/202501/08/2026** **Last Review Date: 01/10/202401/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

****

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3106</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Waiver Programs</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~01/10/2025~~11/13/2025
Last Review Date: ~~01/10/2024~~11/13/2024</td></tr>
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</table>

I. RELATED POLICIES:
MCUG3011 – Criteria for Home Health Services

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

III. DEFINITIONS:
A. DDS: Department of Developmental Services
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."
~~B.~~C. DHCS: Department of Health Care Services
C. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
~~C.~~D. HCBS: Home and Community Based Services
~~D.~~E. IHO: In-Home Operations Waiver
E. Personal Care Services (PCS): Services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer homemaker services support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
State and Federal Waiver Programs ensure ~~member~~Members who may benefit from Medi-Cal Home and Community Based Services (HCBS) Waiver Programs are identified and referred for medical care coordination and care management.

VI. POLICY / PROCEDURE:
A. The Department of Health Care Services (DHCS) administers a number of HCBS Waiver Programs.

These waiver programs include:

1. In-Home Operations Waiver (IHO)
2. Medi-Cal Waiver Program (MCWP) (formerly known as the ~~Acquired Immune Deficiency Syndrome (~~AIDS~~)~~ Medi-Cal Waiver Program)
3. Home and Community Based Services Waiver for the Developmentally Disabled (HCBS-DD)
4. Self-Determination Program (SDP)

~~4.~~5. Assisted Living Waiver (ALW)

~~5.~~6. Home and Community-Based Alternatives (HCB~~ Alternatives~~A) Waiver (~~previously~~ formerly~~titled~~ Nursing Facility/Acute Hospital (NF/AH)Waiver)

~~B.~~ Multipurpose Senior Services Program (MSSP) Waiver

7.

~~C.~~B. Electronic Visit Verification (EVV) Requirements:

1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
2. Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.

~~D.~~C. Criteria Used for Identification

1. The Primary Care Provider (PCP), Specialist, and/or ~~PHC~~Partnership Care Coordination/ Utilization Management Departments refer ~~member~~Members to Waiver Programs.
2. Persons with developmental disabilities are identified through coordination with the R~~r~~egional C~~c~~enters and in the course of utilization and case management services. Members with developmental disabilities who may meet the requirements for participation in this waiver are referred to the HCBS administered by the State Department of Developmental Services (DDS).

~~E.~~D. Referrals and Authorization

1. The PCP requests prior authorization for services from the appropriate State Waiver Program and provides all appropriate medical information. The PCP may request assistance from the Care Coordination department for the following:
   a. Facilitating authorization from appropriate Waiver Program(s)
   b. Completion of the Waiver Program application
   c. Follow up on status of acceptance to appropriate Waiver Program(s)
   d. Medical care coordination of ~~member~~Member while awaiting acceptance and/or placement into a Waiver Program

~~2. Note:~~ No ~~member~~Member may be enrolled in more than one HCBS Waiver Program at a time.

2.

3. ~~PHC~~Partnership maintains the responsibility to provide comprehensive care management and authorize all medically necessary covered services for ~~member~~Members including those accepted into the Waiver Programs. The PCP will continue to treat and coordinate treatment for the ~~member~~Member.
4. Referrals for the In-Home Operations Waiver Program are made via telephone or mail:

   In-Home Operations Branch Intake Unit
   Department of Health Care Services
   ~~1501 Capitol Avenue~~
   MS 4502
   P.O. Box 997437
   Sacramento, CA 95899-7437
   (916) 552-9105 in Sacramento
   ~~(213) 897-6774 in Los Angeles~~

~~Fax: (916) 552-9149~~

5. For the ~~AIDS~~ Medi-Cal Waiver Program (MCWP), patients should be referred to a MCWP Provider in their county (or if their county does not have an MCWP provider, they may be referred to a nearby county that participates in the MCWP). A list of MCWP Providers can be found here: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_MCWP_Provider_List.aspx
Information for the Office of AIDS Medi-Cal Waiver Program is posted on this website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx
Through this waiver program, local agencies provide home and community based services as an alternative to nursing facility care or hospitalization. The agencies are under contract with the
California Department of Public Health
Office of AIDS
(916) 449-5900
4. Members who may qualify for services through the Home and Community Based Services Waiver for the Developmentally Disabled or the Self-Determination Program are referred to the Regional Center responsible for their geographic area as follows:
   a. Alta California Regional Center (provides services in Colusa, Nevada, Placer, Sierra , Sutter, Yolo, and Yuba counties)
   2241 Harvard Street, Suite 100
   Sacramento, CA 95815
   (916) 978-6400
   b. Far Northern Regional Center (provides services in Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity counties)
   1900 Churn Creek Road, Suite 114
   Redding, CA 96002
   (530) 222-4791
   c. Golden Gate Regional Center (provides services in Marin county)
   4000 Civic Center Drive, Suite 310
   San Rafael, CA 94903
   (415) 446-3000
   d. North Bay Regional Center (provides services in Solano, Napa, and Sonoma counties)

Solano/ Napa	Sonoma
610 Airpark Road	520 Mendocino Avenue
Napa, CA 94558	Santa Rosa, CA 95401
(707) 256-1100	(707) 569-2000

   e. Redwood Coast Regional Center (provides services in Del Norte, Humboldt, Lake, and Mendocino counties)

Del Norte County	Humboldt County
1301-A Northcrest Drive	525 2nd Street, Suite 300
Crescent City, CA 95531	Eureka, CA 95501
(707) 464-7488	(707) 445-0893
Lake County	Mendocino County
180 3rd Street	1116 Airport Park Blvd.
Lakeport, CA 95453	Ukiah, CA 95482
(707) 262-0470	(707) 462-3832

   f. Contact information for the State agency is as follows:
   California Department of Developmental Services (DDS)
   1215 O Street
   Sacramento, CA 95814
   Mailing Address:

P. O. Box 944202
Sacramento, CA 94244-2020
Info: (833) 421-0061
TTY: 711

5. The Assisted Living Waiver (ALW) program is only offered in certain counties. Sonoma County is currently the only county which ~~PHC~~Partnership serves that provides ALW services. A list of all participating facilities can be found at this webpage: https://www.dhcs.ca.gov/services/ltc/Documents/List-of-RCFE-ARF-facilities.pdf~~http://www.dhcs.ca.gov/services/ltc/Documents/List-of-RCFE-facilities.pdf~~
Additional downloadable forms related to the ALW program can be found at this website: http://www.dhcs.ca.gov/services/ltc/Pages/Assisted-Living-Waiver-Provider-Resources.aspx
   a. How to enroll: Medi-Cal ~~member~~Members do not submit applications. Medi-Cal ~~member~~Members are enrolled through Care Coordination Agencies, which are providers within the ALW program. Full scope Medi-Cal ~~member~~Members must contact a Care Coordination Agency, which determines each individual's care needs. Assessments are done by registered nurses employed by a Care Coordination Agency (CCA). A list of these agencies by county can be found on this webpage: https://www.dhcs.ca.gov/services/ltc/Documents/Care-Coordination-Agencies.pdf
   ~~2) Contact Information for :~~
   ~~(serving Sonoma County)~~
   ~~3641 Adams Street, Riverside, CA 92504~~
   ~~Phone (844) 657-4748~~
   ~~Fax: (844) 746-7646~~
   ~~Marie Vernon, Program Director~~
   ~~info@allhoursadultcare.com~~
   ~~10) Contact Information for New Horizons CCA:~~
   ~~(serving Sonoma County)~~
   ~~6060 Sunrise Drive, Suite 3200, Citrus Heights, CA 95610~~
   ~~Phone (916) 745-3754~~
   ~~Fax: (916) 512-3473~~
   ~~Debbie Brooke, Program Director~~
   ~~casemanagement@newhorizonscca.com~~
   ~~18) Contact Information for Star Nursing, Inc.:~~
   ~~(serving Sonoma County)~~
   ~~2795 E. Bidwell Street, Suite 100-102, Folsom, CA 95630~~
   ~~Phone: (916) 542-1445~~
   ~~Fax: (877) 687-7400~~
   ~~Program Directors: Nancy, Debi, Lisa, and Ana~~
   ~~care@starnursing.com~~
   ~~26) Contact Information for Vigilans Home Health Services:~~
   ~~(serving Sonoma County)~~
   ~~256 Cajon St #B, Redlands, CA 92373~~
   ~~Phone: (909) 748-7980~~
   ~~Fax: (909) 781-2496~~
   ~~Contacts: Joel Zamora, Adalbert Zamora, Galen Jay Espelita~~
   ~~vigilanscca@gmail.com~~
   ~~gg.~~b. Contact Information for State Program:
   Department of Health Care Services

Long-Term Care Division, Monitoring & Oversight Section
Assisted Living Waiver Program
1501 Capitol Avenue, MS 4503
PO Box 997437
Sacramento, CA 95899-7437
ALW Hotline (916) 552-9322

6. The Home and Community-Based Alternatives (HCBA)Waiver (previously titled Nursing Facility/Acute Hospital Waiver) provides care management services at home to Medi-Cal beneficiaries with high level needs who would otherwise receive care in a facility. Some of the services that may be provided to support Waiver participants in the community include, but are not limited to: in-home nursing services, waiver personal care services, family/caregiver training, home or facility respite, habilitation services, community transition services, environmental accessibility adaptation, medical equipment operating expenses, personal Emergency Response System (PERS) installation, testing, and operation. Application information for the program can be found here: https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx
7. Referrals for the Multipurpose Senior Services Program (MSSP) Waiver program are made by sending the Medi-Cal Member (who is 65 years or older) to a local MSSP site in the county where the Member resides. MSSP site staff will make a certification determination based upon Medi-Cal criteria. A list of MSSP sites can be found here: https://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III Subsections 4.3.15 *(Services for Persons with Developmental Disabilities)*, 4.3.20 (*Home and Community-Based Services Programs*), ~~11, Provisions 11.C. and 15.A. and B. and Exhibit A, Attachment 18, Provisions 11.M, S, and X.~~ 4.4.2 E. (*Populations of Focus for Enhanced Care Management*)

B. Medi-Cal Provider Manual/Guidelines: Home and Community-Based Services (HCBS) *(home)*

~~B.~~C. ~~PHC~~Partnership Memoranda of Understandings (MOUs) with Regional Centers for specific geographical areas

~~C.~~D. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)

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: 11/28/12; 01/20/16; 11/16/16; *06/13/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25

*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

Policy/Procedure Number: MCUP3106		Lead Department: Health Services
Policy/Procedure Title: Waiver Programs		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/10/202511/13/2025** **Last Review Date: 01/10/202411/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3125</td><td colspan="4">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Gender Dysphoria/Surgical Treatment</td><td colspan="4">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/21/2013</td><td colspan="5">Next Review Date: ~~01/10/2025~~01/07/2026
Last Review Date: ~~01/10/2024~~01/07/2025</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="4">☐ Employees</td></tr>
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<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td colspan="2">☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td colspan="2">☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="4">Approval Date: ~~01/10/2024~~01/07/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3039 - Direct Members
C. MCUP3114 - Physical, Occupational and Speech Therapies
D. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
~~D.~~E. MCND9002 - Cultural & Linguistic Program Description

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Gender Dysphoria is a formal diagnosis used by psychologists and physicians to describe persons who experience significant dysphoria, describing the emotional distress over a marked incongruence between one's experienced/expressed gender and assigned gender. These individuals are commonly referred to as transgender or gender nonconforming (TGNC).
B. Medical Necessity (Age 21 and over): As defined per Partnership HealthPlan of California's (~~PHC~~Partnership's) contract with the Department of Health Care Services (DHCS), medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Medical Necessity (Under Age 21): In addition to the definition noted in III. B above, medical necessity for ~~member~~Members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
D. Medi-Cal Rx: The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-service (FFS) delivery system effective January 1, 2022.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

Policy/Procedure Number: MCUP3125		Lead Department: Health Services
Policy/Procedure Title: Gender Dysphoria/Surgical Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/21/2013	**Next Review Date: 01/10/202501/07/2026** **Last Review Date: 01/10/202401/07/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all procedures related to gender dysphoria and shall be reviewed on a case-by-case basis.

B. Continuity of care requests will be reviewed by the ~~PHC~~Partnership Medical Director or Physician Designee for medical necessity and continued care. There must be a clearly established relationship with the provider and the willingness of the provider to continue care.

C. When reviewing a request for the surgical treatment of gender dysphoria, Partnership HealthPlan of California utilizes the most recent criteria as outlined by the World Professional Association for Transgender Health (WPATH) and as defined as a covered benefit according to the All Plan Letter (APL) 20-018 issued by the California Department of Health Care Services (DHCS). All requests will be reviewed by the Chief Medical Officer or Physician Designee for medical necessity.

1. According to the APL 20-018 (excerpted):
   a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender or gender nonconforming beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body, to create a normal appearance to the extent possible" and for transgender ~~member~~Members, may consider gender dysphoria as a developmental abnormality. In the case of transgender or gender nonconforming beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.
   b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."
2. Gender reassignment/ affirming surgery is a covered benefit according to APL 20-018 and will be reviewed according to most recent WPATH criteria for the surgery. The requesting provider must submit evidence in demonstration of meeting either medical necessity or reconstructive surgery criteria consistent with WPATH criteria. This may include, but is not limited to:
   a. Persistent, well-documented gender dysphoria
   b. Capacity to make a fully informed decision and consent for treatment
   c. Consent for gender reassignment/ affirming surgery must be in compliance with current California consent policies and statutes.
   ~~d. An assessment of the member by qualified mental health professionals within the past year that is in agreement with the surgery.~~
   ~~e.~~d. If significant medical or mental health concerns are present, they must be reasonably well controlled
   ~~f. Documented collaboration with, and agreement to, surgery by the beneficiary's primary care provider or provider of transgender or gender nonconforming care~~
3. The list of surgical procedures may include:
   a. For Male to Female (MtF, also known as transfeminine) patients or gender nonconforming patients desiring surgery for de-masculinization
      1) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
      2) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
   b. For Female to Male (FtM, also known as transmasculine) patients or gender nonconforming patients desiring surgery for de-feminization
      1) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)
      2) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses.
   c. It is suggested that health care professionals consider gender-affirming genital procedures in eligible transgender and gender diverse adults seeking these interventions when there is

evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated).

d. Specific considerations: ~~PHC~~Partnership does not categorically limit any services or the frequency of services available to a transgender or gender nonconforming ~~member~~Member, however, the following services are evaluated using the criteria stated below:
   1) For mastectomy and creation of a male chest – no hormone therapy is required.
   2) For breast augmentation – hormone therapy may be required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated.
   3) For hysterectomy, oophorectomy, salpingo-oophorectomy and for orchiectomy – hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual) – to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention. Other surgery specific preauthorization criteria must be met.
   4) For metoidioplasty or phalloplasty (including testicular prostheses) and for vaginoplasty:
      a) Hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual).
      b) 12 continuous months of living in a gender role that is congruent with the patient's identity as documented by the ~~member~~Member's primary care provider (PCP) or transgender care clinician. Exceptions can be made if there are safety considerations for the patient.
   5) Non-genital, Non-breast surgery or treatments that may be considered non-reconstructive and may be considered cosmetic surgery and therefore not a covered benefit will be considered on a case by case basis including: facial feminization surgery, thyroid cartilage reduction, hair reconstruction/removal.
   6) Prior to any pitch changing surgery, speech therapy as conversational therapy should be considered, and for FtM, hormone therapy should be included. Voice training should be part of a comprehensive program to develop either feminine or masculine communication that goes beyond change in pitch to also include intonation, resonance, intensity, syntax, rate of speech, vocabulary, and non-vocal communication. The ~~member~~Member must be able to achieve stimulable conversation. (See also policy MCUP3114 Physical, Occupational and Speech Therapies)
   7) Rhinoplasty may be considered using the guidelines noted in Section VI.C.1.a. and b. above. In order to determine medical necessity, submit the following information:
      a) Photos of the ~~member~~Member's face and nose (two views) are required.
   8) Liposuction, lipofilling (with the exception of breast augmentation), gluteal augmentation (implants/liposuction/lipofilling), facelift, facial lip augmentation/ reduction, and blepharoplasty are evaluated on a case-~~-~~by-~~-~~case basis based on the principles listed in Section VI.C.1. above.
   9) Repeat reconstructive surgery in the absence of physiologic dysfunction (e.g. second breast enhancement) may be considered cosmetic and if so, not a benefit.
   10) Gender nonconforming surgical requests will be reviewed on a case by case basis.

4. Pharmaceutical treatment for gender dysphoria: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter (APL) 22-012 *Revised*, and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/~~Magellan~~ DHCS-contracted pharmacy administrator instead of ~~PHC~~Partnership. This includes medications used for the treatment of gender dysphoria. Refer to the ~~PHC~~Partnership website page for pharmacy- authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

The State Medi-Cal Contract Drugs List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://medi-calrx.dhcs.ca.gov/home/cdl/~~https://files.medi-cal.ca.gov/pubsdoco/Publications.aspx?t=4~~

D. Treatment Authorization Review (TAR)
   1. TARs must be submitted prior to any surgical procedure referenced in section VI.C.3.~~2.f~~ and should demonstrate either medical necessity or reconstructive surgery criteria that is consistent with WPATH criteria and the covered benefit according to DHCS APL 20-018.~~as described in section C.2.~~
   2. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review and determination. Requests for surgical treatment of gender dysphoria shall be reviewed for reconstructive surgery criteria, the standard of care as advised by WPATH, and medical necessity requirements.
      a. Review of reconstructive surgery criteria and medical necessity are considered separate and distinct and may independently serve as the basis for approval of a request.
      b. Where medical necessity is not met, ~~PHC~~Partnership must review the TAR to determine if criteria for reconstructive surgery is met, taking into consideration the gender with which the ~~member~~Member identifies.
      c. Denial of a TAR, in whole or part, must describe the basis for denial for both reconstructive surgery criteria and medical necessity.

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

F. Statement of Non-Discrimination
   1. ~~PHC~~Partnership does not discriminate against transgender individuals and treats beneficiaries in a manner consistent with their gender identity.
   2. ~~PHC~~Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender or gender nonconforming individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily ~~are~~ exclusively available.
   3. ~~PHC~~Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.
   ~~3.~~4. See also policy MCND9002 Cultural & Linguistic Program Description for more information on Partnership's Diversity, Equity and Inclusion (DEI) training programs for contracted network providers.

VII. REFERENCES:

A. World Professional Association for Transgender Health (WPATH) criteria, current version. https://www.wpath.org/soc8~~https://www.wpath.org/publications/soc~~
B. DHCS All Plan Letter (APL) 20-018: Ensuring Access to Transgender Services (10/26/2020)
C. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)
D. Title 42 United States Code (USC) Section 1396d(r)(5)
E. Insurance Gender Nondiscrimination Act (IGNA) Health and Safety Code (HSC) Section 1365.5
F. DHCS APL 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx. (~~07/11/2022~~12/30/2022)

Policy/Procedure Number: MCUP3125		Lead Department: Health Services
Policy/Procedure Title: Gender Dysphoria/Surgical Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/21/2013	**Next Review Date: 01/10/202501/07/2026** **Last Review Date: 01/10/202401/07/2025**	
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: 01/20/16; 02/15/17; 04/19/17; *06/13/18; 09/11/19; 09/09/20; 01/13/21; 09/08/21; 10/12/22; 01/10/24; 01/08/25

*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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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3137</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Palliative Care: Intensive Program (Adult)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/21/2017</td><td colspan="4">Next Review Date: ~~01/10/2025~~01/08/2026
Last Review Date: ~~01/10/2024~~01/08/2025</td></tr>
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</table>

I. RELATED POLICIES:

A. MCUP3020 – Hospice Service Guidelines
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3124 – Referral to Specialists (RAF) Policy
D. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
E. MPCR300 – Physician Credentialing and Re-credentialing Requirements
F. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
G. CGA024 – Medi-Cal Member Grievance System
H. MPQP1022 – Site Review Requirements and Guidelines
I. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. ED: Emergency Department
B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course.
C. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. Palliative Care: Patient and family-centered care that optimizes qualify of life by anticipating, preventing, and treating suffering.
E. Palliative Care Team: A group of healthcare individuals such as a Doctor of Medicine (MD) or Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Medical Social Worker (MSW) and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a ~~member~~Member and the ~~member~~Member's family and assist in identifying sources of pain and discomfort.
F. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (~~PHC~~Partnership) to refer a ~~PHC~~Partnership ~~member~~Member to a specialist for evaluation and/or treatment.
G. TAR: Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

IV. ATTACHMENTS:

A. Adult Palliative Care Eligibility Assessment
B. Palliative Care Patient Summary
C. Engagement and Enrollment Process for Outpatient Palliative Care
D. Application to be a Contracted Outpatient Palliative Care Provider

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services to ~~PHC~~Partnership Medi-Cal eligible beneficiaries ages 21 or older.

VI. POLICY / PROCEDURE:

A. ADULT GENERAL ELIGIBILITY CRITERIA
   1. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment D) and have a palliative care contract in place with ~~PHC~~Partnership.
   2. The Intensive Palliative Care Management benefit is limited to ~~member~~Members who have Partnership HealthPlan of California as their primary insurance.
   3. A ~~member~~Member must meet all criteria below and at least one of the covered disease-specific criteria outlined in Section VI.B.5 to be eligible for Intensive Palliative Care services. Exceptions for other diagnoses will be made on a case by case basis as described below:
      a. The ~~member~~Member is likely to or has started to use the hospital or emergency department as a means to manage unanticipated decompensation in their late stage of illness.
      b. Member is in a late stage of illness (section VI.B.1.a.) and is not eligible for or declines hospice enrollment.
      c. The ~~member~~Member's death within a year would not be unexpected based on clinical status, as documented on the patient summary (Attachment B)
      d. Member has received maximum ~~member~~Member-desired medical therapy, or for whom treatment is no longer effective. Member should be evaluated in their best compensated state after receiving or being offered appropriate treatments to manage their underlying illnesses. Member is not in reversible acute decompensation.
      e. Patient has a Palliative Performance Scale or Karnofsky Performance Scale score of 70 or less or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4.
      f. Member, and if applicable, family/patient-designated support person agree to both of the following:
         1) Willing to attempt in-home, residential or outpatient disease management as recommended by the Palliative Care team instead of first going to the emergency department.
         2) Willing to participate in Advance Care Planning discussions.

B. ADULT MEMBER ENGAGEMENT AND ENROLLMENT PROCESS
   1. Patient Palliative Care Assessment and Consultation (Engagement):
      a. No prior authorization is required for the engagement process before speaking with a ~~member~~Member who meets one or more of the following diagnostic categories.
         1) Congestive Heart Failure (CHF)
         2) Pulmonary Disease
         3) Advanced Cancer
         4) Advanced Liver Disease
         5) Progressive Degenerative Neurologic Disorder
         6) Hematologic Disease
         7) Cerebrovascular Accident
         8) Renal Disease

9) Acquired Immunodeficiency Syndrome
10) Other Conditions

b. If the ~~member~~Member has one of the covered diagnoses listed, and does not meet the general or specific criteria or life expectancy for enrollment, submit a retroactive TAR for the engagement only.
c. If the ~~member~~Member meets the criteria for engagement AND enrollment criteria, submit a TAR for engagement along with the TAR for enrollment. Submit the TAR for engagement with progress or consultation notes documenting the following:
   1) One of the five covered diagnoses or other pre-terminal conditions as defined in section VI.B.5
   2) Date of face to face or telemedicine visit with Doctor of Medicine (MD) or Osteopathy (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN)
   3) Advanced care discussion with goals of care document
   4) Care Plan addressing medical, social, emotional and spiritual needs
   5) Include consultation or hospital discharge notes that confirm the ~~member~~Member's diagnosis, extent of disease, prognosis, functional status and goals of care
d. A multidisciplinary comprehensive assessment is required.
e. Engagement will occur after discharge from the hospital.
f. When requested, ~~PHC~~Partnership will generate regional lists of ~~member~~Members who may qualify for palliative care services, providing these to community primary care and specialty providers to evaluate for potential referral to locally available palliative care clinicians and/or intensive palliative care providers. If ~~PHC~~Partnership determines that an intensive palliative care provider has the demonstrated capacity and capability to do active direct outreach to potential recipients of palliative care, ~~PHC~~Partnership will provide the list of local ~~member~~Members potentially qualifying for intensive palliative care services to the intensive palliative care provider, for the provider to perform this direct engagement coordinated with the ~~member~~Member's primary providers.
g. ~~PHC~~Partnership intensive care management teams may identify and refer care managed ~~member~~Members who are potentially eligible for this benefit, to a contracted ~~PHC~~Partnership palliative care provider

2. Adult Enrollment Criteria (see Attachment C for detailed requirements)
   a. For ~~member~~Members who meet the disease specific criteria (VI.B.5)
      1) Submit a TAR for the ~~member~~Member's enrollment into the Intensive Home Based Palliative Care program to ~~PHC~~Partnership in accordance with ~~PHC~~Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR [VI.B.1.c. 1) thru 4)] as well as:
         a) Eligibility Assessment Form (Attachment A)
         b) Patient Summary document (Attachment B)
   b. For ~~member~~Members in the hospital, enrollment will take place after discharge. The Palliative Care Management TAR will be approved for three months.
   c. The health plan will monitor and collect enrollment, network and utilization data, through the Palliative Care Quality Collaborative (PCQC) tracking system, which contracted intensive palliative care providers will be required to use.
   d. Enrolled ~~member~~Members must have at minimum:
      1) One in-person or video visit by an RN every month
         a) The registered nurse must see the patient face to face a minimum of once in every 12-week period
         b) If face-to-face visits with the RN are not possible due to distance or other operation issues, palliative care providers may submit charges under the "virtual only care"

billing code T2025 GT.

2) One in-person or video visit by a social worker every month
3) Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically.

3. Adult Re-Enrollment Criteria
   A new TAR is required every 3 months for all patients receiving Intensive Outpatient Palliative Care services. The TAR must include documentation and submission of the following items:
   a. Palliative Care Patient Summary (Attachment B) completed by the palliative care physician, nurse practitioner or physician's assistant
   b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued decline in functional status and clinical condition as evidenced by decreasing palliative performance scale scores, weight loss or other specific documentation of decline in function and health (e.g. labs and imaging, include results if completed in the previous 3 months)
   c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.
   d. For remote ~~member~~Members seen only through telemedicine visits, the medical records must include a recent detailed visit by the RN, NP or physician that clearly documents the patient's current clinical condition and functional status.
4. Remote Hospice Level Care
   A ~~member~~Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate. The ~~member~~Member must be pre-approved via ~~PHC~~Partnership's TAR review process for palliative care to allow for billing under code T2025-TN.
   a. The ~~member~~Member must live more than 30 miles from the nearest Medi-Cal Hospice or the palliative care provider must submit documentation that although the ~~member~~Member meets hospice criteria, the local hospice is not able to enroll the ~~member~~Member for non-medical reasons.
   b. The ~~member~~Member must be seen in-person at least once a month by the palliative care RN.
5. Adult Disenrollment Criteria
   a. Member is not eligible for ~~PHC~~Partnership for more than 30 days
   b. Member moves out of the service area
   c. Member declines participation after enrollment
   d. Member refuses to be contacted
   e. Member cannot be reached or is lost to follow-up for 30 days
   f. Member exhibits inappropriate or threatening behavior towards staff
   g. Member is under the influence or illegal drugs or alcohol during visits
   h. Member poses a safety or security risk to staff, other patients or clinic property
   i. Member is deceased
   j. Member is incarcerated for more than 30 days
   k. Member enters a different equally intensive care management program
   l. Member enters hospice
   m. Member's condition stabilizes and/or is unlikely to meet 1 year life expectancy criteria
   n. Member enrolls in Medicare: A ~~member~~Member who becomes eligible for Medicare after enrollment may continue to receive palliative care services until the current TAR expires.
6. Adult Disease Specific Criteria
   a. **Congestive Heart Failure (CHF)**:
      1) The ~~member~~Member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR meets criteria for New York Heart Association (NYHA)

heart failure classification III or higher, AND
   a) The ~~member~~Member has an ejection fraction of < 30% for systolic failure OR
   b) Significant comorbidities such as stage IV renal disease, coronary artery disease with persistent angina, severe lung disease, diabetes with significant vascular or neurologic complications, severe dementia OR
   c) Heart failure due to advanced diastolic dysfunction with preserved ejection fraction OR
   d) Other severe cardiomyopathy or non-operable severe valvular heart disease.

b. **Pulmonary Disease:**
   1) **Chronic Obstructive Pulmonary Disorder (COPD)**: Member must meet 1) or 2)
      a) The ~~member~~Member has a Forced Expiratory Volume (FEV)1 less than 35% predicted and 24-hour oxygen requirement of less than 3 Liters (L) per minute, OR
      b) The ~~member~~Member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.
   2) Other Progressive Pulmonary Disease:
      a) Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis WITH
         i. Disabling dyspnea at rest AND
         ii. Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
         iii. Poorly response or unresponsive to standard treatment.

c. **Advanced Cancer**: Member must meet 1) and 2)
   1) The ~~member~~Member has a diagnosis of stage III or IV cancer, AND
   2) The ~~member~~Member has a Palliative Performance Scale (PPS) or Karnofsky Performance Scale (KPS) score less than or equal to 70, Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 OR has failure of two lines of standard of care therapy (chemotherapy or radiation therapy) OR
   3) Member refuses further treatment for the cancer

d. **Advanced Liver Disease**: Member must meet 1) and 2) combined, or 3) alone
   1) The ~~member~~Member has evidence of irreversible liver damage, serum albumin less than 3.0, and Internal Normalized Ratio (INR) greater than 1.3, AND
   2) The ~~member~~Member has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
   3) The ~~member~~Member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

e. **Progressive Degenerative Neurologic Disorder**
   1) Neurodegenerative condition such as multiple sclerosis, muscular dystrophy, end-stage myasthenia gravis, Parkinson's disease or other progressive neurologic condition with significant deterioration as evidenced by dysphagia, aspiration pneumonia, unintentional weight loss of 10% or more, recurrent infections, significant cognitive decline or dependency on ventilator support.
   2) Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted.
   3) Late stage dementia with progressive decline with both:
      a) FAST scale score of 7a or more AND
      b) Complications such as unintentional weight loss, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

f. **Hematologic Disease**
   1) Myelodysplastic syndrome dependent on transfusion and unresponsive to treatment **OR**
   2) Sickle cell disease with organ failure, severe pulmonary hypertension, stage IV or worse renal disease, or other significant severe vascular disease.

g. **Cerebrovascular Accident**
   1) PPS score of 50% or less **AND**
   2) Progressive unintentional weight loss of 10% or more, **OR**
   3) Recurrent infections such as aspiration pneumonia or sepsis.

h. **Renal Disease:**
   1) Creatinine clearance of 15 ml/min or less **AND**
   2) Discontinuing or declining dialysis and not seeking kidney transplant

i. **Acquired Immunodeficiency Syndrome (AIDS):** A patient with a CD4 count less than 200 or a positive HIV test and an AIDS defining condition who chooses to forego antiviral treatment or has one of these AIDS related conditions:
   1) Advanced AIDS dementia complex
   2) CNS lymphoma or systemic lymphoma unresponsive to treatment
   3) Kaposi's sarcoma unresponsive to treatment
   4) Mycobacterium avium complex infection unresponsive to treatment
   5) Progressive wasting syndrome

j. **Other patients may be considered for the palliative care benefit on a case-by-case basis.** Consideration will depend upon the patient's functional status, pre-terminal condition and disease trajectory, hospital and emergency department utilization or the patient declining hospice services.

7. Providers of Services
   a. ~~PHC~~Partnership will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities who utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to ~~member~~Members in accordance with this policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with ~~PHC~~Partnership policies MPCR300 Physician Credentialing and Re-credentialing Requirements and MPCR301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. ~~PHC~~Partnership will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a ~~member~~Member's home must comply with existing ~~PHC~~Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.
   b. All approved Palliative Care service providers shall be listed in ~~PHC~~Partnership's Provider Directory.
   c. ~~PHC~~Partnership contracted intensive palliative care providers will contact ~~member~~Members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
   d. Provider organization must submit an application to become contracted Intensive Home Based Palliative Care Providers (See Attachment D for application). Criteria for consideration includes the following:
      1) Completed application (Attachment D)
      2) Organization or all providers are contracted Medi-Cal providers
      3) Organization must have the capacity to bill ~~PHC~~Partnership for services provided
      4) Organizations that are already contracted with ~~PHC~~Partnership for other services must be providers in good standing
      5) Clinical staff are trained in palliative care. Minimum training is the Cal State San Marcos Institute for Palliative Care Training Curriculum, or equivalent, which must be completed

by a staff ~~member~~Member no later than 3 months after beginning to work for the Intensive Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.

6) Ability to collect and submit data using the Palliative Care Quality Collaborative system (PCQC) (system access is purchased by ~~PHC~~Partnership for contracted providers). Provider will be required to enter into a Data Sharing Agreement with PCQC in order to submit data through the PCQC System.
7) Core staffing identified (hired or contracted to be hired by contract start date):
   a) Medical Director
   b) Registered Nurse
   c) Social Worker
   d) Administrator
8) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting.

e. Submission of an application does not guarantee that ~~PHC~~Partnership will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.

f. Contracted sites must pass a ~~PHC~~Partnership facility and medical record site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in ~~PHC~~Partnership policy MPQP1022 Site Review Requirements and Guidelines.

VII. REFERENCES:

A. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
B. Centers for Medicare & Medicaid Services (CMS) *Medicare Benefit Policy Manual*
~~C. Department of Health Care Services, (2015).~~
~~D.~~C. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
~~E.~~D. Social Security Act 1812(d)(1)
~~F.~~E. Welfare and Institutions Code Section 14132.75
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
G. Medi-Cal Provider Manual/ Guidelines: Palliative Care *(palli care)*

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:

11/15/17; *02/14/18; 02/13/19; 02/12/20; 02/10/21; 05/11/22: 06/14/23; 01/10/24; 01/08/25

*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:
MCUP3122 - Palliative Care policy was archived 06/21/2017

Policy/Procedure Number: MCUP3137		Lead Department: Health Services
Policy/Procedure Title: Palliative Care: Intensive Program (Adult)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/21/2017	**Next Review Date:** ~~01/10/2025~~01/08/2026 **Last Review Date:** ~~01/10/2024~~01/08/2025	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

The materials provided are guidelines used by ~~PHC~~Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under ~~PHC~~Partnership.~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2016</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/21/2015</td><td colspan="4">Next Review Date: ~~02/14/2025~~ 01/08/2026
Last Review Date: ~~02/14/2024~~01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<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: ~~02/14/2024~~01/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2030 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
C. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCUG3118 – Prenatal & Perinatal Care
F. CMP09 – Investigating & Reporting Fraud, Waste and Abuse
G. CMP26 –Verification of Caller Identity and Release of Information
H. CGA024 – Medi-Cal Member Grievance System
I. CMP36 – Delegation Oversight and Monitoring
J. MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment
K. MCUP3146 – Street Medicine

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance & Appeals
E. Finance
F. Provider Relations

III. DEFINITIONS:

A. NEMT: Non-Emergency Medical Transportation
B. Door-to-Door Service: Member is picked up from the entrance of their pick-up location, receives assistance loading in and out of the vehicle, and is dropped off at the appropriate entrance of the designated drop off location.
~~A.~~C. Door-through-Door Service: Member is provided assistance inside the pick-up location, receives assistance loading in and out of the vehicle, and is dropped off inside the designated drop off location.
~~B.~~D. NMT: Non-Medical Transportation
~~C.~~E. PCS: Provider Certification Statement prescribing the level of transportation necessary based upon the functional and medical limitations of the Member. (See Attachment A)
~~D.~~F. Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
~~E.~~G. Transportation provider: The entity that will actually be transporting the Member.
~~F.~~H. Private vehicle: Any motor vehicle, other than a motor truck, truck tractor, or a bus, and used or maintained for the transportation of persons (Defined by VEH Section 465)

~~G.~~I. California Driving Requirements: Defined by California Vehicle Code (VEH Section 12500, 4000, and 16020)

~~H.~~J. Round Trip: Transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.

~~C.~~ ~~K.~~ Short Notice Request: Any request for transport not allowing five calendar day notice.

K.

L. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to ~~PHC~~ Partnership for review prior to releasing PHI. Until the form has been submitted and validated by ~~PHC~~ Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional verbal consent when the prior verbal consent window of time has expired.

IV. ATTACHMENTS:

A. Provider Certification Statement (PCS) form

V. PURPOSE:

To outline the circumstances and utilization controls by which Partnership HealthPlan of California (~~PHC~~Partnership) will pay for and/or facilitate Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services to Members in accordance with state and federal regulations as cited.

VI. POLICY / PROCEDURE:

A. GENERAL TRANSPORTATION PROGRAM RULES

1. Non ~~PHC~~ Partnership Members are not eligible for transportation services.
   a. Exceptions will be made for those eligible to receive services through the Wellness and Recovery benefit.
2. Authorization shall be granted and/or Medi-Cal reimbursement shall be approved only for the lowest cost type of transportation that is adequate for the Member's medical needs, and is available at the time transport is required.
3. Transportation shall be authorized only to the nearest facility capable of meeting the Member's medical needs.
   a. Consideration will be made to ensure access to care within Department of Health Care Services (DHCS) approved time and distance standards
4. Transportation will be provided for all Medi-Cal services, including those not covered by ~~PHC~~Partnership.
   a. Transport is not covered if the care to be obtained is not a Medi-Cal benefit.
   b. Transportation between a Member's home and an Adult Day Health Care (ADHC) center is included in the per diem reimbursement rate paid to an ADHC center and is not separately reimbursable.
   c. Transportation to obtain medically necessary services for major organ transplants is covered for transplant recipient Members as well as living donors and medically necessary attendants.
      1) Living donors requesting NEMT services are not required to have a PCS on file, nor is a PCS required to approve the NEMT service.
   d. Transportation to pick-up drug prescriptions that cannot be mailed directly to the Member is covered.
   e. Transportation is covered for Members picking up medical supplies, prosthetics, orthotics and other equipment when said supplies and/or equipment is covered by Medi-Cal.

f. Transportation is covered to all Medi-Cal covered street medicine providers including those serving as Primary Care Providers (PCPs).
   1) Members using a street medicine provider as a Primary Care Provider will still be provided transport to a traditional Primary Care Provider if requested, provided the request meets all other applicable criteria.

g. Discharge from an inpatient stay at a hospital, long-term care, or any other Medi-Cal covered institutional setting to the Member's residence is covered.
   1) Requests for transport services of this nature must be made by the discharging or receiving facility.
   2) Transport to an alternate location can also be provided if permission from the alternate location has been granted and the alternate location is within the Member's county of residence.
   3) Requests for transport outside the Member's county of residence will be reviewed on a case by case basis.

5. All requests for transportation services made to ~~PHC~~ Partnership must be submitted five (5) calendar days prior to the date of service.
   a. ~~PHC~~ Partnership will review short notice requests on a case by case basis based on the following criteria:
      1) If the appointment is life threatening/sustaining, ~~PHC~~ Partnership will attempt to secure transportation.
      2) If the appointment is not life threatening/sustaining, has been scheduled with the provider, but the Member waited to request transportation and did not allow five calendar days, the request will be denied.
      3) If the appointment was scheduled by the provider within 5 calendar days, ~~PHC~~ Partnership will attempt to secure transportation.
   b. Exceptions for gas mileage reimbursement (GMR)
      1) Non-advance funds GMR requests will be accepted regardless of days' notice.
      2) Advance funds GMR requests must be made two (2) business days in advance. If the request is made with less than two (2) business days' notice, regular GMR can be requested.
      3) Retroactive requests will not be accepted.
6. All approved transports will be scheduled to ensure the Member is dropped off within 15 minutes of their scheduled appointment and Members will be informed of their pick-up/drop off time when the transport is scheduled.
   a. If the transportation provider does not arrive at the pick-up location in time to ensure the Member arrives at their appointment within 15 minutes of the scheduled appointment time, the Member can call ~~PHC~~ Partnership and transport with an alternate transportation provider will be approved.

7. If an approved transport experiences any disruption due to the assigned Transportation Provider arriving late or failing to arrive, Partnership~~. PHC~~ will provide urgent authorization for a replacement ride to be scheduled.

~~7.~~8. With the written consent of a parent or guardian, a minor between the ages of 12-18 may receive transportation unaccompanied as long as ~~PHC~~ Partnership and the transportation provider accepts the necessary written consent forms and agrees to provide unaccompanied transport. Certain appointments will not require written consent or parent/legal guardian permission to travel unaccompanied as described below:
   a. All Members under age 21
      1) Pregnancy and pregnancy-related services
      2) Family planning services
      3) Sexual assault services

b. All Members at least age 12 and under age 21
   1) Sexually transmitted diseases treatment
   2) Drug and alcohol abuse treatment and counseling
   3) Outpatient mental health treatment and counseling

~~8.~~9. All requests for transportation to medical appointments are subject to appointment verification by Partnership.

~~9.~~10. Transportation for Partnership covered services to Out of Network (OON) providers will be provided with prior authorization and if all other utilization control requirements are met.

~~10.~~11. Transportation for Medi-Cal covered services, carved out of Partnership's responsibility, will be provided and are not subject to Partnership's utilization controls or time and distances standards related to reviewing requests for medical services. Transportation requests to carved out services will only be reviewed in accordance with the rules and regulations listed in this policy.

12. Partnership will store Transportation Provider information, including the name of the driver based on service date, time, pick-up/drop-off location, and Member name. If a Partnership Member files a grievance, this information will be made available to them.

B. NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

Ambulance, litter van and wheelchair van medical transportation services are covered when the Member's medical and physical condition is such that transportation by ordinary means of public or private conveyance is medical contraindicated, and transportation is required for the purpose of obtaining needed medical care.

1. Transportation Providers are required to provide door-to-door or door-through-door service for all authorized NEMT services.

~~1.~~2. NEMT PRIOR AUTHORIZATION REQUIREMENTS

a. Both a Treatment Authorization Request (TAR) and ~~PHC's~~ Partnership's DHCS approved Provider Certification Statement (PCS) (see Attachment A) are required for all NEMT services that have an identified TAR requirement in order to be processed. All TARs received without a PCS are subject to ~~PHC's~~ Partnership's standard Utilization Management (UM) TAR review process as outlined in policy MCUP3041 Treatment Authorization Request (TAR) Review Process. Once submitted to ~~PHC~~Partnership, prescribed NEMT services and the corresponding PCS form cannot be changed or altered.
   1) In urgent situations, when a PCS form cannot reasonably be obtained prior to the requested NEMT service, ~~PHC~~ Partnership can authorize one-time NEMT and accept the PCS post-service. This authorization can be made via phone; however, the service still requires a Treatment Authorization Request (TAR) to be submitted by the Medi-Cal Certified NEMT Provider once a valid PCS can be obtained.
   2) A copy of the PCS form will remain on file for all Members receiving NEMT services.
   3) If needed, ~~PHC~~ Partnership can provide a copy of the PCS to the Medi-Cal Certified NEMT Provider via fax or encrypted email.

b. Providers and Members can call ~~PHC~~ Partnership or any Medi-Cal Certified NEMT Provider directly to request NEMT services. Providers and Members can also call ~~PHC~~ Partnership or the scheduled Medi-Cal Certified NEMT provider to receive status updates on NEMT rides.

c. Only ~~PHC's~~ Partnership's DHCS approved PCS form (Attachment A) will be accepted and must include, at a minimum, the components listed below. All fields must be completed by the provider.
   1) Function Limitations Justification: For NEMT, the provider is required to document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

1) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
2) Modality of Transportation Needed: List the modality of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).
    a) The modality of NEMT provided will match the modality prescribed on the PCS. Partnership will not downgrade the modality. If multiple modalities are selected on the PCS, the modality provided will be the lowest cost modality.
3) Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

d. Providers who can authorize NEMT are physicians, podiatrists, dentists, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, physical therapists, speech therapists, occupational therapists, optometrists, mental health providers, substance use disorder providers or chiropractors.
    1) Authorization must be made by a licensed practitioner consistent with their scope of practice.
e. NEMT services are exempt from prior authorization when provided to a Member being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free-standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.
f. NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility requested to ~~PHC~~ Partnership by a provider, will be provided within three (3) hours of the request. If NEMT services are not provided within the three ~~3~~ hour timeframe, the discharging facility may arrange, and the ~~PHC~~ Partnership must cover, out-of-network NEMT services.
    1) Services arranged by the acute care hospital are payable at no more than the Medi-Cal rate for the corresponding service. If the accepting transportation provider is contracted with ~~PHC~~Partnership, payment will be made at the rate identified in their contract.

~~2.~~3. NEMT OPTIONS

a. AMBULANCE services are covered when the Member's medical condition contraindicates the use of other forms of medical transportation. This service may be used for:
    1) Transfers between facilities for Members who require continuous intravenous medication, medical monitoring or observation.
    2) Transfers from an acute care facility to another acute care facility.
    3) Transport for Members who have recently been placed on oxygen (not chronic emphysema recipients who carry their own oxygen for continuous use).
    4) Transport for Members with chronic conditions who require oxygen if monitoring is required.
b. LITTER VAN service may be used when the Member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    1) Requires that the Member be transported in a prone or supine position, because the Member is incapable of sitting for the period of time needed to transport.
    2) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
c. WHEELCHAIR VAN service may be used when the Member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    1) Renders the Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

2) Requires that the Member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
3) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
4) Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form:
   a) Members who suffer from severe mental confusion
   b) Members with paraplegia
   c) Dialysis recipients
   d) Members with chronic conditions who require oxygen but do not require monitoring

d. AIR TRANSPORT for NEMT will be provided only when transportation by air is necessary because of the Member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

C. NON-MEDICAL TRANSPORTATION (NMT)

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for Members if they are currently using a wheelchair but the limitation is such that the Member is able to ambulate without assistance from the driver. Please refer to the Medi-Cal Member Handbook for further details.

1. SERVICE CONDITIONS FOR NON-MEDICAL TRANSPORTATION SERVICES
   a. NMT coverage includes transportation costs for the Member and one attendant such as a parent, guardian, or spouse able to accompany the Member in a vehicle or on public transportation, which is subject to review and prior authorization at the time of the initial NMT authorization request.
      1) The level of transportation accommodation needed will be based upon the limitations of the Member being transported. Any attendants must be able to safely accompany the Member and not require additional assistance.
   b. The Member cannot be the driver for NMT, unless the Member is eligible to CCS and legally allowed to drive.
   c. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
   d. Transportation to an emergency room or from an emergency room to home or other housing resource is not included in the benefit.
   e. NMT services include roundtrip transportation for a Member by passenger car, taxi cab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
      1) Round Trip Transportation is defined as transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.
      2) Limited exceptions may apply if the Member is homeless.
   f. All ~~PHC~~ Partnership Members requesting NMT will receive an assessment to determine eligibility to NMT and the most appropriate mode of transport for the Member.
      1) The Member/Member's guardian must attest, either in person, electronically, or over the phone, that other transportation resources have been reasonably exhausted and they have no other way to get to their medical appointment. The attestation is required at each request.
      2) Exceptions to the use of public transportation will be made as follows:

a) Member's residence and the appointment site are over three-quarters (3/4) of a mile from a bus line.
b) Member is under the age of 16 if traveling alone.
c) Member is 16 years of age or older and is traveling with more than two (2) children under the age of five (5).
   i. Subject to criteria for additional passengers as stated in section VI.C.1.h. below.
d) Member is in the third trimester of pregnancy and/or Member has a high risk pregnancy.
e) Bus line is not operational on day and/or time of appointment.
f) Bus route requires more than two (2) transfers and/or the duration of transport via bus will be over two (2) hours.
g) Member is undergoing chemotherapy, radiation or dialysis.
h) Member is a transplant patient.
i) Member is age 70 or older.
j) Any other exception for public transportation will need to be medically justified by the PCP or servicing provider.

g. Additional passenger rules:
   1) Members under the age of 21 are allowed two (2) additional passengers if the passengers are parents or legal guardians to the Member.
      a) If the parent or legal guardian is a single caregiver, transport can be provided for additional minor children under the care of the parent or legal guardian. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.
   2) All other Members are allowed one (1) additional passenger
      a) If the Member is a single caregiver, transport can be provided for additional minor children under the care of the Member. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.
h. NMT services will be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the Member and consistent with applicable state and federal disability rights laws.

2. PARENT/LEGAL GUARDIAN-ONLY NMT
   a. In emergent situations when a Member under the age of 21 is transferred to a facility via emergency medical transport, ~~PHC~~ Partnership will authorize parent/guardian only transport services on a case-by-case basis.
      1) If the request is for gas mileage reimbursement (GMR), Members and their guardians have 30 days from the date of service to request this type of reimbursement.
   b. For Members under the age of 21, ~~PHC~~ Partnership may authorize parent/guardian-only transport on a case-by-case basis upon hospital discharge from an inpatient setting if the medically necessary transport provided for the Member cannot also provide transport for one parent or guardian.
      1) If the request is for GMR, Members and/or their guardians have 30 days from the date of service to request this type of reimbursement.
   c. Further parent or guardian-only transports for Members under the age of 21 will be reviewed on a case-by-case basis and in compliance with provisions described under ~~PHC~~ Partnership policy and procedure MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.
3. NMT PRIVATE VEHICLE AUTHORIZATION REQUIREMENTS
   a. GMR requires prior authorization ~~PHC~~Partnership.
      1) Non-advance funds GMR requests will be accepted regardless of days' notice.
      2) Advance funds GMR requests must be made 48 hours in advance. If the request is made with less than 48 hours' notice, regular GMR can be requested.
      3) Retroactive requests will not be accepted.

b. In order to receive GMR for use of a private vehicle, the driver must be compliant with all California driving requirements, which include the following:
   1) Valid driver's license
   2) Valid vehicle registration
   3) Valid vehicle insurance

c. ~~PHC~~ Partnership will only reimburse the driver.

d. Members may not receive reimbursement for driving themselves, unless the Member is eligible to CCS and legally allowed to drive.

e. Mileage reimbursement for gas is consistent with the Internal Revenue Service standard mileage rate for medical transportation when conveyance is in a private vehicle arranged by the Member.

f. The form of reimbursement offered is decided by ~~PHC~~ Partnership and may be in the form of cash, check, gas cards, or other forms of prepaid cards.

g. In order for ~~PHC~~ Partnership to issue payment for GMR requests, the Member or Member's parent/legal guardian must provide the following:
   1) Credentials verifying the driver/payee is in compliance with all California driving requirements as listed above in section VI.C.3.b.
   2) Attendance verification issued by the treating provider on facility letterhead or via the facility's online member portal or mobile application.

h. Partnership will allow the Member 90 calendar days from the date of service to submit all required credentials.

4. SUBMITTING NMT TRANSPORTATION REQUESTS

   a. Requests for transportation can be made by the Member, the Member's authorized representative, or the Member's provider by calling Partnership. Partnership will assess the eligibility and the modes of transportation available within the Member's county of record.
      1) Pursuant to ~~DHCS Policy and Procedure Letter 20-005,~~DHCS APL 24-002, American Indian Members may elect to receive NMT from Indian Health Services also known as tribal health programs in lieu of those services offered by Partnership.~~'s NMT broker~~.

D. CALIFORNIA CHILDREN'S SERVICES (CCS)/WHOLE CHILD MODEL (WCM)

1. For a CCS/WCM eligible Member who is currently hospitalized due to the CCS eligible condition:
   a. ~~PHC~~ Partnership may authorize up to two round trips per Member hospitalization if the hospital stay is projected to be less than seven days in duration based on InterQual® criteria.
   b. If a hospital stay extends beyond seven days, then ~~PHC~~ Partnership may authorize one additional round trip for every seven calendar days of hospitalization
   c. This assistance is not intended to sustain a parent or guardian at a hospital for the Member's entire stay or to pay for the parent or guardian's frequent trips to visit a child while hospitalized. Post discharge if the client's discharge plan documents the need for daily medical visits for treatment of the CCS-eligible condition, and the distance precludes making the trip to the hospital in one twelve-hour day, lodging and meals may be authorized for the Member and parent or guardian.
2. For a CCS/WCM eligible Member and/or the Member's parents(s)/legal guardian(s) choosing to go to a facility/provider that is not the closest CCS approved facility/paneled provider, the transportation costs beyond those to reach the closest provider capable of delivering the level/type of service required by the Member's CCS-eligible condition are the responsibility of the Member and/or parent(s)/legal guardian(s).
3. Transportation may be a benefit for CCS authorized medical care provided outside California. Consultation must be sought from the State Regional Office consultant staff before out-of-state services are authorized.
4. For CCS eligible children, Transportation to a Medical Therapy Unit (MTU) for physical or occupational therapy or to attend a Medical Therapy Conference may be considered if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the Member's access to therapy services when transportation is not included in the child's Individualized Education Plan (IEP).
5. CCS eligible children legally allowed to drive are eligible to receive gas mileage reimbursement and can be reimbursed directly by ~~PHC~~Partnership.

E. NEMT/NMT SERVICES FOR MEMBERS TRANSITIONING TO/FROM ANOTHER MANAGED CARE PLAN (MCP)

1. For Members transitioning to ~~PHC~~ Partnership from another Managed Care Plan (MCP) or from ~~PHC~~ Partnership to another MCP, ~~PHC~~ Partnership will work with the previous/new MCP to support continuation of NEMT/NMT services for transitioning Members by:
   a. The previous MCP will provide authorization data or ~~PHC~~ Partnership will provide authorization data as outlined in section VI.G. or the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
   b. The previous MCP or ~~PHC~~ Partnership will transmit all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to ~~PHC~~ Partnership or new MCP prior to the effective date and on the agreed upon schedule.
2. If a network provider is not available to provide the transitioning Member's scheduled NEMT/NMT service, then ~~PHC~~ Partnership will make a good faith effort to allow the transitioning Member

to keep the scheduled transportation service with an Out-Of-Network (OON) NEMT/NMT provider

F. SCREENING & ENROLLMENT

1. ~~PHC~~ Partnership follows the criteria described in policy MPCR20 Medi-Cal Managed Care Plan Provider Screening and Enrollment, for the screening and enrollment of Transportation Providers.

G. REGULATORY REQUIREMENT

~~PHC~~ Partnership captures and submits data from the PCS form to DHCS as instructed and is obligated to meet the contractually required timely access standards.

VII. REFERENCES:

A. California Code of Regulations (CCR) Title 22 Section 51323
B. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
C. DHCS Transportation Workgroup Frequently Asked Questions (FAQs) re: APL22-008 (05/18/2022)
D. DHCS Numbered Letter (N.L.): 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (8/19/2010)
E. DHCS APL 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (02/08/2024)~~Policy and Procedure Letter (PPL) 20-005 California Rural Indian Health Board (CRIHB) and Managed Care Beneficiary Claims (01/22/2020)~~
F. Medi-Cal Provider Manual/Guidelines: Medical Transportation – Ground *(mc tran gnd)* and Air *(mc tran air)*
G. Welfare and Institutions Code (WIC) Section 14132
H. California Health and Safety Code Section 1250
I. DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (10/18/2021) Attachment 2 Major Organ Transplant Requirements (*Revised* 10/14/2022)
J. DHCS APL 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/2022 and *Revised for FAQs 08/24/2022*)
K. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (08/31/2021)
L. DHCS APL 22-023 Street Medicine Provider: Definitions and Participation in Managed Care (11/08/2022)
M. DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide (11/07/2023)

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: 01/20/16; 08/16/17; *11/14/18; 02/12/20; 08/12/20; 08/11/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24; 01/08/25

*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

Policy/Procedure Number: MCCP2016		Lead Department: Health Services
Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/21/2015	**Next Review Date:** ~~02/14/2025~~ 01/08/2026 **Last Review Date:** ~~02/14/2024~~01/08/2025	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

****

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

In order to appropriately evaluate your request, **complete all form fields** below including **provider signature** and **date** of **signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323, PHC Policy MCCP2016, APL 22-008 and the Medi-Cal Provider Manual]

1. Patients Name	2. Medi-Cal I.D. number

3. Dates of Service (DOS)

From: _____ To: _____

Please complete for the desired date range of NEMT justification. Not to exceed 12 months and dependent on member eligibility.

4. Patient mobilizes via: Wheelchair ☐ Walker ☐ Cane ☐ Other (describe):

5. Functional limitations, (specific *physical* or *mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If patient can utilize taxi, public transport or gas mileage reimbursement please indicate this here.)*

☐ Patient is wheelchair bound and unable to self-transfer ☐ Dialysis ☐ Other (describe):

6. Based on 4 and 5, above, the required mode of transport is:

- ☐ Public Transport – Member is capable of utilizing local bus or para-transit system without assistance
- ☐ Taxi – Member can get from their home to the vehicle and transfer without assistance
- ☐ Wheelchair Van – Member must be transported by wheelchair because of disabling physical or mental limitation or is unable to self-transfer
- ☐ Gurney Van – Member must be transported in a prone or supine position because member is incapable of sitting upright
- ☐ Ambulance – Member's medical condition prevents the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)
- ☐ Air Ambulance – Member's medical condition prevents the use of ground transport (describe):

7. Provider signature (Acceptable signatures: MD, DO, DPM, PA, NP, DDS, CNM, LM, Physical, Speech or Occupational Therapists, and Mental Health/Substance use disorder providers. Personal signature only. No proxy. No stamps) *I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.*	8. Date 9. Medi-Cal Certified? ☐ Yes ☐ No

10. Physician Name (print or type)	11. NPI number
12. Provider specialty (print or type)	13. Telephone number (With area code)
14. Provider address (number, street, city, zip code)	15. Fax Number (With area code)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2029</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Emergency Medical Transportation</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)</td><td colspan="4">Next Review Date: <s>01/10/2025</s>01/08/2026
Last Review Date: <s>01/10/2024</s>01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: <s>01/10/2024</s>01/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. CGA024 - Medi-Cal Member Grievance System
B. CMP09 - Investigating and Reporting Fraud, Waste and Abuse

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Emergency medical condition: Defined by Federal Statute 420.5.C.S 1396b (v)(3) means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
B. Emergency medical transportation (EMT): Ground or air transportation staffed with an Emergency Medical Technician and used to transport a patient with an emergency medical condition to a hospital or acute care facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To outline the circumstances and utilization controls by which Partnership HealthPlan of California (PHC) will facilitate emergency transportation services to members in accordance with state and federal regulations as cited.~~To outline the circumstances and utilization controls by which Partnership HealthPlan of California (Partnership) will facilitate emergency transportation services to members in accordance with state and federal regulations as cited.

VI. POLICY / PROCEDURE:

A. EMERGENCY MEDICAL TRANSPORTATION (EMT)

Emergency medical transportation (EMT) is provided for emergency medical conditions.

Policy/Procedure Number: MCCP2029		Lead Department: Health Services
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date: 01/10/202501/08/2026** **Last Review Date: 01/10/202401/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

1. AIR emergency transportation is covered under the following conditions:
   a. The medical condition of the member precludes other means of medical transport.
2. GROUND emergency transportation is covered when ordinary public or private medical transportation is medically contraindicated and transportation is needed to obtain care.
3. A Treatment Authorization Request (TAR) is not required for emergency air or ground transportation.
4. Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient. When the geographically nearest facility cannot meet the needs of the patient, transportation to the closest facility that can provide the necessary medical care is appropriate.
5. Medical transportation which represents a continuation of an original emergency transportation event is also covered without prior authorization, such as transportation from an emergency room of one hospital on to a second hospital for admission or for emergency services when the initial emergency room cannot provide the appropriate emergency medical treatment.
   a. The transfer is not considered a continuation of the initial emergency if the emergency conveyor leaves the facility to return to its place of business or accepts another call.
6. Emergency transportation provided for the purposes of evaluating a psychiatric crisis and/or for admission to a psychiatric facility is a covered service without a TAR. Counties directly performing this service are eligible providers, and the mode of transportation should be appropriate to the patient's medical and psychiatric needs.
7. Medi-Cal claims billed for out-of-state emergency air medical transportation services are not reimbursable unless a TAR is obtained. This policy is based on the following:
   a. Emergency air medical transportation is a Medi-Cal benefit only when transporting a recipient to the nearest available facility capable of treating a recipient's medical needs.
   b. Only emergency hospital services are Medi-Cal benefits for recipients while they are in Mexico or Canada.
   c. Out-of-state emergency air medical transportation services are Medi-Cal benefits without authorization only to or from specific border communities within the states of Arizona, Nevada or Oregon.
8. Transportation services to or from a foreign country, including Mexico and Canada, are not covered and will not be reimbursed.

VII. REFERENCES:

A. California Code of Regulations (CCR) Title 22 Section 51323
B. Manual of Criteria for Medi-Cal Authorization, Chapter 12.1
C. Medi-Cal Provider Manual: Medical Transportation (*mc tran*)

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: 02/10/21; 02/09/22; 01/11/23; 01/10/24; 01/08/25

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MCCP2029		Lead Department: Health Services
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date: 01/10/202501/08/2026** **Last Review Date: 01/10/202401/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

This policy topic was separated from policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) as of 01/08/2020

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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 PartnershipHC 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 PartnershipHC.

