PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: May 15, 2025
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 listed on the agenda too.
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, May 21, 2025
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
La Clinica, 1450 Fruitvale Ave., Oakland
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Kaiser Permanente, 5820 Owens Drive, Pleasanton
Woodland Clinic, 2330 W. Covell Blvd., Davis

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, Behavioral Health
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
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jensen, Annika, RN, Associate Director of Clinical Integration, CC
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
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
Ward, Lisa, MD, Regional Medical Director, Southwest
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
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)
Durst, Jennifer, Sr Mgr of Performance Improvement, QI (SE/SW)
Escobar, Nicole, S, Mgr of Behavioral Health, Behavioral Health
Foster, Troy, Project Manager II, Quality Improvement
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Director of Quality Measurement, QI
Harrell, Bria, Project Manager I, Configuration
Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani, Stephanie, Manager of Provider Relations Representatives
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico

this page left blank

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

Date: May 21, 2025 **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
La Clinica, 1450 Fruitvale Ave., Oakland
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Kaiser Permanente, 5820 Owens Drive, Pleasanton
Dignity Health Medical Group: Woodland Clinic – 2330 W. Covell Blvd., Davis

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* • April 16 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 14
2	*Acknowledgment and acceptance of draft minutes of the* April 8 Internal Quality Improvement (IQI) Committee			15 – 24
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:35	25 – 35
2	HealthPlan Update	Robert Moore, MD	7:40	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:45	36
	G&A PULSE Report /Issue 16 / April 2025 – *Wellness & Recovery article begins on p. 44*			37 – 52
Health Services Departments	**Behavioral Health** – *is now a Health Services department (f0rmerly in Administration). Specific Behavioral Health-related policies are being transferred from other departments to Behavioral Health ownership, including the Mental Health Services policy on presentation today.*			
	MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services – *the previous ADM52 in Administration is archived: p. 58*			53 – 57
	MPBP8013 – Eating Disorder Management Policy – *the previous MCUP3145 in UM is archived: p. 73*			63 – 71
	Enhanced Health Services			
	MPAP7004 – Community Health Worker (CHW) Services benefit – *the previous MCCP2033 in CC is archived: p. 93*			81 – 91
	MPAP7005 – Street Medicine – *the previous MCUP3146 in UM is archived: p. 111*			103 – 110

	Item	Lead	Time	Page #
Health Services Departments	**Quality Improvement**			
	MCQP1052 – Physical Accessibility Review Survey SR Part C – *new attachment B replaces the old*			119 – 165
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)			167 – 169
	MPQP1047 – Advance Directives – *previously MCQP1047*			170 – 172
	MPQP1055 – Provider Preventable Condition (PPC Reporting)			173 – 177
	MPXG5003 – Major Depression in Adults Clinical Practice Guidelines			179 – 181
	Utilization Management			
	MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions			183 – 191
	MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines			193 – 198
	MPUG3031 – Nebulizer Guidelines			199 – 202
	MPUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults – *previously MCUG3110*			203 – 207
	MPUP3047 – Tuberculosis Related Treatment – *previously MCUP3047*			209 – 214
	MPUP3136 – Fecal Microbiota Transplant (FMT) – *previously MCUP3136*			215 – 217
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization – *previously MCUP3144*			218 – 224
Non-HS	**Network Services**			
	MPNET100 – Access Standards and Monitoring			225 – 236
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	237 – 242
QI	MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	Rachel Newman, RN	7:50	243 – 369
	MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management and Safe Opioid Prescribing	Jeff DeVido, MD	7:56	371 – 402
BH	MPBP8003 – Mental Health Services – *the previous MCUP3028 in UM is archived: p. 437*	Jeff DeVido, MD	8:02	403 – 436
CC	MPCP2026 – Diabetes Prevention Program – *previously MCCP2026*	Shannon Boyle, RN	8:08	469 – 474
	MPCP2034 – Transitional Care Services (TCS) – *previously MCCP2034*		8:16	475 – 488
UM	MPUP3137 – Palliative Care: Intensive Program (Adult) – *previously MCUP3137*	Bettina Spiller, MD	8:24	489 – 508
VI.	**Presentations**			
1	Behavioral Health Overview	Jeff DeVido, MD Mark Bontrager Nicole Escobar	8:30	509 – 526
2	Individual Health Assessments (IHA) Claims & Encounters 2024 Summary / Compliance Report	Rachel Newman, RN	8:50	527 – 538
VII. FYI	QI Initiative: Evaluation of Well-Child Visit Disparity Spring Pilot – *refer questions to James Devan*			539 - 548
	QI Initiative: W15 Newborn Enrollment Pilot – *refer questions to Liz Romero*			549 – 568
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, June 18, 2025			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, April 16, 2025 / 7:33 a.m. – 8:58 a.m. Napa/Solano Room, 1st Floor

Voting Members Present:	Phuong Luu, MD	Michael Strain, PHC Consumer Member
Steven Gwiazdowski, MD, FAAP	John Murphy, MD	Chris Swales, MD
Emma Hackett, MD, FACOG	Robert Quon, MD, FACP	Randolph Thomas, MD

Voting Members Absent: Sara Choudhry, MD; Brandy Lane, PHC Consumer Member; Brian Montenegro, MD; Meagan Mulligan, FNP-BC; Jennifer Wilson, MD

Partnership *Ex-Officio* Members Present:	Kubota, Marshall, MD, Associate Medical Director
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Leung, Stan, Pharm.D, Director of Pharmacy Services
Cox, Bradley, DO, Regional Medical Director (Northeast)	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
DeVido, Jeff, MD, Behavioral Health Clinical Director	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Frankovich, Terry, MD, Associate Medical Director	Randhawa, Manleen, Senior Health Educator, Population Health
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Hightower, Tony, CPhT, Associate Director, UM Regulations	Ruffin, DeLorean, DrPH, Director of Population Health
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Steffen, Nancy, Senior Director of Quality and Performance Improvement
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Watkins, Kory, MBA-HM, Director, Grievance & Appeals
Katz, Dave, MD, Associate Medical Director	

Partnership *Ex-Officio* Members Absent:	Kerlin, Mary, Senior Director of Provider Relations
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	O'Connell, Lisa, Director, Enhanced Health Services
Cotter, James, MD, Associate Medical Director	Spiller, Bettina, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Thornton, Aaron, MD, Associate Medical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives	

Guests:	Hoang, Hanh, PR Representative II, Provider Relations
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Isola, Brandy, Manager of Performance Improvement (Chico)
Brown, Isaac, MBA/MHA, Director of Quality Management, QI	Jarrett-Lee, Kevin, RN, Associate Director of UM
Brunkal, Monika, RPh, Associate Director, Population Health	Matthews, Richard "Doug," MD, Regional Medical Director, Chico
Campbell, Anna, Health Policy Analyst, Utilization Management	Morris, Matthew, MD, Regional Medical Director, Auburn
Cunnigham, Aryana, Policy Analyst, Care Coordination	Nakatani-Phipps. Stephanie, Lead Senior Provider Relations Rep, PR
Devan, James, Manager of Performance Improvement (Redding)	Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
Erickson, Leslie, Program Coordinator II, QI (scribe)	O'Leary, Hannah, MPH, Manager of Population Health, Pop Health
Garcia-Hernandez, Margarita, PhD, Director, Health Analytics	Smith, Christine, Community Health Needs Liaison, Population Health
Grupe, Michele, Mgr of First Five Commissions, Behavioral Health	

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 7:33 a.m. The March 19, 2025 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • March 11 Internal Quality Improvement (IQI) Committee • March 18 Quality Improvement Health Equity Committee (QIHEC) • Feb. 27 Member Grievance Review Committee (MGRC)	Motion to **approve the Q/UAC minutes:** Robert Quon, MD Second: Chris Swales, MD *Approved unanimously* Motion to **accept the other minutes:** Steven Gwiazdowski, MD Second: Robert Quon, MD *Approved unanimously*
II. Standing Updates		

1. Quality Improvement (QI) Department Update
 	
Nancy Steffen, Senior Director of Quality and Performance Improvement, QI
	• Q/UAC may remember that last month we talked about pediatric measures: topical fluoride, developmental screening, well-child visits. This month, it might be helpful to highlight adult measures.
	  ○ On cervical cancer screening: Southeast Regional Medical Director Colleen Townsend, MD, has been working with Provider Relations to inform providers about cervical cancer self-swab options through our laboratory vendors, including in an April 1 webinar with the Women's Health and Perinatal workgroup. The National Committee for Quality Assurance (NCQA) will allow inclusion of the new CPT code for HPV self-swab and the high-risk HPV lab test value set for Health Care Effectiveness Data Information Set (HEDIS®) starting this current measurement year, (MY) 2025.
	  ○ The Chronic Disease workgroup observed Colorectal Cancer Awareness Month in March by meeting with an American Cancer Society representative who shared national statistics on colorectal cancer disparities. The workgroup together with the ACS co-branded an educational flyer that Provider Relations has distributed throughout our network.
	  ▪ We've been looking at ways from a process standpoint to help support our provider organizations in completing a bulk order for Cologuard from Exact Sciences. Q/UAC will recall an evaluation of an intervention that Partnership conducted about 18 months ago with select provider organizations: we got great returns, including custom marketing materials with provider logos, help getting direct ship of those kits to our members, and help getting word to our providers to ensure timely screenings.
	  ▪ We have worked with Exact Sciences to remove the minimum patient order requirement, and we are seeing a new wave of work underway. Kits went out in March to five of our larger organizations. We anticipate good results as we have seen in our prior pilots, and we are starting to plan a second multi-patient order phase for July through September. This is important to note because it will certainly help those providers focused on their QIP measures for 2025, of which colorectal cancer screening is a key measure. A note to anyone working on this measure: this is a limited time only offer.
	• In HEDIS®, as you know, we've been focused in the last several months on data completeness under key measures, in particular the Department of Health Care Services' (DHCS) Managed Care Accountability
		For information only: no formal action required. There were no questions.
		
		Dr. Moore remarked that the 100% award on our D-SNP MOC submission is a great achievement. He congratulated everyone involved whose efforts got us to a three-year review cycle.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Set (MCAS) measures. ○ In completing a data inventory of both Short/Doyle Mental Health and Substance Use Disorder service claims that DHCS provides, we have gained a better onset of data flow to better represent county department behavioral health services that are billed through Medi-Cal. ▪ We looked at 2023 and 2024 data because the State has been focused on making this more readily available to the health plans to more completely evaluate performance under FUA (follow-up after ED visit for substance use) as well as FUM (follow-up after ED visit for mental health). We still have a significant gap in data completeness representing MY 2024. This is something we are diligently tracking with the help of our Health Analytics team. We will report status back to DHCS's chief data officer with whom we have been cultivating an ongoing dialog for this measure as well as for topical fluoride. • Q/UAC will recall that Partnership has our Consumer Awareness of Health Providers and Systems (CAHPS®) "Member Experience" survey, now in the field for both our adult and child populations. We are seeing an increase in the rate of response for both populations at this time in the measurement year. We anticipate further increase in response rate as our survey vendor begins implementing phone follow-up protocols. This includes a combination of one reminder call and three automated calls with live agents available of members pick up and opt in to complete the survey verbally by phone either in English or in Spanish. These calls will continue through the end of April. ○ The CAHPS® outcomes influence our Medicaid star ratings, so we look at this in combination with our quality outcome performance and the NCQA Health Plan Accreditation measure set. Certainly, DHCS looks at this as well, although they administer a separate survey on behalf of the health plans and evaluate us from that survey result. • The Center for Medicare and Medicaid Services (CMS) has informed Partnership that we have earned a high score on the Dual-Eligible Special Needs Plan (D-SNP) Model of Care (MOC) submitted earlier this year, such that we have earned the highest possible review cycle of once every three years, rather than every one or two years. This is a huge achievement. (Many first-time D-SNP health plans can anticipate a one-year cycle for review and updates on the MOC, or even a request for revision.) ○ The MOC is a foundational element in standing up our D-SNP effective Jan. 1, 2026, and articulates how we will deliver this new product line with a focus on quality and case management/care management, and the way we evaluate our population on an ongoing basis to serve and meet their needs.	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• As you know, we continue to track two pieces of California legislation related to obstetric access: ○ Senate Bill 669 would allow small, rural hospitals the option of having a standby perinatal unit. This bill sponsored by the Senate Pro Temp Mike McGuire has passed out of committee with no opposition. Democrats, Republicans, nurses, doctors, everybody is in favor, so it's just sailing through. That's good. ○ AB55 is akin to a sister bill that would change the licensing requirements for alternative birth centers. There was some testimony there, but it did pass out of committee with unanimous support as well. Both bills are now in appropriations.	*Meeting Postscript:* • The Board of Commissioners meets in retreat at the end of this month and may discuss options to help meet State budget shortfalls.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Partnership's Joint Leadership Initiative helps our larger health centers who have opportunity for improving their quality scores. Existing sites are Fairchild, Shasta, Open Door, Adventist Mendocino and Lake, Mendocino Community Health Center, and Solano County Family Health Services. In our new regions, we are adding four locations: Ampla Health, Western Sierra, Well Space, and Oroville Hospital. We have the space because we have successfully "graduated" some provider organizations. • The Regional Medical Director meetings are in full swing, We have just two more: one in Santa Rosa April 25, and one in Marysville May 2. The detailed notes have two versions: the leadership version, and the clinician version. They will be posted and placed in the newsletter to Medical Directors. • At the federal level, the House and Senate are proposing different sized Medicaid cuts with different assumptions and different scopes. There is conflicting information. If there are large cuts, then the State must respond what its plan will be, and that will take several months. The soonest that any changes could happen would likely be September/October, assuming the Feds come up with some large cuts. In the meantime, the State is on a trajectory to not change anything. They have regulatory authority to do quite a bit. Many of the waivers they have extend until later in the Trump presidency or even past that; however, regulatory authority does not equal funding. If funding decisions are required, will core services be cut to preserve the extra things they added? In the end, that decision will be made by the Finance Department and the Governor. o California has been having some funding issues: both the Cal State and University of California systems are facing some significant shortfalls exacerbated by the cuts in federal funding for grants. Then it becomes a question of do we curtail enrollment at the UCs or close campuses versus cut Medi-Cal? It is unlikely campuses will close or enrollment cut. o The State is going full speed ahead on all initiatives they have ordered the health plans to do, including diversity, equity and inclusion training for the network. Health Equity Officer Mohamed Jalloh, Pharm.D is leading Partnership's effort. If any organization is already doing their own DEI, they are invited to show it to him, and he will certify it. It will be an issue in some conservative areas when doctors there are asked to do this mandatory training. That will be an issue. *Q/UAC Conversation:* Dr. Jalloh added: DHCS has made it very clear that we should continue business as usual for the DEI training. Some health plans have already had the forethought to maybe change the name of it because they recognize "DEI" can be triggering, while others have kept it the same. We are exploring the best option because we want to make the decision based on what we think is best for our community versus just trying to react or pro-act based upon what the federal government is saying. The good news is that the State is not going to hold Partnership accountable for a certain percentage of people completing it. The State will hold us accountable to *distribute* the training to our practitioners. The State has said they want us to provide annual completion rates. We asked if there is a threshold they want. They weren't clear. They did say they wanted everyone to be provided the training within 90 days of being contracted. Dr. Moore added that DHCS has not answered 'do you want us to de-certify providers that refuse to do this training?'	• The April 2025 Medical Directors Newsletter was published and then distributed via email to Q/UAC members on April 30. • Senior Director Member Services and Grievance & Appeals Edna Villasenor will provide Leslie with hard copy Member Newsletters. They will be mailed to Q/UAC members after May 13.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Conversation ensued with Q/UAC members asking if there is any regulatory risk or downside to calling "DEI" by another name. (Dr. Jalloh suggested "cultural community connection training.") Dr. Moore liked Dr. Jalloh's term. He cautioned, however, that some will chafe at the mandate itself, and that Partnership still needs a clear answer to 'what happens if I don't do it?' Dr. Jalloh sees no risk with a name change, provided the documentation when submitted reflects the original intent of DHCS's All Plan Letter. Stven Giazdowski, MD, cautioned that some "recalcitrants" might well see through any terminology change and then call into question Partnership's integrity. Q/UAC Consumer Member Michael Strain commented on the recently published Member Newsletter. "It was a good thorough read," he said. "When you get to your DEI issue, in the back, there's one paragraph that's translated into six different languages. There are articles on doula services, on family care services, so any member who reads this already get the idea of inclusion and diversity and equity. It's underlying in the messages we get. For me, it was a pleasure to get this thing that says Partnership is taking care of me as a person. The information we hear here (at Q/UAC) and the work you guys do filters down to the members. We get it; we get the number of services and what's available, how to get help, how to get help when you have a complaint. All sorts of things are filtered down from our agenda to the members. There's even a short article by one of our members about the difference between Medicare and Medi-Cal. It's informative." Dr. Moore said he too is proud of this publication that comes out twice each year. He directed Leslie to obtain hard copies for the Q/UAC members.	
III. Old Business –		
Early Policy Reviews to Accommodate D-SNP Implementation Schedule *Robert Moore, MD* *Chief Medical Officer*	In preparing for our D-SNP Medicare product line going live Jan. 1, 2026, we have existing Medi-Cal policies that need to be minorly adapted to apply and some new Partnership Advantage-only policies that need to go through IQI/Q/UAC/PAC before the September/October timeframe. We are moving many policies that we normally see in September, October, November to May, June, August. We were not planning on having a July meeting. but we may need to for the new policies. This month is light because we are having trouble finishing some policy updates. The next three months will be busy, but then it could be lighter towards the end of the year.	*Meeting Postscript:* • IQI will meet July 8 to consider 8-10 or more new policies that will require much internal discussion. Q/UAC will entertain these policies on Aug. 20.
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	Proposed 2025-2026 Quality Incentive Program Measure Summaries – Hospital and Perinatal QIPs ***Health Services Policies*** <u>Quality Improvement</u> MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guideline for Diabetes Mellitus <u>Utilization Management</u>	The two QIP measure summaries were approved at the Physician Advisory Committee (PAC) on April 9 Motion to **approve slate as presented without MPUP3014:** Steven Gwiazdowski, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MCUP3121 – Neonatal Circumcision MPUP3014 – Emergency Services – ***pulled for discussion*** MPUP3026 – Inter-Rater Reliability Policy MPUP3051 – Long Term Care SSI Regulation **Steven Gwiazdowski, MD, pulled MPUP3014** to question how Claims adjudicates for an instance not listed in this policy (e.g., animal bites) as warranting emergent or urgent care. Robert Quon, MD, asked why any list of conditions is included at all, rather than leaving it to the determination of the Emergency Department. John Murphy, MD, concurred, saying that diagnosis comes after evaluation: a person presenting with a sore throat might have a peritonsillar abscess or a person complaining of belly pain, peritonitis. Dr. Moore acknowledged that conditions, if not evaluated, can progress. He added he did not recall how this policy was initially configured and why. He promised to investigate and asked the Q/UAC to pass the policy today as presented, knowing that answers will be forthcoming in the next 12 months. Meanwhile, he said the "standard is what a lay person would consider an emergency." Partnership is "lenient" on this if a member has sought care out of state, although Partnership had denied claims. Jeff Ribordy, MD, commented that members and ED staff alike should know that a sports physical, whether in- or out-of-state, does not rise to the occasion of emergency care. Randy Thomas, MD, pointed out that Section III.A.1 still uses gender noun and pronoun. **It is now amended to read** "Placing the health of the member (or, in the case of a pregnant *person,* the health of the member and/or *the* unborn child) in serious jeopardy…"	Second: Randy Thomas, MD *Approved unanimously* Motion to **approve MPUP3014 as amended:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: May 14 PAC *Meeting Postscript:* Subject Matter Experts (SMEs) later determined that more D-SNP changes are needed on MPXG5002, and so that policy will be pulled from May 14 PAC consideration.
V. New Business – Discussion Policies – None		
VI. Presentations		
Utilization Management/ Pharmacy Grand Analysis: • MPUD3001 – UM Program Description • Annual (2024) UM Program Evaluation – NCQA UM Standard 1 Element B	Tony "kicked things off" with a summary of the UM Program Description before turning to the Evaluation and Supplemental Treatment Authorization Request (TAR) Report. MPUD3001 is a comprehensive description of our UM program, which includes both our UM and Pharmacy teams. The document is broken down by our program purpose, which provides the reader high level description of the functions of the UM department. We go through our program objectives, which outlines how our UM program operates within the various regulatory frameworks that we are accountable for, including but not limited to both DHCS and NCQA compliance. We outline in our program structure, the roles and responsibilities of both our clinical staff, which includes our medical directors, our nurses and our pharmacists, as well as the roles and responsibilities of our non-clinical staff, which includes our data coordinators, pharmacy technicians, project coordinators, program managers, and our health services analyst. We give a description of our oversight committees, which does include Q/UAC. We then go into our program scope both for UM and for Pharmacy, as well as the benefits and services our teams evaluate. We provide an outline of the mental health services that Partnership provides, including our Specialty	Motion to **approve the MPUD3001 as presented:** Steven Gwiazdowski, MD Second: Randy Thomas, MD *Approved unanimously* **Q/UAC also unanimously accepted the UM Evaluation**: Robert Quon, MD Second: Randy Thomas, MD Next Steps: May 14 PAC Dr. Gwiazdowski asked for

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• Supplemental TAR Report to the 2024 UM Program Evaluation *Tony Hightower, CPhT, Associate Director, UM Regulations* and *Andrea Ocampo, Pharm.D, Clinical Pharmacist, Pharmacy*	Mental Health Services (SMHS) that are currently delegated to Carelon, as well as our interfacing for specialty mental health services through our referrals to the county mental health plans. We provide an outline of our residential substance use disorder (SUD) Wellness & Recovery benefit that we manage. We outline the behavioral health treatments for our members under the age of 21. And then we go into a description of our UM process, the factors we consider when making decisions for UM requests, which includes the pre-authorization of services. We outline our referral management process referring members to specialty services. Then we go into various TAR reviews, concurrent review, our SNFs, sub-acute, and LTAC and recap reviews. We outline UM's role in the discharge planning process and our process for retrospective reviews on services already rendered to our members. We outline our timeliness requirements for both DHCS and NCQA. The PD further outlines our process for Inter-Rater Reliability (IRR) to ensure that our application of criteria is consistent across the entire scope of our team. The PD describes our external communication process, including our determination letters or notices of action, and a description of our translation services available to our members. We currently delegate inpatient services with four of our hospital partners within our service area. This year, we did update how we define medical necessity. A bulk of our work lies in keeping our program structure updated because our teams have been evolving so rapidly over the past couple of years. In the communication section, we made key updates to the non-discrimination statement to align with specific guidance that we received from DHCS. *There were no questions on the PD, and Dr. Moore called for a motion to accept it as presented before Tony and Andrea went on to the Evaluation and Supplemental TAR Report.* Tony noted the 2024 evaluation of the UM program structure looks at our clinical staffing ratios as well as our TAR-to-staff ratios. The program scope, looking at how we maintain our policies in accordance with both DHCS and NCQA requirements, is evaluated and how we conduct our provided medical services is analyzed. We look at timeliness for our TARs according to DHCS and NCQA requirements. We do a deep dive at our application of criteria, both our monthly and quarterly IRR processes as well as providing an annual assessment of the appropriate level of care through our over- and under-utilization activities. We look at the participation of senior level physicians in our interfaces with committees, the PAC, Q/UAC, and, for our Pharmacy team, the Pharmacy & Therapeutics Committee. For our UM clinical staff ratios, we set a threshold at 20% for our nursing-to-medical director ratios. We exceeded our threshold in Quarter 4 because of ramping up staffing as a result of the 10-county expansion. As a result of that staffing ratio deviation, we will be looking at resetting it for calendar year 2025 to better reflect the structure of our teams going forward. UM processed a total of 344,695 TARs in 2024, a 40% increase above calendar year 2023. When we look at our TAR-to-staff ratio for the UM team month over month, we did have deviations from the 20% threshold target across the board because of the increase in staff or increase in TAR volume that we encountered in January 2024. It was a bit of a rocky year for the UM team.	clarity on the number of UM TARs denied. Dr. Moore noted that 1,240 were medical necessity denials, adding that the most common administrative denial occurs when no TAR is required but is submitted anyway. These are automatically denied.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Andrea said that, similar to the UM department, Pharmacy's 2024 TAR volume significantly increased primarily due to the 10-county expansion. We received 10,758 Pharmacy TARS in 2024, a 43% increase above 2023. We continually monitor our TAR-per-pharmacist and TAR-per-technician ratios month-to-month to assess for adequate staffing. Both exceeded our 20% month-to-month threshold January through March. Pharmacy leadership continues to quarterly monitor TAR timeliness and IRR to assess impacts. Tony noted that every year we measure UM participation in our advisory committees. In 2024, quorum was achieved at every single meeting of Q/UAC, P&T, and PAC. That's a big "thank you" to our external partners for participating. Unfortunately though, UM did not meet timeliness goals for the areas of urgent concurrent, urgent pre-service, non-urgent pre-service and post-service requests because of volume and onboarding/training new staff. The good news is that, moving through 2025, the UM team has turned the corner and things are getting back on track. Andrea said Pharmacy achieved an overall timeliness rate of 99% in 2024: when broken down by category, timeliness goals were not met for urgent pre-service requests, which have a 72-hour turnaround time, but they were met for non-urgent pre-service and post-service requests. Some workflow changes have been implemented just to mitigate risks for our timeliness for our urgent requests, including identifying and flagging gene therapy requests at data entry as these tend to require external reviews. Pharmacy also hired some permanent technician staff in Quarter 4 2023/Quarter 1 2024 to address the staffing gaps created by the TAR volume increase. Pharmacy experienced a 90% concurrence rate for all IRR reviewer types. This confirms that our reviewers are consistently and accurately applying evidence-based clinical review criteria. Tony said level of care summarizes our over- and under-utilization activities conducted across the organization to evaluate the services that are requested from the plan. Our evaluation of over/under is performed by various groups – which includes but is not limited to our QI department via the analysis of our HEDIS® data, the conduction and maintenance of the IQI and Q/UAC, through the site review process and then through QI's annual access and availability grand analysis process – as well as the day-to-day UM process weighing potential over under utilizations when we are conducting our UM reviews. The UM department utilizes Change Healthcare's product InterQual® for our external criteria for evaluating UM requests. InterQual is reviewed, discussed, and evaluated annually: that review is coming up in a couple of months with a real time demonstration of how we work through that. UM also leverages medical guidelines, Medicare criteria, various state policy letters and national treatment guidelines in making these decisions. Andrea noted Pharmacy criteria and pharmaceutical drug classes are reviewed in collaboration with external and internal stakeholders on an annual basis, as required by NCQA, and Partnership's P&T and PAC committees. The criteria are selected, reviewed, updated or modified based on feedback from Partnership staff and committees, external providers, state policy letters, national treatment guidelines, such as NCCN (National Comprehensive Cancer Network), among other sources.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Tony said UM internally analyzes data and also looks at external data sources to ensure that the program is operating according to how described in the program description. UM measures both our practitioner experience as well as our member experience. (Partnership on an annual basis surveys both our network providers as well as our members with various questions on how services are being rendered by the program. This includes questions specific to the UM team.) Every year, we work with Provider Relations and Grievance & Appeals in gathering that data, analyzing it and looking for any potential corrective actions or process improvement opportunities that we may identify. Tony said he was "extremely happy" in evaluating the survey results from our network PCPs as well as our specialists. (In years, past, we have had areas that have fallen below the 90% threshold that we have set for ourselves.) This year, for all UM-related questions within that survey we did exceed that 90% threshold. "It is also extremely encouraging that the survey did include our new providers within the new 10-county service areas," Tony added. Andrea said that the Member Experience portion is evaluated via the annual Grievance & Appeals PULSE Report. Although there was an overall increase in Partnership's membership and total number of grievance cases related to the UM process in 2024, we did see a decrease in the number of grievances per 1,000 members when compared to 2023 figures. The primary issue reported in 2024 was access related, with the majority being associated with the RAF and TAR processes. For both, many member concerns alleged providers delayed requests. When investigated, the G&A team did not find any discernible trends. Both the Pharmacy and UM departments provided a TAR supplemental report: this includes a breakdown of each department's respective TAR numbers by category and TAR status type. They also provided a summary breakdown of the percentage of TARs that were approved, modified approved, denied, and administratively denied, and a summary of the percentage of appeals received that were upheld or overturned. Tony summarized that both UM and Pharmacy teams faced challenges in calendar year 2024, largely driven by our expansion and the rapid influx or work that we saw as a result of that expansion. In conclusion, the UM program functions effectively, has a solid program structure, maintains a comprehensive policy library, and receives robust guidance and support from the senior level physicians via both our internal and external committees. As a result, no significant changes will be required for our UM program this year.	
Population Needs Assessment *Hannah O'Leary, MPH, CHES, Manager of Population Health*	This annual report is a compilation of preliminary 2024 findings pulled from various data sources (e.g., local community needs assessments, Partnership claims data, HEDIS® scores, CAHPS® data, etc.) and fulfills NCQA and other regulatory requirements. The 100-page document will be posted on Partnership's external website after the Board of Commissioners considers it this summer. Assessments of our 24 counties identified various social determinants of health, including economic instability, lack of access to quality healthcare, neighborhood and built environment challenges, limited access to quality education, and social/community context challenges (e.g., higher rates of adverse childhood experiences). Data sources further revealed income inequities and food deserts as part of social determinants of health concerns; disparities in health outcomes among marginalized groups; transportation	There were no questions. Next Steps: May 14 PAC Health education sessions around tobacco prevention will roll out in 2025. One has already occurred. Dr. Moore noted that the PNA

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	concerns; 118 wildfires among the environmental concerns; chronic hypertension, depression, and tobacco use in adults, and chronic anxiety, trauma/stress, and depression in our child members. Health disparities across differing rachial/ethnic groups were found in specific measures: controlling high blood pressure; child and adolescent well care visits; Hemoglobin A1c control for diabetes; and pre- and post-natal care visits. Partnership took dozens of actions on these issues in 2024, including the following: • Addressed organizational structure, social and environmental needs, health disparities, and health education/culture and linguistic needs • Hired new regional medical directors for the new Auburn region and the Santa Rosa office too • Created community health needs liaisons team via the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) modalities • Offered grant funding to address housing concerns • Awarded more than $52M in grants to more than 100 Cal-AIM (California Advancing and Innovating Medi-Cal) providers to build capacity in such programs as Enhanced Care Management and Community Supports services • Increased workforce opportunities, including member scholarships to support careers in healthcare, social work and other related fields • Rolled out the new Asthma Emergency Department Visit Outreach Program Campaign • Helped schools expand the use of behavioral health workers • Continued Alinea Medical Imaging contract for mobile mammography services • Conducted a six-month Cervical Cancer Screening Self-Swab pilot • Continued provider recruitment and retention programs • Continued to strengthen collaborative relationships with local Tribal Health providers • Created member-facing videos on several topics to help educate members on mental health, vaccines, and other health issues • Conducted Member/Community informative sessions in both English and Spanish	is an integration of what is happening everywhere with our members and concrete action in the Population Health Management department (such as the incentives offered to pregnant members to go to their prenatal visits) and therefore meets a regulatory need. “Hidden in there are gems of amazing projects that are really well run and have a major impact,” Dr. Moore said of the “well-written” 100+ page report, adding that the Executive Team has reviewed many projects/programs in detail. Time permitting, some of these programs may be presented to Q/UAC this fall.
VII. FYI Attachments and Adjournment		
Pharmacy Operations Update – *refer questions to Stan Leung, Pharm.D*		
Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*		
Q/UAC adjourned at 8:58 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, May 21		

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, April 8, 2025 / 1:30 – 2:51 PM

Members Present: Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services Campbell, Anna, Policy Analyst, Utilization Management Esget, Heather, RN, BSN, ACM, Director of Utilization Management 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, Associate Medical Director Leung, Stan, Pharm.D, Director of Pharmacy Services Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections Randhawa, Manleen, Senior Health Educator, Population Health Ruffin, DeLorean, DrPH, MPH, Director of Population Health Steffen, Nancy, Senior Director of Quality and Performance Improvement Townsend, Colleen, MD, Regional Medical Director (Southeast) Villasenor, Edna, Senior Director, Member Services and G&A
Members Absent: Andrews, Leigha, MBA, Regional Director (Southwest) Ayala, Priscila, Director, Network Services Bjork, Sonja, JD, Chief Executive Officer Brunkal, Monika, RPh, Assoc. Dir., Population Health Davis, Wendi, Chief Operating Officer	Garcia-Hernandez, Margarita, PhD, Director of Health Analytics Kerlin, Mary, Senior Director, Provider Relations Klakken, Vicki, Regional Director (Northwest) Matthews, Richard "Doug," MD, Regional Medical Director (Chico) Sharp, Tim, Regional Director (Northeast) Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Guests: Armstead, Jay, Program Manager II, QI Arrazola, Kelcie, Lead Trainer, Provider Relations Beltran-Nampraseut, Athena, CPhT, Program Manager, QI Bikila, Dejene, Manager of Data Science, Finance Booth, Garnet, Senior Program Manager, Provider Relations Broadhead, Candi, Project Manager II, QI Brito, Alex, Senior Health Data Analyst, Finance Clark, Kristen, Manager of Quality & Training, Member Services Cunningham, Aryana, Policy Analyst, Care Coordination Devan, James, Manager of Performance Improvement, QI (Northeast) DeVido, Jeff, MD, Behavioral Health Clinical Director Durst, Jennifer, Senior Manager of Performance Improvement, QI Erickson, Leslie, Program Coordinator II, QI (scribe) Foster, Troy, Program Manager II, QI (QIPs) Grupe, Michele, Mgr of First Five Commissions, Behavioral Health Gual, Kristine, Director of Quality Measurement, QI Harris, Matthew, Education Specialist, Provider Relations Harris, Vander, Senior Health Data Analyst I, Finance Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn) Jamali, Shahrzad, Improvement Advisor, QI (Chico)	McCune, Amy, Manager of Quality Incentive Programs, QI Moore, Jordan, Provider Education Specialist, Provider Relations Nguyen, Tom, Manager of Health Analytics, Finance Ocampo, Andrea, Pharm.D. Clinical Pharmacist, Pharmacy O'Leary, Hannah, MPH, Manager of Population Health, Pop Health Ooten, Lisa, Pharm.D, Clinical Pharmacist, Pharmacy Payumo, Desiree, RN, Supervisor of Inpatient Nurses, UM Rathnayake, Russ, Senior Health Data Analyst I, Finance Rhorer, Jeanelle, Supervisor of Configuration, Configuration Robertello, Kimberly, Senior Medicare QI Program Manager, QI Roberts, Dorian, Sr. Mgr of PR Representatives, Provider Relations Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast) Sackett, Anthony, Project Manager II, QI (CAHPS®) Shrivastava, Poorva, Sr Health Data Analyst, Health Analytics, Finance Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance Smith, Christine, Community Health Needs Liaison, Population Health Stark, Rebecca, Regional Director (Chico) Stokes, Sarah, Project Coordinator II, QI (HEDIS®) Trosky, Renee, Manager of Provider Relations Compliance Ungaro, Chloe, Senior Program Manager, Provider Relations Vaisenberg, Liat, Associate Director of Health Analytic, Finance

Jensen, Annika, RN, Assoc. Dir., Clinical Integration, Care Coordination	Vance, Brooke, Program Manager I, Network Services
Lee, Donna, Manager of Claims, Claims	Vij, Namita, Program Manager II, Enhanced Health Services
Lee, Heidi, Senior Manager, Network Services	Ward, Lisa, MD, Regional Medical Director (Southwest)
Lopez, Rosalee, Manager of UM Operations, UM	Wellander, Emily, Improvement Advisor, QI
LoPilato, Courtney, Project Coordinator I, Administration	Williams, Joanie, RN, Supervisor of Inpatient Nurses, UM

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 the meeting to order at 1:33 p.m. Approval of the March 11, 2025 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Feb. 27 Member Grievance Review Committee (MGRC)	Motion to approve IQI Minutes: Brigid Gast, RN Second: Isaac Brown Motion to accept other minutes: Marshall Kubota, MD Second: Stan Leung, Pharm.D
II. Old Business –		
Early Policy Reviews to Accommodate D-SNP Implementation Schedule *Robert Moore, MD Chief Medical Officer*	In preparing for our Dual-Eligible Special Needs Plan Medicare product line "Partnership Advantage" going live Jan. 1, 2026, we have policies that need to be minorly adapted to apply and some new PA-only policies that need to go through IQI/Q/UAC/PAC before the September/October timeframe. We are moving many policies that we normally see in September, October, November to May, June, August. We were not planning on having a July meeting, but we may need one for the new policies. This month is light because we are having trouble finishing some policy updates. The next three months will be busy, but then it could be light on policies towards the end of the year. Please review the updated policy timeframe list included as FYI at the end of today's meeting packet. Direct questions and issues to Leslie Erickson, together with a note that your policies have been reviewed for D-SNP applicability. Medical Director for Medicare Services Kermit Jones, JD, MD, encouraged anyone with such questions should reach out to him, Anna Campbell, and/or Kimberly Robertello. Realize, however, that they are not subject matter experts for all specific departments. Dr. Moore reiterated that although the underlying rules differ, our front line work needs to be integrated. Some Medi-Cal benefits may not be covered by Medicare but we still might offer them to D-SNP enrollees, so some policies may present editing difficulties. UM's MPUG3002 – Acupuncture Services Guidelines passed April 9 at PAC may serve as a model how to "thread the needle." See https://public.powerdms.com/PHC/documents/1850078	*Meeting Postscript:* IQI will meet July 8 to consider 8-10 or more new policies that will require much internal discussion. Q/UAC will entertain these policies on Aug. 20.
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies 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		Motion to **approve as presented but for the three pulled policies:** Mark Netherda, MD Second: Marshall Kubota, MD Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MCUP3121 – Neonatal Circumcision MPUP3014 – Emergency Services MPUP3026 – Inter-Rater Reliability Policy MPUP3051 – Long Term Care SSI Regulation ***Non-Health Services Policies*** <u>Credentialing</u> 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 – ***pulled for discussion*** MPCR13C – Osteopathic Manipulation Treatment Credentialing MPCR19 – Skilled Nursing Facility Providers (SNFists) Credentialing Policy MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements – ***pulled for discussion*** MPCR600 – Range of Actions to Improve Practitioner Performance MPCR601 – Fair Hearing and Appeals Process for Adverse Decisions – ***pulled for discussion*** MPCR800 – Delegation of Credentialing and Re-credentialing Activities <u>Provider Relations</u> MPPR203 – Provider Enrollment Status Guidelines MPPR209 – Provide Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions **Anna Campbell pulled three policies to ask questions.** First, should Credentialing polices be marked for Partnership Advantage? Manager of Provider Relations Compliance Renee Trosky agreed they could be. Doctors Moore, Mark Netherda, Marshall Kubota, and Jeff DeVido discussed whether **MPCR13B** is even still necessary and agreed that it is. They rewrote the Purpose Statement and the Policy/Procedure sections, and IQI agreed to these amendments. The policy now reads **V. Purpose**: This policy sets the standards for primary care physicians (PCPs) and non-physician clinicians who may be designated as "~~Suboxone~~ *Buprenorphine* prescribers" and thus eligible to treat patients for substance use disorder without a referral who are assigned to other primary care clinicians. This policy also sets standards for specialist physicians and non-physician specialist clinicians who want to treat patients for substance use disorder without a referral. **VI.B Policy Procedure is dropped altogether and VI.A. is amended**: For purposes of billing and directory listing and to treat patients without requiring a referral, in order to be recognized as a Buprenorphine Prescriber, the physician or non-physician clinician must hold a valid DEA (Drug Enforcement Agency) certificate. Anna suggested **Attachment B of MPCR304** needed editing: references to "Provider Relations" need to be changed to "Network Services" as that business unit handles Credentialing policies. This document is attached to five different policies. Rather than bring all the policies back, Dr. Moore agreed that Attachment B can be brought back on its own to IQI May 13. Anna also noted that this policy defines "allied health practitioners" one way but **MPCR601** lists a different set of credentials. **Dr. Moore noted that MPCR601 is incorrect** and must be changed: Physician Assistants and Nurse Practitioners are not "allied health practitioners." **MPCR304 is further edited** to drop reference to All Plan Letter (APL) 23-034 from Section VI.B.4.i. The References section also needs updating. Anna will send changes to Heidi Lee and Leslie Erickson.	Health Services policies will go to the April 16 Quality/Utilization Advisory Committee (Q/UAC) and the May 14 Physician Advisory Committee (PAC) **MPCR13B is approved as amended**: Mark Netherda, MD Second: Jeff DeVido, MD **MPCR304 is approved as amended**: Anna Campbell Second: Kermit Jones, MD, JD Attachment B should come back in May. **MPCR601 is approved as amended**: Marshall Kubota, MD Second: Anna Campbell *Meeting Postscript:* All Credentialing policies – save MPCR17 on today's discussion calendar – passed the Credentials Committee April 9.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	More discussion ensued on MPCR601's listing of "practitioners." Policy **Definitions Section III.C is thus amended**: Licensed Independent Practitioners (LIP) (includes MD, DO, DPM, DC, DDS, LAc), clinical PA and NP, CRNA, CNM, Mental Health Practitioners (MHP) (includes MFCC, LCSW, LMFT, PhD) and Allied Health Providers (AHP) (PT, OT, Speech and Language Therapists and Optometrists, Audiologists, and Registered Dieticians) that are credentialed by Partnership to perform services specified in their contract. Dr. Netherda mentioned QI policy MPQG1011 passed at PAC Jan. 8 defines "Non-Physician Medical Practitioners" (NPMP), and Dr. Moore said we should agree on either "NPMP" or "non-physician clinician" going forward. He would prefer the latter, should it jibe with National Committee on Quality Assurance (NCQA) nomenclature. Anna has modeled some UM policies after MPQG1011 definitions, so these too might need to be changed in the next review cycle. Program Manager (Network Services) Brooke Vance noted that NCQA refers to NPs as NPs and in no other terms.	
IV. New Business – Discussion Policies		
Policy Owner: Credentialing (Network Services) – *Presenter: Heidi Lee, Senior Manager, Network Services*		
MPCR17 – Standards for Contracted Primary Care *and Urgent Care* Physicians – **NEW TITLE**	**This policy is being reviewed today to encompass Urgent Care physicians, and so "Urgent Care" is being added to the policy title. An OpEx/PMO committee has been created and authorized to review this policy and Utilization Management's MCUP3044 – Urgent Care Services from a contracting perspective and to resolve inconsistencies between the two policies. These policies should come back to IQI later this year.** **II. Impacted Depts:** Provider Relations is added. **III. Definition added:** Urgent Care – according to the American Academy of Urgent Care Medicine, Urgent Care is "the provision of immediate medical service offering outpatient care for the treatment of acute and chronic illness and injury". (Definition of Urgent Care Medicine [Internet]. Available from: http://aaucm.org/about/urgentcare/default.aspx). While urgent care providers may also be the first to diagnosis chronic diseases such as diabetes or asthma, they refer patients to a primary care provider for the management of these conditions. Primary Care Providers may provide urgent care for their assigned continuity patients, as part of primary care. A clinician, who provides *only* urgent care services, without being assigned primary care patients, must meet the credentialing standards for Urgent Care providers. **V. Purpose Statement is updated.** Some physicians apply to be credentialed as a primary care physicians who have not completed a residency in a primary care specialty. This policy sets standards to ensure adequate quality of care for all members assigned to credentialed PCPs. To describe the credentialing and re-credentialing requirements for the following types of practitioners contracted with Partnership HealthPlan of California. (Partnership) Primary Care (PCP) Urgent Care (UC) **VI. Policy Procedure Section C is added.** Urgent Care Providers To be credentialed for contracted Urgent Care Services, or for performing only Urgent Care Services within a Primary Care setting, General Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine or Emergency	Motion to **approve as presented**: Marshall Kubota, MD Second: Mark Netherda, MD Next Steps: April 9 Credentials Committee *Meeting Postscript:* MPCR17 did not pass the Credentials Committee April 9 and should come back to committees in May.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Medicine or practicing under privileges granted when credentialed as a PCP under MPCR17. 2) An NP or PA practicing within their scope of practice. Pediatric Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine, Pediatrics, or Emergency Medicine or practicing under privileges granted when credentialed as a PCP under MPCR17. 2) An NP or PA practicing within their scope of practice. Adult Urgent Care 1) As a physician, at least two years of residency must have been completed in Family Medicine, Internal Medicine, or Emergency Medicine or practicing under privileges granted when credentialed under MPCR17. 2) An NP or PA practicing within their scope of practice. **IX. Position Responsible for Implementing Procedure is updated** to the Director, Network Services. Heidi emphasized and Dr. Moore reiterated that this policy has to do with credentialing and not contracting. There were no questions; however, this policy could come back to IQI later this year.	
V. Presentations		
1. QI Update *Nancy Steffen, Senior Director, Quality Improvement and Performance*	• The Women's Health and Perinatal workgroup under Regional Medical Director Colleen Townsend, MD, and Provider Relations hosted a webinar April 1 to inform providers about cervical cancer self-swab options through their laboratory vendors. NCQA now has a new code for this screening, which we will now apply to our Healthcare Effectiveness Data Information Set (HEDIS®) measure. • Our Chronic Disease workgroup, together with Provider Relations, has sponsored a Colorectal Cancer educational flyer throughout our provider network. "Chronic disease" is part of our accreditation set. Partnership is facilitating a multi-patient Cologuard order on behalf of providers, removing the 200-patient minimum requirements. Kits started shipping March 24. • Partnership's Behavioral Health leadership is working closely with our counties on innovative ways to affect positive changes for mental health service data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are now in the field for both our adult and our child populations. Response rates are thus far favorable. Telephone interviewing begins April 11.	*For information only. No action is required.* There were no questions.
2. Proposed 2025-2026 Quality Incentive Program Measure Summaries – HQIP and PQIP *Troy Foster, Program Manager II, QI*	Troy noted that current Hospital QIP measures will continue for MY 2025-2026, although changes will be made to palliative care capacity, expanding delivery privileges, and health equity. "Doula Support" and "Vaccines for Children Enrollment" are added to the Clinical Domain. 3. The Palliative Care Quality Collaborative (PCQC) dissolved in March. Hospitals will use data from their inpatient EMRs to report to Partnership. Measure requirements for "x-large hospitals" (100 or more beds) are changing. 4. The multi-phase Expanding Delivery Privileges is moving into its second year. "Phase 1" language will be replaced with "Phase 2" language. Hospitals are now required to actively recruit, grant privileges, and demonstrate evidence of family physicians' and nurse midwives' clinical activity. (Doctors Moore and Kubota noted that those who do not complete Phase 1 by July 1, 2025 cannot participate in Phase 2. Dr. Moore advised Troy to make this clear in the specifications.) 5. The health equity measure is switching from an annual report to submission of a Center for Medicare and Medicaid (CMS) Health Equity Attestation.	There were no questions for Troy. <u>Next Steps</u>: • PAC is scheduled to vote on these measure proposals April 9. • Q/UAC will see these proposals on its April 16 consent calendar.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	6. It is suggested to add a multiple-phased Doula Support measure similar to that of Expanding Delivery Privileges to encourage hospitals to allow doulas to support birthing parents during delivery. 7. It is suggested to add a measure incentivizing hospitals to enroll in the cost saving Vaccines for Children program offered by the California Department of public Health (CDPH). Troy noted that Clinical Domain measures of the Perinatal QIP are not changing. The Electronic Clinical Data Systems (ECDS) measure, however, is becoming a "gateway" measure. If a perinatal provider did not complete a contract and implementation with DataLink during the 2024-2025 measurement period, they must complete all implementation phases and participation requirement steps by June 30, 2026 to be eligible for incentive payments in the 2025-2026 measurement year. • "Timely Comprehensive Assessments" is proposed as a new monitoring measure. During the~~y~~ 2025-2026 MY, Partnership will be monitoring claims data looking for members receiving full psychosocial, nutrition, and behavioral health assessments each trimester of pregnancy and once postpartum (up to one year post-delivery).	
3. UM Pharmacy Grand Analysis • MPUD3001 – UM Program Description • 2024 UM Program Evaluation • Supplemental TAR Report *Tony Hightower, CPhT, Assoc. Dir., UM Regulations,* and *Andrea Ocampo, Pharm.D, Clinical Pharmacist*	Tony "kicked things off" with a summary of the UM Program Description before turning to the Evaluation and Supplemental Treatment Authorization Request (TAR) Report. MPUD3001 is a comprehensive description of our UM program, which includes both our UM and Pharmacy teams. The document is broken down by our program purpose, which provides the reader high level description of the functions of the UM department. We go through our program objectives, which outlines how our UM program operates within the various regulatory frameworks that we are accountable for, including but not limited to both DHCS and NCQA compliance. We outline in our program structure, the roles and responsibilities of both our clinical staff, which includes our medical directors, our nurses and our pharmacists, as well as the roles and responsibilities of our non-clinical staff, which includes our data coordinators, pharmacy technicians, project coordinators, program managers, and our health services analyst. We give a description of our oversight committees, which does include Q/UAC. We then go into our program scope both for UM and for Pharmacy, as well as the benefits and services our teams evaluate. We provide an outline of the mental health services that Partnership provides, including our Specialty Mental Health Services (SMHS) that are currently delegated to Carelon, as well as our interfacing for specialty mental health services through our referrals to the county mental health plans. We provide an outline of our residential substance use disorder (SUD) Wellness & Recovery benefit that we manage. We outline the behavioral health treatments for our members under the age of 21. And then we go into a description of our UM process, the factors we consider when making decisions for UM requests, which includes the pre-authorization of services. We outline our referral management process referring members to specialty services. Then we go into various TAR reviews, concurrent review, our SNFs, sub-acute, and LTAC and recap reviews. We outline UM's role in the discharge planning process and our process for retrospective reviews on services already rendered to our members. We outline our timeliness requirements for both DHCS and NCQA. The PD further outlines our process for Inter-Rater Reliability (IRR) to ensure that our application of criteria is consistent across the entire scope of our team. The PD describes our external communication process, including our determination letters or notices of action, and a description of our translation services available to our members. We currently delegate inpatient services with four of our hospital partners within our service area.	Motion to **approve MPUD3001 as presented together with accepting the Evaluation and TAR Supplemental Report**: Stan Leung, Pharm.D Second: Kermit Jones, MD, JD Next Steps: April 25 Q/UAC May 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	This year, we did update how we define medical necessity. A bulk of our work lies in keeping our program structure updated because our teams have been evolving so rapidly over the past couple of years. In the communication section, we made key updates to the non-discrimination statement to align with specific guidance that we received from DHCS. Tony noted the 2024 Evaluation of the UM program structure looks at our clinical staffing ratios as well as our TAR-to-staff ratios. The program scope, looking at how we maintain our policies in accordance with both DHCS and NCQA requirements, is evaluated and how we conduct our provided medical services is analyzed. We look at timeliness for our TARs according to DHCS and NCQA requirements. We do a deep dive at our application of criteria, both our monthly and quarterly IRR processes as well as providing an annual assessment of the appropriate level of care through our over- and under-utilization activities. We look at the participation of senior level physicians in our interfaces with committees, the PAC, Q/UAC, and, for our Pharmacy team, the Pharmacy & Therapeutics Committee. For our UM clinical staff ratios, we set a threshold at 20% for our nursing-to-medical director ratios. We exceeded our threshold in Quarter 4 because of ramping up staffing as a result of the 10-county expansion. As a result of that staffing ratio deviation, we will be looking at resetting it for calendar year 2025 to better reflect the structure of our teams going forward. UM processed a total of 344,695 TARs in 2024, a 40% increase above calendar year 2023. When we look at our TAR-to-staff ratio for the UM team month over month, we did have deviations from the 20% threshold target across the board because of the increase in staff or increase in TAR volume that we encountered in January 2024. It was a bit of a rocky year for the UM team. Andrea said that, similar to the UM department, Pharmacy's 2024 TAR volume significantly increased primarily due to the 10-county expansion. We received 10,758 Pharmacy TARS in 2024, a 43% increase above 2023. We continually monitor our TAR-per-pharmacist and TAR-per-technician ratios month-to- month to assess for adequate staffing. Both exceeded our 20% month-to-month threshold January through March. Pharmacy leadership continues to quarterly monitor TAR timeliness and IRR to assess impacts. Tony noted that every year we measure UM participation in our advisory committees. In 2024, quorum was achieved at every single meeting of Q/UAC, P&T, and PAC. That's a big "thank you" to our external partners for participating. Unfortunately though, UM did not meet timeliness goals for the areas of urgent concurrent, urgent pre-service, non-urgent pre-service and post-service requests because of volume and onboarding/training new staff. The good news is that, moving through 2025, the UM team has turned the corner and things are getting back on track. Andrea said Pharmacy achieved an overall timeliness rate of 99% in 2024: when broken down by category, timeliness goals were not met for urgent pre-service requests, which have a 72-hour turnaround time, but they were met for non-urgent pre-service and post-service requests. Some workflow changes have been implemented just to mitigate risks for our timeliness for our urgent requests, including identifying and flagging gene therapy requests at data entry as these tend to require external reviews. Pharmacy also hired some permanent technician staff in Quarter 4 2023/Quarter 1 2024 to address the staffing gaps created by the TAR volume increase. Pharmacy	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	experienced a 90% concurrence rate for all IRR reviewer types. This confirms that our reviewers are consistently and accurately applying evidence-based clinical review criteria. Tony said level of care summarizes our over- and under-utilization activities conducted across the organization to evaluate the services that are requested from the plan. Our evaluation of over/under is performed by various groups – which includes but is not limited to our QI department via the analysis of our HEDIS® data, the conduction and maintenance of the IQI and Q/UAC, through the site review process and then through QI's annual access and availability grand analysis process – as well as the day-to-day UM process weighing potential over under utilizations when we are conducting our UM reviews. The UM department utilizes Change Healthcare's product InterQual® for our external criteria for evaluating UM requests. InterQual is reviewed, discussed, and evaluated annually: that review is coming up in a couple of months with a real time demonstration of how we work through that. UM also leverages medical guidelines, Medicare criteria, various state policy letters and national treatment guidelines in making these decisions. Andrea noted Pharmacy criteria and pharmaceutical drug classes are reviewed in collaboration with external and internal stakeholders on an annual basis, as required by NCQA, and Partnership's P&T and PAC committees. The criteria are selected, reviewed, updated or modified based on feedback from Partnership staff and committees, external providers, state policy letters, national treatment guidelines, such as NCCN (National Comprehensive Cancer Network), among other sources. Tony said UM internally analyzes data and also looks at external data sources to ensure that the program is operating according to how described in the program description. UM measures both our practitioner experience as well as our member experience. (Partnership on an annual basis surveys both our network providers as well as our members with various questions on how services are being rendered by the program. This includes questions specific to the UM team.) Every year, we work with Provider Relations and Grievance & Appeals in gathering that data, analyzing it and looking for any potential corrective actions or process improvement opportunities that we may identify. Tony said he was "extremely happy" in evaluating the survey results from our network PCPs as well as our specialists. (In years, past, we have had areas that have fallen below the 90% threshold that we have set for ourselves.) This year, for all UM-related questions within that survey we did exceed that 90% threshold. "It is also extremely encouraging that the survey did include our new providers within the new 10-county service areas," Tony added. Andrea said that the Member Experience portion is evaluated via the annual Grievance & Appeals PULSE Report. Although there was an overall increase in Partnership's membership and total number of grievance cases related to the UM process in 2024, we did see a decrease in the number of grievances per 1,000 members when compared to 2023 figures. The primary issue reported in 2024 was access related, with the majority being associated with the RAF and TAR processes. For both, ~~,~~a~~nn~~y member concerns alleged providers delayed requests. When investigated, the G&A team did not find any discernible trends. Both the Pharmacy and UM departments provided a TAR supplemental report: this includes a breakdown of each department's respective TAR numbers by category and TAR status type. They also provided a summary breakdown of the percentage of TARs that were approved, modified approved, denied, and administratively denied, and a summary of the percentage of appeals received that were upheld or overturned.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Tony summarized that both UM and Pharmacy teams faced challenges in calendar year 2024, largely driven by our expansion and the rapid influx or work that we saw as a result of that expansion. In conclusion, the UM program functions effectively, has a solid program structure, maintains a comprehensive policy library, and receives robust guidance and support from the senior level physicians via both our internal and external committees. As a result, no significant changes will be required for our UM program this year.	
4. Population Needs Assessment *Hannah O'Leary, MPH, CHES, Manager of Population Health*	This annual report is a compilation of preliminary 2024 findings pulled from various data sources (e.g., local community needs assessments, Partnership claims data, HEDIS® scores, CAHPS® data, etc.) and fulfills NCQA and other regulatory requirements. The 100-page document will be posted on Partnership's external website after the Board of Commissioners considers it this summer. Local external community needs assessments of our 24 counties identified various social determinants of health, including economic instability (e.g., food insecurity, disparities n access to social services), lack of access to quality healthcare (e.g., provider shortage), neighborhood and built environment challenges (e.g., 118 wildfires and lack of affordable housing, lack of transportation), limited access to quality education, and social/community context challenges (e.g., higher rates of adverse childhood experiences). Data sources further revealed income inequities and food deserts as part of social determinants of health concerns; disparities in health outcomes among marginalized groups; transportation concerns; chronic hypertension, depression, and tobacco use in adults, and chronic anxiety, trauma/stress, and depression in our child members. Health disparities across differing rachial/ethnic groups were found in specific measures: controlling high blood pressure; child and adolescent well care visits; Hemoglobin A1c control for diabetes; and pre- and post-natal care visits. In 2024, our Southern Region had the highest rates of accessing Specialty Mental Health Services, indicating members with serious persistent mental illness are accessing services at a higher rate than in other reporting regions. Both breast cancer and cervical cancer screening rates continue to underperform in the northern counties. Partnership took dozens of actions on these issues in 2024, including the following: • Addressed organizational structure, social and environmental needs, health disparities, and health education/culture and linguistic needs • Hired new regional medical directors for the new Auburn region and the Santa Rosa office too • Created community health needs liaisons team via the Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) modalities • Offered grant funding to address housing concerns • Awarded more than $52M in grants to more than 100 Cal-AIM (California Advancing and Innovating Medi-Cal) providers to build capacity in such programs as Enhanced Care Management and Community Supports services • Increased workforce opportunities, including member scholarships to support careers in healthcare, social work and other related fields • Rolled out the new Asthma Emergency Department Visit Outreach Program Campaign • Helped schools expand the use of behavioral health workers • Continued Alinea Medical Imaging contract for mobile mammography services • Conducted a six-month Cervical Cancer Screening Self-Swab pilot, and are encouraging providers to adopt this method in 2025	There were no questions. Health education sessions around tobacco prevention will roll out this year. Motion to **accept the PNA as presented**: Mark Netherda, MD Second: Marshall Kubota, MD Next Steps: April 16 Q/UAC May 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Continued/continuing to support services for maternal and child health, including our Growing Together program • Continued provider recruitment and retention programs to preserve institutional knowledge and clinical leadership • Continued to strengthen collaborative relationships with local Tribal Health providers • Dedicated a community resource page for all 24 counties • Created member-facing videos on several topics to help educate members on mental health, vaccines, and other health issues • Conducted Member/Community informative sessions in both English and Spanish	
FYI Disseminations		
Pharmacy Operations Update – *refer questions to Director of Pharmacy Services Stan Leung, Pharm.D.*		
Updated 2025 Policy Review Calendar – *refer questions to Leslie Erickson*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:12 p.m. IQI will meet next on Tuesday, May 13, 2025.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MPH, MBA* *Chief Medical Officer and Committee Chair*		

QI Department Update
May 2025
Prepared by Nancy Steffen
Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
Primary Care Provider (PCP) QIP	• The QIP team continues processing final scores and payments, which includes validation and Executive review for approval to distribute payments. The QIP team will announce more exact timing for providers to expect their payments, as soon as it is available. • The final stages of analysis for the new 2025 Reducing Healthcare Disparity measure are in progress. PCP QIP Parent Orgs, who indicated they wanted to participate, will be notified by the end of May to confirm which measure and race/ethnicity of focus they will be assigned for Measurement Year (MY) 2025.
Palliative Care QIP	• Payment for July – December 2024 is in progress. • The program in MY2025 will shift from requiring participating providers to submit assessment data into a palliative care data registry and instead, require them to submit results from administered Patient Satisfaction surveys directly to Partnership. This is in response to the recent dissolution of the Palliative Care Quality Collaborative (PCQC)
Perinatal QIP (PQIP)	• Quarter 3 reports will be distributed to PQIP participants in May. • Measures proposed for Fiscal Year 2025-2026 were approved in April committee meetings (i.e. IQI and PAC). Changes to the program include requiring providers to contract with DataLink, Partnership's certified NCQA HEDIS Data Aggregator (DAV), as a Gateway measure. Participating providers will have until July 2026 to contract with DataLink and demonstrate successful data extraction to Partnership's Data Warehouse and HEDIS teams. Detailed measure specifications will be available in May 2025.
Enhanced Care Management (ECM) QIP	• 2025 Quarter 1 payment has been distributed, as planned. • The ECM QIP team is now hosting refresher and new orientation webinars each quarter. Contact the ECMQIP@partnershiphp.org for more details.

Hospital QIP (HQIP)	• Measures proposed for Fiscal Year 2025-2026 were approved in April committee meetings. The proposed changes approved are outlined below with specifications on track to be available this month.
	  ○ Remove the PCQC requirement from the Palliative Care Capacity measure for Extra Large Hospitals.
	  ○ Move the Expanding Delivery Privileges measure to Phase II
	  ○ Add a new Doula Support measure and a new Vaccines for Children Enrollment (VFC) measure.

Quality Data Tools

TOOL	UPDATE
Partnership Quality Dashboard (PQD)	• PQD 2025 is expected to be released after the launch of Health Rules Payor (HRP), later this year. The Final PCP QIP Payment Summary Dashboard for MY2024, however, is on track for release with upcoming distribution of payments.

eReports	• eReports 2025 is live. With the launch of HRP, eReports will be down for a 2-week period, tentatively mid to late summer. • Enhancements to the Preventive Care Dashboard have been made and the dashboard is live in production. The main enhancement includes the addition of the W30 dashboard, which includes members in the 0-to-30-month age range who need periodic well child visits.

Performance Improvement (PI)

ACTIVITY	UPDATE
State Mandated Work: *Performance Improvement Project (PIP) & Plan-To-Do-Study-Act (PDSA) Cycle*	**DHCS-required Behavioral Health Non-Clinical PIP** • Partnership recently completed a pilot with Open Door Community Health Centers. The first phase of this pilot included enhanced tracking to improve timeliness of follow up care for members with mental health and substance abuse disorder after ED discharge. Specifically, this pilot aimed to increase the percentage of primary care provider notifications for the respective members. Through this pilot, Partnership and Open Door have successfully established a follow-up tracking tool to monitor progress on a weekly basis and recently agreed to extend our collaboration for another year. Throughout the pilot, improvements in the follow-up process have been demonstrated, and valuable data collection continues to track ongoing progress. By extending the pilot, we're hoping to further assess the impact of these efforts on performance of HEDIS measures, Follow-up After ED Visit for Mental Health (FUM) and Follow-up After ED Visit for Substance Abuse (FUA), for potential spread.
Quality Measure Score Improvement (QMSI)	Brief status highlights from the domain specific Quality Measure Score Improvement workgroups at Partnership: • **Elder Care:** In April 2025, we launched a new QMSI group in anticipation of D-SNP Performance Improvement needs. The group is becoming oriented to the measures that will be monitored and learning the CMS STARS Quality structure for the D-SNP program. • **Women's Health & Perinatal:** Exploring opportunities for implementation of true at-home hrHPV testing in anticipation of FDA approving this mode of sample collection in 2025. • **Chronic Disease:** Promotion of TeleMed2U's nutrition services as well as other chronic disease treatments including diabetes, kidney disease, cardiovascular disease, and weight management and bariatric. Population Health is also conducting an asthma member letter campaign for members seen in the ED with a diagnosis of asthma. Letter includes education on asthma self-management through medications and avoiding triggers. • **Pediatric:** Partnership staff are collaborating across all service regions to request that FQHC, Tribal Health Centers, and RHC organizations with dental services change how they bill fluoride varnish services to Denti-Cal. The PI team, joined by our Dental Liaison and Regional leaders, are supporting providers in adopting this custom code mapping. This change is necessary in order for DHCS to capture and pass more complete data to reflect fluoride varnish services being delivered to our members in the dental setting.

	This data is reflected in annual reporting under DHCS' Managed Care Accountability Set (MCAS) via the Topical Fluoride for Children (TFL-CH) measure. • **Behavioral Health:** Collaborating across several departments, including Behavioral Health, Care Coordination, Population Health, Pharmacy, Health Equity, and Quality Improvement, to monitor and evaluate ongoing interventions currently in place. These include the DHCS-mandated IHI Behavioral Health Collaborative Project, the County Departments of Behavioral Health use of Sac Valley Med Share Data Exchange for FUM data, and the deployment of Community Health Workers (CHWs) in hospital emergency departments. These efforts are focused on improving performance on the FUM and FUA measures.
Improvement Academy	• The 2025 Improving Measure Outcomes (IMO) six-part webinar series covering Partnership's Primary Care Provider Quality Incentive Program (PCP QIP) measures concluded in April. Content focused on direct application of best practices including eliminating health disparities with examples from clinical quality improvement team who are doing the work. • The most recent webinars, sessions 5 and 6, focused on Breast and Cervical Cancer Screenings and Diabetes Care. They were held on: 04/09/2025 (72 attendees, representing 37 unique organizations) and 04/23/2025 (number of attendees and represented organizations - still pending) • Micro learnings are a new developmental focus. Micro learnings are short training videos, approximately five minutes long and focus on improving outcomes around priority measures for the provider network. The first microlearning, ePrompts, was successfully completed and recently announced to the network.
Joint Leadership Initiative (JLI)	• All meetings for 2025 have been scheduled. • New Provider Organizations added in 2025 are WellSpace Health, Western Sierra Medical Center, and Oroville Hospital. All three of these organizations are located in the expansion counties.
Regional Improvement Meetings	• The first Regional Quality Improvement meetings for the Chico and Auburn regions are being planned for summer.

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

CAHPS Survey Program - Medi-Cal Product Line and FY 24/25 Org Goals and FY 25/26 Org Goals	**CAHPS Survey Fielding has Concluded for Measurement Year 2024** • For both the Adult and Child populations, the number of surveys completed online, more than doubled the total number of surveys completed through this protocol in 2024. • Final survey results are expected to be available in mid to late August. **FY 25/26 Organizational Goal 5: Member Experience (MX)** • The Goal Sponsor and Owner have approved the draft charter for the FY 25/26 Member Experience (MX) Organizational Goal (Goal #5) • The Goal Owner is scheduled to present the MX Project Charter to Executive leadership on 05/15/2025. Several teams have collaborated in early planning and goal/charter development, including Communications, Member Services, Population Health, Grievance and Appeals, and Transportation Services.
Exact Sciences: Promoting Colorectal Cancer Screenings	**Colorectal Cancer Landing Page** • A provider facing webpage is being developed on Partnership's website with information regarding colorectal cancer. The page will include links to both internal and external resources including Population Health's newly developed education videos on Cologuard, along with ordering options and related educational materials. The Cologuard overview will outline all available options for providers, including instructions on how to effectively address care gaps.

Equity & Practice Transformation Project	**Program Overview**
	• 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).
	
	PDPP Participation and Deliverable Requirements
	• 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. Accepted provider organizations span Partnership's sub-regions, including five (5) from the 2024 - 10 county expansion, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's Enhance Provider Engagement (EPE) program. DHCS has recalculated the final award amounts, due to budget revisions.
	• Following the budget revisions, the dropout rate for the EPT cohort across the state is 5%. All twenty-seven (27) provider organizations sponsored by Partnership remain enrolled and engaged in the program.
	• EPT practices that did not complete the 2024 deliverables, by the 11/01/2024 due date, have until 11/2025 to submit as a requirement to remain enrolled in the program:
	  ○ 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 practices submitted the following deliverables by the 05/01/2025 due date. ○ Year 2 PhmCAT ○ Data to Enable PHM Milestone 2: Implementation Plan ○ Stratified HEDIS-like measures ○ Key Performance Indicators (KPI) reports ○ All Rejected or Unsubmitted 2024 EPT deliverables • PHLC will be reviewing all submissions and will update practices and MCPs on the status of submitted deliverables; if they were accepted, rejected, did not submit, or have been asked to resubmit during the next submission period. • DHCS has run into an unexpected issue operationalizing further EPT payments. DHCS is working to resolve this issue as quickly as possible, knowing that practices are expecting payment for 2024 deliverables submitted and approved. Payments are anticipated to be available this month, delaying distribution to EPT practices. **Statewide Learning Collaborative** 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. • Following the submissions due 05/01/2025, practices are continuing to attend their practice track meetings with PHLC subject matter experts and engage with their peers on the EPT building blocks, best practices, and curriculum. • The next Redwood Learning Community session will take place on 06/24/2025, and the focus of the training session will be announced this month.
Preventative Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventative Care Bridge Project** The Preventative Care Bridge Project, (formerly 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 was designed as a limited grant program; whereby select provider organizations are granted funds to hire a Locum Tenens Provider for a 4-week period in Track 1. **Track 1 Summary and Funding Model** A total budget of $250,000 was approved for Track 1 with some funding remaining, given progress since kick-off; participants have received up to: ○ $45,000 when hiring a Physician. ○ $31,600 when hiring an Advanced Practicing Clinician.

The Grant was paid in two installments:

- 50% upon signing the agreement.
- 50% upon completion of the four-week assignment and submission of a post-program survey.

Program Implementation and Participation

The initial cohort of providers was selected from those participating in the PCP Modified QIP. Out of six extended invitations, four applications were received and approved. The Locum assignment periods were carried out asynchronously through January of 2025. Weekly Provider check-ins and data collection were conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. Locum Providers alleviated a backlog of Well-Child and Adolescent Visits (WCV) while enabling urgent care coverage and allowing patients to schedule visits with their preferred physician.

Track 1 Provider Specific Status Updates

Hill Country Community Clinic, Community Medical Center, and Pit River Health Services completed their grant requirements.

Round Valley Indian Health received an amendment to their agreement to extend their grant offering through May 2025 and are working towards completing their grant requirements.

Track 2 Planning and Executive Review

Track 2 is currently under Executive review. It is proposed for implementation in Q4 of FY 24/25, continuing into FY 25/26. This offers strategic opportunities to address provider shortages, enhance health care quality, and improve patient outcomes. By allocating targeted funding to support temporary staffing, this aims to;

- Improve well child visits (WCV) and cervical cancer screening (CCS) measures
- Strengthen provider networks
- Increase access to care
- Enhance member experience.

If approved, it would expand the scope of the Pilot as follows.

- Funding would be provided to eligible PCPs to support six (6) locum providers for 12-week assignments to increase provider capacity, reduce appointment backlogs, and improve HEDIS and preventive care measures.
- Total proposed funding: $576K, equating to $32K per month for each participating provider (up to six in total).
- Updates to the agreement are currently in progress, pending executive approval.
- Invitations have been extended to five (5) potential provider organizations identified by Performance Improvement (PI) Managers. Four (4) have submitted applications and are currently under review, contingent upon final budgetary approval.

Mobile Mammography Program

Upcoming Event Days (FY Q4)

Upcoming Event Days 04/01/2025 – 06/30/2025			
Region	**# of Provider Organizations**	**# of Provider Sites**	**# of Event Days**
Auburn	2	2	2
Chico	1	2	2
Eureka	4	4	4
Fairfield	1	2	2
Redding	4	4	4
Santa Rosa	2	2	2
Plan Wide	**14**	**16**	**16**

- Scheduling for Mobile Mammography event days for FY Q1 and Q2 (July – December 2025) is currently in progress.

Partnering for Pediatric Lead Prevention Program

LeadCare II Device Access and Evaluation

Partnership continues to support the Partnering for Pediatric Lead Prevention program (PPLP), which funds point-of-care lead testing devices for practices. Applications are now accepted year-round. Details can be found on the PLPP page on Partnership's website. https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Lead-Poisoning-and-Prevention.aspx

Providers approved in Fall 2023 have been evaluated to determine if they met the 2024 QIP 50th benchmark. In total, 9 providers successfully met all program requirements and have proven successful at implementing lead testing into their internal workflows:

- 7 sites have gained full ownership of the LeadCare ll POC device they received:
  - Crescent City Health Center
  - Del Norte Community Health Center
  - Gualala Health Center
  - Hayfork Community Clinic
  - Northern Valley Indian Health Center
  - Shasta Community Health Center
  - Sonoma Plaza Pediatrics
- 2 sites received reimbursement for device purchased within 3 months prior to their application date:
  - Baechtel Creek Medical Clinic
  - Stallant Health & Wellness

Two (2) providers did not meet the 2024 QIP 50th benchmark and have had their participation extended by 6 months with continued support:

	▪ Gravenstein Community Health Center ▪ Redwoods Rural Health Center
QI TRILOGY PROGRAM	• Updates to the FY 2025/26 QI Program Description were completed on 04/28/25. All Program Description submissions were received on time and have successfully gone through the internal review and approval process. The Program Description is now being reviewed and approved by the NCQA consultant. Once this step is completed, the document will move forward to the committees for final approval and signature, starting in July, with the final approval by the Board scheduled for October. The following QI Trilogy documents are in the process of being updated and will be finalized by July 2025. ○ 2024/25 QI Work Plan (Final Updates) – submissions due: 05/12/2025 ○ 2024/25 QI Evaluation – submissions due: 05/30/2025 ○ 2025/26 QI Work Plan – submissions due: 06/18/2025

D-SNP (PARTNERSHIP ADVANTAGE)

ACTIVITY	UPDATE
Project Plan	• The QI team and leaders are currently updating all D-SNP related project plans for the Medicare Leadership Team. Information shared with inform prioritization for work and collaboration between departments.
Model of Care	• The Model of Care (MOC) has been approved by NCQA for a 3-year period and was scored at 100%.
Model of Care Training (Internal and External)	• To comply with regulatory requirements in 2026, two Model of Care (MOC) training courses are being developed with collaboration from Quality, the Office of the Chief Medical Officer (CMO) and Training & Development (T&D) teams. One training is for external providers and the second is for Partnership personnel. The external MOC training will be required for member-facing employees of any contracted organization to complete annually beginning in 2026. The external MOC training will be hosted on Rival, a recently contracted platform used for Partnership's upcoming Health Equity training. Provider Relations will manage communications and tracking of training completions. • Partnership personnel will complete the internal MOC training as part of onboarding or as assigned in early 2026. T&D plans to host the Partnership employee training as part of its Learning Management System (LMS). • The development of training materials is complete and were recently approved for use.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **03/27/2025 TO 04/23/2025**	• 15 PQI referrals were received with 11 coming from Grievance and Appeals, 3 from Care Coordination, and 1 from a Regional Medical Director • 25 cases were processed and closed, with 82 PQI cases currently open • Three cases are currently awaiting review by the Peer Review Committee. • The upgrade of the Sugar CRM PQI Application (Processing, Documentation and Tracking System) is underway, with an anticipated completion by the end of May 2025.

<table>
<tr><td></td><td>

- Five cases were sent to the Medical Review Institute of America (MRIoA) for subject matter expert (SME) review, and one case was referred to an external SME physician.
- An internal PQI/PPC presentation was shared with the Care Coordination Department on 03/27/2025.

</td></tr>
<tr><td>FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 03/31/2025 TO 04/18/2025</td><td>

- As of 04/24/2025, we have a total of 463 PCP and OB sites with an additional 31 reviews due to multiple check-ins (totaling 494 reviews).

- **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	2	1	0	1
Chico	2	2	1	1
Eureka	0	0	0	0
Fairfield	1	1	0	1
Redding	3	3	2	2
Santa Rosa	4	4	0	1
Out of Area	0	0	0	0

New sites opened this period: None

- The Child Health and Disability Prevention Program (CHDP) transitioned to Managed Care Plans as of 07/01/2024. Partnership has since taken on maintaining and facilitating this training for its providers and their staff. We are rebranding CHDP to Comprehensive Health Interventions for Lifelong Development (CHILD). Providers are required to complete CHILD training every three years to align with the Site Review process.

</td></tr>
</table>

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	The MY2024 HEDIS Annual Project is entering its final month. Some recent milestones and successes include:
	• Supplemental data, such as Health Information Exchange (HIE), lab vendor, and immunization registry data, are important data sources for the HEDIS Annual Project. Partnership's HSAG (supporting the MCAS measure audit) and Advent Advisory (supporting the Health Plan Accreditation, or HPA, audit) auditors approved every supplemental data source submitted for the MY2024 HEDIS Project in March 2025.
	  ○ Several supplemental data sources were submitted for the first time by Partnership, including data received from Datalink, a NCQA Certified Data Aggregator, and from a special Medical Record Review project with significant impact on two MCAS "withhold" measures: Well-Child Visits in the First 30 Months of Life (0-15 Months and 15-30 Months).
	  ○ Other data sources passed supplemental data review by the auditors in MY2024 after failure to pass in MY2023, as a result of intense collaboration and data validation efforts between the HEDIS team and HIE vendors.

	• Each year the HEDIS team completes Medical Record Review for a random sample of member charts for seven (7) hybrid measures. In MY2024, the HEDIS team's scope of work for the Medical Record Review expanded significantly as they increased chart sampling for County-level rate reporting – for an expanded set of 24 counties - in addition to Plan-Wide rate reporting. As of 04/22/2025, the team has retrieved, and the RN team has over-read 10,781 records to support MY2024 rate reporting for these seven hybrid measures at the County and Plan-Wide level. • Preliminary MCAS and HPA measure rates have been submitted to auditors for review in April. Preliminary review occurs in April and May, in parallel with a final data refresh and hybrid Medical Record Review completion by May 1st. Final MCAS and HPA rates will be submitted to auditors in May 2025.
HEDIS® Program Overall	• In April the HEDIS team begins engagement with a vendor-supported software solution for DSNP Stars Dashboard reporting and rate analysis. The initial stage of this project will focus on loading MY2024 HEDIS measure data into the dashboard as a baseline for DSNP improvement activities in MY2025 and onward. • Datalink, an NCQA Certified Data Aggregator software, is a new supplemental data source for Partnership and was piloted by the HEDIS team in MY2024. Use of a Certified Data Aggregator is an important strategic initiative for supporting Electronic Clinical Data Systems (ECDS) measure reporting, since NCQA plans to transition all hybrid HEDIS measures to ECDS measures by MY2029. The MY2024 HEDIS Annual Project leveraged records from 103,000 Partnership members as supplemental data, with a Year 1 focus on seven (7) Depression Screening measures: o DSF-E (2) – Depression Screening and Follow Up for Adolescents and Adults o DRR-E (3) - Depression Remission, Response, Follow Up for Adolescents and Adults o PND-E - Prenatal Depression Screening and Follow Up o PDS-E - Postpartum Depression Screening and Follow Up Year 1 impact analysis of the Datalink supplemental data shows Datalink as the sole source of data for six of the seven Depression Screening measures. Preliminary MY2024 rates also show five of the seven Depression Screening measures exceeding the 50th percentile due to Datalink supplemental data. In addition, Datalink data impacted several MCAS Accountable measures, including Controlling Blood Pressure (CBP) and Glycemic Status Assessment for Patients with Diabetes (GSD). The HEDIS team will expand its use of Datalink in MY2025, with a focus on adding practices participating in programs that prioritize Depression Screening measure reporting (32 Perinatal QIP participating practices and 27 practices awarded Equity Practice Transformation funding from DHCS) and supporting the MY2025 transition of three (3) hybrid measures to ECDS reporting: Childhood Immunization Series (CIS-10-E), Immunizations for Adolescents (IMA-2-E), and Cervical Cancer Screening (CCS-E).

QI DEPARTMENT UPDATE – PREPARED BY NANCY STEFFEN
MAY 2025

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION	
ACTIVITY	**UPDATE**
NCQA Health Plan Accreditation (HPA)	• The HPA Mock Renewal Survey is scheduled for 10/27-30/2025. The purpose of the HPA Mock Renewal Survey is to assess Partnership's readiness, address identified gaps and develop action plans for meeting compliance when preparing for Partnership's HPA Renewal Survey scheduled for 09/22/2026. • Calendar holds have been sent for each of the four (4) days of the HPA Mock Renewal Survey, including the opening and closing sessions. Once the agenda has been finalized, these holds will be removed, and individual invitations will be sent for each session. Business Owners will only need to attend the specific sessions for their assigned standards, along with the opening and closing sessions. • An evidence preparation training session will be held on 06/25/2025; the training will be recorded for those unable to attend. Training materials and reference guides will be provided prior to the training. Evidence collection for the HPA Mock Renewal Survey will take place from 07/07/2025-08/22/2025. • A detailed timeline will be developed and shared with Business Owners in the May 2025 Business Owner Check-in Meetings.
NCQA Health Equity Accreditation (HEA)	• Partnership's HEA Initial Survey is scheduled for submission on 06/17/2025. • As of April 2025, Partnership's estimated HEA compliance rate is 93.1%, receiving 27 points out of the 29 total applicable points available. The NCQA Program Management Team is working closely with the Business Owners to ensure all applicable evidence is revised or finalized to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations. The NCQA Program Management Team is waiting for further guidance from NCQA regarding scoring modifications because of the executive orders. More information is expected later this spring. • An Introductory Call with our Accreditation Survey Coordinator (ASC) from NCQA was held on 03/20/2025. During the call, NCQA confirmed the survey process, timeline, and activities with Partnership. Additional details regarding post-survey activities will be discussed in the May 2025 Business Owner Check-in Meetings. • Most of the evidence for the HEA Initial Survey has been submitted and reviewed by the NCQA Program Management Team. There are a few documents pending later submission due to committee review, the HEDIS annual audit and select delegation activities. Beginning in May 2025, the NCQA Program Management Team will upload all evidence to NCQA's online portal in preparation for our submission to NCQA. Once the evidence is uploaded, our NCQA Consultant will review the submission for its completeness and compliance statements. The NCQA Program Management Team will collaborate with the Business Owners to finalize edits, as needed. The final day to submit the HEA Initial Survey evidence to NCQA is 06/17/2025.

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

Consent Calendar

May 21, 2025

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

Note that many Medi-Cal ("MC") policies are being re-lettered "MP" as they are updated to apply to both Medi-Cal and Medicare (Partnership Advantage, eff. Jan. 1, 2026)

		Pages
	G&A PULSE Report / Issue 16 / April 2025 – *Wellness & Recovery article begins on p.44*	37 – 52
Health Services Departments	**Behavioral Health –** *is now a Health Services department. Specific Behavioral Health-related policies are being transferred from other departments to Behavioral Health ownership, including the Mental Health Services policy on presentation today*	
	MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services **–** *the previous ADM52 in Administration is now archived: pp. 58-62*	53 – 57
	MPBP8013 – Eating Disorder Management Policy – *the previous MCUP3145 in UM is now archived: pp. 72-80*	63 – 71
	Enhanced Health Services	
	MPAP7004 – Community Health Worker (CHW) Services Benefit – *the previous MCCP2033 in CC is now archived: pp. 92-102*	81 – 91
	MPAP7005 – Street Medicine – *the previous MCUP3146 in UM is now archived: pp. 111-118*	103 – 110
	Quality Improvement	
	MCQP1052 – Physical Accessibility Review Survey SR Part C	119 – 165
	MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)	167 – 169
	MPQP1047 – Advance Directives – *previously MCQP1047*	170 – 172
	MPQP1055 – Provider Preventable Condition (PPC Reporting)	173 – 177
	MPXG5003 – Major Depression in Adults Clinical Practice Guidelines	179 – 181
	Utilization Management	
	MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions	183 – 191
	MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	193 – 198
	MPUG3031 – Nebulizer Guidelines	199 – 202
	MPUG3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults – *previously MCUP3110*	203 – 207
	MPUP3047 – Tuberculosis Related Treatment – *previously MCUP3047*	209 – 214
	MPUP3136 – Fecal Microbiota Transplant (FMT) – *previously MCUP3136*	215 – 217
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization – *previously MCUP3144*	218 – 224
Non-HS	**Network Services**	
	MPNET100 – Access Standards and Monitoring	225 – 236

Our Mission

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

GRIEVANCE & APPEALS | Pulse Report

INSIDE THIS ISSUE

G&A PULSE REPORT

Issue 16 | APRIL 2025

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 fourth 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.

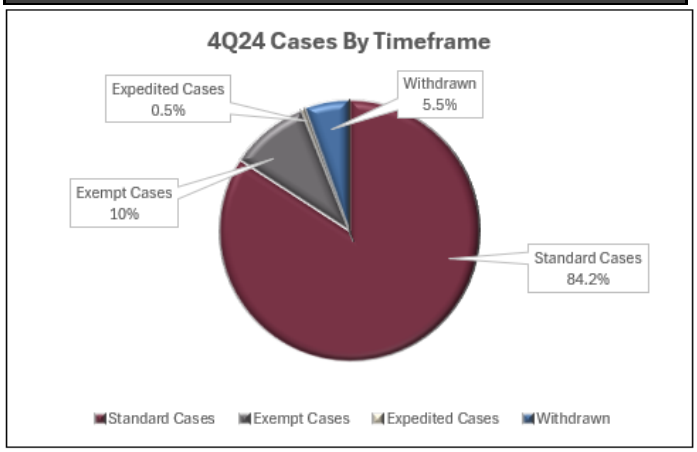
Fluctuations in data can happen. Therefore, the statistics included in this report are presented with a 95% confidence level.

4Q24 HIGHLIGHTS

OVERALL CASE NUMBERS

In 4Q24, G&A investigated 1,916 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,642 cases subject to DHCS-mandated timeframes, 99.3% were closed within the 30-day timeframe. This exceeded our goal of 98.6%.

4Q24 TOTAL # INVESTIGATED CASES		
Case Type	**# Cases**	**% Grand TTL**
Grievance	1406	73.4%
Appeal	234	12.2%
Exempt	188	9.8%
State Hearing	88	4.6%
Grand Total	**1,916**	**100.0%**



KEY POINTS & TRENDS BY CONCERN

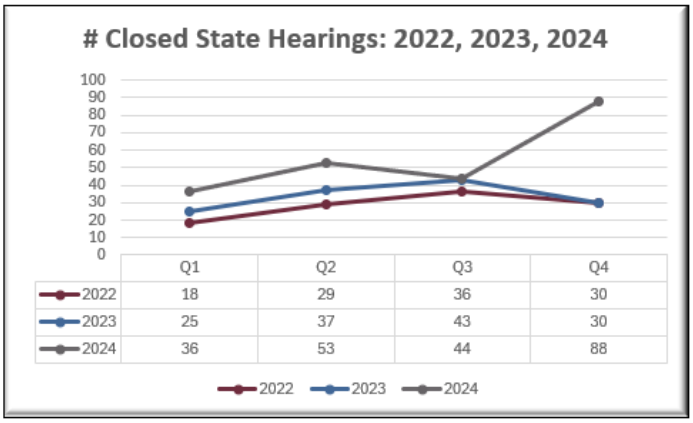
G&A cases are categorized by concern. There can be multiple concerns listed in one case.

Transportation – Transportation-related concerns were the most frequently reported, constituting 43.9% of the total reported concerns. The most prevalent transportation-related problem was missed rides, accounting for 18.5% of the concerns reported. Requests for specific transportation providers and dissatisfaction with a transportation provider's customer service followed as the next highest concerns, at 15.3% and 10.9%, respectively.

Appeals account for 8.6% of all transportation concerns reported. Meal denials were the most commonly appealed, making up 35.9% of the transportation Appeal denials, followed closely by lodging denials at 35.0%.

Provider Service – This category accounted for 40.9% of the total case concerns. The most common issue was Communication, followed by Poor Attitude/Service. Treatment Plan Disputes were the third most commonly reported concern within this category.

State Hearings – There has been a notable increase in State Hearings in 4Q24. A total of 88 State Hearings were closed, primarily involving requests for durable medical equipment, transportation, and transportation-related services such as meals, lodging, and gas mileage reimbursement.



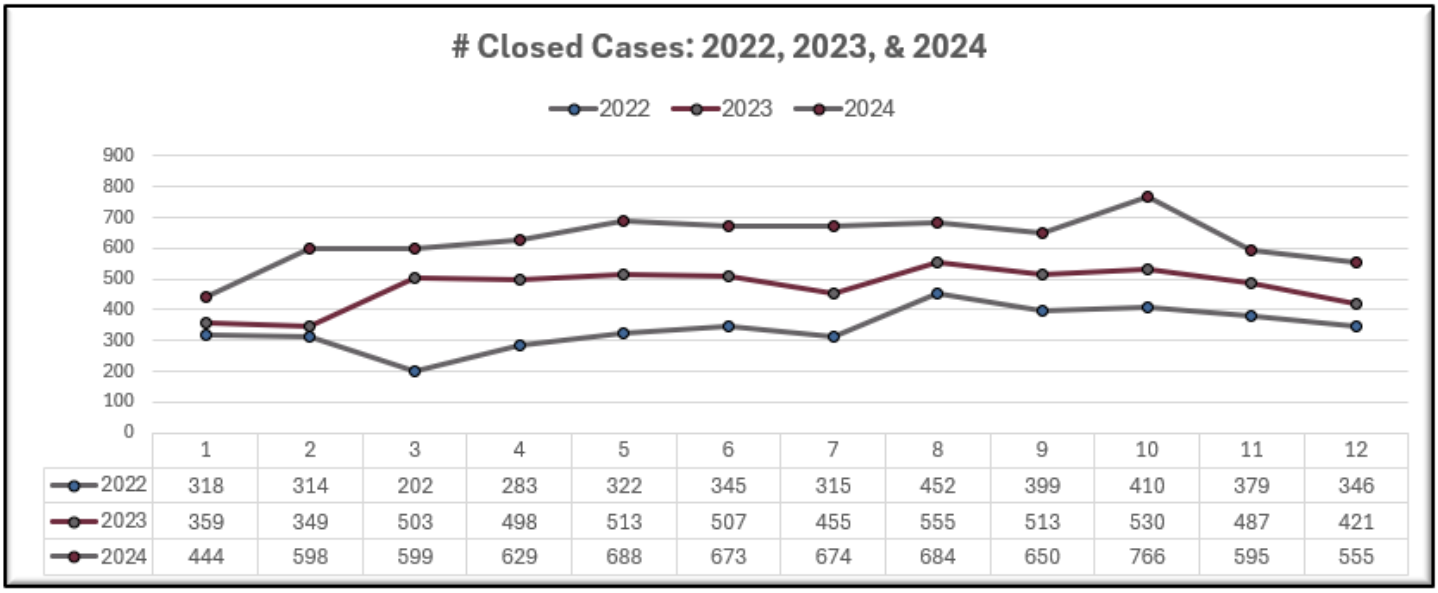
DHCS CATEGORIES

Outpatient Physical Health Services were the most frequently reported Benefit Type at 37.8% of cases, followed by Non-Medical Transportation (NMT) at 33.5% of cases. For the last five (5) quarters, NMT has been the most frequently reported concern.

