



**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE**

**FROM:** Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)  
**DATE:** Oct. 9, 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, Oct. 15, 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, 770 10th St., Arcata  
Chapa-de Indian Health: 11670 Atwood Road, Auburn

**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  
Brown, Isaac, MHA/MBA, *Interim* Sr. Dir. of Quality & Perf. Improvement  
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  
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  
Beltran-Nampraseut, Athena, CPhT, Program Manager, PCP QIP  
Bjork, Sonja, JD, Chief Executive Officer  
Blake, Jill, Regional Director, Auburn  
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance  
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  
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  
Lopez, Eva, CPhT, Project Manager, Palliative Care QIP  
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-Phipps, Stephanie, Manager of Provider Relations Reps  
Power, Kathryn, Regional Director, Southeast  
Quichocho, Sue, Manager of Quality Improvement, QI  
Sharp, Tim, Regional Director, Northeast  
Smith, Christine, Community Health Needs Liaison, Pop Health  
Stark, Rebecca, Regional Director, Chico  
Watson, Deanna, Project Manager (ECM QIP)

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

**Date: Oct. 15, 2025**

**Time: 7:30 – 8:55 a.m.**

**Locations: Partnership HealthPlan of California**

4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room  
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**Other Locations:**

Open Door Community Health Center, 770 10<sup>th</sup> St., Arcata  
Chapa-de Indian Health: 11670 Atwood Road, Auburn

**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 #	
<b>I.</b>	<b>Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes</b>				
<b>1</b>	<i>Approval of</i> • Sept. 17 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 14	
<b>2</b>	<i>Acknowledgment and acceptance of draft minutes of the</i> • Sept. 9 Internal Quality Improvement (IQI) Committee • Sept 25 Substance Use Disorder Internal Quality Improvement (SUIQI) Committee			15 – 32	
<b>II.</b>	<b>Standing Updates</b>				
<b>1</b>	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:37	33 – 42	
<b>2</b>	HealthPlan Update	Robert Moore, MD	7:44	--	
<b>III.</b>	<b>Old Business – None</b>				
<b>IV.</b>	<b>New Business – Consent Calendar</b>				
	Consent Calendar	All	7:52	43	
	Proposed 2026 PCP QIP Measure Set – <i>direct questions to Athena Beltran-Nampraseut</i>			45 – 50	
	Proposed 2026 ECM QIP Measure Set – <i>direct questions to Deanna Watson</i>			51 – 54	
	Proposed 2026 Palliative Care QIP Measure Set – <i>direct questions to Eva Lopez, CPhT</i>			55 – 56	
<b>Health Services Policies</b>	<b>Behavioral Health</b>				
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members ( <i>previously MCUP3103</i> )				57 – 61
	MPBP8007 – Screening and Treatment for Substance Use Disorders ( <i>previously MCUP3101</i> )				63 – 82
	MPBP8013 – Eating Disorder Management Policy				83 – 90
	<b>Care Coordination</b>				
	MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MPBP8011</i>				91 – 102
	<b>Utilization Management</b>				

	Item	Lead	Time	Page #
Health Services Policies	MCUP3101 – Screening and Treatment for Substance Use Disorders – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MPBP8007</i>			103 – 122
	MCUP3103 – Coordination of Care for Child-Welfare Involved Members – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MCBP8015</i>			123 – 127
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			129 – 131
	MCUP3012 – Discharge Planning (Non-capitated Members)			133 – 135
	MCUP3050 – Medication Abortion in the First Trimester			137 – 149
	MCUP3052 – Medical Nutrition Services			151 – 158
	MCUP3115 – Community Based Adults Services			159 – 167
	MCUP3128 – Cardiac Rehabilitation			169 – 174
	MCUP3130 – Osteopathic Manipulation Treatment			175 – 177
	MPUP3078 – Second Medical Opinions			179 – 181
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			183 – 185
	Non HS	<b>Grievance &amp; Appeals</b>		
CGA022 – Member Discrimination Grievance Procedure				187 – 192
<b>V.</b>	<b>New Business – Discussion Policies</b>			
	Synopsis of Changes		--	193 – 196
Health Services Policies	<b>Behavioral Health</b>			
	MPBP8003 – Mental Health Services	Jeff DeVido, MD	8:00	197 – 232
	MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines ( <i>previously MPCP2017</i> )		8:07	233 – 240
	<b>Enhanced Health Services</b>			
	MPAP7003 – CalAIM Community Supports (CS) – <i>previously MCAP7003</i>	Lisa O’Connell, MHA	8:14	241 – 268
	<b>Utilization Management</b>			
	MCUP3015 – Family Planning By-Pass Services	Tony Hightower, CPhT	8:21	269 – 272
MPUP3035 – Preoperative Day Review	8:28		273 – 276	
<b>VI.</b>	<b>Presentation</b>			
<b>1</b>	Health Equity Grand Analysis		8:35	277 – 292
<b>VI.</b>	<b>Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 19, 2025</b>			

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
MEETING MINUTES**

Quality and Utilization Advisory Committee (Q/UAC) Meeting

Wednesday, Sept. 17, 2025 / 7:32 a.m. – 9:12 a.m. - Napa/Solano Room, 1<sup>st</sup> Floor

<p><b><u>Voting Members Present:</u></b> Sara Choudhry, MD Steven Gwiazdowski, MD, FAAP Emma Hackett, MD, FACOG</p>	<p>Brian Montenegro, MD John Murphy, MD Meagan Mulligan, FNP-BC Robert Quon, MD, FACP</p>	<p>Michael Strain, PHC Consumer Member Chris Swales, MD Randolph Thomas, MD Jennifer Wilson, MD</p>
<p><b><u>Voting Members Absent:</u></b> Brandy Lane, Consumer Member; Phuong Luu, MD</p>		
<p><b><u>Partnership Ex-Officio Members Present:</u></b> Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI Bontrager, Mark, Senior Director of Behavioral Health Brown, Isaac, MBA/MHA, Interim Senior Director of Q &amp; P Improvement DeVido, Jeff, Behavioral Health Clinical Director Esget, Heather, RN, BSN, ACM, Director of Utilization Management Glickstein, Mark, MD, Associate Medical Director Hightower, Tony, CPhT, Associate Director, UM Regulations Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer) Jones, Kermit, MD, JD, Medical Director for Medicare Services Katz, Dave, MD, Associate Medical Director</p>	<p>Netherda, Mark, MD, Medical Director for Quality – Vice Chair Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections O’Connell, Lisa, Director, Enhanced Health Services Randhawa, Manleen, Senior Health Educator, Population Health Ribordy, Jeff, MD, Regional Medical Director (Northwest) Ruffin, DeLorean, DrPH, MPH, Director of Population Health Spiller, Bettina, MD, Associate Medical Director 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 &amp; Appeals</p>	
<p><b><u>Partnership Ex-Officio Members Absent:</u></b> Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer Cotter, James, MD, Associate Medical Director Cox, Bradley, DO, Regional Medical Director (Northeast) Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management</p>	<p>Guillory, Ledra, Senior Manager of Provider Relations Representatives Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination Leung, Stan, Pharm.D, Director of Pharmacy Services Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair</p>	
<p><b><u>Guests:</u></b> Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP) Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance Brunkal, Monika, Associate Director, Population Health Bushey, Lindsay, Project Manager I, QI Campbell, Anna, Health Policy Analyst, Utilization Management Chebolu, Radha, Sr. Health Data Analyst II, Finance Chiang, Yuen, Program Manager I, Utilization Management Conner, Maria, Improvement Advisor, QI (Auburn) Cunningham, Aryana, Policy Analyst, Care Coordination Devan, James, Manager of Performance Improvement (Redding) Durst, Jennifer, Senior Manager of Performance Improvement, QI (Santa Rosa) Flourney, Candi, Project Manager II, QI</p>	<p>Frankovich, Terry, MD, Associate Medical Director Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI Jamali, Shahrzad, Improvement Advisor, QI (Chico) Jarrett-Lee, Kevin, Associate Director of Utilization Management (Auburn) Kim, Amanda, Improvement Advisor, QI (Redding) Matthews, Richard “Doug,” MD, Regional Medical Director (Chico) McCune, Amy, Manager of Quality Incentive Programs, QI Morris, Matthew, MD, Regional Medical Director (Auburn) Nakatani-Phipps, Stephanie, Lead Senior Provider Relations Rep, PR O’Leary, Hannah, Manager of Population Health, Pop Health Quichocho, Sue, Manager of Quality Measurement, QI Tryan, Tiffany, Improvement Advisor, QI YoungStone, Kelly, RN, Director of Care Coordination</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p><b>I. Call to Order</b></p> <p>Public Comment – <i>none made</i></p> <p>Introductions – <i>none made</i></p> <p>Approval of Minutes</p>	<p>Committee Vice Chair and Medical Director for Quality Mark Netherda, MD, called the meeting to order at 7:32 a.m. in the planned absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA.</p> <p>The Aug. 20 Q/UAC Minutes were approved as presented without comment.</p> <p><i>Acknowledgment and acceptance of draft meeting minutes of the</i></p> <ul style="list-style-type: none"> <li>• Aug. 12 Internal Quality Improvement (IQI) Committee</li> <li>• July 30 Over/Under Utilization Workgroup</li> <li>• Aug. 7 Population Needs Assessment (PNA) Committee</li> </ul>	<p>Motion to <b>approve the Q/UAC minutes:</b> Steven Gwiazdowski, MD Second: Brian Montenegro, MD <i>Approved unanimously</i></p> <p>Motion to <b>accept the other minutes:</b> Chris Swales, MD Second: John Murphy, MD <i>Approved unanimously</i></p>
<p><b>II. Standing Updates</b></p>		
<p>1. Quality Improvement (QI) Department Update</p> <p><i>Isaac Brown, Interim Senior Director of Quality and Performance Improvement, QI</i></p>	<ul style="list-style-type: none"> <li>• The Over/Under Utilization Workgroup has robust discussions, and is a great opportunity to assess underutilization: is it a data issue? Something else?</li> <li>• If you have not done so, please register for the one-hour Partnership Quality Dashboard (PQD) webinar scheduled for noon Sept. 22. PQD improvement advisors are working to help providers do last pushes to get over thresholds. The new PQC launches Sept. 30. Each year, different clinicians are closing quality care gaps.</li> <li>• Partnership has been educating providers on the use of the Z29.3 ICD code to capture dental fluoride applications. Practices still needing technical assistance here are asked to contact Partnership.</li> <li>• The first ever Regional Quality Improvement meetings in Auburn and Chico took place in July. There was good participation, working through barriers and sharing best practices. (Southwest Regional Medical Director Lisa Ward, MD, later added that a new series of Regional Quality Improvement meetings will begin in Santa Rosa in October for Marin and Sonoma county providers. These will be in two series: one for medium to large practices, and one for small practices.)</li> <li>• We have been doing a pilot over this past year on the use of locum tenens, and these traveling physicians have given us an opportunity to look at different options for access. We've started a second pilot we are calling Preventive Care Bridge Project with four organizations that are going to be utilizing a locum: Ampla Health, Western Sierra Medical Clinic, Shasta Community Health, and Open Door Community Health. They are testing some things for us as far as getting well child visits done during these latter summer months, as well as some cervical cancer screenings. The plan is take all of the learnings from these pilots and apply them to a locum playbook that we'll be able to give out to providers throughout the network to help them understand whether or not the use of locum tenens makes sense for their practice.</li> <li>• We have also been working with the counties on their CHA/CHIP (Community Health Assessment/Community Health Improvement Plan) process, where they have some improvement projects that they are working on, since we had requests for project management support. We have</li> </ul>	<p><i>For information only. There were no questions.</i></p> <p><i>Meeting Postscript: Technical issues on Sept. 22 pushed the PQD kick-off webinar to Sept. 29.</i></p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>project managers, but we don't have project managers for all the counties and all the projects. So, we put together a training program for all those who want to participate, whether you are a county or a clinic or a CBO (community-based organization) or SNF (skilled nursing facility). The idea is to pull people together, teach them about project management skills, and help them work through their projects. We just launched a pilot with 20 participants, and plan for a full launch in early 2026. We're excited to help at scale. It's a virtual option, so we can have as many people join the Webex as the system can handle.</p> <ul style="list-style-type: none"> <li>We did receive a projected National Committee for Quality Assurance (NCQA) STAR rating of 3.0.</li> </ul>	
<p>2. HealthPlan Update</p> <p><i>Mark Netherda, MD Medical Director for Quality</i></p>	<ul style="list-style-type: none"> <li>You may remember that last year we had a 3.5 NCQA STAR rating. We thought we were going to be so rated again this year; however, the way benchmarks move, we missed it by eight one thousandths of a percentage point.</li> <li>The effect of the Centers for Disease Control (CDC) recommendations for vaccines is a big topic certain to be discussed Sept. 18 in a Partnership meeting with the Department of Health Care Services (DHCS). Emergency California legislation has been proposed to allow vaccinations recommended by other organizations, such as the California Department of Public Health (CDPH), the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP). We await clarification from the CDPH and DHCS related to this proposed legislation. <ul style="list-style-type: none"> <li>DHCS as yet has not required Partnership to make any coverage changes for vaccines.</li> <li>The biggest impact may be on pharmacists and pharmacies and what their corporate organizations feel safe in doing.</li> <li>If your organization is concerned, it may be advisable to now stockpile what you can.</li> <li>Any actionable information we get, we will push out to our providers.</li> </ul> </li> <li>Effective Oct. 1, most MRIs and CT scans will no longer require a Treatment Authorization Request (TAR). It was costing more to go through the TAR process than to just let them go through. We are letting radiology practices know this so requests do not kick back. <ul style="list-style-type: none"> <li>Dr. Ward interjected that medical directors should communicate this same message out to community health center and clinic leadership. In Sonoma County, radiology offices have been delegating the TAR process to the community health centers, who should be very relieved to learn of this change.</li> <li>Southwest Regional Medical Director Colleen Townsend, MD, clarified that PET scans are one exception. We limit CTs, especially for pedes, because of the radiation exposure. For adults, virtually any PET scans do require a TAR but most other scans for adults should just go through without authorization.</li> <li>Northeast Regional Medical Director Jeff Ribordy, MD, said this applies to pediatrics too.</li> </ul> </li> <li>Partnership has been advocating for and following the progress of two bills before the California Legislature. Both are now out of committee and on their way to Gov. Gavin Newsom for signature. <ul style="list-style-type: none"> <li>SB 6909 (Senate Pro Tempore Mike McGuire, D-North Coast), the rural hospital stand-by perinatal services bill, was largely written by Partnership together with Plumas Hospital.</li> <li>AB 55 (Mia Bonta, D-Oakland) would expand the eligibility of birthing centers to see certain individuals and Medi-Cal members. It does away with some of the requirements that now surround</li> </ul> </li> </ul>	<p>Q/UAC voter and neonatologist Steven Gwiazdowski, MD, asked where the TAR decisions came from, especially those applying to pedes. Colleen Townsend, MD, said that it was an internal Partnership decision reached in part by the fact that we had a more stringent process around prior authorizations related to imaging that do other health plans. Further, we wanted to get ahead of forthcoming legislation that will, perhaps in 2027, impact our capacity to provide some of these services. Dr. Gwiazdowski expressed concern that a no-TAR process might lower the threshold and that practitioners, particularly allied health professionals who may be less cautious than physicians, will order more than is necessary. Q/UAC voter and family medicine physician Chris Swales, MD, countered that this can be monitored, and Dr. Netherda agreed, saying this is where the Over/Under Utilization Workgroup has a role. Q/UAC voter and internal medicine physician Robert Quon, MD, also advocated letting</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	how these centers need to be both affiliated with and proximate to a hospital.	overutilization “be the “guardrail,” which he noted could lead to a peer review to look at certain providers’ clinical decision making.
<b>III. Old Business – None</b>		
<b>IV. New Business – Consent Calendar (Committee Members as Applicable)</b>		
	G&A PULSE Report, Issue 18, September 2025 – <i>direct questions to Latrice Innes</i> 1 <sup>st</sup> /2 <sup>nd</sup> Qtrs 2025 UM/Pharmacy IRR/Timeliness – <i>direct questions to Tony Hightower, CPhT, and Andrea Ocampo, Pharm.D</i>	No questions were asked.  Motion to <b>approve slate as presented:</b> Brian Montenegro, MD Second: Chris Swales, MD <i>Approved unanimously</i>
	<u>Utilization Management</u> MCUG3118 – Prenatal & Perinatal Care MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21	  <u>Next Steps:</u> Oct. 8 Physician Advisory Committee (PAC)
<b>V. New Business – Discussion Policies</b>		
<b>Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director of UM Regulations</b>		
MCUG3007 – Authorization of Ambulatory Procedures and Services	<p><b>Section IV</b> All attachments have been removed from this section and policy attachment number referenced throughout the policy instead. Information included in the attachments was all duplicated in policies MCUP3041 and MCUP3049.</p> <p><b>Section VI.C.1.</b> A reference to policy MPUP3139 Criteria and Guidelines for Utilization Management was added and information duplicated in that policy was removed.</p> <p><b>Attachment B:</b> While this attachment is being archived from this policy, it is also a shared document with MCUP3041-A. For that purpose, the (Treatment Authorization Request) TAR Requirements document (MCUP3041-A) is also updated at this time to</p> <ul style="list-style-type: none"> <li>• Remove Allergy Injections as a TAR is no longer required</li> <li>• Add Behavioral Health Treatment – TAR is required</li> <li>• Add Hearing Aids – TAR is required</li> <li>• Add ICF - – TAR is required</li> </ul> <p>Tony noted that MCUP3041-A is a “quasi policy,” which we update as needed, even if the MCUP3041 policy itself is not being updated. Dr. Swales asked what “behavioral health treatment” means in this context. UM Policy Analyst Anna Campbell said it has to do with autism, adding that this always required a TAR, as noted in MCUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21, but had not been previously included in the MCUP3041-A list.</p>	<p>Motion to <b>approve as presented:</b> Jennifer Wilson, MD Second: John Murphy, MD <i>Approved unanimously</i></p> <p><u>Next Steps:</u> Oct. 8 PAC</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p>MCUP3013 – Durable Medical Equipment (DME) Authorization</p>	<p>During this annual review, details for Partnership’s enhanced benefit for Compression garments were added [as approved by the Benefit Review Evaluation Workgroup (BREW)]  <b>Section VI.G.3.</b> New section for Compression Garments added  <b>Section VII.G.</b> Reference to BREW form added  <b>Attachment B:</b> Codes E0652, E0675, E0676 were deleted under lymphedema pump/compression devices because they are no longer listed in the Provider Manual.</p> <p>Dr. Swales asked what is the process for people to secure compression garments? A DME order? Dr. Netherda said yes, although some over the counter items are available. Dr. Ribordy added that we once had only covered custom garments, but some providers complained: now we are basically covering most DME.</p> <p>Dr. Wilson asked for clarification: garments are covered for venostasis but not lymphedema? Anna Campbell said the three codes were eliminated from Attachment B because they were no longer part of DHCS guidance; she did not know if they had also been taken out of billing. BREW decided to cover compression garments as an inexpensive means of helping to prevent deep vein thrombosis and blood clots.</p> <p>Dr. Netherda noted that E0675 is a pneumatic compression device specific to treat peripheral artery disease and is distinct from devices used for lymphedema or to prevent venous thromboembolism. E0676 is an intermittent limb compression device.</p> <p><b>A motion was made to approve as presented; however, Anna noted later in the meeting that these three codes had been deleted from one, but not all, sections of the DHCS guidance. The suggestion was made to re-add the three codes.</b></p>	<p>Motion to <b>approve as presented:</b>  Jennifer Wilson, MD  Second: Meagan Mulligan, FNP  <i>Approved unanimously</i></p> <p>Motion to <b>amend by re-adding the three deleted codes:</b>  John Murphy, MD  Second: Jennifer Wilson, MD  <i>Approved unanimously</i></p> <p><u>Next Steps:</u>  Oct. 8 PAC</p>
<p>MCUP3119 – Sterilization Consent Protocol</p>	<p>During the annual review of this policy, we noted that DHCS has replaced Consent Form PM 330 (in use since 1999) with an updated PDF version of the same form that is now named DHCS 8469 and specified as “New 04/2025)  <b>Section III.A. and throughout:</b> Definition updated to DHCS Form 8469 “Consent for Sterilization”  <b>Section VII.C. and D.:</b> Reference to form 8469 updated with new hyperlink. DHCS web page added with hyperlink for information on the new form.</p> <p>Tony noted that while Partnership was updating this policy, DHCS was having technical difficulties and has meanwhile reverted back to using Form 330. These difficulties are to be resolved by Oct. 16, so we will utilize the new form. Dr. Murphy recommended this policy refer to both form numbers, and Anna Campbell responded that it does in several instances.</p>	<p>Motion to <b>approve as presented:</b>  Chris Swales, MD  Second: John Murphy, MD  <i>Approved unanimously</i></p> <p><u>Next Steps:</u>  Oct. 8 PAC</p>
<p>MPUD3001 – Utilization Management Program Description</p>	<p><b>This policy is updating off-cycle to remove references to “Carelton” as our delegated managed behavioral health organization because they are being de-delegated for triage and referral services: Partnership will handle these calls in-house as of Sept. 29.</b>  <b>Page 1:</b> The Behavioral Health department is added to the Health Services department team.  <b>Page 3:</b> The Medical Director program staff description is updated to specify that this position has the authority to make decisions based on medical necessity which result in the approval or denial of coverage</p>	<p><i>There were no questions.</i></p> <p>Motion to <b>approve as presented:</b>  Robert Quon, MD  Second: Jennifer Wilson, MD</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>for UM activities.</p> <p><b>Page 5:</b> The Senior Director of Behavioral Health program staff description is added as part of a new training and education team.</p> <p><b>Page 12:</b> The Nurse Auditor (RN) program staff description is added.</p> <p><b>Page 17-19:</b> The descriptions of the Community Advisory Committee (CAC), Physician Advisory Committee (PAC), Quality/Utilization Advisory Committee (QUAC) and Quality Improvement Health Equity Committee (QIHEC) are updated.</p> <p><b>Page 22-23:</b> The Mental Health section is updated to remove reference to Carelon</p> <p><b>Page 26:</b> A new section is added to describe “Addition of Benefits and Modification of TAR Requirements.”</p> <p>Tony noted that the de-delegation of Carelon for triage and referral services related to mild to moderate mental health services are significant enough to relook at the UM PD, which is typically updated each April/May during the UM Grand Analysis. This occasion provides as opportunity to make other updates, some of which are necessitated by NCQA’s recent release of its 2026 Standards and its updates to UM 1A, including the addition of two new factors. Dr. Netherda commented that we have seen a dramatic increase in staff in the Fairfield office to accommodate bringing the de-delegated services inhouse.</p>	<p><i>Approved unanimously</i></p> <p><u>Next Steps:</u> Oct. 8 PAC</p>
<p><b>Policy Owner: Grievance &amp; Appeals – Presenter: Kory Watkins, MBA-HM, Director of Grievance &amp; Appeals</b></p>		
<p>CGA024 – Medi-Cal Member Grievance System</p>	<p><b>Language is updated according to added and hyperlinked Department of Health Care Services All Plan Letters 25-005 and 24-017</b>, respectively: Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Service, and Alternative Formats and Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements.</p> <p><b>Section I.</b> MCND9004 Regulatory Required Notice and CMP26 Verification of Caller Identity and Release of Information have been added as Related Policies and referenced in the policy text as well.</p> <p><b>Section III. Some definitions have been updated, added or deleted.</b> “Authorized Representative” now aligns with CMP26 and MCUP3037 Appeals of Utilization Management and Pharmacy Decisions.</p> <p><b>VI.G. is deleted</b> since Partnership has brought in-house some Behavioral Health interfaces once delegated to Carelon, including the grievance and appeals function.</p> <p><b>The new VI.G.c. specifies</b> Quality of Care Grievances must be investigated and resolved within 30 calendar days, even if they involve Potential Quality Issue (PQI) concerns.</p> <p><b>VI.O. is added</b> to spell out Transgender (Trans) inclusive care per APL 24-017.</p> <p><b>IX.A. Timeliness Monitoring and Risk Mitigation is modified</b> to say the department uses a “real-time” tracker and will shift staff when necessary.</p> <p><b>XIII. References</b> are updated to reflect the additional APLs.</p> <p>Kory went through the synopsis. Dr. Netherda noted that these changes have already been approved by DHCS, and he commended Kory for working with DHCS to hereby close the Corrective Action Plan (CAP) related to the 2024 DHCS Audit.</p>	<p><i>There were no questions.</i></p> <p>Motion to <b>approve as presented:</b> Randy Thomas, MD Second: Steven Gwiazdowski, MD</p> <p><i>Approved unanimously</i></p> <p><u>Next Steps:</u> Oct. 8 PAC</p>
<p><b>VI. Presentations</b></p>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p><b>MY2024 Primary Care Provider Quality Incentive Program (PCP QIP) Evaluation – Athena Beltran-Nampraseut, Project Manager II, QI</b></p>	
	<p>Athena provided an overview of the program, year-over-year programmatic adjustments and changes, 2024 program performance and payout and summary.</p> <p>The PCP QIP runs on a calendar year. There is a core measurement set, which consists of two domains: clinical and non-clinical. The clinical measures that are assigned are dependent on the practice type: family, internal medicine and pediatrics. For MY 2024, we had 11 clinical measures, and these are divided into three main categories: chronic disease management, preventative screenings, and pediatric access. For 2024, our clinical measures were set at the 90<sup>th</sup> percentile of national Medicaid NCQA Quality Compass benchmarks for full points and then the 50<sup>th</sup> percentile for partial points. There are a few exceptions to these targets. For Colorectal Cancer Screening (CCS), we used our own internal performance data to set our targets: the 50<sup>th</sup> percentile for full points and the 25<sup>th</sup> percentile for partial points. Lead Screening in Children was a new measure for 2024 (it had been a monitoring measure in 2023), so targets were set at the 50<sup>th</sup> percentile for full points; no partial points were available. In 2024, we introduced our expansion (county) providers into the program by setting targets for full points at the 50<sup>th</sup> percentile: no partial points were available.</p> <p>In 2024, we had a total of five non-clinical measures divided among three categories: hospital utilization, primary care utilization and patient experience. Our targets do vary and are specific to the individual measure. Patient Experience is a stand-alone measure with two different options on how providers can earn points: CG-CAHPS (Clinician and Group – Consumer Assessment of Healthcare Providers and Systems) with targets based on access and communication, or a two-part survey submission.</p> <p>The Unit of Service (UOS) measure set is separate from the core measure set; its payment methodology is different and calculated outside of the core measure set. Participation in UOS is optional. Incentives are earned by submission to our inbox with the exception of Extended Office Hours and all claims-based measures, such as Tobacco Use Screening, Dental Fluoride Varnish and Early Administration of the First HPV dose and the Initial Flu Vaccine series.</p> <p>In 2024, we retired the clinical Asthma Medication Ratio measure, and we added Lead Screening in Children to the clinical domain. There were no changes to the non-clinical measures. In the UOS, we added two: Early Administration of the 1<sup>st</sup> HPV Dose and Early Administration of Initial Flu Vaccine Series (two doses).</p> <p>In viewing the plan-wide clinical performance over the past three measurement years, three of our 11 clinical measures performed better than in 2023. Seven measures declined in performance in 2024. Athena then presented legacy county, expansion county and plan-wide providers’ percentages because the targets are different for each of them.</p> <p>In the legacy counties for the Chronic Disease Management measures, a higher percentage of providers earned partial points (50<sup>th</sup> percentile) for the diabetes HbA1c Control and Controlling High Blood Pressure measures in 2024 than in 2023. In all five Preventative Screening measures, providers earned higher percentages of partial points in 2024 compared to 2023. Under Pediatric Access, there was a higher percentage of providers who earned partial points in the Child and Adolescent Well Care Visit during 2024 compared to 2023.</p> <p><b>Dr. Netherda recognized Q/UAC voter and pediatrician Randy Thomas, MD, who had a question.</b> “I was just reading over the HPV vaccines: we’re giving \$50 per vaccine that’s given under the age of 12. Well, how about if somebody gave it five months apart instead of six months? Are they still going to get the reward?” Athena replied the incentive is to encourage vaccine administration by a certain age. Dr. Thomas wondered if it would be more effective to give the patient the \$50 bonus to get in or even \$25 versus giving it to the provider? Dr. Netherda referred that question to Population Health Director DeLorean Ruffin, DrPh. Dr. Ruffin said that on the preventative side, we go to directly to the members and patients with our scripted talking piece to get them to get the vaccines, and then we do follow up calls therefore afterwards to ensure that they did get that vaccination completed. Finally, we will double check that in the California Immunization Registry.</p> <p>Looking at the percentage of providers within our legacy counties who met full points (90<sup>th</sup> percentile), all three scored higher in 2024 than in 2023. Four of the five preventative screen measures also had a higher percentage of providers who earned full points at the 90 percentile compared to the prior measurement year. There was also a higher percentage of providers who earned full points at the 90th percentile in both of the pediatric access measures compared to the prior measurement year.</p> <p><b>Q/UAC voter, internist, and pediatrician John Murphy, MD, asked for clarification,</b> trying to reconcile lower 2024 plan-wide performance for most measures against more providers hitting 90<sup>th</sup> percentile targets in 2024, wondering “are the higher performers overall doing better with a relatively lower number of patients?” Isaac</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Brown responded that the improved 90<sup>th</sup> percentile data is specific to the legacy counties: when you look at the plan-wide rates dropping, much has to do with the 2024 expansion where incoming counties scored lower for many measures, pulling down the plan wide average.</p> <p>Athena noted that despite Partnership raising our 2024 thresholds back up to the pre-pandemic 90<sup>th</sup> percentile and then also seeing some resistance from our provider network, we are still seeing a larger percentage of our providers within our legacy counties earning full points in nine of our 11 clinical measures.</p> <p>This was an introduction year for our expansion counties, so their targets were different from our legacy counties: full points was set at the 50<sup>th</sup> percentile; no partial points were available. More than half of our expansion providers earned full points at the 50<sup>th</sup> percentile in both the Diabetes HbA1c and the Controlling High Blood Pressure clinical measures. About 30% of our expansion providers earned full points in the Breast Cancer Screening (BCS), Colorectal Cancer Screening (CCS), and the Child and Adolescent Well Care Visit measures. Plan-wide, about 50% of our providers earned full points for both the CCS and the Lead Screening in Children measures.</p> <p>In the PCP QIP, we do offer something called Relative Improvement (RI), used to incentivize provider sites to demonstrate improvement in their performance from the prior measurement year. RI is available for most existing clinical measures as long as the provider has a score and received payment for the performance in the prior measurement year. (Thus, expansion county providers could not earn RI in 2024.) Athena then went into how RI factored together with full, partial and no points for each of the clinical measures. Looking at the Child and Adolescent Well Care Visit and the Controlling High Blood Pressure measures, about 14% of providers achieving the 90<sup>th</sup> percentile did so because of the RI bump year over year.</p> <p>Plan-wide in the non-clinical core measurement set, there was an increase in performance with the decline rate in Ambulatory Care Sensitive Admissions and the increased rate of PCP Office Visits. Both Avoidable ED Visits and Risk Adjustment Readmissions had increased rates, thus a decline in performance. She then went through these four measures for full, partial, and no points.</p> <p>In 2024, there were a total of 10 UOS measures, each with its own individual incentive payout amount. Four showed a higher percentage of participation than in 2023. Early Administration of the First HPV Dose had a high participation rate (70%). Altogether, the total payout for all UOS measures was \$1.089M. Advance Care Planning payout remains one of highest year over year since our providers can earn up to \$20,000 per site.</p> <p>Our 2024 PCP QIP payout totaled \$51.9M. The payment methodology included an equity adjustment; the baseline PMPM (per member per month) rate started at \$4. The 2024 weighted average earned PMPM was \$6.84. A majority of our providers earned a PMMP rate between \$9.26 and \$13.99. Eight of our 14 legacy counties had a higher payout in 2024 than in 2023.</p> <p>In summary, in 2024 we made some programmatic changes: we removed Asthma Medication Ratio from the clinical measure set and we added Lead Screening in Children, which previously had been a UOS measure. We added two new UOS, which is that Early Administration of the 1st HPV Dose and the Early Administration of the Initial Flu Vaccine series. The 10-county expansion added more than 100 new PCP sites to the Partnership network. We saw improvement in three of the 11 clinical measures from the prior measurement year. For Healthcare Effectiveness Data Information Set (HEDIS®) benchmarks, we had five of our clinical measures score above the minimum performance level and four below the MPL.</p> <p>Based on performance in 2024 and our current performance in 2025, the following recommendations will be made to PAC on Oct. 8: add a new clinical measure, Kidney Health Evaluation for Patients with Diabetes (KED), and keep two separate measures for BCS based on age range, implementing the heretofore 40-51-year-old monitoring measure as an active measure. So too, current monitoring measures Chlamydia Screening and Well Child Visits in the First 15-30 Months of Life should become active measures. Topical Fluoride in Children will remain as a monitoring measure.</p> <p>Dr. Thomas thanked Athena for her “excellent presentation” and then he expressed concern that “we’re getting paid to give vaccines. I think it really destroys a lot of the credibility that the physician has in trying to convince families that have vaccine hesitancy to get the HPV vaccine. I have pretty good success with the HPV vaccine, but a lot of my patients end up doing it not before 13 (but) when they are 14 or 15. If they know that the doctor’s getting paid for them to get the vaccine by a certain age, I think they’re not going to trust the doctors much.” Q/UAC voter and pediatrician Brian Montenegro, MD agreed: “it’s something that significantly concerns me today.”</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Dr. Murphy added “one other layer. We (La Clinica) do incent some measures, like directly giving patients gift cards, for example, and just internally we made the decision not to incent vaccines, but we do incent the Well Child Visit. And so, from the Health Plan level, a parent or member could have a concern in just a clinic level decision that we made, even though our compliance folks said it wasn’t an inducement to incent for a vaccine. So, we incent for the visit when there is at least an opportunity to have that conversation and, internally, we don’t incent for that vaccine.” Dr Ribordy noted “We get paid for vaccines by private insurance; we get paid the injection fees. The whole point of these programs is to pay for good clinical care; vaccines is the best clinical care we can offer.” Deputy Chief Medical Officer and Medical Director for Medicare Services Kermit Jones, MD, JD, said “we get incentivized to do the majority of everything we do in healthcare. The challenge we have is that for reasons beyond our understanding, vaccines tend to occupy this very unique space of concern with people. From a clinical standpoint, we shouldn’t buy into this.”</p> <p>Dr. Ruffin commented that “it’s also a factor of educating our members, providing health education and the value behind vaccines. This display can be misconstrued, especially in these times. All of us have to combat that on the backside.”</p> <p>Dr. Swales noted that he doesn’t always have time to do that education, given how many things family medicine has to do in a 15- or 20-minutes visit. “If someone says ‘I don’t want vaccines’ I say let it go. If I were to say ‘we get incentivized to talk with you about vaccinations,’ that feels less directly icky to people who are already very intensely focused on this issue.”</p> <p>Dr. Murphy suggested “Maybe one building piece with members or patients is to say ‘we lose money on vaccines since we have a huge amount of infrastructure; we don’t view it as a money making opportunity; it’s a clinical care thing.’”</p> <p>Dr. Gwiazdowski said, “It feels like a quid pro quo: I give the vaccine, I get money, so I wonder if there is a way to do the calculus such that we can do remuneration based on a population health management goal: ‘if your vaccination rate is this, you get that.’” He later added that everything else we do, whether a cervical screening or anticipatory guidance could likewise be remunerated against population-based health management.</p> <p>Dr. Ribordy commented again, agreeing with both doctors Thomas and Swales. “I actually got to the point in my practice where I didn’t even have the conversation anymore. I said ‘if you don’t want to follow the vaccine schedule, you’re not going to see me for well visits.’”</p> <p>Athena reminded the Committee that we do have a provider comments period where feedback is incorporated into our internal discussions when we are making our proposed measure set. She also added that there is a threshold requirement for UOS measures: a minimum of 5% of their assigned members do have to complete these vaccines for Partnership to incentivize.</p> <p>Dr. Netherda thanked everyone for their comments and acknowledged that in these times Partnership needs to “consider the optics on everything we do in a way that we haven’t had to do in the past.”</p> <p>Dr. Montenegro added “As a pediatrician, I’m a huge believer in vaccines. That being said, if I were able to vote on this, I would vote to remove all financial incentives for vaccines because I think if we don’t, we are tone deaf to the current political and cultural climate.” Dr. Ribordy, however, urged caution in “giving in to whatever the current political climate is.”</p> <p>Dr. Gwiazdowski wondered if Partnership could provide providers with an information sheet that could be handed to those who would refuse vaccines. “Just say ‘read this and we’ll follow up.’ I would start by saying ‘hey, if your kid got bit by a rabid dog, would you get the rabies vaccine?’”</p> <p>Auburn Regional Medical Director Matthew Morris, MD, said “Coming from the (Federally Qualified Health Center) / CMO side, I will say that the incentive aspects are really for anything we do; it generally gets put back into the program. So, it does help you to build or hire staff or carve out time for certain staff to help with your vaccine programs.”</p> <p>Director of Health Equity and Health Equity Officer Mohamed “Moe” Jalloh, Pharm.D, said “vaccines is a unique dynamic. When people have blood pressure or diabetes control, that is something that is affecting themselves. When we don’t incentivize, this can hurt herd immunity and decrease the efficacy of vaccines on the long term</p>	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>basis. If we don't have that incentive, we're less likely to have vaccine coverage and that will worsen our herd immunity. That's why we're seeing cases of measles and other diseases we thought were limited resurging."</p> <p>Dr. Swales disagreed: "That has nothing to do with incentives, that's social religious beliefs, right? Incentive is actually a detriment if people find out because there are people you could (otherwise) convince to do it."</p> <p>Dr. Townsend noted providers can chose not to take that incentive and instead give that piece back to the QIP. "You don't have to take the money. I do think there is an opportunity, in supporting what Dr. Morris said, that the funds don't go to individual clinicians, and if they do, that's your organization's decision around how you manage incentives from your health plans. They actually go to the organization, which supports the structure in place around keeping a vaccine registry, helping your patients get in for vaccination appointments, whether its HPV or others, and potentially has the opportunity to provide additional education to your medical assistants, who can provide some of that education as well."</p> <p>Dr. Jones noted "we don't know how big that number is of people who could be convinced if we didn't get the incentive, and whether you get the incentive or not, we're not going to be able to compete with TikTok."</p> <p>Dr. Ward wondered "if we incenent the skill building process for practices rather than the unit of service delivery?" She noted that the Southwest Region was about to have a quality meeting on vaccine efficacy and themselves might elevate this conversations.</p> <p>Dr. Netherda said he saw Dr. Swales' point that people on the fence could go one way or another but that he doesn't know that. He thought there must be literature how well incentives work and on which way they push people. He volunteered to survey the literature, beginning with a link to such a study on Covid vaccine incentives that someone linked in chat duri</p>	
<b>VII. FYI Attachments and Adjournment</b>		
HEDIS® MY 2024 / RY 2025 NCQA Health Plan Accreditation (HPA) Summary of Performance – <i>direct any questions to Kristine Gual</i>		
5-Star QI Strategy Plan / Tactical Plan Update – <i>direct any questions to Isaac Brown</i>		
Community Health Assessment / Community Health Improvement Plan (CHA/CHIP) August Update – <i>direct questions to DeLorean Ruffin</i>		
Q/UAC adjourned at 9:12 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Oct. 15, 2025.		
<p><i>Respectfully submitted by: Leslie Erickson, Program Coordinator II, QI</i></p> <p>Signature of Approval: _____ Date: _____</p> <p><i>Mark Netherda, MD Medical Director for Quality and Committee Vice Chair</i></p>		