PartnershipHC'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

Policy/Procedure Number: MP300			**Lead Department: Member Services**	
Policy/Procedure Title: Member Notification of Provider Termination or Change in Location			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/19/1998		**Next Review Date:** 01/08/2026~~Nov. 7, 2024~~ **Last Review Date:** 01/08/2025~~Nov. 7, 2023~~		
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~~Kevin Spencer~~*			**Approval Date:** 01/08/2025~~Nov. 7, 2023~~	

I. RELATED POLICIES:

A. MPPR209 Provider Network/Subcontractor Terminations and Facility De-certification and Suspensions
B. MCCP2014 Continuity of Care
~~A.~~C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS.:

A. Provider Relations
~~A.~~B. Communications
~~B.~~C. Health Services
~~C.~~D. Regulatory Affairs and Compliance

III. DEFINITIONS:

A. Contracted Network Provider: For the purpose of this policy, any sites of care, clinicians, specialist, provider, group of providers, or entity that has a network provider agreement with Partnership.
~~A. Contracted Members may be assigned to a primary care clinician who is a physician (when applicable) nurse practitioner, or physician assistant. Additionally, Members may be assigned to an for primary care services. Primary Care Provider (PCP) is a general practitioner, internist, pediatrician, family physician, or obstetrician/gynecologist (OB/GYN).~~
~~B. Provider A physician, mid-level clinician, pharmacist, other licensed clinician or other individual providing medical care to a Partnership member, physician's staff member, or authorized billing representative of a physician.~~
~~C. DHCS California Department of Health Care Services~~
~~D.~~B. Medical Home (MH): ~~Medical H~~ ~~ome,~~ The provider identified as the M~~m~~ember's medical home or contracted primary care provider (PCP) site is responsible for managing the Member's~~child's~~ primary care needs and coordinating specialty services.~~is the provider linked to the member and is responsible for managing the member's primary care needs~~

IV. ATTACHMENTS:

A. N\A

V. PURPOSE:

To provide guidance of the plan's obligation to notify members when contractual relationships between Partnership HealthPlan of California (Partnership) and its network providers and subcontractors initiate termination or terminate.
~~To describe how Partnership HealthPlan of California (Partnership) issues member notifications in accordance with all regulatory and contractual requirements.~~when a nNetwork provider andor Ssubcontractor

~~terminates or has a changed location in accordance with all regulatory and contractual requirements.~~

~~To ensure compliance with member notice requirements outlined in DHCS All Plan Letter (APL) 21-003 Medi-Cal Network Provider and Subcontractor Terminations and Title 42 Code of Federal Regulations (CFR) Section 438.10(f)(1) Information Requirements.~~

VI. POLICY / PROCEDURE:

A. Member Notification
   1. Member Services (MS) provides written notice to members affected by a provider's termination or change of location within the requirements and timelines stated in this policy.
   2. MS provides written rescind notice to members when Partnership successfully renegotiates a contract before the effective date of the termination and member notification has already been sent~~termination notices were mailed~~.

B. Member Notification Timelines
   1. Provider Termination
      a. Notices are mailed at least 30 calendar days prior to the effective date of the contract termination or 15 calendar days after receipt of the termination notice, whichever is later, or as directed by California Department of Health Care Services (DHCS).
   2. Contracted Long Term Care (LTC) Facility
      a. Notices are mailed within five business (5) days of receiving notification of a decertified facility closure or effective date of the termination. LTC facilities include, but are not limited to, ~~LTC,~~ s~~S~~killed n~~N~~ursing facilities (SNFs), p~~P~~ediatric and adult~~,~~ ~~S~~subacute facilities, and~~/or r~~~~Respite facilities~~ intermediate care facilities (ICF).
   3. Contracted Network Provider Change of Location
      a. Notices are mailed at least 30 calendar days prior to the effective date of the move, or as soon as possible when Partnership has not received adequate notice of the provider's change of location, and has received all relevant information.

C. Member Notice Review Process
   1. MS manages ~~existing DHCS approved templates and creates new~~the member notices.
   2. The Senior Health Educator and the Communications department review member notices for readability and sixth grade reading level.
   3. DHCS approval is required for new notices, notices for LTC terminations, and/or adjustments to existing DHCS approved templates.

~~Notices are submitted to DHCS for approval at least 60 days prior to the expected date of termination or contract renegotiation.~~

~~E.~~D. Member Notice Content Requirements
   1. Member termination notices must contain the following information:
      a. Reason and effective date of the ~~for~~ termination.~~Effective date of the termination.~~
      b. Name of the terminating provider.
      c. Description of how the termination will affect the member's access to covered services.
      d. A statement that the member may contact ~~the MS Department~~MS to request continuity of care for an ongoing course of treatment from the terminating provider.
      e. ~~MS Department's~~MS's phone number and hours of operation.
      f. DHCS' Office of the Ombudsman toll free phone number.
      g. Instructions on how to access and/or request a provider directory.
      ~~. Language and non-discrimination notices.~~

~~3.~~2. Member PCP/MH termination notices also include:
   a. The member's new PCP/MH assignment and options for selecting a different PCP/MH.
   b. Information regarding the member's new ID card (e.g. enclosed or to be sent).

~~4.~~3. Member hospital termination notices also include the following information, if applicable ~~the name of the~~:
   a. Name of the current PCP/MH and the name of the member's future PCP/MH assignment and options to change.
   b. Member's future hospital assignment or in-network hospital(s) in the member's service area.

~~5.~~4. Member LTC facility termination notices:
   a. DHCS issued template is used, or~~.~~
   b. When DHCS ~~-~~issued template is not used, the "new notice" must include items listed in VI.D.1, mailing date, and a description of how the plan will maintain the ability to provide covered services.

~~6.~~5. Member rescind notices must contain:
   a. An explanation that an agreement has been reached~~,~~ and the provider will continue to be a network provider.
   b. Options to remain with or change providers.
   c. MS Department's phone number and hours of operation.
   d. DHCS' Office of the Ombudsman toll free phone number.
   e. Instructions on how to access and/or request a provider directory.
   ~~. Language and non-discrimination notices.~~

~~8.~~6. Member notices for a provider change of location must contain:
   a. Effective date of the move.
   b. Name of the provider who is changing location.
   c. New location address and phone number.
   d. MS Department's phone number and hours of operation.
   e. DHCS' Office of the Ombudsman toll free phone number.
   f. Instructions on how to access and/or request a provider directory.
   ~~. Language and non-discrimination notices.~~

7. **All notices:**
   a. Are sent in a threshold language based on the member's language code or in other requested languages and/or formats
   b. Includes ~~the~~ -non-discrimination notice and language taglines ~~when and a Directory is not included~~

~~F.~~E. Identification of Impacted Members

1. Member lists for terminating or relocating:
   a. PCPs include all members assigned or linked to PCP/MH (physician assigned practice) or Medical Group.
   b. Specialists include all members regularly seen by the provider or Medical Group.
      i. "Regularly seen" by the provider is defined as a member seen by a specialist for one (1) or more visits during the last 12 ~~twelve~~~~six~~ months or if the member had a major surgical procedure ~~during the previous year~~ performed by the affected provider in the past 12 months.
   c. Hospitals include all members assigned or affiliated with the hospital or who have claims data reflecting one (1) or more visits during the last 12 ~~twelve~~~~6~~ months.
   d. LTC facility include all LTC residents.

~~G.~~F. Significant Provider Termination

1. Provider Relations determines and advises MS when a provider termination is considered

significant.

2. Requires submission of the member notice and additional DHCS reporting, such as a narrative and/or transition plan at least 60 days prior to the expected provider termination. ~~MS assists Provider Relations and Regulatory Affairs and Compliance as needed.~~

~~0.~~

~~I.~~G. Retention

H. MS retains member notices and list of affected members according to CMP30 – Records Retention and Access Requirements.

~~1.~~

~~J. Call Center~~

~~1. Advised of the mailing and the number of affected members.~~

~~2. The notice is posted to the MS Reference Manual for Call Center team to access.~~

~~3. Additional instruction is given when appropriate.~~

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-003 Medi-Cal Network Provider and Subcontractor Terminations (03/03/2021)
B. DHCS Annual Network Certification (ANC) Instruction Manual
C. Title 42 Code of Federal Regulations (CFR) Section 438.10(f)(1) Information Requirements
D. NCQA Guidelines NET 4, Element A
~~D.~~E. ELP 003 Provider Change Notification

VIII. DISTRIBUTION:

A. PowerDMS Policy and Procedures Folder
B. Partnership's Department Directors
C. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Senior Director of Member Services and Grievance

X. REVISION DATES:

Medi-Cal

06/21/00; 02/20/02; 04/12/05; 04/13/06; 06/21/06; 08/12/08; 02/18/09; 03/18/10; 03/07/12; 08/07/13; 11/04/13; 4/20/16; 08/16/17; 04/10/19; 03/11/20; 06/10/20; 01/13/21; 08/11/21; 10/13/21; 11/9/22; 11/07/23; 01/08/25

PREVIOUSLY APPLIED TO:

Partnership *Advantage*:

MP 300 - 01/01/2007 to 01/01/2015

Healthy Families:

MP 300 - 10/01/2010 to 03/01/2013

Healthy Kids

MP 300 – 11/01/2005 to 12/31/2016

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Nov. 20, 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 Number**	**Summary of Revisions** (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Health Equity – *Moe Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*			
MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)	201-210 *CLEAN copy begins on p. 409*	**Changes suggested by senior Health Services leadership at Oct. 8 IQI are now incorporated into this policy revision. Per Nov. 12 IQI,** the Medical Director for Medicare Services and the Director, Enhanced Health Services are now QIHEC members. **Section I. Related Policies.** Added MCNP9002 – Cultural & Linguistic Program Description. **Section VI.B.1.b:** Added that Members are invited to join at the discretion of the co-chairs. **Section VI.B.1.c:** Updated number of official voting members to 9 to 15 to ensure ability to meet quorum threshold and ensure progress of the meeting. **Section VI.B.1.c. 3-4):** Added language mirrors MCNP9022 provisos: • QIHEC makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds. • In alignment with the Consumer Advisory Committee Guiding Principles (see MCND9002, Attachment F), eligible Partnership members, and legal parents, guardians or conservators of an eligible minor (under age 18) Partnership member are eligible to join. **Section VI.B.1.c.6):** Amended to acknowledge that prospective members may be asked to sign Conflict of Interest an Confidentiality agreements. **Section VI.B.6:** Changed meeting frequency from quarterly to every other month due to large number of items that QIHEC will need to review. **Section VI.B.7:** Revised language around the expected content of meeting minutes and the internal departments that receive these minutes and then send them on to DHCS. **Section VI.C.6 & 7:** Added responsibilities to analyze results of Members' grievances around discrimination and any actions taken by the U.S. Equal Employment Opportunity Commission.	Health Services Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.C.12: Added that feedback from Partnership's Community Advisory Committee (CAC) will be solicited for continued Diversity, Equity, and Inclusion (DEI) training programs. **Section VI.C.13:** Added that QIHEC will review, provide input, and vote to approve Partnership's Quality Achievement Community Reinvestment plans in the "Cultivating Improved Health" use category if the Health Plan is subject to the quality achievement community reinvestment requirement by DHCS.	
Policy Owner: Population Health Management – *Presenter: Hannah O'Leary, MPH, Manager of Population Health*			
MCNP9006 – Doula Services	211 - 219	Changed instances of "PHC" to "Partnership, and Partnership URL changed to the current standard (PartnershipHP.org), small grammar changes. Various parts removed that are no longer relevant or are best conveyed in other policies. (See Related Policies section.) **Section I:** added MCND9002 Cultural and Linguistic Program Description to Related Policies. **Section VI.A.2:** added that doulas are "trained birth workers." **Section VI.E.2.d.1:** added "The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days." **Section VI.E.3.b:** added "the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits." **Section VI.H.3:** added "1.Refer to sections VI.E.2. for a description of doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization." **Section VI.I.2:** added "Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services." **Section VI.K.4.a:** added "Doulas must submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes. **Section VI.K.4.b:** added "Partnership will submit data related to doula services utilization and provider network per DHCS requirements." **New Attachment B:** Doula Crosswalk Coding Information This attachment adds a resource for doulas looking for DHCS diagnosis codes. Doulas are required to include a DHCS diagnosis code on their claims.	Provider Relations, Providers, Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Behavioral Health – *Presenter: Mark Bontrager, Senior Director of Behavioral Health*			
MCUP3028 – Mental Health Services	221 - 233	**This policy was updated to include changes per APL 22-029 Revised, Dyadic Services & Family Therapy Benefit.** **Section I:** Policy MCQG1015 – Pediatric Preventive Health Guidelines was added as a Related Policy **Section III. B. – D.:** Definitions were added for Dyad, Dyadic Services Benefit, and Managed Behavioral Healthcare Organization. **Section VI.A.4.d.4):** Language around our closed loop referral process in response to a DHCS Focused Audit **Section VI.J.:** This new section was added to describe how Partnership covers family therapy. **Section VI.N.3.:** This paragraph was added to explain how Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). **Section VI.O.:** This new section was added to describe the Dyadic Services Benefit. **Section VII.N. and O.:** Two new References were added for APL 22-029 Revised: Dyadic Services & Family Therapy Benefit (03/20/2023) and California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits	Provider Relations Providers Member Services
MCUP3101 – Screening and Treatment for Substance Use Disorders	234 - 257	**Section IV. Attachments:** Policy attachments C. and D. were Archived. Instead, the requirements for Brief Behavioral Counseling Intervention/ Referral can be found in the main MCUP3101 policy document. Due to this change, Attachment E. became Attachment C. **Section VI.A.3.b.:** Recommended ICD 10 codes for medical specialists providing office visits for SUD treatment were updated to F11.xx or F10.xx. to avoid the requirement for a RAF. **Section VI.B.3.a. and VI.C.8.a. :** Deleted the word "outpatient." **Section VI.C.3.c. :** Deleted part of this paragraph describing the Application to be a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider. Attachments C and D regarding the application process have been Archived. **Section VI.C.5. and 5.e. and 5.e.1) :** Deleted the word "Contracted"	Provider Relations Configuration

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Utilization Management – *Presenter: Colleen Townsend, MD, Regional Medical Director (Southeast)*			
MCUP3131 – Genetic Screening and Diagnostics	258 - 391	Minor changes in the main policy: **VII. A.** Updated CDC hyperlink in References **IX:** Updated "Position Responsible for Implementing Procedure" to say "Chief Health Services Director." **Attachment A Updates:** **Code 81220:** Added ICD codes E84, X38.49 and Z31.5 as criteria **Code 81221:** Changed to require No TAR per MD review and cost <$500 **Code 81222:** Changed to require No TAR per MD review and cost <$500 **Code 81232:** New coded added for DPYD gene analysis. TAR is required with criteria that Patient had severe and unexpected toxicity (such as myelosuppression, mucositis, diarrhea, neurotoxicity, cardiotoxicity) during treatment with Fluorouracil or Capecitabine chemotherapy **Code 81259:** Changed to require No TAR per MD review and cost <$500 **Codes 81272 and 81273:** Added ICD codes D47.01 and D47.02 as criteria **Code 81336:** Changed to require No TAR per MD review and cost <$500 **Code 81337:** Changed to require No TAR per MD review and cost <$500 **Code 81405:** Added SLSLC22A5 gene (for carnitine deficiency or carnitine uptake defect) as criteria: Allowable when the newborn screen is positive for low carnitine levels or when there is clinical suspicion **Code 81406:** Added DSP gene as criteria: The patient has clinical features suspicious for Arrhymogenic Right Ventricular Myopathy ICD 10 code I42. **Code 81408:** Added COL1A1, COL1A2 genes (Osteogenesis Imperfecta) as criteria with ICD code Q78 **Code 81412:** New coded added for Ashkenazi Jewish-associated disorders. A TAR is required with documented criteria to include Patient is considering pregnancy or is currently pregnant and Patient reports they are of Ashkenazi Jewish descent. **Code 81420:** New statement added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity."	Providers Configuration

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Codes 81457, 81458 and 81459: New codes added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with various criteria stated for both somatic and germline testing. **Codes 81462:** New code added for Solid Organ Neoplasm genomic sequence analysis panel. A TAR is required with criteria to include The patient has a diagnosis of on-small cell lung cancer, and The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and Management is contingent on the test results. **Code 81507:** New statement was added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Codes 81517:** New code added for Liver disease, analysis of 3 biomarkers. No TAR is required. No Criteria listed. **Attachment C Updates:** **Code 0014M:** Deleted effective 01/01/2024 **Code 0204U:** Deleted effective July 2024 **Code 0242U:** Criteria for this code updated to include Hormone receptor-positive, Human Epidermal Growth Factor Receptor 2 (HER2)-negative breast cancer. Criteria removed: "~~The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible~~." **Code 0276U:** Code description updated to remove these words: "~~Hematology (inherited thrombocytopenia~~)" **Code 0327U:** : New statement added to say "Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity." **Code 0329U:** Criteria for this code updated with somatic testing guidelines. **Code 0331U:** Deleted. **Code 0334U:** Criteria for this code updated with somatic testing guidelines. **Code 0337U:** Deleted **Code 0338U:** Deleted **Code 0342U:** Deleted **Code 0343U:** Deleted **Code 0344U:** Deleted	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Code 0353U: Deleted **Code 0354U:** Deleted **Code 0379U:** Criteria updated with somatic testing guidelines. **Code 0391U:** Criteria updated with somatic testing guidelines. **Code 0397U:** Deleted **Code 0408U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required. **Code 0409U:** New code added for Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability. A TAR is required. **Code 0448U:** New code added for Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffin-embedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options. A TAR is required. **Code 0471U:** New code added for Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations. A TAR is required. **Code 0473U:** New code added for Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden. A TAR is required. **Code 0475U:** New code added for Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer. A TAR is required. **Code 0488U:** New code added for Obstetrics (fetal antigen noninvasive prenatal test), cell-free dna sequence analysis for detection of fetal presence or absence of 1 or more of the rh,	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		c, c, d, e, duffy (fya) or kell (k) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected. A TAR is required. **Code 0494U:** New code added for Red blood cell antigen (fetal rhd gene analysis), next-generation sequencing of circulating cell-free dna (cfdna) of blood in pregnant individuals known to be rhd negative, reported as positive or negative. A TAR is required.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCEP6002</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Quality Improvement and Health Equity Committee (QIHEC)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/08/2023</td><td colspan="4">Next Review Date: ~~11/08/2024~~01/08/2026
Last Review Date: ~~11/08/2024~~01/08/2025</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: ~~11/08/2023~~01/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Description
~~B. MPQP1004 – Internal Quality Improvement Committee~~
~~C.~~B. MPQP1002 – Quality/Utilization Advisory Committee
~~D.~~C. MPQP1003 – Physician Advisory Committee (PAC)
~~E.~~D. MPQD1001 – Quality Improvement Program Description
~~F.~~E. CMP10 – Confidentiality
~~G.~~F. ADM21 – Stipends for Committee Members
G. MPQP1008 – Conflict of Interest Policy for QI Activities
H. MCNP9002 – Cultural & Linguistic Program Description

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. **QIHETP**: Partnership HealthPlan of California's (Partnership~~HC~~) Quality Improvement and Health Equity Transformation Program (QIHETP), which outlines the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care services delivered to members in accordance with the standards set forth in applicable laws, regulations and Department of Health Care Services (DHCS) Medi-Cal contract.
B. **QIHEC:** Partnership's ~~HealthPlan of California's (PHC)~~ Quality Improvement and Health Equity Committee (QIHEC), which is co-chaired by the Chief Medical Officer (CMO) or medical director designee, and Partnership's~~HC's~~ Health Equity Officer (HEO), ~~to~~ meets ~~at least quarterly~~every other month to direct all QIHETP findings and required actions.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the structure and responsibilities of PHC's Quality Improvement and Health Equity Committee (QIHEC).

VI. POLICY / PROCEDURE:

A. Committee Purpose:

1. The Quality Improvement and Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal ~~PHC~~ Partnership specific committees.
2. This committee is also responsible for developing actions to address performance deficiencies (e.g., policy recommendations, action plans) and ensuring appropriate follow-up of identified performance deficiencies.
3. The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. The Q/UAC provides recommendations and is overseen by the Physicians Advisory Committee (PAC) (see policy MPQP1003), which subsequently reports to ~~PHC's~~ Partnership's governing Board of Commissioners. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to ~~PHC~~ Partnership members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

B. Committee Structure
   1. Composition
      a. The QIHEC is co-chaired by PHC's CMO, and the Health Equity Officer (HEO). A voting committee member will be designated as a temporary chair, in the absence of both the CMO and HEO.
      ~~a.~~b. Members are invited to join at the discretion of the co-chairs.
      ~~b.~~c. The QIHEC's goal membership ~~for is comprised of a formal~~for formal voting members ~~target of~~is at least 9~~13 to~~ 15~~9~~ representatives from a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership~~PHC~~ members. Also, the QIHEC may include members from the California Department of Public Health (CDPH), members from academic institutions, ethnic services coordinators, community based organization leaders, and tribal health liaisons, and health system leaders.
         1) The network providers who serve as representatives on the QIHEC must reflect Partnership~~HC~~'s broad provider network, including providers who provide health care services to members affected by health disparities, limited English proficiency (LEP), Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs), persons with chronic conditions, and providers who serve as a health equity liaison on behalf of their practice.
            a) The voting members of QIHEC are encouraged to have advanced medical training, experience in health care, experience in health equity initiatives, or have completed some form of DEI or health equity-related training/continued education.
         2) The QIHEC representative(s) ~~must~~ should be from one of the counties served by Partnership~~PHC~~. Also, ~~may solicit~~ input from selected relevant specialists or professionals, if not represented on the QIHEC, ~~committee~~may be solicited *ad hoc*.
         3) QIHECmakes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.
         4) In alignment with the Consumer Advisory Committee Guiding Principles (see MCND9002,

Attachment F), eligible Partnership members, and legal parents, guardians or conservators of an eligible minor (under age 18) Partnership member are eligible to join.

~~2)~~5) Members may serve open terms and may submit resignation to the CMO~~, designee~~ and/or HEO.

~~3)~~6) Possible QIHEC members will follow internal ~~PHC~~ Partnership application procedures for applying for committees that includes external members (e.g., ~~Consumer Advisory Committee~~Quality/Utilization Advisory Committee), including signing Conflict of Interest and Confidentiality agreements.~~.~~ ~~In addition, QIHEC members will be required to submit an attestation to ensure avoidance of conflict of interest.~~

~~c.~~d. Voting members with annual attendance of <50% are evaluated for termination from the QIHEC.

~~d.~~e. The following ~~PHC~~ Partnership staff, serve as ex-officio members:

PHC Quality Improvement and Health Equity Committee Standing Members	
Department Represented	**Position Title**
Administration	Director, Grievance and Appeals
	Chief Operating Officer
Communications	Director of Communications
Finance	Director of Health Analytics
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination~~, and~~ Population Health and Enhanced Health Services)	Chief Medical Officer – Committee Chairman (or Medical Director designee)
	Health Equity Officer – Committee Chairman
	Medical Director for Medicare Services
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Medical Director for Quality
	Director, Enhanced Health Services
	Director(s), Care Coordination
	Director(s), Utilization Management
	Director(s), Population Health
	Senior Health Educator/ Manager of Population Health
	Director, Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
Member Services	Senior Director Member Services

2. Voting: Only committee members~~,~~ who are not ~~PHC~~ Partnership staff~~,~~ may vote. The CMO and/or HEO serves in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members (e.g. 5 to 8 members)~~.~~
3. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each committee member signs an annual Confidentiality Agreement prepared and retained by ~~PHC~~Partnership. This agreement signifies the intent to protect individuals against misuse of information and to ensure all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. ~~The PHC~~Partnership's Confidentiality policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout

QIHEC meetings and proceedings.

4. Compensation: QIHEC committee members who are not ~~PHC~~ Partnership staff are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by ~~PHC~~ Partnership for management responsibilities). This stipend may be in addition to other compensation when a committee member serves as a clinical consultant/physician adviser. For further information, refer to ~~PHC~~ Partnership policy ADM21 Stipends for Committee Members.
5. Conflict of Interest: Each committee member signs an annual Conflict of Interest statement prepared and retained by ~~PHC~~ Partnership. (See policy MPQP1008 Conflict of Interest Policy for QI Activities.)~~.~~
6. Meeting Frequency: The QIHEC committee meets ~~quarterly~~ every other month with the option to add additional meetings if needed.
7. Meeting Minutes: ~~Minutes and a written summary of activities are recorded at all meetings. The written summary and activities shall include QIHEC activities, findings, recommendations, and actions.~~ Minutes shall include QIHEC activities, findings, recommendations, and actions. Minutes are maintained according to the confidentiality policy. Approved minutes are submitted to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance inboxes. RAC submits these minutes to the Department of Health Care Services (DHCS).
   ~~a. PHC shall make the QIHEC meeting minutes and summary of activities publicly available on PHC's website at least on a quarterly basis (with redaction of private or confidential information as required).~~
   ~~b.~~a. Meeting minutes and summaries shall be reported to Q/UAC, PAC and Partnership's~~PHC~~'~~s~~ Board of Commissioners.
   ~~c.~~b. Partnership~~HC~~ shall submit a written summary of QIHEC activities to DHCS upon request.
8. For any Delegated Subcontractors and Downstream Fully Delegated Subcontractors, QIHEC Meeting minutes and summary(s) are submitted through the Delegation Oversight Reporting Subcommittee (DORS) inbox monthly and submitted quarterly, by DORS, to the Department of Healthcare Services (DHCS).

C. Committee Responsibilities
1. Annually review, provide recommendations, and approve the Quality Improvement and Health Equity Transformation Program (QIHETP) Description (MCED6001).
2. Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
   a. Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
   b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
3. Analyze utilization data (e.g., t~~T~~ypes of services, denials, deferrals, modifications) with stratification by race/ethnicity and language.
4. Analyze utilization data of language services and experience with language services with stratification by language.
5. Analyze and evaluate the results of member satisfaction surveys, ~~Grievance and Appeal surveys, and care coordination based surveys~~ with stratification by race/ethnicity and language to ensure culturally competent care.
6. Analyze and evaluate the results of Members' grievances and complaints regarding discrimination, cultural biases, or insensitive practices with stratification by race/ethnicity and/or language.
~~5.~~7. Analyze any actions taken by the US Equal Employment Opportunity Commission regarding discriminatory practices by medical groups and other subcontractors within Partnership's provider network.
~~6.~~8. Analyze and evaluate the strategy and work plans presented by internal groups ~~(e.g. PHM&HE,~~

~~QI/PI, etc)~~ to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans.

~~7.~~9. Analyze and evaluate feedback from Partnership's member representative committees (e.g., Consumer Advisory Committee, Family Advisory Committee ~~CAC, FAC~~)

~~8.~~10. Recommend and review interventions for various departments (e.g., Quality and Performance Improvement ~~(QI/PI)~~, Provider Relations, Population Health, Utilization Management, Member Services, etc.) to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans. This shall include, but is not limited to, policy recommendations, population health based interventions, QI/PI performance improvement project recommendations, etc. The QIHEC will ensure appropriate follow-up of identified gaps using objective metrics.

11. Review provider-related Diversity, Equity and Inclusion (DEI) training completion trends and provide feedback to improve the quality of the continued health equity education. Also, may solicit input from selected relevant specialists or professionals, if not represented on the QIHEC committee.

12. Review feedback from ~~community advisory committee~~CAC for continued DEI training program recommendations and feedback for consideration. This may include~~,~~ involving community leadership and decision-makers (i.e., those with lived experience) in the design and development of education evaluation programs. A summary of the input provided by the Health Equity Officers and QIHEC will be generated on an annual basis

~~9.~~13. Review, provide input, and vote to approve Partnership's Quality Achievement Community Reinvestment plans in the "Cultivating Improved Health" use category if the ~~H~~health ~~P~~plan is subject to the quality achievement community reinvestment requirement by DHCS.. ~~by the MCO~~

~~10.~~14. QIHEC members may seek guidance to address health equity goals throughout their represented organizations.

~~11.~~15. In addition to meeting minutes, the QIHEC shall prepare and present an annual report to ~~PHC's~~ Partnership's Q/UAC and PAC and Board of Commissioners to provide input and guidance to the QIHETP policies and procedures to ensure compliance with QI and Health Equity standards.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Draft Contract (RFP 22-20196) Exhibit A, Attachment III, Section 2.2.3
B. Department of Health Care Services (DHCS) standards
C. National Committee for Quality Assurance (NCQA) Guidelines (~~Effective July 1, 2023~~-2024) HEA Standards 1 to 7

VIII. DISTRIBUTION:

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director of Health Equity

X. REVISION DATES: ~~N/A~~01/08/25

PREVIOUSLY APPLIED TO: N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCEP6002</td><td colspan="4">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Quality Improvement and Health Equity Committee (QIHEC)</td><td colspan="4">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/08/2023</td><td colspan="5">Next Review Date: 01/08/2026
Last Review Date: 01/08/2025</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: 01/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Description
B. MPQP1002 – Quality/Utilization Advisory Committee
C. MPQP1003 – Physician Advisory Committee (PAC)
D. MPQD1001 – Quality Improvement Program Description
E. CMP10 – Confidentiality
F. ADM21 – Stipends for Committee Members
G. MPQP1008 – Conflict of Interest Policy for QI Activities
H. MCNP9002 – Cultural & Linguistic Program Description

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. **QIHETP**: Partnership HealthPlan of California's (Partnership) Quality Improvement and Health Equity Transformation Program (QIHETP), which outlines the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care services delivered to members in accordance with the standards set forth in applicable laws, regulations and Department of Health Care Services (DHCS) Medi-Cal contract.
B. **QIHEC:** Partnership's Quality Improvement and Health Equity Committee (QIHEC), which is co-chaired by the Chief Medical Officer (CMO) or medical director designee, and Partnership's Health Equity Officer (HEO), meets every other month to direct all QIHETP findings and required actions.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the structure and responsibilities of PHC's Quality Improvement and Health Equity Committee (QIHEC).

VI. POLICY / PROCEDURE:

A. Committee Purpose:
   1. The Quality Improvement and Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of

the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership specific committees.

2. This committee is also responsible for developing actions to address performance deficiencies (e.g., policy recommendations, action plans) and ensuring appropriate follow-up of identified performance deficiencies.
3. The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002). The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. The Q/UAC provides recommendations and is overseen by the Physicians Advisory Committee (PAC) (see policy MPQP1003), which subsequently reports to Partnership's governing Board of Commissioners. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

B. Committee Structure
   1. Composition
      a. The QIHEC is co-chaired by PHC's CMO, and the Health Equity Officer (HEO). A voting committee member will be designated as a temporary chair, in the absence of both the CMO and HEO.
      b. Members are invited to join at the discretion of the co-chairs.
      c. The QIHEC's goal membership for formal voting members is at least 9to 15 representatives from a broad range of network providers, including but not limited to, hospitals, clinics, county partners, physicians, subcontractors, and/or downstream subcontractors, as well as Partnership members. Also, the QIHEC may include members from the California Department of Public Health (CDPH), members from academic institutions, ethnic services coordinators, community based organization leaders, and tribal health liaisons, and health system leaders.
         1) The network providers who serve as representatives on the QIHEC must reflect Partnership's broad provider network, including providers who provide health care services to members affected by health disparities, limited English proficiency (LEP), Children with Special Health Care Needs (CSHCN), Seniors and Persons with Disabilities (SPDs), persons with chronic conditions, and providers who serve as a health equity liaison on behalf of their practice.
            a) The voting members of QIHEC are encouraged to have advanced medical training, experience in health care, experience in health equity initiatives, or have completed some form of DEI or health equity-related training/continued education.
         2) The QIHEC representative(s) should be from one of the counties served by Partnership. Also, input from selected relevant specialists or professionals, if not represented on the QIHEC, may be solicited *ad hoc*.
         3) QIHECmakes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.
         4) In alignment with the Consumer Advisory Committee Guiding Principles (see MCND9002, Attachment F), eligible Partnership members, and legal parents, guardians or conservators of an eligible minor (under age 18) Partnership member are eligible to join.
         5) Members may serve open terms and may submit resignation to the CMO and/or HEO.
         6) Possible QIHEC members will follow internal Partnership application procedures for

applying for committees that includes external members (e.g., Quality/Utilization Advisory Committee), including signing Conflict of Interest and Confidentiality agreements.

d. Voting members with annual attendance of <50% are evaluated for termination from the QIHEC.

e. The following Partnership staff, serve as ex-officio members:

PHC Quality Improvement and Health Equity Committee Standing Members	
Department Represented	**Position Title**
Administration	Director, Grievance and Appeals
	Chief Operating Officer
Communications	Director of Communications
Finance	Director of Health Analytics
Health Services (Utilization Management, Quality and Performance Improvement, Pharmacy, Care Coordination, Population Health and Enhanced Health Services)	Chief Medical Officer – Committee Chairman (or Medical Director designee)
	Health Equity Officer – Committee Chairman
	Medical Director for Medicare Services
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Medical Director for Quality
	Director, Enhanced Health Services
	Director(s), Care Coordination
	Director(s), Utilization Management
	Director(s), Population Health
	Senior Health Educator/ Manager of Population Health
	Director, Pharmacy Services
	Regional Medical Director(s)
	Associate Medical Director(s)
Provider Relations	Senior Provider Relations Representative Manager
Member Services	Senior Director Member Services

2. Voting: Only committee members who are not Partnership staff may vote. The CMO and/or HEO serves in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members (e.g. 5 to 8 members)
3. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each committee member signs an annual Confidentiality Agreement prepared and retained by Partnership. This agreement signifies the intent to protect individuals against misuse of information and to ensure all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. Partnership's Confidentiality policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC meetings and proceedings.
4. Compensation: QIHEC committee members who are not Partnership staff are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by Partnership for management responsibilities). This stipend may be in addition to other compensation when a committee member serves as a clinical consultant/physician adviser. For further information, refer to Partnership policy ADM21 Stipends for Committee Members.
5. Conflict of Interest: Each committee member signs an annual Conflict of Interest statement prepared and retained by Partnership. (See policy MPQP1008 Conflict of Interest Policy for QI Activities.)

6. Meeting Frequency: The QIHEC committee meets every other month with the option to add additional meetings if needed.
7. Meeting Minutes: Minutes shall include QIHEC activities, findings, recommendations, and actions. Minutes are maintained according to the confidentiality policy. Approved minutes are submitted to the Delegation Oversight Reporting Subcommittee (DORS) and Regulatory Affairs and Compliance inboxes. RAC submits these minutes to the Department of Health Care Services (DHCS).

    a. Meeting minutes and summaries shall be reported to Q/UAC, PAC and Partnership's' Board of Commissioners.
    b. Partnership shall submit a written summary of QIHEC activities to DHCS upon request.
8. For any Delegated Subcontractors and Downstream Fully Delegated Subcontractors, QIHEC Meeting minutes and summary(s) are submitted through the Delegation Oversight Reporting Subcommittee (DORS) inbox monthly and submitted quarterly, by DORS, to the Department of Healthcare Services (DHCS).

C. Committee Responsibilities

1. Annually review, provide recommendations, and approve the Quality Improvement and Health Equity Transformation Program (QIHETP) Description (MCED6001).
2. Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
    a. Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
    b. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
3. Analyze utilization data (e.g., types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language.
4. Analyze utilization data of language services and experience with language services with stratification by language.
5. Analyze and evaluate the results of member satisfaction surveys, with stratification by race/ethnicity and language to ensure culturally competent care.
6. Analyze and evaluate the results of Members' grievances and complaints regarding discrimination, cultural biases, or insensitive practices with stratification by race/ethnicity and/or language.
7. Analyze any actions taken by the US Equal Employment Opportunity Commission regarding discriminatory practices by medical groups and other subcontractors within Partnership's provider network.
8. Analyze and evaluate the strategy and work plans presented by internal groups to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans.
9. Analyze and evaluate feedback from Partnership's member representative committees (e.g., Consumer Advisory Committee, Family Advisory Committee)
10. Recommend and review interventions for various departments (e.g., Quality and Performance Improvement, Provider Relations, Population Health, Utilization Management, Member Services, etc.) to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans. This shall include, but is not limited to, policy recommendations, population health based interventions, QI/PI performance improvement project recommendations, etc. The QIHEC will ensure appropriate follow-up of identified gaps using objective metrics.
11. Review provider-related Diversity, Equity and Inclusion (DEI) training completion trends and provide feedback to improve the quality of the continued health equity education. Also, may solicit input from selected relevant specialists or professionals, if not represented on the QIHEC committee.

12. Review feedback from CAC for continued DEI training program recommendations and feedback for consideration. This may include involving community leadership and decision-makers (i.e., those with lived experience) in the design and development of education evaluation programs. A summary of the input provided by the Health Equity Officers and QIHEC will be generated on an annual basis
13. Review, provide input, and vote to approve Partnership's Quality Achievement Community Reinvestment plans in the "Cultivating Improved Health" use category if the Health Plan is subject to the quality achievement community reinvestment requirement by DHCS..
14. QIHEC members may seek guidance to address health equity goals throughout their represented organizations.
15. In addition to meeting minutes, the QIHEC shall prepare and present an annual report to Partnership's Q/UAC and PAC and Board of Commissioners to provide input and guidance to the QIHETP policies and procedures to ensure compliance with QI and Health Equity standards.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Draft Contract (RFP 22-20196) Exhibit A, Attachment III, Section 2.2.3
B. Department of Health Care Services (DHCS) standards
C. National Committee for Quality Assurance (NCQA) Guidelines (-2024) HEA Standards 1 to 7

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director of Health Equity

X. REVISION DATES: 01/08/25

PREVIOUSLY APPLIED TO: N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCNP9006</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Doula Services Benefit</td><td colspan="3">☒ ~~☒~~External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 01/10/2024
Effective Date: 01/01/2023</td><td colspan="4">Next Review Date: ~~01/10/2025~~01/08/2026
Last Review Date:
~~01/10/2024~~01/08/2025</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/08~~15~~0/2025~~4~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
~~A.~~B. MCND9002 – Cultural and Linguistic Program Description
~~B.~~C. MCUG3118 – Prenatal & Perinatal Care
~~C.~~D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~D.~~E. MCUP3113 – Telehealth Services
~~E.~~F. MPCR15 – Doula Credentialing and Re-Credentialing Criteria
~~F.~~G. MPNET100 – Access Standards and Monitoring
~~G.~~H. MPPR200 – PHC Provider Contracts
~~H.~~I. MPPRO1102 – Contracted Provider Education
~~I.~~J. MCCP2032 – CalAIM Enhanced Care Management (ECM)
~~J.~~K. MCUP3143~~2~~ – CalAIM Authorization Process for Enhanced Care Management (ECM) and/or ~~———————~~Community Supports (CS)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. The Comprehensive Perinatal Services Program (CPSP): Developed by the California Department of Health Services as an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed at higher rates than traditional obstetrical services. The CPSP provider certification process is locally administered by the county CPSP Coordinator with final approval by California Department of Health Services. Partnership HealthPlan of California (Partnership) encourages, but does not require, perinatal providers to be CPSP certified in order to provide obstetrical services, however they need to provide CPSP-like services or refer to another CPSP Provider for non-obstetric CPSP services.
B. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
C. Doulas are trained birth workers credentialed by Partnership to provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.

D. 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.

IV. ATTACHMENTS:

A. Medi-Cal Doula Services Recommendation form

~~A.~~B. Required ICD Codes for Doula Services

V. PURPOSE:

To define the doula services Medi-Cal benefit (effective January 1, 2023) including services offered and pathways to certification.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) recognizes the doula services benefit as a means to provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of our members while adhering to evidence-based best practices.
   1. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.
   2. Doulas are trained birth workers who ~~also~~ offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.
   3. Doula services may be provided virtually (telehealth) or in-person with locations in any setting including, but not limited to: homes, office visits, hospitals, or alternative birth centers.

B. Doula qualifications, requirements and recommended training are detailed in Partnership's policy MPCR15 Doula Credentialing and Re-Credentialing Criteria.
   1. Doulas must attest that they will support and encourage care in alignment with the American College of Obstetricians and Gynecologists (ACOG) guidelines, including recommended provider visits and vaccinations for the pregnant member and the newborn.

C. Informing providers about the doula benefit
   1. Partnership publicizes our current understanding of the regulatory framework for doulas with our provider network and CBOs in community meetings, provider meetings, and in Provider Newsletters as applicable.
   2. Partnership's Provider Relations department educates providers on doula services through the Medical Director's Newsletter, quarterly Provider Newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

D. Informing members about the doula benefit
   1. Partnership's Health Education team crafts culturally and linguistically appropriate communication to explain doula services to our members.
      a. Members are informed of the Doula Services benefit in the Partnership Member Handbook, known as the Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services and is also available on the Partnership website at ~~www.P~~partnership~~HPhp~~.org in the Members ~~S~~section.
      b. Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the Member Newsletter and that the Partnership webpage is updated with these new services. Members qualifying for doula services are given information about how doulas can provide support during pregnancy, postpartum, and after childbirth, during miscarriage, stillbirth, and abortion.

E. Eligibility for doula services

1. Partnership Members who are currently pregnant or have been pregnant in the last 365 days are considered eligible and are recommended to receive the doula services benefit.
    a. A licensed provider (a physician or other licensed practitioner of healing arts acting within their scope of practice under state law) may provide a recommendation for a Partnership Member to have doula services. This may be noted in the member's medical record and/or a written recommendation forwarded to the doula.
        1) The recommending provider does not need to be enrolled in Medi-Cal or be a Partnership network provider.
        2) DHCS has created an optional Medi-Cal Doula Services Recommendation form that recommending providers may choose to use (see Attachment A).
    b. Doulas must verify that the member's Medi-Cal eligibility for the month of services is valid by contacting Partnership to verify eligibility.
    c. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.
    d. Doulas must document in the records, the name/practice of a collaborating provider involved in the care of the member.
        1) A collaborating provider is a licensed practitioner of the healing arts who is involved in the member's care acting within their scope of practice (LCSW, MD, DO, NP, PA).
2. The DHCS standing recommendation for doula services implemented on November 1, 2023 authorizes the following:
    a. One initial visit.
    b. Up to eight additional visits (may be provided in any combination of prenatal and postpartum visits).
    c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
    d. Up to two extended three-hour postpartum visits after the end of a pregnancy (these two visits would not require the member to meet additional criteria or receive a separate recommendation)
        ~~d.~~1)The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days.
    e. All visits are limited to one per day per member, and only one doula may bill for a visit provided to the same member on the same day (excluding labor and delivery).
        1) On the day of labor/delivery, stillbirth, abortion, or miscarriage support:
            a) One doula may bill for labor and delivery, stillbirth, abortion or miscarriage support, and
            b) One prenatal *or* one postpartum visit may be provided, also. This visit may be billed by a different doula.
3. A Treatment Authorization Request (TAR) is required for additional visits (beyond eight) during the postpartum period (see policy MCUP3041 Treatment Authorization Request (TAR) Review Process).
    a. A recommendation from a physician or other LPHA acting within their scope of practice under state law is required.
    b. The request for additional visits will be evaluated for medical necessity; the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits.~~.~~
    c. The additional recommendation may authorize up to nine (9) additional postpartum visits.

F. Documentation Requirements
1. Doulas must document each visit with:
    a. National Provider Identifier (NPI)
    b. Date, time, and duration of services provided to the member
    c. Service(s) provided

d. Length of time spent with member that day
e. Initial visit records must include documentation of a collaborating or recommending perinatal provider (medical, behavioral health, or licensed CPSP provider)

2. Documentation should be integrated into the member's medical record from the recommending provider, and available for encounter data reporting. Doulas will share documentation with the perinatal providers.
3. Documentation must be accessible to Partnership and DHCS upon request.

G. Standards for Doula Services
1. Partnership will not establish unreasonable or arbitrary barriers for accessing doula services.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste, and abuse of doula services through committees that review for over and under-utilization of services.
3. Partnership utilizes doula services to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate doulas into basic population health management for obstetric care activities. This may include:
   a. Referrals for pregnant members requiring preventive care
   b. Referrals for children requiring well-baby care
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits
5. Partnership will monitor the network to ensure an appropriate network of doulas and coordinate for out-of-network (OON) access to doula services if an in-network doula provider is not available.
~~5.~~
~~6. If the pregnant member desires to have a doula during labor and delivery, Partnership will work with in-network hospitals and birthing centers to allow the doula to be present, in addition to the support person(s).~~
~~7.~~6. Partnership will track quality and utilization measures for doula services as recommended by DHCS.

H. Doula Services Provided
~~1. Doula services may be performed virtually (telehealth) or in-person with locations in any setting, including but not limited to, homes, office visits, hospitals, or alternative birth centers.~~
~~2. Initial doula services include the following authorizations:~~
   ~~a. One initial visit~~
   ~~b. Up to eight (8) additional visits that can be provided in any combination of prenatal and postpartum visits~~
   ~~c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage~~
   ~~d. Up to two extended three-hour postpartum visits after the end of a pregnancy~~
1. Refer to sections VI.E.2. for a description of ~~-~~doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization.~~"~~
~~3.~~2. For pregnancy-related services that are available through Medi-Cal, doulas should work with the member's provider or with Partnership to refer the member to a network provider who is able to render the service. These Medi-Cal services include but are not limited to:
   a. Behavioral health services
   b. Belly binding after cesarean section by clinical personnel
   c. Clinical case coordination
   d. Health care services related to pregnancy, birth, and the postpartum period
   e. Childbirth education group classes
   f. Comprehensive health education including orientation, assessment, and planning (CPSP services)

g. Hypnotherapy (non-specialty mental health services)
h. Lactation consulting, group classes, and supplies
i. Nutrition services (assessment, counseling, and development of care plan)
j. Transportation
k. Medically appropriate Community Supports services

~~4.~~3. Doulas may provide assistive or supportive services (e.g. folding laundry) in the home of the member during a prenatal or postpartum visit, while providing emotional support and offering advice on infant care.
   a. The assistive and supportive services must be incidental to the doula services being provided during that face-to-face visit
   b. The member cannot be billed for the assistive or supportive services

I. Non-Covered Services:
   1. Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.
   ~~1.~~2. Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.
   ~~2.~~3. The following services for pregnant or postpartum beneficiaries are not covered under Medi-Cal or as doula services:
      a. Belly binding (traditional/ceremonial)
      b. Birthing ceremonies (i.e., sealing, closing the bones, etc.)
      c. Group classes on baby wearing
      d. Massage (maternal or infant)
      e. Photography
      f. Placenta encapsulation
      g. Shopping
      h. Vaginal steams
      i. Yoga

J. Training and Education:
   1. Partnership will provide all necessary initial and ongoing trainings and resources for individuals providing doula services as specified in Partnership policy MPPRO1102 Contract Provider Education.

K. Billing, Claims, and Payments
   1. ~~MCPs~~ Partnership ~~must~~ makes payments in compliance with the clean claims requirements and timeframes outlined in the MCP Contract and Timely Payments APL. These requirements apply to both ~~MCPs~~ Partnership and ~~their~~ its Network Providers and Subcontractors.
   2. If a member chooses to see an OON Provider for abortion services, the reimbursement rate must not be lower, and is not required to be higher, than the Medi-Cal Fee-For-Service
   3. Doula services will be reimbursed in accordance with their Network Provider contract and per Medi-Cal guidelines for Doula Services.
      a. Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.
   4. Encounter data
      a. Doulas must~~will~~ submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes.
      b. Partnership will submit data related to doula services utilization and provider network per DHCS requirements.
      ~~a. Partnership shall submit all doula encounters to DHCS using national standard specifications and code sets to be defined by DHCS.~~

~~b. Partnership shall be responsible for submitting all doula encounter data to DHCS.~~

L. Oversight and Quality Monitoring of the Doula Benefit:
   1. Partnership shall monitor the doula benefit to ensure access, quality, outcomes and/or health equity needs and trends. Examples of activities for quality monitoring and oversight include, but are not limited to:
      a. Internal monitoring reports for benefit utilization and/or clinical outcomes
      b. Member satisfaction surveys
      c. Sample chart review identifying clinical outcomes and/or quality for a Partnership member admitted to a contracted facility for delivery who is also receiving the doula benefit.

VII. REFERENCES:
A. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024 Doula Services (*Revised* 11/03/2023)
B. DHCS APL 22-013 Provider Credentialing / Re-credentialing and Screening / Enrollment (*Revised* 08/24/2022)
C. State Plan Amendment (SPA) 22-0002
D. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
E. Medi-Cal Provider Manual/Guidelines: Doula Services

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

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

X. REVISION DATES: 01/08/25~~N/A~~

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

State of California – Health and Human Services Agency Department of Health Care Services

Medi-Cal Doula Services Recommendation

Support for healthy pregnancies and follow-up care

If you are a Medi-Cal beneficiary…

If you are pregnant or were pregnant, you are eligible for doula services up to one year after your pregnancy. Doulas provide physical, emotional, and nonmedical support before and after pregnancy, as well as support during labor and delivery, miscarriage, and abortion. To receive doula services from Medi-Cal, you will need a recommendation from a licensed provider. You can request a recommendation form from a licensed provider[1], for example, a doctor, midwife, or nurse, and then give this signed form to your doula(s) of choice. You can ask for a recommendation even if you do not know who your doula(s) will be yet. Please see www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx for more information.

If you are a doula…

You must retain the record of a licensed provider's recommendation for each member prior to initiation of their doula care, storing the record in a manner consistent with HIPAA requirements.

If you are a licensed provider[1]…

By providing this recommendation of doula services, you acknowledge that the beneficiary would benefit from non-clinical doula services in addition to appropriate clinical care. A recommendation is not the same as a referral, prescription, or medical order[2]. Please use the form below or another document with the same information listed below. You may provide a recommendation without identifying the doula who will serve the member. This recommendation authorizes one initial prenatal visit; eight visits during the perinatal period, including up to one year after pregnancy; support during labor and delivery, miscarriage, or abortion; and two extended postpartum visits.

This form is an example of what can be used to access doula services through Medi-Cal. It is not necessary to use this specific form as long as a clinician's written recommendation is secured with all of the information listed below and retained by the doula.

Licensed Provider's Recommendation for Doula Services		
Beneficiary First Name:	Middle Name:	Last Name:
Beneficiary's Date of Birth:	Licensed Provider's NPI Number:	
Licensed Provider First Name:	Middle Name:	Last Name:
Date of Recommendation:	Licensed Provider's Signature:	

[1]For the doula benefit, Medi-Cal defines a "licensed provider" as a physician or other licensed practitioner of the healing arts, including nurse midwives, nurse practitioners, licensed midwives, and behavioral health providers, acting within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the beneficiary's managed care plan.

[2]Under Medi-Cal, a beneficiary who is pregnant within the past year, and would either benefit from doula services or who requests doula services, would meet the medical necessity criteria for a recommendation for doula services. For mor information, visit www.dhcs.ca.gov.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

What are my rights if I do not agree with a denial of services?
If you do not agree with a denial of a recommendation for services, you can:

- Ask for a State Hearing

STATE HEARING
To ask for a State Hearing, you can fill out the "State Hearing Request" form at www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx and send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may also call to ask for a State Hearing. The number can be very busy so you may get a message to call back later.

Toll free phone: 1-800-952-5253
TTY: 1-800-952-8349

What Are the Time Limits to Ask for a State Hearing?

- You only have 90 days to ask for a hearing. (Note: During the COVID-19 federal Public Health Emergency, you have 210 days to request a hearing.)
- The time limit starts the date of the denial.

Can I Still Get My Treatment and Ask for a State Hearing?
To still get your treatment that the denial notice is stopping or changing, you must:

- Ask for a State Hearing within 10 days from:
  - The date the notice is postmarked, or
  - The date the notice was given to you, or
  - Before the date the notice says your treatment will stop or change.
- Please say that you want to keep getting treatment during the hearing process.

It can take up to 90 days for your case to be decided and an answer sent to you.

Can I Ask for a Quick Hearing?
Yes. This is called an "expedited" hearing. If you think waiting up to 90 days may be risky for you or your child's health, ask your doctor for a letter. The letter must explain how waiting for up to 90 days could be risky for you or your child's life or health. Then you can ask for an expedited hearing. You need to send the letter with your hearing request.

You do not have to attend the State Hearing alone. You may bring someone with you. You can bring a friend, a relative, a lawyer, or anyone you choose. You can speak for yourself or have someone else speak for you.

For more information about the State Hearing process, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Doula Crosswalk Coding Information

October 2024

Starting November 1, 2024, doulas will need to include a “diagnosis code” on claims for services in both fee-for-service and managed care delivery systems. This is required by federal law. Under Medi-Cal’s doula policy, doulas will only use diagnosis codes that describe/identify what occurred at the service. They are not being used for medical and/or diagnostic purposes.

To assist doulas with submitting claims, the Department of Health Care Services (DHCS) created the coding crosswalk below that identifies which diagnosis codes may be billed with each CPT or HCPCS code. Claims will be denied if they do not have a diagnosis code or if they have a different diagnosis code paired with a billing code than what is shown below. The diagnosis code should be entered in field 21A on the CMS 1500 form and diagnosis code should **NOT** have a decimal point on the form.

Doula Billing Code Crosswalk

Billing Code*	Billing Code Service Description+	Diagnosis Code(s)[1]	Diagnosis Code Service Description(s)[2]	Additional Guidance[3]
HCPCS code Z1032	Extended Initial visit	Z32.2 (prenatal)	Encounter for childbirth instruction	Any one of the four diagnosis codes can be used with HCPCS code Z1032. Please note that the initital visit can be either prenatal or postpartum.
		Z32.3 (prenatal)	Encounter for childcare instruction	
		Z39.1 (postpartum)	Encounter for care and examination of lactating mother	
		Z39.2 (postpartum	Encounter for routine postpartum follow-up	
HCPCS code Z1034	Prenatal Visit	Z32.2	Encounter for childbirth instruction	Either diagnosis code can be used with HCPCS code Z1034.
		Z32.3	Childcare instruction	
CPT code 59409	Vaginal Delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59409. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59612	Vaginal delivery after cesarean delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59612. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59620	Cesarean Delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59620. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59840	Abortion	Z33.1	Pregnant state, incremental	Only diagnosis code Z33.1 should be used with CPT code 59840.
HCPCS code T1033	Miscarriage	Z33.1	Pregnant state, incremental	Only diagnosis code Z33.1 should be used with HCPCS code T1033.
HCPCS code Z1038	Postpartum visit	Z39.0	Encounter for care and examination of mother immedidately after delivery	Any of the three diagnosis codes can be used with HCPCS code Z1038. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.1	Encounter for care and examination of lactating mother	
		Z39.2	Encounter for routine postpartum follow-up	
HCPCS code T1032	Postpartum Extended Visit	Z39.0	Encounter for care and examination of mother immedidately after delivery	Any of the three diagnosis codes can be used with HCPCS code T1032. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.1	Encounter for care and examination of lactating mother	
		Z39.2	Encounter for routine postpartum follow-up	

For instructions on how to complete a CMS1500 form, click here

To review the Medi-Cal Provider Manual on Doula Services, click here

To view the Medi-Cal Provider Bulletin, click here

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3028 (previously UP100328)				**Lead Department: Health Services**	
Policy/Procedure Title: Mental Health Services				☒**External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1995		**Next Review Date:** ~~08/14/2025~~01/08/2026 **Last Review Date:** ~~08/14/2024~~01/08/2025			
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**		☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**		☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**		☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**		☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~08/14/2024~~01/08/2025	

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
B. ADM52 – Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services
C. CMP36 – Delegation Oversight and Monitoring
D. MCUG3024 – Inpatient Utilization Management
E. MCUP3014 – Emergency Services
F. MCUP3101 – Screening and Treatment for Substance Use Disorders
G. MCUG3118 – Prenatal & Perinatal Care
H. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
~~H.~~I. MCQG1015 – Pediatric Preventive Health Guidelines

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Closed Loop Referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
B. Dyad: A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad.
C. Dyadic Services Benefit is a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified, and is designed to support the implementation of comprehensive models of dyadic care that work within the pediatric clinic setting to identify and address caregiver and family risk factors for the benefit of the child.
~~B.~~D. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's delegated managed behavioral healthcare organization is Carelon Behavioral Health.~~(MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California's (Partnership's) delegated managed behavioral healthcare organization is Carelon Behavioral Health.~~
~~C.~~E. (MCP) Managed Care Plan: Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to

provide and cover all medically necessary physical health and non-specialty mental health services.

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

~~E.~~G. Medical Necessity: Medically necessary services are reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

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

~~G.~~I. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services*
Managed Care Plans (MCPs) are required to provide or arrange for provision of the following NSMHS:

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

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

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

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:
   1. Members determined to require Non-Specialty Mental Health Services (NSMHS) are served by Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health at (855) 765-9703.
   2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County Mental Health Plan in the Member's county of residence. The administration of such

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

referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Mental Health Plan, consistent with California statutes and regulations.

3. DHCS requires MCPs and MHPs to use the Screening and Transition of Care Tools (Attachments A, B & C) for Members under age 21 (youth) and for Members age 21 and over (adults) to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services. The contents, including the specific wording and order of fields in the Adult and Youth Screening Tools and Transition of Care Tool, must remain intact and unchanged
   a. The Screening Tools (Attachments A & B) identify initial indicators of Member needs in order to make a determination for referral to either the Member's MCP (Partnership) for a clinical assessment and medically necessary NSMHS or the MHP for a clinical assessment and medically necessary SMHS.
      1) The Adult Screening Tool includes screening questions that are intended to elicit information about the following topics:
         a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
         b) Clinical Experiences: Information about whether the Member is currently receiving treatment, if they have sought treatment in the past, and their current or past use of prescription mental health medications.
         c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
         d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
         e) Questions related to substance use disorders (SUD): If a Member responds affirmatively to these SUD questions, they must be offered a referral to the county behavioral health plan or Partnership (for Members residing in one of the 7 counties participating in the Wellness and Recovery regional DMC-ODS program administered by Partnership) for SUD assessment. (*See also policy MCUP3101 Screening and Treatment for Substance Use Disorders*) The Member may decline this referral without impacting their mental health delivery system referral.
      2) The Youth Screening Tool includes screening questions that are intended to elicit information about the following topics:
         a) Safety: Information about whether the Member needs immediate attention and the reason(s) a Member is seeking services
         b) System Involvement: Information about whether the Member is currently receiving treatment, and if they have been involved in foster care, child welfare services, or the juvenile justice system.
         c) Life Circumstances: Information about challenges the Member may be experiencing such as issues related to school, work, relationships, housing, or other circumstances.
         d) Risk: Information about suicidality, self-harm, emergency treatment, and hospitalizations.
         e) SMHS access and referral of other services
   b. Adult and Youth Screening Tool questions must be asked in full using the specific wording provided in the tool and in the specific order the questions appear in the tools, to the extent that the Member is able to respond.
   c. The scoring methodology provided in the Adult Screening Tool and the Youth Screening Tool will determine whether the Member must be referred to the MCP or the MHP for clinical assessment and medically necessary services.
      1) Scoring methodologies within the Adult and Youth Screening Tools must be used to determine an overall score for each screened Member.
      2) MCPs must use the scoring methodology and follow the referral determination generated by the score.

a) For all referrals, the Member must be engaged in the process and appropriate consents must be obtained in accordance with accepted standards of clinical practice.
b) Referral coordination must include sharing the completed Adult or Youth Screening Tool and following up to ensure a timely clinical assessment has been made available to the Member.
c) The MCP must coordinate Member referrals with MHPs or directly to MHP providers delivering SMHS. MCPs may only refer directly to an MHP provider of SMHS if policies and procedures have been established and MOUs are in place with the MHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the Member.

d. The Adult and Youth Screening Tools are administered by Partnership's MBHO, Carelon Behavioral Health, and may be administered in a variety of ways, including in person, by telephone, or by video conference.
   1) The Screening Tools can be administered by clinicians or non-clinicians.
e. The Screening Tools are not required or intended for use with Members who are currently receiving mental health services.
f. The Screening Tools are also not required for use with Members who contact mental health providers directly to seek mental health services. Contracted mental health providers who are contacted directly by Members seeking mental health services may begin the assessment process and provide services during the assessment period without using the Screening Tools.
g. The Adult and Youth Screening Tools do not replace:
   1) MCP policies and procedures that address urgent or emergency care needs, including protocols for emergencies or urgent and emergent crisis referrals
   2) MCP protocols that address clinically appropriate, timely, and equitable access to care
   3) MCP clinical assessments, level of care determinations and service recommendations.
   4) MCP requirements to provide EPSDT services.
h. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a Member is referred to the MCP or MHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.
i. During the assessment period for both youth and adult Members, provision of and payment for NSMHS remain the responsibility of Partnership, even if Member is found to meet criteria for SMHS.

4. MCPs are required to administer the Transition of Care Tool (Attachment C) to facilitate transitions of care to MHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change. When there is a need to refer a Member between levels of care (SMHS and NSMHS), the Transition of Care Tool shall be completed by the treating clinical provider and submitted as part of the referral.
   a. The Transition of Care Tool is used for both adults and youth and is intended to document the Member's information and provide information from the entity making the referral to the receiving delivery system to begin the Member's care transition.
   b. The Transition of Care Tool may be completed in a variety of ways, including in person, by telephone, or by video conference, and is utilized to ensure Members that are receiving mental health services from one delivery system receive timely and coordinated care when their existing services are transitioned to another delivery system or when services need to be added to their existing mental health treatment from another delivery system.
   c. The Transition of Care Tool includes specific fields to document the following elements:
      1) Referring plan contact information and care team
      2) Member demographics and contact information
      3) Member behavioral health diagnosis, cultural and linguistic requests, presenting behaviors/symptoms, environmental factors, behavioral health history, medical history,

and medications
4) Requested services and plan contact information

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

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

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

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

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

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

as at other times of provider unavailability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. In accordance with California Welfare and Institutions Code (WIC) sections 14059.5 and 14184.402, services that are "medically necessary" or a "medical necessity" (see III.F.) to correct or ameliorate health conditions for Members under the age of 21 shall be in accordance with the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code (U.S.C.), which also includes NSMHS. These services are covered by Partnership as Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services (per policy MCCP2022) regardless of whether the services are covered in the state's Medicaid State Plan.

a. Consistent with federal guidance from Centers for Medicare & Medicaid Services (CMS),

behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.