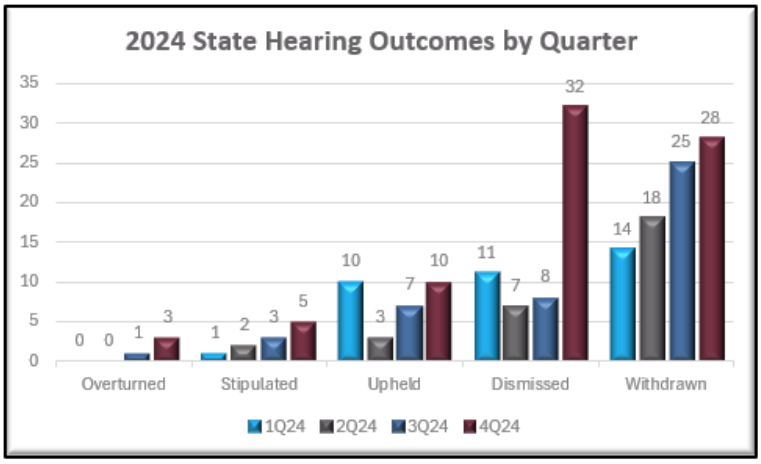
KEY STATISTICS

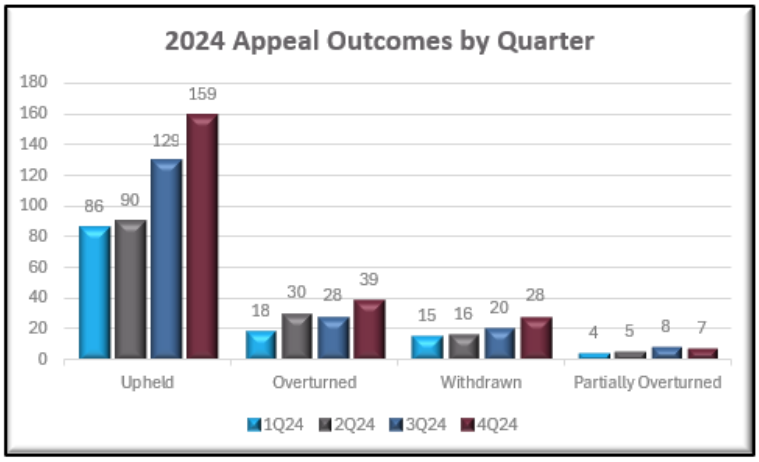
CHARTS OF KEY CASE TRENDS

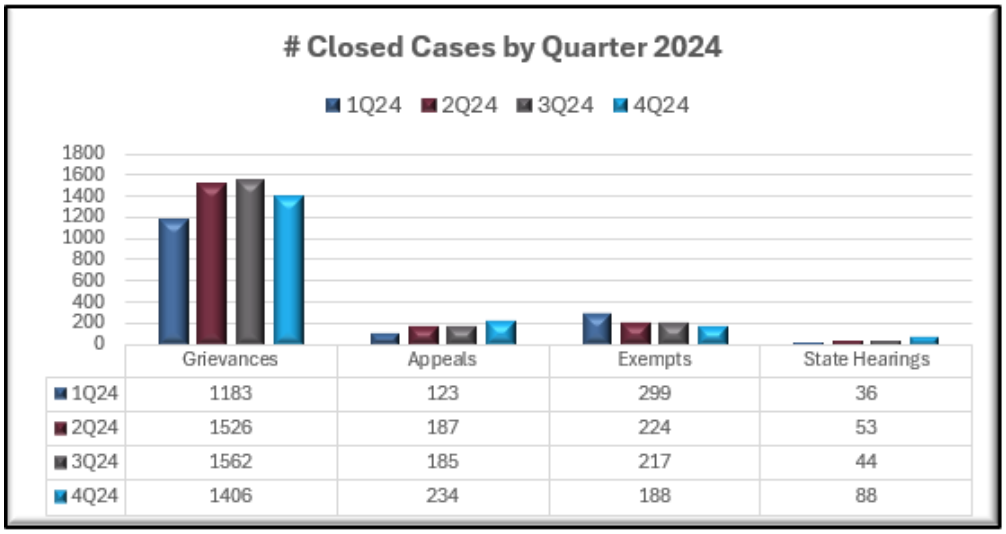
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	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	673	674	684	650	766	595	555







	Grievances	Appeals	Exempts	State Hearings
1Q24	1183	123	299	36
2Q24	1526	187	224	53
3Q24	1562	185	217	44
4Q24	1406	234	188	88

STATISTICS BY REGION

"Deija has worked with me on a few discrimination cases. She is always very kind, helpful and knowledgeable whenever I have any questions."

- Partnership Member

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 closed, the average quarterly membership, and the percentage per 1,000 members.

4Q24 % CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	87	94,819	0.92
Placer	160		1.69
Plumas	14		0.15
Sierra	0		0.00
Grand Total	261		2.75

4Q24 % CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	36	147,049	0.24
Humboldt	194		1.32
Lake	62		0.42
Mendocino	65		0.44
Grand Total	357		2.43

4Q24 % CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	161	188,713	0.85
Colusa	13		0.07
Glenn	14		0.07
Sutter	51		0.27
Yuba	35		0.19
Grand Total	274		1.45

4Q24 % CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	41	135,290	0.30
Modoc	13		0.10
Shasta	197		1.46
Siskiyou	49		0.36
Tehama	50		0.37
Trinity	11		0.08
Grand Total	361		2.67

4Q24 % CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	171	156,877	1.09
Marin	73		0.47
Grand Total	244		1.56

4Q24 % CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	233	182,821	1.27
Napa	42		0.23
Yolo	144		0.79
Grand Total	419		2.29

2024 OVERTURNED STATE HEARINGS

HISTORY AND STATISTICS

In 2024, 113 State Hearings were closed. Of these, six (6) cases, or 5.3% of all closed State Hearings, led to the reversal of Partnership denials. Prior to April 2024, the most recent State Hearing decision overturned was from October 2021.

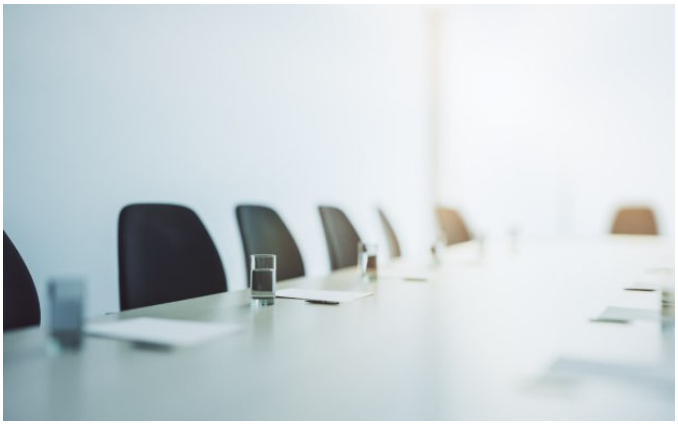
CASE SUMMARIES

In this section, we will review the six (6) overturned cases.

In the first State Hearing case, the member wanted a Continuity of Care request to continue seeing UCSF providers for primary care services. Partnership approved the request for services for six (6) months. The Administrative Law Judge (ALJ) ordered Partnership to approve services for a year, quoting APL 23-022 titled, “Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or After January 1, 2023”.

In the next State Hearing case, the member requested reimbursement for hearing aids purchased from Costco, totaling $829.99. A Treatment Authorization Request (TAR) was not submitted. The court ordered Partnership to process the reimbursement without requiring a TAR. The member based her decision to purchase the hearing aids from this non-contracted provider on partial information provided by both Partnership and the healthcare provider.

In the third State Hearing case, the member's request for facial masculinization surgery was denied. No photographic evidence was submitted to support this request. The ALJ determined that while the absence of photographs was relevant, it did not entirely justify the health plan’s decision to deny the surgery. The ruling emphasized that, although the health plan possessed the authority to request documentation, it also bore the responsibility to ensure that its criteria and requests were transparent, reasonable, and did not impose unwarranted obstacles to care.

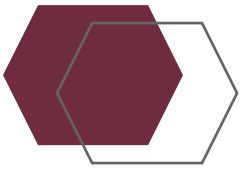


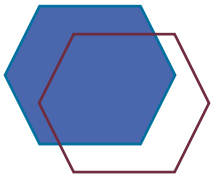
In the fourth case, the member requested an expedited hearing regarding the denial of several power seating features for a heavy-duty group 3 power wheelchair. These features included a powered tilt system, recline, elevating leg rests, and seat elevation. The court overturned the claim for a heavy-duty group 3 power wheelchair with all features except the power tilt system. The member has Multiple Sclerosis, which leads to progressive muscle weakness and severe mobility challenges. They testified to experiencing several falls over the past year and a half. The member’s physician and physical therapist both confirmed that a group 3 power wheelchair with all available power seating features is medically necessary for their condition.

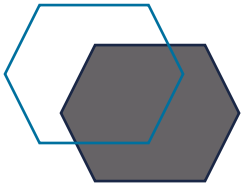
In the fifth case, the member requested lodging and meals for April 24, 2024 and April 25, 2024. One date of service received approval, while the other was denied. During the appeal process, the originally approved date was

documented as denied, and the denied date was recorded as approved. The ALJ decided to grant approval for the additional night of lodging and meals due to discrepancies between the appeal documentation and the initial request. It appears that a date was approved initially and then later "unapproved," which is a determination deemed impermissible by the ALJ.

In the final case, a member wanted facial feminization surgery aimed at eliminating fat from the cheeks and neck. The original request listed 13 procedures, but only those two (2) were denied. The ALJ determined that the denied procedures were medically necessary to address the member's gender dysphoria and were integral to the facial feminization strategy. The ALJ emphasized that these procedures played a vital role in attaining a more feminine appearance.







DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 4Q24.

4Q24 % CASES BY AGE		
Member Age	% Cases	% Membership
Age 0-10	6.1%	18.5%
Age 11-19	4.5%	16.4%
Age 20-44	27.9%	34.5%
Age 45-64	44.3%	19.7%
Age 65+	17.2%	10.9%
Grand Total	100.0%	100.0%

4Q24 % CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	90.6%	76.0%
Spanish	7.4%	20.6%
Other	1.4%	2.0%
Russian	0.5%	0.6%
Punjabi	0.1%	0.5%
Tagalog	0.1%	0.3%
Grand Total	100.0%	100.0%

4Q24 % CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	62.1%	52.0%
Male	37.9%	48.0%
Grand Total	100.0%	100.0%

4Q24 % CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	57.9%	38.5%
Hispanic	14.6%	33.9%
Other/Unknown	4.6%	18.1%
Black (African American)	2.3%	3.5%
Asian	18.0%	2.5%
Native American	14.6%	1.8%
Asian Indian	0.7%	1.5%
Native Hawaiian or Other Pacific Islander	0.3%	0.2%
Grand Total	100.0%	100.0%

4Q24 % OF CASES BY COUNTY			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	8.9%	12.2%	0.19
Solano	12.2%	11.3%	0.26
Butte	8.4%	9.4%	0.18
Shasta	10.3%	7.5%	0.22
Placer	8.4%	6.6%	0.18
Humboldt	10.1%	6.5%	0.21
Yolo	7.5%	5.9%	0.16
Marin	3.8%	5.1%	0.08
Sutter	2.7%	4.8%	0.06
Mendocino	3.4%	4.6%	0.07
Yuba	1.8%	4.0%	0.04
Lake	3.2%	3.8%	0.07
Tehama	2.6%	3.4%	0.06
Nevada	4.5%	3.1%	0.10
Napa	2.2%	3.0%	0.05
Siskiyou	2.6%	2.0%	0.05
Glenn	0.7%	1.5%	0.02
Del Norte	1.9%	1.4%	0.04
Colusa	0.7%	1.1%	0.01
Lassen	2.1%	1.0%	0.05
Plumas	0.7%	0.7%	0.02
Trinity	0.6%	0.6%	0.01
Modoc	0.7%	0.4%	0.01
Sierra	0.0%	0.1%	0.00

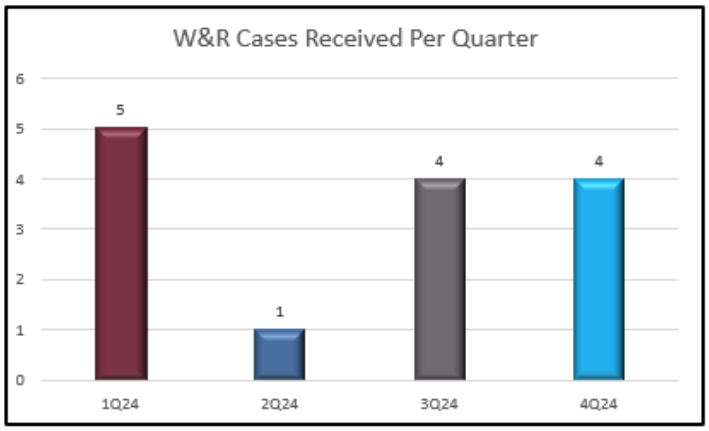
W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 4Q24. 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 due to unique reporting by DHCS.

4Q24 NUMBERS

Four (4) W&R cases were received in 4Q24. Two (2) cases were closed. The other two (2) cases were closed in 1Q25. There were 14 Grievances and zero (0) Appeals reported in the calendar year 2024.



TRENDING ISSUES

Overall, 2024 cases have fallen into the categories of Interpersonal Relationships and Program Requirements.

One (1) case received during 4Q24 was regarding Interpersonal Relationships. The member alleged discrimination based on disability. The member had trouble using the stairs. They received different answers from different staff when they asked to use the elevator. The case was reviewed by different departments, including the Population Health Department for discrimination concerns and a Medical Director for potential quality issues.

After an investigation, it was found that the member could use the elevator after contacting their case manager. The Medical Director did not find any potential quality issues. Discrimination was found to be unlikely.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The table below provides the specific number of W&R cases and the case category Partnership reported to DHCS. All the cases received in 2024 were closed within the 30-day DHCS regulatory timeframe.

2024 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	5
Failure to Respect Enrollee's Rights	0
Interpersonal Relationship Issues	9
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 4Q24.

4Q24 STATISTICS

During 4Q24, a total of 17 CCS-related cases were closed, representing 0.9% of the 1,916 reported cases closed this quarter. These cases are divided into 10 Grievances and seven (7) Appeals.

TRENDING ISSUES

The most reported issue this quarter was transportation-related, with 10 cases (four (4) Appeals and six (6) Grievances) accounting for 58.8% of the total CCS-related cases. The four (4) Appeals were related to reimbursement for meals and/or lodging.

Grievances related to transportation included reporting an unsafe driver, missed rides, late drivers, having a preference in a taxicab company, and issues with their reimbursement card balance.

There was an appeal involving a vest airway lung clearance system. This item is a lung percussion device that provides vibrating chest therapy. The 19-month-old member has a history of recurring pneumonia. The denial was overturned as the item was found to be medically necessary to assist in treating active lung infections and prevent future lung infections.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under civil rights law. There was one (1) case alleging discrimination reported for a CCS member during 4Q24 related to language assistance services. The member's mother claimed she was not updated

on her child's medical treatment while in the hospital. The mother speaks Spanish. Upon investigation, the provider responded the doctor spoke Spanish and interpreter services are always offered. The discharge instructions were provided in Spanish. Discrimination was found to be unlikely.

ETHNICITY AND PREFERRED LANGUAGE

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

4Q24 CASES BY ETHNICITY		
Member Ethnicity	#Cases	% Cases
White	5	29.4%
Other	5	29.4%
Hispanic	3	17.6%
No Response	3	17.6%
Chinese	1	5.9%
Grand Total	17	100.0%

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

4Q24 CCS CASES BY LANGUAGE		
Member Language	# Cases	% Cases
English	11	64.7%
Spanish	3	17.6%
Other	2	11.8%
Mandarin	1	5.9%
Grand Total	17	100.0%

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 4Q24. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

4Q24 DISCRIMINATION STATISTICS

G&A investigated 99 cases related to discrimination allegations in 4Q24. This represented 5.2% of all cases closed. Of the 99 cases, 76 fell under an applicable federal or state civil rights law.

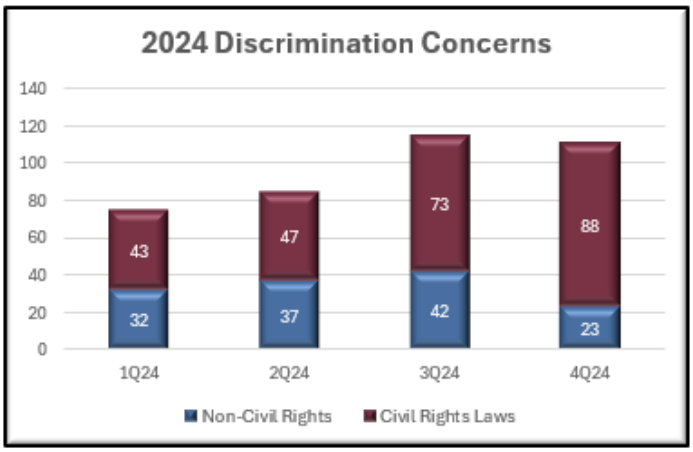
After investigation, it was determined that discrimination likely occurred in five (5) cases, representing 5.0% of discrimination cases. This included a total of nine (9) concerns: three (3) for race or ethnicity, two (2) for disability, two (2) for language assistance services, one (1) for gender, and one (1) for limited English skills.

A member reported a specialist acted unprofessionally, yelling and making accusatory remarks, including using the phrase "you people." The member stated they followed the prescribed dosage but were accused of misuse. The provider dismissed their claims, citing the member's psychiatric history and labeling the allegations as false due to a personality disorder. It was found that this member's concerns were likely discrimination based on the member's disability.

Discrimination allegations that do not fall under a civil rights law accounted for 23 of the 99 alleged discrimination cases filed. Members alleged discrimination based on reasons such as being labeled a medication/drug seeker or having Medi-Cal.

4Q24 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations remained consistent for the last two (2) quarters of 2024.



4Q24 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 Concerns
Race or Ethnicity	3
Language Assistance Serv	3
Disability	2
Gender	1
Limited English Skills	1
Total	10

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

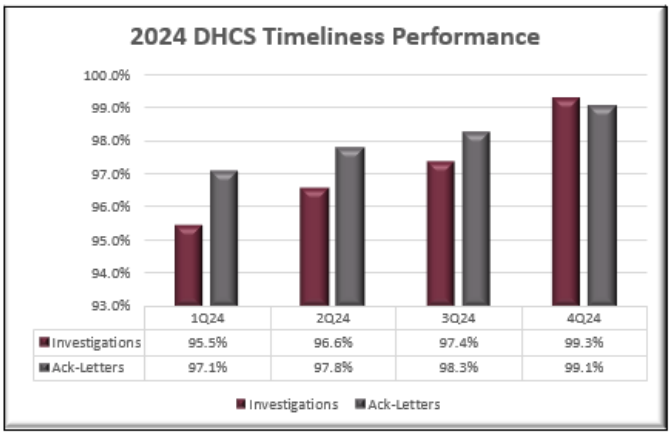
Forty-one (41) Grievances were evaluated for the 3Q24 IRR review. There were two (2) cases that could have been sent to be reviewed by a Medical Director for a potential quality issue (PQI) review.

The first case was a highly complex case regarding an authorization of a PET Scan. The temporary termination of the Dignity contract led to the delay in the member getting the PET scan. There were supposed to be measures in place that ensured the delay did not happen in critical cases like this one. This case was submitted for a PQI investigation by the reviewing Medical Director.

The second case involved a child being seen in the emergency room for a broken arm. A follow-up appointment was scheduled for over two (2) weeks after this visit. They were able to get a walk-in appointment after a few days. However, a minor PQI may have been present if the member had to wait two (2) weeks for the original appointment, as there may have been complications during the healing process.

TIMELINESS

The target timeliness goal for investigations and acknowledgement letters (ack-letters) is 98.6%. For 4Q24, 1,642 cases were subject to DHCS Turnaround Times (TAT). Eleven (11) cases closed outside of the time frame. We achieved 99.3% timeliness for investigations, meeting the threshold. There were 15 late ack-letters, achieving 99.1% timeliness.



4Q24 DHCS Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	11	99.3%	
Ack-Letters	98.6%	15	99.1%	

TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 4Q24.

4Q24 STATISTICS

Transportation cases in 4Q24 accounted for 734 of the total 1,916 cases closed. There were 649 Grievances, 70 Appeals, and 15 State Hearings. While G&A received a notable volume of transportation-related cases, these represent just 0.3% of the 254,659 rides provided to members this quarter, indicating a relatively low incidence rate.

TRENDING ISSUES

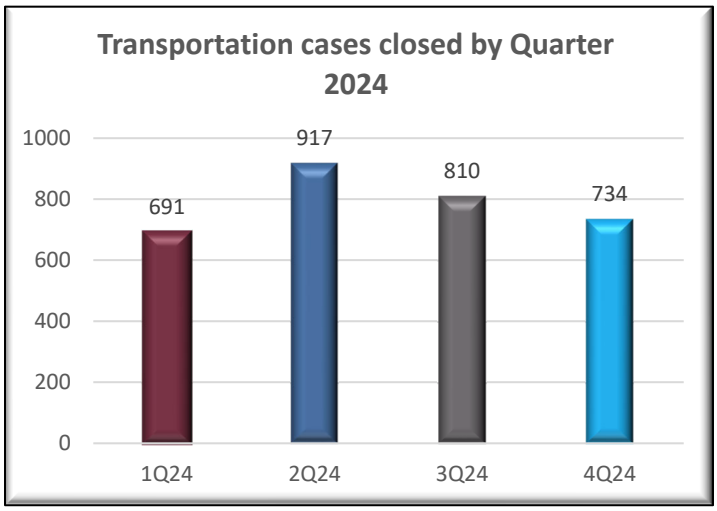
Members most frequently reported issues such as missed or delayed rides, preferences regarding providers, and concerns about driver behavior.

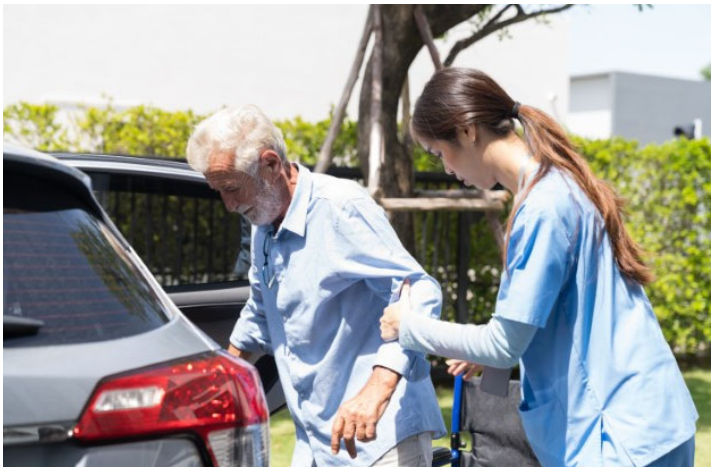
There has been an increase in the number of State Hearings during 2024. The State Hearings were mostly for transportation-related expenses, such as gas mileage reimbursement, meals, and lodging. Most of the denials were upheld.

There was one (1) State Hearing that was overturned by an Administrative Law Judge (ALJ). Member requested lodging for two (2) nights due to the travel distance between their provider's office and the member's home. One (1) night was approved. The other night was denied. The ALJ found that both nights were medically necessary and reasonable given the distance (approximately 270 miles) between the member's home and the provider's office.

Members have also expressed dissatisfaction with the timeframe to receive reimbursement for transportation-related expenses such as gas mileage reimbursement, meals, and lodging. As of April 2025, Partnership's Transportation Services Department reported that gas mileage reimbursement payments are current.

The chart below shows the total number of transportation cases that closed every quarter during 2024.





MEMBER EXPERIENCE

REPORTING PERIOD

As required by the National Committee for Quality Assurance (NCQA), this section reports member dissatisfaction globally in 2024 compared to 2023. For more details, please reference the attached NCQA ME.7 Member Experience Threshold Report.

OVERVIEW

The Member Experience Report tracks increases in case numbers across five (5) specific categories defined by NCQA. Those categories are Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. The threshold for significant change is set at a 10% increase. This report provides insight into which categories experience fluctuations, reflecting the impact of membership growth and overall case filings.

In 2024, a total of 6,149 Grievances and Appeals were closed, compared to 4,261 in 2023. Grievances represented 5,477 cases, while Appeals and Second Level Grievances accounted for 672 cases.

Our membership grew by approximately 33.5%, rising from 678,546 to 905,570 members. This rate went above the 10% threshold of 5.79 to 6.05.

GRIEVANCES

Access and Attitude/Service remain the most frequently reported concerns, accounting for 2,567 and 2,569 cases, respectively. The number of Grievances filed per 1,000 members increased from 2.25 to 2.83 for access-related issues. There were more missed rides reported, causing access issues to

appointments. In 2023, there were two (2) cases related to the Quality of a Provider's Office, while in 2024, this number increased to five (5) cases. As a result, the threshold exceeded the range from 0.00 to 0.01.

APPEALS & SECOND LEVEL GRIEVANCES

G&A met the threshold for all categories of Appeals and Second Level Grievances for 2024. Even with the increase in average membership, it is noted that there were fewer Appeals and Second Level Grievances closed for the year. There were 689 cases closed in 2023 and 672 closed in 2024. The average per 1,000 members went from 1.02 to 0.62.

It should be noted that after the 2023 DHCS Audit, the elimination of Second Level Grievance as a case type was approved. Effective January 1, 2025, this process was replaced with the appeal process to satisfy the guidance provided in APL 21-011.

THE UM EXPERIENCE

REPORTING PERIOD

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

OVERVIEW

There were 270 reported concerns regarding the UM process in 2024 compared to 205 in 2023. While the number of concerns increased year after year, our average membership also grew. As a result, the Grievance rate per 1,000 members remained steady at 0.30 in both 2023 and 2024. We have met the threshold in all categories of the UM1B report. There continues to be communication issues between members and their providers regarding referrals. This resulted in providers delaying or refusing to submit Treatment Authorization Requests (TARs) or Referral Authorization Forms (RAFs).

DISSATISFACTION WITH RAF PROCESS

Of the 270 UM concerns, 179 of them were related to the RAF process. Of those, 119 of the concerns were related to a member's primary care provider allegedly delaying their RAF request, which caused delays in getting appointments with specialists. There were 23 cases referred to Quality Improvement for further research.

RAF Process	
# of Reported Concerns	
Delayed by Provider	119
Refused by Provider	16
Member dislikes overall	14
Delayed by Partnership	14
Other	16
Total	179

DISSATISFACTION WITH TAR PROCESS

Member's concerns related to the TAR process account for 91 of the 270 cases reported. The most significant driver was members alleging their provider delayed submission of their TAR to Partnership, which was reported in 44 of the concerns. In one case, the member alleged that the TAR process was delayed due to discrimination based on language. After the investigation, it was found that discrimination was unlikely as the member did not speak to this particular hospital regarding the service needed

TAR Process	
# of Reported Concerns	
Delayed by Provider	44
Delayed by Partnership	20
Member dislikes overall	12
Refused by Provider	6
Other	9
Total	91

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2024 through December 31, 2024.

APPOINTMENTS

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

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

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

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – Members reported a total of 181 concerns in 2024. In the first half of the year, there were 72 concerns, and during the second half, an additional 109 concerns were reported. These concerns were primarily directed at their primary care providers (PCP) or office staff regarding access to appointments, either in person or by phone. Members expressed dissatisfaction with long wait times for appointments, difficulties in reaching staff when calling, a lack of return calls from providers, and instances where providers refused to see them.

Specialists – Partnership approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists, orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure our members can access timely appointments.

We received 16 reports regarding appointment availability, showing that members encountered difficulties promptly scheduling appointments. Among these 16 cases, seven (7) involved a high-impact provider.

MEETING CULTURAL & LINGUISTIC NEEDS

Partnership monitors our provider network to ensure it effectively meets the diverse cultural, ethnic, racial, gender, and linguistic needs of our membership. There were nine (9) cases filed against medical groups or individual doctors. Specifically, Auburn, Chico, and Fairfield each had two (2) cases filed against their providers, while the Redding region members filed three (3) cases. Members reported they experienced four (4) barriers related to their culture, race, or ethnicity, four (4) related to their linguistic needs, and one (1) related to their gender identity.

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

CONTACT US
Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, CA 94534

2525 Airpark Drive
Redding, CA 96001

www.PartnershipHP.org

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8005 (previously ADM 52)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/21/2015</td><td colspan="4">Next Review Date: 06/11/2026
Last Review Date: 06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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>☐ CREDENTIALS</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: 06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPBP8003 – Mental Health Services
B. CMP36 – Delegation Oversight and Monitoring
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Finance

III. DEFINITIONS:

A. Behavioral Health Plan (BHP) is a county behavioral health plan that is responsible for providing mental health services outlined in Title 9 CCR and Title 22 CCR.
B. Dispute: is a formal disagreement between a Medi-Cal managed care plan (MCP) and a county behavioral health plan (BHP) regarding the provision of and/or payment for mental health services that has not been resolved through informal measures and occurs when either plan makes a formal written request for a Plan Level Dispute Resolution and/or Department of Health Care Services (DHCS) Dispute Resolution.
C. Expedited Dispute Resolution Process: means a resolution more expeditious than what is expected for a standard resolution and shall be resolved within one business day when Partnership HealthPlan of California (Partnership) and the BHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.
D. Member is an eligible beneficiary who is a member of Partnership HealthPlan of California (Partnership), under either the Medi-Cal or Partnership Advantage program.
E. Memorandum of Understanding (MOU): where no reimbursement is to be made, Partnership shall negotiate in good faith an MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.
F. Plan Level Dispute Resolution: means good faith efforts, which shall include a meeting to remedy coverage disputes as formally communicated via written notice by either Partnership or a BHP to either respective party
G. Request for Resolution: means Partnership's written request to DHCS for aid in resolving a dispute between Partnership and a BHP when the dispute could not be rectified via the Plan Level Dispute Resolution.

Policy/Procedure Number: MPBP8005 (previously ADM 52)			Lead Department: Health Services Business Unit: Behavioral Health
Policy/Procedure Title: Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/21/2015			**Next Review Date: 06/11/2026** **Last Review Date: 06/11/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Pursuant to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-013 and any future related DHCS guidance as communicated in writing, the purpose of this policy is to provide a process that allows for a formal system of resolving disputes between Partnership and a BHP when traditional communications are unable to resolve disputes. This policy also clarifies the requirement that medically necessary services will not be delayed during this dispute process.

VI. POLICY / PROCEDURE:

A. Basis for Partnership and BHP relationship
   1. As an MCP, Partnership shall negotiate in good faith and execute memorandum of understanding (MOU) with county BHPs across Partnership's service area to ensure for coordination of Medi-Cal mental health services, delineate the responsibilities of each respective party, and afford for a dispute resolution process.
      a. MOUs shall be entered into and maintained consistent with DHCS APL 23-029 and any future related DHCS guidance as communicated in writing.

B. Guiding Principles
   1. Emphasis on Timely, Collaborative Resolution
      a. The provision of medically necessary services for members will not be delayed during the pendency of any dispute.
      b. Partnership and BHP staff will make a good faith effort to agree to resolutions that are in the best interest of members and are agreeable to all parties involved.
      c. Proactive and timely communication is expected between Partnership and the BHP.

C. Plan Level Dispute Resolution Process is outlined in this policy and referenced in Partnership and BHP MOUs
   1. Partnership or the BHP may seek to remedy a dispute informally through discussion and dialogue. If this fails to resolve the dispute, either plan may request, in writing, a formal meeting between the two plans to identify issues and possible solutions. The receipt of the written request will initiate the Plan Level Dispute timeline in which the dispute must be resolved within 15 business days.
      a. A Request for Plan Level Resolution can be submitted via secure email to either Partnership's Senior Director of Behavioral Health or CEO.
   2. Within 10 business days, the meeting will be conducted at a mutually agreeable time. Representatives from both Partnership and the BHP must participate in the meeting.
   3. Within 5 business days from the date of the meeting, Partnership will issue to the BHP a written final position on the matter in dispute signed by the Chief Executive Officer (CEO) or their designee.
   4. Members will continue to receive medically necessary services while the disagreement or dispute is being resolved in accordance with Title 9, CCR, §1850.525(a).
   5. The Partnership Behavioral Health team will maintain records of Plan Level Dispute Resolutions consistent with applicable Partnership record retention policy.
   6. The Expedited Dispute Resolution Process as outlined in Section E below will be followed if a Member has not received a disputed service (s) and Partnership or the BHP determines that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.

D. DHCS Dispute Resolution Process (For further details, refer to DHCS APL 21-013 Dispute Resolution Process Between BHPs and MCPs)

1. The parties are required to document attempts to resolve the disputed issue(s), including results of the Plan Level Dispute Resolution (Title 9, CCR, §1850.505 (d) (2))
2. If Partnership and the BHP are unable to resolve a dispute at the Plan Level, Partnership may submit a written Request for Resolution to DHCS and signed by Partnership's CEO or their designee. The Request for Resolution must be submitted within 3 business days from the completion of the Plan Level Dispute Resolution process that didn't result in a satisfactory resolution. A Request for Resolution should be submitted via secure email to the DHCS Managed Care Quality and Monitoring Division (MCQMD), at MCQMD@dhcs.ca.gov. Conversely, the BHP may exercise the same process to escalate the dispute to DHCS for resolution.
3. A Request for Resolution submitted to DHCS must contain all of the following:
   a. Summary of disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party;
   b. History of attempts to resolve the issue with the BHP;
   c. Justification for Partnership's desired remedy: and
   d. If applicable, any additional documentation that Partnership deems relevant to resolve the disputed issue(s)
4. Within three (3) business days after DHCS' receipt of a Request for Resolution from Partnership or the BHP, a copy of the Request for Resolution will be forwarded by DHCS to the other party via secure email ("Notification").
   a. Both parties will have three (3) business days to submit a response and any relevant documents to support their position; and
   b. If the responding party fails to respond within three (3) business days, DHCS will decide on the disputed issue(s) based solely on the documentation submitted by the requesting party.
5. At its discretion, DHCS may allow both Partnership and BHP representatives the opportunity to present oral arguments.
6. Within 20 business days from the third business day of the Notification date, DHCS will issue its final decision and communicate it via secure email to both Partnership's CEO or their designee and the BHP Director.
   a. DHCS' decision will state the reasons for the decision, the determination of rates of payment (if rates of payment were disputed), and any actions Partnership and the BHP are required to take to implement the decision.
   b. If DHCS' dispute resolution determination includes a finding that the unsuccessful party has a financial liability to the other party for services rendered by the successful party, Partnership or the BHP is required to follow the financial liability criteria set forth in Title 9, CCR § 1850.530, which specify the provisions regarding financial liability rates and proof of reimbursement.
      1) If necessary, DHCS shall enforce the decision, including withholding funds to meet any financial liability established pursuant to Title 9, CCR, §1850.530 (Title 9, CCR, §1850.520(c)).
7. The provision of medically necessary specialty and other mental health services, physical health care services, or other services shall not be delayed during the dispute.

E. Expedited Dispute Resolution Process
1. Either Partnership or the BHP may seek to enter an Expedited Dispute Resolution Process if a Member has not received a disputed service(s) and Partnership or the BHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain, or regain maximum function.
2. Under this process, both Partnership and the BHP will have one business day to resolve the dispute at the Plan level.
3. If Partnership and the BHP fail to resolve an Expedited dispute within one business day, each party

must file a Request for Resolution with DHCS within one business day. The request must include an affirmation of the Member's stated jeopardy.

4. If either plan fails to submit a Request for Resolution and/or documentation to DHCS, DHCS will base its decision upon the documentation submitted.
5. DHCS will render a decision within one business day upon receipt of said request.

F. To ensure there is not a delay in the provision of medically necessary services to a member during a dispute, the following actions will apply:
   1. When the dispute concerns Partnership's contention that the BHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the BHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the BHP, Partnership shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(b)).
   2. When the dispute concerns the BHP's contention that Partnership is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the BHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(c)).

G. Delegation of Plan Level Dispute Resolution
   1. Partnership does not delegate the responsibility of MCP and BHP dispute resolution, including the handling of Plan Level Dispute Resolution, to any Subcontractor and as such, is directly responsible for facilitating the Plan Level Dispute Resolution.
   2. Where Partnership has delegated responsibility for the provision of Covered Services, consistent with its DHCS Medi-Cal managed care contract, Partnership may seek data, documentation, and information from Subcontractors to support satisfactory dispute resolution.

VII. REFERENCES:

A. Title 9, California Code of Regulations (CCR) Sections §1810.370, §1850.505, §1850.520, §1850.525, and §1850.530
B. Title 22 CCR Section 53855
C. DHCS All Plan Letter (APL) 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (04/08/2022)
D. 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
E. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
F. DHCS Behavioral Health Information Notice BHN 21-034 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Plans (10/04/2021)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Behavioral Health

Policy/Procedure Number: MPBP8005 (previously ADM 52)			**Lead Department: Health Services** Business Unit: Behavioral Health
Policy/Procedure Title: Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/21/2015			**Next Review Date: 06/11/2026** **Last Review Date: 06/11/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

X. REVISION DATES:

MPBP8005
06/11/25

PREVIOUSLY APPLIED TO:

Medi-Cal (ADM52 12/07/21 to 06/11/2025)
12/07/21; ARCHIVED 06/11/25

Medi-Cal (MCUP3127 01/21/2015 to 02/09/2022)
01/21/15; 06/17/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; ARCHIVED 12/07/2021

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ADM52 (previously MCUP3127)</td><td colspan="3">Lead Department: Administration</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Dispute Resolution Between PHC and MHPs in Delivery of Mental Health Services</td><td colspan="3">☒External Policy
☒ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 01/21/2015</td><td colspan="3">Next Review Date: ~~12/06/2022~~N/A
Last Review Date: 12/07/2021</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="4">Approval Signature: Elizabeth Gibboney, CEO</td><td colspan="2">~~Approval~~ Archive Date:
~~12/07/2021~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3028 – Mental Health Services
B. CMP36 – Delegation Oversight and Monitoring
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Behavioral Health
B. Health Services
C. Finance

III. DEFINITIONS:

A. Dispute: is a formal disagreement between a Medi-Cal managed care plan (MCP) and a county mental health plan (MHP) regarding the provision of and/or payment for mental health services that has not been resolved through informal measures and occurs when either plan makes a formal written request for a Plan Level Dispute Resolution and/or Department of Health Care Services (DHCS) Dispute Resolution.
B. Expedited Dispute Resolution Process: means a resolution more expeditious than what is expected for a standard resolution and shall be resolved within one business day when Partnership HealthPlan of California (PHC) and the MHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.
C. Member is an eligible Medi-Cal beneficiary who is a member of Partnership HealthPlan of California (PHC), a Medi-Cal managed care plan.
D. Mental Health Plan (MHP) is a county mental health plan who is responsible for providing mental health services outlined in Title 9 CCR.
E. Memorandum of Understanding (MOU): where no reimbursement is to be made, PHC shall negotiate in good faith an MOU for services provided by said agency. MOU shall describe the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated.
F. Plan Level Dispute Resolution: means good faith efforts, which shall include a meeting to remedy coverage disputes as formally communicated via written notice by either PHC or an MHP to either respective party
G. Request for Resolution: means PHC's written request to DHCS for aid in resolving a dispute between PHC and an MHP when the dispute could not be rectified via the Plan Level Dispute Resolution

Policy/Procedure Number: **ADM52** (previously MCUP3127)		Lead Department: **Administration**
Policy/Procedure Title: Dispute Resolution Between PHC and MHPs in Delivery of Mental Health Services		☒ **External Policy** ☒ **Internal Policy**
Original Date: 01/21/2015	**Next Review Date:** ~~12/06/2022~~N/A **Last Review Date:** 12/07/2021	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

IV. ATTACHMENTS:

A. MOU template between PHC and MHPs

V. PURPOSE:

Pursuant to the Department of Health Care Services (DHCS) All Plan Letter (APL) 21-013 and any future related DHCS guidance as communicated in writing, the purpose of this policy is to provide a process that allows for a formal system of resolving disputes between PHC and an MHP when traditional communications are unable to resolve disputes. This policy also clarifies the requirement that medically necessary services will not be delayed during this dispute process.

VI. POLICY / PROCEDURE:

A. Basis for PHC and MHP relationship
   1. As an MCP, PHC shall negotiate in good faith and execute memorandum of understanding (MOU) with county MHPs across PHC's service area to ensure for coordination of Medi-Cal mental health services, delineate the responsibilities of each respective party, and afford for a dispute resolution process.
      a. MOUs shall be entered into and maintained consistent with DHCS APL 18-015 and any future related DHCS guidance as communicated in writing.

B. Guiding Principles
   1. Emphasis on Timely, Collaborative Resolution
      a. The provision of medically necessary services for members will not be delayed during the pendency of any dispute.
      b. PHC and MHP staff will make a good faith effort to agree to resolutions that are in the best interest of members and are agreeable to all parties involved.
      c. Proactive and timely communication is expected between PHC and the MHP.

C. Plan Level Dispute Resolution Process is outlined in this policy and referenced in PHC and MHP MOUs
   1. PHC or the MHP may seek to remedy a dispute informally through discussion and dialogue. If this fails to resolve the dispute, either plan may request, in writing, a formal meeting between the two plans to identify issues and possible solutions. The receipt of the written request will initiate the Plan Level Dispute timeline in which the dispute must be resolved within 15 business days.
      a. A Request for Plan Level Resolution can be submitted via secure email to either PHC's Behavioral Health Administrator or CEO
   2. Within 10 business days, the meeting will be conducted at a mutually agreeable time. Representatives from both PHC and the MHP must participate in the meeting.
   3. Within 5 business days from the date of the meeting, PHC will issue to the MHP a written final position on the matter in dispute signed by the CEO or their designee.
   4. Members will continue to receive medically necessary services while the disagreement or dispute is being resolved in accordance with Title 9, CCR, §1850.525(a).
   5. The PHC Behavioral Health team will maintain records of Plan Level Dispute Resolutions consistent with applicable PHC record retention policy.
   6. The Expedited Dispute Resolution Process as outlined in Section E below will be followed if a Member has not received a disputed service (s) and PHC or the MHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.

D. DHCS Dispute Resolution Process (For further details, refer to DHCS APL 21-013 Dispute Resolution Process Between MHPs and MCPs)
   1. The parties are required to document attempts to resolve the disputed issue(s), including results of the Plan Level Dispute Resolution (Title 9, CCR, §1850.505 (d) (2))
   2. If PHC and the MHP are unable to resolve a dispute at the Plan Level, PHC may submit a written

Request for Resolution to DHCS and signed by PHC's CEO or their designee. The Request for Resolution must be submitted within 3 business days from the completion of the Plan Level Dispute Resolution process that didn't result in a satisfactory resolution. A Request for Resolution should be submitted via secure email to the DHCS Managed Care Quality and Monitoring Division (MCQMD), at MCQMD@dhcs.ca.gov. Conversely, the MHP may exercise the same process to escalate the dispute to DHCS for resolution.

3. A Request for Resolution submitted to DHCS must contain all of the following:
   a. Summary of disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to the beneficiary by either party;
   b. History of attempts to resolve the issue with the MHP;
   c. Justification for the MCP's desired remedy: and
   d. If applicable, any additional documentation that the MCP deems relevant to resolve the disputed issue(s)
4. Within three (3) business days after DHCS' receipt of a Request for Resolution from PHC or the MHP, a copy of the Request for Resolution will be forwarded by DHCS to the other party via secure email ("Notification").
   a. Both parties will have three (3) business days to submit a response and any relevant documents to support their position; and
   b. If the responding party fails to respond within three (3) business days, DHCS will decide on the disputed issue(s) based solely on the documentation submitted by the requesting party.
5. At its discretion, DHCS may allow both PHC and the MHP representatives the opportunity to present oral arguments.
6. Within 20 business days from the third business day of the Notification date, DHCS will issue its final decision and communicate it via secure email to both PHC's Chief Executive Officer (CEO) or their designee and the MHP Director.
   a. DHCS' decision will state the reasons for the decision, the determination of rates of payment (if rates of payment were disputed), and any actions PHC and the MHP are required to take to implement the decision.
   b. If DHCS' dispute resolution determination includes a finding that the unsuccessful party has a financial liability to the other party for services rendered by the successful party, PHC or the MHP is required to follow the financial liability criteria set forth in Title 9, CCR § 1850.530, which specify the provisions regarding financial liability rates and proof of reimbursement.
      1) If necessary, DHCS shall enforce the decision, including with-holding funds to meet any financial liability established pursuant to Title 9, CCR, §1850.530 (Title 9, CCR, §1850.520(c)).
7. The provision of medically necessary specialty and other mental health services, physical health care services, or other services shall not be delayed during the dispute.

E. Expedited Dispute Resolution Process
1. Either PHC or the MHP may seek to enter an Expedited Dispute Resolution Process if a Member has not received a disputed service (s) and PHC or the MHP determine that the Routine Dispute Resolution timeframe would result in serious jeopardy to the Member's life, health, or the ability of the Member to attain, maintain or regain maximum function.
2. Under this process both PHC and the MHP will have one business day to resolve the dispute at the Plan Level.
3. If PHC and the MHP fail to resolve an Expedited dispute within one business day, each party must file a Request for Resolution, with DHCS, within one business day. The request must include an affirmation of the Member's stated jeopardy.
4. If either plan fails to submit a Request for Resolution and/or documentation to DHCS, DHCS will base its decision based upon the documentation submitted.

5. DHCS will render a decision within one business day upon receipt of said request.

F. In order to ensure there is not a delay in the provision of medically necessary services to a member during a dispute, the following actions will apply:
   1. When the dispute concerns the MCP's (PHC) contention that the MHP is required to deliver specialty mental health services to a beneficiary either because the beneficiary's condition would not be responsive to physical health care based treatment or because the MHP has incorrectly determined the beneficiary's diagnosis to be a diagnosis not covered by the MHP, the MCP shall manage the care of the beneficiary under the terms of its contract with the State until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(b)).
   2. When the dispute concerns the MHP's contention that the MCP is required to deliver physical health care based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, the MHP shall be responsible for providing or arranging and paying for those services to the beneficiary until the dispute is resolved, pursuant to Title 9, CCR, §1850.525 (Title 9, CCR, §1850.525(c)).

G. Delegation of Plan Level Dispute Resolution
   1. PHC does not delegate the responsibility of MCP and MHP dispute resolution, including the handling of Plan Level Dispute Resolution, to any Subcontractor and as such, is directly responsible for facilitating the Plan Level Dispute Resolution.
   2. Where PHC has delegated responsibility for the provision of Covered Services, consistent with its DHCS Medi-Cal managed care contract, PHC may seek data, documentation, and information from Subcontractors in order to support satisfactory dispute resolution.

VII. REFERENCES:

A. Title 9, California Code of Regulations (CCR) Sections §1810.370, §1850.505, §1850.520, §1850.525, and §1850.530
B. DHCS All Plan Letter 17-018 Medi-Cal Managed Care Health Plan Responsibilities for Outpatient Mental Health Services (10/27/2017)
C. DHCS All Plan Letter 18-015 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans (09/19/2018)
D. Attachment 1 to APL18-015 Title 9 Chapter 11 (see §1850.505 and §1850.525)
E. Attachment 2 to APL18-015 Memorandum Of Understanding Requirements For Medi-Cal Managed Care Plans and County Mental Health Plans
F. DHCS All Plan Letter 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
G. County specific Mental Health Plan Memoranda of Understanding (MOUs)

VIII. DISTRIBUTION:

A. PHC Provider Manual
B. PHC Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Administrator

X. REVISION DATES:

ADM52 – Initial 12/07/21; ARCHIVED 06/11/2025 (See MPBP8005)

PREVIOUSLY APPLIED TO:

Medi-Cal (MCUP3127 01/21/2015 to 02/09/2022)
01/21/15; 06/17/15; 04/20/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; ARCHIVED 12/07/2021

Policy/Procedure Number: ADM52 (previously MCUP3127)		**Lead Department: Administration**
Policy/Procedure Title: Dispute Resolution Between PHC and MHPs in Delivery of Mental Health Services		☒ **External Policy** ☒ **Internal Policy**
Original Date: 01/21/2015	**Next Review Date:** ~~12/06/2022~~N/A **Last Review Date: 12/07/2021**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCUP3145~~MPBP8013 (previously MCUP3145)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Eating Disorder Management Policy</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/10/2022 (MCUP3145)</td><td colspan="4">Next Review Date: ~~09/11/2025~~06/11/2026
Last Review Date: ~~09/11/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td>☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE ☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE ☒ PAC</td></tr>
<tr><td>☐ CEO ☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~09/11/2024~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPB~~CU~~P8003~~3028~~ - Mental Health Services
B. MCUG3024 - Inpatient Utilization Management
C. MP~~C~~UP3014 - Emergency Services
D. MCUP3052 - Medical Nutrition Services
E. MPCD2013 - Care Coordination Program Description
F. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
G. MPBP8005~~ADM52~~ - Dispute Resolution Between Partnership and B~~M~~HPs in Delivery of Mental Health Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Behavioral Health Plan (BHP) : A county Behavioral Health Plan in Partnership's service area. BHPs are required to provide and cover all medically necessary SMHS and Substance Use Disorder (SUD) treatment services in accordance with their contracts with DHCS.

~~A.~~B. Eating Disorder: Per the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition, feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.

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

C. Eating Disorder Treatment Levels of Care:

1. **Outpatient**: Patient lives at home and attends weekly (usually 1:1) sessions with their provider. Patient is determined to not need daily medical monitoring and patient is psychiatrically stable enough to live at home and engage in prescribed treatment programming. Eating disorder symptoms are under sufficient control such that individual can function normally in social, educational, or vocational situations and continue to make progress in treatment.
2. **Intensive Outpatient**: Patient lives at home and attends treatment program at a specialized setting

(virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs 2 to 3 times per week for at least three (3) hours each time, and groups in addition to 1:1 treatment may be part of the program. The patient is medically and psychiatrically stable enough to live at home, and they will often maintain work and/or school obligations while engaging in treatment.

3. **Partial Hospital**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs five (5) days per week for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals. Patient remains medically and psychiatrically stable enough to live at home, but requires highly structured, intensive, eating disorder treatment to reduce eating disorder symptoms and achieve progress towards recovery.
4. **Residential**: Patient lives at a specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors. Patient is medically stable. Treatment typically involves programming that occurs daily for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals, and co-occurring psychiatric care. All meals and snacks are supervised and provided in a supportive environment. Depending on the program, more complex medical needs such as nasogastric tube feeding may or may not be available.
5. **Inpatient Eating Disorder Program**: Patient lives at specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors, and lower levels of care have often proven to provide insufficient structure and monitoring to improve eating disorder symptoms. Oftentimes, the patient requires additional medical or psychiatric oversight for complex issues or needs that are not able to be handled in Residential level of care (e.g., nasogastric tube feeding, significant mood or psychiatric instability that requires active daily management). Focus is on weight restoration.
6. **Inpatient Acute Care Medical Hospital**: Patient is medically unstable (i.e., unstable or depressed vital signs, laboratory findings indicative of acute physiologic risk, complications from coexisting medical conditions such as diabetes) and often also psychiatrically unstable (i.e., suicidality, rapidly worsening mood or other psychiatric symptoms). Focus is on weight restoration and stabilization of acute medical abnormalities.
7. **Inpatient Acute Care Psychiatric Hospital**: In most instances, patient is not acutely medically unstable (see Inpatient Acute Care Medical Hospital above), but has active psychiatric symptoms that require specialty inpatient psychiatric care (e.g., significant mood symptoms, suicidality/homicidality, psychosis). Most units will not be equipped to manage lines/tubes. Focus is on achieving stabilization of acute psychiatric symptoms, not necessarily eating disorder treatment.

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

E. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services* Managed Care Plans (MCPs) are responsible for providing or arranging for medically necessary NSMHS provided to M~~m~~embers which include *(per Reference VII.D)*:

1. Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services
2. Psychological 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

F. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

G. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services* County ~~Mental~~ Behavioral Health Plans (B~~M~~HPs) are required to provide and cover all medically necessary SMHS for Medi-Cal Members in accordance with their contracts with the California Department of Health Care Services (DHCS).

1. For Partnership Advantage Members who meet criteria for SMHS provided by a county BHP, Partnership will coordinate with BHP providers to ensure Members have access to and are connected with medically necessary services delivered by the BHP as described in section VI.D. of this policy.

IV. ATTACHMENTS:

A. Eating Disorder Process Flow Chart
B. Eating Disorder Bidirectional Form

V. PURPOSE:

To delineate how appropriate and effective services and treatments for Partnership members with eating disorders are coordinated between Partnership, which provides medically necessary physical health and non-specialty mental health services, and the county ~~Mental~~ Behavioral Health Plans in Partnership's service area, which provide all medically necessary specialty mental health services.

VI. POLICY / PROCEDURE:

A. Coordinating appropriate and effective services and treatment for M~~m~~embers with eating disorders is a shared responsibility between Partnership HealthPlan (Partnership) and each county ~~Mental~~ Behavioral Health Plan (B~~M~~HP) in Partnership's service area.

1. When evaluating requests for M~~m~~embers under age 21, both Partnership and B~~M~~HPs will consider EPSDT criteria, including assessment of whether the service is necessary to correct or ameliorate the condition and whether or not the service is generally only available to Members over age 21 (*see policy MCCP2022 Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services*).
2. Effective January 1, 2026, Partnership will coordinate appropriate and effective services and treatment for Partnership Advantage Members who receive both Medi-Cal and Medicare services. For service information specific to Partnership Advantage Members, see section VI.E. of this policy.

B. As a Managed Care Plan, Partnership is responsible for all medically necessary physical health components of eating disorder treatment and providing or arranging medically necessary non-specialty mental health services (NSMHS) (*see III.E.~~B~~ above*) for our M~~m~~embers.

1. Partnership provides inpatient hospitalization for M~~m~~embers with physical health conditions,

[1] As per APL 22-012 *Revised*, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. ~~this does not include medications dispensed from pharmacies and covered under Medi-Cal Rx.~~ Please refer to the State Medi-Cal Rx webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.
-Effective January 1, 2026, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization. Partnership also provides or arranges for NSMHS for Mmembers requiring these services.

2. Partnership covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. Emergency services include professional services and facility charges claimed by emergency departments including, but not limited to the following: 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 that are medically necessary to stabilize the Mmember.
3. If a Member requires partial hospitalization and or a residential eating disorder program, Partnership is responsible for the medically necessary physical health components of the treatment, including locating, arranging, and following up to ensure services were rendered. (The BMHP is responsible for the medically necessary Specialty Mental Health Services (SMHS) components.)
4. Partnership provides case management to coordinate and ensure the provision of all medically necessary services, including out of network services if necessary.
5. Registered Dieticians (RDs) may bill Partnership for CPT codes 98970 thru 98972 for monitoring meal plan journals virtually between sessions when treating a Member who has been diagnosed with an eating disorder. No TAR is required when the Member has an eating disorder diagnosis code on record.

C. BMHPs are responsible to provide and cover all medically necessary Specialty Mental Health Services (SMHS), *aka Serious and Persistent Mental Health Services*, for Medi-Cal Members in accordance with their contracts with the Department of Health Care Services (DHCS).
   1. If a Member requires partial hospitalization and or a residential eating disorder programs, the BMHP is responsible for the medically necessary SMHS components, and Partnership is responsible for the medically necessary physical health components of the treatment.
   2. Partnership and each county BMHP shall execute a Specialty Mental Health Services Memorandum of Understanding (MOU) to document the following:
      a. The division of financial responsibility. In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the BMHP for residential level treatment for eating disorders pursuant to APL 22-003.
      b. A plan in the event that Partnership and the BMHP cannot agree on how to divide financial responsibility. (*see policy MPBP8005ADM52 Dispute Resolution Between Partnership and BMHPs in Delivery of Mental Health Services*)
      c. Details about which plan will be responsible for establishing contracts detailing payment mechanisms with providers.
      d. A requirement that any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both Partnership and the BMHP.
      e. Specification of procedures to ensure timely and complete exchange of information by both the BMHP and Partnership for the purposes of medical and behavioral health care coordination to ensure the Mmember's medical record is complete and Partnership can meet its care coordination obligations. These procedures are either incorporated in the MOU or shared with the BMHP as part of the related policies which further describe how the provisions on the MOU are carried out.

D. Partnership will not delay the case management and care coordination, as well as the coverage of, medically necessary services pending the resolution of a dispute. *(see policy MPBP8005ADM52 Dispute Resolution Between Partnership and BMHPs in Delivery of Mental Health Services*)

D. Partnership Advantage Members

E.

1. Partnership Advantage Mmembers in need of eating disorder treatment will be provided care coordination to ensure they have full access to all medically necessary services for the treatment of eating disorders thatto which they are entitled.

1.

2. Partnership is fully responsible for the following levels of care for eating disorders for Partnership Advantage Members:
   a. acute and psychiatric inpatient treatment
   b. , partial hospitalization
   c. , intensive outpatient program services and
   a. outpatient services.
   d.

2. Residential treatment for eating disorders is not a covered service under Medicare. and Partnership Advantage Mmembers in need of this level of care will be provided care coordination, and treatment services will be a shared responsibility with the Mmember's county BHP pursuant to the cost-sharing arrangement agreed to between Partnership and the respective BHP.

3.

3.4. For Partnership Advantage Mmembers who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure Mmembers have access to, and are connected with, medically necessary services delivered by the BHP.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders (03/17/2022)
B. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
C. 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 (12/30/2022)
D. Welfare and Institutions Code (WIC) Section 14184.402 (b)-(d), (f), (i)(1)
E. Title 22 of the California Code of Regulations (CCR) Section 53855
F. DHCS APL 23-029 *Revised* Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/202301/08/2025)
   1. Specialty Mental Health Services Memorandum of Understanding Template
G. Practice Guideline for the Treatment of Patients with Eating Disorders: Third Edition. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
H. Alliance for Eating Disorders: Types of Eating Disorder Treatment. https://www.allianceforeatingdisorders.com/types-of-eating-disorder-treatment-levels-of-care/
I. Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database
   1. Article A57480 Billing and Coding: Psychiatry and Psychology Services
   2. Medicare National Coverage Determinations (NCD) Manual 100-03
J. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).
H.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

Policy/Procedure Number: MPC~~C~~BPU~~8013~~P3145~~ (previously MCUP3145)			**Lead Department: Health Services** **Business Unit: Behavioral Health**
Policy/Procedure Title: Eating Disorder Management Policy			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/10/2022 (MCUP3145)		**Next Review Date: 09/11/202506/11/2026** **Last Review Date: 09/11/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer; Behavioral Health Clinical Director

X. REVISION DATES:
MPBP8013:
06/11/25
~~09/13/23; 09/11/24~~

PREVIOUSLY APPLIED TO: ~~N/A~~
MCUP3145 08/10/2022 – 06/11/2025

Eating Disorder Process

(Inpatient, Residential, Partial Hospitalization Program (PHP), and Intensive Outpatient Program (IOP)

Note: Partnership HealthPlan of California (Partnership) and County share UM responsibilities. Partnership may maintain provider lists and contracts with providers

Eating Disorder Identification
PCP, Carelon, County, Health Plan, Hospital, UM identifies Eating Disorder and submits referral for assessment

APL 22-003/ BHIN 22-009

See Provider List below for assessment/Refer Outpatient to Carelon

Carelon:
Carelon will locate and refer member to outpatient ED provider based on recommendation
(855) 765-9703

Screening/Assessment:
- Provider conducts screening & recommends level of care
- Provider notifies Partnership BH Team of completed assessment and level of care recommendation Member
- reaches out to Partnership and County
- *If member meets criteria for higher level of care, provider will notify Partnership CC Team/BH Team to coordinate care*

Partnership Team:
Member reaches out to Partnership via ED_Collab@partnershiphp.org email address

County Behavioral Health:
Member reaches out to County Mental Health via Access Team

If member is in Acute Hospital BH Team/County will coordinate services based on need.

Urgent member:
- Members in an acute setting needing transition to another program
- Cases should be handled in an Urgent manner
- BH Team will contact county to discuss coordinate of care
- BH Team/County will determine needed assessments
- Strike Team will meet as needed within a timely manner
- PHC CC Team will provide case management services Partnership
- and County Behavioral Health will coordinate on members transition of care or placement into facility

Acute/Urgent Cases

County Behavioral Health:
- County monitors county compliance with MOU
- County pays Share of Cost invoices to Partnership based on agreements
- For disagreements: PHC Strike Team will meet with near immediate response to discuss next steps for complex case. Member will have access to care during determination.
- County will enroll member in appropriate mental health services/ programs, if not already enrolled.
- County will maintain clinical coordination with provider.

Email Coordination Bidirectional Form

Partnership Strike Team
Strike team can be called to discuss cases as needed

Partnership BH Team:
- BH will track members and status of members
- Monitor/report analytics to stakeholders and provide training on program
- BH will coordinate with County on all care
- BH Team will maintain provider lists, contracts with providers
- BH Team will monitor Partnership compliance with agreements
- BH Team will notify County Mental Health of referrals.

Partnership Care Coordination:
- Provides case management for ED members
- Consults with BH Team
- Ensures member has medical necessary services such as dietitians
- CC Coordinates placement provider with County/BH Team
- CC/BH Team schedules admit date, tests, and transportation as needed once approved by Partnership UM and County UM. CC will ensure approval prior to placement.

Approval:
- County Behavioral Health will notify Partnership of approval within 48 hours, excluding weekends and holidays via Bidirectional form

Disagreements:
- Partnership Strike Team will meet with near immediate response to determine next steps for complex case. Partnership Strike Team will include Partnership staff and County staff can attend.

Treatment without Prior Autorization:
- Should disputes arise between parties that cannot be resolved at the MCP and MHP level, MCP will follow the dispute resolution process contained in APL 21-013/BHIN 21-034 ("Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans")

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership and County share UM responsibilities. Partnership may maintain provider lists and contracts with providers

Step 1:

- Ensure member has Eating Disorder assessment, can be from any Eating Disorder specialist, BHH preferred.
- Members without assessment can be referred to Bright Heart Health for assessment by calling **925-621-8526** and requesting "Eating Disorder Level of Care Assessment"

Step 2:

- Partnership and county should be notified of referral to Bright Heart Health at **BH_Collab@partnershiphp.org**
- Once assessment is received, Partnership and/or county will coordinate with the other to determine services needed, locate provider and coordinate next steps
- County and Partnership can coordinate care by sending Bidirectional between parties

Step 2a:
For immediate assistance needed

- Notify Partnership at **BH_Collab@partershiphp.org** for members needing immediate assistance/services
- Partnership will reach out to Member's county and provider submitting referral
- Partnership and county will coordinate care via bidirectional form

Step 3:

- Partnership Care Coordination will reach out and assist member in connecting with PCP for medical needs
- Partnership Care Coordination will coordinate with BH Team for next steps on ED placement
- Partnership Care Coordination will assist member with transportation or other medical services needed

Step 4:

- County and Partnership BH Team will coordinate with provider and make referrals to providers as needed
- Partnership BH Team will submit bidirectional to leadership for LOA approval
- Partnership BH Team and county will agree on who will contract with provider
- Contracting entity (Partnership or County) will complete contracts with provider
- BH Team will provide county clinical contact to provider

Step 5:

- Partnership and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- County and Partnership will receive UM updates from providers
- Partnership BH Team and county will coordinate follow on care for members

Step 6:

- Claims adjudication
- For Medi-Cal only, Partnership and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- For Partnership Advantage Members, Partnership shall be responsible for PHP and IOP levels of care
- Contracting entity (Partnership or County) will adjudicate claims and bill the other party for share of cost
- Contracting entity (Partnership or County) will provide other party copy of claims/invoice for payment

BH Administrator approval
Stamp will go here

Eating Disorder Bidirectional Form

Please submit the form to the Partnership Behavioral Health (BH) Team at ED_Collab@partnershiphp.org

DATE OF REQUEST:

REQUESTER NAME: **EMAIL:**

URGENT (SAME DAY, END OF BUSINESS) ☐ **PRIORITY** (WITHIN 2 BUSINESS DAYS) ☐ **ROUTINE** (WITHIN 4 BUSINESS DAYS) ☐

Level of care recommendation completed: **Yes** ☐ **No** ☐ (Please contact Partnership BH department for assistance with an assessment, if needed)

Member Information

Name:	Address:	Phone:	
PCP:	**County/Agency:**	**CIN:**	**DOB:**
	Select County		

Services Requested

Inpatient: ☐
Residential: ☐
Partial Hospitalization (PHP): ☐

Intensive Outpatient (IOP): ☐
Care Coordination: ☐
Dietitian: ☐

Do you want Partnership to contract with the provider:
Yes: ☐ No: ☐

** For outpatient services, refer to Carelon with standard referral process

Requested Provider Information

** The provider you would like member to be connected to.

Provider:	Address:	Admission Phone:
Contact Name:	**Phone:**	**Email:**

Referral Submitted: **Yes** ☐ No ☐

Admission Date: (If known) Length of Stay: (If known)

Clinical Information

(Included information should be BMI, height, weight, any medical conditions, co-occuring disorders, diagnosis(es), family or social concerns, homelessness, etc.)

Contact Information

BH Team Coordinator:	Eric Rushing	**Phone:**	(530) 351-9027	**Email:**	erushing@partnershiphp.org
Partnership Care Coordinator Name:		**Phone:**		**Email:**	
County Clinician Name:		**Phone:**		**Email:**	
County Fiscal Name:		**Phone:**		**Email:**	
Primary Care Doctor:		**Phone:**		**Email:**	

Would you like the provider to send clinical updates to your clinician? **Yes** ☐ **No** ☐

Approval Signatures:

Partnership Behavioral Health Representative

County Representative

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3145				**Lead Department: Health Services**	
Policy/Procedure Title: Eating Disorder Management Policy				☒**External Policy** ☐ **Internal Policy**	
Original Date: 08/10/2022			**Next Review Date:** ~~09/11/2025~~N/A **Last Review Date:** 09/11/2024		
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				~~Approval~~ Archive **Date:** ~~09/11/2024~~06/11/2025	

I. RELATED POLICIES:

A. MCUP3028 - Mental Health Services
B. MCUG3024 - Inpatient Utilization Management
C. MCUP3014 - Emergency Services
D. MCUP3052 - Medical Nutrition Services
E. MPCD2013 - Care Coordination Program Description
F. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
G. ADM52 - Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Eating Disorder: Per the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition, feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.
B. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services* Managed Care Plans (MCPs) are responsible for providing or arranging for medically necessary NSMHS provided to members which include *(per Reference VII.D)*:
   1. Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services
   2. Psychological 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

[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 webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.

C. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services* Mental Health Plans (MHPs) are required to provide and cover all medically necessary SMHS in accordance with their contracts with the California Department of Health Care Services (DHCS).

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

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

F. Eating Disorder Treatment Levels of Care:

1. **Outpatient**: Patient lives at home and attends weekly (usually 1:1) sessions with their provider. Patient is determined to not need daily medical monitoring and patient is psychiatrically stable enough to live at home and engage in prescribed treatment programming. Eating disorder symptoms are under sufficient control such that individual can function normally in social, educational, or vocational situations and continue to make progress in treatment.
2. **Intensive Outpatient**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs 2 to 3 times per week for at least three (3) hours each time, and groups in addition to 1:1 treatment may be part of the program. The patient is medically and psychiatrically stable enough to live at home, and they will often maintain work and/or school obligations while engaging in treatment.
3. **Partial Hospital**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs five (5) days per week for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals. Patient remains medically and psychiatrically stable enough to live at home, but requires highly structured, intensive, eating disorder treatment to reduce eating disorder symptoms and achieve progress towards recovery.
4. **Residential**: Patient lives at a specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors. Patient is medically stable. Treatment typically involves programming that occurs daily for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals, and co-occurring psychiatric care. All meals and snacks are supervised and provided in a supportive environment. Depending on the program, more complex medical needs such as nasogastric tube feeding may or may not be available.
5. **Inpatient Eating Disorder Program**: Patient lives at specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors, and lower levels of care have often proven to provide insufficient structure and monitoring to improve eating disorder symptoms. Oftentimes, the patient requires additional medical or psychiatric oversight for complex issues or needs that are not able to be handled in Residential level of care (e.g., nasogastric tube feeding, significant mood or psychiatric instability that requires active daily management). Focus is on weight restoration.
6. **Inpatient Acute Care Medical Hospital**: Patient is medically unstable (i.e., unstable or depressed vital signs, laboratory findings indicative of acute physiologic risk, complications from coexisting medical conditions such as diabetes) and often also psychiatrically unstable (i.e., suicidality, rapidly worsening mood or other psychiatric symptoms). Focus is on weight restoration and stabilization of acute medical abnormalities.
7. **Inpatient Acute Care Psychiatric Hospital**: In most instances, patient is not acutely medically unstable (see Inpatient Acute Care Medical Hospital above), but has active psychiatric symptoms

that require specialty inpatient psychiatric care (e.g., significant mood symptoms, suicidality/homicidality, psychosis). Most units will not be equipped to manage lines/tubes. Focus is on achieving stabilization of acute psychiatric symptoms, not necessarily eating disorder treatment.

IV. ATTACHMENTS:

A. Eating Disorder Process Flow Chart
B. Eating Disorder Bidirectional Form

V. PURPOSE:

To delineate how appropriate and effective services and treatments for Partnership members with eating disorders are coordinated between Partnership, which provides medically necessary physical health and non-specialty mental health services, and the county Mental Health Plans in Partnership's service area, which provide all medically necessary specialty mental health services.

VI. POLICY / PROCEDURE:

A. Coordinating appropriate and effective services and treatment for members with eating disorders is a shared responsibility between Partnership HealthPlan (Partnership) and each county Mental Health Plan (MHP) in Partnership's service area. When evaluating requests for members under age 21, both Partnership and MHPs will consider EPSDT criteria, including assessment of whether the service is necessary to correct or ameliorate the condition and whether or not the service is generally only available to Members over age 21 (*see policy MCCP2022 Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services*).
    1. As a Managed Care Plan, Partnership is responsible for all medically necessary physical health components of eating disorder treatment and providing or arranging medically necessary non-specialty mental health services (NSMHS) (*see III.B above*) for our members.
        a. Partnership provides inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization. Partnership also provides or arranges for NSMHS for members requiring these services.
        b. Partnership covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. Emergency services include professional services and facility charges claimed by emergency departments including, but not limited to the following: 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 that are medically necessary to stabilize the member.
        c. If a Member requires partial hospitalization and a residential eating disorder program, Partnership is responsible for the medically necessary physical health components of the treatment, including locating, arranging, and following up to ensure services were rendered. (The MHP is responsible for the medically necessary Specialty Mental Health Services (SMHS) components.)
        d. Partnership provides case management to coordinate and ensure the provision of all medically necessary services, including out of network services if necessary.
        e. Registered Dieticians (RDs) may bill Partnership for CPT codes 98970 thru 98972 for monitoring meal plan journals virtually between sessions when treating a Member who has been diagnosed with an eating disorder. No TAR is required when the Member has an eating disorder diagnosis code on record.
    2. MHPs are responsible to provide and cover all medically necessary Specialty Mental Health

Services (SMHS), *aka Serious and Persistent Mental Health Services*, in accordance with their contracts with the Department of Health Care Services (DHCS).

a. If a Member requires partial hospitalization and a residential eating disorder programs, the MHP is responsible for the medically necessary SMHS components, and Partnership is responsible for the medically necessary physical health components of the treatment.

3. Partnership and each county MHP shall execute a Specialty Mental Health Services Memorandum of Understanding (MOU) to document the following:
   a. The division of financial responsibility. In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the MHP for residential level treatment for eating disorders pursuant to APL 22-003.
   b. A plan in the event that Partnership and the MHP cannot agree on how to divide financial responsibility. (*see policy ADM52 Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services*)
   c. Details about which plan will be responsible for establishing contracts detailing payment mechanisms with providers.
   d. A requirement that any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both Partnership and the MHP.
   e. Specification of procedures to ensure timely and complete exchange of information by both the MHP and Partnership for the purposes of medical and behavioral health care coordination to ensure the member's medical record is complete and Partnership can meet its care coordination obligations. These procedures are either incorporated in the MOU or shared with the MHP as part of the related policies which further describe how the provisions on the MOU are carried out.
4. Partnership will not delay the case management and care coordination, as well as the coverage of, medically necessary services pending the resolution of a dispute. *(see policy ADM52 Dispute Resolution Between Partnership and MHPs in Delivery of Mental Health Services*)

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders (03/17/2022)
B. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
C. 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 (12/30/2022)
D. Welfare and Institutions Code (WIC) Section 14184.402 (b)-(d), (f), (i)(1)
E. Title 22 of the California Code of Regulations (CCR) Section 53855
F. 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
G. Practice Guideline for the Treatment of Patients with Eating Disorders: Third Edition. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
H. Alliance for Eating Disorders: Types of Eating Disorder Treatment. https://www.allianceforeatingdisorders.com/types-of-eating-disorder-treatment-levels-of-care/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

Policy/Procedure Number: MCUP3145		Lead Department: Health Services
Policy/Procedure Title: Eating Disorder Management Policy		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/10/2022	**Next Review Date: 09/11/2025N/A** **Last Review Date: 09/11/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer; Behavioral Health Clinical Director

X. REVISION DATES: 09/13/23; 09/11/24; ARCHIVED 06/11/2025

PREVIOUSLY APPLIED TO: N/A

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership HealthPlan of California (PHC) and County share UM responsibilities. PHC may maintain provider lists and contracts with providers

Eating Disorder Identification
PCP, Carelon, County, Health Plan, Hospital, UM identifies Eating Disorder and submits referral for assessment

APL 22-003/ BHIN 22-009

See Provider List below for assessment/Refer Outpatient to Carelon

Carelon:
Carelon will locate and refer member to outpatient ED provider based on recommendation
(855) 765-9703

Screening/Assessment:
- Provider conducts screening & recommends level of care
- Provider notifies PHC BH Team of completed assessment and level of care recommendation
- Member reaches out to PHC and County
- *If member meets criteria for higher level of care, provider will notify PHC CC Team/BH Team to coordinate care*

PHC Team:
Member reaches out to PHC via ED_Collab@partnershiphp.org email address

County Mental Health:
Member reaches out to County Mental Health via Access Team

If member is in Acute Hospital BH Team/County will coordinate services based on need.

County Mental Health:
- County monitors county compliance with MOU
- County pays Share of Cost invoices to PHC based on agreements
- For disagreements: PHC Strike Team will meet with near immediate response to discuss next steps for complex case. Member will have access to care during determination.
- County will enroll member in appropriate mental health services/programs, if not already enrolled
- County will maintain clinical coordination with provider

Email Coordination Bidirectional Form

PHC BH Team:
- BH will track members and status of members
- Monitor/report analytics to stakeholders and provide training on program
- BH will coordinate with County on all care
- BH Team will maintain provider lists, contracts with providers
- BH Team will monitor PHC compliance with agreements
- BH Team will notify County Mental Health of referrals.

PHC Care Coordination:
- Provides case management for ED members
- Consults with BH Team
- Ensures member has medically necessary services such as dietitians
- CC Coordinates placement provider with County/BH Team
- CC/BH Team schedules admit date, tests, and transportation as needed once approved by PHC UM and County UM. CC will ensure approval prior to placement.

Urgent member:
- Members in an acute setting needing transition to another program
- Cases should be handled in an Urgent manner
- BH Team will contact county to discuss coordination of care
- BH Team/County will determine needed assessments
- Strike Team will meet as needed within a timely manner
- PHC CC Team will provide case management services
- PHC and County Mental Health will coordinate on Member's transition of care or placement into facility

Acute/Urgent Cases

PHC Strike Team
Strike team can be called to discuss cases as needed

Approval:
- County Mental Health will notify PHC of approval within 48 hours, excluding weekends and holidays via bidirectional form

Disagreements:
- PHC Strike Team will meet with near immediate response to determine next steps for complex case. PHC Strike Team will include PHC staff and County staff can attend.

Treatment without Prior Authorization:
- Should disputes arise between parties that cannot be resolved at the MCP and MHP level, MCP will follow the dispute resolution process contained in APL 21-013/BHIN 21-034 ("Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans")

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership HealthPlan of California (PHC) and County share UM responsibilities. PHC may maintain provider lists and contracts with providers

Step 1:
- Ensure member has Eating Disorder assessment, can be from any Eating Disorder specialist, Bright Heart Health (BHH) preferred.
- Members without assessment can be referred to Bright Heart Health for assessment by calling **925-621-8526** and requesting "Eating Disorder Level of Care Assessment"

Step 2:
- Partnership and county should be notified of referral to Bright Heart Health at **BH_Collab@partnershiphp.org**
- Once assessment is received, PHC and/or county will coordinate with the other to determine services needed, locate provider and coordinate next steps
- County and PHC can coordinate care by sending bidirectional form between parties

Step 2a:
For immediate assistance needed
- Notify PHC at **BH_Collab@partershiphp.org** for members needing immediate assistance/services
- PHC will reach out to Member's county and provider submitting referral
- PHC and county will coordinate care via bidirectional form

Step 3:
- PHC Care Coordination will reach out and assist member in connecting with PCP for medical needs
- PHC Care Coordination will coordinate with BH Team for next steps on ED placement
- PHC Care Coordination will assist member with transportation or other medical services needed

Step 4:
- County and PHC BH Team will coordinate with provider and make referrals to providers as needed
- PHC BH Team will submit bidirectional form to leadership for LOA approval
- PHC BH Team and county will agree on who will contract with provider
- Contracting entity (PHC or County) will complete contracts with provider
- BH Team will provide county clinical contact to provider

Step 5:
- PHC and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- County and PHC will receive UM updates from providers
- PHC BH Team and county will coordinate follow on care for Members

Step 6:
- Claims adjudication
- PHC and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- Contracting entity (PHC or County) will adjudicate claims and bill the other party for share of cost
- Contracting entity (PHC or County) will provide other party copy of claims/invoice for payment

BH Administrator approval
Stamp will go here

Eating Disorder Bidirectional Form

Please submit the form to the Partnership Behavioral Health (BH) Team at ED_Collab@partnershiphp.org

DATE OF REQUEST:

REQUESTER NAME: **EMAIL:**

URGENT (SAME DAY, END OF BUSINESS) ☐ **PRIORITY** (WITHIN 2 BUSINESS DAYS) ☐ **ROUTINE** (WITHIN 4 BUSINESS DAYS) ☐

Level of care recommendation completed: **Yes** ☐ **No** ☐ (Please contact Partnership BH department for assistance with an assessment if needed)

Member Information

Name:	Address:	Phone:	
PCP:	**County/Agency:**	**CIN:**	**DOB:**
	Select County		

Services Requested

Inpatient: ☐
Residential: ☐
Partial Hospitalization (PHP): ☐
Intensive Outpatient (IOP): ☐
Care Coordination: ☐
Dietitian: ☐

Do you want Partnership to contract with the provider: Yes: ☐ No: ☐

** For outpatient services, refer to Carelon with standard referral process

Requested Provider Information

** The provider you would like member to be connected to.

Provider:	Address:	Admission Phone:
Contact Name:	**Phone:**	**Email:**

Referral Submitted: **Yes** ☐ No ☐ Admission Date: (If known) Length of Stay: (If known)

Clinical Information

(Included information should be BMI, height, weight, any medical conditions, co-occuring disorders, diagnosis(es), family or social concerns, homelessness, etc.)

Contact Information

BH Team Coordinator:	Eric Rushing	**Phone:**	(530) 351-9027	**Email:**	erushing@partnershiphp.org
Partnership Care Coordinator Name:		**Phone:**		**Email:**	
County Clinician Name:		**Phone:**		**Email:**	
County Fiscal Name:		**Phone:**		**Email:**	
Primary Care Doctor:		**Phone:**		**Email:**	

Would you like the provider to send clinical updates to your clinician? **Yes** ☐ **No** ☐

Approval Signatures:

Partnership Behavioral Health Representative

County Representative

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPC~~C~~AP7004 (*previously MCCP2033*)				**Lead Department:** Health Services Business Unit: EHS	
Policy/Procedure Title: Community Health Worker (CHW) Services Benefit				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/08/2023 **Effective Date:** 07/01/2022 vs. DHCS			**Next Review Date:** ~~10/09/2025~~06/10/2026 **Last Review Date:** ~~10/09/2024~~06/11/2025		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	~~☒~~ ☒**Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIAL~~ING~~S**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~10/09/2024~~06/11/2025	

I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
B. MCCP2032 – CalAIM Enhanced Care Management (ECM)
C. ~~MCUP3142~~ MCAP7003 – CalAIM Community Supports (CS)
D. ~~MCUP3143~~ MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
E. MCUP3041 – Treatment Authorization Request (TAR) Review Process
F. MCUP3113 – Telehealth Services
G. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
H. ~~MCUP3146~~ MPAP7005 – Street Medicine

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by Dual-Eligible Special Needs Plans (D-SNPs) as determined by the State.

~~A.~~B. 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.~~C. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.

~~C.~~D. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their

community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

~~D.~~E. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

~~E.~~F. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.51532).

~~F.~~G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are ~~community~~ community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

~~G.~~H. 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.

I. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).

~~H.~~J. ~~)~~.Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~I.~~K. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

~~J.~~L. Supervising Providers: The organizations with which Partnership HealthPlan of California (Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL 24-006-, oversees CHWs and the services delivered to Partnership Members, and submits claims for services provided by CHWs.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the Community Health Worker (CHW) Medi-Cal benefit (effective July 1, 2022), including categories of service and pathways to CHW certification.

VI. POLICY / PROCEDURE:

A. Partnership recognizes the CHW benefit as a means to ensure that members have improved access to culturally competent services that link health and social resources with the intent to improve the overall

quality of health and wellbeing of the member population. CHW services may be provided through multiple entities including contracted primary care providers (PCPs), community-based organizations (CBOs), as well as via health plan staff trained to perform services normally provided by CHWs

B. CHW Qualifications
   1. Per APL 24-006 Community Health Worker Services Benefit-, CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.
   2. CHWs must demonstrate, and Supervising providers must maintain evidence of, minimum qualifications that may be met through one of the following means:
      a. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
         1) CHW Certificate: A CHW Certificate allows a CHW to provide all covered CHW services including violence prevention services. It must be a valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas as determined by the Supervising Provider:
            a) communication
            b) interpersonal and relationship building
            c) service coordination and navigation
            d) capacity building
            e) advocacy
            f) education and facilitation
            g) individual and community assessment
            h) professional skills and conduct
            i) outreach
            j) evaluation and research, and
            k) basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider.
            l) Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 24-006, including violence prevention services.
         2) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.
            a) A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or completion of a general CHW Certificate.
      b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
         1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.

3. Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area.

C. Supervising Provider Responsibilities
1. The Supervising Provider ensures that CHWs meet all required qualifications, maintains evidence of the CHW's experience (as mentioned in section VI.B.2.) and training, and oversees CHWs and the services delivered to Partnership Members.
2. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, nor do they need to have a licensed provider on staff in order to contract with Partnership to provide CHW services.
3. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is responsible for ensuring the provision of CHW services complies with all applicable requirements.
4. Supervising Providers must provide direct or indirect oversight to CHWs.
   a. Supervising providers (or their Subcontractors contracting with or employing CHWs to provide covered CHW services to the MCP's Members) must ensure CHWs have adequate supervision and training.
   b. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of the care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
   c. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
5. See policy MPCR11 Credentialing of Community Health Worker (CHW) Supervising Providers for further information on credentialing requirements for Supervising Providers.

D. Partnership CHW Workforce Initiative
1. Partnership actively supports local partnerships and CHW training across our network, including funding by the Health Resources and Services Administration (HRSA).
2. Partnership encourages providers to integrate CHWs into basic Population Health Management (PHM) and preventive care, and to give anticipatory guidance in support of the primary care team, Enhanced Care Management (ECM) teams, and perinatal care teams.
3. Partnership surveys our provider network periodically to get an understanding of how many CHWs are providing services, what area of focus/training the CHWs have, and if they have capacity for referrals from outside agencies.
4. Partnership is actively building a mechanism for Partnership staff and outside providers to search for organizations with CHW capacity for outside referrals, so they can make referrals to CHWs matched to the needs of individual members.

E. Informing providers about the CHW benefit
1. Partnership publicizes our current understanding of the regulatory framework for CHWs with our provider network and community-based organizations in community meetings, provider meetings, and in provider newsletters.
2. Partnership's Provider Relations department educates providers on CHW services through the Medical Director's newsletter, Provider quarterly newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

F. Informing members about the CHW benefit
1. Partnership's Health Education team crafts communications that are culturally and linguistically appropriate and explain CHW services to our members. Details of the CHW benefit and services are outlined in Partnership's Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services.

2. 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.
3. CHW can provide qualifying members with specific support and offer tailored communication about how these services can support their health and wellbeing. Members referred to these services can be provided with materials explaining the services and are given the option to opt out of CHW services.

G. Member Eligibility for CHW services

~~1.~~ Members who meet the eligibility criteria for receiving CHW services have a standing recommendation issued by DHCS. ~~CHW services require a written recommendation submitted to Partnership by a physician or other licensed practitioner of the healthy arts, within their scope of practice under state law.~~

~~a. Partnership accepts recommendations for CHW services from other licensed practitioners, whether they are in the Network or Out of Network Providers, within their scope of practice. Other licensed practitioners who can recommend CHW services within their scope of practice include physician assistants, nurse practitioners, clinical nurse specialists, podiatrist, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocation nurses, and pharmacists.~~

~~b.~~a. For CHW services rendered in the ED, the treating Provider may ~~verbally recommend CHWs to initiate services and later~~ document the recommendation in the Member's medical record of the ED visit. ~~The required recommendation can be provided by a written recommendation placed in the Member's record.~~

2. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider, whom does not need to be Medi-Cal enrolled, must determine whether a Member meets eligibility criteria based on the presence of one or more of the following before recommending CHW services:
   a. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
   c. Any stressful life event presented via the Adverse Childhood Events (ACEs) screening.
   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
   f. One or more visits to a hospital emergency department (ED) within the previous six months.
   g. One or more hospital visits or hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
   h. One or more stays at a detox facility within the previous year.
   i. Two or more missed medical appointments within the previous six months.
   j. Member expressed need for support in health system navigation or resource coordination services.
   k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.

3. CHW violence prevention services are specific to community violence (e.g. gang violence) and are available to Members who meet any of the following circumstances as determined by a licensed practitioner:
   a. The Member has been violently injured as a result of community violence.
   b. The Member is at significant risk of experiencing violent injury as a result of community violence.
   c. The Member has experienced chronic exposure to community violence.
4. CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

H. Assessing and Identifying Member Needs for CHW Services
1. In addition to recommending that Providers identify member needs for CHW services, Partnership also assesses member needs for services and determines priority populations using a data driven approach. Partnership attempts outreach to identified members and their Providers and offers to connect the qualifying Members to needed CHW services. Data sources may include, but are not limited to, using past and current Member utilization/encounters, Partnership's proprietary risk score model, risk stratification and segmentation methodology, utilization reports showing member hospitalizations and ED visits, data on health risks and clinical core gaps, demographic and SDOH data, referrals from the community (including Provider referrals) for services, member self-referral to identify members who may benefit from CHW services, and needs assessments.
2. Populations of special focus include:
   a. Children who need preventive care
   b. Members who under-utilize primary care
   c. Pregnant or newly delivered members
   d. Members who have behavioral health needs, substance use disorders (SUD), or conditions requiring integration of physical and behavioral health.
   e. Members newly released from incarceration.