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA**  
**INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES**  
Tuesday, Sept 9, 2025 / 1:32 – 2:51 PM

**Members Present:**

Bjork, Sonja, JD, Chief Executive Officer  
 Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health  
 Brown, Isaac, MHA/MBA, Interim Sr. Dir. of Q & P Improvement  
 Brundage O’Connell, Lisa, MHA, Director of Enhanced Health Services  
 Brunkal, Monika, RPh, Assoc. Dir., Population Health  
 Campbell, Anna, Policy Analyst, Utilization Management  
 DeVido, Jeff, MD, Behavioral Health Clinical Director  
 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  
 Leung, Stan, Pharm.D, Director of Pharmacy Services  
 Matthews, Richard “Doug,” MD, Regional Medical Director (Chico)  
 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  
 Villasenor, Edna, Senior Director, Member Services and G&A  
 Ward, Lisa, MD, Regional Medical Director (Southwest)

**Members Absent:**

Andrews, Leigha, MBA, Regional Director (Southwest)  
 Ayala, Priscila, Director of Network Services  
 Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer  
 Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI  
 Davis, Wendi, Chief Operating Officer  
 Garcia-Hernandez, Margarita, PhD, Director of Health Analytics  
 Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services

Kerlin, Mary, Senior Director, Provider Relations  
 Klakken, Vicki, Regional Director (Northwest)  
 Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair  
 Sharp, Tim, Regional Director (Northeast)  
 Townsend, Colleen, MD, Regional Medical Director (Southeast)  
 Turnipseed, Amy, Senior Director of External and Regulatory Affairs  
 YoungStone, Kelly, RN, Director of Care Coordination, Care Coordination

**Guests:**

Akintan, Folo, MBBS/MD MPH MBA, Epidemiologist, Population Health  
 Allen, Angier, Senior Data Scientist I, Finance  
 Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)  
 Bikila, Dejene, Manager of Data Science, Finance  
 Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance  
 Chebolu, Radha, Senior Health Data Analyst II, Finance  
 Chiang, Yuen, Program Manager I, Utilization Management  
 Clark, Kristen, Manager, Quality & Training, Member Services  
 Cunningham, Aryana, Policy Analyst, Care Coordination  
 Devan, James, Manager of Performance Improvement, QI (Northeast)  
 Erickson, Leslie, Program Coordinator II, QI (scribe)  
 Flournoy, Candi, Project Manager II, QI  
 Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI  
 Hanusiak, Kenzie, Sr. Mgr, Regulatory Affairs & Compliance  
 Harris, Vander, Senior Health Data Analyst I, Finance  
 Hendrix, Hillary, Exec. Asst. to the Sr. Dir. of Behavioral Health  
 Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)  
 Jamali, Shahrzad, Improvement Advisor, QI (Chico)  
 Jarrett-Lee, Kevin, RN, Associate Director, Utilization Management  
 Kubota, Marshall, MD, Associate Medical Director

Lee, Donna, Manager of Claims, Claims  
 Lopez, Eva, CPhT, Program Manager I, QI (Palliative Care QIP)  
 McCune, Amy, Manager of Quality Incentive Programs, QI  
 Moraghebi, Roudabeh, Manager of Health Analysts, Finance  
 Moore, Jordan, Education Specialist, Provider relations  
 Morris, Matthew, MD, Regional Medical Director (Auburn)  
 Muncy, Kellie, Mgr of Change Management & Configuration, Configuration  
 Newell, Amber, CPhT, Program Manager I, QI  
 Nguyen, Tom, Manager of Health Analysts, Finance  
 Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy  
 Quichocho, Sue, Manager of Quality Measurement, QI  
 Rathnayake, Russ, Senior Health Data Analyst I, Finance  
 Robertello, Kimberly, PhD, Sr. Medicare QI Program Manager, QI  
 Romero, Liz, MPH, MCHES, Improvement Advisor, QI (Northeast)  
 Salehi, Tiphonie, Sr. Health Data Analyst I, Finance  
 Seale, J’aime, PR Lead, Network Services  
 Selig, Barb, Manager of Quality Improvement Programs, QI  
 Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance  
 Smith, Christine, Community Health Needs Liaison, Population Health  
 Spiller, Bettina, Associate Medical Director  
 Stark, Rebecca, Regional Director (Chico)

Kufner, Annie, LVN, Sr. Program Analyst, Configuration Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance Kung, Jen, Senior Health Data Analyst II, Finance	Thomas, Penny, Senior Health Data Analyst I, Finance Vance, Brooke, Program Manager I, Network Services Wellander, Emily, Improvement Advisor, QI (Santa Rosa) Yu, Fei, Senior Data Scientist I, Finance
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AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<b>I. Call to Order</b> <ul style="list-style-type: none"> <li>• Introductions</li> <li>• Approval / Acceptance of Minutes</li> </ul>	<p>Medical Director for Quality and IQI Vice Chair Mark Netherda, MD, called the meeting to order at 1:32 p.m. in the planned absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA..</p> <ul style="list-style-type: none"> <li>• Several staff attended IQI for the first time: <ul style="list-style-type: none"> <li>○ Angier Allen, Senior Data Scientist I, Finance</li> <li>○ Hillary Hendrix, Exec. Asst. to the Sr. Dir. of Behavioral Health</li> <li>○ Annie Kufner, LVN, Sr. Program Analyst, Configuration</li> <li>○ Shreya Kulkarni, Policy Analyst, Regulatory Affairs &amp; Compliance</li> <li>○ Fei Yu, Senior Data Scientist I, Finance</li> </ul> </li> <li>• Approval of the Aug. 12 IQI Minutes</li> <li>• Acknowledgment and Acceptance of the draft minutes of the <ul style="list-style-type: none"> <li>○ July 30 Over/Under Utilization Workgroup</li> <li>○ Aug. 7 Population Needs Assessment (PNA) Committee</li> </ul> </li> </ul>	<p>Motion to <b>approve IQI Minutes</b>: Anna Campbell Second: Isaac Brown, MHA/MBA</p> <p>Motion to <b>accept other minutes</b>: Isaac Brown Second: Mohamed Jalloh, Pharm.D</p>
<b>II. Old Business - None</b>		
<b>III. New Business Consent Calendar</b> (Committee Members as applicable)		
<p>G&amp;A PULSE Report, Issue 18, September 2025 – <i>direct questions to Latrice Innes</i></p> <p><b>Health Services Policies</b> <u>Utilization Management</u> MCUG3118 – Prenatal &amp; Perinatal Care MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21</p> <p><b>Non-Health Services Policies</b> <u>Network Services - Credentialing</u> MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements MPCR304 – Allied Health Practitioners Credentialing and Re-credentialing Requirements</p> <p><u>Network Services - Compliance</u> MPNET102 – DHCS Network Certification Requirements</p> <p>Anna Campbell <b>pulled MPNET102</b> to question the inclusion of a “DHCS Approval” date line, an anomaly heretofore unseen in Health Services and non-Health Services policies before this committee. How do we know that DHCS would approve it on Oct. 8 as stated? <b>Brooke Vance will take the policy back for more work and bring it back to IQI on Oct. 7.</b></p>		<p>Motion to <b>approve slate without MPNET102</b>: Isaac Brown Second: Anna Campbell</p> <p><u>Next Steps</u>: Health Services policies will go to the Sept. 17 Quality/Utilization Advisory Committee (Q/UAC) and to the Oct. 8 Physician Advisory Committee (PAC)</p> <p>The two approved credentialing policies will go to the Sept. 10 Credentials Committee</p>
<b>IV. New Business – Discussion Policies</b>		
<b>Policy Owner: Utilization Management</b> – <i>Presenter: Tony Hightower, CPhT, Associate Director, UM</i>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
<p>MCUG3007 – Authorization of Ambulatory Procedures and Services</p>	<p><b>Section IV</b> All attachments have been removed from this section and policy attachment number referenced throughout the policy instead. Information included in the attachments was all duplicated in policies MCUP3041 and MCUP3049.</p> <p><b>Section VI.C.1.</b> A reference to policy MPUP3139 Criteria and Guidelines for Utilization Management was added and information duplicate in that policy was removed.</p> <p><b>Attachment B:</b> While this attachment is being archived from this policy, it is also a shared document with <b>MCUP3041-A.</b> For that purpose, the (Treatment Authorization Request) TAR Requirements document <b>is also updated at this time to</b></p> <ul style="list-style-type: none"> <li>• Remove Allergy Injections as a TAR is no longer required</li> <li>• Add Behavioral Health Treatment – TAR is required</li> <li>• Add Hearing Aids – TAR is required</li> <li>• Add ICF - – TAR is required</li> </ul> <p>Tony explained that duplicative information contained in other policies is now deleted from this one. <b>Anna Campbell will substitute the word “Credentials” for “Credentialing” in this policy header and in the other UM policies too.</b></p>	<p><i>There were no questions.</i></p> <p>Motion to <b>approve as presented:</b> Anna Campbell Second: Lisa Ward, MD</p> <p><u>Next Steps:</u> Sept. 17 Q/UAC Oct. 7 PAC</p>
<p>MCUP3013 – Durable Meical Equipment (DME) Authorization</p>	<p>During this annual review, details for Partnership’s enhanced benefit for Compression garments were added [as approved by the Benefit Review Evaluation Workgroup (BREW)]</p> <p><b>Section VI.G.3.</b> New section for Compression Garments added</p> <p><b>Section VII.G.</b> Reference to BREW form added</p> <p><b>Attachment B:</b> Codes E0652, E0675, E0676 were deleted under lymphedema pump/compression devices because they are no longer listed in the Provider Manual</p> <p>Mark Netherda, MD, asked if the changes could possibly decrease TARs, and Tony replied this is possible.</p>	<p>Motion to <b>approve as presented:</b> Lisa Ward, MD Second: Anna Campbell</p> <p><u>Next Steps:</u> Sept. 17 Q/UAC Oct. 7 PAC</p>
<p>MCUP3119 – Sterilization Consent Protocol</p>	<p>During the annual review of this policy, we noted that DHCS has replaced Consent Form PM 330 (in use since 1999) with an updated PDF version of the same form that is now named DHCS 8469 and specified as “New 04/2025)</p> <p><b>Section III.A. and throughout:</b> Definition updated to DHCS Form 8469 “Consent for Sterilization”</p> <p><b>Section VII.C. and D.:</b> Reference to form 8469 updated with new hyperlink. DHCS web page added with hyperlink for information on the new form</p> <p><b>Post meeting, it was discovered that DHCS has yet to update its website with the new form.</b> Interested parties can continue to access the old form until further notice.</p>	<p><i>There were no questions.</i></p> <p>Motion to <b>approve as presented:</b> Doug Matthews, MD Second: Lisa O’Connell, MHA</p> <p><u>Next Steps:</u> Sept. 17 Q/UAC Oct. 7 PAC</p>
<p>MPUD3001 – Utilization Management Program Description</p>	<p><b>This policy is updating off-cycle to remove references to “Carelon” as our delegated managed behavioral health organization because they are being de-delegated for triage and referral services: Partnership will handle these calls in-house as of Sept. 29.</b></p> <p><b>Page 1:</b> The Behavioral Health department is added to the Health Services department team.</p>	<p>Motion to <b>approve as presented:</b> Doug Matthews, MD Second: Brigid Gast, RN</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p><b>Page 3:</b> The Medical Director program staff description is updated to specify that this position has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.</p> <p><b>Page 5:</b> The Senior Director of Behavioral Health program staff description is added.</p> <p><b>Page 12:</b> The Nurse Auditor (RN) program staff description is added as a new position as part of a new training team.</p> <p><b>Page 17-19:</b> The descriptions of the Community Advisory Committee (CAC), Physician Advisory Committee (PAC), Quality/Utilization Advisory Committee (QUAC) and Quality Improvement Health Equity Committee (QIHEC) are updated.</p> <p><b>Page 22-23:</b> The Mental Health section is updated to remove reference to Carelon</p> <p><b>Page 26:</b> A new section is added to describe “Addition of Benefits and Modification of TAR Requirements.”</p> <p>Tony noted that it is rare to update the UM PD off-cycle (it usually updates within UM’s Grand Analysis at IQI and Q/UAC each April) but that the Carelon de-delegation necessitated it. Also, the National Committee for Quality Assurance (NCQA) just released its 2026 Standards, adding Factors 5 &amp; 6 to Health Plan Accreditation UM requirements and specifying how Partnership must demonstrate that a committee exists to oversee UM. Q/UAC serves as this committee, Tony said. Dr. Netherda asked if the policy will be used at NCQA evidence, and Tony replied “yes.”</p>	<p><u>Next Steps:</u> Sept. 17 Q/UAC Oct. 7 PAC</p>
<p><b>Policy Owner: Grievance &amp; Appeals – Presenter: Latrice Innes, Compliance Manager, Grievance &amp; Appeals</b></p>		
<p>CGA024 – Medical Member Grievance System</p>	<p><b>Language is updated according to added and hyperlinked Department of Health Care Services All Plan Letters 25-005 and 24-017, respectively:</b> Standards for Determining Threshold Languages, Nondiscrimination Requirements, Language Assistance Service, and Alternative Formats and Transgender, Gender Diverse or Intersex Cultural Competency Training Program and Provider Directory Requirements.</p> <p><b>Section I.</b> MCND9004 Regulatory Required Notice has been added as a Related Polic and referenced in the policy text as well.</p> <p><b>Section III. Some definitions have been updated, added or deleted.</b></p> <p><b>VI.G. is deleted</b> since Partnership has brought in-house some Behavioral Health interfaces once delegated to Carelon.</p> <p><b>The new VI.G.c. specifies</b> Quality of Care Grievances must be investigated and resolved within 30 calendar days, even if they involve Potential Quality Issue (PQI) concerns.</p> <p><b>VI.O. is added</b> to spell out Transgender (Trans) inclusive care per APL 24-017.</p> <p><b>IX.A. Timeliness Monitoring and Risk Mitigation is modified</b> to say the department uses a “real-time” tracker and will shift staff when necessary.</p> <p><b>XIII. References</b> are updated to reflect the additional APLs.</p> <p>Latrice presented, saying the new VI.G.c. and reworked IX.A. addresses a Corrective Action Plan. Dr. Netherda asked if this now closes that CAP, and Director of Grievance &amp; Appeals Kory Watkins said that it does: the CAP will be closed post Oct. 8 PAC policy approval. <b>Before IQI met, UM Policy Analyst Anna Campbell noted that this policy defines “authorized representative” differently</b> than does UM’s MCUP3037. At IQI, Senior Manager of Regulatory Affairs &amp; Compliance Kenzie Hanusiak added that the “authorized representative”</p>	<p>Motion to <b>approve as amended:</b> Lisa Ward, MD Second: Doug Matthews, MD</p> <p><u>Next Steps:</u> Sept. 17 Q/UAC Oct. 7 PAC</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	definition should align with MCUP3037 and with CMP-26 Verification of Caller Identity and Release of Information too. <b>The definition will be updated and these two policies added as “Related Policies” herein before Q/UAC considers the policy Sept. 17.</b>	
<b>V. Presentations</b>		
<b>QI Update – Isaac Brown, MPH/MBA, Interim Senior Director, Quality Improvement and Performance</b>		
	<ul style="list-style-type: none"> <li>• There are 73 items on the Tactical Plan Update for 5-Star Quality Strategy closing out FY 2024/2025 4<sup>th</sup> Quarter. Everyone is encouraged to read that document included as FYI in today’s packet.</li> <li>• We are now busy preparing payments for our Quality Incentive Programs (QIPs). These QIPs do incentivize good behavior among our providers. One of the main tools is the Partnership Quality Dashboard, which, along with eReports, helps everyone understand where care gaps may exist. Although the go-live of the new core claims system, Health Rules Payor, has been delayed, Partnership is launching the PQD at the end of this month. Interested persons may register at <a href="https://partnershiphp.webex.com/weblink/register/re98a70312b7c4eec1e0c15e735ccacd5">https://partnershiphp.webex.com/weblink/register/re98a70312b7c4eec1e0c15e735ccacd5</a> to attend the hour-long webinar at noon Monday, Sept. 22.</li> <li>• Thank you everyone for educating each other on the new work-around code and utilizing it too on dental fluoride treatments in children. The data is starting to come through, and we should see the results for this Healthcare Effectiveness Data Information Set (HEDIS®) Managed Care Accountability Measure (MCAS) improve.</li> <li>• The first Regional Quality Improvement meetings for the Auburn and Chico regions took place at the end of July. Partnership shared “best practices” and year-end 2024 PCP QIP data by county. Twenty-three individuals representing one half of the 18 parent organizations in the Chico Region attended. Thirteen persons representing six of the 11 parent organizations in the Auburn Region attended.</li> <li>• The second pilot of the Preventive Care Bridge Project (formerly the Locum Tenens Pilot Initiative) is underway. Care gaps are closing within the four participating providers: Western Sierra Medical Clinic, Shasta Community Health, Open Door Community Health, and Ampla Health. Providers report no-show rates are lower than expected. A compendium or “playbook” of lessons learned and best practices in the use of locum tenens will be developed and shared in future with the entire network.</li> <li>• The Quality Improvement Project Toolkit and Training Program is being launched to provide project management support. Twenty persons will attend a six-session webinar over 12 weeks to cover all phases of the project life cycle and focus on applying those methods to real-world QI efforts. A broader effort will launch in the new year.</li> <li>• NCQA has informed Partnership that our projected “Star Rating” on the HEDIS® measures is 3.0.</li> </ul>	For information only.
<b>2024 Primary Care Provider Quality Incentive Program (PCP QIP) Evaluation – Athena Beltran-Nampraseut, CPhT, Program Manager II, QI</b>		
	<p>Athena provided an overview of the program, year-over-year programmatic adjustments and changes, Measurement Year 2024 program performance and payout details before summarizing. The PCP QIP runs on a calendar year. There is a core measurement set which consists of two domains: clinical and non-clinical. The clinical measures that are assigned are dependent on the practice type: family, internal medicine and pediatrics.</p> <p>For MY 2024, we had 11 clinical measures, and these are divided into three main categories: chronic disease management, preventative screenings, and pediatric access. For 2024, our clinical measures were set at the 90<sup>th</sup> percentile of national Medicaid NCQA Quality Compass benchmarks for full points and then the 50<sup>th</sup> percentile for partial points. There are a few exceptions to these targets. For colorectal cancer screening, we used our own internal performance data to set our targets: the 50<sup>th</sup> percentile for full points and the 25<sup>th</sup> percentile for partial points. Lead Screening in Children was a new measure for 2024, so targets were set at the 50<sup>th</sup> percentile for full</p>	<p>Based on performance in 2024 and our current performance in 2025, the following is recommended:</p> <ul style="list-style-type: none"> <li>• Add a new clinical measure, Kidney Health Evaluation for Patients with Diabetes (KED)</li> </ul>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>points; no partial points were available. In 2024, we introduced our expansion (county) providers into the program by setting our targets for full points at the 50<sup>th</sup> percentile: no partial points were available.</p> <p>In 2024, we had a total of five non-clinical measures divided among three categories: hospital utilization, primary care utilization and patient experience. The targets vary and are specific to the individual measure. The patient experience measure is a stand-alone: with two different options on how providers can earn points: CG-CAHPS (Clinician and Group - Consumer Assessment of Healthcare Providers and Systems) with targets based on access and communication, or a two-part survey submission.</p> <p>The Unit of Service (UOS) measure set is separate from the core measure set; its payment methodology is different and calculated outside of the core measure set. Participation in UOS is optional. Incentives are earned by submission to our inbox with the exception of Extended Office Hours and all claims-based measures, such as Tobacco Use Screening, Dental Fluoride Varnish and Early Administration of the First HPV Dose or the Initial Flu Vaccine series.</p> <p>In 2024, the clinical Asthma Medication Ratio measure was retired, Lead Screening in Children was added (thus it was removed as a monitoring measure). There were no changes to the non-clinical measures. In the UOS, we added two: Early Administration of the 1<sup>st</sup> HPV Dose and Early Administration of Initial Flu Vaccine Series (two doses). Viewing the plan-wide clinical performance over the past three measurement years, there was an increase in performance for three of our 11 clinical measures. Seven measures declined in performance in 2024.</p> <p>Athena presented different views of our providers’ percentages specific to our legacy counties, expansion counties, and plan wide because the targets differed. In MY 2024, a higher percentage of providers in the legacy counties earned partial points (50<sup>th</sup> percentile) for the chronic disease management measures Diabetes HbA1c Control and Controlling High Blood Pressure than in MY 2023. In all five preventative screening measures, providers earned higher percentages of partial points in MY 2024 compared to MY 2023. Under pediatric access, there was a higher percentage of providers who earned partial points in the Child and Adolescent Well Care Visit during 2024 compared to 2023.</p> <p>Looking at legacy county providers who met full points (90<sup>th</sup> percentile), all three chronic disease management measures had a higher percentage in 2024 compared to 2023. Under the preventative screens, four of the five measures also had a higher percentage of providers who earned full points compared to the prior measurement year. And then lastly, under pediatric access, there was a higher percentage of providers who earned full points in both of these measures compared to the prior measurement year.</p> <p>Despite Partnership raising its 2024 thresholds back up to the pre-pandemic 90<sup>th</sup> percentile and then also seeing some resistance from our provider network, we’re still seeing a larger percentage of our providers within our legacy counties earning full points in nine of our 11 clinical measures.</p> <p>Again, 2024 was an introduction year for our expansion counties, so their targets were different from our legacy counties: full points were set at the 50<sup>th</sup> percentile; no partial points were available. More than half of our expansion providers earned full points at the 50<sup>th</sup> percentile in both Diabetes HbA1c and Controlling High Blood Pressure. About 30% of our expansion providers earned full points in the Breast Cancer Screening (BCS), Colorectal Cancer Screening (CCS), and the Child Health and Adolescent Well Care Visits.</p> <p>Plan-wide, about 50% of our providers earned full points for Lead Screening in Children and full points in the CCS measure.</p> <p>In the PCP QIP, we do offer something called “Relative Improvement” used to incentivize provider sites to demonstrate improvement in their performance from the prior measurement year. A RI is available for most existing clinical measures as long as the provider has a score and received payment for the performance in the prior measurement year.</p>	<ul style="list-style-type: none"> <li>• Keep two separate measures for BCS based on age range, implementing the heretofore 40-51-year-old monitoring measure as an active measure.</li> <li>• So too, monitoring measures Chlamydia Screening and Well Child Visits in the First 15-30 Months of Life become active measures.</li> <li>• Topical Fluoride in Children will remain a monitoring measure.</li> </ul> <p>Dr. Netherda commented that to the extent the 2026 program recommendations (to be presented at October quality committees) align with HEDIS® measures, providers meeting the first helps Partnership meet the second, creating a “win-win” all around.</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	<p>Athena then went into RI methodology and calculations and how RI factored together with full, partial and no points for each of the clinical measures. Expansion county providers could not earn RI. Legacy county providers could, and about 14% of those earning full points in the Child and Adolescent Well Care Visits and the Controlling High Blood Pressure did so because of RI year over year.</p> <p>Plan-wide in the non-clinical core measurement set, there was an increase in performance with the decline rate in Ambulatory Care Sensitive Admissions and the increased rate of PCP Office Visits. Both Avoidable ED Visits and Risk Adjustment Readmissions had increased rates and thus a decline in performance. Athena then went through these four measures for full, partial, and no points.</p> <p>In 2024, there were a total of 10 UOS measures, each with its own individual incentive payout amount. Four showed a higher percentage of participation than in 2023. Early Administration of the First HPV Dose had a high participation rate (70%). Altogether, the total payout for all UOS measures was \$1.089M. Advance Care Planning payout remains one of highest payouts year over year since our providers can earn up to \$20,000 per site.</p> <p>For MY 2024, our total payout for the PCPQIP was \$51.9M. The payment methodology includes an equity adjustment, and the baseline PMPM (per member per month) rate starts at \$4. The 2024 weighted average PMPM earned was \$6.84. A majority of our providers earned a PMPM rate between \$9.26 and \$13.99. Eight of our legacy counties had a higher payout in 2024 compared to 2023.</p> <p>In summary, in 2024 we made some programmatic changes: we removed Asthma Medication Ratio as a clinical measure, and we added one new clinical measure: Lead Screening in Children, which in 2023 had been a UOS measure. We added two new UOS measures, Early Administration of the 1st HPV Dose and the Early Administration of the Initial Flu Vaccine series. Some program performance things to mention is that we underwent an expansion, which was 10 additional counties encompassing more than 100 new PCP sites. We saw improvement in three of the 11 clinical measures from the prior measurement year. For HEDIS® benchmarks, we had five of our clinical measures score above the minimum performance level and four below the MPL.</p>	
<p><b>1<sup>st</sup>/2<sup>nd</sup> Qtr 2025 UM/Pharmacy Inter-Rater Reliability (IRR) and Timeliness Report – Andrea Ocampo, Pharm.D, Pharmacy, and Tony Hightower, CPhT, UM</b></p>		
	<p>Andrea and Tony each presented data for the first six months of calendar year 2025. Andrea noted that, for Q1 and Q2 2025, pharmacy met the 95% timeliness goal for all TAR categories based on NCQA standards (urgent pre-service, non-urgent pre-service, and post-service). Please note, this report only includes Adverse Benefit Decision (ABD) determinations resulting from medical necessity review and does not include all TARs reviewed.</p> <p>For IRR, both pharmacy technicians and pharmacists met the concurrence goal of 90% or higher. Pharmacy technicians had a concurrence rate of 100% for Q1 and Q2 2025, while pharmacists had a concurrence rate of 99% for Q1 and Q2 2025. A high concurrence rate means that reviewers are consistently and accurately applying evidence based clinical review criteria.</p> <p>TARs per tech per day remained stable from Jan-June 2025. A new pharmacist was hired in May: the TARs per pharmacist per day dropped to eight from April onwards. Another pharmacist retired in July, so it is expected that the TARs per pharmacist per day rate will increase in the latter part of the year. Pharmacy TAR volume for the first half of 2025 has remained steady compared to the first half of 2024, with only a 4.7% increase YOY.</p> <p>Tony noted that UM was compliant in two categories for the bulk of our (non-behavioral healthcare decisions) outpatient reviews; however, “the margin for error is trickier as the denominator is low” in the urgent preservice and post-service categories. UM did hit most IRR concurrence targets, although UM just missed the 90% threshold for Q2 Inpatient IRR. “We have now put into effect annual formalized training to ensure application of criteria consistent across all reviewers and IRR reviewers as well,” Tony said, adding that he expects concurrence rate will soon be above 90%.</p>	<p>Tony noted that outpatient teams are doing some cross training to make sure reviews are more efficient. Teams are moving toward operationalizing weekend staffing, which is now being done on an <i>ad hoc</i> basis. “This will help us with our 72-hour receipts,” he said.</p> <p>Dr. Netherda was interested in how 2025 TAR volume compared to the same period in 2024. He appreciated having the two columns side by side to compare.</p>

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Kenzie Hanusiak asked if, like Pharmacy, the ABD parameters also apply to UM's tallies. Tony replied that NCQA and DHCS reporting differs. For the purpose of IRR, it is typically done on denials. Andrea noted that Pharmacy technicians cannot deny TARs.	Anna Campbell said she would get back to Kenzie on her question.
<b>FYI:</b>	HEDIS® MY 2024/ RY 2025 Managed Care Accountability Set (MCAS) Summary of Performance – <i>refer questions to Kristine Gual</i>	
	HEDIS® MY 2024 / RY 2025 NCQA Health Plan Accreditation (HPA) Summary of Performance – <i>refer questions to Kristine Gual</i>	
	5-Star QI Strategy Plan / Tactical Plan Update – <i>refer question to Isaac Brown</i>	
	Community Health Assessment / Community Health Improvement Plan (CHA / CHIP) August Update – <i>refer questions to DeLorean Ruffine, DrPh</i>	
<b>VI. Adjournment</b>		
Dr. Netherda adjourned the meeting at 2:51 p.m. IQI will meet next Tuesday, Oct. 7, 2025.		
<p data-bbox="86 565 1098 597"><i>Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement</i></p> <p data-bbox="86 605 825 638"><i>Approval Signature: _____ Date: _____</i></p> <p data-bbox="86 703 720 760"><i>Mark Netherda, MD Medical Director for Quality and Committee Vice Chair</i></p>		



## MEETING AGENDA / MINUTES

<b>Meeting/Project Name:</b>	<b>Substance Use Internal Quality Improvement Committee Meeting (SUIQI)</b>		
<b>Date of Meeting:</b>	<b>09/25/2025</b>	<b>Time:</b>	<b>10:00 AM</b>
<b>Meeting Facilitator:</b>	<b>Stephanie Wilson</b>	<b>Location:</b>	<b>Webex</b>

### Meeting Objective/s

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services\* oversight. Activities and progress are reported to the IQIC.

### Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1. Welcome and Introductions	Stephanie Wilson	5 Minutes
2. Review and Approve Minutes	Stephanie Wilson	5 Minutes
3. Behavioral Health Director Update <ul style="list-style-type: none"> <li>a. Data Sharing – MCP MOU Requirements</li> <li>b. Transitional Rent</li> </ul>	Mark Bontrager	10 Minutes
4. Wellness and Recovery Program Updates, Enhancements, and Highlights <ul style="list-style-type: none"> <li>a. New Partnership Access Team and 24/7 Access Line</li> <li>b. HSAG               <ul style="list-style-type: none"> <li>i. PMV</li> <li>ii. PIPs</li> </ul> </li> <li>c. Treatment Perception Surveys</li> <li>d. Community Supports</li> <li>e. CalOMS System Updates and TA</li> <li>f. SUIQI Agenda and Materials</li> </ul>	Nicole Esobar, Kara Kusalich, Stephanie Wilson	20 Minutes
5. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Grievances &amp; Appeals               <ul style="list-style-type: none"> <li>i. FY 24-25 4<sup>th</sup> Quarter Report</li> <li>ii. MCPAR</li> </ul> </li> </ul>	Latrice Innes	5 Minutes
6. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. New Providers for Quarter               <ul style="list-style-type: none"> <li>i. No New Providers – Several Providers in Contracting and Credentialing Process</li> <li>ii. Provider Recruitment</li> </ul> </li> <li>b. Credentialed Network Providers</li> </ul>	Kara Kusalich, Cindy Wilson	10 Minutes

<ul style="list-style-type: none"> <li>c. Provider Compliance Summary <ul style="list-style-type: none"> <li>i. Open Admissions CalOMS Reporting</li> <li>ii. DATAR Reporting</li> <li>iii. Provider CAP Compliance – No CAPs</li> </ul> </li> </ul>		
<ul style="list-style-type: none"> <li>7. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Utilization Management <ul style="list-style-type: none"> <li>i. TARs and TAR Denials</li> <li>ii. Member Utilization by Level and County</li> <li>iii. Timely Access</li> <li>iv. Transitions of Care</li> <li>v. Transportation</li> </ul> </li> </ul> </li> </ul>	Cindy Wilson	10 Minutes
<ul style="list-style-type: none"> <li>8. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Claims Processing <ul style="list-style-type: none"> <li>i. Timeliness of Claims Processing for Quarter</li> <li>ii. Denial Rates</li> <li>iii. DHCS Short Doyle Acceptance Rate</li> </ul> </li> </ul> </li> </ul>	Nicole Escobar	5 Minutes
<ul style="list-style-type: none"> <li>9. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Quality Improvement Program Activities <ul style="list-style-type: none"> <li>i. W&amp;R Provider Site Reviews</li> <li>ii. W&amp;R CAP Score Tracking</li> </ul> </li> </ul> </li> </ul>	Stephanie Wilson	5 Minutes
<ul style="list-style-type: none"> <li>10. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Member Services <ul style="list-style-type: none"> <li>i. Beneficiary Access Line/Call Center Statistics</li> <li>ii. Member Correspondence</li> </ul> </li> </ul> </li> </ul>	Cindy Wilson	5 Minutes
<ul style="list-style-type: none"> <li>11. Monitoring and Oversight <ul style="list-style-type: none"> <li>a. Compliance <ul style="list-style-type: none"> <li>i. BHINs &amp; Policy Updates <ul style="list-style-type: none"> <li>1. 25-019</li> <li>2. 25-023</li> <li>3. 25-025</li> <li>4. 25-026</li> <li>5. 25-028</li> <li>6. 25-029</li> </ul> </li> </ul> </li> </ul> </li> </ul>	Stephanie Wilson	5 Minutes
12. Walk On Items	Stephanie Wilson	5 Minutes
13. Wrap and Closing	Stephanie Wilson	5 Minutes

<b>Attendees</b>		
<b>Name</b>	<b>Department/Division</b>	<b>Attended</b>
Amy Cone	Humboldt County	X
Michelle Thomas	Humboldt County	X
Nancy Starck	Humboldt County	X
Tiffany Armstrong	Lassen County	X
Isabel Gallego	Mendocino County	X
Maria Machado	Mendocino County	X
Navin Bhandari	Mendocino County	X
Nathan Hobbs	Napa County	X
Annika Jensen	Partnership	X
Carina Glover	Partnership	X
Cindy Wilson	Partnership	X
Diana Rose	Partnership	X
Joanie Williams	Partnership	X
Kara Kusalich	Partnership	X
Latrice Innes	Partnership	X
Mark Bontrager	Partnership	X
Matt Ramsey	Partnership	X
Nicole Escobar	Partnership	X
Sitara Cavanagh	Partnership	X
Stephanie Wilson	Partnership	X
Vivian Agudelo	Partnership	X
Amber Brock	Shasta County	X
Bailey Cogger	Shasta County	X
Joanna Chorpensing	Shasta County	X
Sarah Collard	Siskiyou County	X
Loraine Wisler	Siskiyou County	X
Diana Tolentino	Solano County	X
Mary Kate Whall	Solano County	X
Megan Ray	Solano County	X
Ruth Leonard	Solano County	X

## Notes, Decisions, Issues

1. Welcome and Introductions
  - a. Stephanie started meeting reviewing housekeeping items and meeting agenda
2. Review and Approve Minutes – SUIQI May 2025
  - a. Approved by Nancy Starck and Tiffany Armstrong
3. Behavioral Health Director Update
  - a. Data Sharing – MCP MOU Requirements
    - i. Draft BHIN came out regarding data sharing between County BHPs and MHPs – expectation down the road is that we do some data sharing
    - ii. Engagement with County BHPs to find a way to share data timely and accurately
    - iii. Annual reporting on quality outcomes need to have complete data
    - iv. CalMHSA is being engaged in this discussion to see if there are some back-end opportunities for a number of our counties who use their EHR system
  - b. Transitional Rent
    - i. Benefit going live 1/1/2026 for county behavioral health clients who are houseless or at risk of being houseless
    - ii. New MCP plan benefit to provide up to 182 days of transitional rent
    - iii. Partnership is obligated to engage County BHP partners and they have their right of first refusal to become the transitional rent provider
  - c. Nancy: Do you know off hand the BHIN number for the data sharing?
    - i. Mark: Currently in draft, so no attached number, but I can send it out.
4. Wellness and Recovery Program Updates, Enhancements, and Highlights
  - a. New Partnership Access Team and 24/7 Access Line
    - i. Soft launch of BH Access Line today
    - ii. Relationship for member-facing activities is ending with Carelon, and we are bringing in-house our access line, care coordination, as well as G&A.
    - iii. Date given to PCPs and Community Partners: 9/29 but we moved up to 9/25 – calls started at 8:30am
    - iv. Joanna: Is Partnership sending out any materials to counties with updated information on phone number?
      1. Nicole: Yes. Some of those materials have been sent out by our Provider Relations Department, but just as a reminder, the phone number did not change. Although the number remained the same, a new email address has been created and shared within our community. ([BH-access@partnershiphp.org](mailto:BH-access@partnershiphp.org))
    - v. Nancy: Does this mean that when a person or provider calls the access line, they're talking to a Partnership employee? Is Carelon just processing claims?
      1. Nicole: Carelon is still contracted for network services: credentialing, contracting, and claims payment
  - b. HSAG
    - i. PMV
      1. Still pending feedback on performance measure validation
    - ii. PIPs
      1. Initial findings received 9/24/25
      2. Each county received an email with the attached documents
      3. Revisions must be submitted by 10/24/25 – meetings will be scheduled with each county to review and ensure everything is submitted back to HSAG

- c. Treatment Perception Surveys
    - i. BHIN 25-025 regarding TPS came out 6/27/25
    - ii. Survey period: 10/20/25-10/24/25
    - iii. Partnership working with UCLA – all regional model providers, QR codes, and links have been received
    - iv. Partnership is in the process of putting together the materials for each individual provider
      - 1. Goal to be distributed by 10/3/25
      - 2. Materials will include: QR codes, links, paper surveys, fillable flyers for providers to fill out to include their details, and detailed instructions on how to share the surveys with members
    - v. All paper surveys will be mailed to Partnership office and then Partnership will mail them to UCLA by deadline of 11/21/25. Once UCLA has compiled all the data, they will analyze and generate a report at a county, provider, and statewide level.
      - 1. Typically available in February. Will be shared with counties once received
    - vi. Partnership will be available to support before, during, and after the survey period
  - d. Community Supports
    - i. Changes effective 1/1/2025
      - 1. Post-hospitalization and recruiting care requirements have changed
        - a. Members are eligible for up to 182 days, within a 12-month rolling period for these benefits
        - b. Notices have been sent out into the communities because people do depend on these services
      - 2. Nathan: Who is allowed to make these referrals? Can other staff members from county generate the referral or must it be the SUD RES Program?
        - a. Nicole: Entities can make these referrals if they are providing care coordination activities to members.
      - 3. Nathan: Do they need to bill for Care Coordination?
        - a. Nicole: They don't need to bill for Case Management or Care Coordination services, but they need to be well informed in the member's care.
  - e. CalOMS System Updates and TA
    - i. Changes were made to meet compliance with BHIN 24-030
    - ii. Additional changes have been made 331 errors
      - 1. On admission info page, the fields for "County Paying for Services" and "Special Services Contract ID" will be grayed out to prevent data mistakenly being entered
      - 2. Anticipated completion date: 10/16/2025
  - f. SUIQI Agenda and Materials
    - i. SUIQI agenda has been updated to cross-reference sections in IGA where we are collaborating and disseminating data.
    - ii. SUIQI addendum has been created to help crosswalk data shared in SUIQI in relation to the agenda as well as to Sharefile.
      - 1. Addendum includes link to the data – link goes to Regional Model Monitoring folder in ShareFile
      - 2. Will be included in each SUIQI meeting and found in ShareFile, along with SUIQI notes and agenda
5. Monitoring and Oversight
- a. Grievances & Appeals
    - i. FY 24-25 4th Quarter Report

1. Pulse report shared on screen (attached)
  2. Only one case reported for Mendocino County
    - a. Discrimination grievance: Member felt as if they were being discriminated against because of their religious beliefs. Member had some behavior issues and program director confirmed information. Program director mentioned the person the member had conflicts with no longer works there but did not confirm that this issue was because of that employee. Also, program director mentioned the program is not faith-based and members could go out outside of the program to attend religious services.
    - b. Based on everything received, it was determined discrimination was deemed unlikely in this case
  3. Several cases closed – as previously discussed
  - ii. MCPAR
    1. Submitted 8/29/2025
    2. Each county has a specific folder in the Regional Model Monitoring folder for the beneficiary problem resolution progress process, the EE section, where MCPAR and proof of submission lives along with quarterly reports
6. Monitoring and Oversight
- a. New Providers for Quarter
    - i. No New Providers – Several Providers in Contracting and Credentialing Process
    - ii. Provider Recruitment
      1. Partnership actively working to grow and strengthen our network and reduce gaps in services
      2. Regular meetings with potential providers to discuss:
        - a. Partnership opportunities
        - b. Contracting options
        - c. Program benefits
        - d. Additional services such as ECM and CS
      3. Recently, meetings have been focused on providers interested in working with Partnership through the Regional Model
      4. Some providers have shown interest in offering Youth Services (OP, IOP, NTP, and RES) and Adult Services (full continuum from OP to RES 3.5 LOC)
      5. Partnership aiming to continue engaging with these providers until full partnerships are established
      6. Once a provider is fully contracted, counties will be notified and the network of their availability
      7. Please let Partnership know of any providers that should be contacted
  - b. Credentialed Network Providers
    - i. List of newly credentialed network providers can be found in SUIQI packet
    - ii. 36 credentialed network providers between January and June of this year – average of 6 per month
  - c. Provider Compliance Summary
    - i. Open Admissions CalOMS Reporting
      1. Monitored to ensure current and accurate
      2. OA must be updated with an annual update at 12 months or discharged if services are complete

3. Admissions that are not updated or discharged within 14 months are considered out of compliance
  4. Point-in-Time OA Report is pulled from DHCS data before the 20<sup>th</sup> of each month and shared with providers to support data accuracy and compliance
  5. Table 1 shared on screen (attached) shows overall number of records appearing in each OA report pulled during the fiscal year
    - a. Overall, compliance remains exceptionally high throughout all three months of Q4
    - b. Compliance improved steadily from April to June, with a decreasing number of out-of-compliance records each month
  6. Table 2 shared on screen (attached) shows Admission Data by Service Type
    - a. IOP/OP services consistently had the highest number of admissions
    - b. Detox and RES increased in June, suggesting a possible shift in service demand or availability
  - ii. DATAR Reporting
    1. Shared on screen (attached)
    2. FY 24-25 4<sup>th</sup> Quarter – all providers reported on time
      - a. Prior to January 2025, Medmark had staffing and access issues to enter DATAR data. For a period, in the Fall, Partnership also did not have access to enter data for providers while our access was changing from a former staff member. However, we were able to resolve those issues thus bringing our compliance back to 100% in January for the region.
    3. FY 24-25 average in time reporting was 98.58%
    4. FY 23-24 average in time reporting was 91%; we see continued improvement in this area
  - iii. Provider CAP Compliance – No CAPs
7. Monitoring and Oversight
- a. Utilization Management
    - i. TARs and TAR Denials
      1. TARs
        - a. 99.99% TAR approval rate for Q4
        - b. 467 out of 469 approved for this quarter – only two denials
        - c. 4% increase in number approved TARs 23-24 (1,751) vs 24-25 (1,830)
      2. TAR Denials
        - a. Shared on screen and reviewed (attached)
    - ii. Length of Stay
      1. FY 24-25, Region finished 4<sup>th</sup> Quarter with highest LOS for the year at 49 days
        - a. Q1: 43 Days
        - b. Q2: 44 Days
        - c. Q3: 41 Days
        - d. Q4: 49 Days
      2. 3-year average: 45 days, which is very close to the 24-25 average: 44.25 days
    - iii. Demographics
      1. 23-24 Total Participating Members: 5,635
      2. 24-25 Total Participating Members: 5,803
      3. 168 more members, 3% increase in participating members from last fiscal year
    - iv. Member Utilization by Level and County

1. Static – no significant change from 23-24: 541,218 visits
  2. Across the region, 39% of members and 68% of visits are OTP/NTP
- v. Timely Access
1. Non-Urgent 23-24: 94%
  2. Non-Urgent 24-25: 95%; 1% improvement
  3. Urgent 23-24: 92%
  4. Urgent 24-25: 95%; 3% improvement
  5. Average Days:
    - a. Non-Urgent 23-24: 2.5
    - b. Non-Urgent 24-25: 2.4; 0.04% improvement
    - c. Urgent 23-24: 1.9
    - d. Urgent 24-25: 1.6; 19% improvement
  6. 1-3 days between LOC screening
    - a. Non-Urgent 23-24: 87%
    - b. Non-Urgent 24-25: 88%; 1% improvement
    - c. Urgent 23-24: 92%
    - d. Urgent 24-25: 95%; 3% improvement
- vi. Transitions of Care
1. 23-24 vs 24-25 step up-down from 7.66 to 6.2 = 19% improvement – 1.46 days less waiting
- vii. Transportation
1. FY 24-25
  2. 41% are Drug Rehab
  3. 46% of all trips are BH
  4. 51% are 1-10 miles
  5. 20% are for Accessibility (NEMT)

8. Monitoring and Oversight

a. Claims Processing

i. Timeliness of Claims Processing for Quarter

1. 160,000 claims processed during Q4 24-25
2. Total of \$17.8 million paid to our provider network
3. 95% of claims processed within 14 days
4. 90% processed within seven days

ii. Denial Rates

1. Unable to print out, but will be included in minutes
2. Denial rates continue to average about 10%

iii. DHCS Short Doyle Acceptance Rate

1. Three large projects currently working on with DHCS: Other health insurance, ongoing issues with taxonomy codes, and claims related to claims that have been processed incorrectly and DHCS has requested for Partnership to resend in as replacement claims.
  - a. These claims will not affect county invoicing processes as they are not being re-processed. They will not touch PUMP or Room & Board invoices. You will see an impact onto your 835 files.

9. Monitoring and Oversight

a. Quality Improvement Program Activities

i. W&R Provider Site Reviews

1. 25 site reviews completed during Q4 24-25 which resulted in 19 CAPs that were closed during this time
  - a. Seven of those CAPs were the same provider, but with different site locations. Deficiencies were the same deficiencies
2. All providers have completed their CAPs
3. Of 19 caps, 13 were medical records related and 6 were facility site review related
  - a. 13 Medical, common findings:
    - i. Missing documented physical exam and/or referral to Partnership Care Coordination
    - ii. No evidence of required number of counseling sessions for the LOC client was in
    - iii. Discharge plans not present for each client with a known end date of service
    - iv. Late signed progress notes
    - v. Medical Necessities were not determined appropriately
    - vi. LOC Assessment was not completed within 72 hours of admission for RES patients
    - vii. Partnership specific ROI not included
    - viii. Discharge summaries missing all elements, including new items which address medication and housing needs
    - ix. For clients that were administratively discharged, they were missing three documented attempts of outreach within 30 days of last FTF
  - b. 6 Facility Site Reviews, common findings:
    - i. Staff missing proof of ASAM training,
    - ii. Staff missing proof of DMC-ODS training
    - iii. Medical Directors missing proof of 5 hours of CEs related to Addiction Medicine
    - iv. Staff files missing required documentation
4. Spreadsheet included in SUIQI packet and will be placed in ShareFile

ii. W&R CAP Score Tracking

1. Site Review Team has put together a CAP score and tracking spreadsheet (shared on screen and attached)
  - a. Completed for FY 24-25 and being carried into FY 25-26
  - b. Spreadsheet tracks date of the provider's review, if the CAP was issued, and CAP status
  - c. Spreadsheet breaks down the facility site review and the medical records review to allow to see which areas the provers are having challenges in

d. Spreadsheet will be presented quarterly in SUIQI and placed in ShareFile

10. Monitoring and Oversight

a. Member Services

i. Beneficiary Access Line/Call Center Statistics

1. Q4 call volume was consistent with Q3 – 74% of calls resulted in a residential referral
2. 23-24: 3232 Calls
3. 24-25: 3335 Calls
4. Increase of 103 calls for 24-25, 3% increase
5. 33 abandoned calls in 24-25 compared to 47 in 23-24
6. Calls answered within 30 seconds: 23-24: 33 seconds whereas 24-25: 18.5 seconds

ii. Member Correspondence

1. On 6/23/2025 Partnership sent out Notice of Significant Changes regarding the Traditional Healthcare Practices

11. Monitoring and Oversight

a. Compliance

i. BHINs & Policy Updates – All attached

1. 25-019: TGI Training Requirements
2. 25-023: Enforcement Actions
3. 25-025: TPS
4. 25-026: Provider Directory Requirements
5. 25-028: Enhanced CHW Services
6. 25-029: New Requirements for (AOD) Counselors

12. Walk On Items

a. None

13. Wrap and Closing

- a. Adjourned 11:13 AM
- b. Next meeting: December 2025

**Action Items**

Action	Owner	Due Date
1. Meeting notes and SUIQI packet	Carina Glover	09/30/2025



**QI DEPARTMENT UPDATE**  
**OCTOBER 2025**  
**PREPARED BY ISAAC BROWN**  
**INTERIM SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT**

<b><u>QUALITY INCENTIVE PROGRAMS (QIPs)</u></b>	
<b>PROGRAM</b>	<b>UPDATE</b>
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	<ul style="list-style-type: none"> <li>• Sprint season (October – December) is upon us!</li> <li>• 10/01/2025 is the release of four (4) new upload templates: HbA1c, CBP, W15 and W15-30</li> <li>• All 2025 CG CAHPS results were shared with qualifying providers on September 12<sup>th</sup></li> <li>• ECDS measure: Late contracting period for 2025 with DataLink runs from 10/01/2025 – 12/31/2025.</li> <li>• MY2026 proposed measures will be presented at PAC this month</li> </ul>
PALLIATIVE CARE QUALITY INCENTIVE PROGRAM (PALLIATIVE CARE QIP)	<ul style="list-style-type: none"> <li>• MY2026 proposed measures will be presented at PAC this month</li> <li>• 2025 January – June payment will begin processing this month</li> </ul>
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	<ul style="list-style-type: none"> <li>• FY24/25 payment will begin processing this month</li> </ul>
ENHANCED CARE MANAGEMENT QUALITY INCENTIVE PROGRAM (ECM QIP)	<ul style="list-style-type: none"> <li>• Q2 2025 payments will distribute this month</li> <li>• MY2026 proposed measures will be presented at PAC this month, no proposed changes to the measure set.</li> </ul>
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	<ul style="list-style-type: none"> <li>• FY24/25 payment will begin processing this month</li> </ul>

<b><u>QUALITY DATA TOOLS</u></b>	
<b>TOOL</b>	<b>UPDATE</b>
PARTNERSHIP QUALITY DASHBOARD (PQD)	<ul style="list-style-type: none"> <li>• 2025 PQD has launched!</li> <li>• 2025 PQD Kick Off webinar has been posted to the Partnership HealthPlan public facing webpage</li> </ul>
eREPORTS	<ul style="list-style-type: none"> <li>• 2026 eReports development has begun</li> </ul>

<b><u>PERFORMANCE IMPROVEMENT (PI)</u></b>	
<b>ACTIVITY</b>	<b>UPDATE</b>
STATE MANDATED WORK: <i>PERFORMANCE IMPROVEMENT PROJECT (PIP) &amp; PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE</i>	<ul style="list-style-type: none"> <li>• <b>Southern Region (Children’s Health Domain):</b> Work continues in Sonoma County to improve Lead Screening and Fluoride varnish.</li> <li>• <b>Northern Region (Children's Health, Chronic Disease, Reproductive Health &amp; Cancer Prevention Domains):</b> Multiple interventions are underway in the North, such as expediting newborn membership enrollment, academic detailing for</li> </ul>

	<p>medication-based measures like asthma and diabetes, increasing mammography access through mobile mammography and fixed-imaging, and more.</p> <ul style="list-style-type: none"> <li>• <b>Next update to DHCS due 10/31/2025</b></li> </ul>
<p>QUALITY MEASURE SCORE IMPROVEMENT</p>	<ul style="list-style-type: none"> <li>• <b>Pediatrics:</b> continuing 2024-2025 work on TFL, LSC, W30+2, and W30+6. Finalizing new work on WCV, DEV, CIS 10, and IMA. <ul style="list-style-type: none"> <li>○ <b>Project Focus:</b> Partnership with Anderson RX in Shasta County to complete 3 school-focused immunization events in August 2025: Over <b>130</b> Students vaccinated <ul style="list-style-type: none"> <li>♣ <b>Next event planned for spring 2026</b> - more students are anticipated to attend due to additional communication</li> </ul> </li> </ul> </li> <li>• <b>Chronic Disease:</b> Working to set measure priorities and workplan for 2025-26. DHCS has proposed removing the Asthma Medication Ratio measure from accountability following NCQA removal and is considering a replacement measure.</li> <li>• <b>Women’s Health and Perinatal:</b> No updates</li> <li>• <b>Behavioral Health:</b> The BH workgroup is looking at new proposed DHCS accountable measures and impact on prioritization of existing measures. One potential new measure is depression screening in adolescents and adults. BH workgroup is working on setting measure priorities for MY 2026.</li> <li>• <b>Elder Care:</b> This workgroup is on hiatus as we are preparing for the new DSNP launch date in 2027. The next full workgroup meeting will take place in December 2025. Until then, a smaller planning group will continue to meet monthly.</li> </ul>
<p>IMPROVEMENT ACADEMY</p>	<ul style="list-style-type: none"> <li>• The finalized schedule for the 2026 Improving Measure Outcomes Webinar Series has been announced. <ul style="list-style-type: none"> <li>○ 02/11/2026 - Pediatric Preventive Care (0 - 30 months)</li> <li>○ 02/25/2026 - Pediatric Preventive Care (3 - 17 years)</li> <li>○ 03/11/2026 - Preventive Cancer Screenings</li> <li>○ 03/25/2026 - Chronic Disease</li> <li>○ 04/08/2026 – Sexual Health Screenings</li> <li>○ 04/22/2026 - Perinatal Care</li> </ul> </li> <li>• Each webinar will cover Partnership’s Primary Care Provider Quality Incentive Program measures. Content will focus on direct application of best practices including eliminating health disparities with examples from quality improvement teams.</li> </ul>
<p>JOINT LEADERSHIP INITIATIVE (JLI)</p>	<ul style="list-style-type: none"> <li>• Recent JLI Updates <ul style="list-style-type: none"> <li>• Solano County Family Health Services: Focused JLI on 08/18/2025 <ul style="list-style-type: none"> <li>○ Welcomed new Chief Operations Officer</li> <li>○ Onboarding 9 new clinicians</li> <li>○ Prioritizing improvements to pediatric access</li> </ul> </li> </ul> </li> <li>• Upcoming 2025 JLI meetings: <ul style="list-style-type: none"> <li>• WellSpace Health 10/14/2025</li> <li>• Oroville Hospital 10/20/2025</li> <li>• Shasta Community Health Center 10/21/2025</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• Ampla Health 11/03/2025</li> <li>• MCHC 11/17/2025</li> <li>• Western Sierra Medical Center 12/08/2025</li> <li>• Solano Family Health Services 12/09/2025</li> </ul>
REGIONAL IMPROVEMENT MEETINGS	<ul style="list-style-type: none"> <li>• The first Regional Quality Improvement meeting for the Santa Rosa Region is scheduled for 10/07/2025 and will focus on the topic of immunization measure improvement, covering strategies for vaccine hesitancy and immunization inventory management. This will take place at the Santa Rosa office, 495 Tesconi Circle in Santa Rosa, and also has a virtual option. To register for in-person attendance click here: <a href="https://www.eventbrite.com/e/santa-rosa-regional-quality-meeting-tickets-1636390009569?aff=oddtcreator">https://www.eventbrite.com/e/santa-rosa-regional-quality-meeting-tickets-1636390009569?aff=oddtcreator</a>. To attend virtually please send a request to the Performance Improvement team at <a href="mailto:PIT@partnershiphp.org">PIT@partnershiphp.org</a>.</li> <li>• The Fairfield Regional Quality Improvement meeting was held on 09/16/2025. MY2024 Topics included 2024 QIP and HEDIS rates as well as a presentation on Telehealth</li> <li>• The next Auburn Regional Quality meeting is scheduled for 10/06/2025, and the next Chico Regional Quality meeting is scheduled for 10/27/2025. Both of these meetings will be held virtually. For an invitation to one of these meetings please send a request to the Performance Improvement team at <a href="mailto:PIT@partnershiphp.org">PIT@partnershiphp.org</a>.</li> <li>• The Eureka and Redding Regional Quality Improvement meetings were held on 09/09/2025 and 09/30/2025 respectively. The QI team presented the MY2024 HEDIS results and led discussion around measure barriers and opportunities. QI also shared important dates for the PCP QIP program for the remainder of the 2025 calendar year.</li> </ul>

**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 25/26 ORG GOALS	<p><b>CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey.</b></p> <ul style="list-style-type: none"> <li>• Pre-planning discussions for the regulated CAHPS® Survey (MY 2025) are underway. Considerations include:                             <ul style="list-style-type: none"> <li>o Oversampling strategy, modifications to the mixed protocols (i.e., phone calls, mailers), and supplemental questions.</li> <li>o Formal population submission for 2026 NCQA Patient Experience Health Plan Star Rating.</li> </ul> </li> </ul> <p><b>Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)</b></p> <ul style="list-style-type: none"> <li>• Organizational goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement.</li> </ul>

	<ul style="list-style-type: none"><li>• For more insights on goal progress and milestone accomplishments for Q1, please visit the OpEx PMO internal goal dashboard (<a href="#">Partnership4Me</a>, under Smart Links).</li></ul> <p><b>NCQA Health Plan Accreditation Requirement Update</b></p> <ul style="list-style-type: none"><li>• The Member Experience Grand Analysis (ME 7) is under review by QI leadership and Partnership’s NCQA consultant. The analysis will begin making its way through the formal Committee approval process, in November.</li></ul>
<p>EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS</p>	<p><b>Colorectal Cancer Web Page</b></p> <p>A new provider-facing webpage is now available on Partnership’s website to support colorectal cancer screening efforts. The page includes a variety of internal and external resources, including:</p> <ul style="list-style-type: none"><li>• Educational Cologuard videos for providers to share with their patients (developed by the Population Health Team)</li><li>• Information on ordering FIT tests</li><li>• Links to provider and patient materials</li></ul> <p>The Cologuard overview outlines available screening options and includes guidance on how to effectively address care gaps.</p> <p>For more information about Colorectal Cancer Screening opportunities and resources visit <a href="https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx">https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx</a></p> <p><b>Bulk Order Offering</b></p> <p>All providers may bulk order Cologuard directly from Exact Sciences any time during the year by contacting <a href="mailto:PHC@exactsciences.com">PHC@exactsciences.com</a>. No program enrollment or Partnership pre-approval is required.</p> <p><b>Partnership Facilitated Order</b></p> <p>Partnership continues to facilitate multi-patient orders, where orders are submitted on behalf of providers to Exact Sciences. Facilitated Orders removes the two hundred (200) patient minimum requirement that some providers face when placing a bulk order directly with Exact Sciences.</p> <ul style="list-style-type: none"><li>o Seven provider orgs participated in the most recent Facilitated Order. Submissions were accepted from 07/21/2025 through 08/18/2025. Kits are tentatively scheduled to ship date on 09/29/2025. This aligns with QIP’s timeline for addressing 2025 and 2026 PCP QIP Measures.</li><li>o The next Facilitated Order is scheduled to launch on 01/19/2026 and is aligned with Colorectal Cancer Awareness Month in March.</li></ul>

<p>EQUITY &amp; PRACTICE TRANSFORMATION PROJECT</p>	<p><b>PDPP Participation and Deliverables</b></p> <ul style="list-style-type: none"><li>• The following three (3) provider organizations have opted out of continuing to participate in the EPT Program due to either limited bandwidth and/or staff.<ul style="list-style-type: none"><li>○ Fairchild Medical Clinic</li><li>○ Lassen Indian Health Clinic</li><li>○ Northern Valley Indian Health</li></ul></li><li>• Per PHLC, DHCS notified Solano Family Health Services that they were removed from the EPT program for not completing the required Year 2 PhmCAT.</li><li>• The remaining twenty-three (23) provider organizations are working on completing their milestone deliverables for the November 2025 EPT deliverable submissions due on 11/01/2025.</li><li>• To continue participating in the EPT program, provider organizations are to follow the updated deliverable submission requirements:<ul style="list-style-type: none"><li>○ By November 2025, practices should complete the 2025 PhmCAT and at least one additional deliverable from program year 1.</li><li>○ By May 2026, practices should complete the 2026 PhmCAT and successfully submit the following deliverables:<ul style="list-style-type: none"><li>▪ Data Policy &amp; Procedure</li><li>▪ Empanelment Policy &amp; Procedure</li><li>▪ Data Implementation Plan</li><li>▪ Disparity Reduction Plan</li><li>▪ One Model of Care deliverable</li></ul></li></ul></li></ul> <p><b>EPT MCP Reporting Requirements</b></p> <p>DHCS is asking Managed Care Plans (MCPs) to produce quarterly rolling quality measure rates using the <a href="#">California Technical Specifications (CaTS)</a> so that performance can be tracked for all EPT deliverables that include HEDIS-like measures. This has been a concern for MCPs because of the risks involved with data sharing, complexity of attribution, and ensuring timely rate production and payment to providers for completed deliverables.</p> <ul style="list-style-type: none"><li>• DHCS provided two (2) possible solutions for the MY2024 CaTS rate delivery:<ul style="list-style-type: none"><li>○ Option 1: (High encouraged by DHCS) MCPs to use a third-party solution contracted by Pop Health Learning Center (PHLC) called Innovaccer to process data and produce rates. Data releases to PHLC and Innovaccer were due on 09/08/2025.</li><li>○ Option 2: MCPs may submit self-produced rates using CaTS by 10/31/2025.</li></ul></li><li>• Partnership will proceed with Option 2. The HEDIS team will move forward with preparing CaTS rates for all EPT sites for MY2024.</li><li>• All work on the PHLC DSA is suspended.</li></ul>
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- The requirement for quarterly rolling year rate delivery will impact the cadence for the HEDIS monthly project going forward.

PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)

Locum providers are in place at all sites and initial observations include:

- **WSMC** – Locum has made significant impact and will extend contract. Peds backlog is substantial, limited outreach needed. Strategic use of locum beyond preventive visits.
- **Open Door** - Well child visits increased after school resumed; more afternoon appointments being scheduled. August 2025 WCV were over 100 more than August 2024, helping avoid end-of-year crunch. CCS visits continue to show low patient engagement.
- **Shasta** – Outreach to unassigned for CCS and under age 5 for WCV. Barriers include inaccurate contact info, lack of patient education and willingness to complete preventive visits, and preference for assigned PCP.
- **Ampla** - Outreach and scheduling remain difficult. Temporary provider for Pediatrics (Peds) is hard “sell” to patients. High no-show rate for CCS appointments – expressed need for more patient education.

Provider Org	Total Visits	PHC Members	WCV	CCS	No-show Rate	Avg. Visit/Day (anticipated 16-20/day)
<b>WSMC</b> <i>Start: June 30</i>	593	466	511	0	26.2%	12
<b>Open Door</b> <i>Start: July 14</i>	331	318	271	36	16.0%	9
<b>Shasta</b> <i>Start: July 28</i>	263	258	225	38	27.3%	9
<b>Ampla</b> <i>Start: Aug 18</i>	57	56	19	37	51.7%	6

MOBILE MAMMOGRAPHY PROGRAM

- Current Event Days for FY 25/26 Q1 (July – September)

Current Event Days 07/01/2025 – 09/30/2025			
Region	# of Provider Organizations	# of Provider Sites	# of Event Days
<b>Auburn</b>	0	0	0
<b>Chico</b>	1	2	2

	<table border="1"> <tr> <td><b>Eureka</b></td> <td>3</td> <td>9</td> <td>9</td> </tr> <tr> <td><b>Fairfield</b></td> <td>2</td> <td>4</td> <td>4</td> </tr> <tr> <td><b>Redding</b></td> <td>2</td> <td>3</td> <td>4</td> </tr> <tr> <td><b>Santa Rosa</b></td> <td>2</td> <td>2</td> <td>2</td> </tr> <tr> <td><b>Plan Wide</b></td> <td><b>10</b></td> <td><b>20</b></td> <td><b>21</b></td> </tr> </table>	<b>Eureka</b>	3	9	9	<b>Fairfield</b>	2	4	4	<b>Redding</b>	2	3	4	<b>Santa Rosa</b>	2	2	2	<b>Plan Wide</b>	<b>10</b>	<b>20</b>	<b>21</b>
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	<ul style="list-style-type: none"> <li>Scheduling for Mobile Mammography event days for FY 25/26 Q2 (October – December 2025) is currently in progress.</li> </ul>																				
<p>PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM</p>	<p>No recent update at this time.</p>																				
<p>QI TRILOGY PROGRAM</p>	<ul style="list-style-type: none"> <li>All Trilogy documents (FY2025/26 QI Program Description; FY2024/25 QI Work Plan; FY2024/25 QI Evaluation; and FY2025/26 QI Work Plan) have been completed and are currently pending Board approval on 10/22/2025.</li> <li>The following documents have been annotated, bookmarked and submitted to the NCQA Team, in preparation for the mock audit survey in October. All required documents have been reviewed and accepted by the NCQA Team.             <ul style="list-style-type: none"> <li>FY 23-24 QI Program Description</li> <li>FY 24-25 QI Program Description</li> <li>FY 24-25 QI Work Plan</li> <li>FY 23-24 QI Program Evaluation</li> <li>2023 &amp; 2025 QUAC Policy</li> <li>2025 QUAC &amp; PAC Rosters</li> <li>QI 1A Compliance Statement</li> <li>QI 1B Compliance Statement</li> <li>QI 1C Compliance Statement</li> </ul> </li> <li>In preparation for the upcoming FY 25–26 QI Trilogy season, the Trilogy team is reviewing current tools, resources, and practices to enhance the document preparation and submission process. On 09/12/2025, an internal survey was distributed to all Trilogy subject matter experts (122 participants) to gather input and identify opportunities for improvement.</li> </ul>																				
<p>QI PROJECT TRAINING PROGRAM</p>	<ul style="list-style-type: none"> <li>The pilot cohort (20 participants) launched 09/10/2025 and will run through November 2025.</li> <li>The training curriculum is undergoing final edits</li> <li>A dedicated Toolkit Hub webpage is live on the Improvement Academy webpage</li> <li>The full program launch is planned for Q1 CY2026</li> </ul>																				

<b><u>D-SNP</u></b>	<ul style="list-style-type: none"> <li>The QI Department is continuing its collaboration with Wakely (part of HMA) to develop a HEDIS visualization dashboard and a Stars analytics tool. As an extension of this work, the Medicare Quality team is working with the HEDIS team, IT, Pharmacy and Health Analytics to generate baseline data for all Medicare Stars measures for CY2025. This data will be used as part of the Stars Analytics tool to understand baseline Stars performance headed into program launch.</li> <li>“Capturing Patient Acuity through Coding Part 2”, a webinar addressing coding acuity for D-SNP, is tentatively scheduled for Wednesday, 10/08/2025 at 12 p.m. and will be led by Dr. Kermit Jones, Medical Director of Medicare Services at Partnership. The webinar will be promoted to physicians and coding support personnel in the Partnership Advantage counties. Attendees will be eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation. Ninety-five individuals from 39 organizations have registered for the webinar. Registration is available <a href="#">here</a>.</li> <li>The Medicare Quality team is developing an approach to share Stars and DHCS measure information with key stakeholders in a centralized, cloud-based format. This would allow measure sponsors, business owners and process owners key measure information including data sources, measures descriptions and current interventions. Upon finalization, stakeholders from across the organization will be able to access the material.</li> </ul>
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**QUALITY ASSURANCE AND MEMBER SAFETY**

ACTIVITY	UPDATE																																			
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 08/24/2025 TO 9/29/2025	<ul style="list-style-type: none"> <li>34 PQI referrals were received with 30 coming from Grievance and Appeals, three from Utilization Management, and one from a Regional Medical Director.</li> <li>17 PQI cases were processed and closed.</li> <li>81 PQI cases are currently open.</li> <li>One case was discussed at Peer Review Committee (PRC) on 09/17/2025 and there are three awaiting reviews.</li> <li>One case was sent to an external Subject Matter Expert for review.</li> </ul>																																			
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 08/25/2025-09/26/2025	<ul style="list-style-type: none"> <li>As of 9/26/2025, we have a total of 520 reviews including PCP, OB, Multiple check-ins, and delegated reviews.</li> </ul> <p><b>Primary Care and OB Reviews:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Region</th> <th># of FSR conducted</th> <th># of MRR conducted</th> <th># of FSR CAP issued</th> <th># of MRR CAP issued</th> </tr> </thead> <tbody> <tr> <td>Auburn</td> <td>2</td> <td>3</td> <td>2</td> <td>2</td> </tr> <tr> <td>Chico</td> <td>9</td> <td>10</td> <td>1</td> <td>6</td> </tr> <tr> <td>Eureka</td> <td>4</td> <td>4</td> <td>1</td> <td>1</td> </tr> <tr> <td>Fairfield</td> <td>4</td> <td>3</td> <td>0</td> <td>1</td> </tr> <tr> <td>Redding</td> <td>2</td> <td>1</td> <td>1</td> <td>1</td> </tr> <tr> <td>Santa Rosa</td> <td>2</td> <td>1</td> <td>0</td> <td>1</td> </tr> </tbody> </table>	Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued	Auburn	2	3	2	2	Chico	9	10	1	6	Eureka	4	4	1	1	Fairfield	4	3	0	1	Redding	2	1	1	1	Santa Rosa	2	1	0	1
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	<p>New sites opened this period →</p> <ul style="list-style-type: none"> <li>• Chico – Sutter North Medical Group</li> <li>• Fairfield – NorthBay Health Primary Care</li> <li>• Redding – Mayers Rural Health Center-OB</li> <li>• Santa Rosa – MarinHealth Medical Network</li> </ul>
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**HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS®)**

ACTIVITY	UPDATE
Annual HEDIS® Projects	<ul style="list-style-type: none"> <li>• The MY2024 Annual Summaries of Performance are posted on the Partnership website. The Annual Summaries of Performance include county-level data on HEDIS measures, as well as year over year performance trends for the fourteen (14) legacy Partnership counties and assessment of results.                             <ul style="list-style-type: none"> <li>○ <a href="#">MY2024 DHCS MCAS Annual Summary of Performance</a></li> <li>○ <a href="#">MY2024 NCQA Health Plan Accreditation Annual Summary of Performance</a></li> </ul> </li> </ul>
HEDIS® Program Overall	<ul style="list-style-type: none"> <li>• DHCS shared its final MY2024 MCAS sanctions methodology with Managed Care Plans, including Partnership, on September 22, 2025. In summary:                             <ul style="list-style-type: none"> <li>○ DHCS will move forward with county-level sanctions on the 18 MCAS measures for MY2024 with performance below the Minimum Performance Level (MPL).</li> <li>○ For counties with small measure denominators (under 100 members), DHCS will aggregate numerators and denominators with neighboring counties in the same Quality Rating Region to meet the minimum eligible population threshold of 100 members. Any aggregated counties will be noted in the first Notice of Intent to Sanction letter that DHCS intends to send in early October.</li> <li>○ Partnership’s proposal to aggregate county-level measure rates at the Quality Rating Region was rejected.</li> </ul> </li> <li>• Partnership expects to receive a Notice of Intent to Sanction letter from DHCS in early October 2025, with Meet and Confer meetings to appeal proposed sanctions to be scheduled in mid-October 2025.</li> </ul>

**NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION**

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	<ul style="list-style-type: none"> <li>• Evidence for the HPA Mock Renewal Survey scheduled for 10/27-30/2025 has been shared with our consultant, Managed Healthcare Resources (MHR). Since Partnership will be held accountable to the new 2026 HPA Standards and Guidelines for our 2026 HPA Renewal Survey, MHR will review all evidence against the new standards prior to the HPA Mock Renewal Survey. During the four (4) days of the HPA Mock Renewal Survey, MHR will share their findings and provide their recommendations for survey compliance, as needed. Business Owners can submit additional clarifying documents within three (3) days of the scheduled session(s). The NCQA Program Management Team will share an Action Plan (AP) with each</li> </ul>

	<p>Business Owner (BO) by 11/13/2025 that will list all recommendations identified by MHR to meet 2026 survey compliance. BOs are required to complete and submit the AP to the NCQA Program Management Team by 12/05/2025.</p> <ul style="list-style-type: none"> <li>• The NCQA Program Management Team has submitted our formal application for the 2026 HPA Renewal Survey to NCQA requesting a survey date of 09/15/2026. For the file review requirements, all files must be in compliance beginning <u>Monday, 09/15/2025 (with the exception of credentialing, the look-back period began on 09/15/2023)</u>. Once NCQA has confirmed Partnership’s survey date, the NCQA Program Management Team will prepare a detailed timeline outlining the pre- and post-survey activities.</li> <li>• The NCQA Program Management Team distributed the 2026 HPA Workbook to all BOs on 09/30/2025. The 2026 HPA Workbook contains the Work Plan and Evidence Submission Library for each BO. BOs are asked to confirm the information prepopulated in the workbook, and provide updates, as needed, along with their attestations. The completed workbook is due to the NCQA Program Managed Team by 10/24/2025. This activity is required as part of the FY 25-26 NCQA-related HPA Key Activities, Milestone 2.</li> </ul>
<p>NCQA Health Equity Accreditation (HEA)</p>	<ul style="list-style-type: none"> <li>• NCQA awarded Partnership the official Health Equity Accreditation status on 08/06/2025. To maintain this status, Partnership undergoes a survey every three (3) years. Partnership’s HEA Renewal Survey is tentatively scheduled for 05/16/2028. As of 09/15/2025, NCQA’s website has been updated to reflect Partnership’s Health Equity Accreditation status.</li> </ul>

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

**Consent Calendar**

Oct. 15, 2025

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

**Some Medi-Cal (“MC”) policies are being updated as “MP” to apply to both Medi-Cal and Medicare (Partnership Advantage, eff. ~ Jan. 1, 2027)**

		<b>Pages</b>
Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set <sup>1</sup> – <i>direct questions to Athena Beltran-Nampraseut</i>		45 – 50
Proposed 2026 Enhanced Care Management (ECM) QIP Measure Set <sup>1</sup> – <i>direct questions to Deanna Watson</i>		51 – 54
Proposed 2026 Palliative Care QIP Measure Set <sup>1</sup> – <i>direct questions to Eva Lopez, CPhT</i>		55 – 56
<b>Health Services Policies</b>	<b>Behavioral Health</b>	
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members ( <i>previously MCUP3103</i> )	57 – 61
	MPBP8007 – Screening and Treatment for Substance Use Disorders ( <i>previously MCUP3101</i> )	63 – 82
	MPBP8013 – Eating Disorder Management Policy	83 – 90
	<b>Care Coordination</b>	
	MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MPBP8011</i>	91 – 102
	<b>Utilization Management</b>	
	MCUP3101 – Screening and Treatment for Substance Use Disorders – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MPBP8007</i>	103 – 122
	MCUP3103 – Coordination of Care for Child-Welfare Involved Members – <b>ARCHIVE</b> – <i>see new Behavioral Health policy MCBP8015</i>	123 – 127
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines	129 – 131
	MCUP3012 – Discharge Planning (Non-capitated Members)	133 – 135
	MCUP3050 – Medication Abortion in the First Trimester	137 – 149
	MCUP3052 – Medical Nutrition Services	151 – 158
	MCUP3115 – Community Based Adults Services	159 – 167
	MCUP3128 – Cardiac Rehabilitation	169 – 174
	MCUP3130 – Osteopathic Manipulation Treatment	175 – 177
	MPUP3078 – Second Medical Opinions	179 – 181
	MPUP3116 – Positron Emission Tomography Scants (PET Scans)	183 – 185
<b>Non-HS Policies</b>	<b>Grievance &amp; Appeals</b>	
	CGA022 – Member Discrimination Grievance Procedure	187 – 192

<sup>1</sup> These three measure sets were approved at the Oct. 8 Physician Advisory Committee (PAC)

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## Summary of Proposed Measure Changes for Measurement Year 2026

### **(A) Core Measurement Set Measures**

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Hospital Utilization; 3) Primary Care Utilization; and 4) Patient Experience. Individual measure values will be assigned to the final and approved measurement set.