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

G. Partnership provides or arranges for the provision of NSMHS including outpatient laboratory tests, medications, supplies and supplements prescribed by NSMHS mental health providers in-network and PCPs as follows:
   1. Partnership covers physician administered drugs administered by a health care professional in a clinic, physician's office, or outpatient setting through the medical benefit, to assess and treat mental health conditions
   2. Partnership does not cover pharmacy benefits and services pursuant to APL 22-012 *Revised* and the Medi-Cal Rx program. 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 Education & Outreach page at this website: https://medi-calrx.dhcs.ca.gov/home/education/

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

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

J. Partnership covers family therapy under Medi-Cal's NSMHS benefit, including for Members ages 20 or below who are at risk for behavioral health concerns and for whom clinical literature would support that the risk is significant such that family therapy is indicated, but may not have a mental health diagnosis. Family therapy is composed of at least two family members receiving therapy together provided by a mental health provider to improve parent/child or caregiver/child relationships and encourage bonding, resolving conflicts, and creating a positive home environment.
   1. All family members do not need to be present for each service.
   2. Members ages 20 or below may receive up to five family therapy sessions before a mental health diagnosis is required.
   3. Family therapy is delivered without regard to the five session limit for Members under age 21 with any of the following risk factors:
      a. mental health disorders or parents/caregivers with related risk factors, including separation from a parent/caregiver due to incarceration, immigration, or death
      b. foster care placement
      c. food insecurity
      d. housing instability

e. exposure to domestic violence or trauma
f. maltreatment
g. severe/persistent bullying
h. discrimination

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

~~K.~~L. Partnership is responsible for the provision of Medications for Addiction Treatment (MAT) in primary care, inpatient hospital, emergency departments, and other contracted medical settings as well as for emergency services necessary to stabilize the Member. *(see also policy MCUP3101 Screening and Treatment for Substance Use Disorders)*

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

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

1. Partnership provides information regarding mental health services for Members in the Partnership Medi-Cal Member Handbook as well as through Partnership's website www.partnershiphp.org. Applicable Member informing materials state that referral and prior authorization are not required for a Member to seek an initial mental health assessment from a network mental health provider.
2. Partnership covers the cost of an initial mental health assessment completed by an out-of-network provider only if there are no in-network providers that can complete the necessary service within the applicable timely access to care requirements.
3. Pursuant to DHCS requirements and the Memorandums of Understanding (MOU) template, Partnership will execute MOUs with County Mental Health Plans for the purpose of sharing clinical data in order to better coordinate care of Members, improve quality and meet the requirements of the Behavioral Health Quality Incentive Program (BHQIP). To the extent permitted by law, Partnership will exchange with county partners, member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health.

O. Dyadic Services Benefit

Partnership reimburses for all medically necessary mental health services pursuant to the Non-Specialty Mental Health Services: Psychiatric and Psychological Services section of the Medi-Cal Provider Manual. Dyadic Services is a new benefit pursuant to the Medi-Cal Provider Manual, APL 22-029 *Revised* and California Welfare and Institutions Code section 14132.755. Tribal health programs (THPs), Rural Health Clinics (RHCs), and Federal Qualified Health Centers (FQHCs) are eligible to receive their All-Inclusive Rate from the plans if Dyadic Care services are provided by a billable Provider.

1. Dyadic Services Provider Requirements and Qualifications
   a. Provider Types:

Dyadic caregiver services may be provided by the medical well-child provider in addition to the provider types listed below.

1) Dyadic Services may be provided by Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, and Psychiatrists.
2) Associate Marriage and Family Therapists, Associate Professional Clinical Counselors, Associate Clinical Social Workers, and Psychology Assistants may render services under a supervising clinician.
3) Appropriately trained nonclinical staff, including Community Health Workers (CHWs), are not precluded from screening Members for issues related to Social Drivers of Health (SDOH) or performing other nonclinical support tasks as a component of the Dyadic Behavioral Health (DBH) visit, as long as the screening is not separately billed.

b. Provider Requirements:
   1) Providers of Dyadic Services must be enrolled as a Medi-Cal provider AND
   2) Possess a National Provider Identifier (NPI) number that is entered in the 274 Network Provider File.

c. Reimbursement for Services:
   1) The delivery of these services and family therapy are considered non-specialty mental health services and are billable to Partnership's contracted MBHO (Carelon Behavioral Health).
   2) There are no prior authorization requirements nor will there be any unreasonable barriers to access and services.
   3) All Dyadic Services must be billed under the Medi-Cal ID of the Member ages 20 or below.

2. Member Eligibility Criteria for Dyadic Services
   a. Children (Members ages 20 or below) and their parent(s)/caregiver(s) are eligible for Dyadic Behavioral Health (DBH) well-child visits when delivered according to the Bright Futures/American Academy of Pediatrics periodicity schedule for behavioral/social/emotional screening assessment, and when medically necessary, in accordance with Medi-Cal's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards.
      1) Under EPSDT standards, a diagnosis is not required to qualify for services.
      2) DBH well-child visits are intended to be universal per the Bright Futures periodicity schedule for behavioral/social/emotional screening assessment. The DBH well-child visits do not need a particular recommendation or referral and must be offered as an appropriate service option even if the Member does not request them.
      3) The family is eligible to receive Dyadic Services so long as the child is enrolled in Medi-Cal. The parent(s) or caregiver(s) does not need to be enrolled in Medi-Cal or have other coverage so long as the care is for the direct benefit of the child.
3. Covered Dyadic Services
   a. MCPs may offer the Dyadic Services benefit through telehealth or in-person with locations in any setting including, but not limited to, pediatric primary care settings, doctor's offices or clinics, inpatient or outpatient settings in hospitals, the Member's home, school-based sites, or community settings.
   b. Encounters for Dyadic Services must be submitted with allowable current procedural terminology codes as outlined in the Medi-Cal Provider Manual.
   c. Multiple Dyadic Services are allowed on the same day and may be reimbursed at the fee-for-service (FFS) rate.
   d. Dyadic Services rendered by behavioral health staff are reimbursed when they have not been previously completed as part of the medical well child visit.
   e. Dyadic Caregiver Services, including screening, assessment, and brief intervention, may be billed either by the medical well child provider or the DBH provider, but not by both when rendered on

the same day.

f. Covered Dyadic Services are behavioral health services for children (Members ages 20 or below) and/or their parent(s) or caregiver(s), and include:
   1) DBH Well-Child Visits
      a) DBH well-child visits are provided for the child and caregiver(s) or parent(s) at medical visits. The DBH portion of the well-child visit must be limited to those services not already covered in the medical well-child visit.
      b) When possible and operationally feasible, the DBH well-child visit should occur on the same day as the medical well-child visit. When this is not possible, MCPs must ensure the DBH well-child visit is scheduled as close as possible to the medical well-child visit, consistent with timely access requirements.
      c) MCPs may deliver DBH well-child visits as part of the HealthySteps program, a different DBH program, or in a clinical setting without a certified DBH program as long as all of the following components are included:
         i. Behavioral health history for child and parent(s) or caregiver(s), including parent(s) or caregiver(s) interview addressing child's temperament, relationship with others, interests, abilities, and parent or caregiver concerns.
         ii. Developmental history of the child.
         iii. Observation of behavior of child and parent(s) or caregiver(s) and interaction between child and parent(s) or caregiver(s).
         iv. Mental status assessment of parent(s) or caregiver(s).
         v. Screening for family needs, which may include tobacco use, substance use, utility needs, transportation needs, and interpersonal safety, including guns in the home.
         vi. Screening for SDOH such as poverty, food insecurity, housing instability, access to safe drinking water, and community level violence.
         vii. Age-appropriate anticipatory guidance focused on behavioral health promotion/risk factor reduction, which may include:
            a. Educating parent(s) or caregiver(s) on how their life experiences (e.g., Adverse Childhood Experiences (ACEs) impact their child's development and their parenting.
            b. Educating parent(s) or caregiver(s) on how their child's life experiences (e.g., (ACEs) impact their child's development.
            c. Information and resources to support the child through different stages of development as indicated.
         viii. Making essential referrals and connections to community resources through care coordination and helping caregiver(s) prioritize needs.
   2) Dyadic Comprehensive Community Supports Services, separate and distinct from California Advancing and Innovating Medi-Cal's (CalAIM) Community Supports, help the child (Member ages 20 or below) and their parent(s) or caregiver(s) gain access to needed medical, social, educational, and other health-related services, and may include any of the following:
      a) Assistance in maintaining, monitoring, and modifying covered services, as outlined in the dyad's service plan, to address an identified clinical need.
      b) Brief telephone or face-to-face interactions with a person, family, or other involved member of the clinical team, for the purpose of offering assistance in accessing an identified clinical service.
      c) Assistance in finding and connecting to necessary resources other than covered services to meet basic needs.
      d) Communication and coordination of care with the child's family, medical and dental health care Providers, community resources, and other involved supports including educational, social, judicial, community and other state agencies.

e) Outreach and follow-up of crisis contacts and missed appointments.
f) Other activities as needed to address the dyad's identified treatment and/or support needs.

3) Dyadic Psychoeducational Services for psychoeducational services provided to the child age 20 or below and/or parent(s) or caregiver(s). These services must be planned, structured interventions that involve presenting or demonstrating information with the goal of preventing the development or worsening of behavioral health conditions and achieving optimal mental health and long-term resilience.
4) Dyadic Family Training and Counseling for Child Development for family training and counseling provided to both the child age 20 or below and parent(s) or caregiver(s). These services include brief training and counseling related to a child's behavioral issues, developmentally appropriate parenting strategies, parent/child interactions, and other related issues.
5) Dyadic Parent or Caregiver Services: Dyadic parent or caregiver services are services delivered to a parent or caregiver during a child's visit that is attended by the child and parent or caregiver, including the following assessment, screening, counseling, and brief intervention services provided to the parent or caregiver for the benefit of the child (Member ages 20 or below) as appropriate:
a) Brief Emotional/Behavioral Assessment
b) ACEs Screening
c) Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment
d) Depression Screening
e) Health Behavior Assessments and Interventions
~~a)~~f) Psychiatric Diagnostic Evaluation
~~b)~~g)Tobacco Cessation Counseling

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

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

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 10, Section 10.8.D
B. Medi-Cal Provider Manual/ Guidelines: Non-Specialty Mental Health Services: Psychiatric and Psychological Services *(non spec mental)*
C. Title 9 of the California Code of Regulations (CCR) Chapter 11
D. Title 9 CCR Sections 1820.205, 1830.205, 1830.210, 1850.505, 1850.515, 1850.525, 1850.535
E. Title 22 CCR Section 53855

F. Subpart K of Part 438 of Title 42 of the Code of Federal Regulations (CFR)
G. Title 42 United States Code (USC) § 1396d(r)(5)
H. Welfare and Institutions Codes (WIC) § 14059.5, 14132.03, 14184.402 § 14189
I. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
   a. Specialty Mental Health Services Memorandum of Understanding Template
   b. Substance Use Disorder Treatment Services Memorandum of Understanding Template
J. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
K. DHCS APL 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)
L. DHCS APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (04/08/2022)
M. DHCS APL 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)
N. DHCS, APL 22-029 *Revised* Dyadic Services & Family Therapy Benefit (03/20/2023)
~~M.~~O. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
~~N.~~P. Behavioral Health Information Notice (BHIN) 21-073
~~O.~~Q. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
~~County specific Mental Health Plan Memoranda of Understanding (MOUs)~~

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

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

X. REVISION DATES: 08/11/95; 10/10/97 (name change only); 06/21/00; 12/19/2001; 08/20/03, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 10/15/08; 04/21/10; 03/16/11; 08/15/12; 05/20/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 10/12/22; 06/14/23; 04/10/24; 08/14/24; 01/08/25

*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:

****

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3101</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Screening and Treatment for Substance Use Disorders</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/21/2012</td><td colspan="4">Next Review Date: ~~06/12/2025~~01/08/2026
Last Review Date: ~~06/12/2024~~01/08/2025</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: ~~06/12/2024~~01/08/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
B. MCUP3028 – Mental Health Services
C. MCQP1021 – Initial Health Appointment
D. MPQP1022 – Site Review Requirements and Guidelines
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MCQG1005 – Adult Preventive Health Guidelines
G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
H. CMP26 – Verification of Caller Identity and Release of Information.

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with "addiction." According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as "non-medical use" of prescription medications). The most common substance use disorders in the United States include the following:
   1. Alcohol Use Disorder
   2. Tobacco Use Disorder
   3. Cannabis Use Disorder
   4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
   5. Opioid Use Disorder

B. Unhealthy Alcohol Use (UAU): Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder

(e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:

1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks for adult men over a 2-hour period.
2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.

C. Standard Alcohol Drink (US definition): 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz "shot" of hard liquor (about 40% alcohol)

D. Unhealthy Drug Use (UDU): The United States Preventive Services Taskforce (USPSTF) defines UDU as "the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual." Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, ~~PHC~~Partnership expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.

E. Unhealthy Drug Use Screening (UDUS): According to USPSTF, UDUS is defined as "asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format." It does not refer to body fluid substance screening.

F. **SABIRT**: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment: An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:

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

SABIRT represents an expansion of SBIRT with the addition of "brief assessment" (e.g., use of a validated assessment tool to determine if unhealthy alcohol of drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.

G. Covered Program: pursuant to 42 CFR Part 2 §2.11, means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.

H. Records: pursuant to 42 CFR Part 2 §2.11, means any information, whether recorded or not, created by,

received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

IV. ATTACHMENTS:

A. Recommended Tools and Training Resources for SABIRT
B. Pocket Screening and Brief Intervention for Alcohol Use Disorders
~~C. Application to be a Contracted Brief Behavioral Counseling Intervention/Referral to Treatment Provider~~
~~D. Review Documentation for Applicants to become a Contracted Behavioral Counseling Intervention/ Referral to Treatment Provider~~
~~E.~~C. Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders

V. PURPOSE:

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

VI. POLICY / PROCEDURE:

A. Covered Services:
   1. Alcohol and Other Drug Treatment Services covered through the Counties:
      Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California's (~~PHC~~Partnership's) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
   2. Wellness and Recovery Benefit through ~~PHC~~Partnership:
      Effective July 1, 2020, ~~PHC~~Partnership ~~member~~Members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
      a. Member has been determined eligible for full scope Medi-Cal
      b. Member is not institutionalized
      c. Member has a substance-related and addictive disorder per the current "Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition" (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
      d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND
      e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County
   3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by ~~PHC~~Partnership medical providers should be billed to ~~PHC~~Partnership as any other encounter, using appropriate encounter and management CPT codes.
      a. Many of the medications used to treat addictions (often referred to as Medications for Addiction

Treatment, or [MAT]) require no special or additional training or certification.

1) Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder.
2) Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice.
    a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
    b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings.

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

c. Adjunctive counseling for SUD by non-licensed providers is not covered by ~~PHC~~Partnership, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the ~~member~~Member is a qualifying ~~member~~Member for SUD services through the Wellness and Recovery Program.

4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter (APL) 21-014. These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all ~~member~~Members aged 11 years and older, including pregnant ~~member~~Members.
    a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § 2.14 and may be released in compliance with ~~PHC~~Partnership policy CMP-26 Verification of Caller Identity and Release of Information.
5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of ~~member~~Members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy MCQG1005 Adult Preventive Health Guidelines.

B. ~~PHC~~Partnership Responsibility, Related to SUD Services

1. Identification
    a. ~~PHC~~Partnership may identify a ~~member~~Member in need of SUD services through one of the following:
        1) Telephone inquiries from Member or Provider
        2) During Prior Authorization and/or Concurrent Review Processes
        3) Through Care Coordination programs activity
        4) Through call center activities performed by ~~PHC~~Partnership's delegated managed behavioral health organization
2. Referral
    a. ~~PHC~~Partnership, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the ~~PHC~~Partnership website (see VI.C.8.c. below for details). If a placement within the Member's service area is not available, the ~~member~~Member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from ~~PHC~~Partnership is required for referral to outpatient substance use services. (Please note, in ~~PHC~~Partnership's Wellness & Recovery benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MCUP3144 Residential

Substance Use Disorder Treatment Authorization for further information.)

3. Coordination of Care
   a. ~~PHC~~Partnership will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of ~~member~~Members entering treatment for ~~outpatient~~ Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the ~~member~~Member's Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient's consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.
   b. Wherever possible, ~~PHC~~Partnership will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.

C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
   1. Overview.
      a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act's requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen ~~member~~Members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
      b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.
      c. Unhealthy Drug Use: Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as cocaine and heroin. However, studies have demonstrated significantly positive benefits from

various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

2. Non-Covered Services
   a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is "Have you consumed **any** beer, wine or other alcoholic beverage in the past year."
3. Covered Services
   a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to ~~PHC~~Partnership ~~member~~Members via the evidence of coverage and via ~~PHC~~Partnership's external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
      1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the ~~member~~Member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
      2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
      3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
   b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant ~~member~~Members, primary care includes clinicians caring for the pregnant ~~member~~Member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
   c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the ~~member~~Member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, ~~PHC~~Partnership contracted medical specialists and credentialed SUD counselors. PCPs may also utilize ~~PHC~~Partnership's delegated managed behavioral health organization using the referral forms and process described in ~~PHC~~Partnership policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting.~~. Any non-PCP provider or organization wanting to provide Brief Behavioral Counseling Intervention services needs to apply to PHC, and be approved by the Chief Medical Officer (CMO) or Medical Director designee. Attachment C is an application~~

~~form "Application to be a Contracted Brief Behavioral Counseling Intervention/Referral to Treatment Provider." Attachment D is the review documentation for applicants, with a checklist of review criteria. Each application will be reviewed by a Performance Improvement Clinical Specialist (PICS) who conducts site reviews in the Quality and Performance Improvement Department at~~ ~~PHC, whose findings and recommendations will be provided to the CMO or Medical Director Designee for final decision upon approval. Once a Provider or organization is approved as a subcontractor, no prior authorization for SABIRT services is required.~~

4. Training and Proficiency - Primary Care Providers
   Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:
   a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
      1) Licensed Physician
      2) Physician Assistant
      3) Nurse Practitioner
      4) Psychologist
   b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
      1) Licensed Marriage and Family Therapist
      2) Registered Nurse
      3) Certified Nurse Midwife
      4) Licensed Midwife
      5) Licensed Clinical Social Worker
      6) Licensed Professional Clinical Counselor
   c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.
   d. Other ~~member~~Members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
      1) They have at least 100 hours of clinical experience in their current role.
      2) They are trained to provide the services they are providing
      3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
   e. Providers must develop policies and procedures for SABIRT services. These should include:
      1) The PCP site will maintain a list of licensed and registered professionals and non-licensed ~~member~~Members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
      2) A quality assurance process for SABIRT services
      3) ~~PHC~~Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
   f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health Services at ~~PHC~~Partnership.

5. Training and Proficiency – ~~Contracted~~ Brief Behavioral Counseling Intervention/Referral to Treatment Providers
   a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
      1) Licensed Physician
      2) Physician Assistant
      3) Nurse Practitioner
      4) Psychologist
   b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
      1) Licensed Marriage and Family Therapist
      2) Registered Nurse
      3) Certified Nurse Midwife
      4) Licensed Midwife
      5) Licensed Clinical Social Worker
      6) Licensed Professional Clinical Counselor
   c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.
   d. Other ~~member~~Members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
      1) They have at least 100 hours of clinical experience in their current role.
      2) They are trained to provide the services they are providing
      3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
   e. ~~Contracted~~ Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services~~, which will be submitted and approved by PHC prior to providing services~~. These should include:
      1) The ~~Contracted~~ Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
      2) A quality assurance process for SABIRT services
      3) ~~PHC~~Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
6. Screening and Brief Assessment
   a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
   b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
   c. The screening and brief assessment process does not diagnose a disorder, but it does determine whether a problem exists. Providers should consider risks and benefits of administration of

screening and assessment tools, including discussion of these as part of informed consent, as well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.

d. Screening and Brief Assessment Tools
   1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.
   2) Note that a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:
      a) AUDIT (10 question screening and assessment)
      b) AUDIT-C (3 question screening also validated in pregnant individuals)
      c) NIAAA Single Alcohol Screening Question (SASQ)

7. Brief Intervention:
   i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to ~~member~~Members who are identified as having risky or hazardous alcohol use.
   b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the ~~member~~Member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
      1) Personalized feedback
      2) Education and resources
      3) Negotiated action plans
      4) Drinking use diaries, and
      5) Stress management.
   c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team ~~member~~Member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
      1) Feedback to the patient regarding screening and assessment results
      2) Discussion of negative consequences that have occurred and the overall severity of the problem
      3) Supporting the patient in making behavior changes
      4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
         a) Providers must make good faith efforts to confirm whether ~~member~~Members receive referred treatments and document when, where, and any next steps following treatment.

8. SABIRT Referral to Treatment
   a. No prior authorization is required for SABIRT services or for referral to ~~outpatient~~ services related to substance use or abuse.
   b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5, or those whose diagnoses are uncertain, should be referred for further evaluation and treatment.
   c. PCPs in counties without ~~PHC~~Partnership Wellness and Recovery coverage should refer

~~member~~Members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California county contacts for local substance use disorder treatment information and referrals can be found on the ~~PHC~~Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx under the heading "Alcohol and Drug Treatment." In ~~PHC~~Partnership Wellness and Recovery counties, the referral process is outlined on the ~~PHC~~Partnership website at this page: https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx. Referrals to treatment must be documented in the medical record.

9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the ~~member~~Member and the time spent with the ~~member~~Member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
    a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
    b. Documentation should also include:
        1) The service provided (e.g., screen and brief intervention)
        2) The name of the screening instrument and the score on the electronic health record
        3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
        4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
    a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
        1) Review ~~member~~Member's response to an age-appropriate, validated alcohol or drug use screening question
        2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
        3) Conduct Brief Behavioral Counseling Intervention sessions
        4) Refer ~~member~~Members with potential unhealthy alcohol or drug use and/or SUD for treatment
    b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
    c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
    a. The following billing codes should be used for billing SABIRT services to patients with:
        1) Medi-Cal and no other primary insurance coverage (such as Medicare):
            a) Annual alcohol misuse screening: G0442
            b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)
            c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050
        2) Medicare/Medi-Cal ~~member~~Members should have SABIRT billed through Medicare, using approved Medicare codes.

VII. REFERENCES:

A. For clinician support: NIAAA's Clinician Guide "Helping Patients Who Drink Too Much" provides two methods for screening: a "single question" to use during a clinical interview and a written self-report instrument (AUDIT). http://www.niaaa.nih.gov/guide

B. The AUDIT and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions https://www.samhsa.gov/national-coe-integrated-health-solutions
C. Quick reference guide for screening for drug use in general medical settings: screening_qr.pdf (nih.gov)
D. NIDA Quick Screen and NIDA Modified ASSIST: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf
E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings: https://www.who.int/publications/i/item/978924159938-2
F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: https://www.drugabuse.gov/taps/#/
G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification. J Addict Med. 2011 Sep;5(3):221-6.
H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a
I. Information on the Medicare SBIRT benefit and requirements: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf
J. Substance Abuse and Mental Health Services Administration (SAMHSA) website: https://www.samhsa.gov/disorders/substance-use
K. Operational Instructional Letter (OIL) 398-13
L. DHCS: All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
N. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
    1. Specialty Mental Health Services Memorandum of Understanding Template
    2. Substance Use Disorder Treatment Services Memorandum of Understanding Template
O. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)
P. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4), Part 2 §2.11 and § 2.14
Q. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
R. InterQual® Behavioral Health Criteria

VIII. DISTRIBUTION:

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

REVISION DATES: 03/21/12; 02/19/14; 06/18/14; 06/17/15; 04/20/16; 03/15/17; 08/16/17; *02/14/18; 08/08/18; 11/14/18; 11/13/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 06/14/23; 06/12/24; 01/08/25

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

Policy/Procedure Number: MCUP3101		Lead Department: Health Services
Policy/Procedure Title: Screening and Treatment for Substance Use Disorders		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/21/2012	**Next Review Date: 06/12/202501/08/2026** **Last Review Date: 06/12/202401/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO: N/A

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

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

The materials provided are guidelines used by ~~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

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
AUDIT NIDA - The Alcohol Use Disorders Identification Test (10 questions) ******Meets* **HEDIS** *measure for IHA*	X	X	NIDA DHCS NCQA				X		
AUDIT-C NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) ******Meets* **HEDIS** *measure for IHA*	X		NIDA NIAAA USPSTF DHCS	X			X		
SASQ NIAAA Single Alcohol Screening Question ******Meets* **HEDIS** *measure for IHA*	X		NIAAA USPSTF	X			X		
TAPS-1 Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
TAPS-2 Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
NIDA Quick Screen (4 questions) *(Recommended by DHCS,ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)*	X		NIDA DHCS USPSTF ACOG	X			X	X	X
NIDA-Modified ASSIST NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) *(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)*		X	NIDA DHCS USPSTF				X	X	X

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
DAST-10 Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
DAST-20 Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
4P's Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
4 P's Plus *(Plus includes additional questions about depression and domestic violence)*		X	ACOG	X			X	X	X
CRAFFT Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X *(Appropriate for non-pregnant adolescents)*		X	X	
MAST-G Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
PRO (Prenatal Risk Overview) *(Recommended by USPSTF but official website is no longer available)*			USPSTF	X			X	X	X

*As per VI.C.6.d.2) of policy MCUP3101, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
ACOG	The American College of Obstetricians and Gynecologists	Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
NCQA/ HEDIS	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH)	NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities • Underage and College Drinking Research • Treatment Navigator tool • Surveillance Reports and Epidemiologic Resources • Additional Reports and Resources
NIDA	National Institute on Drug Abuse	Screening and Assessment Tools: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2) https://sbirt.clinicalencounters.com/activity/sbirt-core/ • Four hour training: $49 per individual; group rates are available • CME/CE NYS OASAS Credit approved

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
SAMHSA	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings https://www.samhsa.gov/brss-tacs/video-trainings • Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:
USPSTF	United States Preventive Services Task Force	• Alcohol screening and intervention tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions • Unhealthy Drug Use Screening Tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening • USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation https://edhub.ama-assn.org/jn-learning/audio-player/18514824

Updated

A POCKET GUIDE FOR

Alcohol Screening and Brief Intervention

Updated 2005 Edition

This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide.*

Visit ***www.niaaa.nih.gov/guide*** for related professional support resources, including:

- patient education handouts
- preformatted progress notes
- animated slide show for training
- materials in Spanish

Or contact:

NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
(301) 443–3860
www.niaaa.nih.gov

NIAAA National Institute on Alcohol Abuse and Alcoholism

NATIONAL INSTITUTES OF HEALTH

HOW TO SCREEN FOR HEAVY DRINKING

STEP 1 Ask About Alcohol Use

Ask: Do you sometimes drink beer, wine, or other alcoholic beverages?

NO → Screening complete.

YES → **Ask the screening question about heavy drinking days:**

How many times in the past year have you had . . .

5 or more drinks in a day? *(for men)*

4 or more drinks in a day? *(for women)*

One standard drink is equivalent to 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

Is the answer 1 or more times?

NO →

- **Advise staying within these limits:**

  Maximum Drinking Limits

  For healthy **men up to age 65**—
  - no more than **4** drinks in a **day** AND
  - no more than **14** drinks in a **week**

  For healthy **women** (and healthy **men over age 65**)—
  - no more than **3** drinks in a **day** AND
  - no more than **7** drinks in a **week**
- **Recommend lower limits or abstinence** as indicated: for example, for patients who take **medications** that interact with alcohol, have a **health condition** exacerbated by alcohol, or are **pregnant** (advise abstinence)
- **Rescreen** annually

→ YES

- Your patient is an at-risk drinker. For a more complete picture of the drinking pattern, **determine the weekly average:**
  - On average, how many **days** a week do you have an alcoholic drink? ☐
  - On a typical drinking day, how many **drinks** do you have? ☐
  - **Weekly average** ☐
- **Record** heavy drinking days in past year and weekly average in chart.

→ **GO TO STEP 2**

HOW TO ASSESS FOR ALCOHOL USE DISORDERS

STEP 2 Assess For Alcohol Use Disorders

Next, determine if there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment* or *distress*.

Determine whether, in the past 12 months, your patient's drinking has **repeatedly** caused or contributed to

- ☐ **risk** of bodily harm (drinking and driving, operating machinery, swimming)
- ☐ **relationship** trouble (family or friends)
- ☐ **role failure** (interference with home, work, or school obligations)
- ☐ **run-ins** with the law (arrests or other legal problems)

If yes to **one or more** → your patient has **alcohol abuse**.

In either case, proceed to assess for dependence symptoms.

Determine whether, in the past 12 months, your patient has

- ☐ **not been able to cut down or stop** (repeated failed attempts)
- ☐ **not been able to stick to drinking limits** (repeatedly gone over them)
- ☐ **shown tolerance** (needed to drink a lot more to get the same effect)
- ☐ **shown signs of withdrawal** (tremors, sweating, nausea, or insomnia when trying to quit or cut down)
- ☐ **kept drinking despite problems** (recurrent physical or psychological problems)
- ☐ **spent a lot of time drinking** (or anticipating or recovering from drinking)
- ☐ **spent less time on other matters** (activities that had been important or pleasurable)

If yes to **three or more** → your patient has **alcohol dependence**.

Does patient meet criteria for abuse or dependence?

NO → **GO TO STEPS 3 & 4 for AT-RISK DRINKING**

YES → **GO TO STEPS 3 & 4 for ALCOHOL USE DISORDERS**

HOW TO CONDUCT A BRIEF INTERVENTION

FOR AT-RISK DRINKING (no abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Gauge readiness to change drinking habits.**

Is patient ready to commit to change?

NO →
- **Restate your concern.**
- **Encourage reflection.**
- **Address barriers to change.**
- **Reaffirm your willingness to help.**

YES →
- **Help set a goal.**
- **Agree on a plan.**
- **Provide educational materials.** (See *www.niaaa.nih.gov/guide.*)

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support positive change** and address barriers.
- **Renegotiate goal and plan;** consider a trial of abstinence.
- **Consider engaging significant others.**
- **Reassess diagnosis** if patient is unable to either cut down or abstain.

YES →
- **Reinforce and support continued adherence** to recommendations.
- **Renegotiate drinking goals** as indicated (e.g., if the medical condition changes or if an abstaining patient wishes to resume drinking).
- **Encourage to return** if unable to maintain adherence.
- **Rescreen** at least annually.

FOR ALCOHOL USE DISORDERS (abuse or dependence)

STEP 3 Advise and Assist

- **State your conclusion and recommendation clearly** and relate them to medical concerns or findings.
- **Negotiate a drinking goal.**
- **Consider evaluation by an addiction specialist.**
- **Consider recommending a mutual help group.**
- For patients who have dependence, **consider**
  - the need for **medically managed withdrawal** (detoxification) and treat accordingly.
  - prescribing a **medication** for alcohol dependence for patients who endorse abstinence as a goal.
- **Arrange followup appointments**, including medication management support if needed.

STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.

Was patient able to meet and sustain drinking goal?

NO →
- **Acknowledge that change is difficult.**
- **Support efforts** to cut down or abstain.
- **Relate drinking to ongoing problems** as appropriate.
- **Consider** (if not yet done):
  - consulting with an **addiction specialist.**
  - recommending a **mutual help group.**
  - engaging **significant others.**
  - prescribing a **medication** for alcohol-dependent patients who endorse abstinence as a goal.
- **Address coexisting disorders**—medical and psychiatric—as needed.

YES →
- **Reinforce and support continued adherence.**
- **Coordinate care** with specialists as appropriate.
- **Maintain medications** for alcohol dependence for at least 3 months and as clinically indicated thereafter.
- **Treat coexisting nicotine dependence.**
- **Address coexisting disorders**—medical and psychiatric—as needed.

WHAT'S A STANDARD DRINK?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz.  5% alcohol	• 12 oz. = 1 • 16 oz. = 1.3 • 22 oz. = 2 • 40 oz. = 3.3
MALT LIQUOR	
8–9 oz.  7% alcohol	• 12 oz. = 1.5 • 16 oz. = 2 • 22 oz. = 2.5 • 40 oz. = 4.5
TABLE WINE	
5 oz.  12% alcohol	• a 750-mL (25-oz.) bottle = 5
80-proof SPIRITS (hard liquor)	
1.5 oz.  40% alcohol	• a mixed drink = 1 or more* • a pint (16 oz.) = 11 • a fifth (25 oz.) = 17 • 1.75 L (59 oz.) = 39

***Note:** Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

DRINKING PATTERNS

WHAT'S YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
Based on the following limits—number of drinks: On any **DAY**—Never more than **4** (men) or **3** (women) **– and –** In a typical **WEEK**—No more than **14** (men) or **7** (women)	**Percentage of U.S. adults aged 18 or older***	**Combined prevalence of alcohol abuse and dependence**
Never exceed the daily or weekly limits (2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)	 **72%**	fewer than **1 in 100**
Exceed only the daily limit (More than 8 out of 10 in this group exceed the daily limit *less than once a week*)	 **16%**	**1 in 5**
Exceed both daily and weekly limits (8 out of 10 in this group exceed the daily limit *once a week or more*)	**10%**	almost **1 in 2**

*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Source: 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide NIAAA survey of 43,093 U.S. adults aged 18 or older.

PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 16 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit *http://medlineplus.gov*.

	Naltrexone (Depade®, ReVia®)	**Extended-Release Injectable Naltrexone** (Vivitrol®)	**Acamprosate** (Campral®)	**Disulfiram** (Antabuse®)
Action	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
Contraindications	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
Precautions	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required, and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see *www.niaaa.nih.gov/guide*.
Serious adverse reactions	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
Common side effects	Nausea; vomiting; decreased appetite; headache; dizziness; fatigue; somnolence; anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea; somnolence.	Metallic after-taste; dermatitis; transient mild drowsiness.
Examples of drug interactions	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
Usual adult dosage	*Oral dose:* 50 mg daily. *Before prescribing:* Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, a naloxone challenge test should be employed. Evaluate liver function. *Laboratory followup:* Monitor liver function.	*IM dose:* 380 mg given as a deep intramuscular gluteal injection, once monthly. *Before prescribing:* Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition. *Laboratory followup:* Monitor liver function.	*Oral dose:* 666 mg (two 333-mg tablets) three times daily; *or* for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily. *Before prescribing:* Evaluate renal function. Establish abstinence.	*Oral dose:* 250 mg daily (range 125 mg to 500 mg). *Before prescribing:* Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash). *Laboratory followup:* Monitor liver function.

Note: Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

Application to be a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider For Partnership HealthPlan of California

Name of Organization:_____

Address and Phone Number of Organization: _____

_____

Organizational Contact for Questions: Name: _____

Email:_____

- Primary Care Organization(s) that will be referring patients for Brief Behavioral Counseling Intervention/Referral to Treatment:

  Name of Organization(s) (or individual clinicians if in solo/small group practice)

  _____

  City and County where organization(s) located:

  _____

- List of clinicians who will be performing Brief Behavioral Counseling Intervention and Referral to Therapy services
  - Name
  - Licensure Type
  - SABIRT-related Training [description of training, length of training related to Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)]
- Submit Organizational Policy/Procedures describing how Brief Behavioral Counseling Intervention and Referral to Treatment will be performed, including training requirements, flow of patients, and Quality Assurance related to SABIRT services.
- Submit 3 samples (with patient identifying details redacted) of clinical documentation for Brief Behavioral Counseling Intervention.

<u>Attestation of Supervising Physician or Psychologist</u>:

I attest that I oversee Brief Behavioral Counseling Intervention and Referral to Treatment services for alcohol misuse/use disorder or substance use disorder for adults, performed at my institution for patients referred by local Primary Care Providers. I will assure that the staff above are well trained and competent at performing these services. I certify that the above application is accurate.

Name of Supervising Clinician:_____

Title of Supervising Clinician:_____

Date of Signature:_____

Opportunities & Indications for Screening Youth for Alcohol Use

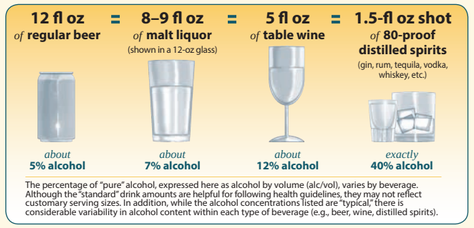
- As part of an **annual examination**
- As part of an **acute care visit**
- In the **emergency department** or urgent care center
- **When seeing patients who:**
  - you **have not seen in a while**
  - are likely to drink, such as youth who **smoke cigarettes**
  - have **conditions associated with increased risk** for substance abuse, such as:
    - depression
    - anxiety
    - ADD/ADHD
    - conduct problems
  - have **health problems that might be alcohol related**, such as:
    - accidents or injury
    - sexually transmitted infections or unintended pregnancy
    - changes in eating or sleeping patterns
    - gastrointestinal disturbances
    - chronic pain
  - show **substantial behavioral changes**, such as:
    - increased oppositional behavior
    - significant mood changes
    - loss of interest in activities
    - change of friends
    - a drop in grade point average
    - large number of unexcused absences in school

1 in 3 children start drinking by the end of 8th grade. Of them, half report having been drunk.

You are in a prime position to help your patients avoid alcohol related harm.

What Counts as a Drink? A Binge?

The drinks shown below are different sizes, but each one has about the same amount of pure alcohol (14 grams or 0.6 fluid ounce) and counts as a single "standard" drink. These serve as examples; alcohol content can vary greatly across different types of beer, malt liquor, and wine.



The percentage of "pure" alcohol, expressed here as alcohol by volume (alc/vol), varies by beverage. Although the "standard" drink amounts are helpful for following health guidelines, they may not reflect customary serving sizes. In addition, while the alcohol concentrations listed are "typical," there is considerable variability in alcohol content within each type of beverage (e.g., beer, wine, distilled spirits).

Below is the approximate number of standard drinks in different-sized containers of:

regular beer	malt liquor	table wine	80-proof distilled spirits
12 fl oz = **1**	12 fl oz = **1.5**	5-fl oz glass = **1**	a shot *(1.5 oz)* = **1**
16 fl oz = **1.3**	16 fl oz = **2**	25 fl oz = **5**	750 ml *(a "fifth")* = **17**
40 fl oz = **3.3**	40 fl oz = **4.5**	*(a regular 750-ml bottle)*	1.75 L *(a "handle")* = **39**

What kinds of alcohol are kids drinking these days?

All kinds, with variations by region and fad. In many areas, distilled spirits appear to be gaining on or overtaking beer and "flavored alcohol beverages" in popularity among youth, whereas wine appears less preferred. Young people are also mixing alcohol with caffeine, either in premixed drinks or by adding liquor to energy drinks. With this dangerous combination, drinkers may feel somewhat less drunk than if they'd had alcohol alone, but they are just as impaired and more likely to take risks.

What's a "child-sized" or "teen-sized" binge?

Boys		Girls	
Ages **9–13**	3 drinks	Ages **9–17**	3 drinks
Ages **14–15**	4 drinks		
Ages **16+**	5 drinks		

See the full Guide, page 15, for details about these estimates.

Brief Intervention & Referral Resources

Four Basic Principles of Motivational Interviewing:

- **Express Empathy** with a warm, nonjudgmental stance, active listening, and reflecting back what is said.
- **Develop Discrepancy** between the patient's choice to drink and his or her goals, values, or beliefs.
- **Roll with Resistance** by acknowledging the patient's viewpoint, avoiding a debate, and affirming autonomy.
- **Support Self-efficacy** by expressing confidence and pointing to strengths and past successes.

For more information, see the full Guide, page 29, or visit:

- www.motivationalinterview.org
- www.motivationalinterview.net

To Find Local Specialty Treatment Options:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospitals and mental health service organizations.
- Contact the Substance Abuse Facility Treatment Locator (seek centers specializing in adolescents) at 1–800–662–HELP or visit www.findtreatment.samhsa.gov.
- For more suggestions, see the full Guide, p. 34.

List your local resources below.

Questions About Providing Confidential Health Care to Youth?

All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol. See the full Guide, page 25, for more information.

For details specific to your specialty and State:

- See confidentiality policy statements from professional organization(s):
  - American Academy of Pediatrics
  - American Academy of Family Physicians
  - Society for Adolescent Health and Medicine
  - American Medical Association
- Contact your State medical society for information on your State's laws.
- Visit the Center for Adolescent Health and the Law for monographs on minor consent laws professional association policies: www.cahl.org.

This Pocket Guide was produced by the National Institute on Alcohol Abuse and Alcoholism in collaboration with the American Academy of Pediatrics.

NIH National Institute on Alcohol Abuse and Alcoholism

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Order copies of this Pocket Guide, along with the full 40-page Guide, from **www.niaaa.nih.gov/YouthGuide** or call 1-888-MY-NIAAA (888-696-4222)

A POCKET GUIDE FOR

ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH

2011 Edition

This pocket guide is condensed from the NIAAA Guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide.* It was produced in collaboration with the American Academy of Pediatrics.

To order more copies of this Pocket Guide, or sets with the full 40-page Guide and the Pocket Guide, and for related professional support resources, visit **www.niaaa.nih.gov/YouthGuide** or contact the NIAAA Publications Distribution Center
P.O. Box 10686, Rockville, MD 20849-0686
301–443–3860

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

NIH National Institute on Alcohol Abuse and Alcoholism

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*For **ALL** Patients…*

STEP 1: Ask the Two Screening Questions

For elementary and middle school patients, start with the friends' question. Choose the questions that align with the patient's school level, as opposed to age, for patients ages 11 or 14. Exclude alcohol use for religious purposes.

Elementary School (ages 9–11)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: Any drinking?
"How about you—have you ***ever*** had more than a few sips of any drink containing alcohol?"

ANY drinking:
Highest Risk

Middle School (ages 11–14)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: How many days?
"How about you—in the ***past year***, **on how many days** have you had more than a few sips of any drink containing alcohol?"

ANY drinking:
Moderate or **Highest Risk**
(depending on age and frequency)

High School (ages 14–18)

Patient: How many days?
"In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"

Lower, **Moderate**, or **Highest Risk**
(depending on age and frequency)

Friends: How much?
"If your friends drink, **how many drinks** do they usually drink on an occasion?"

Binge drinking by friends heightens concern.
(See "What Counts as a Drink? A Binge?" on reverse)

*For Patients Who **DO NOT** Drink…*

STEP 2: Guide Patient

Do friends drink?

NO

Neither patient nor patient's friends drink

- **Praise choices** of not drinking and of having nondrinking friends.

YES

Patient does not drink, but friends do

- **Praise choice** of not drinking.
- **Consider probing a little** using a neutral tone: "When your friends were drinking, you didn't drink. Tell me more about about that." If the patient admits to drinking, go to Step 2 for Patients Who Do Drink; otherwise, see below.

- **Reinforce healthy choices** with praise and encouragement.
- **Elicit and affirm reasons** to stay alcohol free.
- **Educate**, if the patient is open, about drinking risks related to brain development and later alcohol dependence.

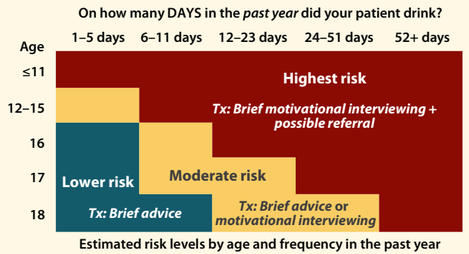
- **Rescreen next year** at the latest.

- **Explore** how your patient plans to stay alcohol free when friends drink.
- **Advise** against riding in car with driver who has been drinking or using drugs.
- **Rescreen** at next visit.

ASSESSMENT COMPLETE for patients who do not drink.

*For Patients Who **DO** Drink…*

STEP 2: Assess Risk



Estimated risk levels by age and frequency in the past year

Factor in friends:

- **For elementary and middle school students:** Having friends who drink heightens concern.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender (see "What Counts as a Drink? A Binge?" on reverse).

Include what you already know about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- **Ask about the drinking pattern:** *"How much do you usually have? What's the most you've had at any one time?"* If patient reports bingeing, ask: *"How often do you drink that much?"*
- **Ask about problems experienced or risks taken:** Examples include getting lower grades or missing classes; drinking and driving or riding in a car driven by someone who has been drinking; having unplanned, unsafe sex; getting into fights; getting injured; having memory blackouts; and passing out.
- **Ask whether the patient has used anything else to get high in the past year**, and consider using other formal tools to help gauge risk.

STEP 3: Advise and Assist

Lower Risk:

- **Provide brief advice** to stop drinking.
- **Notice the good:** Reinforce strengths and healthy decisions.
- **Explore and troubleshoot** influence of friends who drink.

Moderate Risk:

- **Does patient have alcohol-related problems**?
  - **If no**, provide beefed-up brief advice.
  - **If yes**, conduct brief motivational interviewing.
- **Ask if parents know** (see Highest Risk, below, for suggestions).
- **Arrange for followup**, ideally within a month.

Highest Risk:

- **Conduct brief motivational interviewing.**
- **Ask if parents know …**
  - **If no**, consider breaking confidentiality to engage parent.
  - **If yes**, ask patient permission to speak with parent.
- **Consider referral** for further evaluation or treatment.
- **If you observe signs of acute danger** (e.g., drinking and driving, binge drinking, or using alcohol with other drugs) **take immediate steps to ensure safety**.
- **Arrange for followup** within a month.

FOR ALL PATIENTS WHO DRINK

- **Collaborate on a personal goal and action plan** for your patient. Refer to page 31 in the full Guide for sample abstinence, cutting back, and contingency plans. For some patients, the goal will be accepting a referral to specialized treatment.
- **Advise your patient not to drink and drive or ride in a car with an impaired driver.**
- **Plan a full psychosocial interview** for the next visit if needed.

STEP 4: At Followup, Continue Support

Was patient able to meet and sustain goal(s)?

Patients may not return for an alcohol-specific followup, but they may do so for other reasons. In either case, **ask about alcohol use and any associated problems**. Review the patient's goal(s) and assess whether he or she was able to meet and sustain them.

No, patient was not able to meet/sustain goal(s):

- **Reassess** the risk level (see Step 2 for drinkers).
- **Acknowledge** that change is difficult, that it's normal not to be successful on the first try, and that reaching a goal is a learning process.
- **Notice the good by:**
  - **praising** honesty and efforts.
  - **reinforcing** strengths.
  - **supporting** any positive change.
- **Relate drinking to associated consequences or problems** to enhance motivation.
- **Identify and address challenges and opportunities** in reaching the goal.
- If the following measures are not already under way, **consider**:
  - **engaging** parents.
  - **referring** for further evaluation.
- **Reinforce** the importance of the goal(s) and plan and **renegotiate** specific steps, as needed.
- **Conduct, complete, or update** the comprehensive psychosocial interview.

Yes, patient was able to meet/sustain goal(s):

- **Reinforce and support** continued adherence to recommendations.
- **Notice the good:** Praise progress and reinforce strengths and healthy decisions.
- **Elicit future goals** to build on prior ones.
- **Conduct, complete, or update** the comprehensive psychosocial interview.
- **Rescreen** at least annually.

Review Documentation for Applicants to Become a Contracted Brief Behavioral Counseling Intervention/ Referral to Treatment Provider

To be completed by PHC staff:

Name of Organization:_____Date submitted:_____

Criteria (Internal Checklist)

_____Licensed Clinicians need to be Credentialed with PHC or Carelon Behavioral Health (formerly known as Beacon)

_____Must be a Medi-Cal Provider, in good standing

_____Must set up electronic billing with PHC

_____Must fulfill all parts of the MCUP3101 policy regarding training, proficiency, standards, quality assurance processes etc. for the Brief Behavioral Counseling Intervention benefit

_____Must have referral relationship with PHC PCPs performing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) services

_____Confirm adequacy of documentation of SABIRT

_____Application Complete

_____Attestation signed

Reviewed by Name:_____

Title:_____Date:_____

Signature:_____

Opportunities & Indications for Screening Youth for Alcohol Use

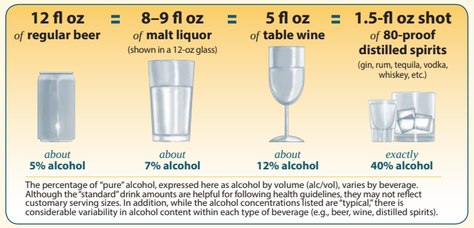
- As part of an **annual examination**
- As part of an **acute care visit**
- In the **emergency department** or urgent care center
- **When seeing patients who:**
  - you **have not seen in a while**
  - are likely to drink, such as youth who **smoke cigarettes**
  - have **conditions associated with increased risk** for substance abuse, such as:
    - depression
    - anxiety
    - ADD/ADHD
    - conduct problems
  - have **health problems that might be alcohol related**, such as:
    - accidents or injury
    - sexually transmitted infections or unintended pregnancy
    - changes in eating or sleeping patterns
    - gastrointestinal disturbances
    - chronic pain
  - show **substantial behavioral changes**, such as:
    - increased oppositional behavior
    - significant mood changes
    - loss of interest in activities
    - change of friends
    - a drop in grade point average
    - large number of unexcused absences in school

1 in 3 children start drinking by the end of 8th grade. Of them, half report having been drunk.

You are in a prime position to help your patients avoid alcohol related harm.

What Counts as a Drink? A Binge?

The drinks shown below are different sizes, but each one has about the same amount of pure alcohol (14 grams or 0.6 fluid ounce) and counts as a single "standard" drink. These serve as examples; alcohol content can vary greatly across different types of beer, malt liquor, and wine.



Below is the approximate number of standard drinks in different-sized containers of:

regular beer	malt liquor	table wine	80-proof distilled spirits
12 fl oz = **1**	12 fl oz = **1.5**	5-fl oz glass = **1**	a shot *(1.5 oz)* = **1**
16 fl oz = **1.3**	16 fl oz = **2**	25 fl oz = **5**	750 ml *(a "fifth")* = **17**
40 fl oz = **3.3**	40 fl oz = **4.5**	*(a regular 750-ml bottle)*	1.75 L *(a "handle")* = **39**

What kinds of alcohol are kids drinking these days?

All kinds, with variations by region and fad. In many areas, distilled spirits appear to be gaining on or overtaking beer and "flavored alcohol beverages" in popularity among youth, whereas wine appears less preferred. Young people are also mixing alcohol with caffeine, either in premixed drinks or by adding liquor to energy drinks. With this dangerous combination, drinkers may feel somewhat less drunk than if they'd had alcohol alone, but they are just as impaired and more likely to take risks.

What's a "child-sized" or "teen-sized" binge?

Boys		Girls	
Ages **9–13**	3 drinks	Ages **9–17**	3 drinks
Ages **14–15**	4 drinks		
Ages **16+**	5 drinks		

See the full Guide, page 15, for details about these estimates.

Brief Intervention & Referral Resources

Four Basic Principles of Motivational Interviewing:

- **Express Empathy** with a warm, nonjudgmental stance, active listening, and reflecting back what is said.
- **Develop Discrepancy** between the patient's choice to drink and his or her goals, values, or beliefs.
- **Roll with Resistance** by acknowledging the patient's viewpoint, avoiding a debate, and affirming autonomy.
- **Support Self-efficacy** by expressing confidence and pointing to strengths and past successes.

For more information, see the full Guide, page 29, or visit

- www.motivationalinterview.org
- www.motivationalinterview.net

To Find Local Specialty Treatment Options:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospitals and mental health service organizations.
- Contact the Substance Abuse Facility Treatment Locator (seek centers specializing in adolescents) at 1–800–662–HELP or visit www.findtreatment.samhsa.gov.
- For more suggestions, see the full Guide, p. 34.

List your local resources below.

Questions About Providing Confidential Health Care to Youth?

All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol. See the full Guide, page 25, for more information.

For details specific to your specialty and State:

See confidentiality policy statements from professional organization(s):

- American Academy of Pediatrics
- American Academy of Family Physicians
- Society for Adolescent Health and Medicine
- American Medical Association

- Contact your State medical society for information on your State's laws.
- Visit the Center for Adolescent Health and the Law for monographs on minor consent laws professional association policies: www.cahl.org.

This Pocket Guide was produced by the National Institute on Alcohol Abuse and Alcoholism in collaboration with the American Academy of Pediatrics.

NIH National Institute on Alcohol Abuse and Alcoholism

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Order copies of this Pocket Guide, along with the full 40-page Guide, from **www.niaaa.nih.gov/YouthGuide** or call 1-888-MY-NIAAA (888-696-4222)

A POCKET GUIDE FOR

ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH

2011 Edition

This pocket guide is condensed from the NIAAA Guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide.* It was produced in collaboration with the American Academy of Pediatrics.

To order more copies of this Pocket Guide, or sets with the full 40-page Guide and the Pocket Guide, and for related professional support resources, visit **www.niaaa.nih.gov/YouthGuide** or contact the NIAAA Publications Distribution Center P.O. Box 10686, Rockville, MD 20849-0686 301–443–3860

NIH National Institute on Alcohol Abuse and Alcoholism

NIH Publication No. 11-7806
Revised October 2015

*For **ALL** Patients…* | *For Patients Who **DO NOT** Drink…* | *For Patients Who **DO** Drink…*

STEP 1: Ask the Two Screening Questions

For elementary and middle school patients, start with the friends' question. Choose the questions that align with the patient's school level, as opposed to age, for patients ages 11 or 14. Exclude alcohol use for religious purposes.

Elementary School (ages 9–11)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: Any drinking?
"How about you—have you ***ever*** had more than a few sips of any drink containing alcohol?"

ANY drinking:
Highest Risk

Middle School (ages 11–14)

Friends: Any drinking?
"Do you have any friends who drank beer, wine, or any drink containing alcohol in the ***past year***?"

ANY drinking by friends heightens concern.

Patient: How many days?
"How about you—in the ***past year***, **on how many days** have you had more than a few sips of any drink containing alcohol?"

ANY drinking:
Moderate or **Highest Risk**
(depending on age and frequency)

High School (ages 14–18)

Patient: How many days?
"In the ***past year***, **on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"

Lower, **Moderate**, or **Highest Risk**
(depending on age and frequency)

Friends: How much?
"If your friends drink, **how many drinks** do they usually drink on an occasion?"

Binge drinking by friends heightens concern.
(See "What Counts as a Drink? A Binge?" on reverse)

STEP 2: Guide Patient

Do friends drink?

NO

Neither patient nor patient's friends drink

- **Praise choices** of not drinking and of having nondrinking friends.

YES

Patient does not drink, but friends do

- **Praise choice** of not drinking.
- **Consider probing a little** using a neutral tone: "When your friends were drinking, you didn't drink. Tell me more about about that." If the patient admits to drinking, go to Step 2 for Patients Who Do Drink; otherwise, see below.

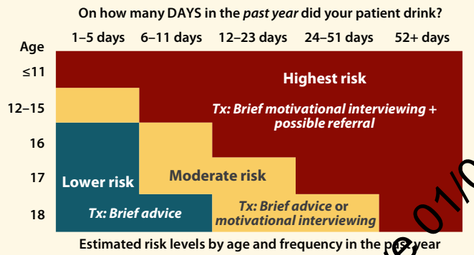
- **Reinforce healthy choices** with praise and encouragement.
- **Elicit and affirm reasons** to stay alcohol free.
- **Educate**, if the patient is open, about drinking risks related to brain development and later alcohol dependence.

- **Rescreen next year** at the latest.

- **Explore** how your patient plans to stay alcohol free when friends drink.
- **Advise** against riding in car with driver who has been drinking or using drugs.
- **Rescreen** at next visit.

ASSESSMENT COMPLETE for patients who do not drink.

STEP 2: Assess Risk



Estimated risk levels by age and frequency in the past year

Factor in friends:

- **For elementary and middle school students:** Having friends who drink heightens concern.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender (see "What Counts as a Drink? A Binge?" on reverse).

Include what you already know about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

For moderate and highest risk patients:

- **Ask about the drinking pattern:** *"How much do you usually have? What's the most you've had at any one time?"* If patient reports bingeing, ask: *"How often do you drink that much?"*
- **Ask about problems experienced or risks taken:** Examples include getting lower grades or missing classes; drinking and driving or riding in a car driven by someone who has been drinking; having unplanned, unsafe sex; getting into fights; getting injured; having memory blackouts; and passing out.
- **Ask whether the patient has used anything else to get high in the past year**, and consider using other formal tools to help gauge risk.

STEP 3: Advise and Assist

Lower Risk:

- **Provide brief advice** to stop drinking.
- **Provide the good:** Reinforce strengths and healthy decisions.
- **Explore and troubleshoot** influence of friends who drink.

Moderate Risk:

- **Does patient have alcohol-related problems**?
  - **If no**, provide beefed-up brief advice.
  - **If yes**, conduct brief motivational interviewing.
- **Ask if parents know** (see Highest Risk, below, for suggestions).
- **Arrange for followup**, ideally within a month.

Highest Risk:

- **Conduct brief motivational interviewing.**
- **Ask if parents know …**
  - **If no**, consider breaking confidentiality to engage parent.
  - **If yes**, ask patient permission to speak with parent.
- **Consider referral** for further evaluation or treatment.
- **If you observe signs of acute danger** (e.g., drinking and driving, binge drinking, or using alcohol with other drugs) **take immediate steps to ensure safety**.
- **Arrange for followup** within a month.

FOR ALL PATIENTS WHO DRINK

- **Collaborate on a personal goal and action plan** for your patient. Refer to page 31 in the full Guide for sample abstinence, cutting back, and contingency plans. For some patients, the goal will be accepting a referral to specialized treatment.
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- **Relate drinking to associated consequences or problems** to enhance motivation.
- **Identify and address challenges and opportunities** in reaching the goal.
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- **Reinforce and support** continued adherence to recommendations.
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- **Elicit future goals** to build on prior ones.
- **Conduct, complete, or update** the comprehensive psychosocial interview.
- **Rescreen** at least annually.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3131</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Genetic Screening and Diagnostics</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/19/2015</td><td colspan="4">Next Review Date: ~~10/11/2024~~01/08/2026
Last Review Date: ~~10/11/2023~~01/08/2025</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: ~~10/11/2023~~01/08/2025</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:
A. Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment.
B. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Multianalyte Assays with Algorithmic Analyses (MAAA): Procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays and non-nucleic acid-based assays (for example, proteins, polypeptides, lipids, carbohydrates).
D. Proprietary Lab Analyses (PLA): A range of proprietary laboratory services and tests which may include, but is not limited to, multianalyte assays with algorithmic analyses (MAAA) and genomic sequencing procedures (GSP).

IV. ATTACHMENTS:
A. Genetic Testing Requirements
B. Family History Screening Tool
C. Proprietary Laboratory Analyses (PLA) Requirements

V. PURPOSE:
To provide criteria for medical necessity and benefit coverage of genetic testing. Genetic testing is a rapidly expanding aspect of medical care which can be useful for diagnosing disease, guiding treatment, and/or identifying possible genetic risks for development of disease. Given the rapid evolution of this field, it is impossible to establish guidelines to reliably inform when genetic testing is appropriate which will remain valid for a significant time frame. Therefore, the purpose of this policy is to describe the criteria for evaluating requests for genetic testing, and to cite the external professional resources on which we will rely to make coverage determination.

Policy/Procedure Number: MCUP3131		Lead Department: Health Services
Policy/Procedure Title: Genetic Screening and Diagnostics		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/19/2015	**Next Review Date: 10/11/202401/08/2026** **Last Review Date: 10/11/202301/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. Genetic testing generally aims to achieve one of the following goals:
   1. Confirm the diagnosis of a genetic disease
   2. Identify genetic factors which significantly increase an individual's risk for developing a disease
   3. Determine whether a high-risk couple's genetic makeup increases the risk of their children having a genetic disease
   4. Help determine prognosis, effectiveness of various treatment options, and guide management of appropriate diseases
   5. Prenatal or newborn genetic testing to identify diseases in high-risk situations

B. Partnership HealthPlan of California's ~~(PHC's)~~ intent is to follow National Comprehensive Cancer Network (NCCN) guidelines. Decisions about which genetic tests to approve will rely on the most up-to-date recommendations provided by the Centers for Disease Control and Prevention, the National Comprehensive Cancer Network, and the American College of Medical Genetics and Genomics. See Section VII. for URLs for these guidelines.