I. Documentation Requirements
1. CHWs are required to document the dates and time/duration of services provided to Members, which should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
2. Documentation must be accessible to the Supervising Provider upon their request.
3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

J. Authorization for CHW Services and Care Plans
1. Partnership does not require prior authorization for CHW services as preventive care for the first 12 units with a limit of four (4) units a day.
2. For Members who need multiple CHW services or continued CHW services in excess of 12 units, a prior authorization request (TAR) is required (see Partnership Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for requirements and procedures).
   a. Documentation to be provided with the TAR includes ~~the original written recommendation,~~ a written care plan that must be written by one or more individual licensed providers (with the exception of services provided in the ED) which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.
      1) The care plan must state the following:
         a) Specify the condition that the service is being ordered for and be relevant to the condition
         b) Include a list of other health care professionals providing treatment for the condition or barrier
         c) Contain written objectives that specifically address the recipient's condition or barrier

affecting their health
   d) List the specific services required for meeting the written objectives
   e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives
2) The Provider submitting the care plan does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
3) CHWs may participate in the development of the care plan and may take a lead role in drafting the care plan if done in collaboration with the Member's care team and/or other Providers ~~which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.~~.
4) The plan of care may not exceed a period of one year.
5) The care plan must state the following:
   a) Specify the condition that the service is being ordered for and be relevant to the condition
   b) Include a list of other health care professionals providing treatment for the condition or barrier
   c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
   d) List the specific services required for meeting the written objectives; and
   e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives.
6) A licensed Provider must review the member's care plan at least every six months from the effective date of the initial care plan. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.
   a) TARs will be authorized for 6 months and reauthorization will be contingent upon submission of a reviewed/updated care plan.
   b) If there is a significant change in the member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

K. Partnership's CHW Program Standards
1. Partnership will not establish unreasonable or arbitrary barriers for accessing coverage.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste and abuse of CHW services through committees that review for over and under-utilization of services.
3. Partnership uses CHWs to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate CHWs into basic population health management and preventive care activities. This may include:
   a. Referrals for families with children requiring preventive care
   b. Referrals for vulnerable pregnant members who may benefit from added support through pregnancy and the first year of a child's life
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits.
5. Partnership will encourage recruitment of CHWs who have lived experience with incarceration, behavioral health concerns, homelessness, and other vulnerable populations to provide CHW services to members facing these challenges.
6. Partnership will track quality indicators for those members who use CHW services compared to a matched sample of members who do not agree to CHW services. For example:
   a. HEDIS compliance with well-child visits for families requiring preventive care

b. HEDIS compliance with prenatal, post-partum, and well-baby visits for pregnant mothers
c. Member satisfaction post benefit-utilization for a representative sample of those using the CHW benefit.

7. Partnership will assess the CHW workforce through several means:
   a. Surveying providers known to be using CHWs to determine the number of CHWs engaged by provider, the particular population of focus for each CHW, and a percentage of population covered calculated by provider and by county.
   b. Tracking utilization rates using the DHCS-designated CPT/HCPCS billing codes for CHW services that are not billed under global services (such as ECM or perinatal services).

L. CHW Services Provided
1. CHW services can be provided as individual or group ~~sessions, and~~sessions and can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services may also be provided via telehealth (see policy MCUP3113 Telehealth Services). There are no service location limits.
2. Services may be provided to a parent or legal guardian of Members under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. Services for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal or Partnership Advantage, the Member must be present during the session. Covered services do not require a license.
3. CHWs may render street ~~medicine~~medicine, and the Supervising Provider would bill Partnership for any appropriate and applicable services within the scope of the CHW benefit. (Street Medicine services are defined by DHCS in APL 24-001 *Street Medicine Provider: Definitions and Participation In Managed Care* dated 01/12/2024)
4. Covered CHW services do not include any service that requires a license.
5. CHW Services include:
   a. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
   b. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care, including, and communicating cultural and language preferences to providers. Health navigation includes connecting Members to community resources necessary to promote health; addressing barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
      1) Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
      2) Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
      3) Help a Member enroll or maintain enrollment in government or other assistance programs related to improving their health, if such navigation services are provided pursuant to a plan of care.
   c. Screening and Assessment: Providing screening and assessment services that do not require a ~~license, and~~license and assisting Members with connecting to appropriate services to improve their health, including connecting individuals and families with community-based resources.
   d. Individual Support or Advocacy: Assisting Members in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative or other covered benefits.

M. Non-Covered CHW Services
   1. Non-covered CHW services include, but are not limited to:
      a. Clinical case management/care management that requires a license
      b. Child care
      c. Chore services, including shopping and cooking meals
      d. Companion services
      e. Employment services
      f. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
      g. Delivery of medication, medical equipment, or medical supply
      h. Personal care services/Homemaker services
      i. Respite care
      j. Services that duplicate another covered Medi-Cal service already being provided to a Member
      k. Socialization
      l. Transporting members
      m. Services provided to individuals not enrolled in Medi-Cal, except as noted above
      n. Services that require a license
      o. Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. (CHW services are distinct and separate from Peer Support Services.)

N. Partnership is actively working towards establishing closed loop referrals for services provided by CHWs, peer counselors (peer support not duplicative of other covered Medi-Cal or Medicare D-SNP benefits), and local community organizations, as defined at III.~~A~~B. above. Closed loop referrals are currently accomplished through:
   1. Tracking member referrals through Partnership's case management system and sharing access to this system with providers.
   2. Leveraging Community Information Exchanges (CIEs) to allow community-based organizations and their staff to have insight into services and referrals made on behalf of shared members/clients.
   3. Establishing protocols for documenting and sharing referral data in shared systems.

O. Billing, Claims, and Payments
   1. CHW services will be reimbursed through a CHW Supervising Provider in accordance with its Provider ~~contract..~~contract.
   2. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services.
   3. Claims for CHW services will be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined in the Medi-Cal Provider Manual at Community Health Worker (CHW) Preventive Services (*chw prev*).
   4. Partnership does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the care plan as described in section VI.J.2.
   5. Encounter data:
      a. Partnership shall submit all CHW encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
      b. Partnership shall be responsible for submitting to DHCS all CHW encounter data, including encounter data for CHW generated under subcontracting arrangements.
      ~~c. In the event the CHW Supervising Provider is unable to submit CHW encounters to Partnership using the national standard specifications and code sets to be defined by DHCS, Partnership shall be responsible for converting CHW Supervising Providers' invoices data into the national standard specifications and code sets for submission to DHCS.~~

6. Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM or CICM, which is inclusive of the services within the CHW benefit. Through Partnership's Claims process, Partnership shall ensure that members shall not receive duplicative services through CHW and/or ECM or CICM. Please see Partnership policies MCCP2032 CalAIM Enhanced Care Management and ~~MCUP3143~~ ~~MCAL7001~~ MCAP7001CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
7. Tribal clinics may bill Partnership for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Medi-Cal Provider Manual
~~8.~~ For purposes of the services rendered by CHWs, FQHC and Rural Health Clinic (RHC) providers are not authorized as supervising providers in the Medi-Cal State Plan. Although FQHC and RHC providers may use CHWs to provide covered CHW preventive services, CHWs are not considered to be FQHC and RHC billable providers.~~Pursuant to Welfare and Institutions Code (WIC) 14087.325 (d), Partnership is required to reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that Partnership would make for the same scope of services if the services were furnished by another provider type that is not an FQHC or RHC.~~

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) supersedes APL 22-016
B. State Plan Amendment (SPA) 22-0001
C. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
D. Welfare and Institutions Code (WIC) 14087.325(d)
E. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
F. DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) supersedes APL 22-023
~~F.~~G. DHCS Standing Order

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
MPAP7004: 06/11/25

Partnership Advantage (effective Jan. 1, 2026)
06/11/25

PREVIOUSLY APPLIED TO: ~~N/A~~
MCCP2033: 02/0823 (effective 07/01/22); 02/14/24; 1/09/24 – 06/11/25

****

Policy/Procedure Number: ~~MCCP2003~~MPAP7004			**Lead Department: Health Services** **Business Unit: EHS**
Policy/Procedure Title: Community Health Worker (CHW) Services Benefit			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/08/2023 Effective Date: 07/01/2022 vs. DHCS		**Next Review Date: 10/09/202506/10/2026** **Last Review Date: 10/09/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☒~~ **Partnership Advantage**

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.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2033</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Community Health Worker (CHW) Services Benefit</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 02/08/2023
Effective Date: 07/01/2022 vs. DHCS</td><td colspan="4">Next Review Date: ~~10/09/2025~~N/A
Last Review Date: 10/09/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Archived Date: 06/11/2025~~Approval Date: 10/09/2024~~</td></tr>
</table>

I. RELATED POLICIES:

A. MCND9001 – Population Health Management Strategy & Program Description
B. MCCP2032 – CalAIM Enhanced Care Management (ECM)
C. MCUP3142 – CalAIM Community Supports (CS)
D. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
E. MCUP3041 – Treatment Authorization Request (TAR) Review Process
F. MCUP3113 – Telehealth Services
G. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
H. MCUP3146 – Street Medicine

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Closed loop referral: A closed loop referral means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and /or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.
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. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.
D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions

or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

E. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.51532).

F. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM

G. Licensed Practitioner of the Healing Arts (LPHA): For the purposes of this policy, an individual who, within the scope of State law, has the ability and appropriate state licensure to independently make a clinical assessment, certify a diagnosis and recommend treatment.

H. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP).

I. Street Medicine: Refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment.

J. Supervising Providers: The organizations with which Partnership HealthPlan of California (Partnership) contracts that employ or otherwise oversee the CHWs. The Supervising Provider must be a licensed provider, a hospital including the Emergency Department (ED), outpatient clinic, local health jurisdiction (LHJ), or community-based organization (CBO). The Supervising Provider ensures that CHWs meet Department of Health Care Services (DHCS) qualifications as listed in APL 24-006 , oversees CHWs and the services delivered to Partnership Members, and submits claims for services provided by CHWs.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the Community Health Worker (CHW) Medi-Cal benefit (effective July 1, 2022) including categories of service and pathways to CHW certification.

VI. POLICY / PROCEDURE:

A. Partnership recognizes the CHW benefit as a means to ensure that members have improved access to culturally competent services that link health and social resources with the intent to improve the overall quality of health and wellbeing of the member population. CHW services may be provided through multiple entities including contracted primary care providers (PCPs), community-based organizations (CBOs), as well as via health plan staff trained to perform services normally provided by CHWs

B. CHW Qualifications

1. Per APL 24-006 Community Health Worker Services Benefit , CHWs must have lived experience that aligns with and provides a connection between the CHW and the Member or population served. This may include, but is not limited to, experience related to incarceration, military service, pregnancy and birth, disability, foster system placement, homelessness, mental health conditions or substance use, or being a survivor of domestic or intimate partner violence or abuse and exploitation. Lived experience may also include shared race, ethnicity, sexual orientation, gender identity, language, or cultural background with one or more linguistic, cultural, or other groups in the community for which the CHW is providing services.

2. CHWs must demonstrate, and Supervising providers must maintain evidence of, minimum qualifications that may be met through one of the following means:
   a. Certificate Pathway: CHWs demonstrating qualifications through the Certificate Pathway must provide proof of completion of at least one of the following certificates:
      1) CHW Certificate: A CHW Certificate allows a CHW to provide all covered CHW services including violence prevention services. It must be a valid certificate of completion of a curriculum that attests to demonstrated skills and/or practical training in the following areas as determined by the Supervising Provider:
         a) communication
         b) interpersonal and relationship building
         c) service coordination and navigation
         d) capacity building
         e) advocacy
         f) education and facilitation
         g) individual and community assessment
         h) professional skills and conduct
         i) outreach
         j) evaluation and research, and
         k) basic knowledge in public health principles and Social Drivers of Health (SDOH), as determined by the Supervising Provider.
         l) Certificate programs must also include field experience as a requirement. A CHW Certificate allows a CHW to provide all covered CHW services described in APL 24-006, including violence prevention services.
      2) Violence Prevention Professional Certificate: For individuals providing CHW violence prevention services only, a Violence Prevention Professional (VPP) Certificate issued by Health Alliance for Violence Intervention or a certificate of completion in gang intervention training from the Urban Peace Institute.
         a) A VPP Certificate allows a CHW to provide CHW violence prevention services only. A CHW providing services other than violence prevention services must demonstrate qualification through either the Work Experience Pathway or completion of a general CHW Certificate.
   b. Work Experience Pathway: Individuals having at least 2,000 hours working as a CHW in paid or volunteer positions within the previous three years and who demonstrate skills and practical training in the areas described above (as determined and validated by the Supervising Provider) may provide CHW services without a certificate for a maximum period of 18 months.
      1) A CHW who does not have CHW certification must earn certification, as described above, within 18 months of the first CHW visit provided to a Member.
3. Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area.

C. Supervising Provider Responsibilities
1. The Supervising Provider ensures that CHWs meet all required qualifications, maintains evidence of the CHW's experience (as mentioned in section VI.B.2.) and training, and oversees CHWs and the services delivered to Partnership Members.
2. The Supervising Provider does not need to be the same entity as the Provider who made the referral for CHW services, nor do they need to have a licensed provider on staff in order to contract with Partnership to provide CHW services.
3. Supervising Providers do not need to be physically present at the location when CHWs provide services to Members. Management and day-to-day supervision of CHWs as employees may be delegated as determined by the Supervising Provider. However, the Supervising Provider is

responsible for ensuring the provision of CHW services complies with all applicable requirements.

4. Supervising Providers must provide direct or indirect oversight to CHWs.
    a. Supervising providers (or their Subcontractors contracting with or employing CHWs to provide covered CHW services to the MCP's Members) must ensure CHWs have adequate supervision and training.
    b. Direct oversight includes, but is not limited to, guiding CHWs in providing services, participating in the development of the care plan, and following up on the progression of CHW services to ensure that services are provided in compliance with all applicable requirements.
    c. Indirect oversight includes, but is not limited to, ensuring connectivity of CHWs with the ordering entity and ensuring appropriate services are provided in compliance with all applicable requirements.
5. See policy MPCR11 Credentialing of Community Health Worker (CHW) Supervising Providers for further information on credentialing requirements for Supervising Providers.

D. Partnership CHW Workforce Initiative
1. Partnership actively supports local partnerships and CHW training across our network, including funding by the Health Resources and Services Administration (HRSA).
2. Partnership encourages providers to integrate CHWs into basic Population Health Management (PHM) and preventive care, and to give anticipatory guidance in support of the primary care team, Enhanced Care Management (ECM) teams, and perinatal care teams.
3. Partnership surveys our provider network periodically to get an understanding of how many CHWs are providing services, what area of focus/training the CHWs have, and if they have capacity for referrals from outside agencies.
4. Partnership is actively building a mechanism for Partnership staff and outside providers to search for organizations with CHW capacity for outside referrals, so they can make referrals to CHWs matched to the needs of individual members.

E. Informing providers about the CHW benefit
1. Partnership publicizes our current understanding of the regulatory framework for CHWs with our provider network and community based organizations in community meetings, provider meetings, and in provider newsletters.
2. Partnership's Provider Relations department educates providers on CHW services through the Medical Director's newsletter, Provider quarterly newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

F. Informing members about the CHW benefit
1. Partnership's Health Education team crafts communications that are culturally and linguistically appropriate and explain CHW services to our members. Details of the CHW benefit and services are outlined in Partnership's Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services.
2. 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.
3. CHW can provide qualifying members with specific support and offer tailored communication about how these services can support their health and wellbeing. Members referred to these services can be provided with materials explaining the services and are given the option to opt out of CHW services.

G. Member Eligibility for CHW services
1. CHW services require a written recommendation submitted to Partnership by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law.
    a. Partnership accepts recommendations for CHW Services from other licensed practitioners, whether they are in the Network or Out-of-Network Providers, within their scope of practice. Other licensed practitioners who can recommend CHW services within their scope of practice

include physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

b. For CHW services rendered in the ED, the treating Provider may verbally recommend CHWs to initiate services and later document the recommendation in the Member's medical record of the ED visit.
c. The required recommendation can be provided by a written recommendation placed in the Member's record.

2. CHW services are considered medically necessary for Members with one or more chronic health conditions (including behavioral health) or exposure to violence and trauma, who are at risk for a chronic health condition or environmental health exposure, who face barriers in meeting their health or health-related social needs, and/or who would benefit from preventive services. The recommending Provider, whom does not need to be Medi-Cal enrolled, must determine whether a Member meets eligibility criteria based on the presence of one or more of the following before recommending CHW services:
   a. Diagnosis of one or more chronic health (including behavioral health) conditions, or a suspected mental disorder or substance use disorder that has not yet been diagnosed.
   b. Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, elevated blood lead levels or childhood lead exposure, etc.) that indicate risk but do not yet warrant diagnosis of a chronic condition.
   c. Any stressful life event presented via the Adverse Childhood Events (ACEs) screening.
   d. Presence of known risk factors, including domestic or intimate partner violence, tobacco use, excessive alcohol use, and/or drug misuse.
   e. Results of a SDOH screening indicating unmet health-related social needs, such as housing or food insecurity.
   f. One or more visits to a hospital emergency department (ED) within the previous six months.
   g. One or more hospital visits or hospital inpatient stays, including stays at a psychiatric facility, within the previous six months, or being at risk of institutionalization.
   h. One or more stays at a detox facility within the previous year.
   i. Two or more missed medical appointments within the previous six months.
   j. Member expressed need for support in health system navigation or resource coordination services.
   k. Need for recommended preventive services, including updated immunizations, annual dental visit, and well-child care visits for children.
3. CHW violence prevention services are specific to community violence (e.g. gang violence) and are available to Members who meet any of the following circumstances as determined by a licensed practitioner:
   a. The Member has been violently injured as a result of community violence.
   b. The Member is at significant risk of experiencing violent injury as a result of community violence.
   c. The Member has experienced chronic exposure to community violence.
4. CHW services can be provided to Members for interpersonal/domestic violence through the other pathways with training/experience specific to those needs.

H. Assessing and Identifying Member Needs for CHW Services
1. In addition to recommending that Providers identify member needs for CHW services, Partnership also assesses member needs for services and determines priority populations using a data driven approach. Partnership attempts outreach to identified members and their Providers and offers to

connect the qualifying Members to needed CHW services. Data sources may include, but are not limited to, using past and current Member utilization/encounters, Partnership's proprietary risk score model, risk stratification and segmentation methodology, utilization reports showing member hospitalizations and ED visits, data on health risks and clinical core gaps, demographic and SDOH data, referrals from the community (including Provider referrals) for services, member self-referral to identify members who may benefit from CHW services, and needs assessments.

2. Populations of special focus include:
   a. Children who need preventive care
   b. Members who under-utilize primary care
   c. Pregnant or newly delivered members
   d. Members who have behavioral health needs, substance use disorders (SUD), or conditions requiring integration of physical and behavioral health.
   e. Members newly released from incarceration.

I. Documentation Requirements
   1. CHWs are required to document the dates and time/duration of services provided to Members, which should also reflect information on the nature of the service provided and support the length of time spent with the patient that day.
   2. Documentation must be accessible to the Supervising Provider upon their request.
   3. Documentation should be integrated into the Member's medical record and available for encounter data reporting.

J. Authorization for CHW Services and Care Plans
   1. Partnership does not require prior authorization for CHW services as preventive care for the first 12 units with a limit of four (4) units a day.
   2. For Members who need multiple CHW services or continued CHW services in excess of 12 units, a prior authorization request (TAR) is required (see Partnership Policy MCUP3041 Treatment Authorization Request (TAR) Review Process for requirements and procedures).
      a. Documentation to be provided with the TAR includes the original written recommendation, a written care plan that must be written by one or more individual licensed providers (with the exception of services provided in the ED) which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.
         1) The care plan must state the following:
            a) Specify the condition that the service is being ordered for and be relevant to the condition
            b) Include a list of other health care professionals providing treatment for the condition or barrier
            c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
            d) List the specific services required for meeting the written objectives
            e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives
         2) The Provider submitting the care plan does not need to be the same Provider who initially recommended CHW services or the Supervising Provider for CHW services.
         3) CHWs may participate in the development of the care plan and may take a lead role in drafting the care plan if done in collaboration with the Member's care team and/or other Providers which may include the recommending Provider and other licensed Providers affiliated with the CHW Supervising Provider.
         4) The plan of care may not exceed a period of one year.
         5) The care plan must state the following:
            a) Specify the condition that the service is being ordered for and be relevant to the

condition
   b) Include a list of other health care professionals providing treatment for the condition or barrier
   c) Contain written objectives that specifically address the recipient's condition or barrier affecting their health
   d) List the specific services required for meeting the written objectives; and
   e) Include the frequency and duration of CHW services (not to exceed the Provider's order) to be provided to meet the care plan's objectives.
6) A licensed Provider must review the member's care plan at least every six months from the effective date of the initial care plan. The licensed Provider must determine if progress is being made toward the written objective and whether services are still medically necessary.
   a) TARs will be authorized for 6 months and reauthorization will be contingent upon submission of a reviewed/updated care plan.
   b) If there is a significant change in the member's condition, Providers should consider amending the plan for continuing care or discontinuing services if the objectives have been met.

K. Partnership's CHW Program Standards
1. Partnership will not establish unreasonable or arbitrary barriers for accessing coverage.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste and abuse of CHW services through committees that review for over and under-utilization of services.
3. Partnership uses CHWs to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate CHWs into basic population health management and preventive care activities. This may include:
   a. Referrals for families with children requiring preventive care
   b. Referrals for vulnerable pregnant members who may benefit from added support through pregnancy and the first year of a child's life
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits.
5. Partnership will encourage recruitment of CHWs who have lived experience with incarceration, behavioral health concerns, homelessness, and other vulnerable populations to provide CHW services to members facing these challenges.
6. Partnership will track quality indicators for those members who use CHW services compared to a matched sample of members who do not agree to CHW services. For example:
   a. HEDIS compliance with well-child visits for families requiring preventive care
   b. HEDIS compliance with prenatal, post-partum, and well-baby visits for pregnant mothers
   c. Member satisfaction post benefit-utilization for a representative sample of those using the CHW benefit.
7. Partnership will assess the CHW workforce through several means:
   a. Surveying providers known to be using CHWs to determine the number of CHWs engaged by provider, the particular population of focus for each CHW, and a percentage of population covered calculated by provider and by county.
   b. Tracking utilization rates using the DHCS-designated CPT/HCPCS billing codes for CHW services that are not billed under global services (such as ECM or perinatal services).

L. CHW Services Provided
1. CHW services can be provided as individual or group sessions, and can also be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. Services may also be provided via telehealth (see policy MCUP3113

Telehealth Services). There are no service location limits.

2. Services may be provided to a parent or legal guardian of Members under age 21 for the direct benefit of the Member, in accordance with a recommendation from a licensed Provider. Services for the direct benefit of the Member must be billed under the Member's Medi-Cal ID. If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session. Covered services do not require a license.
3. CHWs may render street medicine and the Supervising Provider would bill Partnership for any appropriate and applicable services within the scope of the CHW benefit. (Street Medicine services are defined by DHCS in APL 24-001 *Street Medicine Provider: Definitions and Participation In Managed Care* dated 01/12/2024)
4. Covered CHW services do not include any service that requires a license.
5. CHW Services include:
   a. Health Education: Promoting a Member's health or addressing barriers to physical and mental health care, such as through providing information or instruction on health topics. Health Education content must be consistent with established or recognized health care standards and may include coaching and goal setting to improve a Member's health or ability to self-manage their health conditions.
   b. Health Navigation: Providing information, training, referrals, or support to assist Members to access health care, understand the health care delivery system, or engage in their own care, including, and communicating cultural and language preferences to providers. Health navigation includes connecting Members to community resources necessary to promote health; addressing barriers to care, including connecting to medical translation/interpretation or transportation services; or address health-related social needs. Under Health Navigation, CHWs can also:
      1) Serve as a cultural liaison or assist a licensed health care Provider to participate in the development of a plan of care, as part of a health care team;
      2) Perform outreach and resource coordination to encourage and facilitate the use of appropriate preventive services; or
      3) Help a Member enroll or maintain enrollment in government or other assistance programs related to improving their health, if such navigation services are provided pursuant to a plan of care.
   c. Screening and Assessment: Providing screening and assessment services that do not require a license, and assisting Members with connecting to appropriate services to improve their health, including connecting individuals and families with community-based resources.
   d. Individual Support or Advocacy: Assisting Members in preventing the onset or exacerbation of a health condition, or preventing injury or violence. This includes peer support as well if not duplicative or other covered benefits.

M. Non-Covered CHW Services
   1. Non-covered CHW services include, but are not limited to:
      a. Clinical case management/care management that requires a license
      b. Child care
      c. Chore services, including shopping and cooking meals
      d. Companion services
      e. Employment services
      f. Helping a Member enroll in government or other assistance programs that are not related to improving their health as part of a plan of care
      g. Delivery of medication, medical equipment, or medical supply
      h. Personal care services/Homemaker services
      i. Respite care
      j. Services that duplicate another covered Medi-Cal service already being provided to a Member

k. Socialization
l. Transporting members
m. Services provided to individuals not enrolled in Medi-Cal, except as noted above
n. Services that require a license
o. Peer Support Services as covered under the Drug Medi-Cal, Drug Medi-Cal Organized Delivery System, and Specialty Mental Health Services programs. (CHW services are distinct and separate from Peer Support Services.)

N. Partnership is actively working towards establishing closed loop referrals for services provided by CHWs, peer counselors (peer support not duplicative of other covered Medi-Cal benefits), and local community organizations, as defined at III.A. above. Closed loop referrals are currently accomplished through:
1. Tracking member referrals through Partnership's case management system and sharing access to this system with providers.
2. Leveraging Community Information Exchanges (CIEs) to allow community-based organizations and their staff to have insight into services and referrals made on behalf of shared members/clients.
3. Establishing protocols for documenting and sharing referral data in shared systems.

O. Billing, Claims, and Payments
1. CHW services will be reimbursed through a CHW Supervising Provider in accordance with its Provider contract..
2. Claims processes must adhere to contractual requirements related to claims processing and encounter data submissions including use of approved codes pursuant to the Medi-Cal Provider Manual for CHW Preventive Services.
3. Claims for CHW services will be submitted by the Supervising Provider with allowable current procedural terminology (CPT) codes as outlined in the Medi-Cal Provider Manual at Community Health Worker (CHW) Preventive Services (*chw prev*).
4. Partnership does not require prior authorization for CHW services; however, quantity limits can be applied based on goals detailed in the care plan as described in section VI.J.2.
5. Encounter data
   a. Partnership shall submit all CHW encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
   b. Partnership shall be responsible for submitting to DHCS all CHW encounter data, including encounter data for CHW generated under subcontracting arrangements.
   c. In the event the CHW Supervising Provider is unable to submit CHW encounters to Partnership using the national standard specifications and code sets to be defined by DHCS, Partnership shall be responsible for converting CHW Supervising Providers' invoice data into the national standard specifications and code sets for submission to DHCS.
6. Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. Through Partnership's Claims process, Partnership shall ensure that members shall not receive duplicative services through CHW and/or ECM. Please see Partnership policies MCCP2032 CalAIM Enhanced Care Management and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).
7. Tribal clinics may bill Partnership for CHW services at the Fee-for-Service rates using the CPT codes as outlined in the Medi-Cal Provider Manual.
8. Pursuant to Welfare and Institutions Code (WIC) 14087.325(d), Partnership is required to reimburse contracted Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in a manner that is no less than the level and amount of payment that Partnership would make for the same scope of services if the services were furnished by another provider type that is not an FQHC or RHC.

Policy/Procedure Number: MCCP2033		Lead Department: Health Services
Policy/Procedure Title: Community Health Worker (CHW) Services Benefit		☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/08/2023 Effective Date: 07/01/2022 vs. DHCS	**Next Review Date:** N/A~~10/09/2025~~ **Last Review Date: 10/09/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) supersedes APL 22-016
B. State Plan Amendment (SPA) 22-0001
C. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
D. Welfare and Institutions Code (WIC) 14087.325(d)
E. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
F. DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) supersedes APL 22-023

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 02/14/24; 10/09/24; ARCHIVED 06/11/2025

PREVIOUSLY APPLIED TO: N/A

****

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

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

The materials provided are guidelines used by Partnership 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="3">Policy/Procedure Number: ~~MCUP3146~~MPAP7005 (previously MCUP3146)</td><td colspan="3">Lead Department: Health Services
Business Unit: EHS</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Street Medicine</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/12/2023</td><td colspan="4">Next Review Date: ~~05/08/2025~~06/11/2026
Last Review Date: ~~05/08/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ 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">☐ CREDENTIAL~~S~~ING</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: ~~05/08/2024~~ 6/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. ~~MCUP3142~~ MCAP7003 – CalAIM Community Supports (CS)
C. ~~MCUP3143~~ MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or ~~————————~~Community Supports (CS)
D. MCCP2033 – Community Health Worker (CHW) Services Benefit
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. MCUP3041 – Treatment Authorization Request (TAR) Review Process
G. MPCR300 – ~~-~~Physician Credentialing and Re-Credentialing Requirements
H. MPCR301 – ~~-~~Non-Physician Clinician Credentialing and Re-Credentialing Requirements
I. MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-Credentialing Requirements
J. MPCR17 – Standards for Contracted Primary Care Providers
K. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
L. MPNET100 – Access Standards and Monitoring
M. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS~~:~~ M

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

III. DEFINITIONS:

A. 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 Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by 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.
B. Certified Nurse Midwife (CNM): A CNM is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing.
C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotores,

community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Supports Services (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

E. Community Supports Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

~~Dual-Eligible Special Needs Plan (D-SNP): D-SNPs are Medicare Advantage plans that provide specialized care to beneficiaries dually eligible for Medicare and Medi-Cal and offer care coordination and wrap-around services. This plan is known as Partnership Advantage at Partnership HealthPlan of California. (See definition of Partnership Advantage below)~~

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

G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

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

I. Medical Home: The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs

J. Mobile Medicine: Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed and specified location. Note that this is not considered street medicine as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location.

K. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual-Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~K.~~L. Street Medicine: Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.

~~L.~~M. Unsheltered Homelessness: Situations in which individuals are not regularly accessing shelters or transitional housing programs and are instead often sleeping in encampments, under underpasses, in

their vehicles, or other locations not meant for human habitation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To define the opportunities for providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.~~ To define the opportunities for street medicine providers to address the clinical and non-clinical needs of ~~Medi-Cal~~ Partnership HealthPlan Members experiencing unsheltered homelessness.

VI. POLICY / PROCEDURE:

A. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. The Department of Health Care Services (DHCS) recognizes the benefit that street medicine can provide, and with this in mind, encourages Managed Care Plans (MCPs) to adopt requirements for street medicine providers as outlined in APL 24-001 Street Medicine Provider: Definitions and Participation In Managed Care that allow for maximum provider participation while maintaining high quality care.
   1. The Department of Health Care Services (DHCS) does not require a street medicine provider to be affiliated with a brick-and-~~-~~mortar facility.
   2. DHCS does not prescribe any particular contracting type for MCPs (i.e.~~,~~ Partnership) and street medicine providers.
   ~~3. There is no required effective start date for the operations of a street medicine program since utilization of street medicine providers is voluntary for MCPs.~~

B. Partnership covers the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers acting in the following ways:
   1. In the role of the Member's assigned primary care provider (PCP)
   2. In a direct contracting arrangement with Partnership
   3. As a referring or treating contracted provider directly contracted with Partnership
   4. As an ECM provider (as defined in III.F. and G.) or as a Community Supports Provider (as defined in III.D. and E.)

C. DHCS has outlined provisions for various street medicine scenarios as follows:
   1. Street Medicine Provider as a Member's Assigned Primary Care Provider (PCP)
      a. "Street medicine provider" refers to a licensed medical provider (e.g., Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).
         1) A non-physician medical practitioner (PA, NP, and CNM), must have a supervising Physician who is a practicing street medicine provider.
      b. Contracted street medicine providers may choose to serve as the Member's assigned PCP upon Member election. In order to serve as a PCP, the street medicine Provider must meet Partnership's eligibility criteria for being a PCP per policy MPCR17 Standards for Contracted Primary Care Providers, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice~~,~~ and agree to serve in a PCP role.

1) Street medicine providers willing to serve in a PCP capacity are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and exceptional Provider-Member patient interactions.
2) If the street medicine provider is willing to be the Member's assigned PCP, the provider must initiate the request via telephone call to Partnership's Member Services department (800) 863-4155 with the Member on the line, and both parties must confirm to Partnership the Member's choice in selecting the street medicine provider to be their assigned PCP. The street medicine provider will then be assigned as the Member's PCP and will be responsible for overseeing the Member's care.

c. Street medicine providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of primary care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical care, including but not limited to:
   1) Care coordination and health promotion, such as those services offered under Basic Population Health Management (BPHM)
   2) Support for Members, their families, and their authorized representatives
   3) Referral to specialists, including behavioral health, community, and social support services, when needed
   4) The use of health information technology to link services, as feasible and appropriate; and
   5) Provision of primary and preventative services to assigned Members

d. Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review as follows:
   1) For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Partnership will conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and policy MPQP1022, Site Review Requirements and Guidelines.
   2) For street medicine providers serving as an assigned PCP in the unsheltered environments, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, Partnership will conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine provider to ensure Member safety. The condensed FSR and MRR requirements will be based on, and reflective of, the full FSR and MRR requirements as outlined in APL 22-017.

e. Street medicine providers who elect to be PCPs are required to develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the street medicine Provider. This includes access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate Non-Emergency medical and Non-Medical Transportation services as well as expeditious referrals to ECM and Community Supports.

f. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301

Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.

g. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.
   1) If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" Provider. But in that case, Partnership must vet the qualifications of the street medicine provider to ensure they can meet Partnership's standards of participation, similar to the credentialing process and requirements outlined in APL 22-013 and in accordance with Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.

h. Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards (as part of Annual Network Certification requirements) because the Member does not have a permanent residential address and the street medicine provider is meeting the Member at their lived environment. Additionally, service location requirement for PCPs, as specified in the MCP Contract, is not applicable to street medicine providers serving as PCPs, as they are not rendering services at a brick-and-mortar location

2. Street Medicine Provider in a Direct Contracting Arrangement with Partnership
   a. To facilitate direct access, DHCS encourages Partnership to contract directly with street medicine providers. This is an option even if the provision of health care services is delegated to a Subcontractor.
      1) Direct contracts with street medicine providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and reduce contracting complexity for street medicine providers.
      2) The street medicine provider would be subject to the same Partnership administrative processes (e.g. billing protocols, credentialing requirements, authorization guidelines, etc.) rather than having multiple processes and requirements under each subcontracting entity.
      3) The payment arrangement would be between the MCP and the street medicine Provider.
      4) Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to medically necessary covered services within Partnership's network, and must coordinate care with Partnership, the Subcontractor, and/or Independent Physician/Provider Association (IPA) as appropriate.
3. Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
   a. The contracted street medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine providers must have processes in place to work with Partnership, the Member's PCP, and/or the ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.
   b. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
   c. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.

4. Street Medicine Provider as an ECM and/or Community Supports Provider
   a. A street medicine provider can be contracted to provide both PCP and ECM or Community Supports services to a Member but must avoid duplication of services. Street medicine providers that are also ECM or Community Support providers are required to do the following:
      1) Enroll in Medi-Cal if there is a state-level enrollment pathway
      2) Fulfill all ECM or Community Supports requirements per policies MCCP2032 CalAIM Enhanced Care Management (ECM), ~~MCUP3142~~ MCAP7003 CalAIM Community Supports (CS) and ~~MCUP3143~~ MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
      3) Have the capacity to provide culturally appropriate and timely in-person care management activities; and
      4) Have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management

D. Billing/Reimbursement Street medicine
   1. Contracted street medicine providers rendering services to Medi-Cal and/or Partnership Advantage eligible ~~individuals~~ members are to bill Partnership based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street medicine providers rendering services to beneficiaries eligible for fee-for-service (FFS) Medi-Cal, not assigned to Partnership, should bill Medi-Call FFS consistent with the requirements set forth in the FFS provider manual.
   2. Street medicine providers must comply with the billing provisions for street medicine providers as applicable to Partnership policies and procedures.
   3. If a street medicine provider is a Federally Qualified Health Clinic (FQHC), they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC would be paid their applicable PPS rate when the street medicine provider is a billable clinic provider.
   4. Street medicine providers can also be reimbursed for providing other State Plan benefits (e.g . Community Health Worker (CHW) services are often provided in street medicine programs and can be billed by the contracted CHW supervising provider organization).
      a. Partnership is responsible for ensuring non-duplication of services with any other covered benefit, program, and/or delivery system.

E. ~~Medi-Cal~~ Eligibility
   1. Street medicine Providers are required to verify the ~~Medi-Cal~~Mm~~m~~ember's eligibility with Partnership of individuals they encounter in the provision of health care services.

F. Authorizations
   1. No Prior Authorization is needed for a Member to see a street medicine provider if the Member seeks services directly from a street medicine provider related to the Member's primary care. This means that a Partnership-contracted street medicine provider that meets all of Partnership's required administrative processes could provide services to a Member and receive payment for those services, even if the Member is assigned to another PCP.
   2. If a Member needs medical services that do require prior authorization, all Partnership contracted street medicine providers must follow the requirements of Partnership policies MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process.

G. Data Sharing, Reporting and Administration
   1. Contracted street medicine providers must comply with all applicable Partnership administration requirements in accordance with federal and state laws as well as Partnership data sharing and reporting requirements and the provider's contract with Partnership, based on provider contracting type.

2. Partnership ensures street medicine providers are given the necessary provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024)
B. DHCS APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (09/22/2022)
C. DHCS APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment (07/19/2022) *revised 01/02/2025*
D. DHCS APL 22-016 ~~*Revised*~~ Community Health Worker Services Benefit (09/09/2022) *revised 09/18/2023*
E. State Plan Amendment (SPA) 22-0001
F. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
G. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
H. Street Medicine Institute: https://www.streetmedicine.org/
I. "Addressing Unsheltered Homelessness in California" (August 2021): A report by the Division of Social Work and the Center for Health Practice, Policy & Research at the California State University, Sacramento prepared for the Homelessness Coordinating and Financing Council in the California Business, Consumer Services, and Housing Agency https://bcsh.ca.gov/calich/documents/2021_heap_case_study1.pdf
~~I. CalAIM Dual Eligible Special Needs Plan Policy Guide-Contract year 2026 (published December 2024)~~

VIII. DISTRIBUTION:

B. Partnership Department Directors
C. Partnership Provider Manual

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

REVISION DATES: 05/08/24

PREVIOUSLY APPLIED TO: ~~N/A~~
MCUP3146 Street Medicine (04/12/2023 – 05/14/2025 – 6/11/25~~)~~

****

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

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

Policy/Procedure Number: ~~MCUP3146~~**MPAP7005** (previously MCUP3146)			**Lead Department: Health Services** **Business Unit: EHS**
Policy/Procedure Title: Street Medicine			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/12/2023		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

Policy/Procedure Number: MCUP3146				**Lead Department: Health Services**	
Policy/Procedure Title: Street Medicine				☒**External Policy** ☐ **Internal Policy**	
Original Date: 04/12/2023		**Next Review Date:** ~~05/08/2025~~N/A **Last Review Date:** 05/08/2024			
Applies to:	☒ **Medi-Cal**			☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**		☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**		☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**		☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**		☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Archived~~Approval~~ Date:** ~~05/08/2024~~06/11/2025	

I. RELATED POLICIES:

A. MCCP2032 – CalAIM Enhanced Care Management (ECM)
B. MCUP3142 – CalAIM Community Supports (CS)
C. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
D. MCCP2033 – Community Health Worker (CHW) Services Benefit
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. MCUP3041 – Treatment Authorization Request (TAR) Review Process
G. MPCR300 – Physician Credentialing and Re-Credentialing Requirements
H. MPCR301 – Non-Physician Clinician Credentialing and Re-Credentialing Requirements
I. MPCR302 – Behavioral and Mental Health Practitioner Credentialing and Re-Credentialing Requirements
J. MPCR17 – Standards for Contracted Primary Care Providers
K. MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers
L. MPNET100 – Access Standards and Monitoring
M. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. 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 Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by 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.
B. Certified Nurse Midwife (CNM): A CNM is licensed as a Registered Nurse and certified as a Nurse Midwife by the California Board of Registered Nursing.
C. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotors,

community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Supports Services (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS)approval. Under CalAIM, these services are known as Community Supports (CS).
E. Community Supports Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports
F. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
H. Managed Care Plan (MCP): Partnership HealthPlan of California is contracted as a DHCS Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.
I. Medical Home: The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs
J. Mobile Medicine: Health care services provided at shelters, mobile units/recreational vehicles (RV), or other sites with a fixed and specified location. Note that this is not considered street medicine as it requires people experiencing unsheltered homelessness to visit a health care provider at the provider's fixed, specified location.
K. Street Medicine: Street medicine refers to a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment. Note that mobile units/RVs that go to the individual experiencing unsheltered homelessness in their lived environment ("on the street") is considered street medicine.
L. Unsheltered Homelessness: Situations in which individuals are not regularly accessing shelters or transitional housing programs and are instead often sleeping in encampments, under underpasses, in their vehicles, or other locations not meant for human habitation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the opportunities for providers to address clinical and non-clinical needs of their Medi-Cal Members experiencing unsheltered homelessness.

VI. POLICY / PROCEDURE:

A. The fundamental approach of street medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. The Department of Health Care Services (DHCS)

recognizes the benefit that street medicine can provide, and with this in mind, encourages Managed Care Plans (MCPs) to adopt requirements for street medicine providers as outlined in APL 24-001 Street Medicine Provider: Definitions and Participation In Managed Care that allow for maximum provider participation while maintaining high quality care.

1. The Department of Health Care Services (DHCS) does not require a street medicine provider to be affiliated with a brick-and-mortar facility.
2. DHCS does not prescribe any particular contracting type for MCPs (i.e. Partnership) and street medicine providers.
3. There is no required effective start date for the operations of a street medicine program since utilization of street medicine providers is voluntary for MCPs.

B. Partnership covers the provision of medical services for their Members experiencing unsheltered homelessness through street medicine providers acting in the following ways:
   1. In the role of the Member's assigned primary care provider (PCP)
   2. In a direct contracting arrangement with Partnership
   3. As a referring or treating contracted provider directly contracted with Partnership
   4. As an ECM provider (as defined in III.F. and G.) or as a Community Supports Provider (as defined in III.D. and E.)

C. DHCS has outlined provisions for various street medicine scenarios as follows:
   1. Street Medicine Provider as a Member's Assigned Primary Care Provider (PCP)
      a. "Street medicine provider" refers to a licensed medical provider (e.g., Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Nurse Practitioner (NP), Certified Nurse Midwife (CNM)) who conducts patient visits outside of the four walls of clinics or hospitals and directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas).
         1) A non-physician medical practitioner (PA, NP, and CNM), must have a supervising Physician who is a practicing street medicine provider.
      b. Contracted street medicine providers may choose to serve as the Member's assigned PCP upon Member election. In order to serve as a PCP, the street medicine Provider must meet Partnership's eligibility criteria for being a PCP per policy MPCR17 Standards for Contracted Primary Care Providers, be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice~~,~~ and agree to serve in a PCP role.
         1) Street medicine providers willing to serve in a PCP capacity are advised to assess and examine the level and quality of the establishment of the treatment relationship at the time of initial engagement when considering an agreement to be a Member's assigned PCP, as DHCS envisions dynamic and exceptional Provider-Member patient interactions.
         2) If the street medicine provider is willing to be the Member's assigned PCP, the provider must initiate the request via telephone call to Partnership's Member Services department (800) 863-4155 with the Member on the line, and both parties must confirm to Partnership the Member's choice in selecting the street medicine provider to be their assigned PCP. The street medicine provider will then be assigned as the Member's PCP and will be responsible for overseeing the Member's care.
      c. Street medicine providers, when elected by Members to act as their assigned PCP, are responsible for providing the full array of primary care services, including but not limited to, preventive services, and the treatment of acute and chronic conditions. Thus, street medicine providers who choose to act as a Member's assigned PCP must agree to provide the essential components of the Medical Home in order to provide comprehensive and continuous medical

care, including but not limited to:

1) Care coordination and health promotion, such as those services offered under Basic Population Health Management (BPHM)
2) Support for Members, their families, and their authorized representatives
3) Referral to specialists, including behavioral health, community, and social support services, when needed
4) The use of health information technology to link services, as feasible and appropriate; and
5) Provision of primary and preventative services to assigned Members

d. Street medicine providers who are serving in an assigned PCP capacity are required to undergo the appropriate level of site review process, which is either a full or a condensed review as follows:
   1) For street medicine providers serving as an assigned PCP, and that are affiliated with a brick-and-mortar facility or that operate a mobile unit/RV, Partnership will conduct the full review process of the street medicine provider and affiliated facility in accordance with APL 22-017: Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and policy MPQP1022, Site Review Requirements and Guidelines.
   2) For street medicine providers serving as an assigned PCP in the unsheltered environments, and that are not affiliated with a brick-and-mortar facility or mobile unit/RV, Partnership will conduct a condensed Facility Site Review (FSR) and Medical Record Review (MRR) of the street medicine provider to ensure Member safety. The condensed FSR and MRR requirements will be based on, and reflective of, the full FSR and MRR requirements as outlined in APL 22-017.
e. Street medicine providers who elect to be PCPs are required to develop and maintain protocols for identifying and transferring Members to a higher level of care if needed when the Member's service needs are beyond the capabilities and/or qualifications of the street medicine Provider. This includes access to urgent and emergency care, specialty care, mental health and substance use disorder treatment, ancillary services, and appropriate Non-Emergency medical and Non-Medical Transportation services as well as expeditious referrals to ECM and Community Supports.
f. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
g. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013: Provider Credentialing/Re-Credentialing and Screening/Enrollment.
   1) If there is not a state-level enrollment pathway, the street medicine provider is not required to meet the credentialing requirements in APL 22-013 in order to become an "in-network" Provider. But in that case, Partnership must vet the qualifications of the street medicine provider to ensure they can meet Partnership's standards of participation, similar to the credentialing process and requirements outlined in APL 22-013 and in accordance with Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
h. Providers elected as a Member's assigned PCP are exempt from PCP time and distance standards (as part of Annual Network Certification requirements) because the Member does not have a permanent residential address and the street medicine provider is meeting the Member at their lived environment. Additionally, service location requirement for PCPs, as specified in the

MCP Contract, is not applicable to street medicine providers serving as PCPs, as they are not rendering services at a brick-and-mortar location

2. Street Medicine Provider in a Direct Contracting Arrangement with Partnership
   a. To facilitate direct access, DHCS encourages Partnership to contract directly with street medicine providers. This is an option even if the provision of health care services is delegated to a Subcontractor.
      1) Direct contracts with street medicine providers can allow ready access to health care services for individuals experiencing unsheltered homelessness and reduce contracting complexity for street medicine providers.
      2) The street medicine provider would be subject to the same Partnership administrative processes (e.g. billing protocols, credentialing requirements, authorization guidelines, etc.) rather than having multiple processes and requirements under each subcontracting entity.
      3) The payment arrangement would be between the MCP and the street medicine Provider.
      4) Under a direct contracting arrangement, the street medicine provider must have the ability to refer Members to medically necessary covered services within Partnership's network, and must coordinate care with Partnership, the Subcontractor, and/or Independent Physician/Provider Association (IPA) as appropriate.
3. Street Medicine Providers Serving Solely as Referring or Treating Contracted Provider
   a. The contracted street medicine provider has the right to decline the additional responsibilities of an assigned PCP, and instead, care for Members in a non-PCP capacity as a referring or treating contracted provider working with individuals experiencing unsheltered homelessness. To provide care in this capacity, street medicine providers must have processes in place to work with Partnership, the Member's PCP, and/or the ECM Care Manager to ensure the Member has referrals to primary care, Community Supports, behavioral health services, and other social services as needed.
   b. Licensed providers must follow Partnership credentialing requirements as per Partnership policies MPCR300 Physician Credentialing and Re-Credentialing Requirements, MPCR301 Non-Physician Clinician Credentialing and Re-Credentialing Requirements, and MPCR302 Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements.
   c. Licensed providers must be enrolled as a Medi-Cal provider in accordance with APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment.
4. Street Medicine Provider as an ECM and/or Community Supports Provider
   a. A street medicine provider can be contracted to provide both PCP and ECM or Community Supports services to a Member but must avoid duplication of services. Street medicine providers that are also ECM or Community Support providers are required to do the following:
      1) Enroll in Medi-Cal if there is a state-level enrollment pathway
      2) Fulfill all ECM or Community Supports requirements per policies MCCP2032 CalAIM Enhanced Care Management (ECM), MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
      3) Have the capacity to provide culturally appropriate and timely in-person care management activities; and
      4) Have formal agreements, data systems, and processes in place with entities across sectors to support care coordination and care management

D. Billing/Reimbursement Street medicine
   1. Contracted street medicine providers rendering services to Medi-Cal eligible individuals are to bill Partnership based on the eligibility of the individual, for appropriate and applicable services within their scope of practice. Street medicine providers rendering services to beneficiaries

eligible for fee-for-service (FFS) Medi-Cal, not assigned to Partnership, should bill Medi-Call FFS consistent with the requirements set forth in the FFS provider manual.

2. Street medicine providers must comply with the billing provisions for street medicine providers as applicable to Partnership policies and procedures.
3. If a street medicine provider is a Federally Qualified Health Clinic (FQHC), they can still be reimbursed at their applicable Prospective Payment System (PPS) rate when such services are being provided outside the four walls and where the Member is located. The FQHC would be paid their applicable PPS rate when the street medicine provider is a billable clinic provider.
4. Street medicine providers can also be reimbursed for providing other State Plan benefits (e.g . Community Health Worker (CHW) services are often provided in street medicine programs and can be billed by the contracted CHW supervising provider organization).
    a. Partnership is responsible for ensuring non-duplication of services with any other covered benefit, program, and/or delivery system.

E. Medi-Cal Eligibility
1. Street medicine Providers are required to verify the Medi-Cal eligibility with Partnership of individuals they encounter in the provision of health care services.

F. Authorizations
1. No Prior Authorization is needed for a Member to see a street medicine provider if the Member seeks services directly from a street medicine provider related to the Member's primary care. This means that a Partnership-contracted street medicine provider that meets all of Partnership's required administrative processes could provide services to a Member and receive payment for those services, even if the Member is assigned to another PCP.
2. If a Member needs medical services that do require prior authorization, all Partnership contracted street medicine providers must follow the requirements of Partnership policies MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process.

G. Data Sharing, Reporting and Administration
1. Contracted street medicine providers must comply with all applicable Partnership administration requirements in accordance with federal and state laws as well as Partnership data sharing and reporting requirements and the provider's contract with Partnership, based on provider contracting type.
2. Partnership ensures street medicine providers are given the necessary provider training and manuals and have adequate systems in place to adhere to administration requirements, such as grievances and appeals, referrals, after-hours and timely access, prior authorizations, quality improvement, performance measures, and electronic health records.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024)
B. DHCS APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (09/22/2022)
C. DHCS APL 22-013 Provider Credentialing/Re-Credentialing and Screening/Enrollment (07/19/2022)
D. DHCS APL 22-016 *Revised* Community Health Worker Services Benefit (09/09/2022)
E. State Plan Amendment (SPA) 22-0001
F. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
G. Medi-Cal Provider Manual/ Guidelines: Community Health Worker (CHW) Preventive Services (*chw prev*)
H. Street Medicine Institute: https://www.streetmedicine.org/
I. "Addressing Unsheltered Homelessness in California" (August 2021): A report by the Division of Social Work and the Center for Health Practice, Policy & Research at the California State University,

Policy/Procedure Number: ~~MCUP3146~~MCAP7004		Lead Department: Health Services
Policy/Procedure Title: Street Medicine		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/12/2023	**Next Review Date: 05/08/2025N/A** **Last Review Date: 05/08/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

Sacramento prepared for the Homelessness Coordinating and Financing Council in the California Business, Consumer Services, and Housing Agency
https://bcsh.ca.gov/calich/documents/2021_heap_case_study1.pdf

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

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

X. REVISION DATES: 05/08/24; ARCHIVED 06/11/2025

PREVIOUSLY APPLIED TO: N/A

****

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

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

The materials provided are guidelines used by Partnership 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.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1052				**Lead Department: ~~Health Services~~** Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C				☒**External Policy** ☐ **Internal Policy**	
Original Date: 02/20/2013			**Next Review Date: 06/11/2026~~06/12/2025~~** **Last Review Date: ~~06/12/2024~~06/11/2025**		
Applies to:	☐**Employees**		☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD MPH, MBA*				**Approval Date: ~~06/12/2024~~06/11/2025**	

I. RELATED POLICIES:

A. MPQP1022 - Site Review Requirements and Guidelines
B. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Provider Relations
B. Quality Improvement

III. DEFINITIONS:

A. The Physical Accessibility Review Survey (PARS) is an on-site review of a provider office site's structural amenities vis-a-vis the potential for an adverse effect on seniors or persons with disabilities.
B. Primary Care Provider (PCP): the PCP is a general practitioner, internist, pediatrician, family physician, obstetrician/gynecologist (OB/GYN), nurse practitioner or physician assistant.
C. High Volume Specialist: a provider in Any Partnership HealthPlan of California's (Partnership's) ~~Southern Region~~ that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year ~~or a provider in Partnership's Northern Region that has billed at least 350 visits during the prior calendar year and who saw a minimum of 150 unique members during the prior calendar year~~. Specialist types are those recommended by the American Board of Medical Specialties (ABMS). A specialist is defined as: A physician specialist, Board Certified by an ABMS Member Board is a licensed physician who focuses their practice in a particular area of medicine or patient care and may concentrate on certain body systems, specific age groups or complex scientific techniques to diagnose or treat particular medical conditions.
D. High Volume Ancillary Provider: a provider in Partnership's ~~Southern~~ Regions that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar ~~year or a provider in Partnership's Northern Region that has billed at least 350 visits during the prior calendar year and who saw a minimum of 150 unique members during the prior calendar year.~~ Ancillary providers may provide audiology, community based adult services (CBAS), dialysis, occupational/speech/physical therapy, nutritional education, and home infusion or other such services.
~~E. Hospitals: Since hospitals represent a unique group of ancillary providers, Partnership will collaborate with our network hospitals to assess whether they meet the elements in the PARS tool and will make the findings available on the Partnership website and provider directories. See Attachment B.~~
~~F.~~E. Excluded Providers: Certain provider types are excluded from the Partnership assessment of accessibility for Seniors and Persons with Disabilities (SPDs). They include licensed and certified facilities, dental and vision providers, Long Term Care (LTC) facilities, imaging centers, pharmacies and labs, medical transportation, medical supplies, and Durable Medical Equipment (DME) sites. Non-contracted

providers are excluded from Partnership assessment of accessibility for SPDs.

IV. ATTACHMENTS:

A. Physical Accessibility Review Survey Guidelines/Tool
~~B. Hospital Letter~~
~~C.~~B. PARS Close Letter Template

V. PURPOSE:

To define the scope and frequency of performing the Physical Accessibility Review Survey (PARS) for PCPs and High Volume Ancillary and Specialist Providers (HVASP). The PARS tool was developed by a collaborative coalition made up of staff from the California Department of Health Care Services (DHCS) and Medi-Cal Managed Care Health Plans and meets DHCS standards. The purpose of the PARS is to assess the physical accessibility of provider sites using a set of standards mindful of the needs of seniors or persons with disabilities. Results of the PARS will be made available through the Partnership website and provider directories.

VI. POLICY / PROCEDURE:

Partnership will conduct a PARS at the time of the initial site review for newly credentialed PCPs and at least once every three years thereafter. Providers determined to be HVSAPs will be reviewed every three years following their initial PARS assessment. Partnership will notify DHCS of any changes made to the HVASP methodology by January 31st of each year in accordance with MMCD Policy Letter 12-006 (see references below.) Annually, no later than April 15th, Partnership will apply the methodology approved by DHCS to identify any new HVASP that meet the criteria described in Section III. Providers that no longer meet the HVASP definition, will be deleted from the list to survey. Newly identified HVASP providers will receive a PARS assessment within six (6) months of such identification.

A. Requirements
   1. PARS is an on-site review of the office site and covers critical elements across:
      a. Parking
      b. Exterior Building
      c. Interior Building
      d. Restroom
      e. Exam Room
      f. Exam Table/Scale

B. Scheduling - A member of the Quality Improvement department's Quality Inspections team or designee (aka the PARS Reviewer) conducts the PARS. (Refer to Section VI.E. for delegation criteria.)
   1. The Quality Inspections team schedules the physical accessibility reviews and provides information to the provider on preparing for the review in the following situations:
      a. Providers who change site locations subsequent to receiving a PARS assessment must receive a new review. A Provider Relations' Credentialing Specialist will notify the Inspections team of relocating/relocated providers so that the team can schedule the review within sixty (60) days of the notification date or the date the site opened.
      b. Newly identified providers based on the annual HVASP methodology will be assessed within six months of being identified.
      c. PCPs and existing HVASPs that continue to meet the High Volume methodology will be assessed every three years.

C. Review
   1. The PARS Reviewer will conduct the review, using the most recent DHCS PARS tool.

a. Review Criteria
   1) Criteria are scored as Yes, No, or Not Applicable
   2) Access is identified as Basic or Limited, as well as Medical Equipment Access (if applicable)
   3) There is no Corrective Action Plan (CAP) required when elements of the review do not meet the standards

2. Results Notification:
   a. Partnership Contracted Provider
      1) The Partnership contracted provider will receive a final close letter within sixty (60) days of the review, which will indicate the level of access and the appropriate accessibility indicator. – See Attachment C.
   b. Provider Relations
      1) The results of the PARS will be forwarded to the Partnership Provider Relations department on a quarterly basis. Provider Relations staff will make the information available on the Partnership website and in the provider directories in accordance with MMCD Policy Letter 12-006.

D. Physical Access Designation
1. Access designations are documented in the Partnership HealthPlan Provider Directory as required by MMCD 12-006.
   a. Basic Access: Demonstrates access for SPDs meet the Basic Access requirements, for all Critical Elements (CE) in the following areas: parking, building, elevator, doctor's office, exam room and restroom.
   b. Limited Access: Demonstrates access for SPDs where one or more of the Critical Elements (CE) are missing or incomplete in the following areas: parking, building, elevator, doctor's office, exam room, and restroom.
   c. Medical Equipment Access: Demonstrates the PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of basic or limited access as appropriate.
   d. Provider Directory Indicators noted:
      In addition to identifying the locations' accessibility level, the following should be identified (where applicable) such;
      P = Parking EB = Exterior Building IB = Interior Building
      R = Restroom E = Exam Room T = Exam Table/Scale

E. Delegation of PARS functions
1. Organizations or groups who have one or more DHCS Certified Site Reviewers or appropriately trained personnel may be determined eligible, at Partnership discretion, to perform PARS functions. An organization or group 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 PARS functions for all PCP sites no less than once every three years.
4. Delegated organizations and/or groups will provide timely copies of all PARS reviews conducted at the site level, within Partnership's service area, when requested.
5. Partnership's Quality Inspections team will track all PARS conducted by the delegated entities.
6. For organizations and groups that are more than one year past due for PARS at the site level or otherwise missing a PARS, the Inspections team will refer to Partnership's Delegation Oversight Reporting Sub-Committee (DORS), which is managed by Partnership's Compliance unit within the Administration department, for action.
7. As part of the oversight process, Partnership may perform one or more repeat PARS on sites that have had the PARS performed by a delegated entity.

Policy/Procedure Number: MCQP1052			**Lead Department: Health Services** -Business Unit: Quality Improvement
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/20/2013		**Next Review Date:** ~~06/12/2025~~06/11/2026 **Last Review Date:** ~~06/12/2024~~06/11/2025	
Applies to:	☐**Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

A. MMCD Policy Letter 12-006 Revised Facility Site Review Tool (Aug. 12, 2012)
B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006)
C. DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-based Adult Service Providers (Oct. 28, 2015)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: 02/19/14; 02/18/15; 02/17/16, 02/15/17; *03/14/18; 03/11/20; 3/10/21; 05/12/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25

*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:

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name:
Phone: FAX:	Contact Person Name:

	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access
Medical Equipment Access: PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.	☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

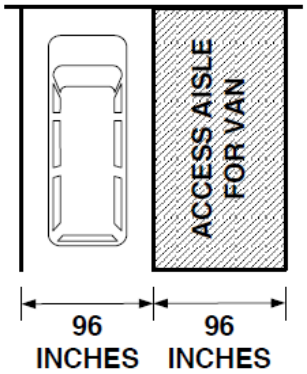
I certify that there have been no changes since the last physical accessibility review:

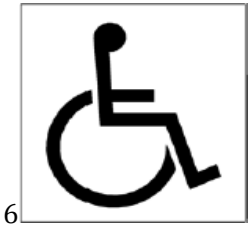
Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

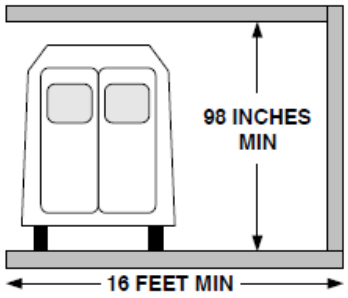
Name: _____ Signature: _____ Date: _____

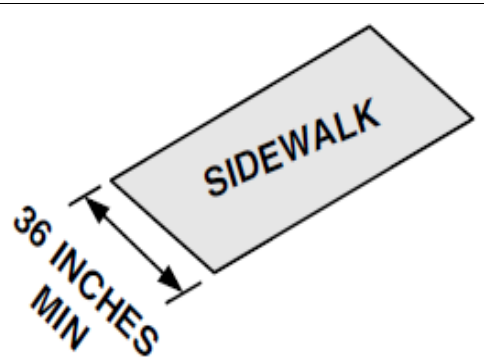
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	**Are the correct number of accessible parking spaces provided?** **1 to 25 total spaces – 1 required** **26 to 50 – 2 required** **51 to 75 – 3 required** **76 to 100 – 4 required** **101 to 150 – 5 required** **151 to 200 – 6 required** **201 to 300 – 7 required** **301 to 400 – 8 required**	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle. 				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

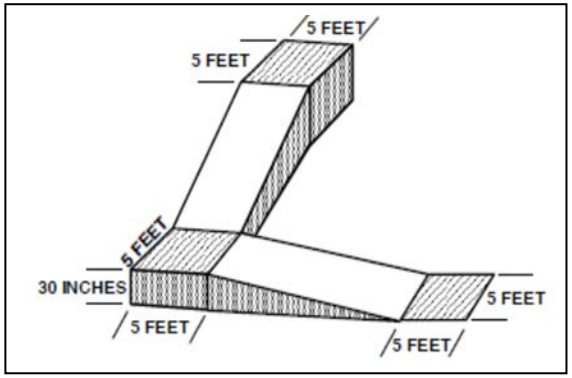
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
7 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the parking locations?**	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	**Do curbs on the route from off-street public parking have curb ramps at the drop off locations?**	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

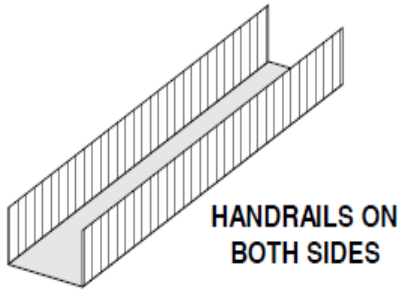
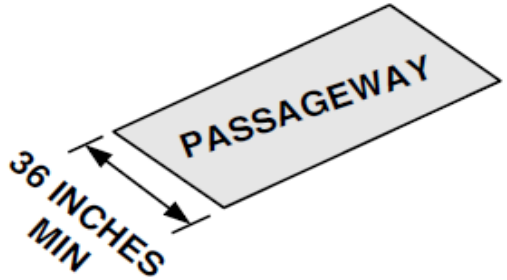
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	**Is VAN accessible parking provided?**	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

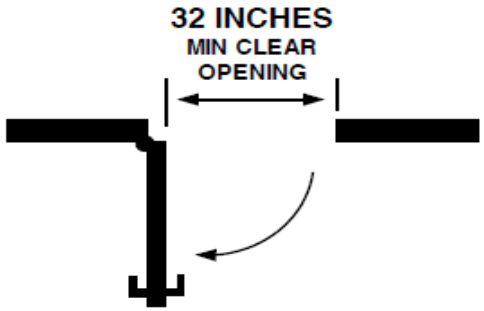
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					

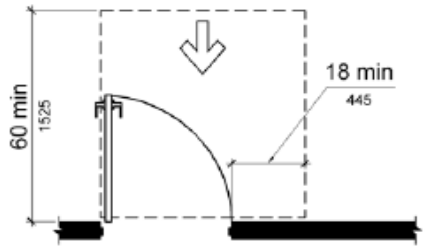
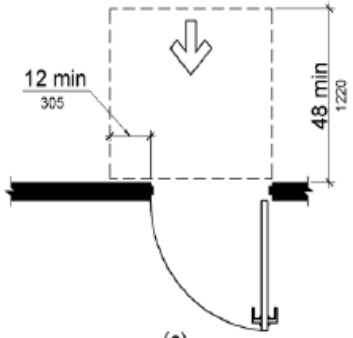
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
20 (CE)	**Is each run (leg) of the ramp no longer than 30 feet between landings?**	**Each "run," shown in the white sections in the diagram below, must be no longer than 30 feet.** 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

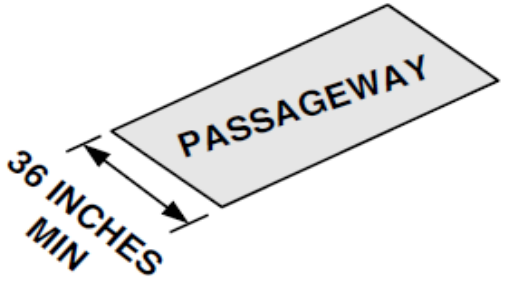
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
22 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	If the ramp is not longer than 6 feet, check NA.  				
23 (CE)	**Are all ramps at least 36 inches wide?**	 				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	**If a main entrance is not accessible, is there another accessible entrance?**	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

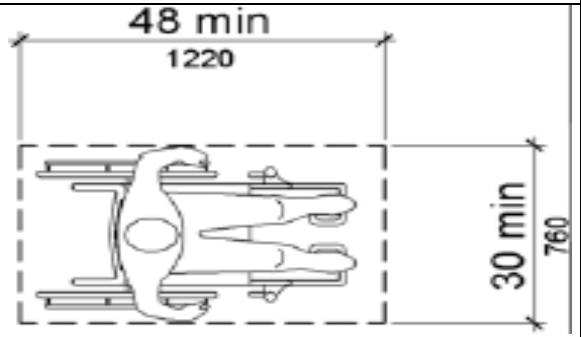
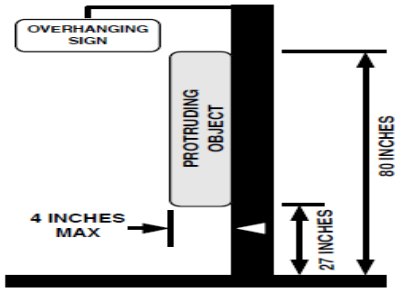
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
27 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	When measuring double doors, measure the opening with one door open to 90°.  				
28 (CE)	**Is space available for a wheelchair user to approach, maneuver, and open the door?**	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

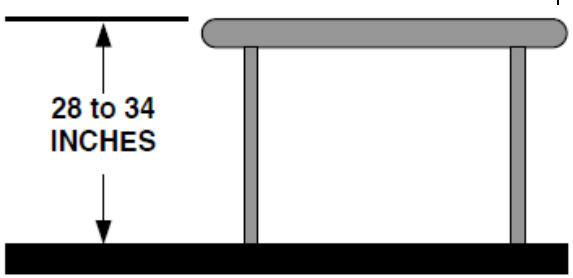
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

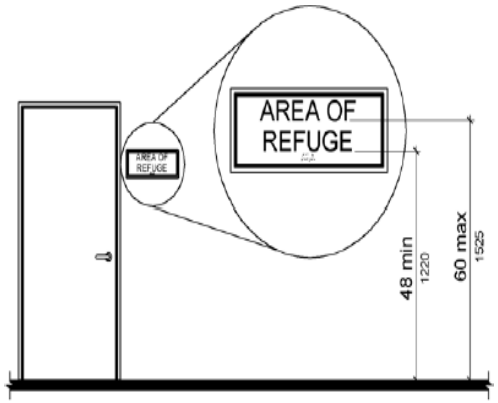
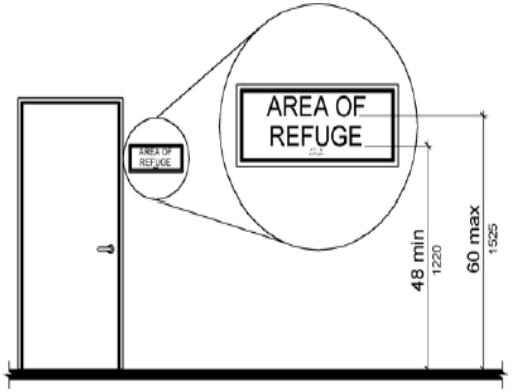
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
30	Are there automatic doors?	Self explanatory.				
31 (CE)	**Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?**	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

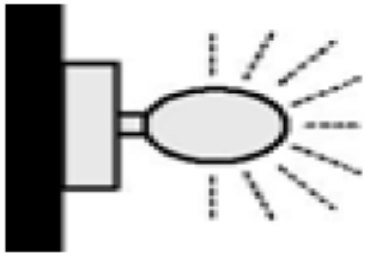
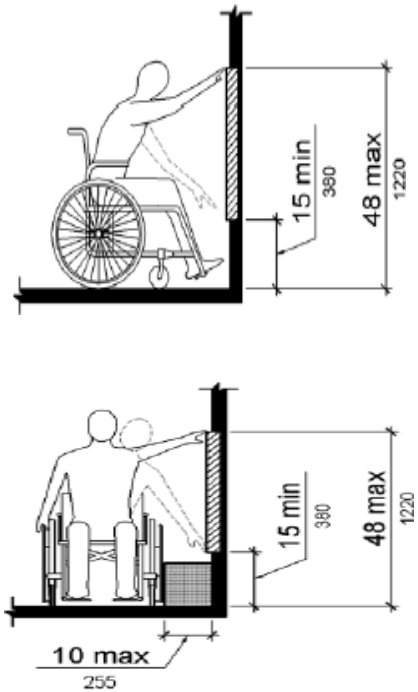
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
37 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	**If a platform lift is used, can it be used without assistance?**	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

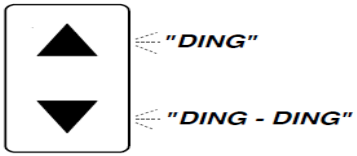
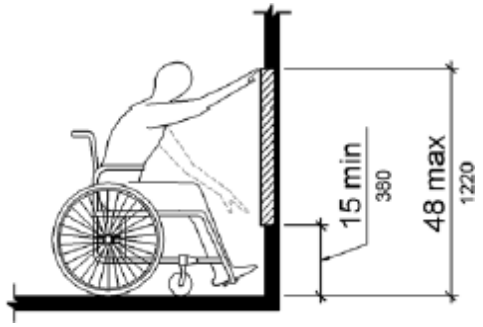
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

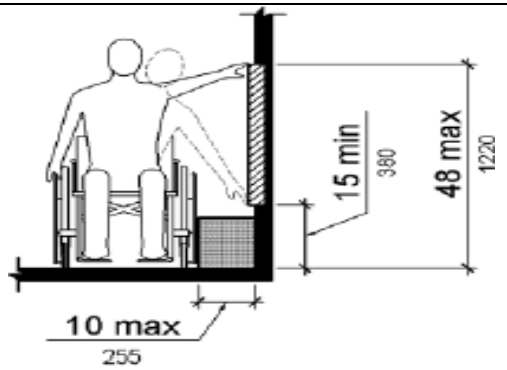
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

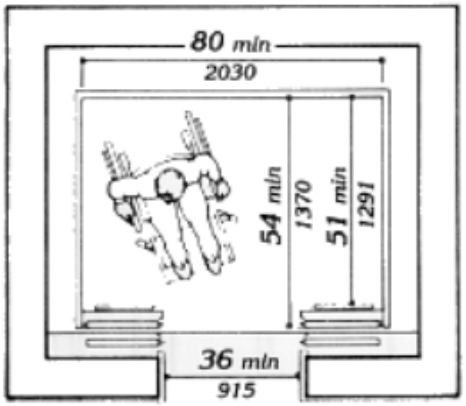
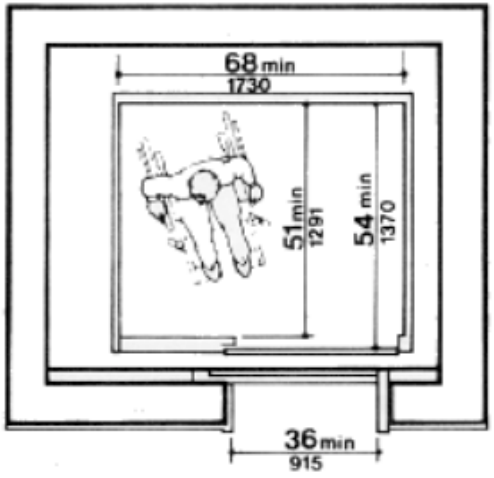
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	Self explanatory.				

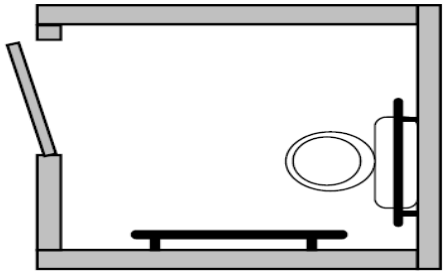
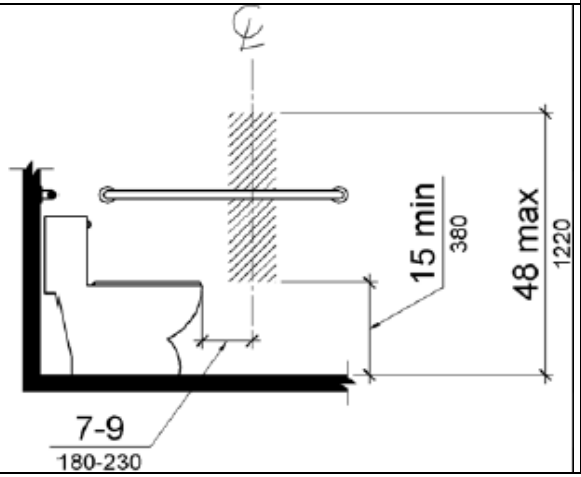
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
54 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	**Is there a raised letter and Braille sign on each side of each elevator jamb?**	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

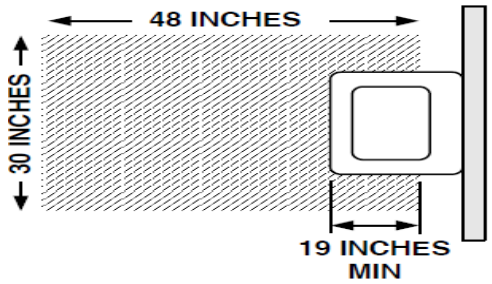
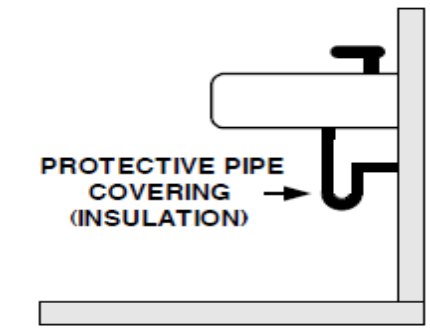
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						

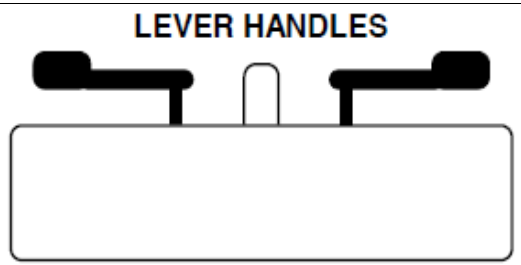
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
57 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a) 				

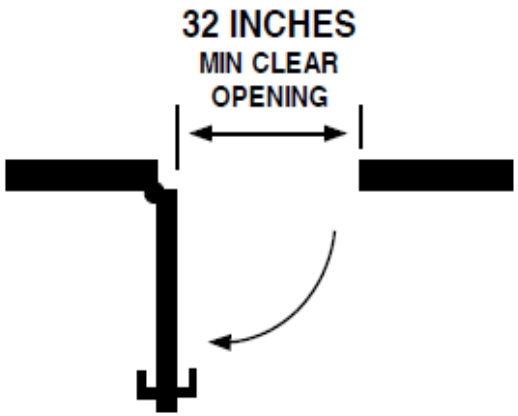
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
58 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

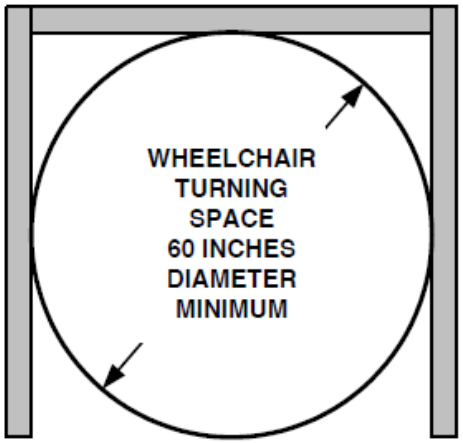
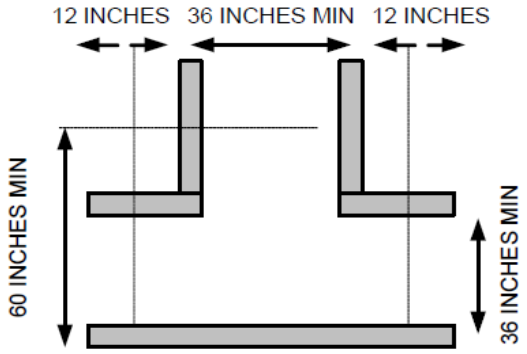
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

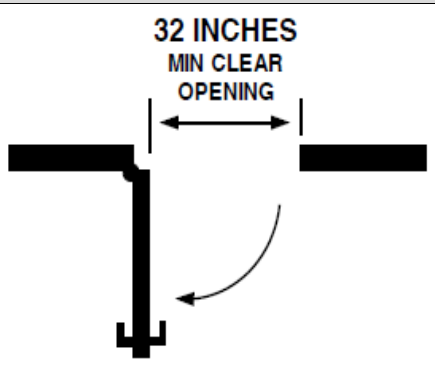
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	**For all toilet rooms with and without stalls:** **Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					

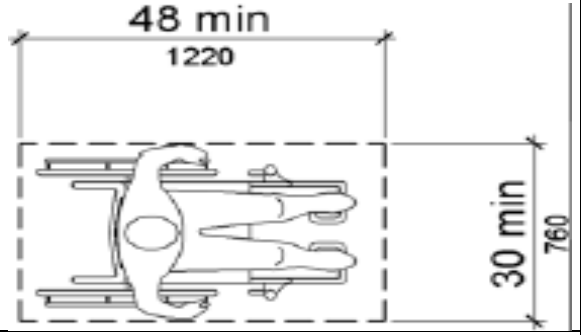
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
68 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	A knob handle would not be accessible.				

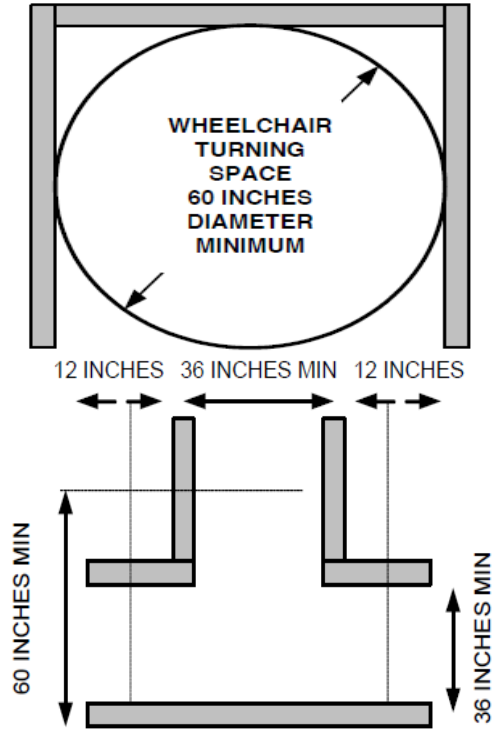
Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
						
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITHOUT STALLS					
75 (CE)	***Toilet room without stalls:*** **Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
	TOILET ROOM WITH STALLS					
77 (CE)	***Toilet Room with stalls:*** **Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?**	If there is no toilet room with stalls, check NA.  				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	**Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
81 (ME)	**Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?**	Self explanatory				
82 (ME)	**Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?**	9 				
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	**Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?**					

Question #	Criteria (CE = Critical Elements)	Explanation/Guidelines	Yes	No	N/A	Comments
86 (ME)	**Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?**	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design
U.S Department of Justice
http://www.ada.gov/2010ADAstandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:
2009 California Building Standards Code with California Errata and Amendments
State of California
Department of General Services
Division of the State Architect
Updated April 27, 2010
http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:
"Health Care Usability Profile V3"

Oregon Health & Science University RRTC: Health & Wellness
Authors: Drum, C.E., Davis, C.E., Berardinelli, M., Cline, A., Laing, R., Horner-Johnson, W., & Krahn, G.
Oregon Institute on Disability and Development
Portland, OR 97239
rrtc@ohsu.edu
healthwellness.org

Date

Hospital Name
Hospital Contact person name
Address
City State Zip

Dear:

The Department of Health Care Services (DHCS) requires hospitals to complete a Physical Accessibility Review Survey (PARS). Partnership HealthPlan of California (Partnership) requests your assistance in answering the questions on the enclosed PARS and signing the attestation.

Please have your facility-designated staff complete and submit the PARS and the accompanying attestation by xxxxx to:

Email: fsr@partnershiphp.org
Fax: 530-999-6950

In addition to hospitals, the PARS is required for all primary care providers, high-volume specialists, and ancillary providers that serve the seniors and persons with disabilities (SPD) population. The PARS tool and guidelines are based on compliance with the Americans with Disabilities Act (ADA). The PARS tool consists of critical access elements to assist members in selecting the facility that can best serve them. Based on the outcome of the PARS evaluation, each hospital site and the above-noted providers are designated as having either Basic Access or Limited Access, along with specific accessibility indicator designations for parking, external building, interior building, restrooms, examination rooms, and medical equipment (for example, accessible weight scales and adjustable exam tables). We appreciate your assistance in completing the attached attestation.

If you have questions about the PARS, please contact the above email for further guidance. We are also available to visit your site and complete the PARS form for your site if requested.

Sincerely,

Manager of Clinical Compliance Inspections Team

Enclosures:
Policy Letter 12-006

PARS Survey and Guidelines
Attestation Page

Hospital Physical Accessibility Review Survey 2012 (Attachment C)

California Department of Health Care Services Medi-Cal Managed Care Division

Physical Accessibility Review Survey Completion Attestation

I have completed the Physical Accessibility Review Survey (PARS) for the _____ review performed
(Hospital Name)

on _____.
(Date of Review)

I affirm the PARS was conducted and completed as indicated on the attached tool. I hereby authorize the health plan to furnish to all collaborative health plans, any government agencies that have authority over the health plans, and authorized county entities in the State of California, the PARS results this facility.

_____	_____	_____
Hospital Administrator/Designee Signature	**Printed Name and Title**	**Date**

Please return completed PARS along with this signed attestation via email or fax:

Partnership HealthPlan of California
Email: FSR@partnershiphp.org
Fax: (530) 999-6950

May 8, 2025~~June 14, 2024~~

Site Name
Attn: Contact name, Title
Address
City, State, Zip

RE: Physical Accessibility Review Survey (PARS) / FSR-Attachment C

Dear Ms. / Mr. last name of contact,

In compliance with the Department of Health Care Services (DHCS), Medi-Cal Managed Care Division Policy Letter 12-006, Partnership HealthPlan of California (Partnership) has been conducting assessments of our network providers' offices to determine the level of physical accessibility of provider sites, including primary care physician, and specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

The information gathered will allow PHC to provide information to assist Partnership members in choosing provider sites that will be able to meet their needs.

The access level below will be denoted in the Partnership Provider Directory and on the Partnership website, as well as the Accessibility Indicators next to your individual information.

Accessibility Levels:

☐ Basic Access	Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
☐ Limited Access	Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
☐ Medical Equipment Access	The site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.

Accessibility categories: (checked boxes indicate what will be identified in the directory):

- ☐ **P**-Parking and pedestrian walkways
- ☐ **EB**-Exterior entrance to medical office buildings or office complexes
- ☐ **IB**-Interior entrance to medical office buildings or office complexes
- ☐ **R**- Restroom accessibility
- ☐ **E**- Maneuverability and access to waiting rooms and exam/treatment rooms
- ☐ **T***- Adjustable exam table and a weight scale that can accommodate a wheelchair or scooter.

*Please note that this is in addition to the other Accessibility Indicators and will not affect the level of basic accessibility.

A copy of the survey tool was provided to you at the time the site visit was scheduled. Please let us know if you need another copy.

Deficiencies for each category are:

- **P (Parking)**: The guidelines state:
  - There must be at least 1 ADA parking space for every 25 regular spaces.
  - Curbs on the route from off-street public parking must have curb ramps at the parking locations.
  - Curbs on the route from off-street public parking must have curb ramps at the drop off locations
  - There must be at least 1 VAN accessible parking space provided. To qualify, the parking space and access aisle must be at least 92" each or at least a total of 192" overall.
- **EB (Exterior Building):** The guidelines state:
  - If accessible route crosses a curb, there must be a curb ramp provided to the building entrance from: Parking, Public Transpiration, and Public Sidewalk.
  - If ramp is present, each run (leg) of the ramp should be no longer than 30' between landings.
  - If ramp is over 6' long, handrails must be provided on both sides of the ramp and be mounted between 34" and 38" above the ramp surface.
  - Handrails must be at least 36" wide.
  - If the main entrance is not accessible, there must be another accessible entrance.
  - The entrance doors must have a minimum opening of at least 32" when opened at 90 degrees.
  - There must be space available for a wheelchair user to approach, maneuver, and open the door (Pull doors requires a clear space of 60" perpendicular X 18" parallel to the doorway; Push doors require 48" perpendicular to the doorway).
  - Entrance doors must have handles that can be opened without grasping, pinching or twisting the wrist.
- **IB (Interior Building):** The guidelines state:
  - All interior paths of travel must be at least 36" wide.
  - If there are stairs on the accessible route, handrails must be on each side.
  - If a platform lift is used, it must be available without assistance.
  - If there is an elevator, is available for public/patient use during business hours?
  - The elevator equipped with both visible and audible door opening/closing and floor indicators.
  - The elevator must have raised letter and Braille signs on each site of each elevator jamb.
  - The elevator hall call buttons must be no higher than 48" from the floor.
  - The elevator car must be large enough for a wheelchair or scooter user to enter, turn to reach the controls, & exit (Must be 36" wide doorway with: centered doorway-51" long X 80" wide care, side doorway-54" long X 68" wide.

- The buttons on the control panel inside the elevator must have Braille and raised characters/symbols.

- **R (Restroom)**: The guidelines state:
  - Grab bars must be provided, one on the wall behind the toilet and one on the wall next to the toilet (must be mounted in a horizontal position between 33" and 36" above the floor).
  - The toilet paper dispenser must be mounted below the side grab bar with the centerline of dispenser between 7" and 9" in front of the toilet, and at least 15" high.
  - There must be space which is at least 30" wide and 48" deep to allow wheelchair user to park in front of the sink (space must extend at least 17" under the sink from the front edge, although it can extend up to 19" underneath).
  - Faucet handles must be operable with one hand and without grasping, pinching, or twisting.
  - Doorways must have a minimum opening of 32" with the door open at 90 degree.
  - For toilet rooms with stalls, there must be a 60" diameter turning circle or 60" x 60" "t"-shaped space inside the stall to allow a turnaround for wheelchair and scooter users.
- **E (Exam room):**
  - The exam room doorways must have a minimum clear opening of 32" with the door open at 90 degrees.
  - There must be a 60" diameter or a 60" x 60" "t"-shaped space for 180 degree turns.
- **T (Exam Table/Scale):**
  - There must be a height adjustable exam table that lowers to between 17" and 19" from the floor to the top of the cushion.
  - There must be space next to height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table (30" wide x 48" long).
  - There must be a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient.

Although these are considered a critical element, corrective action is not required as the assessment is for informational purposes only at this time.

Please contact me if you have any questions.

Thank you for your assistance with the review.

Sincerely,

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1038</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/28/2008</td><td colspan="4">Next Review Date: ~~02/12/2026~~06/11/2026
Last Review Date: ~~02/12/2025~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ 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">☐ CREDENTIALS</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: ~~02/12/2025~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:
N/A

II. IMPACTED DEPTS:
A. Health Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. California Physician Orders for Life-Sustaining Treatment (POLST) Revised Form effective April 1, 2017 and available at: https://capolst.org/.

V. PURPOSE:
To establish Partnership HealthPlan of California's policy for use of the Physician Orders for Life-Sustaining Treatment (POLST) form.

VI. POLICY / PROCEDURE:
The Physician Orders for Life-Sustaining Treatment (POLST) is a physician order sheet. The POLST translates a person's wishes for medical treatment at the end of life into a set of physician orders that are followed throughout the medical system, including during transport between medical facilities. It constitutes a uniform document which implements a person's wishes in all health care settings.

A. The POLST is not an Advance Directive and does not take the place of one. Patients should still be encouraged to complete an Advance Directive if they do not have one. The POLST translates the Advance Directive into physician orders. It also replaces the emergency medical services (EMS) form that gives resuscitation directions to emergency response staff in a patient's home or any residential care facility.
   1. The POLST is optional and not required. It can be an alternative to the "Pre-Hospital Do Not Resuscitate," "Preferred Intensity of Care" and "Preferred Intensity of Treatment" forms, although POLST is more comprehensive in that it addresses other life-sustaining treatment in addition to resuscitative measures.
   2. The primary population for completion of a POLST form is anyone with a life-limiting illness who is appropriate for end-of-life planning. However, the POLST form is valid for any patient.
   3. The POLST may be changed by the patient, surrogate decision-maker (if patient is incapable of expressing their wishes), or the physician.

4. ~~Effective January 1, 2016, a~~ A physician, nurse practitioner, or physician assistant must sign the POLST. It also should be signed by the patient or legally recognized decision-maker.
5. If the possibility of resuscitation arises (patient has no pulse and no respiration), Part A: Attempt Resuscitation or Do Not Attempt Resuscitation orders are followed.
6. If any section of the POLST is not completed, the highest level of treatment must be provided until further discussion with physician, nurse practitioner, or physician assistant. As with other physician orders, new orders can supersede the initial POLST.
7. The physician, nurse practitioner, or physician assistant will be notified if the patient or legally recognized decision-maker requests a change in the POLST treatment decisions.
8. In the skilled nursing setting, the POLST may be used in place of other facility cardiopulmonary resuscitation (CPR) treatment decision forms; dual forms are not necessary.