#### Key:

New Measure || Change to Measure Design || ~~Measure removed~~

2025 Measures	2026 Recommendations
<b>Clinical Domain</b>	
<p><b>Family Medicine:</b></p> <ol style="list-style-type: none"> <li>1. Breast Cancer Screening (52-74yo)</li> <li>2. Breast Cancer Screening (40-51yo) - <b>Monitoring</b></li> <li>3. Cervical Cancer Screening</li> <li>4. Child and Adolescent Well Care Visits</li> <li>5. Childhood Immunization Status: Combo 10</li> <li>6. Colorectal Cancer Screening</li> <li>7. Comprehensive Diabetes Care: HbA1c Control</li> <li>8. Comprehensive Diabetes Care: Eye Exams</li> <li>9. Controlling High Blood Pressure</li> <li>10. Immunizations for Adolescents – Combo 2</li> <li>11. Well-Child Visits in the First 15 Months of Life</li> <li>12. Lead Screening in Children</li> <li>13. Chlamydia Screening in Women (both age groups: 16-24yo) – <b>Monitoring</b></li> <li>14. Well-Child Visits in the first 15-30 months of life – <b>Monitoring</b></li> <li>15. Topical fluoride in Children – <b>Monitoring</b></li> <li>16. Reducing Healthcare Disparity (<b>Participation is Optional</b>)</li> </ol>	<p><b>Family Medicine:</b></p> <ol style="list-style-type: none"> <li>1. <b>Breast Cancer Screening (40-74yo)</b></li> <li>2. Cervical Cancer Screening</li> <li>3. Child and Adolescent Well Care Visits</li> <li>4. Childhood Immunization Status: Combo 10</li> <li>5. Colorectal Cancer Screening</li> <li>6. Comprehensive Diabetes Care: HbA1c Control</li> <li>7. Comprehensive Diabetes Care: Eye Exams</li> <li>8. Controlling High Blood Pressure</li> <li>9. Immunizations for Adolescents – Combo 2</li> <li>10. Well-Child Visits in the First 15 Months of Life</li> <li>11. Lead Screening in Children</li> <li>12. <b>Chlamydia Screening in Women (16-24yo)</b></li> <li>13. Well-Child Visits in the first 15-30 months of life – <b>Monitoring</b></li> <li>14. Topical fluoride in Children – <b>Monitoring</b></li> <li>15. Reducing Healthcare Disparity (<b>Participation is Optional</b>)</li> <li>16. <b>Kidney Health Evaluation for Patients with Diabetes</b></li> </ol>
<b>Clinical Domain</b>	
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**Clinical Domain**

<p><b>Pediatric Medicine:</b></p> <ul style="list-style-type: none"> <li>1. Child and Adolescent Well Care Visits</li> <li>2. Childhood Immunization Status: Combo 10</li> <li>3. Immunizations for Adolescents – Combo 2</li> <li>4. Well-Child Visits in the First 15 Months of Life</li> <li>5. Lead Screening in Children</li> <li>6. Chlamydia Screening in Women (16-20yo)</li> <li>7. Well-Child Visits in the first 15-30 months of life</li> <li>8. Topical fluoride in Children - <b>Monitoring</b></li> <li>9. Reducing Healthcare Disparity (<b>Participation is Optional</b>)</li> </ul>	<p><b>Pediatric Medicine:</b></p> <ul style="list-style-type: none"> <li>1. Child and Adolescent Well Care Visits</li> <li>2. Childhood Immunization Status: Combo 10</li> <li>3. Immunizations for Adolescents – Combo 2</li> <li>4. Well-Child Visits in the First 15 Months of Life</li> <li>5. Lead Screening in Children</li> <li>6. Chlamydia Screening in Women (16-20yo)</li> <li>7. Well-Child Visits in the first 15-30 months of life</li> <li>8. Topical fluoride in Children - <b>Monitoring</b></li> <li>9. Reducing Healthcare Disparity (<b>Participation is Optional</b>)</li> </ul>
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**Hospital Utilization**

<p><b>Family Medicine &amp; Internal Medicine:</b></p> <ul style="list-style-type: none"> <li>1. Ambulatory Care Sensitive Admissions</li> <li>2. Follow-up within 7 days after Hospital Discharge</li> </ul>	<p><b>Family Medicine &amp; Internal Medicine:</b></p> <ul style="list-style-type: none"> <li>1. Ambulatory Care Sensitive Admissions</li> <li>2. Follow-up within 7 days after Hospital Discharge</li> </ul>
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**Primary Care Utilization**

<p><b>All Practice Types:</b></p> <ul style="list-style-type: none"> <li>1. Avoidable ED Visits</li> <li>2. PCP Office Visits</li> </ul>	<p><b>All Practice Types:</b></p> <ul style="list-style-type: none"> <li>1. Avoidable ED Visits</li> <li>2. PCP Office Visits</li> </ul>
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**Patient Experience**

<p><b>All Practice Types:</b></p> <ul style="list-style-type: none"> <li>1. Patient Experience</li> </ul>	<p><b>All Practice Types:</b></p> <ul style="list-style-type: none"> <li>1. Patient Experience</li> </ul>
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**(B) Unit of Service Measures**

Providers receive payment for each unit of service they provide.

Unit of Service	
<b>All Practice Types:</b> <ol style="list-style-type: none"> <li>1. Advance Care Planning Attestations</li> <li>2. Extended Office Hours</li> <li>3. PCMH Certification</li> <li>4. Peer-led &amp; Pediatric Group Visits</li> <li>5. Health Information Exchange</li> <li>6. Health Equity</li> <li>7. Tobacco Use Screening</li> <li>8. Electronic Clinical Data Systems (ECDS)</li> <li>9. Academic Detailing</li> </ol>	<b>All Practice Types:</b> <ol style="list-style-type: none"> <li>1. Advance Care Planning Attestations</li> <li>2. Extended Office Hours</li> <li>3. PCMH Certification</li> <li>4. Peer-led &amp; Pediatric Group Visits</li> <li>5. Health Information Exchange</li> <li>6. Health Equity</li> <li>7. Tobacco Use Screening</li> <li>8. Electronic Clinical Data Systems (ECDS)</li> <li>9. Academic Detailing</li> </ol>
Unit of Service	
<b>Family &amp; Pediatric Medicine:</b> <ol style="list-style-type: none"> <li>1. Early Administration of the 1<sup>st</sup> HPV Dose</li> <li>2. Early Administration of Flu Initiation and Booster Doses</li> </ol>	<b>Family &amp; Pediatric Medicine:</b> <ol style="list-style-type: none"> <li><del>1. Early Administration of the 1<sup>st</sup> HPV Dose</del></li> <li><del>2. Early Administration of Flu Initiation and Booster Doses</del></li> </ol>

## Programmatic Changes:

### I. Descriptions of Potential 2026 Measure Changes for Core Measurement Set

#### A. Change(s) to Existing Measures – Core Measurement Set

##### I. Breast Cancer Screening (40-74yo) - Family Practice & Internal Medicine

**Measure Change:** In MY2025, a separate Breast Cancer Screening measure specific to the age population of 40-51yo was created and implemented as a monitoring measure. This was to allow an adjustment period for members and providers to “get caught up” on screening in this eligible population with the anticipation of this population being combined into one measure with 52-74yo population as an active MY2026 core measure for the combined population of 40-74yo.

**Measure Rationale:** In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more

women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024).

## II. **Chlamydia Screening (Family Practice:16-24yo, Internal Medicine: 21-24yo, Pediatrics: 16-20yo)**

**Measure change:** In MY2025, Chlamydia Screening measure was implemented as active measure for pediatric practices only and a monitoring measure for both family and internal medicine practices. This was to allow an adjustment period for family and internal medicine practices, who have a larger measure set than pediatric practices, with the anticipation of this measure moving to an active measure in MY2026. With implementation during MY2026, there are no changes to the denominator/numerator logic.

**Measure Rationale:** The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: “Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV”. Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

## B. **Potential Additions as New Measures – Core Measurement Set**

### I. **Kidney Health Evaluation for Patients with Diabetes (Family Practice & Internal Medicine)**

**Measure Rationale:** Chronic kidney disease (CKD) is a common and serious complication of diabetes, affecting up to 40% of adults with the condition. Diabetes also contributes to higher rates of cardiovascular events, kidney disease or failure, and even early mortality. The Kidney Health Evaluation for Patients with Diabetes (KED) measure promotes early detection in adults aged 18-85 with type 1 or type 2 diabetes who received

a kidney health evaluation during the measurement year and incentivizes intervention by ensuring patients receive both an estimated glomerular filtration rate (eGFR) **and** urine albumin-to-creatinine ratio (uACR) annually. Despite strong evidence and clear clinical guidelines, fewer than half of adults with diabetes receive both tests each year, highlighting a significant care gap. According to The National Committee for Quality Assurance, “Diabetic kidney disease is one of the most common adverse outcomes of diabetes, affecting 20%–40% of patients with diabetes. CDC simulation studies showed that uACR screening for early detection of CKD was cost-effective in patients with diabetes, at \$50 thousand per quality-adjusted life-year.” Adoption of this measure drives an evidence-based and cost-effective practice which supports better long-term outcomes for patients with diabetes. (NCQA, State of Health Care Quality Report – Kidney Health Evaluation for Patient with Diabetes)

## II. Descriptions of Potential 2026 Measure Changes for Unit of Service Measurement Set

### A. Change(s) to Existing Measures – Unit of Service

#### I. Retirement of the Early Administration of the 1<sup>st</sup> HPV Dose

**Rationale:** Prior analysis of the Adolescent Immunization Series found that HPV was the most commonly missed immunization in the adolescent series. This resulted in a majority of adolescents not meeting the measure requirements. Partnership offered an incentive for early administration of the 1<sup>st</sup> HPV dose for adolescents ages of 9-12 years with the intent to increase the HPV vaccine completion rates. When evaluating the effectiveness of this unit of service measure, there was no discernable difference in the completion rates of early administration of 1<sup>st</sup> or 2<sup>nd</sup> HPV dose when incentivized. Therefore, Partnership has chosen to retire this measure.

#### II. Retirement of the Early Administration of Initial Flu Vaccine Series

**Rationale:** Prior analysis of the Childhood Immunization Series found that Initial Flu Vaccine series was the most commonly missed vaccines of the entire immunization series. This resulted in a majority of children aging out of the measure before receiving their entire immunization series, therefore not meeting the measure. Partnership offered an incentive for early administration of initial flu

vaccine Series in children ages of 7 to 15 months with the intent to increase the flu administration rates. When evaluating the effectiveness of this unit of service measure, there was no discernable difference in the completion rates of early administration of initial flu vaccine series. Therefore, Partnership has chosen to retire this measure.

**B. Potential Additions as New Measures – Unit of Service**

N/A

## MY 2026 Enhanced Care Management (ECM) QIP Measurement Set Proposal

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

Current MY 2025 Measurement Set	Proposed MY 2026 Measurement Set
<p><b>Gateway Measure: Timely Reporting</b></p> <p><u>Reporting Periods:</u>            Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec</p> <p><u>Description:</u> Providers are required to submit three (3) monthly reports (Return Transmission File - RTF, Initial Outreach Tracker File - IOT, and Provider Capacity Survey) on or before their due date.</p> <p><u>Incentive:</u> \$100 per member per month            Dollars earned are placed into an incentive pool.</p> <ul style="list-style-type: none"> <li>• 100% incentive will be placed in incentive pool if all reports are received on or before the due date.</li> <li>• 50% incentive will be placed in incentive pool if all reports are received within one (1) week or five (5) business days past the due date.</li> <li>• Reports received after five (5) business days will not be eligible for an incentive pool or participation in other program measures.</li> </ul>	<p>No changes</p>

<p><b>Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 Days</b></p> <p><u>Reporting Periods:</u> Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec</p> <p><u>Description:</u> Providers must upload Care Plans and the ROI forms for ECM enrolled members into PointClickCare within 60 days of TAR request date.</p> <p><u>Incentive pool allotment:</u> 25%</p> <p><u>Targets:</u></p> <ul style="list-style-type: none"> <li>• Full credit: <math>\geq 70\%</math></li> <li>• Partial credit: 60% - 69%</li> </ul> <p><u>Reporting:</u> No reporting to Partnership HealthPlan is required. Partnership will audit PointClickCare® for evidence of uploaded documents.</p>	<p>No changes</p>
<p><b>Measure 2: PHQ9 Depression Screening</b></p> <p><u>Reporting Periods:</u> Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec</p> <p><u>Description:</u> Depression screening should be completed with ECM enrolled members as part of initial assessment and development of Care Plan.</p> <p><u>Incentive pool allotment:</u> 25%</p> <p><u>Targets:</u></p> <ul style="list-style-type: none"> <li>• Full credit: <math>\geq 90\%</math></li> <li>• Partial credit: 80% - 89%</li> </ul> <p><u>Reporting:</u> Providers will submit a screening template quarterly with member names, CIN, DOB, and PHQ-9 screening date and score.</p>	<p>No changes</p>

**Measure 3: Controlling Blood Pressure (CBP)  
– Blood Pressure Screening**

Reporting Periods:

Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec

Description: Blood pressure screening must be completed by an in-person visit by ECM staff, a clinic visit, or patient use of PHC approved home blood pressure kit for enrolled ECM members (regardless of prior diagnosis of hypertension).

Incentive pool allotment: 25%

Targets:

- Full credit:  $\geq 80\%$
- Partial credit: 70% - 79%

Reporting: Providers will submit a screening template quarterly with member names, CIN, DOB, and PHQ-9 screening date and score.

No changes

**Measure 4: Timely Review of Ed/Admissions Notifications in PointClickCare®**

No changes

Reporting Periods:

Quarterly: Jan-Mar; Apr-Jun; Jul-Sep; Oct-Dec

**Part 1**

Description: As a prerequisite for participation in Part 2, providers are required to set up the Notification Alerts function in PointClickCare®. Providers must contact PointClickCare® for assistance.

Incentive pool allotment: 25%

No partial credit.

Reporting: No reporting to Partnership HealthPlan is required. PointClickCare® will provide report to Partnership listing providers with Notification Alert functions and correct cohorts set up properly.

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**Part 2:**

Description: Providers are required to review ED/Admissions notifications received in PointClickCare® within 72 hours of receiving notifications.

Incentive pool allotment: 25%

Targets:

Full credit:  $\geq 70\%$  of reviewed notifications

Partial credit: 60-69% of reviewed notifications

NOTE: Providers with a denominator of five or less members with an ED visit/admission in a quarter will default to Part 1 of this measure and receive credit for notifications set up properly in PointClickCare®

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## Palliative Care Quality Incentive Program Summary of Proposed 2026 Measures

### Key:

New Measure | 
 Change to Measure Design | 
 Measure removed

2025 Measures	2026 Recommendations
<b>Utilization</b>	
<p><b>1. Avoiding Hospitalization &amp; Emergency Room Visits</b></p> <ul style="list-style-type: none"> <li>\$240 PMPM if no inpatient or ED use per calendar month</li> </ul>	<p><b>1. Avoiding Hospitalization &amp; Emergency Room Visits</b></p> <ul style="list-style-type: none"> <li>\$240 PMPM if no inpatient or ED use per calendar month</li> </ul> <p><i>CHANGE:</i> <span style="color: red;">No recommended changes</span></p>
<b>Quality</b>	
<p><b>2. Completion of POLST</b></p> <ul style="list-style-type: none"> <li>\$120 PMPM once a signed POLST is completed</li> </ul> <p><b>3. Completion of a Palliative Care Survey</b></p> <ul style="list-style-type: none"> <li>Palliative providers can earn an incentive per Partnership member enrolled in the palliative care program who was administered a survey within the measure period</li> </ul> <p>Measure period I: January 1 – June 30 Measure period II: July 1 – December 31</p>	<p><b>2. Completion of POLST</b></p> <ul style="list-style-type: none"> <li>\$120 PMPM once a signed POLST is completed</li> </ul> <p><del><b>3. Completion of a Palliative Care Survey</b></del></p> <p><del>                     Palliative providers can earn an incentive per Partnership member enrolled in the palliative care program who was administered a survey within the measure period                 </del></p> <p><del>Measure period I: January 1 – June 30 Measure period II: July 1 – December 31</del></p> <p><b>3. Completion of a Standardized Patient Symptom Assessment</b></p> <ul style="list-style-type: none"> <li>\$120 PMPM if two (2) standardized patient symptom assessments are completed, with all essential data elements included.</li> </ul> <p>Thresholds:</p> <ul style="list-style-type: none"> <li><span style="color: blue;">≥ 70%</span> of data elements entered on assessments = Full points (\$120 PMPM)</li> </ul>

- 50-69% of data elements entered on assessments = Partial points (\$60 PMPM)

**CHANGE:**

*Measure III: Completion of a Palliative Care Survey has been replaced by the new Measure III: Completion of a Standardized Patient Symptom Assessment*

- *On February 14, 2025, PCQC informed the Palliative Care QIP team that they were dissolving and closing their doors on April 17, 2025. Measure III: Completion of a Palliative Care Survey was created as a temporary replacement for the former Measure III: Completion of Standardized PCQC Assessment and Use of PCQC Tool for the remainder of MY2025 because PCQC was no longer able to provide the supplemental data required to process payment.*
- *During the Palliative Care Clinician Workgroup held on April 2, 2025, palliative care providers confirmed they all use of the Edmonton Symptom Assessment System or ESAS and could submit the ESAS data directly to Partnership HealthPlan. The Palliative Care QIP team created a new Measure III: Completion of a Standardized Patient Symptom Assessment based on this feedback.*

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>Policy/Procedure Number:</b> MCBP8015 ( <i>previously</i> MCUP3103)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Coordination of Care for Child Welfare-Involved Members		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> <a href="#">03/12/2026</a> <b>Last Review Date:</b> <a href="#">03/12/2025</a>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <a href="#">03/12/2025</a>

**I. RELATED POLICIES:**

- A. ~~MP~~UP3039 - Direct Members
- B. MCCP2024 - Whole Child Model for California Children’s Services (CCS)
- C. ~~MP~~AP7003 - CalAIM Community Supports (CS)
- D. ~~MCCP2032~~-[MCAP7002](#) - CalAIM Enhanced Care Management (ECM)
- E. MPQD1001- Quality and Performance Improvement Program Description

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. Assembly Bill 2083: (Chapter 815, Statutes of 2018) System of Care for Children and Youth Memorandum of Understanding (MOU). This assembly bill requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Entities must develop a coordinated, timely, and trauma-informed system-of-care approach, implementing related MOUs on the county level and establishing a joint interagency resolution team on the state level to assist counties in serving those children and youth.
- B. California Children’s Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
- C. Child Welfare-Involved Youth: Children and youth who meet one or more of the following conditions:
  - 1. Are under age 21 and are currently receiving foster care in California
  - 2. Are under age 21 and previously received foster care in California or another state within the last 12 months
  - 3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
  - 4. Are under age 18 and are eligible for and/or in California’s Adoption Assistance Program;
  - 5. Are under age 18 and are currently receiving or have received services from California’s Family Maintenance program within the last 12 months
- D. Child Welfare Liaison: A Child Welfare Liaison in a Managed Care Plan (MCP) is a designated professional who serves as the key point of contact between the health plan and child welfare agencies. Their role is to ensure that children and youth in foster care receive coordinated, timely, and appropriate health services.

<b>Policy/Procedure Number:</b> MCBP8015 (previously MCUP3103)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
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<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> 03/12/2026 <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- ~~D.E.~~ Children in Foster Care: Children who are in out-of-home placement under the care and custody of county welfare and probation departments.
- ~~E.F.~~ 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.
- ~~F.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.
- ~~G.H.~~ ECM Lead Care Manager: A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multidisciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
- ~~H.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 and coordinating specialty services.
- ~~I.J.~~ Resource Family: In California, a Resource Family is a caregiver who provides out-of-home care for children in foster care. The Resource Family is approved to provide care on a temporary (foster care) and/or permanent (adoption and legal guardianship) basis and includes all types of caregivers in the child welfare and probation systems, formerly known as foster parents, approved relatives or approved Non-Relative Extended Family Member.
- ~~J.K.~~ Whole Child Model: 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. N/A

#### V. PURPOSE:

To describe Partnership HealthPlan of California's coordination of care for child welfare-involved youth.

#### VI. POLICY / PROCEDURE:

- A. Partnership communicates with foster care agencies, group homes and resource families for those Members identified as child welfare-involved by the Medi-Cal Eligibility Data System (MEDS).
- B. If a Member is identified as being a child welfare-involved youth, a review of medically necessary services that require prior authorization will be performed by Partnership's Utilization Management (UM) Department.
  1. Foster care Members will be assigned to Direct Member status. (See policy MCUP3039 Direct Members)
  2. Medically necessary services will be authorized to the in-network or out-of-network provider when indicated and medically necessary and appropriate.
  3. Members identified as being high risk are referred to case management. Referrals are indicated for Members who are in need of multiple referrals and services, complex medical needs, or need for coordination of services with multiple agencies.
  4. Child welfare-involved youth who are also medically eligible for services under the Whole Child

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<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> 03/12/2026 <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

Model (CCS children) are assigned a medical home. The provider identified as the child’s medical home is responsible for managing the child’s primary care needs and coordinating the child’s care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s).

5. Family caregivers of foster care program beneficiaries may be eligible for respite services through CalAIM Community Supports Services as per Partnership policy [MCUP3142MCAP7003](#).
- C. The Child Welfare Liaison shall be the primary internal and external contact for any concerns or assistance needed for child welfare-involved youth.
1. Effective January 1, 2024, as per the Department of Health Care Services (DHCS) All Plan Letter ([APL 24-013](#)) “Managed Care Plan Child Welfare Liaison,” Partnership designates a Child Welfare Liaison to ensure the needs of Members involved with child welfare and foster care are met.
  2. Partnership designates an appropriate number of staff to serve as Child Welfare Liaison(s) to meet the health care needs of children and youth involved in child welfare in each county of Partnership’s service area.
    - a. Additional Child Welfare Liaisons are designated as needed to ensure the health care needs of children and youth involved in child welfare are met. Staffing is commensurate to the number of Members involved in child welfare enrolled with Partnership.
    - b. Partnership reassesses staffing levels at regular intervals to ensure effectiveness in serving children and youth involved in child welfare throughout Partnership’s service areas.
  3. Roles and Responsibilities of the Child Welfare Liaison
    - a. The Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these Members are met.
    - b. The Child Welfare Liaison serves as a leader within Partnership to advocate on behalf of children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services.
    - c. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member’s care coordination, including contracted ECM Lead Care Manager or the Children and Youth Involved in Child Welfare Population of Focus and applicable county child welfare staff as described in APL 24-013.
    - d. The Child Welfare Liaison’s duties are not intended to duplicate care coordination activities provided by other staff members or Providers, but rather to support and act as a resource to solve escalated issues regarding Partnership’s services as they arise.
    - e. [A centralized internal and external facing mailbox is designated to access support from the Child Welfare Liaisons \(ChildWelfareLiaison@partnershiphp.org\).](#)
    - f. The Child Welfare Liaison’s roles and responsibilities include, but are not limited to, the following:
      - 1) Technical Assistance: Supports internal and external staff in care coordination and issue resolution
      - 2) Contact Point: Serves as a contact for resolving member service access issues
      - 3) Referral Pathways: Collaborates with County Child Welfare as well as internal and external ECM staff to ensure effective ECM referral processes
      - 4) Enrollment Support: Assists with member enrollment/disenrollment during County changes
      - 5) Service Coordination: Navigates and coordinates various benefits and services
      - 6) Internal Coordination: Works with additional internal liaisons for specific member populations
      - 7) County Liaison Coordination: Collaborates with designated county liaisons as needed
      - 8) Quarterly Meetings: Attends meetings with county child welfare agencies
      - 9) Quality Improvement Input: Participates in quality improvement activities
      - 10) Training Compliance: Ensures adherence to training provisions of the MOU
      - 11) Foster Youth Rights: Educates staff on the Foster Youth Bill of Rights
      - 12) Trauma-Informed Care: Promotes trauma-informed approaches in interactions

<b>Policy/Procedure Number:</b> MCBP8015 (previously MCUP3103)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
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<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> 03/12/2026 <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

4. To enhance relationships between Partnership and county child welfare agencies for youth involved in child welfare, the Child Welfare Liaison shall:
  - a. Participate in Partnership’s Community Advisory Committee (CAC), the Quality Improvement Health Equity Committee (QIHEC) Committee, and additional committees and meetings that potentially impact Members involved in child welfare and foster care.
  - b. Collaborate with Counties to identify opportunities for coordination of, and alignment with, each County Interagency Leadership Team’s efforts in implementing the AB 2083 System of Care for Children and Youth MOU, and participate in the Systems of Care Local Interagency Leadership Team meetings to which Partnership is invited.
  - c. Collaborate with other Child Welfare Liaisons internally and with Child Welfare Liaisons in other Managed Care Plans to discuss best practices, lessons learned, and sharing of information and resources.
5. Partnership designates staff for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities and meet the criteria of having the expertise, demonstrable experience, or sufficient training in the following programs, processes, and practices:
  - a. Child welfare services and county behavioral health services
  - b. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes
  - c. Trauma-informed care practices
6. The Child Welfare Liaison’s additional expertise, experience, and training shall include, but is not limited to, the following:
  - a. Have a Master’s degree and/or other additional training in social work, public health nursing, or another related field
  - b. Have familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information
  - c. Have experience or training in coordinating care within child welfare services and juvenile justice systems and understand the [Foster Youth Bill of Rights](#).
7. Partnership will notify the county child welfare agency and DHCS of a change in the designated Child Welfare Liaison as soon as practicable, but no later than five working days from the change.
8. Partnership will submit the Child Welfare Liaison contact information to the “Liaison Directory” section available on the Managed Care Operations Division (MCPD)-MCP Submission Portal.
  - a. For delegated Subcontractors that serve children and youth involved with child welfare, Partnership will submit contact information of the Subcontractor’s Child Welfare Liaison(s) to the MCPD-MCP Submission Portal. Partnership shall ensure Subcontractors’ compliance with the requirements of APL 24-013.
9. Partnership conducts quality improvement activities pursuant to policy MPQD1001 Quality and Performance Improvement Program Description.
- D. As necessary, the Department of Social Services Foster Care Program’s Social Workers may be contacted by Partnership Member Services Representatives, the County Child Welfare Liaison, and/or Health Services Case Management staff to facilitate coordination of care.
- E. If the child has been placed outside of the counties Partnership serves, the County Child Welfare Liaison, a Member Services Representative or the Care Coordination Department will assist in the coordination of the change of county by connecting the foster caregiver, county welfare services agency, county probation department, or any other person authorized to make medical decision to the Department of Health Care Services (DHCS) Ombudsman as per Assembly Bill [\(AB\) 1512, Torrico Medi-Cal: Foster Children](#), October 2007.

<b>Policy/Procedure Number:</b> MCBP8015 (previously MCUP3103)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Coordination of Care for Child Welfare-Involved Members		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> 03/12/2026 <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

**VII. REFERENCES:**

- A. Department of Health Care Services (DHCS) All County Welfare Directors Letter ([ACWDL 97-02](#)) "Participation of Foster Care and Adoption Assistance Program Children in Medi-Cal Managed Care" (January 13, 1997)
- B. DHCS [ACWDL 00-22](#) "Letter To Notify Counties of Three New Aid Codes For Children in the Kinship Guardian Assistance Payment and Adoption Assistance Programs" (April 10, 2000)
- C. Other applicable DHCS All County Welfare Directors Letters (ACWDLs) regarding Foster Care as cataloged on this website: <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx>
- D. Assembly Bill ([AB 1512, Torrico. Medi-Cal: Foster Children](#)) approved and filed October 11, 2007.
- E. 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. [County Social Services Programs and Child Welfare MOU template](#) (DHCS Contract Attachment B)
- F. DHCS All Plan Letter ([APL 24-013](#)) Managed Care Plan Child Welfare Liaison (09/18/2024)
- G. [California Foster Youth Bill of Rights](#)

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:** 04/18/12; 02/18/15; 02/17/16; 02/15/17; \*03/14/18; 03/13/19; 03/11/20; 02/10/21; 05/11/22; 05/10/23; 05/08/24; 03/12/25; [MCBP8015: 11/12/25](#)

\*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](#)  
[MCUP3103 \(04/21/20210 -11/12/2025\)](#)

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> <del>MCUP3101</del> <a href="#">MPBP8007</a> (previously <a href="#">MCUP3101</a> )		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Screening and Treatment for Substance Use Disorders		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 03/21/2012		<b>Next Review Date:</b> <del>01/08/2026</del> <a href="#">11/12/2026</a> <b>Last Review Date:</b> <del>01/08/2025</del> <a href="#">11/12/2025</a>	
<b>Applies to:</b>	<input type="checkbox"/> Employees	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> <a href="#">Partnership Advantage</a>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <del>01/08/2026</del> <a href="#">11/12/2025</a>

**I. RELATED POLICIES:**

- A. [MPCP2017-MPBP8011](#) – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
- B. [MCUP3028-MPBP8003](#) – Mental Health Services
- C. MCQP1021 – Initial Health Appointment
- D. MPQP1022 – Site Review Requirements and Guidelines
- E. MCQG1015 – Pediatric Preventive Health Guidelines
- F. [MPCQG1005](#) – Adult Preventive Health Guidelines
- G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
- H. CMP26 – Verification of Caller Identity and Release of Information.

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

- A. Covered Program: pursuant to [42 CFR Part 2 §2.11](#), means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.
- B. Partnership Advantage: Effective January 1, 2027, 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-C. Records: pursuant to [42 CFR Part 2 §2.11](#), means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral

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for Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

~~C.D.~~ **SABIRT: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment:**

An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:

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

SABIRT represents an expansion of SBIRT with the addition of “brief assessment” (e.g., use of a validated assessment tool to determine if unhealthy alcohol or drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.

~~D.E.~~ **Standard Alcohol Drink (US definition):** 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz “shot” of hard liquor (about 40% alcohol)

~~E.F.~~ **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

~~F.G.~~ **Unhealthy Alcohol Use (UAU):** Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder (e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:

1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks

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for adult men over a 2-hour period.

2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.

**G.H. Unhealthy Drug Use (UDU):** The United States Preventive Services Taskforce (USPSTF) defines UDU as “the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.” Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, Partnership expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.

**H.I. Unhealthy Drug Use Screening (UDUS):** According to USPSTF, UDUS is defined as “asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format.” It does not refer to body fluid substance screening.