C. A Treatment Authorization Request (TAR) is required for certain genetic testing as outlined in Attachments A and C. Please note ~~PHC~~Partnership requirements may differ from California Department of Health Care Services (DHCS) Requirements. Please use ~~PHC~~Partnership's grids entitled Genetic Testing Requirements (Attachment A) and Proprietary Laboratory Analyses (PLA) Requirements (Attachment C) for ~~PHC~~Partnership members.
   1. When a TAR is required, medical necessity will be determined upon TAR submission and the following factors will be considered for genetic testing requests:
      a. A definitive diagnosis cannot be made without performing the genetic test being requested AND the results of the genetic testing will influence the treatment or medical management of the patient.
      b. There are identifiable reasons to perform the genetic tests being requested, including a relevant family history or the presence of a clinical condition which suggests a genetic component is relevant to diagnosis or management.
      c. Genetic testing is needed to help guide family planning decisions.
      d. The accuracy of the test has been established, with low proportions of false positive and false negative results.
      e. If a common single gene test is likely to be the cause of the genetic issue in question, a multi-gene test will not be approved until after the single gene test result is negative.
         1) Multi-gene testing may be considered for those who have tested negative (or indeterminate) for one particular syndrome but whose personal and family history is suggestive of an inherited susceptibility.
         2) Multi-gene testing may be considered in cases where more than one pathogenic or likely pathogenic variant could influence a condition.
         3) Clinical documentation indicating clinical impact of the testing that supports medical necessity will be required.
      f. In performing genetic testing of parents to determine risk of an autosomal recessive disease in their offspring, one parent will be tested initially. The other parent will only be tested if the first parent's test indicates the genetic abnormality is present.
      g. The test will be ordered by a clinician who has familiarity with the genetic testing being requested and who has the appropriate expertise to understand the implications of the test and how to follow-up the results.
      h. Testing for any specific gene mutation will only be approved once for the lifetime of any individual person except with a valid TAR override.
      i. Non-disease specific gene panel testing will not be approved (e.g. ancestral testing).

j. Testing solely for the purposes of determining paternity or familial relationships will not be approved.
k. Genetic testing needed for forensic purposes is not covered.
l. Genetic testing will not be approved if the results or outcome may pose a harm to the individual.
m. Genetic testing will not be approved if the only purpose for ordering the testing is one of the following:
   1) As part of a research project
   2) For general screening purposes where there are no high-risk factors indicating that genetic testing may be useful
n. Where the results of the genetic testing have no therapeutic or medical management implications: If expert guidance is not available to validate the appropriateness of a particular genetic test, ~~PHC~~Partnership reserves the right to request the patient see a geneticist prior to approving the test.

2. In accordance with state law, effective July 1, 2022, no prior authorization is required for medically necessary cancer biomarker testing for members diagnosed with, or being monitored for progression or recurrence of, advanced or metastatic stage 3 or 4 cancer when the treatment is associated with an FDA-approved cancer therapy.
   a. No prior authorization is required, however, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
   b. ~~PHC~~Partnership may still require prior authorization for biomarker testing for such members if the biomarker test is not associated with an FDA-approved cancer therapy.
   c. In a prepayment review of each claim, ~~PHC~~Partnership's Chief Medical Officer or Physician Designee will access the FDA's approved drug database at https://www.accessdata.fda.gov/scripts/cder/daf/ to verify that the treatment plan includes documentation of an agent that is an FDA-approved treatment in the setting of advanced or recurrent cancer and for which the biomarker test (for which the claim is submitted) is medically necessary to determine treatment options.
3. Rapid Whole Genome Sequencing (rWGS) is a covered benefit for any member who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit (ICU).
   a. This includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing.
   b. rWGS is an emerging method of diagnosing conditions in time to affect ICU care of children one year of age or younger. rWGS is not a benefit for other ages or settings.
   b. No prior authorization is required, however, a prepayment review after the service has been provided may review the submitted documents to ensure that the documentation reflects medical necessity.

D. Certain genetic tests are not covered by ~~PHC~~Partnership, however, if ordered by a medical geneticist with appropriate supporting documents attached to the TAR, the request will be considered on an individual basis.
E. For Hereditary Cancer Testing, it is recommended that the provider complete a Family History Screening Tool (Attachment B).
F. For genetic tests related to pregnancy and newborns, please refer to Medi-Cal guidelines in the Genetic Counseling and Screening section *gene coun* 1 – 8.

VII. REFERENCES:

A. Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/genomics-and-health/about/genetic-counseling.html~~https://www.cdc.gov/genomics/gtesting/genetic_counseling_testing.htm~~
B. National Comprehensive Cancer Network (NCCN): NCCN Guidelines for Treatment by Cancer Type

C. American College of Medical Genetics and Genomics (ACMG) guidelines: Genetics in Medicine
D. Medi-Cal Provider Manual/ Guidelines: Pathology: Molecular Pathology *(path molec)*, Genetic Counseling and Screening *(gene coun)* and Proprietary Laboratory Analyses (PLA) *(prop lab)*
E. Lynch Syndrome PREMM5 Model: Prediction Model for MLH1, MSH2, MSH6, PMS2, and EPCAM Gene Mutations: http://premm.dfci.harvard.edu/ Kastrinos F, Uno H, Alvero C, McFarland A, Yurgelun MB, Kulke MH, Schrag D, Meyerhardt JA, Fuchs CS, Mayer RJ, Ng K, Steyerberg EW, Syngal S. Development and Validation of the PREMM5 Model for Comprehensive Risk Assessment of Lynch Syndrome. Journal of Clinical Oncology. 2017 Jul 1;35(19):2165-2172. doi: 10.1200/JCO.2016.69.6120. Epub 2017 May 10.
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010 Cancer Biomarker Testing (06/22/2022)
G. Assembly Bill (AB) 133, 2021-2022 Regular Session, Rapid Whole Genome Sequencing
H. California Department of Public Health (CDPH) California Genetic Disease Screening Program (GDSP) https://sis2-prod.powerappsportals.us/homepage/

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 Director

X. REVISION DATES:
8/19/15; 11/18/15; 06/15/16; 02/15/17; 08/16/17; *05/09/18; 09/12/18; 03/13/19; 08/14/19; 11/13/19; 05/13/20; 08/12/20; 05/12/21; 09/08/21; 10/12/22; 10/11/23; 01/08/25

*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:
MCUP3108 BRCA - Gene Sequence Analysis was archived 08/19/2015

****

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.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81105 – 81112 **Human Platelet Antigen Genotyping**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): D69.51 or P61.0	Once-in-a-lifetime, any provider, except with valid TAR override	
81120 **IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble), common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C71.0 – C71.9 or C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81121 **IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial), common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C71.0 – C71.9 or C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81161 **DMD (dystrophin) deletion analysis, and duplication analysis, if performed**	No	ICD-10-CM diagnosis code G71.00 (muscular dystrophy) G71.01, G71.02 or G71.09 is required on the claim.	Once-in-a-lifetime, any provider, except with valid TAR override	
81162 **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	A TAR for code 81162 requires documentation as follows: 1) The patient has personal or family history that suggests an inherited cancer susceptibility based on a standard assessment tool: See Attachment B for an example or one of the following tools: • Ontario Family History Assessment Tool • Manchester Scoring System • Referral Screening Tool • Pedigree Assessment Tool	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third-degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. (*Cont'd)*

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	• 7-Question Family History Screening Tool • International Breast Cancer Intervention Study instrument • Brief versions of BRCAPRO; AND 2) The patient is willing to talk with a health professional who is suitably trained to provide genetic counseling and interpret test results; AND 3) The test results will aid in the decision-making Additionally, a TAR for code 81162 requires documentation of *one or more* of the following numbered criteria Per NCCN Guidelines Version 1.2020 Hereditary Cancer Testing Criteria, testing is clinical indicated in the following scenarios: 1) An individual from a family with a known pathogenic /likely pathogenic variant in cancer susceptibility gene mutation; OR 2) Individuals meeting criteria below and previously tested NEGATIVE in single gene analysis desiring multiple gene sequencing 3) Personal history of cancer • Diagnosed at ≤45 years of age; OR • Diagnosed at 46 - 50 yo with: - An unknown or limited family history; OR - An additional breast cancer primary at any age - One or more close blood relatives with breast, ovarian, pancreatic or prostate cancer (Gleason score ≥7) • Diagnosed at ≤60 years of age with triple negative breast cancer; OR • Diagnosed at any age with: – One or more close blood relatives with: o breast cancer diagnosed at ≤50 years of age; or o Ovarian carcinoma; or	Once-in-a-lifetime, any provider, except with valid TAR override *	Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer. See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	○ Male breast cancer; or ○ Metastatic prostate cancer; or ○ Pancreatic cancer – 2 or more additional diagnoses of breast cancer at any age in patient and/or in close blood relatives; or • Ashkenazi Jewish ancestry; OR • Personal history of Male Breast Cancer; or • Personal history of Ovarian carcinoma (includes fallopian tube cancer and peritoneal cancer); or • Personal history of pancreatic cancer; or • Personal history of metastatic prostate cancer (biopsy-proven and/or with radiographic evidence; include distant metastasis and regional bed or nodes; not biochemical recurrence); or • Personal history of high-grade prostate cancer (Gleason score ≥7) at any age with: – Ashkenazi Jewish ancestry; or – One or more close blood relatives with ovarian carcinoma, pancreatic cancer or metastatic prostate cancer at any age or breast cancer under 50 years of age; or – 2 or more close blood relatives with breast or prostate cancer (any grade) at any age • A mutation identified on tumor genomic testing that has clinical implications if also identified in the germ line • To aid in systemic therapy decision-making 4) Family History of Cancer • An affected or unaffected individual with first- or second degree-blood relative meeting any criteria above (except those meeting criteria ONLY for systemic therapy decisions)	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis**	Yes	• An affected or unaffected individual who does NOT meet criteria but has a probability of greater than or equal to 5% of at BRCA 1 / 2 pathogenic variant based on prior probability models For BRACAnalysis CDx testing for breast cancer, all of the following TAR criteria must be met: • Patient has metastatic breast cancer. • Patient is human epidermal growth factor receptor 2 (HER2)-negative. • Patient has previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. • Patient's additional treatment is contingent on the test results. ***** An approved TAR that meets the necessary criteria listed below to override the once-in-a-lifetime frequency is required: In Advanced Ovarian Cancer: For patients with previous germline BRCA test (blood sample), additional somatic BRCA testing (tumor sample) may be necessary when treatment with Lynparza™ (olaparib) is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer. Olaparib has FDA approval for use in some Ovarian Cancer diagnosis where there is a mutation in the germline or somatic BRCA.
81163 **BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81164 **BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) gene analysis; full duplication/deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81165 **BRCA1 (BRCA1, DNA repair associated) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81166 **BRCA1 (BRCA1, DNA repair associated) gene analysis; full -duplication/ deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81167 **BRCA2 (BRCA2, DNA repair associated) gene analysis; full -duplication/ deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81168 **CCND1/IGH (t[11;14])(eg. mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.10 thru C83.19	Once-in-a-lifetime, any provider, except with valid TAR override	
81170 **ALB1 gene analysis, variants in the kinase domain**	Yes	Requires documentation on the TAR that the recipient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81171 **AFF2 (AF4/FMR2 family, member 2 [FMR2]) gene analysis evaluation to detect abnormal alleles**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): F70, F71, F80.0 – F89, H93.25, R48.0, R62.0 – R62.59, F82, F88, R48.2	Once-in-a-lifetime, any provider, except with valid TAR override	
81172 **AFF2 (AF4/FMR2 family, member 2 [FMR2]) gene analysis; characterization of alleles**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): F70, F71, F80.0 – F89, H93.25, R48.0, R62.0 – R62.59, F82, F88, R48.2	Once-in-a-lifetime, any provider, except with valid TAR override	
81173 **AR (androgen receptor) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81173 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81174 **AR (androgen receptor) gene analysis; known familial variant**	Yes	A TAR for CPT code 81174 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81175 **ASXL gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C93.10 – C93.12, D46.0 – D46.C, D47.1	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81176 **ASXL gene analysis, targeted sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C93.10 – C93.12, D46.0 – D46.C, D47.1	Once-in-a-lifetime, any provider, except with valid TAR override	
81177 **ATN1 (atrophin 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81177 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for dentatorubral pallidoluysian atrophy, and • The patient requires the service as a confirmatory test for dentatorubral pallidoluysian atrophy	Once-in-a-lifetime; any provider, except with valid TAR override	
81178 **ATXN1 (ataxin 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81178 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 1 (SCA1), and • The patient requires the service as a confirmatory test for SCA1	Once-in-a-lifetime, any provider, except with valid TAR override	
81179 **ATXN2 (ataxin 2) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81179 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 2 (SCA2), and • The patient requires the service as a confirmatory test for SCA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81180 **ATXN3 (ataxin 3) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81180 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 3 (SCA3), and • The patient requires the service as a confirmatory test for SCA3	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81181 **ATXN7 (ataxin 7) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81181 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 7 (SCA7), and • The patient requires the service as a confirmatory test for SCA7	Once-in-a-lifetime, any provider, except with valid TAR override	
81182 **ATXN8OS (ATXN8 opposite strand [non-protein coding]) gene analysis, evaluation to detect abnormal**	Yes	A TAR for CPT code 81182 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 8 (SCA8), and • The patient requires the service as a confirmatory test for SCA8	Once-in-a-lifetime, any provider, except with valid TAR override	
81183 **ATXN10 (ataxin 10) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81183 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 10 (SCA10), and • The patient requires the service as a confirmatory test for SCA10	Once-in-a-lifetime, any provider, except with valid TAR override	
81184 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81184 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81185 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; full gene sequen**ce	Yes	A TAR for CPT code 81185 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81186 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; known familial variant**	Yes	A TAR for CPT code 81186 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81187 **CNBP (CCHC-type zinc finger nucleic acid binding protein) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81187 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Myotonic dystrophy type 2 (MD2), and • The patient requires the service as a confirmatory test for MD2	Once-in-a-lifetime, any provider, except with valid TAR override	
81188 **CSTB (cystatin B) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81188 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81189 **CSTB (cystatin B) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81189 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81190 **CSTB (cystatin B) gene analysis; known familial variant(s)**	Yes	A TAR for CPT code 81190 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81191 **NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis**	Yes	A TAR for CPT code 81191 requires documentation of the following criteria: Adult and pediatric patients with solid tumors with any one of the following clinical scenario: • Metastatic tumor or where surgical resection is likely to result in severe morbidity, or • Have no satisfactory alternative treatments or have progressed following treatment	N/A	
81192 **NTRK2 (neurotrophic receptor tyrosine kinase 2)(eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81193 **NTRK3 (neurotrophic receptor tyrosine kinase 3)(eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81194 **NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81201 **APC** **gene analysis; full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, D12.0 – D12.9, K63.5, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
81202 **APC** **gene analysis; known familial variants**	Yes	Requires documentation on the Treatment Authorization Request (TAR) of a family history of familial adenomatous polyposis that includes a relative with a known deleterious APC mutation	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81203 **APC** **gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, D12.0 – D12.9, K63.5, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
81204 **AR (androgen receptor) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81204 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime. any provider, except with valid TAR override	
81206 **BCR/ABL1 translocation analysis; major breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81207 **BCR/ABL1 translocation analysis; minor breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81208 **BCR/ABL1 translocation analysis; other breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81210 **BRAF (B-Raf proto-oncogene, serine/threonine kinase)**, gene analysis, **V600 variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, C19, C20, C33, C34.00 – C34.92, C43.0 – C43.9, C79.2 or D03.0 – D03.9	Once-in-a-lifetime, any provider, except with valid TAR override	
81212 **BRCA1, BRCA2 gene analysis; variants**	Yes	Requires documentation on the TAR of the following: • An individual is of an ethnicity associated with the Ashkenazi Jewish population No additional family history may be required	Once-in-a-lifetime, any provider, except with valid TAR override	See Attachment B - Family History Screening Tool which is suggested for use prior to ordering BRCA testing

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81215 **BRCA1 (breast cancer 1) gene analysis; known familial variant**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81216 **BRCA2 (breast cancer 2) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81217 **BRCA2 (breast cancer 2) gene analysis; known familial variant**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81218 **CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02, C92.40 – C92.42 or C92.50 – C92.52	Once-in-a-lifetime, any provider, except with valid TAR override	
81219 **CALR (calreticulin) gene analysis, common variants in exon 9**	No	One of the following ICD-10-CM codes is required on the claim: C92.10 – C92.12, D45, D47.3 or D75.81	Once-in-a-lifetime, any provider, except with valid TAR override	
81220 **CFTR (cystic fibrosis transmembrane conductance regulator) gene analysis; common variants**	No	When used to bill for cystic-fibrosis screening requires ICD-10-CM codes E84, O09.00 thru O09.93, X38.49, Z31.430, Z31.440, Z31.5, Z34.00 thru Z34.03, Z34.80 thru Z34.83, Z34.90 thru Z34.93 Not reimbursable with code 81224 for same date of service, recipient and provider May be billed separately with an appropriate National Correct Coding Initiative (NCCI) associated modifier Refer to the *Genetic Counseling and Screening* section in the Medi-Cal Manual for additional information	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81221 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; known familial variants	~~Yes~~No	~~TAR requires documentation of t~~The following criteria should be documented: • The Patient has a strong clinical presentation suspicious of CF, and • Family with known variant not included in the test for common variants	Once-in-a-lifetime~~,~~ any provider, except with valid TAR override	
81222 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; duplication/deletion variants	~~Yes~~No	~~TAR requires a documentation of the~~The following criteria should be documented: • The patient has a strongclinical ~~-~~presentation suspicious of CF, and • Gene test for common variants did not result in twodisease-causing variants in CFTR	Once-in-a-lifetime~~,~~ any provider, except with valid TAR override	
81223 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; full gene sequence	Yes	TAR requires documentation of the following criteria: • Patient has intermediate sweat chloride result, or • Patient with confirmed or suspected CF, with unknowngenotype, and additional treatment or assessment of prognosis is contingent on the result of the test, or • Patient with normal sweat chloride results despite a strong clinical suspicion of CF	Once-in-a-lifetime, any provider, except with valid TAR override	
81224 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	No	When used to bill for cystic-fibrosis testing requires ICD-10-CM diagnosis code N46.9	Once-in-a-lifetime, any provider, except with valid TAR override	
81225	No	Billable with any valid ICD-10-CM diagnosis code.	Once-in-a-lifetime,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19), gene analysis, common variants			any provider, except with valid TAR override	
81232 **DPYD (dihydropyrimidine dehydrogenase) gene analysis, common variant(s)**	Yes	A TAR requires documentation of the following criteria: • Patient had severe and unexpected toxicity (such as myelosuppression, mucositis, diarrhea, neurotoxicity, cardiotoxicity) during treatment with Fluorouracil or Capecitabine chemotherapy.	Once-in-a-lifetime, any provider, except with valid TAR override	
81233 **BTK (Bruton's tyrosine kinase) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D80.0 – D80.6, C91.10 – C91.12, C83.00 – C83.09	Once-in-a-lifetime, any provider, except with valid TAR override	
81234 **DMPK (DM1 protein kinase) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81234 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myotonic dystrophy type 1 (MD1), and • The patient requires the service as a diagnostic test for MD1.	Once-in-a-lifetime, any provider, except with valid TAR override	
81235 **EGFR (epidermal growth factor receptor) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim: C33, C34.00 – C34.92	Once-in-a-lifetime, any provider, except with valid TAR override	
81236 **EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D47.1, D47.3, C83.30 – C83.39	Not more than once per month	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81237 **EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) gene analysis, common variant(s)**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D47.1, D47.3, C83.30 – C83.39	Not more than once per month	
81238 **F9 (coagulation factor IX) full gene analysis sequence**	No	ICD-10-CM code D67 is required on the claim (except with valid TAR)	Once-in-a-lifetime, any provider, except with valid TAR override	
81239 **DMPK (DM1 protein kinase) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81239 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myotonic dystrophy type 1 (MD1), and • The patient requires the service as a diagnostic test for MD1.	Once-in-a-lifetime, any provider, except with valid TAR override	
81243 **FMR1 (fragile X mental retardation 1) gene analysis; evaluation to detect abnormal alleles**	No	One of the following ICD-10-CM codes is required on the claim: F70, F71 – F73, F78, F80.0 – F84.2, F88, F89, H93.25, R48.2, R62.0, R62.50 – R62.59	Once-in-a-lifetime, any provider, except with valid TAR override	
81244 **FMR1 (fragile X mental retardation 1) gene analysis; characterization of alleles**	No	One of the following ICD-10-CM codes is required on the claim: F70, F71 – F73, F78, F80.0 – F84.2, F88, F89, H93.25, R48.2, R62.0, R62.50 – R62.59	Once-in-a-lifetime, any provider, except with valid TAR override	
81245 **FLT3 (fms-related tyrosine kinase 3), gene analysis;**	No	One of the following ICD-10-CM codes is required on the claim:	Once-in-a-lifetime, any	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
internal tandem duplication (ITD) variants		C92.00 – C92.02, C92.60 - C92.62 or C92.A0 – C92.A2	provider, except with valid TAR override	
81246 **FLT3 (fms-related tyrosine kinase 3), gene analysis; tyrosine kinase domain (TKD) variants**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02, C92.60 - C92.62 or C92.A0 – C92.A2	Once-in-a-lifetime, any provider, except with valid TAR override	
81250 **G6PC (glucose-6-phosphatase, catalytic subunit) gene analysis, common variants**	Yes	The patient has clinical features suspicious for, or requires the laboratory service as a diagnostic test for glycogen storage disease, type 1a	Once-in-a-lifetime, any provider, except with valid TAR override	
81256 **HFE (hemochromatosis) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim: E83.10, E83.110 or E83.118 – E83.119	Once-in-a-lifetime, any provider, except with valid TAR override	
81257 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; common deletions or variant**	No	N/A	Once-in-a- Lifetime, any provider, except with valid TAR override	
81258 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; known familial variant**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81259 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; full gene sequence**	~~Yes~~No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81260 **IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinas complex-associated protein) gene analysis, common variants**	No	Indicated for: • Hypotonia in infancy • Decreased or absent deep tendon reflexes • Decreased taste and absence of fungiform papillae of the tongue • Absence of overflow tears with emotional crying (alacrima) • Absence of axon flare response after intradermal histamine injection • Pupillary hypersensitivity to parasympathomimetic agents	Once-in-a-lifetime, any provider, except with valid TAR override	While DHCS requires a TAR for this test, PHC has chosen to have no TAR requirement.
81265 **Comparative analysis using Short Tandem Repeat markers**	No	One of the following ICD-10-CM codes is required on the claim: C81.00 – C96.9, D45, T86.00 – T86.09 or T86.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81266 **Comparative analysis using Short Tandem Repeat markers; each additional specimen**	No	One of the following ICD-10-CM codes is required on the claim: C81.00 – C96.9, D45, T86.00 – T86.09 or T86.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81267 **Chimerism (engraftment) analysis, post transplantation specimen; without cell selection**	No	One of the following ICD-10-CM codes is required on the claim: T86.01, T86.02, T86.09 or T86.5	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81268 **Chimerism (engraftment) analysis, post transplantation specimen; with cell selection**	No	One of the following ICD-10-CM codes is required on the claim: T86.01, T86.02, T86.09 or T86.5	N/A	
81269 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; duplication/ deletion variants**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81270 **JAK2 (Janus kinase 2) gene analysis, p. Val617Phe (V617F) variant**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02, D45, D47.1 or D47.3	Once-in-a-lifetime, any provider, except with valid TAR override	
81271 **HTT (huntingtin) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81271 requires documentation of the following criteria: • For adults, the patient has unequivocal motor signs of Huntington's disease (HD) and requires the service to confirm the diagnosis • For children, the patient has a family history of HD and develops symptoms that raise the suspicion for juvenile-onset HD as exemplified by two or more of the following: – Declining school performance – Seizures – Oral motor dysfunction – Rigidity – Gait disturbance	Once-in-a-lifetime, any provider, except with valid TAR override	
81272 **KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene**	No	One of the following ICD-10-CM codes is required on the claim: C43.70 - C43.72, C92.00 – C92.02, C92.40 – C92.42, C92.50 – C92.52, D03.70 – D03.72, D47.01, D47.02 or D48.1	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
homolog), gene analysis, targeted sequence analysis			valid TAR override	
81273 **KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog), gene analysis, D816 variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C96.20 – C96.29, D47.01, D47.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81274 **HTT (huntingtin) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81274 requires documentation of the following criteria: • For adults, the patient has unequivocal motor signs of Huntington's disease (HD) and requires the service to confirm the diagnosis • For children, the patient has a family history of HD and develops symptoms that raise the suspicion for juvenile-onset HD as exemplified by two or more of the following: – Declining school performance – Seizures – Oral motor dysfunction – Rigidity – Gait disturbance	Once-in-a-lifetime, any provider, except with valid TAR override	
81275 **KRAS (Kirsten rat sarcoma viral oncogene homolog) gene analysis; variants in exon 2**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81276 **KRAS (Kristen rat sarcoma viral oncogene homolog) gene analysis; additional variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81278 **IGH @/BLC2 (t[4; 18]) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative**	Yes	A TAR for CPT code 81278 requires documentation of the following criteria: The patient has clinical features suspicious for, or requires the service as a diagnostic test for follicular lymphoma	Once-in-a-lifetime, any provider, except with valid TAR override	
81279 **JAK2 (Janus kinase 2)(eg, myeloproliferative disorder) gene analysis, (eg, exons 12and 13)**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 thru C91.02, D45, D47.1 or D47.3	N/A	
81283 **IFNL3 (interferon, lambda 3), gene analysis, rs12979860 variant**	No	ICD-10-CM code B18.2 is required on the claim (except with valid TAR)	Once-in-a-lifetime, any provider, except with valid TAR override	
81284 **FXN (frataxin) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81284 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81285 **FXN (frataxin) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81285 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81286	Yes	A TAR for CPT code 81286 requires documentation of the following criteria:	Once-in-a-lifetime,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
FXN (frataxin) gene analysis; full gene sequence		• The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	any provider, except with valid TAR override	
81287 **MGMT (0-6 methylguanin-DNA methyltransferase) methylation analysis**	No	Indicated for: • The patient has the diagnosis of glioblastoma multiforme, and • Treatment strategy will be contingent on the test results • Reimbursable when billed with ICD-10: C71.9.	Once-in-a-lifetime, any provider, except with valid TAR override	While DHCS requires a TAR for this test, PHC has chosen to have no TAR requirement when billed with ICD-10 code C71.9
81288 **MLH1 gene analysis; promoter methylation analysis**	Yes	Document the following criteria on the TAR: • Patient with cancer(s) associated with Lynch Syndrome, and • The tumor demonstrates microsatellite instability or immunohistochemistry results indicating loss of MLH1 protein expression	Once-in-a-lifetime, any provider, except with valid TAR override	
81289 **FXN (frataxin) gene analysis; known familial variant(s)**	Yes	A TAR for CPT code 81289 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81292 **MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81293	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known	Once-in-a-lifetime,	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing:

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; known familial variants		deleterious MLH1 mutation	any provider, except with valid TAR override	http://premm.dfci.harvard.edu/
81294 **MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81295 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81296 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious MSH2 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81297 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81298 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also reimburse for these ICD-10 codes: C56.1 – C56.9

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81299 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious MSH6 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81300 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81301 **Microsatellite instability analysis of markers for mismatch repair deficiency includes comparison of neoplastic and normal tissue, if performed**	No	Reimbursable for patients who meet one of the following criteria: the patient is diagnosed with one of the Lynch syndrome-associated cancers; or, the patient is diagnosed with an unresectable or metastatic solid tumor and the treatment will be contingent on the test result.	Once-in-a-lifetime, any provider, except with valid TAR override	
81305 **MYD88 (myeloid differentiation primary response 88) (gene analysis, p.Leu265Pro (L265P) variant**	No	The following ICD-10-CM code is required on the claim (except with valid TAR): C88.0	Once-in-a-lifetime, any provider, except with valid TAR override	
81306 **NUDT15 (nudix hydrolase 15) gene analysis, common variant(s)**	Yes	A TAR for CPT code 81306 requires documentation of the following criteria: • The patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also authorize 81306 for the purpose of predicting toxicity to azathioprine prior to initiation of treatment for SLE and other recognized conditions when treatment with long term azathioprine is being considered.
81309 **PIK3CA gene analysis, targeted sequence analysis**	Yes	A TAR/SAR for CPT code 81309 requires documentation of the following criteria: • The patient has confirmed diagnosis of breast cancer • Treatment is contingent on the result of the test	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81310 **NPM1 (nucleophosmin) gene analysis, exon 12 variants**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81311 **NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) gene analysis, variants in exon 2 and exon 3**	No	One of the following ICD-10-CM codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81312 **PABPN1 (poly[A] binding protein nuclear 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81312 requires documentation of the following criteria: • The patient has symptoms of ptosis and dysphagia, and • The patient requires the service as a confirmatory test for Oculopharyngeal Muscular Dystrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81314 **PDGFRA (platelet-derived growth factor receptor, alpha polypeptide), gene analysis, targeted sequence analysis**	No	ICD-10-CM code D48.1 is required on the claim.	Once-in-a-lifetime, any provider, except with valid TAR override	
81315 **PML/RAR-alpha (promyelocytic leukemia/retinoic acid receptor alpha) translocation analysis; common breakpoints**	No	One of the following ICD-10-CM codes is required on the claim: C92.40 – C92.42	N/A	
81316 **PML/RAR-alpha (promyelocytic**	No	One of the following ICD-10-CM codes is required on the claim: C92.40 – C92.42	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
leukemia/retinoic acid receptor alpha) translocation analysis; single breakpoint				
81317 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81318 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious PMS2 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81319 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81320 **PLCG2 (phospholipase C gamma 2) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C91.10 – C91.12	Once-in-a-lifetime, any provider, except with valid TAR override	
81321 **PTEN (phosphatase and tensin homolog) gene analysis; full sequence analysis**	Yes	A TAR for CPT-4 code 81321 requires documentation of one or more of the following numbered criteria: 1. Individual with a personal history of: • Bannayan-Riley-Ruvalcaba syndrome, or • Adult Lhermitte-Duclos disease, or • Autism spectrum disorder AND macrocephaly, or • Two or more biopsy-proven trichilemmomas, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued below *Continued from above* **81321** **PTEN (phosphatase and tensin homolog) gene analysis; full sequence analysis**	*Continued* Yes	• Two or more major criteria (one macrocephaly), or • Three major criteria without macrocephaly, or • One major and three or more minor criteria, or • Four or more minor criteria (please see list below) 2. At-risk individual: With a relative who has a clinical diagnosis of Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome for whom testing has not been performed AND who has any one major criterion or two minor criteria Major Criteria • Breast cancer • Mucocutaneous lesions • One biopsy-proven trichilemmoma • Multiple palmoplantar keratosis • Multifocal or extensive oral mucosal papillomatosis • Multiple cutaneous facial papules (often verrucous) • Macular pigmentation of glans penis • Macroencephaly (megalocephaly, ie, ≥97th percentile) • Endometrial cancer • Non-medullary thyroid cancer • Multiple GI tract hamartomas or ganglioneuromas Minor Criteria • Other thyroid lesions (adenoma, nodule, goiter) • Mental retardation (IQ ≤75) • Autism spectrum disorder • Single GI tract hamartoma or ganglioneuroma • Fibrocystic disease of the breast • Lipomas • Fibromas • Renal cell carcinoma • Uterine fibroids	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81322 **PTEN gene analysis; known familial variant**	Yes	Requires documentation on the TAR that patient is from a family with a known PTEN mutation	Once-in-a-lifetime, any provider, except with valid TAR override	
81323 **PTEN gene analysis; duplication/deletion variant**	Yes	Requires documentation on the TAR of a negative result in the full sequence analysis in PTEN (CPT-4 code 81321), and that patient meets one or more criteria listed under code 81321	Once-in-a-lifetime, any provider, except with valid TAR override	
81329 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; dosage/deletion analysis, includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): O09.00 thru O09.93, Z31.430, Z31.440, Z34.00 – Z34.03, Z34.80 – Z34.83, Z34.90 – Z34.93	Once-in-a-lifetime, any provider, except with valid TAR override	
81331 **SNRPN/UBE3A methylation analysis**	Yes	Document the following age-specific criteria on the TAR • Birth to 2 years: Hypotonia with poor suck • 2 – 6 years: Hypotonia with history of poor suck and global development delay • 6 – 13 years: History of hypotonia with poor suck (hypotonia often persists); global development delay; and excessive eating (hyperphagia; obsession with food) with central obesity if uncontrolled • 13 years – adult: Cognitive impairment – usually mild mental retardation; excessive eating (hyperphagia; obsession with food) with central obesity if uncontrolled; and hypothalamic hypogonadism and/or typical behavior problems (including temper tantrums and obsessive-compulsive features)	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81334 **RUNX1 (runt related transcription factor 1), gene analysis, targeted sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C92.00 – C92.02, C92.40 – C92.A2	Once-in-a-lifetime, any provider, except with valid TAR override	
81335 **TPMT (thiopurine S-methyltransferase), gene analysis, common variants**	Yes	The service requires a TAR with documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also authorize 81335 for the purpose of predicting toxicity to azathioprine prior to initiation of treatment for SLE and other recognized conditions when treatment with long term azathioprine is being considered.
81336 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; full gene sequence**	~~Yes~~No	~~A TAR for CPT code 81336 requires documentation of T~~the following criteria should be documented: • The patient has clinical signs or symptoms suspicious for spinal muscular atrophy, and • The patient requires the service as a confirmatory test for spinal muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81337 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; known familial sequence variant(s)**	~~Yes~~No	~~A TAR for CPT code 81337 requires documentation of T~~the following criteria should be documented: • The patient has clinical signs or symptoms suspicious for spinal muscular atrophy, and • The patient requires the service as a confirmatory test for spinal muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81338 **MPL (MPL proto-oncogene, thrombopoietin recepter) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A,W515K, W515L, W515R)**	Yes	A TAR for CPT code 81338 requires documentation of the following criteria: The patient has clinical features suspicious for, or requires the service as a diagnostic test for, myeloproliferative disorder	N/A	
81339 **MPL (MPL proto-oncogene, thrombopoietin**	Yes	A TAR for CPT code 81339 requires documentation of the following criteria:	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
recepter) (eg, myeloproliferative disorder) gene analysis; sequenceanalysis, exon 10		The patient has clinical features suspicious for, or requires the service as a diagnostic test for, myeloproliferative disorder		
81340 **TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)**	Yes	A TAR for CPT code 81340 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	Once-in-a-lifetime, any provider, except with valid TAR override	
81341 **TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)**	Yes	A TAR for CPT code 81341 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	Once-in-a-lifetime, any provider, except with valid TAR override	
81342 **TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)**	Yes	A TAR for CPT code 81342 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	Once-in-a-lifetime, any provider, except with valid TAR override	
81343 **PPP2R2B (protein phosphatase 2 regulatory**	Yes	A TAR for CPT code 81343 requires documentation of the following criteria:	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
subunit Bbeta) gene analysis, evaluation to detect abnormal alleles		• The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 12 (SCA12), and • The patient requires the service as a confirmatory test for SCA12	valid TAR override	
81344 **TBP (TATA box binding protein) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81344 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 17 (SCA17), and • The patient requires the service as a confirmatory test for SCA17	Once-in-a-lifetime, any provider, except with valid TAR override	
81345 **TERT (telomerase reverse transcriptase) gene analysis, targeted sequence analysis**	Yes	Document the following criteria on the TAR: The patient has the diagnosis of grade II, III or IV glioma.	Once-in-a-lifetime, any provider, except with valid TAR override	
81347 **SF3B1 (splicing factor[3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81348 **SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg,P95H, P95L)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81351 **TP53 (tumorprotein 53) (eg, Li- Fraumeni syndrome) gene analysis; fullgene sequence** *Continued Below* *Continued from above* **81351** **TP53 (tumorprotein 53) (eg, Li- Fraumeni syndrome) gene analysis; fullgene sequence**	Yes Yes	A TAR for CPT code 81351 requires documentation for one of the following numbered criteria: 1. All of the following conditions: • The patient has sarcoma diagnosed before 45 years of age,and • A first-degree relative with anycancer before 45 years of age,and • A first or second-degree relative with any cancer before 45 years ofage, or a sarcoma at any age; or 2. All of the following conditions: • A tumor belonging to the Li- Fraumeni Syndrome (LFS) tumorspectrum (soft tissue sarcoma, osteosarcoma, pre-menopausal breast cancer, brain tumor, adrenocortical carcinoma, leukemia or lung bronchoalveolarcancer) before 46 years of age, and • At least one first or second-degreerelative with an LFS tumor (exceptbreast cancer if the patient has breast cancer) before 56 years of age or with multiple tumors; or 3. The patient has multiple tumors (except multiple breast tumors), two of which belong to the LFS tumor spectrum, and the first occurred before 46 years of age; or 4. The patient is diagnosed with adrenocortical carcinoma or choroidplexus tumor.	N/A N/A	
81352 **TP53 (tumor protein53) (eg, Li-Fraumenisyndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)**	Yes	See CPT code 81351 for TAR criteria and billing requirements.	N/A	
81353 **TP53 (tumor protein53) (eg, Li-Fraumenisyndrome)**	Yes	See CPT code 81351 for TAR criteria and billing requirements.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
gene analysis; known familial variant				
81357 **U2AF1 (U2 small nuclear RNA auxiliaryfactor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg S34F, S34Y, Q157R,Q157P)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81360 **ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/argine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)**	No	One of the following ICD-10-CMcodes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81361 **HBB (hemoglobin, subunit beta); common variant(s) (e.g., HbS, HbC, HbE)**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81362 **HBB (hemoglobin, subunit beta); known familial variant(s)**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81363	No	N/A	Once-in-a-lifetime, any provider,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
HBB (hemoglobin, subunit beta); duplication/deletion variant(s)			except with valid TAR override	
81364 **HBB (hemoglobin, subunit beta); full gene sequence**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81370 – 81383 **Human Leukocyte Antigen Typing**	No TAR required	CPT-4 codes 81370 – 81380, 81382 and 81383 (human leukocyte antigen typing) are reimbursable only with an ICD-10-CM diagnosis in the range of Z94.0 – Z94.9. CPT-4 code 81381 (HLA Class I typing, high resolution, one allele or allele group, each) is only reimbursable with an ICD-10-CM diagnosis of B20, F31.0 – F31.9, G40.001 – G40.919, G50.0, R75, Z01.812, Z21, Z94.0 – Z94.9.	Once-in-a-lifetime, any provider, except with valid TAR override	
81400 **Molecular Pathology Procedure, Level 1**	Yes	Providers are required to document one of the following on the TAR: • CCR5 (chemokine C-C motif receptor 5): – Initial test: ❖ The use of a CCR5 inhibitor is being considered, or ❖ The patient exhibits virologic failure on a CCR5 inhibitor – Subsequent tests: ❖ A previous Trofile test was performed including the test date and the results showing that the patient has a CCR5 virus, and, ❖ The patient's previous Trofile test was not less than 90 days from subsequent request, and,	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued below *Continued from above*		❖ The patient has clinical scenario such as, but not limited to the following: • The treatment with CCR5 antagonist drug therapy was interrupted and the clinician wishes to reinstitute CCR5 antagonist drug therapy, or, • The patient had a Trofile test performed previously that showed that the recipient had the CCR5 virus, but the CCR5 antagonist drug therapy was never initiated. Claims without documentation showing the preceding criteria have been met will be denied.		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81401 **Molecular Pathology Procedure, Level 2**	Yes	Coverage for CPT-4 code 81401 (molecular pathology procedure, Level 2) is limited to the listed services. Reimbursement for code 81401 requires an approved TAR and requires providers to document one of the following on the TAR: • ABCC8 (familial hyperinsulinism): – The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI), failed medical therapy, and – The patient is under evaluation for surgical intervention • ABL (c-abl oncogene 1, receptor tyrosine kinase) – The patient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy • ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib resistance), T315I variant – The patient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy • APOE (apolipoprotein E) (for example, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (for example, 2, 3, 4) – The patient has clinical signs and symptoms consistent with Alzheimer Disease, and – Medical treatment strategy will be contingent on the test results. • DEK/NUP214 (t [6; 9])(e.g., acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed – The patient has acute myeloid leukemia and the test is intended for the process of risk stratification • E2A/PBX1 (acute lymphocytic leukemia):	Once-in-a-lifetime, any provider, except with valid TAR override	
Continued below	*Continued*			

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81401** **Molecular Pathology Procedure, Level 2** *Continued below*	Yes *Continued*	– The patient has the diagnosis of acute lymphocytic/lymphoblastic leukemia, and – Treatment or monitoring strategy will be contingent on the test results • ETV6/RUNX1 (acute lymphocytic leukemia) – The patient has the diagnosis of acute lymphocytic or lymphoblastic leukemia, and requires the test for assessment of cancer prognosis • H19 (Beckwith-Wiedemann syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Beckwith-Wiedemann syndrome • KCNQ1OT1 (Beckwith-Wiedemann syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Beckwith-Wiedemann syndrome • MLL/AFF1 (acute lymphoblastic leukemia): – The patient has the diagnosis of acute lymphoblastic leukemia, and – Treatment or monitoring strategy will be contingent on the test results • MLL/MLLT3 (acute myeloid leukemia): – The patient has the diagnosis of acute myeloid leukemia, and – Treatment or monitoring strategy will be contingent on the test results • MUTYH (MYH-associated polyposis) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for MUTYH- associated polyposis • MT-ATP6 (neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome) – The patient has clinical features suspicious for, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81401** **Molecular Pathology Procedure, Level 2**	Yes	requires the service as a confirmatory test for NARP or Leigh syndrome • PRSS1 (hereditary pancreatitis): – An unexplained documented episode of acute pancreatitis in childhood, or – Recurrent acute attacks of pancreatitis of unknown cause, or – Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or – A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance • PYGM (glycogen storage disease type V, McArdle disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type V • RUNX1/RUNX1T1 (t[8;21]) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute myeloid leukemia Claims without documentation showing the preceding criteria have been met will be denied.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81402 **Molecular Pathology Procedure, Level 3**	Yes	Coverage for CPT-4 code 81402 (molecular pathology procedure, Level 3) is limited to the listed services. Reimbursement for code 81402 requires an approved TAR and requires providers to document one of the following on the TAR: • Chromosome 1p-/19q- (e.g. glial tumors), deletion analysis – Patient with diagnosis of grade II, III or IV glioma • MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants: – The patient has clinical signs and symptoms suspicious for familial MEFV, and – The patient requires the service as a confirmatory test for familial MEFV	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81403 **Molecular Pathology Procedure, Level 4** *Continued below*	Yes	Coverage for CPT-4 code 81403 (molecular pathology procedure, Level 4) is limited to the listed services. Reimbursement for code 81403 requires an approved TAR and requires providers to document one of the following on the TAR: • DNMT3A (acute myeloid leukemia): – The patient has diagnosis of acute myeloid leukemia, and – The treatment strategy will be contingent on test results • EPCAM (Lynch syndrome) – The patient has one of the following: - Colon cancer - Uterine cancer - Lynch syndrome - Family history of colorectal cancer, uterine cancer or Lynch syndrome - Presence of synchronous, metachronous colorectal or other Lynch-associated tumors • KCNC3 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • KCNJ11 (familial hyperinsulinism): For persistent hyperinsulinemic hypoglycemia of infancy (PHHI) ❖ The patient has PHHI and failed medical therapy, and ❖ The patient is under evaluation for surgical intervention For suspected developmental delay, epilepsy and neonatal diabetes (DEND) syndrome: ❖ The patient has developmental delay, epilepsy and neonatal diabetes	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81403** **Molecular Pathology Procedure, Level 4**	Yes	❖ The confirmation of the diagnosis and the treatment strategy is contingent on the test result • KIR (killer cell immunoglobulin-like receptor for hematopoietic stem cell transplantation): – The patient has diagnosis of acute myeloid leukemia or multiple myeloma, and The test is used for donor search process for patients considering hematopoietic stem cell transplantation • Known family variant not otherwise specified, for gene listed in Molecular Pathology Procedure Levels 1 - 3 or identified during a genomic sequencing procedure (GSP), DNA sequence analysis, each variant exon: – Documentation of the specific gene listed in Molecular Pathology Procedure Levels 1 - 3 or GSP for which further analysis is being requested • MICA (solid organ transplantation): – The patient is undergoing evaluation for kidney transplantation, or – The patient is post kidney transplantation *Continued*	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81403** **Molecular Pathology Procedure, Level 4**	Yes	• NDP (Norrie disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Norrie disease • SH2D1A (X-linked lymphoproliferative syndrome) – The patient has a single X chromosome with the diagnosis of: – Common variable immune deficiency, or – Hypogammaglobulinemia, or – Hemophagocytic lymphohistiocytosis, or – Severe infectious mononucleosis, or – Lymphoma, or – Family history of X-linked lymphoproliferative syndrome • VHL (von Hippel-Lindau tumor suppressor), deletion/duplication analysis – The patient has clinical features suspicious for, or requires the service as a diagnostic test for von Hippel-Lindau syndrome Claims without documentation showing the preceding criteria have been met will be denied.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81404 **Molecular Pathology Procedure, Level 5** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81404 (molecular pathology procedure Level 5) is limited to the listed services. Reimbursement for code 81404 requires an approved Treatment Authorization Request (TAR) and requires providers to document one of the following on the TAR: • ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain), targeted sequence analysis: – The patient has elevated C4-C on newborn screening test, and – Confirmation (urine acylglycines or urine organic acids) that C4 (butyrylcarnitine) and/or ethylmalonic acid (EMA) are elevated • CD40LG (X-linked hyper IgM syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for hyperimmunoglobulin M syndromes • EMD (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • EPM2A (progressive myoclonus epilepsy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for progressive myoclonus epilepsy • FHL1 (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants: – The patient has clinical signs and symptoms suspicious for familial MEFV, and – The patient requires the service as a	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81404** **Molecular Pathology Procedure, Level 5** *Continued below*	Yes *Continued*	confirmatory test for familial MEFV • NDP (Norrie disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Norrie disease • PDX1 (pancreatic and duodenal homeobox 1) – The patient requires the service as a diagnostic test for (maturity onset diabetes of the young) MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • PRNP (genetic prion disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for genetic prion disease • PRSS1 (hereditary pancreatitis): – An unexplained documented episode of acute pancreatitis in childhood, or – Recurrent acute attacks of pancreatitis of unknown cause, or – Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or – A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance • RET (ret proto-oncogene), common variants – The patient has a personal history of primary C cell hyperplasia, Medullary Thyroid Carcinoma (MTC), or Multiple Endocrine Neoplasia (MEN), type 2B, or – The patient has a family history consistent with MEN, type 2B or MTC,	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81404** **Molecular Pathology Procedure, Level 5**	Yes	and at risk for autosomal dominant inheritance of the syndrome • SH2D1A (X-linked lymphoproliferative syndrome) – The patient has a single X chromosome with the diagnosis of: – Common variable immune deficiency, or – Hypogammaglobulinemia, or – Hemophagocytic lymphohistiocytosis, or – Severe infectious mononucleosis, or – Lymphoma, or – Family history of X-linked lymphoproliferative syndrome • SPINK1 (hereditary pancreatitis): − An unexplained documented episode of acute pancreatitis in childhood, or − Recurrent acute attacks of pancreatitis of unknown cause, or − Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or − A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance • VHL (von Hippel-Lindau tumor suppressor), full gene sequence – the patient has clinical features suspicious for, or requires the service as a diagnostic test for von Hippel-Lindau syndrome Claims without documentation showing the preceding criteria have been met will be denied.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81405 **Molecular Pathology Procedure, Level 6** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81405 (molecular pathology procedure, level 6) is limited to the listed services. Reimbursement for code 81405 requires an approved TAR and requires providers to document one of the following on the TAR: • ABCD1 (adrenoleukodystrophy): – The patient has clinical features suspicious for adrenoleukodystrophy, and – Measurement of plasma concentration of very long chain fatty acids (VLCFA) is inconclusive, and – The service is required as a confirmatory test for the diagnosis of adrenoleukodystrophy • ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain), full gene sequence: – The patient has elevated C4-C on newborn screening test, and – Confirmation (urine acylglycines or urine organic acids) that C4 (butyrylcarnitine) and/or ethylmalonic acid (EMA) are elevated • CPOX (coproporphyrinogen oxidase), full gene sequence: – The patient has elevated urinary and fecal coproporphyrin III, and – The patient requires the service as a confirmatory test for hereditary coproporphyria • CTRC (chymotrypsin C) (e.g, hereditary pancreatitis), full gene sequence: – The patient has an unexplained documented episode of acute pancreatitis in childhood, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes *Continued*	– Recurrent acute attacks of pancreatitis of unknown cause, or – Chronic pancreatitis or possible chronic pancreatitis (ie, does not meet diagnostic criteria but clinical evidence of chronic pancreatitis is noted) of unknown cause, particularly with onset younger than 25 years of age, or – A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance – Evidence of pancreatitis related disorders (male infertility or bronchiectasis) • EMD (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • GDF2 (Growth/Differentiation Factor 2) – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • GLA (galactosidase alpha [for example, Fabry disease]), full gene sequence: – The patient has a family member with documented disease-causing mutation, and	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes *Continued*	– The decision whether to initiate enzyme replacement therapy will be contingent on the results • HNF1A (HNF1 homeobox A) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • HNF1B (HNF1 homeobox B) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • LAMP2 (Danon disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease IIb (Danon disease) • NF2 (neurofibromatosis, type 2): – The patient has clinical features suspicious for, or requires the service as a confirmatory test for type 2 neurofibromatosis, OR – The patient is at high risk for neurofibromatosis with one or more of the following: – A first-degree relative with type 2 neurofibromatosis – Multiple spinal tumors (schwannomas, meningiomas) – Cutaneous schwannomas – Sporadic vestibular schwannoma younger than 30 years of age, or spinal	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes	tumor or meningioma younger than 20 years of age • NPHS2 (steroid resistant nephrotic syndrome [SRNS]) – The patient has clinical diagnosis of SRNS, and – Treatment will be contingent on the test results • OTC (ornithine transcarbamylase deficiency) – The patient has clinical signs and symptoms of urea cycle disorders with positive biochemical laboratory results and requires the service as a confirmatory test for ornithine transcarbamylase deficiency • PKLR (pyruvate kinase, liver and RBC), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for pyruvate kinase deficiency • RASA1 – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • RET (multiple endocrine neoplasia [MEN], type 2A and familial medullary thyroid carcinoma [MTC]) – exons 10, 11, 13 – 16: – The patient has a personal history of MTC, or MEN, type 2A, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*		– The patient has pheochromocytoma and a family history of MTC or pheochromocytoma, or – The patient has sporadic MEN2-related tumors and is younger than 35 years of age, multicentric tumors in one organ, and/or two different organs affected, or – The patient has a family history consistent with MEN, type 2A • RET (ret proto-oncogen), targeted sequence analysis: – The patient has a personal history of primary C cell hyperplasie, MTC, or MEN, type 2A, or – The patient has a family history consistent with MEN, type 2A or MTC, and at risk for autosomal dominant inheritance of the syndrome • SLC2A1 (glucose transporter type 1 [GLUT 1] deficiency syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for GLUT 1 deficiency syndrome • SLSLC22A5 (for carnitine deficiency or carnitine uptake defect) – allowable when the newborn screen is positive for low carnitine levels or when there is clinical suspicion • SPRED1 (Legius syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Legius syndrome • TCF4 (Pitt-Hopkins syndrome)		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*		– The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • THRB (Thyroid Hormone Receptor, Beta) (e.g., thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of more than 5 exons – The patient has clinical presentation suspicious for Resistance to Thyroid Hormone- beta (RTH-beta) with any one of the following: o Elevated free T4 and/or free T3 with normal or mildly elevated TSH o Goiter or tachycardia regardless of other clinical signs and symptoms of thyroid dysfunction o Requiring high doses of T4 or T3 to reduce the TSH secretion or to induce the appropriate responses in peripheral tissues o No evidence of thyroid hormone binding abnormalities or pituitary adenoma o Family history of thyroid disease or RTH-beta – The test is needed to confirm the diagnosis of RTH-beta • TSC1 (tuberous sclerosis complex 1) – duplication/deletion analysis - The patient has signs or symptoms of		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above		tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • WT1 (Wilms tumor 1) – full gene sequence – The patient has suspected or confirmed acute myeloid leukemia, and the result of the test will influence the diagnosis, prognosis and/or therapeutic management		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81406 **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81406 (molecular pathology procedure, Level 7) is limited to the listed services. Reimbursement for code 81406 requires an approved TAR and requires providers to document one of the following on the TAR: • ACADVL (very long chain acyl-coenzyme A dehydrogenase deficiency) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for ACADVL • AFG3L2 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • ATP7B (Wilson disease): – The patient has clinical features suspicious for Wilson disease, and – Diagnosis cannot be made based on the results of biochemical testing and liver biopsy, and – The patient requires the service as a confirmatory test for Wilson disease • BTK (X-linked agammaglobulinemia): – Patient with a single X chromosome has clinical features suspicious for X-linked agammaglobulinemia, and – Patient with a single X chromosome has less than two percent CD19+ B cells • CDH1 (hereditary diffuse gastric cancer): – Two gastric cancer cases in family, one confirmed diffuse gastric cancer younger than 50 years of age, or – Three confirmed diffuse gastric cancer cases in first or second degree relatives, regardless of age, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**	Yes *Continued*	– Diffuse gastric cancer diagnosed younger than 40 years of age, or – Personal or family history of diffuse gastric cancer and lobular breast cancer, one diagnosed younger than 50 years of age • CNTNAP2 (Pitt-Hopkins-like syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • DSP The patient has clinical features suspicious for Arrhymogenic Right Ventricular Myopathy ICD 10 code I42. • GCK (glucokinase [hexokinase 4]) – The patient requires the service as diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • GDF2 (Growth/Differentiation Factor 2) – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • GLUD1 (familial hyperinsulinism): – The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI) and failed medical therapy, and – The patient is under evaluation for surgical intervention • HMBS (hydroxymethylbilane synthase), full gene sequence – The patient has clinical	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	features suspicious for, or requires the service as a confirmatory test for acute intermittent porphyria • HNF4A (hepatocyte nuclear factor 4, alpha) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • IDUA (iduronidase, alpha-L) (eg, mucopolysaccharidosis type I), full gene sequence. – The patient has clinical signs and symptoms consistent with mucopolysaccharidosis type I, and – Treatment option (allogeneic transplantation or gene therapy) will be contingent on the test results • JAG1 (Alagille syndrome) – duplication/deletion – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Alagille syndrome • KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2 [e.g. epileptic encephalopathy], full gene sequence) – The patient has clinical symptoms and electroencephalogram (EEG) patterns consistent with early infantile epileptic encephalopathy, and – Treatment is contingent on test results • MUTYH (MYH-associated polyposis) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for MUTYH-associated polyposis	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	• NF2 (neurofibromatosis, type 2): – The patient has clinical features suspicious for, or requires the service as a confirmatory test for type 2 neurofibromatosis, or – The patient is at high risk for neurofibromatosis with one or more of the following o A first-degree relative with type 2 neurofibromatosis o Multiple spinal tumors (schwannomas, meningiomas) o Cutaneous schwannomas o Sporadic vestibular schwannoma younger than 30 years of age, or spinal tumor or meningioma younger than 20 years of age • PCSK9 (proprotein convertase subtilisin/kexin type 9) (e.g., familial hypercholesterolemia), full gene sequence – Patient has coronary artery disease (CAD) or has risk factors for CAD – The intention to treat or not to treat with PCSK9 inhibitors will be contingent, at least in part, on the test results • PHEX (phosphate-regulating endopeptidase homolog, X-Linked) (e.g. hypophosphatemic rickets), full gene sequence – The patient is undergoing evaluation for X-Linked Hypophosphatemia (XLH); and – Diagnosis was not able to be established based on biochemical testing, which included the following tests:	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	– Serum calcium, phosphate and alkaline phosphatase, and – PTH, 25 hydroxyvitamin D, and 1,25 dihydroxyvitamin D, and – Urinary calcium excretion; and 3. The confirmation of the diagnosis and the treatment strategy is contingent on the test result. • POLG (polymerase [DNA directed], gamma [e.g., Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia], full gene sequence). TAR may be approved based on one of the following numbered criteria: – The patient is undergoing consideration for treatment using valproic acid, or – The patient is undergoing evaluation for potentially having any one of the following conditions: o Alpers-Huttenlocher syndrome o Ataxia neuropathy spectrum (ANS), previously known as mitochondrial recessive ataxia syndrome (MIRAS) and sensory ataxia neuropathy, dysarthria and ophthalmoplegia (SANDO) o Autosomal dominant progressive external ophthalmoplegia o Autosomal recessive progressive external ophthalmoplegia o Childhood myocerebrohepatopathy spectrum o Myoclonic epilepsy myopathy sensory ataxia	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**	Yes	• PPOX (protoporphyrinogen oxidase), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute variegate porphyria • PRKCG (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • PYGM (glycogen storage disease type V, McArdle disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type V (McArdle disease) • RASA1 – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • RPE65 (retinal pigment epithelium-specific protein 65kDa) – Patient has a clinical diagnosis of retinal dystrophy, and – The decision for gene therapy is contingent on the test results • SCNN1A (pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for pseudohypoaldosteronism • SCNN1B (Liddle syndrome, pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Liddle syndrome, pseudohypoaldosteronism	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**		• SCNN1G (Liddle syndrome, pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Liddle syndrome, pseudohypoaldosteronism • SLC37A4 (glycogen storage disease, type Ib) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease, type Ib • TCF4 (Pitt-Hopkins syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • TSC1 (tuberous sclerosis complex 1) – full gene sequence – The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • TSC2 (tuberous sclerosis complex 2) – duplication/deletion analysis – The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • UMOD (glomerulocystic kidney disease with hyperuricemia and isosthenuria) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glomerulocystic kidney disease with hyperuricemia and isosthenuria • WAS (Wiskott-Aldrich syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Wiskott-Aldrich syndrome		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81407 **Molecular Pathology Procedure, Level 8** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81407 (molecular pathology procedure, Level 8) is limited to the listed services. Reimbursement for code 81407 requires an approved TAR and requires providers to document one of the following on the TAR: • ABCC8 (familial hyperinsulinism): – The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI) who failed medical therapy, and – The patient is under evaluation for surgical intervention • AGL (glycogen storage disease type III) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type III	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81407 **Molecular Pathology Procedure, Level 8**	Yes	• JAG1 (Alagille syndrome) – full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Alagille syndrome • NOTCH (notch 1) – full gene sequence – The patient has suspected or confirmed acute lymphoblastic leukemia, and the result of the test will influence the diagnosis, prognosis and/or therapeutic management • NPHS1 (congenital Finnish nephrosis) − The patient has clinical diagnosis of steroid-resistant nephritic syndrome (SRNS)/congenital Finnish nephrosis, and − Treatment will be contingent on the test results • SCN1A – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Dravet syndrome • SPTBN2 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • TSC2 (tuberous sclerosis complex 2) – full gene sequence – The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81408 **Molecular Pathology Procedure, Level 9**	Yes	Coverage for CPT-4 code 81408 (molecular pathology procedure, Level 9) is limited to the listed services. Reimbursement for code 81408 requires an approved Treatment Authorization Request (TAR) explaining that the following criteria have been met: • COL1A1, COL1A2 (Osteogenesis Imperfecta) ICD 10 code: Q78 • ITPR1 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • DMD (dsytophin), full gene analysis – Patient has a clinical diagnosis of dystrophinopathy based on the history, physical examination and elevated creatine kinase (CK) level – Result of the DMD (dystrophin) deletion or duplication is negative • NF1 (neurofibromatosis 1) – The patient has clinical features suspicious for NF1 and requires genetic testing to confirm the diagnosis (one or more signs of NF 1 present, but not enough to make clinical diagnosis), OR – Asymptomatic individual with a first, second, or third-degree relative with established diagnosis of NF1.	Once-in-a-lifetime, any provider, except with valid TAR override	First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81412 **Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least nine genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1**	Yes	A TAR requires documentation of the following criteria: • Patient is considering pregnancy or is currently pregnant, and • Patient reports they are of Ashkenazi Jewish descent (family history with one Ashkenazi Jewish grandparent or more, or more immediate family members), and • The panel includes only the conditions specified by American College of Obstetricians and Gynecologists (ACOG) (e.g., [ACOG] Carrier Screening for Genetic Conditions) and/or by American College of Medical Genetics and Genomics [ACMG] for individuals of Ashkenazi Jewish descent	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81413 **Cardiac Ion Channelopathies genomic sequence analysis panel, must include sequencing of at least 10 genes**	Yes	Reimbursement for CPT-4 code 81413 must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A. The required TAR must document a copy of the report of the physician-interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause	Once-in-a-lifetime, any provider, except with valid TAR override	
81414 **Cardiac ion channelopathies; genomic sequence analysis panel, must include sequencing of at least 2 genes**	Yes	Reimbursement for CPT-4 code 81414 must include sequencing of at least 2 genes, including KCNH2 and KCNQ1. The required TAR must document a copy of the report of the physician-interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81419 **Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9AG, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2**	Yes	The required TAR must document the following: • Patient has specific epilepsy syndrome of unknown cause for which a number of genetic etiologies exist. • The test is needed for identifying the underlying diagnosis • The diagnostic or treatment strategy will be contingent on test results	N/A	
81420 **Fetal chromosomal aneuploidy genomic sequence analysis panel, must include analysis of chromosomes 13, 18, and 21**	No	N/A	Payable no more than once per pregnancy	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81432 **Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes** *Continued below*	Yes	A TAR with documentation of one or more the following criteria is required: 1. An individual from a family member with a known deleterious BRCA mutation; or 2. Personal history of breast cancer (invasive or ductal carcinoma in situ) plus one of more of the following: • Diagnosed at ≤45 years of age, or • Diagnosed at 46 – 50 years of age with: – An additional breast cancer primary at any age – One or more close blood relatives with breast cancer at any age – One or more close blood relatives with prostate cancer (Gleason score ≥7) – An unknown or limited family history; or • Diagnosed at ≤60 years of age with a triple negative breast cancer; or • Diagnosed at any age with: – One or more close relatives with: ❖ Breast cancer diagnosed at ≤50 years of age; ❖ Ovarian carcinoma; or ❖ Male Breast cancer; or ❖ Metastatic prostate cancer; or ❖ Pancreatic cancer – Two or more additional diagnosis of breast cancer at any age in patient and/or in close blood relatives; or – Ashkenazi Jewish ancestry: or **3.** Personal history of ovarian carcinoma (includes fallopian tube and primary peritoneal cancers); or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81432** **Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes**		**4.** Personal history of male breast cancer; or **5.** Personal history of pancreatic cancer, or **6.** Personal history of metastatic prostate cancer (biopsy-proven and/or with radiographic evidence; includes distant metastasis and regional bed or nodes; not biochemical recurrence); or **7.** Personal history of high-grade prostate cancer (Gleason score ≥7) at any age with: • One or more close blood relatives (first, second or third-degree) with ovarian carcinoma, pancreatic cancer or metastatic prostate cancer at any age or breast cancer under 50 years of age; or • Two or more close blood relatives (first, second, or third-degree relatives on the same side of family) with breast or prostate cancer (any grade) at any age; or • Ashkenazi Jewish ancestry; or **8.** BRCA1/2 pathogenic/likely pathogenic variant detected by tumor profiling on any tumor type in the absence of germline pathogenic/likely pathogenic variant analysis; or **9.** For an individual without history of breast or ovarian cancer, but with one or more first or second-degree blood relative meeting any of the above criteria		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81434 **Hereditary retinal disorders (e.g., retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR and USH2A**	Yes	A TAR is required with the following documentation: • Patient has a clinical diagnosis of retinal dystrophy (retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy) and • The decision for gene therapy is contingent on the test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81435 **Hereditary Colon Cancer Disorders; Genomic sequence analysis panel, must include sequencing of at least 10 genes**	No	Reimbursement for CPT-4 code 81435 must include analysis of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4 and STK11. Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030 - Z85.038, Z85.040 - Z85.048, Z85.42, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
81436 **Hereditary colon cancer disorders; genomic sequence analysis panel, must include sequencing of at least 5 genes**	No	Reimbursement for CPT-4 code 81436 must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11. Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030 – Z85.038, Z85.040 – Z85.048, Z85.42 or Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81439 **Inherited Cardiomyopathy Genomic sequence analysis panel, must include sequencing of at least 5 genes**	No	Reimbursement for CPT-4 code 81439 must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN. Reimbursable only when billed in conjunction with ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49. A TAR may override the frequency limit and required ICD-10-CM diagnosis codes.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81445 **Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, 5 to 50 genes**	Yes	A TAR for CPT code 81445 requires documentation of the following criteria: • For Somatic Testing: – The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and – The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of canceror repeat testing using the same NGS test only when anew primary cancer diagnosis is made by the treating physician, and – The decision for additional cancer treatment is contingent on the test results. • For Germline Testing: – Ovarian or breast cancer,and – Clinical indication for germline (inherited) testingfor hereditary breast or ovarian cancer (i.e., American College of – Obstetrician Gynecologists'criteria for further genetic evaluation for hereditary [germline] breast and ovarian cancer), and – A risk factor for germline (inherited) breast or ovariancancer, and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick), and – Has not been previously tested with the same germline test using NGS forthe same germline genetic content. • Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a Companion Diagnostic Device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81448 **Hereditary peripheral neuropathies, genomic sequence analysis panel, must include sequencing of at least 5 neuropathy-related genes**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): G11.4, G60.0	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81455 **Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (e.g., ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET),**	Yes	A TAR for CPT code 81455 requires documentation of the following criteria: For Somatic Testing: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing: • Ovarian or breast cancer,and • Clinical indication for germline (inherited) testingfor hereditary breast or ovarian cancer (i.e., American College of Obstetrician Gynecologists'criteria for further genetic evaluation for hereditary [germline] breast and ovarian cancer), and • A risk factor for germline (inherited) breast or ovarian cancer, and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick), and • Has not been previously tested with the same germline test using NGS forthe same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is FDA-approved as a Companion Diagnostic Device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81457 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability**	Yes	A TAR for CPT code 81457 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81458 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability**	Yes	A TAR for CPT code 81458 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81459 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements**	Yes	A TAR for CPT code 81459 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81462 **Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (e.g., plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements**	Yes	A TAR for CPT code 81462 requires documentation of the following criteria: 1. The patient has a diagnosis of on-small cell lung cancer, and 2. The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and 3. Management is contingent on the test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81479 **Unlisted Molecular Pathology Procedure**	Yes	Specific service being requested under this code must be defined and clinical documentation must be included for diagnosis and treatment recommendation.	N/A	Frequency will be determined by the clinical information submitted.
81500 **Oncology (ovarian), biochemical assays of two proteins**	No	Reimbursable for members who meet the following criteria: • 18 years of age or older • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist ICD-10-CM diagnosis code R19.09 is required for reimbursement	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81503 **Oncology (ovarian), biochemical assays of five proteins**	No	Reimbursable for members who meet the following criteria: • 18 years of age or older • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist CPT code 81503 is reimbursable only when billed in conjunction with at least one of the following ICD-10-CM diagnosis codes: D39.10 – D39.12, N83.00 – N83.02, N83.10 – N83.12, N83.201, N83.202, N83.209, N83.291, N83.292, N83.299, R19.00, R19.03 – R19.05, R19.07 or R19.09.	N/A	
81507 **Fetal aneuploidy (trisomy 21, 18 and 13)** **DNA sequence analysis of selected regions**	No	N/A	Payable no more than once per pregnancy	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.
81508 **Fetal congenital abnormalities, biochemical assays of two proteins**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81509 **Fetal congenital abnormalities, biochemical assays of three proteins**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81510 **Fetal congenital abnormalities, biochemical assays of three analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81511 **Fetal congenital abnormalities, biochemical assays of four analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81512 **Fetal congenital abnormalities, biochemical assays of five analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81517 **Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver related clinical events within 5 years**	No	N/A	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81518+ **Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes** +See note at the end of this table	Yes	Requires a *Treatment Authorization Request* (TAR) with documentation of the following criteria: • The recipient is estrogen and/or progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative or lymph node positive with up to three positive nodes. • The recipient has stage I or stage II breast cancer. • The recipient is disease-free (or no evidence of metastasis). • Test results will be used in determining treatment management of the patient for chemotherapy and/or extended endocrine therapy. Use CPT code 81518 when billing for Breast Cancer Index.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81519+ **Oncology (breast), mRNA, gene expression profiling by real time RT-PCR of 21 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is premenopausal and lymph node negative or has 1-3 positive lymph nodes (no distant metastasis) • OR when the recipient is post-menopausal 0 - 3 positive lymph nodes(no distant metastasis) • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81519 when billing for Oncotype Dx.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81520+ **Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative. • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81520 when billing for Prosigna.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81521+ **Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient has high clinical risk per MINDACT categorization. • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative or lymph node positive. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81521 when billing for MammaPrint. As noted in the 2017 ASCO guideline, the Adjuvant! Online website was not functional. As an alternative, clinicians can determine a patient's clinical risk status by using the printed version of the Adjuvant! Online clinical risk criteria found in the Data Supplement of the MINDACT publication.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81522+ **Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative. • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT 81522 when billing for EndoPredict.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81523+ **Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis** +See note at the end of this table	No	For reference, here are the criteria outlined by DHCS: • The recipient has high clinical risk per MINDACT categorization. • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2- receptor negative. • The recipient is lymph node negative or lymph node positive. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81523 when billing for MammaPrint. As noted in the 2017 ASCO guideline, the Adjuvant! Online website was not functional. As an alternative, clinicians can determine a patient's clinical risk status by using the printed version of the Adjuvant! Online clinical risk criteria found in the Data Supplement of the MINDACT publication.	Once in a lifetime	
81528 **Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers**	No	Reimbursable for recipients 45 – 75 years of age. For recipients outside this age range, providers must submit a TAR documenting medical necessity. * For recipients requiring additional tests within a year, providers must submit a TAR documenting medical necessity.	No more than once every two years *	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81541 **oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score** *Cont'd*	Yes	The following criteria must be documented on the TAR: 1. For identification of patients with Prostate Cancer who are most likely to benefit from active surveillance or treatment. • Coverage is limited to Decipher®, Prolaris® and ProMark. Gene expression profiling for prostate cancer may be billed as follows: – Decipher® Prostate – Use CPT code 81542 – Prolaris® – Use CPT code 81541 – ProMark – Use CPT code 81599 • The patient must have one of the following: – Higher volume Grade Group 1 – Favorable intermediate risk (e.g., Grade Group 2, percentage of positive biopsy scores, 50 percent and no more than on NCCN intermediate-risk factor) – Discordant features in their risk stratification (e.g., palpable mass with Grade Group 1) – Other features associated with progression while on active surveillance (e.g., high PSA density and certain germline or somatic mutations) – Unfavorable intermediate-risk when considering decisions to proceed with treatment (i.e. add androgen deprivation therapy to radiation) • Result of the test, when considered as a whole with routine clinical factors, is	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **81541** **oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score**		likely to influence the decision to proceed with surveillance or treatment 2. For post-prostatectomy patients who seek guidance on adjuvant vs. salvage radiation: • Coverage is limited to Decipher Genomic Classifier • Result of the test, when considered as a whole with routine clinical factors, is likely to affect treatment		
81542 **oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score**	Yes	See CPT code 81541 for TAR criteria and billing requirements.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81546 **Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)**	Yes	The following numbered criteria must be documented on the TAR: 1. The patient is under evaluation for thyroid nodule(s) 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: • Follicular lesion of undetermined significance (FLUS), Bethesda III, or • Atypia of undetermined significance (AUS), Bethesda III, or • Follicular neoplasm, Bethesda IV. 3. The diagnostic or treatment strategy will be contingent on test results	N/A	
81552 **Oncology (uveal melanoma), mRNA, gene expression profiling by real -time RT-PCR of 15 genes**	No	An ICD-10-CD diagnosis code from the following ranges must be documented: C69.30 – C69.32 or C69.40 – C69.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81596 **Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays**	No	The following ICD-10-CM code is required on the claim (except with valid TAR): B18.2	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
88261 – 88269 **88280** **Karyotype (aka Cytogenetic Studies)**	No	Karyotype testing for codes 88261-3 may be ordered once in a lifetime in children with phenotype of syndrome most commonly associated with a chromosomal abnormality. For perinatal indication, see Medi-Cal guidelines in the Genetic Counseling and Screening section gene coun 2.	Once-in-a-lifetime, any provider, except with valid TAR override	