B. Recommendations for completing a POLST form with the patient:
1. If the patient or surrogate decision maker chooses to complete a POLST form, the physician, nurse practitioner, or physician assistant or designated staff member will discuss the treatment options in the POLST form. Discussion will also include the patient's Advance Directive (if done) or other statements the patient has made regarding their wishes for end of life care and treatments. The likelihood of treatment success and the potential for causing suffering should be discussed when deciding upon CPR and medical interventions. Additional information about medical interventions is available for patients and families in the POLST Patient Handout.
2. The POLST form is completed according to the patient's expressed wishes.
3. The physician, nurse practitioner, or physician assistant and the patient or his/her legally recognized decision-maker will sign the POLST form.
4. The POLST instructions and form are available ~~in PHC's threshold languages, including Spanish, Russian, and Tagalog. See~~ at capolst.org/polst-for-healthcare-providers/forms/. Members needing assistance with translation should contact Partnership's Member Services department.

C. Review of POLST form:
1. The physician, nurse practitioner, or physician assistant and patient or legally recognized decision-maker may review or revise the POLST at any time.
2. During care plan conferences or discharge planning, the physician may review the POLST to see if the patient's condition warrants review or revision.
3. The POLST can also be marked "VOID" and a new POLST completed. The original POLST marked "VOID" should be signed and dated. A copy of POLST marked "VOID" is kept in medical record directly behind the current POLST.
4. As the patient moves from one health care setting to another or to home, the most current, original POLST form (including copies of any Advance Directive) should accompany the patient.

D. Recommendations for when a patient with a POLST form is admitted to a health care facility:
1. The physician, nurse practitioner, or physician assistant, nurse, social worker or designated staff member will review the contents of the POLST form with the patient or surrogate decision maker.
2. POLST orders will be honored by the staff. Resuscitation orders will be transcribed into the patient's medical orders.
3. If the POLST is signed by a physician, nurse practitioner, or physician assistant who is not a member of the medical staff, POLST orders will be followed until reviewed by a credentialed member of the medical staff. POLST orders are continued, unless the attending physician writes new orders.
4. The POLST form is copied for the medical record (or scanned into the electronic medical record).At the time of discharge, the Discharge Summary should note that patient has a POLST form. The original POLST should be sent with the patient at discharge or transfer from the facility.

Policy/Procedure Number: MPQP1038			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Physician Orders for Life-Sustaining Treatment (POLST)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/28/2008		**Next Review Date:** ~~02/12/2026~~06/11/2026 **Last Review Date:** ~~02/12/2025~~06/11/2025	
Applies to:	☐**Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

VII. REFERENCES:
California Physician Orders for Life-Sustaining Treatment https://capolst.org/

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
Medi-Cal
08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19, 02/12/20; 02/10/21; 02/09/22; 02/08/23; 02/14/24; 02/12/25; 06/11/25

Partnership Advantage (effective Jan. 1, 2026)
N/A

*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:
PartnershipAdvantage:
MPQP1038 - 08/20/2008 to 01/01/2015

Healthy Families:
MPQP1038 - 11/17/2010 to 03/01/2013

Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1038 - 08/28/08; 08/19/09; 11/17/10; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 01/20/16 to 12/01/16

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPC<s>C</s>QP1047 (previously MCP<s>P</s>QP1047)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Advance Directives</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/17/2009</td><td colspan="4">Next Review Date: <s>06/12/2025</s>06/11/2026
Last Review Date: <s>06/12/2024</s>06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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>☐ CREDENTIALS</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>06/12/2024</s>06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1038 – Physician Orders for Life-Sustaining Treatment
B. MPQP1022 – Site Review Requirements and Guidelines

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
B. Advance Directives include two parts:
   1. A health care proxy (sometimes called "durable power of attorney"), which names someone the member trusts to make decisions about their health care if the member cannot.
   2. A living will describes which treatment(s) the member wants if the member's life is threatened, including dialysis, breathing machines, resuscitation, and tube feeding.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define member rights to have an Advance Health Care Directive (aka Advance Directive), and define practitioner and health plan responsibility to provide Advance Directive information to Partnership HealthPlan of California (Partnership) members who are adults or emancipated minors.

VI. POLICY / PROCEDURE:

A. Regarding Members

Policy/Procedure Number: MPCQP1047 (previously MCPQP1047)		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Advance Directives		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/17/2009		**Next Review Date: 06/12/202506/11/2026** **Last Review Date: 06/12/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

1. Partnership advises members about Advance Health Care Directives and their right to execute one. The Advance Directive form enables the individual to express his or her preferences for life-sustaining treatment and to elect an individual to make health care decisions in a situation where the individual is unable to make decisions for themselves. Members receive this information from Partnership in the Evidence of Coverage document on enrollment and information about Advance Directives is available on the Partnership website. Partnership will notify members within 90 days if there are changes in state or federal law regarding Advance Directives. Partnership acknowledges that members have the right to not fill out part or all of the Advance Directive form as a matter of conscience. Partnership will not discriminate in any way against a member who chooses to not fill out part or all of an Advance Directive form. If a member is incapacitated at the time of initial enrollment and unable to receive information (due to the incapacitating condition or to a mental disorder) or articulate whether they have executed an Advance Directive, Partnership will give Advance Directive information to the member's family or surrogate in the same manner that we issue other materials about policies and procedures. When the incapacity has resolved, Partnership Care Coordination staff will discuss advance care planning with the member, including the recommendation to complete an Advance Directive.

~~1.~~ Regarding Partnership Advantage Members: Medicare covers and utilizes advance care planning, as part of the annual wellness visit or as a separate medically necessary service. Medicare Part B covers voluntary advance care planning, including discussions about end-of-life care preferences. The member may update their Advance Directive at any time.

B. Regarding Practitioners

1. Partnership regularly provides education on Advance Directives to all contracted providers for whom advance care planning is an appropriate part of their scope of practice. Partnership encourages its clinicians to discuss the right to execute an Advance Directive and to honor the Advance Directive of any individual who completes the form. The primary care provider (PCP) and/or specialist should periodically review the Advance Directive with the patient to ensure the elections made on the form continue to reflect the current wishes of the individual. The PCP should keep a copy of an executed Advance Directive in the medical record. PCPs should not condition the provision of care or discriminate against an individual based on whether the patient has executed an Advance Directive or on the contents of that Advance Directive. Partnership acknowledges that health care providing organizations, and individual clinicians practicing in each organization, may conscientiously object to implementing parts of executed Advance Directives. In such cases, it is expected that the organization and/or individual practitioner will inform the member that they cannot implement those portions of the Advance Directive to which there is conscientious objection. The member should be offered the right to switch their care to an organization or practitioner who will follow the requests in their Advance Directive.

~~1.~~2. Medicare reimburses healthcare providers for advance care planning discussions with Medicare beneficiaries. Utilize CPT codes 99497 and 99498 for billing advance care planning services. When billing for multiple advance care planning services, a change in the patient's health status or wishes regarding end-of-life care must be documented.

~~2.~~3. Partnership Facility Site and Medical Record Review (see MPQP1022) on primary care provider sites determines if providers offer Advance Directive information. Documentation in the medical record should indicate if the PCP discussed Advance Directives with the patient and/or if the patient executed or refused an Advance Directive. Evidence of a discussion of the Advance Directive is sufficient to meet site review requirements.

C. Regarding Partnership Staff

1. Partnership provides education of its staff regarding our policies and procedures about Advance Directives.

D. Regarding the Community

1. Partnership, in partnership with various community organizations, encourages community education regarding Advance Directives, emphasizing that they are designed to enhance individual's control over their medical treatment plans.

VII. REFERENCES:

A. Title 42, Code of Federal Regulations, Sections 422.128 and 489.100
B. California Probate Code, Sections 4670 through 4743
C. Medi-Cal Handbook / Evidence of Coverage
D. Medicare Managed Care Manual
~~D.~~E. https://www.medicare.gov/coverage/advance-care-planning
~~E.~~F. Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/California-Advance-Health-Care-Directive.aspx
~~F.~~G. Multiple Advanced Directive options can be found on the California Coalition for Compassionate Care website: https://coalitionccc.org/CCCC/Resources/ACP-Tools-Resource-List.aspx

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
08/18/10; 05/21/08; 05/20/09; 10/17/12; 10/16/13; 10/15/14; 10/21/15; 10/19/16; 04/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 6/12/24; 06/11/25

Partnership Advantage (effective Jan. 1, 2026)
06/11/25

*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*:
PAQI 101 – 06/21/2006 to 05/21/2008
PAQP1036 – 05/21/2008 to 10/17/2012
MPQP1047 – 10/17/2012 to 01/01/2015

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1055				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/03/2012 (CMP-36)			**Next Review Date: ~~06/12/2025~~06/11/2026** **Last Review Date: ~~06/12/2024~~06/11/2025**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: ~~06/12/2024~~06/11/2025**	

I. RELATED POLICIES:

A. MPQP1016 – Potential Quality Issue Investigation and Resolution
B. FIN 405 – Treatment of Recoveries of Overpayments to Providers
C. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Finance
D. Provider Relations
E. Regulatory Affairs & Compliance

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~A.~~B. Provider Preventable Condition (PPC): specified and defined Health Care Acquired Condition (HCAC or HAC) or Other Provider Preventable Condition (PPC), which is a medical condition or complication that a patient develops during a hospital stay or ambulatory surgical encounter that was not present at admission. See Title 42 of the Code of Federal Regulations Sections §447.26, 434.6, 438.3 and Welfare and Institutions Code Section 14131.11 for original documentation related to these terms.

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

~~C.~~D. OPPC and HCAC definitions, according to the Department of Health Care Services (DHCS), can be found here: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx)

~~D.~~E. Other Provider Preventable Conditions (OPPC) for purposes of Medicaid include the following (may occur in any health care setting):

1. Wrong surgery or wrong invasive procedure
2. Surgery or invasive procedure on the wrong body part
3. Surgery or invasive procedure on the wrong patient

~~E.~~F. Health Care Acquired Condition (HCAC or HAC) for purposes of Medicaid include the following (for inpatient hospital settings only):

1. Air embolism
2. Blood incompatibility transfusion
3. Catheter-associated urinary tract infection (UTI)
4. Falls and trauma that result in fractures, dislocations, intracranial injuries, crushing injuries, burns and electric shock
5. Foreign object retained after surgery
6. Iatrogenic pneumothorax with venous catheterization
7. Manifestations of poor glycemic control
   a. Diabetic ketoacidosis
   b. Nonketotic hyperosmolar coma
   c. Hypoglycemic coma
   d. Secondary diabetes with ketoacidosis
   e. Secondary diabetes with hyperosmolarity
8. Stage III and IV pressure ulcers that developed during the patient's hospital stay
9. Surgical site infection following:
   a. Mediastinitis following coronary artery bypass graft (CABG)
   b. Bariatric surgery, including laparoscopic gastric bypass, gastroenterostomy and laparoscopic gastric restrictive surgery
   c. Orthopedic procedures for spine, neck, shoulder, and elbow
   d. Cardiac implantable electronic device (CIED) procedures
10. Vascular catheter-associated infection
11. Deep vein thrombosis (DVT)/pulmonary embolism (PE) (excluding pregnant women and children under 21 years of age) resulting from:
    a. Total knee replacement
    b. Hip replacement

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Title 42 of the Code of Federal Regulations, Sections 447.26, 434.6 and 438.3 and Welfare and Institutions Code Section 14131.11 prohibit the payment of Medicaid/Medi-Cal funds to a provider for the treatment of a PPC except when the PPC existed prior to the initiation of treatment for that beneficiary by that provider. Furthermore, the federal Centers for Medicare & Medicaid Services (CMS) specified that managed care organizations must participate in reporting PPC-related encounters.

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

VI. POLICY / PROCEDURE:

A. Reporting Requirements

1. Providers must report potential PPCs directly to the DHCS Audits & Investigations (A&I) Unit after discovery of the event and confirmation that the patient is a Medi-Cal beneficiary. Online reporting guidance at: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx. Reporting is required for all Medi-Cal beneficiaries, including those eligible for Medicare or other insurance coverage.

2. Any potential PPC pertaining to a Partnership member must also be reported directly to Partnership. Providers should forward potential PPCs to the Quality Improvement (QI) department via a secure email at PQI@partnershiphp.org. The email must be encrypted through a secure messaging system.
3. Partnership follows ~~-~~up on all provider self-reported potential PPCs to ensure that appropriate notification has also been sent by the provider to the DHCS A&I Unit.
4. Potential PPCs may also be reported to the QI department by Partnership staff or community members, per the PQI identification methods identified in MPQP1016 Potential Quality Issue Investigation and Resolution.
5. Request for information about the PPC process or how to report a PPC may be referred to the QI department's Member Safety & Clinical Investigations team via PQI@partnershiphp.org.

B. Partnership Screening for PPCs
1. Partnership's Claims department on a monthly basis screens encounter data, ~~on a monthly basis,~~ including data received from network providers, for the presence of PPC-specific billing codes. The Claims department on a monthly basis in a report format forwards identified e~~E~~ncounters ~~identified are forwarded by the Claims department to PQI@partnershiphp.org on a monthly basis in a report format, and are reviewed~~ to PQI@partnershiphp.org. T~~by t~~he Clinical Investigations team will review these reports.~~.~~

C. Clinical Review of Potential PPCs
1. Potential PPCs are investigated according to the PQI investigation processes outlined in MPQP1016 – Potential Quality Issue Investigation and Resolution.
2. The scope of review includes both a medical record and claims history review.
3. All potential PPCs are forwarded to the Chief Medical Officer (CMO) or physician designee for secondary review.
4. Potential PPC cases may be reviewed by the Partnership Peer Review Committee for additional potential actions/remedies, as noted in MPQP1016.

D. Reporting Confirmed PPCs
1. The QI department reports all confirmed PPCs previously unreported to the DHCS A&I unit via the online reporting module: http://www.dhcs.ca.gov/individuals/Pages/AI_PPC.aspx.
2. Notification of the reported incident is also sent to Partnership's internal ~~Compliance Oversight Department~~Regulatory Affairs & Compliance department at RAC_Inbox@partnershiphp.org. ~~(RAC_Inbox@partnershiphp.org.~~

E. Payment Recoupment for Confirmed PPCs
1. If the case is determined to be a PPC, the medical record will be reviewed to determine which, if any extra procedures, length of hospitalization, medications or other items/ actions were provided to the member exclusively because of the PPC. Documentation of this review will be placed in the QI department PQI case file.
2. The CMO or physician designee will discuss the case with a representative of Claims, Finance – Cost Avoidance Unit, Provider Relations and Utilization Management departments who are well versed in provider reimbursement. Using the results of the PPC clinical review, and a review of the federal code, this group will recommend which, if any, charges are recommended for recoupment. Partnership's CMO and Chief Financial Officer (CFO) will review and act upon this recommendation.
3. The Finance – Cost Avoidance Unit will process any recoupment in accordance with Partnership Policy FIN-405 – Treatment of Recoveries of Overpayments to Providers.
4. Contractor, Subcontractor, Downstream Subcontractor, or Network Provider and shall not pay any Provider claims nor reimburse a Provider for a PPC in accordance with 42

CFR section 438.3(g)

F. Communication
   1. The QI department will notify the provider of the results of the potential PPC clinical investigation according to MPQP1016.
   2. For confirmed PPCs, the Finance – Cost Avoidance Unit will communicate with the provider the recommendations of the PPC financial review and the mechanism of recoupment proposed, if indicated.
   3. Any objections raised by the provider regarding final case determinations will be escalated to the CFO and CMO for review.

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

H. Document Retention
   1. Copies of all PPC submissions to DHCS by Partnership or Partnership providers~~,~~ and supporting medical record evidence will be maintained by Partnership in accordance with Partnership document retention policy CMP30.

I. Oversight
   1. An annual summary PPC report will be presented to ~~the~~ Partnership's Internal Quality Improvement (IQI) Committee, ~~the~~ Quality and Utilization Advisory Committee (Q/UAC), and ~~the~~ Compliance Committee.

VII. REFERENCES:

A. Department of Health Care Services All Plan Letter 17-009 (DHCS APL 17-009): Reporting Requirements Related to Provider Preventable Conditions (05/23/2017)
B. DHCS Medi-Cal Guidance on Reporting PPCs (last modified 03/23/2021)
C. DHCS PPC Frequently Asked Questions (last modified 03/23/2021)
D. DHCS PPC Online Reporting System
E. Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Parts 434, 438, and 447 - Medicaid Program; Payment Adjustment for Provider Preventable Conditions including Health Care-Acquired Conditions, effective July 1, 2011 https://www.govinfo.gov/content/pkg/FR-2011-06-06/pdf/2011-13819.pdf,
F. Centers for Medicare & Medicaid Services, Hospital-Acquired Conditions https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitalacqcond?redirect=/hospitalacqcond?redirect=/hospitalacqcond//

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

Policy/Procedure Number: MPQP1055			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Provider Preventable Condition (PPC) Reporting			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/03/2012 (CMP36)			**Next Review Date: ~~06/12/2025~~06/11/2026** **Last Review Date: ~~06/12/2024~~06/11/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/19/16, 06/14/17, *03/14/18; 03/13/19; 03/11/20; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25

*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.

Partnership Advantage (effective Jan. 1, 2026)
N/A

PREVIOUSLY APPLIED TO:
CMP 36, Provider Preventable Conditions – 09/03/2013 to 10/19/2016, now archived.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPXG5003</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Major Depression in Adults Clinical Practice Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/19/2000</td><td colspan="4">Next Review Date: ~~10/09/2025~~06/11/2026
Last Review Date: ~~10/09/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ 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>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/09/2024~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indication for Referral Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Provider Relations

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. Clinical Decision Flow Chart

V. PURPOSE:

To define the appropriate diagnostic criteria and therapy for patients with major depression.

This guideline is meant to be a basic guideline, not an enforceable standard, and is intended to assist the primary care professional in caring for Partnership HealthPlan of California (Partnership) adult members with major depression. Recommendations are not intended to replace sound clinical judgment in caring for individual patients.

VI. POLICY / PROCEDURE:

A. Overview

Nationally accepted clinical practice guidelines for depression are created and updated regularly. Pharmacologic choices for depression also continually change as new products enter the market. For these reasons, and upon the recommendation of Partnership's Physician Advisory Committee, this clinical practice guideline (CPG) will be annually updated with the appropriate internet references, which will provide timely guidelines for the management of major depression in adults.

VII. REFERENCES:

A. From the American Psychiatric Association: Practice Guideline for the Treatment of Patients with Major Depressive Disorder (2010) https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf
B. From the American Psychological Association: APA Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts (February 2019) https://www.apa.org/depression-guideline/guideline.pdf

C. From the US Preventive Services Task Force (USPSTF) Final Recommendation Statement (June 20, 2023) Depression and Suicide Risk in Adults: Screening: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults
D. National Institute of Mental Health: Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study (2006): https://www.nimh.nih.gov/funding/clinical-research/practical/stard
E. U.S. Department of Veterans Affairs. VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide ~~(2019)~~(2024): https://www.healthquality.va.gov/guidelines/mh/srb/index.asp
F. VA/DoD Clinical Practice Guidelines: Management of Major Depressive Disorder (2022) https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFinal508.pdf

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

VIII. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

IX. REVISION DATES:
Medi-Cal
09/18/02; 10/20/04; 11/15/06; 05/18/11; 06/19/13; 7/27/15; 08/19/15; 08/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 04/14/21; 06/08/22; 06/14/23; 06/12/24; ~~09/11/24~~ 10/09/24; 06/11/25

Partnership Advantage (effective Jan. 1, 2026)
N/A

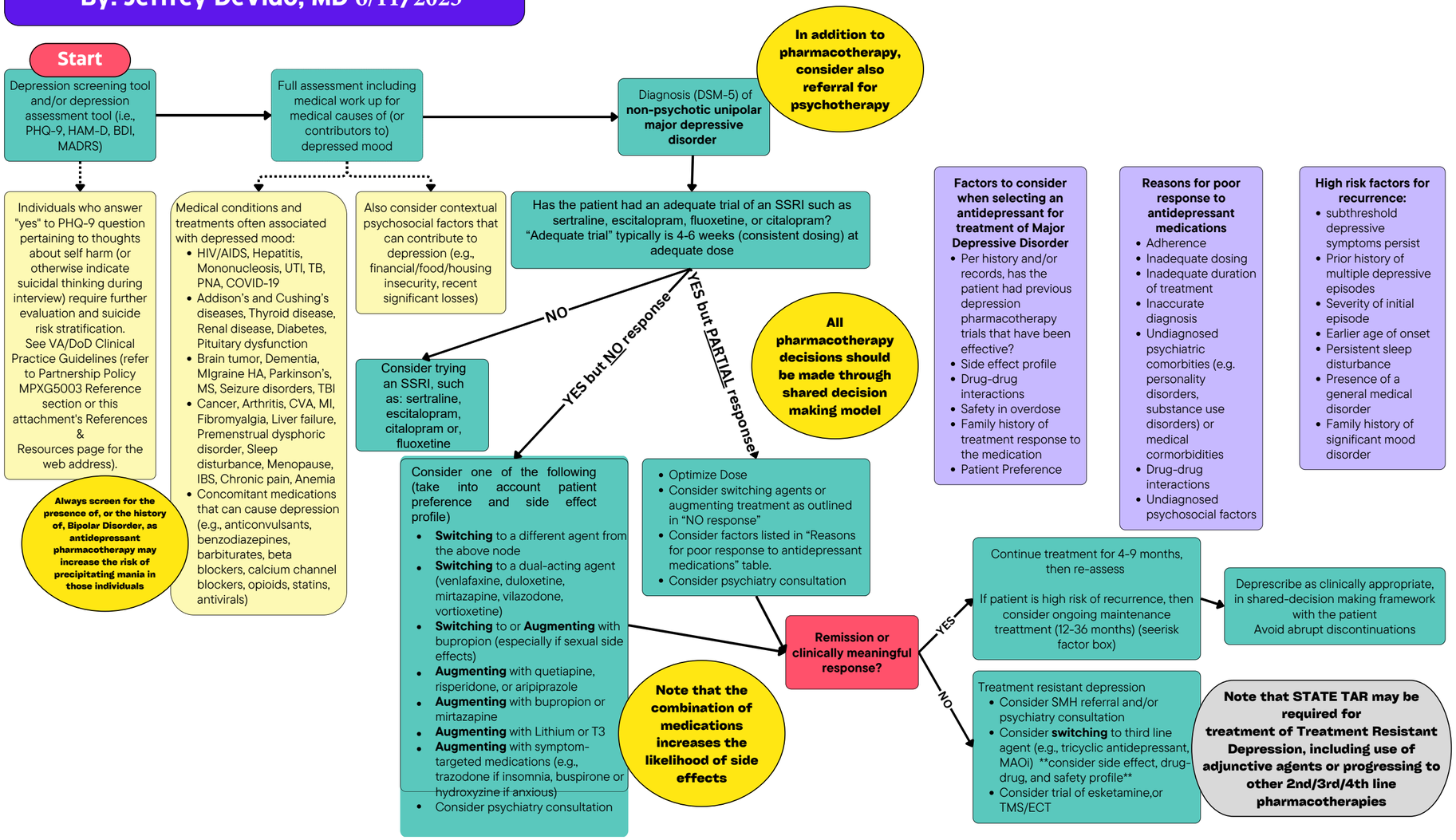
*Through 2017, Approval Date reflective of the Quality Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

IX. PREVIOUSLY APPLIED TO:
Healthy Families
05/18/11
Partnership*Advantage*
11/15/06; 05/18/11
Healthy Kids
11/15/06; 05/18/11; 08/19/15, 08/19/16 (Healthy Kids Program ended 12/01/2016)

Adult Depression Treatment Flow Diagram
(MPXG5003 Policy Attachment A)
By: Jeffrey DeVido, MD 6/11/2025

PROVIDERS PLEASE NOTE:

Medi-Cal mental health treatment services are divided between county specialty mental health (SMH) and managed care plan non-specialty mental health (NSMH) programs. The differentiation is based on clinical severity, with higher severity patients being preferentially routed to SMH systems of care. For members with Partnership Advantage, Partnership is responsible for coordination of services for all levels of severity [See: MPBP8003].



This algorithm is drawn from several sources listed below. This algorithm is not intended to be comprehensive or definitive; rather, it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care practice settings.

- Osser, DN (ed). Psychopharmacology Algorithms: Clinical Guidance from the Psychopharmacology Algorithm Project at the Harvard South Shore Psychiatry Residency Program. Wolters Kluwer, New York, 2021.
- Schatzberg, AF and Nemeroff CB (eds). The American Psychiatric Association Publishing Textbook of Psychopharmacology, 5th Ed. APA Publishing, Arlington, VA, 2017.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3037 (previously UP100337 and MCUP3057)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Appeals of Utilization Management/ Pharmacy Decisions</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: ~~05/08/2025~~06/11/2026
Last Review Date: ~~05/08/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☐ Partnership Advantage</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: ~~05/08/2024~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPPRGR210 – Provider Grievance
B. CGA024 – Medi-Cal Member Grievance System
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCRP4068 – Medical Benefit Medication TAR Policy
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. CMP36 – Delegation Oversight and Monitoring
G. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

B. Administrative Denial – Any denial of services that does not qualify as an Adverse Benefit Determination (ABD). An Administrative Denial is not subject to the appeal process and notification is only communicated to the provider.

C. Appeal – is a ~~member~~Member or provider request to Partnership HealthPlan of California (Partnership) for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.

D. Authorized Representative: An adult Member has the right to designate a friend, family ~~member~~Member, or other person to have access to certain protected health information (PHI) to assist the ~~member~~Member with making medical decisions. The ~~member~~Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by 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~~Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.

E. Deemed Exhaustion: In the event that the MCP fails to adhere to the state and federal notice and timeframe requirements for either a NOA or a NAR, including the MCP's failure to provide a fully translated notice, the ~~member~~Member is deemed to have exhausted the MCP's internal appeal process and may initiate a state hearing.

F. Notice of Action (NOA): – A formal letter informing a ~~member~~Member of an Adverse Benefit Determination.

E. Notice of Appeal Resolution (NAR): A formal letter informing a ~~member~~Member that an Adverse Benefit Determination has been overturned or upheld.

IV. ATTACHMENTS:

A. Request for Appeal/Expedited Appeal of UM or Pharmacy Decision
B. Member Authorization for Provider Appeal
C. UM and Pharmacy Appeal Acknowledgement Letter

V. PURPOSE:

To describe the process for a Partnership Medi-Cal M~~m~~ember, a M~~m~~ember's authorized representative, or a provider acting on behalf of a M~~m~~ember, to appeal Utilization Management (UM) or Pharmacy decisions determined by Partnership HealthPlan of California.

VI. POLICY / PROCEDURE:

A. General Appeal Rights

1. Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal ~~member~~Member or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which ~~member~~Members retain their access.
2. Pursuant to 42 CFR 438.408 (f)(1), Partnership may only offer a single appeal of an Adverse Benefit Determination (ABD) for a ~~member~~Member, a ~~member~~Member's authorized representative, or a provider acting on behalf of a ~~member~~Member. This requirement of a single appeal stands whether the ~~member~~Member or authorized representative files an appeal directly with Partnership's Grievances and Appeals department (~~member~~Member would be directed there after calling into the Member Services Department) or the provider files the appeal through Partnership's Utilization Management or Pharmacy departments. Upon notification of the plan's decision to uphold the original ABD or in instances of deemed exhaustion, the ~~member~~Member, the ~~member~~Member's authorized representative, or a provider acting on behalf of a ~~member~~Member, has the right to request a State Fair Hearing
3. Partnership ensures all ~~member~~Members have access to and can fully participate in the Grievance

and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of ~~member~~Member informing materials e.g. Grievance and Appeal procedures, forms, and Partnership responses to Grievance and Appeals, as well as access to qualified oral interpreters, Video Remote Interpreters (VRI), telephone relay systems and other devices that aid individuals with hearing and/or visual disabilities.

4. Upon request from the ~~member~~Member, Partnership shall provide the ~~member~~Member or ~~member~~Member's authorized representative the opportunity to review the ~~member~~Member's case file including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Partnership in connection with any standard or expedited Appeal of a Notice of Action. This information will be provided free of charge and sufficiently in advance of the resolution.

B. Appeals of Adverse Benefit Determinations

1. The ~~member~~Member, the ~~member~~Member's authorized representative, or the provider acting on behalf of the ~~member~~Member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter.
2. A ~~member~~Member or a ~~member~~Member's authorized representative may initiate an appeal by contacting Partnership's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the Partnership Grievance and Appeals department for processing. A provider may request an appeal on behalf of a ~~member~~Member, with written consent from that ~~member~~Member, by faxing or writing Partnership's UM or Pharmacy Department. An appeal initiated in this way will also be considered a Member Appeal but will be processed by the UM or Pharmacy department as applicable. The ~~member~~Member or provider may use the "Request for Appeal/ Expedited Appeal of UM or Pharmacy Decision" form if desired (See Attachment A). After receipt of the request for appeal, Partnership will provide written acknowledgement to the ~~member~~Member and provider that is dated and postmarked within five (5) calendar days of receipt of the appeal. If the request for appeal from a provider is not accompanied by written consent from the ~~member~~Member, Partnership will provide the "Member Authorization for Provider Appeal" form with the written acknowledgement and proceed with the request.
3. Partnership has 30 calendar days from the receipt of the appeal request to render a determination.
4. The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity.
5. The following types of appeal requests do not require physician review (but will be processed by UM or Pharmacy licensed clinical staff) as the determinations are not based on medical necessity criteria:
   a. Member not eligible with Partnership on date of service
   b. Member has other insurance
   c. Share of Cost (SOC) - It is the provider's responsibility to update the ~~member~~Member's share of cost in the State's Medi-Cal Eligibility Verification System. Members have no eligibility with Partnership, nor can claims be paid, until their SOC has been satisfied each month.
6. If Partnership's determination specifies the requested service is not a covered benefit, Partnership shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the provider and ~~member~~Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.
7. When a decision has been made, the provider and/or ~~member~~Member, if applicable, are notified in writing within 5 business days with a Notice of Appeal Resolution (NAR) letter. Partnership is not required to notify the ~~member~~Member of a decision when the ~~member~~Member is not at financial

risk for the services being requested (e.g. acute concurrent reviews).

8. Providers who disagree with the appeal resolution may file a grievance with Partnership by the process described in the Provider Grievance policy MPPRGR210.

C. Expedited Appeals of ABD Determinations

1. Expedited appeals may be initiated by the ~~member~~Member, the ~~member~~Member's authorized representative, or the provider acting on behalf of the ~~member~~Member. A ~~member~~Member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a ~~member~~Member with the ~~member~~Member's written consent by faxing or writing the Partnership UM or Pharmacy Department. If the request for expedited appeal is not accompanied by written consent from the ~~member~~Member, the Plan will proceed with the request. Expedited appeals are performed by Partnership only when, in the judgment of the Chief Medical Director (CMO) or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the ~~member~~Member. If the CMO or Physician Designee determines that the appeal does not meet criteria to be expedited, the appeal will be reviewed according to the standard timeframe described in VI.B.
2. Partnership refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after the receipt of the request for an expedited appeal. Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a ~~member~~Member who has received emergency services but has not been discharged from a facility. Partnership provides verbal confirmation of its decisions concurrent with mailing of written notification no later than seventy-two (72) hours after receipt of an expedited appeal.
3. If the expedited appeal involves a concurrent review determination, the ~~member~~Member continues to receive services until a decision is made and written notification is sent to the provider. Partnership is not required to notify the ~~member~~Member of a concurrent decision as the ~~member~~Member is not at financial risk for the services being requested.

D. UM or Pharmacy Administrative Denials (Not Subject to the Appeal Process)

1. UM or Pharmacy licensed clinical staff may process the following list of administrative denials for determinations based on administrative criteria only (determinations not based on medical necessity criteria).
   a. A TAR is not required
   b. Duplicate request
   c. TAR or service line not accepted due to invalid procedure code (CPT or HCPCS)
2. Administrative denials are not subject to the appeal process.
3. Each month a report of all administrative denials is reviewed and signed by the Chief Medical Officer or Physician Designee.
4. If a provider has received an administrative denial and believes the decision was based on incorrect information, the provider should submit a NEW Treatment Authorization Request (TAR) to the Health Services Department with the required documentation, within the timeframes defined for submission, so that the TAR may be processed. [See policy MCUP3041 Treatment Authorization Request (TAR) Review Process.]

Policy/Procedure Number: MCUP3037 (previously UP100337)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Appeals of Utilization Management/ Pharmacy Decisions			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VII. REFERENCES:

A. In compliance with the California Department of Health Care Services (DHCS) contract, specifically Exhibit A, Attachment III. 2.3 Utilization Management Program and Exhibit A, Attachment III. 4.6 Member Grievance and Appeal System
B. California Health and Safety Code (HSC) 1367.01(h)(3)
C. Title 42 Code of Federal Regulations (CFR) Section 438.408 (f)(1)
D. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 20254) UM 7 Denial Notices

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 10/10/97 (name change only); 05/17/00, 09/20/00; 04/18/01; 01/16/02; 08/20/03; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 04/21/10; 08/15/12; 01/20/16; 10/19/16; 04/19/17; 08/16/17; *09/12/18; 08/14/19; 08/12/20; 08/11/21; 11/10/21; 05/11/22; 05/10/23; 05/08/24; 06/11/25

*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:
MCUP3057 - Provider Appeals of Health Services Administrative Denials was archived 08/14/2019

****

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
Request for
Appeal/ Expedited Appeal of UM or Pharmacy Decision

Requesting Provider: _____
Please Print

Member Name: _____
Please Print

Member's Authorized Representative: _____
(if applicable) Please Print

ID Number _____

Service Denied _____

Date of Denial _____

TAR Number _____

Do you wish this request to be expedited? ☐ Yes ☐ No
Expedited appeals are performed only when a delay in decision making might seriously jeopardize the life or health of the member.

Please state the reason: _____

I am supplying additional clinical information and wish to appeal the original decision
Please sign and date and attach documentation to this form

_____

-----OR-----

I do not have additional clinical information. I am appealing the original decision

Please sign and Date:

_____

Please submit completed form to PHC UM Dept. Fax: (707) 863-4118 or Pharmacy Dept. Fax: (707) 863-4330

Fairfield Office – 4665 Business Center Drive, Fairfield, CA 94534
Redding Office – 2525 Airpark Drive, Redding, CA 96001

MEMBER AUTHORIZATION FOR PROVIDER APPEAL

*[*Date*]*

Hospital/Clinic/Pharmacy Name
Treating Provider Name
Address
City, State ZIP

Member Name
Address
City, State, Zip

Re: (Insert Member Name) Appeal Authorization
Member CIN:_____
TAR #:_____
RAF#:_____

Dear Partnership HealthPlan of California (Partnership):

I would like to file an Appeal regarding the Notice of Action (NOA) received for: _____

_____

_____

_____

I,_____, authorize my Physician,_____, to submit this Appeal on my behalf.

I understand that if I have any questions regarding this Appeal, I can contact Partnership at the number provided within the Your Rights Notice attached.

_____
Print Member Name

_____
Print Physician Name

_____
Member Signature

_____
Physician Signature

_____
Date:

_____
Date:

Mailed On:

Fairfield Office – 4665 Business Center Drive, Fairfield, CA 94534
Redding Office – 2525 Airpark Drive, Redding, CA 96001

Appeal Acknowledgement Letter

Date

Member Name
Address
City, State, Zip

Hospital/Clinic/Pharmacy Name ~~Member Name~~
~~Treating Provider Name~~ Address
~~Address~~ City, State, Zip
~~City, State ZIP~~ ATTN:

~~Re: (Insert Member Name)~~
~~Member~~ CIN #:
Referral/Treatment Authorization #:

~~**Appeal Acknowledgement Letter**~~

Dear (Text] ~~Insert Physician Name/ Member Name:)~~

On [Date], Partnership HealthPlan of California ~~We have~~ received ~~your~~ the r~~R~~equest that you or your Healthcare Facility, who has filed on your behalf, for the appeal of [text]. ~~dated (Insert Date), regarding the Notice of Action for (Insert Service Requested) for the member noted above.~~

We are currently reviewing your appeal and you will be contacted ~~you~~ if we have any questions. You will receive a Notice of Appeal Resolution within 30 calendar days from the date we received ~~your~~ the appeal request. If you think waiting 30 days will harm the health of yourself/the member, you might be able to get an answer within 72 hours. Please call the Partnership Utilization Management (UM) Department or Pharmacy Department below and ask for an **Expedited Appeal.**

Member: Please sign the included ~~attached~~ Member Authorization for Provider Appeal form and return to Partnership in the envelope included.

The decision on your matter will be made based on the information available to Partnership at the time of review. You have the right to provide evidence and testimony on this matter to be considered in the decision-making process. The evidence you may want to submit includes any comments, documents, records, and other information you would like considered.

If you have any questions or concerns regarding your Appeal, you can contact us at:

~~PHC~~ Partnership Health Services
4665 Business Center Drive

Fairfield, CA 94534
Call (800) 863-4144 or TTY (800) 735-2929
Pharmacy Fax: (707) ~~419-7900~~863-4330
UM Fax: (707) 863-4118

Sincerely,

Robert Moore, MD, MPH, MBA
Chief Medical Officer
Partnership HealthPlan of California

~~**Mailed On:**~~

~~CC: [Insert Provider or Member Name]~~
~~Enclosed for Member: Member Authorization for Provider Appeal form~~
~~Nondiscrimination Notice~~
~~Language Assistance Notice~~

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MPUG3025 (previously UG100325)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Insulin Infusion Pump and Continuous Glucose Monitor Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/19/1996</td><td colspan="4">Next Review Date: 06/11/2026
Last Review Date: 06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUG3007 - Authorization of Ambulatory Procedures and Services
C. MCUP3042 - Technology Assessment
D. MCUP3013 - Durable Medical Equipment (DME) Authorization
E. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Continuous glucose monitor: A device to measures glucose levels in the interstitial fluid through the use of a sensor placed under the skin. A transmitter sends information about glucose levels to a wireless monitor attached externally. These devices display glucose levels at either 1 or 5 minute intervals with the option to set alarms alerting the individual to abnormal glucose levels. Greater amounts of data collection may provide more insight regarding glucose patterns.
C. Diabetologist: A physician who is Board Certified in Advanced Diabetes Management (BC-ADM). [*Note that this is not an American Board of Medical Specialties (ABMS) board certification*.]
D. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be 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.
E. Insulin pump: Also known as subcutaneous insulin infusion (CSII), an insulin pump is an external ambulatory infusion device used for managing insulin-requiring Diabetes Mellitus (DM). By continuous administration of short acting insulin at preselected rate, the insulin pump can improve the patient glycemic control and delay, prevent, or reduce their risk of complications (e.g. neuropathy, nephropathy, retinopathy.)

F. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

G. Whole Child Model (WCM): This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. CCS NL 06-1120 Authorization of Insulin Infusion Pumps - Revised 11/17/2020
B. CCS NL 15-1222 Continuous Glucose Monitoring Systems as a CCS/GHPP Program Benefit - 12/23/2022

V. PURPOSE:

To describe the guidelines used by Partnership HealthPlan of California's Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for an external insulin infusion pump and/or a continuous glucose monitor.

VI. GUIDELINE / PROCEDURE:

A. Partnership reviews Treatment Authorization Requests (TARs) for external insulin infusion pumps and/or a continuous glucose monitors according to appropriate regulatory guidance as described in policy MPUP3139 Criteria and Guidelines for Utilization Management.
   1. For Partnership Medi-Cal Members: TARs are reviewed according to required standards set forth by the State of California Department of Health Care Services (DHCS) and criteria provided in the DHCS Medi-Cal Provider Manual Guidelines.
      a. InterQual® and other industry accepted guidelines will also be used, along with other policies developed by Partnership, as described in MPUP3139 Criteria and Guidelines for Utilization Management.
      b. For Members under the age of 21 who are eligible for California Children's Services (CCS), please also refer to CCS guidelines for Insulin Infusion Pumps in Attachment A and CCS guidelines for Continuous Glucose Monitoring (CGM) in Attachment B.
   2. For Partnership Advantage Members: TARs are reviewed according to Section 40 of the CMS Medicare guidance for Part C & D Organization/ Coverage Determinations and other CMS guidelines and criteria sets that may include, but are not limited, to the following:
      a. Medicare National Coverage Determination (NCD) Manual
         1) For insulin infusion pumps see NCD 280.14
      b. Medicare Local Coverage Determination (LCD) policy
         1) For external insulin infusion pumps see L33794
         2) For glucose monitors see L33822
      c. In the event that national and/or local coverage determination is silent on the matter, Partnership uses InterQual® and other industry accepted guidelines, along with other policies developed by Partnership, as described in MPUP3139 Criteria and Guidelines for Utilization Management.

B. An insulin infusion pump must be ordered by the Primary Care Provider (PCP) or endocrinologist or diabetologist treating the member through a referral from the PCP. For Direct Members, the insulin

infusion pump must be ordered by the physician who is currently managing the medical care for the member.

1. Partnership utilizes InterQual® criteria to determine the necessity of a pump.
   a. For Partnership Advantage Members, Medicare guidelines will also be considered.
2. The TAR for an insulin infusion pump must include documentation of the medical necessity for home use of the insulin infusion pump that includes the following information related to the condition:
   a. A valid order/prescription
   b. The most recent Hgb A1c results
   c. Chart notes from the PCP or specialist managing the diabetes care of the member which include the following:
      1) Length of time the member has had diabetes
      2) Documentation the insulin pump is needed as part of the plan of care in managing the diabetes
      3) Evaluation of the member's compliance with the diabetes treatment plan
      4) 30 consecutive day self-tested blood glucose log
3. Partnership authorizes the least costly medically necessary insulin pump.
   a. Omnipod pumps may be considered for CCS members on a case by case basis according to criteria specified in CCS Numbered Letter 06-1120 (Attachment A).
   b. Omnipod pumps may be considered for Partnership Advantage Members on a case by case basis according to Section 40 of the CMS Medicare guidance for Part C Organization Determinations and criteria stated in NCD 280.14 and LCD L33794.
4. Insulin infusion pumps should only be prescribed and managed by practitioners familiar with this operation.

C. Continuous glucose monitoring (CGM) requests will be reviewed on a case by case basis for medical necessity according to Medi-Cal or Medicare guidelines (including Medicare LCD L33822) as applicable for Partnership Medi-Cal or Partnership Advantage Members. CGMs can be authorized through Partnership if ordered through a contracted Durable Medical equipment (DME) provider, or they can be dispensed through a pharmacy provider as described below.

1. To Authorize through Partnership if ordered through a Contracted DME Provider:
   a. The TAR for a CGM should include documentation of the medical necessity for home use of CGM therapy that includes the following information related to the condition:
      1) A valid order/prescription
      2) The most recent Hgb A1c results
      3) Chart notes from the PCP or specialist managing the diabetes care of the member with the following information:
         a) Length of time the member has had diabetes
         b) Documentation that CGM is needed as part of the plan of care in managing the diabetes
         c) Evaluation of the member's compliance with the diabetes treatment plan
         d) Documentation by provider that member checks blood glucose readings 3- 4 times daily.
2. CGMs Dispensed through a Pharmacy Provider:
   a. Partnership Medi-Cal Members: The pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Rx Education & Outreach page at this website https://medi-calrx.dhcs.ca.gov/home/education/
   b. Partnership Advantage Members: Effective January 1, 2026, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.
      1) Note that Medicare prohibits Part D (pharmacy) coverage when Part B (DME) is available.

3. Continuous Glucose Monitoring is proven and considered medically necessary in the following clinical scenarios:
   a. Short-term (3 - 7 days) of continuous glucose monitoring by a healthcare provider for diagnostic purposes is proven and medically necessary for patients with diabetes. Current Procedural Terminology (CPT) codes used for this service are 95250 and 95251. Limit one of each code per dates of service in a single calendar month. No TAR is required.
   b. Long-term continuous glucose monitoring for personal use at home is proven and medically necessary as a supplement to self-monitoring of blood glucose (SMBG) for patients with type 1 diabetes, cystic fibrosis related diabetes, or sequelae of a CCS eligible condition that requires chronic insulin therapy, who have demonstrated adherence to a physician ordered diabetic treatment plan.
      1) InterQual® criteria will apply for coverage determination for adults and children with type 1 diabetes mellitus.
      2) CGMs are a covered benefit for children 20 years of age or younger with type 1 diabetes mellitus.
   c. Long-term continuous glucose monitoring for patients with type 2 or gestational diabetes are reviewed on a case-by-case basis for medical necessity. CGM for patients with type 2 diabetes may be indicated for patients with:
      1) Recurrent severe hypoglycemic {two of more episodes in a 30-day period of ADA Level 2 hypoglycemia [blood glucose less than 3.0 mmol/L (54 mg/dl) with unawareness in a patient taking insulin]} or despite appropriate modifications in insulin regimen and compliance with frequent self-monitoring (at least 4 finger sticks/day), OR
      2) Frequent nocturnal hypoglycemia {ADA Level 1 hypoglycemia [blood glucose of 3.9 mmol/L (70 mg/dl) or less despite modifications to insulin treatment]} and compliance with frequent glucose self-monitoring (at least four times a day), OR
      3) Poor diabetes control when ordered by a diabetologist as defined in III.C., a board certified endocrinologist, or an internal medicine or family physician.
         a) InterQual® criteria will apply for coverage determination.
3. Long term CGM is considered experimental and investigational for nesidioblastosis (primary islet cell hypertrophy) and for monitoring blood glucose in non-diabetic persons following gastric bypass surgery.
4. CGM using an implantable glucose sensor is considered investigational and unproven and therefore not covered for non-U.S. Food and Drug Administration (FDA) approved devices.

VII. REFERENCES:

A. InterQual® 2025 DME criteria – Continuous Glucose Monitoring, Insulin Pumps, and Automated Insulin Delivery Technology.
B. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 280.14 Infusion Pumps. Implementation date 02/18/2005 or any subsequent updates published by CMS.
C. Medicare Local Coverage Determination (LCD) L33794 External Infusion Pumps Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.
D. Medicare Local Coverage Determination (LCD) L33822 Continuous Glucose Monitors, Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.
E. McCulloch DK. Blood glucose self-monitoring in management of adults with diabetes mellitus. UpToDate Inc., Waltham, MA.
F. International Hypoglycemia Study Group. Diabetes Care. November 21, 2016 http://care.diabetesjournals.org/content/early/2016/11/09/dc16-2215
E. *Diabetes Care* 2019;42(8):1593-1603. International Consensus Report: Clinical Targets for

Continuous Glucose Monitoring Data Interpretation: Recommendations from the International Consensus on Time in Range.

F. *Diabetes Therapy* 2019;10:853-863. A View Beyond HbA1c: Role of Continuous Glucose Monitoring.
G. CCS Numbered Letter (NL) 06-1120 Authorization of Insulin Infusion Pumps - Revised 11/17/2020
H. CCS Numbered Letter (NL) 15-1222 Continuous Glucose Monitoring Systems as a CCS/GHPP Program Benefit - 12/23/2022
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX (*Revised* 12/30/2022)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Effective 01/01/2026)
06/11/25

Medi-Cal
04/28/00; 06/20/01; 09/18/02; 09/15/04; 11/16/05; 08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16; 04/19/17; 10/18/17; *11/14/18; 11/13/19; 10/14/20; 02/10/21; 04/14/21; 03/09/22; 03/08/23; 03/13/24; 06/11/25

*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:

Healthy Kids MPUG3025 (Healthy Kids program ended 12/01/2016)
08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16 to 12/01/2016

Healthy Families
MPUG3025 - 10/01/10 to 03/01/2014

****

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

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPUG3031 (previously UG100331)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Nebulizer Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 05/30/1995</td><td colspan="4">Next Review Date: ~~05/08/2025~~06/11/2026
Last Review Date: ~~05/08/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~05/08/2024~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUP3013 - Durable Medical Equipment (DME) Authorization
C. MCUP3039 - Direct Members
D. MPXG5001 - Clinical Practice Guidelines for the Diagnosis & Management of Asthma

II. IMPACTED DEPTS:

A. Health Services
B. Member Services
C. Claims

III. DEFINITIONS:

A. ~~N/A~~Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the 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.

~~A.~~B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) request for a nebulizer.

Policy/Procedure Number: MPUG3031 (previously UG100331)		**Lead Department: Health Services** **Business Unit: Utilization Management**	
Policy/Procedure Title: Nebulizer Guidelines		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 05/30/1995		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. GUIDELINE / PROCEDURE:

A. A nebulizer must be ordered by the primary care provider (PCP) or specialist who is treating the Mmember. For Direct Members, the nebulizer must be ordered by the provider who is currently managing the medical care for the Mmember.

B. A nebulizer can be ordered for a Mmember when it is reasonable and necessary to improve a condition related to breathing ~~who requires regular nebulizer treatments and has one of the following diagnoses~~such as:
   1. Chronic Lung Disease
   2. Cystic Fibrosis
   3. Asthma
   4. Bronchopulmonary Dysplasia (Pediatric)

C. For Medicare criteria specific to Partnership Advantage Members, refer to the Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4 and Medicare Local Coverage Determination (LCD) L33370 Nebulizers.

D. A nebulizer does not require a TAR when the billed price is less than $200 including tax. A diagnosis of respiratory need is still required for medical justification of a nebulizer.

E. When the billed price including tax is $200 or more, a TAR is required and it must include documentation of medical necessity of chronic home use of nebulizer therapy and the following information related to the condition:
   1. Description of the severity and frequency of the symptoms
   2. Frequency of emergency visits if present
   3. Frequency of hospitalizations if present
   4. Trial and failure of treatment with a metered dose inhaler (MDI)

F. The physician order must include:
   1. Medications[1] to be administered with the nebulizer
      a. Partnership Medi-Cal Members: The pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Rx Education & Outreach page at this website https://medi-calrx.dhcs.ca.gov/home/education/
      b. Partnership Advantage Members: Effective January 1, 2026, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.
         1) Note that Medicare prohibits Part D (pharmacy) coverage when Part B (DME) is available.

      ~~a.~~
   2. Frequency of administration
   3. Length of time the Mmember requires the nebulizer

G. The TAR should include information or assessment regarding the patient/caretaker's ability to use the equipment properly.

H. Nebulizers may be purchased for Partnership ~~HealthPlan of California~~ Mmembers who have a chronic or non-reversible respiratory condition. Otherwise, authorization of rental equipment will be reviewed on an individual basis for Mmembers with a short term illness.

I. Members may be able to obtain a nebulizer (and certain other medical devices that do not require a TAR) through the Partnership Medical Equipment Distribution Services (PMEDS) program when ~~they meet medical criteria and~~ their Provider submits a request form on their behalf. The PMEDS program serves

[1] ~~Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised "Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx," and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. Please refer to the State Medi-Cal Rx Education & Outreach page at this website:~~ https://medi-calrx.dhcs.ca.gov/home/education/

all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. Forms and information can be found on the Partnership website at https://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx

J. ~~www.partnershiphp.org in the Provider Section. Keywords: Medical Equipment Distribution Services Request Form~~

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines

B. DHCS All Plan Letter (APL) 22-012 *Revised* – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx 12/30/2022)

~~B.~~

C. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Sections 200.2 Nebulized Beta Adrenergic Agonist Therapy for Lung Diseases (Revision 173 Issued 09/04/14 effective upon Implementation of ICD-10) and 280.1 Durable Medical Equipment Reference List (Revision effective 05/16/2023)

~~C.~~D. Medicare Local Coverage Determination (LCD) L33370 Nebulizers Revision Effective Date 01/01/2024 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES:

04/28/00; 06/20/01; 09/18/02; 10/20/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 03/11/20; 02/10/21; 03/09/22; 04/12/23; 05/08/24; 06/11/25

*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:

Healthy Kids MPUG3031 (Healthy Kids program ended 12/01/2016)
01/21/15 to 12/01/2016

****

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.

Policy/Procedure Number: MPUG3031 (previously UG100331)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Nebulizer Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/30/1995		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPC~~C~~UG3110 (previously MCUG3110, MPUG3110)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 11/18/2009</td><td colspan="4">Next Review Date: ~~06/12/2025~~06/11/2026
Last Review Date: ~~06/12/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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~~ CREDENTIALS</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~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF)
C. MCUP3013 – Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Obstructive Sleep Apnea (OSA) is a disorder that is characterized by obstructive apneas, obstructive hypopneas, and/or respiratory related arousals caused by repetitive collapse of the upper airway during sleep.

~~A.~~B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The following guideline discusses the current recommendations for the evaluation and management of obstructive sleep apnea (OSA) in adults.

VI. GUIDELINE / PROCEDURE:

A. OSA is an important disorder because it is common and patients with OSA are at increased risk for poor neurocognitive performance and organ system dysfunction due to repeated arousals or hypoxemia during

sleep over months to years. The severity and duration of OSA necessary for these sequelae likely varies among individuals. Despite its importance, medical practitioners often under-recognize OSA. Cardinal features of obstructive sleep apnea (OSA) in adults include:

1. Perturbations of a regular respiratory pattern during sleep, including obstructive apneas, hypopneas, or respiratory effort related arousals.
2. Daytime symptoms attributable to disrupted sleep, such as sleepiness, fatigue, or poor concentration.
3. Signs of disturbed sleep, such as snoring with restlessness. Simple snoring alone does not require a work up. If patients who have significant snoring have additional findings, such as obesity, daytime sleepiness, witnessed apneas, or morning headaches, further evaluation for obstructive sleep apnea should be considered.

B. RISK FACTORS

1. Risk factors for OSA include obesity and craniofacial or upper airway soft tissue abnormalities, while potential risk factors include heredity, smoking, and nasal congestion.
   a. Obesity is the best documented risk factor for OSA.
   b. Craniofacial or upper airway soft tissue abnormalities increase the likelihood of having or developing OSA.
   c. A family history of OSA
   d. Current smoking
   e. Nasal congestion
   f. Diabetes or insulin resistance
   g. Older age

C. DIAGNOSIS

1. If patients are suspected of having sleep apnea based on the history or if the patient is at high risk for the condition, evaluation with a sleep study should be considered.
2. Overnight pulse oximetry study (Current Procedural Terminology [CPT] 94762)
   a. Partnership Medi-Cal: Code 94762 is not a Medi-Cal benefit~~, and is not covered by Partnership HealthPlan of California (PHC).~~.
   b. Partnership Advantage: Code 94762 may by covered for Partnership Advantage Members according to Medicare criteria. See Medicare National Coverage Determination (NCD) 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA).

~~2.~~3. A Treatment Authorization Request (TAR) is not required for CPT 95782 (polysomnography for Members younger than 6 years of age).

~~3.~~4. Unattended Sleep Study:

   a. A home unattended portable multimodal monitoring (CPT codes 95800, 95801, and 95806 or HCPCS codes G0398, G0399, and G0400) is required prior to having a facility-based attended diagnostic sleep study in the following circumstances:
      1) When there is a high pre-test probability of moderate to severe obstructive sleep apnea on clinical grounds (excessive daytime drowsiness AND at least one of the following: habitual loud snoring, hypertension, nocturnal gasping or choking, witnessed apnea, or frequent awakenings) OR
      2) The patient has had a screening overnight pulse ox study which showed likely OSA, AND
      3) If there are no co-morbid conditions that would impact the accuracy of the sleep study (e.g. neuromuscular disease, history of stroke, significant cardiopulmonary disease, chronic opioid use, severe insomnia, impaired dexterity or mobility, cognitive impairment),
   b. This diagnostic evaluation should only be interpreted by a specialist with experience in administering and interpreting this test.
   c. No prior authorization is required for home sleep studies. Unattended sleep studies are not covered for diagnoses other than OSA. Reimbursement for home sleep studies is limited to one per year. Reimbursement for home sleep studies beyond 1 per year requires a TAR for medical

necessity.

4.5. An attended diagnostic sleep study (CPT 95808, 95810 or 95811) is generally indicated when one or more of the following conditions are diagnosed or suspected:

a. Narcolepsy
b. Idiopathic CNS Hypersomnia
c. Sleep disordered breathing due to central sleep apnea
d. Parasomnia
e. Nocturnal Oxygen Desaturation
f. Disorders of REM Sleep
g. Suspicion of OSA in mission critical workers such as airline pilots, bus drivers, truck drivers, taxi drivers, rideshare service company drivers, and others in whom falling asleep at work could have a major negative impact

5.6. Attended sleep studies must be ordered by the primary care provider (PCP) or by the specialist who is treating the memberMember. For Direct Members, the study must be ordered by the physician who is currently managing the medical care for the memberMember. Prior authorization is required by PHCPartnership for an attended sleep study, and PHCPartnership utilizes InterQual® criteria to determine the medical necessity of this service. For Partnership Advantage Members, Medicare criteria will be considered including, but not limited to, Medicare National Coverage Determination (NCD) 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA).

6.7. The use of polysomnography for a complaint of insomnia is not considered medically necessary and is not covered because there is no convincing evidence that polysomnography is useful or improves outcome results for this symptom.

7.8. If there is some question about the need for sleep study, a specialist consultation should be obtained.

D. TREATMENT: Correct diagnosis is the foundation for a treatment plan for sleep disorders. This section focuses on the treatment of obstructive sleep apnea.

1. Many options exist for treatment of obstructive sleep apnea. These include behavior modification (including weight loss, exercise, sleep position, alcohol avoidance), surgical options, pharmacologic treatment and Continuous Positive Airway Pressure (CPAP).
2. For the initial approval of CPAP, InterQual® Criteria (*noninvasive airway assistive devices*) must be met and a sleep study performed within the past 12 months and documented OSA is required. When CPAP is selected as the treatment modality, it may be titrated in a sleep study laboratory (CPT 95810) or at home, with a self-titrating CPAP device (Healthcare Common Procedure Coding System [HCPCS] code: E0601). Determination of which titration method is needed is made by the treating physicians. Both titration methods require prior diagnosis of OSA and should only be done under the supervision of a clinician with experience coaching a patient on the use of CPAP.
3. For approval of renewal of CPAP authorization, InterQual® Criteria *(noninvasive airway assistive devices*) apply.

E. EQUIPMENT REQUIREMENTS: PHCPartnership follows Centers for Medicare and Medicaid Services (CMS) standards for specifications for equipment permissible for diagnosis of obstructive sleep apnea, interpretation of sleep studies, and titration of CPAP as per (Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA), implementation date 08/10/2009 or any subsequent updates published by CMS and CAG#0093R2, March, 13 2008, or any subsequent updates published by CMS) including Local Coverage Determinations (LCDs)(LCD) L33718 Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Revision Effective Date 01/01/2024 or any subsequent updates published by CMS..

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

Guideline/Procedure Number: MPCUG3110 (previously MCUPG3110, MPUG3110)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2009		**Next Review Date: 06/12/202506/11/2026** **Last Review Date: 06/12/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VII. REFERENCES:

~~A. Centers for Medicare & Medicaid Services (CMS) Standards: CAG#0093R2, March, 13 2008, or any subsequent updates published by CMS~~

~~B.~~A. Medi-Cal Provider Manual/ Guidelines including Medicine: Neurology and Neuromuscular (*medneneu*)

~~C.~~B. InterQual® criteria: Durable Medical Equipment: Non-invasive airway assistive devices, July 2023 Release

~~D.~~C. InterQual® criteria: Procedures: Sleep studies, July 2023 Release

D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults; UpToDate: published online 10/05/2023.

E. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.4.1. Sleep Testing for Obstructive Sleep Apnea (OSA). Implementation date 08/10/2009 or any subsequent updates published by CMS.

~~E.~~F. Medicare Local Coverage Determination (LCD) L33718 Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. Revision Effective Date 01/01/2024 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Departmental Directors

B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
06/11/25

Medi-Cal
10/01/10; 04/18/12; 02/20/13; 10/15/14; 01/20/16; 11/16/16; 11/15/17; *02/13/19; 02/12/20; 01/13/21; 02/09/22; 05/11/22; 06/14/23; 06/12/24; (MPUG3110) 06/11/25

*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:

Healthy Kids
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013

PartnershipAdvantage:
MPUG3110 - 11/18/09; 10/01/10; 04/18/12 to 2/20/2013
PAUG3123 – 02/20/13 to 01/01/15 (PA program ended 01/01/2015)

Healthy Families:
MPUG3110 - 10/01/10; 04/18/12 to 02/20/2013

****

Guideline/Procedure Number: MPCUG3110 (previously MCUPG3110, MPUG3110)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 11/18/2009		**Next Review Date: 06/12/202506/11/2026** **Last Review Date: 06/12/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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 PHCPARTNERSHIP 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 PHCPARTNERSHIP.

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

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP<s>C</s>UP3047 (previously MCUP3047, UP100347)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Tuberculosis Related Treatment</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/31/2000</td><td colspan="4">Next Review Date: <s>05/08/2025</s>06/11/2026
Last Review Date: <s>05/08/2024</s>06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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>☐ CREDENTIAL<s>SING</s></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>05/08/2024</s>06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MP<s>C</s>QG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
C. MPQP1048 – Reporting Communicable Diseases
<s>B.</s>D. MCCP2035 – Local Health Department (LHD) Coordination

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. DOT: Directly Observed Therapy or the Direct Observation of the ingestion of prescribed anti-Tuberculosis medications by tuberculosis (TB) infected persons. DOT includes:
   1. Delivering of prescribed medications
   2. Assisting with the means to ingest prescribed medications
   3. Observing the ingestion of prescribed medications
   4. Monitoring for signs of non-adherence or adverse side effects
   5. Documenting that prescribed medications have been ingested and
   6. Reporting compliance and/or other problems

B. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

C. Tuberculosis (TB) related treatment means all outpatient services necessary for the medical management and follow-up of TB infection and/or active disease. This may include medical therapy, Targeted Case Management (as defined in Title 22, CCR, Section 51276) and DOT when provided by a provider meeting the qualifications (as defined in section 51276.)

IV. ATTACHMENTS:

Policy/Procedure Number: MPCUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services~~Error! No text of specified style in document.~~ **Business Unit:** Utilization Management
Policy/Procedure Title: Tuberculosis Related Treatment			☒ **External Policy** ☐ **Internal Policy**
Original Date: 07/31/2000		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

A. TB Screening Guidelines (Flowcharts)

V. PURPOSE:

To define the roles of Partnership HealthPlan of California (Partnership) in providing TB Control and DOT for Medi-Cal and Partnership Advantage beneficiaries.

VI. POLICY / PROCEDURE:

A. Program Guidelines:

1. Partnership covers the screening, diagnosis, and follow-up care related to tuberculosis.
   a. Partnership Medi-Cal: Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in 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/ DHCS ~~-~~contracted pharmacy administrator instead of Partnership. This includes medications used for the treatment of tuberculosis.
   ~~a.~~b. Partnership Advantage: Effective January 1, 2026, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager that will provide medications used for the treatment of tuberculosis.
2. Partnership will reference the current guidelines from the Center for Disease Control and Prevention (CDC), and the American Thoracic Society (ATS). For TB screening, Partnership network providers will use guidelines from the American Academy of Pediatrics (AAP) for persons age 0-20 years and from the United States Preventative Services Taskforce (USPSTF) for adults age 21 or over. The California Department of Public Health (CDPH) TB Risk Assessment Tools should be used to identify adult and pediatric patients at risk for TB.
3. Partnership network providers use laboratories that conform to Title 17, CCR, Section 2505 and CDC and ATS requirements.
4. Partnership Providers shall report all cases of confirmed or suspected active tuberculosis (TB) to the local county health department (LHD) within one day of identification in accordance with Title 17, CCR, Section 2500.

B. Directly Observed Therapy (DOT)

1. Partnership Providers shall refer members with active tuberculosis (TB) to the local health department for DOT if the M~~m~~ember has any of the following risk categories:
   a. Member with demonstrated multi~~ple~~ drug ~~-~~-resistan~~tce~~ tuberculosis (MDR ~~-~~-TB)
   b. Member whose treatment has failed or who has relapsed after completing a prior regimen
   c. Member is a child or adolescent
   d. Member has demonstrated failed adherence/failure to keep appointments
2. Members in the following categories shall be referred if, in the opinion of the providers, the M~~m~~ember is at risk for non-adherence:
   a. Substance users
   b. Members with mental illness
   c. Elderly members
   d. Child and adolescent members
   e. Members with unmet housing needs
   f. Members with complex medical needs (e.g. end-stage renal disease, diabetes mellitus)
   g. Members with language and/or cultural barriers
   h. Members who have demonstrated any other reason to suspect non-adherence
3. In addition, Partnership Providers are expected to follow any local county health department regulations and instructions regarding the treatment of identified or suspected cases of active tuberculosis not covered by the above language.

Policy/Procedure Number: MPCUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services~~Error! No text of specified style in document.~~ **Business Unit:** Utilization Management
Policy/Procedure Title: Tuberculosis Related Treatment			☒ **External Policy** ☐ **Internal Policy**
Original Date: 07/31/2000		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

4. Since DOT services are provided outside of Partnership's contract with the California Department of Health Care Services (DHCS), a Partnership Referral Authorization Form (RAF) is NOT required and services will be reimbursed directly by the State of California.
5. The Local Health Department TB Control Program for DOT shall inform the HealthPlan of any changes to policy or of providers failing to refer members needing services.
6. Partnership maintains Memoranda of Understanding (MOUs) with each county it serves to ensure joint case management and care coordination with LHD TB Control Programs. Partnership provides all medically necessary covered services to members with TB on DOT.

VII. REFERENCES:

A. Center for Disease Control (CDC) guidelines https://www.cdc.gov/tb
~~A.~~B. Center for Disease Control (CDC) "TB 101for Health Care Workers https://www.cdc.gov/tb/webcourses/TB101/page16489.html
~~B.~~C. American Thoracic Society (ATS) guidelines https://www.thoracic.org/statements/tuberculosis-pneumonia.php
~~C.~~D. American Academy of Pediatrics (AAP) guidelines https://www.aap.org/
E. United States Preventative Services Taskforce (USPSTF) guidelines https://www.uspreventiveservicestaskforce.org/uspstf/
~~D.~~F. Medi-Cal Provider Manual/ Guidelines: Tuberculosis Program (*tuber*)
~~E.~~G. Title 17, California Code of Regulations (CCR) Section 2500
~~F.~~H. Title 17, California Code of Regulations (CCR) Section 2505
~~G.~~I. Title 22, California Code of Regulations (CCR) Section 51276
~~H.~~J. DHCS All Plan Letter (APL) 22-012 *Revised* – Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
~~I.~~K. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023)
   1. Local Health Department Memorandum of Understanding template (DHCS Contract Attachment F)

L. California Department of Public Health (CDPH) TB Risk Assessment Tools
~~J.~~M. California Department of Public Health (CDPH) Information for Physicians Regarding Directly Observed Therapy (DOT) for Active Tuberculosis (TB)
~~K.~~N. California Tuberculosis Controllers Association (CTCA), Latent Tuberculosis Infection Guidance for Preventing Tuberculosis in California, available at: https://ctca.org/guidelines/guidelines-latent-tuberculosis-infection-guideline/

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
06/11/25

Medi-Cal:
09/19/01; 10/16/02; 10/20/04; 10/19/05, 10/18/06; 10/17/07; 10/15/08, 01/20/10; 01/18/12; 05/20/15;

Policy/Procedure Number: MPCUP3047 (previously MCUP3047, UP100347)			**Lead Department:** Health Services~~Error! No text of specified style in document.~~ **Business Unit:** Utilization Management
Policy/Procedure Title: Tuberculosis Related Treatment			☒ **External Policy** ☐ **Internal Policy**
Original Date: 07/31/2000		**Next Review Date: 05/08/202506/11/2026** **Last Review Date: 05/08/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

04/20/16; 04/19/17; *06/13/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 04/12/23; 05/08/24; 06/11/25

*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

****

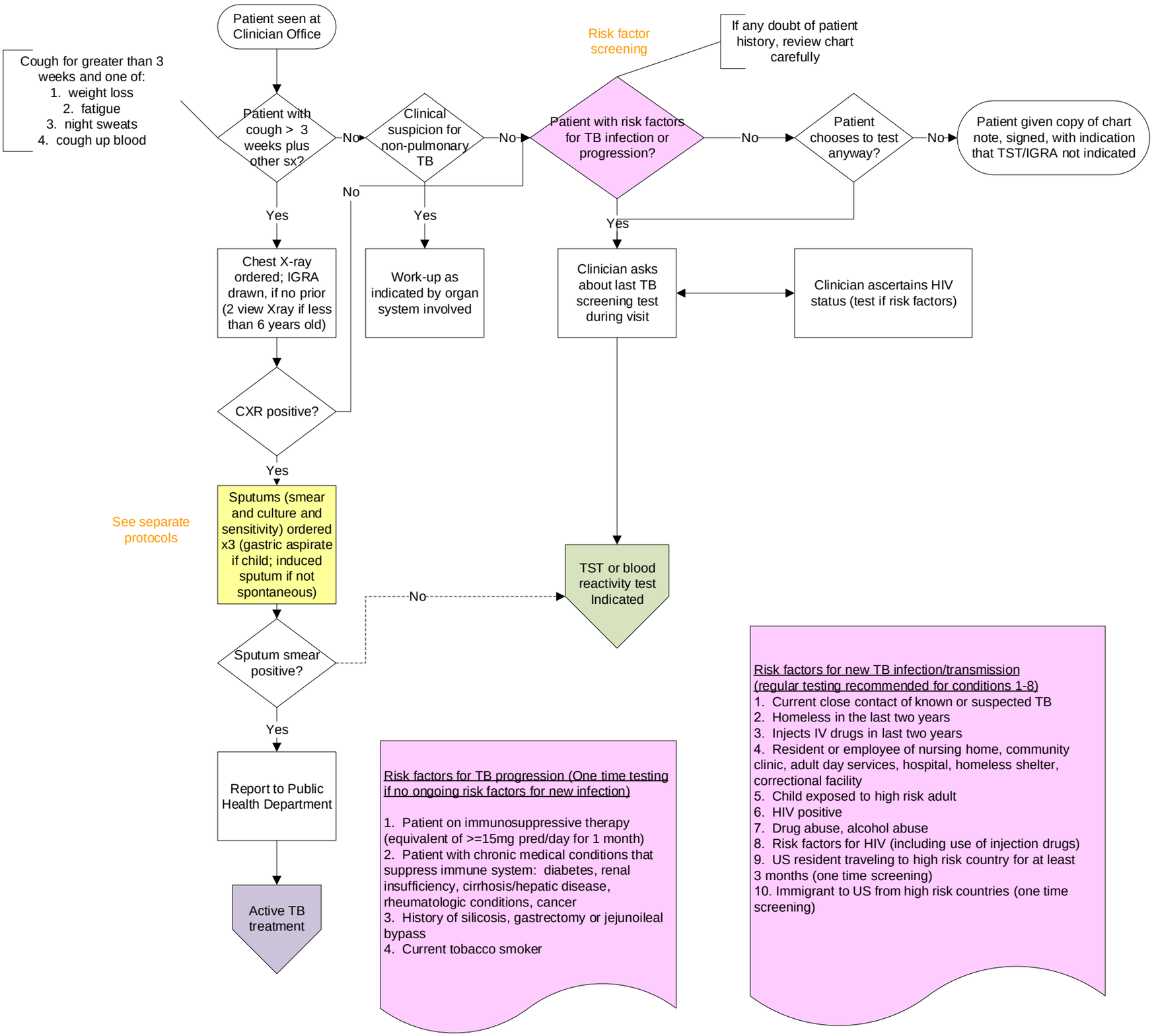
In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- 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

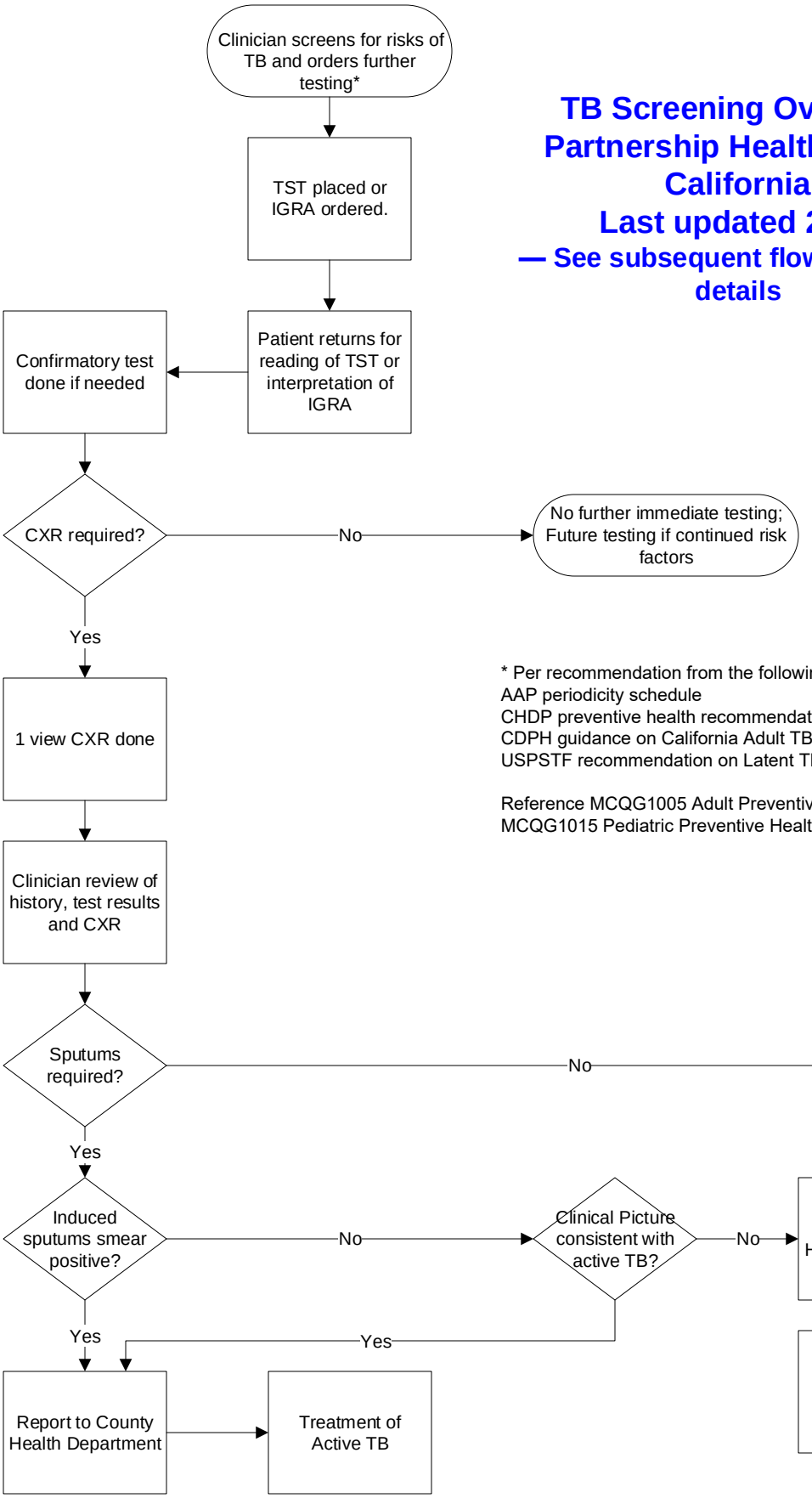
The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

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

TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2023



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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MP~~C~~UP3136 (previously MCUP3136)			**Lead Department: Health Services** **Business Unit:** Utilization Management		
Policy/Procedure Title: Fecal Microbiota Transplant (FMT)			☒ **External Policy** ☐ **Internal Policy**		
Original Date: 05/17/2017		**Next Review Date:** ~~06/12/2025~~06/11/2026 **Last Review Date:** ~~06/12/2024~~06/11/2025			
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**		
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**		
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**	
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**	
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~S~~ING**	☐ **DEPT. DIRECTOR/OFFICER**		
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/12/2024~~06/11/2025		

I. RELATED POLICIES:
- A. MCUP3041 – Treatment Authorization Review (TAR) Review Process
- B. MCUP3142 – Technology Assessment

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

III. DEFINITIONS:
- A. Fecal microbiota transplantation (FMT) – the transfer of a processed stool specimen from a healthy donor to a diseased recipient for the purpose of restoring a normal population of bacteria to the colon of the recipient. Also known as fecal biotherapy, fecal bacteriotherapy, stool or fecal transplant, fecal transfusion, fecal enema and human probiotic infusion.
- B. *Clostridioides* (formerly *Clostridium*) *difficile* infection (CDI) - confirmed stool test positive for toxigenic *C. difficile* and patient currently has symptoms of watery diarrhea.
- C. Non-severe CDI – CDI with documented White Blood Cell Count ≤15,000 cells/ml and serum creatinine <1.5 mg/dL. [E]
- D. Severe CDI - CDI with WBC >15,000 cells/mL and/or serum creatinine ≥1.5 mg/dL. [E]
- E. Complicated/fulminant CDI – CDI associated with hypotension or shock, ileus or megacolon. [E]
- F. Recurrent or relapsing CDI (RCDI) – a second or greater episode of documented CDI.

IV. ATTACHMENTS:
- A. N/A

V. PURPOSE:

The purpose of the FMT policy is to assist Utilization Management (UM) staff with decision making when reviewing Treatment Authorization Requests (TARs) for FMT to treat confirmed recurrent CDI that has failed standard CDI treatment.

VI. POLICY / PROCEDURE:
- A. A Treatment Authorization Request (TAR) is required for all FMT procedures.
- B. Partnership HealthPlan of California (~~PHC~~Partnership) considers FMT medically indicated in cases of recurrent CDI as follows:
  1. Eligibility Criteria~~ – Must meet ALL criteria below~~:
     - a. Member must be 18 years of age or older.
     - b. Documentation of current symptomatic recurrent CDI.

c. Documentation of at least a moderate **second or more** episode of RCDI (as defined above) which is a third episode or more of CDI, unresponsive to standard AND alternate treatments.
   1) FMT is no longer recommended as first line treatment for fulminant CDI.[E]
d. Patient is not immunocompromised (including neutropenia).
e. Severe or fulminant CDI in the hospital and the patient is not improving after completing standard antimicrobial therapy for CDI.
~~e.~~f. All other uses of FMT are considered experimental or investigational, including first line treatment of CDI and the treatment of inflammatory bowel disease.

2. Methodology
   a. FMT is limited to centers of expertise.
   b. FMT may be administered by colonoscopy, nasogastric or jejunal tube, enema, or oral route, as available from the provider performing the procedure.
   c. The provider performing the FMT and facility providing the transplant materials must comply with the U.S. Food and Drug Administration's regulations regarding FMT[A].

VII. REFERENCES:

A. U.S. FDA Vaccines, Blood and Biologics Bulletin- Guidance for Industry: Enforcement Policy Regarding Investigational New Drug Requirements for Use of Fecal Microbiota for Transplantation to Treat *Clostridium difficile* Infection Not Responsive to Standard Therapies November 2022
B. TJ Borody, MD et al. Fecal microbiota transplantation for treatment of *Clostridioides difficile* infection; UpToDate. Accessed 04/12/2024
C. Moore T, et al. Fecal Microbiota Transplantation: A Practical Update for the Infectious Disease Specialist; Clin Infect Dis (2014) 58 (4) 541-545; doi.org/10.1093/CID/cit950. Accessed March 24, 2017
D. Cho, Janice M. *et al*. Update on Treatment of *Clostridioides difficile* Infection; Mayo Clin Proc. April 2020; 95(4): 758-769. https://www.mayoclinicproceedings.org/ Accessed March 23, 2021.
E. Johnson, Stuart et al. Clinical Practice Guideline by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA): 2021 Focused Update Guidelines on Management of *Clostridioides difficile* Infection in Adults *Clinical Infectious Diseases*, Volume 73, Issue 5, 1 September 2021, Pages e1029–e1044, https://doi.org/10.1093/cid/ciab549 Accessed March 30, 2022.
F. Consideration for Use of Fecal Microbiota-Based Therapies in Adults With GI Disorders. Gastroenterology, Volume 166, Issue 3, p.435. March 2024.
G. Shapiro, M. (2024, February 21). AGA now recommends fecal microbiota transplant for the majority of recurrent C. diff patients. American Gastroenterological Association. https://gastro.org/press-releases/aga-recommends-fecal-transplant-for-recurrent-cdiff-patients/

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
06/11/25

Medi-Cal
*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; (MPUP3136)
06/11/25

Policy/Procedure Number: MPUP3136 (previously MCUP3136)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Fecal Microbiota Transplant (FMT)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 05/17/2017		**Next Review Date: 06/12/202506/11/2026** **Last Review Date: 06/12/202406/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

PREVIOUSLY APPLIED TO:
N/A

****

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

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

The materials provided are guidelines used by ~~PHC~~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.

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/13/2019 (MCCP2028)
Effective Date: 07/01/2020 (MCCP2028)</td><td colspan="3">Next Review Date: 06/11/2026
Last Review Date: 06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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: 06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

A. Administration
B. Behavioral Health
C. Claims
D. Health Services
E. Member Services
F. Provider Relations

III. DEFINITIONS

A. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. Currently using ASAM Criteria 3rd Edition.

B. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

C. Behavioral Health Clinical Director – The Partnership HealthPlan of California (Partnership) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of Partnership activities. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use disorder treatment related services.

D. Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

E. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with Title 42 Code of Federal Regulations (CFR) 438.210 (a) (4).

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

G. Non-Urgent Request – A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

H. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

I. Program Beneficiary – A person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

J. Residential Treatment – As defined for DMC purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

K. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
   2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (Partnership) to process Treatment Authorization Requests (TARs) for residential substance use disorder treatment services.

Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 11/13/2019 (MCCP2028) Effective Date: 07/01/2020 (MCCP2028)		**Next Review Date: 06/11/2026** **Last Review Date: 06/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)

1. Partnership HealthPlan of California (Partnership) authorizes residential treatment services for substance use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:
   a. Adults (Age 21 or older)
      1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco Related Disorders and Non-Substance Related Disorders).
      2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM Criteria, 3rd Edition. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to Partnership.
   b. Adolescents up to the twenty-first [21st] birthday)
      1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.
      2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to Partnership.
   c. Program beneficiaries (as defined in III.I.) who are also Partnership Advantage Members (as defined in III.H), are eligible for residential SUD treatment under their Medi-Cal benefit as described in this policy.
2. Partnership utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. Partnership shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview

1. When the Medi-Cal eligible beneficiary) presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary of the assessment findings and a treatment plan to the Partnership Health Services Department for review.
   a. TAR determinations cannot be made by Partnership until all required documents and information are received.
   b. TARs should be submitted electronically via Partnership's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to Partnership's Health Services Department for review.

3. Partnership's Utilization Management (UM) staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within 5 business days of receipt of the request.
    a. Partnership's UM staff includes nurse coordinators who are Registered Nurses (RNs) with specialized ASAM training who can approve and defer (pend) the TAR, or deny the TAR for administrative reasons (e.g. TAR not required, duplicate request, or invalid code). Any decision requiring medical necessity determination will be referred to a Physician as per 3.b. below. The nurse coordinator reviews the information received from the residential treatment provider utilizing the approved review guidelines as described in section VI.A. above.
    b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.C. above) or Physician Designee for further evaluation. When a TAR requires clinician review, the nurse coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.
    c. Notification of approved TARs will be provided to the provider at the time of decision, but no later than 24 hours from the date of decision.
4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process
1. Partnership will review the program beneficiary's progress periodically throughout their length of stay as appropriate.
2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to Partnership no later than five business days prior to the expiration of the previous authorization.
    a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and Partnership will review and notify the provider of the determination (approved, modified, deferred/pended, or denied) within 5 business days of receipt of the request.
2. Adults (Age 21 or older)
    a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from Partnership.
    b. After completing 90 days of treatment, Partnership may approve extensions of the stay based upon medical necessity and the treatment plan.
3. Adolescents up to the twenty-first [21st] birthday)
    a. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
    b. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
4. Pregnant/Post-Partum Beneficiaries
    a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy). Extension beyond 60 days will require prior approval from Partnership and must be to a non-perinatal level of care.
    b. Providers will be required to provide proof of pregnancy or delivery date for each new TAR submitted to Partnership.

D. Notification of Denials/Modifications/Appeals Process
1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification

is mailed to the Medi-Cal eligible beneficiary within two (2) business days of the decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

E. Behavioral Health Clinical Director Residential SUD TAR Reviews
   1. The Behavioral Health Clinical Director may be consulted by UM nurses to review any case for which their expertise may be necessary, as determined by UM nurses upon review of case materials from provider.
   2. The Behavioral Health Clinical Director will review for medical necessity any request for residential SUD treatment episode exceeding 3 episodes in the prior 365 days.
   3. The Behavioral Health Clinical Director will review for medical necessity any request for extension of residential SUD treatment exceeding 90 contiguous days (adults), or 45 days (adolescents).

VII. REFERENCES:

A. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
B. Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
C. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
D. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
E. Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-021 Drug Medi-Cal Organized Delivery System – Updated Policy on Residential Treatment Limitations (May 14, 2021)
F. InterQual® Behavioral Health Criteria
G. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025) UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A
H. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
I. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (Re-release date 12/20/2024) https://www.dhcs.ca.gov/provgovpart/Documents/CY2026-D-SNP-Policy-Guide.pdf

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:

MPUP3144 (06/11/2025)
06/11/25

Medi-Cal MCUP3144 (05/11/2022):
06/14/23; 06/12/24

PREVIOUSLY APPLIED TO:
MCCP2028
04/08/20, 04/14/21; 09/08/2021 – 05/10/2022

****

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="3">Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)</td><td colspan="3">Lead Department: Network Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Access Standards and Monitoring</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/19/2003</td><td colspan="4">Next Review Date: ~~06/11/2025~~06/11/2026
Last Review Date: ~~06/12/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</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>☐~~☒~~ CREDENTIALS</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~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2018 – Advice Nurse Program

II. IMPACTED DEPTS:

A. Member Services
B. Provider Relations
C. Health Services
D. Finance
E. Compliance

III. DEFINITIONS:

A. High-Impact Specialist: Partnership HealthPlan of California (Partnership) shall annually identify high-impact specialists by a) identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or b) identifying practitioner types where treatment requires significant resources. Partnership will include oncology/hematology as a high impact specialty type every year.

B. High-Volume Behavioral Healthcare Practitioner: Partnership shall identify high volume behavioral healthcare practitioner types by assessing the number of unique members seen by a given practitioner type within a calendar year. Partnership annually selects the top four practitioner types with the largest numbers of unique members seen.

C. High-Volume Specialist (Non-Hospital Specialist): Partnership shall identify high-volume specialists by using available claim and encounter data to identify the number of unique members seen by a given specialty type within a calendar year. Partnership will select the top six specialty types with the largest numbers of unique members seen. Partnership will include obstetrics/gynecology as a high-volume specialty type every year.

D. Rural Counties: Counties with a population density of <50 people per square mile (according to current Department of Health Care Services (DHCS) standards) include Del Norte, Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Trinity.

E. Suburban or Small Counties: Counties with a population density of 51 to 200 people per square mile (according to current DHCS standards) include Lake, Napa and Yolo.

F. Urban or Medium Counties: Counties with a population density of 201 to 600 people per square mile (according to current DHCS standards) include Marin, Solano and Sonoma.

G. Triage or Screening: The assessment of a member's health concerns and symptoms via communication, with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, for the purpose of determining the urgency of the member's need for care.

H. Triage or Screening Wait Time: The time waiting to speak by telephone with a physician, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care.
I. Urgent Care: Health care for a condition that requires prompt attention.

IV. ATTACHMENTS:
A. Standards for Core Specialists

V. PURPOSE:
To define access standards and the framework for monitoring compliance with those standards across primary care, specialty care and mental health care.

VI. POLICY / PROCEDURE:
Partnership HealthPlan of California is committed to ensuring that its members have the availability of and accessibility to providers to meet their health care needs. Partnership has established standards for the numbers and types of clinicians and facilities, as well as for their geographic distribution, appointment accessibility and office and telephone availability. Partnership monitors provider availability and accessibility on an annual basis Partnership will monitor and ensure sufficient providers are in the network and service areas for provider types that include but are not limited to: CalAIM, Enhanced Care Management, Community Supports, Community Health Workers, and the Department of Health Care Services (DHCS)-mandated benefits or services. Partnership will collaborate with network hospitals and birthing centers to eliminate barriers to doula access when accompanying Members for prenatal visits, labor and delivery support, and postpartum visits, regardless of outcome: stillbirth, abortion, miscarriage, or live birth.

A. Availability of Practitioners
   1. Partnership maintains an adequate network of primary care, behavioral healthcare and specialty care practitioners and monitors how effectively this network meets the needs and preferences of our members.
   2. Partnership maintains an overall ratio of total network physicians to members of 1 FTE physician to every 1,200 members (DHCS standard).
   3. Cultural Needs and Preferences:
      a. Partnership assesses the cultural, ethnic, racial and linguistic needs of its members annually and adjusts the availability of practitioners within the network, if necessary (National Committee for Quality Assurance [NCQA] requirement).
   4. Practitioners Providing Primary Care: To evaluate the availability of practitioners who provide primary care services, including general medicine or family medicine, internal medicine and pediatrics, Partnership:
      a. Establishes ~~measureable~~measurable standards for the number of each type of practitioner providing primary care.

Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)			**Lead Department: Network Services**
Policy/Procedure Title: Access Standards and Monitoring			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/19/2003			**Next Review Date:** ~~06/11/2025~~06/11/2026 **Last Review Date:** ~~06/12/2024~~06/11/2025
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

NUMBER OF PRACTITIONERS, PRIMARY CARE [1]		
Practitioner Type	**Measure: Ratio**	**Standard/Performance Goal**
Primary Care Provider overall	Primary care provider to member (adult and children)	1:≤ 2,000
Family Practice/General Practice	Family or General practice practitioner to member (adult and children)	1:≤ 2,000
Pediatrics	Pediatricians to members (children)	1:≤ 2,000
Internist	Internists to members (adult)	1:≤ 3,000

b. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, PRIMARY CARE [2]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
Primary Care Physician overall	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%
Family Medicine /General Practitioner	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Pediatrics	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Internist	1 within 30 miles and 60 minutes from the member's residence	≥ 95%
Obstetrics/Gynecology	1 within 10 miles and 30 minutes from the member's residence (DHCS standard)	≥ 95%

c. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care (NCQA requirement).
d. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care (NCQA requirement).

5. Practitioners Providing Specialty Care: To evaluate the availability of specialists in Partnership's delivery system, Partnership:
   a. Identifies high-volume specialists (NCQA requirement) by assessing the number of unique members seen by a given specialty type within a calendar year. Partnership annually selects the top six specialty types with the largest numbers of unique members seen. Ratios for identified high- volume specialists that are also an identified core specialist will be the same as the core specialty standard. (See Attachment A.)
   b. Identifies high-impact specialists (NCQA requirement) by identifying practitioner types who treat conditions that have high mortality and morbidity rates and/or identifying practitioner types where treatment requires significant resources. Partnership's current high-impact specialty type is:

[1] DHCS requires an overall PCP-to-member ratio of 1 FTE PCP to every 2,000 members. NCQA requires health plans to set ratio goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact performance goals are internally determined by Partnership.

[2] DHCS requires member access to primary care overall within 10 miles and 30 minutes from member's residence. NCQA requires health plans to set geographic distribution goals individually by primary care provider type, including Family Practice, Pediatrics, and Internist; however, the exact standards and performance goals are internally determined by Partnership.

1) Oncology/Hematology

c. Monitors geographic availability for additional specialty types defined by DHCS as "Core Specialists."

DHCS ADULT AND PEDIATRIC CORE SPECIALISTS			
Cardiology/Interventional Cardiology*	Gastroenterology	Nephrology	Orthopedic Surgery*
Dermatology*	General Surgery*	Neurology	Physical Medicine and Rehabilitation
Endocrinology	Oncology/ Hematology **		Psychiatry
ENT/Otolaryngology	HIV/AIDS Specialists/Infectious Diseases	Ophthalmology*	Pulmonology
*High-volume specialty type; **High-impact specialty type			

NUMBER OF PRACTITONERS, HIGH IMPACT		
Practitioner Type	Measure Ratio	Standard Performance Goal (Ratio of specialists to members)
Oncology/Hematology	Oncology Hematology to Member	1: ≤ 25,000

d. Establishes ~~measureable~~measurable standards for the geographic distribution of each type of specialist (high-volume, high-impact, and DHCS Core).

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, SPECIALTY CARE [3]		
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**
• Cardiology*+ • Dermatology*+ • Endocrinology+ • ENT/Otolaryngology+ • Gastroenterology+ • General Surgery*+ • HIV/AIDS Specialists/Infectious Diseases+ • Nephrology+ • Neurology+ • Obstetrics/Gynecology (as specialist)* • Ophthalmology*+ • Orthopedics*+ • Physical Medicine and Rehabilitation+ • Pulmonology+	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%
Oncology/Hematology **+		≥ 80%
*High-volume specialty type; **High-impact specialty type; +DHCS Core Specialists		

e. Analyzes performance against the established specialty care availability standards at least annually (NCQA requirement).

6. Practitioners Providing Behavioral Healthcare: To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, Partnership:
   ~~a.~~ Identifies high volume behavioral healthcare practitioners (NCQA requirement) by assessing the number of unique members seen by a given practitioner type within a calendar year. Partnership annually selects the top four practitioner types with the largest numbers of unique members seen. Partnership's current high-volume practitioner types are:
      1) Psychiatrist
      2) Clinical psychologists
      3) Licensed Clinical Social Worker
      4) Marriage and Family counselor
   b. Establishes measurable standards for the number of each type of high-volume behavioral healthcare practitioner.

[3] DHCS sets geographic distribution requirements for all DHCS Core Specialty types. NCQA requires geographic distribution standards for all high-volume and high-impact specialty types but does not dictate the exact standards or performance goals. Partnership has adopted the DHCS geographic distribution standard across all monitored specialty types; the performance goal is internally determined by Partnership.

NUMBER OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [4]		
Practitioner Type	**Measure: Ratio**	**Standard/ Performance Goal**
Psychiatrist	Psychiatrist to members	1: ≤50,000
Clinical psychologist	Clinical psychologist to member	1: ≤30,000
Licensed clinical social	Licensed clinical social worker to member	1: ≤10,000
Marriage and family counselor	Marriage and family counselors to members	1: ≤10,000

c. Establishes ~~measureable~~measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner.

GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS, BEHAVIORAL HEALTHCARE [5]		
Practitioner Type	**Standard: Geographic Distance**	**Performance Goal**
• Psychiatrist[+] • Clinical psychologist • Licensed clinical social • Marriage and family counselor [+]DHCS Core Specialist	• Urban/Medium: One within 30 miles and 60 minutes from member's residence • Suburban/Small: One within 45 miles and 75 minutes from member's residence • Rural: One within 60 miles and 90 minutes from member's residence (DHCS Standard)	≥ 90%

~~c.~~d. Analyzes performance against the established behavioral healthcare availability standards annually (NCQA requirement).

7. Pharmacy: To evaluate the availability of pharmacy services, Partnership establishes ~~measureable~~measurable standards for the geographic distribution of pharmacies.

GEOGRAPHIC DISTRIBUTION OF PHARMACIES	
Practitioner Type	**Standard: Geographic Distance**
Pharmacy	One within 10 miles and 30 minutes from member's residence (DHCS standard)

8. Hospitals: To evaluate the availability of hospital services, Partnership establishes measureable standards for the geographic distribution of hospitals.

GEOGRAPHIC DISTRIBUTION OF HOSPITALS	
Practitioner Type	**Standard: Geographic Distance**
Hospital	One within 15 miles and 30 minutes from member's residence (DHCS standard)

[4] NCQA requires Partnership to establish measurable standards for the number of each type of high-volume behavioral healthcare practitioners; however, the exact standards are internally determined by Partnership.

[5] DHCS sets geographic distribution requirements for psychiatrists (DHCS Core Specialty). NCQA requires geographic distribution standards for all high-volume behavioral health care practitioner types, but does not dictate the exact standards. Partnership has adopted the DHCS geographic distribution standards across all monitored behavioral health care practitioner types; the performance goal is internally determined by Partnership.

B. Accessibility of Services

Partnership provides and maintains appropriate access to primary care, specialty care and behavioral healthcare services. These timeframes will only be extended if it is determined by the treating health provider that waiting will not have a detrimental impact on the member's health and it must be noted in the member's medical record.

1. Access to Primary Care

~~c.~~a. Regular and Routine Care Appointments:

1) Non-Urgent Primary Care Appointments: These appointments include preventive visits and follow-up visits. Appointments should be provided within 10 business days of request.
2) Prenatal Care Appointments: Pregnant members should be provided an initial prenatal care appointment within 10 business days of request.
3) Newborn Appointments: Infants discharged from hospital in less than 48 hours of life after delivery should be seen within 48 hours of discharge. The follow-up visit can take place in a home or clinic setting as long as the health care professionals examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician or his or her designees on the day of the visit where the PCP is not examining the infant. (Partnership standard)

~~a.~~b. Urgent Care Appointments

1) Appointments that do not require prior authorization- within 48 hours of a request.

ACCESSIBILITY TO PRIMARY CARE PRACTITIONERS [6]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care primary care appointments within 10 business days of request (DHCS standard)	≥ 90%
Prenatal Care appointments within 10 business days of request (DHCS standard)	≥ 90%
Newborn appointments within 48 hours of discharge (Partnership standard)	≥ 90%
Urgent Care appointments without prior authorization within 48 hours of request (DHCS standard)	≥ 90%

2. Access to Specialty Care

a. Appointments for non-urgent specialty care shall be provided within 15 business days of member's referral. (This standard applies to all Specialty type referenced in section A.4.e.)

ACCESSIBILITY TO SPECIALTY CARE PRACTITIONERS [7]	
Timely Access Standard	**Performance Goal**
Non-Urgent Care specialty appointments within 15 business days of request (DHCS standard)	≥ 80%

3. Access to Behavioral Healthcare

a. Routine office visits (initial and follow-up care) within 10 business days of member's request (DHCS and NCQA standard).
b. Urgent and Emergency care: Coverage for moderate to severe behavioral health is a carved out

[6] NCQA requires that Partnership set primary care appointment accessibility standards for regular and routine care appointments and urgent care appointments, but does not dictate what the standards should be. Where indicated, Partnership has adopted the DHCS appointment access standard.

[7] NCQA requires that Partnership set specialty care appointment accessibility standards for high-volume and high-impact specialty care but does not dictate what the standards should be. Where indicated, Partnership has adopted the DHCS appointment access standard.

benefit and members are referred out to county emergency services. Members who contact Partnership or contact our delegated providers, Beacon Health Options and Kaiser Permanente, with a psychiatric emergency are immediately redirected to county mental health providers for appropriate psychiatric crises intervention and follow-up care. Both Partnership and our delegated providers have policies and protocols in place to ensure the member's safety and well-being during such redirection.

ACCESSIBILITY TO BEHAVIORAL HEALTHCARE	
Timely Access Standard	**Performance Goal**
Routine office visits (initial and follow-up care) within 10 business days of request (DHCS standard)	≥ 80%

4. Access to Long Term Services and Support (LTSS)
   a. Access to LTSS services within 14 calendar days of request for rural and small counties
   b. Access to LTSS services within 7 business days of request for medium counties
   c. Access to LTSS services within 5 business days of request for dense counties

ACCESSIBILITY TO LONG TERM SERVICES AND SUPPORT Standards effective post PAC approval – June 2019			
Timely Access Standard by County Size			
	Rural/Small	Medium	**Performance Goal**
Skilled Nursing Facility Intermediate Care Facility/Developmentally Disabled (ICF-DD)	Within 14 calendar days of request	Within 7 business days of request	≥ 80%

5. Access to Emergency Care
   a. Emergency treatment must be available immediately to all members 24 hours a day. During hours when PCP offices are closed, members should be directed to an after-hours or emergency care location depending on the nature of the problem.

C. Primary Care Practitioner and Specialty Care Office Hours and Telephone Access Standards
   1. Regular Business Hours
      a. PCP practices must be open and staffed by a clinician(s) who is available to members for a minimum of 20 hours per week. PCPs with multiple sites less than ten (10) miles apart that see members at either site may combine open hours to meet the requirements. Exceptions to this requirement can be made by the Partnership Chief Medical Officer (CMO) based on need for access to primary care services. PCP sites granted this exception must assist members with coordination of care when the assigned PCP office is not open and submit a referral authorization to another PCP site.
      b. Office hours and an emergency 24-hour number must be displayed in a clearly visible area, window, or door.
      c. Hours of operation must be adequate and convenient for members to schedule appointments and should not in any way discriminate against Partnership HealthPlan members.

d. When calling the provider's office:
   1) Phone calls are answered within 5 rings
   2) Maximum time on hold is 5 minutes
   3) Phone messages left for provider during regular business hours should be responded to within 30 minutes of the call.
   4) Number of minutes waiting from scheduled appointment time to being seen must not exceed 30 minutes unless practitioner unexpectedly delayed.
   5) Emergency calls must be immediately reviewed by a qualified clinician who will determine urgency of the appointment or referral as indicated.

2. After Hours[8]
   a. Provider practices must be available or arrange for services 24 hours/7 days per week.
   b. The telephone triage or screening services must be provided in a timely manner appropriate for the member's condition; the member's wait time for screening or triage services must not exceed 30 minutes.
   c. Medically unlicensed persons handling member calls may ask questions on behalf of a licensed person to help ascertain the condition of the member so that the member can be referred to licensed staff. Unlicensed persons cannot use the answers to those questions to assess or make any decisions regarding the condition of a member, or to determine when a member needs to be seen by a licensed medical professional.
   d. After-hours advice must be provided by a licensed or registered professional whose scope of practice includes making assessments and recommending interventions.
      1) Provider must make best efforts to ensure a Member's existing Mental Health Provider is notified during an Urgent Care situation.
   e. Provider offices may use the Partnership Advice Nurse line, which is available to members 24 hours a day, 7 days a week. Providers who use Partnership Advice Nurse Line for after-hours support must actively promote the service to Partnership members.
   f. Provider offices must communicate their after-hours procedure to members. At a minimum, this communication should include:
      1) Clear communication to patients via answering machine or on call service:
         a) To call 911 or go to the nearest Emergency Room for medical emergencies.
         b) How to access after-hours medical advice
      2) Posted after hour procedure on provider site door and communicated verbally or by informational packets.

After Hours Access	
Timely Access Standard	**Performance Goal**
Answering machine or answering services	≥ 90%
Instructions to call 911/ER	≥ 90%
Instructions to reach MD/Advice Nurse	≥ 90%
Wait times for screening or triage services must not exceed 30 minutes	≥ 90%

D. Assessment of Network Adequacy
   1. On an annual basis, Partnership analyzes access and availability performance against the standards set forth in this policy. Additionally, Partnership annually assesses member experience with

[8] NCQA requires that Partnership set primary care after-hours care standards.

network adequacy by analyzing patient experience survey results, data from network adequacy grievances and appeals, and requests for/utilization of out-of-network services (NCQA requirement). This analysis informs Partnership of any access issues specific to geographic areas and/or types of providers. Where applicable, Partnership implements interventions to address opportunities for improvement and measures the effectiveness of those interventions (NCQA requirement). Analysis results and related interventions are reviewed by Partnership's Quality Improvement committees.

~~1.~~2. Partnership conducts additional assessment of network language and cultural deficits that may exist. Analysis results and related interventions are reviewed by Partnership's Director of Health Equity and the Population Health team. Actions will be taken to address any identified gaps which may include, but not limited to, additional telephone or video interpretation services; resources for culturally and linguistically appropriate health education materials; lists of ancillary providers who offer services in non-English languages; community resources that focus on specific cultural or linguistic services; and practitioner training for diversity, equity, and language services.

~~2.~~3. Network adequacy for organizations delegated for primary care, specialty care, or behavioral healthcare: Partnership annually reviews its delegate's network management procedures and evaluates delegate's performance against NCQA and DHCS standards for delegated activities. Partnership also semiannually evaluates regular reports, as specified in the delegation agreement.

E. Communication
   1. Partnership communicates access standards to:
      a. Members through newsletters, Evidence of Coverage (EOC) and other education materials. Provider directories are also available to members online or upon request.
      b. Providers through the Provider Manual, provider newsletter and/or bulletins, initial provider training and during monthly provider training sessions.

VII. REFERENCES:

A. DHCS Contract
B. 2025~~4~~ NCQA Network Adequacy Standards:
   1. NET 1:
      a. Element A – Factors 1-2
      b. Element B – Factors 1-4
      c. Element C – Factors 1-5
      d. Element D – Factors 1-4
   2. NET 2:
      a. Element A – Factors 1-3
      b. Element B – Factors 1-4
      c. Element C – Factors 1-2
   3. NET 3:
      a. Element A – Factors 1-4
      b. Element B – Factors 1-3
      c. Element C – Factors 1-3

C. DHCS All Plan Letter (APL) 20-003, Network Certification Requirements (Feb. 27, 2020)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director, Network Services

Policy/Procedure Number: MPNET100 (previously MPQP1023/QP100123)			**Lead Department: Network Services**
Policy/Procedure Title: Access Standards and Monitoring			☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/19/2003			**Next Review Date: ~~06/11/2025~~05/12/2026** **Last Review Date: ~~06/12/2024~~05/13/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

X. REVISION DATES:

Medi-Cal

09/15/04; 03/15/06; 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15; 09/20/17; *03/14/18; 08/08/18; 06/12/19; 04/08/20; 5/12/21, 10/13/21, 06/08/22, 08/09/23, 06/12/24, 06/11/25~~05/13/25~~

*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:

Medi-Cal

MPQP1023 – 02/19/2003 to 04/08/2020

PartnershipAdvantage:

QP10012 - 06/21/2006 to 12/21/2006

MPQP1023 – 12/21/2006 to 01/01/2015

Healthy Families:

MPQP1023 - 02/16/2011 to 03/01/2013

Healthy Kids

KK QI 205 - 11/15/2005 to 06/21/06

MPQP1023 – 06/21/06; 12/20/06; 06/18/08; 10/21/09; 02/16/11; 10/31/12; 03/20/13; 03/19/14; 05/20/15 to 12/01/16 (Healthy Kids program ended 12/01/2016)

STANDARDS FOR CORE SPECIALISTS

Standards for Core Specialists are established by PHC Chief Medical Officer and the Quality Utilization Advisory Committee (QUAC).

Specialty	Physician to Member Ratio
Cardiology	1:10,000
Opthalmology	1:10,000
OB/Gyn	1:5,000
Pulmonology	1:25,000
Podiatry	1:20,000
Orthopedic	1:10,000
Gastroenterology	1:10,000
General Surgery	1:10,000
Dermatology	1:15,000
Neurology	1:15,000
Otolaryngology	1:25,000
Urology	1:15,000
Oncology / Hematology	1:25,000
Endocrinology	1:25,000
Nephrology	1:25,000
Pain Management	1:25,000
Physical Medicine/Rehab	1:50,000

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the May 21, 2025 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: Quality Improvement – *Presenter: Rachel Newman, RN, Manager of Clinical Compliance, QI*			
MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	243 – 369	**Attachment D Change:** PARS to CBAS **C1 and C2 –** Added three new sections on the Facility Site Review Tool and Medical Record Tool: Telehealth, Peer Support Services and Adolescent services. **VI.E.3:** A reduced number of medical records may be reviewed at the discretion of the plan based on actual services. **VI.F:** Corrective Action Plan: extended timeframe from 30 days to return CAP to 60 days **VI.M:** Removed Delegation this is covered under the section J – Outside entity reviews **Attachments A and B:** Updated the site review tools with the new sections and new guidelines	Health Services Network Services Regulatory Affairs & Compliance Claims Member Services Grievance & Appeals
Policy Owner: Quality Improvement – *Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director*			
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management and Safe Opioid Prescribing	371 – 402	**This CPG policy has been updated with suggestions for assessment and reassessment timeframes. References have been augmented, updated, and hyperlink accessibility verified. This CPG will apply to Partnership Advantage, Partnership's D-SNP product effective Jan. 1, 2026.** **Definitions:** "Partnership Advantage" is now defined in the policy and added where appropriate in each of the attachments' introductory remarks. **The introduction to Section VI. Guideline/Procedure is updated** to include mention of Partnership's seven "Wellness and Recovery" program counties. Further, the following is added: "The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and observe the patient through telehealth modalities might be conducted." **VI.A.5. now additionally notes:** Any illegal drug usage *(or non-medical use of prescribed medications)* should be identified, documents, and addressed. **VI.A.8 is added**: Both the CDC and UpToDate recommend that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months or more frequently for most patients.	Health Services Claims Member Services Provider Relations

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)
		VI.C.2.e. is amended: Offer to prescribe naloxone for any patient prescribed opioids. Intranasal naloxone is also available at pharmacies without a physician's prescription, although for Medi-Cal **and/or Medicare** to cover it, a prescription is required. **A new VI.D is added:** Follow-up and monitoring during chronic opioid therapy: 1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change. 2. Patients who are transitioned to or have dosing increases of methadone (for pain) should be seen within three days, or within one week for other ER/LA opioids. **Reference section is updated with three additional hyperlinked citations**: D. CDC Clinical Practice Guideline for Prescribing Opioids for Pain. (2022) I. National Institute on Drug Abuse, National Institute of Health. Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS). N. UpToDate. Use of opioids in the management of chronic pain in adults. (Dec. 9, 2024) **Attachments A-D are updated** as necessary to accommodate these changes.	
Policy Owner: Behavioral Health – *Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director*			
MPBP8003 – Mental Health Services *the previous MCUP3028 residing in UM is now archived on pp. 437-468*	403 - 436	**This policy was updated to reflect changes per APLs 24-012 and 24-019 as well as for the Partnership Advantage D-SNP program we will operate effective January 1, 2026.** **Title:** Ownership of this policy was transferred from the UM Department to the Behavioral Health department. The number will now be MPBP8003, which reflects that it is a Multi-Plan policy applicable to both our Medi-Cal and Partnership Advantage Lines of Business. **Section III.F:** The definition formerly describing "Mental Health Plan (MHP)" was updated to reflect "Behavioral Health Plan (BHP)" as per new guidance from DHCS. The definition was also updated to include Substance Use Disorder (SUD) treatment services as a contract responsibility for BHPs. MHP was updated to BHP throughout the document. **Section III.J:** The definition of Partnership Advantage was added. **Section III.K:** The definition of Professional Person **Section III.L:** The definition of Specialty Mental Health Services (SMHS) was updated to say that for Partnership Advantage Members, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP. **Section VI.A.:** Specified that Partnership provides mental health services to Medi-	Health Services Claims Member Services

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)
		Cal Members and will also provide mental health services to Partnership Advantage Members effective January 1, 2026. **Section VI.B.1.a:** Per APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements, added a link and reference to Partnership's Member Outreach & Education Campaign for Non-Specialty Mental Health Services (NSMHS). **Section VI.E.:** Per APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling, added a new policy section to describe the APL requirements. **Section VI.T.:** A new policy section was added to define Medicare guidelines for Mental Health Services for Partnership Advantage Members. **Section VII. R:** Added new Reference for APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements **Section VII. S:** Added new Reference for APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling **Section VII. T:** Added new Reference for California Family Code section 6924 **Section VII. U:** Added new Reference for State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP **Section VII. V:** Added new References for Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii) **Section VII. W:** Added new Reference for Medicare Managed Care Manual, Ch. 4 § 110.1.1	
Policy Owner: Care Coordination – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*			
MPCP2026 – Diabetes Prevention Program *previously MCCP2026*	469 – 474	**This policy was updated to include regulations for the Partnership Advantage D-SNP line of business that will be effective January 1, 2026.** Policy number updated from MCCP2026 to MPCP2026 to reflect Multi Plan Policy **Definitions Added:** Medicare Diabetes Prevention Program (MDPP) Partnership Advantage **Purpose revised:** To provide an overview of these external programs; Diabetes Prevention Program and Medicare Diabetes Prevention Program, including eligibility requirements and participation process. **VI.A updated** to reflect Medicare Prevention Program and reference the Member Handbook for more information	Health Services Claims 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)
		VI.B reorganized to include MDPP Specific Eligibility Criteria section and add a separate section VI.B.3 to combine the DPP and MDPP program participants eligible members clinical requirements as they are the same for both programs. **VI.C.2 updated** to reflect MDPP **VI.D.1 reorganized** the section to have specific DPP program under one section and added VI.D.2 to have specific MDPP program structure under its own section to show the differences. **VI.D.1.c.2)** updated to reference both APL 18-018 Diabetes Prevention Program (11/16/2018) and The Medi-Cal Provider Manual (March 2022) **VI.E updated** section to reflect Delivery Methods for DPP and MDPP Sessions Partnership will cover the following methods for DPP sessions and MDPP sessions (for Partnership Advantage members) as deemed clinically appropriate **VI.G through VI.I updated** to reflect MDPP **VI.J updated to include**: Members may be able to obtain certain medical devices that do not require a Treatment Authorization Request (TAR). The PMEDS program serves all Partnership Members as an efficient means of fulfilling orders for certain home medical devices that are prescribed by medical providers. **Referenced added:** Medi-Cal Provider Manual/Guidelines: Diabetes Prevention Program Prediabetes Risk Test Sheet National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet Medicare Diabetes Prevention Program (MDPP) Basics **Disclaimer added**	
MPCP2034 – Transitional Care Services (TCS) *previously MCCP2034*	475 – 488	**This policy was updated to include regulations for Partnership Advantage D-SNP line of business that will be effective January 1, 2026** **Related Policies Updated**: MCUP3142 updated to reflect new policy number MCAP7003- CalAIM Community Supports (CS) MCUP3143 updated to reflect new policy number MCAP7001- CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) **Definition rephrased**: Admission, Discharge, and Transfer (ADT) data **Definitions added:** California Integrated Care Management (CICM) HCBS: Home and Community Based Services	Health Services Behavioral Health Claims 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)
		Individualized Care Plan (ICP) Interdisciplinary Care Team (ICT) Partnership Advantage **Purpose updated to include:** This policy was written based on the request by DHCS as part of their PHM Policy Guide and the CalAIM Dual Eligible Special Needs Plan Policy Guide **VI.A.1 updated** to reflect: Across the settings, the TCS shall prioritize member-centered care by: **VI.A.1.f section added**: Updating a Partnership Advantage Member's Individualized Care Plan (ICP) as appropriate and distributing the updated ICP to the ICT. **VI.B. TCS Member Eligibility & Identification** section moved from VI.C **VI.B.1.b added**: All Partnership Advantage enrolled members **VI.B.1.c added**: All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low- risk designations **VI.C.1.c.1) updated to include:** Partnership will include those who are Partnership Advantage Members in California Integrated Care Management (CICM) **VI.C.1.c.2)c) added:** Any Partnership Advantage Member who is eligible for CICM Population of Focus. **VI.C.10.a updated to include**: PA Members (CICM) as members who must be identified by the TCS Care Manager as they may be newly eligible for ongoing care management **VI.D.2 updated to include**: PA Members; CICM benefit as a benefit for which high-risk Members identified for TCS shall be referred to as appropriate. **VI.D.3 section added**: Partnership Advantage members are assigned a Primary Case Manager for all of the member's care coordination, including TCS. **VI.D.10 updated to include**: CICM as one of the programs for which the TCS Care Manager must ensure non-duplication of services **VI.E.1.d updated to include:** CICM as a program for which the Member could be enrolled in **VI.E.1.f updated to include:** CICM as a program for which a Member could be considered for eligibility after a transition. **VI.E.2.b updated to include**: CICM as a program where Partnership will use data including any information from admission, to identify newly qualified Members for outreach and enrollment as appropriate **VI.G.3.b updated to include**: CICM as a program for additional care management needs are addressed **VI.G.5 updated to include:** CICM as a program for additional care management needs are addressed **References added:** CalAIM Dual Eligible Special Needs Plan Policy Guide (2025)	

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)
		References updated: DHCS APL-23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 01/08/2025)	
Policy Owner: Utilization Management – *Presenter: Bettina Spiller, MD, Associate Medical Director*			
MPUP3137 – Palliative Care: Intensive Program (Adults) p*reviously MCUP3137*	489 – 508	**This policy was updated to include the Partnership Advantage D-SNP program we will operate effective January 1, 2026. It was also updated to reflect the dissolution of the Palliative Care Quality Collaborative system.** **Section III.C:** Definition of Interdisciplinary Care Team (ICT) for Partnership Advantage Members was added. **Section III.E:** Definition of Partnership Advantage was added. **Section V:** Purpose statement was updated to remove reference to "Medi-Cal" so that the purpose applies to all types of Partnership Members. **Section VI.A.2:** Added clarification that the Intensive Palliative Care Management (IO benefit is available to both Medi-Cal and Partnership Advantage Members. **Section VI.A.3.f.1):** Clarified that Partnership Advantage Members will have a Palliative Care ICT. **Section VI.B.2.c.:** Deleted paragraph that referred to the Palliative Care Quality Collaborative system as our method of monitoring enrollment and network and data utilization data. **Section VI.B.5.n.:** Differentiated Partnership Members enrolled with an outside Medicare plan who are *not* eligible for Intensive Palliative Care with Partnership, from Partnership Advantage Members who are eligible for the benefit. **Section VI.B.7.d.6):** Deleted paragraph that specified Providers must enter into a Data Sharing Agreement with the Palliative Care Quality Collaborative system because it has been disbanded. **Section VIIH.:** Added Reference for the DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" Attachments A – D: All were updated to reflect MPUP change.	Health Services Provider Relations Member Services Claims

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/18/2004		**Next Review Date:** 06/11/2026~~06/12/2025~~ **Last Review Date:** 06/11/2025~~06/12/2024~~		
Applies to:	☐**Employees**	☒**Medi-Cal**	☐**Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~S~~ING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** 06/11/2025~~06/12/2024~~	

I. RELATED POLICIES:

A. MPQP1022 - Site Review (SR) Requirements and Guidelines
B. MPQP1016 - Potential Quality Issue Investigation & Resolution
C. MPQP1053 - Peer Review Committee
D. CMP36 - Delegation Oversight and Monitoring
E. MCUP3144 - Residential Substance Use Disorder Treatment Authorization
F. MCUG3118 - Prenatal and Perinatal Care
G. MCUP3101 - Screening and Treatment for Substance Use Disorders
H. CMP41 - Wellness and Recovery Program Records
I. MPCR601 - Fair Hearings Process for Adverse Credentialing Decisions
J. MPCR300 – Physician Credentialing and Re-credentialing Requirements
K. MPQP1052 Physical Accessibility Review Survey – SR Part C
L. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline

II. IMPACTED DEPTS:

A. Health Services
B. Network Services
C. Regulatory Affairs and Compliance
D. Claims
E. Member Services
F. Grievance & Appeals

III. DEFINITIONS:

A. Substance Use Disorder Treatment Provider: Person or entity that provides direct alcohol and other drug treatment services and has been certified by the State as meeting the certification requirements for participation in the Drug Medi-Cal (DMC) program set forth in the DMC certification Standards for Substance Abuse Clinics and Standards for Drug Treatment Programs in California.

~~B.~~ 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

C. Drug Medi-Cal Organized Delivery System (DMC-ODS):an opt-in 1115 waiver program available in California since 2015 that provides for the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. Of Partnership's 24 counties, seven participate in a Partnership-organized DMC-ODS program ("Wellness and Recovery Program"): Humboldt, Mendocino, Shasta, Siskiyou, Solano, Modoc, and Lassen counties. Five other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Marin, Yolo, Napa, Nevada and Placer counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "state plan" DMC program.

D. Non- Physician Medical Practitioners (NPMP) are defined as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNM) and licensed midwives (LM). See MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines.

E. Licensed Practitioner of the Healing Arts (LPHA) includes physicians, NPs, PAs, registered nurses (RNs), registered pharmacists, licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor, licensed marriage and family therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. See MCUP3144 - Residential Substance Use Disorder Treatment Authorization.

IV. ATTACHMENTS:

A. SUD Facility Site Review (FSR) Tool
B. SUD Facility Site Review (FSR) Guidelines
C. SUD Medical Record Review (MRR) Tool and Guidelines
D. ~~Physical Accessibility Review Survey (PARS)~~Community Based Adult Services (CBAS) Physical Accessibility Review Survey

V. PURPOSE:

A. To provide Substance Use Disorder (SUD) Service providers a guideline for Substance Use Disorder Facility Site Review (SUD FSR) and Substance Use Disorder Medical Record Review (SUD MRR) requirements and processes. This policy will apply to DMC ~~ODS~~ certified providers contracted with Partnership HealthPlan of California (Partnership).

B. The purpose of the SUD FSR and SUD MRR is to ensure that practice sites have sufficient capacity to:
   1. Provide appropriate SUD services
   2. Carry out processes that support continuity and coordination of care
   3. Operate in compliance with industry documentation standards of format and legal protocols
   4. Maintain patient safety standards and practices, and
   5. Operate in compliance with applicable federal, state, and local laws and regulations. Findings of the Site Review are used to:
      a. Provide information for credentialing/re-credentialing decisions

b. Identify areas where education and technical assistance is needed
c. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:

A. Requirements

~~1. Partnership will conduct annual (Partnershipfiscal year July 1- June 30 calendar) onsite monitoring reviews of services and subcontracted services, and submit a secure copy of their monitoring and audit reports to the Department of Health Care Services (DHCS) within two weeks of issuance.~~ Partnership will perform annual monitoring reviews of services and subcontracted services, aligned with the fiscal year (July 1 – June 30). A secure copy of the resulting monitoring and audit reports must be submitted to the Department of Health Care Services (DHCS) within two weeks of the report's issuance.

B. Site Review Personnel

1. The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by Partnership personnel. At a minimum, Partnership's Site Review team will consist of one of the following staff: a physician, a registered nurse (RN), or other Non-Physician Medical Practitioner (NPMP).
2. Licensed physicians, RNs, NPMPs, and Certified Counselors, are eligible to act as Site Reviewers and may perform a site review (SR) independently and sign off on the FSR and MRR tools. Partnership will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute. ~~**Reviews of survey elements will be completed by the appropriate category of reviewer, as noted by survey labels (e.g., LPHA or RN/Physician/NPMP only).**~~
3. Site reviewer personnel ~~s~~ can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review~~s~~ procedures.

C. **Site Review (SUD SR)** – A Substance Use Disorder Site Review consists of two basic components: the Substance Use Disorder Facility Site Review (SUD FSR) and the Substance Use Disorder Medical Record Review (SUD MRR). (See Attachments A, B, and C.) Provider Relations' Credentials staff assesses the accreditation status of Substance Use Disorder Treatment Providers as part of the credentialing process.

1. A SUD FSR is required to be completed prior to final credentialing of the site. The SUD FSR consists of the ~~following 10~~following sections. (See Attachments A and B.)
   a. Access/Safety
   b. Office Management
   c. Policy/Procedures
   d. Program Policy Booklet
   e. Intake Packet
   f. Interpreter Services
   g. Staff Requirements
   h. Detox Facility
   i. Perinatal Services
   j. Pharmaceutical/Laboratory
   k. Telehealth
   l. Peer support services
   ~~j.~~m. Adolescent services

2. A SUD MRR consists of up to 10 randomly selected member medical records and consists of the following ~~nine~~ sections (See Attachment C.)

a. Format Criteria
b. Intake Services
c. Care Planning Guidelines-treatment plans- NTP Only
d. Care Planning Guidelines- Problem Lists- All LOC (except NTP)
e. Treatment Services Discharge Services
~~e.~~f. Care Coordination Services
~~f.~~g. Residential Services
h. Perinatal/Family Services
i. Telehealth
j. Peer support services
k. Adolescent services

3. Community Based Adult Servies (CBAS) Physical Accessibility Review Survey (PARS)~~Physical Accessibility Review Survey (PARS)~~ (See Attachment D.)
   a. During the Initial SUD SSR and subsequent annual SUD SRs, a PARS will be addressed every year at all ~~Substance Use Disorder~~substance use disorder program ~~practice~~ sites within the Partnership ~~Medi-Cal~~DMC-ODS network.

D. Initial SUD SR
1. An initial SUD SR includes a SUD FSR.
   a. The SUD FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Credentialing is not completed until the site has received a passing score and Corrective Action Plan (CAP) items are signed off. An initial SUD FSR is not required when a new provider joins a site that has a current passing SUD FSR score.
2. An initial SUD MRR must be completed within 11 months of the SUD FSR assuming services have been rendered. This may be deferred based on claims.
3. Additional scenarios that require an Initial SUD SR, but are not limited ~~to,~~to instances when:
   a. A new site is added to the Partnership network.
   b. The site relocates.

E. Subsequent SUD SRs
1. Subsequent SUD SRs consist of a SUD FSR and SUD MRR conducted annually during Partnership's fiscal calendar year. The SUD FSR and SUD MRR are scored separately by the Site Reviewer.
2. Site reviews may be conducted more frequently based on monitoring, evaluation, or follow up related to an applied CAP.
3. The SUD MRR score is based on a review of randomly selected records ~~based off the~~from the previous ~~prior~~ fiscal year. Up to10 medical records will be reviewed unless there are not enough member claims to support this. If Partnership is unable to generate a list of 10 medical records, due to a lack of claims, Partnership will conduct the medical records review with the records available. A reduced number of records may be reviewed at the discretion of the Plan based on actual services rendered
4. ~~The site reviewer will advise the practice site of any deficiencies in high priority elements during the SUD SR. Compliance level categories include: Exempted Pass, Conditional pass, and Not Pass.~~
5. ~~The total points on the SUD FSR or SUD MRR will differ from site to site because the "not applicable" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" (non-applicable) or "No" shall include an explanation regarding the exemption.~~
   a. ~~The reviewer will advise the practice site of any deficiencies during the Site Review.~~
   b. ~~The reviewer conducting the site review is responsible for providing the site with the CAP requirements, including the CAP template and appropriate documentation as listed below:~~

~~1) The specific deficiency~~
~~2) Recommended corrective actions~~
~~3) CAP due dates~~
~~4) Instructions for CAP submission to Partnership~~

~~6.~~5. ~~Compliance level categories for SUD FSR include:~~

~~Compliance Category~~	~~FSR Score~~	~~MRR Score~~
~~Exempted Pass (No CAP required)~~	~~90% or above without deficiencies in High Priority Elements related to ASAM, SABG, Perinatal and Pharmaceutical/Laboratory~~	~~90% or above and all section scores above 80%/~~
~~Conditional Pass (CAP required)~~	~~80-89%~~ ~~**OR**~~ ~~90% or above with deficiencies in High Priority Elements related to ASAM, SABG, Perinatal and Pharmaceutical/Laboratory~~	~~80-89%~~ ~~**OR**~~ ~~90% or above with one or more section scores below 80%.~~
~~Not Pass (CAP required)~~	~~79% and below~~	~~79% and below~~

~~7. Outside Entity Reviews~~
~~8. Partnership will determine whether to conduct a SUD SR or accept review findings from an outside entity that performed the most recent review if the collaboration processes is defined in detail and meets and/or exceeds the standards according to this policy. A copy of the annual reviews will be provided by the entity or Partnership will conduct the review. If Partnership accepts these reviews, Partnership will still do a complete on site SUD Site Review at a minimum of every three years. Partnership will submit a copy of outside entity reviews to DHCS as proof of annual monitoring.~~

~~F. Focused Review~~
~~1. A focused review is a targeted review of one or more specific areas of the SUD FSR or SUD MRR. Partnership must not substitute a focused review for the SUD SR. Focused reviews may be used to monitor providers between SUD SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.~~
~~2. Site Reviewers utilize the appropriate sections of the SUD FSR and SUD MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.~~
~~3. All deficiencies identified in a focused review must require the completion and verification of the corrective action plan (CAP) according to the CAP timelines.~~

~~G.~~ ~~Requirements for New Practitioners at a Site~~
~~1. A SUD SR will not be repeated if a new provider is added to a provider site that has a current passing SUD SR score. If a Substance Use Disorder Treatment provider moves to a site that has not undergone a previous SUD SR, Partnership performs a SUD SR at this site.~~

~~H.~~F. Corrective Action Plan (CAP) Requirements and Timelines

If Partnership determines that a provider is out of compliance following a site review, Partnership will issue a CAP identifying found deficiencies. ~~that includes a description of findings. Findings are requirements deemed out of compliance during the site review.~~ The provider ~~would be required to~~must submit a CAP response to Partnership within 60 calendar days of receipt of the CAP.
The CAP must include the following information:

- Description of corrective actions that will be taken by the provider to address ~~findings and incremental milestones the provider will achieve in order to reach full compliance;~~deficiencies
- ~~Timeline for implementation and/or~~ Date of completion of corrective action(s);
- Supporting~~Proposed~~ evidence of correction ~~that will be submitted to Partnership~~;
  - ~~If the provider has evidence to support correction at the time the CAP is due, the provider must submit the actual evidence of correction to Partnership.~~
- ~~Mechanism for monitoring the effectiveness of corrective actions over time; and~~
- Site Provider, Program Director or designee (e.g., compliance administrator) name, and the date of their approval of the CAP.

The provider shall submit the CAP and supporting documentation as applicable electronically email to W&RQuality@partnershiphp.org ~~<<<insert email>>>~~ or as specified by Partnership. Upon receipt of the CAP, Partnership will provide an Acknowledgement ~~Letter~~ emailwithin five business days. ~~The program must resolve CAPs within 90 days of receiving the Partnership Acknowledgement Letter.~~ Partnership may approve an extended resolution timeline only if necessary and appropriate. ~~Failure to completely resolve the outstanding CAP(s) within the Partnership approved CAP resolution timeline will place the program out of compliance, and their ability to participate in the W&R provider network may be suspended.~~

~~A CAP is required for SUD sites that have a SUD FSR / SUD MRR conditional pass or not pass score, on a focused review, or for deficiencies identified by Partnership through oversight and monitoring activities. Partnership may require a CAP for other findings identified during the survey that require correction, regardless of the score.~~

~~1. Conditional Pass~~

~~Partnership will provide the practice site with a review findings report and a formal written request for corrections of all deficiencies within 10 calendar days after the site visit. The practice site must submit a CAP to Partnership addressing deficiencies within 30 calendar days of the written initial CAP request date. Partnership will then review/revise/approve the CAP. Under extenuating circumstances, an extension will be given in 30-day increments to complete deficiencies that have not been addressed may be granted.~~

~~2. Not Pass~~

~~a. Survey deficiencies must be corrected by the provider and verified by Partnership within the CAP timelines. Partnership reserves the right to remove any provider with a not pass score from the provider network.~~

~~3. CAP Documentation~~

~~a. CAPs will be completed using a standard format and form. The minimum elements to be included on a CAP:~~

~~1) CAP Documentation~~
~~2) Correction Date~~
~~3) Practitioner Comments~~
~~4) Signature and Title of Responsible Practitioner or Designee~~
~~5) Evidence of the Corrections~~

~~Completion and Closure Dates~~

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)			☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004		**Next Review Date:** 06/11/2026~~06/12/2025~~ **Last Review Date:** ~~06/12/2024~~06/11/2025	
Applies to:	☐**Employees**	☒**Medi-Cal**	☐**Partnership Advantage**

Compliance level categories for SUD FSR include:

Compliance Category	FSR Score	MRR Score
Exempted Pass (No CAP required)	No Deficiencies noted. Score of 100%	No Deficiencies noted. Score of 100%
Conditional Pass (CAP required)	Deficiencies noted. Score of 99%-80%	Deficiencies noted. Score of 99%-80%
Not Pass (CAP required)	79% and below	79% and below

~~I.~~G. Non-Compliance with Corrective Action Process

1. Providers who do not correct survey deficiencies, or do not cooperate with the CAP process within the established CAP timelines may result in referral to the Partnership CMO; Provider Relations staff and/or the Credentials Committee. Actions taken by the Credentials Committee may include termination of the site from the provider network. If Partnership chooses to remove the site from the network, per IGA, Exhibit A: Partnership shall make a good faith effort to give written notice of termination of a network provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her ~~primary~~ care from, or was seen on a regular basis by, the terminated provider.

~~J.~~H. Organizational Provider Appeals

1. See Partnership Policy MPCR601 "Fair Hearings Process for Adverse Credentialing Decisions" for appeal procedures.
2. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and Partnership will complete a new site review upon approval.

~~K.~~I. Systematic Monitoring

1. Monitoring following the SUD SR will include, but is not limited to, data gathered through the following sources in order to coincide with ODS monitoring requirement 4.2.2:
   a. Potential Quality Issue information (reviewed when identified)
   b. Focused review or other on-site visit

J. Outside Entity Reviews

1. Outside reviews will be accepted on a case by case basis upon review by Partnership Site Review and Behavioral Health team.

2. ~~-~~If Partnership accepts these reviews, Partnership will still do a complete on site SUD Site Review at a minimum of every three years. Partnership will submit a copy of outside entity reviews to DHCS as proof of annual monitoring.

K. Focused Review

1. A focused review is a targeted review of one or more specific areas of the SUD FSR or SUD MRR. Partnership must not substitute a focused review for the SUD SR. Focused reviews may be used to monitor providers between SUD SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
2. Site Reviewers utilize the appropriate sections of the SUD FSR and SUD MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
~~2.~~3. All deficiencies identified in a focused review must require the completion and verification of the corrective action plan (CAP) according to the CAP timelines.

L. Potential Quality of Care Issues

1. Potential quality of care issues identified during the course of the Site Review will be conducted in accordance with the Partnership policy for Potential Quality Issue Investigation and Resolution. The clinical reviewer will complete a PQI Report Form, and submit it Partnership's Quality Improvement department for follow up review.

~~M. Delegation of Site Reviews~~

~~1. Delegation Agreement~~

~~a. Prior to delegating Site Review to an outside entity, Partnership will establish a formal, mutually agreed upon Delegation Agreement that will:~~

~~1) Identify specific delegated functions~~
~~2) Specify policies/procedures to be used for delegated functions~~
~~3) Specify reporting requirements of the delegate~~
~~4) Specify Partnership training, communication, and oversight activities~~

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter (APL) 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review (Sept. 22, 2022) supersedes APL 20-006
B. MMCD Policy Letter (PL) 12-006 Revised Facility Site Review Tool (Aug. 9, 2012)
C. DHCS All Plan Letter (APL) 15-023 Facility Site Review Tools for Ancillary Services and Community-Based Adult Services Providers (Oct. 8, 2015)
D. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)
E. DHCS Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
F. DHCS Behavioral Health Information Notice (BHIN) 21-056 Ongoing-Compliance-Monitoring-FY-2021-22 (Sept. 14, 2021)
G. BHIN 24-001 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026 (Dec. 21, 2023) supersedes BHIN 23-001
H. BHIN 23-068 Updates to Documentation Requirements for all Specialty Mental Health (SMH), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS Services (Nov. 20, 2023) supersedes BHIN 22-019

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)			☒**External Policy** ☐**Internal Policy**
Original Date: 02/18/2004		**Next Review Date: 06/11/2026~~06/12/2025~~** **Last Review Date: ~~06/12/2024~~06/11/2025**	
Applies to:	☐**Employees**	☒**Medi-Cal**	☐**Partnership Advantage**

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
05/18/05; 04/19/06; 06/20/07; 06/18/08; 07/15/09; 09/15/10; 02/20/13; 05/15/13; 05/21/14; 09/20/17; *10/10/18; 11/13/19; 04/08/20; 04/14/21; 05/11/22; 01/11/23; 05/10/23; 06/12/24; 06/11/25

*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*:
MPQP1025 - 06/20/2007 to 02/20/2013
Healthy Families:
MPQP1025 - 10/01/2010 to 02/20/2013
Healthy Kids
MPQP1025 - 06/20/2007 to 02/20/2013

Facility Site Review Survey
Substance Use Disorder (SUD) Treatment Services

Site ID	Phone:	Fax:	Review Date:
Facility Name:	Contact Name/Title:		
Full Address:			
Reviewer Name/Title:			
Staff on site: ___CADC I/II/III ___ LAADC ___ SUDCC ___LCSW ___LMFT ___ASW ___MFTI ___RADT ___RADT II ___MD ___NP ___RN ___LVN ___Clerical Other_____			

Visit Purpose	Certifications	Clinic type
☐ Initial Full Scope ☐ Monitoring ☐ Periodic Full Scope ☐ Follow-up ☐ Focused Review ☐ Ed/TA ☐Other _____	Most current DMC Certification Number _____ Issuance Date: _____	☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 Perinatal Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 ☐ OTP/NTP ☐ Withdrawal Management (3.2)

Site Review Scores

		Pts. poss.	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Access/Safety**	**16**				
II.	**Office Management**	**5**				
III.	**Policy/Procedures**	**21**				
IV.	**Program Policy Booklet**	**27**				
V.	**Intake Packet**	**9**				
VI.	**Interpreter Services**	**7**				
VII.	**Staff Requirements**	**30**				
VIII.	**Detox Facility**	**7**				
IX.	**Perinatal Services**	**19**				
X.	**Pharmaceutical/ Laboratory**	**8**				
		149				
		Total Pts. Poss.	**Total Yes Pts.**	**Total No Pts.**	**Total N/A Pts.**	

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all ten sections.
3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ (Points given) ÷ _____ (Total/ Adjusted points) = _____ (Decimal Score) X 100 = _____% (Compliance Rate)

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire FSR, regardless of the Total FSR score. ***Any deficiency in SABG or ASAM requirements requires a CAP.***

_____**Exempted Pass: 90% or above:**
(Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:**
(Total FSR is 80-89% *OR* *any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

Facility Site Review Guidelines for Substance Use Disorder (SUD) Treatment Services

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions."

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include: 1) Exempted Pass: 90% or above, 2) Conditional Pass: 80-89%, and 3) Not Pass: below 80%. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all 10 (10) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all ten (10) sections. (16) Access/Safety (5) Office Management (21) Policy/Procedures (27) Program Policy Booklet (9) Intake Packet (7) Interpreter Services (30) Staff Requirements (7) Detox Facility (19) Perinatal Services (8) Pharmaceutical/Laboratory **149 (POINTS)**
Step 3: Subtract "N/A" points from 149 total points possible. 149 (Total points possible) – 6 (N/A points) 143 ("Adjusted" total points possible)	**Step 4**: Divide total points given by 143 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{\text{126 or "adjusted" total}}$ or $\frac{126}{143} = .8811 = 88\%$

Criteria	Access/Safety Reviewer Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	**A1. ADA Regulations**: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. **Exit doors**: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Additionally:** communication shall be at a maximum 6th grade level. Reading materials available in large print. **AOD 12000,** "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **A2. Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

Criteria	I. Access/Safety Reviewer Guidelines (Continued)
B. Site environment is maintained in a clean and sanitary condition.	**B1.** The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained. **B2.** Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition. **B3. AOD 12000, "**Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **B4.** **B5.** **B6.**
C. Site environment is safe for all patients, visitors, and personnel.	**Ordinances**: Sites must meet city, county, and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews. **C.1) Fire safety and prevention: T**here is evidence staff has received safety training and/or has safety information **C2. Non-medical emergency procedures:** Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. **C3. Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel. **C4. Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas. **C5. Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign. **C6. Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway. **C7. Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition. **C1. C8. Fire Fighting/Protection Equipment**: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devises. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. Specific information for handling fire emergency procedures is available on site to staff. **Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

Criteria	II. Office Management Reviewer Guidelines
A. Confidentiality of personal medical information is protected according to State and federal guidelines.	**A1. Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations. **A2. Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. **A3. Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies. **A4.** **A5. Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761). PER THE **INTERGOVERNMENTAL AGREEMENT**: **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.
Criteria	**III. Policy/Procedure Reviewer Guidelines**
A. Site has a policy/procedure that addresses each of the following:	**AOD 12010** Program Policies Site has a policy/procedure that addresses each of the following: (each policy in this section should be obtained for evidence) The policies and procedures shall contain, but not be limited to, the following: **1. Obtaining appropriate documentation of admission and readmission criteria-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **2. Determining appropriate Medical Necessity-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **3. Proof of Managed Care eligibility as payment-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **4. Completing ASAM, how is criteria used to determine medical necessity-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **5. Completion of all appropriate and required documentation during intake-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. **6. Completion of initial Problem list and/or Treatment plan-** Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. 7. **Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program-** Program notify clients of their right to services from an alternative service provider if they

object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year.

8. **Does the program adhere to priority administration requirements and provides interim services when required**- (a) Pregnant injecting drug users (b) Pregnant substance users (c) Injecting drug users (d) All Others. The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days. Interim Services. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s) •Pregnant members receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission
9. **Maintaining confidentiality**- Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
10. **Missed appointments**- If a client fails to keep a scheduled appointment, the program shall discuss the missed appointment with the client and shall document the discussion and any action taken in the client's file.
11. **Progress note requirements**- MC-ODS Progress Notes (1) Providers shall create progress notes for the provision of all Medi-Cal behavioral health delivery system services. Each progress note shall provide sufficient detail to support the service code(s) selected for the service type(s) as indicated by the service code description(s).11 (i) Should more than one provider render a service, either to a single member or to a group, at least one progress note per member must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific involvement and duration of direct patient care for each provider of the service. (2) Progress notes for all non-group services shall include: (I) The type of service rendered. (ii) (iii) The date that the service was provided to the member. Duration of direct patient care for the service.12 (iv) Location/place of service. (v) A typed or legibly printed name, signature of the service provider, and date of signature. (vi) A brief description of how the service addressed the member's behavioral health needs (e.g., symptom, condition, diagnosis, and/or risk factors).13 (vii) A brief summary of next steps.14 (3) For group services: (i) When a group service is rendered, a list of participants is required to be documented and maintained by the provider. (ii) (iii) Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in (2)(i-v) above.15 The progress note for the group service encounter shall also include a brief description of the member's response to the service.16 (4) Generally speaking, the contents of the progress note shall support the service code(s) selected and support effective clinical care and coordination among providers. Notes shall include the minimum elements described in (2) or (3) above, but the nature and extent of the information included may vary based on the service type and the member's clinical needs. Some notes may appropriately contain less descriptive detail than others.17 If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress note. (5) Providers shall complete progress notes within three (3) business days of providing a service, with the exception of notes for crisis services, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0). (6) Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled

services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC/DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, and Day Rehabilitation).18 If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.

12. **Process for self-administered medications-** The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.
13. **Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational-** 1. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone. 2. Care coordination shall be provided to a beneficiary in conjunction with all levels of treatment. Care coordination may also be delivered and claimed as a standalone service. Through executed memoranda of understanding, the Contractor shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a beneficiary-centered and whole-person approach to wellness.3. Care coordination services shall be provided by an LPHA or a registered/certified counselor.4. Care coordination services shall include one or more of the following components:
    i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
    ii. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
    iii. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
14. **Clients to obtain or have access to MAT**- The Contractor shall require that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for beneficiaries while they are receiving treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not they seek reimbursement through DMC-ODS. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to be tapered off medications as a condition of entering or remaining in the program. The Contractor shall monitor the referral process or provision of MAT services. 6. Beneficiaries needing or utilizing MAT shall be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a beneficiary who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g.,telehealth), different staff, and/or different services (e.g., Medi-Cal Peer Support Services). If the DMC-ODS provider is not capable of continuing to treat the beneficiary, the DMC-ODS provider shall assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.
15. **Fraud, Waste and Abuse-** Program must have a policy addressing definition of FWA and procedure for reporting.

5. Program Integrity Requirements (42 CFR §438.608). i. The Contractor, and its subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, or abuse. A compliance program that includes, at a minimum, all the following elements:1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.

16. **Medical record release procedures are compliant with State and federal guidelines**- Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.
17. **All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen**- Hospitals, acute psychiatric hospitals, skilled nursing facilities, primary care clinics, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761).
18. **Serving Native Americans**- The Program shall ensure the availability of culturally competent AOD prevention, treatment, and recovery services to the sites American Indian/American Native population
19. **Serving Co-Occurring clients**- Does the Program provide Co-occurring disorder clients with coordinated/integrated care for both their mental health and substance abuse conditions? If yes, what mechanisms are used to provide this service?
    i. MOU with mental health Program(s)
    ii. Referral to COD Program
    iii. Co-case management with mental health Program
    iv. Provide both mental health and substance abuse treatment at a substance abuse program
20. **Program policy on group counseling -** The Program provides documented curriculum that includes individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.
21. **Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment**- They are as follows: Motivational Interviewing, Cognitive- Behavioral Therapy, Trauma-Informed Treatment, Psycho-Education, and Relapse Prevention.
    - A policy that states what Curriculum are used in counseling. These should coincide to the trainings the providers have taken.

Criteria	IV. Program Policy Booklet Reviewer Guidelines
A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted)	**AOD 12010** Program Policies All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following: 1. Program mission and philosophy statement(s). 2. Program description, objectives, and evaluation plan 3. Admission and readmission; including client assignment to counselor and contact information 4. Intake Services 5. Discharge Services 6. Recovery Services 7. Individual and group sessions 8. Alumni involvement and use of volunteers 9. Recreational activities 10. Detoxification services, if applicable 11. Program administration and personnel practices 12. Client grievances/complaints 13. Fiscal practices and budget mechanisms 14. Continuous quality improvement 15. Client rights 16. Medical Policies 17. Nondiscrimination in provision of employment and services 18. Community relations 19. Confidentiality 20. Maintenance of program in a clean, safe and sanitary physical environment 21. Maintenance and disposal of client files 22. Drug screening 23. Staff code of conduct as specified in section 13020 of these Standards 24. Client code of conduct 25. Care Coordination/Case Management 26. Continuing Services 27. Cultural Competency Program around CLAS standards (includes **all** of the 15 Standards)- The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.(42 C.F.R. § 438.206(c)(2).

Criteria	V. Intake Packet Reviewer Guidelines
B. A copy of a complete admissions/intake packet should be provided (A copy of this packet should be obtained, if posted photo should be taken)	**A1.** At a minimum, the following shall be included during the intake process IV. OM E1-E4 (A-D). These formally stated copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries. 1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay 2) Complaint process and grievance procedures 3) Appeal process for involuntary discharge 4) Program rules and expectations 5) Client rights and responsibilities 6) Consent to release information 7) HIPAA notification 8) Consent to treat 9) Admission agreement

Criteria	VI. Interpreter Services Reviewer Guidelines
A. Interpreter Services	**D1.** All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. ***Note:*** https://lep.gov/commonly-asked-questions **D2.** • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member. • ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record.

<table>
<tr><th>Criteria</th><th colspan="3">VII. Staff Requirements Reviewer Guidelines</th></tr>
<tr><td>A. Personnel Files maintained on all employees, LPHA, Medical Director and Volunteers/interns contain the following:</td><td colspan="3">A1.-A12. Personnel files must contain the following:
1) Application for employment and/or resume
2) Signed employment confirmation statement/duty statement
3) Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position
4) Performance evaluations
5) Health records/status as required by program or Title 9
6) Other personnel actions (e.g. Commendations, disciplines, status change, employment incidents and/or injuries)
7) Training documentation relative to substance use disorders and treatment
8) Current registration, certification, intern status, or licensure:</td></tr>
<tr><td></td><td colspan="3"><table>
<tr><th>Medical Professional</th><th>License/Certification</th><th>Issuing Agency</th></tr>
<tr><td>Doctor of Medicine</td><td>Physician’s & Surgeon’s Certificate
DEA Registration</td><td>Medical Board of CA
Drug Enforcement Administration</td></tr>
<tr><td>Psychiatrist/Psychologist</td><td>Physician’s & Surgeon’s Certificate with specialty training</td><td>Medical Board of California</td></tr>
<tr><td>Nurse Practitioner (NP)</td><td>RN License w/NP Certification and Furnishing Number</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Registered Nurse (RN)</td><td>RN License</td><td>CA Board of Registered Nursing</td></tr>
<tr><td>Registered Pharmacist</td><td>Pharmacist License</td><td>CA State Board of Pharmacy</td></tr>
<tr><td>Physicians’ Assistant (PA)</td><td>PA License.
DEA Registration</td><td>Medical Board of CA
DEA</td></tr>
<tr><td>Licensed Practitioner Healing Arts</td><td>LPHA</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Marriage and Family Therapist</td><td>MFT</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Licensed Clinical Social Worker</td><td>LCSW</td><td>Board of Behavioral Sciences</td></tr>
<tr><td>Licensed Professional Clinical Counselor</td><td>LPCC</td><td>Board of Behavioral science</td></tr>
<tr><td>Psychiatric Technician</td><td>Psychiatric Technician</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
<tr><td>Licensed Vocational Nurse (LVN):</td><td>LVN License</td><td>CA Board of Vocational Nursing and Psychiatric Technicians</td></tr>
</table></td></tr>
</table>

	Note: All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Any license/certification that has been approved during the current re/credentialing process need not be re-checked during the site review. Any licenses/certifications not included in the re/credentialing process must be checked for current status as part of the site review process. Although sites with centralized personnel departments are not required to keep documents or copies on site, copies and/or lists of currently certified or credentialed personnel must be readily available when requested by reviewers. 1) Proof of continuing education required by licensing or certifying agency and program; 2) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well. 3) Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement) For registered and certified counselors, a copy of registration or certification According to AOD 8000 b., "Counseling services may only be provided by individuals registered or certified pursuant to California Code of Regulations, Title 9, Division 4, and Chapter 8 or by a licensed professional acting within their scope of practice." 8 Hour class at hire should be done on day one (Reviewer to Obtain copies of licenses)

B. Program/Facility has a written plan for training that is updated annually (Proof of training should be readily available)	**B1. Title 22, C-19020-** The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information. **B2**.Intergovernmental Agreement Exhibit A, Attachment I, III, GG, 3,ii, a The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. • Applies to all providers who co-sign or conduct medical necessity assessments. **B3.** All Employees must complete mandatory DMC-ODS training, provided by PHC on an annual basis. **B4**. Providers will implement and train appropriate staff on at least two of the following EBPs based on the timeline established in the county implementation plan. The required EBP's include: Motivational Interviewing, Cognitive-Behavior Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education. Note: Proof of appropriate staff training related to the Evidence Base Practices (EBP's) currently being used on site. **B5.** New staff are trained in the CalOMS Tx data collection and reporting methods: • CalOMS Tx data is reported in a manner consistent with their county contract as well as within the timelines outlines in the State-County contract • a client admission record is uploaded when the participants have been admitted into treatment, and treatment services have started • admission information is gathered within seven days of a person's entry into treatment • annual update is completed for program participants in treatment for a period of 12 months or more, had no break in service exceeding 30 days and participated continuously in the same modality and program • administrative discharges are used only when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview either in person or by phone • a client is discharged if there has been no contact with the client for 30 days **B6.** The Program shall have policies, procedures and practices in place to ensure DATAR is reported in a manner consistent with their county contract as well within the timelines outlined in the State-County contract **B7.** The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. **B8.** Title 22, C-19020- The program must have a written plan that is updated annually for the training needs of staff. Site personnel have received information and/or training about member rights. Evidence is verifiable for any occurrences of staff training which may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc. If there is no verifiable evidence of staff training, staff is able to locate written member rights information on site and explain how to use information. **B9.** Staff shall be trained on the Trafficking Victims Protection Act of 2000. Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702" **B10.** All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training. **B11**. Proof of continuing education required by licensing or certifying agency and program. (pg 169 IGA)

	B12. Professional staff (LPHA's) receive a minimum of **5 hours** continuing education related to addiction medicine each year. **B13.** All staff and volunteers whose functions require or necessitate contact with clients or food preparation shall be tested for tuberculosis. The tuberculosis test shall be conducted under licensed medical supervision not more than 45 working days prior to or 5 working days after employment and renewed annually from the date of the last tuberculosis test. Staff and volunteers with a known record of tuberculosis or a record of positive testing shall not be required to obtain a tuberculosis skin test. Unless there is documentation that the staff or volunteer completed at least 6 months of preventive therapy, the staff or volunteer shall be required to obtain, within 30 working days of employment, a chest x-ray result and a physician's statement that he/she does not have communicable tuberculosis and has been under regular care and monitoring for tuberculosis. A chest x-ray within the prior 6 months is acceptable. The physician's statement shall be renewed annually. Any staff or volunteer who has the symptoms of tuberculosis or an abnormal chest x-ray consistent with tuberculosis shall be temporarily barred from contact with clients and other program staff until a written physician's clearance is obtained. At the discretion of the program director, tuberculosis testing need not be required for support or ancillary staff whose functions do not necessitate contact with clients or food preparation, and who are not headquartered at the program. **B14**. Written code of conduct addresses at least the following: a) Use of drugs and/or alcohol; b) Prohibition of social/business relationship with clients or their family members for personal gain; c) Prohibition of sexual contact with clients; d) Conflict of interest; e) Providing services beyond scope; f) Discrimination against clients or staff; g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff; h) Protection of client confidentiality; i) The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under; j) Cooperation with compliant investigations.
C. Professional health care personnel have current California Licenses and Certification.	**C1**. Cross reference with credentialing team **C2. <u>Title 22,</u> D-13010-** There has to be at minimum 30% of staff who are certified or licensed to be providing Drug/Alcohol Counseling. **C3.** Make sure there is proof that this is occurring. Make note of any verbal communication **C4.** NTPs shall comply with all federal and state NTP licensing requirements (Likely has a policy)

Criteria	VIII. Detox
A. During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)	**AOD 11040-** During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: **A1**. In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training. **A2.** In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training. **Clients shall not be used to fulfill the requirements of this section.**
B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.	A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.
C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).	**C1**. Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files. **C2**. Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files. **C3.** Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services **C4.** Naloxone training policy and completion of naloxone training

Criteria	IX. Perinatal Services Reviewer Guidelines
A. These standards apply to programs who provide SUD treatment to pregnant and parenting persons, which includes: Pregnant persons; persons with dependent children; persons attempting to regain custody of their children; Postpartum persons and their children; or persons with substance exposed infants	**A1.** The Program publicizes that pregnant persons are given preference in admission to recovery and treatment programs and encourages persons in need of treatment services to access them. The Program shall ensure that Injection drug-using persons must be admitted within 14 days after request or within 120 days if interim services are provided interim Services are: HIV and TB education and counseling and testing; Referrals for prenatal care; Education on the effects of AOD use on the fetus. **A2.** The Program publicizes that pregnant persons are given preference in admission to recovery and treatment programs and encourages these persons in need of treatment services to access them. •
B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s)	**B1.** The Program publicizes that pregnant persons are given preference in admission to recovery and treatment programs and encourages these persons in need of treatment services to access them. **B2.** The Program shall ensure that Pregnant persons are referred for interim services within 48 hours if a treatment slot is not available (To assist in making appropriate referrals, the County must make available a current directory of community resources.) and if placed on waiting list, pregnant persons are at top of waiting list. **B3.** The Program shall ensure that Injection drug-using pregnant persons must be admitted within 14 days after request or within 120 days if interim services are provided. Interim Services are: • HIV and TB education and counseling and testing; • Referrals for prenatal care; • Education on the effects of AOD use on the fetus
C. Programs shall:	**C1.** The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services. **C2.** Child care may be provided on-site or off-site for participants' children who are between 37 months and 12 years of age. Child care for children between 13 and 17 years of age, if necessary or appropriate, may be on-site or off-site as long as their inclusion in the program does not negatively impact the younger children. In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment. The Pro-Children Act of 1994 prohibits smoking in any indoor facility where services for children are federally funded **C3.** The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect. **C4.** Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her. **C5.** The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services **C6.** Provide or arrange for primary medical care for women in treatment **C7.** The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must

	document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment. **C8.** The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services for women in need of transportation. **C9.** The Program shall ensure a vehicle log is maintained **C10.** The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect. **C11.** The Program shall provide or arrange for the following services: (a) Educational/vocational training and life skills resources (b) TB and HIV education and counseling (c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information

Criteria	VI. Pharmaceutical/Laboratory: Pharmaceutical/Laboratory Services Reviewer Guidelines
A. Drugs and medication supplies are maintained secured to prevent unauthorized access.	**Deficiencies:** All deficiencies related to Pharmaceutical Services (e.g. medication maintenance, storage, safety, distribution, etc.) must be addressed in a corrective action plan. **IV.A.1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.** **Security**: • All drugs for dispensing are stored in an area that is secured at all times (CA B&P Code, §4172). The Medical Board defines "area that is secure" to mean a locked storage area within a physician's office. • Keys to locked storage area are available only to staff authorized by the physician to have access (16 CCR, Chapter 2, Division 13, Section 1356.3) • The Medical Board of California interprets "all drugs" to also include both sample and over-the-counter drugs (22 CCR §75032 and §75033) **IV.A.2) Controlled substances** Controlled substances are stored separately from other drugs in a securely locked, substantially constructed cabinet (Control Substances Act, CFR 1301.75). Control substances include all Schedule I, II, III, IV, and V substances listed in the CA Health and Safety Code, Sections 11053-11057, and do not need to be double locked. Personnel with authorized access to controlled substances include physicians, dentists, podiatrists, physician's assistants, licensed nurses, and pharmacists. **IV.A.3)** Written records are maintained including all medications (inclusive of controlled substances) and include inventory list(s) that have: provider's name, name of medication, original quantity of drug, dose, date, name of patient receiving drug, name of authorized person dispensing drug, and number of remaining doses. **Note**: During business hours, the drawer, cabinet, or room containing drugs, medication supplies, or hazardous substances may remain unlocked ***only*** if there is no access to area by unauthorized persons. Whenever drugs, medication supplies, or hazardous substances are unlocked, authorized clinic personnel must remain in the immediate area ***at all times***. At all other times, drugs, medication supplies and hazardous substances must be securely locked. Controlled substances are locked at all times. **IV.A.4** There must not be any expired medications on site. **IV.A.5** Site has a procedure to check expiration date and a method to dispose of expired medications. **IV.A.6** Site has a procedure to check expiration date and a method to dispose of expired lab test supplies. IV. A.7. Site has a procedure to dispose of Sharps materials **IV.A.8** For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.

Facility Site Review Survey
Substance Use Disorder (SUD) Treatment Services

Site ID	Phone:	Fax:	Review Date:
Facility Name:	Contact Name/Title:		
Full Address:			
Reviewer Name/Title:			
Staff on site: ___CADC I/II/III ___ LAADC ___ SUDCC ___LCSW ___LMFT ___ASW ___MFTI ___RADT ___RADT II ___MD ___NP ___RN ___LVN ___Clerical Other_____			

Visit Purpose	Certifications	Clinic type
☐ Initial Full Scope ☐ Monitoring ☐ Periodic Full Scope ☐ Follow-up ☐ Focused Review ☐ Ed/TA ☐Other _____	Most Current:~~Most current~~ DMC Certification Number _____ Issuance Date: _____	☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent_____ Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 Perinatal Residential ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ 3.7 ☐ 4.0 ☐ OTP/NTP ☐ Withdrawal Management (3.2)

Site Review Scores

		Pts. poss.	Yes Pts. Given	No's	N/A's	Section Score %
I.	**Access/Safety**	1~~6~~3				
II.	~~Personnel~~Office Management	~~12~~5				
III.	~~SABG Requirements~~Policy/ Procedures	~~43~~21				
IV.	~~Office Management~~Program Policy Booklet	~~60~~27				
V.	Intake Packet	9				
VI.	Interpreter Services	7				
VII.	Staff Requirements	30				
VIII.	Detox Facility	7				
~~V.~~IX.	**Perinatal Services**	1~~0~~9				
~~VI.~~X.	**Pharmaceutical/ Laboratory**	~~8~~7				
		1~~49~~53				

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all ten~~six~~ sections.
3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.
4) Divide total points given by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%
Points given | Total/ Adjusted points | Decimal Score | Compliance Rate

Compliance Rate

Note: Any section score of < 80% requires a CAP for the entire FSR, regardless of the Total FSR score. ***Any deficiency in ~~SABG or~~ ASAM requirements requires a CAP.***

_____**~~Exempted~~ Pass: 90% or above:**
(Total score is ≥ 90% *and* all section scores are 80% or above)

_____**Conditional Pass: 80-89%:**
(Total FSR is 80-89% *OR* *any* section(s) score is < 80%)

_____**Not Pass: Below 80%**

_____CAP Required

_____Other follow-up

Next Review Due: _____

	Total Pts. Poss.	Total Yes Pts.	Total No Pts.	Total N/A Pts.	

Facility Site Review Guidelines for Substance Use Disorder (SUD) Treatment Services

California Department of Health Services
Medi-Cal Managed Care Division

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perimeters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions."

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include: 1) Exempted Pass: 90% or above, 2) Conditional Pass: 80-89%, and 3) Not Pass: below 80%. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "**RN/MD/LPHA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all 10~~ten~~~~six~~ (10~~6~~) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all 10 ~~ten~~~~six~~ (10~~6~~) sections.
	(16) Access/Safety
	(5) Office Management
	(21) Policy/Procedures
	(27) Program Policy Booklet
	(9) Intake Packet
	(7) Interpreter Services
	(30) Staff Requirements
	(7) Detox Facility

Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Font: 11 pt

	(19) Perinatal Services (8) Pharmaceutical/Laboratory ~~13 (Access/safety)~~ ~~12 (Personnel)~~ ~~43 (SABG Requirements)~~ ~~60 (Office Management)~~ ~~19 (Perinatal Services)~~ ~~7 (Pharmaceutical/Laboratory)~~ **~~153~~ 149 (POINTS)**
Step 3: Subtract "N/A" points from 149~~54~~ total points possible. 149~~54~~ (Total points possible) – 6 (N/A points) 143~~48~~ ("Adjusted" total points possible)	**Step 4**: Divide total points given by 143~~48~~ or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points given / 12~~1~~6 or "adjusted" total or 126~~137~~ / 143~~48~~ =. ~~9256~~ 88111 = 88~~93~~%

~~This page left blank on purpose.~~

Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Indent: Left: 0"
Formatted: Indent: First line: 0"
Formatted: Indent: Left: 0", First line: 0"
Formatted: Indent: First line: 0"
Formatted: Left

Formatted Table

Access/Safety Reviewer Guidelines
A1. ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed, or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). **Parking**: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. **Ramps**: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1 foot rise in 20 feet of horizontal run. **Exit doors**: The width of exit doorways (at least 32 in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. **Elevators**: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean. **Clear Floor Space**: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. **Sanitary Facilities**: Restroom and hand washing facilities are accessible to able bodied and physically disabled persons. A wheel chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. **Additionally:** communication shall be at a maximum 6th grade level. Reading materials available in large print. **AOD 12000,** "Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment." **A2. Note:** A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. **Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**

I. Access/Safety

RN/MD/LPHA Review only

Site Access/Safety Survey Criteria	Wt	Yes	No	NA	Score
A. Site is accessible and useable by individuals with physical disabilities CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)					
1) Site is accessible and useable by individual with physical disabilities	**1**	1)____	1)____	1)____	
2) If the site is NOT accessible, are reasonable alternatives available?	**1**	2)____	2)____	2)____	

Site Access/Safety Survey Criteria	Wt	Yes	No	NA	Score
B. Site environment is maintained in a clean and sanitary condition. 8 CCR §5193; 28 CCR §1300.80					
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	1	1)	1)	1)	
2) Restrooms are clean and contain appropriate sanitary supplies	1			2)	
3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.	1	2)	2)	3)	
4) The Program is free from all of the following (AOD 20000)	1	3)	3)		
a. Broken glass, filth, litter, or debris		4)	4)	4)	
b. Flies, insects, or other vermin					
c. Toxic chemicals or noxious fumes and odors					
d. Exposed electrical wiring					
e. Other health or safety hazards					
5) Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities	1				
6) The program shall safely dispose if contaminated water and chemicals used for cleaning purposes	1	5)	5)		
		6)	6)		
				5)	
				6)	

~~Comments: Write comments for all "No" (0 points) and "N/A" scores.~~
~~2 points possible this page~~

Formatted: Font: Not Bold
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Font: Not Bold
Formatted: Font: Times New Roman, 11 pt
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: Not Bold
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Space Before: 15 pt
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: Times New Roman, 11 pt
Formatted: Indent: Left: 0.5", Right: 0", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: Times New Roman, 11 pt
Formatted: Indent: Left: 0.5", Right: 0", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Normal, No bullets or numbering
Formatted: Font: Not Bold
Formatted ...
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Space Before: 3 pt
Formatted: Space Before: 6 pt

~~I. Access/Safety Reviewer Guidelines (Continued)~~
~~**B1.** The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained.~~ ~~**B2.** Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the "housekeeping" or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.~~ ~~**B3. AOD 12000, "**Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug free environment."~~
~~**Ordinances**: Sites must meet city, county, and state fire safety and prevention ordinances. Reviewers should be aware of applicable city and county ordinances in the areas in which they conduct reviews.~~ ~~**C6. Evacuation Routes**: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.~~ ~~**C2. Non-medical emergency procedures:** Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know ***where to locate*** information on site, and ***how to use*** information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.~~ ~~**C3. Illumination**: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.~~ ~~**C4. Access Aisle**: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.~~ ~~**C5. Exits**: Exit doorways are unobstructed and clearly marked by a readily visible "Exit" sign.~~ ~~**C7. Electrical Safety**: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.~~ ~~**C1. C8. Fire Fighting/Protection Equipment**: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devises. At least one of the following types of fire safety equipment is on site:~~ ~~1) Smoke Detector with intact, working batteries~~ ~~2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances~~ ~~3) Automatic Sprinkler System with sufficient clearance (10 in.) between sprinkler heads and stored materials.~~ ~~4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag.~~ ~~Specific information for handling fire emergency procedures is available on site to staff.~~ ~~**Note: Specific measurements are provided strictly for "*reference only*" for the reviewer. Site reviewers are *NOT* expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.**~~

Comments: Write comments for all "No" (0 points) and "N/A" scores.
8 points possible this page

Formatted Table

Formatted: Font: 11 pt

I. Access/Safety

RN/MD/LPHA Review only ~~I. Access/Safety~~

~~RN/MD/LPHA Review only~~

Site Access/Safety Survey Criteria (Continued)	Wt	Yes	No	NA	Score
C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34 **There is evidence that staff has received safety training and/or has safety information available in the following:**					
1) Fire safety and prevention	1	1)	1)	1)	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	1				
3) Lighting is adequate in all areas to ensure safety.	1	2)	2)	2)	
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	1	3)	3)	3)	
5) Exit doors are clearly marked with "Exit" signs.	1	4)	4)	4)	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	1	5)	5)	5)	
7) Electrical cords and outlets are in good working condition.	1	6)	6)	6)	
8) At least one type of firefighting/protection equipment is accessible at all times.	1	7)	7)	7)	
~~B. Site environment is maintained in a clean and sanitary condition.~~ ~~8 CCR §5193; 28 CCR §1300.80~~		8)	8)	8)	
~~1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.~~	~~1~~				
~~2) Restrooms are clean and contain appropriate sanitary supplies~~	~~1~~	~~1)~~	~~1)~~	~~1)~~	
~~3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.~~	~~1~~	~~2)~~	~~2)~~	~~2)~~	
		~~3)~~	~~3)~~	~~3)~~	

Formatted: Caption

Formatted Table

Formatted: Font: Times New Roman, Bold

Formatted: Normal, No bullets or numbering

Formatted: Right: 0"

Formatted: Normal, Right: 0", No bullets or numbering

Formatted: Normal, Right: 0"

Formatted: Normal, Right: 0", Space After: 0 pt, No bullets or numbering

Formatted: Normal, Right: 0", Space After: 0 pt

Formatted: Normal, Right: 0", No bullets or numbering

Formatted: Right: 0"

C. Site environment is safe for all patients, visitors, and personnel. 8 CCR §3220; 22 CCR §53230; 24 CCR, §2, §3, §9; 28 CCR §1300.80; 29 CFR §1910.301, §1926.34 **There is evidence that staff has received safety training and/or has safety information available in the following:**					
1) Fire safety and prevention	1	1)____	1)____	1)____	
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	1	2)____	2)____	2)____	
3) Lighting is adequate in all areas to ensure safety.	1	3)____	3)____	3)____	
4) Exit doors and aisles are unobstructed and egress (escape) accessible.	1	4)____	4)____	4)____	
5) Exit doors are clearly marked with "Exit" signs.	1	5)____	5)____	5)____	
6) Clearly diagramed "Evacuation Routes" for emergencies are posted in a visible location.	1	6)____	6)____	6)____	
7) Electrical cords and outlets are in good working condition.	1	7)____	7)____	7)____	
8) At least one type of firefighting/protection equipment is accessible at all times.	1	8)____	8)____	8)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 8 points possible this page 16 points possible in this section **Comments:** Write comments for all "No" (0 points) and "N/A" scores. 11 points possible this page 13 points possible in this section Total Total					

Formatted: Font: 11 pt, Bold

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Tab stops: 5.66", Left + Not at 6.33"

~~Medical Board of CA~~ ~~Drug Enforcement Administration~~
~~Medical Board of California~~
~~CA Board of Registered Nursing~~
~~CA Board of Registered Nursing~~
~~CA State Board of Pharmacy~~
~~Medical Board of CA~~ ~~DEA~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral Sciences~~
~~Board of Behavioral science~~
~~CA Board of Vocational Nursing and Psychiatric Technicians~~
~~CA Board of Vocational Nursing and Psychiatric Technicians~~

RN/MD/LPHA Review only

II. Office Management

Formatted Table

Formatted: Font: 22 pt

Formatted: Centered

Formatted: Font: 9 pt

Formatted: No widow/orphan control

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR					
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	1	1)	1)	1)	
2) Procedures are followed to maintain the confidentiality of personal patient information.	1	2)	2)	2)	
3) Medical record release procedures are compliant with State and federal guidelines.	1	3)	3)	3)	
4) Copies of the following shall be posted in a prominent place accessible to all beneficiaries: a. Statement of non-Discrimination b. PHC grievance policy and phone number c. Appeal process for involuntary discharge d. Program rules and expectations	1	4)	4)	4)	
5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	1	5)	5)	5)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 5 points possible in this section Total					

Formatted: Font: 14 pt
Formatted: Centered
Formatted Table
Formatted: Font: Times New Roman, 11 pt
Formatted: Indent: Left: 0.5", Right: 0", Line spacing: single, No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.75" + Indent at: 1"
Formatted: Left
Formatted: Font: 11 pt
Formatted Table
Formatted: Font: 11 pt
Formatted: Font: 12 pt
Formatted: Font: 12 pt

III. ~~Personnel~~Policy/Procedure

RN/MD/LPHA Review only

Site Specific Policy/Procedure~~Site Personnel Survey~~ Survey Criteria	Wt	Yes	No	NA	Score

Formatted Table

A. Site has a policy/procedure that addresses each of the following:					
A. (each policy in this section should be obtained for evidence)Professional health care personnel have current California Licenses and Certifications.					
CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110		1)____			
		2)____			
	1	3)____		1)____	
1) Obtaining appropriate documentation of admission and readmission criteria All required Professional Licenses and Certifications, issued from the appropriate licensing/certification agency, are current.	1	4)____	1)____	2)____	
2) Determining appropriate Medical Necessity The Substance Abuse Clinic has a Licensed Physician designated as Medical Director.	1	5)____	2)____	3)____	
	1	6)____	3)____	4)____	
3) Proof of MediCal eligibility as paymentThe program/facility has a written plan for training staff that is updated annually.	1	7)____	4)____	5)____	
	1		5)____	6)____	
4) Completing ASAM, how is criteria used to determine medical necessity	1	8)____	6)____	7)____	
5) Completion of all appropriate and required documentation during intake			7)____		
6) Completion of initial Problem list and/or Treatment plan	1	9)____		8)____	
7) Notification to clients of their right to services from an alternative service provider if they object to the religious character of the program		10)____			
	1	11)____	8)____	9)____	
8) Does the program adhere to priority administration requirements and provides interim services when required	1	12)____		10)____	
	1	13)____	9)____	11)____	
9) Maintaining confidentiality	1		10)____	12)____	
10) Missed appointments	1	14)____	11)____	13)____	
11) Progress note requirements		15)____	12)____		
12) Process for self-administered medications	1		13)____	14)____	
13) Case management/care coordination referrals for education, vocation, counseling, job referral, legal, medical, and dental, social and recreational	1	16)____		15)____	
		17)____	14)____		
14) Clients to obtain or have access to MAT	1		15)____	16)____	
15) Fraud, Waste and Abuse	1	18)____		17)____	
16) Medical record release procedures are compliant with State and federal guidelines		19)____	16)____		
17) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen	1	20)____	17)____	18)____	
	1			19)____	
18) Serving Native Americans	1	21) 2)____	18)____	20)____	
19) Serving Co-Occurring clients.			19)____	21)____	
20) Program policy on group counseling- List EBPs used: _____, _____	11	)____	20)____		
4) Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatmentProfessional staff (LPHA's) receive a minimum of 5 hours continuing	1	3)____		1)____	
	1	4)____		2)____	
		5)____	21) 1)____	3)____	

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"
Formatted: Left, Line spacing: single
Formatted: Left, Space Before: 12 pt
Formatted: Font: Not Bold
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: List Paragraph, Indent: Left: 0.25"
Formatted: Line spacing: single
Formatted: Left
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Font: 11 pt
Formatted: Space After: 3 pt, Line spacing: single
Formatted: Font color: Auto
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Space After: 3 pt, Line spacing: single
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Space After: 3 pt, Line spacing: single
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Space After: 3 pt, Line spacing: single
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Line spacing: single
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Space Before: 12 pt
Formatted: Line spacing: single
Formatted: Line spacing: single
Formatted: Space After: 0 pt, Line spacing: single
Formatted: Line spacing: single

Site Specific Policy/Procedure~~Site Personnel Survey~~ Survey Criteria	Wt	Yes	No	NA	Score
~~education related to addiction medicine each year~~ ~~5)~~21) ~~At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.~~	~~1~~ ~~1~~		~~2)~~ ~~3)~~ ~~4)~~ ~~5)~~	~~4)~~ ~~5)~~	
Comments: Write comments for all "NO" (0 Points) and "N/A" scores 21 points in this section Total					

~~**Comments:** Write comments for all "No" (0 points) and "N/A" scores.~~
~~5 points possible this page~~

IV. Program Policy Booklet

RN/MD/LPHA Review only

Formatted Table
Formatted: Space Before: 12 pt
Formatted: Left, Space Before: 12 pt
Formatted: Font: 11 pt, Bold
Formatted: Font: 11 pt
Formatted: Font: 11 pt
Formatted: Tab stops: 0.92", Left + 5.46", Left
Formatted: Font: 12 pt

Program Policy Booklet Survey Criteria	Wt	Yes	No	NA	Score
A. Site has a program policy booklet that is available to all employees and volunteers that includes the following, but not limited to: (A copy of this booklet should be obtained, location should be noted)					
1) Program Mission and Philosophy Statement	1	1)	1)	1)	
2) Program Description, objectives, and evaluation plan.	1	2)	2)	2)	
3) Admission and Re-admission; including client assignment to counselor and contact information	1	3)	3)	3)	
4) Intake Services	1	4)	4)	4)	
5) Discharge Services	1	5)	5)	5)	
6) Recovery Services	1	6)	6)	6)	
7) Individual and Group Sessions	1	7)	7)	7)	
8) Alumni involvement and Use of volunteers	1	8)	8)	8)	
9) Recreational activities	1	9)	9)	9)	
10) Detoxification Services (if applicable)	1	10)	10)	10)	
11) Program administration and personnel practices	1	11)	11)	11)	
12) Client grievances/complaints	1	12)	12)	12)	
13) Fiscal practices and budget mechanisms	1	13)	13)	13)	
14) Continuous quality improvement	1	14)	14)	14)	
15) Client rights	1	15)	15)	15)	
16) Medical policies	1	16)	16)	16)	
17) Nondiscrimination in provision of employment and services	1	17)	17)	17)	
18) Community Relations	1	18)	18)	18)	
19) Confidentiality	1	19)	19)	19)	
20) Maintenance of program in a clean, safe, and sanitary physical environment	1	20)	20)	20)	
21) Maintenance and disposal of client files	1	21)	21)	21)	
22) Drug screening	1	22)	22)	22)	
23) Staff code of conduct as specified in section 13020 of these Standards	1	23)	23)	23)	
24) Client code of conduct	1	24)	24)	24)	
25) Care Coordination/Case Management	1	25)	25)	25)	
26) Continuing Services	1	26)	26)	26)	
27) Cultural Competency Program around CLAS standards (inclusive of all 15 standards)	1	27)	27)	27)	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
27 points possible in this section Total					

Formatted: Font: Times New Roman, 11 pt, Bold

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Left, Add space between paragraphs of the same style

Formatted: Font: Times New Roman, 8 pt

Formatted: Font: 11 pt

Formatted Table

Formatted: Font: 12 pt

Formatted: Font: 11 pt

Formatted: Font: 12 pt

V. Intake Packet

RN/MD/LPHA Review only

Intake Packet Survey Criteria	Wt	Yes	No	NA	Score
A. A copy of a complete admissions/intake packet should be provided (A copy of this packet should be obtained, if posted photo should be taken)					
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	1	1)	1)	1)	
2) Complaint process and grievance procedures	1	2)	2)	2)	
3) Appeal process for involuntary discharge	1	3)	3)	3)	
4) Program rules and expectations	1	4)	4)	4)	
5) Client rights and responsibilities	1	5)	5)	5)	
6) Consent to release information	1	6)	6)	6)	
7) HIPAA notification	1	7)	7)	7)	
8) Consent to treat	1	8)	8)	8)	
9) Admission agreement	1	9)	9)	9)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 9 points possible in this section Total					

Formatted: Font: Not Bold
Formatted: Font: 12 pt
Formatted: Font: 12 pt
Formatted: Font: Not Bold
Formatted: Font: 12 pt
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Left
Formatted: Font: 12 pt
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 12 pt
Formatted: Normal, No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 12 pt
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted ...
Formatted: Font: 12 pt
Formatted: Normal, No bullets or numbering
Formatted ...
Formatted: Font: 12 pt
Formatted: Normal, No bullets or numbering
Formatted ...
Formatted: Normal, No bullets or numbering
Formatted ...
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted ...
Formatted: Normal, No bullets or numbering
Formatted ...
Formatted: Font: 11 pt
Formatted: Font: 12 pt
Formatted: Font: 11 pt
Formatted: Font: 12 pt

VI. Interpreter Services

RN/MD/LPHA Review only

Interpreter Services Survey Criteria	Wt	Yes	No	NA	Score
A. Interpreter services (a copy of policy should be obtained)					
1) All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities.	1	1)	1)	1)	
2) Note: `https://lep.gov/commonly-asked-questions D2`.	1	2)	2)	2)	
3) If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources.	1	3)	3)	3)	
4) Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients.	1	4)	4)	4)	
5) Family or friends should not be used as interpreters, unless specifically requested by the member.	1	5)	5)	5)	
6) ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services.	1	6)	6)	6)	
7) A request for or refusal of language/interpreter services must be documented in the member's medical record.	1	7)	7)	7)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

7 points possible in this section Total

Formatted: Font: Not Bold
Formatted: Centered, Line spacing: single
Formatted: Left, Space Before: 12 pt, Line spacing: single
Formatted: Line spacing: single
Formatted: Font: Not Bold
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Field Code Changed ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted ...
Formatted Table ...
Formatted ...
Formatted ...