#### IV. ATTACHMENTS:

- A. [Recommended Tools and Training Resources for SABIRT](#)
- B. [Pocket Screening and Brief Intervention for Alcohol Use Disorders](#)
- C. [Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders](#)

#### V. PURPOSE:

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

#### VI. POLICY / PROCEDURE:

##### A. Covered Services:

1. Alcohol and Other Drug Treatment Services covered through the Counties:  
Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California’s (Partnership’s) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
2. Wellness and Recovery Benefit through Partnership:  
Effective July 1, 2020, Partnership Members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
  - a. Member has been determined eligible for full scope Medi-Cal
  - b. Member is not institutionalized
  - c. Member has a substance-related and addictive disorder per the current “Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition” (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
  - d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND

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- e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County
  3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy [MPCP2017-MBPB8011](#) Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by Partnership medical providers should be billed to Partnership as any other encounter, using appropriate encounter and management CPT codes.
    - a. Many of the medications used to treat addictions (often referred to as Medications for Addiction Treatment, or [MAT]) require no special or additional training or certification.
      - 1) Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder.
      - 2) Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice.
        - a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
        - b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings.
    - b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists providing office visits for substance use disorder treatment may use the ICD 10 code F11.xx or F10.xx to avoid the requirement for a Referral Authorization normally required for assigned patients.
    - c. Adjunctive counseling for SUD by non-licensed providers is not covered by Partnership, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the Member is a qualifying Member for SUD services through the Wellness and Recovery Program.
  4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter [\(APL\) 21-014](#). These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all Members aged 11 years and older, including pregnant Members.
    - a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § [2.14](#) and may be released in compliance with Partnership policy CMP-26 Verification of Caller Identity and Release of Information.
  5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of Members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
  6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy [MPCQG1005](#) Adult Preventive Health Guidelines.
- B. Partnership Responsibility, Related to SUD Services
1. Identification
    - a. Partnership may identify a Member in need of SUD services through one of the following:
      - 1) Telephone inquiries from Member or Provider
      - 2) During Prior Authorization and/or Concurrent Review Processes
      - 3) Through Care Coordination programs activity
      - 4) Through call center activities performed by Partnership’s delegated managed behavioral health organization
  2. Referral

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- a. Partnership, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the Partnership website (see VI.C.8.c. below for details). If a placement within the Member’s service area is not available, the Member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from Partnership is required for referral to outpatient substance use services. (Please note, in Partnership’s Wellness & Recovery benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MPEUP3144 Residential Substance Use Disorder Treatment Authorization for further information.)
3. Coordination of Care
  - a. Partnership will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of Members entering treatment for Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the Member’s Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient’s consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.
  - b. Wherever possible, Partnership will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.
- C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
  1. Overview.
    - a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act’s requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen Members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
    - b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood

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alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.

- c. **Unhealthy Drug Use:** Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as cocaine and heroin. However, studies have demonstrated significantly positive benefits from various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

2. Non-Covered Services

- a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is “Have you consumed **any** beer, wine or other alcoholic beverage in the past year.”

3. Covered Services

- a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to Partnership Members via the evidence of coverage and via Partnership’s external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
  - 1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the Member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
  - 2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
  - 3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
- b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant Members, primary care includes clinicians caring for the pregnant Member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
- c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the

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Member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, Partnership contracted medical specialists and credentialed SUD counselors. PCPs may also utilize Partnership's delegated managed behavioral health organization using the referral forms and process described in Partnership policy [MPCP2017-MBPB8011](#) Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting.

4. Training and Proficiency - Primary Care Providers

Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:

- a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
  - 1) Licensed Physician
  - 2) Physician Assistant
  - 3) Nurse Practitioner
  - 4) Psychologist
- b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
  - 1) Licensed Marriage and Family Therapist
  - 2) Registered Nurse
  - 3) Certified Nurse Midwife
  - 4) Licensed Midwife
  - 5) Licensed Clinical Social Worker
  - 6) Licensed Professional Clinical Counselor
- c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.
- d. Other Members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
  - 1) They have at least 100 hours of clinical experience in their current role.
  - 2) They are trained to provide the services they are providing
  - 3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
- e. Providers must develop policies and procedures for SABIRT services. These should include:
  - 1) The PCP site will maintain a list of licensed and registered professionals and non-licensed Members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
  - 2) A quality assurance process for SABIRT services
  - 3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
- f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health

<b>Policy/Procedure Number: MCUP3101MPBP8007 (previously MCUP3101)</b>		<b>Lead Department: Health Services Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Screening and Treatment for Substance Use Disorders		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 03/21/2012		<b>Next Review Date:</b> 01/08/2026 <b>Last Review Date:</b> 01/08/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <a href="#">Partnership Advantage</a>

Services at Partnership.

5. Training and Proficiency – Brief Behavioral Counseling Intervention/Referral to Treatment Providers
  - a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
    - 1) Licensed Physician
    - 2) Physician Assistant
    - 3) Nurse Practitioner
    - 4) Psychologist
  - b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
    - 1) Licensed Marriage and Family Therapist
    - 2) Registered Nurse
    - 3) Certified Nurse Midwife
    - 4) Licensed Midwife
    - 5) Licensed Clinical Social Worker
    - 6) Licensed Professional Clinical Counselor
  - c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.
  - d. Other Members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
    - 1) They have at least 100 hours of clinical experience in their current role.
    - 2) They are trained to provide the services they are providing
    - 3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
  - e. Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services. These should include:
    - 1) The Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
    - 2) A quality assurance process for SABIRT services
    - 3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
6. Screening and Brief Assessment
  - a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
  - b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
  - c. The screening and brief assessment process does not diagnose a disorder, but it does determine

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whether a problem exists. Providers should consider risks and benefits of administration of screening and assessment tools, including discussion of these as part of informed consent, as well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.

- d. Screening and Brief Assessment Tools
  - 1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.
  - 2) Note that a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:
    - a) AUDIT (10 question screening and assessment)
    - b) AUDIT-C (3 question screening also validated in pregnant individuals)
    - c) NIAAA Single Alcohol Screening Question (SASQ)
7. Brief Intervention:
  - i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to Members who are identified as having risky or hazardous alcohol use.
  - b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the Member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
    - 1) Personalized feedback
    - 2) Education and resources
    - 3) Negotiated action plans
    - 4) Drinking use diaries, and
    - 5) Stress management.
  - c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team Member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
    - 1) Feedback to the patient regarding screening and assessment results
    - 2) Discussion of negative consequences that have occurred and the overall severity of the problem
    - 3) Supporting the patient in making behavior changes
    - 4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
      - a) Providers must make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment.
8. SABIRT Referral to Treatment
  - a. No prior authorization is required for SABIRT services or for referral to services related to substance use or abuse.
  - b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5, or those whose diagnoses are uncertain, should be referred for further

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evaluation and treatment.

- c. PCPs in counties without Partnership Wellness and Recovery coverage should refer Members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California county contacts for local substance use disorder treatment information and referrals can be found on the Partnership website: <http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx> under the heading “Alcohol and Drug Treatment.” In Partnership Wellness and Recovery counties, the referral process is outlined on the Partnership website at this page: <https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx>. Referrals to treatment must be documented in the medical record.
9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the Member and the time spent with the Member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
  - a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
  - b. Documentation should also include:
    - 1) The service provided (e.g., screen and brief intervention)
    - 2) The name of the screening instrument and the score on the electronic health record
    - 3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
    - 4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
  - a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
    - 1) Review Member’s response to an age-appropriate, validated alcohol or drug use screening question
    - 2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
    - 3) Conduct Brief Behavioral Counseling Intervention sessions
    - 4) Refer Members with potential unhealthy alcohol or drug use and/or SUD for treatment
  - b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
  - c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
  - a. The following billing codes should be used for billing SABIRT services to patients with:
    - 1) Medi-Cal and no other primary insurance coverage (such as Medicare):
      - a) Annual alcohol misuse screening: G0442
      - b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)
      - c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050
    - 2) Medicare/Medi-Cal Members should have SABIRT billed through Medicare, using approved Medicare codes.

## VII. REFERENCES:

- A. For clinician support: NIAAA’s Clinician Guide “Helping Patients Who Drink Too Much” provides two methods for screening: a “single question” to use during a clinical interview and a written self-report

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- instrument (AUDIT). <http://www.niaaa.nih.gov/guide>
- B. The **AUDIT** and **AUDIT-C** screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions <https://www.samhsa.gov/national-coe-integrated-health-solutions>
- C. Quick reference guide for screening for drug use in general medical settings: [screening\\_qr.pdf \(nih.gov\)](#)
- D. NIDA Quick Screen and NIDA Modified ASSIST:  
<https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf>
- E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings:  
<https://www.who.int/publications/i/item/978924159938-2>
- F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: <https://www.drugabuse.gov/taps/#/>
- G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. [Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification.](#) J Addict Med. 2011 Sep;5(3):221-6.
- H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization <https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a>
- I. Information on the Medicare SBIRT benefit and requirements: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt\\_factsheet\\_icn904084.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf)
- J. Substance Abuse and Mental Health Services Administration (SAMHSA) website:  
<https://www.samhsa.gov/disorders/substance-use>
- K. Operational Instructional Letter (OIL) 398-13
- L. DHCS: All Plan Letter [\(APL\) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.](#) (10/11/2021)
- M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services  
[Drug Medi-Cal Organized Delivery System \(DMC-ODS\)](#) webpage
- N. DHCS [APL 23-029](#) Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
1. [Specialty Mental Health Services Memorandum of Understanding Template](#)
  2. [Substance Use Disorder Treatment Services Memorandum of Understanding Template](#)
- O. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (<https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening>)
- P. Title 42 Code of Federal Regulations (CFR) Section [438.210](#) (a)(4), Part 2 [§2.11](#) and [§ 2.14](#)
- Q. Title 22 California Code of Regulations (CCR) Sections [51303](#) and [51340.1](#)
- R. InterQual® Behavioral Health Criteria
- S. [Medicare Claims Processing Manual 100-04: Chapter 18 Preventive and Screening Services, Section 180 Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. Implementation date 12/27/2011 or any subsequent updates published by CMS.](#)
- T. [Medicare National Coverage Determinations \(NCD\) Manual 100-03: Chapter 1, Part 4, Section 210.8 Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse Implementation date 12/27/2011 or any subsequent updates published by CMS.](#)
- R.—

## VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

<b>Policy/Procedure Number: MCUP3101MPBP8007 (previously MCUP3101)</b>		<b>Lead Department: Health Services Business Unit: Behavioral Health</b>	
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**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:** Chief Medical Officer

**X. REVISION DATES:**

[Partnership Advantage \(Program effective January 1, 2027\)-20267  
11/12/25](#)

[Medi-Cal:](#)

03/21/12; 02/19/14; 06/18/14; 06/17/15; 04/20/16; 03/15/17; 08/16/17; \*02/14/18; 08/08/18; 11/14/18; 11/13/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 06/14/23; 06/12/24; 01/08/25; [11/12/25](#)

\*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.

## Partnership HealthPlan of California

### Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Name of Tool	Validated Tool Type		Agencies Recommending Agencies	Populations			Substances Types		
	Screening Tools	Brief Assessment Tools		Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
<b>AUDIT</b> NIDA - The Alcohol Use Disorders Identification Test (10 questions) <i>*Meets HEDIS measure for IHA</i>	X	X	NIDA DHCS NCQA				X		
<b>AUDIT-C</b> NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) <i>*Meets HEDIS measure for IHA</i>	X		NIDA NIAAA USPSTF DHCS	X			X		
<b>SASQ</b> NIAAA Single Alcohol Screening Question <i>*Meets HEDIS measure for IHA</i>	X		NIAAA USPSTF	X			X		
<b>TAPS-1</b> Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
<b>TAPS-2</b> Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
<b>NIDA Quick Screen</b> (4 questions) <i>(Recommended by DHCS, ACOG and USPSTF, but NIDA now recommends TAPS- 1 instead)</i>	X		NIDA DHCS USPSTF ACOG	X			X	X	X
<b>NIDA-Modified ASSIST</b> NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) <i>(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)</i>		X	NIDA DHCS USPSTF				X	X	X

## Partnership HealthPlan of California

### Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Name of Tool	Validated Tool Type		Agencies Recommending Agencies	Populations			Substances Types		
	Screening Tools	Brief Assessment Tools		Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
<b><u>DAST-10</u></b> Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
<b><u>DAST-20</u></b> Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
<b><u>4P's</u></b> Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
<b><u>4 P's Plus</u></b> <i>(Plus includes additional questions about depression and domestic violence)</i>		X	ACOG	X			X	X	X
<b><u>CRAFFT</u></b> Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X <i>(Appropriate for non- pregnant adolescents)</i>		X	X	
<b><u>MAST-G</u></b> Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
<b><u>PRO (Prenatal Risk Overview)</u></b> <i>(Recommended by USPSTF but official website is no longer available)</i>			USPSTF	X			X	X	X

\*As per VI.C.6.d.2) of policy [MCUP3101-MPBP8007](#), a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

**Partnership HealthPlan of California**  
Recommended Tools and Training Resources for  
**Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment**  
**(SABIRT)**

**Acronyms, Agencies and Resources (Tools and Trainings):**

Acronym	Agency	Resources and Website Information
<b>ACOG</b>	The American College of Obstetricians and Gynecologists	<p>Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications  <a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications</a></p> <p>Opioid Use and Opioid Use Disorder in Pregnancy  <a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy</a></p>
<b>NCQA/HEDIS</b>	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	<p>Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans  <a href="https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf">https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf</a></p>
<b>NIAAA</b>	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH))	<p>NIAAA Evidence-Based Products for Health Professionals and Community Leaders:  <a href="https://www.niaaa.nih.gov/health-professionals-communities">https://www.niaaa.nih.gov/health-professionals-communities</a></p> <ul style="list-style-type: none"> <li>• Underage and College Drinking Research</li> <li>• Treatment Navigator tool</li> <li>• Surveillance Reports and Epidemiologic Resources</li> <li>• Additional Reports and Resources</li> </ul>
<b>NIDA</b>	National Institute on Drug Abuse	<p>Screening and Assessment Tools:  <a href="https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools">https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools</a></p>
<b>SBIRT</b> Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	<p>SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2)  <a href="https://sbirt.clinicalencounters.com/activity/sbirt-core/">https://sbirt.clinicalencounters.com/activity/sbirt-core/</a></p> <ul style="list-style-type: none"> <li>• Four hour training: \$49 per individual; group rates are available</li> <li>• CME/CE NYS OASAS Credit approved</li> </ul>

**Partnership HealthPlan of California**  
Recommended Tools and Training Resources for  
**Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment**  
(SABIRT)

**Acronyms, Agencies and Resources (Tools and Trainings):**

Acronym	Agency	Resources and Website Information
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings <a href="https://www.samhsa.gov/brss-tacs/video-trainings">https://www.samhsa.gov/brss-tacs/video-trainings</a> <ul style="list-style-type: none"><li>• Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:</li></ul>
<b>USPSTF</b>	United States Preventive Services Task Force	<ul style="list-style-type: none"><li>• Alcohol screening and intervention tools: <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions</a></li><li>• Unhealthy Drug Use Screening Tools: <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening</a></li><li>• USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation <a href="https://edhub.ama-assn.org/jn-learning/audio-player/18514824">https://edhub.ama-assn.org/jn-learning/audio-player/18514824</a></li></ul>

Updated

# A POCKET GUIDE FOR Alcohol Screening and Brief Intervention

Updated 2005 Edition

This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide*.

Visit [www.niaaa.nih.gov/guide](http://www.niaaa.nih.gov/guide) for related

professional support resources, including:

- patient education handouts
- preformatted progress notes
- animated slide show for training
- materials in Spanish

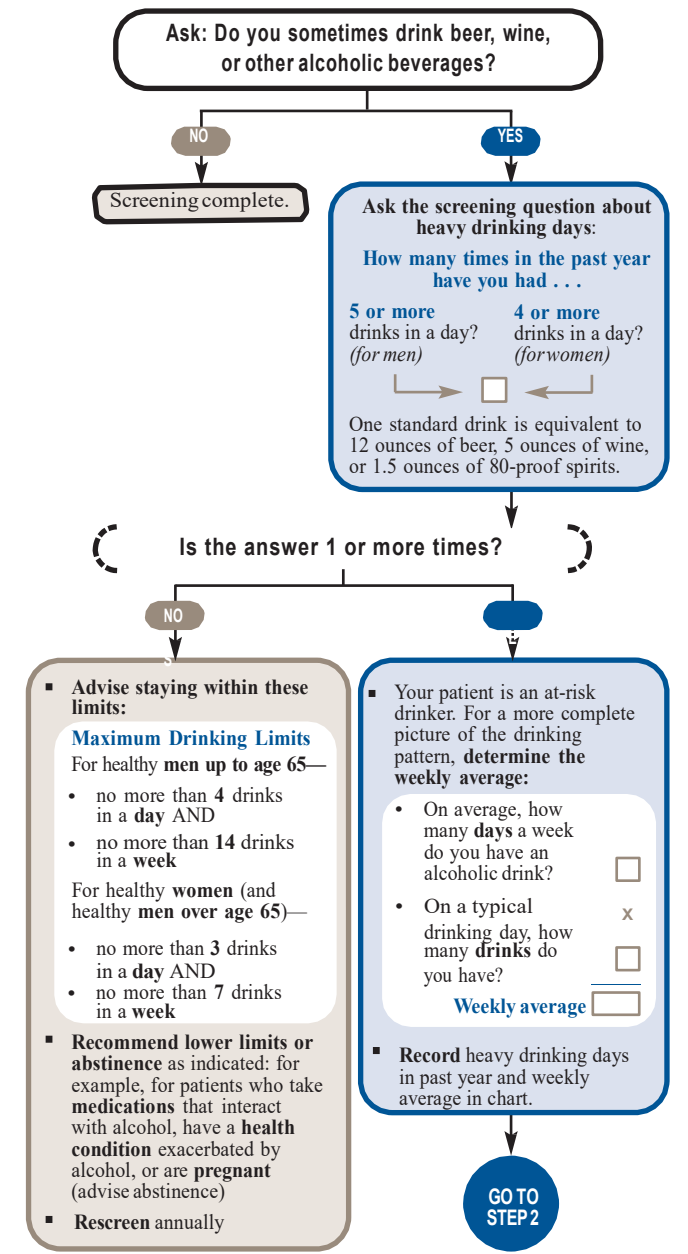
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## HOW TO SCREEN FOR HEAVY DRINKING

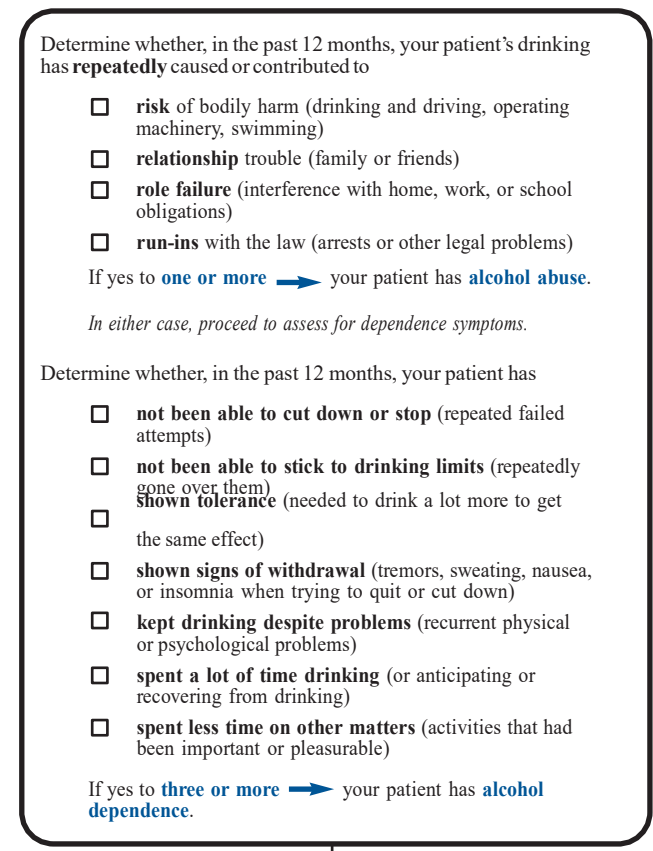
### STEP 1 Ask About Alcohol Use



## HOW TO ASSESS FOR ALCOHOL USE DISORDERS

### STEP 2 Assess For Alcohol Use Disorders

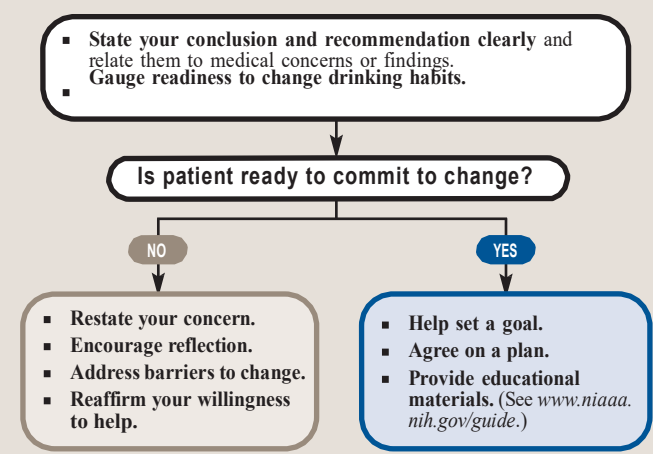
Next, determine if there is a *maladaptive pattern of alcohol use*, causing *clinically significant impairment or distress*.



## HOW TO CONDUCT A BRIEF INTERVENTION

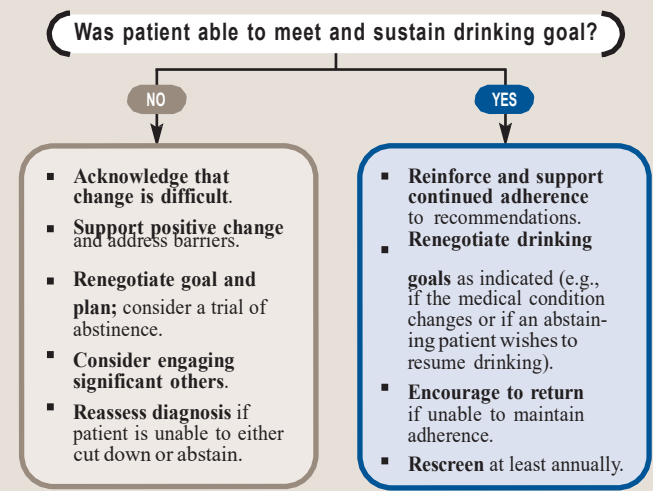
### FOR AT-RISK DRINKING (no abuse or dependence)

#### STEP 3 Advise and Assist



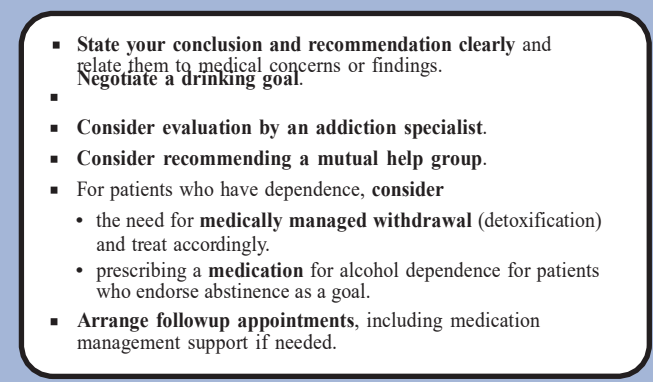
#### STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.



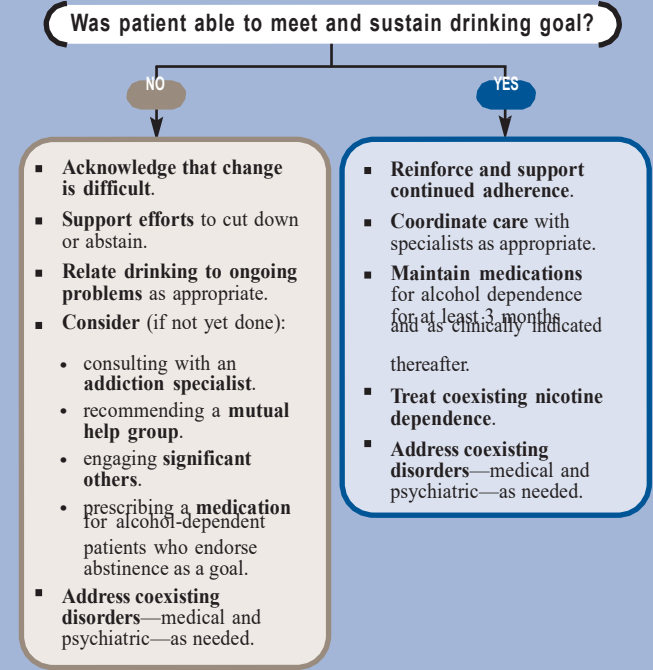
### FOR ALCOHOL USE DISORDERS (abuse or dependence)

#### STEP 3 Advise and Assist







#### STEP 4 At Followup: Continue Support

REMINDER: Document alcohol use and review goals at each visit.






# WHAT'S A STANDARD DRINK?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
<b>BEER or COOLER</b>	
 <p>12 oz. 5% alcohol</p>	<ul style="list-style-type: none"> <li>• 12 oz. = 1</li> <li>• 16 oz. = 1.3</li> <li>• 22 oz. = 2</li> <li>• 40 oz. = 3.3</li> </ul>
<b>MALT LIQUOR</b>	
 <p>8–9 oz. 7% alcohol</p>	<ul style="list-style-type: none"> <li>• 12 oz. = 1.5</li> <li>• 16 oz. = 2</li> <li>• 22 oz. = 2.5</li> <li>• 40 oz. = 4.5</li> </ul>
<b>TABLE WINE</b>	
 <p>5 oz. 12% alcohol</p>	<ul style="list-style-type: none"> <li>• a 750-mL (25-oz.) bottle = 5</li> </ul>
<b>80-proof SPIRITS (hard liquor)</b>	
 <p>1.5 oz. 40% alcohol</p>	<ul style="list-style-type: none"> <li>• a mixed drink = 1 or more*</li> <li>• a pint (16 oz.) = 11</li> <li>• a fifth (25 oz.) = 17</li> <li>• 1.75 L (59 oz.) = 39</li> </ul>

\*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three more standard drinks.

# DRINKING PATTERNS

WHAT'S YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
<p><b>Based on the following limits—number of drinks:</b></p> <p>On any <b>DAY</b>—Never more than <b>4</b> (men) or <b>3</b> (women)</p> <p>– and –</p> <p>In a typical <b>WEEK</b>—No more than <b>14</b> (men) or <b>7</b> (women)</p>	<p>Percentage of U.S. adults aged 18 or older*</p>	<p>Combined prevalence of alcohol abuse and dependence</p>
<p><b>Never exceed the daily or weekly limits</b></p> <p>(2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)</p>	 <p>72%</p>	<p>fewer than <b>1 in 100</b></p>
<p><b>Exceed only the daily limit</b></p> <p>(More than 8 out of 10 in this group exceed the daily limit <i>less than once a week</i>)</p>	 <p>16%</p>	<p><b>1 in 5</b></p>
<p><b>Exceed both daily and weekly limits</b></p> <p>(8 out of 10 in this group exceed the daily limit <i>once a week or more</i>)</p>	 <p>10%</p>	<p>almost <b>1 in 2</b></p>

\*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Source: 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide NIAAA survey of 43,093 U.S. adults aged 18 or older.

# PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 16 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit <http://medlineplus.gov>.

	<b>Naltrexone</b> (Depade <sup>®</sup> , ReVia <sup>®</sup> )	<b>Extended-Release Injectable Naltrexone</b> (Vivitrol <sup>®</sup> )	<b>Acamprosate</b> (Campral <sup>®</sup> )	<b>Disulfiram</b> (Antabuse <sup>®</sup> )
<b>Action</b>	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
<b>Contraindications</b>	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
<b>Precautions</b>	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required, and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see <a href="http://www.niaaa.nih.gov/guide">www.niaaa.nih.gov/guide</a> .	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see <a href="http://www.niaaa.nih.gov/guide">www.niaaa.nih.gov/guide</a> .
<b>Serious adverse reactions</b>	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
<b>Common side effects</b>	Nausea; vomiting; decreased appetite; headache; dizziness; fatigue; somnolence; anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea; somnolence.	Metallic after-taste; dermatitis; transient mild drowsiness.
<b>Examples of drug interactions</b>	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
<b>Usual adult dosage</b>	<p>Oral dose: 50 mg daily.</p> <p>Before prescribing: Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, a naloxone challenge test should be employed. Evaluate liver function.</p> <p>Laboratory followup: Monitor liver function.</p>	<p>IM dose: 380 mg given as a deep intramuscular gluteal injection, once monthly.</p> <p>Before prescribing: Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition.</p> <p>Laboratory followup: Monitor liver function.</p>	<p>Oral dose: 666 mg (two 333-mg tablets) three times daily; or for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily.</p> <p>Before prescribing: Evaluate renal function. Establish abstinence.</p>	<p>Oral dose: 250 mg daily (range 125 mg to 500 mg).</p> <p>Before prescribing: Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash).</p> <p>Laboratory followup: Monitor liver function.</p>

Note: Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

## Opportunities & Indications for Screening Youth for Alcohol Use

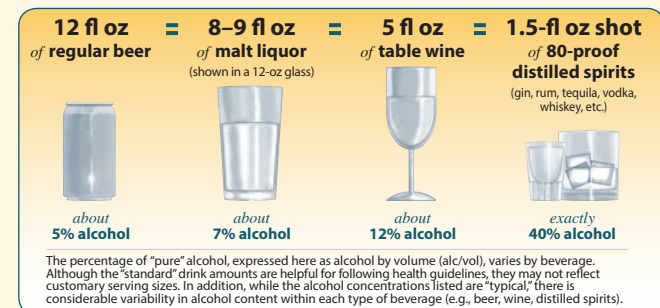
- As part of an **annual examination**
- As part of an **acute care visit**
- In the **emergency department** or urgent care center
- **When seeing patients who:**
  - you **have not seen in a while**
  - are likely to drink, such as youth who **smoke cigarettes**
  - have **conditions associated with increased risk** for substance abuse, such as:
    - depression
    - anxiety
    - ADD/ADHD
    - conduct problems
  - have **health problems that might be alcohol related**, such as:
    - accidents or injury
    - sexually transmitted infections or unintended pregnancy
    - changes in eating or sleeping patterns
    - gastrointestinal disturbances
    - chronic pain
  - show **substantial behavioral changes**, such as:
    - increased oppositional behavior
    - significant mood changes
    - loss of interest in activities
    - change of friends
    - a drop in grade point average
    - large number of unexcused absences in school

**1 in 3 children start drinking by the end of 8th grade. Of them, half report having been drunk.**

**You are in a prime position to help your patients avoid alcohol related harm.**

## What Counts as a Drink? A Binge?

The drinks shown below are different sizes, but each one has about the same amount of pure alcohol (14 grams or 0.6 fluid ounce) and counts as a single “standard” drink. These serve as examples; alcohol content can vary greatly across different types of beer, malt liquor, and wine.



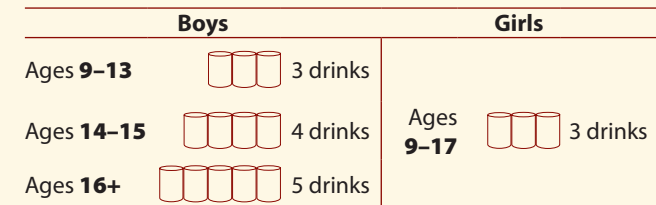
Below is the approximate number of standard drinks in different-sized containers of:

regular beer	malt liquor	table wine	80-proof distilled spirits
12 fl oz = <b>1</b>	12 fl oz = <b>1.5</b>	5-fl oz glass = <b>1</b>	a shot (1.5 oz) = <b>1</b>
16 fl oz = <b>1.3</b>	16 fl oz = <b>2</b>	25 fl oz = <b>5</b>	750 ml (a “fifth”) = <b>17</b>
40 fl oz = <b>3.3</b>	40 fl oz = <b>4.5</b>	(a regular 750-ml bottle)	1.75 L (a “handle”) = <b>39</b>

### What kinds of alcohol are kids drinking these days?

All kinds, with variations by region and fad. In many areas, distilled spirits appear to be gaining on or overtaking beer and “flavored alcohol beverages” in popularity among youth, whereas wine appears less preferred. Young people are also mixing alcohol with caffeine, either in premixed drinks or by adding liquor to energy drinks. With this dangerous combination, drinkers may feel somewhat less drunk than if they’d had alcohol alone, but they are just as impaired and more likely to take risks.

### What’s a “child-sized” or “teen-sized” binge?



See the full Guide, page 15, for details about these estimates.

## Brief Intervention & Referral Resources

### Four Basic Principles of Motivational Interviewing:

- **Express Empathy** with a warm, nonjudgmental stance, active listening, and reflecting back what is said.
- **Develop Discrepancy** between the patient’s choice to drink and his or her goals, values, or beliefs.
- **Roll with Resistance** by acknowledging the patient’s viewpoint, avoiding a debate, and affirming autonomy.
- **Support Self-efficacy** by expressing confidence and pointing to strengths and past successes.

For more information, see the full Guide, page 29, or visit:

- [www.motivationalinterview.org](http://www.motivationalinterview.org)
- [www.motivationalinterview.net](http://www.motivationalinterview.net)

### To Find Local Specialty Treatment Options:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospitals and mental health service organizations.
- Contact the Substance Abuse Facility Treatment Locator (seek centers specializing in adolescents) at 1–800–662–HELP or visit [www.findtreatment.samhsa.gov](http://www.findtreatment.samhsa.gov).
- For more suggestions, see the full Guide, p. 34.

List your local resources below.

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## Questions About Providing Confidential Health Care to Youth?

All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol. See the full Guide, page 25, for more information.

For details specific to your specialty and State:

- See confidentiality policy statements from professional organization(s):
  - American Academy of Pediatrics
  - American Academy of Family Physicians
  - Society for Adolescent Health and Medicine
  - American Medical Association
- Contact your State medical society for information on your State’s laws.
- Visit the Center for Adolescent Health and the Law for monographs on minor consent laws professional association policies: [www.cahl.org](http://www.cahl.org).

This Pocket Guide was produced by the National Institute on Alcohol Abuse and Alcoholism in collaboration with the American Academy of Pediatrics.



Order copies of this Pocket Guide, along with the full 40-page Guide, from [www.niaaa.nih.gov/YouthGuide](http://www.niaaa.nih.gov/YouthGuide) or call 1-888-MY-NIAAA (888-696-4222)

# A POCKET GUIDE FOR ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH



2011 Edition

This pocket guide is condensed from the NIAAA Guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide*. It was produced in collaboration with the American Academy of Pediatrics.

To order more copies of this Pocket Guide, or sets with the full 40-page Guide and the Pocket Guide, and for related professional support resources, visit [www.niaaa.nih.gov/YouthGuide](http://www.niaaa.nih.gov/YouthGuide) or contact the NIAAA Publications Distribution Center P.O. Box 10686, Rockville, MD 20849-0686 301–443–3860



**STEP 1: Ask the Two Screening Questions**

For elementary and middle school patients, start with the friends' question. Choose the questions that align with the patient's school level, as opposed to age, for patients ages 11 or 14. Exclude alcohol use for religious purposes.