+**Note:**
These benefits are limited to EndoPredict, Oncotype Dx, Prosigna (PAM50 risk of recurrence score) and Breast Cancer Index.
Use CPT code 81518 when billing for Breast Cancer Index.
Use CPT code 81519 when billing for Oncotype Dx.
Use CPT code 81520 when billing for Prosigna.
Use CPT code 81521 when billing for MammaPrint.
Use CPT code 81522 when billing for EndoPredict.

These once-in-a-lifetime benefits may be billed for the same recipient and any provider. Providers need an approved TAR and documentation showing that the recipient has a new second primary breast cancer that meets the necessary criteria as listed above to override the once-in-a-lifetime frequency.

Concurrent use of more than one test is not recommended as there is no data to support that ordering multiple assays in an individual patient would be beneficial in guiding treatment decisions.

We are committed to your health through cancer prevention.

Please fill out this brief questionnaire as thoroughly as possible so that we are better prepared to help you.

If you filled out this form within the last 6 months and nothing has changed, please initial here:

_____

TURN OVER

Screening: Your Personal and Family History of Cancer

Patient Name: _____ Date of Birth: _____

If you have a **personal or family history** of the following cancers, please indicate **WHO** and **AGE at diagnosis**. Include parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, great aunts/uncles, great grandparents and cousins.

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	**EXAMPLE:** *Breast Cancer*	_____	_____	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Ovarian cancer** *(Peritoneal/Fallopian Tube)*				
Y	N	**Are you of Ashkenazi Jewish descent?**				
Y	N	**Colon/Rectal cancer**				
Y	N	**Endometrial (uterine) cancer**				
Y	N	**10 or more colon polyps in a lifetime** *(Specify #)*				
Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Other Cancers**				
Y	N	**Have you or anyone in your family had genetic testing for a cancer syndrome?** **If YES, WHEN: _____ RESULTS:_____**				

Breast Cancer Risk Model Information for FEMALES only:

Your current height (ft/in) _____

Your current weight (lbs) _____

Your menopausal status:

☐ Pre-menopausal

☐ Peri-menopausal
(time before menopause marked by irregular cycles)

☐ Post-menopausal
(permanent cessation of period for 12 months or longer)

Age of onset _____

Your age at time of first menstrual period _____

Your age at time of first live birth: _____

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ Don't know

If yes, are you a: ☐ Current user: How many years ago did you start? _____
How many more years do you intend to use? _____

☐ Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? _____

Number of daughters _____

Number of sisters _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Patient meets guidelines for testing: ☐ YES ☐ NO CLINICIAN SIGNATURE: _____

IF YES: ☐ ACCEPTED ☐ DECLINED If Declined: Counseling Provided and Patient Signed:_____

HBOC: Personal or Family History

ONE person with (out to 2nd degree):
*Breast Cancer under 50
*Ovarian Cancer any age
*Male Breast Ca any age
*Triple Negative Breast Ca at or under 60
*Metastatic Prostate Cancer
*Breast Cancer any age and Ashkenazi
*Pancreatic Cancer any age and Ashkenazi Jewish heritage

TWO persons with (out to 3rd degree):
*Breast Ca, 1 at or under 50
*Breast Ca and Ovarian Ca any age

THREE persons with (out to 3rd degree):
*Breast and/or Pancreatic and/or Ovarian and/or Prostate (Gleason > 6) any age

LYNCH: Personal or Family History**

ONE person with (out to 2nd degree):
*Endometrial Ca at or under 50
*Colon Ca at or under 50

TWO persons with (out to 2nd degree):
*Endo or Colon Ca over 50 and a Lynch cancer < 50

THREE persons with (out to 3rd degree):
*Lynch cancers, 1 being Endo or Colon, any age

FAP/AFAP: Personal or Family History

ONE person with (out to 2nd degree):
*10 or more colon polyps in a lifetime

**Lynch cancers: Endo, CRC, Ovarian, Stomach, Brain, Pancreas, Small Bowel, Biliary Tract, Ureter/Renal Pelvis, Sebaceous Adenoma

1st degree: parents, siblings, children. 2nd degree: grandparents, aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Proprietary Laboratory Analyses (PLA) codes represent proprietary laboratory services. The following codes may include a range of laboratory tests including, but not limited to multianalyte assays with algorithmic analyses (MAAA) and genomic sequencing procedures (GSP). MAAAs are procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays and non-nucleic acid-based assays (for example, proteins, polypeptides, lipids, carbohydrates). Consistent with CPT® coding guidelines, when a PLA code is available, the specific PLA code takes precedence.				
~~**0014M**~~ ~~**Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver-related clinical events within 5 years**~~	~~No~~	~~ICD-10 K70 – K76, B18~~ ~~And ordered by Infectious Disease or Liver Specialist~~	~~N/A~~	
0017M **Oncology (diffuse large b-cell lymphoma [dlbcl]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffin embedded tissue, algorithm reported as cell of origin**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39	Once in a lifetime, except with valid TAR override	
0001U **Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported**	No	Ordered by hematologist/oncologist	N/A	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0003U **Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score**	No	The following ICD-10-CM diagnosis code is required on the claim: R19.09 Reimbursable for females who meet the following criteria: • 18 years of age or older and • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist	Once in a lifetime, except with valid TAR override	
0016U **Oncology (hematolymphoid neoplasia), RNA, NCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.10 thru C92.12	Once per year	
0017U **Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report pf JAK2 mutation not detected or detected**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: D45, D47.1 or D47.3	Once per year	
0018U **Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy** *Continues*	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient is under evaluation for thyroid nodules(s) and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following:	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **0018U** **Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy**	Yes	a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV And the diagnostic or treatment strategy will be contingent on test results.	Once-in-a-lifetime, except with valid TAR override	
0022U **Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider.**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has a diagnosis of non-small cell lung cancer (NSCLC). • Treatment is contingent on test results	Once in a lifetime, except with valid TAR override	
0023U **Oncology (acute myelogenous leukemia), DNA, gentotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0026U **Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")** *Continues*	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s) and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following:	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **0026U** **Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy").**	Yes	a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV And the diagnostic or treatment strategy will be contingent on test results	Once-in-a-lifetime, except with valid TAR override	
0027U **JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: D45, D47.1 or D47.3	Once per year	
0034U **TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(e.g., thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5).**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression	Once-in-a-lifetime, except with valid TAR override	
0035U **Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative** *Continues*	Yes	The service requires a TAR with documentation of the following criteria: 1. Rapidly progressive dementia with at least two out of the following four clinical features: a. Myoclonus b. Visual or cerebellar signs c. Pyramid/extrapyramidal signs d. Akinetic mutism	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **0035U** **Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative**	Yes	2. And a positive result on at least one of the following tests: a. Characteristic changes in an EEG (periodic sharp wave complexes) during an illness of any duration b. High signal in caudate/putamen in magnetic resonance imaging (MRI) brain scan or at least two cortical regions (temporal, parietal occipital) either on diffusion-weighted imaging (DWI) or fluid attenuated inversion recovery (FLAIR) 3. And routine investigations do not indicate an alternative diagnosis	Once-in-a-lifetime, except with valid TAR override	
0037U **Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden.**	As Noted	A TAR is not required when the following criteria are met: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. A TAR is required for all other cancer diagnosis that are not advanced. Required Documentation: diagnosis and stage of malignancy and the chart notes, must show the medical necessity for this test for therapeutic decisions.	N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0040U **BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative**	No	The following ICD-10-CM diagnosis code is required on the claim: C92.10.	Once per year, except with valid TAR override	
0046U **FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0047U **Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score** *(continues)*	Yes Yes	The coverage policy for Gene Expression Profile (GEP) for prostate cancer is based on the 2019 American Society of Clinical Oncologist (ASCO) Guideline titled, "Molecular Biomarkers in Localized Prostate Cancer: ASCO Guideline. For identification of patients with prostate cancer who are most likely to benefit from active surveillance or treatment: • Coverage is limited to Oncotype Dx Prostate – Use PLA code 0047U The service requires a TAR with documentation of the following criteria: 1. The patient must have one of the following: a. Higher volume Grade Group 1 or b. Favorable intermediate risk (e.g., Grade Group 2, percentage of positive biopsy cores, 50 percent, and no more than one NCCN intermediate-risk factor) or	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
(continued from above) **0047U** **Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score**		c. Discordant features in their risk stratification (e.g., palpable mass with Grade Group 1) or d. Other features associated with progression while on active surveillance (e.g., high PSA density and certain germline or somatic mutations) or e. Unfavorable intermediate-risk when considering decisions to proceed with treatment (i.e. add androgen deprivation therapy to radiation). 2. Result of the test, when considered as a whole with routine clinical factors, is likely to influence the decision to proceed with surveillance or treatment. For post-prostatectomy patients who seek guidance on adjuvant vs. salvage radiation: 1. Coverage is limited to Decipher Genomic Classifier 2. Result of the test, when considered as a whole without routine clinical factors, is likely to affect treatment	Once-in-a-lifetime, except with valid TAR override	
0049U **NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0050U **Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0058U **Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus oncoprotein (small T antigen), serum, quantitative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C4A.0, C4A.10 thru C4A.12, C4A.20 thru C4A.22, C4A.30 thru C4A.39, C4A.51 thru C4A.59, C4A.60 thru C4A.62, C4A.70 thru C4A.72, C4A.8, C4A.9	Once-in-a-lifetime, except with valid TAR override	
0059U **Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C4A.0, C4A.10 thru C4A.12, C4A.20 thru C4A.22, C4A.30 thru C4A.39, C4A.51 thru C4A.59, C4A.60 thru C4A.62, C4A.70 thru C4A.72, C4A.8, C4A.9	Once-in-a-lifetime, except with valid TAR override	
0081U **Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C69.30 thru C69.32, C69.40 thru C69.42 Repeat testing requires chart notes that show results will direct treatment	Once per year, except with valid TAR override	
0084U **Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens**	No	Hematology must order	N/A	
0087U **Cardiology (heart transplant), mRNA gene expression profiling by**	No	The following ICD-10-CM diagnosis code is required on the claim: Z94.1	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score				
0088U **Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection**	No	The following ICD-10-CM diagnosis code is required on the claim: Z94.0	Once per year	
0120U **Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.30 thru C83.39, C85.20 thru C85.29	Once per year	
0154U **Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C67.0 thru C67.9	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0155U Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (e.g., breast cancer) gene analysis (i.e., p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y)	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C50.011 thru C50.929	Once-in-a-lifetime, except with valid TAR override	
0157U APC (APC regulator of WNT signaling pathway) (e.g., familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C18.0 thru C18.9, D12.0 thru D12.9, K63.5, Z86.010	Once-in-a-lifetime, except with valid TAR override	
0158U MLH1 (mutL homolog 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0159U MSH2 (mutS homolog 2) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0160U MSH6 (mutS homolog 6) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9,	Once-in-a-lifetime, except with	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
(List separately in addition to code for primary procedure)		Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	valid TAR override	
0161U **PMS2 (PMS1 homolog 2, mismatch repair system component) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0162U **Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0165U **Peanut allergen-specific quantitative assessment of epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and probability of peanut allergy.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: Z01.82, Z91.010 Repeat testing requires chart notes that show results will direct treatment.	Once per year except with valid TAR override with clinical justification	
0169U **NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism) gene analysis, common variants**	Yes	The service requires a TAR with documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, except with valid TAR override	
0171U **Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and**	No	One of the following ICD-10-CM diagnosis codes is required on the claim:	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence		C92.00, C92.01, C92.02, C92.10 thru C92.22, C95.10, D45, D46.0, D46.1, D46.20 thru D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.1, D47.3.		
0172U **Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score**	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has advanced ovarian, fallopian tube or primary peritoneal cancer and 2. Treatment is contingent on the result of the test	Once-in-a-lifetime, except with valid TAR override	
0177U **Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status**	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has confirmed diagnosis of breast cancer and 2. Treatment is contingent the result of the test	Once-in-a-lifetime, except with valid TAR override	
0178U **Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction.**	No	DX code Z91.01, CPT 95180 Ordered by Allergist TAR override if >50 /day above ICD-10 codes with clinical notes showing the medical necessity	50/day, except with valid TAR override	
0180U **Red cell antigen (ABO blood group) genotyping (ABO), gene analysis**	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Sanger/chain termination/ conventional sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyl-transferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons				
0181U **Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1**	No	Ordered by hematologist	Once per year	
0182U **Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10**	No	Ordered by hematologist	Once per year	
0183U **Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19**	No	Ordered by hematologist	Once per year	
0184U **Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2**	No	Ordered by hematologist	Once per year	
0185U **Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4**	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0186U Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	No	Ordered by hematologist	Once per year	
0187U Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	No	Ordered by hematologist	Once per year	
0188U Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	No	Ordered by hematologist	Once per year	
0189U Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	No	Ordered by hematologist	Once per year	
0190U Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3	No	Ordered by hematologist	Once per year	
0191U Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6	No	Ordered by hematologist	Once per year	
0192U	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9				
0193U **Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26**	No	Ordered by hematologist	Once per year	
0194U **Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8**	No	Ordered by hematologist	Once per year	
0195U **KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)**	No	Ordered by hematologist	Once per year	
0196U **Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3**	No	Ordered by hematologist	Once per year	
0197U **Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1**	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0198U **Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/ conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5**	No	Ordered by hematologist	Once per year	
0199U **Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12**	No	Ordered by hematologist	Once per year	
0200U **Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3**	No	Ordered by hematologist	Once per year	
~~**0204U**~~ ~~**Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected**~~	~~Yes~~	~~The service requires a TAR with documentation of the following criteria:~~ ~~1. The patient is under evaluation for thyroid nodule(s) and~~ ~~2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following:~~ ~~a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or~~ ~~b. Atypia of undetermined significance~~	~~Once in a lifetime~~	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		~~(AUS), Bethesda III, or~~ ~~c. Follicular neoplasm, Bethesda IV.~~ ~~3. And the diagnostic or treatment strategy will be contingent on test results~~		
0216U **Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, ~~G11.1,~~ G11.3, G11.9, G11.10, G11.11, G11.19, R26.0, R27.0.	Once per year except with valid TAR override	
0217U **Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, ~~G11.1,~~ G11.3, G11.9, G11.10, G11.11, G11.19 R26.0, R27.0.	Once per year, except with valid TAR override	
0218U **Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has a clinical diagnosis of dystrophinopathy based on the history, physical examination and elevated creatinine kinase (CK) level and • Result of the DMD (dystrophin) deletion or duplication is negative	N/A	
0219U	No	One of the following ICD-10-CM diagnosis codes is required on the claim: B20, Z21. TAR	Once per year, except with	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (ie, protease [PR], reverse transcriptase [RT], integrase [INT]), algorithm reported as prediction of antiviral drug susceptibility		override with above ICD 10 and Clinical notes showing medical necessity for repeat testing	valid TAR override	
0221U **Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene**	No	Ordered by hematologist	Once per year	
0222U **Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal promoter, exons 1-10, portions of introns 2-3**	No	Ordered by hematologist	Once per year	
0230U **AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once in a lifetime	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0231U **CACNA1A (calcium voltage-gated channel subunit alpha 1A) (e.g., spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	N/A	
0232U **CSTB (cystatin B) (e.g., progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once in a lifetime	
0233U **FXN (frataxin) (e.g., Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once in a lifetime	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0234U **MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Rett syndrome, and • The patient requires the service as a confirmatory test for Rett syndrome	Once in a lifetime	
0235U **PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions** *(continues)*	Yes	The service requires a TAR with documentation of the following criteria: 1. Individual with a personal history of: a. Bannayan-Riley-Ruvalcaba syndrome, or b. Adult Lhermitte-Duclos disease, or c. Autism spectrum disorder AND macrocephaly, or d. Two or more biopsy-proven trichilemmomas, or e. Two or more major criteria (one macrocephaly), or f. Three major criteria without macrocephaly, or g. One major and three or more minor criteria, or h. Four or more minor criteria (please see list of major and minor criteria below) 2. At-risk individual a. With a relative who has a clinical diagnosis of Cowden syndrome or b. Bannayan-Riley-Ruvalcaba syndrome for whom testing has not been performed AND who has any one major criterion or two minor criteria **Clinical Criteria:** Major Criteria • Breast Cancer • Mucocutaneous lesions	N/A	
(continued from above) **0235U** **PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions,**	Yes		N/A	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
and variants in non-uniquely mappable regions		• One biopsy-proven trichilemmoma • Multiple palmoplantar keratosis • Multifocal or extensive oral mucosal papillomatosis • Multiple cutaneous facial papules (often verrucous) • Macular pigmentation of glans penis • Macroencephaly (megalocephaly, ie, ≥97th percentile) • Endometrial cancer • Non-medullary thyroid cancer • Multiple GI tract hamartomas or ganglioneuromas **Minor Criteria** • Other thyroid lesions (adenoma, nodule, goiter) • Mental retardation (IQ ≤75) • Autism spectrum disorder • Single GI tract hamartoma or ganglioneuroma • Fibrocystic disease of the breast • Lipomas • Fibromas • Renal cell carcinoma • Uterine fibroids		
0236U **SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (e.g., spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions,**	Yes	The service requires a TAR. One of the following ICD-10-CM diagnosis codes is required on the claim: O09.00 thru O09.93, Z31.430, Z31.440, Z34.00 thru Z34.03, Z34.80 thru Z34.83,]Z34.90 thru Z34.93.	Once in a lifetime, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
duplications and deletions, and mobile element insertions				
0237U **Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR. The TAR must document a copy of the report of the physician interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause	Once in a lifetime, except with valid TAR override	
0238U **Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once in a lifetime	
0239U **Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions,**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient has a diagnosis of either: − Non-small cell lung cancer (plasma), or − Metastatic castrate resistant prostate cancer 2. And treatment is contingent on the test	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
deletions, select rearrangements, and copy number variations		result.		
0242U **Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has diagnosis of either – Non-small cell lung cancer, ~~and~~or – Hormone receptor-positive, Human Epidermal Growth Factor Receptor 2 (HER2)-negative breast cancer • ~~–~~Treatment is contingent on test result • ~~The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible~~	Once in a lifetime	
0244U **Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue** *Continues*	As Noted	The service may require a TAR For Somatic Testing (tumor) when specific testing is aimed at identifying therapeutic targets, a TAR is not required when: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results.	N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **0244U** **Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue**	As Noted	For somatic testing in the setting of cancers at stage 1 -2, TAR is required to include the diagnosis, stage and chart notes to show how results will direct treatments <u>For Germline Testing a TAR is required with the following documentation:</u> • Ovarian or breast cancer; and • Clinical indication for germline (inherited) testing for hereditary breast or ovarian cancer (ie, American College of Obstetrician and Gynecologists' criteria for further genetic evaluation for hereditary (germline) breast and ovarian cancer) and • A risk factor for germline (inherited) breast or ovarian cancer; and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick) and • Has not been previously tested with the same germline test using NGS for the same germline genetic content.	N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0245U **Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage** *Continues*	Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s) 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: a. Follicular lesion of	Once in a lifetime	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **0245U** **Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage**	Yes	undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV. 3. And the diagnostic or treatment strategy will be contingent on test results	Once in a lifetime	
0246U **Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens**	No	Ordered by hematologist	Once	
0268U **Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid**	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has clinical signs of symptoms for atypical hemolytic uremic syndrome (aHUS), and 2. The patient requires the service as a diagnostic test for aHUS	Once in a lifetime	
0269U **Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid**	Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient has clinical signs of symptoms suspicious for autosomal dominant congenita thrombocytopenia, and 2. The patient requires the service as a diagnostic test for autosomal dominant congenital thrombocytopenia	Once in a lifetime	
0271U	No	One of the following ICD-10-CM diagnosis codes is required on the claim:	Once in a lifetime,	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid		D70.0, D70.1, D70.2, D70.3, D70.4, D70.8, and D70.9. TAR over-ride allowed for ICD-10 codes	except with valid TAR override	
0276U **~~Hematology (inherited thrombocytopenia),~~ Gg enomic sequence analysis of 42 genes for detection of abnormalities associated with inherited thrombocytopenia (low platelet count)**	Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient has clinical signs or symptoms suspicious for inherited thrombocytopenia, and 2. The patient requires the service as a diagnostic test for inherited thrombocytopenia	Once in a lifetime	
0282U **Red blood cell antigen typing, dna, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes**	No	Ordered by hematologist	Once per year	
0286U **CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants**	Yes	The service requires a TAR A TAR requires documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression	N/A	
0287U **Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s), and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
cancer recurrence, reported as a categorical risk result (low, intermediate, high)		of the following: a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV. 3. And the diagnostic or treatment strategy will be contingent on test results		
0314U **Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant**	Yes	Ordered by Dermatology or Oncologist ICD-10 C43 and clinical notes showing medical necessity for repeat testing	One unit per day, except with valid TAR override	
0326U **Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden**	Yes	A TAR is required for malignancy diagnosis. Clinical information must be submitted showing diagnosis, staging and medical necessity where the treatment is directed by the results.	Once after recurrence, MORE frequently if there is a recurrence or progression with TAR override for medical necessity where treatment is directed by results	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
				authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0327U **Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed**	Yes	A TAR is required with clinical information indicating pregnancy and not previously tested in this pregnancy.	Once per pregnancy, consider repeat with TAR override for medical necessity showing indication for repeat testing and treatment is directed by results	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.
0329U **Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations**	Yes	A TAR is required with ~~clinical information indicating malignancy and cancer diagnosis and chart notes demonstrating medical necessity where treatment is directed by results~~documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary	Once per year and /or after recurrence or progression with TAR override for medical necessity where treatment is directed by results	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and The decision for additional cancer treatment is contingent on the test results.		considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
~~**0331U**~~ ~~**Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alterations**~~	~~Yes~~	~~A TAR is required with clinical information indicating Extra Medullary Multiple Myeloma or Multiple Myeloma and will document the treatment implications of the results~~	~~Once per year and /or after recurrence or progression TAR required that shows medical necessity including treatment is directed by results~~	~~Research suggests can be used to differential Extramedullary MM vs Multiple Myeloma – does not appear to have treatment implications – Nature: *ci Rep* **11**, 14671 (2021). https://doi.org/10.1038/s41598-021-93835-z. UpToDate and NCCN do not support nor direct the use of this analysis for standard diagnosis and treatment~~
0333U **Oncology (liver), surveillance for hepatocellular carcinoma (hcc) in highrisk patients, analysis of methylation patterns on circulating cell-free dna (cfdna) plus measurement of serum of afp/afp-l3 and oncoprotein des-gammacarboxy-prothrombin (dcp),**	Yes	TAR Required with Dx of High risk for hepatocellular carcinoma, notation that standard surveillance AFP and imagining is insufficient or inconclusive and subsequent treatment options contingent on results	Once in a lifetime	Of note this testing is NOT supported in the 2023 NCCN guidelines

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
algorithm reported as normal or abnormal result				
0334U **Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin embedded (ffpe) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden**	Yes	A TAR is required ~~. Solid organ malignancy~~ with documentation ~~showing treatment choices contingent on results~~of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results.	Once in a lifetime	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
~~**0337U**~~ ~~**Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential cd138, cd38, cd19, and cd45 protein**~~	~~Yes~~	~~TAR required with diagnosis plasma cell disorder or myeloma with documentation showing treatment choices contingent on results.~~	~~Once in a lifetime~~	~~NCCN guideline recommendations will be reviewed for medical necessity~~

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
~~**0338U**~~ ~~**Oncology (solid tumor), circulating tumor cell selection, identification, morphological characterization, detection and enumeration based on differential epcam, cytokeratins 8, 18, and 19, and cd45 protein biomarkers, and quantification of her2 protein biomarker expressing cells, peripheral blood**~~	~~Yes~~	~~TAR required. Solid organ malignancy with documentation showing treatment choices contingent on results~~	~~Once in a lifetime~~	~~NCCN guideline recommendations will be reviewed for medical necessity~~
0339U **Oncology (prostate), mrna expression profiling of hoxc6 and dlx1, reverse transcription polymerase chain reaction (rt-pcr), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C61, D07.5. Allow TAR/SAR override.	Once in 36 months, except with valid TAR override	
0341U **Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid**	Yes	TAR required with Prenatal Care diagnosis and clinical information showing medical necessity including explanation of why the covered code 0327U cannot be used	Once per pregnancy	
~~**0342U**~~ ~~**Oncology (pancreatic cancer), multiplex immunoassay of c5, c4, cystatin c, factor b, osteoprotegerin (opg), gelsolin, igfbp3, ca125 and multiplex electrochemiluminescent immunoassay (eclia) for ca19 9, serum, diagnostic algorithm reported qualitatively as positive, negative, or borderline**~~	~~No~~	~~One of the following ICD-10-CM diagnosis codes is required on the claim:~~ ~~C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9.~~	~~Once in a lifetime~~	
~~**0343U**~~ ~~**Oncology (prostate), exosome based**~~	~~No~~	~~One of the following ICD-10-CM diagnosis codes is required on the claim:~~	~~Once in 36 months,~~	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
~~analysis of 442 small noncoding rnas (sncrnas) by quantitative reverse transcription polymerase chain reaction (rt-qpcr), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of prostate cancer~~		~~C61, D07.5~~	~~except with valid TAR override~~	
~~0344U~~ ~~Hepatology (nonalcoholic fatty liver disease [nafld]), semiquantitative evaluation of 28 lipid markers by liquid chromatography with tandem mass spectrometry (lc-ms/ms), serum, reported as at-risk for nonalcoholic steatohepatitis (nash) or not nash~~	~~Yes~~	~~TAR required with diagnosis 76.0 Nonalcoholic Fatty Liver Disease or K75.8 or K76.0 and chart notes showing documentation of how treatment options are contingent upon results.~~	~~Once in a lifetime~~	
~~0353U~~ ~~Infectious agent detection by nucleic acid (DNA), chlamydia trachomatis and neisseria gonorrhoeae, multiplex amplified probe technique, urine, vaginal, pharyngeal, or rectal, each pathogen reported as detected or not detected~~	~~No~~		~~Three times a year,~~ ~~except with valid TAR override~~	
~~0354U~~ ~~Human papilloma virus (hpv), high risk types (i.e, 16, 18, 31, 33, 45, 52 and 58) qualitative mrna expression of e6/e7 by quantitative polymerase chain reaction (qpcr)~~	~~No~~		~~Three times in a lifetime,~~ ~~except with valid TAR override~~	
0359U **Oncology (prostate cancer), analysis of all prostate-specific antigen (PSA) structural isoforms by phase separation and immunoassay, plasma, algorithm reports risk of cancer**	No	Reimbursable for males who meet the following criteria: • 40 years of age or older • One of the following ICD-10-CM diagnosis codes is required on the claim: N40.0, N40.1, N40.2, N40.3, Z12.5, Z80.42	Twice per year, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0364U Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (pcr) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (mrd) with quantitation of disease burden, when appropriate	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C90.00, C90.01, C90.02, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12.	N/A Allow TAR override	
0369U Infectious agent detection by nucleic acid (dna and rna), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique	No	TAR Diagnosis of Gastrointestinal infection and documentation showing that testing is required to direct treatment	Once per year, except with valid TAR override	
0371U Infectious agent detection by nucleic acid (dna or rna), genitourinary pathogen, semiquantitative identification, dna from 16 bacterial organisms and 1 fungal organism, multiplex amplified probe technique via quantitative polymerase chain reaction (qpcr), urine	Yes	TAR required with diagnosis of Urinary Tract infection and documentation showing that testing is required to direct treatment	N/A	
0372U Infectious disease (genitourinary pathogens), antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score	Yes	Documentation of genitourinary tract infection and risk for antibiotic resistance ICD 10 Z16, Z16.24	N/A	
0373U Infectious agent detection by nucleic acid (dna and rna), respiratory tract infection, 17 bacteria, 8 fungus, 13 virus, and 16	Yes	Documentation of respiratory tract infection and risk for antibiotic resistance ICD 10 Z16, Z16.24	Two times per year,	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
antibiotic-resistance genes, multiplex amplified probe technique, upper or lower respiratory specimen			except with valid TAR override	
0374U **Infectious agent detection by nucleic acid (dna or rna), genitourinary pathogens, identification of 21 bacterial and fungal organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique, urine**	Yes	Documentation of genitourinary tract infection and risk for antibiotic resistance	N/A	
0378U **Rfc1 (replication factor c subunit 1), repeat expansion variant analysis by traditional and repeat-primed pcr, blood, saliva, or buccal swab**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, G11.2, G11.3, G11.4, G11.8, G11.9, G11.10, G11.11, G11.19, G32.81, G60.2, G80.4, R26.0, R27.0.	Once in a lifetime, except with valid TAR override	
0379U **Targeted genomic sequence analysis panel, solid organ neoplasm, dna (523 genes) and rna (55 genes) by next-generation sequencing, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutational burden**	Yes	A TAR is required ~~for malignancy diagnosis. Clinical information must be submitted showing diagnosis, staging and medical necessity where the treatment is directed by the results.~~with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and	Once in a lifetime, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		The decision for additional cancer treatment is contingent on the test results.		prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0381U **Maple syrup urine disease monitoring by patient-collected blood card sample, quantitative measurement of allo-isoleucine, leucine, isoleucine, and valine, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E71.0, E71.2	Allow TAR override for tests of more than 20 per year with documentation demonstrating medical need for more frequent testing	
0382U **Hyperphenylalaninemia monitoring by patient-collected blood card sample, quantitative measurement of phenylalanine and tyrosine, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E70.0 and E70.1	N/A Allow TAR override	
0383U **Tyrosinemia type i monitoring by patient-collected blood card sample, quantitative measurement of tyrosine, phenylalanine, methionine, succinylacetone, nitisinone, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E70.20, E70.21, E70.29	N/A Allow TAR override	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0388U **Oncology (non-small cell lung cancer), next-generation sequencing with identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection**	Yes	TAR requires documentation of the following criteria: • The patient has a diagnosis of non-small cell lung cancer • The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible • Management is contingent on the test results	Once in a lifetime, except with valid TAR override	
0391U **Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleotide variants, splice-site variants, insertions/deletions, copy number alterations, gene fusions, tumor mutational burden, and microsatellite instability, with algorithm quantifying immunotherapy response score**	Yes	A TAR is required -with documentation of the following criteria: ~~for malignancy diagnosis. Clinical information must be submitted showing diagnosis, staging and medical necessity where the treatment is directed by the results.~~ For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results.	Once in a lifetime, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
~~0397U~~ ~~Oncology (non-small cell lung cancer), cell-free DNA from plasma, targeted sequence analysis of at least 109 genes, including sequence variants, substitutions, insertions, deletions, select rearrangements, and copy number variations~~	~~Yes~~	~~TAR requires documentation of the following criteria:~~ ~~• The patient has a diagnosis of non-small cell lung cancer~~ ~~• The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible~~ ~~• Management is contingent on the test results~~	~~Once in a lifetime,~~ ~~except with valid TAR override~~	~~NCCN guideline recommendations will be reviewed for medical necessity~~
0409U Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability	Yes	A TAR is required with documentation of the following criteria: • The patient has a diagnosis of non-small cell lung cancer, and • The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and • Management is contingent on the test results	Once in a lifetime except with valid TAR override	
0448U Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffin-embedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options	Yes	A TAR is required with documentation of the following criteria: • The patient has been diagnosed with either non-small cell lung cancer (NSCLC) or colorectal cancer, and • Management is contingent on the test results	Once in a lifetime except with valid TAR override	
0471U Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations	Yes	A TAR is required with documentation of the following criteria: • The patient has been diagnosed with colorectal cancer, and • Management is contingent on the test results	Once in a lifetime except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

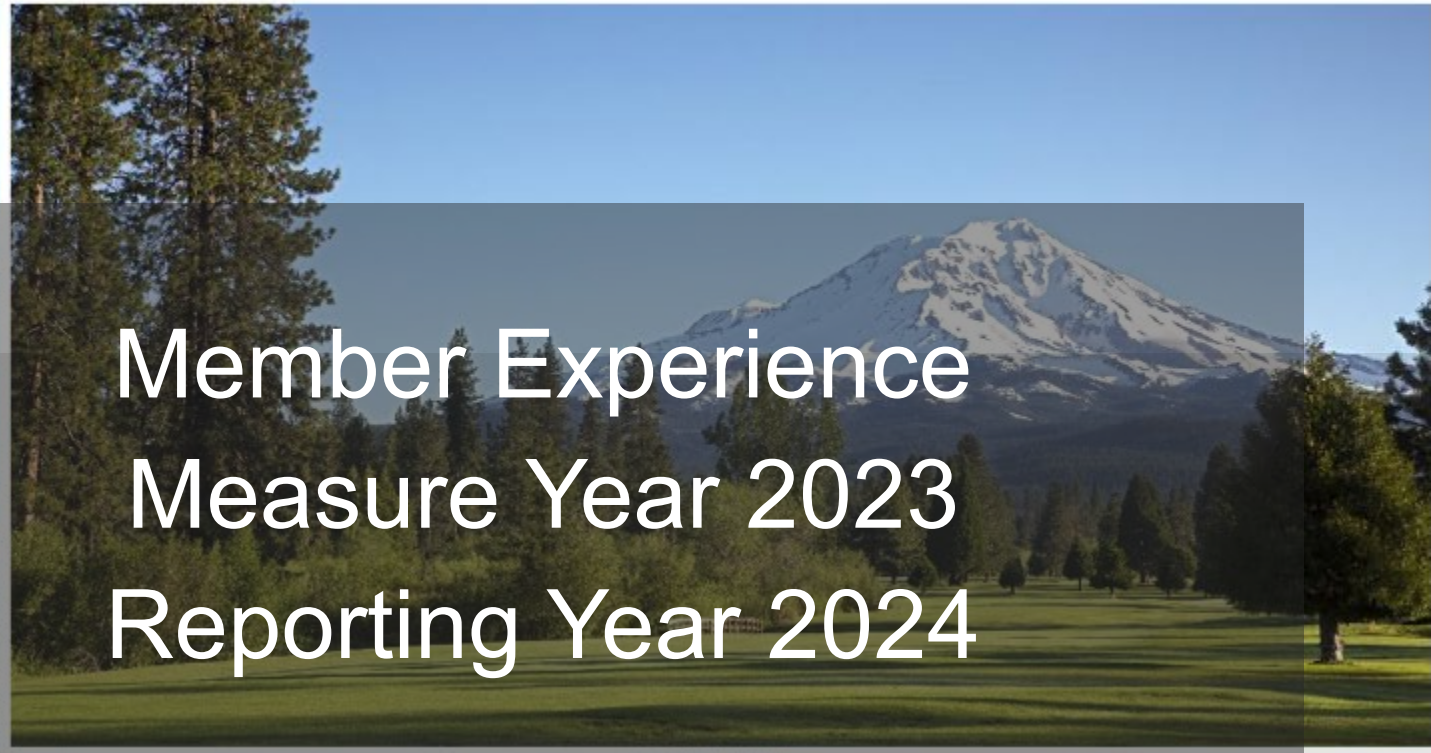
CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0473U **Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-mutation burden**	Yes	A TAR is required with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. Independent of the above criteria, somatic testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once in a lifetime except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0475U **Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for**	Yes	A TAR requires documentation of the following criteria: For Germline Testing • The patient has prostate cancer, and • The patient has a clinical indication for germline (inherited) testing for hereditary cancer (e.g., NCCN Guidelines for Prostate Cancer), and	Once in a lifetime except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
prostate cancer		• The patient has a risk factor for germline (inherited) cancer (e.g., NCCN Guidelines for Prostate Cancer), and • The patient has not been previously tested with the same germline genetic content.		
0488U **Obstetrics (fetal antigen noninvasive prenatal test), cell-free dna sequence analysis for detection of fetal presence or absence of 1 or more of the rh, c, c, d, e, duffy (fya) or kell (k) antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected**	Yes	A TAR requires documentation of the following criteria: For fetal RhD status • The patient is currently pregnant, and • The pregnant patient is RhD negative, and • The pregnant patient has not been tested with another cell-free DNA test for fetal RhD status during the same pregnancy. For fetal status of non-RhD red blood cell (RBC) antigens • The patient is currently pregnant, and • The pregnant patient has alloantibodies to one or more non-RhD RBC antigens, and • The paternal non-RhD RBC antigen status is either heterozygous or unknown, and • The pregnant patient has not been tested with another cell-free DNA test to determine fetal status of non-RhD RBC antigens during the same pregnancy.	N/A	Reimbursement will be limited to once per pregnancy.
0494U **Red blood cell antigen (fetal rhd gene analysis), next-generation sequencing of circulating cell-free dna (cfdna) of blood in pregnant individuals known to be rhd negative, reported as positive or negative**	Yes	A TAR is required with documentation of the following criteria: For fetal RhD status • The patient is currently pregnant, and • The pregnant patient is RhD negative, and	N/A	Reimbursement will be limited to once per pregnancy, unless there is documentation of medical necessity.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• The pregnant patient has not been tested with another cell-free DNA test to determine fetal RhD status during the same pregnancy.		



PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Member Experience Measure Year 2023 Reporting Year 2024

Anthony Sackett, QI CAHPS® Program Manager II
Kory Watkins, Director of Grievance & Appeals
November 2024

Meeting Objectives

- MY 2023 - RY 2024 Regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Scores
- Key Learnings
- 2023 Grievances and Appeals & Second Level Grievances
- Q&A

Adult | CAHPS® Regulated Survey Results

Summary Rate Change:

- GNC: -2.4%
- GCQ: -1.4%
- RPD: +3.1%
- RHP: -2.3%
- RHC: -9.4%

Patient Experience	Summary Rate Performance	HEDIS QC Benchmark Rankings
Getting Care		
Getting Needed Care (% Always or Usually)	74.0%	7th
Getting Care Quickly (% Always or Usually)	68.1%	<5th
Satisfaction with Plan Physicians		
Rating of Personal Doctor (% 9+10)	70.0%	64th
Satisfaction with Plan and Plan Services		
Rating of Health Plan (% 9 + 10)	54.5%	13th
Rating of Health Care (% 9 + 10)	46.3%	5th

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

10th Percentile 33rd Percentile 67th Percentile 90th Percentile

NCQA HealthPlan Star Rating

3.5 Stars

Reference the presentation Appendix for additional insights

ADULT | CAHPS® NON-REGULATED SURVEY RESULTS

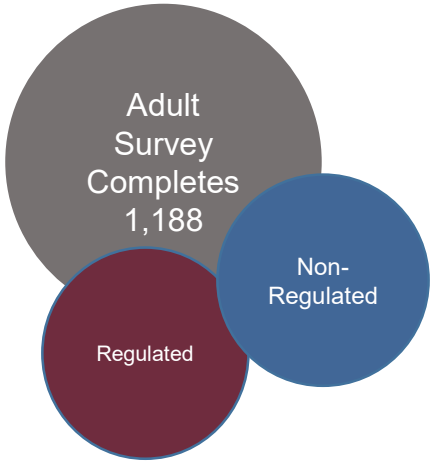
KEY FINDING:

Understanding of Benefits/Services
- ❑ 47%: Fair or poor understanding

Benefit Resource
- ❑ 35.7%: Ask provider/office staff
- ❑ 29.1%: Call Partnership
- ❑ 23.1%: Partnership website
- ❑ 7.9%: Member handbook

HEALTH CARE DELIVERY

Patient Experience	Summary Rate Performance	HEDIS QC Benchmark Rankings
[redacted]		
Satisfaction with Plan and Plan Services		
Rating of Health Plan (% 9 + 10)	54.5%	13th
Rating of Health Care (% 9 + 10)	46.3%	5th



CHILD | CAHPS® REGULATED SURVEY RESULTS

SUMMARY RATE CHANGE:

- GNC: +0.4
- GCQ: +2.6
- RPD: +1.1
- RHP: +0.1
- RHC: -5.3

Patient Experience	Summary Rate Performance	HEDIS QC Benchmark Rankings
Getting Care		
Getting Needed Care (% Always or Usually)	77.0%	14th
Getting Care Quickly (% Always or Usually)	78.9%	9th
Satisfaction with Plan Physicians		
Rating of Personal Doctor (% 9+10)	75.5%	47th
Satisfaction with Plan and Plan Services		
Rating of Health Plan (% 9 + 10)	68.1%	24th
Rating of Health Care (% 9+10)	58.8%	<5th

Healthcare Effectiveness Data and Information Set (HEDIS)
Quality Compass (QC) Benchmarks

10th Percentile 33rd Percentile 67th Percentile 90th Percentile

Reference the presentation Appendix for additional insights.

MEASURES HEALTH EQUITY

KEY FINDINGS:

ADULT

- Members reporting Good, Fair/Poor Overall, and Mental Health are scoring Rate the Health Plan, Health Care, and Specialist lower than the average plan score.

CHILD

- Families with children reporting Fair/Poor Overall and Mental Health are scoring Rate the Health Plan lower than the average plan score.

- American Indian or Alaska Natives are also expressing more dissatisfaction with the plan.

Reference the presentation Appendix for additional insights

GRIEVANCES

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

KEY FINDING:

- 6.3% annual growth in Partnership's membership
- Grievances increased from 2,556 to 3,572, a notable 28.5% increase

- *Thresholds are based on complaints per 1,000 members*
- *The denominator equals the monthly average member base of each reporting period*

APPEALS & SECOND LEVEL GRIEVANCES

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

KEY FINDING:

- Appeals and Second Level Grievances decreased from 1.19 to 1.02
- One NCQA Category, Quality of Care, exceeded the threshold

- *Thresholds are based on complaints per 1,000 members*
- *The denominator equals the monthly average member base of each reporting period*

‘24/25 Organizational Goal #4
Access & Member Experience

Organizational Goal #4 focuses on three main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans

2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans

3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

QUESTIONS?

APPENDIX

References

HEALTH PLAN RATING (HPR)

Partnership was 0.043 points from rounding up to a 4.0 Star Rating!

HEALTH PLAN RATING (HPR)

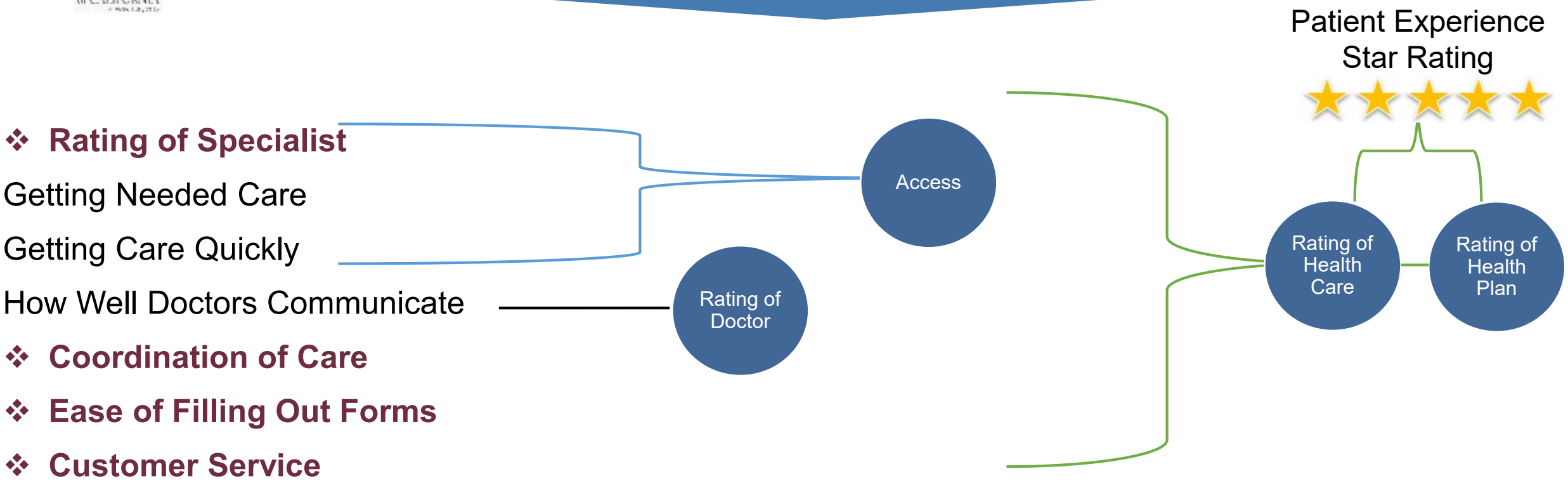
Health Plan Rating Components	Partnership's Star Ratings
Patient Experience - (Adult CAHPS®)	1.5
Prevention & Equity (HEDIS)	3.5
Treatment (HEDIS)	3
Bonus for Accreditation	0.5
Overall Rating	**3.5**

Weighted Average 3.0

Patient Experience (Adult Survey Results)
Getting Care
***Getting Needed Care (Usually+ Always)
***Getting Care Quickly (Usually + Always)
Satisfaction with Plan Physicians
Rating of Personal Doctor (9+10)
Satisfaction with Health Plan Services
Rating of Health Plan (9+10)
Rating of Health Care (9+10)

***Withhold Measures

Influence | Key-Driver Measures



- Non-NCQA health plan star rating (HPR) measures that influence HPR summary rates.

ADULT - REGULATED SURVEY

NCQA RATING MEASURES

ADULT Summary Rate Scores	Rate Definition	MY2022 RY2023 (n=380)	MY2023 RY2024 (n=510)	Change
Rating Items				
★ 8. Rating of Health Care	9 + 10	55.7%	46.3%	-9.4%
★ 18. Rating of Personal Doctor		66.9%	70.0%	3.1%
22. Rating of Specialist ●		64.4%	69.5%	5.1%
★ 28. Rating of Health Plan		56.8%	54.5%	-2.3%
★ **Getting Needed Care**		**76.4%**	**74.0%**	-2.4%
9. Getting care, tests, or treatment	Always + Usually	76.9%	76.1%	-0.8%
20. Getting specialist appointment		75.9%	71.9%	-4.0%
★ **Getting Care Quickly**		**69.5%**	**68.1%**	-1.4%
4. Getting urgent care		68.9%	69.8%	0.9%
6. Getting routine care		70.0%	66.3%	-3.7%
How Well Doctors Communicate ●		**92.9%**	**92.6%**	-0.3%
12. Dr. explained things		92.5%	93.3%	0.8%
13. Dr. listened carefully		93.0%	92.9%	-0.1%
14. Dr. showed respect		94.9%	91.7%	-3.2%
15. Dr. spent enough time		91.2%	92.4%	1.2%
Customer Service ●		**88.6%**	**87.0%**	-1.6%
24. Provided information or help		83.5%	80.7%	-2.8%
25. Treated with courtesy and respect		93.8%	93.3%	-0.5%
17. Coordination of Care ●		**86.6%**	**78.8%**	-7.8%
27. Ease of Filling Out Forms ●		**96.0%**	**92.7%**	-3.3%

Patient Experience
★ 1.5 Star Rating

Measures with Impact and Influence ●

CHILD - REGULATED SURVEY

NCQA RATING MEASURES

	CHILD Summary Rate Scores	Rate Definition	MY2022 RY2023 (n=611)	MY2023 RY2024 (n=659)	Change
	Rating Items				
★	8. Rating of Health Care	9 + 10	64.2%	58.9%	-5.3%
★	21. Rating of Personal Doctor		74.4%	75.5%	1.1%
	25. Rating of Specialist ●		69.5%	63.8%	-5.7%
★	31. Rating of Health Plan		68.0%	68.1%	0.1%
★	**Getting Needed Care**		**76.7%**	**77.1%**	0.4%
	9. Getting care, tests, or treatment	Always + Usually	81.3%	81.3%	0.0%
	23. Getting specialist appointment		72.0%	72.8%	0.8%
★	**Getting Care Quickly**		**76.3%**	**78.9%**	2.6%
	4. Getting urgent care		78.6%	83.7%	5.1%
	6. Getting routine care		74.1%	74.2%	0.1%
	How Well Doctors Communicate ●		**92.7%**	**93.0%**	0.3%
	12. Dr. explained things		93.8%	93.6%	-0.2%
	13. Dr. listened carefully		92.9%	94.7%	1.8%
	14. Dr. showed respect		95.6%	96.3%	0.7%
	17. Dr. spent enough time		88.4%	87.7%	-0.7%
	Customer Service ●		**89.9%**	**91.2%**	1.3%
	27. Provided information or help		85.1%	86.0%	0.9%
	28. Treated with courtesy and respect		94.7%	96.4%	1.7%
	20. Coordination of Care ●		**81.1%**	**80.4%**	-0.7%
	30. Ease of Filling Out Forms ●		**94.4%**	**94.2%**	-0.2%

Patient Experience ★ 2 Star Rating

Measures with Impact and Influence ●

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®) PROGRAM

2023-2024

MEMBER EXPERIENCE GRAND ANALYSIS (NCQA ME 7 REPORT)

PERIOD

(JULY 1, 2023 – JUNE 30, 2024)

PRODUCTION DATE

SEPTEMBER 2024

PARTNERSHIP HEALTHPLAN of CALIFORNIA

A Public Agency

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EXECUTIVE SUMMARY

CAHPS® PROGRAM

SUMMARY

Partnership experienced a season of change this reporting period. There was executive level changes to include a new Chief Executive Officer, Chief Operating Officer, and Chief Technology Officer. Additionally in January of 2024, Partnership expanded its service area by ten (10) additional northern counties. It is important to note the ten (10) new county members are not included in the Measure Year (MY) 2023 survey results but will be included in the MY 2024 survey sample frame.

QUALITY IMPROVEMENT

The Quality Improvement Department's Consumer Assessment of Healthcare Providers & Systems (CAHPS®) program provides programmatic structure and resource commitment to effectively administer National Committee for Quality Assurance (NCQA) requirements and influence organizational change to improve member experience and the health plan rating.

Our approach and discipline to leverage team strengths will provide the necessary skill set to apply a mixed methodology, including quality improvement tools and program management principles of plan-do-study-act (PDSA); lean; root-causal-analysis; data analytics; qualitative and quantitative analysis . As the team identifies new opportunities or lessons learned, we are continuously exploring and identifying pathways to improve. The established program is designed to be flexible, allowing us to adapt and pivot between each fiscal year.

ANNUAL ASSESSMENT OF NONBEHAVIORAL HEALTHCARE COMPLAINTS AND APPEALS

GRIEVANCES

Partnership experienced a 6.3% growth in membership, rising from 638,303 members in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances filed per 1,000 members from 4.00 to 5.26, Table VI. The analyses observed a decrease in the number of Appeals and Second Level Grievances filed in 2023, resulting in a decline in Second Level Grievances filed per 1,000 members from 1.19 to 1.02, Table VII.

An observed 6.3% increase in membership may have contributed to a 28.5% increase in Grievances filed, that led to three (3) Grievance thresholds not being met: Access, Attitude/Service, and Quality of Care. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides. Attitude/Service issues were mostly regarding insufficient communication between the member and the provider's office. Communication and treatment plan disputes were the most frequently reported Quality of Care concerns. Two (2) categories, Billing/Financial and Quality of Provider Office, did meet the threshold for 2023, Table VI.

APPEALS & SECOND LEVEL GRIEVANCES

The Appeals and Second Level Grievances saw an overall decrease in numbers. While four (4) categories (Access, Attitude/Service, Billing/Financial, and Quality of Provider Office) successfully maintained stability by not exceeding the 10% threshold. One (1) category, Quality of Care, saw an increase from one

(1) case in 2022 to nine (9) cases in 2023, surpassing the threshold. These cases consisted of treatment plan disputes that caused delay in the care the members received and communication issues such as the provider not returning the member's calls, Table VII.

CAHPS® Measure Year 2023 | Reporting Year 2024 Plan Performance

A summary of the MY 2023 CAHPS® survey performance for Adult and Child, identified barriers, Fiscal Year (FY) 2024-2025 intervention and improvement focus are outlined below.