VII. Staff Requirements

RN/MD/LPHA Review only

Staff Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Personnel files maintained on all employees, LPHA, Medical Director and volunteers/interns contain the following: CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110 (Obtain a complete copy of all documents)					
1) Application for employment and/or resume	1	1)	1)	1)	
2) Signed employment confirmation statement/duty statement	1	2)	2)	2)	
3) Job description includes all of the following: Position title and classification; Duties and responsibilities; Lines of supervision; Education, training, work experience, and other qualifications for the position.	1	3)	3)	3)	
4) Performance evaluations	1	4)	4)	4)	
5) Health records/status as required by program or Title 9	1	5)	5)	5)	
6) Other personnel actions	1	6)	6)	6)	
7) Training documentation relative to substance use disorders and treatment	1	7)	7)	7)	
8) Current registration, certification, intern status, or licensure	1	8)	8)	8)	
9) Proof of continuing education required by licensing or certifying agency and program	1	9)	9)	9)	
10) Program Code of Conduct and for registered, certified, and licensed staff	1	10)	10)	10)	
11) Signed annual confidentiality agreement (if not available, a yearly training can meet this requirement)	1	11)	11)	11)	
12) For registered and certified counselors, a copy of registration or certification	1	12)	12)	12)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
12 points possible this page

Formatted ...

Formatted: Left

VII. Staff Requirements continued

RN/MD/LPHA Review only

Staff Requirements Survey Criteria Continued	Wt	Yes	No	NA	Score

B. Program/Facility has a written plan for training staff that is updated annually (Proof of training should be readily available)					
1) The program/facility has a written plan for training staff that is updated annually	1	1) ____	1) ____	1) ____	
2) All providers and staff conducting, reviewing, using ASAM assessments have completed the two e-Trainings.	1	2) ____	2) ____	2) ____	
3) All employees have mandatory training on annual DMC-ODS requirements	1	3) ____	3) ____	3) ____	
4) All appropriate staff have received regular training on evidence based practices (EBP)	1	4) ____	4) ____	4) ____	
5) Staff are trained in the CalOMS treatment data collection and reporting methods	1	5) ____	5) ____	5) ____	
6) Staff are trained in the DATAR reporting methods	1	6) ____	6) ____	6) ____	
7) Cultural and Linguistic training annually	1	7) ____	7) ____	7) ____	
8) Title 22 training	1	8) ____	8) ____	8) ____	
9) Education on the Trafficking Victims Protection Act of 2000	1	9) ____	9) ____	9) ____	
10) Annual confidentiality training	1	10) ____	10) ____	10) ____	
11) ONLY MEDICAL DIRECTOR minimum of five hours of continuing medical education related to addiction medicine each year for medical director	1	11) ____	11) ____	11) ____	
12) ONLY LPHA minimum of five hours of continuing medical education related to addiction medicine each year for LPHA	1	12) ____	12) ____	12) ____	
13) Tuberculosis (TB) Testing is offered and performed onsite for all staff who have contact with food preparation and/or any clients.	1	13) ____	13) ____	13) ____	
14) A code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.	1	14) ____	14) ____	14) ____	

Comments: Write comments for all “No” (0 points) and “N/A” scores.

14 points possible this page

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 2 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted: Right: -0.06"

Formatted: Line spacing: single

Formatted: Line spacing: single

Formatted: Font: Times New Roman, 11 pt, Bold

Formatted: Font: Times New Roman, 11 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted ...

Formatted ...

Formatted ...

Formatted ...

Formatted ...

Formatted: Space After: 9 pt

Formatted ...

Formatted: Font: Times New Roman, 11 pt

Formatted: Font: 11 pt

Formatted: No widow/orphan control, Tab stops: 6.33",

VII. Staff Requirements continued

RN/MD/LPHA Review only

Staff Requirements Survey Criteria Continued	Wt	Yes	No	NA	Score
C. Professional health care personnel have current California Licenses and Certifications. CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110					
1) All staff have received appropriate credentialing	1	1)	1)	1)	
2) At least 30% of staff providing counseling are licensed or certified as Drug & Alcohol Counselors.	1	2)	2)	2)	
3) Staff files are maintained for the required length of time. (6 years current)	1	3)	3)	3)	
4) NTP/OTP program only Facility must provide policy showing conforming to CCR, Title 9, and Division 4 with regard to medication practices	1	4)	4)	4)	
Comments: Write comments for all "No" (0 points) and "N/A" scores. 4 points possible this page 30 points possible this section. Total					

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Font: 11 pt

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: 11 pt

Formatted: Normal, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Times New Roman, 11 pt

Formatted: Normal, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Times New Roman, 11 pt

Formatted: Font: 11 pt

Formatted Table

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

VIII. ~~Personnel continued~~Detox

RN/MD/LPHA Review only

~~Site Personnel~~Detox Survey Criteria	Wt	Yes	No	NA	Score
A. During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows: (Clients shall not be used to fulfill the requirements of this section.)~~Professional health care personnel have current California Licenses and Certifications.~~					
~~CA Business & Professional (B&P) Code §2050, §2585, §2725, §2746, §2834, §3500, §4110~~					
1) In a program with 15 or fewer clients who are receiving detoxification services, there shall be at least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.	1	1)____	1)____	1)____	
~~6) All providers and staff conducting ASAM assessments have completed the two e-Trainings.~~	1			2)____	
2) In a program with more than 15 clients who are receiving detoxification services, there shall be at least two staff members or volunteers, per every 15 clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training.	1	2)____	2)____		
~~7) All employees have mandatory training on annual DMC-ODS requirements.~~	~~1~~	~~6)~~____	~~6)~~____	~~6)~~____	
~~8) All appropriate staff have received regular training on evidence based practices (EBP)~~	~~1~~			~~7)~~____	
~~9) Tuberculosis (TB) Testing is offered and performed onsite for all staff.~~	~~1~~	~~7)~~____	~~7)~~____	~~8)~~____	
~~10) There is adequate staff on duty at all times with CPR certificate and current first aid training.~~	~~1~~			~~9)~~____	
~~11) Staff files are maintained for the required length of time.~~	~~1~~	~~8)~~____	~~8)~~____	~~10)~~____	
		~~9)~~____	~~9)~~____	~~11)~~____	
		~~10)~~____	~~10)~~____		
		~~11)~~____	~~11)~~____		
B. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.	**1**	1)____	1)____	1)____	
~~B. Counseling services are only provided by registered or certified individuals.~~					

Formatted: Space Before: 12 pt
Formatted: Line spacing: Multiple 1.15 li
Formatted: Left
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 14 pt, Check spelling and grammar
Formatted: Font: Times New Roman, 11 pt
Formatted: Normal, No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Space Before: 12 pt
Formatted: Space Before: 12 pt
Formatted: Indent: Left: 0.5", Right: 0", Line spacing: single, No bullets or numbering
Formatted: Font: Bold
Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 2 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"
Formatted: Font color: Auto
Formatted: Font: Bold
Formatted: Indent: Left: 0.25", No bullets or numbering

~~Site Personnel~~Detox Survey Criteria	Wt	Yes	No	NA	Score
C. Evidence of personnel training shall be implemented and maintained by the licensee pursuant to CCR, Title 9, Section 10564(k).					
1) Evidence of eight (8) hours of training annually that covers the needs of residents who receive Withdrawal Management services in personnel files.	1	1)____	1)____	1)____	
2) Evidence of repeated orientation training within 14-days for returning staff following a 180 continuous day break in employment personnel files.	1	2)____	2)____	2)____	
3) Evidence of six (6) hours of orientation training for all personnel providing WM services, monitoring and supervising the provision of Withdrawal Management services	1	3)____	3)____	3)____	
4) Naloxone training policy and completion of naloxone training	1	4)____	4)____	4)____	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
7~~7~~ points possible in this ~~page~~section ~~12 points possible this section.~~	Total				
~~Total~~					

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Left

Formatted: Font: Times New Roman, 11 pt

Formatted: Normal, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Left

Formatted: Font: Times New Roman, 11 pt

Formatted: Normal, No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Times New Roman, 11 pt

Formatted: Normal, No bullets or numbering

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

~~Criteria~~	~~III. SABG Requirements Reviewer Guidelines~~
~~A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs~~	
~~1. Personnel files are maintained on all employees, volunteers/interns and contain the following required documentation:~~	~~Personnel files must contain the following:~~ ~~a) Application for employment and/or resume;~~ ~~b) Signed employment confirmation statement/duty statement;~~ ~~c) Job description;~~ ~~d) Performance evaluations;~~ ~~e) Health records/status as required by program or Title 9;~~ ~~f) Other personnel actions (e.g. Commendations, disciplines, status change, employment incidents and/or injuries);~~ ~~g) Training documentation relative to substance use disorders and treatment;~~ ~~h) Current registration, certification, intern status, or licensure;~~ ~~i) Proof of continuing education required by licensing or certifying agency and program;~~ ~~j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.~~
~~2. Job descriptions are developed, revised as needed, and are approved by the program's governing body.~~	~~The job descriptions shall include:~~ ~~a) Position title and classification;~~ ~~b) Duties and responsibilities;~~ ~~c) Lines of supervision;~~ ~~d) Education, training, work experience, and other qualifications for the position.~~
~~3. Written code of conduct for employees, volunteers/interns is established; and addresses the required topics.~~	~~Written code of conduct addresses at least the following:~~ ~~a) Use of drugs and/or alcohol;~~ ~~b) Prohibition of social/business relationship with clients or their family members for personal gain;~~ ~~c) Prohibition of sexual contact with clients;~~ ~~d) Conflict of interest;~~ ~~e) Providing services beyond scope;~~ ~~f) Discrimination against clients or staff;~~ ~~g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff;~~ ~~h) Protection of client confidentiality;~~ ~~i) The element found in the code of conduct(s)for the certifying organization(s) the program's counselors are certified under;~~ ~~j) Cooperation with compliant investigations.~~

Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Widow/Orphan control

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
1. Personnel files maintained on all employees and volunteers/interns contain the following:	1	1a) ____	1a) ____	1a) ____	
a) Application for employment and/or resume	1	1b) ____	1b) ____	1b) ____	
b) Signed employment confirmation statement/duty statement	1	1c) ____	1c) ____	1c) ____	
c) Job description	1	1d) ____	1d) ____	1d) ____	
d) Performance evaluations	1	1e) ____	1e) ____	1e) ____	
e) Health records/status as required by program or Title 9	1	1f) ____	1f) ____	1f) ____	
f) Other personnel actions	1	1g) ____	1g) ____	1g) ____	
g) Training documentation relative to substance use disorders and treatment	1	1h) ____	1h) ____	1h) ____	
h) Current registration, certification, intern status, or licensure	1	1i) ____	1i) ____	1i) ____	
i) Proof of continuing education required by licensing or certifying agency and program	1	1j) ____	1j) ____	1j) ____	
j) Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying body's code of conduct as well.					
2. Job descriptions shall be developed, revised as needed, approved by the program's governing body, and include:	1	2a) ____	2a) ____	2a) ____	
a) Position title and classification;	1	2b) ____	2b) ____	2b) ____	
b) Duties and responsibilities;	1	2c) ____	2c) ____	2c) ____	
c) Lines of supervision;	1	2d) ____	2d) ____	2d) ____	
d) Education, training, work experience, and other qualifications for the position.					
3. Written code of conduct for employees and volunteers/interns shall be established, which address at least the following:	1	3a) ____	3a) ____	3a) ____	
a) Use of drugs and/or alcohol;	1	3b) ____	3b) ____	3b) ____	
b) Prohibition of social/business relationship with clients or their family members for personal gain;	1	3c) ____	3c) ____	3c) ____	
c) Prohibition of sexual contact with clients;	1	3d) ____	3d) ____	3d) ____	
d) Conflict of interest;	1	3e) ____	3e) ____	3e) ____	
e) Providing services beyond scope;	1	3f) ____	3f) ____	3f) ____	
f) Discrimination against clients or staff;	1	3g) ____	3g) ____	3g) ____	
g) Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff;	1	3h) ____	3h) ____	3h) ____	
h) Protection of client confidentiality;	1	3i) ____	3i) ____	3i) ____	
i) The element found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under	1	3j) ____	3j) ____	3j) ____	
j) Cooperation with compliant investigations.					

Comments: Write comments for all "No" (0 points) and "N/A" scores. 13 points possible this page

Formatted ... (repeated)

Criteria	III. SABG Requirements Reviewer Guidelines
4. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	Personnel Files: If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address: a) Recruitment; b) Screening; c) Selection; d) Training and orientation; e) Duties and assignments; f) Scope of practice; g) Supervision; h) Evaluation; i) Protection of client confidentiality.
5. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs funded by Substance Abuse and Prevention Treatment Block Grant (SABG).	Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director. a) All Staff b) Certified Staff c) Medical Director d) Volunteers/Interns
6. Staff will receive Cultural and Linguistic training. Annually	The program shall promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. (Notate the topic of trainings conducted, including if they are in-house, outside or PHC)
7. Proof that staff have received education on the Trafficking Victims Protection Act of 2000	Staff shall be trained on the Trafficking Victims Protection Act of 2000. Trafficking Victims Act: "Shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702"
8. All staff will sign confidentiality agreements and/or have proof of training annually.	All employee files shall contain either a new confidentiality agreement signed each year or proof of annual training.

Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Left, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Left
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Left
Formatted: Widow/Orphan control
Formatted: Left
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Left
Formatted: Widow/Orphan control

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
A. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
4. If a program utilizes the services of volunteers and or interns, procedures shall be implemented which address:	1	4a)____	4a)____	4a)____	
a) Recruitment;	1	4b)____	4b)____	4b)____	
b) Screening;	1	4c)____	4c)____	4c)____	
c) Selection;	1	4d)____	4d)____	4d)____	
d) Training and orientation;	1	4e)____	4e)____	4e)____	
e) Duties and assignments;	1	4f)____	4f)____	4f)____	
f) Scope of practice;	1	4g)____	4g)____	4g)____	
g) Supervision;	1	4h)____	4h)____	4h)____	
h) Evaluation;	1	4i)____	4i)____	4i)____	
i) Protection of client confidentiality.	1	5a)____	5a)____	5a)____	
	1	5b)____	5b)____	5b)____	
5. Written roles and responsibilities and a code of conduct for the following staff (if applicable) shall be clearly documented, signed, and dated by an authorized program representative and the medical director.	1	5c)____	5c)____	5c)____	
a) All Staff	1	5d)____	5d)____	5d)____	
b) Certified Staff					
c) Medical Director	1	6)____	6)____	6)____	
d) Volunteers/Intern		7)____	7)____	7)____	
	1				
6. Staff will receive Cultural and Linguistic training annually.		8)____	8)____	8)____	
	1				
7. Proof that staff have received education on the Trafficking Victims Protection Act of 2000					
8. All staff will sign confidentiality agreements, and/or have proof of training annually					

Comments: Write comments for all "No" (0 points) and "N/A" scores.
16 points possible this page

Formatted ... (repeated)

~~Criteria~~	~~III. SABG Requirements Reviewer Guidelines~~
~~9. Staff are trained in the CalOMS treatment data collection and reporting methods~~	~~•The Program shall have policies, procedures and practices in place to ensure:~~ ~~• new staff are trained in the CalOMS Tx data collection and reporting methods~~ ~~• CalOMS Tx data is reported in a manner consistent with their county contract as well as within the timelines outlines in the State-County contract~~ ~~• a client admission record is uploaded when the participants have been admitted into treatment, and treatment services have started~~ ~~• admission information is gathered within seven days of a person's entry into treatment~~ ~~• annual update is completed for program participants in treatment for a period of 12 months or more, had no break in service exceeding 30 days and participated continuously in the same modality and program~~ ~~• administrative discharges are used only when the client has stopped appearing for treatment services without leave from or notification to the AOD treatment program and the client cannot be located to be discharged and complete the CalOMS Tx discharge interview either in person or by phone~~ ~~• a client is discharged if there has been no contact with the client for 30 days~~
~~10. Staff are trained in the DATAR reporting methods~~	~~The Program shall have policies, procedures and practices in place to ensure DATAR is reported in a manner consistent with their county contract as well within the timelines outlined in the State-County contract~~
~~11. CalOMS information is submitted on a timely basis~~	~~The program shall submit CalOMS information on a timely basis~~

Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Left
Formatted: Normal, Left, No bullets or numbering
Formatted: Normal, No bullets or numbering
Formatted: Left
Formatted: Normal, No bullets or numbering
Formatted: Left
Formatted: Widow/Orphan control

III. SABG Requirements

RN/MD/LPHA Review only

SABG Requirements Survey Criteria	Wt	Yes	No	NA	Score
B. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).					
9. Staff are trained in the CalOMS treatment data collection and reporting methods	1	9)_____	9)_____	9)_____	
10. Staff are trained in the DATAR reporting methods	1	10)_____	10)_____ 11)_____	10)_____	
11. CalOMS information is submitted on a timely basis	1	11)_____		11)_____	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					
3 points possible this page					
43 points possible this section. Total					

Criteria	IV. Office Management Reviewer Guidelines

Formatted: Left, Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, Indent: Left: 0", Right: 0"
Formatted: Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Normal, Right: 0", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Normal
Formatted: Normal, Right: 0", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Normal
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Space Before: 0 pt, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Normal, Right: 0", Space Before: 0 pt, After: 0 pt, No bullets or numbering
Formatted: Right: 0", Widow/Orphan control
Formatted: Left, Right: 0", Widow/Orphan control
Formatted: Space Before: 0 pt, Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Widow/Orphan control, Tab stops: Not at 6.33"
Formatted: Left, None, Don't keep with next
Formatted: Left

A. Medical records are available for the Provider at each scheduled patient encounter.	**A1.** The process/system established on site provides for the availability of medical records, including outpatient, inpatient, referral services, and significant telephone consultations for patient encounters. **A2.** Medical records are filed that allows for ease of accessibility within the facility, or in an approved health record storage facility off the facility premises (22 CCR, § 75055). **A3/4. Adequacy of Medical Record/treatment record keeping:** The reviewers must discuss office documentation practices with the practitioner or practitioner staff. This discussion must include the forms and methods used to keep the information in a consistent manner. It must also include how the practice insures the confidentiality of records. The reviewers must assess the record for orderliness of the record and documentation practices. To ensure member confidentiality the reviewer may review "blinded" medical/treatment records or a model instead of an actual record.
B. Site shall discuss the following processes and provide supporting policies:	Site shall be able to thoroughly discuss the following processes and provide supporting policies: B1-6 Staff should be able to speak to process and produce policy to review. Review blank forms, see where they are stored. B7. Program notify clients of their right to services from an alternative service provider if they object to the religious character of the program. The program shall refer to alternative providers when necessitated by religious objection. • Programs must document the total number of referrals necessitated by religious objection to other alternative SUD providers, and annually submits this information to PHC Wellness and Recovery program by e-mail wellnessandrecovery@partnershiphp.org, by Sept 15, each year. B8. Does the Program adhere to priority admission requirements as follows: (a) Pregnant injecting drug users (b) Pregnant substance abusers (c) Injecting drug users (d) All Others The program shall admit IV drug users within **14 days** of request or provide interim services and admit within **120 days** Interim Services: The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s): •Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission •The Program shall make interim services available, either on-site or by referral, within **48 hours** for those individuals who are in need of treatment and who cannot be admitted within **14 days** of their request for treatment •The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission •The Program shall maintain contact with individuals awaiting treatment admission

Formatted: Normal, No bullets or numbering

Formatted: Normal, No bullets or numbering

Formatted: Normal, No bullets or numbering

Formatted: Widow/Orphan control

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
A) Medical records are available for the Provider at each scheduled patient encounter. 22 CCR §75055; 27 CCR §1300.70					
1) Medical records are readily retrievable for scheduled patient encounters.	1	1)___	1)___	1)___	
2) Medical documents are filed in a timely manner to ensure availability for patient encounters.	1	2)___	2)___	2)___	
3) Site has a system in place to ensure medical records are maintained in a consistent manner.	1	3)___	3)___	3)___	
4) There is an individual medical record is established for each member	1	4)___	4)___	4)___	
5) Medical record contains signed HIPAA notification	1	5)___	5)___	5)___	
B) Site shall discuss the following processes and provide supporting policies:					
1) What is your process for obtaining appropriate documentation of admission and readmission criteria.	1	1)___	1)___	1)___	
2) How do you determine appropriate Medical Necessity	1	2)___	2)___	2)___	
3) How do you show proof of eligibility as payment.	1	3)___	3)___	3)___	
4) Process for completing ASAM, how is criteria used to determine medical necessity. (visualize copy)	1	4)___	4)___	4)___	
5) Process for completing all appropriate and required documentation during intake. (Visualize intake packet and make site "walk" you through process start to finish) adapt to LOC	1	5)___	5)___	5)___	
6) Process for completing initial Treatment plan and/or Problem list (Visualize blank form/ how generated in computer)	1	6)___	6)___	6)___	
7) How do you notify clients of their right to services from an alternative service provider if they object to the religious character of the program	1	7)___	7)___	7)___	
8) Does the program adhere to priority administration requirements and provides interim services when required	1	8)___	8)___	8)___	

Comments: Write comments for all "No" (0 points) and "N/A" scores.

13 points possible this page

Criteria	IV. Office Management Reviewer Guidelines

Formatted ... (×50)

~~C. Medical record confidentiality is maintained according to State and Federal guidelines.~~	~~**B1. Privacy**: Patients have the right to privacy for dressing/undressing, physical examination and medical consultation. Practices are in place to safeguard patient privacy. Because dressing areas and examination room configurations vary greatly, reviewers will make site-specific determinations.~~ ~~**B2. Confidentiality**: Personnel follow site policy/procedures for maintaining confidentiality of individual patient information. Individual patient conditions or information is not discussed in front of other patients or visitors, displayed, or left unattended in reception and/or patient flow areas.~~ ~~**B4. Electronic records**: Electronic record-keeping system procedures have been established to ensure patient confidentiality, prevent unauthorized access, authenticate electronic signatures, and maintain upkeep of computer systems. Security protection includes an off-site backup storage system, an image mechanism with the ability to copy documents, a mechanism to ensure that recorded input is unalterable, and file recovery procedures. Confidentiality protection may also include use of encryption, detailed user access controls, transaction logs, and blinded files.~~ ~~**B3. Record release**: Medical records are not released without written, signed consent from the patient or patient's representative, identifying the specific medical information to be released as well as an end date for the authorization. The release terms, such as to whom records are released and for what purposes, should also be described. This does not prevent release of statistical or summary data, or exchange of individual identifiable medical information between individuals or institutions providing care, fiscal intermediaries, research entities and State or local official agencies.~~ ~~**B5. Record retention:** Hospitals, acute psychiatric hospitals, skilled nursing facilities, *primary care clinics*, psychology, psychiatric clinics, and SUD facilities must maintain medical records and exposed x-rays for a minimum of 10 years following patient discharge, except for minors (Title 22, CCR, and Section 75055). Records of minors must be maintained for at least one year after a minor has reached age 17, but in no event for less than 7 years (Title 22, CCR, and Section 75055). Each Plan must maintain all records and documentation (including medical records) necessary to verify information and reports required by statute, regulation or contractual obligation for 5 years from the end of the fiscal year in which the Plan contract expires or is terminated (Title 22, CCR, Section 53761).~~ ~~PER THE **INTERGOVERNMENTAL AGREEMENT**: **DHCS** AND **CMS** MAY AUDIT **10 YEARS** FROM THE DATE THE STATE PREPAID HEALTH INSURANCE PROGRAM (PHIP) INTERGOVERNMENTAL AGREEMENT EXPIRES, OR FROM THE DATE OF THE COMPLETION OF ANY AUDIT, WHICHEVER IS LATER.~~

Formatted: Normal, No bullets or numbering

Formatted: Widow/Orphan control

~~IV. Office Management~~

Formatted: Left, Right: 0", Widow/Orphan control

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
B. Confidentiality of personal medical information is protected according to State and federal guidelines. 22 CCR §51009, §53761, §75055; §27 CCR §1300.70; CA Civil Code §56.10 (Confidentiality of Medical Information Act) 42CFR					
1) Substance Use Disorder consult and therapy rooms safeguard patients' right to privacy.	1	1)	1)	1)	
2) Procedures are followed to maintain the confidentiality of personal patient information.	1	2)	2)	2)	
3) Medical record release procedures are compliant with State and federal guidelines.	1	3)	3)	3)	
4) Storage and transmittal of medical records preserves confidentiality and security.	1	4)	4)	4)	
5) All patient's health service records must be retained for a minimum of ten (10) years from the patient's discharge date or seven years after a minor patient reaches the age of eighteen.	1	5)	5)	5)	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
5points possible this page

Formatted: Widow/Orphan control
Formatted: Normal, Indent: Left: 0", First line: 0", Right: 0"
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Left, Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Normal, Right: 0", Line spacing: single, No bullets or numbering
Formatted: Right: 0", Line spacing: single, Widow/Orphan control
Formatted: Normal, Right: 0", Line spacing: single, No bullets or numbering
Formatted: Right: 0", Line spacing: single, Widow/Orphan control
Formatted: Normal, Right: 0", Line spacing: single, No bullets or numbering
Formatted: Right: 0", Line spacing: single, Widow/Orphan control
Formatted ...
Formatted ...
Formatted ...
Formatted: Space After: 0 pt, Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Left, Widow/Orphan control
Formatted: Right: 0", Widow/Orphan control
Formatted: Widow/Orphan control, Tab stops: Not at 8.13"
Formatted: Right: 0", Widow/Orphan control
Formatted: Widow/Orphan control
Formatted: Widow/Orphan control, Tab stops: Not at 5.44"
Formatted ...
Formatted ...

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
C. All program policies and procedures shall be contained in a manual that is located at each certified site and that shall be available to staff and volunteers. The policies and procedures shall contain, but not be limited to, the following:					
1) Program Mission and Philosophy Statement	1	1)____	1)____	1)____	
2) Program Description, objectives, and evaluation plan.	1	2)____	2)____	2)____	
3) Admission and Re-admission	1	3)____	3)____	3)____	
4) Intake Services	1	4)____	4)____	4)____	
5) Discharge Services	1	5)____	5)____	5)____	
6) Recovery Services	1	6)____	6)____	6)____	
7) Individual and Group Sessions	1	7)____	7)____	7)____	
8) Alumni involvement and Use of volunteers	1	8)____	8)____	8)____	
9) Recreational activities	1	9)____	9)____	9)____	
10) Detoxification Services (if applicable)	1	10)____	10)____	10)____	
11) Program administration and personnel practices	1	11)____	11)____	11)____	
12) Client grievances/complaints	1	12)____	12)____	12)____	
13) Evidence of fiscal practices and budget mechanisms	1	13)____	13)____	13)____	
14) Continuous quality improvement	1	14)____	14)____	14)____	
15) Client rights	1	15)____	15)____	15)____	
16) Medical policies	1	16)____	16)____	16)____	
17) Nondiscrimination in provision of employment and services;	1	17)____	17)____	17)____	
18) Community Relations	1	18)____	18)____	18)____	
19) Confidentiality	1	19)____	19)____	19)____	
20) Maintenance of program in a clean, safe, and sanitary physical environment;	1	20)____	20)____	20)____	
21) Maintenance and disposal of client files	1	21)____	21)____	21)____	
22) Drug screening	1	22)____	22)____	22)____	
23) Staff code of conduct as specified in section 13020 of these Standards	1	23)____	23)____	23)____	
24) Client code of conduct	1	24)____	24)____	24)____	
25) Care Coordination/Case Management	1	25)____	25)____	25)____	
26) Continuing Services	1	26)____	26)____	26)____	
27) Cultural Competency Program around CLAS standards	1	27)____	27)____	27)____	
28) All NTP/OTP medical policies shall conform to CCR, Title 9, Division 4, Chapter 4 with regard to medication practices	1	28)____	28)____	28)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores. 28 points possible this page

Criteria	IV. Office Management Reviewer Guidelines (Continued)

Formatted: Left, Right: 0", Add space between paragraphs of the same style, Widow/Orphan control
Formatted: Right: 0", Add space between paragraphs of the same style, Widow/Orphan control
Formatted: Normal
Formatted: Normal, Indent: Left: 0", First line: 0", Right: 0"
Formatted: Normal
Formatted: Normal, Indent: Left: 0", First line: 0"
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Add space between paragraphs of the same style, Line spacing: single, Widow/Orphan control
Formatted: Add space between paragraphs of the same style, Line spacing: single, Widow/Orphan control
Formatted: Add space between paragraphs of the same style, Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Space Before: 0 pt, Line spacing: single, Widow/Orphan control
Formatted: Space Before: 0 pt, Line spacing: single, Widow/Orphan control
Formatted ...
Formatted ...
Formatted ...
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted ...
Formatted ...
Formatted ...
Formatted: Normal, No bullets or numbering
Formatted ...
Formatted ...
Formatted: Right: 0", Widow/Orphan control
Formatted: Left, None, Don't keep with next
Formatted: Left

D. There is 24-hour access to interpreter services for non-or limited-English proficient (LEP) members.	**D1.** All sites must provide 24-hour interpreter services for all members either through telephone language services or interpreters on site. Site personnel used as interpreters have been assessed for their medical interpretation performance skills/capabilities. ***Note:*** https://lep.gov/commonly-asked-questions **D2.** • If bilingual staff are asked to interpret or translate, they should be qualified to do so. Assessment of ability, training on interpreter ethics and standards, and clear policies that delineate appropriate use of bilingual staff, staff or contract interpreters and translators, will help ensure quality and effective use of resources. • Those utilizing the services of interpreters and translators should request information about certification, assessments taken, qualifications, experience, and training. Quality of interpretation should be a focus of concern for all recipients. • Family or friends should not be used as interpreters, unless specifically requested by the member. • ACA 2010 § 1557: prohibits from using low-quality video remote interpreting services or relying on unqualified staff, translators when providing language assistance services. • A request for or refusal of language/interpreter services must be documented in the member's medical record.
E. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.	Copies of the following should be available to beneficiaries: 1) Statement of nondiscrimination, 2) PHC grievance phone number and packet, 3) Appeal process for involuntary discharge, 4) Program rules and expectations
F. Group sign in sheets include the printed names, signatures, dates, start and end times and topic of discussion.	Sign in sheets MUST include all of these components: 1) Printed name and signature of the client 2) Printed name, title and signature of the counselor 3) Date of session 4) Start and end times 5) Topic
G. Counseling Groups consist of between 2 and 12 clients.	The Counseling Group must consist of between 2 and 12 clients per Title 22: "(B) For day care habilitative services, group counseling shall be conducted with no less than two and no more than twelve clients at the same time, only one of whom needs to be a Medi-Cal beneficiary."
H. Services offered to the American Indian/ American Native population	The Program shall ensure the availability of culturally competent AOD prevention, treatment, and recovery services to the site's American Indian/American Native population
I. Services offered/members referred to Mental Health Programs for Co-occurring disorder clients	Does the Program provide Co-occurring disorder clients with coordinated/integrated care for both their mental health and substance abuse conditions? If yes, what mechanisms are used to provide this service? o (a) MOU with mental health Program(s) o (b) Referral to COD Program o (c) Co-case management with mental health Program o (d) Provide both mental health and substance abuse treatment at a substance abuse program

Formatted: Normal, No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Left, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control

IV. Office Management

RN/MD/LPHA Review only

Office Management Survey Criteria	Wt	Yes	No	NA	Score
D. There is 24 hour access to interpreter services for non- or limited English proficient (LEP) members. 22 CCR §53751; 27 CCR 1300.67.04					
1) Interpreter services are made available in identified threshold languages specified for location of site.	1	1)____	1)____	1)____	
2) Persons providing language interpreter services, including sign language on site, are trained in medical interpretation.	1	2)____	2)____	2)____	
E. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries.					
1) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay	1	1)____	1)____	1)____	
2) Complaint process and grievance procedures	1	2)____	2)____	2)____	
3) Appeal process for involuntary discharge	1	3)____	3)____	3)____	
4) Program rules and expectations	1	4)____	4)____	4)____	
F. Group sign in sheets include required elements below:	1				
1) Printed name and signature of the client	1				
2) Printed name, title and signature of the counselor	1	1)____	1)____	1)____	
3) Date of session	1	2)____	2)____	2)____	
4) Start and end times	1	3)____	3)____	3)____	
5) Topic		4)____	4)____	4)____	
		5)____	5)____	5)____	
G. Counseling Groups consist of between 2 and 12 clients.	1	1)____	1)____	1)____	
H. Program offers services to the American Indian/ American Native population	1	1)____	1)____	1)____	
I. Services offered/members referred to Mental Health Programs for Co-occurring disorder clients	1	1)____	1)____	1)____	

Formatted ...

Office Management Survey Criteria	Wt	Yes	No	NA	Score
Comments: Write comments for all "No" (0 points) and "N/A" scores. 14 points possible for this page 60 points possible for section Total					

Criteria	V. Perinatal Services Reviewer Guidelines
A. Relevant services offered to perinatal patients.	Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include: 1) Mother/child rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Evidence of coordination of ancillary services in the case management note.
B. Daycare facilities are available to Outpatient Perinatal Patients.	In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment.
C. Perinatal/Pediatric Patient Care	Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.

Formatted: Normal
Formatted: Normal, Indent: Left: 0", First line: 0", Right: 0"
Formatted: Normal
Formatted: Normal, Indent: Left: 0", First line: 0"
Formatted: Right: 0", Widow/Orphan control
Formatted: Left, Add space between paragraphs of the same style, Line spacing: single, Widow/Orphan control
Formatted: Add space between paragraphs of the same style, Line spacing: single, Widow/Orphan control
Formatted: Line spacing: single, Widow/Orphan control
Formatted: Left, None, Don't keep with next
Formatted: Left
Formatted: Normal, No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, No bullets or numbering
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control
Formatted: Normal, Right: 0", No bullets or numbering
Formatted: Widow/Orphan control

IXV. Perinatal Services

RN/MD/LPHA Review only

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
A. These standards apply to programs who provide SUD treatment to pregnant and parenting women, which includes: Pregnant women; Women with dependent children; Women attempting to regain custody of their children; Postpartum women and their children; or Women with substance exposed infants					
~~A. Relevant services offered to perinatal patients.~~ ~~Per Title 22 (page 11-12 Documentation, Modalities, and Services) these services must be offered to perinatal patients under DMC-ODS services. Relevant services include:~~	1	1)____	1)____	1)____	
1) The Program publicizes that pregnant women are given preference in admission to recovery and treatment programs and encourage women in need of treatment services to access them ~~Mother/child rehabilitative services.~~	1	2)____	2)____	2)____	
2) Does the Program adhere to priority admission requirements as follows: a. Pregnant injecting drug users b. Pregnant substance abusers c. Injecting drug users d. All Others	1	3)____	3)____	3)____	
3) The program shall admit IV drug users within 14 days of request or provide interim services and admit within 120 days~~Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant.~~ ~~3) Evidence of coordination of ancillary services in the case management note.~~					

Formatted: Right: 0", Add space between paragraphs of the same style, Widow/Orphan control

Formatted: Font: 11 pt

Formatted: List Paragraph, Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: A, B, C, … + Start at: 1 + Alignment: Left + Aligned at: 0" + Indent at: 0.25"

Formatted Table

Formatted: List Paragraph, Space Before: 0 pt

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.25", No bullets or numbering

Formatted: List Paragraph, Space Before: 0 pt

Formatted: Space Before: 6 pt

Formatted: List Paragraph, Space Before: 6 pt, Numbered + Level: 1 + Numbering Style: a, b, c, … + Start at: 1 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: List Paragraph, Indent: Left: 0.75", Space Before: 6 pt

Formatted: Font: Times New Roman, 11 pt

Formatted: List Paragraph, Right: 0", Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Formatted: List Paragraph, Indent: Left: 0"

Formatted: Font: Courier, 12 pt

Formatted: List Paragraph, Indent: Left: 0", Right: 0", Space Before: 0 pt

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
B. The Program shall have in place policies, procedures, and practices to support the provision Interim services within their program(s)					
1) Pregnant women receiving interim services shall be placed at the top of the waiting list for program admission	1	1)____	1)____	1)____	
2) The Program shall make interim services available, either on-site or by referral, within 48 hours for those individuals who are in need of treatment and who cannot be admitted within 14 days of their request for treatment	1	2)____	2)____	2)____	
3) The Program shall have an established waiting list that includes a unique patient identifier for injecting drug users seeking treatment, including patients receiving interim services while awaiting admission	1	3)____	3)____	3)____	
4) The Program shall maintain contact with individuals awaiting treatment admission	1	4)____	4)____	4)____	
~~B.~~5) The Program shall ensure that Injection drug-using women must be admitted within 14 days after request or within 120 days if interim services are provided~~Daycare facilities are available to Outpatient Perinatal Patients.~~	1	5)____	5)____	5)____	

Formatted: Font: Bold
Formatted: Font: 10 pt
Formatted: Font: Bold
Formatted: Indent: Left: 0.25", No bullets or numbering
Formatted: Font: Not Bold
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 10 pt
Formatted: Indent: Left: 0.5", No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 10 pt
Formatted: Normal, No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Font: 10 pt
Formatted: Normal, No bullets or numbering
Formatted: Font: 10 pt
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"
Formatted: Normal, No bullets or numbering
Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 0.25" + Indent at: 0.5"

Perinatal Services Survey Criteria	Wt	Yes	No	NA	Score
C. The Program shall:					
1) The Program shall make referrals based on individual assessments, such as 12 step groups, housing support, food and legal aid, case management, children's services, medical service and social services	1	1)____	1)____	1)____	
2) The Program shall ensure that child care is provided on-site for participants' children between birth and 36 months while the mothers are participating in the program.	1	2)____	2)____	2)____	
3) Program has a policy that addresses therapeutic intervention for children of the women receiving SUD treatment services to address the child's: Developmental needs, Sexual Abuse, physical abuse and neglect.	1	3)____	3)____	3)____	
4) Program shall ensure Perinatal /Pediatric Patient Care is available	1	4)____	4)____	4)____	
5) Program shall provide or arrange for sufficient case management	1	5)____	5)____	5)____	
6) Program shall provide or arrange for primary medical care for women in treatment	1	6)____	6)____	6)____	
7) Program shall provide or arrange for primary pediatric care	1	7)____	7)____	7)____	
8) Program shall provide or arrange for transportation	1	8)____	8)____	8)____	
9) Program shall maintain a vehicle log	1	9)____	9)____	9)____	
10) Program shall provide or arrange therapeutic interventions for children	1	10)____	10)____	10)____	
11) Program shall program shall provide or arrange for required services	1	11)____	11)____	11)____	
C. Perinatal/Pediatric Patient Care					
Comments: Write comments for all "No" (0 points) and "N/A" scores. 11 points possible this page 19 points possible for this section Total					

Comments: Write comments for all "No" (0 points) and "N/A" scores.
5 points possible this page

Formatted: Left

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
D.) Pregnant women are given preference in admission to recovery and treatment programs	1	1)____	1)____	1)____	
E.) Pregnant women are referred for interim services within 48 hours if a treatment slot is not available	1	2)____	2)____	2)____	
F.) Pregnant women who are waitlisted are referred to other programs	1	3)____	3)____	3)____	
G.) Injection drug-using pregnant women are admitted or interim services are provided	1	4)____	4)____	4)____	
H.) Child care is provided on-site for participants' children	1	5)____	5)____	5)____	
I.) Referrals are made based on individual assessments	1	6)____	6)____	6)____	
	1	7)____	7)____	7)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 points possible this page

Criteria	V. Perinatal Reviewer Guidelines
D. Provide or arrange for sufficient case management	The Program shall provide or arrange for sufficient case management to ensure that women and their children have access to primary medical care, pediatric care, and other needed services

K. Provide or arrange for primary medical care for women in treatment	The Program shall provide or arrange for primary medical care for women in treatment, including referrals for prenatal care.
L. Provide or arrange for primary pediatric care	The Program shall provide or arrange for primary pediatric care, including immunizations, for dependent children. Programs providing direct primary medical care for women and/or primary pediatric care for dependent children must seek alternative funding for these services before using federal perinatal funds. Medi-Cal, Medicare and other health insurance must be billed first, and programs using federal perinatal funds must document that alternative funding is not available. Programs may use client fees. State General Funds cannot be used to provide medical treatment.
M. Provide or arrange for transportation	The Program provides or arranges for transportation to and from the recovery and treatment site, and to and from ancillary services or women in need of transportation.
N. Vehicle log is maintained	The Program shall ensure a vehicle log is maintained
O. Provide or arrange therapeutic interventions for children	The Program shall provide or arrange therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.
P. Program shall provide or arrange for required services	The Program shall provide or arrange for the following services: (a) Educational/vocational training and life skills resources (b) TB and HIV education and counseling (c) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information

V. Perinatal Services

RN/MD/LPHA Review only

Perinatal Survey Criteria	Wt	Yes	No	NA	Score
J.) Provide or arrange for sufficient case management	1	1)	1)	1)	
K.) Provide or arrange for primary medical care for women in treatment	1	2)	2)	2)	
L.) Provide or arrange for primary pediatric care	1	3)	3)	3)	
M.) Provide or arrange for transportation	1	4)	4)	4)	
N.) Vehicle log is maintained	1	5)	5)	5)	
O.) Provide or arrange therapeutic interventions for children	1	6)	6)	6)	
P.) Program shall provide or arrange for required services	1	7)	7)	7)	
Comments: Write comments for all "No" (0 points) and "N/A" scores.					

7 points possible this page
19 points possible for this section
Total

VI. Pharmaceutical/Laboratory

RN/MD Review only

Pharmaceutical/Laboratory Services Survey Criteria	Wt	Yes	No	NA	Score
A. Drugs and medication supplies are maintained securely to prevent unauthorized access. CA B&P Code §4051.3, §4071, §4172; 22 CCR §75037(a-g), §75039; 21 CFR §1301.75, §1301.76, §1302.22					
1) Drugs are stored in specifically designated cupboards, cabinets, closets, or drawers.	**1**	1)____	1)____	1)____	
2) Controlled drugs are stored in a locked space accessible only to authorized personnel.	**1**	2)____	2)____	2)____	
3) A dose-by-dose medication log is maintained.	**1**	3)____	3)____	3)____	
4) There are no expired medications on site.	**1**	4)____	4)____	4)____	
5) Site has a procedure to check expiration date and a method to dispose of expired medications.	**1**	5)____	5)____	5)____	
6) Site has a procedure to check expiration date and a method to dispose of expired lab test supplies.	**1**	6)____	6)____	6)____	
~~6)~~7) Site has appropriate process for handling Sharps	**1**	7)____	7)____	7)____	
~~7)~~8) For MAT Treatment Only: Where medications are a part of the beneficiary's treatment, provider practices conform to medical policies with regard to different dosing levels, administration and take home practices.	1	8)____	8)____	8)____	

Comments: Write comments for all "No" (0 points) and "N/A" scores.
7 Points possible for this section

Total

Formatted

Formatted: Font: Times New Roman, 11 pt

Formatted: Indent: Left: 0.5", Right: 0", Space Before: 0 pt, No bullets or numbering

Formatted: Font: Not Bold

Formatted: Centered

Formatted: Left

Reviewer Comments:

If more than one Reviewer, both must sign here.

Reviewer Signature: _____ Reviewer Signature: _____

Reviewer Name: _____ Reviewer Name: _____

Reviewer Title: _____ Reviewer Title: _____

Medical Record Review Survey
Substance Use Disorder (SUD) Treatment Services

No. of Records: _____

Facility Name		**Site ID**		**Date of Review**	
Full Address		**Phone**		**Fax**	
Contact Name/Title			**Email**		
Reviewer Name/Title					

Visit Purpose		**Clinic Type/Level of Care**
☐ **Initial Full Scope** ☐**Monitoring** ☐ **Periodic Full Scope** ☐**Follow-up** ☐ **Focused Review** ☐**Ed/TA** ☐ **Other** _____ **(type)**		☐ Outpatient (1) ☐ Perinatal Outpatient (1) ☐ Intensive Outpatient (2.1) ☐ Intensive Perinatal Outpatient (2.1) ☐ Youth/Adolescent If Youth services are offered in conjunction with regular services, at least 50% of charts must be that modality Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 Perinatal Residential ☐3.1 ☐3.3 ☐3.5 ☐3.7 ☐4.0 ☐ Withdrawal Management. (3.2) ☐ OTP/NTP If Perinatal services are offered in conjunction with regular services, at least 50% of charts must be that modality

Purpose: Medical Record Review Guidelines provide standards, directions, instructions, rules, regulations, perimeters, or indicators for the medical record survey; and shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Medical Record Review for Substance Use Disorder (SUD) Treatment Services

California Department of Health Care Services
Medi-Cal Managed Care Division

Scoring: Survey score is based on a review standard of 10 records per Licensed Practitioner of the Healing Arts (LPHA). Documented evidence found in the hard copy (paper) medical records and/or electronic medical records are used for survey criteria determinations. An Exempted Pass is 90%. Conditional Pass is 80-89%. Not Pass is below 80%. The minimum passing score is 80%. A corrective action plan (CAP) is required for a total MRR score below 90%. Also, any section score of less than 80% requires a CAP for the entire MRR, regardless of the total MRR score. Not applicable ("N/A") applies to any criterion that does not apply to the medical record being reviewed, and must be explained in the comment section. Medical records shall be randomly selected using methodology decided upon by the reviewer. Ten (10) medical records are surveyed for each LPHA. Sites where documentation of patient care by all LPHA on site occurs in universally shared medical records shall be reviewed as a "shared" medical record system. Scores calculated on shared medical records apply to each LPHA sharing the records. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled "□ □ **RN/MD/LPHA Review only".**

Directions: Score one point if criterion is met. Score zero points if criterion is not met. Do not score partial points for any criterion. If 10 shared records are reviewed, score calculation shall be the same as for 10 records reviewed for a single LPHA. Multiply by 100 to calculate percentage rate. Reviewers have the option to request additional records to review, but must calculate scores accordingly. Reviewers are expected to determine the most appropriate method(s) on each site to ascertain information needed to complete the survey.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2**: Add points given for all nine (9) sections. (Format points given) (Intake Services points given) (Care Planning Guidelines – treatment plans – NTP Only points given) (Care Planning Guidelines – Problem Lists – All LOC *except NTP* points given) (Treatment Services points given) (Discharge Services points given) (Care Coordination Services points given) (Residential Services points given) (Perinatal/Family Services points given) **= (Total points given)**
Step 3: Subtract the "N/A" points from total points possible. (Total points possible) – (N/A points) = ("Adjusted" total points possible)	**Step 4**: Divide total points given by the "adjusted" points possible, then multiply by 100 to calculate percentage rate. Total points given / "Adjusted" total points possible Example: 267 / 305 = 0.875 X 100 = **88%**

This page left blank

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	**AOD 12020**, "A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies."
B. Chart contents are securely fastened and consistently organized.	Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per PHC requirements.

I. Format Criteria

Criteria Met=Yes **Criteria not Met=No** **Not applicable= N/A**		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
Age/Gender												
Admission Date												
Discharge Date												
A. An individual medical record is established for each member.	**1**											
B. Chart contents are securely fastened and consistently organized.	**1**											

Comments:

Criteria	II. Intake Services Reviewer Guidelines
A. Medical record contains a signed Consent to Release Information document.	There is evidence of a Consent to Release Information document signed and in the client file for review. This is per **42 CFR.** A signed release of information (ROI) is present and includes Partnership HealthPlan, the County, and entities that assist in the coordination of care indicated in the treatment plan.
B. Medical record contains signed HIPAA notification.	There is evidence of a HIPAA (Health Information Portability and Accountability Act) notification signed and in the client file for review.
C. Medical record contains signed Client Rights document.	There is evidence of a Client's Rights document available in the client file for review.
D. Medical record contains signed Consent to Treatment document.	The beneficiary shall sign a consent for treatment form.
E. Medical record contains signed Program Rules document.	There is evidence of a Program Rules document signed and in the client file for review.
F. Medical record contains signed admission agreement.	There is evidence of an Admission Agreement and in the client file for review.
G. Medical record contains evidence of Medi-Cal/Partnership eligibility verification.	There is evidence of Partnership or Medi-Cal eligibility in the client file for review.
H. Medical record contains a documented physical exam.	A physical exam must be in documented in the patient's chart within 30 days of admission into program. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician, PA, or Nurse Practitioner (N.P.). b. **OR** c. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). d. Contact Partnerships Care Coordination (CC) team to assist the member with establishing a PCP provider that will be able to perform the necessary physical exam. • Perinatal Patients o Physician shall review the most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12 month period prior to the admission date. • Alternatively, a physician or non-physician medical practitioner may perform a physical examination within 30 calendar days of admission. 22 CCR § 51303, 42 CFR § 438.210(a)(4) **PHC contract states if client has not been seen in longer than 6 months, client will be referred to Partnerhsip Care Coordination department to aid in receiving medical care.**

I. Medical Record indicates MAT services were offered or member was referred	
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	

II. Intake Services

Criteria Met=Yes **Criteria not Met=No** **Not applicable= N/A** **Criteria met: Give one (1) point.** **Criteria not met: 0 points** **Criteria not applicable: N/A**		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Medical record contains a signed Consent to Release Information document.	**1**											
B. Medical record contains signed HIPAA notification.	**1**											
C. Medical record contains signed Client Rights document.	**1**											
D. Medical record contains signed Consent to Treatment document.	**1**											
E. Medical record contains signed Program Rules document.	**1**											
F. Medical record contains signed Admission Agreement.	**1**											
G. Medical record contains evidence of Medi-Cal/Partnership eligibility verification.	**1**											
H. Medical record contains a documented physical exam within 30 days of admission.	**1**											
I. Medical Record indicates MAT services were offered or member was referred	**1**											
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	**1**											

Comments:

Criteria	II. Intake Services Reviewer Guidelines (Continued)
K. Appropriate documentation of admission and readmission criteria.	Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
L. Medical Necessity determined appropriately.	Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. **Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i.** *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. For beneficiaries 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. For beneficiaries under 21 years of age, a service is deemed medically necessary if the service can improve or correct a screened health condition, such as SUD. The service does not have to correct the issue. It can sustain, support, improve or make the condition more tolerable to be necessary. These services are covered under Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. **The diagnosis and medical necessity determination shall be completed within 30 calendar days of the first face-to-face interaction. Medical necessity determination for homeless patients shall be completed within 60 days.**
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	There must be documentation from the facility to the client for engagement in treatment. Medical record contains documentation of missed/excused group sessions and/or individual counseling sessions.
N. Medical record contains evidence the provider accepts proof of eligibility as payment.	**Per Title 22,** providers must accept proof of Medi-Cal/Partnership eligibility as payment in full for treatment services rendered upon intake and monthly. **NOTE**: This is ***except*** when there is a share of cost (SOC).
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	• • American Society of Addiction Medicine (ASAM) Criteria shall be documented by the diagnosing individual (Medical Director or LPHA) and used to determine placement and level of services needed. Adults must meet the ASAM criteria definition of medical necessity for services. • Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. • The assessment shall include a typed or legibly printed name of the service provider, provider signature , provider title (or credentials), and date of signature- • Assessments shall be updated as clinically appropriate, or as needed if the member's condition changes • For adolescent clients, a developmentally appropriate ASAM tool shall be used • RESIDENTIAL ASAM Criteria Assessment is required before a DMC-ODS plan authorizes a residential treatment level of care. **AUTOMATIC CAP IF ASAM IS NOT COMPLETED
P. Medical record contains evidence of appropriate documentation during intake.	The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.

II. Intake Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
K. Appropriate documentation of admission and readmission criteria.	**1**											
L. Medical Necessity is determined appropriately.	**1**											
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	**1**											
N. Medical record contains evidence the provider accepts proof of eligibility as payment.	**1**											
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	**1**											
P. Medical record contains evidence of appropriate documentation during intake.	**1**											

Comments:

Criteria	III. Care Planning Guidelines – Treatment Plans – NTP ONLY
A. Medical record contains the most recent Treatment Plan.	The most recent treatment plan must be in the file.
B. Medical record contains a legibly signed treatment plan during appropriate timeframe.	**Signature:** If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within ***15 calendar days*** of being signed by the counselor. Withdrawal Management within one business day of admission. • It must be signed by the beneficiary (client) and the counselor within ***30 days*** of admission to treatment. • IF the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. **Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment.** **Legibility:** means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.

C. Treatment plan is client specific and AOD 7110 compliant.	Per **Title 22**, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished.
	• Statement of problems
	• Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed
	  • Action steps should include: Target dates
	  • Type and frequency of counseling/services
	  • Diagnosis as documented by the Medical Director or LPHA
	  • Assignment of primary therapist or counselor
	  • Documentation of physical exam requirements
	  • Documentation demonstrates the client played an active role in creating the treatment plan.
	  • Recovery/discharge plan is part of ongoing treatment plan goals.
	• **Timeframe:** Within 30 calendar days from beneficiary's admission to treatment

A. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	The Ongoing Treatment Plan must be: • Completed with 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per Title 22, It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment. Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.

III. Care Planning Guidelines – Treatment Plans – NTP ONLY

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Medical record contains the most recent Treatment Plan.	**1**											
B. Medical record contains a legibly signed treatment plan during appropriate timeframe.	**1**											
C. Treatment plan is client specific and AOD 7110 compliant.	**1**											
D. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	**1**											

Comments:

Criteria	III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)
A. A problem list is established for each patient	The problem list supports the medical necessity of each service provided.
B. Problem list includes all the required elements	The problem list includes a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through the assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include all of the following, but is not limited to: A diagnosis given by a LPHA. Should include specifiers from the DSM, if applicable. Problems identified by provider acting within their scope of practice, if any. Problems or illness provided by client or significant support person, if any. Name and title of provider who identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
C. Problem list is updated in a reasonable time frame	Any problems identified during a subsequent intervention may be added to the problem list. Problems should be updated on an ongoing basis when there is a relevant change. Provider is required to update when problems change and in a reasonable time.

III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. A problem list is established for each client	**1**											
B. Problem list includes all the required elements	**1**											
C. Problem list is updated in a reasonable time frame	**1**											

Comments:

Criteria	IV. Treatment Services Reviewer Guidelines
A. Counseling session attendance is appropriately documented in the chart.	According to **AOD 8000 c. 1-4,** "The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client's treatment plan or recovery plan goals". This is also illustrated in **§ 51341.1. Drug Medi-Cal Substance Use Disorder Services.**22 CA ADC § 51341.1
B. Progress notes contain the minimum required documentation according to Tittle 22 and AOD 7100b.	For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b. Per **Title 22 and AOD 7100 b**, LPHA or Counselor must have these elements in their progress notes for **all** patients enrolled in outpatient services: 1) Topic of the session 2) Description of beneficiary's progress toward treatment plan goals 3) Date of each treatment service 4) Start and end time of each treatment service 5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within 3 days of the session** 6) Identifies if the service was in-person, telephone or telehealth 7) Location of service and how confidentiality was maintained (if provided in the community) is clearly documented 8) If case management services are provided, additional criteria of: a description of how the services relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referral. 9) For Crisis services, documentation must be completed within 24-hours of incidence.
C. There is evidence of at least two Evidence Based Practices (EBPs) being used and documented in the progress notes	Intergovernmental Agreement Exhibit A, Attachment I Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • **Motivational Interviewing**: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • **Cognitive- Behavioral Therapy**: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. • **Trauma-Informed Treatment**: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice, and control. • **Psycho-Education:** Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. • **Relapse Prevention:** A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.

IV. Treatment Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Counseling session attendance is appropriately documented in the chart.	**1**											
B. Progress notes contain the minimum required documentation according to Title 22 and AOD 7100b.BHIN 23-068												
1) Topic of the session	**1**											
2) Description of beneficiary's progress toward treatment plan goals.	**1**											
3) Date of each treatment service.	**1**											
4) Start and end time of each treatment service.	**1**											
5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) **within 3 days of the session**	**1**											
6) Identifies if the service was in-person, telephone or telehealth	**1**											
7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented	**1**											
C. There is evidence of at least two Evidence Based Practices (EBPs) being used.	**1**											

Comments:

Criteria	IV. Treatment Services Reviewer Guidelines (Continued)
H. Medical record contains evidence of the required number of monthly counseling sessions.	Per **Title 22 and AOD standards:** Outpatient - two individual or group counseling sessions each month Intensive Outpatient – progress note for each session Residential –daily When applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within 3 days There is evidence of the required number of counseling hours for each LOC. (OP 9 hours or less a week, IOP more than 9 hours a week, Residential: WM: NTP
I. Progress notes contain a narrative of treatment plan progress, goals, and action steps.	Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps. The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.
J. Program provides individual and group counseling sessions to clients.	According to AOD 8000 a., "The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client's treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients' needs."
K. Medical record contains evidence of provider coordination of care	Both the discharging and admitting PROVIDER agencies shall ensure the transition to appropriate LOC. This may include a step-up or step-down in DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary. Provider Agencies shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services A warm hand off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

IV. Treatment Services (Continued)

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
H. Medical record contains evidence of the required number of monthly counseling sessions.	**1**											
I. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps.	**1**											
J. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	**1**											
K.. Medical record contains evidence of provider coordination of care to ensure smooth transitions between LOCs	**1**											

Comments:

Criteria	V. Discharge Services Reviewer Criteria
A. Discharge plan or Discharge Summary is documented in the chart	Per **Title 22:** "A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact." If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: • A description of each of the beneficiary's relapse triggers. • A plan to assist the beneficiary to avoid relapse when confronted with a trigger • A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the patient and the counselor	During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the patient and shall be documented in the patient's record. **This is N/A if the provider loses contact with the client.**
C. Discharge plan or summary shall include the following elements.	This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit. According to **AOD 7120 b. ,** A discharge summary shall include the following elements: 1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program; 2) Description of treatment episodes; 3) Description of recovery services completed 4) Current alcohol and/or other drug usage 5) Vocational and educational achievement 6) Client's continuing recovery or discharge plan signed by counselor and client 7) Transfers and referrals 8) Client's comments 9) Beneficiary's prognosis 10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.

IV. Discharge Services

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	Score
A. Discharge plan or Discharge Summary is documented in the chart	**1**											
B. The discharge plan is signed by both the patient and the counselor	**1**											
C. Discharge plan or summary shall include the following elements: elements												
1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;	**1**											
2) Description of treatment episodes;	**1**											
3) Description of recovery services completed	**1**											
4) Current alcohol and/or other drug usage	**1**											
5) Vocational and educational achievement	**1**											
6) Client's discharge summary signed by counselor and client	**1**											
7) Transfers and referrals	**1**											
8) Client's comments	**1**											
9) Beneficiary's prognosis	**1**											
10) 1 Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	**1**											
11) Medication needs were addressed in the discharge planning	**1**											

Comments:

Criteria	VI. Care Coordination Reviewer Criteria
A. Care coordination shall be provided in conjunction with all levels of treatment.deemed necessary	Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	- Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. - Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. - Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.
C. Clinical Peer to Peer Consultation must be documented with a progress note	Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction Psychiatrists, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to beneficiaries. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.

VI. Care Coordination **Automatic CAP if no or N/A**

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Care coordination shall be provided in conjunction with all levels of treatment deemed necessary	**1**											
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	**1**											
C. Clinical Peer to Peer Consultation must be documented with a progress note	**1**											

Comments:

Criteria	VI. Residential Reviewer Criteria Only if Applicable
A. Medical record contains evidence of prior authorization for services.	Residential Treatment requires a Prior Authorization for services.
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	Evidence of multidimensional LOC assessment is completed within 72 hours of admission is present
C. There is oversight of self-administered medications.	There is documentation present in the chart that illustrates oversight of patient's taking their medication.
D. Medical record contains documentation of a TB test, results, and services offered.	A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client. There has been Tuberculosis (TB) testing done and care received based on results. It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
E. Adult beneficiaries in Residential Treatment shall be re-assessed every 30 days, Youth every 30 days.	Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 30 days, unless there are significant changes warranting more frequent reassessments.

V. Residential

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Medical record contains evidence of prior authorization for services.	**1**											
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	**1**											
C. There is oversight of self- administered medications.	**1**											
D. Medical record contains documentation of a TB test performed, results, and services offered with a diagnosis of TB	**1**											
E. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 30 days	**1**											

Comments:

Criteria	VII. Perinatal/Family Criteria – Only if Applicable
A. Relevant services offered to perinatal patients or clients with families.	1) Mother/child/ family rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Educational/vocational training and life skills resources 4) TB and HIV education and counseling 5) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding (d) Parenting skills-building and child development information 6) Child care is offered for women to receive primary medical care services gender-specific treatment services.
B. Daycare facilities are available to Outpatient Perinatal Patients. .	In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment Program provides/arranges for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's: i. Developmental needs; ii. Sexual abuse; iii. Physical abuse; and Neglect
C. Perinatal/Pediatric Patient Care	Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
E. Interim services have been offered	If client waited more than 48 hours for treatment, indication of the offering of interim services and the outcome of that offering is included in the patients chart
F. IVDU Interim services have been offered	If the patient uses needles, documentation that the patient received expedited admission within 14 days after the request or within 120 days if interim services were provided.
G. Transportation have been offered/provided	Evidence of transportation provided to perinatal, postnatal, or well child appointments indicated within chart
H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	

VII. Perinatal/Family Criteria – Only if Applicable

Age/Gender		MR #1	MR #2	MR #3	MR #4	MR #5	MR #6	MR #7	MR #8	MR #9	MR #10	**Score**
A. Relevant services offered to perinatal patients or clients with families.	**1**											
B. Daycare facilities are available to Outpatient Perinatal Patients.	**1**											
C. Perinatal/Pediatric Patient Care	**1**											
E. Interim services have been offered	**1**											
F. IVDU Interim services have been offered	**1**											
G. Transportation have been offered/provided	**1**											
H. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	**1**											

Comments:

If more than one Reviewer, both must sign here.

Reviewer 1 Signature: _____ Reviewer 2 Signature: _____

Reviewer 1 Name: _____ Reviewer 2 Name: _____

Reviewer 1 Title: _____ Reviewer 2 Title: _____

Reviewer Comments/Notes:

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☒ CBAS ☐ Other	Date of Review: Name of Reviewer:
Address: City:	Health Plan Name: Partnership HealthPlan of CA
Phone: FAX: (	Contact Person Name:
	Level of Access:
Basic Access: Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.	☐ Basic Access
Limited Access: Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.	☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

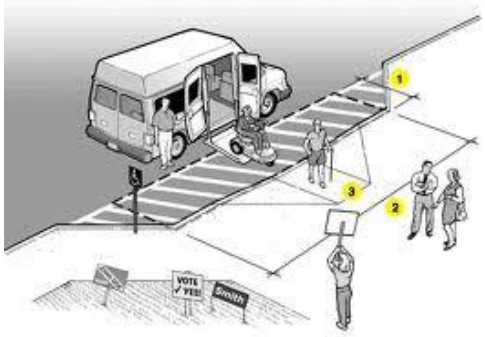
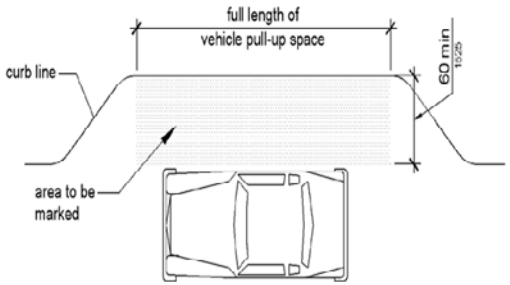
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

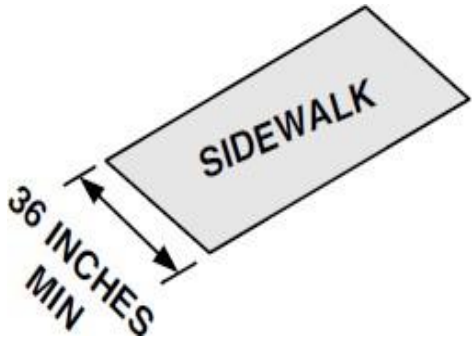
Name: _____ Signature: _____ Date: _____

PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

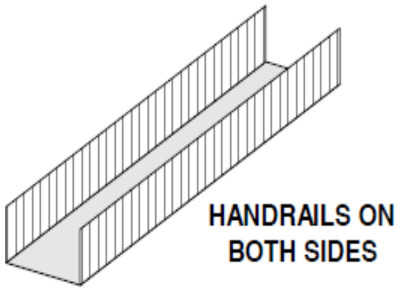
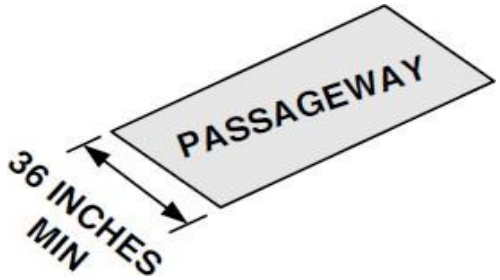
4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

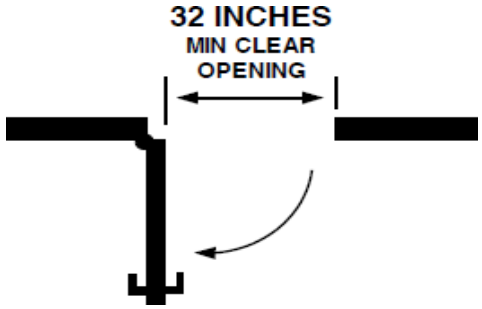
6 (CE)	**Is a passenger loading zone provided with a vehicular pull-up space.**	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

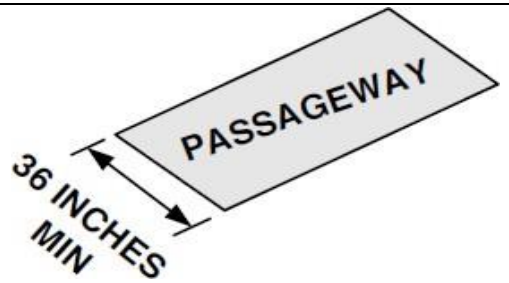
7 (CE)	**Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?**	**Access aisles serving vehicle pull-up *spaces* shall be a minimum of 60 inches wide.**  				
8 (CE)	**Do curbs on the route have curb ramps at the drop off locations?**	**Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.**				

EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)						
9 (CE)	**For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)**	**Self explanatory.**				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)					
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
11	Is the accessible route to the	An example of a stable surface is a floor or				

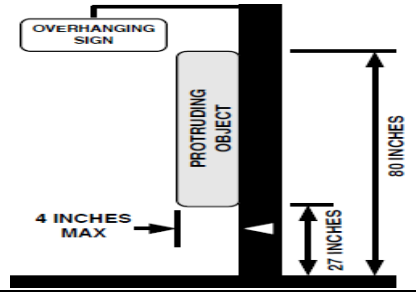
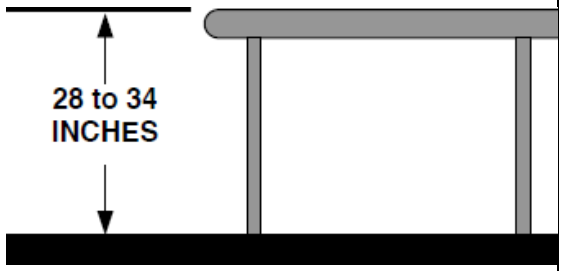
11	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Public Transportation					
	b. Public sidewalk?					
	c. Drop off?					
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				

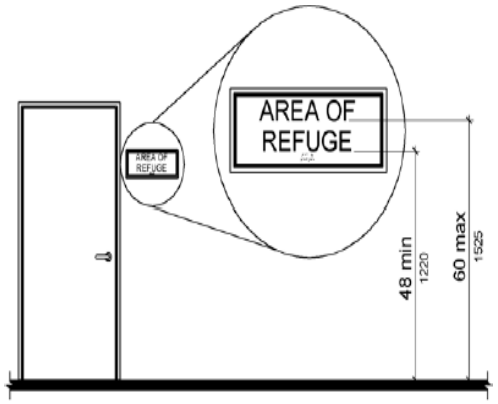
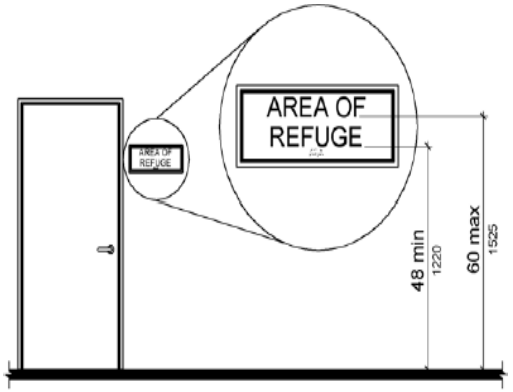
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	**Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?**	**If the ramp is not longer than 6 feet, check N/A.**  				
16 (CE)	**Are all ramps at least 36 inches wide?**	 				

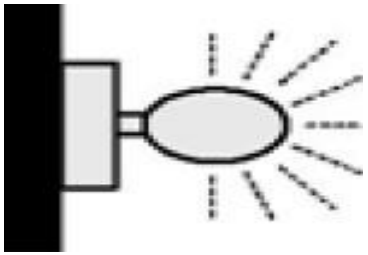
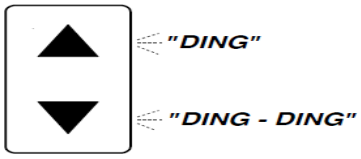
BUILDING ENTRANCE						
17 (CE)	**Is the main entrance accessible?**	**Self explanatory.**				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
20 (CE)	**Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?**	**When measuring double doors, measure the opening with one door open to 90°.** 				

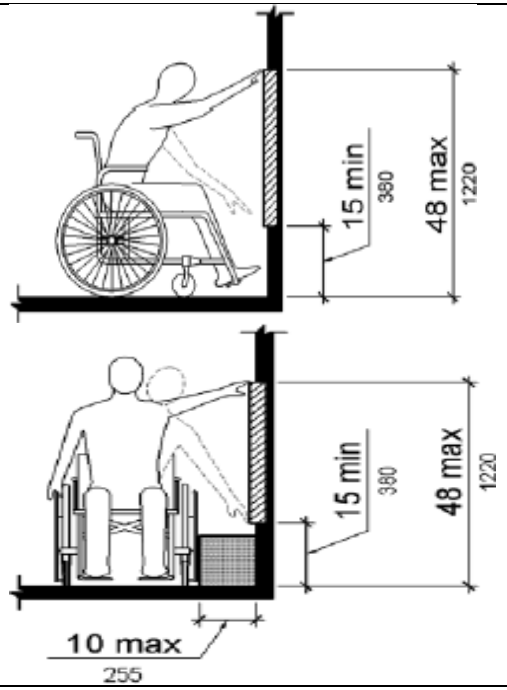
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	**Are <u>ALL</u> interior paths of travel at least 36 inches wide?**					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

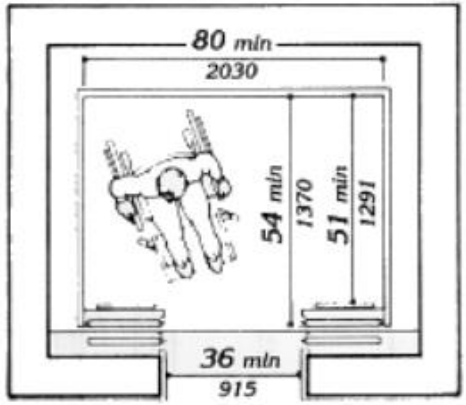
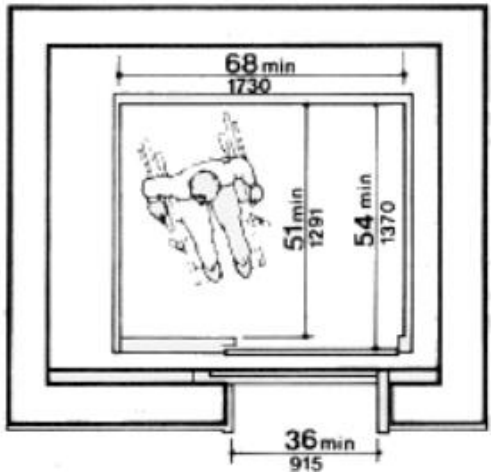
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	**If there are stairs on the accessible route, are there handrails on each side?**	**If there are no stairs, check N/A.**				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it.  				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 				

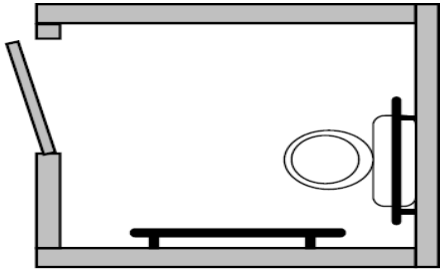
32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

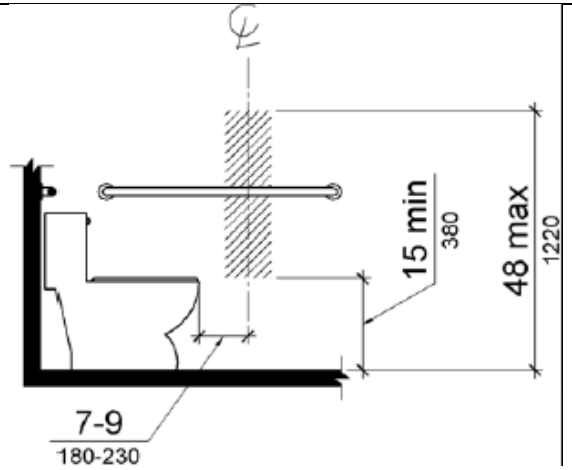
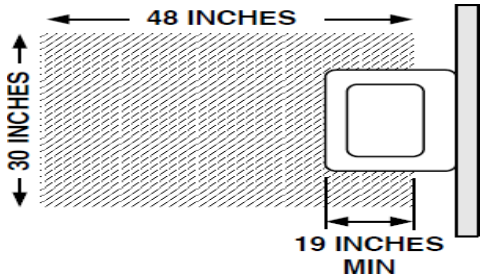
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	**If needed, is the elevator available for public/patient use during business hours?**	**Self explanatory.**				
37 (CE)	**Is the elevator equipped with both visible and audible door opening/closing and floor indicators?**	**A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement.** 				

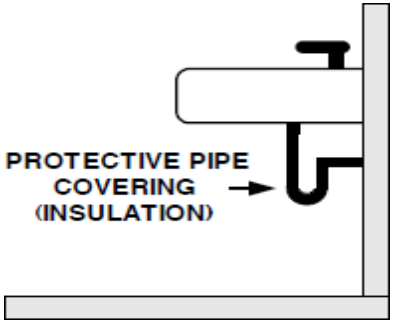
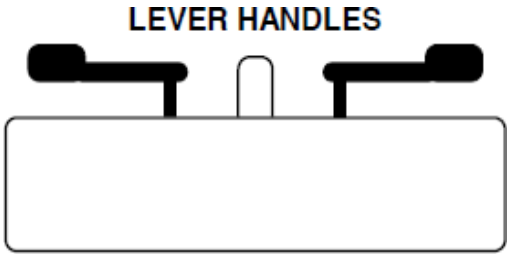
38 (CE)	**Are there raised letter and Braille sign on each side of each elevator jamb?**	**These signs allow everyone to know which floor they are on before entering or exiting the elevator.**				
39 (CE)	**Are the hall call buttons for the elevator no higher than 48 inches from the floor?**					

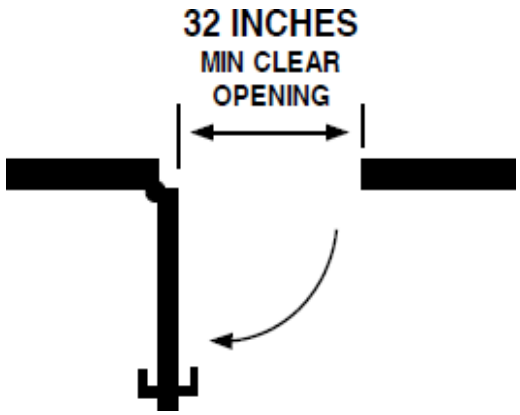
40 (CE)	**Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?**	**The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.**  (a)  				
41 (CE)	**Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?**	**Self explanatory.**				

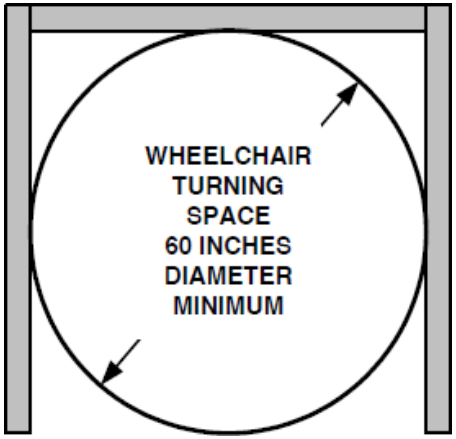
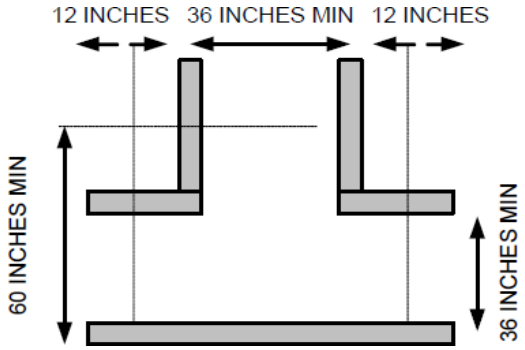
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

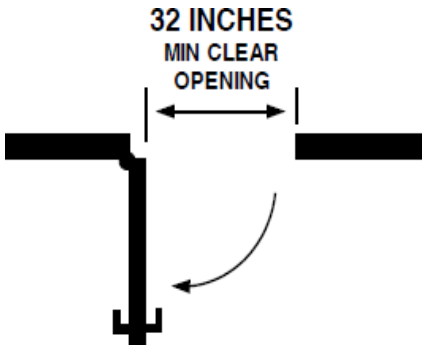
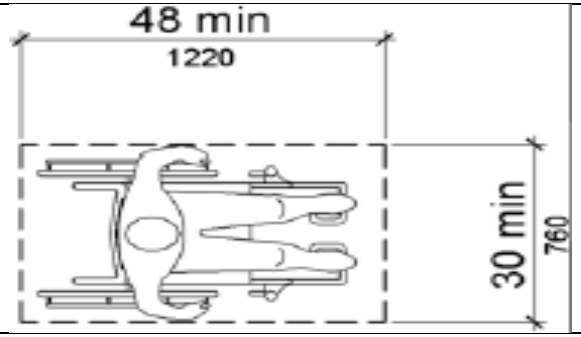
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):						
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	**Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?**	**Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface.** 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	**Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?**					
50 (CE)	**Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?**	**This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath.** 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	**Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)**	**A knob handle would not be accessible.** 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	**Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	**Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?**	 				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	**Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?**					
61 (CE)	**There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:**					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

this page left blank

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 06/16/2004		**Next Review Date: ~~08/14/2025~~06/11/2026** **Last Review Date: ~~08/14/2024~~06/11/2025**		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date: ~~08/14/2024~~06/11/2025**	

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook. ~~N/A~~

IV. ATTACHMENTS:

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

V. PURPOSE:

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

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

Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/16/2004			**Next Review Date: 08/14/202506/11/2026** **Last Review Date: 08/14/202406/11/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

VI. GUIDELINE / PROCEDURE:

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

This guideline recognizes the services and responsibilities of primary care providers (PCPs), pain management and other specialists in caring for members with chronic pain. This guideline is highly dependent upon the individual clinical circumstances and the delivery system. Because of these circumstances, expectations may appropriately deviate from the guideline. The PCP is responsible for coordinating all services required by the patient except when precipitous circumstances preclude the PCP's role. The scope of the responsibility is comprehensive~~,~~ (i.e., all required services including preventive services). The PCP should provide those services, which can be provided within his/her competence, and should obtain consultation when additional knowledge or skills are required. Partnership recognizes that differences in skill levels exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for specialty referral to a pain management specialist. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation.

Consultation includes advice received from a telephone discussion with a specialist, e-consults, telehealth consultations and the referral of a patient to a specialist for services. The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and/or observe the patient through telehealth modalities might be conducted. When care by a specialist is required, it is the responsibility of the PCP and the specialist to coordinate all services.

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

A. The PCP should be responsible for providing the following basic pain management services:
   1. The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. Functional capacity should be evaluated and is the key target of any treatment. In addition, the PCP should assess for the presence of psychiatric disorders, substance use disorders, and substance misuse. Assessment should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain, should be considered. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.
   2. A thorough physical exam should be performed as clinically indicated.
   3. When medications with addictive/dependence potential are being used or being considered, the PCP should distinguish between ~~physiologic~~physiological dependence, tolerance, or addiction/substance use disorder.
   4. A pain management agreement is an important part of the scope of pain management. PCPs should consider a pain management agreement for all chronic pain patients who they are following.

5. A referral to a pain management center should be considered when appropriate. Members should not be referred to a pain management specialist until treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists as indicated. All potential co-occurring psychiatric illnesses should be evaluated and under treatment when appropriate. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist. Referrals solely for purpose~~s~~ of reducing a PCP caseload of opioid-using patients should not be made.
6. Consider referring a member with complex pain management as indicated under Pain Management Specialist referral or whenever the PCP feels the member would benefit from pain management evaluation based on his/her sound clinical judgment.
7. For members who have been referred and evaluated by a pain management or other specialist, the PCP should participate in the ongoing follow-up as jointly determined by the PCP and the specialist for members with these conditions who have reached a high degree of stability.
~~7.~~8. Both the CDC and UpToDate recommend that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months or more frequently for most patients.

B. Specialist Referral

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

1. Pain Management Specialist
   a. Complex pain management where the diagnosis is unclear, or the condition is unresponsive to standard medication and non-pharmacologic therapy for a period of 3 to 6 months.
   b. Complex pain management compromised by severe functional impairment.
   c. Complex Regional Pain Syndrome (CRPS).
   d. Complex pain management complicated by mental health condition or substance use disorder unresponsive to usual therapy and treatment by an appropriate behavioral health specialist.
   e. For performance and/or supervision of procedures done by pain management specialists. (See MCUP3049 Attachment A: Medical Necessity Criteria for Pain Management Procedures.) ~~– Pain Management Specialty Services.)~~
2. Refer to other specialists such as neurology, orthopedics, rheumatology, physical medicine and rehabilitation or behavioral health. Specific indications for referral to specialties other than pain management are beyond the scope of this guideline. The PCP should perform a careful evaluation of conditions with a known cause and initiate conservative therapy consistent with the PCP's skill and best judgment. Expert consultation should be considered in situations where the diagnosis is uncertain, the member has not responded to usual conservative therapy or specialty care is required based on the diagnosis.
3. After initial specialist consultation, or a significant change in the patient status or when the specialist terminates care of patient, the specialist is responsible to send all relevant information back to the PCP.
4. Patients with suspected substance use disorder (SUD) should be assessed by the PCP or be referred for assessment. In many instances, opioid use disorder (OUD) and other SUDs can be evaluated and treated by the PCP, ~~such as through the~~ usinge ~~of~~ Medications for Addiction Treatment (MAT). Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice. Another MAT for OUD, methadone, is available for outpatient treatment only through certified narcotic treatment programs (NTP) with some exceptions for acute care hospitals and emergency department settings. ~~-~~ PCPs cannot prescribe methadone for the treatment of OUD under the guise of treating pain. However, sublingual buprenorphine products can be prescribed simultaneously for both pain and OUD. Naltrexone

products should not be co-prescribed with any opioid medication, as naltrexone is an opioid receptor antagonist. ~~In the event that~~If referral is warranted, providers and patients can call Carelon Behavioral Health at (855) 765-9703 for referral information and options if the patient resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access departments. In addition, regardless of county of residence, for buprenorphine providers, patients and providers may visit the Partnership provider directory or the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator website (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator). It can be helpful for PCPs or staff at the PCP office to assist patients in securing a referral connection with an assessing provider, or a substance use disorder treatment provider. PCPs should also note that a specialized DEA waiver (known previously as the "X-Waiver") is no longer required for the prescribing of FDA-approved buprenorphine products for the treatment of opioid use disorder, and there are no longer any patient limits for prescribing under these circumstances. All PCPs, therefore, with DEA certification to prescribe Schedule II-V controlled substances may now prescribe FDA-approved buprenorphine products for the treatment of opioid use disorder.

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

C. Opioid Prescribing Guidelines For Physicians

1. Initial treatment considerations should include non-pharmacological therapies, including physical therapy, acupuncture, chiropractic treatment, activity modifications (rest, splinting), and mobility assistance (canes.)
2. Based on provider skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain.
    a. Initial pharmacologic treatment should rely on non-opioid analgesics, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDS).
    b. The use of opioids (tramadol, and opioids such as codeine, hydrocodone, methadone, oxycodone, morphine, and fentanyl) should be reserved for:
        1) Temporary use following trauma or surgery if non-opioid treatment is inadequate, with plan for discontinuation.
        2) For chronic use intermittently at the lowest doses in combination with other non-pharmacologic and non-opioid therapies.
        3) Severe functional disability, at the lowest doses in combination with other non-pharmacologic and non-opioid therapies (may involve ongoing regular doses~~.~~).
        4) Chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
    c. Before committing patients to long-term regular opioid treatment that may become lifelong, the patient's age should be taken into consideration, and the risks of physiologic dependence and misuse potential should be discussed with patients.
    d. Opioids in the frail elderly may be contraindicated due to safety concerns.
    e. Offer to prescribe naloxone for any patient prescribed opioids. Intranasal naloxone is also available at pharmacies without a physician's prescription, although for Medi-Cal and/or Medicare to cover it, a prescription is required.

3. Pain modulating agents should be considered when appropriate, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants, (gabapentin, pregabalin and carbamazepine.)
4. As a minimum standard, when starting opioid therapy for acute, subacute, or chronic pain – not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease – clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
    a. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs. Certain in-office toxicology screens are covered by Partnership (See Important Provider Notice on Partnership's website for details.) Consider a confirmatory urine test if the results of an in-office screen are unexpected, because false positive and negative screening results are common. If a patient is at higher risk for substance use disorder (SUD), diversion, or substance misuse, strongly consider more frequent toxicology screens. Ensure that the toxicology screen used can detect the relevant medications or substances of interest.
        1) Validated screening tools for substance misuse or substance use disorder can be helpful, such as:
            a) Drug Abuse Screening Test (DAST): https://cde.drugabuse.gov/instrument/e9053390-ee9c-9140-e040-bb89ad433d69
            b) Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS-1)
                i. A self or clinician-administered tool available in online platform, TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component, TAPS-2 as described below.
                ii. After a positive screen on TAPS-1, TAPS-2 guides clinicians through brief substance-specific assessment questions to arrive at a risk level for that substance.
    b. For pregnant individuals, consider using any of the validated tools recommended by the American College of Obstetricians and Gynecologists (ACOG): the 4Ps Plus (Parents, Partner, Past and Present), TAPs, or the CRAFFT (Driven in a **C**ar while high or with someone who was, use drugs or alcohol to **R**elax, ever use when **A**lone, ever **F**orget what you did while using, ever have **F**riends tell you to cut down, ever gotten into **T**rouble on account of use).
    c. Consider a signed medication use agreement with the prescriber or prescribing office.
    d. Provider to check California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.
    e. Schedule at a minimum, three office visits yearly for chronic pain and monitoring opioid use.
    f. Educate patients on proper safe storage of opioid medications to help prevent diversion (i.e., lock boxes).
    g. Utilize CURES, pill counts, and urine drug screens to minimize the potential for diversion/resale or distribution of prescribed opioid medications.
4. Further Recommendations for PCPs and Specialists are found in Attachment A, Partnership Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines.

D. Follow-up and monitoring during chronic opioid therapy
    1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.

2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.

~~D.~~E. Community Pharmacy Guidelines

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

~~E.~~F. Emergency Room (ED) Guidelines

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

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

~~F.~~G. Dentist Guidelines

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

~~G.~~H. Indicators Monitored by Partnership

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

VII. REFERENCES:

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified ~~May 13, 2024~~April 22, 2025

B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, ~~Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/~~ Accessibility verified on ~~May 6, 2024~~April 22, 2025

C. Centers for Disease Control. ~~CDC Guideline for Prescribing Opioids for Chronic Pain~~Overdose Prevention. ~~https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.~~ Accessibility verified ~~May 6, 2024~~April 22, 2025

~~C.~~D. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. Accessibility verified April 22, 2025.

~~D.~~E. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. ~~Available at: http://www.cfp.ca/content/57/11/1257.full.pdf~~ Accessibility verified on ~~May 6, 2024~~April 22,2025

~~E.~~F. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. ~~Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf~~ Accessibility verified ~~on May 6, 2024~~April 22, 2025

~~F.~~G. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid

Addiction, August 2016. ~~, Available at https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf.~~ Accessibility verified on ~~May 6, 2024~~April 22, 2025

H. Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023.~~,~~ ~~https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf.~~ Accessibility verified ~~May 6, 2024~~April 22, 2025

~~G.~~I. National Institute on Drug Abuse, National Institute of Health. Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS). Accessibility verified April 22, 2025.

~~H.~~J. 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. Accessibility verified April 22, 2025

~~I.~~K. SAMHSA Buprenorphine Quick Start Guide~~:~~ ~~https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf.~~ Accessibility verified April 22, 2025

~~J.~~L. The Provider's Clinical Support System (PCSS). Accessibility verified April 22, 2025~~:~~ ~~https://pcssnow.org~~

M. The University of California, San Francisco National Clinician Consultation Center warmline. Accessibility verified April 22, 2025~~:~~ ~~https://nccc.ucsf.edu~~

~~K.~~N. UpToDate. Use of opioids in the management of chronic pain in adults. (Dec. 9, 2024) Accessibility verified April 23, 2025

VIII. DISTRIBUTION:

A. Partnership ~~P~~provider Manual
B. Partnership Department Directors

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/20/04; 03/15/06; 03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16; 04/19/17; *03/14/18; 04/10/19; 03/11/20; 04/14/21; 06/08/22; 09/13/23; 08/14/24; 06/11/25

*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.

Partnership Advantage (effective Jan. 1, 2026)
N/A

PREVIOUSLY APPLIED TO:

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

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

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

Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/16/2004			**Next Review Date: 08/14/202506/11/2026** **Last Review Date: 08/14/202406/11/2025**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Primary Care & Specialist Prescribing Guidelines

Introduction

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

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

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

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

Effective Jan. 1, 2026, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

Recommendations

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

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

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

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

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

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

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

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

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

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

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

E. ~~E.~~ Routine monitoring of patients on chronic opioid therapy.

1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.
2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.