**Elementary School (ages 9–11)**

**Friends: Any drinking?**  
 "Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?"  
**ANY drinking by friends heightens concern.**

**Patient: Any drinking?**  
 "How about you—have you **ever** had more than a few sips of any drink containing alcohol?"  
**ANY drinking: Highest Risk**

**Middle School (ages 11–14)**

**Friends: Any drinking?**  
 "Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?"  
**ANY drinking by friends heightens concern.**

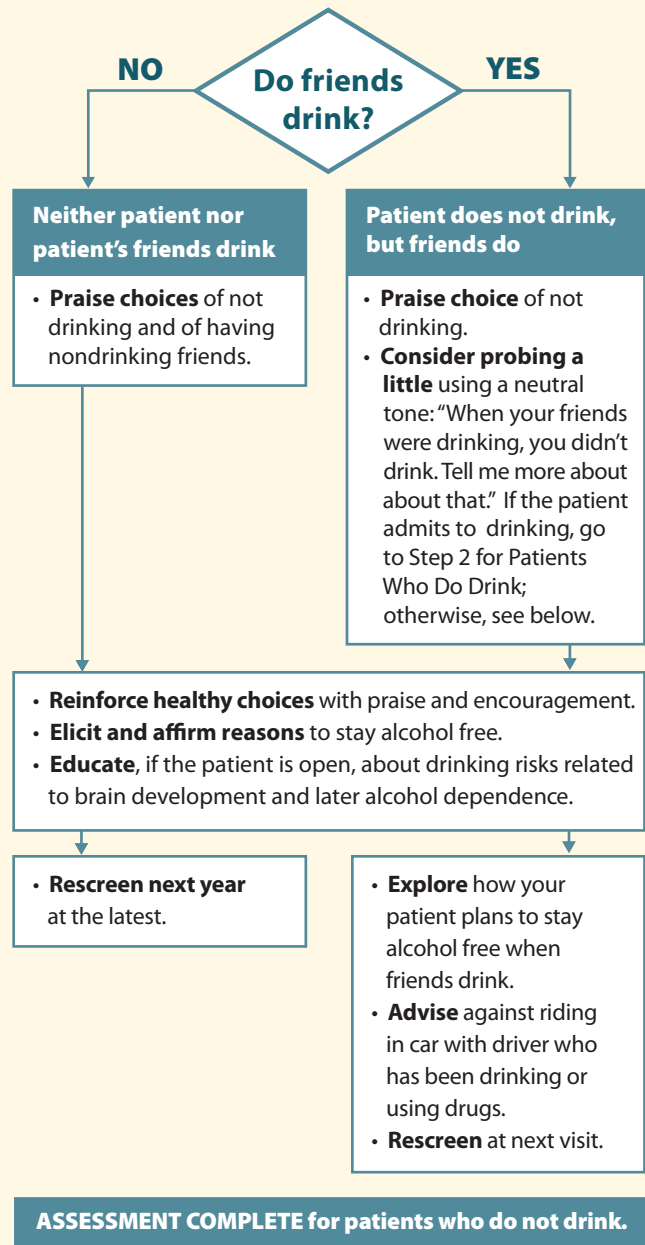
**Patient: How many days?**  
 "How about you—in the **past year, on how many days** have you had more than a few sips of any drink containing alcohol?"  
**ANY drinking: Moderate or Highest Risk**  
 (depending on age and frequency)

**High School (ages 14–18)**

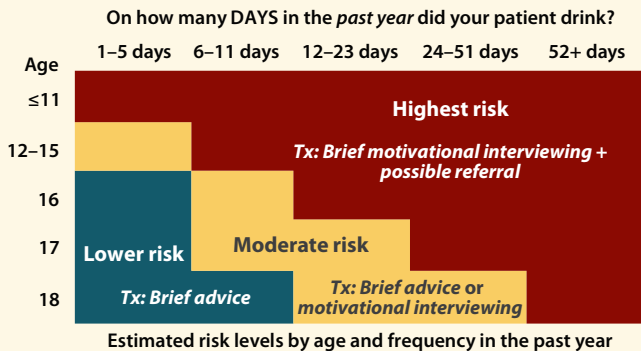
**Patient: How many days?**  
 "In the **past year, on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?"  
**Lower, Moderate, or Highest Risk**  
 (depending on age and frequency)

**Friends: How much?**  
 "If your friends drink, **how many drinks** do they usually drink on an occasion?"  
**Binge drinking by friends heightens concern.**  
 (See "What Counts as a Drink? A Binge?" on reverse)

**STEP 2: Guide Patient**



**STEP 2: Assess Risk**



**Factor in friends:**

- **For elementary and middle school students:** Having friends who drink heightens concern.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 3 to 5 drinks, depending on age and gender (see "What Counts as a Drink? A Binge?" on reverse).

**Include what you already know** about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

**For moderate and highest risk patients:**

- **Ask about the drinking pattern:** "How much do you usually have? What's the most you've had at any one time?" If patient reports bingeing, ask: "How often do you drink that much?"
- **Ask about problems experienced or risks taken:** Examples include getting lower grades or missing classes; drinking and driving or riding in a car driven by someone who has been drinking; having unplanned, unsafe sex; getting into fights; getting injured; having memory blackouts; and passing out.
- **Ask whether the patient has used anything else to get high in the past year,** and consider using other formal tools to help gauge risk.

**STEP 3: Advise and Assist**

**Lower Risk:**

- **Provide brief advice** to stop drinking.
- **Notice the good:** Reinforce strengths and healthy decisions.
- **Explore and troubleshoot** influence of friends who drink.

**Moderate Risk:**

- **Does patient have alcohol-related problems?**
  - **If no,** provide beefed-up brief advice.
  - **If yes,** conduct brief motivational interviewing.
- **Ask if parents know** (see Highest Risk, below, for suggestions).
- **Arrange for followup,** ideally within a month.

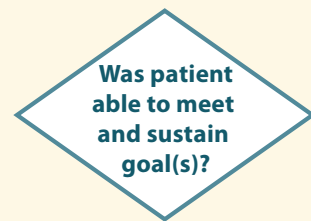
**Highest Risk:**

- **Conduct brief motivational interviewing.**
- **Ask if parents know ...**
  - **If no,** consider breaking confidentiality to engage parent.
  - **If yes,** ask patient permission to speak with parent.
- **Consider referral** for further evaluation or treatment.
- **If you observe signs of acute danger** (e.g., drinking and driving, binge drinking, or using alcohol with other drugs) **take immediate steps to ensure safety.**
- **Arrange for followup** within a month.

**FOR ALL PATIENTS WHO DRINK**

- **Collaborate on a personal goal and action plan** for your patient. Refer to page 31 in the full Guide for sample abstinence, cutting back, and contingency plans. For some patients, the goal will be accepting a referral to specialized treatment.
- **Advise your patient not to drink and drive or ride in a car with an impaired driver.**
- **Plan a full psychosocial interview** for the next visit if needed.

**STEP 4: At Followup, Continue Support**



Patients may not return for an alcohol-specific followup, but they may do so for other reasons. In either case, **ask about alcohol use and any associated problems.** Review the patient's goal(s) and assess whether he or she was able to meet and sustain them.

**No, patient was not able to meet/sustain goal(s):**

- **Reassess** the risk level (see Step 2 for drinkers).
- **Acknowledge** that change is difficult, that it's normal not to be successful on the first try, and that reaching a goal is a learning process.
- **Notice the good by:**
  - **praising** honesty and efforts.
  - **reinforcing** strengths.
  - **supporting** any positive change.
- **Relate drinking to associated consequences or problems** to enhance motivation.
- **Identify and address challenges and opportunities** in reaching the goal.
- If the following measures are not already under way, **consider:**
  - **engaging** parents.
  - **referring** for further evaluation.
- **Reinforce** the importance of the goal(s) and plan and **renegotiate** specific steps, as needed.
- **Conduct, complete, or update** the comprehensive psychosocial interview.

**Yes, patient was able to meet/sustain goal(s):**

- **Reinforce and support** continued adherence to recommendations.
- **Notice the good:** Praise progress and reinforce strengths and healthy decisions.
- **Elicit future goals** to build on prior ones.
- **Conduct, complete, or update** the comprehensive psychosocial interview.
- **Rescreen** at least annually.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPBP8013 (previously MCUP3145)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Eating Disorder Management Policy		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 08/10/2022 (MCUP3145)		<b>Next Review Date:</b> <del>06/11/2026</del> <u>11/12/2026</u> <b>Last Review Date:</b> <del>06/11/2025</del> <u>11/12/2025</u>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <del>06/11/2025</del> <u>11/12/2025</u>

**I. RELATED POLICIES:**

- A. MPBP8003 - Mental Health Services
- B. MCUG3024 - Inpatient Utilization Management
- C. MPUP3014 - 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 - Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services

**II. IMPACTED DEPTS:**

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

<b>Policy/Procedure Number: MPBP8013</b> (previously MCUP3145)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
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<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

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 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<sup>1</sup>, supplies, and supplements

<sup>1</sup> As per [APL 22-012 Revised](#), the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx webpage: <https://medi-calrx.dhcs.ca.gov/home/cdl/>.

Effective January 1, 2027, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

<b>Policy/Procedure Number: MPBP8013</b> (previously MCUP3145)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Eating Disorder Management Policy		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 08/10/2022 (MCUP3145)		<b>Next Review Date:</b> 06/11/202611/12/2026 <b>Last Review Date:</b> 06/11/202511/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

- F. Partnership Advantage: Effective January 1, 2027, 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 Behavioral Health Plans (BHPs) 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 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 Members with eating disorders is a shared responsibility between Partnership HealthPlan (Partnership) and each county Behavioral Health Plan (BHP) in Partnership’s service area.
  1. When evaluating requests for Members under age 21, both Partnership and BHPs 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, 2027, 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. above*) for our Members.
  1. 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.
  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

<b>Policy/Procedure Number: MPBP8013</b> (previously MCUP3145)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Eating Disorder Management Policy		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 08/10/2022 (MCUP3145)		<b>Next Review Date:</b> 06/11/2026 <b>Last Review Date:</b> 06/11/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

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.

3. If a Member requires partial hospitalization 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 BHP 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 Dietitians (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. BHPs 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 or a residential eating disorder program, the BHP 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 BHP 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 BHP for residential level treatment for eating disorders pursuant to APL 22-003.
    - b. A plan in the event that Partnership and the BHP cannot agree on how to divide financial responsibility. (*see policy MPBP8005 Dispute Resolution Between Partnership and BHPs 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 BHP.
    - e. Specification of procedures to ensure timely and complete exchange of information by both the BHP 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 BHP 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 MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services*)
- E. Partnership Advantage Members
1. Partnership Advantage Members 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 to which they are entitled.
  2. Partnership is fully responsible for the following levels of care for eating disorders for Partnership Advantage Members:

<b>Policy/Procedure Number:</b> MPBP8013 (previously MCUP3145)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Eating Disorder Management Policy		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 08/10/2022 (MCUP3145)		<b>Next Review Date:</b> 06/11/2026 <b>Last Review Date:</b> 06/11/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

- a. acute and psychiatric inpatient treatment
  - b. partial hospitalization
  - c. intensive outpatient program services
  - d. outpatient services
3. Residential treatment for eating disorders is not a covered service under Medicare. Partnership Advantage Members in need of this level of care will be provided care coordination, and treatment services will be a shared responsibility with the Member's county BHP pursuant to the cost-sharing arrangement agreed to between Partnership and the respective BHP.
  4. 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.

**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 (01/08/2025)
  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](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).

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:**

MPBP8013:  
06/11/25; [11/12/25](#)

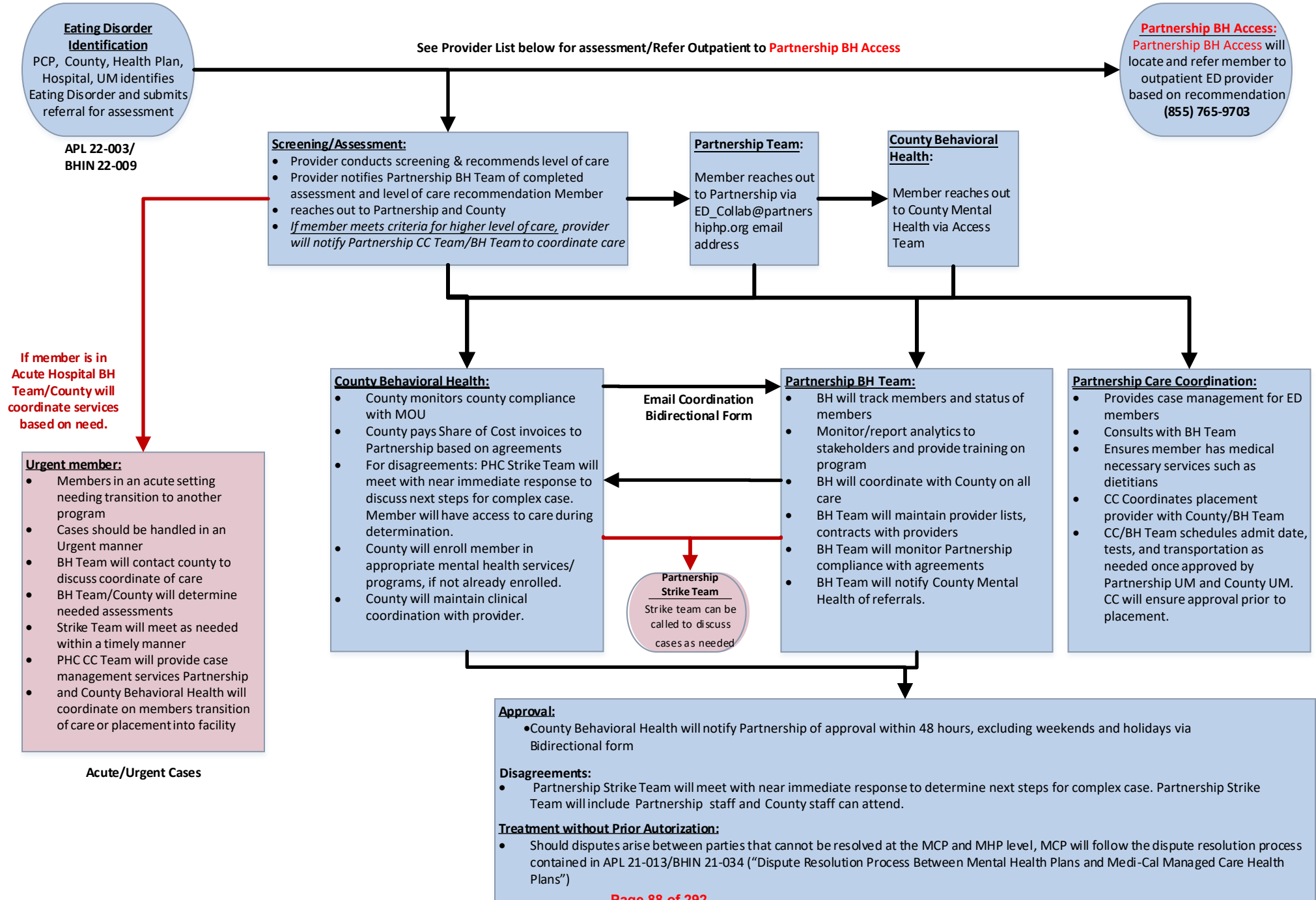
**PREVIOUSLY APPLIED TO:**

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 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” **or by calling Equip Health at (855) 387-4378.**
- 
- 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@partnershiphp.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
-



# 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:**

<b>URGENT</b> (SAME DAY, END OF BUSINESS)				<b>PRIORITY</b> (WITHIN 2 BUSINESS DAYS)		<b>ROUTINE</b> (WITHIN 4 BUSINESS DAYS)	
<b>Level of care recommendation completed:</b>				<b>Yes</b>		<b>No</b>	
(Please contact Partnership BH department for assistance with an assessment, if needed)							
<b>Member Information</b>							
<b>Name:</b>			<b>Address:</b>			<b>Phone:</b>	
<b>PCP:</b>			<b>County/Agency:</b>			<b>CIN:</b>	<b>DOB:</b>
<b>Services Requested</b>							
Inpatient:		Intensive Outpatient (IOP):		Do you want Partnership to contract with the provider:			
Residential:		Care Coordination:		Yes:		No:	
Partial Hospitalization (PHP):		Dietitian:		** For outpatient services, refer to Carelon with standard referral process			
<b>Requested Provider Information</b>							
** The provider you would like member to be connected to.							
<b>Provider:</b>			<b>Address:</b>			<b>Admission Phone:</b>	
<b>Contact Name:</b>			<b>Phone:</b>			<b>Email:</b>	
Referral Submitted:		<b>Yes</b>		<b>No</b>		Admission Date: (If known) Length of Stay: (If known)	
<b>Clinical Information</b>							
(Included information should be BMI, height, weight, any medical conditions, co-occurring disorders, diagnosis(es), family or social concerns, homelessness, etc.)							
<b>Contact Information</b>							
<b>BH Team Coordinator:</b>			<b>Phone:</b>		<b>Email:</b>		
<b>Partnership Care Coordinator Name:</b>			<b>Phone:</b>		<b>Email:</b>		
<b>County Clinician Name:</b>			<b>Phone:</b>		<b>Email:</b>		
<b>County Fiscal Name:</b>			<b>Phone:</b>		<b>Email:</b>		
<b>Primary Care Doctor:</b>			<b>Phone:</b>		<b>Email:</b>		
Would you like the provider to send clinical updates to your clinician? <b>Yes</b> <b>No</b>							

**Approval Signatures:**

\_\_\_\_\_  
**Partnership Behavioral Health Representative**

\_\_\_\_\_  
**County Representative**

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> N/A <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALING</b>	<input checked="" type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Archived Date:</b> 11/12/2025 <b>Approval Date:</b> 2/12/2025	

**I. RELATED POLICIES:**

- A. MCUP3101 - Screening and Treatment for Substance Use Disorders
- B. MCQG1005 - Adult Preventive Health Guidelines
- C. MCUP3028 - Mental Health Services
- D. MPUP3126 - Behavioral Health Treatment (BHT) for Members Under the Age of 21
- E. MCQG1015- Pediatric Preventive Health Guidelines

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. 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<sup>1</sup>, supplies, and supplements
- B. Specialty Mental Health Services (SMHS) aka Serious and Persistent Mental Health Services are those provided by County Mental Health Plans, generally 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](#).

**IV. ATTACHMENTS:**

- A. [Carelon/ Partnership Behavioral Health Care Management Referral Form \(including Authorization for Carelon Behavioral Health, Inc. to Release Confidential Information\)](#)
- B. [Carelon/ Partnership Primary Care Provider \(PCP\) Referral Form \(including Authorization for Carelon Behavioral Health, Inc. to Release Confidential Information\)](#)

<sup>1</sup> As per [APL 22-012 Revised](#), this does not include medications covered by Medi-Cal Rx: <https://medi-calrx.dhcs.ca.gov/home/education/>

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> N/A <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

**V. PURPOSE:**

The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership HealthPlan of California’s delegated managed behavioral health organization, Carelon Behavioral Health (855) 765-9703, and for referral to County Mental Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between primary care providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.

**VI. POLICY / PROCEDURE:**

- A. Partnership utilizes this guideline to generally define the services and responsibilities of PCPs and behavioral health providers. PCPs are responsible for all services within the scope of primary care required by the patient except when clinical circumstances preclude the PCP role. The PCP’s services are personal, and their responsibility is continuous. The scope of the responsibility is comprehensive, (i.e., all required services including preventive services). The PCP should provide those services which can be provided within their competence and should obtain consultation when additional knowledge or skills are required. Partnership recognizes that differences in skill level exist among PCPs; this document serves as a general guideline to define the scope of services and the indications for specialty referrals. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a specialist and the referral of a patient to a specialist for services. When care by specialists is required, it is the responsibility of the PCP and the specialists to coordinate all services.
- B. The PCP should be responsible for providing the following in regards to basic behavioral health conditions:
1. Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations.
  2. Routinely screen for common behavioral health and substance use disorder conditions.
    - a. The plan has adopted, and Partnership contracted providers are expected to follow, the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Routine screening for depression is recommended by the USPSTF. Please refer to Partnership’s Adult Preventive Health Guidelines policy MCQG1005 and Pediatric Preventive Health Guidelines policy MCQG1015 for further details.
    - b. Additionally, current versions of behavioral health and substance use disorder screening forms may be found on the Carelon Behavioral Health (formerly known as Beacon) website at this address: <https://www.carelonbehavioralhealth.com/providers/resources/provider-toolkit>
    - c. Screening for alcohol misuse is also required. Please refer to policy MCUP3101 Screening and Treatment for Substance Use Disorders for details.
  3. Ascertain whether individuals are experiencing symptoms that would warrant emergent or urgent psychiatric evaluation, such as significant suicidal or homicidal ideation and/or grave disability as defined by the Lanterman-Petris-Short Act (LPS) (see this web page: <https://ajud.assembly.ca.gov/sites/ajud.assembly.ca.gov/files/Kim%20Lewis%2C%20National%20Health%20Law%20Program%20slides.pdf>), active substance intoxication/withdrawal/use disorder, or disorganized thinking or psychomotoric agitation, and making appropriate referrals to complete these evaluations as clinically indicated.
  4. Evaluate and provide ongoing management for the following:
    - a. Psychiatric factors affecting a medical condition and psychiatric symptoms precipitated by medications being used to treat medical conditions
    - b. Personality disorders that meet (or do not meet) the full criteria for a Diagnostic and Statistical Manual (DSM) diagnosis and the severity of which does not necessitate SMHS.

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <u>02/12/2026</u> <b>N/A</b> <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- c. Medical assessments of members to evaluate and treat general medical conditions causing or exacerbating psychiatric symptoms.
  - d. Initial diagnosis and treatment of dementia. Differentiate dementia from other disorders effecting cognition, such as delirium, schizophrenia, substance misuse, and depression. Manage general medical factors that improve or worsen dementia. (See policy MCQG1005 - Adult Preventive Health Guidelines for more information on cognitive health assessments for members who are 65 years of age or older)
- C. The PCP should be responsible for the initial evaluation and referral for behavioral health services as follows:
1. Medi-Cal only Members (with no Medicare):
    - a. All mental health services for these members are provided either by Carelon Behavioral Health’s network of providers for Non-Specialty Mental Health Services (mild to moderate behavioral health conditions) or by County Mental Health Plans for Specialty Mental Health services (aka serious and persistent mental health services).
    - b. Substance use disorder and substance misuse services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties are provided by Partnership HealthPlan. Substance use disorder and substance misuse services for members in other counties are provided by County Substance Use Programs. In all counties, substance use disorder and substance misuse treatment services may also be provided within the Partnership network through Medications for Addiction Treatment (MAT); see policy MCUP3101 Screening and Treatment for Substance Use Disorders for further information.
  2. PCP may determine a diagnosis or provisional diagnosis for the following behavioral health conditions: schizophrenia/psychotic disorder, bipolar depression, depression, anxiety disorder, impulse control disorder, adjustment disorder, personality disorder (except anti-social), eating disorder, pervasive developmental disorder, disruptive behavior/attention deficit disorder, feeding and eating/elimination disorders, other disorders of infancy, childhood, or adolescence, somatoform disorders, factitious disorders, dissociative disorders, paraphilias, gender dysphoria, substance-related and addictive disorders.
  3. PCP should determine the level of functional impairment in the following life domains resulting from the behavioral health condition:
    - a. Independent living skills
    - b. Social relations
    - c. Physical condition (chronic medical condition)
    - d. Vocational/ Employment
    - e. Sexual Functioning
    - f. Self-care
    - g. Decision making
    - h. Legal
    - i. Residential instability
  4. PCP should assess risk factors linked to the further deterioration of behavioral health conditions such as:
    - a. Psychiatric hospitalization
    - b. Criminal behaviors and criminal justice system involvement
    - c. Suicidal/homicidal ideations and behavior
    - d. Experiencing psychotic or mood symptoms (especially in youth and transitional aged youth)
    - e. Self-injurious behavior (especially that which required medical attention)
    - f. Sexual aggression with risk of re-offending
    - g. Inability to adequately self-care
    - h. Ongoing substance misuse

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> N/A <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

5. For mental health conditions, PCP should refer Medi-Cal-only members to Carelon Behavioral Health when a provisional diagnosis is present or the diagnosis is uncertain, where functional impairment is considered to be in mild to moderate range, and where there are no deterioration/risk factors.
  - a. When Member's needs are outside PCP scope, PCP may refer for Outpatient Behavioral Health Services for therapy or medication management via Carelon's network of providers by providing the member with the Carelon Behavioral Health referral number (855) 765-9703. PCP can also fax a Carelon/Partnership PCP Referral Form (Attachment B) to Carelon at fax: (877) 321-1787 or use secure email to: [medi-cal.referral@carelon.com](mailto:medi-cal.referral@carelon.com). Licensed Mental Health Providers at Carelon will utilize DHCS Screening and Transition of Care Tools as per [footnote 3](#) in [APL 22-028](#) to determine the appropriate mental health delivery system referral, including coordination with county MHP if necessary (see policy MCUP3028 Mental Health Services for more information).
  - b. PCP may request PCP Decision Support, which allows consultative peer discussion related to member diagnostic and medication clarification; the PCP may request a telephone consultation with a Carelon psychiatrist using the Carelon/Partnership [PCP Referral Form](#) (Attachment B). Before phone consult with Carelon, PCP should fax medication list and last 2 PCP progress notes for Psychiatrist review. Fax: (877) 321-1787 or secure email: [medi-cal.referral@carelon.com](mailto:medi-cal.referral@carelon.com)
  - c. PCP may refer for Local Care Management to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community services by sending the Carelon/Partnership Behavioral Health Care Management Referral Form (Attachment A) to Carelon Fax: (855) 371-2279 or email: [MediCal\\_PHP@carelon.com](mailto:MediCal_PHP@carelon.com)
  - d. Primary care sites with integrated behavioral health, whose mental health professionals are credentialed with Carelon, may co-manage patients who would qualify for the NSMHS mental health benefit.
  - e. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership member based on their current clinical competence and in collaboration with the behavioral health specialist as appropriate.
6. PCP should refer members to County Mental Health Plans when a provisional diagnosis is present and when functional impairment is considered to be in the SMHS (moderate to severe) range, and/or when any risk factor is present.
  - a. The process of accessing mental health services in each county may be different. For initial telephone contacts, PCPs can refer to this webpage for County Mental Health contact information: <http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx>.
  - b. Patients with emergency psychiatric conditions should be referred for emergency evaluation, calling the county-designated crisis phone number to arrange for services: [https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/CrisisLines\\_Final\\_MH.pdf](https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/CrisisLines_Final_MH.pdf).
  - c. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership member based on their current clinical competence and in collaboration with the behavioral health specialist, as appropriate.
  - d. Federally Qualified Health Centers (FQHCs) with integrated mental health may provide outpatient services for patients who would otherwise qualify for County Specialty Mental Health Services. These services are billed directly to the State.
7. PCP should screen and refer Medi-Cal-only Members with substance use disorders and misuse as follows:

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> <b>N/A</b> <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- a. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) should be performed by PCP.
- b. The process of accessing substance use disorder services in each county may be different.
  - 1) For Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties, members should be referred to Carelon Behavioral Health (855) 765-9703 for call center assistance to identify substance use disorder service providers.
  - 2) In all other counties, the first point of telephone contact for substance use disorder referrals for each county can be located on the Partnership website on this webpage under the heading “Alcohol and Drug Treatment”: <http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx>
- c. For details on substance use disorder and alcohol misuse screening and referral, see policy MCUP3101 Screening and Treatment for Substance Use Disorders.
- d. Provide ongoing follow-up as jointly determined by the PCP and Substance Use Disorder treatment provider for members whose substance use disorder conditions have reached a high degree of stability.
8. Psychiatric manifestations of neurologic disorders, developmental neurologic disorders, traumatic brain injury, and cognitive impairment: A specialist in neuropsychiatry is ideally suited to assist with these cases. Providers can refer to Carelon Behavioral Health to refer members for this service. Providers may also request case management from Carelon to assist in establishing connections for these services using the Carelon/Partnership Behavioral Health Care Management Referral Form (Attachment A).
9. Behavioral Health Treatment (BHT) for Medi-Cal only Members Under the Age of 21: BHT is covered by Partnership for members under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit. A Treatment Authorization Request (TAR) is required. See policy MPUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21.
10. School-aged children may also have some assessment and treatment covered through their schools. School-based mental health services include a broad range of services, settings, and strategies. These services may include academic counseling, brief interventions to address behavior problems, family counseling, suicide prevention, and assessment and referral to other systems. Further information is available through your county mental health department.

## VII. REFERENCES:

- A. Latest USPSTF Guide to Clinical Preventive Services
- B. County specific Mental Health Plan Memoranda of Understandings (MOUs)
- C. Welfare and Institutions Code Sections 14132.03 and 14189
- D. Title 9 of the California Code of Regulations, Chapter 11
- E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/23)
  - Specialty Mental Health Services Memorandum of Understanding Template
  - Substance Use Disorder Treatment Services Memorandum of Understanding Template
  - Drug Medi-Cal State Plan Memorandum of Understanding Template
- F. DHCS All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
- G. DHCS All Plan Letter (APL) 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022)

## VIII. DISTRIBUTION:

- A. Partnership Provider Manual

<b>Policy/Procedure Number:</b> MPCP2017 (previously MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services Business Unit: Care Coordination	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <u>02/12/2026</u> <b>Last Review Date:</b> 02/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

B. Partnership Department Directors

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

**X. REVISION DATES:** 04/19/17; \*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25; ARCHIVED 11/12/2025

\*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:**

Medi-Cal - MPQP1024

Original Date: 02/18/2004

Revision dates: 05/18/05; 04/19/06; 04/18/07; 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15

Healthy Kids - MPCP2017, MPQP1024 (Healthy Kids Program ended 12/01/2016)

Original Date: 04/18/2007

Revision dates: 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15 to 12/01/2016

Partnership Advantage:

MPQG1024 – 04/18/2007 to 11/17/2010

MPQP1024 – 11/17/2010 to 01/01/2015

Healthy Families:

MPQP1024 - 11/17/10 to 03/01/2013

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

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

The materials provided are guidelines used by 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.



**Carelon Behavioral Health, Inc. / Partnership Health Plan of California  
Behavioral Health Care Management Referral Form**

Referral Date: \_\_\_\_\_ Member Name: \_\_\_\_\_ Medi-Cal CIN ID#: \_\_\_\_\_

DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Phone: \_\_\_\_\_ (home); \_\_\_\_\_ (parent/guardian's cell); \_\_\_\_\_ (member's cell)

Member address: \_\_\_\_\_

Member notified of this referral:  Yes  No

Parent/guardian notified of this referral:  Yes  No

**If the member is a minor 12 and older**, who is requesting MH care management and services?

- Member only (parent/guardian is unaware)  Parent/guardian only  Both member and parent/guardian

Does the minor 12 and older have capacity to give consent to services?  Yes  No If no, please explain \_\_\_\_\_

Best day/time to reach the member: \_\_\_\_\_ Best day and time to reach the parent/guardian: \_\_\_\_\_

PCP Clinic/Agency: \_\_\_\_\_ Name of PCP: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

**REFERRAL SOURCE:**

- Health Plan  PCP  Behavioral Health Provider  Specialty Provider  Community Partner  Hospital

**Referring Clinic/Agency/Location:** \_\_\_\_\_ **Referring Provider:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Contact Phone #:** \_\_\_\_\_ **Fax#:** \_\_\_\_\_

**Referral for Care Management:** Local behavioral health care coordination services to: link members to mental health providers, engage members with history of non-compliance and/or link them to community support services, and assist with coordination between multiple agencies

Requested Services:  Individual/Group Therapy  Family Therapy  Medication Management  Other: \_\_\_\_\_

**Referral Reason** (check all that apply):

- |                                                                                 |                                                                                                                                    |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Depression/Anxiety                                     | <input type="checkbox"/> Suicidal or Homicidal Ideation: If yes, Current <input type="checkbox"/> History <input type="checkbox"/> |
| <input type="checkbox"/> Poor self-care due to mental health                    | <input type="checkbox"/> Response Given on HRA: _____                                                                              |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusional) | <input type="checkbox"/> Difficulties Maintaining Relationships                                                                    |
| <input type="checkbox"/> PTSD/Trauma                                            | <input type="checkbox"/> Gender Identity                                                                                           |
| <input type="checkbox"/> Violence/Aggressive Behavior                           | <input type="checkbox"/> Legal, Child or Elder Abuse                                                                               |
| <input type="checkbox"/> Difficult/Unable to Complete ADLs                      | <input type="checkbox"/> Adverse Childhood Experiences (ACEs): Score _____                                                         |
| <input type="checkbox"/> Difficult/unable to go to work/school                  | <input type="checkbox"/> Chronic Pain                                                                                              |
| <input type="checkbox"/> Perinatal Depression and/or Anxiety                    | <input type="checkbox"/> Other: _____                                                                                              |

Step-down from County SMHS: Yes  No

Substance Use: If yes, Current  History  Substance Use (type): \_\_\_\_\_

Mental health and medical diagnoses: \_\_\_\_\_

Medications (list below or send medication list with this form): \_\_\_\_\_

Additional Information: \_\_\_\_\_

**Member Motivation for Services:**

- Member wants services for self (or dependent)  
 Member is unsure or ambivalent about services for self (or dependent)  
 Member does not want services or does not believe they are needed  
 Member has not been informed of this referral to Beacon

Please complete the form as fully as possible. Send referral via secure email: [MediCal\\_PHP@carelon.com](mailto:MediCal_PHP@carelon.com) or fax to: 855.371.2279

For members 12 and older, in certain situations under privacy law AB1184, a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.



Authorization for Carelon Behavioral Health, Inc. to Release Confidential Information



Important: By completing all sections of this form you allow Carelon Behavioral Health, Inc. to disclose health care information to the individuals you identify for up to one year.

Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up care that may be needed.

If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.

SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I, (Member Name) authorize Carelon Behavioral Health (or any Carelon Behavioral Health subsidiary holding my information) to disclose my health care information as described below.

Additional Member Identifying Information Member ID#: - DOB: Phone Number: Name of Health Plan:

SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

Phone number of who will be receiving your information:

Is it ok to include information from past, present, and/or future treating provider(s)?: X Yes No

SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason ("At my request" is an acceptable response):

Specify, if possible: X Care Coordination/Management Claim Assistance Quality of Care Review Other (Please explain reason):

SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

BY INITIALING the items on the following page, you authorize Carelon Behavioral Health to release specific types of information to the party identified in Section 2 above:

Mental health information and/or records (INITIALS REQUIRED)

Alcohol or substance use information and/or records (INITIALS REQUIRED)

Optional: Claims info Authorizations Explanation of benefit letters Denials/Appeals info Clinical notes

HIV/AIDS related information and/or records (INITIALS REQUIRED)

Other health information, please specify (INITIALS REQUIRED):

Special instructions, if any (you may specify provider, date span, service type, etc.):



SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect for one year or until I revoke it, in the manner described below or until (insert expiration date or event) \_\_\_\_\_ (whichever is shorter).

SECTION 6: WHAT ARE MY RIGHTS?

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
You have a right to revoke this authorization at any time. But if you revoke this authorization, the revocation will not affect the disclosure of any information that Carelon Behavioral Health has already sent to the recipient.
If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance use treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

Signature of the Member or the Member's Legally Authorized Representative

Date

Print Name

\* NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.

Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.

Archived 11/12/2015 - Refer to MPB011-A

Referral Date: \_\_\_\_\_ Member Name: \_\_\_\_\_ Medi-Cal CIN ID#: \_\_\_\_\_

DOB: \_\_\_\_\_ Parent/Guardian Name: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Phone: \_\_\_\_\_ (home); \_\_\_\_\_ (parent/guardian's cell); \_\_\_\_\_ (member's cell)

Member address: \_\_\_\_\_

Does the minor 12 and older have capacity to give consent to services?  Yes  No If no, please explain \_\_\_\_\_

Best day/time to reach the member: \_\_\_\_\_ Best day and time to reach the parent/guardian: \_\_\_\_\_

PCP Clinic/Agency: \_\_\_\_\_ Name of PCP: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

**To receive a confirmation of this referral's outcome, please check the box below noting preferred method and contact details:**

Email address: \_\_\_\_\_  Fax Number: \_\_\_\_\_

**Please check** to confirm member eligibility was verified

**PCP Request (one request per referral form)**

**PCP Decision Support:** To obtain a mental health educational conversation with a Carelon Behavioral Health psychiatrist related to psychiatric diagnoses/medications. Contact the National Peer Advisor line: **Office Hours:** 6am-5pm PST Monday – Friday  
**Please call phone number: 877-241-5575**

**Referral for Outpatient Behavioral Health Services:** Refer members for therapy or medication management via Carelon Behavioral Health's network of providers when their needs are outside the PCP scope of practice. Carelon Behavioral Health can coordinate member care with county mental health. Fax: **877.321.1787** OR secure email: [Medi-Cal.Referral@carelon.com](mailto:Medi-Cal.Referral@carelon.com)

**Referral for Local Care Management:** (select the appropriate referral reason(s) below)

- Treatment adherence
- Medication adherence
- Linkage to community support services
- Complex case (e.g. medical and behavioral health needs, maternal mental health, etc...), please specify: \_\_\_\_\_

Fax: **855.371.2279** OR secure email: [MediCal\\_PHP@carelon.com](mailto:MediCal_PHP@carelon.com)

**Request Reason** (check all that apply):

**Symptoms:**

- |                                                                                |                                                       |                                       |
|--------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Depression                                            | <input type="checkbox"/> Perinatal depression/anxiety | <input type="checkbox"/> PTSD/Trauma  |
| <input type="checkbox"/> Poor self-care due to mental health                   | <input type="checkbox"/> Violence/Aggressive behavior | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusions) | <input type="checkbox"/> Psychological testing        | <input type="checkbox"/> Anxiety      |
| <input type="checkbox"/> Adverse Childhood experiences (ACEs)                  | <input type="checkbox"/> Neuropsychological testing   |                                       |
| <input type="checkbox"/> Substance use, please specify: _____                  |                                                       |                                       |
| <input type="checkbox"/> Other BH symptoms: _____                              |                                                       |                                       |

**Impairments:**

- Difficulties/Unable to complete ADLs  Difficulties maintaining relationships  Legal  CPS
- Difficulties/Unable to go to work/school  Other: \_\_\_\_\_

**Medications** (list below or send medication list with this form, please include dosage):  
\_\_\_\_\_

**Motivation for Services** (check all that apply)

- Member (or guardian) has been informed of referral to Carelon Behavioral Health
- Member wants services for self (or dependent)
- Member is unsure or ambivalent about services for self (or dependent)
- If applicable, Member has completed a PHQ-2/PHQ-9, Score \_\_\_\_\_

**For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.**

**Important:** By completing all sections of this form you allow Carelon Behavioral Health, Inc. to disclose health care information to the individuals you identify for up to one year. You may allow Carelon Behavioral Health to share health care information with your family, providers, legal representative, or **anyone** that you wish to have access. Please fill in all sections as incomplete forms may be returned.