Adult

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking decline in seven (7) of nine (9) measures, Table I.

Table: I

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	<5th	Not Met	Decline
Rating of Health Care (% 8, 9, 10)	5th	Not Met	Decline
Rating of Personal Doctor (% 8, 9, 10)	51st	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	41st	Met	Improvement
Getting Needed Care (% Always or Usually)	7th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	<5th	Not Met	Decline
Care Coordination (% Always or Usually)	11th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	48th	Met	Decline
Customer Service (% Always or Usually)	18th	Not Met	Decline

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

Child

Measured performance compared to the plan's 33rd percentile benchmark ranking indicates member dissatisfaction in the following measures. In comparison to MY 2022 ranking performance, MY 2023 demonstrates an overall ranking improvement in seven (7) of nine (9) measures, and one noted as maintaining similar ranking, with a marginal decline of 3.5% in score performance with Rating of Health Care, Table II.

Table: II

Measure Attribute	Plan Performance		
	MY 2023 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2023 Ranking Compared to MY 2022
Rating of Health Plan (% 8, 9, 10)	45th	Met	Improvement
Rating of Health Care (% 8, 9, 10)	<5th	Not Met	No Change
Rating of Personal Doctor (% 8, 9, 10)	55th	Met	Improvement
Rating of Specialist Seen Most Often (% 8, 9, 10)	21st	Not Met	Decline
Getting Needed Care (% Always or Usually)	14th	Not Met	Improvement
Getting Care Quickly (% Always or Usually)	9th	Not Met	Improvement
Care Coordination (% Always or Usually)	40th	Not Met	Improvement
How Well Doctors Communicate (% Always or Usually)	22nd	Met	Improvement
Customer Service (% Always or Usually)	89th	Met	Improvement

Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass (QC) Benchmarks

IDENTIFICATION OF OPPORTUNITIES AND PRIORITY

Over the next fiscal year, the focus of Organizational Goal # 4 Access to Care and Member Experience Improvement is to develop and when applicable, revise existing strategies and plan tactics through the actions of understanding the landscape of the primary care provider and specialty provider networks, identify gaps, and develop targeted actions, Appendix A.

The QI CAHPS® programmatic framework is helping to drive and influence a multi-disciplinary approach to improve the member experience through long and short-term strategies. The team priority this year will pilot a smaller focus at the county and region level to target low performing composite and rating measures linked to access.

MEMBER EXPERIENCE (ME) – PRIORITY FLAG

Partnership determines ME through the analysis of multiple CAHPS® rating and composite measures. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The QI CAHPS® Team intends to shepherd organizational guidance on the measures marked with a priority flag. These measures are considered influence drivers and when those scores improve member experience, the Rating of Health Plan and Rating of Healthcare measures improve.

Causal Factors

The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field, and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

- **County Expansion - HealthPlan Growth**
  - Previously noted in January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.
- **Regional Service Disruption**
  - In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

❖ Rating of Health Plan

Partnership is focused on two (2) additional barriers outside of the FY 2024-2025 Org. Goals (Appendix A): 1) Benefit literacy. The CAHPS® Team used non-regulated survey results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by Population Health Management (PHM). Benefit themes point to coverage confusion between Partnership and state carve out coverage (Medi-Cal Dental/Pharmacy), vision, and Partnership administered transportation services, and 2) Customer Service calls related to covered benefit or service questions. Member shared comments including: calling plan multiple times about the same issue, calls being transferred multiple times, customer service representative provided unclear or incomplete information making it challenging for the members to understand, Appendix C.

Access To Care – Priority Flag

Member access to primary and specialty care continues to be a top focus and priority for Partnership. Through several data sources and Association for Community Affiliated Plans CAHPS® Collaborative. Partnership is aware there is a national and regional shortage of clinical professionals and aging clinical professionals retiring, Appendix E. The fluctuation of Access measure performance identified below coupled with performance not improving to pre-COVID, indicates inconsistency with access to care and service delivery.

❖ Getting Needed Care (GNC)

Partnership continues to observe a general decline with Adult and Child GNC composite questions (Q9. & Q20.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

ADULT: The GNC measure declined by -2.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS Quality Compass (QC) benchmark ranking decline to the 7th percentile ranking from the 14th percentile ranking compared to MY 2022. The highest noted summary rate score of 81.60% occurred in the reporting year (RY) 2021 for MY 2020. The marked -5.6% decline of GNC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed a minimal increase of 0.4% of a percentage point in the RY 2023 for MY 2022, followed by another decline of -2.4% performance in the RY 2024 for MY 2023.

CHILD: The GNC measure marginally improved by 0.4% of a percentage point, and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking also improved to the 14th percentile ranking from the 10th percentile ranking compared to MY 2022. Similar yet dissimilar to the Adult trend performance, the highest summary rate score for Child was 83.20% and occurred in the RY 2020 for MY 2019. The marked -2.5% decline of GNC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes the following: -1.1% (MY 2021) and -2.9% (MY 2022).

❖ **GETTING CARE QUICKLY (GCQ)**

Partnership continues to observe a general decline with Adult and Child GCQ composite (Q4 & Q6.), measures, and overall summary rate score. Performance analysis by population is highlighted below.

ADULT: The GCQ measure declined by -1.4% and did not meet or exceed the plan 33rd percentile benchmark ranking target. The HEDIS QC benchmark ranking MY 2023 declined below the 5th percentile ranking established in MY 2022. The highest summary rate score of 80.30% occurred in the RY 2021 for MY 2020. The marked -7.4% decline of GQC trend began in the RY 2022, for MY 2021 survey results. Continuing the performance trend, Partnership observed the following decline of -3.40% for MY2022.

CHILD: Although the GCQ measure saw a marked improve score of 2.6%, the measure did not meet or exceed the plan 33rd percentile benchmark target. The HEDIS QC benchmark ranking mirrored the score performance by increasing MY 2022 below the 5th percentile ranking to 9th percentile ranking in MY 2023. The highest summary rate score for Child was 88.80% and occurred in the RY 2020 for MY 2019. The marked -7.7% decline of GQC trend began in the RY 2021, for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 3% in MY 2021 and another decline of -7.8% in MY 2022.

❖ **RATING OF SPECIALIST (RATING)**

Partnership continues to observe survey performance variations related to the Rating of Specialist measure, GNC, and GQC composite measures linked to specialty providers seen most often. As previously noted, improving member access to Primary Care Providers (PCP) and Specialists Providers are a top priority. Access interventions has been a continued organization focus and is covered in prior Member Experience (ME 7) Grand Analysis reporting periods. The complete details of actions taken during the

FY 2023-2024 goal period are available in Appendix B. The trending overview and qualitative analysis by population is provided below.

ADULT: The Rating of Specialist (Q22.) measure improved by 5.1%, meeting the plan's 33rd percentile benchmark target and increased the HEDIS QC benchmark ranking to the 41st percentile from the 26th percentile. The highest summary rate score of 71.50% occurred in the RY 2021 for MY 2020. The marked -4.8% decline of rating trend began in the RY 2022 for MY 2021 survey results. Continuing the performance trend, Partnership observed another decline of -2.3% for MY2022.

CHILD - PRIORITY FLAG: The Rating of Specialist (Q22.) measure saw a marked decline -5.7%. The measure did not meet or exceed the plan's 33rd percentile benchmark target. The HEDIS QC benchmark percentile ranking also declined to the 24th percentile ranking from the 34th percentile in MY 2022. The highest summary rate score for Child was 74.4% and occurred in the RY 2020 for MY 2019. The marked -10.8% rating measure decline began in the RY 2021 for MY 2020 survey results. Continuing the performance trend, Partnership observes summary rate fluctuations ranging from an increase of 6.8% in MY 2021 and another marginal decline of -0.9% of a percentage point in MY 2022.

CAUSAL FACTORS

The ME 7 qualitative analysis also includes findings detailed in the Network Adequacy Assessment Report (NET 3) aligned with MY 2023 CAHPS® survey results. A summary below captures factors that link to member dissatisfaction on respective declines with priority flagged measures.

- Membership 6.3% annual growth.
- Grievance notable findings:
  - As previously noted, the leading filed Grievances in 2023 were Access at 1,526 (43%), almost half of 3,572 closed grievance cases.
  - Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
  - Partnership did not met the access grievance threshold for 2023.
- Geographic impacts
  - Northern county members are experiencing greater travel distance and time to access primary care and specialty care.
  - Northern and Southern county assigned members observed longer wait times to beseen for the following specialists: Cardiology, Dermatology, and Ophthalmology.

SUMMARY OF ACTIVITIES AND INTERVENTIONS

The detailed activities for the FY 2023-2024 Quality Improvement Department Goal CAHPS® Score Improvement (CSI) available in Appendix B, Table XV demonstrates cross-department action focused on interventions. The highlighted examples below showcase completed goals/actions targeting Access and, furthermore, document continuous improvement.

❖ **HUMAN RESOURCE/WORKFORCE DEVELOPMENT DEPARTMENT**

- **Completed Action:** Improve Access with Provider Recruitment Support. Contracted with a third-party talent search firm to partner and support recruitment and placement of multiple clinical vacancies within the Partnership contracted primary care and specialty care provider network.
- **Completed Action:** Improve Access with Provider Retention. Successfully added and facilitated a retention bonus to the 2024 Provider Recruitment Program (PRP).

❖ **ORGANIZATIONAL GOAL #4 | FY 2024-2025**

ACCESS & MEMBER EXPERIENCE

The summary table below includes improvement focus based on the outcome of MY 2023-2024 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned, Table: III.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	Access	1,2	Yes	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

The two (2) workgroups Access and Member Experience will collaborate through FY 2024-2025 to implement short and long-term strategies and plan development focused on the identified barriers and milestone summaries listed below.

- **Milestone 1:** The **Access Workgroup** will develop and propose a multi-year Access Strategy plan that is inclusive of understanding the landscape of our specialty care and primary care provider network and identifying gaps.
- **Milestone 2:** The **Access Workgroup** will develop and propose a multi-year Access Tactical plan that outlines targeted actions to drive Milestone 1 objectives.

- **Milestone 3:** The **Member Experience (ME) Workgroup** will drive CSI FY 2023-2024 pilot from analysis phase to Strike-Team "action" phase. The enhanced ME improvement strategy is continuous, with the intent to leverage quarterly data (G&A, PHM) sources to drive proactive interventions throughout FY 2024-2025.
- **Milestone 4:** The **Member Experience (ME) Workgroup** will focus on developing and proposing member communication and engagement enhancements through existing platforms or new tool development.
- **Milestone 5:** The **Member Experience (ME) Workgroup** will define and develop Member Informative Session (MIS) program strategy and framework.
- **Milestone 6:** The **Member Experience (ME) Workgroup** will implement Year 1 of the texting program as approved by the monthly texting workgroup.
- **Milestone 7:** The **Member Experience (ME) Workgroup** will continue with Your Partner in Health branding campaign to develop a Partnership Awareness - grassroots communications strategy.
- **Milestone 8:** The **Member Experience (ME) Workgroup** will collaborate with the Quality Improvement Pay-for-Performance Team to explore Unit-of-Service measure development opportunities.

MEMBER EXPERIENCE

2023-2024 GRAND ANALYSIS

Partnership HealthPlan of California (Partnership) measures the Members' Experience through monitoring of annual regulated and non-regulated surveys and grievance and appeals reporting. The Member Experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focus activities. Our commitment to ensuring our members receive high-quality healthcare services and excellent customer service directly aligns with Partnership's mission and vision. In 2021, Partnership achieved NCQA Health Plan Accreditation and in September of 2023 another organizational milestone was reached with our first official NCQA Health Plan Star Rating of 3.5 out of 5 Stars. These two achievements demonstrate 30 years of organizational commitment to cultivate a culture of quality, and purpose to our mission, "To help our members and the communities we serve, be healthy." The method and accreditation requirement for how our member's rate our service is through the administration of the CAHPS® regulated survey, and the collection of various member data resources used to assess member satisfaction with Partnership and the provider network.

Partnership maintains a multidisciplinary approach to improve the member experience through the administration of the QI Department CAHPS® Program and organizational goal alignment intended to improve the health plan member engagement and service experience.

Organizational efforts to improve member experience is included in the ME 7 Grand Analyses and covers both fiscal year and CAHPS® MY 2023 and RY 2024. The evaluation period highlights fiscal year improvement that directly aligns with Partnership's NCQA Member Experience Priority Ranking: 1) Access, 2) Health Equity, 3) Rating of Health Plan, and 4) Attitude and Service. The analyses herein will interchangeably reference this period as a measure year or MY 2023-2024 and includes the 2023 Grievances and Appeals Annual Report and the continuous monitoring of complaints, grievances, and appeals data for calendar year 2022.

OBJECTIVE

The intent of this report is to meet the requirements of NCQA standards ME7: Element C and D. The objectives are to assess member experience through G&A Department and CAHPS® scores QI Department quantitative and qualitative analyses, identify opportunities for improvement and set priorities.

The primary ME 7 report contributors include:

1. Nancy Steffen, Senior Director of Quality and Performance Improvement
2. Isaac Brown, Director of Quality and Performance Improvement
3. Barbara Selig, Manager of Quality Improvement Programs
4. Anthony Sackett, Program Manager II, Quality Improvement Programs
5. Andrea Thomas, Project Manager I, Quality Improvement Programs
6. Kory Watkins, Director of Grievance & Appeals
7. Latrice Innes, Manager of Grievance & Appeals Compliance

DEPARTMENT OVERVIEW:

GRIEVANCE AND APPEALS

The G&A Department is responsible for the execution of Department of Healthcare Services (DHCS) APL 21-011, also known as the "Final Rule", which mandates that members have a right to report any problem(s) while using their Partnership Medi-Cal plan and Partnership has an obligation to investigate objectively.

The G&A analysts are responsible for investigating, monitoring, and reporting on members' dissatisfaction experiences related to Partnership, health plan delivery, and services provided within a clinical and non-clinical setting. The role G&A serves on behalf of our member is to advocate, mediate, educate, and ensure each member receives high-quality healthcare services across the healthcare continuum. The G&A Department performs quarterly and annual reporting, and through their analyses, they provide insight into service dissatisfaction. Through continuous monitoring and reporting, the G&A Team makes data-driven decisions to address, improve, and transform member dissatisfaction into innovative system-wide changes with the purpose to improve the overall member experience.

QUALITY IMPROVEMENT | CAHPS® PROGRAM

The Quality Improvement Department - CAHPS® Program manages the contract administration of conducting an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey designed and governed by the Agency of Healthcare Research and Quality (AHRQ). The team is also responsible for:

- Leading the ME 7 report production, performing quantitative and qualitative analyses on survey results and other plan delivery data aligned with NCQA ME 7 Standards C and D and elements intended to drive continuous improvement activities and interventions.

- CAHPS® programmatic alignment with two (2) of the five (5) FY 24-25 Organizational Metrics, 1) Achieve a 4.0 Star NCQA Health Plan Rating (HPR), 2) Achieve a 2.5 Star NCQA, Patient Experience (CAHPS®) HPR.
- Presenting annual survey results, HEDIS Quality Compass benchmarks, and NCQA reportable measures.
- Leading goal activities, discussion, and collaboration with program charter members.

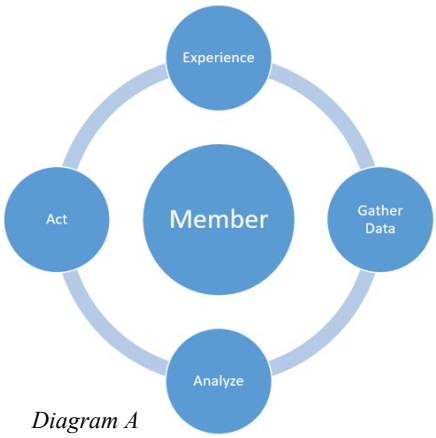


Diagram A

PROGRAM FRAMEWORK

The CAHPS® programmatic framework is rooted in the discipline of continuous quality improvement (CQI). A combined member-centric and CQI process illustrates continuous purpose, *Diagram A*. Action that is focused on listening to member experiences, collecting data, performing analyses, and data-driven improvements to target or influence the member experience, health outcomes, perception of the health plan, and score performance. The outcome of these improvement activities align with the Partnership mission and vision.

METHODOLOGY

ANALYSIS WORKGROUP

As noted in ME7: Element C & D, the health plan is required to conduct a side-by-side annual quantitative and qualitative analysis of our data sources and make recommendations for interventions to ultimately improve our healthcare delivery system and most importantly, overall member experience. Partnership established internal thresholds and benchmarks as a strategy to set realistic goals for underperforming measures.

The QI CAHPS® Team leads continuous activities and organizational influence focused on CAHPS® score improvement. Partnership relies on various internal and external data sources to manage health plan and health service delivery that includes the annual G&A and CAHPS® data sources as a guide to evaluate member satisfaction and improvement effectiveness. Program administration relies on two key documents: 1) CAHPS® Program Charter and 2) Organizational Goal #4 Charter. These documents are used to drive stakeholder commitment, outline specific actions to improve service delivery and experience, and serves as communication and strategic guiding tools.

DATA SOURCES

GRIEVANCE AND APPEALS: Partnership utilized NCQA's required data sources, which are G&A reporting and CAHPS® scores. The G&A analysts provided reporting from January 1, 2023, through December 31, 2023. Also shown is the previous year, 2022 G&A data. It's important to note that multiple reporting categories can apply to any given grievance, appeal, or second-level grievance. Therefore, the stated metrics herein reflect the number of concerns expressed by our members during the reporting periods,

rather than actual case counts. In addition, please note that internally, Partnership refers to a member's dispute of a denied grievance as a "Second Level Grievance". Throughout this document, we will reference appeals as "Appeals" and "Second Level Grievances".

CAHPS® SURVEY: Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of our CAHPS® survey on a yearly basis. The CAHPS® regulated survey results is one of several sources used to complete the ME 7 analysis for MY 2023-2024 and includes the last two survey cycles, MY 2023 and MY 2022 surveys.

DATA MAPPING

GRIEVANCE AND APPEALS: NCQA standards ME7: Element C & D requires that the organization aggregate G&A data into five (5) specific categories (Quality of Care, Quality of Practitioner Office Site, Attitude and Service, Billing/Financial Issues, and Access). Since Partnership's categorization is structured to meet DHCS requirements, the team (consisting of key individuals from impacted departments, including Member Services, Health Services, G&A, Quality Improvement, and Communications) mapped Partnership reporting categories to that of the five (5) NCQA required categories.

CAHPS® SURVEY: Partnership reports on the eight (8) CAHPS® NCQA rating and composites measures including: Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service.

THRESHOLDS & BENCHMARKS

As part of the NCQA process and to better evaluate member experience, thresholds, and benchmarks have been set to measure our performance.

- GRIEVANCES AND APPEALS

  For each category, a ratio of the number of grievances per 1,000 members is used as a performance metric. Our numerator will be the total amount of Grievances or Appeals/Second Level Grievances for the reporting period, and our denominator will be the monthly average member base of each reporting period. If we see a 10% increase in any of the five (5) categories, it is flagged for discussion based on the number of grievances per 1,000 members.

- CAHPS® SURVEY

  The CAHPS® Team in collaboration with program charter stakeholders established methods to measure member satisfaction through continuous monitoring, analyses, improvement activities and interventions. The annual analyses is centered on evaluating improvement effectiveness through the actions of quantitative and qualitative analyses. To achieve this, Partnership relies on the Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass benchmarks and internal performance targets.

In addition to the mentioned eight (8) NCQA rating and composite summary measures, the CAHPS® program also includes, *How Well Doctors Communicate* as an additional monitoring and performance measure. It should be mentioned the CAHPS® program increased the prior year's 25th percentile performance levels to the 33rd percentile, Table IV. Summary measures performing below the 33rd percentile target are flagged for review and discussion.

Table: IV

CAHPS® COMPOSITE MEASURES	CAHPS® PROGRAM TARGET
Getting Needed Care	Rating and composite measures ≥ 33rd percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS® RATING MEASURES	
Rating of Health Plan	
Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

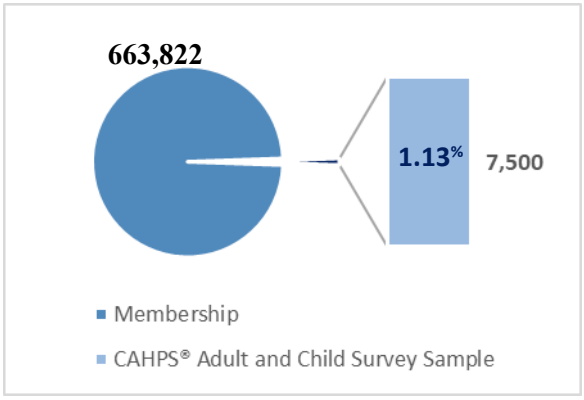
SURVEY METHODOLOGY

The CAHPS® survey is administered to capture accurate and complete information about HealthPlan member-reported experiences and specifically aims to measure how well plans are meeting covered member expectations. It also determines which areas of service have the greatest influence on member overall satisfaction and identifies areas of opportunity to improve the quality of care and service delivery.

SURVEY SAMPLE SIZE

Survey sample size includes Adult and Children populations based on NCQA member sample frame eligibility requirements. The annual survey results provide a retrospective performance on key NCQA ratings and composite measures. Typically the regulated survey is conducted in February of each calendar year, and members are asked to share their experiences over the past six (6) months that consists of dates-of-service between the months of July 1st and December 31st of the prior year. Survey questions target member experiences and engagement with a physician, non-emergent clinical setting, health plan, and health plan delivery of covered benefits within Partnership's fourteen (14) county service area.

In January of 2024, Partnership expanded its service area by ten (10) additional northern counties. ***As noted the ten (10) new-county-members are not included in the MY 2023 survey results but will be included in the MY 2024 survey sample frame.***



OVERSAMPLE STRATEGY

Analyses of MY 2022 survey responses identified low Adult responses for reportable measures requiring a plan to obtain at least 100 responses for a related rating and composite measures.

As a proactive strategy, the QI CAHPS® Team increased the MY 2023 Adult sample size from 100% to 150% above the required minimum sample frame with the intent to improve reportable survey responses (denominators) in the CAHPS® domain and, moreover, mitigate risk of not meeting the minimum requirement. The QI CAHPS® Team has maintained an over-sampling strategy for several survey cycles. The combined Adult and Child sample size of 7,500 represent 1.13% of DHCS eligible member assignment for December 2023 (663,822). An over sample comparison table by population highlights the minimum sample requirement, over sample percentage, and samples size for each respective measure year, Table V.

Table: V

Measure Year	Minimum Sample Size	Oversample %	Survey Sample Size		Minimum Sample Size	Oversample %	Survey Sample Size
	Adult				Child		
2023-2024	1,350	150%	3,375		1,650	150%	4,125
2022-2023		100%	2,700			150%	4,125

ANNUAL ASSESSMENT OF NON-BEHAVIORAL HEALTHCARE COMPLAINTS AND APPEALS

GRIEVANCES | APPEALS & SECOND LEVEL GRIEVANCES

The G&A data and quantitative analysis are grouped by 1) Grievances and 2) Appeals & Second Level Grievances (SLG) and include the total cases filed for current and prior reporting periods. Data is further stratified by the five (5) defined NCQA service categories; includes threshold calculations by reported cases; (category/average monthly member base); and denotes if the threshold is met or not met.

The G&A performance thresholds are set based on prior year's performance, and targets are set at the level of each NCQA grievance and appeal category. A summary threshold for annual performance is also provided, reference Table VI and Table VII. This data represents all member filings within the 2023 calendar year.

Table: VI

Grievances Only Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Grievances	Grievances p/1,000	Avg PHC Membership	Grievances	Grievances p/1,000	Threshold	Threshold Met?
Access	638,303	1,055	1.65	678,546	1,526	2.25	1.82	No
Attitude/Service		1,278	2.00		1,752	2.58	2.20	No
Billing/Financial		113	0.18		106	0.16	0.19	Yes
Quality of Care		106	0.17		186	0.27	0.18	No
Quality of Provider Office		4	0.01		2	0.00	0.01	Yes
TOTAL		2,556	4.00		3,572	5.26	4.40	No

RESULTS & THRESHOLDS – GRIEVANCES ONLY

The trending data in Table VI includes annual reporting periods between January 1, 2023, and December 31, 2023, and the previous year, January 1, 2022, and December 31, 2022.

There were a total of 4,261 closed G&A cases in calendar year 2023, compared to 3,318 in calendar year 2022. The two (2) case types that comprise the leading filed Grievances were Attitude/Service at 1,752 (49%) followed by Access at 1,526 (43%) of 3,572 closed grievance cases.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs. 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Avg PHC Membership	Appeals & SLG	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	638,303	332	0.52	678,546	350	0.52	0.57	Yes
Attitude/Service		47	0.07		33	0.05	0.08	Yes
Billing/Financial		382	0.60		297	0.44	0.66	Yes
Quality of Care		1	0.00		9	0.01	0.00	No
Quality of Provider Office		0	0.00		0	0.00	0.00	Yes
TOTAL		762	1.19		689	1.02	1.31	Yes

RESULTS & THRESHOLDS – APPEALS & SECOND LEVEL GRIEVANCES

The trending data in Table VII includes annual reporting periods between January 1, 2023, and December 31, 2023, and the previous year January 1, 2022, and December 31, 2022. In 2023, the health plan received 689 Appeals and Second Level Grievance cases, an observed 9.6% decrease compared to 762 cases filed in 2022. A noted decrease in two (2) NCQA categories: Attitude/Service, and Billing/Financial.

SUMMARY HIGHLIGHTS:

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

GRIEVANCES SUMMARY: Partnership met two out of the five (5) grievance thresholds for 2023, including Billing/Financial and Quality of Provider Office. The three threshold not met include: Access, Attitude/Service, and Quality of Care (QOC). Comparing results to 2022, all threshold were met except QOC, marking an overall decline of NCQA category thresholds.

APPEALS & SECOND LEVEL GRIEVANCES SUMMARY: One (1) out of five (5) thresholds were not met in 2023, Quality of Care. Although the threshold for QOC was not met in the current reporting period, it is important to call attention that QOC cases went from one (1) case in 2022 to nine (9) cases in 2023.

IDENTIFICATION OF OPPORTUNITIES

- Access related issues continue to impact our members as the provider network, in particular in our more rural service areas, struggles to attract and retain clinical staff.

GRIEVANCES AND SECOND LEVEL GRIEVANCES BY NCQA CATEGORY

  - Access: long wait times for providers.
  - Service and Attitude: transportation late arrivals or missed ride issues.
  - Quality of Care concerns: Treatment plan disputes causing delays in care and provider communication.
- 6.3% annual growth in Partnership's membership.
- Grievance cases filed per 1,000 members increased to 5.26 from 4.00, a notable 28.5% increase.
- Appeals and Second Level Grievances filed per 1,000 members decreased from 1.19 to 1.02.

QUANTITATIVE ANALYSIS
MY 2023 CAHPS® SURVEY

PLAN PERFORMANCE
Previously noted, the CAHPS® Program evaluates plan performance against an internal plan benchmark set at the 33rd percentile for both rating and composite measures. It should be noted that the difference between the plan benchmark and NCQA ratable measures is that for each rating measures, the CAHPS® workgroup includes the percent of ratings (8, 9 or 10) as another target to use for team-oriented goal activities, whereas HPR only includes rating (% of 9 or 10) scores.

Additionally, the annual evaluation takes into consideration survey trends from PressGaney portfolio of business, and/or book-of-business (BoB), and AHRQ 2023 CAHPS® Chart Book. The CAHPS® Team considers industry trends as another measurement to evalute the plan against other member survey engagement, and NCQA rating measure peformance relative to other Medicaid Managed Care Plans, Appendix E.

The CAHPS® survey plan performance for MY 2023-2024, MY 2022-2023, and comparable analyses are included in each section by population and illustrated within Table VIII and Table IX. ***As referenced above in Section Methodology, the CAHPS® Program raised the plan performance benchmark to the 33rd percentile from the 25th percentile.***

ADULT CAHPS® PLAN PERFORMANCE

The comparison table illustrates Adult CAHPS® survey scores by MY 2022 and MY 2023.

Table: VIII

	ADULT CAHPS Composite	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	MY 2022 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?	2023-2024 (15.3.% Response Rate) Sample Size 3,375 Total Returns 510	MY 2023 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	73.8%	18th	PHC ≥ 25th	No	68.4%	<5th	PHC ≥ 33rd	No
	Rating of All Health Care (% 8, 9, 10)	74.9%	40th	PHC ≥ 25th	Yes	66.9%	5th	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	81.5%	42nd	PHC ≥ 25th	Yes	82.8%	51st	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.1%	26th	PHC ≥ 25th	Yes	81.0%	41st	PHC ≥ 33rd	Yes
Composite Measure	Getting Needed Care (% Always or Usually)	76.4%	14th	PHC ≥ 25th	No	74.0%	7th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	69.5%	5th	PHC ≥ 25th	No	68.1%	<5th	PHC ≥ 33rd	No
	Care Coordination (% Always or Usually)	86.6%	73rd	PHC ≥ 25th	Yes	78.8%	11th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.9%	51st	PHC ≥ 25th	Yes	92.6%	48th	PHC ≥ 33rd	Yes
	Customer Service (% Always or Usually)	88.6%	38th	PHC ≥ 25th	Yes	87.0%	18th	PHC ≥ 33rd	No

Plan Performance Target: 33rd Percentile

RATING MEASURES

- In MY2023, there was a noted decline of two (2) measures, ***Rating of Health Plan*** and ***Rating of All Health Care,*** and an observed improvement in benchmark rates for ***Rating of Personal Doctor and Rating of Specialist Seen Most Often*** compared to MY 2022.
- Plan Performance MET: ***Rating of Personal Doctor and Rating of Specialist Seen Most Often*** (% 8, 9, 10).

COMPOSITE MEASURES

- In MY2023, there was a noted decline of all five (5) composite measures, and only one (1) measure exceeded the 33rd percentile performance target.
- Plan Performance MET: ***How Well Doctors Communicate*** *(% always or usually).*

CHILD CAHPS® PLAN PERFORMANCE

The comparison table illustrates Child CAHPS® survey scores by measure years; MY 2022, and MY 2023.

Table: IX

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Ranking	Partnership (PHC) Benchmark	Partnership Benchmark Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	84.7%	33rd	PHC ≥ 25th	Yes	86.5%	45th	PHC ≥ 33rd	Yes
	Rating of All Health Care (% 8, 9, 10)	80.4%	<5th	PHC ≥ 25th	No	76.9%	<5th	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	90.5%	51st	PHC ≥ 25th	Yes	89.9%	55th	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	85.2%	34th	PHC ≥ 25th	Yes	81.5%	21st	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	76.7%	10th	PHC ≥ 25th	No	77.1%	14th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	76.3%	<5th	PHC ≥ 25th	No	78.9%	9th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.7%	26th	PHC ≥ 25th	Yes	93.0%	40th	PHC ≥ 33rd	Yes
	Care Coordination (% Always or Usually)	81.1%	19th	PHC ≥ 25th	No	80.4%	22nd	PHC ≥ 33rd	No
	Customer Service (% Always or Usually)	89.9%	73rd	PHC ≥ 25th	Yes	91.2%	89th	PHC ≥ 33rd	Yes

Plan Performance Target: 33rd Percentile

Rating Measures

- In MY2023, there was a noted decline of two (2) measures, ***Rating of All Health Care and Rating of Specialist Seen Most Often,*** and an observed improvement in benchmark rates for ***Rating of Health Plan and Rating of Personal Doctor*** compared to MY 2022.
- Plan Performance MET: ***Rating of Health Plan and Rating of Personal Doctor*** *(% 8, 9, 10).*

Composite Measures

- In MY2023, there was a noted improvement of four (4) composite measures, and only two (2) measures exceeded the plan 33rd percentile performance target.
- Plan Performance MET: ***How Well Doctors Communicate and Customer Service*** *(% always or usually).*

Partnership CAHPS® Survey Results–NCQA Patient Experience Star Rating

Rating and Composite Summary Rate Performance

Table: X

ADULT
HEDIS/CAHPS® Measures Required for Health Plan Accreditation
Quality Compass Reporting Year Summary Rate Trend

Patient Experience	RY 2022	RY 2023	RY 2024	Performance Trend
	Summary Rate Performance			
Getting Care				
Getting Needed Care (% Always or Usually)	76.0%	76.4%	73.9%	
Getting Care Quickly (% Always or Usually)	72.9%	69.5%	68.0%	
Satisfaction with Plan Physicians				
Rating of Personal Doctor (% 9 + 10)	61.8%	66.9%	70.0%	
Satisfaction with Plan and Plan Services				
Rating of Health Plan (% 9 + 10)	54.5%	56.8%	54.4%	
Rating of Health Care (% 9 + 10)	51.5%	55.7%	46.3%	

RY 2024 Patient Experience 1.5 Star Rating

Table: X
Summary Rates are defined by NCQA in the HEDIS 2024 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

Adult Notable Findings for RY 2024

- Adult oversampling strategy contributed to meeting the 100 survey response threshold for all NCQA Reportable measures.
- RY 2024 Patient Experience Star Rating Estimate: 1.5, ***no change from prior year.***
- Getting Care (% Always or Usually): ***A decrease in Access related measures has an overall impact to Rating of Health Plan and Rating of Health Care measures.***
    - Getting Needed Care - Score decline of -2.4 compared to RY 2023
    - Getting Care Quickly - Score decline of -1.4 compared to RY 2023
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Score increase of +3.1 compared to RY 2023
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Score decline of -2.3 compared to RY 2023
    - Rating of Health Care - Significant decline of -9.4 compared to RY 2023

Table: XI

CHILD HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend				
Patient Experience	RY 2022	RY 2023	RY 2024	Performance Trend
	Summary Rate Performance			
Getting Care				
Getting Needed Care (% Always or Usually)	79.6%	76.7%	77.0%	
Getting Care Quickly (% Always or Usually)	84.1%	76.3%	78.9%	
Satisfaction with Plan Physicians				
Rating of Personal Doctor (% 9+10)	74.6%	74.4%	75.5%	
Satisfaction with Plan and Plan Services				
Rating of Health Plan (% 9 + 10)	66.9%	68.0%	68.1%	
Rating of Health Care (% 9 + 10)	65.6%	64.2%	58.8%	

Table: XI
Summary Rates are defined by NCQA in the HEDIS 2024 CAHPS® 5.1H guidelines and generally represent the most favorable response percentages.

CHILD NOTABLE FINDINGS FOR RY 2024:

- Child oversampling strategy contributed to meeting the 100 survey response threshold for all NCQA reportable measures.
- RY 2024 Patient Experience Star Rating Estimate: 2.0, ***an increase of +.5 from prior year.***
- Getting Care (% Always or Usually): ***An increase in Access related measures has an overall impact to Rating of Health Plan and Rating of Health Care measures.***
    - Getting Needed Care - Score increase of +0.4 compared to RY 2023
    - Getting Care Quickly - Score increase of +2.6 compared to RY 2023
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Score increase of +1.1 compared to RY 2023
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Score increase of +0.1 compared to RY 2023
    - Rating of Health Care - Significant decline of -5.3 compared to RY 2023

APPENDIX

MEMBER EXPERIENCE

APPENDIX A

2024-2025 ORGANIZATION GOAL #4

The CAHPS® Program Manager has been appointed to lead ***Goal 4: Access to Care and Member Experience Improvement***. The Access to Care/Member Experience Improvement organizational goal will focus on three (3) main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans
2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans
3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

Goal Overview and Impact Summary

Improving access to care and enhancing member experience are pivotal for fostering a healthcare system that prioritizes both quality and member experience.

The CAHPS® regulated survey measures adult and child (member/patient) experience or perception of key aspects of their care. As an accredited health plan, we may designate which CAHPS® survey we want scored, either adult or child population. Last measure year, we chose child survey results that earned us 2.0 Patient Experience (CAHPS®) rating and an overall NCQA 3.5 Star Health Plan rating. This measure year Partnership designated adult survey results to be included in the scoring.

This fiscal year Partnership aims to achieve or exceed a 2.5 Star NCQA Patient Experience (CAHPS®) rating and achieve or exceed a 4.0 Star NCQA Health Plan rating. The Goal #4 Team will continue to build on the prior year's interventions and improvement activities. The established FY 2024-2025 goals are intended to impact or influence positive change on the key focus areas:

Access to Care: Improving access to care serves as the gateway to improve patient/member experience and health outcomes. As an organization, Partnership must plan to navigate through access obstacles linked to ever-changing membership levels, clinical staffing shortages, and economic climate at state, county and federal levels. Over the next fiscal goal period, our plan is to broaden our approach with the stewardship of Workforce Development leadership. In scope is to incorporate the past four (4) years of implemented access improvements and lessons learned through the 5-Star Quality Strategic and Tactical Plans, and, where applicable, adjust them as we develop a comprehensive Access Strategy and Tactical Plan fully dedicated to access moving forward.

Member Experience: Advancing the Quality Improvement (QI) CAHPS® programmatic framework will require implementing interventions rooted in present barriers and before eligible members participate in the regulated CAHPS® survey. Lessons learned through CSI activities over the past two (2) fiscal goal periods have paved the path forward. The plan is to leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide Goal #4 Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Positive Reputation and Brand Identity: Continue to distinguish Partnership as a Managed Care Plan leader that is committed to member-centered care, leading to a positive reputation and member awareness, "our story" within the communities we serve.

Effective Communication: Enhance member communication through texting, email, and Partnership mobile application designed to centralize and simplify all member-facing online websites/tools/platforms. This will help drive usability and value by engaging members through various communication modalities in delivering proactive resources that promote health education, covered benefits literacy, wellness, and preventative care resources.

Member Engagement and Adherence: Empower members with knowledge and resources intended to lead to greater engagement in their own care and increased adherence to treatment plans, resulting in better long-term health outcomes.

Enhanced Digital Experience: Develop a user-friendly mobile app and enhance member portal functionality and methods to empower members to self-serve and inform Partnership how they would prefer to engage with us. The plan is to build upon member demographic collection integration through existing C-Square enhancements.

APPENDIX B

IMPROVEMENT ACTIVITIES & ACTIONS TAKEN

In FY 2022-2023, CAHPS® stakeholders continued the established FY 2021-2022 process to evaluate data sources, including CAHPS® MY 2022 survey results and the 2022 Annual G&A and Second Level Grievances data. This included the analysis of said sources, improvement recommendations and NCQA Steering Committee approval to proceed with intervention activities focused on improving Access to Care and Member Experience.

The goal-setting approach this reporting period was slightly different to account for organizational change from a team goal to a department goal structure. The FY 2023-2024 QI CAHPS® Score Improvement (CSI) Department goal aimed to address overall member experience with an emphasis on improving equitable access to care as evaluated using MY 2022 / RY 2023 CAHPS® survey results and G&A data. The approach will include implementation of short and long term interventions[1] that target workforce development, expand primary care access and favorable member experience, and increased HealthPlan branding and promotion.

CAHPS® SCORE IMPROVEMENT (CSI) PARTICIPANTS

The FY 2023-2024 QI Department CSI Goal cross-department workgroup participants illustrate organization-wide participants involved in a multi-disciplinary approach focused on improvement activities and strategic CSI planning during the reporting and evaluation period, Table: XII.

Table: XII

GOAL WORKGROUP PARTICIPANTS	
WORKGROUP	**DEPARTMENT | NAME**
CAHPS® SCORE IMPROVEMENT OVERSIGHT WORKGROUP/GOAL LEAD: ANDREA THOMAS CO-LEAD: ANTHONY SACKETT	**ADMIN – SANTA ROSA:** Lynn Scuri
	COMMUNICATIONS: Dustin Lyda
	GRIEVANCE & APPEALS: Kory Watkins
	HR/WORKFORCE DEVELOPMENT: Cody Thompson, David Lavine
	MEMBER SERVICES: Edna Villasenor
	OFFICE OF THE CMO: Jeff Ribordy, MD, Mohammed Jalloh, PharmD
	PMO/OPEX: Hannah Petersen, Matt Hintereder, William Kinder
	POPULATION HEALTH MANAGEMENT: Monika Brunkal, Nicole Curreri
	PROVIDER RELATIONS: Ledra Guillory, Garnet Booth, Stephanie Nakatani
	QI: Anthony Sackett, Andrea Thomas, Barb Selig, Isaac Brown, Nancy Steffen
	TRANSPORTATION SERVICES: Melissa McCartney, Michelle Mootz

CAHPS® SCORE IMPROVEMENT (CSI) INTERVENTIONS

It should be highlighted that through continuous discovery our program has consistently evolved since CAHPS® program inception. To this point, our team placed more emphasis on analyzing existing delivery of services and covered benefits to gain a different perspective of member perception and linkage to satisfied and dissatisfied experiences.

The table below represents potential improvement focus to known member barriers, intervention ideas referenced in the FY 2023-2024 QI Program Evaluation and a status check mark indicates an influence of change, adoption, or linkage to department goal activities this fiscal year.

Table: XIV

IMPROVEMENT FOCUS	IDEAS	STATUS
Member Experience (ME)	Listen more through all established member engagement channels and determine whether these are adequate. Member focus groups are a potential intervention under evaluation.	
Rating of Health Plan	Operational awareness of member-supporting activities and internal/external communication. An operational improvement to remove work silos between departments is under review and consideration.	
ME	Continue to support Partnership branding and broader member and community awareness of the importance of CAHPS® survey participation.	✓
ME & Service/Attitude	Partnership Transportation, support, collaborate, and evaluate member experience with the Transportation Services Department and take timely action with what we learn.	✓
Access	Workforce Development, Partner with Workforce Development Associate Director and regional staff to: • Support local activities to bolster residency programs by engaging residents to help improve retention • Provide resources to help update and analyze PCP vacancy data and support other Workforce Development tactics linked to improving Access	✓
Access	Telehealth, where applicable support PMO regional-based telehealth to improve member and provider utilization and the influence of improving access and member experience.	✓
Rating of Health Plan	Develop key preventative indicators (KPI) to resolve service line issues quickly. An operational improvement pilot is under review and consideration.	
Access & Service/Attitude	• G&A complaints to identify member service delivery dissatisfaction themes. • PHM community member engagement survey and call campaign data. • Transportation member satisfaction data collection, analysis and, if applicable, proposed interventions. • Develop a process to quickly identify service delivery issues through real-time data with the intent to proactively investigate, validate, and implement solutions to improve member satisfaction.	✓ ✓ ✓

	• Remove operational barriers, Treatment Authorization Request denials and provider training opportunities.	

FY 2023-2024 SUMMARY OF ACTIVITIES AND INTERVENTIONS

The summary table below includes improvement focus based on the outcome of MY 2022-2023 quantitative and qualitative analyses, and root casual analysis. This table also highlights organizational priority of member barriers identified through the actions outlined in the CAHPS® Program Description and goal specific within the FY 2023-2024 CAHPS® Program Charter. Further the improvement or intervention focus status may include: New, Continue, Adjust, Monitor or Maintain. A summary of each improvement focus, accomplishment or outcome maybe referenced in Table XV.

Table: XV

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
		YES / NO	# OF DEPTS.	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Access	Yes	7	
Continue	Member Experience	Yes		
New	Customer Service			
New	Attitude/Service			
Continue	Health Care Rating	Yes		
Continue	Health Plan Rating	Yes		

Drawing on new discoveries and lessons learned in FY 2022-2023 CSI, goal efforts pivoted in FY 2023-2024 from four (4) distinct workgroups into one (1) collaborative Oversight Workgroup. This change afforded our team the ability to remove cross-department work silos and improve department leader collaboration by linking to external QI Department goal activities that directly and indirectly influence member experiences, Appendix D.

Further, restructuring allowed external departments to adopt or align with the CSI goal. As a result, implementation of new improvement activities and interventions that targeted workforce development, improved access to care, transportation services, direct-to-member activities, and increased Partnership branding and awareness were the focus of this collaborative workgroup. Seven (7) departments officially adopted the CSI goal and three (3) departments closely aligned their goals with CSI.

Additionally, an opportunity presented itself mid-year where the CAHPS® Team was invited to a webinar brainstorming session in order to fulfill Partnership's Northern Region Consortia partners, Health Alliance of Northern California (HANC) and North Coast Clinics Network (NCCN), contractual agreement. The CAHPS® Team suggested a Patient Experience webinar, which stemmed from the team's CG-CAHPS® / Provider Network – Improve Communications Scores Pilot referenced above. The outcome was a

webinar entitled *Incorporating Patient Experience in Quality Improvement Projects and Plans,* which was held on May 7, 2024. The learning objectives for participants viewing this webinar were as follows:

- Describe how patient experience impacts clinical outcomes, patient satisfaction, provider/staff satisfaction, and healthcare quality.
- Identify opportunities to assess patient experience data from a Quality Improvement (QI) perspective.
- Apply QI methodology to patient experience improvement activities.
- Discuss strategies for involving patients and their families in the QI process.

There were 53 external individuals, representing 34 unique organizations, who attended this webinar. The webinar recording is posted under "On-Demand" webinars on the Quality page of Partnership's website. An article in the summer 2024 edition of the Partnership Provider Relations newsletter focusing on CAHPS® and Member Experience as a true partnership between the health plan and providers highlighted this webinar and encouraged providers to view the recording.

In FY 2023-2024 Partnership restructured the former fiscal goal to a department goal process with metric alignment to measure effectiveness of improvement. The CAHPS® Program will still maintain our annual programmatic focus but owning the responsibility of delivery is shared among four (4) departments: Communications, Member Services, HR/Workforce Development, and Quality Improvement.

Table: XVI

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
HR/Workforce Development QI CSI Department Goal adopted: yes	**Intervention/Improvement Status: New** Intervention: Contract with Third Party Recruiter Impact on CSI: Improve Access with Provider Recruitment Barrier: Access to Care	Successfully facilitated the execution of a contingency search firm agreement with CompHealth as wells as creating a contingency search firm Letter of Agreement for partners and provided to sites in Solano County. Five (5) of the six (6) partners (Communicare+Ole, Winters Health, Community Medical Center, LaClinica, and Northbay) signed the agreement. The remaining site is currently in the contracting phase as of the date of this update. Additionally, four (4) sites have provided open position details. • Three (3) openings with Community Medical Centers (Family medicine positions in Dixon, Internal Medicine in Vacaville, and a Pediatric opening in Vacaville) • Two (2) openings with La Clinica de La Raza (Family medicine positions in North Vallejo and Vallejo Medical)

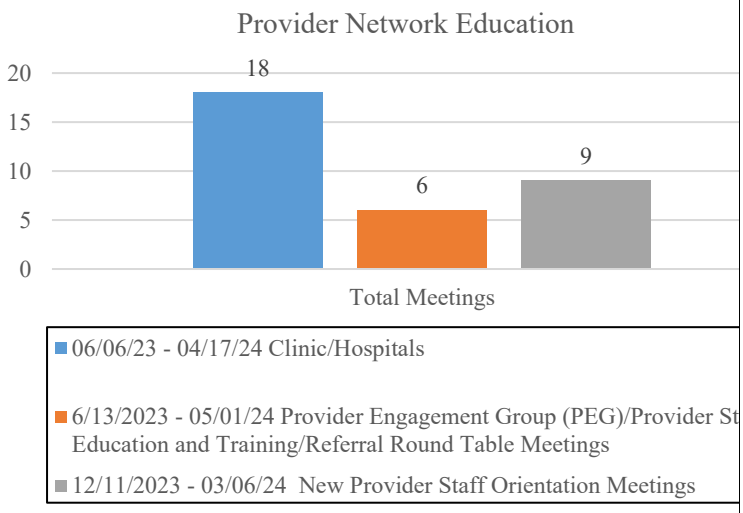
CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
		• Five (5) openings with NorthBay Medical (Family medicine positions in American Canyon, Dixon, Fairfield, Green Valley, and Vacaville) • One (1) opening with Winters Healthcare (Family medicine position in Winters/Esparto) With this information, CompHealth works to market the positions to candidates searching for opportunities. There have been 14 candidates formally introduced by CompHealth to three (3) provider organizations (Community Medical Centers, La Clinica de La Raza, and NorthBay). Four (4) interviews have taken place with candidates in the month of April 2024 (three (3) with Community Medical Centers and one (1) with NorthBay).
	Intervention/Improvement Status: Continue Intervention: Provider Resident Retention Program Impact on CSI: Improve Access with Provider Retention Barrier: Access to Care	Successfully facilitated adding the resident retention bonus to the 2024 Provider Recruitment Program (PRP) Agreement, which launched the first week of January 2024. Of the 65 grant requests submitted to the program as of May 1, 2024, six (6) requests included the additional $20,000 resident retention bonus. To date, one (1) of the offers made, including the $20,000 bonus, has been accepted. There is a possibility that the five (5) remaining requests for program support, including a resident bonus, could be accepted and the resident bonus payment facilitated before graduation. Since the 2024 recruitment program launched in January and physician residents graduate in late June, the opportunity for provider sites to be able to align the bonus successfully may have been difficult. With continued promotion of PRP in the upcoming fiscal year, higher utilization and retention of additional regional residents is expected.
	Intervention/Improvement Status: Continue Improvement Activity: Provider Network Vacancy Survey Impact on CSI: Improve Access with Provider Recruitment Barriers: Access to Care	The Provider Network Vacancy survey for Report Year 2024 was successfully launched to partner sites with 500 or more assigned members. The survey was completed between April 1, 2024 and April 19, 2024. Compared to the Measurement Year (MY) 2022/2023 site survey where there was a 74% response rate, initial review of the MY2023/2024 survey results showed nearly an 80% response rate from organizations polled. The increase in response rate can be attributed to initial engagement from the Partnership team with executives at provider sites as well as multiple follow-ups with clinic managers, Human Resource departments, and recruiters. Final survey results are being compiled.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
OpEx/PMO Telehealth Program QI CSI Department Goal Adopted: No	**Intervention/Improvement Status: New** Intervention: Increase DTM utilization by 25% through DTM grant Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	In FY 2022-2023, Direct-to-Member (DTM) utilization spiked significantly over the prior fiscal year to 1,974 from 543 visits in FY 2021-2022. For FY 2023-2024, the goal was to increase DTM by 25%. Through March, or nine (9) months, DTM utilization has 4,373 completed visits representing a 122% increase. DTM Grant executed with five (5) organizations: Alliance Medical; Redwood Coast Medical Services (RCMS); Redwood Rural Health Center (RRHC); Stallant Health; and Sutter Coast. All five (5) are set to achieve their goals. • Alliance – 143/200 visits completed through March. 117% increase over FY 2022-2023 • RCMS – 63/50 visits completed through March. Did zero (0) visits in FY 2022-2023 • RRHC – 150/100 visits completed through March. 217% increase over FY 2022-2023 • Stallant – 429/150 visits completed through March. 1,489% increase over FY 2022-2023 • Sutter Cost – 127/150 visits completed through March. 75% increase over FY 2022-2023 Collectively these organizations represent 101 completed DTM visits per month over nine (9) months, which is a 290% increase collectively over their collective 26 visits per month in FY 2022-2023.
Communications QI CSI Department Goal Adopted: No	**Intervention/Improvement Status: New** Improvement Activity: Your Partner in Health: Partnership Branding/Awareness Strategy Impact on CSI: Knowing who Partnership is relative to health plan administrator/Managed Care Plan (MCP)	The new Your Partner in Health campaign officially launched on October 1, 2023 in all 24 counties Partnership serves. The goal of the campaign is to reiterate to members that Partnership is here to help them with all their Medi-Cal needs. Your Partner in Health is the organization's slogan and branding campaign/initiative to ultimately raise awareness of who Partnership is and what the organization does for members and the broader community. Strategies included outdoor, radio, social media, streaming, and digital with messaging aimed to target specific populations.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Barriers: Health Plan Rating / Health Care Rating	
	Intervention/Improvement Status: New Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	Partnership's newly appointed Chief Information Officer is taking the necessary steps to re-evaluate the predecessor's work related to the vendor selection and cyber security considerations. The unforeseen activities affect the ability to execute a contract and submit a texting plan to Department of Healthcare Services (DHCS) for review and approval. In conclusion, the member texting platform is unlikely to launch by June of 2024.
Member Services QI CSI Department Goal Adopted: No	Improvement Activity: Member Texting Engagement Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention/Improvement Status: New Intervention: Optimizing Translation Services Impact on CSI: Member Experience / Health Plan Ratings Barriers: Health Plan Rating / Health Care Rating	Conducted two (2) webinars in November 2023 for providers to engage with AMN vendor to introduce the phone/video remote interpreting (VRI) services and how to utilize. Two (2) additional webinars were completed in January and February 2024. Additionally, covered options of obtaining the AMN platform for video remote interpreting (license [using the provider's owned devices] or securing tablets and stands).
Population Health Management QI CSI Department Goal Adopted: yes	Improvement Activity: Member Texting Engagement Platform Impact on CSI: Improve member connection with the plan by communicating through preferred channels Barriers: Health Plan Rating / Health Care Rating	See Communication's update above.
Transportation Services QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: New** Improvement Activity: Transportation Gas Mileage Reimbursement Service Recovery Impact on CSI: Member Experience / Health Plan Ratings Barriers: Customer Service / Health Plan Rating	During the course of this fiscal cycle, the Transportation Team worked to automate Gas Mileage Reimbursement payments. Process improvements were identified and implemented, which should increase satisfaction and timely payments moving forward. Out of 40,629 gas mileage reimbursement trips, there were a total of 122 related grievances filed between May 1, 2023 – April 1, 2024. Findings are being reviewed and methods for identifying improvements to increase Customer Service ratings are being developed. One such metric being used to measure improvements in processes is the Gas Mileage Reimbursement Service Recovery Outcall Project. During this pilot project, the Transportation Team will attempt making two (2) calls to members having filed a gas mileage reimbursement grievance to gauge if the member is now satisfied as to receiving timely gas mileage reimbursements. The goal is to achieve successfully connecting with 20% (or 25) members.

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention/Improvement Status: New Improvement Activity: Transportation Active Utilizer Survey Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care Barrier: Access to Care	This activity was abandoned due to Transportation Team being severely understaffed this fiscal year and prioritization of gas mileage reimbursement service recovery efforts.
Grievance & Appeals QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: Continue** Improvement Activity: Participate in dialogue channel to provide real-time member satisfaction data and methods to drive key preventive indicators (KPIs). A KPI will have defined risk thresholds, which will provide Partnership more real-time opportunities prior to the survey. G&A will evaluate trends through grievance and appeal data and provide to the workgroup. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	Grievance & Appeals (G&A) participated in regular meetings with key stakeholders to discuss intervention ideas and opportunities. Through regular evaluation of trends using G&A data, the team provided the workgroup with analyses to be used for data-driven recommendations. This enabled informed decision-making and targeted interventions.
	Intervention/Improvement Status: New Improvement Activity: Participate in analysis	G&A effectively participated in activities aimed at understanding and improving areas of opportunity within the plan. By actively engaging in the analysis process, the team gained insights into the plan's strengths and areas for improvement. Through collaborative efforts within the

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	activity to better understand where the plan's areas of opportunity are. Participate in workgroup to write summaries to track relative milestones G&A participates in. Impact on CSI: Access to Care / Member Experience / Health Plan Ratings / Health Care / Specialty Care Barriers: Health Plan Rating	workgroup, G&A added valuable contributions to summaries related to CSI.
Provider Relations QI CSI Department Goal Adopted: yes	**Intervention/Improvement Status: New** Improvement Activity: Provider Network Education Impact on CSI: Health Plan Ratings / Member Experience Barriers: Health Plan Rating	Throughout this fiscal cycle, the Provider Relations Team reviewed flyers, PowerPoint presentations, and hosted meetings with providers in support of educating the network on Transportation Services and Benefits and Work Force Development Programs (Provider Recruitment and Provider Retention Initiatives). These meetings included, and not limited to, Operations, Provider Staff Education and  Trainings, Provider Engagement, and Referral Roundtables.
Admin – Santa Rosa Office	**Intervention/Improvement Status: New** Intervention: Identify primary care providers in	Using Primary Care Tableau Utilization reports, four practices were identified in the Southwest region providing > 25% of primary care visits via telehealth. Organizations included in the study were: West County Health Centers, Long Valley Health Center, Marin Community Clinics, and

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
QI CSI Department Goal Adopted: yes	the Southwest Region that are providing a significant percent of visits via telehealth (>10% of total); interview providers and summarize the ways telehealth is being used and perceived impact on access to care. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	Alliance Health Centers. A survey was developed and meetings scheduled with leaders from each primary care organization to administer survey and discuss use of primary care telehealth. Information gleaned from surveys was used to create one-page summary documents for each organization. A meeting was scheduled with all participants on May 30, 2024 to share details from each organization and jointly develop primary care telehealth best practices. **Study Participants**: The four (4) health centers in the study provide between 26 – 43% of their primary care visits via telehealth, most often as audio visits rather than video visits. **Common Uses of Primary Care Telehealth**: Telehealth visits are most commonly used for same day appointments and triage and follow-up visits to review imaging and lab results. One provider routinely uses telehealth for Emergency Department and hospital patient follow-up. Follow-up to eConsults also noted as a potential use for primary care telehealth visits. **Telehealth Staffing**: The staffing and structure used to provide primary care telehealth services varies quite a bit from one organization to another. Some rely exclusively on current staff, others contract with remote staff. **Member Satisfaction**: While most organizations have not done a formal telehealth member satisfaction survey, all sites stated that telehealth is well received by their patients, though many still prefer in-office visits, depending on the nature and scope of the visit. For example, one clinic noted patients receiving medication assisted treatment are grateful for the telehealth option, thereby reducing the need for frequent visits to the clinic. **Provider Satisfaction**: Providers appreciate the flexibility afforded by telehealth to work remotely or even with telehealth visits integrated into their daily in-office schedule. One (1) provider sites that telehealth helps with provider satisfaction and retention. **Primary Care Telehealth**: All health centers participating in the study state that primary care telehealth is an important tool to help address access to care. One (1) organization emphasized “Telehealth is here to stay”.
	Intervention/Improvement Status: New	The Southwest Direct-to-Member (DTM) workgroup was formed to include staff from the Telehealth Team, Provider Relations, and Regional staff to assess current use of DTM

CSI Goal Oversight Workgroup Participants		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Intervention: Engage at least two providers in the Southwest Region to implement DTM or increase DTM physician visits to at least 50 visits for FY 2023-24. Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings Barrier: Access to Care	by provider and develop joint outreach and promotional strategies. A dashboard was developed to monitor progress. Specific strategies were reviewed and refreshed at each quarterly meeting. As a result, there was a significant increase in the use of DTM services by provider offices in the Southwest, with an average increase of over 101% from the previous six (6) months. Eight (8) providers met the goal of greater than 50 DTM visits in the goal period.
Office of the CMO – Northern Region QI CSI Department Goal adopted: yes	**Intervention/Improvement Status: New** Intervention: Engagement with Tribal Health Organizations Impact on CSI: Member Experience / Health Care / Health Plan Ratings Barriers: Access to Care / Member Experience	This intervention aimed to support engagement with tribal health providers in an effort to improve the health and well-being of tribal communities. A Tribal Conference was successfully held in October of 2023. 14 tribal health providers were in attendance in addition to representatives from Department of Healthcare Services, Indigenous Pact, Indian Health Organizations, and Partnership leaders. Also occurring in October 2023 were Better Birthing Coalition site visits to K'ima:w Medical Center and ceremony sites on Hoopa Reservation and Sue-Meg village. In February 2024, a successful workshop was led by Indigenous Pact, a tribal healthcare consultant, for key Partnership staff. The intent of the workshop was to increase Partnership staff and leadership's knowledge around tribal history, beliefs and practices, which in turn would improve relationships and communication between organizations. Upcoming meetings, not yet scheduled as of this update, with K'ima:w Medical Center leadership will be centered around CalAIM and quality work.
	Intervention/Improvement Status: New Intervention: Work Collaboratively with Telehealth Team and TeleMed2U to Promote DTM Model	Throughout the fiscal year, worked collaboratively with Telehealth Team and provided Subject Matter Expert support for provider outreach to increase use of DTM and other telehealth services.

<table>
<tr><th colspan="3">CSI Goal Oversight Workgroup Participants</th></tr>
<tr><th>Department | Action</th><th>Goal | Milestones</th><th>Accomplishments</th></tr>
<tr><td></td><td>Impact on CSI: Member Experience / Specialty Access / Health Care / Health Plan Ratings

Barriers: Access to Care / Member Experience</td><td></td></tr>
<tr><td rowspan="2">Quality Improvement</td><td>Intervention/Improvement Status: New

Improvement Activity: Implement CAHPS® Drill Down Survey, and gather all member-centric data points to include but not limited to; community/member-facing engagement activities, and call campaign data points

Impact on CSI: Member Experience / Health Plan Ratings

Barriers: Member Experience / Health Plan Ratings</td><td>Implementation of the non-regulated CAHPS® Drill Down Survey for the Adult population was completed. The purpose of the non-regulated survey was to help identify potential root causes and/or qualitative insight to responses garnered in the regulated Measurement Year 2023 Report Year 2024 CAHPS® survey. To incentivize members to complete the Drill Down survey, a $30 Walmart gift card was offered. The survey timeline and methodology were as follows.