F. The following monitoring standards for patients on opioid therapy should be used by all clinicians in Partnership's regions.

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

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

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

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

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

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

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

1. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur. While not mandatory, consider checking CURES even when prescribing Schedule V medications.
3. Schedule at least three office visits yearly for chronic pain patients using opioids.
4. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g., "must last 28 days".) Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply.)
5. Develop an office policy on breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication.
6. Develop an office policy for offering medications for addiction treatment (MAT), and referral for substance use disorder treatment, if appropriate.
7. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.

8. Offer to prescribe naloxone to patients at risk of overdose, or to family members or friends (with consent of the patient) of those who may be at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. Although, California law permits pharmacists to furnish naloxone without a physician's prescription, a prescription or standing order is required for dispensing to Medi-Cal patients in order for the pharmacy to be reimbursed by Medi-Cal. See http://prescribetoprevent.org/ for details. Intranasal naloxone is available at a pharmacy without a physician's prescription, although Medi-Cal and Medicare payment requires a prescription.
9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.
10. Medication lock boxes are available through Partnership's Medical Equipment Distribution Services (PMEDS) program.

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

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

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

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

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Community Pharmacy Guidelines

Key Points from Other Guidelines

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

References

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified April 22, 2025
B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Accessibility verified on April 22, 2025
C. Centers for Disease Control. Overdose Prevention. Accessibility verified April 22, 2025
D. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. Accessibility verified April 22, 2025.
E. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. Accessibility verified on April 22,2025
F. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Accessibility verified April 22, 2025
G. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August 2016. Accessibility verified on April 22, 2025
H. Medical Board of California, Guidelines for Prescribing Controlled Substances for Pain, July 2023. Accessibility verified April 22, 2025
I. National Institute on Drug Abuse, National Institute of Health. Tobacco, Alcohol, Prescription medication, and other Substance use Tool (TAPS). Accessibility verified April 22, 2025.
J. 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. Accessibility verified April 22, 2025
K. SAMHSA Buprenorphine Quick Start Guide Accessibility verified April 22, 2025
L. The Provider's Clinical Support System (PCSS). Accessibility verified April 22, 2025
M. The University of California, San Francisco National Clinician Consultation Center warmline. Accessibility verified April 22, 2025

N. UpToDate. Use of opioids in the management of chronic pain in adults. (Dec. 9, 2024) Accessibility verified April 23, 2025

American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) _ Download accessibility verified May 13, 2024

Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/ Accessibility verified May 13, 2024

CA Bridge. Transforming Addiction Treatment through 24/7 Access in Emergency Departments. https://bridgetotreatment.org/addiction-treatment/ca-bridge/ Accessibility verified May 13, 2024

Centers for Disease Control. CDC Guideline for Prescribing Opioids for Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf Accessibility verified May 13, 2024

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49. Available at: http://dx.doi.org/10.15585/mmwr.rr6501e1 Accessibility verified May 13, 2024

Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of The College of Family Physicians of Canada. Vol 57, November 2011. Available at: http://www.cfp.ca/content/57/11/1257.full.pdf Accessibility verified May 13, 2024

Opioid Prescribers Group. Southern Oregon Opioid Prescribing Guidelines. https://www.oregonpainguidance.org/oregon-health-authority/state-guidelines/ Accessibility verified May 13, 2024

Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf Accessibility verified May 13, 2024

Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684. Available at: https://www.painphysicianjournal.com/current/pdf?article=MTIzMg%3D%3D&journal=49 Accessibility verified May 13, 2024

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

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

Appendix A

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

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

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

____ Total score = D + I + R + E

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

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

Functional Pain Scale

(developed by Kaiser Health Plan)

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Community Pharmacy Guidelines

Introduction

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

Effective Jan. 1, 2026, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

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

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

Recommendations

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

B. Each pharmacy should define the circumstances for checking the CURES report of a patient. Options include:
   1. All patients with a prescription for a controlled drug
   2. New prescriptions for a controlled drug
   3. Patients with behavior suspicious for substance use disorder or diversion. Examples include:
      a. Patient is paying cash for a medication when they have active insurance coverage.
      b. Patient has no active filling history at this pharmacy, but presents a prescription for a controlled medication.

c. Patient has multiple prescriptions, but only wants to pick up the narcotic.
d. Patient has a prescription with an unusually high quantity of pain medications.
e. Patient's doctor's office is not within reasonable distance of the pharmacy.
f. Subject to professional judgment.
g. Patient's home address is not within a reasonable distance from the pharmacy or the doctor's office.
h. Patient looks nervous and tries to hurry the pharmacy staff.
i. Patient is unable to provide a valid ID.
j. Patient presents a story that sounds too suspicious to be true.
k. A significant number of customers appear with prescriptions from the same prescriber and for the same controlled medication.
l. Patient shows "unusual knowledge of controlled substances."

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

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

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

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

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

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

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

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from Other Guidelines

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

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

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

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

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

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

References

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified April 22, 2025

B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Accessibility verified on April 22, 2025

C. California State Board of Pharmacy. A Pharmacist Has a Corresponding Responsibility. Accessibility verified April 23, 2025.

D. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. Accessibility verified April 22, 2025.

E. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. Accessibility verified on April 22,2025

F. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Accessibility verified April 22, 2025

G. Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684. _Accessibiltiy verified April 23, 2025

H. U.S. Department of Justice. Drug Enforcement Administration. Diversion Control Division. Pharmacist's Manual (PDF) (revised 2022). Accessibility verified April 23, 2025

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Emergency Department Guidelines

Introduction

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

Effective Jan. 1, 2026, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

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

Recommendations

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

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

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

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

E. In patients with a suspected or documented history of substance misuse or SUD, take a careful history and after appropriate medical work up; if opioid analgesia is indicated, carefully balance the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. Potential indicators of substance misuse behaviors include:

1. Patient goes to an emergency room outside of the community they live in (or multiple) with suspected aim to secure opioid analgesic medications
2. Patient paying cash for ED visit.
3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.
4. Patient reports that their medications were lost or stolen.
5. CURES report reveals multiple controlled substance prescribers in multiple locations.
6. Collateral sources indicate a history of maladaptive behaviors in relation to controlled substances.

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

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

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

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

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

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

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

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

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

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

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

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

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

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

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

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

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

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

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

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

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

References

A. CA Bridge. Transforming Addiction Treatment through 24/7 Access in Emergency Departments. Accessibility verified April 23, 2025.
B. CA Bridge. CA Bridge Study Finds Emergency Department Buprenorphine Linked to Sustainied Opioid Use Disorder Treatment. (Feb. 7, 2024) Accessibility verified April 23, 2025
C. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified April 22, 2025
D. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Accessibility verified on April 22, 2025
E. Centers for Disease Control. Overdose Prevention. Accessibility verified April 22, 2025
F. CDC. CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022. Accessibility verified April 22, 2025.
G. Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August 2016. Accessibility verified April 23, 2025
H. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of the College of Family Physicians of Canada. Vol 57, November 2011. Accessibility verified on April 22,2025
I. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Accessibility verified April 22, 2025
J. Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684. Accessibility verified April 23, 2025
~~A.~~K. Substance Abuse and Mental Health Services Administration (SAMHSA). Buprenorphine Quick Start Guide Accessibility verified April 22, 2025
~~B. CA Bridge. . https://bridgetotreatment.org/addiction-treatment/ca-bridge/ Accessibility verified May 13, 2024~~
~~CA Bridge. CA Bridge Study Finds Emergency Department Buprenorphine Linked to Sustainied Opioid Use Disorder Treatment. (Feb. 7, 2024)~~

American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) _ Download accessibility verified May 13, 2024

Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/ Accessibility verified May 13, 2024

Centers for Disease Control. Guidelines for Prescribing Opioids for Chronic Pain. https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf Accessibility verified May 13, 2024

Herring, Andrew A., MD, Emergency Department Medication-Assisted Treatment of Opioid Addiction, August, 2016. https:/www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf. Accessibility verified May 13, 2024

Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of The College of Family Physicians of Canada. Vol 57, November 2011. Available at: http://www.cfp.ca/content/57/11/1257.full.pdf Accessibility verified May 13, 2024

Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf Accessibility verified May 13, 2024

Silverman S, . Pain Physician 2009: 12:679-684. Available at: https://www.painphysicianjournal.com/current/pdf?article=MTIzMg%3D%3D&journal=49 Accessibility verified May 13, 2024

Substance Abuse and Mental Health Services Administration (SAMHSA). Treatment locator. https://www.samhsa.gov/medication-assisted-treahttps://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator. Accessibility verified May 13, 2024

PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Dental Prescribing Guidelines

Introduction

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

Effective Jan. 1, 2026, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications and prevention of chronic opioid misuse and diversion. Partnership has reviewed the literature on this topic, and has the following recommendations for our dental colleagues:

Recommendations

Partnership recommends dentists prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)

Dentists should not prescribe opioids for patients already on opioid pain meds prescribed by another physician.

Dentists should also adhere to the Primary Care Clinician Prescribing Guidelines below:

1. If narcotic pain medication is prescribed, limit use to short periods (i.e., no more than 4 days) and only for conditions that are typically associated with more severe pain.

2. Discuss the risk of opioid dependence, opioid addiction, tolerance, and hyperalgesia with patients initiated on opioid treatment.

3. Assess for risk of substance use disorder and diversion, using a standardized tool if needed (see appendix for example). If patient is at high risk, consider baseline urine toxicology screen, use of non-opioids modalities to treat pain and carefully balance need for adequate analgesia against risk of misuse/diversion/overdose and behavioral destabilization.

4. Patients between 18 to 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.

5. Initiation and continuation of use of opioid pain medications for chronic, non-cancer and non-terminal pain should be weighed carefully by any prescriber. It is not appropriate for a dentist to prescribe chronic opioids. This should be done by the primary care provider.
NOTE: There are standards required by Partnerhip to PCPs and Specialists covering patients with chronic pain or chronic opioid use. These may be found in MPXG5008 itself.

6. Chronic use of opioid medication (particularly when combined with other sedating medications such as benzodiazepines and muscle relaxants) or alcohol use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid induced hyperalgesia, which ultimately causes the patient increased pain and debility. Unlike acute pain or pain associated with metastatic cancer or end-of-life care, the goal of opioid therapy for chronic non-cancer, non-terminal pain is improved functioning, not necessarily elimination of pain.

7. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every ~~4~~ three months thereafter if the substance remains part of the treatment of the patient.

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

Other Guidelines for Safe Opioid Prescribing

Emergency Room Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

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

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

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

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

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

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

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

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

References

A. American Pain Society (jpain.org). Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review. (February 2009) – Download accessibility verified ~~May 13, 2024~~April 23. 2025

~~A.~~B. Becker DE. Pain Management: Part 1: Managing Acute and Postoperative Dental Pain. Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67, ~~Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2886920/~~ Accessibility verified ~~May 13, 2024~~April 23, 2025

~~B.~~C. Centers for Disease Control. Overdose Prevention. ~~https://www.cdc.gov/drugoverdose/pdf/Guidelines_At-A-Glance-508.pdf~~ Accessibility verified ~~May 13, 2024~~April 23, 2025

~~C.~~D. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain: Clinical Summary for Family Physicians. The Official Journal of The College of Family Physicians of Canada. Vol 57, November 2011. ~~Available at: http://www.cfp.ca/content/57/11/1257.full.pdf~~ Accessibility verified ~~May 13, 2024~~April 23, 2025

~~D.~~E. Prescribe to Prevent: Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals: Prescribing Naloxone. ~~Available at: http://www.prescribetoprevent.org/wp-content/uploads/2012/11/one-pager_12.pdf~~ Accessibility verified ~~May 13, 2024~~April 23, 2025

~~E.~~F. Silverman S, Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner. Pain Physician 2009: 12:679-684. ~~Available at: https://www.painphysicianjournal.com/current/pdf?article=MTIzMg%3D%3D&journal=49~~ Accessibility verified ~~May 13, 2024~~April 23, 2025

Appendix A

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk ≥ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCUP3028~~ MPBP8003 (previously MCUP3028, UP100328)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Mental Health Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1995</td><td colspan="4">Next Review Date: ~~01/08/2026~~06/11/2026
Last Review Date: ~~01/08/2025~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ 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~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
B. ~~ADM52~~ MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services
C. CMP36 – Delegation Oversight and Monitoring
D. MCUG3024 – Inpatient Utilization Management
E. MP~~C~~UP3014 – 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
I. MCQG1015 – Pediatric Preventive Health Guidelines

II. IMPACTED DEPTS:

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

F. (B~~M~~HP) ~~Mental~~ Behavioral Health Plan: A county ~~Mental~~ Behavioral Health Plan in Partnerships' service area. B~~M~~HPs are required to provide and cover all medically necessary SMHS and Substance Use Disorder (SUD) treatment services in accordance with their contracts with DHCS.

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.

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

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

J. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

K. Professional Person: A "professional person" in Family Code section 6924 means either (1) a professional person as defined in H&S section 124260 or (2) a chief administrator of an agency referred to in Fam. Code section 6924, subdivision (a)(1) and (3). AB 665 added several professionals to the definition of a "professional person," including a registered psychologist, a registered psychosocial assistant, an associate clinical social worker, and a board-certified or board eligible psychiatrist.

~~J.~~L. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services*
County ~~Mental~~ Behavioral Health Plans (B~~M~~HPs) are contractually required to provide or arrange for the provision of SMHS for Medi-Cal 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.
1. For Partnership Advantage Members who meet criteria for SMHS and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP as described in section VI.T. of this policy.

[1] As per APL 22-012 *Revised*, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. ~~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/*
Effective January 1, 2026, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

M. 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. Partnership HealthPlan of California provides mental health services for Medi-Cal Members. Effective January 1, 2026, Partnership will also provide mental health services for Partnership Advantage Members who are eligible to receive both Medi-Cal and Medicare services.
   1. For services specific to Partnership Advantage Members, see section VI.T. of this policy below.

~~A.~~B. 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.
   a. Partnership maintains a Member Outreach & Education Campaign for Non-Specialty Mental Health Services (NSMHS) which details how NSMHS utilization assessments and population assessments are used to inform NSMHS outreach and education to enhance Member understanding of access to covered NSMHS. This document can be located on Partnership's website.
2. Members determined to require Specialty Mental Health Services (SMHS) are referred to the County ~~Mental~~ Behavioral Health Plan in the Member's county of responsibility~~residence~~. ~~–~~The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County ~~Mental~~ Behavioral Health Plan (BHP), consistent with California statutes and regulations.
3. DHCS requires MCPs and B~~M~~HPs 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 B~~M~~HP 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 B~~M~~HP 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 BM~~H~~HP 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 BM~~H~~HPs or directly to BM~~H~~HP providers delivering SMHS. MCPs may only refer directly to a~~n~~ BM~~H~~HP provider of SMHS if policies and procedures have been established and MOUs are in place with the BM~~H~~HP 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 BMHP, 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 BMHPs 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 BMHP, or directly to a~~n~~ BMHP provider delivering SMHS if appropriate processes have been established in coordination with BMHPs.
      2) Coordinate Member care services with BMHPs 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 behavioral health services between NSMHS, 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 Member 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 B~~M~~HP.

e. The determination to transition services to and/or add services from the B~~M~~HP 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.~~C. 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.~~D. 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.

E. California Health and Safety Code (HSC) section 124260(b)(1) allows minors 12 and older to consent to mental health treatment if they are mature enough to participate.
   1. Effective July 1, 2024, without consent from a parent or legal guardian, minors 12 years of age or older may consent to non-specialty outpatient Medi-Cal mental health treatment or counseling if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the outpatient services.
   2. The professional person must use their clinical judgment and expertise to make a determination regarding the minor's maturity to participate intelligently in these services.
   3. MCPs are responsible for ensuring that minors can consent to non-specialty outpatient Medi-Cal mental health treatment or counseling and county Behavioral Health Plans (BHPs) are responsible for ensuring that minors can consent to specialty mental health outpatient treatment or counseling in accordance with Family Code section 6924 and DHCS guidance. Minors already eligible for full scope Medi-Cal can consent to outpatient mental health services without applying to enroll in limited scope Medi-Cal for Minor Consent Services.
   4. The professional person treating or counseling the minor must consult with the minor before determining whether involvement of the parent or guardian would be appropriate.
   5. State law requires that the parent or guardian of a minor receiving outpatient mental health treatment or counseling be involved in the treatment unless, after consulting with the minor, the professional person determines that the involvement of the minor's parent or guardian would be inappropriate.
   6. MCPs, Network Providers, Subcontractors, or Downstream Subcontractors must establish and

ensure safeguards are in place to suppress confidential information and prevent appointment notifications, Notice of Adverse Benefit Determination documents, and any other communication that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian. MCPs, Network Providers, Subcontractors, or Downstream Subcontractors are prohibited from disclosing any information relating to Minor Consent Services without the express consent of the minor.

7. Following consultation with the minor, the professional person must note their determination regarding the appropriateness of involvement of the parent or guardian in the Member record, stating either:
   a. Whether and when the person attempted to contact the minor's parent or guardian, and whether the attempt to contact was successful; or
   b. The reason why, in the professional person's opinion, it would be inappropriate to contact the minor's parent or guardian.

~~D.~~F. The County ~~Mental~~ Behavioral Health Plan's (B~~M~~HP's) role in providing mental health services:

1. County B~~M~~HPs 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.~~G. 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~~ MPBP8011Scope 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 B~~M~~HP'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.~~H. Managed Care Plan's responsibility for providing NSMHS:

1. Partnership is responsible for the delivery of NSMHS (as defined in III.I~~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.H~~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.~~I. 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.~~J. 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.~~K. 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 B~~M~~HP, 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.~~L. 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

~~K.~~M. 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.

~~L.~~N. 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~~ MPBP8007 Screening and Treatment for Substance Use Disorders)*

~~M.~~O. 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 MPBP8007~~MCUP3101~~ Screening and Treatment for Substance Use Disorders.)*

~~N.~~P. 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.

Q. 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

f) Psychiatric Diagnostic Evaluation
g) Tobacco Cessation Counseling

R. Dispute Resolution
1. If a dispute occurs between the local County ~~Mental~~ Behavioral Health Plan (B~~M~~HP) and Partnership HealthPlan of California (Partnership) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the B~~M~~HP and Partnership will participate in a dispute resolution process as defined in Partnership Policy ~~ADM52~~ MPBP8005 Dispute Resolution Between Partnership and B~~M~~HPs in Delivery of Mental Health Services.
   a. Partnership does not delegate the responsibility of MCP and B~~M~~HP dispute resolution to any Subcontractor.

S. 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.

T. Partnership Advantage Mental Health Services (Effective January 1, 2026)
1. Availability: Partnership maintains a telephone line for behavioral health assistance 24 hours per day, 7 days a week, to provide information, referral to treatment for conditions pursuant to 42 CFR § 438.3(q). Behavioral-health services are available 24 hours a day, 7 days a week, when medically necessary, per 42 CFR § 438.206(c)(1)(iii)
2. Non-Discrimination: In accordance with 42 CFR § 422.110(a), Partnership ensures that Partnership Advantage members may self-refer for an outpatient mental health assessment or service with a contracted in-network mental health provider without prior authorization requirements and does not deny or limit service if medical necessity requirements are met.
3. Coordination: For Partnership Advantage members who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure members have access to and are connected with medically necessary services delivered by the BHP.
4. Access: Partnership includes providers specializing in behavioral health in its network and meets the appointment-wait-time standards pursuant to 42 CFR § 422.112(a)(6)(i) as follows: emergency services immediately and routine/preventative services within 30 business days. However, where Medi-Cal timely access standards are more strict than Medicare requirements, Partnership will default to those timely access requirements. When required behavioral health services are unavailable or inadequate in-network, Partnership arranges for and covers medically necessary services through non-contracted providers at in-network cost-sharing per 42 CFR § 422.112(a)(1)(iii) and Medicare Managed Care Manual, Ch. 4 § 110.1.1.
5. Screenings: Partnership ensures for Partnership Advantage members that the primary care providers in its network incorporate the following behavioral health screenings as part of every Annual Wellness Visit (first and subsequent) under 42 C.F.R. § 410.15, Depression & Substance Use Disorder screenings among others.
6. Coverage: Partnership shall cover behavioral health services in accordance with Medicare Advantage requirements, including:
   a. Inpatient psychiatric hospital services as a basic Medicare Part A benefit, subject to the 190-day lifetime maximum on inpatient psychiatric care (42 CFR § 422.100(c)(1); 42 CFR § 409.62).
      1) Coverage for inpatient psychiatric services beyond the lifetime maximum will be the

responsibility of the Member's county BHP.

b. Outpatient behavioral health services under Medicare Part B including diagnostic and therapeutic services, incident-to-physician services, and mental health counselor services (42 CFR § 410.10; 42 CFR § 410.54).
   1) Covered services also include Electroconvulsive Therapy (ECT) whether delivered in an inpatient or outpatient setting, partial hospitalization and intensive outpatient treatment.
   2) Additionally, the treatment of Opioid Use Disorder is a covered service in Partnership Advantage as provided by Opioid Treatment Programs (OTPs). Some services are subject to a Treatment Authorization Request (TAR) and approval.

~~c.~~ Residential treatment for substance use disorders is not a covered service under Medicare, and Partnership Advantage members in need of this level of care will be provided care coordination and referral to their county BHP for services.

~~d.~~c.

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)
O. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
P. Behavioral Health Information Notice (BHIN) 21-073
Q. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System
R. DHCS APL 24-012 Non-Specialty Mental Health Services: Member Outreach, Education, And Experience Requirements (09/17/2024)
S. DHCS APL 24-019 Minor Consent to Outpatient Mental Health Treatment or Counseling (12/31/2024)
T. California Family Code section 6924
U. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).
V. Code of Federal Regulations: 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 CFR § 410.10; 42 CFR § 410.54; 42 CFR § 422.100(c)(1); 42 CFR § 409.62; 42 C.F.R. § 410.15; 42 CFR § 422.112(a)(1)(iii); 42 CFR § 438.3(q); 42 CFR § 438.206(c)(1)(iii)
~~Q.~~W. Medicare Managed Care Manual, Ch. 4 § 110.1.1

Policy/Procedure Number: ~~MCUP3028~~ MPBP8003 (previously MCUP3028, UP100328)			**Lead Department: Health Services** **Business Unit: Behavioral Health**
Policy/Procedure Title: Mental Health Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1995		**Next Review Date: 01/08/202606/11/2026** **Last Review Date: 01/08/202506/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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;~~

X.

MPHP8003 ~~*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~~

06/11/2025

~~*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:
MCUP3028: ? – 06/11/2025
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; Transferred to MPBP8003 06/11/25

*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.

UP100328: 04/25/1995 – ?

****

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.

Adult Screening Tool for Medi-Cal Mental Health Services

The Adult Screening Tool for Medi-Cal Mental Health Services is required for use when an individual age 21 or older, who is not currently receiving mental health services, contacts the Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Adult Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. Each scored question is a "Yes" or "No" question. Not every question is scored.
2. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
3. Select/mark the number in the "Yes" or "No" column based on the response provided.
4. If the individual is unable or chooses not to answer a question, skip the question and score it as "0."
5. If the individual responds "Yes" to question 11, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality after the screening is completed. Referral coordination should include sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
6. A response of "Yes" to question 13 or 14 does not impact the screening score. If the individual responds "Yes" to question 13 or question 14, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
7. Once responses to questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

8. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

Adult Screening Tool for Medi-Cal Mental Health Services

Name:	Date of Birth:
Age:	***NOTE:*** *If age 20 or younger, switch to the "Youth Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No
2. Can you tell me the reason you are seeking mental health services today?	
3. Are you currently receiving mental health treatment? • If yes, where are you receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

Question	Yes	No
4. Have you ever sought help before today for your mental health needs?	☐ 1	☐ 0
5. Are you currently taking, or have you ever taken, any prescription mental health medication?	☐ 1	☐ 0
6. Are you without housing or a safe place to sleep?	☐ 1	☐ 0
7. Are you having difficulties in important areas of your life like school, work, relationships, or housing, because of how you are feeling or due to your mental health?	☐ 1	☐ 0
8. Have you recently had any changes or challenges with areas of your life, such as personal hygiene, sleep, energy level, appetite, weight, sexual activity, concentration, or motivation?	☐ 1	☐ 0
9. Have you completely withdrawn from all or almost all of your relationships, such as family, friends, or other important people?	☐ 1	☐ 0
10. Have you sought emergency treatment for emotional distress or been admitted to a psychiatric hospital in the past year?	☐ 1	☐ 0
a. If yes, have you had more than one hospitalization?	☐ 1	☐ 0
b. If yes, was your last hospitalization within the last six months?	☐ 1	☐ 0
11. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and not wake up?[1] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
12. Have you recently engaged in any self-harming behavior like cutting or hurting yourself?	☐ 2	☐ 0

Question	Yes	No
13. Are you concerned about your current level of alcohol or drug use?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –
14. Has alcohol or any other drug or medication caused you to behave in a way that was dangerous to yourself or others (e.g., impaired driving, overdose, aggression, loss of memory, being arrested, etc.)?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #8

If score is 6 or above, refer to the MHP per instruction #8

[1] A response of "yes" to question 11 results in immediate coordination of a referral to a clinician for further evaluation of suicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

[2] Questions 13 and 14 are not scored. A response of "yes" results in a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

Clear Form

Youth Screening Tool for Medi-Cal Mental Health Services

The Youth Screening Tool for Medi-Cal Mental Health Services is required for use when an individual under age 21, or a person on behalf of an individual under age 21, who is not currently receiving mental health services, contacts their Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Youth Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. There are two versions of the Youth Screening Tool for Medi-Cal Mental Health Services:
    - One version of the tool is used when a youth is responding on their own behalf: ***Youth Screening Tool for Medi-Cal Mental Health Services: Youth Respondent.***
    - One version of the tool is used when a person is responding on behalf of the youth: ***Youth Screening Tool for Medi-Cal Mental Health Services: Respondent on Behalf of Youth***.
2. The answer to screening question 2 determines which version of the tool is used.
3. Each scored question is a “Yes” or “No” question. Not every question is scored.
4. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
5. Select/mark the number in the “Yes” or “No” column based on the response provided.
6. If the youth, or the person responding on their behalf, is unable or chooses not to answer a question, skip the question and score it as “0.”

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

7. If a response to question 5 indicates that a child who is age 3 or younger has not seen a pediatrician in the last 6 months, or that a child/youth age 4 or older has not seen a pediatrician or primary care physician (PCP) in the last year, the screener must offer to connect them to their MCP for a pediatrician/PCP visit in addition to the mental health delivery system referral generated by the screening score.[2]
8. If the youth, or the person responding on their behalf, responds "Yes" to question 6, 7, or 9, they meet criteria for specialty mental health services per BHIN 21-073. In these cases, the screening is not required, and the screener must offer and coordinate a referral for clinical assessment by the MHP. Referral coordination must include follow up to ensure an assessment has been made available to the individual. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.
9. If the youth, or the person responding on their behalf, responds "Yes" to question 19, 20, or 21, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. Referral coordination should include sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
10. A response of "Yes" to question 17 does not impact the screening score. If the youth, or the person responding on their behalf, responds "Yes" to question 17, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
11. Once responses to all questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.
12. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

[2] Bright Futures well-child visit guidelines indicate a child age 4 and older should be seen by a pediatrician annually, and a child age 3 and under should be seen by a pediatrician every 1, 3, or 6 months depending on their age.

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

Name:	Date of Birth:
Age:	***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If someone else, please switch to the "Respondent on Behalf of Youth" version of the tool.*

3. Can you tell me the reason you are seeking mental health services today?

4. Are you currently receiving mental health treatment? • If yes, where are you receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

5. When was the last time you saw your pediatrician or primary care doctor?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Are you currently or have you ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Are you currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Have you ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Are you currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Have you ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Are you having thoughts, feelings or behaviors that make it hard for you at home, school, or work?	☐ 1	☐ 0
12. Are you having thoughts, feelings, or behaviors that make it hard to be with your friends or have fun?	☐ 1	☐ 0
13. Are you often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the person who takes care of you often not around or unable to take care of you?	☐ 1	☐ 0
15. Do you feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting you?	☐ 1	☐ 0
17. Are you having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —

Question	Yes	No
18. Is anyone in your family or who lives with you having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Do you hurt yourself on purpose?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Do you have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of your family told you that you need help with anxiety, depression, or your behaviors?	☐ 2	☐ 0
23. Have you been seen in the hospital to get help for a mental health condition within the last six months?	☐ 2	☐ 0

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #11

If score is 6 or above, refer to the MHP per instruction #11

1 Questions 6, 7, and 9 are not scored. A response of "Yes" results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of "Yes" results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of "Yes" to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Youth Screening Tool for Medi-Cal Mental Health Services

Respondent on Behalf of Youth

Name:	Date of Birth:
Age:	***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If calling about themself, switch to the "Youth Respondent" version of the tool.*

3. Can you tell me the reason you are seeking mental health services for the child/youth today?

4. Is the child/youth currently receiving mental health treatment? • If yes, where are they receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP or MCP do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

5. When was the last time the child/youth saw their pediatrician or primary care provider?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Is the child/youth currently or have they ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Is the child/youth currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Has the child/youth ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Is the child/youth currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Has the child/youth ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Is the child/youth having thoughts, feelings or behaviors that make it hard for them at home, school, or work?	☐ 1	☐ 0
12. Is the child/youth having thoughts, feelings, or behaviors that make it hard to be with their friends or have fun?	☐ 1	☐ 0
13. Is the child/youth often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the primary caretaker for the child/youth often not around or unable to take care of the child/youth?	☐ 1	☐ 0
15. Does the child/youth feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting the child/youth?	☐ 1	☐ 0

Question	Yes	No
17. Is the child/youth having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —
18. Is anyone in the child/youth's family or who lives with them having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Does the child/youth self-harm or behave in a manner that may cause harm to themselves?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, has the child/youth had thoughts about ending their life, wished they were dead, or wished they could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Does the child/youth have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of the child/youth's family said that the child/youth needs help with anxiety, depression, or their behaviors?	☐ 2	☐ 0
23. Has the child/youth been seen in a hospital for a mental health condition within the last six months?	☐ 2	☐ 0

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #11

If score is 6 or above, refer to the MHP per instruction #11

1 Questions 6, 7, and 9 are not scored. A response of “Yes” results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of “Yes” results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of “Yes” to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Transition of Care Tool for Medi-Cal Mental Health Services

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Instructions: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the plan the beneficiary is being referred to.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:

BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐	
	Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐	
Address:		
City:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

BENEFICIARY INFORMATION

Behavioral Health Diagnosis or Diagnoses, if known:

Supporting Clinical Documents Included:

Cultural and Linguistic Requests:

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

☐ Additional Pages Attached

BENEFICIARY INFORMATION

Current Environmental Factors (including changes in caregiver relationships, living environment, and/or educational considerations):

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors and/or traumatic experiences):

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Additional Pages Attached

BENEFICIARY INFORMATION	
Referring Provider/Current Care Team:	Phone:

SERVICES REQUESTED: ☐ Transition of Care ☐ Addition of Service(s)

What service(s) is the beneficiary being referred for?

TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION

☐ Managed Care Plan:

Managed Care Plan Contact Information

Fax: Phone: Toll Free: TTY:

☐ County Mental Health Plan:

County Mental Health Plan Contact Information

Fax: Phone: Toll Free: TTY:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3028 (previously UP100328)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Mental Health Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1995</td><td colspan="4">Next Review Date: ~~01/08/2026~~N/A
Last Review Date: 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">Archive~~Approval~~ Date:
~~01/08/2025~~06/11/2025</td></tr>
</table>

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

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.

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.

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

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

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 referrals is addressed in the respective Memorandum of Understanding (MOU) with each County

[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/*

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 behavioral health services between NSMHS, 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 Member 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

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.

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)*

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.)*

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
   f) Psychiatric Diagnostic Evaluation
   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)
O. California Welfare and Institutions Code section 14132.755, Dyadic Behavioral Health Visits
P. Behavioral Health Information Notice (BHIN) 21-073
Q. California Health Care Foundation explanation of The Drug Medi-Cal Organized Delivery System

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; ARCHIVED 06/11/2025

*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.

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: 01/08/2026N/A** **Last Review Date: 01/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

Adult Screening Tool for Medi-Cal Mental Health Services

The Adult Screening Tool for Medi-Cal Mental Health Services is required for use when an individual age 21 or older, who is not currently receiving mental health services, contacts the Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Adult Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. Each scored question is a "Yes" or "No" question. Not every question is scored.
2. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
3. Select/mark the number in the "Yes" or "No" column based on the response provided.
4. If the individual is unable or chooses not to answer a question, skip the question and score it as "0."
5. If the individual responds "Yes" to question 11, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality after the screening is completed. Referral coordination should include sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
6. A response of "Yes" to question 13 or 14 does not impact the screening score. If the individual responds "Yes" to question 13 or question 14, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
7. Once responses to questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

8. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Adult Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

Adult Screening Tool for Medi-Cal Mental Health Services

Name:	Date of Birth:
Age: ***NOTE:*** *If age 20 or younger, switch to the "Youth Screening Tool for Medi-Cal Mental Health Services."*	
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation? ***NOTE:*** *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*	☐ Yes ☐ No
2. Can you tell me the reason you are seeking mental health services today?	
3. Are you currently receiving mental health treatment? • If yes, where are you receiving those services? ***NOTE:*** *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*	☐ Yes ☐ No

Question	Yes	No
4. Have you ever sought help before today for your mental health needs?	☐ 1	☐ 0
5. Are you currently taking, or have you ever taken, any prescription mental health medication?	☐ 1	☐ 0
6. Are you without housing or a safe place to sleep?	☐ 1	☐ 0
7. Are you having difficulties in important areas of your life like school, work, relationships, or housing, because of how you are feeling or due to your mental health?	☐ 1	☐ 0
8. Have you recently had any changes or challenges with areas of your life, such as personal hygiene, sleep, energy level, appetite, weight, sexual activity, concentration, or motivation?	☐ 1	☐ 0
9. Have you completely withdrawn from all or almost all of your relationships, such as family, friends, or other important people?	☐ 1	☐ 0
10. Have you sought emergency treatment for emotional distress or been admitted to a psychiatric hospital in the past year?	☐ 1	☐ 0
a. If yes, have you had more than one hospitalization?	☐ 1	☐ 0
b. If yes, was your last hospitalization within the last six months?	☐ 1	☐ 0
11. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and not wake up?[1] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
12. Have you recently engaged in any self-harming behavior like cutting or hurting yourself?	☐ 2	☐ 0

Question	Yes	No
13. Are you concerned about your current level of alcohol or drug use?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –
14. Has alcohol or any other drug or medication caused you to behave in a way that was dangerous to yourself or others (e.g., impaired driving, overdose, aggression, loss of memory, being arrested, etc.)?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ –	☐ –

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #8

If score is 6 or above, refer to the MHP per instruction #8

[1] A response of "yes" to question 11 results in immediate coordination of a referral to a clinician for further evaluation of suicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

[2] Questions 13 and 14 are not scored. A response of "yes" results in a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

Clear Form

Youth Screening Tool for Medi-Cal Mental Health Services

The Youth Screening Tool for Medi-Cal Mental Health Services is required for use when an individual under age 21, or a person on behalf of an individual under age 21, who is not currently receiving mental health services, contacts their Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) to seek mental health services. This tool determines whether an individual should be referred to the MCP delivery system or to the MHP delivery system for a clinical assessment and ensures that individuals have timely access to the appropriate mental health delivery system. The Youth Screening Tool for Medi-Cal Mental Health Services is not required to be used when individuals contact mental health providers directly to seek mental health services.[1]

Instructions:

1. There are two versions of the Youth Screening Tool for Medi-Cal Mental Health Services:
    - One version of the tool is used when a youth is responding on their own behalf: ***Youth Screening Tool for Medi-Cal Mental Health Services: Youth Respondent.***
    - One version of the tool is used when a person is responding on behalf of the youth: ***Youth Screening Tool for Medi-Cal Mental Health Services: Respondent on Behalf of Youth***.
2. The answer to screening question 2 determines which version of the tool is used.
3. Each scored question is a “Yes” or “No” question. Not every question is scored.
4. Each scored question has a defined number of points for the selected answer. The number of points for each question cannot be more or less than what is on the scoresheet.
5. Select/mark the number in the “Yes” or “No” column based on the response provided.
6. If the youth, or the person responding on their behalf, is unable or chooses not to answer a question, skip the question and score it as “0.”

[1] As described in APL 22-028 and BHIN 22-065, MCPs and MHPs must allow contracted mental health providers who are contacted directly by individuals seeking mental health services to begin the assessment process and provide services during the assessment period without using the Screening Tools, consistent with the No Wrong Door for Mental Health Services Policy described in BHIN 22-011.

7. If a response to question 5 indicates that a child who is age 3 or younger has not seen a pediatrician in the last 6 months, or that a child/youth age 4 or older has not seen a pediatrician or primary care physician (PCP) in the last year, the screener must offer to connect them to their MCP for a pediatrician/PCP visit in addition to the mental health delivery system referral generated by the screening score.[2]
8. If the youth, or the person responding on their behalf, responds "Yes" to question 6, 7, or 9, they meet criteria for specialty mental health services per BHIN 21-073. In these cases, the screening is not required, and the screener must offer and coordinate a referral for clinical assessment by the MHP. Referral coordination must include follow up to ensure an assessment has been made available to the individual. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.
9. If the youth, or the person responding on their behalf, responds "Yes" to question 19, 20, or 21, the screener must immediately offer and coordinate a referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. Referral coordination should include sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services. The referral and subsequent clinical evaluation may or may not impact the mental health delivery system referral generated by the screening score.
10. A response of "Yes" to question 17 does not impact the screening score. If the youth, or the person responding on their behalf, responds "Yes" to question 17, the screener must offer and coordinate a referral to the county behavioral health plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score. The individual may decline this referral without impact to the mental health delivery system referral.
11. Once responses to all questions have been documented, the selected/marked numbers in the "Yes" column should be added together and that total number should be entered in the "Total Score" box.
    a. Individuals with a total score of 0 – 5 must be referred to the MCP for a clinical assessment.
    b. Individuals with a total score of 6 and above must be referred to the MHP for a clinical assessment.
12. Once a score has been generated, a referral must be coordinated.
    a. If the individual's score requires referral within the same delivery system, a timely clinical assessment must be offered and provided.
    b. If the individual's score requires referral to the other mental health delivery system (i.e., MCP to MHP or MHP to MCP), the referral must be coordinated with the other delivery system, including sharing the completed Youth Screening Tool for Medi-Cal Mental Health Services and following up to ensure a timely clinical assessment has been made available to the individual.

[2] Bright Futures well-child visit guidelines indicate a child age 4 and older should be seen by a pediatrician annually, and a child age 3 and under should be seen by a pediatrician every 1, 3, or 6 months depending on their age.

Youth Screening Tool for Medi-Cal Mental Health Services

Youth Respondent

Name:	Date of Birth:
Age:	***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ☐ Yes ☐ No

NOTE: *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If someone else, please switch to the "Respondent on Behalf of Youth" version of the tool.*

3. Can you tell me the reason you are seeking mental health services today?

4. Are you currently receiving mental health treatment? ☐ Yes ☐ No
   - If yes, where are you receiving those services?

NOTE: *If the individual is currently receiving mental health services from their MCP or MHP, do not finish the screening. Instead, connect them with their current provider for further assessment.*

5. When was the last time you saw your pediatrician or primary care doctor?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Are you currently or have you ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Are you currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Have you ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Are you currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Have you ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Are you having thoughts, feelings or behaviors that make it hard for you at home, school, or work?	☐ 1	☐ 0
12. Are you having thoughts, feelings, or behaviors that make it hard to be with your friends or have fun?	☐ 1	☐ 0
13. Are you often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the person who takes care of you often not around or unable to take care of you?	☐ 1	☐ 0
15. Do you feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting you?	☐ 1	☐ 0
17. Are you having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —

Question	Yes	No
18. Is anyone in your family or who lives with you having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Do you hurt yourself on purpose?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, have you had thoughts about ending your life, wished you were dead, or wished you could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Do you have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of your family told you that you need help with anxiety, depression, or your behaviors?	☐ 2	☐ 0
23. Have you been seen in the hospital to get help for a mental health condition within the last six months?	☐ 2	☐ 0

Total Score: 0

If score is 0 – 5, refer to the MCP per instruction #11

If score is 6 or above, refer to the MHP per instruction #11

1 Questions 6, 7, and 9 are not scored. A response of "Yes" results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of "Yes" results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of "Yes" to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Youth Screening Tool for Medi-Cal Mental Health Services

Respondent on Behalf of Youth

Name:	Date of Birth:
Age:	***NOTE:*** *If age 21 or older, switch to the "Adult Screening Tool for Medi-Cal Mental Health Services."*
Medi-Cal Number (CIN):	

1. Is this an emergency or crisis situation? ☐ Yes ☐ No

NOTE: *If yes, do not finish the screening and handle according to existing emergency or crisis protocols.*

2. Are you calling about yourself or about someone else? ☐ Self ☐ Someone else
   - If calling about someone else, who are you calling about and what is your relationship to them?

NOTE: *If calling about themself, switch to the "Youth Respondent" version of the tool.*

3. Can you tell me the reason you are seeking mental health services for the child/youth today?

4. Is the child/youth currently receiving mental health treatment? ☐ Yes ☐ No
   - If yes, where are they receiving those services?

NOTE: *If the individual is currently receiving mental health services from their MCP or MHP or MCP do not finish the screening. Instead, connect them with their current provider for further assessment.*

5. When was the last time the child/youth saw their pediatrician or primary care provider?

NOTE: *If the child/youth is age 3 or younger and has not seen a pediatrician in over 6 months or age 4 and older and has not seen a pediatrician or primary care physician (PCP) in over a year, continue the screening and connect them to their MCP for a pediatrician/PCP visit.*

Question	Yes	No
6. Is the child/youth currently or have they ever been in juvenile hall, on probation, or under court supervision?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
7. Is the child/youth currently in foster care or involved in the child welfare system?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
8. Has the child/youth ever been in foster care or involved in the child welfare system?	☐ 1	☐ 0
9. Is the child/youth currently without housing or a safe place to sleep?[1] ***NOTE:*** *If yes, stop the screening and refer to the MHP for clinical assessment.*	☐ —	☐ —
10. Has the child/youth ever been without housing or a safe place to sleep?	☐ 1	☐ 0
11. Is the child/youth having thoughts, feelings or behaviors that make it hard for them at home, school, or work?	☐ 1	☐ 0
12. Is the child/youth having thoughts, feelings, or behaviors that make it hard to be with their friends or have fun?	☐ 1	☐ 0
13. Is the child/youth often absent from school, work, or activities due to not feeling well?	☐ 1	☐ 0
14. Is the primary caretaker for the child/youth often not around or unable to take care of the child/youth?	☐ 1	☐ 0
15. Does the child/youth feel unsupported or unsafe?	☐ 1	☐ 0
16. Is anyone hurting the child/youth?	☐ 1	☐ 0

Question	Yes	No
17. Is the child/youth having trouble with drugs or alcohol?[2] ***NOTE:*** *If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.*	☐ —	☐ —
18. Is anyone in the child/youth's family or who lives with them having trouble with drugs or alcohol?	☐ 1	☐ 0
19. Does the child/youth self-harm or behave in a manner that may cause harm to themselves?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
20. In the past month, has the child/youth had thoughts about ending their life, wished they were dead, or wished they could go to sleep and never wake up?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.*	☐ 2	☐ 0
21. Does the child/youth have plans to hurt others?[3] ***NOTE:*** *If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.*	☐ 2	☐ 0
22. Has someone outside of the child/youth's family said that the child/youth needs help with anxiety, depression, or their behaviors?	☐ 2	☐ 0
23. Has the child/youth been seen in a hospital for a mental health condition within the last six months?	☐ 2	☐ 0
Total Score: 0 **If score is 0 – 5, refer to the MCP per instruction #11** **If score is 6 or above, refer to the MHP per instruction #11**		

1 Questions 6, 7, and 9 are not scored. A response of "Yes" results in a referral to the MHP for clinical assessment. Please reference BHIN 21-073 for additional detail on specialty mental health services criteria and definitions of key terminology.

2 Question 17 is not scored. A response of "Yes" results in a referral to the county plan for substance use disorder assessment in addition to the mental health delivery system referral generated by the screening score.

3 A response of "Yes" to questions 19, 20, and 21 results in immediate coordination of referral to a clinician for further evaluation of suicidality and/or homicidality after the screening is completed. The referral and subsequent evaluation may or may not impact the mental health delivery system referral generated by the screening score.

Transition of Care Tool for Medi-Cal Mental Health Services

The Transition of Care Tool for Medi-Cal Mental Health Services (hereafter referred to as the Transition of Care Tool) leverages existing clinical information to document an individual's mental health needs and facilitate a referral to the individual's Medi-Cal Managed Care Plan (MCP) or county Mental Health Plan (MHP) as needed. The Transition of Care Tool is to be used when an individual who is receiving mental health services from one delivery system experiences a change in their service needs and 1) their existing services need to be transitioned to the other delivery system or 2) services need to be added to their existing mental health treatment from the other delivery system.

Instructions: The determination to transition services to and/or add services from the other mental health delivery system must be made by a clinician in alignment with protocols. Once a clinician has made the determination to transition care or refer for services, all of the following actions must be taken:

1. Complete the Transition of Care Tool.
2. Send the Transition of Care Tool and any relevant supporting documentation to the plan the beneficiary is being referred to.
3. Continue to provide necessary mental health services and coordinate the transition of care or service referral with the receiving plan, including follow up to ensure services have been made available to the individual.

Transition of Care Tool for Medi-Cal Mental Health Services

REFERRING PLAN INFORMATION		
☐ County Mental Health Plan ☐ Managed Care Plan		
Submitting Plan:		
Plan Contact Name:	Title:	
Phone:	Email:	
Address:		
City:	State:	Zip:

BENEFICIARY INFORMATION		
Beneficiary's Name:		Date of Birth:
Beneficiary's Preferred Name:		
☐ Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	**Gender Identity:** ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Non-Binary ☐	
	Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐	
Address:		
City:	State:	Zip:
Phone:	Email:	
Caregiver/Guardian:	Phone:	
Medi-Cal Number (CIN)/SSN:		

BENEFICIARY INFORMATION

Behavioral Health Diagnosis or Diagnoses, if known:

Supporting Clinical Documents Included:

Cultural and Linguistic Requests:

Current Presenting Symptoms/Behaviors (including substance use if appropriate):

☐ Additional Pages Attached

BENEFICIARY INFORMATION

Current Environmental Factors (including changes in caregiver relationships, living environment, and/or educational considerations):

☐ Additional Pages Attached

Brief Behavioral Health History (including psychosocial stressors and/or traumatic experiences):

☐ Additional Pages Attached

Brief Medical History:

☐ Additional Pages Attached

Current Medications/Dosage:

☐ Additional Pages Attached

BENEFICIARY INFORMATION	
Referring Provider/Current Care Team:	Phone:
SERVICES REQUESTED: ☐ Transition of Care ☐ Addition of Service(s)	
What service(s) is the beneficiary being referred for?	
TRANSITION OF CARE OR SERVICE REFERRAL DESTINATION	
☐ Managed Care Plan:	
Managed Care Plan Contact Information	
Fax: Phone: Toll Free: TTY:	
☐ County Mental Health Plan:	
County Mental Health Plan Contact Information	
Fax: Phone: Toll Free: TTY:	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP~~C~~CP2026 (previously MCCP2026)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Diabetes Prevention Program</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/13/2019
Effective Date: 01/01/2019 per DHCS</td><td colspan="4">Next Review Date: ~~06/12/2025~~06/11/2026
Last Review Date: ~~06/12/2024~~06/11/2025</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td colspan="2">☒~~☐~~ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ 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>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~SING~~</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~~06/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3052 - Medical Nutrition Services
B. MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Diabetes Prevention Program (DPP): An evidence-based lifestyle change program, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.

~~A.~~B. Lifestyle Coach (also known as Peer Coaches): A person formally trained in Centers for Disease Control and Prevention (CDC) approved curriculum for a minimum of 12 hours or approximately two days. A lifestyle coach may have credentials [e.g. Physician, Registered Dietician (RD), and Registered Nurse (RN)], but they are not required. The CDC approved training may be provided by one of the following:

1. A training entity listed on the CDC website
2. A private organization with a national network of CDC recognized program sites
3. A CDC recognized virtual organization with national reach or
4. A Master Trainer, as designated by the CDC recognized program, who has delivered that lifestyle change program for at least one year and has completed a Master Trainer program offered by a training entity listed on the CDC website.

C. Medicare Diabetes Prevention Program (MDPP): An evidence-based lifestyle change program for individuals eligible for Medicare, available to Partnership Advantage members, taught by lifestyle coaches designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes.

D. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS) - approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

Policy/Procedure Number: MPCP2026 (previously MCCP2026)			**Lead Department:** Business Unit: Care Coordination
Policy/Procedure Title: Diabetes Prevention Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/13/2019 **Effective Date:** 01/01/2019 per DHCS			**Next Review Date:** 06/11/2026~~06/12/2025~~ **Last Review Date:** 06/11/2025 ~~06/12/2024~~
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

IV. ATTACHMENTS:

A. NA

V. PURPOSE:

To provide an overview of these external programs; Diabetes Prevention Program and Medicare Diabetes Prevention Program, including eligibility requirements and participation processes.~~To describe the Diabetes Prevention Program a provide eligibility requirements and processes for participation.~~

VI. POLICY / PROCEDURE:

A. Program Description

The~~e~~ Diabetes Prevention Program (DPP) and Medicare Diabetes Prevention Program (MDPP) are ~~is an~~ evidence-based lifestyle change programs established by the CDC, taught by lifestyle coaches and designed to prevent or delay the onset of type 2 diabetes among individuals diagnosed with pre-diabetes. Members must meet certain criteria to join, reference the Member Handbook for more information. https://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Handbooks.aspx

B. Eligibility Criteria

1. DPP Eligibility Criteria:

   Medi-Cal Members must meet the CDC Diabetes Prevention Program eligibility requirements to qualify for participation in the DPP benefit. The requirements are as follows:

   a. Must be 18 years or older
   b. Must not be pregnant at the time of enrollment. (A participant who becomes pregnant during the program may continue at the discretion of their health care provider and the program delivery organization.)
   c. Must have a body mass index (BMI) of ≥ 25 kg/m^2 (≥ 23 kg/m^2 if Asian American)
   d. Participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment.
   ~~e.~~ Must have a positive screening for pre-diabetes based on the CDC Prediabetes Screening Test
   e.
   f. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy (allowed for CDC recognition and may be self-reported; not allowed for MDPP participants)

2. MDPP Specific Eligibility Criteria:

   a. Partnership Advantage Members must meet the CDC Medicare Diabetes Prevention Program (MDPP) eligibility requirements to qualify for participation in the MDPP benefit. The requirements are as follows:

      1) Must be enrolled as a Partnership Advantage Member
      2) Participants cannot have end-stage renal disease (ESRD) at any point during the MDPP services period. A Member who previously had ESRD may be eligible to participate in MDPP if:
         a) It has been 12 months after the month the Member stops dialysis treatments, or
         b) It has been 36 months after the month the Member had a kidney transplant.
      3) Participants cannot have received MDPP services previously.
      ~~1)~~ All other requirements for MDPP are listed above in VI.B.1.b-e for reference.
      4)

3. All DPP & MDPP program eligible ~~participants~~members must ~~be considered eligible based on~~also meet one of the following clinical requirements~~ either~~:

   a. A blood test within the past year meeting one of the following specifications:

      1) Fasting glucose of 100 to 125 mg/dl
      2) Plasma glucose reading of 140 to 199 mg/dl ~~Plasma glucose~~ measured 2 hours after a 75 g

glucose load ~~of 140 to 199 mg/dl~~

3) HbA1c of 5.7 to 6.4%

b. Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy

c. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.

~~—~~A health care professional may refer potential participants to the program, but a referral or treatment authorization are not required for participation. Members meeting the eligibility criteria may self-refer.

~~—~~

~~a.~~d.

C. Provider Requirements

1. Diabetes Prevention Program and Medicare Diabetes Prevention ~~providers~~Program providers must comply with the most current CDC Diabetes Prevention Recognition Program (DPRP) guidelines and obtain pending, preliminary or full CDC recognition.
2. DPP and MDPP Providers must use a CDC approved lifestyle change curriculum that includes all of the following;
   a. Emphasizes self-monitoring, self-efficiency and problem solving
   b. Provides for coach feedback
   c. Includes participant materials to support program goals
   d. Requires participant weigh-ins to track and achieve program goals

D. Program Structure

1. DPP Program Structure
   a. The core DPP benefit includes a minimum of 22 DPP sessions for the first 12 months of the DPP benefit. These visits are typically once a week for the first 6 months.
   b. The core benefit is followed by maintenance sessions once a month for the next 6 months.
   c. Thereafter, Partnership will cover 12 months of ongoing maintenance sessions to qualified members to promote continued healthy behavior. A member qualifies for the ongoing maintenance sessions if:
      1) The member achieves and/or maintains a minimum weight loss of 5% from the first core session, and
      2) The member meets the attendance requirement as outlined in the Medi-Cal Manual in accordance with Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018) and The Medi-Cal Provider Manual (March 2022) .
      3) Weigh-ins are required, but may be obtained in these ways:
      4) In person at a DPP Session or DPP Provider location
      5) Remote weigh-in at the member's home using scales with digital or Bluetooth communications ability
   d. Self-reported weigh-ins with or without confirmatory documentation
2. MDPP Program Structure
   a. The core MDPP benefit includes 16 weekly core sessions over months 1-6, and 6 monthly core maintenance sessions in months 7-12.
      ~~—~~The remaining details of the MDPP Program Structure are listed above in VI.D.1.c-~~e~~d for reference.
   b.

~~D.~~E. Delivery Methods for ~~MDPP and~~ DPP and MDPP Sessions

Partnership will cover the following methods for DPP sessions and MDPP sessions (for Partnership Advantage members) as deemed clinically appropriate:

1. In-Person: Members must be physically present in a classroom or classroom-like setting with a lifestyle coach.
2. Distance Learning: Distance learning occurs when lifestyle coach(es) deliver sessions via remote classroom or telehealth. The lifestyle coach is present in one location while participants call in or participate by ~~video-conference~~videoconference from another location.
3. Online: Online delivery can be conducted either through synchronous real-time interactive audio and video telehealth communication or through asynchronous store and forward telehealth communication.

Combination: Members may use a combination of in-person, distance learning or online delivery methods.

4.

~~E.~~F. DPP Frequency

The DPP benefit for Medi-Cal M~~m~~embers only may be offered as often as necessary, but the M~~m~~ember's medical record must indicate that the M~~m~~ember's medical condition or circumstance warrants repeat or additional participation in the DPP benefit. Examples of circumstance that may warrant repeat or additional participation include:

1. Member switched enrollment from one Managed Care Plan (MCP) to a different MCP
2. Member transitioned from Fee for Service Medi-Cal into an MCP
3. Member moved to a different county
4. Member experienced a lapse in Medi-Cal enrollment
5. Member has or had medical conditions that hinder DPP session attendance

~~F.~~G. Curriculum and Translations

1. Partnership will ensure that MDPP & DPP providers use a CDC approved curriculum. MDPP & DPP Providers may use either the official CDC curriculum or a modified curriculum that has been approved by the CDC.
2. Partnership will monitor the MDPP & DPP providers to ensure that the MDPP & DPP services are provided in a culturally and linguistically appropriate manner and that the curriculum materials are translated and made available to members in a timely manner and meet all the requirements per Welfare and Institutions Code (WIC) Section 14029.91, Part 92 of Title 45 of the Code of Federal Regulations (CFR) and Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116].

~~G.~~H. Documentation of Performance-Based Codes

Partnership will ensure that any MDPP and DPP providers are informed and comply with all applicable state and federal laws and regulations, contract requirements and other Department of Health Care Services (DHCS) guidance, including All Plan Letters (APLs) and Policy Letters.

~~H.~~I. Ancillary Care Services Provider

Partnership credentials and re-credentials ~~all of~~all the types of ancillary care service providers which includes MDPP and DPP, refer to Partnership Policy MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements for more details.

~~I.~~J. Partnership Medical Equipment Distribution Services (PMEDS) Program

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

~~medical criteriacriteria, and their Provider submits a request form on their behalf. Forms can be found on the Partnership website at in the Provider Section. Keywords: Medical Equipment Distribution Services Request Form.~~

VII. REFERENCES:

A. DHCS All Plan Letter (APL) 18-018 Diabetes Prevention Program (11/16/2018)
B. Medi-Cal Provider Manual/Guidelines: Diabetes Prevention Program (*diabetes*)
~~B.~~C. Welfare and Institutions Code (WIC) Section 14029.91
~~C.~~D. Part 92 of Title 45 of the Code of Federal Regulations (CFR)
E. Section 1557 of the federal Patient Protection and Affordable Care Act [42 United States Code (USC) Section 18116]
~~D.~~F. Prediabetes Risk Test Sheet https://www.cdc.gov/diabetes/prevention/pdf/Prediabetes-Risk-Test-Final.pdf
G. Centers for Disease Control and Prevention, Diabetes Prevention Recognition Program Standards and Operating Procedures (03/01/2021) https://ncpa.org/sites/default/files/2021-05/2021-DPRP-Standards-and-Operating-Procedures.pdf ~~May 1, 2021~~
H. National Diabetes Prevention Program, Preventing Type 2 Diabetes with Medicare (05/15/2024) https://www.cdc.gov/diabetes-prevention/lifestyle-change-program/ndpp-medicare-program.html
I. Medicare Diabetes Prevention Program (MDPP) Expanded Model Fact Sheet https://www.cms.gov/priorities/innovation/Files/x/MDPP_Overview_Fact_Sheet.pdf
J. Medicare Diabetes Prevention Program (MDPP) Medicare Advantage Fact Sheet https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf
K. Medicare Diabetes Prevention Program (MDPP) Basics (04/30/2024) https://coveragetoolkit.org/medicare/mdpp-basics/

~~E.~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2026)
06/11/25

Medi-Cal
06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25

PREVIOUSLY APPLIED TO:

~~N/A~~**********

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

- Consistent with sound clinical principles and processes

Policy/Procedure Number: MPCP2026 (previously MCCP2026)			**Lead Department:** Business Unit: Care Coordination
Policy/Procedure Title: Diabetes Prevention Program			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/13/2019 **Effective Date:** 01/01/2019 per DHCS			**Next Review Date:** 06/11/2026~~06/12/2025~~ **Last Review Date:** 06/11/2025 ~~06/12/2024~~
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**

- 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="3">Policy/Procedure Number: MPCP2034 (previously MCCP2034)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transitional Care Services (TCS)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/12/2024
Effective Date: 01/01/2023</td><td colspan="3">Next Review Date: 06/12/202406/11/20265
Last Review Date: 06/12/202406/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</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>☐ CREDENTIALS</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: 06/12/202406/11/2025</td></tr>
</table>

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MCCP2007 – Complex Case Management
D. MCCP2032 – CalAIM: Enhanced Care Management (ECM)
E. MCAP7003MCUP3142 – CalAIM Community Supports (CS)
F. MCAP7001MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MCND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MCUG3011 – Criteria for Home Health Services
L. MCUP3028 – Mental Health Services
M. MCUP3101 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O. MCUP3064 – Communications Services
P. MCCP2018 – Advice Nurse Program
Q. MCCP2033 – Community Health Worker (CHW) Services Benefit

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Accountable Care Organizations (ACO): These are groups of hospitals, doctors, and other health care providers that come together voluntarily to provide coordinated high-quality care to assigned groups of patients.
B. Admission, Discharge, and Transfer (ADT) data: Feeds providingefor timely notifications of Mmember needs at the time of admission, hospital discharge, anddischarge, and transfer data and reducing

~~inefficiencies by sharing M~~member information ~~in standard~~standardized formats.

~~B.~~C. California Integrated Care Management (CICM): California-specific requirements for integrated care coordination for specific vulnerable populations covered by D-SNPs as determined by the state

~~C.~~D. 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.

~~D.~~E. Community Health Worker (CHW): Individuals known by a variety of job titles, such as promotors, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted M~~m~~embers of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

~~E.~~F. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(c) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help M~~m~~embers receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

~~F.~~G. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

~~G.~~H. Complex Case Management (CCM): The process of applying evidence-based practices to individual M~~m~~embers to assist them with the coordination of their care and promote their well-being.

~~H.~~I. Drug Medi-Cal Organized Delivery System (DMC-ODS): An opt-in 1115 waiver program available in California since 2015 that provides the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In the DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services which enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance use treatment, and coordinates with other systems of care. Of Partnership's 24 counties, 7 participate in ~~Partnership'~~Partnership's Regional DMC-ODS program (aka as Partnership's "Wellness and Recovery Program" see III.Q.): Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. Five other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Marin, Napa, Nevada, Placer, and Yolo counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed "State Plan" DMC program.

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

K. HCBS: Home and Community Based Services

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

~~I.~~M. Interdisciplinary Care Team (ICT): ICT will only be applicable for Partnership Advantage (PA) Members. A group of key stakeholders including, at minimum, the Member, their Primary Care Provider (PCP), and case manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes the oversight and coordination of care for D-SNP Members and may include additional specialists and family Members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings.

~~J.~~N. Longitudinal Support: This means that a single relationship must span the whole transition.

O. Long-Term Services & Supports (LTSS): These ~~include~~ services and supports are designed to enable~~allow~~ a M~~m~~ember with functional limitations and/or chronic illnesses ~~the ability~~ to live or work in the setting of their ~~Member's~~ choice. This~~,~~ ~~which~~ may include the Member's home, a worksite, a p~~P~~rovider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS encompasses~~includes~~ both Long-Term Care (LTC) and Home and Community Based Services (HCBS), and includes both carved-in and carved-out services.

P. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~K.~~Q. PointClickCare (PCC) formerly Collective Medical Technologies (CMT): A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s data sharing and information exchange system. This platform provides Admission, Discharge, and Transfer data on members from providers, facilities, and community partners that is reportable or integrated in Partnership systems.

~~L.~~R. Population Health Management (PHM) Service: A State-wide service that collects and links Medi-Cal beneficiary information from disparate sources and performs risk stratification and segmentation (RSS) and risk-tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions, and allows for multiparty data access and use in accordance with state and federal law and policy.

~~M.~~S. Risk Stratification and Segmentation (RSS)**:** Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process leverages data from multiple data sources to separate its M~~m~~ember populations into different risk groups and/or meaningful subsets using information collected through a proprietary algorithm and other data sources that include population and M~~m~~ember assessments, demographic data, and utilization data. Partnership's RSS results in the categorization of M~~m~~embers with care needs at all levels and intensities. When available, Partnership will also incorporate the standardized risk tier criteria provided through DHCS's PHM Service (defined in III.M. above), which will include a single, statewide, open-source RSS methodology for risk stratification that will place all Medi-Cal M~~m~~embers into high, medium-rising, and low-risk tiers.

~~N.~~T. 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 M~~m~~embers who have significant impairment or reasonable probability of functional deterioration due to a diagnosed or suspected mental health disorder as described in Behavioral Health

Policy/Procedure Number: **MPCP2034** *(previously MCCP2034)*			**Lead Department:** Health Services Business Unit: Care Coordination
Policy/Procedure Title: Transitional Care Services (TCS)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/12/2024 **Effective Date:** 01/01/2023			**Next Review Date:** ~~06/12/2025~~ **06/11/2026** **Last Review Date:** **06/11/2025**~~06/12/2024~~
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

Information Notice (BHIN) 21-073.

~~O.~~U. Transitional Care Services (TCS): A set of activities and interventions provided to M~~m~~embers transferring from one institutional care setting or level of care to another institution or lower level of care, including home settings.

~~P.~~V. TCS Care Manager: Regardless of organizational setting or job title, an individual who shall serve as the identified single point of contact who is responsible for the provision of transitional care services for a M~~m~~ember~~.~~

W. Wellness & Recovery Program (W&R): Partnership's regional Drug Medi-Cal Organized Delivery System waivered program in seven counties within Partnership's service area.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

~~To describe and define Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and members to ensure safe, effective, quality coordination of care and planning across health care settings.~~

~~This policy was written based on the request by DHCS as part of their PHM Policy Guide. Full implementation of the activities and requirements outlined in this policy are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities.~~To describe and define Partnership HealthPlan of California (Partnership's) Transitional Care Services (TCS) as required by the DHCS Population Health Management (PHM) Policy Guide. This policy shall also outline the collaboration between Partnership's Health Services staff, provider network, and Members to ensure safe, effective, quality coordination of care and planning across health care settings. This policy was written based on the request by DHCS as part of their PHM Policy Guide and the CalAIM Dual Eligible Special Needs Plan Policy Guide. ~~Full implementation of the activities and requirements outlined in this policy for members other than those enrolled in the Partnership Advantage plan are on pause until DHCS provides finalized guidance to Partnership on the funding source for these activities and has indicated they have finalized the PHM Policy Guide as it relates to TCS activities.~~

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. ~~Across these settings, thea TCS Ccare Mmanager, in collaboration with the rest of the InterdisciplinaryM Care Team (ICT), shall prioritize and ensure Mmember-centered care and activities for Medi-Cal and Partnership Advantage Mmembers by:~~Across these settings, TCS shall prioritize member-centered care by:
    a. Ensuring M~~m~~embers are supported with discharge planning until they have been successfully connected to all needed services and supports.

b. Ensuring that a single point of contact, herein referred to as a TCS Ccare Mmanager, can assist throughout all high-risk Mmembers' transitions, providing longitudinal support, and ensuring all required services are completed.
c. Ensuring that a dedicated TCS Team and a phone number is available to support lower-risk transitioning Mmembers telephonically when needed.
d. Ensuring Mmembers receive timely follow-up care after emergency department (ED) visits for mental health or Substance Use Disorder (SUD) issues.
e. Ensuring Mmembers receive timely follow-up after ED visits for pregnant and postpartum individuals (through 12 months postpartum), given the association of ED visits and maternal morbidity and mortality.
f. Updating a Partnership Advantage Member's Individualized Care Plan (ICP) as appropriate and distributing the updated ICP to the ICT.

B. TCS Member Eligibility & Identification:
1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Members shall be proactively identified for TCS services.
a. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MCND9001 Population Health Management Strategy & Program Description.
b. All Partnership Advantage enrolled members.
1) For the purpose of identifying TCS for Partnership Advantage, members receive all services in Section VI.B. and VI.C. required for High Risk members.
c. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations.
d. High-risk transitioning Members means all Members that meets criteria under MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other Members assessed as high-risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
e. In addition to these groups, and in recognition of high-risk of poor outcomes in transition for Partnership Members enrolled in multiple payors, those transitioning from SNFs, and those at high-risk who are potentially not captured in criteria mentioned in section VI.C.1.c, Partnership must also consider the following Members high-risk for the purpose of TCS:
1) Any Member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
2) Any Member transitioning to or from a SNF
3) Any Member that is identified as high-risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS
f. Lower-risk transition Members are defined as those not included in the high-risk transitioning Members noted above.
2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in Member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a Member's admission, transfer or discharge.

a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify Members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

~~B.~~ Transitional Care Services shall include the following:

C.

1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:
   a. Engages the M~~m~~ember/legal guardian/caregiver(s)/legal representative/authorized representative ~~/caregiver(s)/legal guardian/authorized representative~~, as appropriate, when being discharged from a hospital, institution, or facility.
   b. Focuses on the M~~m~~ember's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
   c. Uses a consistent assessment process and/or assessment tools to identify M~~m~~embers who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently required to identify these M~~m~~embers and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
      1) For high-risk M~~m~~embers, Partnership must ensure the discharging facility shares this information with Partnership's TCS C~~c~~are M~~m~~anager and that the discharging facilities have processes in place to refer ~~to~~ M~~m~~embers to Enhanced Care Management (ECM) or CS, as needed. Partnership will include those who are Partnership Advantage Members in California Integrated Care Management (CICM)
      2) For M~~m~~embers not already classified as high~~-~~risk by Partnership per Section VI.C.1, the discharging facility must have processes in place to leverage the assessment to identify M~~m~~embers who may benefit from high-risk TCS services. This process must include referrals to Partnership for:
         a) Any M~~m~~ember who has a specialty mental health need or SUD.
         b) Any M~~m~~ember who is eligible for an ECM Population of Focus.
         ~~b)~~c) Any Partnership Advantage Member who is eligible for CICM Population of Focus.
         ~~c)~~d) Any M~~m~~ember whom the clinical team feels is high~~-~~risk and may benefit from more intensive transitional care support upon discharge.
   d. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.
2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS), Long Term Support Services (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.
3. Ensuring that medication reconciliation is conducted both pre- and post-transition, ~~that~~ includinges education and counseling about the M~~m~~ember's medications.
4. Ensuring all necessary prior authorizations required for a M~~m~~ember's discharge are completed in timeframes consistent with the M~~m~~ember's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:

a. Therapy
b. Home care / Home Health
c. Medical supplies
d. Prescription medications
e. Durable Medical Equipment (DME)

5. Coordination to ensure appropriate ~~attendance and~~ follow-ups are completed for post-discharge appointments includes ~~attendance and follow-~~ up as follows:
   a. Ensuringe the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
   b. Confirming hospital has secured necessary follow-up appointments prior to discharge.
   c. Assisting with scheduling/arranging transportation when necessary for follow-up appointments.
   d. Ensuringe needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health treatment initiation.
6. Follow-up with Mmember and/or their legal guardian/caregiver(s)/legal representative/authorized representative ~~guardian/caregiver/legal representative/authorized representative~~ to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited orto no contact with the identified TCS Ccare Mmanager. In suchthese cases, ~~at a minimum,~~ the TCS Ccare Mmanager must, at a minimum, act as a liaison to coordinateing care among the discharging facility, the Pprimary Ccare Pprovider (PCP), and Partnership.
8. Coordination and verification that the Mmember is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the Mmember, their legal guardian/caregiver(s)/legal representative/authorized representative ~~acaregiver(s)/guardian/authorized representative~~ and the care team including, but not limited to, hospitals, physicians (including the Mmember's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the TCS Ccare Mmanager is to coordinate with discharging facilities to ~~to ensure the TCS Ccare Mmanager~~ fully understands the Mmember's ~~the~~ potential needs and ~~the needed follow-up plans~~follow-up plans. Additionally, the TCS Care Manager must ~~needed for the member and to~~ ensure the Mmember participates in the care plan and receives and comprehend~~understand~~s the information about their required~~needed~~ care. To achieve~~do~~ this, the TCS Ccare Mmanager must complete the following:
    a. Risk Assessment: The TCS Ccare Mmanager must assess ~~member's~~Mmembers' risk for adverse outcomes to inform needed TCS. This must ~~include,~~include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS Ccare Mmanager may supplement this risk assessment ~~as needed~~ through Mmember engagement as needed. During this process, the TCS Ccare Mmanager must also identify Mmembers who may be newly eligible for ongoing care management (ECM/CCM), or for PA Members (CICM), and/or Community Supports and make appropriate referrals.
    b. Discharge Instructions: The TCS Ccare Mmanager must receive and review a copy of the discharging facility's discharge instructions given to the Mmember, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon Mmember engagement, the TCS Ccare Mmanager must review the discharge instructions with the Mmember and ensure that Mmember can have any questions answered. A best practice (not

required) is for the TCS Ccare Mmanager to work with the facility to ensure that the TCS Ccare Mmanager's name and contact information are integrated into the discharge documents.

c. Discharge Summary and Clinical Information Sharing: The TCS Care Managers must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the ~~needed clinical information~~clinical information needed from the discharging facility, including the discharge summary.

d. Preadmission Sstatus: ~~which I~~includes living arrangements, physical and mental function, SUD needs, social support, DME usagees, and other services received prior to admission.

e. Pre-discharge Ssupport Nneeds: ~~which I~~includes the ~~M~~Mmember's medical condition, physical and mental function, financial resources, and social supports at the time of discharge.

f. Discharge Llocation:~~, which is T~~the hospital, institution, or facility to which the Mmember was admitted.

g. Specific Aagency or Hhome: R~~r~~ecommended by the hospital, institution, or facility after the ~~M~~Mmember's discharge based ~~up~~on the Mm~~M~~ember's needs and preferences.

h. Specific Sservices Nneeded Aafter the Member's Ddischarge:~~,~~ A sspecific description of the type of placement preferred by the Member, the~~specific description of~~ type of placement agreed to by the Member, ~~specific description of~~the agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling.

i. Summary of Participation in the Discharge Planning Process: A summary of the nature and outcome of the participation of the Mmember/legal guardian/caregiver(s)/legal representative/authorized representative~~caregiver(s)/legal guardian/authorized representative~~ in the discharge planning process.

j. Anticipated Pproblems and Further Actions: Anticipated problems in implementing post-discharge plans~~,~~ and further actions contemplated by the hospital, institution, or facility to be included in the Member's Medical Record.

k. Information on Post-Discharge Care and Services: Information regarding available care, services, and supports that are in the Mmember's community once the Mmember is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Mmember.

l. TCS Care Manager Information: The TCS Care Mmanager's name and contact information, along with ~~and~~ a description of TCS, should also be included.

~~11.~~ Ensures that the Discharge Planning Document shall use language that is culturally, linguistically and literacy-level appropriate, and be shared with the Mmember, their legal guardian/caregiver(s)/legal representative/authorized representative, ~~caregiver(s)/legal guardian/authorized representative,~~ treating providers, PCP~~primary care providers~~, discharging facility and the receiving provider.

11.

~~C. TCS Member Eligibility & Identification:~~

~~1. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Mmembers shall be proactively identified for TCS services.~~

~~a. Pursuant to the DHCS Population Health Management (PHM) policy guide, Partnership Mmembers identified as 'high risk' must be offered TCS services beginning January 1, 2023. Partnership must offer support for TCS for lower-risk transitioning Mmembers effective January 1, 2024.~~

~~For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy MCND9001 Population Health Management Strategy & Program Description.~~

~~All Partnership Advantage enrolled members.~~

~~For the purpose of identifying TCS for Partnership Advantage, members receive all services in Section VI.B. and VI.C. required for High Risk members.~~

~~b. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations.~~

~~c. High-risk transitioning Mmembers means all Mmembers that meets criteria under MCCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services Section VI.D.1 and other Mmembers assessed as high- risk by RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.~~

~~d. In addition to these groups, and in recognition of high- risk of poor outcomes in transition for Partnership Mmembers enrolled in multiple payors, those transitioning from SNFs, and those at high- risk who are potentially not captured in criteria mentioned in section VI.C.1.c, Partnership must also consider the following Mmembers high-risk for the purpose of TCS:~~

~~1) Any Mmember who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Mmember who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility~~

~~2) Any Mmember transitioning to or from a SNF~~

~~3) Any Mmember that is identified as high- risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS~~

~~e. Lower-risk transition Mmembers are defined as those not included in the high-risk transitioning Mmembers noted above.~~

~~2. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in Mmember identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).~~

~~3. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a Mmember's admission, transfer or discharge.~~

~~a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify Mmembers who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.~~

D. TCS Care Manager, Care Manager Assignment, & TCS Team

1. Once a high-risk M~~m~~ember has been admitted, Partnership shall identify a TCS C~~c~~are M~~m~~anager who shall serve as the single point of contact for the M~~m~~ember to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.
   a. For M~~m~~embers enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS C~~c~~are M~~m~~anager and perform all TCS services for the M~~m~~ember.
   b. For M~~m~~embers enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS C~~c~~are M~~m~~anager and perform all ECM services for the M~~m~~ember. For more information regarding the ECM benefit, see Partnership Policy MCCP2032 CalAIM Enhanced Care

Management (ECM).

2. For high-risk Mmembers identified for TCS, the Mmember shall be referred to Partnership's CCM program, ~~or~~ ECM benefit, or for PA Members; CICM benefit, as appropriate.

~~2.~~3. Partnership Advantage members are assigned a Primary Case Manager for all of the member's care coordination, including TCS. The PA primary case manager is the primary responsible person for longitudinal support and to collaborate with the staff involved with member transitions and will invite participation to the ICT based on a prioritized and active need in the ICP addressing transitions. Transitions of care involved staff (not all inclusive of inpatient review nurse coordinators, LTSS nurse coordinators, for example) provide clinical support and expertise related to transitions between care settings including LTSS.

~~3.~~4. For lower-risk Mmembers identified for TCS, Partnership is required:

a. To ensure Mmember has access to a ~~specialized~~ dedicated to provide assistance for any TCS need ~~TCS Team~~ (at Partnership or a delegate) for a period of at least 30 days from discharge.
b. To ensure Mmember can ~~outreach~~ reach ~~to~~ a dedicated telephonic support service. See Partnership Policy MCUP30~~4~~64 Communication Services~~, and~~ MCCP2018 Advice Nurse Program, and latest Member Handbook for more details.
c. To facilitate ~~as needed~~ Mmembers' ambulatory follow-up within 30 days of discharge for necessary post-discharge service, as needed.

~~4.~~5. For all other Mmembers identified for TCS, ~~W~~Partnership shall evaluate and identify an appropriate TCS Ccare Mmanager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, PCP~~primary care provider~~s, and/or other contracted agencies.

a. Facility staff who help with discharge planning should work with, but not take the place of the responsible TCS Ccare Mmanager, unless Partnership has formally assigned the facility to act as the TCS Ccare Mmanager.

~~5.~~6. ~~The ADT notification platform, PCC formerly CMT, shall be used to notify~~ Tthe TCS Ccarse Mmanager is notified of the Mmember's admission, discharge and/or transfer status including the location of admission and facility contact information.

~~6.~~7. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS Ccare Mmanager for the facility to include in the discharge planning document.

~~7.~~8. Partnership will provide the TCS Ccare Mmanager's contact information to the Mmember, legal guardian/caregiver(s)/legal representative/authorized representative, ~~member's parents, legal guardians, or authorized representative,~~ as part of the ~~discharge planning document~~TCS engagement.

~~8.~~9. The TCS Ccarse Mmanager must obtain permission from the Mmember, legal guardian/caregiver(s)/legal representative~~members' parents, legal guardians, or authorized representatives~~, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)

~~9.~~10. The TCS Ccare Mmanager must also ensure non-duplication of services provided through other programs such as ECM, CCM, CICM Targeted Case Management, etc.

~~10.~~11. The assigned TCS Ccare Mmanager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post-discharge.

~~11.~~12. High-Risk Member Outreach: The identified TCS Ccare Mmanager is responsible for contacting the Mmember within ~~calendar~~ 7 calendar days of discharge and supporting the Mmember in all needed TCS care identified at discharge, as well as ~~any~~addressing any new needs identified through engagement with the Mmember or their care providers.

13. Low-Risk Member Outreach: ~~Direct communication about the dedicated TCS team and phone line~~

~~and how to access it.~~ Partnership must make best efforts to ensure M~~m~~embers receive direct communication about the dedicated TCS team and phone line, and how to access it, ~~this information~~ no later than 24 hours after the plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating information into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of notification can be utilized.

E. End of TCS
   1. High-Risk Members
      a. TCS will end once the M~~m~~ember has been connected to needed services as identified in the discharge risk assessment or in the discharge planning document. TCS should extend at least 30 days post-discharge.
      b. If Partnership has delegated TCS to another contracted entity (e.g. hospital, PCP), Partnership will ensure that the delegate follows and coordinates services for the M~~m~~ember until all aforementioned activities are completed. A monitoring plan would be in place to ensure all required TCS are completed.
         1) This arrangement for managed care plan (MCP) contracted entities to provide TCS is not considered formal delegation. ~~and~~ T~~t~~herefore, Partnership is not subject to the requirements outlined in APL 23-006 "Delegation and Subcontractor Network Certification."
      c. For those M~~m~~embers who have ongoing unmet needs post-TCS, eligibility for ECM or CCM should be reconsidered.
      d. If the M~~m~~ember is enrolled in ECM, ~~or~~ CCM, or CICM and if the TCS C~~c~~are M~~m~~anager responsible for TCS will not continue as their ECM, ~~or~~ CCM, or CICM Lead Care Manager, the M~~m~~ember should be connected to their new TCS C~~c~~are M~~m~~anager through a referral.
      e. For M~~m~~embers who are unresponsive to Partnership's outreach attempts or did not attend scheduled follow-up ambulatory visits, Partnership must make reasonable effort to ensure M~~m~~embers:
         1) Are aware that TCS support is available for at least 30 days.
         2) Are engaged and that follow-up ambulatory visits are completed.
      f. For M~~m~~embers with multiple care transitions within a 30-day period, Partnership must ensure the same TCS C~~c~~are M~~m~~anager is assigned to support the M~~m~~ember through all ~~these~~ transitions. If the second transition occurs~~is~~ within 7 days of the first transition, ~~then~~ the TCS C~~c~~are M~~m~~anager must facilitate, as needed, a follow-up visit to be completed within 7 ~~-~~days post-discharge after the last transition. The TCS C~~c~~are M~~m~~anager must also provide TCS support for at least 30 days after the last transition. These M~~m~~embers should be considered for ECM/CCM/CICM and/or CS eligibility.
   2. Lower-Risk Members
      a. Partnership must continue to offer TCS support through a dedicated telephonic team for at least 30 days post-discharge.
      b. In addition to accepting referrals to longer term care management at any point during the transition, Partnership will use data including any information from admission, to identify newly qualified M~~m~~embers for outreach and enrollment into ECM/CCM/CICM and/or CS as appropriate.
   3. Partnership may utilize Community Health Worker's (CHW's) when available through the CHW benefit to facilitate M~~m~~ember outreach and engagement. Refer to Partnership policy MCCP2033 Community Health Worker (CHW) Services Benefit for details.

F. Prior Authorization and Timely Discharge
   1. Partnership adheres to regulatory prior authorization processing timeframes. The timely processing

of authorizations supports Partnership's contracted providers in discharge planning and ensuring necessary services and supports are in place prior to discharge. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process describes how Partnership monitors performance and complies with regulatory prior authorization processing timeframes and standards as well as APL 21-011 "Grievance and Appeal Requirements, Notice and "Your Rights" Templates".

2. As described in Partnership policy MPUD3001 Utilization Management Program Description, M~~m~~embers are evaluated for appropriateness of care setting pursuant to medical necessity and the documented discharge plan. The discharge plan shall take into account the continuing care needs and initiation of arrangements for services or placement needed after discharge.
    a. Partnership shall collaborate with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.
3. To support effective discharge planning practices, Partnership shall ensure all network providers (e.g. hospitals, acute care facilities, institutions, etc.) educate their discharge staff on the services, supplies, medications, and DME that require a Treatment Authorization Request (TAR). A list of items that require prior authorization is attached to Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A. The policy is made available on Partnership's website for further education and to support the provider network and discharge planning staff.
4. Partnership maintains mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services that apply to each of our Network Providers and Out-of-Network Provider hospitals within our Service Area.

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
1. Partnership is responsible for providing TCS to Partnership assigned M~~m~~embers even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible M~~m~~ember, in-patient acute psychiatric admissions, etc.)
2. For M~~m~~embers who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these M~~m~~embers, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.
3. For M~~m~~embers who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the M~~m~~ember's care upon discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (10/11/2023).
    a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
    b. Partnership shall identify a TCS C~~c~~are M~~m~~anager for these M~~m~~embers to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM, or CS are addressed.
    c. TCS for this transfer/discharge end once the M~~m~~ember is admitted to the behavioral health facility and connected to all needed services, including care coordination.

~~d.~~ After the M~~m~~ember's treatment at the behavioral health facility is complete and the M~~m~~ember is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

4. For Partnership members who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
   a. The member's Medicare Medi-Cal Plan (MMP) or the member's Dual-Eligible Special Needs Program (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership shall not provide TCS or assign a transitional care manager for M~~m~~ember enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).

~~If the member is enrolled in ECM or Partnership's CCM Program, Partnership shall notify the care manager of the admission, discharge or transfer status.~~

~~a. For Partnership members who are enrolled in Medicare FFS or Medicare Advantage plans that are not a D-SNP, Partnership shall ensure and provide TCS.~~

5. Drug Medi-Cal Organized Delivery System (DMC-ODS) or Partnership's Wellness and Recovery services:
   a. For M~~m~~embers needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
   b. For M~~m~~embers needing SUD services in the counties not participating in Partnership's Wellness & Recovery program, Partnership shall identify a TCS C~~c~~are M~~m~~anager for these M~~m~~embers to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM or Community Supports (CS) are addressed.
   c. TCS for this transfer/discharge end once the M~~m~~ember is admitted to the behavioral health facility and connected to all needed services, including care coordination.
   d. After the M~~m~~ember's treatment at the behavioral health facility is complete and the M~~m~~ember is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

H. DHCS Monitoring of TCS
   1. If Partnership contracts with or delegates to facilities or providers to provide full scope or specific components of TCS, Partnership must have robust monitoring and enforcement process in place to hold facilities or providers accountable for providing all required TCS outlined above.
   2. For more details on what DHCS will monitor with Partnerships' TCS implementation through specific PHM Monitoring Key Performance Indicators (KPIs), refer to the CalAIM Population Health Management Policy Guide for more details.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)
C. DHCS APL -23-006 Delegation and Subcontractor Network Certification (03/28/2023)
D. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans

and Third-Party Entities (*Revised* 01/08/2025~~10/11/2023~~)

1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)

F. Title 42 Code of Federal Regulations (CFR) Section 438.208

G. CalAIM Dual Eligible Special Needs Plans Policy Guide (2025)

H. CalAIM Population Health Management Policy Guide (2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
06/11/25

Partnership Advantage (Program effective January 1, 2026)
06/11/25

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="3">Policy/Procedure Number: MP<s>C</s>UP3137 (previously MCUP3137)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</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: <s>01/08/2026</s>06/11/2026
Last Review Date: <s>01/08/2025</s>06/11/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Parternship Advantage</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>☐ CREDENTIAL<s>SING</s></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>01/08/2025</s>06/11/2025</td></tr>
</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. Interdisciplinary Care Team (ICT): ICT will only be applicable for Partnership Advantage Members. A group of key stakeholders including, at minimum, the Member, their Primary Care Provider (PCP), and case manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes the oversight and coordination of care for Partnership Advantage Members and may include additional specialists and family members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings. For Partnership Advantage Members with a serious illness participating in the palliative care program, Partnership will use a palliative care ICT.
~~C.~~D. 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.
E. Partnership Advantage: Effective January 1, 2026, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage

and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Partnership Advantage Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

~~D.~~F. Palliative Care: Patient and family-centered care that optimizes qualify of life by anticipating, preventing, and treating suffering.

~~E.~~G. 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 and the Member's family and assist in identifying sources of pain and discomfort.

~~F.~~H. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California (Partnership) to refer a Partnership Member to a specialist for evaluation and/or treatment.

~~G.~~I. 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~~ for ~~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 Partnership.
   2. The Intensive Palliative Care Management benefit is limited to Members who have Partnership HealthPlan of California as their primary insurance, either for Medi-Cal, or as a Partnership Advantage Member.
   3. A 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 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'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-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 (and Palliative Care ICT for Partnership Advantage Members) 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 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 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 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'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, Partnership will generate regional lists of 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 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, Partnership will provide the list of local 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's primary providers.
   g. Partnership intensive care management teams may identify and refer care managed Members who are potentially eligible for this benefit, to a contracted Partnership palliative care provider
2. Adult Enrollment Criteria (see Attachment C for detailed requirements)
   a. For Members who meet the disease specific criteria (VI.B.5)

1) Submit a TAR for the Member's enrollment into the Intensive Home Based Palliative Care program to Partnership in accordance with 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 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.~~c. Enrolled 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 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 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 must be pre-approved via Partnership's TAR review process for palliative care to allow for billing under code T2025-TN.
   a. The 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 meets hospice criteria, the local hospice is not able to enroll the Member for non-medical reasons.
   b. The 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 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 with another health plan: A Member who becomes eligible for Medicare after enrollment into Partnership Medi-Cal may continue to receive palliative care services until the current TAR expires.
   1) Members who enroll into the Partnership Advantage (Medicare) plan are eligible for Intensive Outpatient Palliative Care through Partnership.

6. Adult Disease Specific Criteria
   a. **Congestive Heart Failure (CHF)**:
      1) The 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 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 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 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 has a diagnosis of stage III or IV cancer, AND
      2) The 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 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 has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices, OR
3) The 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. 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 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 Partnership policies MPCR300 Physician Credentialing and Re-credentialing Requirements and MPCR301 Non-Physician Clinician Credentialing and Re-credentialing Requirements. 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's home must comply with existing 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 Partnership's Provider Directory.

c. Partnership contracted intensive palliative care providers will contact 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 Partnership for services provided
   4) Organizations that are already contracted with 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 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 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)~~6) 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)~~7) 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 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 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 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. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
D. Social Security Act 1812(d)(1)
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)*
~~G.~~H. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (Re-release date 12/20/2024)

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

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

X. REVISION DATES:
Partnership Advantage (Program effective January 1, 2026)
06/11/25

Medi-Cal
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; (MPUP3137)
06/11/25

*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

****

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
Palliative Care Eligibility Assessment Form
ADULTS

Name: _____

DOB: _____

CIN: _____

Type of Insurance: _____

Name of Palliative Care Program: _____

General criteria: Check each of the following that apply (All needed for eligibility).

- ☐ Patient who is likely to or has started to use the hospital as a means to manage unanticipated decompensation in their late stage of illness. This refers to unplanned 'decompensation,' not elective procedures.
- ☐ Patient evaluated in their best compensated state
- ☐ The patient's death within a year would not be unexpected based on clinical status.
- ☐ Patients and Families are both:
  a. Willing to attempt in-home disease management by the palliative care team instead of first going to the emergency department AND
  b. Willing to participate in Advance Care Planning
- ☐ At least one of the following is true:
  a. Patient is intolerant to further therapy
  b. Patient declines further therapy
  c. Patient repeatedly decompensates due to severe non-compliance
- ☐ Palliative Performance Scale (PPS) or Karnofsky Performance Score (KPS) less than or equal to 70% or an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 (refer to pages 5 -7 of this document for these scales)

In addition, one of the following diagnoses must be selected, and the associated severity criteria met:

1. **Congestive Heart Failure (CHF)**
   - ☐ The member has been hospitalized with a primary diagnosis of CHF with no further invasive interventions planned OR
   - ☐ New York Heart Association (NYHA) heart failure classification III or higher NYHA (Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea or angina pain.)