*Please note: It is also important for your doctor to have access to your medical information to ensure you receive the best care possible, including any follow-up medical care that may be needed. To allow Carelon Behavioral Health the ability to send your health care information to your doctor, complete and sign this form. We will only send information that pertains to your care.*

**If your request involves alcohol or substance use information, please pay attention to the special instructions in the applicable sections.**

## SECTION 1: WHOSE HEALTH CARE INFORMATION IS TO BE RELEASED?

I, \_\_\_\_\_ (**Member Name**) authorize Carelon Behavioral Health, Inc. (or any Carelon Behavioral Health subsidiary holding my information) to disclose my health care information as described below.

**Additional Member Identifying Information**    Member ID#: \_\_\_\_\_    DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Phone Number: \_\_\_\_\_    Name of Health Plan: \_\_\_\_\_

## SECTION 2: WHO IS TO RECEIVE THIS HEALTH CARE INFORMATION?

Print the Name(s) of person, provider or entity who will be receiving your information and contact information (if known):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone Number of who will be receiving your information: \_\_\_\_\_

Is it ok to include information from past, present, and/or future treating provider(s)?:    Yes    No

## SECTION 3: WHY SHOULD THIS HEALTH CARE INFORMATION BE RELEASED?

Reason: ("At my request" is an acceptable response):

\_\_\_\_\_  
 Specify, if possible:     Care Coordination/Management     Claim Assistance     Quality of Care Review  
 Other (Please explain reason): \_\_\_\_\_

## SECTION 4: WHAT HEALTH CARE INFORMATION MAY BE RELEASED?

**BY INITIALING** the following items, you are authorizing Carelon Behavioral Health to release specific types of information to the party identified in Section 2 above:

- \_\_\_\_\_ Mental health information and/or records (**INITIALS REQUIRED**)
- \_\_\_\_\_ Alcohol or substance use information and/or records (**INITIALS REQUIRED**)

HIV/AIDS related information and/or records **(INITIALS REQUIRED)**

Other health information, please specify **(INITIALS REQUIRED)**: \_\_\_\_\_

Special instructions, if any (you may specify provider, date span, service type, etc.): \_\_\_\_\_

**Optional:**    Claims info    Authorizations    Explanation of benefit letters    Denials/Appeals info    Clinical notes

## SECTION 5: HOW LONG SHOULD THIS AUTHORIZATION LAST?

This authorization shall be in force and effect **for one year** or until I revoke it, in the manner described below or until **(insert expiration date or event)** \_\_\_\_\_ (whichever is shorter).

## SECTION 6: WHAT ARE MY RIGHTS?:

- You have a right to request a copy of this form and to request a copy of the information that is being disclosed.
- You do not have to sign this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits.
- The information disclosed by this authorization may be at risk for re-disclosure by the recipient and if that happens, it might no longer be protected by federal privacy laws.
- You have a right to revoke this authorization at any time. **But if you revoke this authorization, the revocation will not affect the disclosure of any information that Carelon Behavioral Health has already sent to the recipient.**
- If you authorized release of alcohol or substance use information to a healthcare organization that is not your treating provider, for the next two years, you have the right to find out who within that organization actually saw your information. You should contact the organization directly for that information.

Please note that if you have authorized the release of ONLY alcohol or substance abuse treatment records, you may revoke this authorization verbally. Revocation involving all other types of health care records must be in writing.

\_\_\_\_\_  
Signature of the Member or the Member's Legally Authorized Representative\*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

**\* NOTE: If you are signing as the individual's Legally Authorized Representative, attach a copy of the appropriate legal document(s) granting you the authority to do so. Examples would be a health care power of attorney, a court order, guardianship papers, etc. A financial or business power of attorney is NOT sufficient.**

**Please contact the phone number for behavioral health, mental health, or substance use services on your medical ID card with any questions or to determine where to mail or fax your request.**

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MCUP3101		<b>Lead Department:</b> Health Services	
<b>Policy/Procedure Title:</b> Screening and Treatment for Substance Use Disorders		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 03/21/2012		<b>Next Review Date:</b> <del>N/A</del> 01/08/2026 <b>Last Review Date:</b> 01/08/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> Employees		
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> FAC
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING <input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Archive Approval Date:</b> <del>01/08/2025</del> 11/12/2025	

**I. RELATED POLICIES:**

- A. MPCP2017 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
- B. MCUP3028 – Mental Health Services
- C. MCQP1021 – Initial Health Appointment
- D. MPQP1022 – Site Review Requirements and Guidelines
- E. MCQG1015 – Pediatric Preventive Health Guidelines
- F. MCQG1005 – Adult Preventive Health Guidelines
- G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
- H. CMP26 – Verification of Caller Identity and Release of Information.

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

- A. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with “addiction.” According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as “non-medical use” of prescription medications). The most common substance use disorders in the United States include the following:
  - 1. Alcohol Use Disorder
  - 2. Tobacco Use Disorder
  - 3. Cannabis Use Disorder
  - 4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
  - 5. Opioid Use Disorder
- B. Unhealthy Alcohol Use (UAU): Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder

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(e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:

1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks for adult men over a 2-hour period.
2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.
- C. Standard Alcohol Drink (US definition): 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz “shot” of hard liquor (about 40% alcohol)
- D. Unhealthy Drug Use (UDU): The United States Preventive Services Taskforce (USPSTF) defines UDU as “the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual.” Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, Partnership expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.
- E. Unhealthy Drug Use Screening (UDUS): According to USPSTF, UDUS is defined as “asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format.” It does not refer to body fluid substance screening.
- F. SABIRT: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment: An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:
  1. Screening - a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
  2. Brief intervention - a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
  3. Referral to treatment - a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

SABIRT represents an expansion of SBIRT with the addition of “brief assessment” (e.g., use of a validated assessment tool to determine if unhealthy alcohol or drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.
- G. Covered Program: pursuant to [42 CFR Part 2 §2.11](#), means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.
- H. Records: pursuant to [42 CFR Part 2 §2.11](#), means any information, whether recorded or not, created by,

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received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

**IV. ATTACHMENTS:**

- A. [Recommended Tools and Training Resources for SABIRT](#)
- B. [Pocket Screening and Brief Intervention for Alcohol Use Disorders](#)
- C. [Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders](#)

**V. PURPOSE:**

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

**VI. POLICY / PROCEDURE:**

A. Covered Services:

1. Alcohol and Other Drug Treatment Services covered through the Counties:  
Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51301.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California's (Partnership's) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
2. Wellness and Recovery Benefit through Partnership:  
Effective July 1, 2020, Partnership Members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
  - a. Member has been determined eligible for full scope Medi-Cal
  - b. Member is not institutionalized
  - c. Member has a substance-related and addictive disorder per the current "Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition" (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
  - d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services

AND

  - e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County
3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPCP2017 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by Partnership medical providers should be billed to Partnership as any other encounter, using appropriate encounter and management CPT codes.
  - a. Many of the medications used to treat addictions (often referred to as Medications for Addiction Treatment, or [MAT]) require no special or additional training or certification.
    - 1) Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder.

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- 2) Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice.
  - a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
  - b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings.
- b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists providing office visits for substance use disorder treatment may use the ICD 10 code F11.xx or F10.xx to avoid the requirement for a Referral Authorization normally required for assigned patients.
- c. Adjunctive counseling for SUD by non-licensed providers is not covered by Partnership, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the Member is a qualifying Member for SUD services through the Wellness and Recovery Program.
4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter [\(APL\) 21-014](#). These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all Members aged 11 years and older, including pregnant Members.
  - a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § [2.14](#) and may be released in compliance with Partnership policy CMP-26 Verification of Caller Identity and Release of Information.
5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of Members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy MCQG1005 Adult Preventive Health Guidelines.
- B. Partnership Responsibility, Related to SUD Services
  1. Identification
    - a. Partnership may identify a Member in need of SUD services through one of the following:
      - 1) Telephone inquiries from Member or Provider
      - 2) During Prior Authorization and/or Concurrent Review Processes
      - 3) Through Care Coordination programs activity
      - 4) Through call center activities performed by Partnership's delegated managed behavioral health organization
  2. Referral
    - a. Partnership, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the Partnership website (see VI.C.8.c. below for details). If a placement within the Member's service area is not available, the Member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from Partnership is required for referral to outpatient substance use services. (Please note, in Partnership's Wellness & Recovery benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MCUP3144 Residential Substance Use Disorder Treatment Authorization for further information.)
  3. Coordination of Care
    - a. Partnership will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the

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Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of Members entering treatment for Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the Member's Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient's consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.

- b. Wherever possible, Partnership will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.
- C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
  1. Overview.
    - a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act's requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen Members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
    - b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.
    - c. Unhealthy Drug Use: Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as cocaine and heroin. However, studies have demonstrated significantly positive benefits from various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

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2. Non-Covered Services
  - a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is “Have you consumed **any** beer, wine or other alcoholic beverage in the past year.”
3. Covered Services
  - a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to Partnership Members via the evidence of coverage and via Partnership’s external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
    - 1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the Member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
    - 2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
    - 3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
  - b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant Members, primary care includes clinicians caring for the pregnant Member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
  - c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the Member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, Partnership contracted medical specialists and credentialed SUD counselors. PCPs may also utilize Partnership’s delegated managed behavioral health organization using the referral forms and process described in Partnership policy MPCP2017 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting.
4. Training and Proficiency - Primary Care Providers
 

Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:

  - a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
    - 1) Licensed Physician
    - 2) Physician Assistant

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- 3) Nurse Practitioner
- 4) Psychologist
- b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
  - 1) Licensed Marriage and Family Therapist
  - 2) Registered Nurse
  - 3) Certified Nurse Midwife
  - 4) Licensed Midwife
  - 5) Licensed Clinical Social Worker
  - 6) Licensed Professional Clinical Counselor
- c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.
- d. Other Members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
  - 1) They have at least 100 hours of clinical experience in their current role.
  - 2) They are trained to provide the services they are providing
  - 3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
- e. Providers must develop policies and procedures for SABIRT services. These should include:
  - 1) The PCP site will maintain a list of licensed and registered professionals and non-licensed Members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
  - 2) A quality assurance process for SABIRT services
  - 3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
- f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health Services at Partnership.
5. Training and Proficiency – Brief Behavioral Counseling Intervention/Referral to Treatment Providers
  - a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
    - 1) Licensed Physician
    - 2) Physician Assistant
    - 3) Nurse Practitioner
    - 4) Psychologist
  - b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
    - 1) Licensed Marriage and Family Therapist
    - 2) Registered Nurse
    - 3) Certified Nurse Midwife

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- 4) Licensed Midwife
- 5) Licensed Clinical Social Worker
- 6) Licensed Professional Clinical Counselor
- c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.
- d. Other Members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
  - 1) They have at least 100 hours of clinical experience in their current role.
  - 2) They are trained to provide the services they are providing
  - 3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
- e. Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services. These should include:
  - 1) The Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
  - 2) A quality assurance process for SABIRT services
  - 3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
6. Screening and Brief Assessment
  - a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
  - b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
  - c. The screening and brief assessment process does not diagnose a disorder, but it does determine whether a problem exists. Providers should consider risks and benefits of administration of screening and assessment tools, including discussion of these as part of informed consent, as well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.
  - d. Screening and Brief Assessment Tools
    - 1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.
    - 2) Note that a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:
      - a) AUDIT (10 question screening and assessment)
      - b) AUDIT-C (3 question screening also validated in pregnant individuals)
      - c) NIAAA Single Alcohol Screening Question (SASQ)

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7. Brief Intervention:
- i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to Members who are identified as having risky or hazardous alcohol use.
  - b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the Member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
    - 1) Personalized feedback
    - 2) Education and resources
    - 3) Negotiated action plans
    - 4) Drinking use diaries, and
    - 5) Stress management.
  - c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team Member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
    - 1) Feedback to the patient regarding screening and assessment results
    - 2) Discussion of negative consequences that have occurred and the overall severity of the problem
    - 3) Supporting the patient in making behavior changes
    - 4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
      - a) Providers must make good faith efforts to confirm whether Members receive referred treatments and document when, where, and any next steps following treatment.
8. SABIRT Referral to Treatment
- a. No prior authorization is required for SABIRT services or for referral to services related to substance use or abuse.
  - b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5; or those whose diagnoses are uncertain, should be referred for further evaluation and treatment.
  - c. PCPs in counties without Partnership Wellness and Recovery coverage should refer Members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California County contacts for local substance use disorder treatment information and referrals can be found on the Partnership website: <http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx> under the heading "Alcohol and Drug Treatment." In Partnership Wellness and Recovery counties, the referral process is outlined on the Partnership website at this page: <https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx>. Referrals to treatment must be documented in the medical record.
9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the Member and the time spent with the Member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
- a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
  - b. Documentation should also include:
    - 1) The service provided (e.g., screen and brief intervention)

<b>Policy/Procedure Number: MCUP3101</b>		<b>Lead Department: Health Services</b>
<b>Policy/Procedure Title: Screening and Treatment for Substance Use Disorders</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>
<b>Original Date: 03/21/2012</b>	<b>Next Review Date: N/A01/08/2026</b> <b>Last Review Date: 01/08/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

- 2) The name of the screening instrument and the score on the electronic health record
  - 3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
  - 4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
- a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
    - 1) Review Member's response to an age-appropriate, validated alcohol or drug use screening question
    - 2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
    - 3) Conduct Brief Behavioral Counseling Intervention sessions
    - 4) Refer Members with potential unhealthy alcohol or drug use and/or SUD for treatment
  - b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
  - c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
- a. The following billing codes should be used for billing SABIRT services to patients with:
    - 1) Medi-Cal and no other primary insurance coverage (such as Medicare):
      - a) Annual alcohol misuse screening: G0442
      - b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)
      - c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050
    - 2) Medicare/Medi-Cal Members should have SABIRT billed through Medicare, using approved Medicare codes

## VII. REFERENCES:

- A. For clinician support: NIAAA's Clinician Guide "Helping Patients Who Drink Too Much" provides two methods for screening: a "single question" to use during a clinical interview and a written self-report instrument (AUDIT). <http://www.niaaa.nih.gov/guide>
- B. The **AUDIT** and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions <https://www.samhsa.gov/national-coe-integrated-health-solutions>
- C. Quick reference guide for screening for drug use in general medical settings: [screening\\_qr.pdf \(nih.gov\)](#)
- D. NIDA Quick Screen and NIDA Modified ASSIST: <https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf>
- E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings: <https://www.who.int/publications/i/item/978924159938-2>
- F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: <https://www.drugabuse.gov/taps/#/>
- G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. [Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification.](#) J Addict Med. 2011 Sep;5(3):221-6.
- H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization <https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a>
- I. Information on the Medicare SBIRT benefit and requirements: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt\\_factsheet\\_icn904084.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf)

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<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

- J. Substance Abuse and Mental Health Services Administration (SAMHSA) website: <https://www.samhsa.gov/disorders/substance-use>
- K. Operational Instructional Letter (OIL) 398-13
- L. DHCS: All Plan Letter [\(APL\) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment.](#) (10/11/2021)
- M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services [Drug Medi-Cal Organized Delivery System \(DMC-ODS\)](#) webpage
- N. DHCS [APL 23-029](#) Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/2023)
  1. [Specialty Mental Health Services Memorandum of Understanding Template](#)
  2. [Substance Use Disorder Treatment Services Memorandum of Understanding Template](#)
- O. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (<https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening>)
- P. Title 42 Code of Federal Regulations (CFR) Section [438.210](#) (a)(4), Part 2, § [2.11](#) and § [2.14](#)
- Q. Title 22 California Code of Regulations (CCR) Sections [51303](#) and [51340.1](#)
- R. InterQual® Behavioral Health Criteria

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:** Chief Medical Officer

**X. REVISION DATES:** 03/21/12; 02/19/14; 06/18/14; 06/17/15; 04/20/16; 03/15/17; 08/16/17; \*02/14/18; 08/08/18; 11/14/18; 11/13/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 06/14/23; 06/12/24; 01/08/25; [ARCHIVED 11/12/2025](#)

\*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:** 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.

<b>Policy/Procedure Number: MCUP3101</b>		<b>Lead Department: Health Services</b>
<b>Policy/Procedure Title:</b> Screening and Treatment for Substance Use Disorders		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>
<b>Original Date:</b> 03/21/2012	<b>Next Review Date:</b> N/A01/08/2026 <b>Last Review Date:</b> 01/08/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

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

ARCHIVED 11/12/2025 - Refer to MPBP8007

## Partnership HealthPlan of California

### Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Name of Tool	Validated Tool Type		Agencies Recommending Agencies	Populations			Substances Types		
	Screening Tools	Brief Assessment Tools		Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
<b>AUDIT</b> NIDA - The Alcohol Use Disorders Identification Test (10 questions) <i>*Meets HEDIS measure for IHA</i>	X	X	NIDA DHCS NCQA				X		
<b>AUDIT-C</b> NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) <i>*Meets HEDIS measure for IHA</i>	X		NIDA NIAAA USPSTF DHCS	X			X		
<b>SASQ</b> NIAAA Single Alcohol Screening Question <i>*Meets HEDIS measure for IHA</i>	X		NIAAA USPSTF	X			X		
<b>TAPS-1</b> Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
<b>TAPS-2</b> Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
<b>NIDA Quick Screen</b> (4 questions) <i>(Recommended by DHCS, ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)</i>	X		NIDA DHCS USPSTF ACOG	X			X	X	X
<b>NIDA-Modified ASSIST</b> NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions)		X	NIDA DHCS USPSTF				X	X	X

## Partnership HealthPlan of California

### Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Name of Tool	Validated Tool Type		Agencies Recommending Agencies	Populations			Substances Types		
	Screening Tools	Brief Assessment Tools		Appropriate for Pregnancy	Appropriate for Adolescents	Appropriate for Geriatric	Alcohol	Drugs	Tobacco
<i>(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)</i>									
<b><u>DAST-10</u></b> Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
<b><u>DAST-20</u></b> Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
<b><u>4P's</u></b> Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
<b><u>4 P's Plus</u></b> <i>(Plus includes additional questions about depression and domestic violence)</i>		X	ACOG	X			X	X	X
<b><u>CRAFFT</u></b> Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X <i>(Appropriate for non-pregnant adolescents)</i>		X	X	
<b><u>MAST-G</u></b> Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
<b><u>PRO (Prenatal Risk Overview)</u></b> <i>(Recommended by USPSTF but official website is no longer available)</i>			USPSTF	X			X	X	X

\*As per VI.C.6.d.2) of policy MCUP3101, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

**Partnership HealthPlan of California**  
Recommended Tools and Training Resources for  
**Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment**  
(SABIRT)

<b>Acronyms, Agencies and Resources (Tools and Trainings):</b>		
<b>Acronym</b>	<b>Agency</b>	<b>Resources and Website Information</b>
<b>ACOG</b>	The American College of Obstetricians and Gynecologists	<p>Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications  <a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications</a></p> <p>Opioid Use and Opioid Use Disorder in Pregnancy  <a href="https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy">https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy</a></p>
<b>NCQA/HEDIS</b>	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	<p>Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans  <a href="https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf">https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf</a></p>
<b>NIAAA</b>	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH))	<p>NIAAA Evidence-Based Products for Health Professionals and Community Leaders:  <a href="https://www.niaaa.nih.gov/health-professionals-communities">https://www.niaaa.nih.gov/health-professionals-communities</a></p> <ul style="list-style-type: none"> <li>• Underage and College Drinking Research</li> <li>• Treatment Navigator tool</li> <li>• Surveillance Reports and Epidemiologic Resources</li> <li>• Additional Reports and Resources</li> </ul>
<b>NIDA</b>	National Institute on Drug Abuse	<p>Screening and Assessment Tools:  <a href="https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools">https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools</a></p>
<b>SBIRT Training</b> 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	<p>SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2)  <a href="https://sbirt.clinicalencounters.com/activity/sbirt-core/">https://sbirt.clinicalencounters.com/activity/sbirt-core/</a></p> <ul style="list-style-type: none"> <li>• Four hour training: \$49 per individual; group rates are available</li> </ul>

**Partnership HealthPlan of California**  
 Recommended Tools and Training Resources for  
**Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)**

<b>Acronyms, Agencies and Resources (Tools and Trainings):</b>		
<b>Acronym</b>	<b>Agency</b>	<b>Resources and Website Information</b>
		<ul style="list-style-type: none"> <li>• CME/CE NYS OASAS Credit approved</li> </ul>
<b>SAMHSA</b>	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings <a href="https://www.samhsa.gov/brss-tacs/video-trainings">https://www.samhsa.gov/brss-tacs/video-trainings</a> <ul style="list-style-type: none"> <li>• Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:</li> </ul>
<b>USPSTF</b>	United States Preventive Services Task Force	<ul style="list-style-type: none"> <li>• Alcohol screening and intervention tools: <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions</a></li> <li>• Unhealthy Drug Use Screening Tools: <a href="https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening">https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening</a></li> <li>• USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation <a href="https://edhub.ama-assn.org/jn-learning/audio-player/18514824">https://edhub.ama-assn.org/jn-learning/audio-player/18514824</a></li> </ul>

ARCHIVED 11/12/2025 - NEW MPBP

Updated

# A POCKET GUIDE FOR Alcohol Screening and Brief Intervention

Updated 2005 Edition

This pocket guide is condensed from the 34-page NIAAA guide, *Helping Patients Who Drink Too Much: A Clinician's Guide*.

Visit [www.niaaa.nih.gov/guide](http://www.niaaa.nih.gov/guide) for related

professional support resources, including:

- patient education handouts
- preformatted progress notes
- animated slide show for training
- materials in Spanish

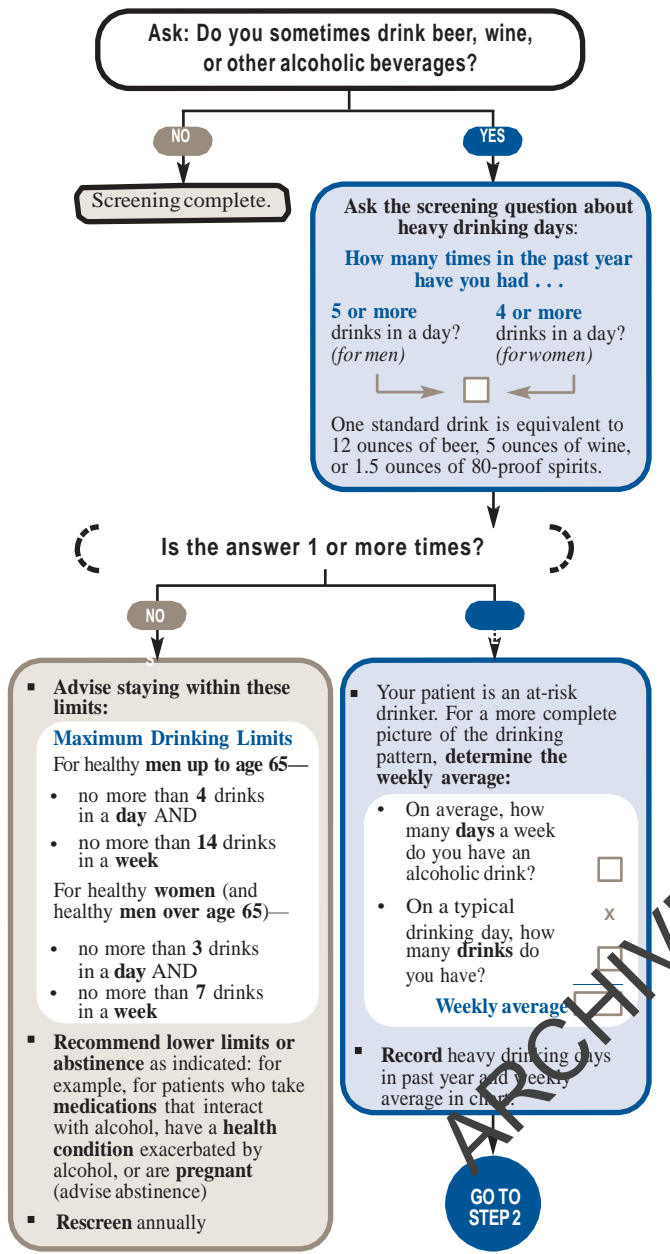
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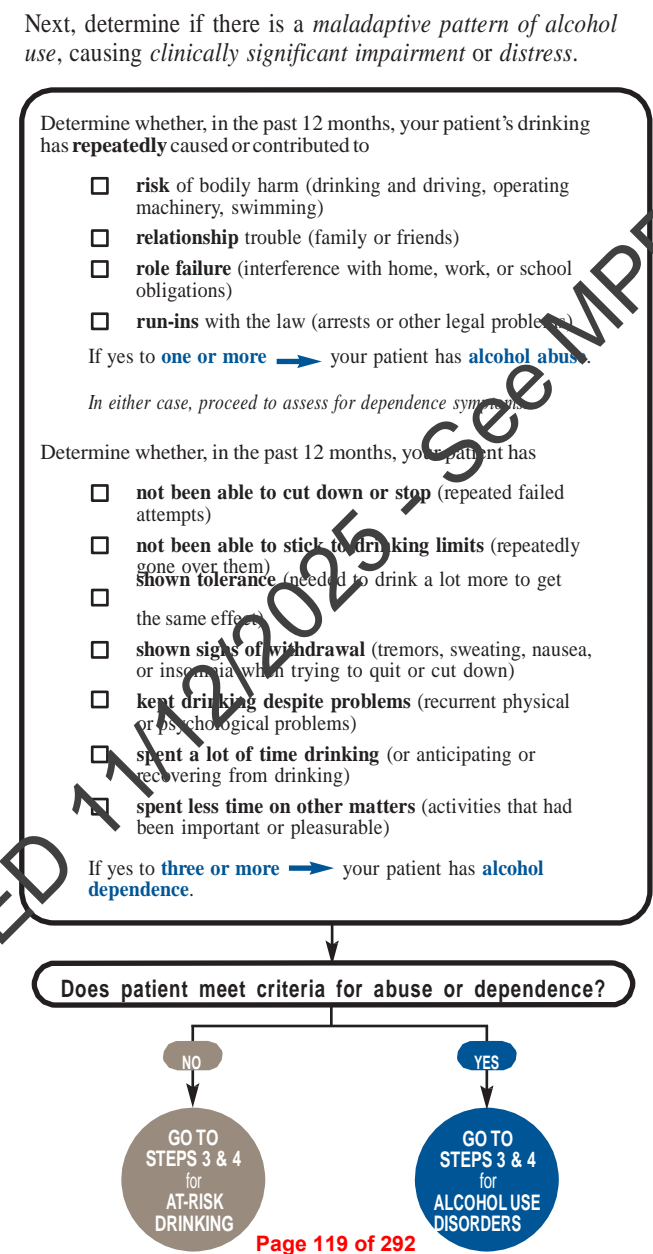
## HOW TO SCREEN FOR HEAVY DRINKING

### STEP 1 Ask About Alcohol Use



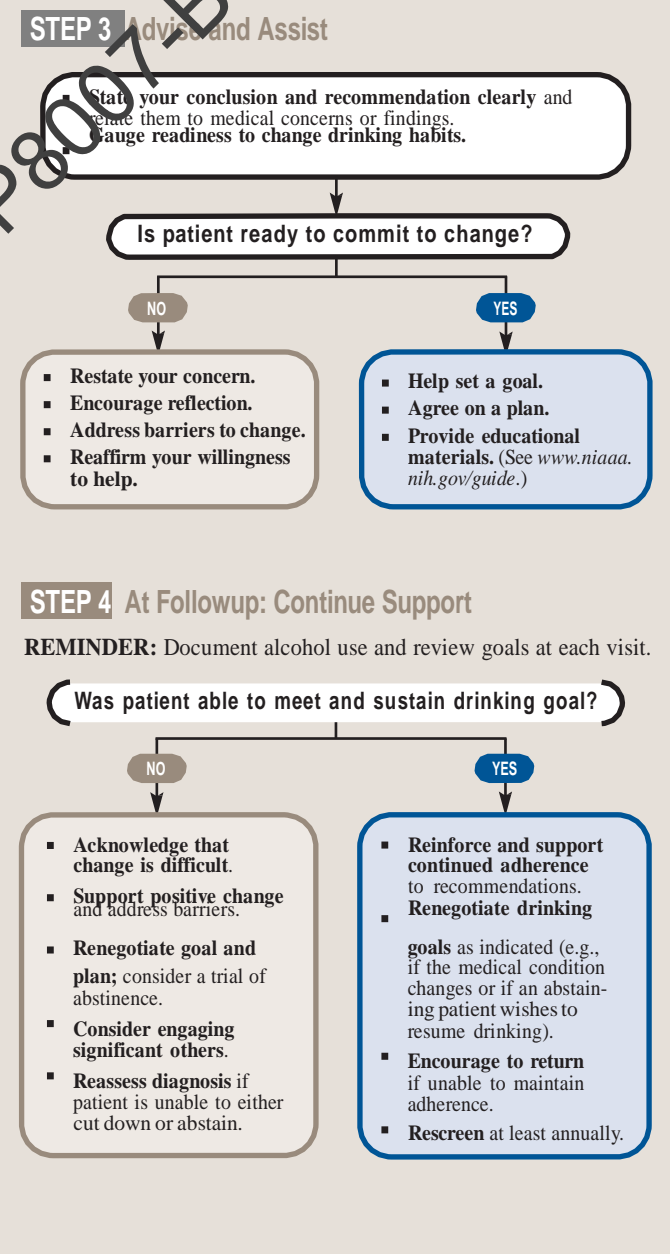
## HOW TO ASSESS FOR ALCOHOL USE DISORDERS

### STEP 2 Assess For Alcohol Use Disorders

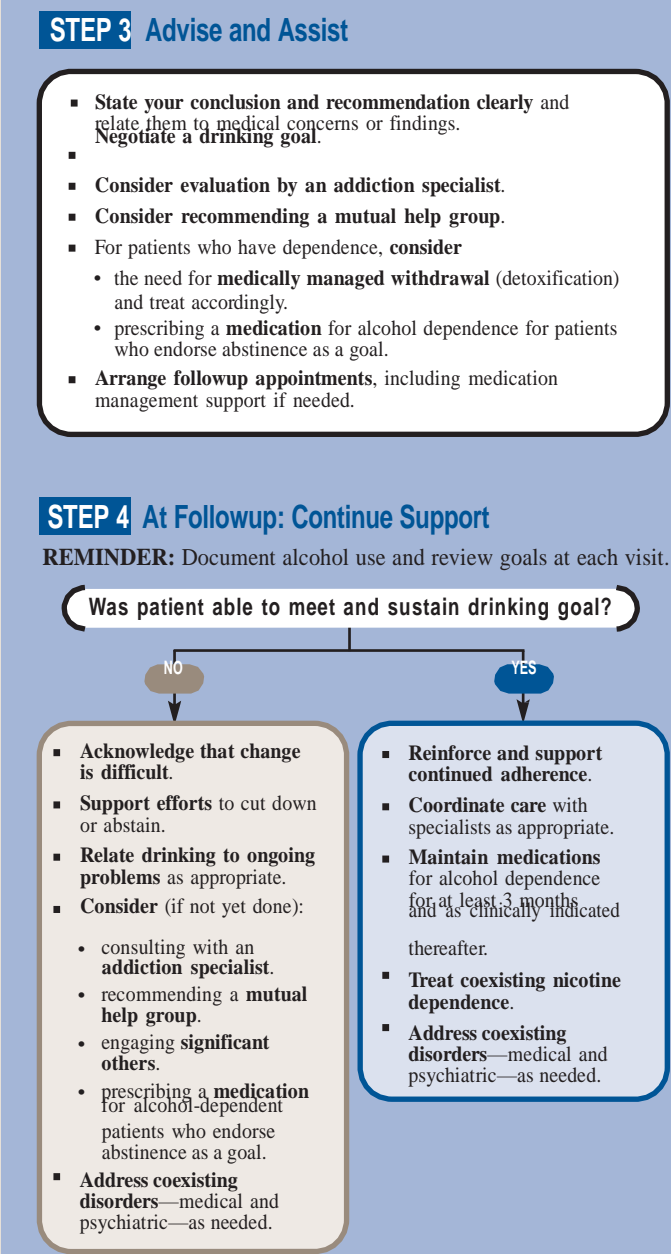


## HOW TO CONDUCT A BRIEF INTERVENTION

### FOR AT-RISK DRINKING (no abuse or dependence)







### FOR ALCOHOL USE DISORDERS (abuse or dependence)



# WHAT'S A STANDARD DRINK?

A standard drink in the United States is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons). Below are U.S. standard drink equivalents as well as the number of standard drinks in different container sizes for each beverage. These are approximate, since different brands and types of beverages vary in their actual alcohol content.

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
<b>BEER or COOLER</b>	
 <p>12 oz. 5% alcohol</p>	<ul style="list-style-type: none"> <li>• 12 oz. = 1</li> <li>• 16 oz. = 1.3</li> <li>• 22 oz. = 2</li> <li>• 40 oz. = 3.3</li> </ul>
<b>MALT LIQUOR</b>	
 <p>8–9 oz. 7% alcohol</p>	<ul style="list-style-type: none"> <li>• 12 oz. = 1.5</li> <li>• 16 oz. = 2</li> <li>• 22 oz. = 2.5</li> <li>• 40 oz. = 4.5</li> </ul>
<b>TABLE WINE</b>	
 <p>5 oz. 12% alcohol</p>	<ul style="list-style-type: none"> <li>• a 750-mL (25-oz.) bottle = 5</li> </ul>
<b>80-proof SPIRITS (hard liquor)</b>	
 <p>1.5 oz. 40% alcohol</p>	<ul style="list-style-type: none"> <li>• a mixed drink = 1 or more*</li> <li>• a pint (16 oz.) = 11</li> <li>• a fifth (25 oz.) = 17</li> <li>• 1.75 L (59 oz.) = 39</li> </ul>

\*Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

# DRINKING PATTERNS

WHAT'S YOUR DRINKING PATTERN?	HOW COMMON IS THIS PATTERN?	HOW COMMON ARE ALCOHOL DISORDERS IN DRINKERS WITH THIS PATTERN?
<p><b>Based on the following limits—number of drinks:</b></p> <p>On any <b>DAY</b>—Never more than <b>4</b> (men) or <b>3</b> (women)</p> <p>– and –</p> <p>In a typical <b>WEEK</b>—No more than <b>14</b> (men) or <b>7</b> (women)</p>	<p>Percentage of U.S. adults aged 18 or older*</p>	<p>Combined prevalence of alcohol abuse and dependence</p>
<p><b>Never exceed the daily or weekly limits</b></p> <p>(2 out of 3 people in this group abstain or drink fewer than 12 drinks a year)</p>	<p>72%</p>	<p>fewer than <b>1 in 100</b></p>
<p><b>Exceed only the daily limit</b></p> <p>(More than 8 out of 10 in this group exceed the daily limit <i>less than once a week</i>)</p>	<p>16%</p>	<p><b>1 in 5</b></p>
<p><b>Exceed both daily and weekly limits</b></p> <p>(8 out of 10 in this group exceed the daily limit <i>once a week or more</i>)</p>	<p>10%</p>	<p>almost <b>1 in 2</b></p>

\*Not included in the chart, for simplicity, are the 2 percent of U.S. adults who exceed *only* the weekly limits. The combined prevalence of alcohol use disorders in this group is 8 percent.

Source: 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a nationwide NIAAA survey of 43,093 U.S. adults aged 18 or older.

# PRESCRIBING MEDICATIONS

The chart below contains excerpts from page 16 of NIAAA's *Helping Patients Who Drink Too Much: A Clinician's Guide*. It does *not* provide complete information and is not meant to be a substitute for the patient package inserts or other drug references used by clinicians. For patient information, visit <http://medlineplus.gov>.