<table><tr><th>Task Name</th><th>Date</th></tr><tr><td>Survey Mailed (First attempt)</td><td>March 18, 2024</td></tr><tr><td>Survey Mailed (Second attempt)</td><td>April 3, 2024</td></tr><tr><td>Telephonic Reminders Begin</td><td>April 17, 2024</td></tr><tr><td>Drill Down Survey Concludes</td><td>May 29, 2024</td></tr></table>
A total of 694 surveys were completed; incentives are in the process of being administered to members. Survey results and analysis are pending and will be outlined in the MY2023-2024 Member Experience Grand Analysis.</td></tr>
<tr><td>Intervention/Improvement Status: Continue

Improvement Activity: Analysis and Risk Identification of Grievance and Appeals Data

Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors</td><td>As part of a pilot program, 2023 G&A data and Population Health Management member surveys were reviewed / analyzed. For Population Health Management, themes/requests among members were identified, some of which pointed to third parties (i.e., mental health, dental, etc.) The various grievance and appeals data was categorized and aligned with National Committee for Quality & Assurance's (NCQA) defined categories of Access; Attitude and Service; Billing and Financial; Quality of Care; and Quality of Practitioner Site. The intent was to identify an on-going method to capture member feedback (active listening) that may demonstrate network wide or health plan wide</td></tr>
</table>

CSI GOAL OVERSIGHT WORKGROUP PARTICIPANTS		
Department | Action	**Goal | Milestones**	**Accomplishments**
	Communicate / Customer Service Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	themes requiring adjustments in member-facing communications, branding, and educational activities. This activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results. The intent is to effect change and/or implement steps to address barriers sooner rather than later. Support of the CAHPS® Oversight Workgroup was garnered to move the pilot forward into the next fiscal year and establish a small group of Subject Matter Experts to provide further guidance on what other data sets could be identified pointing to themes of member dissatisfaction; data/interventions to be accessed on a quarterly basis. Ongoing meetings with G&A and other key stakeholders will continue in the next fiscal year.
	Intervention/Improvement Status: New Intervention: CG-CAHPS® / Provider Network – Improve Communications Scores Pilot (*Select at least one mid-to-large Parent Organizations, ≥ 1,200 assigned members*) Impact on CSI: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service Barriers: Health Care Rating / Health Plan Rating / Rating of Personal Doctor / How Well Doctors Communicate / Customer Service	This intervention was implemented with a provider located in Partnership's Southwest region. Part one involved contracting with the Crossroads Group to establish a system of continuous patient experience surveying and reporting. The Crossroads Group is a well-established company, with extensive experience serving Federally Qualified Health Centers (FQHCs), which offers comprehensive patient experience surveying, data analysis and reporting. The intent was for this provider to use patient experience data provided by the Crossroads group to carry out at least two (2) Quality Improvement Projects addressing patient satisfaction, with specific aims and defined Plan-Do-Study-Act cycles by June 30, 2024. Part two entailed a four-hour, interactive training on patient-centered communication in the primary care setting for all providers and clinical staff. The training would be specifically tailored to strengthen team-based communication techniques to increase patient satisfaction and clinical efficiency. A sustainability plan and training materials for providers and staff who onboard in the future would also be developed. As of the date of this update, this provider successfully launched their post-visit patient experience survey program and collected survey data via live phone interviews from over 1,000 patients in Q1 2024. In addition to receiving an executive summary, the provider also has access to a real-time dashboard displaying up-to-the-minute data, which allows data to be filtered/analyzed in multiple ways.

APPENDIX C

CAHPS® NON-REGULATED SURVEY

BACKGROUND

As a strategy, the CAHPS® Program contracted with PressGaney to administer a CAHPS® Adult non-regulated drill down (DD) survey at the same time of the CAHPS® regulated survey. The intent behind the strategic approach offers Partnership another mode to collect member experience data linked to NCQA CAHPS® reportable rating and composite measures.

SURVEY KEY DIFFERENCES

- The plan's ability to modify questions to better understand member survey responses is an alternate means of providing the health plan with potential root causes of why or how a member is feeling related to the asked question.

- The DD survey is modeled after the previously described regulated survey and includes similar mixed survey protocols, methodology, and the same HEDIS survey sample frame. However, a de-duplication process is in place to mitigate over surveying, survey-confusion, or unintended abrasion.

- An option to offer survey participants a thank you gift in the form of a $30 Walmart card to incentivize members to participate and complete the survey in its entirety.

- The DD survey questions are different by design and, therefore, survey results will not exactly align with regulated questions or HEDIS Quality Compass benchmarks.

SURVEY QUESTION DEVELOPMENT

The CAHPS® Team, in collaboration with key internal stakeholders developed survey questions linked to Partnership covered benefits and health care delivery services. The outcome of cross-department survey question collaboration is included in the tables below. Including department, attribute (focus), and questions, Tables: XIII[a-d].

ADULT DD SURVEY ADMINISTRATION HIGHLIGHTS

The gift card administration was managed by the QI Department, who partnered with the PHM Department to conduct outreach efforts to non-English, Spanish speaking members. The highlighted outcomes are listed below.

- Adult population (18 years or older)
- Total Survey Responses: 554 | English
- 5,000 sample frame
- Total Survey Responses: 140 | Spanish
- Language format: English and Spanish
- Response rate: 694-16 ineligible, survey completes = (678/5,000), 13.6%

- 673 Gift cards mailed

ADULT DD SURVEY RESULTS
CORRELATION TO REGULATED NCQA REPORTABLE RATING AND COMPOSITE MEASURES

As previously noted, the DD survey completes (n=678), combined with the regulated survey completes (n=510) is a combined total of 1,188 completed surveys. To date, this is the largest single member population and experience data collection within a survey measure year for Partnership.

QUANTITATIVE ANALYSIS
The quantitative analysis displayed in the tables below aligns key rating and composite measure questions with DD member survey responses and other survey questions considered to be key drivers that influence and impact the overall NCQA Health Plan Star Rating.

QUALITATIVE ANALYSIS
The qualitative analysis will include comparing the results of the DD survey to those of the CAHPS® regulated survey and provide key findings regarding how our members think and feel about key questions or attributes.

The quantitative and qualitative analysis tables when applicable will include Adult CAHPS® regulated rating or composite measure MY 2023 performance, followed by similar or influenced DD questions, highlight survey responses, and offer comparative key findings. ***Survey questions where applicable are developed into DD questions by asking key subsequent questions. The survey includes several gate questions, which when applicable advances members to the next question. Therefore the noted sample size will change.***

DD SURVEY NOTABLE FINDINGS

- **MEMBER SATISFACTION**
  - Members shared they are 87% (n=678), very or somewhat satisfied with Partnership Health Plan of California.
- **PLAN COVERED BENEFITS AND SERVICES**
  - More than a third of respondents 36% (n=678), ask either their provider or clinical staff questions related to benefit coverage or health services. While another 29% prefer to contact Partnership Member Services, and the remaining are self-reliant and choose to reference Partnership printed materials or website.
- **COVERED BENEFIT LITERACY**
  - Over 53% consider their understanding of benefits and coverage at excellent or very good, while 47% of members scored less than excellent or very good regarding understanding benefits. The CAHPS® Team has used DD results to validate and link benefit literacy gaps and themes gathered through members surveyed at in-person community events by PHM. Benefit themes point to coverage confusion between Partnership and state carve out coverage, Medi-Cal

(Dental/Pharmacy), vision, and transportation services. Although only 18% consider benefits and coverage confusing, the CAHPS® Team believes this number is higher given the complexity and distinction between state and Partnership covered benefits.

- **PARTNERSHIP CUSTOMER SERVICE**
  - Partnership prides itself with providing professional, courteous, respectful and top-notch member-facing customer service (Q25). In addition to our internal methods to monitor satisfaction levels, we also evaluate CAHPS® regulated survey performance. Over the past three CAHPS® regulated measure years, Adult and Child results scored in the lower (Adult) to mid (Child) 90th percentile. In comparison to providing information or help, our scores are in the low (Adult) to mid (Child) 80th percentile over the same measure period.
- **MEMBER SUPPORT AND ISSUE RESOLUTION**
  - Although only 16% (n=678) indicate they called Partnership customer service (Q25) only 25% (n=102) answered somewhat or strongly disagree with the posed survey question (Q27), "Question or issue was resolved." Additional comments shared include members called multiple times regarding the same issue, members placed on hold too long, and some members felt the phone system was confusing to navigate.
- **HEALTH EQUITY | HEALTH PLAN RATING – INTERPRETER EXPERIENCE**
  - As previously noted, the CAHPS® and DD Survey is only offered in two language formats, English and Spanish. Members answering the following questions represent Hispanic and Latino members.
  - The non-English speaking members (n=158), who relied on interpreter and language services while speaking with Partnership staff, shared that 69% (%9 + 10) had the best possible experience, while 31%, worst possible experience. Also important to note, the Adult CAHPS® regulated survey received a similar rating score related health plan interpreter services (n=171) 67.3%.
- **GETTING CARE QUICKLY**
  - Almost 40% of members participating in the DD survey experienced an illness, injury or condition requiring care right away (Q2), and 12.5% indicated experiencing a life-threating emergency (Q3. Member reported responses demonstrate less than half (n=263) required services in a non PCP setting.
- **KIND OF CARE NEEDED AND CLINICAL SETTING**
  - The correlating survey emergent care options (Q3 - Q5) indicate that one-third (39%) of surveyed respondents sought care within an Emergency Department (ED) setting for non-emergent, life-threating services. It is worth mentioning, the CAHPS® Team and internal stakeholders do not rely on DD survey data to inform Partnership of ED over-utilization of non-emergent care. It does, however, align with the intent to tease out and elevate learnings (Q5) as to the why. The collected data will serve to facilitate discussions and to drive quality improvement activities.

HOW WELL DOCTORS COMMUNICATE

- Members (n=678) responded favorably with posed DD questions (Q11a-d). This aligns with the CAHPS® regulated survey Rating of Personal Doctor summary composite score of 70% and HEDIS Quality Compass ranking 64th percentile.
  - 90% of members (Q11d) felt their personal doctor spoke in a way that was easy to understand, ***whereas 97% shared their personal doctor used medical words they did not understand (Q12).***

- 80% of members (Q11a, Q11c) felt their personal doctor spent enough time and encouraged them to talk about health problems or concerns.
- 85% of members felt their personal doctor answered all their questions.

Table: XIII-[a]

DEPARTMENT: TRANSPORTATION SERVICES ATTRIBUTE / FOCUS: ACCESS, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q9. If you had a challenge in the last 6 months getting care right away or as soon as needed for an illness, injury or condition, what was the problem? *(Mark all that apply)*: ***Option, Did not have transportation to the appointment***
Q26. What was the reason you called customer service? (Mark all that apply): ***Option, Request transportation services.***
Q35. Are you aware that help with transportation to your medical appointments is available through your health plan?
Q36. In the past 6 months, has lack of transportation kept you from medical appointments?
Q37. Some health plans help with transportation to a doctor's offices or clinics. This help can be a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?

Table: XIII-[b]

DEPARTMENT: OPEX/PMO – TELEHEALTH PROGRAM ATTRIBUTE / FOCUS: ACCESS, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q30. In the past 6 months, did you have a telehealth visit?
Q31. Please indicate why you did NOT have any Telehealth visits in the last 6 months. *(Mark all that apply)*
Q32. If you had a choice, how likely would you be to choose a telehealth visit with your provider instead of having an in person visit with your provider?
Q33. You indicated that you had a telehealth visit in the last 6 months. *(Mark all that apply)*
Q34. What do you view as the main benefit to telehealth services? *(Mark only one)*

Table: XIII-c

DEPARTMENT: MEMBER SERVICES ATTRIBUTE / FOCUS: CUSTOMER SERVICE, BENEFIT LITERACY, MEMBER EXPERIENCE
QUESTIONS
Q22. Which of the following resources do you prefer to use when you need to find information about your health benefits and coverage? Q23. Overall, how would you rate your understanding of your health care benefits and the coverage provided by your health plan? Q24. Is the information about your health plan's coverage and benefits confusing? Q25. In the past 6 months, did you call your health plan's customer service? Q26. What was the reason you called customer service? (Mark all that apply.) Q27. My question and or issue was resolved to my complete satisfaction. Q28. If you answered question #27 with Somewhat Disagree or Strongly Disagree, please provide reason. (Mark all that apply.) Q29. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Table: XIII-d

DEPARTMENT: HEALTH EQUITY ATTRIBUTE / FOCUS: CLAS SERVICES, MEMBER & PATIENT EXPERIENCE
QUESTIONS
Q11. In the last 6 months, how often did your personal doctor do each of the following? Option d) Spoke to you in a way that was easy to understand. Q12. In the last 6 months, did your personal doctor use medical words you did not understand? Q13. In the last 6 months, have you had problems communicating with your doctor or other cultural, personal, or religious beliefs? Q14. In the last 6 months, have you had a hard time speaking with or understanding your doctor or other health care provider because you spoke different languages? Q15. In the last 6 months, have you been treated unfairly at your personal doctor's office because of your race or ethnicity?

Q18. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your doctor or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Q29. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

CAHPS® Regulated Survey		
Rating Measure		
Rating of Health Care (% 9 + 10) Respondents (n=326)	Score: 46.3% ⬇	HEDIS Quality Compass Ranking: 5th Percentile
Non-Regulated - DD Survey		
Questions that Influence Rating Measure	Member Insight – How members feel and what they're saying	
Q2. In the last 6 months, did you have an illness, injury, or condition that needed care right away?	Response (n=678): ▪ *61%: No* ▪ *39%: Yes*	
Q3. What kind of care did you need?	Response (n=263): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *48.3%: Lab tests or treatments.* ▪ *43.0%: Urgent care needed right away, such as for the flu virus, back pain, fever or sprain.* ▪ *40.3%: Appointment with a specialist.* ▪ *31.9%: Annual wellness exam or checkup.* ▪ *30.8%: Non-urgent care for illness/sick visit (for example, cough, sore throat, flu symptoms, etc.)* ▪ *16%: Other.* ▪ *12.5%: Life-threatening emergency.*	
Q4. Where did you go to get the care you needed right away for an illness, injury or condition?	Response (n=263): ▪ *42.1%: Hospital emergency room.* ▪ *22.2%: Personal doctor's office.* ▪ *15.4%: Walk-in clinic.* ▪ *10.4%: Specialist Office.* ▪ *8.1%: Other.* ▪ *1.8%: Did not get care needed for illness, injury or condition.*	
Q5. If you had to be seen in the hospital emergency room, why?	Response (n=263): ▪ *46.9%: Does not apply.*	

	▪ *14.8%: Other* ▪ *12.3%: Personal doctor's office was closed.* ▪ *11.1%: Personal doctor's office told me to go to the emergency room.* ▪ *7.8%: Life-threatening emergency.* ▪ *4.1%: I do not have a personal doctor.* ▪ *2.9%: I always go to the emergency room for care.*

CAHPS® Regulated Survey		
Rating Measure		
Rating of Health Plan (% 9 + 10) Respondents (n=490)	Score: 54.5% ⬇	HEDIS Quality Compass Ranking: 13th Percentile

Non-Regulated - DD Survey	
Questions that Influence Measure	Member Insight – How members feel and what they're saying
Q20. Satisfaction with Partnership.	Response (n=678): ▪ *87%: Very or somewhat satisfied.* ▪ *13%: Somewhat dissatisfied or very dissatisfied.*
Q22. Which of the following resources do you prefer to use when you need to find information about your health benefits and coverage.	Response (n=678): ▪ *35.7% Ask provider or someone at my provider's office.* ▪ *29.1%: Call the health plan's customer service department.* ▪ *23.1%: My health plan's web site.* ▪ *7.9%: Look first in the health plan's member handbook.* ▪ *4.2%: Other.*
Q23. Rating of understanding of benefits and coverage.	Response (n=678): ▪ *53%: Excellent or very good understanding of health benefits and coverage.* ▪ *47%: Fair or poor understanding of health benefits and coverage.*
Q24. Is the information about your health plan's coverage and benefits confusing?	Response (n=678): ▪ *81.8%: No, do not find coverage and benefits confusing.* ▪ *11.1%: Yes, find coverage and benefits confusing.* ▪ *7.1%: Other.*
Q25. Called customer service.	Response (n=678): ▪ *84%: No, member did not call plan customer service.* ▪ *16%: Yes, member called plan customer service.*
Q26. Reason for calling customer service.	Response (n=100): *The question format is multiple choice; therefore, percentages do not equal 100%.*

	▪ *33%: Coverage or benefit information (i.e. dental, vision).* ▪ *26%: Referral information.* ▪ *18%: Prior authorization, find a provider, medication coverage information.* ▪ *15%: Request new member ID card.* ▪ *11%: Request transportation services.* ▪ *9%: File a complaint, grievance or appeal.* ▪ *8%: Change my personal doctor.*
Q27. Question and or issue was resolved.	Response (n=102): ▪ *75%: Member strongly or somewhat agrees that issue was resolved.* ▪ *25%: Member somewhat or strongly disagrees that issue was resolved.*
Q28. If you answered question #27 with Somewhat Disagree or Strongly Disagree, please provide reason.	Response (n=28) *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *50%: Other, please specify.* ▪ *35.7%: Called customer service several times about the same issue.* ▪ *32.1%: Call was transferred multiple times.* ▪ *28.6%: Placed on hold too long.* ▪ *21.4%: Customer service representative provided unclear or incomplete information.* ▪ *17.9%: Customer service representative spoke in a way that was unclear and hard to understand.* ▪ *14.3%: Member confused by recorded message on how to navigate to a customer service representative.* ▪ *10.7%: Customer service representative was not knowledgeable.* ▪ *3.6%: Medication coverage information.*
Q29. Rating of experience with interpreter with Health Plan.	Response (n=158): ▪ *69%: Plan interpreter (non-English speaker), best possible experience, % 9 +10.* ▪ *31%: Plan interpreter (non-English speaker), worst possible experience.*

CAHPS® REGULATED SURVEY		
COMPOSITE MEASURE		
Getting Needed Care **% Always + Usually** Respondents (n=271)	Score: 74.0% ⬇	HEDIS Quality Compass Ranking: 7th Percentile
NON-REGULATED - DD SURVEY		

Questions that Influence Measures	Member Insight – How members feel and what they're saying
Q7. In the last 6 months, how long did you have to wait between making an initial appointment and being seen by your personal doctor?	Response (n=541): ▪ *19.6%: 4 to 7 days.* ▪ *18.3%: 15 to 30 days.* ▪ *14.6%: 31 to 60 days.* ▪ *12.6%: 8 to 14 days.* ▪ *10.2%: More than 60 days.* ▪ *9.2%: Same day.* ▪ *6.7%: 3 days.* ▪ *5.0%: 2 days.* ▪ *3.9%: 1 day.*
Q8. Did you feel that the amount of time you had to wait for your appointment was reasonable?	Response (n=556): ▪ *66%: Yes, members felt the wait time to be seen was reasonable.* ▪ *34%: No, members did not feel the wait time to be seen was reasonable.*
Q9. If you had a challenge in the last 6 months getting care right away or as soon as needed for an illness, injury or condition, what was the problem?	Response (n=289): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *68.5%: Scheduling an appointment right away.* ▪ *24.2%: Receiving approval from my health plan.* ▪ *23.5%: Finding a location near me.* ▪ *15.6%: Other* ▪ *12.5%: Did not have transportation to the appointment.* ▪ *11.1%: Appointment with a specialist.*
Q10. In thinking about your experiences in the last 6 months, how sure are you that you will be able to get an appointment as soon as you need it for healthcare services, tests or treatments?	Response (n=678): ▪ *59%: Very sure or sure, members feel their able to get an appointment as soon as needed for healthcare services, tests and treatments.* ▪ *41%: Somewhat sure or not at all sure.*
Q38. Made Specialist Appointment	Response (n=678): ▪ *63%: No, in the last 6 months, member did not make an appointment with a specialist.* ▪ *37%: Yes, in the last 6 months, member made an appointment with a specialist.*
Q39. Had problems getting Specialty Care, tests or treatments	Response (n=253): ▪ *76%: No, member did not have problems getting specialty care, tests or treatments.* ▪ *24%: Yes, member had problems getting specialty care, tests or treatments.*

Q40. If you had challenges scheduling a specialist appointment, what type of appointment were you looking for?	Response (n=58): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *70.7%: Scheduling an appointment with a specialist they want to see.* ▪ *27.6%: Dental.* ▪ *24.1%: Other.* ▪ *20.7%: Scheduling radiology services (for example, X-rays, MRI, CT scan) appointment.* ▪ *20.7%: Lab work (for example, blood tests).* ▪ *12.1%: Annual check-up appointment.* ▪ *12.1%: Mental health services (for example, counseling or therapy).* ▪ *12.1%: Vision services.* ▪ *1.7%: Obtaining vaccinations or shots.*
Q41. What was the challenge when you tried to get an appointment with a specialist?	Response (n=58): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *50.9%: Getting an appointment as soon as I needed.* ▪ *42.1%: Untimely referral.* ▪ *38.6%: Finding a specialist near me.* ▪ *26.3%: Finding a specialty I needed.* ▪ *22.8%: Specialist did not accept my health insurance.* ▪ *21.1%: Unable to be seen by selected specialist.*

CAHPS® Regulated Survey Question		
Rating Measure		
Rating of Personal Doctor Respondents (n=320)	Score: 70.0% ⬆	HEDIS Quality Compass Ranking: 64th Percentile
Non-Regulated - DD Survey Questions		
Questions that Influence Rating Measure	Member Insight – How members feel and what they're saying	
Q11 (a-d). In the last 6 months, how often did your personal doctor do each of the following?		
Q11a. Spend enough time with you	Response (n=678): ▪ *80%: Always or Usually* ▪ *20%: Sometimes or Never*	
Q11b. Answer all your questions to your satisfaction	Response (n=678): ▪ *85%: Always or Usually* ▪ *15%: Sometimes or Never*	
Q11c. Encourage you to talk about all health problems or concerns	Response (n=678): ▪ *80%: Always or Usually* ▪ *20%: Sometimes or Never*	

Q11d. Spoke to you in a way that was easy to understand	Response (n=678): ▪ *90%: Always or Usually* ▪ *10%: Sometimes or Never*
Q12. In the last 6 months, did your personal doctor use medical words you did not understand?	Response (n=561): ▪ *93%: Always or Usually* ▪ *7%: Sometimes or never*
Q13. In the last 6 months, have you had problems communicating with your doctor or other cultural, personal, or religious beliefs?	Response (n=678): ▪ *95%: No* ▪ *5%: Yes*
Q14. In the last 6 months, have you had a hard time speaking with or understanding your doctor or other health care provider because you spoke a different language?	Response (n=678): ▪ *95%: No* ▪ *5%: Yes*
Q15. In the last 6 months, have you been treated because of your race or ethnicity?	Response (n=678): ▪ *98%: Never* ▪ *2%: Sometimes*
Q16. If you answered question #15 with Sometimes, Usually, Always, did you share your experience with your health plan (Member Services or Grievance & Appeals Department)?	Response (n=135): ▪ *84%: No* ▪ *16%: Yes*
Q17. If yes to question #16, how would you rate your Health Plan experience (with 0 being the worst possible experience, and 10 being the best possible experience)?	Response (n=131): ▪ *48%: % 9 + 10* ▪ *52%: % 0 - 8*
Q18. In the last 6 months, if you needed an interpreter (non-English speaker) or language services to help communicate with your doctor or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?	Response (n=179): ▪ *73%: % 9 + 10* ▪ *27%: % 0 - 8*

COVERED BENEFIT – OPEX/PMO - TELEHEALTH PROGRAM	
NON-REGULATED - SUPPLEMENTAL QUESTIONS	
INFORMING QUESTIONS	MEMBER INSIGHT – HOW MEMBERS FEEL AND WHAT THEY'RE SAYING
Q30. In the past 6 months, did you have a telehealth visit?	Response (n=678): ▪ *72%: No* ▪ *28%: Yes*
Q31. Please indicate why you did NOT have any telehealth visits in the last 6 months.	Response (n=434): *The question format is multiple choice; therefore, percentages do not equal 100%.*

	▪ *41.9%: Medical situation was not appropriate for telehealth.* ▪ *38.0% Unaware doctor or specialist offered telehealth/video visits.* ▪ *25.3% Unaware health plan covered telehealth/video visits.* ▪ *14.5%: Do not own technology (laptop, tablet, smartphone).* ▪ *12.0%: Do not feel comfortable using telehealth for medical, behavioral or specialist health visits.* ▪ *10.8%: No internet access* ▪ *7.8%: Lack technical knowledge or private space for visit.* ▪ *2.3%: Limited phone minutes, and do not want to use them for telehealth visit.*
Q32. If you had a choice, how likely would you be to choose a telehealth visit with your provider instead of having an in person visit with your provider?	Response (n=471): ▪ *68%: Very Likely* ▪ *32%: Likely*
Q33. You indicated that you had a telehealth visit in the last 6 months.	Response (n=206): *The question format is multiple choice; therefore, percentages do not equal 100%.* ▪ *83.5%: Yes, and open to more telehealth visits in the future.* ▪ *16.5%: Yes, but the process is too hard, I prefer in-person.* ▪ *10.7%: Yes, but I do not want to have more telehealth visits in the future.* ▪ *6.8%: Yes, but the doctor's office had technical issues.*
Q34. What do you view as the main benefit to telehealth services?	Response (n=388): ▪ *41.0%: Quicker access.* ▪ *21.9%: No need for transportation.* ▪ *14.9%: Ability to receive care from home, avoid crowded waiting rooms.* ▪ *9.5%: Greater access to care in remote areas.* ▪ *8.5%: Ability to take less time off work.* ▪ *4.1%: Greater privacy.*

Covered Benefit – Transportation Services	
Non-Regulated - DD Survey Questions	
Informing Questions	Member Insight – How members feel and what they're saying
Q35. Are you aware that help with transportation to your medical appointments is available through your health plan?	Response (n=678): ▪ *56%: No* ▪ *44%: Yes*
Q36. In the past 6 months, has lack of transportation kept you from medical appointments?	Response (n=678): ▪ *94%: Never* ▪ *6%: Sometimes*
Q37. Some health plans help with transportation a shuttle bus, tokens or vouchers for a bus or taxi, or payments for mileage. In the last 6 months, did you phone your health plan to get help with transportation?	Response (n=678): ▪ *94%: No* ▪ *6%: Yes*

APPENDIX D

FY 2023-2024 Lessons Learned

- ❑ Cross-Department Collaboration: Direct dialogue with Senior Leadership this past fiscal year was of particular importance in order to maintain operational awareness of member-supporting activities. This was accomplished through regular attendance at monthly NCQA Steering Committee meetings. Oversight Workgroup attendees were invited to join on an ad-hoc basis when their Subject Matter Expertise relative to their interventions/activities was needed.

  This level of organizational integration helped Partnership:

  1) Leverage improvement activities and interventions to meet regulatory requirements
  2) Collaborate, strategize, and optimize when and how joint improvement activities were approached
  3) Optimize internal allocation of staff to improvement activities

  - One example of successful cross-department collaboration was OpEx's intervention of increasing Direct-to-Member (DTM) telehealth utilization and the Admin-Santa Rosa Team's efforts. For additional details reference, Appendix B, Table XIV.
  - The Admin-Santa Rosa Team directly targeted their Southwest (SW) Region interventions.
    - Engagement of two (2) SW providers to implement / increase DTM visits to at least 50 visits and identify SW providers utilizing a significant percent of telehealth visits and jointly develop a primary care telehealth best practice document to share among providers experiencing barriers with access.
  - At Oversight meetings, the Op/Ex Team continually asked for workgroup attendee's partnership in promoting DTM and provided an excellent forum to provide further collaboration on each department's telehealth efforts, all aimed at influencing improving access and member experience.
- ❑ Oversight Workgroup participants agreed to move the operational improvement pilot aimed at identifying key preventative indicators (KPI) forward into the next fiscal cycle. The intent of the pilot was to identify an on-going method to capture member feedback that may demonstrate network wide or health plan wide themes (KPIs) requiring adjustments in member-facing communications, branding, and educational activities.
  - Activity would provide active listening in real time as opposed to waiting for yearly CAHPS® survey results in an effort to implement changes to address barriers sooner rather than later. For the purposes of this pilot, 2023 Grievance and Appeals data and Population Health member engagement surveys were analyzed. The results of the pilot garnered support from the CAHPS® Score Improvement (CSI) Oversight Workgroup. As a next step, it was agreed upon to move the pilot forward into the next fiscal cycle establishing a small group of Subject Matter Experts to provide further guidance on what other possible data sets could be identified pointing to themes of member dissatisfaction.
- ❑ The CAHPS® Team began attending the 2024 Consumer Advisory Committee (CAC) quarterly meetings. CAC acts as a liaison group between members and Partnership and provides another mechanism to obtain feedback on existing/proposed CAHPS® interventions and activities.

- As an example, a small pilot for Partnership branded ID card sleeves is currently taking place. The sleeve would allow members to keep both their state issued Department of Health Care Services (DHCS) Medi-Cal card and their Partnership card together. Results of the pilot will be shared at an upcoming CAC meeting as well as requesting their input before concluding the pilot.

❑ Association for Community Affiliated Plans (ACAP). The CAHPS® Team and several Senior Leaders participated in the first ACAP sponsored CAHPS® Collaborative. This provided the opportunity to engage with nine (9) plans in several markets across the nation.

- **Medicaid Child Data Observations**
  - The member respondent population is of similar health status and slightly more diverse than other ACAP collaborative participants.
  - Partnership has performance results similar to other plans.
  - Rating measures tend relatively to be lower than other measures.
  - Those with fair/poor mental health status gave lower scores on the rating measures.
- **Medicaid Adult Data Observations**
  - Overall CAHPS® scores are lower than other Medicaid plans.
  - Most rates are trending down as well.
  - Those with fair/poor mental health status appear to have a much worse care experience.
- **Network Management**
  - The Plan must understand provider network coverage and availability. Sometimes time and distance can be adequate while access still is poor.
- **Provider Network**
  - Most of the members' experience with health care is going to be with the providers in a care setting. Without affecting this, plans have limited ability to move CAHPS® rates overall.
- Defining impactful interventions can be difficult to develop based on the results of the CAHPS® survey.
- **CAHPS® Response Rates**
  - Response rates have decreased and administrative costs have increased. Plans are looking for alternative means to assess member experience on a more real-time basis.
- **Influencing Member Experience**
  More complex operationally compared to influencing many clinical measures.

APPENDIX E

MEDICAID HEALTHCARE HEALTH PLAN TRENDS

PressGaney, an NCQA certified vendor is a an industry leader with more than 30 years of CAHPS® survey project management, and analytic reporting experience. Managing a Health Plan company Book-of-Business (BoB) portfolio includes more than 80% of our nation's Medicare, Medicaid, and Managed Care Health Plans (MCP) products.

PressGaney completed a thorough CAHPS® 5.1 H portfolio data analysis of their administered MY 2023 Medicaid Adult and Child samples. Survey responses include 200 Plans / 50,297 respondents. Their analysis compares the current Partnership HealthPlan of California (Partnership) respondent rate and measures performance against Partnership's year-over-year performance, HEDIS®, and PressGaney BoB benchmarks. The Press Ganey BoB is used to monitor health plan trends by comparing side-by-side aggregate scores over the past four years.

MY 2023-2024 TREND HIGHLIGHTS

AHRQ-CAHPS® Health Plan Survey Database[1]

The AHRQ 2023 Chart Book continues to indicate a national Medicaid downward trend in all four (4) composite measures, reference source below. It is significant to recognize the impact of a post-COVID disruption to healthcare delivery and key to underscore the 2023 U.S. healthcare industry and American Hospital Association (AHA) linkage to severe workforce shortages at every level. The AHA estimated the healthcare industry was likely to experience a shortage of up to 124,000 physicians by the end of 2023.[2]

Key observation include: 1) all composite measures were relatively stable or slightly increasing until 2021, 2) Getting Needed Care and Getting Care Quickly showed large declines from 2021-2023, and 3) How Well Doctors Communicate and Health Plan Information and Customer Service showed smaller declines from, 2021-2023, reference source below.

PRESSGANEY BOB

- The BoB average respondent rates (174 - 200 Plans) for both populations had a noticeable downward trend between reporting years 2020 - 2024. Relative to Partnership respondent rates, the health plan performed above the average Press Ganey BoB.
- The BoB response rate aligns with the noted industry downward trend through the same reporting period.

MEDICAID TRENDS

- Medicaid Adult Population: Among the Medicaid Adult population, no measures declined by more than 1% compared to 2023. Rating of Personal Doctor (% 9 or 10) and Rating of Specialist (% 9 or 10) have increased by more than 1%. All scores have decreased overall since 2020. Rating of Health Care Quality and Getting Care Quickly are the largest decrease of at least 2% lower than the 2020 scores

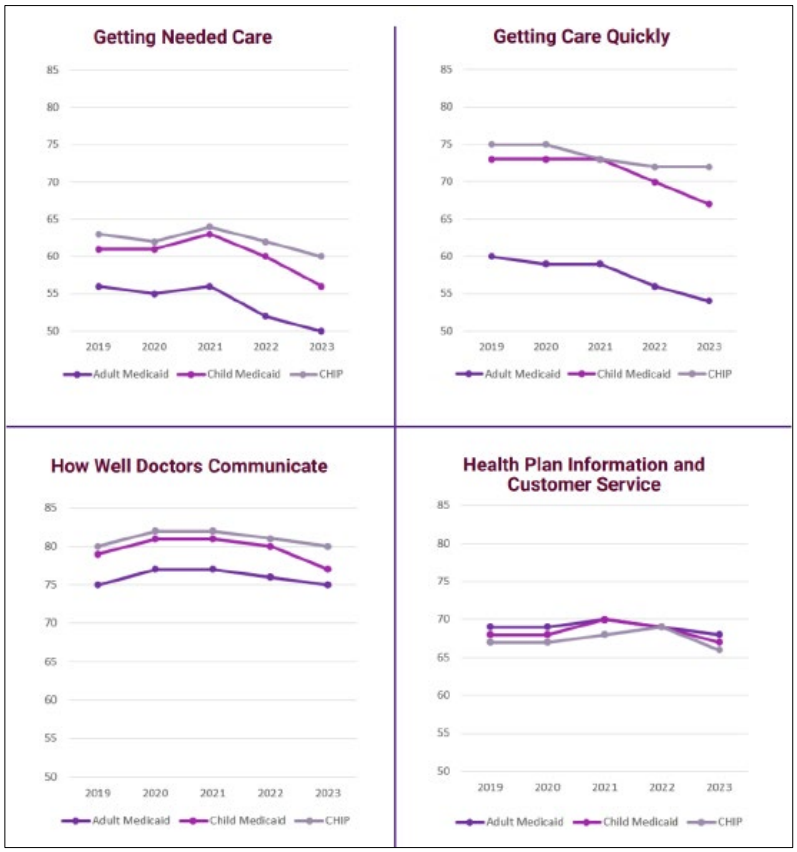
- Medicaid Child Population: Among the Medicaid Child population, no measures declined by more than 1% compared to 2023. Rating of Specialist, Getting Needed Care, and Getting Care Quickly have increased by more than 1% since 2023. All scores have decreased overall since 2020. Rating of Health Care Quality and Getting Care Quickly are the largest decrease of at least 2% lower than the 2020 scores

REFERENCES

[1]AHRQ-CAHPS® Health Plan Survey Database
AHRQ 2023 CAHPS® CHART BOOK.

2023 Chart Book
https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2023-hp-chartbook.pdf

[2] American Hospital Association (AHA) Fact Sheet: Strengthening the Health Care Workforce https://www.aha.org/fact-sheets/2021-05-26-fact-sheet-strengthening-health-care-workforce



Grand Analysis: Network Access

Assessment of Network Adequacy

Renee Trosky
Manager of Network Services Compliance

November 2024

Standards for Network Management

Availability of Practitioners

- Cultural Needs and Preferences
- Primary Care Practitioners
- Specialty Care Practitioners

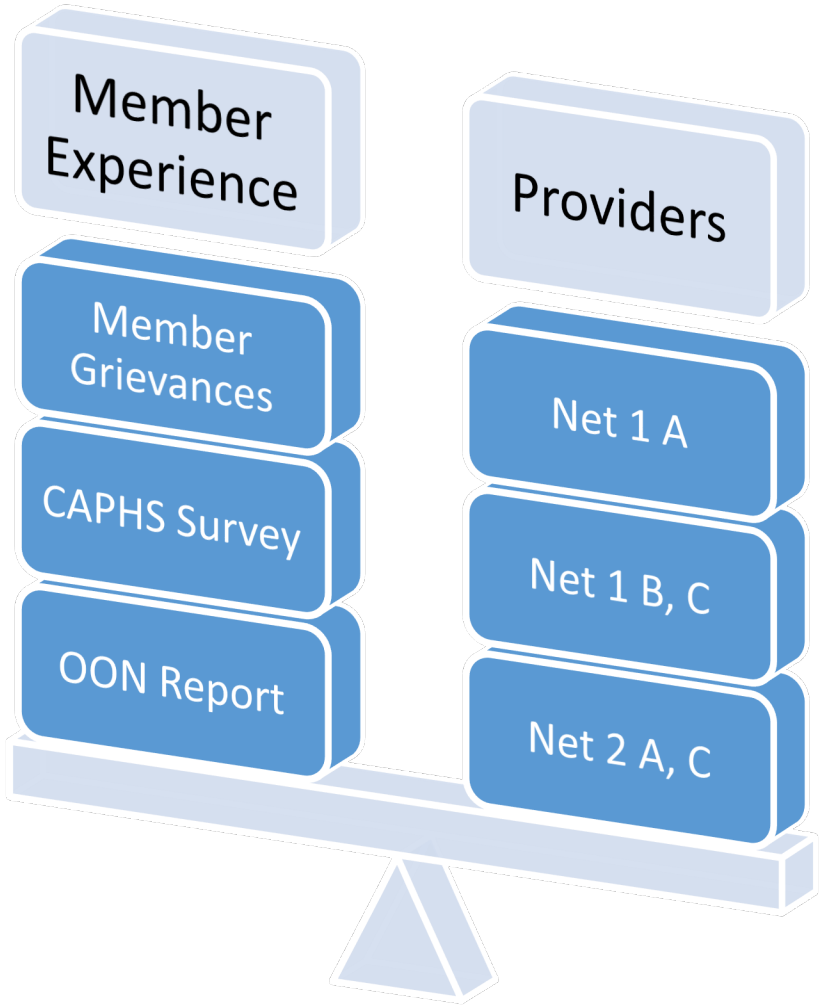
Accessibility of Services

- Primary Care Practitioners
- Specialty Care Practitioners

Assessment of Network Adequacy

Network Adequacy Data Elements

- **Member Grievances (ME7) NCQA "Access" Category**
- **CAPHS Survey (ME7)**
- **The Population Needs Assessment (PNA)**
- **Out of Network Requests (UM)**
- **Practitioner Availability Cultural and Linguistics Needs (Net 1 A)**
- **Practitioner Availability Ratio & Geographic Distribution (Net 1 B, C)**
- **Accessibility of Services (Net 2 A, C)**



Data: Member Grievances ME7

In 2023, our members submitted 3,572 grievances. The analysis attributes 43% of all cases to Access.

In comparison to the 2022 reporting period, our members submitted 2,556 grievances. Similarly, analysis attributes 41% of all cases to Access.

Grievances Only Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,055	638,303	1.65	1,526	678,546	2.25	1.82	No

- **Notable Findings:** PHC failed to meet the access grievance threshold in 2023.

Data: Grievances ME7
Appeals and Second Level Grievances

In 2023, the health plan received 689 Appeals and Second Level Grievance cases, a 10% decrease in case filings from 2022, with Access contributing 50.1% of the total.

In comparison to the 2022 reporting period, the health plan received 762 Appeals and Second Level Grievances cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	332	638,303	0.52	350	678,546	0.52	0.57	Yes

Notable Findings: PHC met the threshold level for Access despite a 5.2% increase in Appeals and Second Level Grievances from 2022.

CAHPS Composite Scores
Adult

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	76.0%	7th	PHC ≥ 25th	No	76.4%	14th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	72.9%	5th	PHC ≥ 25th	No	69.5%	5th	PHC ≥ 25th	No

Notable Findings: The Adult Composite score for getting needed care had a slight increase, and getting care quickly had a slight decrease with both failing to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access, which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

CAHPS Composite Scores
Child

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	PHC ≥ 25th	No	76.7%	10th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	84.1%	25th	PHC ≥ 25th	Yes	76.3%	<5th	PHC ≥ 25th	No

- **Notable Findings:** The Child composite scores for both measures experienced a decrease with a noticeable drop in Getting Care Quickly of 7.8%. Both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience, which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

Data: Out of Network Requests (OON Report)

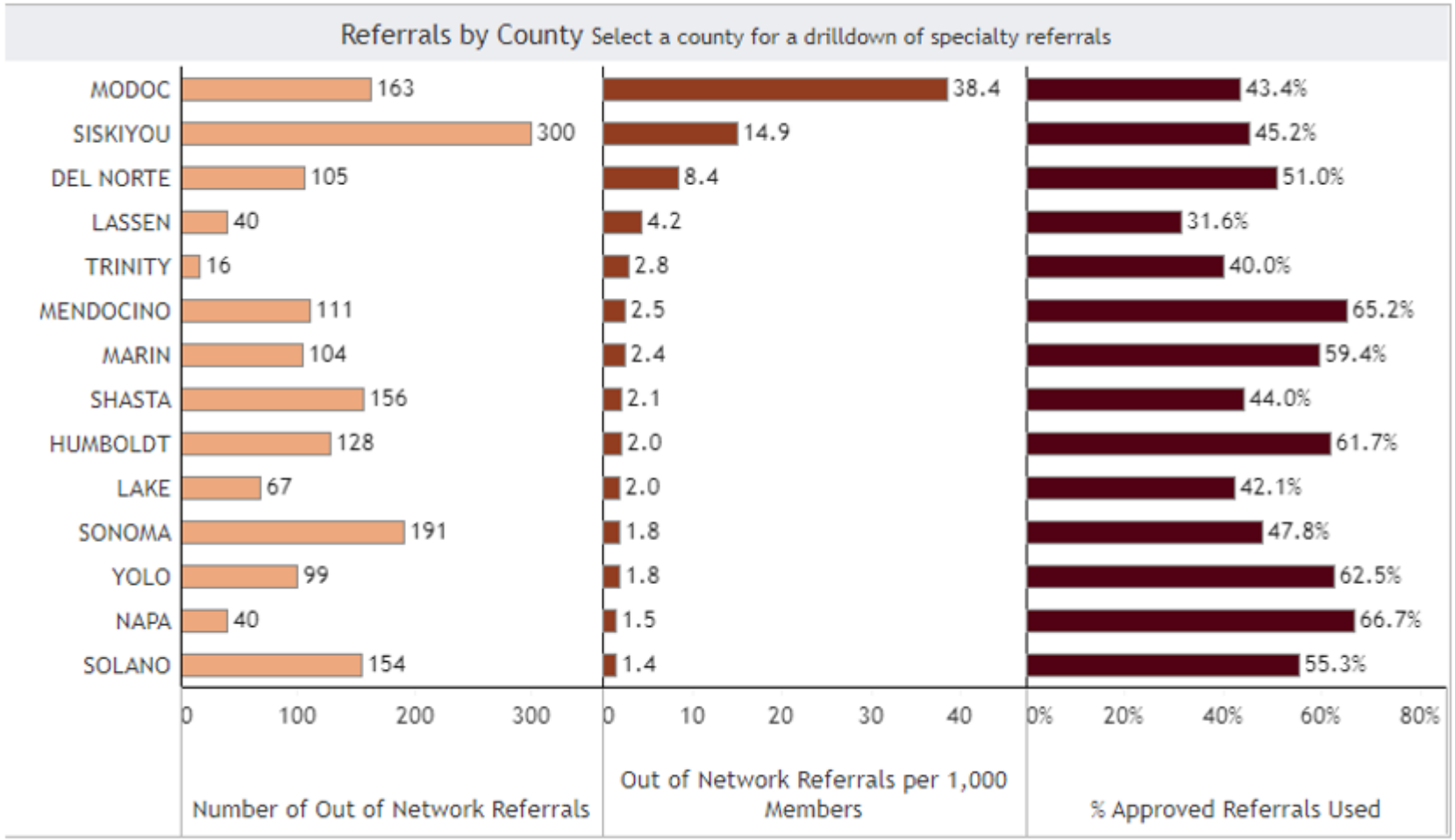
Out-of-Network Requests:

Out of Network requests and utilization from January 2023 – December 2023. The out of network referrals per 1,000 members' threshold is less than or equal to 20.

	NORTHERN	SOUTHERN	Grand Total
Number OON Referrals	908	766	1,674
Membership	189,248	418,171	607,419
Out of Network Referrals per 1,000 Members	4.8	1.8	2.8
% Referrals Approved	55.7%	28.5%	43.2%
% of Approved Referrals Used	46.6%	55.0%	49.2%
Referrals Serviced	236	120	356

- For the period of January 2023 – December 2023, as a plan, PHC met the goal of less than 20 per 1,000 members for referrals. OON referrals for the northern region was 4.8 per 1,000 members and OON referrals for the southern region was 1.8 per 1,000 members.

Data: Out of Network Requests (OON Report)



Ratios

The following table summarizes the findings for Primary Care practitioners:

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure : Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	833	616,313	Primary Care Practitioner to Member (adult and children)	1:739	1:≤ 2,000	MET
Family or General Practice	517	616,313	Family or General Practice Practitioner to Member (adult and children)	1:1,192	1:≤ 2,000	MET
Pediatrics	171	193,201	Pediatricians to Members (children)	1:1,129	1:≤ 2,000	MET
Internist	145	423,112	Internists to Members (adult)	1:2,918	1:≤ 3,000	MET

Table 1: Practitioner Ratios: Primary Care (April 1, 2023)

Third Next Available Survey

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE ROUTINE APPOINTMENT ACCESSIBILITY

Third Next Available (3NA) Survey Findings 2023									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94%	91.7%	92.9%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94.4%	90.4%	92.4%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	96.9%	100.0%	98.5%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	95.3%	96.9%	96.1%	≥ 90%	Met

Table 1: Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2023).

Data: Grand Analysis Reports

2023 Summary

2020-2021 PHC Availability and Accessibility Adequacy Report

Measure or Description	Performance Standard Met for Plan?	Notes
Grievance Data: Member Complaints NCQA Access Category & Appeals and Second Level Grievances	*Partially Met	*PHC failed to meet the access grievance threshold however, met the Appeals and Second Level Grievances threshold despite a 5.2% increase since 2022.
Member Experience: CAHPS Composite Results	Did Not Meet	.
Out of Network Requests	Met	
Net 1A: Language, Ethnicity, Gender, Cultural Preference	Met	
Net 1B: Ratio Practitioner	Met	
Net 1C: Geographic Distribution	*Met	*Met Plan-Wide distribution, however, Lassen and Modoc Counties fell below the standard for Ophthalmology and Hematology/Oncology
Net 2: Third Next Available (3NA)	Met	

Interventions

- PHC was able to recruit 66 new primary care practitioners to the network between May 1 2023 and December 1, 2023 with 27 of them going to 6 of our most rural northern counties.
    - *Planned Action*: Partnership has had success with the sponsored workforce development program to date and will continue the strategy in an effort to continue recruitment of physicians, NP's, PA's, and licensed behavioral health clinicians including SUD counselors.
    - *Planned Action*: Expand efforts to strengthen recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery to the 2024 workforce development program

NETWORK ADEQUACY REPORT

ASSESSMENT OF NETWORK ADEQUACY

NET 3, ELEMENT A, B: ASSESSMENT OF MEMBER EXPERIENCE ACCESSING THE NETWORK & OPPORTUNITIES TO IMPROVE ACCESS TO NON-BEHAVIORAL HEALTHCARE SERVICES

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Section 1: Objective

The purpose of this report is to evaluate all aspects of data related to Network Adequacy to ensure Partnership HealthPlan of California (PHC) provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, and hospitals. PHC follows the NCQA Network Management Standard requirements and this report will present those findings.

Utilizing access data of our current network, this report evaluates and summarizes the following:

- Member Grievance (Complaints) appeals and member experience about network adequacy for non-behavioral healthcare services from ME7: Element C and D.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results from ME 7 report.
- Utilization of out-of-network services.
- Practitioner Availability summarized results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in (Net 1 Element A Cultural Needs and Preferences).
- High Volume and High Impact specialty geographic distribution and Practitioner Ratios (NET 1 Practitioner Availability of Services - Elements B and C).
- Routine Primary Care, Urgent Care, Non- Urgent Specialty Care Practitioner (NET 2 - Accessibility of Services - Elements A and C).
- Analysis from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.

This report and comprehensive analysis was conducted in collaboration between PHC's Provider Relations Department, Health Analytics, Grievance & Appeals and Office of the Chief Medical Officer. Findings were reviewed with a multi-disciplinary team made up of the Chief Medical Officer, Senior Director of Provider Relations, Manager of Provider Relations Compliance, Senior Director of Member Services & Grievance and Appeals, Director of Grievance and Appeals, Senior Director of Quality and Performance HS Quality Improvement, and Provider Relations Compliance Program Managers

In addition, this team identified opportunities for improvement and approved implementation of appropriate actions.

Section 2: Methodology

The following data sources were used to evaluate Network Adequacy:

***MEMBER GRIEVANCE (COMPLAINTS)*:** From the full volume of member complaints evaluated annually, this analysis includes a subset of those complaints that are specifically focused on network adequacy or access to care. Complaint category used was “access”, which includes all complaints related to appointment access or availability within the network.

MEMBER APPEALS: Member appeals and second level grievances data.

2022-2023 CAHPS: Survey results from ME 7 report for Adult and Child.

***OUT OF NETWORK (OON) REQUESTS*:** Referrals and a prior authorization are required for all OON requests. Data supplied from the Utilization Management system is used to determine number of requests, whether approved or denied. Claims data is pulled to determine how many of the approved referrals were used. Out of network referral, request and claims are analyzed per 1, 000 members. Referral request and claims counts are analyzed at the plan and regional level.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES): PHC collects data every year on language, culture and ethnicity/race of our members and compares the data against practitioners to determine if there is adequate practitioner coverage to meet our members’ needs. Member Ethnicity/Race – all self-reported member race/ethnicity is identified and assessed against provider ethnicity/race. Provider Ethnicity/Race – data from the Medical Board of California's Physician Survey of allopathic physicians and surgeons (licensees) is to analyze practitioner ethnicity/race. Member Grievance Reports: data is collected and analyzed for member concerns regarding discrimination and linguistic needs. Cultural Preference is assessed utilizing the Health Education and Cultural and Linguistic Population Needs Assessment (PNA). The PNA investigates member’s health status and behaviors; cultural and linguistic needs, community health education and cultural and linguistic programs and resources, health disparities, and gaps in services.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS):

PHC obtained data for contracted primary care, high volume, and high impact specialties from our Data Warehouse which then populates Quest Analytics software to evaluate geographic distribution compared to our established geographic standards set forth in policy (MPNET 100) that were in effect at the time of production. Additionally, practitioner ratios were evaluated for primary care, high volume, and high-impact specialty practitioners. The analysis is based on a comparison to our established standards.

PRACTITIONER ACCESSIBILITY: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE):

The Third Next Available (3NA) survey is a cross-sectional, one-time call during business hours, to provider offices, to evaluate access. This survey is used to evaluate primary care and high volume/high impact specialty appointment access using the following performance standards:

Routine Primary Care Appointments	**< 10 Business Days of Request**
Prenatal Care Appointments	**< 10 Business Days of Request**
Newborn Appointments	**< 48 hours of Discharge of Request**
Urgent Care Appointments	**< 48 hours of Request of Request**
Non-Urgent Specialty Care Appointments	**< 15 Business Days of Request**

The survey is administered by PHC's provider relations staff annually during the months of February and March and includes all PCP sites and identified high volume/high impact specialist that meet a set threshold of 200 unique member visits a year. The 2022 3NA surveyed 254 primary care provider sites, 255 specialty provider sites, and 110 prenatal provider sites. PHC's Well-managed benchmark analysis to evaluate specialty use trends within our network.

Member Grievances: from the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. The grievance category is used as the "access" category, which includes all grievances related to appointment access for primary care and specialty care providers. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023.

***BEHAVIORAL HEALTH PRACTITIONER AVAILABILITY AND ACCESSIBILITY*:** Behavioral health data is analyzed in the Annual Behavioral Health Report. Additionally, Carelon Health Options is PHC's delegated entities, and are NCQA accredited.

Section 3: Quantitative Analysis:

MEMBER GRIEVANCES:

TOTAL ACCESS MEMBER COMPLAINTS

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2023, there were a total of 3,572 grievances submitted by our members. The analysis attributes 43% of all cases to Access.

In comparison to the 2022 reporting period, there were a total of 2,556 grievances submitted by our members. Similarly, analysis attributes 41% of all cases to Access.

Grievances Only Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,055	638,303	1.65	1,526	678,546	2.25	1.82	No

- **Notable Findings:** PHC failed to meet the access grievance threshold in 2023.

MEMBER APPEALS:

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2023, the health plan received 689 Appeals and Second Level Grievance cases, a 10% decrease in case filings from 2022, with Access contributing 50.1% of the total.

In comparison to the 2022 reporting period, the health plan received a total of 762 Appeals and Second Level Grievances cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2022 vs 2023								
	Previous Period: 2022			Current Period: 2023				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	332	638,303	0.52	350	678,546	0.52	0.57	Yes

Notable Findings: PHC met the threshold level for Access despite a 5.2% increase in Appeals and Second Level Grievances from 2022.

There were 4,261 Grievances, Second Level Grievances, and Appeals closed in 2023 compared to 3,318 in 2022. These cases are broken into two (2) groups – Grievances accounted for 3,572, and Appeals and Second Level Grievances accounted for 689.

Our membership experienced a 6.3% growth, rising from 638,303 in 2022 to 678,546 members in 2023. Alongside our membership increase, there was a rise in Grievances received in 2023, leading to an increase in Grievances files per 1,000 members from 4.00 to 5.26. We saw a decrease in the number of Appeals and Second Level Grievances files in 2023.

With a 6.3% increase in membership and 28.5% increase in Grievances file, three thresholds for Grievances were not met one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed rides.

PHC was able to meet the minimum threshold for Appeals & SLGs regardless of a 5.2% increase from 2022. Despite membership growth of 6.3%, the total number of cases filed per 1,000 members decreased from 1.19 to 1.02.

PRIMARY CARE ACCESS MEMBER COMPLAINTS

PHC further analyzes total access complaints by region and practitioner group to determine if there any access trends. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023. The threshold for review is based on the total number of complaints of two or more in any one category and a rate of 4/1000 members.

Primary Care Access Grievance Data Northern Region (January 1, 2023 – December 31, 2023)

Region	County	Provider Name	Appt. Availability	Office Availability	Telephone Availability	Total	Total Members Assigned to Provider	Rate per 1000 Members
Northern	Del Norte	Del Norte Community Clinic	1			1	4426	.23
Northern	Shasta	Anderson Family Health	1			1	3914	.26
Northern	Shasta	Anderson Walk In Clinic			1	1	2612	.38
Northern	Shasta	Center of Hope	2			2	2437	.82
Northern	Shasta	Hill Country Community Clinic	2			2	2507	.80
Northern	Shasta	Lassen Medical Center – Red Bluff	1			1	318	3.1
Northern	Shasta	Shasta Community Health Center	3			3	20,930	.14
Northern	Siskiyou	Fairchild Medical Clinic	1			1	5728	.17
Northern	Siskiyou	Karuk Tribal Health Clinic	1			1	441	2.3
Northern	Humboldt	Fortuna Community Health Center	1			1	3464	.29
Northern	Humboldt	North Country Clinic	1			1	4042	.25
Northern	Humboldt	Redwoods Community Health Center	6			6	6956	.86

Northern	Humboldt	WeCare at Scotia Bluffs	1			1	1862	.54
Northern	Lassen	Northeastern Rural Health Clinic	1			1	5073	.20
Northern	Lassen	Lassen Indian Health Cntr	2			2	558	3.6
Northern	Lassen	Westwood Family Practice	1			1	515	1.9
		Northern Region Totals:	**29**	**0**	**1**	**30**		

Member Complaints Primary Care Northern Region (Everest Data, 2023)

- **Notable finding:** The total number of Northern Region member complaints regarding access increased since 2022 from 14 total to 30 in 2023, with appointment availability as the common type of grievance. Despite the over-all increase, the per 1000 member grievances were within the threshold so no opportunities were identified.

- Redwood Community Health Center had the most grievances in appointment availability as well as overall. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.

- Lassen Medical Center, Karuk Tribal Health, and Lassen Indian Health Center had the highest per member ratings. Karuk Tribal Health and Lassen Medical Center both had only 1 grievance and Lassen Indian Health Center with two grievances regarding their appointment availability. A trend could not be established due to low member complaints over the course of a year. No further action is required at this time.

Primary Care Access Grievance Data Southern Region (January 1, 2023 – December 31, 2023)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
Southern	Lake	Lakeview Health Center	2			2	3418	.59
Southern	Marin	Marin Health Medical Network	1			1	1558	.64
Southern	Marin	Marin Community Larkspur Clinic			1	1	1164	.86
Southern	Marin	Marin Community Novato Clinic			1	1	4188	.24
Southern	Marin	Marin Community San Rafael Clinic	3			3	12,404	.24
Southern	Mendocino	Hillside Health Center	3			3	8101	.37
Southern	Mendocino	Baechtel Creek Medical Clinic	1			1	1527	.65
Southern	Napa	Ole Health	1			1	3824	.26
Southern	Napa	Ole Health	2			2	11610	.17
Southern	Solano	Community Medical Center Vacaville	2		1	3	6804	.44
Southern	Solano	La Clinica -North Vallejo	3	1	2	6	8534	.70
Southern	Solano	La Clinica -Vallejo	2			2	6103	.33

Southern	Solano	OLE Health	3			3	4560	.66
Southern	Solano	OLE Health	1			1	4573	.22
Southern	Solano	Solano County Health Services - Vallejo	9			9	12874	.70
Southern	Solano	Solano County Health Services - Fairfield	3			3	4177	.72
Southern	Solano	Solano County Health Services - Fairfield	2			2	3918	.51
Southern	Solano	Solano County Health Services – Vacaville	5			5	4486	1.1
Southern	Solano	Sutter Medical Foundation Dixson	1			1	535	1.9
Southern	Solano	Sutter Medical Group Vacaville			1	1	1170	.85
Southern	Sonoma	Rohnert Park Health Center Clinic	2			2	6289	.32
Southern	Sonoma	Santa Rosa Community Health – Dutton			1	1	8182	.12
Southern	Sonoma	Vista Family Health Ctr	1		1	2	8865	.23
Southern	Yolo	Woodland Clinic	1			1	8589	.12
Southern	Yolo	Sutter Medical Grp –Yolo	1			1	1152	.87
Southern	Yolo	Salud Clinic	1			1	4857	.21
Southern	Yolo	Hansen Family Health	1			1	3067	.33
Southern Region Totals:			**51**	**1**	**8**	**60**		

Member Complaints Primary Care Southern Region (Everest Data, 2023)

- **Notable findings:** The total number of Southern Region member access complaints increased since 2022 from 24 total to 60 in 2023 with appointment availability being most common type of grievance. Despite the over-all increase, the per 1000 member grievances were within the threshold so no opportunities were identified.
  - Solano County Health Services, Vallejo had the most grievances in the appointment category. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.
  - La Clinica – North Vallejo had the second highest number of grievances overall. However, the rating per 1000 members was within the standard. No further action is required at this time.

SPECIALTY CARE MEMBER COMPLAINTS:

Specialty Care Access Grievance Data (January 1, 2023 – December 31, 2023)							
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**High Volume or High Impact Specialty**
Northern	**Siskiyou**	Nino Pitiuri, MD	**1**			**1**	**High Volume Specialty** OB/GYN
Northern	**Humboldt**	Humboldt Dermatology	**1**			**1**	**High Volume Specialty** Dermatology
Southern	**Marin**	Bay Area Ortho Surgery and Sports Med	**1**			**1**	**High Volume Specialty** Orthopedic Surgery
Southern	**Solano**	Sutter Medical Group Solano	**1**			**1**	**High Volume Specialty** OB/GYN

Specialty Care Access Grievance Data (Everest, 2023)

Notable findings: In 2023, access to specialty care member complaints were low. Four high-volume specialties had one appointment complaint each for the reporting year. A trend could not be established due to low member complaints. No further action is required at this time.

2022- 2023 CAHPS Composite Scores:

CAHPS Results from ME7 Report: Adult Response

Below is a year-by-year comparison of the Composite scores: January 2023–December 31, 2023 and the previous year, January 1, 2022 – December 31, 2022 for the Adult Survey. In Year 2022-2023, we received 8 more completed surveys than in Year FY 2021-2022, with a negligible higher increase in response rate by 0.2%. However, it is noteworthy that all questions met the 100 sample size criteria for 2022-2023.

	ADULT CAHPS Composite	2021-2022 (14.1% Response Rate) Sample Size 2,700 Total Returns 372	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.3% Response Rate) Sample Size 2,700 Total Returns 380	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	**76.0%**	**7th**	**PHC ≥ 25th**	**No**	**76.4%**	**14th**	**PHC ≥ 25th**	**No**
	Getting Care Quickly (% Always or Usually)	**72.9%**	**5th**	**PHC ≥ 25th**	**No**	**69.5%**	**5th**	**PHC ≥ 25th**	**No**

Notable Findings: The Adult Composite score for getting needed care had a slight increase, and getting care quickly had a slight decrease with both failing to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

CAHPS Results from ME7 Report: Child Response

Below is a year by year comparison scores: January 1, 2023 – December 31, 2023 and the previous year, January 1, 2022 and December 31, 2022. In Year 2022-2023, we received 24 more completed surveys than in Year 2021-2022 increasing the response rate by 0.4%. It is also noteworthy that all questions met the 100 sample size criteria.