   AND one of the following:

   - ☐ The member has an ejection fraction of < 30 for systolic failure
   - ☐ 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
   - ☐ Heart failure due to advanced diastolic dysfunction with preserved ejection fraction
   - ☐ Other severe cardiomyopathy or non-operable severe valvular heart disease

2. **Pulmonary Disease:**
   Chronic Obstructive Pulmonary Disorder (COPD): Member must meet 1 or 2
   - ☐ The 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
   - ☐ The member has a 24-hour oxygen requirement of greater than or equal to 3L per minute.

3. **Progressive Pulmonary Disease:**
   Idiopathic Pulmonary fibrosis, Primary Pulmonary Hypertension, or Cystic Fibrosis
   All of the following:
   - ☐ Disabling dyspnea at rest AND
   - ☐ Hypoxemia (oxygen saturation < 88%) on 2 LPM AND
   - ☐ Poorly response or unresponsive to standard treatment.

4. **Advanced Cancer:** Member must meet 1 and 2
   - ☐ The member has a diagnosis of stage III or IV cancer

   AND
   - ☐ The member has an Eastern Cooperative Oncology Group (ECOG) score of 3 or 4 OR
   - ☐ The member has failed of two lines of standard of care therapy (chemotherapy or radiation therapy) OR
   - ☐ The member refuses further cancer treatment

5. **Advanced Liver Disease:** Member must meet 1 and 2 combined or 3 alone
   - ☐ The member has evidence of irreversible liver damage, serum albumin <3.0, and Internal Normalized Ratio (INR) > 1.3 AND
   - ☐ The member has a history of ascites, bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or esophageal varices

   OR
   - ☐ The member has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.

6. **Progressive Degenerative Neurologic Disorder**
   - ☐ 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 any of the following:
     - ☐ dysphagia
     - ☐ aspiration pneumonia
     - ☐ unintentional weight loss of 10% or more
     - ☐ recurrent infections
     - ☐ significant cognitive decline
     - ☐ dependency on ventilator support
   - ☐ Amyotrophic Lateral Sclerosis (ALS) with a PPS score of 70 or less and a vital capacity of less than 55% predicted
   - ☐ Late stage dementia with progressive decline with both:
     - ☐ FAST scale score of 7a or more AND
     - ☐ Complications such as unintentional weight loss of 10% or more, dysphagia, aspiration pneumonia or a PPS score of 40% or less.

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

8. **Cerebrovascular Accident**
   - ☐ PPS score of 50% or less

   AND
   - ☐ Progressive unintentional weight loss of 10% or more, **OR**
   - ☐ Recurrent infections such as aspiration pneumonia or sepsis.

9. **Renal Disease:**
   - ☐ Creatinine clearance of 15 ml/min or less **AND**
   - ☐ Discontinuing or declining dialysis and not seeking kidney transplant

10. **Acquired Immunodeficiency Syndrome (AIDS):** A CD4 count less than 200 or a positive HIV test and an AIDS defining condition
    - ☐ Chooses to forego antiviral treatment

    Or has one of these AIDS related conditions:
    - ☐ Advanced AIDS dementia complex
    - ☐ CNS lymphoma or systemic lymphoma unresponsive to treatment
    - ☐ Kaposi's sarcoma unresponsive to treatment
    - ☐ Mycobacterium avium complex infection unresponsive to treatment
    - ☐ Progressive wasting syndrome

11. **Other Covered Conditions may be considered on a case to case basis:**
    - ☐ Serious pre-terminal medical condition with a life expectancy of one year or less
    - ☐ PPS score of 70% or less
    - ☐ Member has received maximal member-desired treatment or treatment is no longer effective
    - ☐ Member is using inpatient or emergency department utilization for symptom management

Palliative Performance Scale

%	Ambulation 1	Activity & Evidence of Disease 2	Self-Care 3	Intake 4	Conscious Level 5
100	Full	Normal Activity, No Evidence of Disease	Full	Normal	
90	Full	Normal Activity, Some Evidence of Disease	Full	Normal	
80	Full	Normal Activity with Effort, Evidence of Disease	Full	Normal or Reduced	
70	Reduced	Unable to do normal work	Full	Normal or Reduced	
60	Reduced	Unable for most activities, Significant Disease	Occasional Assistance	Normal or Reduced	
50	Mainly Chair	Minimal Activity, Extensive Disease	Considerable Assistance	Normal or Reduced	Full ± Confusion
40	Mainly Bed	As Above	Mainly Assisted	Normal or Reduced	Full or Drowsy ± Confusion
30	Bed Bound	As Above	Total Care	Reduced	Full or Drowsy ± Confusion
20	Moribund	As Above	Total Care	Sips	Full or Drowsy ± Confusion
10	Moribund	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death			0	0
Rate					

Karnofsky Performance Status Scale

Able to carry on normal activity and to work; no special care needed	100	Normal no complaints, no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance but is able to care for most of his/her personal needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospital admission necessary; active supportive treatment
	20	Very sick, hospital admission necessary; active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Deceased

Eastern Cooperative Oncology Group Performance Status Scale

Grade	ECOG Performance Status
0	Fully Active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g. light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities.; up and about more than 50% or waking hours
3	Capable of only limited self-care; confined to bed or chair more than 50% of waking hours
4	Completely disabled; cannot carry on any self-care. Totally confined to bed or chair
5	Dead

Palliative Care Patient Summary

Patient Name: _____

Patient DOB: _____

Document the specific clinical factors, functional capacity and complicating conditions that affect the patient's life expectancy:

_____
_____
_____
_____
_____

☐ The patient's death within a year would not be unexpected based on clinical status.

I confirm that I composed this narrative statement and that it is based on my review of the patient's medical record and/or my personal examination of the patient.

_____

Physician Date

Data Requirements:

Initial Enrollment:

1. Please include specialist consultation notes that document the diagnosis, extent of disease, prior treatments and outcomes and the options remaining to the member.
2. Please include specific information about the member's functional capacity including ambulation, activity level, and capacity for self-care.

Re-enrollment:

1. Please include specific information to document that the member continues to meet the general and specific criteria for the Partnership palliative care benefit.
2. Please include specific information about the member's functional capacity including ambulation, activity level, capacity for self-care and extent of disease.

Engagement and Enrollment Process for Outpatient Palliative Care

PHCPartnership HealthPlan of California does not require a Referral Authorization (RAF) from a primary care provider (PCP) to refer patients for palliative care services. A Treatment Authorization Request (TAR) will be required for all Palliative Care Services (engagement and enrollment) and should be faxed or electronically submitted from the palliative care provider to the Health Services Department for review, no less than once every three months, based upon medical necessity criteria and in accordance with PHCPartnership Policy MCUP3041 TAR Review Process. The TAR request for Palliative Care services must include, at a minimum, documentation and/or treatment plan addressing the following:

1. Advanced Care Planning: includes discussions about advance directives and Physicians Authorization for Life Sustaining Treatment (POLST) forms. These discussions take place between a physician and other qualified healthcare professional and a memberMember, family member or surrogate in counseling.

2. Assessment and Consultation: palliative care assessment and consultation services may be provided at the same time as advanced care planning, or in subsequent patient conversations. The goal of the palliative care consultation is to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include but are not limited to:
   a) Treatment plans, including palliative care and curative care
   b) Pain control, medication side effects, symptom control
   c) Emotional and/or social challenges
   d) Spiritual concerns
   e) Patient goals
   f) Advance Directives, including POLST forms

3. Plan of Care: a plan of care should be developed with the engagement of the memberMember and/or his/hertheir healthcare representative. If a memberMember already has a plan of care in place, that plan should be updated to reflect any changes resulting from the palliative care consultation. A memberMember's plan of care must include all authorized palliative care including, but not limited to, symptom management and curative care.

If a memberMember continues to meet the above minimum eligibility criteria, he/she may continue to access both palliative care services and curative care until the condition improves, stabilizes, or results in death. PHCPartnership will review treatment plan notes with TAR submission to assess for changes in the memberMember's condition and continued palliative care needs. PHCPartnership may discontinue palliative care for memberMembers for whom palliative care is no longer medically necessary.

Partnership HealthPlan of California

Application to be a Contracted Outpatient Palliative Care Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization** (

2. **Contact Information:**
   Administrative Contact of Parent Organization (if applicable)
   Name

   Title

   Phone

   e-mail

   Billing Department
   Name

   Title

   Phone

   e-mail

   Palliative Care Program Director

   Name

   Title

   Phone

   e-mail

   Palliative Care Medical Director
   Name

   Title

   Phone

   e-mail

3. Does your organization currently contract with Partnership HealthPlan of California?

   Yes ☐ No ☐

4. Medi-Cal provider number:

Palliative Care Program Description

5. Describe any palliative care services *currently provided* by your organization. Include current volume of services, the service delivery model, outcomes and the criteria for enrollment.

6. Number of patients enrolled annually in your organization's palliative care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

7. Number of patients enrolled annually in your organization's ☐ hospice or ☐ home care program (if applicable)

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

8. Does your organization provide palliative care services to children? ☐ Yes ☐ No
   If Yes, please describe level of experience and training in pediatric palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible and interested in community-based palliative care?

10. What geographic areas will your palliative care program serve?

11. Describe how your organization will partner with local hospice agency(s) and/or home health agencies.

12. Provide a narrative outlining:
(1) Staff disciplines and FTE your organization will use to provide 24/7 telephonic care (with access to a nurse), assessments, pain/symptom management, advance care planning, POLST, acute management plan, assess caregiver support, transition support, case management and medical oversight? If your organization will contract for some of these services, please describe the contractual arrangements. Include description of current and planned training and/or certification in palliative care.

13. How will your palliative care program be distinct from chronic disease case management and hospice programs? How will this distinction be communicated to providers and patients?

14. Attachments:

    a. C.V. of Medical Director of program
    b. Letter of commitment from applicant's parent organization or major funder of a new organization not affiliated with a larger corporate sponsor
    c. Letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology, pulmonology, cardiology)
    d. If organization is not a hospice organization, a letter or memorandum of understanding with local hospice organizations who can accept patients who need hospice care.
    e. Annual Audited Financial Statements

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Behavioral Health Overview Internal Quality Improvement Committee (IQI)

May 13, 2025

BH Overview

- Children & Youth Behavioral Health Initiative – School Initiatives
  - Student Behavioral Health Incentive Program (SBHIP) – Wrap up
  - School-Linked Multi-Payer Fee Schedule
- Mental Health Utilization
- Behavioral Health Program Changes in 2024 and 2025
- Eating Disorder Treatment
- Wellness & Recovery (SUD)

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Student Behavioral Health Incentive Program (SBHIP)

SBHIP: Three-year project for MCPs to partner with schools

- **24 County Office of Education (COE) partners**
- **121 Local Educational Agency (LEA) partners**
- **41 total targeted interventions**
- **$30 million in funding for Schools in Partnership's Region**

Program Ended December 31, 2024!

ACCREDITED NCQA HEALTH PLAN

Purpose of SBHIP

"Break down *silos* and improve coordination of child and adolescent student behavioral health services through increased communication with schools, school affiliated programs, *managed care plans*, counties, and mental health providers."

"Increase access to prevention, early intervention, and other behavioral health services on or near school campuses or by a school-affiliated behavioral health provider."

SBHIP By The Numbers

- 28 new Wellness Centers at schools across 7 counties, with more than 2,600 student visits
- New MH screenings at 16 LEAs across 5 counties; more than 3,600 additional students screened
- Social/Emotional Learning & Wellness Programs launched in more than 8 counties
- BH staffing expanded by more than 76 FTE positions/providers across 16 counties
- Educator & staff training in MH, SEL across 9 counties – more than 1600 staff trained
- Data tracking systems and/or closed loop referral processes established in 11 counties
- Care Teams launched across 4 counties
- Teletherapy expanded in at least 3 counties
- Suicide Prevention programs launched in 2 counties

SBHIP in Action

Mental Health and Support Resources

Del Norte Unified School District

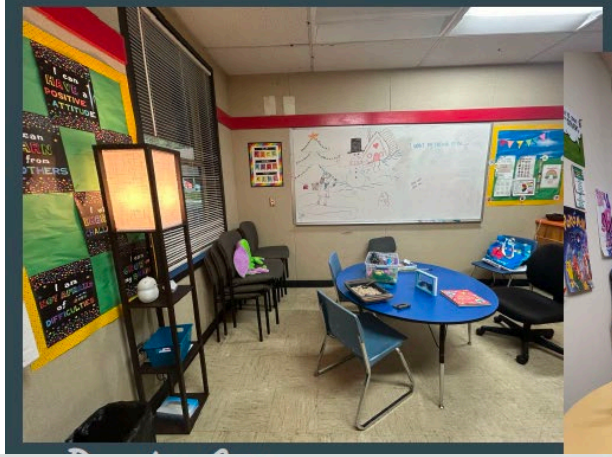
Equipping Students for Success

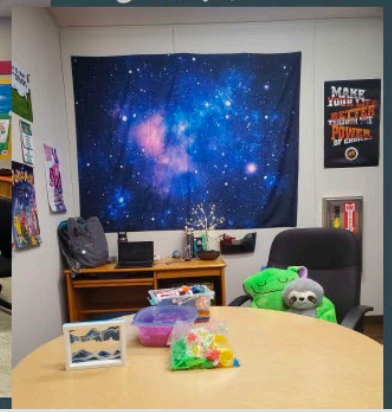
SBHIP in Action

Wellness Centers

Clinicians:
Megan
Jennife

Burnt Ranch



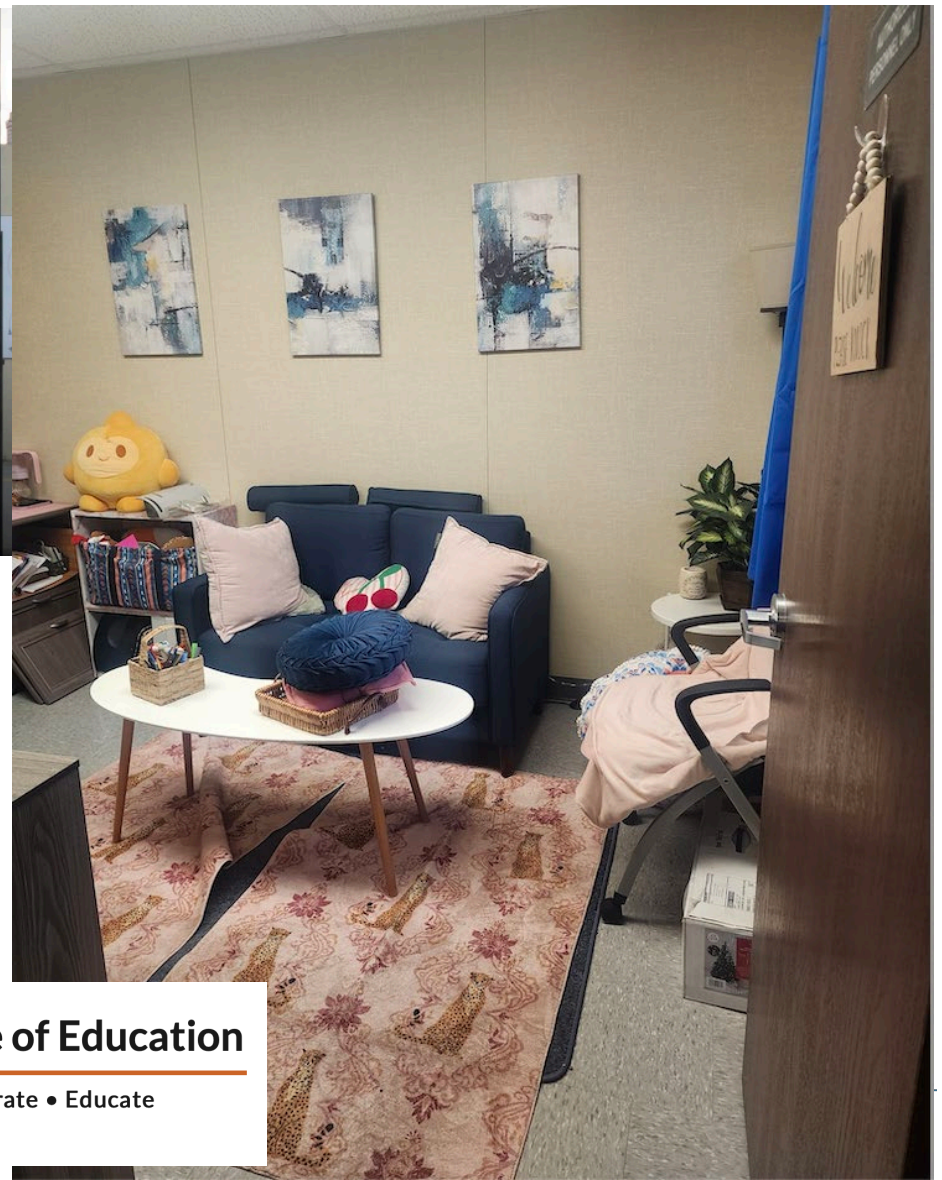


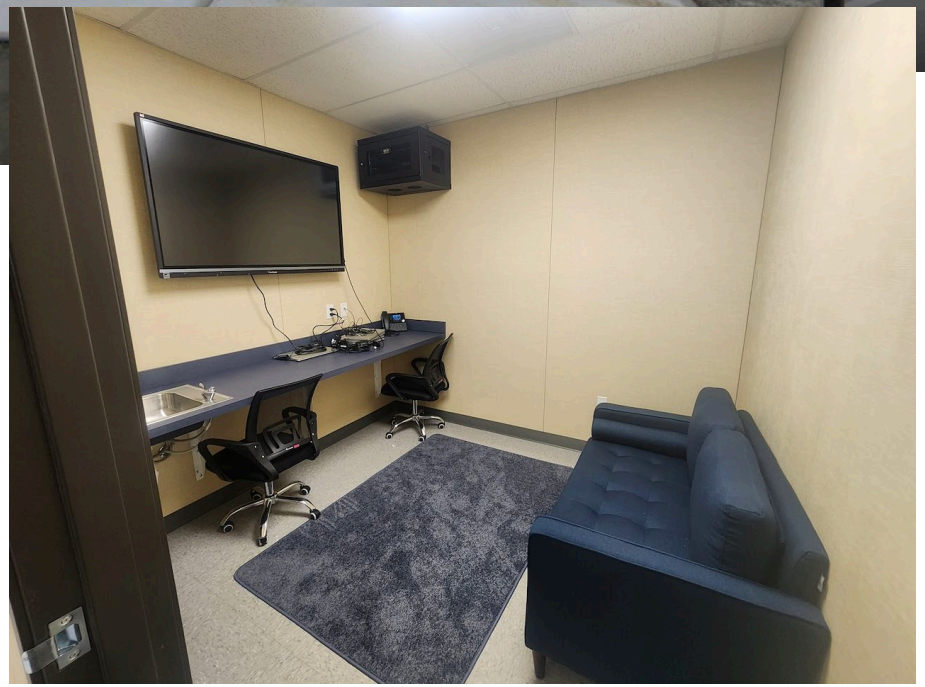
- Calm
- Resi
- Soci
- Lear
- Con
- Com
- Resi
- Supp
- well

Weaverville Elementary School Counseling Space

TRINITY COUNTY
OFFICE OF EDUCATION

SBHIP in Action





MAXWELL Unified School District

Colusa County Office of Education

Communicate • Collaborate • Operate • Educate

SBHIP in Action

Medi-Cal Billing Vendor RFP Process

The California Children's Trust and Lucid Partnerships supported the Shasta County Office of Education to complete a RFP process for a new Medi-Cal Billing Vendor. The documents created during that process are being shared to help other COEs and LEAs complete similar RFP processes.

RFP & Attachments
- RFP
- Timeline
- FAQ
- Medi-Cal Summary Table

RFP Review & Vendor Interviews
- Draft Scoring Rubric for RFP
- Initial Draft of Vendor Interview Questions
- Final Interview Questions
- Reference Check Questions

Correspondence
- Vendor List
- Internal Emails to Keep Staff Updated
- Acknowledgment of RFP Submission
- Vendor Interview Reminder
- Post Interview Correspondence with Vendors
- Correspondence with Reference Check
- Contract Offer to Vendor

CA Children's Trust's Reference
- 10 Tips to Maximize Your School-Based Medi-Cal Reimbursement through the LEA Billing Program
- Suggested Steps and Actions for the Medi-Cal Vendor RFP Process

SHASTA COUNTY OFFICE OF EDUCATION | lucid | California Children's Trust

For more information contact Joy Garcia at (530) 410-3050 or jgarcia@shastacoe.org.

CommunityConnect

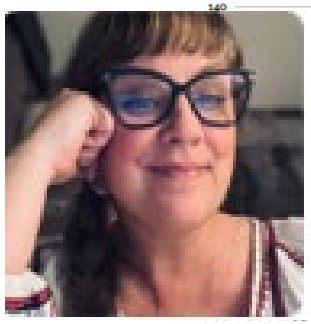
SHASTA COUNTY OFFICE OF EDUCATION

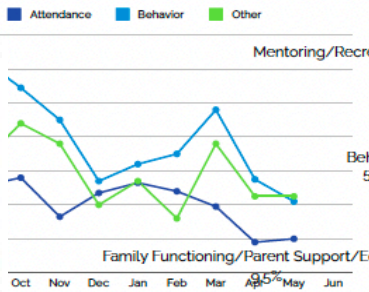
Community Connect summary of referrals received from **83 Shasta County Schools** from August-May 2024. Community Connect services are provided all year long with Case Management services provided by Clinicians and Community Connect Coordinators. All services are voluntary. Case Managers work with the guardians of referred students and complete assessments, provide linkages to community based organizations, and offer strengths-based and trauma focused supports.

1712	377	773	562
Total Referrals	Attendance Referrals	Behavior Referrals	Other Referrals
% change from same timeframe in 22/23	-3%	-59%	+27%	+135%

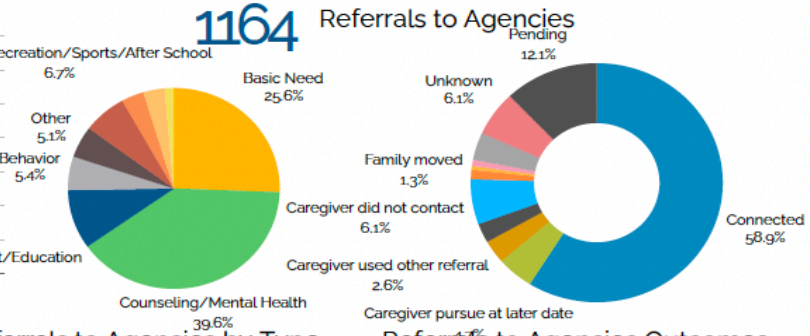
82% % of those Community Connect made contact with. This included those pending contact

85% % of those who accepted services once contact was established





Received by Month



Referrals to Agencies by Type

Referrals to Agencies Outcomes

Post SBHIP: Next Steps for Behavioral Health in Schools

* Multi-Payer Fee Schedule

- ***All*** health plans will reimburse for 'school-linked' behavioral health services beginning 2024
- Administered by Third Party Administrator (Carelon) for DHCS
- New Provider types (Wellness Coaches, Guidance Counselors, PPS)
- Rolling Implementation by cohorts

Cohort I:

PHC Counties:

Butte – Butte COE

Humboldt – Humboldt Court & Community; Southern Humboldt USD;

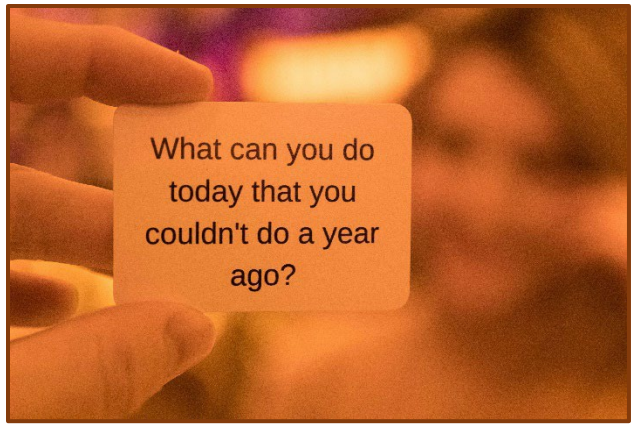
Nevada Joint USD

Placer – Placer COE; Roseville Joint USD

Shasta – Shasta COE Solano – Solano

COE

Tehama – Tehama COE; Red Bluff Union SD



First Claims Accepted statewide for this new billing system – <u>Nevada Union and Solano</u>!!

Non-Specialty Mental Health Utilization

CY 2024

* Over 76k Members utilized NSMHS
* 8% Penetration Rate for NSMHS

CY2023

- Average of 10 visits per utilizer
- 32% Telehealth Visits
- Diagnoses:
  - 44% Anxiety Disorders
  - 25% Depressive Disorders

CY 2024

Average of 10 visits per utilizer

44% Telehealth Visits

Diagnoses:

45% Anxiety Disorders

25% Depressive Disorders

Program Changes in 2024 and into 2025

HEDIS – FUM/ FUA (focus on access to care)

- Leveraging lessons learned from 2024 pilots to better outline pathways for follow-up to ED services for MH & SUD diagnosis (IHI Collaborative, CHW grant, FUA/FUM grant – Sutter, CBH)
- Looking at data to determine the "why" behind missed numerator hits (dx, CPT code, timeliness)
- Educating providers on follow up from ED visits, including best practices in coding
- Partnering with counties to close gaps in data

NCQA Standards Revised

- Removal of the Grand Analysis for QI4

County Child Welfare & First 5 Commissions

- New relationships, care coordination and MOU requirements

Carelon De-delegation

- In September of 2025 Partnership will de-delegate the following member facing activities from Carelon and administer in-house:
  - Access line (both mental health and SUD)
  - Care coordination
  - Grievances & appeals

Program Improvements 2025 & Beyond

Spravato – leading the effort to provide clinical practice guidelines

Transcranial Magnetic Stimulation – newly added to NSMH services

- Clinical criteria under review

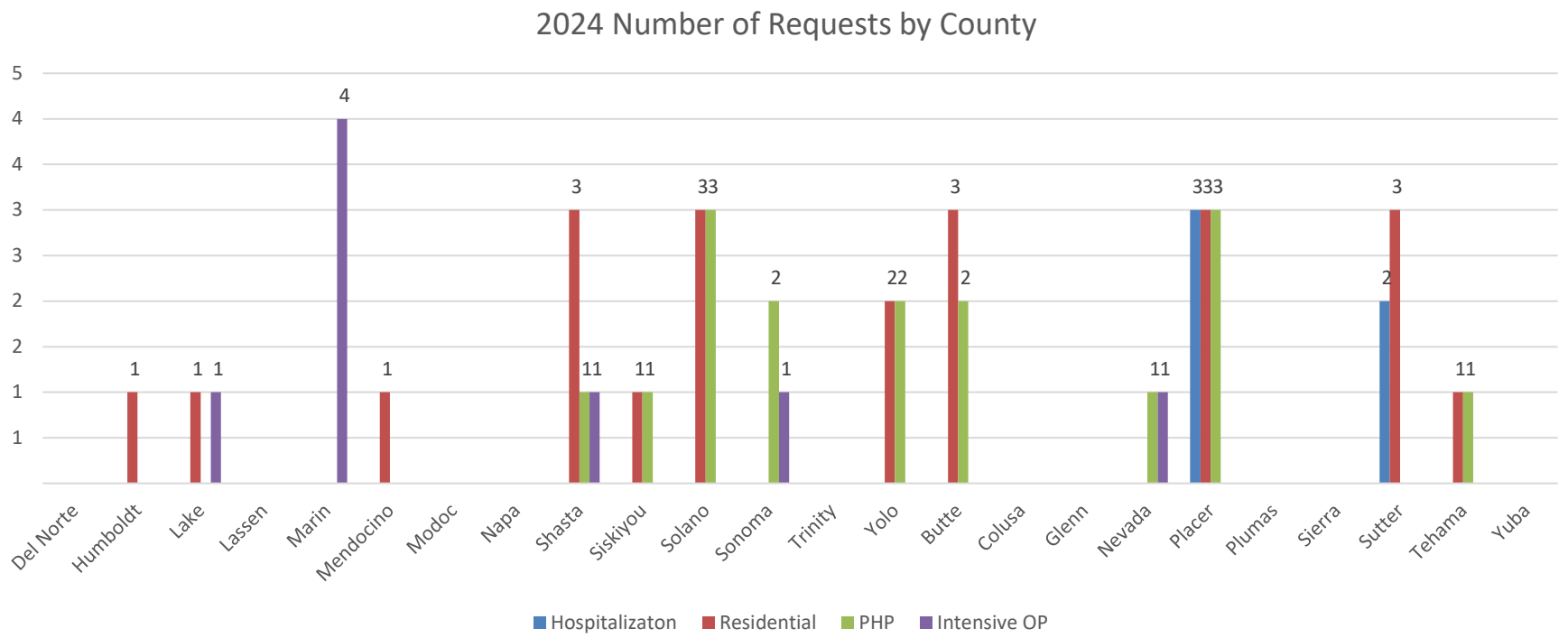
Narcan Distribution - offering of Narcan for Partnership Staff to expand access in community

Medicare Advantage (DSNP) – planning for 2026 implementation and new responsibilities for higher levels of care in behavioral health

- Developing clinical criteria to be used for psychiatric inpatient, IOP, and PHP in conjunction with Interqual guidelines
- Modifying policies to reflect CMS requirements including referrals, treatment authorization, clinical justification, and prescribing guidelines

Eating Disorder Treatment

Eating Disorder Treatment is a shared financial responsibility with county Mental Health Plans (MHPs) at certain treatment levels: Residential, Partial and IOP

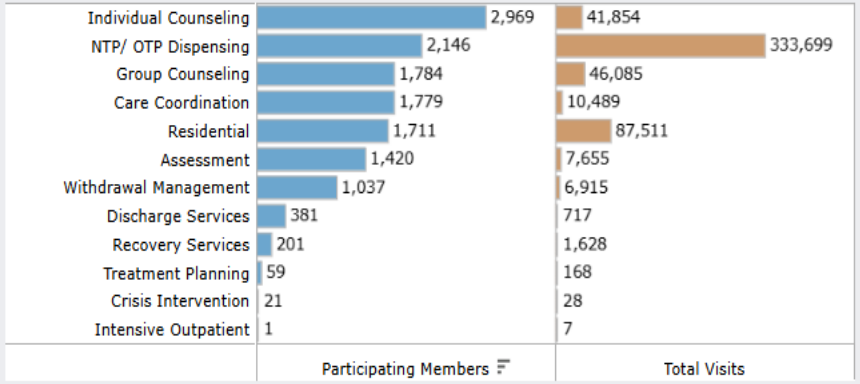


Wellness & Recovery – CY 2024

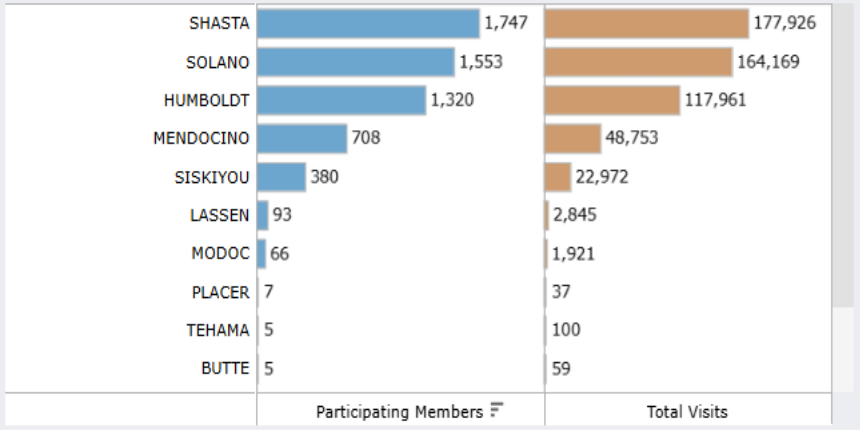
5,815
Total participating Members

536,756
Total Visits

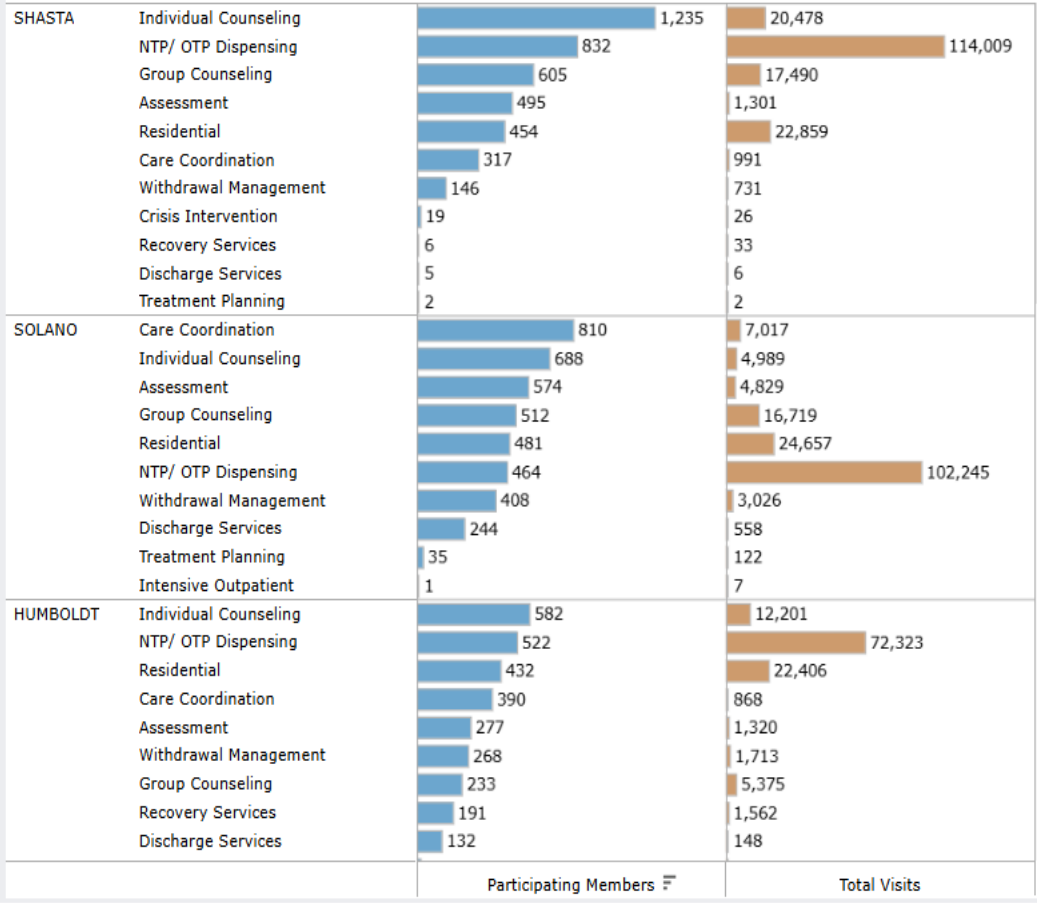
Members and Total Visits By Service Type



Members and Total Visits By County



Members and Total Visits By Service Type and County



Nearly 600 additional members served this year over 2023 (11.3%)

5 providers added to the network for a total of 72 programs

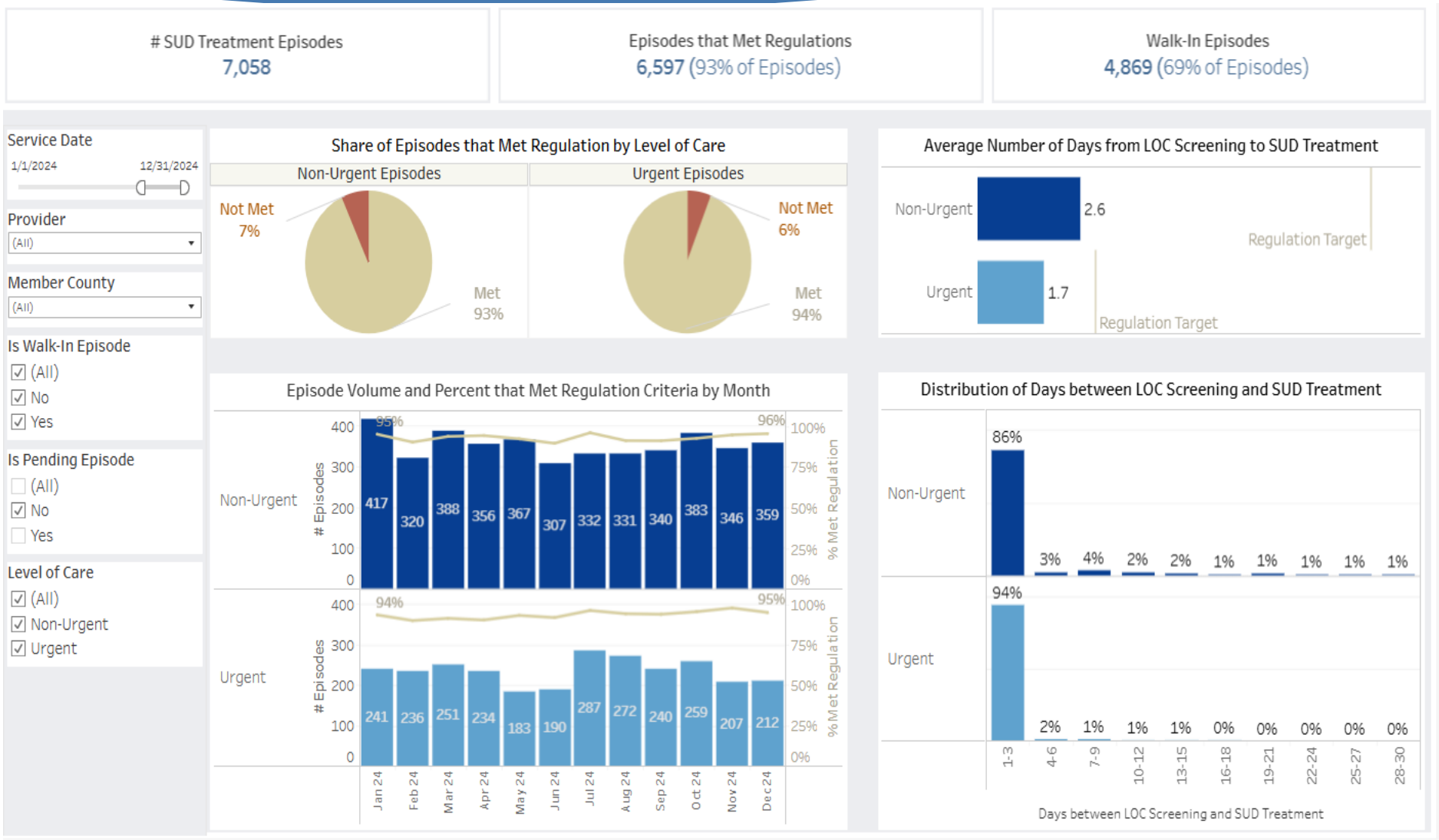
9 additional programs slated to join network in early FY25/26

W&R – Timely Access – CY 2024

Access to services has been maintained by >80% since inception in 2020.

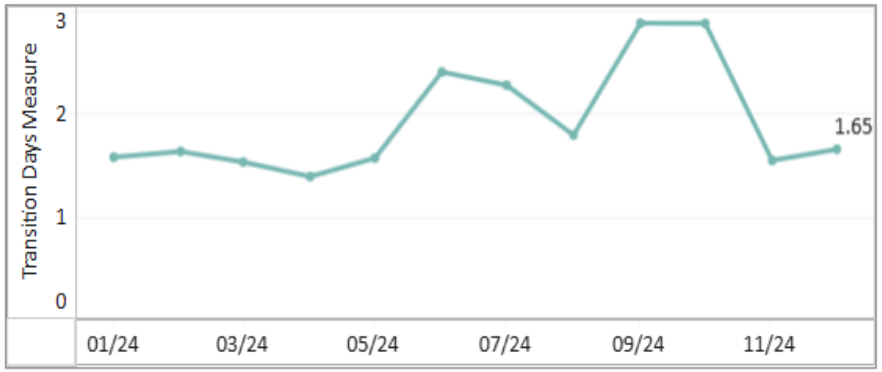
Improvement made in connections between EDs and treatment providers through CHW work. This work also improves FUA scores.

Direct referrals have increased over the last year by 12%.

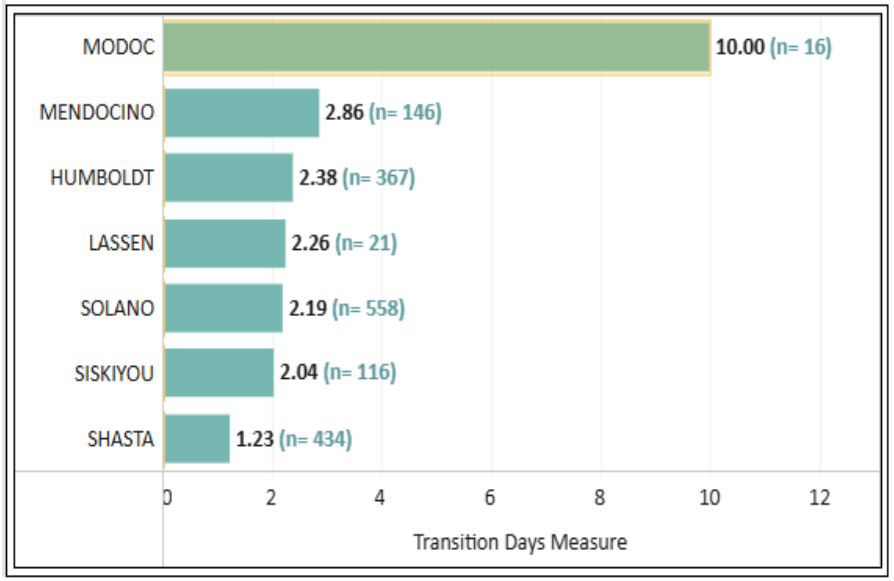


W&R - Transitions of Care – CY 2024

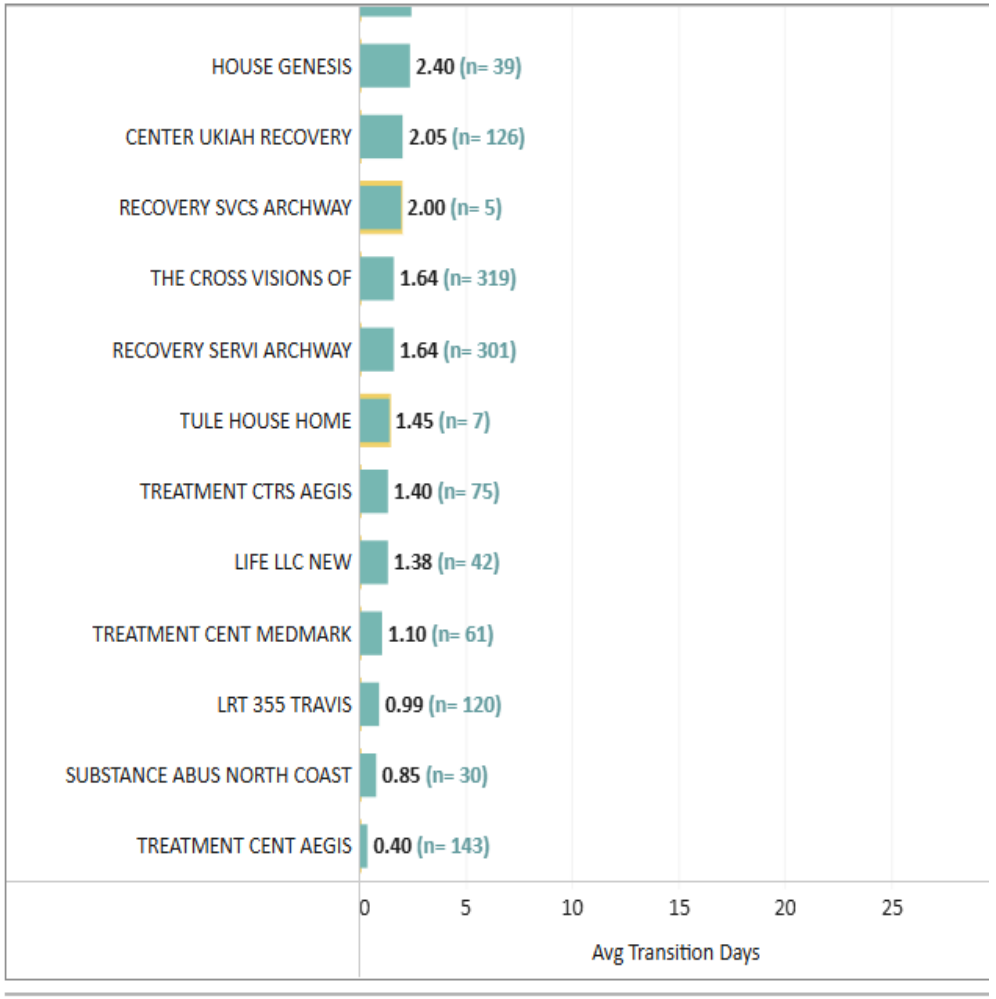
Average Days of Transition over Time



Average Days of Transition by County



Average Days of Transition by Service Provider

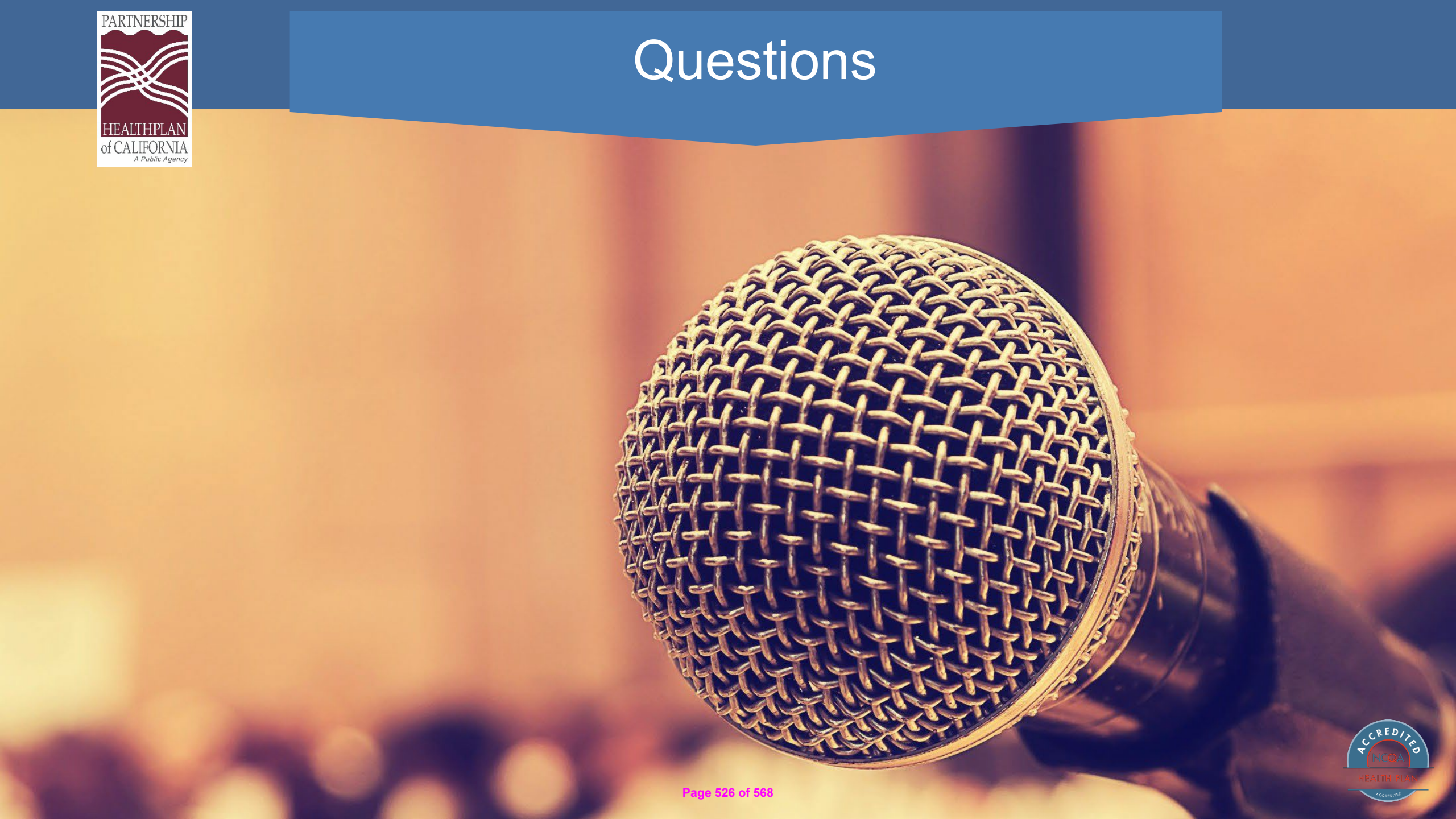


Continued focus on relationship building amongst the network to ensure referrals to higher or lower levels of care occur

Increased awareness of MAT services for members, provided each program with referral options, added to medical record review requirements

Looking for improved options for medical clearance in 2025

Questions



Reporting Period: 01/01/2024-12/31/2024
Prepared By: Leah Imhoff, Program Manager I
Presented By: Rachel Newman, Manager of Clinical Compliance

Initial Health Appointment

Overview

In January 2023, DHCS issued APL 22-030 which changed the name to the Initial Health Appointment (IHA) and discontinued the requirement of a Staying Healthy Assessment (SHA) questionnaire to be completed by the member and reviewed by the Primary Care Physician (PCP) annually. The Staying Health Assessment (SHA) was replaced by the Member Risk Assessment effective January 1, 2024.

The initial Member Risk Assessment is related to health and social needs of members, including cultural, linguistic, and health education needs; health disparities and inequities; lack of coverage/access to care; and social drivers of health (SDOH) shall be conducted. An assessment of at least one of the following risk assessment domains meets the standard: Social Determinants of Health (SDOH), Adverse Childhood Experiences (ACEs), and/or Pediatric ACEs and Related Life Events Screener (PEARLs).

Partnership ensures that network providers will complete an Initial Health Appointment (IHA) for new members within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 90 days of a member's assignment to a PCP (whichever is most recent). The Initial Health Appointment (IHA) is 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. Partnership abides by DHCS guidance for member screening and assessment, and monitors assessments through the Site Review process.

Requirements for an Initial Health Appointment (IHA):

- Must be performed by a Provider within the primary care medical setting.
- Must be provided in a way that is culturally and linguistically appropriate for the Member.
- Must be documented in the Member's medical record.

An IHA must include all of the following:

- 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
- The diagnosis and plan for treatment of any diseases.
- Member risk assessment
- 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.

If the provider is unable to complete an IHA within the appropriate timeframe, providers are encouraged to outreach to the member with a minimum of 2 documented attempts. This is monitored through the Site Review process.

Methodology – see attached data report

Our IHA compliance report captures encounter data for members enrolled in Partnership between January 1, 2024 and December 31, 2024. Additional criteria was built into the report to accommodate claims lag of approximately three months. The report looks for 8 months of continuous enrollment.

With continuous efforts over the last year and a half of editing the report to capture an IHA approved visit, we feel as we are closer to the most accurate a report can be without a DHCS approved IHA procedure code. These efforts have included shifting our focus to the fourth month for new enrollees whereas before members that started as Direct members were excluded from this report. This has brought our enrollment numbers from the hundreds up to the thousands for each month. We have also included a more claims-centric approach to help capture these members, that includes when the visit happened, where the visit was completed, and what procedure and diagnosis codes are attached to the visit. For a more detailed list of the changes made to the report, information can be provided upon request.

Potential IHA Scores Based on Claims Submission:

Partnership uses an array of codes that were most probable to represent the completion of an IHA. These codes can be found on Attachment B of our IHA Policy.

- 2022 54.45%
- 2023 53.02%
- 2024 40.07%

The data with the most accuracy comes from our Site Review process since these records are reviewed individually by our DHCS Certified Site Review Nurses. For MY 2024 2,509 records qualified for IHA during the Medical Record Review (MRR) Process. Out of these records, 94.8% were compliant. These members met the history and physical requirements and the timeline standards for the IHA.

Barriers

1. The ability to efficiently capture IHA-related elements from code sets is another large barrier to gleaning this information from medical records. During the FY 2021-2022 audit, Partnership discussed with DHCS the difficulties we face in data capture due to the lack of a singular billing code to capture IHA compliance. The recently released APL 22-

030 does not offer guidance on data capture or coding for completion of IHA or member refusal of IHA's.

2. Previously, we used billing data to represent Partnerships potential IHA compliance rates. However, without the use of a singular billing code, the data needs to be validated at the medical record level to verify accuracy. The best way to validate this is through our Site Review process until DHCS is able to assign a single billing code for data tracking purposes.
3. The release of the CalAim Population Health Management Strategy Guide Update in August of 2023, states that DHCS will leverage Managed Care Accountability Sets (MCAS) measure focused on preventative services as a proxy for monitoring IHA. This is currently being discussed at the Site Review MCP Workgroups and is on hold for further guidance as DHCS Population Health and DHCS Site Review Team work through the details of monitoring compliance.

DHCS

We are happy to announce our 23-24 DHCS FY Audit was successful and no corrective action plan was issued.

Partnership was under a DHCS Corrective Action Plan (CAP) for IHA for FY 2021-2022. As a result of these findings, Partnership was under this CAP for the entire audit period of FY 2022-2023. We worked closely with the DHCS Audit Monitoring Unit, and were able to close the Initial Health Appointment CAP portion as of October 2023.

Improvement Activities

Miscellaneous Continuous Efforts:

1. Sites receive a monthly email reminding them to retrieve the list of new enrollees and are educated to document their outreach attempts to new members. If they have outreached two times and documented each, they are compliant for that member. We are providing spreadsheets for the sites to document their efforts, as many sites do not wish to open a new chart before the member is located and makes an appointment. This was changed from a three attempt outreach to a two attempt outreach based off the Population Health Management Policy Guide and APL 22-030.
2. A collaborative meeting is held quarterly which includes Care Coordination, Claims, Health Education, Quality, Utilization Management, Population Health, Provider Relations and Member Services departments to increase efforts to inform members and providers of the need for members to come in for the IHA. The diversity of departments represented by this workgroup allows for unique perspectives on the opportunities and barriers to IHA performance.

3. Newsletter Articles: Information continues to be shared through our Provider and Member Newsletters. These articles are available on the Partnership website.
4. Provider education is available on the Partnership website including a webinar for new Providers.
5. Newly credentialed providers are educated on IHA process and a new member packet is sent out to members informing them of the importance of an IHA. This information is also provided in the member handbook.
6. The 2023/2024 Smart Goal includes performing 18 Initial Health Appointment (IHA) focused audits on selected PCP sites, outside of and in addition to the scheduled Facility Site Review process. Focused audits will consist of 10 members eligible for an IHA. Partnership will issue a Corrective Action Plan (CAP) to those provider sites that are not meeting APL 22-030 standards. CAP will require staff education on the IHA process. **Goal Outcome:** 19 IHA focused audits of sites completed. 19 Corrective Action Plans (CAPs) were issued. This goal helped the Inspections team review the logic that is being pulled from our IHA report to find reporting discrepancies. This also provided the team one-on-one time to educate providers on changes with IHA guidelines as evidenced by the corrective action plans.
7. The 2023/2024 Smart Goal includes that the Inspections team will attend and present Blood Lead Screening (BLS) and Initial Health Appointment (IHA) slides at a minimum of 10 Clinical Operations Meetings. These customized meetings with providers and practice staff allow for direct interaction with Partnership staff from multiple departments. They provide a forum for Partnership to present updates on specific topic, review identified gaps in care and to field questions directly from providers about various topics of concern. **Goal Outcome:** Inspections presented IHA and/or BLS slides at 37 Ops meetings. Worked closely with PR on scheduling and providing slides. Continue attending Ops Meetings for Provider Education. These operation meetings provided the Inspections team opportunities to educate on Blood Lead Screening and the Initial Health Appointment, while answering FAQs and providing information with the goal of improving compliance.
8. Monthly mailers are sent to Providers along with address labels for newly enrolled members so providers can reach out to members to schedule an IHA.
9. Currently researching to include Robo Calls to members as a reminder to schedule IHA.
10. Providers are able to run reports of their newly assigned members in Partnership's Provider Online Services portal. QI will be researching with IT to see if a module can be created for providers to submit their outreach efforts through Provider Online Services. This is a long term goal as IT has multiple competing projects.
11. Members are reminded when calling in by member services to reach out to their PCP for an IHA with prerecorded hold messages and again when speaking to a member services representative.

12. With the change of vendor for our Site Review process in April 2023, we now have a staff writer that is attached to our CAP process that informs providers on ways to improve their compliance in all areas of the tool which includes IHA.
13. The Site Review Team offers 1:1 educational training about IHA requirements at every site review exit interview. This educational piece is also posted on the Partnership Website. Partnership Billing Guide and IHA education PowerPoint are provided as an educational piece. This is provided during the site review exit interview process. IHA PowerPoint is used for 1:1 or group education with providers.
14. Internal and external quality improvement committees review the results from completed Site Reviews, including review of Initial Health Assessments, at least annually. Provide constructive feedback regarding existing processes.

MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

All Regions

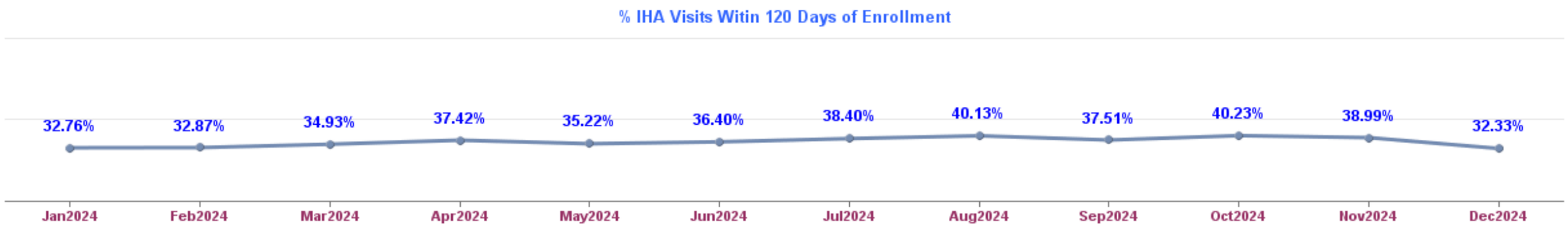
		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	251597	10141	11974	12208	10100	10645	9612	9601	10726	9602	10553	17841	**374600**
B	IHA Visits <= 120 Days	94846	4067	4743	4795	4012	4289	3968	4090	4427	4075	4276	6423	**144011**
C	New enrollees With Visits > 120 Days	59729	1799	2144	2112	1686	1643	1249	1040	982	624	364	39	**73411**
D	New Enrollment With No Visits	97022	4275	5087	5301	4402	4713	4395	4471	5317	4903	5913	11379	**157178**
E	% New enrollees With Visits <= 120 Days	37.70%	40.10%	39.61%	39.28%	39.72%	40.29%	41.28%	42.60%	41.27%	42.44%	40.52%	36.00%	**40.07%**
F	% New enrollees With Visits > 120 Days	23.74%	17.74%	17.91%	17.30%	16.69%	15.43%	12.99%	10.83%	9.16%	6.50%	3.45%	0.22%	**12.66%**
G	% New enrollees With No Visits	38.56%	42.16%	42.48%	43.42%	43.58%	44.27%	45.72%	46.57%	49.57%	51.06%	56.03%	63.78%	**47.27%**

MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Auburn

		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	66200	1719	1692	1705	1516	1404	1263	1211	1333	1372	1349	2818	**83582**
B	IHA Visits <= 120 Days	21684	565	591	638	534	511	485	486	500	552	526	911	**27983**
C	New enrollees With Visits > 120 Days	15561	346	347	306	266	205	165	127	122	97	43	12	**17597**
D	New Enrollment With No Visits	28955	808	754	761	716	688	613	598	711	723	780	1895	**38002**
E	% New enrollees With Visits <= 120 Days	32.76%	32.87%	34.93%	37.42%	35.22%	36.40%	38.40%	40.13%	37.51%	40.23%	38.99%	32.33%	**36.43%**
F	% New enrollees With Visits > 120 Days	23.51%	20.13%	20.51%	17.95%	17.55%	14.60%	13.06%	10.49%	9.15%	7.07%	3.19%	0.43%	**13.14%**
G	% New enrollees With No Visits	43.74%	47.00%	44.56%	44.63%	47.23%	49.00%	48.54%	49.38%	53.34%	52.70%	57.82%	67.25%	**50.43%**



MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Chico

		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	137443	2495	2703	2621	2230	2167	2037	1902	2078	1853	1984	3669	**163182**
B	IHA Visits <= 120 Days	57228	1107	1140	1063	901	913	847	882	903	821	865	1493	**68163**
C	New enrollees With Visits > 120 Days	32363	457	485	461	383	356	298	197	216	118	58	3	**35395**
D	New Enrollment With No Visits	47852	931	1078	1097	946	898	892	823	959	914	1061	2173	**59624**
E	% New enrollees With Visits <= 120 Days	41.64%	44.37%	42.18%	40.56%	40.40%	42.13%	41.58%	46.37%	43.46%	44.31%	43.60%	40.69%	**42.61%**
F	% New enrollees With Visits > 120 Days	23.55%	18.32%	17.94%	17.59%	17.17%	16.43%	14.63%	10.36%	10.39%	6.37%	2.92%	0.08%	**12.98%**
G	% New enrollees With No Visits	34.82%	37.31%	39.88%	41.85%	42.42%	41.44%	43.79%	43.27%	46.15%	49.33%	53.48%	59.23%	**44.41%**

MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Eureka

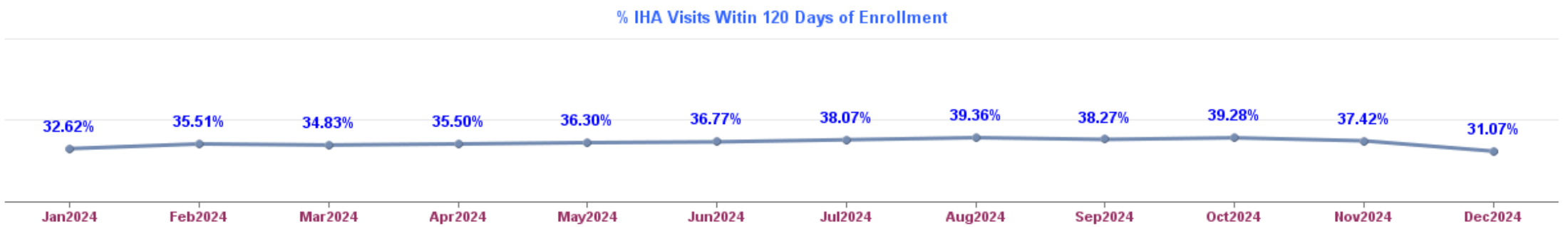
		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	4101	1060	1423	1535	1247	1459	1268	1301	1511	1419	1680	1517	**19521**
B	IHA Visits <= 120 Days	1467	458	617	615	527	611	548	549	607	607	639	562	**7807**
C	New enrollees With Visits > 120 Days	937	187	267	240	185	242	139	136	149	99	73	2	**2656**
D	New Enrollment With No Visits	1697	415	539	680	535	606	581	616	755	713	968	953	**9058**
E	% New enrollees With Visits <= 120 Days	35.77%	43.21%	43.36%	40.07%	42.26%	41.88%	43.22%	42.20%	40.17%	42.78%	38.04%	37.05%	**40.83%**
F	% New enrollees With Visits > 120 Days	22.85%	17.64%	18.76%	15.64%	14.84%	16.59%	10.96%	10.45%	9.86%	6.98%	4.35%	0.13%	**12.42%**
G	% New enrollees With No Visits	41.38%	39.15%	37.88%	44.30%	42.90%	41.54%	45.82%	47.35%	49.97%	50.25%	57.62%	62.82%	**46.75%**

MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Fairfield

		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	8913	1977	2492	2600	2135	2320	1923	2096	2349	1927	2226	4934	**35892**
B	IHA Visits <= 120 Days	2907	702	868	923	775	853	732	825	899	757	833	1533	**12607**
C	New enrollees With Visits > 120 Days	1833	314	437	419	348	344	240	240	209	119	84	12	**4599**
D	New Enrollment With No Visits	4173	961	1187	1258	1012	1123	951	1031	1241	1051	1309	3389	**18686**
E	% New enrollees With Visits <= 120 Days	32.62%	35.51%	34.83%	35.50%	36.30%	36.77%	38.07%	39.36%	38.27%	39.28%	37.42%	31.07%	**36.25%**
F	% New enrollees With Visits > 120 Days	20.57%	15.88%	17.54%	16.12%	16.30%	14.83%	12.48%	11.45%	8.90%	6.18%	3.77%	0.24%	**12.02%**
G	% New enrollees With No Visits	46.82%	48.61%	47.63%	48.38%	47.40%	48.41%	49.45%	49.19%	52.83%	54.54%	58.81%	68.69%	**51.73%**

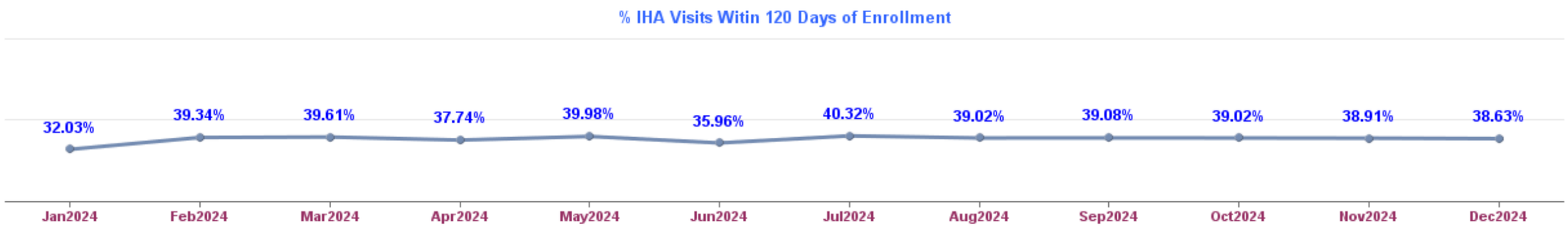


MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Redding

		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	23755	1144	1545	1476	1208	1357	1332	1330	1484	1425	1488	1385	**38929**
B	IHA Visits <= 120 Days	7609	450	612	557	483	488	537	519	580	556	579	535	**13505**
C	New enrollees With Visits > 120 Days	6430	208	247	248	192	214	170	144	120	93	47	0	**8113**
D	New Enrollment With No Visits	9716	486	686	671	533	655	625	667	784	776	862	850	**17311**
E	% New enrollees With Visits <= 120 Days	32.03%	39.34%	39.61%	37.74%	39.98%	35.96%	40.32%	39.02%	39.08%	39.02%	38.91%	38.63%	**38.30%**
F	% New enrollees With Visits > 120 Days	27.07%	18.18%	15.99%	16.80%	15.89%	15.77%	12.76%	10.83%	8.09%	6.53%	3.16%	0.00%	**12.59%**
G	% New enrollees With No Visits	40.90%	42.48%	44.40%	45.46%	44.12%	48.27%	46.92%	50.15%	52.83%	54.46%	57.93%	61.37%	**49.11%**

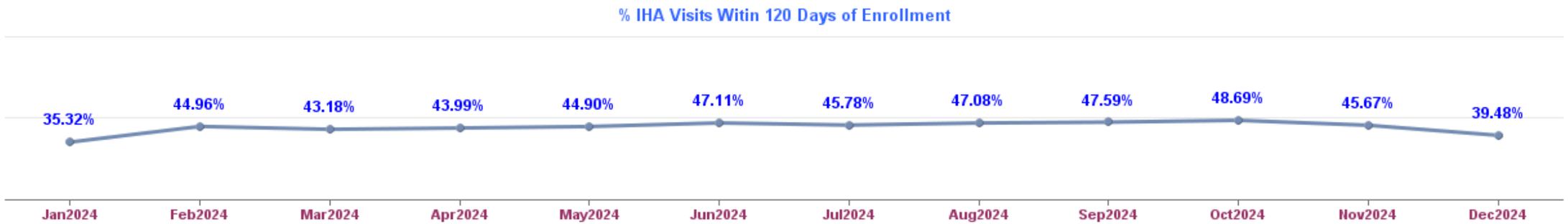


MEDICAL PROGRAM - INITIAL HEALTH ASSESSMENT COMPLIANCE REPORT : NEW ENROLLEES CONTINUOUSLY ENROLLED (CE)

Claims and Eligibility Date 01/01/2024 thru 12/31/2024 Report Run Date: 4/17/25

Santa Rosa

		Eligibility Year 2024												
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals
A	New Eligibility	11185	1746	2119	2271	1764	1938	1789	1761	1971	1606	1826	3518	**33494**
B	IHA Visits <= 120 Days	3951	785	915	999	792	913	819	829	938	782	834	1389	**13946**
C	New enrollees With Visits > 120 Days	2605	287	361	438	312	282	237	196	166	98	59	10	**5051**
D	New Enrollment With No Visits	4629	674	843	834	660	743	733	736	867	726	933	2119	**14497**
E	% New enrollees With Visits <= 120 Days	35.32%	44.96%	43.18%	43.99%	44.90%	47.11%	45.78%	47.08%	47.59%	48.69%	45.67%	39.48%	**44.48%**
F	% New enrollees With Visits > 120 Days	23.29%	16.44%	17.04%	19.29%	17.69%	14.55%	13.25%	11.13%	8.42%	6.10%	3.23%	0.28%	**12.56%**
G	% New enrollees With No Visits	41.39%	38.60%	39.78%	36.72%	37.41%	38.34%	40.97%	41.79%	43.99%	45.21%	51.10%	60.23%	**42.96%**



Child and Adolescent Well Care Disparity Sprint

James Devan, Manager of Performance Improvement

Agenda

- Background and rationale
- Project planning and rollout
- Challenges & lessons learned
- Planning ahead

Background on Withholds

- Starting in measurement year 2024 DHCS withholds percentage of plan revenue to be earned back through quality measurement
- In late August 2024 DHCS informed plans of an opportunity to earn unearned withhold dollars through disparity intervention
  - DHCS selected Child and Adolescent Well Visits as measure of focus
  - DHCS identified two disparity groups in each of the four legacy reporting regions based on MY2022 HEDIS data
    - Northeast: Asian, Native Hawaiian/Other Pacific Islander
    - Northwest: Black or African American, White
    - Southeast: American Indian/Alaskan Native, Native Hawaiian/Other Pacific Islander
    - Southwest: American Indian/Alaskan Native, White
  - Improvements would need to be made by end of December 2024

Partnership's Approach

- Partnership developed a proposal by mid October to offer per-member incentives of $200 for select providers to conduct well visits for members in the disparity groups
- Partnership identified a small group of practices who held a large portion of the eligible populations and sought their participation. A small cohort was ideal due to time constraints and resources available
- Partnership developed custom gap lists for providers to use for eligible incentives, as well as offered updated reports showing well visits that were captured via claims
- Providers had to complete visits by December 31st 2024, and submit claims to Partnership by January 30th 2025 to qualify for the incentive

Challenges

- Communication from DHCS – there were many unknowns from the announcement that Partnership had to confirm from the state, especially around withhold methodology and possible disparity group changes
- Member demographics – race and ethnicity data was inconsistent and had to be organized (IE Hawaiian and Other Pacific Islander)
- Unassigned members – Partnership had to develop custom denominators to account for Direct Members and other criteria
- Timeline
  - Visits had to be completed by end of calendar year with little time to outreach and schedule
  - Had to use letters of intent while formal agreements were developed to reduce delays in starting the campaign
- Uncertainty on funds – DHCS did not articulate what potential dollars could be earned back, leading Partnership to balance conservative estimates with incentive

The Populations

Per DHCS Request/WCV Proposal Using Data we have: % of current regional disparity attempting to close

	Population of Focus by Region:	NE	NE	NW	SW	SE	SE		
	Current Region	Native Hawaiian and Other Pacific Islanders	Asian	Black/African American	Amerian Indian/ Alaska Native	Amerian Indian/ Alaska Native	Native Hawaiian, and Other Pacific Islanders	Member Totals	New Rating Region/Withholds-Earnback Assessment Basis
Shasta CHC	NE	152	173					325	North
Churn Creek/Redding Rancheria	NE	41	35					76	North
Open Door CHC	NW			130				130	North
Lake County Tribal Health	SW				192			192	North
Sonoma County Indian Health Project	SW				168			168	South
La Clinica	SE					11	24	35	South
Communicare+Ole	SE					21	28	49	South
Community Medical Centers	SE					17	16	33	South
Northbay Healthcare	SE					8	15	23	South
	Total members in gap represented within proposed PCP orgs to invite	193	208	130	360	57	83	1031	
	Total members in gap by Population of Focus per Region	464	502	190	975	143	185	2459	
	% of current regional disparity attempting to close	**41.59**	**41.43**	**68.42**	**36.92**	**39.86**	**44.86**	**41.93**	

- Partnership elected to exclude the white population due to population size vs time and resource constraints
- Participating providers:
  - Nine (9) providers identified as potential participants due to volume
  - Five (5) providers agreed to participate, while others opted out for various reasons
    - One (1) provider was not interested in incentives but wanted to engage the members anyways and get the unassigned members assigned to their practice

Measure Results

- Providers outreached, scheduled, and saw members through 2024
- Providers had until the end of February 2025 to submit well visit claims for 2024 (extended from end of January)
- Offered validation period to confirm visit capture

Population	Count (% of total)
Total Populations of Focus (excluding white pop)	2,459 (100%)
Selected Provider Population	1,031 (42%)
Participating Provider Population	380 (15%)
Visits Completed	48 (2%)
Total Incentives Earned	$9,600

Provider Feedback

- Issues with data
  - Providers sometimes had race and ethnicity data that did not mirror Partnership's data
  - Members would sometimes change providers or drop coverage
- Timing – providers needed more notice to outreach, schedule, and conduct visits
- Communication – Partnership wasn't able to define ambiguous elements of the program to a level that is consistent with normal Partnership programs
- Use of funds:
  - Member incentives – results were mixed as to ability to get patients seen
  - Non-financial efforts – several providers noted successes came from outreach and engagement and the ability to operationalize funds
- Future interest – most providers expressed interest in a future effort if issues identified were addressed
- Commitment to equity – most providers indicated a desire to address inequities for their members, and even members in the communities who were not assigned

Lessons Learned

- Funding for equity activities appears to be a viable strategy
- More time is needed to address disparity issues holistically
- Further work needs to be done to improve race and ethnicity data, especially for Native Americans and Hispanic members
- DHCS data is outdated for current equity efforts
  - DHCS used MY2022 HEDIS data to identify disparities
  - Partnership analyzed MY2023 data and half the populations identified by DHCS are no longer showing disparities and new disparities have emerged
- Partnership needs a global way of addressing inequities, not just for selected practices
- DHCS will continue to use child and adolescent well visits as a means to keep money within the plans and provider network

Moving Forward

- Partnership has added an optional Reducing Healthcare Disparity measure to the PCP QIP to incentivize health equity activities
  - Providers with sufficient member volume (2,400 unique member visits in 2024) are invited to participate
  - Providers must reply with intent to participate by end of March
  - Partnership's QIP team and Health Equity Officer will identify which race/ethnicity disparity group to address for 2025
  - Providers can earn up to 7% enhancement to 2025 QIP payment by reducing the identified disparity
- Additional non-incentive efforts to address equity and disparities are underway

Newborn Pilot Project in Solano County

Liz Romero, MPH, MCHES
Improvement Advisor

DHCS Health Equity Performance Improvement Project

- DHCS conducts annual health disparities reports and shares the data with managed care plans (MCPs) so plans can tailor quality improvement resources to target populations.

- MCPs are required to conduct a health equity performance improvement project (PIP) that addresses health equity in one of the following domains:
    - Child/Adolescent Health
    - Women's Health
    - Disease Management/Behavioral Health

- The goal is to improve health outcomes for members and ensure that MCPs are meeting the needs of all their Medi-Cal members

Background Information

- DHCS has assigned Partnership a 2-year Health Equity PIP focused on the Well Child Visit Birth-15 Months (W30-6) HEDIS Measure.
  - W30-6: Assesses children who turned 15 months old during the measurement year and had at least six well-child visits with a primary care physician during their first 15 months of life.

- Partnership and DHCS agreed to focus the PIP on African American rates of completion of the W30-6 measure.

- Partnership has chosen to locate PIP activities in Solano County as this is where the largest number of African American children we serve are located.

Solano County W15 Data

HEDIS MPL (50th) MY

2021: 54.92 2022: 55.72 2023: 58.38

SOLANO		
MY-2021	MY-2022	MY-2023
28.93	39.97	35.70

Solano County W15 Data by Race

	SOLANO		
	MY-2021	MY-2022	MY-2023
American Indian a..	25.00	25.00	0.00
Asian/PacificIslander	36.36	41.54	40.85
Black	22.88	36.90	28.82
Hispanic	30.46	42.26	40.91
Other/Unknown	28.04	39.82	32.02
White	30.00	36.73	25.00

Overarching System Challenges

- Most newborns are not assigned a Medi-Cal ID until their second month of life.

- Newborns are considered Direct Members during their first month of life, and can be seen by any PCP or Pediatrician
    - Claims are received under the mother's Medi-Cal ID

- Once the baby has been assigned a Medi-Cal ID, Partnership receives claims that use the baby's Medi-Cal ID. Linking a mother and baby's Medi-Cal ID's can be challenging.

Overarching System Challenges

- Without linked ID's, babies can be put into auto-assignment, which can disrupt their PCP relationship

- Solano County experiences high level of access issues:
  - Many panels not open to new members
  - Lack of access
  - High grievance rates

Impact

The delays in Medi-Cal ID assignment, therefore, not only cause undercounts for well child visits within the W30-6 HEDIS measure, but also have a disruptive impact on babies' healthcare throughout our provider network, and erode the relationship between the family, clinical team, and health plan.

Our Approach

- Formed W15 PIP Taskforce with members from Quality Improvement, Population Health, and Member Services.
- The taskforce meets biweekly to brainstorm, implement, and evaluate new program ideas.

Phone Outreach Pilot Project

- **Partnered with North Bay:** North Bay has the only labor and delivery unit serving all of Solano County's Medi-Cal membership. A centralized intervention in this setting would impact the entire county.

- **Goal:** To assist with MCal enrollment, newborn PCP selection, and support the coordination of pre-appointment follow up.

- **Process:** PHC teamed up with North Bay Health to implement a Phone Outreach Pilot from August 17th-September 30th.
    1. Upon discharge of newly delivered mothers, North Bay staff informed patients that PHC staff will be contacting them. Patients were given the number the call will come from and Partnership's Growing Together Program flyer.
    2. NorthBay emailed PHC staff a daily list of newly delivered mothers.
    3. Partnership staff called mothers on the list within 72 hours.

What was Covered During the Call?

1. **MediCal Enrollment-** Inquired if the member completed a MediCal Enrollment Form. If they had not, a form was sent to them.

2. **Newborn PCP Selection-** Completed a PCP selection form for the newborn. Forms are kept on file while we wait for the baby to be enrolled. The form collects mother's CIN to help us capture well baby visits occurring within the first 2 months of life.

3. **Well Baby Visit Scheduling-** Assisted moms with scheduling their next well baby visit.

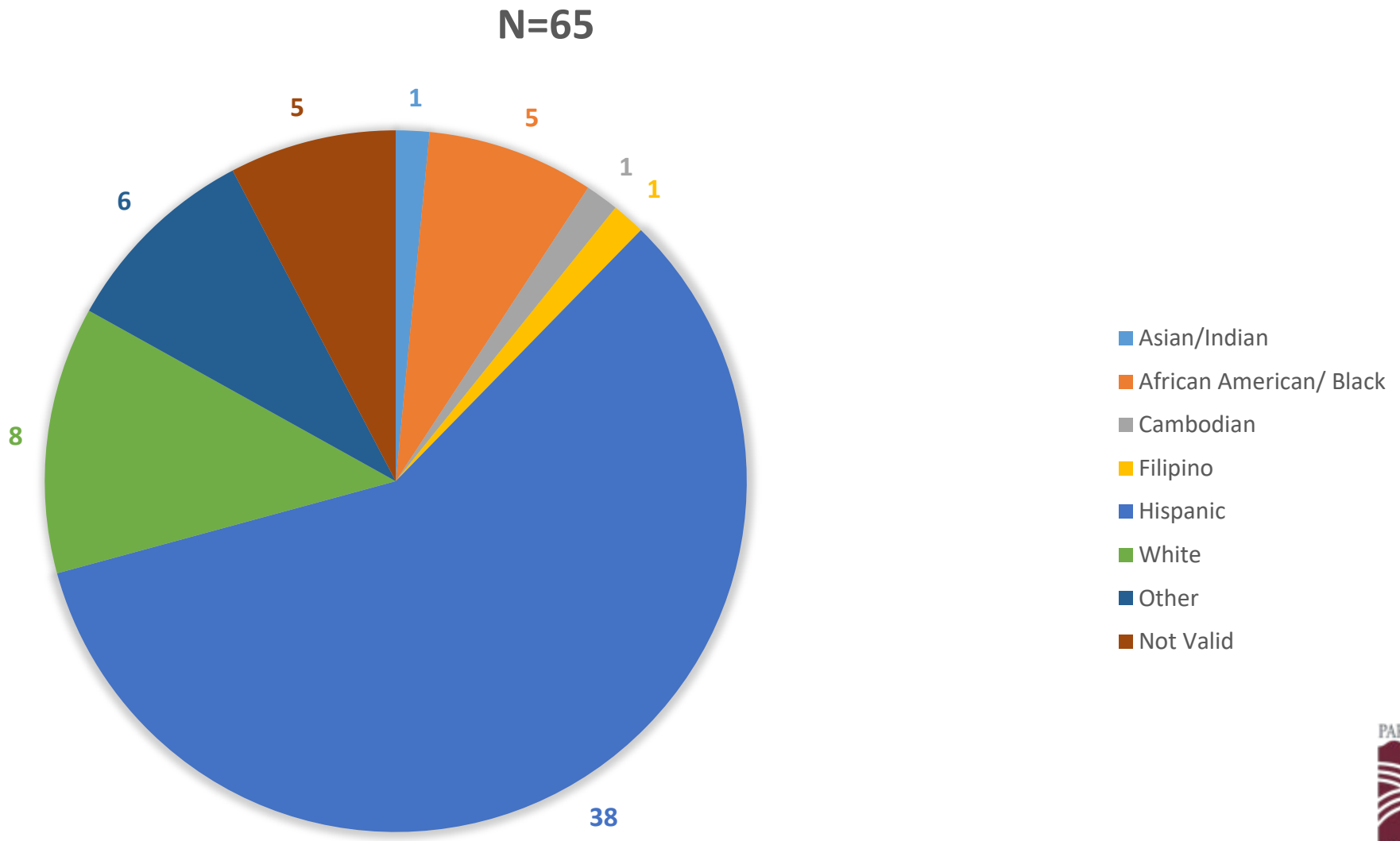
4. **Resources-** Connected mother to resources as needed (eg: transportation to well baby visit or postpartum visits)

5. **Growing Together Program-** Encouraged them to enroll in the Growing Together Program.

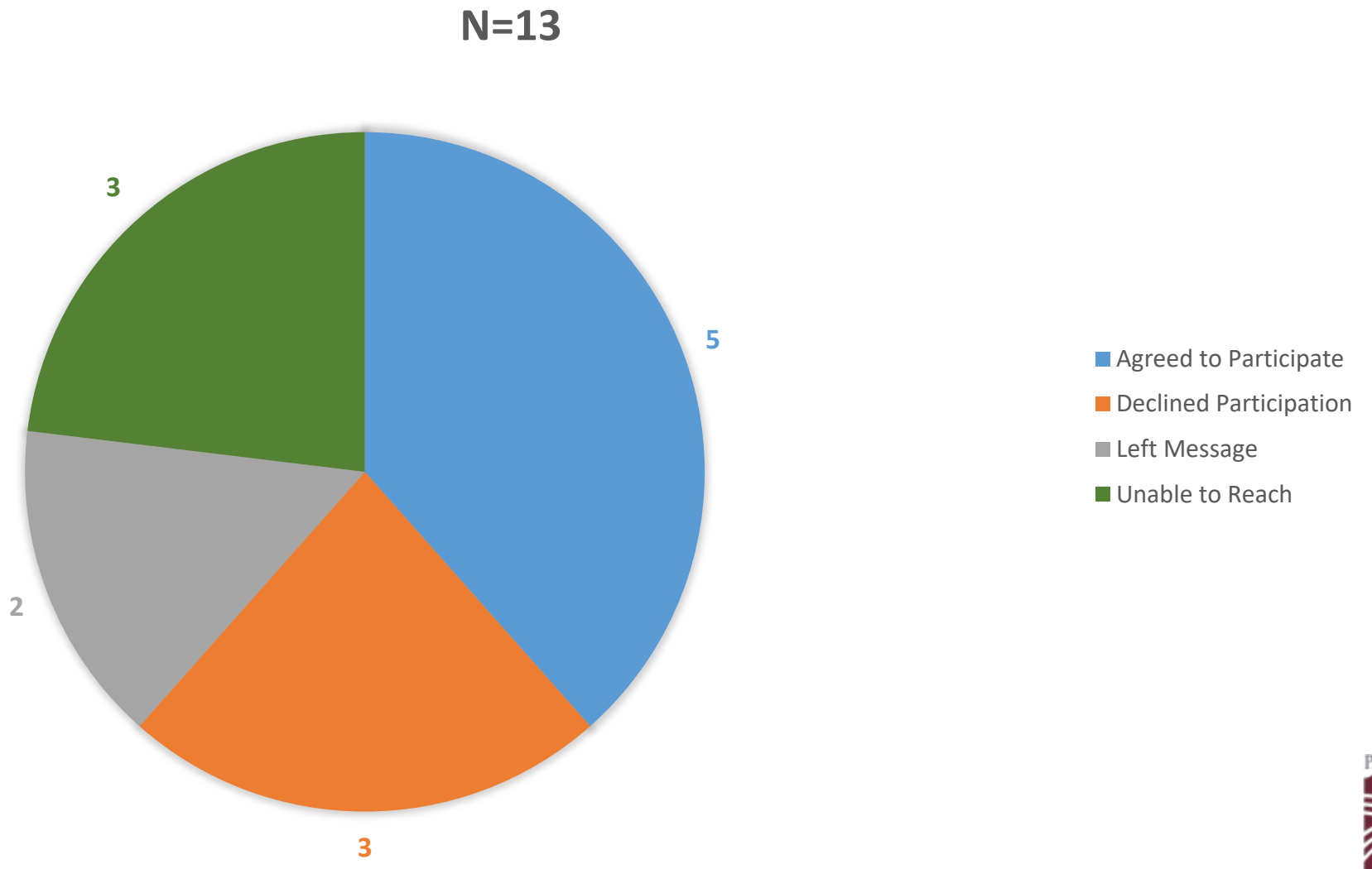
Results

Participation N= 126	
Agreed to Participate	65
Declined Participation	14
Left Message	23
Unable to Reach	24

Agreed to Participate: By Ethnicity/Race



Participation Level for African American/Black Members



Results

- 81% reach rate
- 51.6% engagement rate
- 55 people have registered for the Growing Together Program
- 48 people have completed a newborn PCP selection form

Let's Compare

August 17th, 2024 - September 30th, 2024

	Pilot	Healthy Babies Campaign
Unique Participants	126	1,840
Reach	81%	25.3%
Engagement	51.6%	14.9%

Lessons Learned- What Worked

- **Warm Hand-offs Work:** Informing newly delivered mothers before being discharge from the hospital about the upcoming call increased the likelihood of them answering the phone.

- **Early Focus on Well Baby Visits:** Informing newly delivered mothers why Partnership would be calling prompted families to begin thinking about scheduling their well-baby visits.

- **A Centralized Phone Number is Important:** Providing newly delivered mothers with the number that Partnership would be calling from further ensured higher answer rates.

Lessons Learned- What Needs Improvement

- **Timing of Calls:** Calling 72 hours after delivery proved too early as mother required additional time to adjust to their new normal and to make informed decisions about their newborn's primary care provider.

- **Project Not Sustainable In Current State:**
  - This pilot required us to pull a wellness coach away from her work to focus on this project full time.
  - NorthBay does not have the capacity to continue sending us a daily list of newly delivered mothers.

Actions Taken Post-Pilot

- Partnership
  - **Newborn PCP Selection Form-** Completion of this form has now been included in the existing Postpartum outreach call script
  - **Outreach Script-** Select questions from the outreach script used during this pilot have been integrated into the existing Postpartum outreach call script.
  - **New Call Timing-** Newly delivered mothers receive a call from a Pop Health Coach 2 weeks after delivery

- NorthBay
  - We have asked that they continue to inform newly delivered mothers that they should expect a call from Partnership.

Next Steps

- In Solano County
  - We are actively exploring new strategies to test and implement.
    - We are interested in gathering direct feedback from members to better understand the challenges they face when scheduling and attending Well-Baby visits, as well as selecting their newborn's PCP.

- Outside of Solano County
  - Conversation have begun regarding implementation of a similar pilot project with Fairchild
    - A centralized phone number will be needed to increase success of this second pilot.