	CHILD CAHPS Composite	2021-2022 (14.5% Response Rate) Sample Size 4,125 Total Returns 587	2022 Percentile Rate	PHC Benchmark	PHC Benchmark Met?	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	2023 Percentile Rate	PHC Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	79.6%	10th	PHC ≥ 25th	No	76.7%	10th	PHC ≥ 25th	No
	Getting Care Quickly (% Always or Usually)	84.1%	25th	PHC ≥ 25th	Yes	76.3%	<5th	PHC ≥ 25th	No

- **Notable Findings:** The Child composite scores for both measures experienced a decrease with a noticeable drop in Getting Care Quickly of 7.8%. Both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2023-2024.

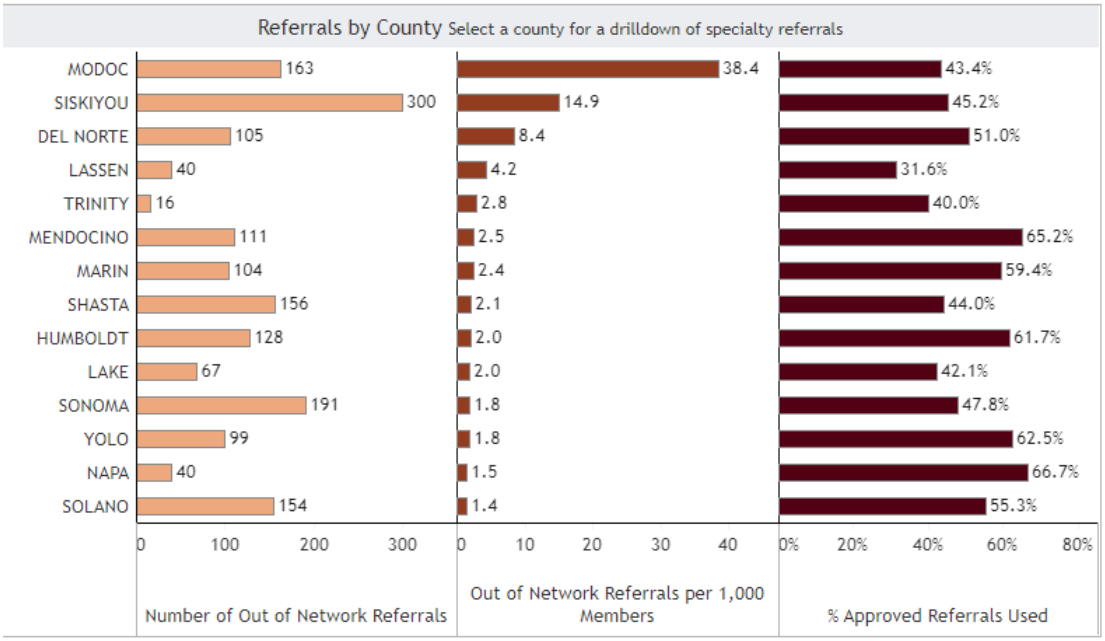
QUALITATIVE ANALYSIS FOR MEMBER SATISFACTION: GRIEVANCE, APPEALS, AND CAHPS

The healthcare system in California and throughout the country has continued to grapple with workforce shortages for both clinical and non-clinical staff. Thus resulting in greater difficulty in obtaining timely appointments. There was an increase in Grievances related to the Quality of Provider Offices in 2023. Members reported 90 concerns against their primary care provider (PCP) or provider's office staff regarding access to appointments in person or by phone, compared to 84 in 2022. The majority of the concerns members reported were in relation to appointment availability, for example, having to wait up to 30 days for an appointment and even longer for specialty appointments and procedures. Partnership continues to work on addressing this challenge by working to support our network and seeking to contract with new providers, predominantly in rural areas.

Out-of-Network Requests:

Out of Network requests and utilization from January 2023 – December 2023. The out of network referrals per 1,000 members' threshold is less than or equal to 20.

	NORTHERN	SOUTHERN	Grand Total
Number OON Referrals	908	766	1,674
Membership	189,248	418,171	607,419
Out of Network Referrals per 1,000 Members	4.8	1.8	2.8
% Referrals Approved	55.7%	28.5%	43.2%
% of Approved Referrals Used	46.6%	55.0%	49.2%
Referrals Serviced	236	120	356



- **Notable findings:** For the period of January 2023 – December 2023, as a plan, PHC met the goal of less than 20 per 1,000 members for referrals. OON referrals for the northern region was 4.8 per 1,000 members and OON referrals for the southern region was 1.8 per 1,000 members.

  Out of 1,674 OON Referral requests submitted, 723 were approved with 55.7% of those being in the northern region, specifically Modoc, Siskiyou, and Del Norte counties, where access is much harder than the southern region due to rural terrain and a patient population that is typically too small for a specialist to maintain a viable practice. The three specialties with the highest OON referrals included: Cardiovascular Disease/Internal Medicine with 59.5% of approved referrals used, Gastroenterology with 45.2% of approved referrals used, and Orthopedic Surgery with 46.7% of approved referrals used. Of the 723 approved referrals plan wide, 356 (49.2%) were used.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES)

Availability standards and detailed analysis are provided in the annual Network Adequacy Report Availability of Practitioners reports. For this grand analysis, we have summarized the results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in 2023. Practitioner to member ratios and geographic distribution data for primary care, high volume specialties, and high impact specialties.

ETHNICITY/RACE COMPARISON:

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report			Goal 1:2000 Physician to Member Ratio
Race/Ethnicity	**PHC Members 686,844**	**Physician 14,283**	
White	**37.5%**	**60.97%**	**1:30**
Hispanic	**30.9%**	**7.62%**	**1:195**
Other	**11.1%**	**2.01%**	**1:265**
Unknown	**8.8%**	**2.01%**	**1:199**
Black	**5.3%**	**4.44%**	**1:50**
Native American	**2.2%**	**1.17%**	**1:90**
Filipino	**1.8%**	**4.52%**	**1:15**
Asian/Pacific Islander	**1.0%**	**1.17%**	**1:27**
Asian Indian	**0.8%**	**6.37%**	**1:6**
Vietnamese	**0.6%**	**1.42%**	**1:21**

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Amysis Data, April 2023 / Medical Board of California Data, June 2021)

- **Notable Findings:** The self-reported ethnicity/race comparison indications plan wide we met our ratio performance goal of 1:2000 starting from the highest number of member (self-reported) ethnicity/race.

ASSESSING PRACTITIONER AND MEMBER LANGUAGE:

PHC has applied a general standard for PCP to member ratio, which is 1:500 for all threshold languages to establish a point of comparison. The standard is considered compliant if the member to provider ratio is less than 1:500 for each threshold language. For this study, we will look at PHC's top three (3) threshold languages, which are Spanish, Tagalog, and Russian.

Practitioner Language					
Threshold Language	**Provider**	**Member**	**2023 Ratio**	**Performance Goal**	**Goal Met?**
Spanish	360	135,827	1:377	1:500	Met
Tagalog	71	3,269	1:46	1:500	Met
Russian	29	2,205	1:76	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, April 2023)

- **Notable Finding:** As a plan PHC met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog and Russian).

To further assess how PHC is meeting member language needs, we looked at office staff languages spoken at provider sites as it compares to the top three (3) threshold languages of Spanish, Tagalog, and Russian.

Practitioner Office Staff Language				
Threshold Language	**Provider Sites**	**Member**	**Performance Goal**	**2023 Ratio**
Spanish	326	135,827	1:500	1:416
Tagalog	96	3,269	1:500	1:34
Russian	28	2,205	1:500	1:78

Practitioner Language to Member Language (SUGAR Data, April 2023)

- **Notable Finding:** Provider site language to member language ratios meets the performance goal. Office staff capabilities for threshold languages are sufficient to meet member needs.

GRIEVANCE DATA (MEMBER COMPLAINTS)

PHC looks at network adequacy for issues pertaining to race, ethnicity, and language to ensure practitioners are meeting member needs. This report identifies member-reported grievances which are classified into four discrimination categories which include: Cultural, Ethnic, Racial, and LGBTQ+. For Language grievances, we identify language discrimination and language barriers.

CULTURAL, ETHNIC, RACIAL, LGBTQ+ DISCRIMINATION GRIEVANCES

2023 Discrimination Grievances (January 1, 2023 - December 31, 2023)							
Region	County	Provider	Specialty	Discrimination Grievances			
				CE&R Discrim	Language Discrim	Language Barrier	LGBTQ+ Discrim
South	Mendocino	Adventist Health Ukiah Valley	Nutrition Services	1	0	0	0
South	Solano	DaVita Dialysis - Napa	Renal Dialysis Clinic	1	0	0	0
South	Lake	Elhakim, Samer MD	Family Medicine	0	1	0	0
South	Solano	La Clinica - Vallejo	Pediatrics	1	0	0	0
South	Mendocino	North Coast Family Health Center-Clinic	Pain Management	1	0	0	0
South	Solano	Solano County Health & Social Services	Internal Medicine	1	0	0	0
South	Solano	Sutter Medical Foundation	Orthopedic Surgery	0	1	0	0
South	Sonoma	Sutter Medical Group of the Redwoods	General Surgery	0	1	0	0
South	Solano	Sutter Solano Medical Center	General Medicine	1	0	0	0
South	Marin	Marin Health Network	ENT (Family Practice)	0	1	0	0
South	Solano	Vacaville Urgent Care Medical Group	Urgent Care	1	0	0	0
North	Shasta	Fletscher, Walter Lyle, MD	Cardiovascular Disease/Internal Medicine	0	1	0	0
North	Lassen	Lassen Indian Health Center	Family Practice	2	0	0	0
North	Shasta	Mercy Medical Center-Redding	Emergency Medicine	0	1	0	0
North	Trinity	Meredith, Randall John, MD	Family Medicine	0	0	0	1
North	Shasta	Shasta Regional Medical Center	Psychiatry	0	2	0	0
North	Humboldt	Southern Humboldt Community Clinic	Family Practice	0	0	1	0

Source: 2023 Discrimination Grievances Data: 1Q24 Grievance and Appeals PULSE Report

- **Notable Findings:** The most commonly reported problem was alleged discrimination due to race or ethnicity. The second most common was alleged discrimination due to language. All concerns were addressed by the usual grievance process. Further action is not required.

- An examination of discrimination cases from 2022 to 2023 showed a significant reduction of 21.4%. This decline is particularly noteworthy given the overall year-over-year increase of 39.3% in total grievance cases.

One contributing factor to this decline could be attributed to our comprehensive approach in handling cases of alleged discrimination. Upon identifying instances where discrimination is likely to have occurred by a provider, G&A initiates a proactive measure of implementing a Soft-Warning Letter aimed at fostering awareness and corrective action within the provider community. These letters serve as a formal communication channel providing educational resources that are tailored to assist in understanding and implementing practices that promote inclusivity and prevent discrimination against our members.

LINGUISTIC NEEDS

As a plan, PHC met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog, and Russian). When comparing our linguistic data to grievances, there was a decrease in language discrimination from ten in 2022 to eight in 2023. Shasta County was the highest reported county however, none of the providers within the county had more than one grievance, and therefore, there is no trend to address.

PHC offers no-cost linguistic services which include, oral interpreters, and sign language interpreters. Many practices have providers and medical staff who speak languages spoken by plan members. Written informing materials are fully translated into the threshold languages upon request.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

PRACTITIONER RATIOS: PRIMARY CARE

The following table summarizes the findings for Primary Care practitioners:

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure : Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**833**	**616,313**	**Primary Care Practitioner to Member (adult and children)**	**1:739**	**1:≤ 2,000**	**MET**
Family or General Practice	**517**	**616,313**	**Family or General Practice Practitioner to Member (adult and children)**	**1:1,192**	**1:≤ 2,000**	**MET**
Pediatrics	**171**	**193,201**	**Pediatricians to Members (children)**	**1:1,129**	**1:≤ 2,000**	**MET**
Internist	**145**	**423,112**	**Internists to Members (adult)**	**1:2,918**	**1:≤ 3,000**	**MET**

Practitioner Ratios: Primary Care (April 1, 2023)

- **Notable findings:** The Plan met the standard for all Primary Care Practitioners. No interventions are indicated at this time.

PHC experienced an 8.2% increase in total membership compared to 2022. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network.

PROVIDER RATIOS: HIGH VOLUME SPECIALISTS

The following table summarizes the findings for High Volume Specialists:

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	479	254,936	OB-GYN to Member	1:287	1:≤ 5,000	MET
Cardiology	574	616,313	Cardiologist to Member	1:1,074	1:≤ 10,000	MET
General Surgery	427	616,313	General Surgery to Member	1:1,443	1:≤ 10,000	MET
Orthopedic	335	616,313	Orthopedic Surgeon to Member	1:1,840	1:≤ 10,000	MET
Ophthalmology	248	616,313	Ophthalmologist to Member	1:2,485	1:≤ 10,000	MET
Dermatology	204	616,313	Dermatologist to Member	1:3,021	1:≤ 15,000	MET

Practitioner Ratios: High Volume Specialist (April 1, 2023)

- **Notable findings:** The six high-volume specialties utilized by members remained unchanged from last year (2022). PHC met the provider ratio standards for all high-volume specialist providers. Interventions are not indicated at this time.

PRACTITIONER RATIO: HIGH IMPACT SPECIALISTS

The following table summarizes the findings for High Impact Specialists.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	**428**	**616,313**	**Oncology Hematology to Member**	**1:1,440**	**1: ≤ 25,000**	**MET**

Practitioner Ratio: High Impact Specialists (April 1, 2023)

- **Notable findings:** Plan-wide, the practitioner to member ratio for Oncology/Hematology practitioners fell comfortably within the performance standard. No plan-wide interventions are indicated at this time.

GEOGRAPHIC DISTRIBUTION: PRIMARY CARE PRACTITIONERS

The following table summarizes the findings for the Primary Care Practitioners.

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**1 within 10 miles or 30 minutes from the member's residence**	**97.9%**	**≥ 95%**	**MET**
Family Medicine or General Practitioner	**1 within 10 miles or 30 minutes from the member's residence**	**99.8%**	**≥ 95%**	**MET**
Pediatrics	**1 within 10 miles or 30 minutes from the member's residence**	**97.4%**	**≥ 95%**	**MET**
Internist	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, May 2023)

- **Notable findings:** PHC met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty. No interventions are indicated at this time.

Geographic Distribution of Primary Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Northeast	**Lassen**	**Primary Care**	**1 within 10 miles or 30 minutes from the member's residence**	**88.8%**	**≥ 95%**	**Not MET**

Geographic Distribution of Primary Care Lassen County (Quest Analytics, May 2023)

- **Notable findings:** A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 8627 PHC members in Lassen County, 968 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:663. This is indicative of a rural county where the population is widely dispersed and the providers are located in or near towns and cities.

Rural areas generally have family physicians that serve as primary care physicians, as the population is not sufficient to sustain pediatric and internal medicine specialists. Taking the presence of family physicians into account, there is sufficient access to primary care physicians. Lassen County primary care clinics benefit from PHC's primary care recruitment program that incentivizes practitioners to serve this rural county.

There are no known qualified primary care providers that can be added to the network at this time. Nonetheless, continued general support of the primary care workforce, like our primary care recruitment program and our primary care Quality Incentive Program, are prudent to maintain the primary care network that we have.

PART V: GEOGRAPHIC ACCESS: SPECIALISTS

The following table summarizes the findings for High Volume and High Impact Specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		100%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		100%	≥90%	MET
Ophthalmology		98.5%	≥90%	MET
Orthopedics		100%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		97.8%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, May 2023)

- **Notable findings:** All geographic distribution of High Volume and High Impact Specialty standards were met plan wide. Interventions are not indicated at this time.

County Size Categories by Population			
Size Category	**Population Density**	**# of Counties**	**PHC Counties**
Rural	≤50 people per square mile	8	Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity
Small	51 to 200 people per square mile	3	Lake, Napa, and Yolo
Medium	201 to 599 people per square mile	3	Marin, Solano, and Sonoma

County Size Categories by Population (DHCS, Standard for County Size by Population, 2023)

When the data is broken down to the county level, two rural counties did not meet the 60 miles or 90 minutes standard for access to specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Northern	Lassen	Ophthalmology	Rural standard: % of members' residence is 60 miles or 90 minutes from a specialist's office.	16.0%	≥ 80%	Not MET
	Lassen	Hematology/Oncology		8.3%	≥ 80%	Not MET
	Modoc	Ophthalmology		20.8%	≥ 80%	Not MET
	Modoc	Hematology/Oncology		0.9%	≥ 80%	Not MET
	Modoc	Physical Medicine and Rehabilitation		0.9%	≥ 80%	Not MET
	Modoc	ENT/Otolaryngology		7.2%	≥ 80%	Not MET

Geographic Distribution of Specialty Care - Not Met Score by County (Quest Analytics, May 2023)

Specialty	County	Average Miles	Average Minutes
Ophthalmology	Lassen	84	92
	Modoc	91	99
Hematology/Oncology	Lassen	86	94
	Modoc	116	127
ENT/Otolaryngology	Modoc	98	107
Physical Medicine and Rehabilitation	Modoc	115	126

- **Notable findings:** The average miles or minutes for members outside of the access standard ranges from 1 – 55 miles or 2 – 37 minutes.

PHC contracts with all available high-volume specialists that practice within Modoc and Lassen counties. These areas are sparsely populated and have an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. PHC will assist members in making appointments and arrange transportation for the member to see a specialist that is outside of the time or distance standards.

PHC's continues to review all sources of data related to access to specialty care, for monitoring trends and implementing focused strategies on the area of greatest need. This includes a robust telemedicine and e-Consult program. Many telehealth specialties are available to members via video

appointments arranged at primary care offices. In addition, direct-to-member video telehealth between specialist providers and members is available through Partnership's contract with TeleMed2U.

PRACTITIONER ACCESSIBILITY RESULTS: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE)

The data for assessing regular and routine care, urgent care, and after-hours care is collected by PHC's Provider Relations staff using the Third Next Available (3NA) methodology for appointment access and the after-business hours' survey for telephone and triage services. All PCPs are surveyed (no sampling). The 2023 3NA surveyed 248 primary care provider sites, 329 specialty provider sites, and 120 prenatal provider sites.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE ROUTINE APPOINTMENT ACCESSIBILITY

Third Next Available (3NA) Survey Findings 2023									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94%	91.7%	92.9%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94.4%	90.4%	92.4%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	96.9%	100.0%	98.5%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	95.3%	96.9%	96.1%	≥ 90%	Met

Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2023).

- **Notable findings**: The 3NA survey results show that as a plan we met our 2023 performance goal of 90% across all Primary Care Provider appointments.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE TELEPHONE ACCESSIBILITY:

Third Next Available (3NA) Survey Findings (Primary Care) 2023									
Measurements	Standard	Median Performance Rates			Percentage of Clinics Meeting PCP Standards			Goal	2022 Goal Met?
		North	South	Plan	North	South	Plan		
# Rings before phone answered	≤ 5 rings	2.0	2.0	2.0	100%	100%	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	1.0	2.0	1.5	100%	100%	100%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10.0	10.0	10.0	100%	100%	100%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	1.0	2.0	1.5	100%	100%	100%	≥ 90%	Met

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2023).

- **Notable findings:** The 3NA survey results show that as a plan we met our 2022 performance goal of 90% telephone accessibility and wait time measurements.

SURVEY RESULTS - PRIMARY CARE AFTER BUSINESS HOURS

After Business Hours Survey Findings Primary Care 2023											
Measurements	Standard	Q1 2023		Q2 2023		Q3 2023		Q4 2023		Goal	Goal Met?
		North	South	North	South	North	South	North	South		
Answering Machine/ Answering Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Instructions to call 911/ER	100%	100%	100%	100%	99%	100%	100%	100%	100%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	100%	100%	100%	100%	99%	100%	96%	100%	100%	≥ 90%	Met
Wait times for screening or triage services	≥ 30 minutes	100%	100%	100%	99%	100%	99%	100%	100%	≥ 90%	Met

Survey Results Primary Care After Business Hours (PR Rep Survey, 2023).

- **Notable findings:** The 3NA survey results show that as a plan PHC met 2023 goals for Primary Care After Business Hours Accessibility measurements.

3NA SURVEY RESULTS - ACCESS TO PRIMARY CARE BY COUNTY

The data for assessing access to care by county is pulled from the 3NA survey results. The 2023 3NA findings below summarize the access by county.

PCP 3NA Results by County

% of Clinics Meeting PCP Standards by County

		% Meeting Target - Adult	% Meeting Target - Peds	% Meeting Target - Newborn	% Meeting Target - Urgent	# Clinics
North	Del Norte	86%	100%	100%	100%	7
	Humboldt	96%	95%	100%	96%	27
	Lassen	100%	100%	100%	100%	5
	Modoc	100%	100%	100%	100%	4
	Shasta	85%	81%	94%	90%	21
	Siskiyou	100%	100%	100%	100%	17
	Trinity	100%	100%	75%	75%	4
South	Lake	92%	88%	100%	93%	15
	Marin	84%	100%	100%	91%	23
	Mendocino	89%	87%	100%	100%	20
	Napa	73%	57%	100%	93%	15
	Solano	90%	75%	100%	100%	25
	Sonoma	100%	100%	100%	98%	41
	Yolo	100%	100%	100%	100%	23

3NA Survey Median Number of Business Days for Appointments by County (PR Reps 3NA Survey, 2023)

- **Notable Findings:** When the 3NA data is broken down by county we find eight counties had clinics that failed to meet the appointment standards:

  - Del Norte County - seven sites were surveyed and one failed to meet the adult appointment standard.
  - Shasta County - twenty-one sites were surveyed with five failing to meet appointment standards in either adult or pediatric appointment standard and one that failed the newborn standard.
  - Mendocino County - twenty sites were surveyed with two failing to meet either the adult appointment or pediatric standard and one failing both standards.

- Trinity County – four sites were surveyed with one failing to meet the newborn and urgent appointment standard.
- Lake County – fifteen sites were surveyed with one site failing both adult and pediatric appointment standard and one failing the urgent appointment standard.
- Marin County – twenty-three sites were surveyed with three sites failing the adult appointment standard and two failing the urgent standard.
- Napa County – fifteen sites were surveyed with three failing the adult and pediatric standard and one failing the urgent appointment standard.
- Solano County – twenty-five sites were surveyed with two failing pediatric, one failing adult and one failing both adult and pediatric appointment standards.

All sites that fail to meet the standard will be resurveyed and issued a corrective action plan if needed.

Trends for PCP Appointments Meeting Targets

➢ **Notable Finding:** There has been a downward trend for adult and pediatric PCP appointments across both regions since 2020.

3NA SURVEY RESULTS - ACCESS TO PRENATAL CARE[1]

The data for assessing access to prenatal care by county is also pulled from the 3NA survey results.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt			% of Clinics Meeting Prenatal Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

- **Notable Findings:** The 3NA survey results show that as a plan we are meeting our 2023 performance goal for prenatal care appointments.

Prenatal Appointment Access by County			
Region	County	Service Location	Days to Prenatal Appointment
Northern	Del Norte	Sutter Coast Community Clinic- OB/GYN	12
	Humboldt	K'imaw Medical Center	19
		UIHS-Potawot Health Village	11
	Shasta	Selah Women's Health	12
Southern	Lake	Sutter Lakeside Community Clinic	12
	Mendocino	Adventist Health Physicians Network	26
		Hillside Health Center	15
		Little Lake Health Center	11
	Solano	La Clinica Great Beginnings	20
		SMG Solano OB/GYN	22

- **Notable Findings:** When breaking down the Prenatal Appointment Access by County we find that 10 providers failed to meet the standard within 10 business days. All sites that fail to meet the standard will be resurveyed and issued a corrective action plan if needed.

[1] DHCS requirement-3NA results, Access to Prenatal Care.

ACCESS TO SPECIALTY CARE

The data for assessing access to specialty care is collected by PHC's Provider Relations staff using the 3NA methodology for appointment access and the After Business Hours survey for telephone and triage services. Data results for urgent care and after business hours' survey findings are not required by NCQA, however, they are included in this report to meet DHCS requirements. The 3NA high-volume, high-impact specialists are selected from a list of all specialty offices that served 200 or more unique members in the measurement year. If a county does not meet the 200 unique members seen, the provider with the highest unique members seen is selected to ensure we account for all counties.

The following tables summarize the findings for specialty care providers.

3NA SPECIALTY CARE OVERALL

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established Specialty Appointment			% of Sites Meeting Specialty Care Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Specialty Care	Non-urgent specialty care appointments within 15 business days	9.0	8.0	7.0	78.8%	82.0%	80.4%	≥ 80%	Met
Specialty Care	Next urgent appointment ≤ 48 hours	0.0	1.0	1.0	92.9%	95.8%	94.4%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2023)

- **Notable Finding:** As a Plan, we met the 2023 goal for non-urgent and urgent specialty care appointments. However, both regions have suffered an overall decrease in the number of sites meeting both the non-urgent and urgent appointment goal.

Trends for Specialty Appointments Meeting Targets

- **Notable Finding:** There has been a downward trend for routine and urgent specialty care appointments across both regions since 2020. Most notably, the northern region suffered a 14% decrease in sites meeting the non-urgent appointment standard.

3NA SURVEY RESULTS: SPECIALTY CARE ACCESSIBILITY

Specialty Care Accessibility Survey Findings									
Measurements	Standard	Median Performance Rates			% of Sites Meeting Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
# rings before phone answered	≤ 5 rings	2	2	2	100%	100%	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	0.0	1.0	1.0	100%	98.9%	99.2	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	5	10	10	100%	100%	100%	≥ 90%	Met
Return call	≤ 30 minutes	1	1	1	100%	99.5%	99.6%	≥ 90%	Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2023)

- **Notable Findings:** As a plan, we met our 2023 goal for appointment and telephone access to specialty care providers.

Survey Results: After Business Hours Specialty Care

The after-business hour's survey includes all specialty care providers (no sampling).

After Business Hours Survey Findings Specialty Care 2023											
Measurements	Standard	Q1 2023		Q2 2023		Q3 2023		Q4 2023		Goal	Goal Met?
		North	North	North	North	North	South	North	South		
Answering Machine/ Answering Services	100%	100%	100%	100%	100%	99%	100%	100%	100%	≥ 90%	Met
Instructions to call 911/ER	100%	100%	99%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Instructions to reach MD or Advice Nurse	100%	100%	99%	100%	100%	94%	99%	100%	99%	≥ 90%	Met
Wait times for screening or triage services	≤ 30 minutes	100%	99%	100%	100%	90%	99%	100%	99%	≥ 90%	Met

Table 1: Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2023)

Notable Findings: PHC met the After Business Hours Accessibility Specialty Care goals for each quarter in 2023. No further action is required at this time.

High Volume Specialties Third Next Available Survey Results

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Volume Specialties	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Cardiology	7	8	7	63%	81%	77%	≥ 80.0%	Not Met
Dermatology	9.5	17	12	100%	50%	67%	≥ 80.0%	Not Met
General Surgery	7	5	5	100%	89%	93%	≥ 80.0%	Met
Obstetrics Gynecology	5	6	4	100%	90%	94%	≥ 80.0%	Met
Ophthalmology	18	9	8	60%	78%	73%	≥ 80.0%	Not Met
Orthopedic Surgery	7.5	7.5	7.5	89%	93%	92%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2023)

- **Notable finding:** As a plan, three high-volume specialties fell below the established median 15-day appointment goal in 2023 as compared to 2022. Ophthalmology had a slight improvement in the northern region but continued to fall short of the 2023 goal.

High Volume: Ophthalmology 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Ophthalmology Appointment
Northern	Humboldt	Humboldt Medical Eye Associates	36
		North Coast Ophthalmology - Eureka	39
	Shasta	Anderson Eye Care	31
Southern	Marin	West Coast Retina Medical Group – Corte Madera	18
	Mendocino	Ukiah Valley Specialist	23
	Solano	Solano Eye Specialist	53
	Sonoma	North Bay Eye Associates – Santa Rosa	43
	Sonoma	North Bay Eye Associates - Sonoma	20

- **Notable finding:** When breaking down the Ophthalmology Appointment Access by County we find that 3 providers in the northern region and five providers in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all 8 having passed. No direct barriers were identified.

High Volume: Dermatology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Southern	Napa	Brent Loftis, DP	17
	Solano	Solano Dermatology Associates - Vallejo	16
	Sonoma	NorCal Dermatology & Cosmetics	43
		Sutter Medical Group of the Redwoods	70
	Yolo	Woodland Clinic	18

- **Notable finding:** When breaking down the Dermatology Appointment Access by County we find that four providers in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except 2 sites. Corrective Action Plans (CAP) were issued to both providers. NorCal Dermatology & Cosmetics reported a high member demand with appointments being booked out despite being fully staffed. Sutter Medical Group of the Redwoods reported a high number of inappropriate referrals that are impacting their current availability. The CAPs and reported barriers to timely access were shared with the CMO and the information was taken to the PHC Specialty Access Group for discussion.

High Volume: Cardiology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Northern	Shasta	BV Chandramouli, MD	40
		The Cardiovascular Center	36
Southern	Sonoma	Providence Medical Group	74
	Yolo	Sutter Medical Group	46
	Lake	Adventist Health Clearlake	43
	Mendocino	Adventist Health Ukiah Valley	35

- **Notable finding:** When breaking down the Cardiology Appointment Access by County we find that two providers in the northern region and four in the southern region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except one. A CAP was issued to The Providence Medical Group who reported they were not experiencing any staffing issues at the time but were receiving a large number of referrals that were directly impacting their availability. The Provider CAP and reported barrier to timely access was shared with the CMO and the information was taken to the PHC Specialty Access Group for discussion.

HIGH IMPACT SPECIALTY THIRD NEXT AVAILABLE SURVEY RESULTS

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Impact Specialty	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Oncology Hematology	5.5	4.5	4.5	100%	93%	94%	≥ 80%	Met

3NA Survey High Impact Specialty (PR Rep Survey, 2023)

- **Notable finding**: As a plan, we met the appointment standard for our identified high-impact specialty

Section 4: Qualitative Analysis

ACCESS TO PRIMARY CARE

As a plan, PHC met the 90% performance goal for all Primary Care Provider appointments including, adult, pediatrics, newborn, prenatal, and urgent care. When breaking down the primary care access standard 3NA survey data by percentages of clinics in the county that meet the standard we find three counties in the northern region and five in the southern region had lower percentages of appointment compliance. This is an increase from just three counties last year. All sites that fail to meet the standard were resurveyed and issued a corrective action plan if needed.

The total number of member complaints regarding appointment availability increased in both the Northern and Southern regions since 2022 with appointment availability being the most common type of access grievance. The Northern Region experienced a 54% total increase with Redwood Community Health Center having the most grievances in appointment availability as well as overall. The Southern Region experienced a 60% total increase with Solano County Health Services, Vallejo having the most grievances in the appointment category. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is required at this time.

Identified drivers of access challenges continue to be the same as last year, these include:

- An aging physician workforce and a growing, aging population: The COVID-19 Pandemic has exacerbated an existing trending shortage of physicians nationwide. Since 2021 there has been a marked increase in physician retirements prior to the typical age of 65. Additionally, our nation's largest population, the Baby Boomers, are reaching ages where their need for medical care is increasing.
- Practice is closed to new patients: Closing a practice to new patients in one of the ways in which a primary care office can manage their work load in terms of provider to member ratios. A primary care office that is experiencing a shorting in medical care staff cannot continue to accept new patients.

ACCESS TO SPECIALTY CARE

As a Plan, we met our ≥ 80% performance goal for three of the six identified high-volume specialties. Ophthalmology had a slight improvement in the northern region but continued to fall short of the 2023 goal. Both regions continued to fall short of the overall goal upon initial survey. Cardiology failed to meet the goal in the Northern Region but exceeded the goal in the Southern Region at 81%. Dermatology fell short of the goal in the Southern Region but exceeded the goal at 100% in the Northern Region. In 2023, access to specialty care member complaints were low. Two high-volume specialties had one appointment complaint each for the reporting year. A trend could not be established due to low member complaints requiring no action to be taken.

Access to specialty care appointments continues to be an area we must constantly address. The main drivers of access challenges for specialty types that typically fall short of meeting the 15-day accessibility standards are:

- Rural locations where the population is not sufficient to support certain specialty physicians.
- An aging physician workforce and a growing, aging population: The COVID-19 Pandemic has exacerbated an existing trending shortage of physicians nationwide. Since 2021 there has been a marked increase in physician retirements prior to the typical age of 65. Additionally, our nation's largest population, the Baby Boomers, are reaching ages where their need for medical care is increasing.

- Telehealth options not appropriate for all types of specialty care.

Section 5: Summary of Findings

The plan is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and three of six specialty care, high-volume and high-impact (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis.

PHC has experienced a downward trend for adult and pediatric PCP as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are now feeling the effects of a national shortage of providers due to the effects of Covid-19 on health care providers and an aging provider community.

While PHC failed to meet the 15-day appointment standard for Ophthalmology and Cardiology in the northern region, and Dermatology in the southern region, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Additionally, Ophthalmology is not a specialty that lends itself to the use of telehealth appointments. PHC monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement.

The 2023 CAHPS data from the ME7 (Member Experience) report indicates performance below the twenty-fifth percentile benchmark for getting care quickly and getting care needed for Adult. The Child survey indicates PHC was below the twenty-fifth percentile benchmark for getting care needed and getting care quickly. This is a decrease from 2022 when getting care quickly for child performance met the benchmark. The response rate for Adult was 14.3% and Child was 14.9%. In comparison to last year, the impacts to staffing have seemingly become worse while the demand for in person care is growing. Residual impacts from COVID have only exacerbated the issue. From this impact the most frequently reported Access-related concern was regarding provider services, which accounted for 48.4% of the cases. Issues reported in this category included providers unable to see members due to staffing shortages, providers not letting members know about changes to their scheduled appointments, and members having a hard time reaching their provider by phone.

Within the Access category in the Appeals and 2nd Level Grievances, Members raised 125 concerns regarding appointment delays with their primary care provider (PCP) or provider's office staff with the primary focus of reported concerns revolving around appointment availability. Notably, members expressed dissatisfaction with prolonged appointment wait times and challenges securing appointments with specialist in a timely manner, hindering their ability to promptly address their urgent needs. Partnership continues to work on addressing this challenge by working to support our network and seeking to contract with new providers, predominantly in rural areas.

There were no identified gaps in the provider ratios overall. PHC experienced an 8.2% increase in total membership compared to 2022. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network and PHC is actively recruiting for all categories of Primary Care, specifically in those rural areas that traditionally have low numbers of Internal Medicine providers.

While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with an available service provider. There are no qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. PHC requests and receives approval for Alternative Access Standards (AAS) on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, PHC will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Section 5: Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Partnership's provider network is challenged by a national shortage of providers, combined with an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Opportunity: Increase the number of contracted primary care and high-volume specialty care practitioners.

- Effectiveness of Prior Actions: Partnership has started a sponsored workforce development program that offers a sign-on bonus for providers when they contract

with Medi-Cal for the first time, and if they come from a county outside of the 14 counties that Partnership serves. This updated program is taking place between January 2021 – January 2024 with the bonuses being paid out over multiple payments over a 36-month term for physicians, NP's, and PA's and 12 months for licensed behavioral health clinicians including SUD counselors. The strategy is to hold providers in place longer term. To date there has been an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. PHC was able to recruit 66 new primary care practitioners to the network between May 1 2023 and December 1, 2023 with 27 of them going to 6 of our most rural northern counties. Initial retention details look favorable but we may not know completely until the 36-month time period and payments take place.

- *Planned Action*: Partnership has had success with the sponsored workforce development program to date and will continue the strategy in an effort to continue recruitment of physicians, NP's, PA's, and licensed behavioral health clinicians including SUD counselors.
- *Planned Action*: Expand efforts to strengthen recruitment of support specialty providers by adding obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery to the 2024 workforce development program
- *Planned Action*: Conduct a retrospective assessment of specialty providers to identify additional opportunities to better use telehealth as a way to increase access to care, particularly in the rural counties.

2025 QI Committees Meeting Schedules and Material Deadlines

Policies and Presentations (usually) due last Tuesday of preceding month:
Dec. 26, 2024; Jan. 28, 2025; Feb. 25; March 25; April 29; May 27; July 29; Aug. 26; Sept. 23; Oct. 28

Internal Quality Improvement (IQI) Committee

All meetings are held 2nd Tuesdays from 1:30 to 3:30 PM; July and December are tentative*
*Note: * Jan. 7 and Oct. 7 are first Tuesdays **

Jan. 7, 2024*	**April 8, 2025**	July 8, 2025	**Oct. 7, 2025***
Feb. 11, 2025	**May 13, 2025**	**Aug. 12, 2025**	**Nov. 11, 2025**
March 11, 2025	**June 10, 2025**	**Sept. 9, 2025**	Dec. 9, 2025

Per MPQP1004, Standing Committee Members are required to appoint and send a designee if unable to attend:
Administration: CEO; COO; Chief Strategy & Government Affairs Officer;
Regional Directors; Compliance Manager, Grievance & Appeals
Configuration: Configuration Department Leadership / ***Finance:*** Director, Health Analytics
Health Services *(UM, QI, Pharmacy, CC, PHM, EHS, and HE):* Chief Medical Officer – Committee Chair;
Medical Director for Quality – Vice Chair; Medical Director for Medicare Services; Chief Health Services Officer;
Senior Director of Quality and Performance Improvement; Director of Health Equity (Health Equity Officer);
Senior Director, Care Management; Directors of Utilization Management, Population Health; Pharmacy Services,
Enhanced Health Services, and Quality Management; Associate Director(s), Utilization Management, and Population Health;
Manager of Care Coordination Regulatory Performance; Manager of Member Safety – Quality Investigations;
Manager, Clinical Compliance – Quality Inspections; Senior Health Educator; Policy Analyst, Health Services
Regional Directors; Regional Medical Director(s); Associate Medical Director(s)
Member Services: Senior Director of Member Services & Grievance
Provider Relations: Senior Director, Provider Relations; Associate Director of Provider Relations

Quality/Utilization Advisory Committee (Q/UAC)

All meetings are held 3rd Wednesdays from 7:30 to 9:00 AM; July and December are tentative
CONFIDENTIAL Peer Review Committee meets immediately thereafter: 9 to 10 AM and may need to meet in July and December, depending on caseload.

Jan. 15, 2025	**April 16, 2025**	July 16, 2025	**Oct. 15, 2025**
Feb. 19, 2025	**May 21, 2025**	**Aug. 20, 2025**	**Nov. 19, 2025**
March 19, 2025	**June 18, 2025**	**Sept. 17, 2025**	Dec. 17, 2025

Per MPQP1002, the following Partnership staff, excluding the CMO and Medical Directors, serve as *ex-officio* members:
Administration: Director, Grievance and Appeals
Health Services: Chief Medical Officer – Committee Chair; Medical Director for Quality – Vice Chair;
Medical Director for Medicare Services; Clinical Director of Behavioral Health; Chief Health Services Officer;
Senior Director of Quality and Performance Improvement; Director of Health Equity (Health Equity Officer);
Directors of Population Health, Enhanced Health Services, and Pharmacy Services;
Director(s) and Associate Director(s) of Care Coordination and Utilization Management;
Manager, Member Safety – Quality Investigations; Manager, Clinical Compliance – Quality Inspections; Senior Health Educator;
Regional Directors; Regional Medical Director(s); Associate Medical Director(s)
Provider Relations: Senior Provider Relations Rep Manager

Meetings are held at Fairfield (West), with video connection to Partnership's Redding (Airpark) and remote callers.

2025 QI Committees Presentations Calendar

As of Oct. 18, 2024 (subject to change)

The Internal Quality Improvement (IQI) and Quality/Utilization Advisory Committee (Q/UAC) will not meet in July and December.

Non-footnoted topics are scheduled for full presentations at both IQI and Q/UAC.

January – *due Thurs., Dec. 26, 2024* 2024 CG-CAHPS Analysis (Amber Newell) 2024 Referral Follow-up (Robert Moore, MD) [1] 2023-24 Hospital QIP Evaluation (Troy Foster) [1a] 2023-24 Perinatal QIP Evaluation (Deanna Watson) [1a] 2024 Oversight Audits: CY2023 Carelon (Gary Robinson) [2] QI Initiative: Evaluation of Cervical Cancer Self-Swab Testing Pilot (Brandy Isola/Emily Wellander) [8]	**February** – *due Tues., Jan. 28, 2025* PQI/PPC 2024 Annual Report (Robert Bides) Site Review Report (Rachel Newman) PARS Report (Rachel Newman) Care Coordination Grand Analysis (Brigid Gast) D-SNP Model of Care (Kermit Jones, MD/K. Robertello)
March – *due Tues., Feb. 24, 2025* Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 2024-2025 QI Work Plan Update (Nancy Steffen) [2a] 2024 C&L/QIHETP Work Plan – Final Update (Moe Jalloh) [3] ***C&L Trilogy*** [3] (Hannah O'Leary): 2024 C&L Program Evaluation; 2025 C&L Program Description; 2025 C&L / QIHEPT Work Plan	**April** – *due Tues., March 25, 2025* UM Program Description (Tony Hightower) [3] UM/Pharmacy Evaluation/Grand Analysis (UM/Pharm Team) [3] Pharmacy Operations Update (Stan Leung, Pharm.D) [2a] Population Needs Assessment (Hannah O'Leary) [3] Proposed 2025-26 HQIP Measures Summary (Troy Foster) [1] Proposed 2025-26 Perinatal QIP Measure Summary (Deanna Watson) [1]
May – *due Tues., April 29, 2025* IHA – Claims & Encounters Summary (Rachel Newman) [1] Grand Analysis: Behavioral Health Coord (Nicole Escobar) [3] Behavioral Health Overview (Mark Bontrager/Jeff Devido, MD)[7] QI Initiative: Evaluation of WCV Disparity Sprint Pilot [8] QI Initiative: W15 Newborn Enrollment Pilot [8] (James Devan/Kristine Gual)	**June** – *due Tues., May 27, 2025* PHM Work Plan (TBD) [2a, 3] PHM Strategy & Grand Analysis (Hannah O'Leary) [3, 4] InterQual® Annual Review (UM Team) [3] Annual Grievance & Appeals (Kory Watkins) [3]
August – *due Tues., July 29, 2025 (Q/UAC minutes to NCQA HPA)* HEDIS® Annual Performance (Sue Quichocho) [4] PQI/PPC 1st & 2nd Qtr 2025 (Robert Bides) [2] 2024-2025 QI Work Plan Final Update (Nancy Steffen) [3, 4, 5] ***QI Trilogy*** [3, 4, 5] (Nancy Steffen): 2024-2025 QI Evaluation; 2025-2026 QI Work Plan; 2025-2026 QI Program Description	**September** – *due Tues., due Aug. 26, 2025* 2024 PCP QIP Program Evaluation (A. Beltran-Nampraseut) 3NA Survey Results (Vander Harris) Proposed 2026 ECM Measure Summary (Deanna Watson) [1] 1st/2nd Qtr UM/Pharmacy IRR/Timeliness (UM Team/Stan) [1, 3] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 5-Star QI Strategy Plan / Tactical Plan Update (Nancy) [2a]
October – *due Tues., Sept. 23, 2025* Grand Analysis: Health Equity (Moe Jalloh, Pharm.D) [9] Proposed 2026 PCP QIP Measures Summary (Athena Beltran-Nampraseut)[1] Proposed 2026 Palliative Care QIP Summary (Eva Lopez) [1] QI Initiative: Evaluation of DataLink Pilot (TBD) [8]	**November** – *due Tues., Oct. 28, 2025* Grievance & Appeals PULSE Quarterly (Latrice Innes) [2, 6] Grand Analysis: Member Experience (Anthony Sackett) [6] Grand Analysis: Network Access/Adequacy (Renee Trosky) UM Delegation to Capitated Hospitals (Tony Hightower) [2]
January 2026 – *due Tues., Dec. 30, 2025* 2025 Referral Follow-up (Robert Moore, MD) [1]	2024-25 Hospital QIP Evaluation (Troy Foster)[1a] 2024-25 Perinatal QIP Evaluation (Deanna Watson) [1a] 2025 CG-CAHPS Analysis (Amber Newell)

[1] Short presentation at IQI; on Q/UAC consent calendar for acceptance (no presentation)
[1a] Short presentation at IQI; FYI handout at Q/UAC (no vote required)
[2] On both IQI & Q/UAC consent calendars for acceptance (no presentation)
[2a] FYI handouts at both IQI and Q/UAC (no presentation; no vote required)
[3] Timed for NCQA considerations
[4] to include HEDIS® Activity Update
[5] QI Trilogy documents to be approved at Q/UAC in August, PAC in September, Board in October (Q/UAC & PAC minutes included in NCQA evidence for QI 1 Element D)
[6] includes analysis of annual CAHPS data
[7] includes Wellness & Recovery Benefit components
[8] Short presentation at IQI. Will be presented at Q/UAC if time allows; otherwise, will be included as FYI in the Q/UAC packet. 2025 topic may not repeat in 2026.
[9] to include HEDIS® & PCP/QIP data

Health Services and Other External Policies before 2025 IQI/QUAC

As of Nov. 7, 2024: subject to frequent change.

NOTE: Policies in bold-face type have attachments.

Policies should be renewed once in a 12-month cycle but may come back early and more than once in a calendar year per APL, NCQA needs, etc.

Health Services Policy Point Persons
Care Coordination: Alondra Diaz/Shannon Boyle
Enhanced Health Services: Lisa O'Connell/Danielle Biasotti
Health Equity: Mohamed Jalloh
Pharmacy: Janet Ramos/Stan Leung
Population Health: Greg Allen Friedman/Hannah O'Leary
Quality Improvement: Leslie Erickson
Utilization Management: Anna Campbell/Tony Hightower

Non-Health Services Policy Point Persons

Credentialing: Renee Trosky/Brooke Vance/Heidi Lee
Grievance & Appeals: Jayne Cappello/Latrice Innes
Member Services: Anna Hernandez/Edna Villasenor
Network Services: Renee Trosky/Priscila Ayala
Transportation: Debra Frederick/Aaron Maxwell

Note: *Pharmacy policies track IQI/P&T/PAC. Pharmacy policies should go to IQI the month before they are to be considered in QUARTERLY P&T. (New Pharmacy policies may develop in 2025 to reflect D-SNP needs effective Jan. 1, 2026.)*

	IQI Meets	P&T	PAC Approval Date
MCRP4065 – Drug Utilization Review (DUR) Program	March 11	April 10	May 14, 2025
MPRP4034 – Pharmaceutical Patient Safety	March 11	April 10	May 14, 2025
MCRP4064 – Continuation of Prescription Drugs	June 10	July 10	Aug. 13, 2025
MCRP4068 – Medical Benefit Medication TAR Policy	June 10	July 10	Aug. 13, 2025
MPRP4001 – Pharmacy & Therapeutics (P&T) Committee	June 10	July 10	Aug. 13, 2025
MCRP4066 – AB1114 Benefit Implementation	Sept. 9	Oct. 9	Nov. 12, 2025
MPRP4062 – Drug Wastage Payments	Sept. 9	Oct. 9	Nov. 12, 2025

Note: *Credentialing policies are reviewed and approved at the Credentials Committee the day following IQI review.*

***November 2024** meetings (Oct. 29 submission deadline); **PAC approved policies should carry 01/08/2025 date** – NO IQI/QUAC/PAC meetings in December 2024*			
Health Equity	MCEP6002	Quality Improvement and Health Equity Committee (QIHEC)	Old Business
Population Health	**MCNP9006**	Doula Services Benefit	Discussion
Quality Improvement	**MCQG1015** **MCQP1021** **MPQG1011**	Pediatric Preventive Health Guidelines Initial Health Appointment Non-Physician Medical Practitioners & Medical Assistants Practice Guideline	Consent
Utilization Management	MCUP3028 **MCUP3101** MCUP3102 MCUP3106 MCUP3125 **MCUP3131** **MCUP3137**	Mental Health Services Screening and Treatment for Substance Use Disorders Vision Care Waiver Programs Gender Dysphoria/Surgical Treatment Genetic Screening & Diagnostics Palliative Care Intensive Program (Adult)	Discussion Discussion Consent Consent Consent Discussion Consent
No Care Coordination, Enhanced Health Services, Grievance & Appeals, Network Services (NS)			
Credentialing	**MPCR100** MPCR102 **MPCR300**	Credential and Re-credential Decision Making Process Provider Directory Accuracy Physician Credentialing and Re-credentialing Requirements	Consent
Member Services (MS)	MP300	Member Notification of Provider Termination or Change in Location	Old Business
Transportation	MCCP2016 MCCP2029	Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Emergency Medical Transportation	Consent
January 2025** meetings (Dec. 26, 2024 submission deadline); **PAC approved policies carry 02/12/2025 date			
Care Coordination	MCCP2018 **MCCP2024** MCCP2031 **MPCP2017**	Advice Nurse Program Whole Child Model for California Children's Services (CCS) Private Duty Nursing under EPSDT Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines	
Enhanced Health Services (EHS)	**MCUP3142** **MCUP3143**	CalAIM Community Supports (CS) CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)	
Quality Improvement	**MCQG1005** MPQP1018 **MPQP1038** MPQP1053	Adult Preventive Health Guidelines Preventive Health Guidelines Physician Orders for Life-Sustaining Treatment (POLST) Peer Review Committee	
Utilization Management	MCUP3044 MCUP3104 MCUP3113 MPUP3129	Urgent Care Services Transplant Authorization Process Telehealth Services Podiatry Services	
No EHS, Health Equity, Population Health, MS, NS			

Health Services and Other External Policies before 2025 IQI/QUAC

As of Nov. 7, 2024: subject to frequent change.

NOTE: Policies in bold-face type have attachments.

Policies should be renewed once in a 12-month cycle but may come back early and more than once in a calendar year per APL, NCQA needs, etc.

Credentialing	**MPCR11**	Credentialing of Community Health Workers (CHW) Supervising Providers
	MPCR20	Medi-Cal Managed Care Plan Provider Screening and Enrollment
	MPCR700	Assessment of Organizational Providers
Grievance & Appeals	CGA024	Medi-Cal Member Grievance System
Transportation	MCCP2030	Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
February** 2025 meetings (Jan. 28, 2025 submission deadline); **PAC approved policies carry 03/12/2025 date		
Care Coordination	MCCP2020	Lactation Policy and Guidelines
	MCCP2021	Women, Infants and Children (WIC) Supplemental Food Program
	MCCP2035	Local Health Department (LHD) Coordination
	MPCD2013	Care Coordination Program Description
	MPCP2002	California Children's Services
Quality Improvement	**MPQP1022**	Site Review Requirements and Guidelines
Utilization Management	**MCUG3019**	Hearing Aid Guidelines
	MCUP3034	PCP-to-PCP Transfers & Assignment of New Members to PCP
	MPUG3025	Insulin Infusion Pump and Continuous Glucose Monitor Guidelines
	MPUP3018	Health Services Review of Observation Code Billing
	MPUP3048	Dental Services (including Dental Anesthesia)
No EHS, Health Equity, Population Health, G&A, NS, Transportation		
Credentialing	MPCR16	Lactation Consultant Credentialing Policy
	MPCR101	Ensuring Non-discriminatory Credentialing and Re-credentialing processes
	MPCR303	Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements
	MPCR500	Ongoing Monitoring and Interventions
Member Services	**MC305**	Distribution of Member Rights and Responsibilities
March** 2025 meetings (Feb. 25, 2025 submission deadline); **PAC approved policies carry 04/12/2025 date		
Population Health	**MCND9002**	Cultural & Linguistic Program Description *(one leg of the new C&L Trilogy presentation)*
Quality Improvement	MPQP1002	Quality/Utilization Advisory Committee
	MPQP1003	Physician Advisory Committee (PAC)
	MPQP1004	Internal Quality Improvement Committee
Utilization Management	MCUG3002	Acupuncture Service Guidelines
	MCUG3011	Criteria for Home Health Services
	MCUP3039	Direct Members
	MCUP3064	Communication Services
	MCUP3124	Referral to Specialists (RAF) Policy
	MPUP3126	Behavioral Health Treatment (BHT) for Members Under the Age of 21
No Care Coordination, EHS, Health Equity, G&A, MS, NS, Transportation		
Credentialing	**MPCR400**	Provider Credentialing and Re-credentialing Verification Process and Record Security
	MPCR601	Fair Hearing and Appeal Process for Adverse Decisions
	MPCR701	Ancillary Care Services Provider Credentialing and Re-credentialing Requirements
April** 2025 meetings (March 25, 2025 submission deadline); **PAC approved policies carry 05/14/2025 date		
EHS	MCUP3146	Street Medicine
Quality Improvement	MPQP1006	Clinical Practice Guidelines
	MPXG5001	Clinical Practice Guidelines for the Diagnosis & Management of Asthma
	MPXG5002	Clinical Practice Guidelines for Diabetes Mellitus
Utilization Management	MCUP3014	Emergency Services
	MCUP3037	Appeals of Utilization Management/Pharmacy Decisions
	MCUP3047	Tuberculosis Related Treatment
	MCUP3051	Long Term Care SSI Regulation
	MCUP3103	Coordination of Care for Members in Foster Care
	MCUP3121	Neonatal Circumcision
	MPUD3001	Utilization Management Program Description
	MPUG3031	Nebulizer Guidelines
	MPUP3026	Inter-Rater Reliability Policy
	MPUP3059	Negative Pressure Wound Therapy (NPWT) Device/Pump
No Care Coordination, Health Equity, Population Health, G&A, MS, Transportation		
Credentialing	**MPCR4B**	Identification of HIV/AIDS Specialists
	MPCR13	Credentialing of Pain Management Specialist
	MPCR13A	Credentialing of Hospice and Palliative Care Medicine Specialist
	MPCR13B	Buprenorphine Prescriber Credentialing
	MPCR13C	Osteopathic Manipulation Treatment Credentialing

	MPCR19	Skilled Nursing Facility Providers (SNFists) Credentialing Policy
	MPCR304	Allied Health Practitioners Credentialing and Re-credentialing Requirements
	MPCR600	Range of Actions to Improve Practitioner Performance
	MPCR800	Delegation of Credentialing and Re-credentialing Activities
Network Services	MPPR203	Provider Enrollment Status Guidelines
May** 2025 meetings (April 29, 2025 submission deadline); **PAC approved policies carry 06/11/2025 date		
Care Coordination	MCCP2025	Pediatric Quality Committee Policy
	MCCP2026	Diabetes Prevention Program
	MCCP2034	Transitional Care Services (TCS)
	MPCP2006	Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
Quality Improvement	**MCQP1025**	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
	MCQP1047	Advance Directives
	MCQP1052	Physical Accessibility Review Survey – SR Part C
	MPQP1016	Potential Quality Issue Investigation and Resolution
	MPQP1055	Provider Preventable Conditions (PPC) Reporting
Utilization Management	MCUG3110	Evaluation and Management of Obstructive Sleep Apnea in Adults
	MCUG3134	Hospital Bed / Specialty Mattress Guidelines
	MCUP3028	Mental Health Services
	MCUP3041	Treatment Authorization Request (TAR) Review Process
	MCUP3114	Physical, Occupational and Speech Therapies
	MCUP3136	Fecal Microbiota Transplant (FMT)
	MCUP3144	Residential Substance Use Disorder Treatment Authorization
No EHS, Health Equity, Population Health, Credentialing, G&A, MS, Transportation		
Network Services	**MPNET100**	Access Standards and Monitoring
	MPPR208	Provider Notification of Provider Termination, Site Closure or Change in Location Information
June** 2025 meetings (May 27, 2025 submission deadline); **PAC approved policies carry 08/13/2025 date – NO IQI/QUAC/PAC meetings in July 2025		
Care Coordination	**MCCP2014**	Continuity of Care (Medi-Cal)
Population Health	MCND9001	Population Health Management Strategy & Program Description
Quality Improvement	**MPXG5008**	Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
	MPXG5009	Lactation Clinical Practice Guideline
Utilization Management	MCUP3041-A	TAR Requirements *attachment to MCUP3041*
	MCUP3013	Durable Medical Equipment (DME) Authorization
	MCUP3042	Technology Assessment
	MCUP3053	Acute Inpatient Administrative Days
	MCUP3133	Wheelchair Mobility, Seating and Positional Components
	MCUP3138	External Independent Medical Review
	MCUP3139	Criteria and Guidelines for Utilization Management
	MCUP3141	Delegation of Inpatient Utilization Management
	MPUP3006	Appropriate Service & Coverage Policy
No EHS, Health Equity, G&A, Transportation		
Credentialing	MPCR602	Reporting Actions to Authorities
Member Services	MC334	American Indian Rights and Protections
Network Services	MPNET101	Wellness and Recovery Access Standards and Monitoring
	MPPRGR210	Provider Grievance
August** 2025 meetings (July 29, 2025 submission deadline); **PAC approved policies carry 09/10/2025 date		
Care Coordination	NCCP2022	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
Population Health	**MCNP9004**	Regulatory Required Notices and Taglines
Quality Improvement	MPQD1001	Quality and Performance Improvement Program Description [one leg of the QI Trilogy]
	MPQP1048	Reporting Communicable Diseases
Utilization Management	**MCUG3007**	Authorization of Ambulatory Procedures
	MCUG3010	Chiropractic Services
	MCUG3024	Inpatient Utilization Management
	MCUG3118	Prenatal and Perinatal Care
	MCUP3012	Discharge Planning (Non-capitated Members)
	MCUP3052	Medical Nutrition Services
	MCUP3111	Pulmonary Rehabilitation

	MCUP3119	Sterilization Consent Protocol
	MCUP3130	Osteopathic Manipulation Treatment
	MCUP3140	Palliative Care: Pediatric Program for Members Under the Age of 21
	MCUP3145	Eating Disorder Management Policy
	MPUP3078	Second Medical Opinions
No EHS, Health Equity, G&A, NS, Transportation		
Credentialing	**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 nd Re-credentials Requirements
Member Services	**MP301**	Assisting Providers with Missed Appointments
	MP316	Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior
September** 2025 meetings (Aug. 26, 2025 submission deadline); **PAC approved policies carry 10/08/2025 date		
Care Coordination	MCCP2007	Complex Case Management
	MCCP2019	Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Service
	MCCP2023	New Member Needs Assessment
EHS	MCCP2033	Community Health Worker (CHW) Services Benefit
Quality Improvement	**MPXG5003**	Major Depression in Adults Clinical Practice Guidelines
Utilization Management	**MCUG3022**	Incontinence Guidelines
	MCUP3003	Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services
	MCUP3015	Family Planning By-Pass Services
	MCUP3050	Medication Abortion in the First Trimester
	MCUP3115	Community Based Adult Services
	MCUP3128	Cardiac Rehabilitation
	MPUP3035	Preoperative Day Review
No Health Equity, Population Health, G&A, MS, Transportation		
Credentialing	MPCR13D	Registered Pharmacists for AB1114 Credentialing
Network Services	MPPR200	Partnership Provider Contracts
	MPPR207	Annual Physician Satisfaction Survey
	MPPR209	Provider Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions
October** 2025 meetings (Sept. 23, 2025 submission deadline); **PAC approved policies carry 11/12/2025 date		
Enhanced Health Services (EHS)	**MCCP2032**	CalAIM Enhanced Care Management (ECM)
Health Equity	MCED6001	Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description
Quality Improvement	**MPQP1008**	Conflict of Interest Policy for QI Activities
Utilization Management	MCUG3032	Orthotic and Prosthetic Appliances
	MCUG3038	Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
	MCUG3058	Utilization Review Guidelines for ICF/DD, ICF/DD-H, ICF/DD-N Facilities
	MCUP3020	Hospice Service Guidelines
	MCUP3049	Pain Management Specialty Services
	MPUP3116	Positron Emission Tomography (PET Scans)
No Care Coordination, Population Health, MS, NS, Transportation		
Credentialing	**MPCR15**	Doula Credentialing and Re-credentialing Criteria
	MPCR17	Standards for Contracted Primary Care Physicians
	MPCR200	Credentials Committee and CMO Credentialing Program Responsibilities
Grievance & Appeals	CGA022	Member Discrimination Grievance Procedure
November** 2025 meetings (Oct. 28, 2025 submission deadline); **PAC approved policies carry 01/14/2026 date – NO IQI/QUAC/PAC meetings in December 2025		
Health Equity	MCEP6002	Quality Improvement and Health Equity Committee (QIHEC)
Population Health	**MCNP9006**	Doula Services Benefit
Quality Improvement	**MCQG1015**	Pediatric Preventive Health Guidelines
	MCQP1021	Initial Health Appointment
	MPQG1011	Non-Physician Medical Practitioners & Medical Assistants Practice Guideline
Utilization Management	MCUP3028	Mental Health Services
	MCUP3101	Screening and Treatment for Substance Use Disorders
	MCUP3102	Vision Care
	MCUP3106	Waiver Programs

	MCUP3125 **MCUP3131** **MCUP3137**	Gender Dysphoria/Surgical Treatment Genetic Screening & Diagnostics Palliative Care Intensive Program (Adult)
No Care Coordination, EHS, G&A, NS		
Credentialing	**MPCR100** MPCR102 **MPCR300**	Credential and Re-credential Decision Making Process Provider Directory Accuracy Physician Credentialing and Re-credentialing Requirements
Member Services	MP300	Member Notification of Provider Termination or Change in Location
Transportation	MCCP2016 MCCP2029	Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Emergency Medical Transportation