	Naltrexone (Depade <sup>®</sup> , ReVia <sup>®</sup> )	Extended-Release Injectable Naltrexone (Vivitrol <sup>®</sup> )	Acamprosate (Campral <sup>®</sup> )	Disulfiram (Antabuse <sup>®</sup> )
<b>Action</b>	Blocks opioid receptors, resulting in reduced craving and reduced reward in response to drinking.	Same as oral naltrexone; 30-day duration.	Affects glutamate and GABA neurotransmitter systems, but its alcohol-related action is unclear.	Inhibits intermediate metabolism of alcohol, causing a buildup of acetaldehyde and a reaction of flushing, sweating, nausea, and tachycardia if a patient drinks alcohol.
<b>Contraindications</b>	Currently using opioids or in acute opioid withdrawal; anticipated need for opioid analgesics; acute hepatitis or liver failure.	Same as oral naltrexone, plus inadequate muscle mass for deep intramuscular injection; rash or infection at the injection site.	Severe renal impairment (CrCl ≤ 30 mL/min).	Concomitant use of alcohol or alcohol-containing preparations or metronidazole; coronary artery disease; severe myocardial disease; hypersensitivity to rubber (thiuram) derivatives.
<b>Precautions</b>	Other hepatic disease; renal impairment; history of suicide attempts or depression. If opioid analgesia is needed, larger doses may be required, and respiratory depression may be deeper and more prolonged. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see <a href="http://www.niaaa.nih.gov/guide">www.niaaa.nih.gov/guide</a> .	Same as oral naltrexone, plus hemophilia or other bleeding problems.	Moderate renal impairment (dose adjustment for CrCl between 30 and 50 mL/min); depression or suicidal ideation and behavior. Pregnancy Category C.	Hepatic cirrhosis or insufficiency; cerebrovascular disease or cerebral damage; psychoses (current or history); diabetes mellitus; epilepsy; hypothyroidism; renal impairment. Pregnancy Category C. Advise patients to carry a wallet card to alert medical personnel in the event of an emergency. For wallet card information, see <a href="http://www.niaaa.nih.gov/guide">www.niaaa.nih.gov/guide</a> .
<b>Serious adverse reactions</b>	Will precipitate severe withdrawal if the patient is dependent on opioids; hepatotoxicity (although does not appear to be a hepatotoxin at the recommended doses).	Same as oral naltrexone, plus infection at the injection site; depression; and rare events including allergic pneumonia and suicidal ideation and behavior.	Rare events include suicidal ideation and behavior.	Disulfiram-alcohol reaction, hepatotoxicity, optic neuritis, peripheral neuropathy, psychotic reactions.
<b>Common side effects</b>	Nausea; vomiting; decreased appetite; headache; dizziness; fatigue; somnolence; anxiety.	Same as oral naltrexone, plus a reaction at the injection site; joint pain; muscle aches or cramps.	Diarrhea; somnolence.	Metallic after-taste; dermatitis; transient mild drowsiness.
<b>Examples of drug interactions</b>	Opioid medications (blocks action).	Same as oral naltrexone.	No clinically relevant interactions known.	Anticoagulants such as warfarin; isoniazid; metronidazole; phenytoin; any nonprescription drug containing alcohol.
<b>Usual adult dosage</b>	<p>Oral dose: 50 mg daily.</p> <p><i>Before prescribing:</i> Patients must be opioid-free for a minimum of 7 to 10 days before starting. If you feel that there's a risk of precipitating an opioid withdrawal reaction, a naloxone challenge test should be employed. Evaluate liver function.</p> <p><i>Laboratory followup:</i> Monitor liver function.</p>	<p><i>IM dose:</i> 380 mg given as a deep intramuscular gluteal injection, once monthly.</p> <p><i>Before prescribing:</i> Same as oral naltrexone, plus examine the injection site for adequate muscle mass and skin condition.</p> <p><i>Laboratory followup:</i> Monitor liver function.</p>	<p>Oral dose: 666 mg (two 333-mg tablets) three times daily; or for patients with moderate renal impairment (CrCl 30 to 50 mL/min), reduce to 333 mg (one tablet) three times daily.</p> <p><i>Before prescribing:</i> Evaluate renal function. Establish abstinence.</p>	<p>Oral dose: 250 mg daily (range 125 mg to 500 mg).</p> <p><i>Before prescribing:</i> Evaluate liver function. Warn the patient (1) not to take disulfiram for at least 12 hours after drinking and that a disulfiram-alcohol reaction can occur up to 2 weeks after the last dose and (2) to avoid alcohol in the diet (e.g., sauces and vinegars), over-the-counter medications (e.g., cough syrups), and toiletries (e.g., cologne, mouthwash).</p> <p><i>Laboratory followup:</i> Monitor liver function.</p>

Note: Whether or not a medication should be prescribed and in what amount is a matter between individuals and their health care providers. The prescribing information provided here is not a substitute for a provider's judgment in an individual circumstance and the NIH accepts no liability or responsibility for use of the information with regard to particular patients.

## Opportunities & Indications for Screening Youth for Alcohol Use

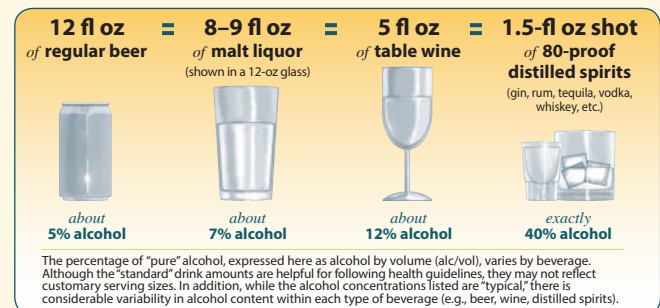
- As part of an **annual examination**
- As part of an **acute care visit**
- In the **emergency department** or urgent care center
- **When seeing patients who:**
  - you **have not seen in a while**
  - are likely to drink, such as youth who **smoke cigarettes**
  - have **conditions associated with increased risk** for substance abuse, such as:
    - depression
    - anxiety
    - ADD/ADHD
    - conduct problems
  - have **health problems that might be alcohol related**, such as:
    - accidents or injury
    - sexually transmitted infections or unintended pregnancy
    - changes in eating or sleeping patterns
    - gastrointestinal disturbances
    - chronic pain
  - show **substantial behavioral changes**, such as:
    - increased oppositional behavior
    - significant mood changes
    - loss of interest in activities
    - change of friends
    - a drop in grade point average
    - large number of unexcused absences in school

**1 in 3 children start drinking by the end of 8th grade. Of them, half report having been drunk.**

**You are in a prime position to help your patients avoid alcohol related harm.**

## What Counts as a Drink? A Binge?

The drinks shown below are different sizes, but each one has about the same amount of pure alcohol (14 grams or 0.6 fluid ounce) and counts as a single “standard” drink. These serve as examples; alcohol content can vary greatly across different types of beer, malt liquor, and wine.



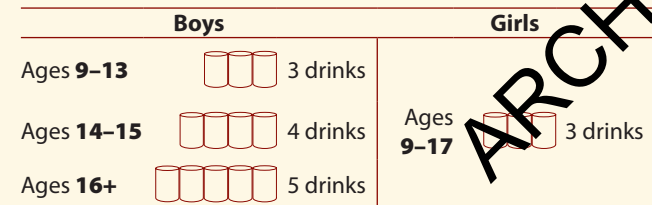
Below is the approximate number of standard drinks in different-sized containers of:

regular beer	malt liquor	table wine	80-proof distilled spirits
12 fl oz = <b>1</b>	12 fl oz = <b>1.5</b>	5-fl oz glass = <b>1</b>	a shot (1.5 oz) = <b>1</b>
16 fl oz = <b>1.3</b>	16 fl oz = <b>2</b>	25 fl oz = <b>5</b>	750 ml (a “fifth”) = <b>17</b>
40 fl oz = <b>3.3</b>	40 fl oz = <b>4.5</b>	(a regular 750-ml bottle)	1.75 L (a “handle”) = <b>39</b>

### What kinds of alcohol are kids drinking these days?

All kinds, with variations by region and fad. In many areas, distilled spirits appear to be gaining on or overtaking beer and “flavored alcohol beverages” in popularity among youth, whereas wine appears less preferred. Young people are also mixing alcohol with caffeine, either in premixed drinks or by adding liquor to energy drinks. With this dangerous combination, drinkers may feel somewhat less drunk than if they’d had alcohol alone, but they are just as impaired and more likely to take risks.

### What’s a “child-sized” or “teen-sized” binge?



See the full Guide, page 15, for details about these estimates.

## Brief Intervention & Referral Resources

### Four Basic Principles of Motivational Interviewing:

- **Express Empathy** with a warm, nonjudgmental stance, active listening, and reflecting back what is said.
- **Develop Discrepancy** between the patient’s choice to drink and his or her goals, values, or beliefs.
- **Roll with Resistance** by acknowledging the patient’s viewpoint, avoiding a debate, and affirming autonomy.
- **Support Self-efficacy** by expressing confidence and pointing to strengths and past successes.

For more information, see the full Guide, page 29, or visit:

- [www.motivationalinterview.org](http://www.motivationalinterview.org)
- [www.motivationalinterview.net](http://www.motivationalinterview.net)

### To Find Local Specialty Treatment Options:

- Ask behavioral health practitioners affiliated with your practice for recommendations.
- Seek local directories of behavioral health services.
- Contact local hospital and mental health service organizations.
- Contact the Substance Abuse Facility Treatment Locator (seek centers specializing in adolescents) at 1–800–662–HELP or visit [www.findtreatment.samhsa.gov](http://www.findtreatment.samhsa.gov).

• For more suggestions, see the full Guide, p. 34.

List your local resources below.

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## Questions About Providing Confidential Health Care to Youth?

All of the major medical organizations and numerous current laws support the ability of clinicians to provide confidential health care, within established guidelines, for adolescents who use alcohol. See the full Guide, page 25, for more information.

For details specific to your specialty and State:

See confidentiality policy statements from professional organization(s):

- American Academy of Pediatrics
- American Academy of Family Physicians
- Society for Adolescent Health and Medicine
- American Medical Association
- Contact your State medical society for information on your State’s laws.
- Visit the Center for Adolescent Health and the Law for monographs on minor consent laws professional association policies: [www.cahl.org](http://www.cahl.org).

This Pocket Guide was produced by the National Institute on Alcohol Abuse and Alcoholism in collaboration with the American Academy of Pediatrics.



Order copies of this Pocket Guide, along with the full 40-page Guide, from [www.niaaa.nih.gov/YouthGuide](http://www.niaaa.nih.gov/YouthGuide) or call 1-888-MY-NIAAA (888-696-4222)

# A POCKET GUIDE FOR ALCOHOL SCREENING AND BRIEF INTERVENTION FOR YOUTH



2011 Edition

This pocket guide is condensed from the NIAAA Guide, *Alcohol Screening and Brief Intervention for Youth: A Practitioner’s Guide*. It was produced in collaboration with the American Academy of Pediatrics.

To order more copies of this Pocket Guide, or sets with the full 40-page Guide and the Pocket Guide, and for related professional support resources, visit [www.niaaa.nih.gov/YouthGuide](http://www.niaaa.nih.gov/YouthGuide) or contact the NIAAA Publications Distribution Center P.O. Box 10686, Rockville, MD 20849-0686 301–443–3860



**STEP 1: Ask the Two Screening Questions**

For elementary and middle school patients, start with the friends' question. Choose the questions that align with the patient's school level, as opposed to age, for patients ages 11 or 14. Exclude alcohol use for religious purposes.

**Elementary School (ages 9–11)**

**Friends: Any drinking?**  
“Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?”  
**ANY drinking by friends heightens concern.**

**Patient: Any drinking?**  
“How about you—have you **ever** had more than a few sips of any drink containing alcohol?”  
**ANY drinking: Highest Risk**

**Middle School (ages 11–14)**

**Friends: Any drinking?**  
“Do you have any friends who drank beer, wine, or any drink containing alcohol in the **past year**?”  
**ANY drinking by friends heightens concern.**

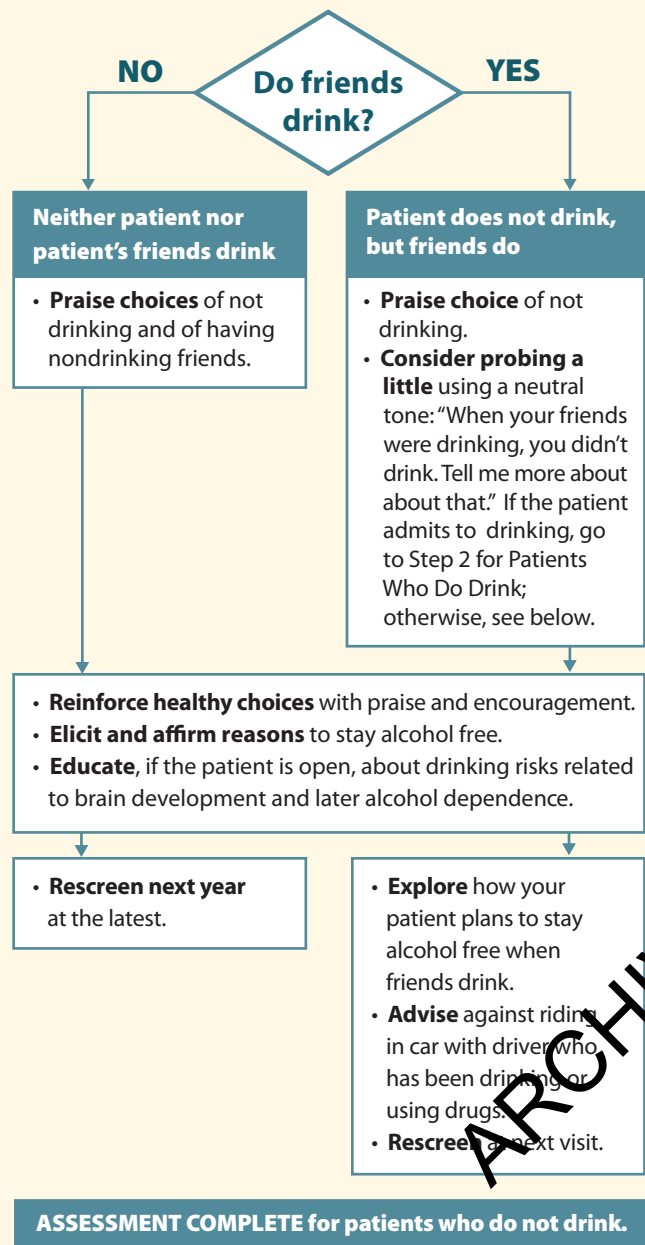
**Patient: How many days?**  
“How about you—in the **past year, on how many days** have you had more than a few sips of any drink containing alcohol?”  
**ANY drinking: Moderate or Highest Risk (depending on age and frequency)**

**High School (ages 14–18)**

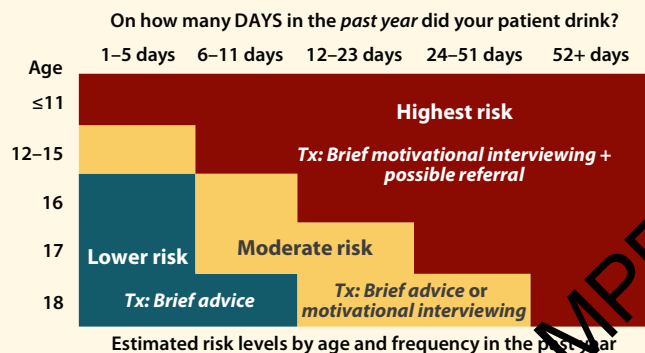
**Patient: How many days?**  
“In the **past year, on how many days** have you had more than a few sips of beer, wine, or any drink containing alcohol?”  
**Lower, Moderate, or Highest Risk (depending on age and frequency)**

**Friends: How much?**  
“If your friends drink, **how many drinks** do they usually drink on an occasion?”  
**Binge drinking by friends heightens concern.**  
(See “What Counts as a Drink? A Binge?” on reverse)

**STEP 2: Guide Patient**



**STEP 2: Assess Risk**



**Factor in friends:**

- **For elementary and middle school students:** Having friends who drink heightens concern.
- **For high school students:** Having friends who binge drink heightens concern. Recent research estimates that binge drinking levels for youth start at 2 to 5 drinks, depending on age and gender (see “What Counts as a Drink? A Binge?” on reverse).

**Include what you already know** about the patient's physical and psychosocial development in your risk evaluation, along with other relevant factors such as the level of family support, drinking and smoking habits of parents and siblings, school functioning, or trouble with authority figures.

**For moderate and highest risk patients:**

- **Ask about the drinking pattern:** “How much do you usually have? What's the most you've had at any one time?” If patient reports bingeing, ask: “How often do you drink that much?”
- **Ask about problems experienced or risks taken:** Examples include getting lower grades or missing classes; drinking and driving or riding in a car driven by someone who has been drinking; having unplanned, unsafe sex; getting into fights; getting injured; having memory blackouts; and passing out.
- **Ask whether the patient has used anything else to get high in the past year,** and consider using other formal tools to help gauge risk.

**STEP 3: Advise and Assist**

**Lower Risk:**

- Provide **brief advice** to stop drinking.
- **Notice the good:** Reinforce strengths and healthy decisions.
- **Explore and troubleshoot** influence of friends who drink.

**Moderate Risk:**

- **Does patient have alcohol-related problems?**
  - If **no**, provide beefed-up brief advice.
  - If **yes**, conduct brief motivational interviewing.
- **Ask if parents know** (see Highest Risk, below, for suggestions).
- **Arrange for followup**, ideally within a month.

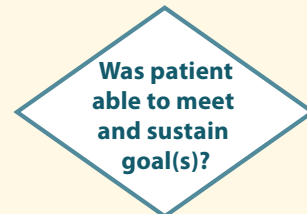
**Highest Risk:**

- **Conduct brief motivational interviewing.**
- **Ask if parents know ...**
  - If **no**, consider breaking confidentiality to engage parent.
  - If **yes**, ask patient permission to speak with parent.
- **Consider referral** for further evaluation or treatment.
- **If you observe signs of acute danger** (e.g., drinking and driving, binge drinking, or using alcohol with other drugs) **take immediate steps to ensure safety.**
- **Arrange for followup** within a month.

**FOR ALL PATIENTS WHO DRINK**

- **Collaborate on a personal goal and action plan** for your patient. Refer to page 31 in the full Guide for sample abstinence, cutting back, and contingency plans. For some patients, the goal will be accepting a referral to specialized treatment.
- **Advise your patient not to drink and drive or ride in a car with an impaired driver.**
- **Plan a full psychosocial interview** for the next visit if needed.

**STEP 4: At Followup, Continue Support**



Patients may not return for an alcohol-specific followup, but they may do so for other reasons. In either case, **ask about alcohol use and any associated problems.** Review the patient's goal(s) and assess whether he or she was able to meet and sustain them.

**No, patient was not able to meet/sustain goal(s):**

- **Reassess** the risk level (see Step 2 for drinkers).
- **Acknowledge** that change is difficult, that it's normal not to be successful on the first try, and that reaching a goal is a learning process.
- **Notice the good by:**
  - **praising** honesty and efforts.
  - **reinforcing** strengths.
  - **supporting** any positive change.
- **Relate drinking to associated consequences or problems** to enhance motivation.
- **Identify and address challenges and opportunities** in reaching the goal.
- If the following measures are not already under way, **consider:**
  - **engaging** parents.
  - **referring** for further evaluation.
- **Reinforce** the importance of the goal(s) and plan and **renegotiate** specific steps, as needed.
- **Conduct, complete, or update** the comprehensive psychosocial interview.

**Yes, patient was able to meet/sustain goal(s):**

- **Reinforce and support** continued adherence to recommendations.
- **Notice the good:** Praise progress and reinforce strengths and healthy decisions.
- **Elicit future goals** to build on prior ones.
- **Conduct, complete, or update** the comprehensive psychosocial interview.
- **Rescreen** at least annually.

ARCHIVED 11/12/2025 See MPBP8007-C

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>Policy/Procedure Number: MCUP3103</b>		<b>Lead Department: Health Services</b> Business Unit: Behavioral Health	
<b>Policy/Procedure Title:</b> Coordination of Care for Child Welfare-Involved Members		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> <del>03/12/2026</del> N/A <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALING</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval-Archive Date:</b> 03/12/2025 11/12/2025	

**I. RELATED POLICIES:**

- A. MCUP3039 - Direct Members
- B. MCCP2024 - Whole Child Model for California Children’s Services (CCS)
- C. MCAP7003 - CalAIM Community Supports (CS)
- D. MCCP2032 - CalAIM Enhanced Care Management (ECM)
- E. MPQD1001- Quality and Performance Improvement Program Description

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. Assembly Bill 2083: (Chapter 815, Statutes of 2018) System of Care for Children and Youth Memorandum of Understanding (MOU). This assembly bill requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Entities must develop a coordinated, timely, and trauma-informed system-of-care approach, implementing related MOUs on the county level and establishing a joint interagency resolution team on the state level to assist counties in serving those children and youth.
- B. California Children’s Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
- C. Child Welfare-Involved Youth: Children and youth who meet one or more of the following conditions:
  - 1. Are under age 21 and are currently receiving foster care in California
  - 2. Are under age 21 and previously received foster care in California or another state within the last 12 months
  - 3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
  - 4. Are under age 18 and are eligible for and/or in California’s Adoption Assistance Program;
  - 5. Are under age 18 and are currently receiving or have received services from California’s Family Maintenance program within the last 12 months
- D. Children in Foster Care: Children who are in out-of-home placement under the care and custody of county welfare and probation departments.
- E. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP)

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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.

- 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. ECM Lead Care Manager : A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multidisciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.
- H. 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.
- I. Resource Family: In California, a Resource Family is a caregiver who provides out-of-home care for children in foster care. The Resource Family is approved to provide care on a temporary (foster care) and/or permanent (adoption and legal guardianship) basis and includes all types of caregivers in the child welfare and probation systems, formerly known as foster parents, approved relatives or approved Non-Relative Extended Family Member.
- J. Whole Child Model: 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. N/A

#### V. PURPOSE:

To describe Partnership HealthPlan of California's coordination of care for child welfare-involved youth.

#### VI. POLICY / PROCEDURE:

- A. Partnership communicates with foster care agencies, group homes and resource families for those Members identified as child welfare-involved by the Medi-Cal Eligibility Data System (MEDS).
- B. If a Member is identified as being a child welfare-involved youth, a review of medically necessary services that require prior authorization will be performed by Partnership's Utilization Management (UM) Department.
  1. Foster care Members will be assigned to Direct Member status. (See policy MCUP3039 Direct Members)
  2. Medically necessary services will be authorized to the in-network or out-of-network provider when indicated and medically necessary and appropriate.
  3. Members identified as being high risk are referred to case management. Referrals are indicated for Members who are in need of multiple referrals and services, complex medical needs, or need for coordination of services with multiple agencies.
  4. Child welfare-involved youth who are also medically eligible for services under the Whole Child Model (CCS children) are assigned a medical home. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s).

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5. Family caregivers of foster care program beneficiaries may be eligible for respite services through CalAIM Community Supports Services as per Partnership policy MCUP3142.
- C. The Child Welfare Liaison shall be the primary internal and external contact for any concerns or assistance needed for child welfare-involved youth.
  1. Effective January 1, 2024, as per the Department of Health Care Services (DHCS) All Plan Letter ([APL 24-013](#)) “Managed Care Plan Child Welfare Liaison,” Partnership designates a Child Welfare Liaison to ensure the needs of Members involved with child welfare and foster care are met.
  2. Partnership designates an appropriate number of staff to serve as Child Welfare Liaison(s) to meet the health care needs of children and youth involved in child welfare in each county of Partnership’s service area.
    - a. Additional Child Welfare Liaisons are designated as needed to ensure the health care needs of children and youth involved in child welfare are met. Staffing is commensurate to the number of Members involved in child welfare enrolled with Partnership.
    - b. Partnership reassesses staffing levels at regular intervals to ensure effectiveness in serving children and youth involved in child welfare throughout Partnership’s service areas.
  3. Roles and Responsibilities of the Child Welfare Liaison
    - a. The Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these Members are met.
    - b. The Child Welfare Liaison serves as a leader within Partnership to advocate on behalf of children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services.
    - c. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member’s care coordination, including contracted ECM Lead Care Manager or the Children and Youth Involved in Child Welfare Population of Focus and applicable county child welfare staff as described in APL 24-013.
    - d. The Child Welfare Liaison’s duties are not intended to duplicate care coordination activities provided by other staff members or Providers, but rather to support and act as a resource to solve escalated issues regarding Partnership’s services as they arise.
    - e. The Child Welfare Liaison’s roles and responsibilities include, but are not limited to, the following:
      - 1) Technical Assistance: Supports internal and external staff in care coordination and issue resolution
      - 2) Contact Point: Serves as a contact for resolving member service access issues
      - 3) Referral Pathways: Collaborates with County Child Welfare as well as internal and external ECM staff to ensure effective ECM referral processes
      - 4) Enrollment Support: Assists with member enrollment/disenrollment during County changes
      - 5) Service Coordination: Navigates and coordinates various benefits and services
      - 6) Internal Coordination: Works with additional internal liaisons for specific member populations
      - 7) County Liaison Coordination: Collaborates with designated county liaisons as needed
      - 8) Quarterly Meetings: Attends meetings with county child welfare agencies
      - 9) Quality Improvement Input: Participates in quality improvement activities
      - 10) Training Compliance: Ensures adherence to training provisions of the MOU
      - 11) Foster Youth Rights: Educates staff on the Foster Youth Bill of Rights
      - 12) Trauma-Informed Care: Promotes trauma-informed approaches in interactions
  4. To enhance relationships between Partnership and county child welfare agencies for youth involved in child welfare, the Child Welfare Liaison shall:
    - a. Participate in Partnership’s Community Advisory Committee (CAC), the Quality Improvement Health Equity Committee (QIHEC) Committee, and additional committees and meetings that potentially impact Members involved in child welfare and foster care.

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- b. Collaborate with Counties to identify opportunities for coordination of, and alignment with, each County Interagency Leadership Team’s efforts in implementing the AB 2083 System of Care for Children and Youth MOU, and participate in the Systems of Care Local Interagency Leadership Team meetings to which Partnership is invited.
- c. Collaborate with other Child Welfare Liaisons internally and with Child Welfare Liaisons in other Managed Care Plans to discuss best practices, lessons learned, and sharing of information and resources.
5. Partnership designates staff for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities and meet the criteria of having the expertise, demonstrable experience, or sufficient training in the following programs, processes, and practices:
  - a. Child welfare services and county behavioral health services
  - b. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes
  - c. Trauma-informed care practices
6. The Child Welfare Liaison’s additional expertise, experience, and training shall include, but is not limited to, the following:
  - a. Have a Master’s degree and/or other additional training in social work, public health nursing, or another related field
  - b. Have familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information
  - c. Have experience or training in coordinating care within child welfare services and juvenile justice systems and understand the [Foster Youth Bill of Rights](#).
7. Partnership will notify the county child welfare agency and DHCS of a change in the designated Child Welfare Liaison as soon as practicable, but no later than five working days from the change.
8. Partnership will submit the Child Welfare Liaison contact information to the “Liaison Directory” section available on the Managed Care Operations Division (MCOB)-MCP Submission Portal.
  - a. For delegated Subcontractors that serve children and youth involved with child welfare, Partnership will submit contact information of the Subcontractor’s Child Welfare Liaison(s) to the MCOB-MCP Submission Portal. Partnership shall ensure Subcontractors’ compliance with the requirements of APL 24-013.
9. Partnership conducts quality improvement activities pursuant to policy MPQD1001 Quality and Performance Improvement Program Description.
- D. As necessary, the Department of Social Services Foster Care Program’s Social Workers may be contacted by Partnership Member Services Representatives, the County Child Welfare Liaison, and/or Health Services Case Management staff to facilitate coordination of care.
- E. If the child has been placed outside of the counties Partnership serves, the County Child Welfare Liaison, a Member Services Representative or the Care Coordination Department will assist in the coordination of the change of county by connecting the foster caregiver, county welfare services agency, county probation department, or any other person authorized to make medical decision to the Department of Health Care Services (DHCS) Ombudsman as per Assembly Bill [\(AB\) 1512, Torrico Medi-Cal: Foster Children](#), October 2007.

**VII. REFERENCES:**

- A. Department of Health Care Services (DHCS) All County Welfare Directors Letter [\(ACWDL\) 97-02](#) “Participation of Foster Care and Adoption Assistance Program Children in Medi-Cal Managed Care” (January 13, 1997)
- B. DHCS [ACWDL 00-22](#) “Letter To Notify Counties of Three New Aid Codes For Children in the Kinship Guardian Assistance Payment and Adoption Assistance Programs” (April 10, 2000)

<b>Policy/Procedure Number: MCUP3103</b>		<b>Lead Department: Health Services Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Coordination of Care for Child Welfare-Involved Members		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/21/2010		<b>Next Review Date:</b> 03/12/2026N/A <b>Last Review Date:</b> 03/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- C. Other applicable DHCS All County Welfare Directors Letters (ACWDLs) regarding Foster Care as cataloged on this website: <https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx>
- D. Assembly Bill (AB) 1512, Torrico, Medi-Cal: Foster Children approved and filed October 11, 2007.
- E. 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. [County Social Services Programs and Child Welfare MOU template](#) (DHCS Contract Attachment B)
- F. DHCS All Plan Letter (APL) 24-013 Managed Care Plan Child Welfare Liaison (09/18/2024)
- G. [California Foster Youth Bill of Rights](#)

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:** 04/18/12; 02/18/15; 02/17/16; 02/15/17; \*03/14/18; 03/13/19; 03/11/20; 02/10/21; 05/11/22; 05/10/23; 05/08/24; 03/12/25; [ARCHIVED 11/12/25](#)

\*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

ARCHIVED 11/12/2025 - See MCBP8015

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
GUIDELINE / PROCEDURE**

<b>Guideline/Procedure Number:</b> MCUG3032 (previously UG100332)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> <a href="#">Utilization Management</a>	
<b>Guideline/Procedure Title:</b> Orthotic and Prosthetic Appliances Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/21/1995		<b>Next Review Date:</b> <del>11/13/2025</del> <a href="#">11/12/2026</a> <b>Last Review Date:</b> <del>11/13/2024</del> <a href="#">11/12/2025</a>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALING</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> <i>Robert Moore, MD, MPH, MBA</i>			<b>Approval Date:</b> <del>11/13/2024</del> <a href="#">11/12/2025</a>

**I. RELATED POLICIES:**

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCUP3013 – Durable Medical Equipment (DME) Authorization

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

N/A

**IV. ATTACHMENTS:**

- A. N/A

**V. PURPOSE:**

To describe the criteria for approval of orthotic and prosthetic appliances.

**VI. GUIDELINE / PROCEDURE:**

- A. Partnership HealthPlan of California ([PHCPartnership](#)) covers orthotic and prosthetic appliances when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by a physician, a podiatrist or a non-physician medical practitioner functioning within the scope of their license. [PHCPartnership](#) utilizes Medi-Cal and InterQual® criteria to determine medical necessity for authorizations of orthotic and prosthetic devices. External independent consultants may be utilized on a case-by-case basis. Exceptions to these guidelines may be made based on the individual needs of the ~~member~~[Member](#) or the unique characteristics of the delivery system.
- B. The definition of medical necessity is health care services that are necessary to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed appliances will be covered only as medically necessary to restore bodily functions essential to activities of daily living, to prevent significant disability or serious deterioration of health, or to alleviate severe pain. The prescribing physician or podiatrist must supply the vendor with information required to document the medical necessity for the item.
- C. A Treatment Authorization Request (TAR) is required when the cost for repair/maintenance, purchase or rental exceeds \$250 for orthotics or \$500 for prosthetics.

<b>Guideline/Procedure Number:</b> MCUG3032 (previously UG100332)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Guideline/Procedure Title:</b> Orthotic and Prosthetic Appliances Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/21/1995		<b>Next Review Date:</b> 11/13/2025 <b>Last Review Date:</b> 11/13/2024	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

- D. TAR requests for orthotic or prosthetic appliances must include the diagnosis related to the functional disability, a copy of prescribing physician prescription, a statement concerning the ~~member~~Member's functional disability that would benefit from the appliance, and a statement explaining the reason more cost effective options would not meet the ~~member~~Member's needs.
- E. A repair of an appliance will not be authorized when the repair cost is equal to or exceeds the purchase cost of a new appliance.
- F. For appliance claims submitted by report, the vendor must list the item description, manufacturer name, model number, catalog page, suggested retail price, cost of part(s) used, cost of labor per hour and total cost/hours, description of and medical justification for any special features (custom modification or special accessories) and medical condition necessitating the appliance.
- G. Orthopedic Shoes
1. Stock orthopedic and stock conventional shoes are a covered benefit when a. or b. is met below:
    - a. At least one of the shoes is an integral part of a leg brace and is medically necessary for the proper functioning of the brace or
    - b. The recipient has a diagnosis of Diabetes Mellitus and one or more of the following conditions:
      - 1) Current foot ulcers or a history of foot ulceration
      - 2) Previous foot amputation
      - 3) Peripheral neuropathy with evidence of callous formation of either foot
      - 4) Peripheral vascular disease
      - 5) Positive monofilament examination indicating diabetic neuropathy
      - 6) Deformity of either foot, such as rocker bottom foot or Charcot foot
  2. Modification of stock conventional shoes or stock orthopedic shoes is covered when the patient's medical need can be satisfied with such modification.
  3. Custom-made orthopedic shoes are reimbursable if the recipient's medical need cannot be met by modifications to stock orthopedic or stock conventional shoes. Clinical conditions that might require custom-made shoes include but are not limited to Charcot or rheumatoid foot deformities, some partial foot amputations, or when a patient requires a muscle flap to cover a large or unusual soft tissue foot defect that then is too bulky to be accommodated by an in-depth shoe.
  4. The prescribing physician must document the nature, cause and severity of the foot problem leading to the conclusion that a custom-made orthopedic shoe is the only alternative (CCR, Title 22, Section 51315). A custom-made shoe has the following characteristics:
    - a. Made and molded to patient model for a specific patient
    - b. Constructed over a positive model of the patient's foot
    - c. Made from leather or other suitable material of equal quality
    - d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants
    - e. Has some form of shoe closure
- H. Custom Foot Orthotics
1. Orthotics are covered when medically necessary for the following acute or chronic foot conditions:
    - a. Rehabilitative foot orthotics following foot surgery or trauma
    - b. Plantar fasciitis
    - c. Inflammatory conditions such as bursitis of the foot, tenosynovitis, plantar fascial fibromatosis
    - d. Neurologically impaired feet
    - e. Vascular conditions of the foot including poor circulation or peripheral vascular disease
    - f. Musculoskeletal deformities such as bunions, hallux valgus, talipes deformities, toe deformities
  2. Foot orthotics are not medically necessary and are not covered for the following conditions:
    - a. Back pain
    - b. Knee pain
    - c. Pes planus (flat feet)

<b>Guideline/Procedure Number:</b> MCUG3032 (previously UG100332)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Guideline/Procedure Title:</b> Orthotic and Prosthetic Appliances Guidelines		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 02/21/1995		<b>Next Review Date:</b> 11/13/2025 <b>Last Review Date:</b> 11/13/2024	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

- d. Pronation
- e. Corns or calluses
- f. Hip osteoarthritis
- g. Lower leg injuries
- I. Dynamic Splinting
  - 1. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case by case basis as described in MCUP3013 Durable Medical Equipment (DME) Authorization.

**VII. REFERENCES:**

- A. Medi-Cal Provider Manual/ Guidelines: Orthotic and Prosthetic Appliances and Services ([ortho](#))
- B. InterQual® Durable Medical Equipment Criteria
- C. Title 22 California Code of Regulations (CCR) [51315](#) and [51315.1](#)

**VIII. DISTRIBUTION:**

- A. [PHCPartnership](#) Department Directors
- B. [PHCPartnership](#) Provider Manual

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

**X. REVISION DATES:** 06/1/00; 09/20/00; 12/19/01; 11/20/02; 09/15/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/20/16; 09/21/16; 09/20/17; \*10/10/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 11/08/23; 11/13/24; [11/12/25](#)

\*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 [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.

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MCUP3012 (previously UP100312)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Discharge Planning (Non-capitated Members)		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 05/27/1999		<b>Next Review Date:</b> <u>09/11/2025</u> <u>11/12/2026</u> <b>Last Review Date:</b> <u>09/11/2024</u> <u>11/12/2025</u>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS <u>SING</u>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval Date:</b> <u>09/11/2024</u> <u>11/12/2025</u>	

**I. RELATED POLICIES:**

- A. MCUP3020 - Hospice Services Guidelines
- B. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
- C. MCCP2019 - Identification and Care Coordination for Seniors and Persons with Disabilities
- D. MCUG3024 - Inpatient Utilization Management
- E. MCCP2024 - Whole Child Model for California Children’s Services (CCS)
- F. MPCUG3011 - Criteria for Home Health Services
- G. MCCP2031 - Private Duty Nursing under EPSDT
- ~~G.~~ H. MPCP2034 - Transitional Care Services (TCS)

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

Discharge Planning is the coordinated process that evaluates a patient's needs and ensures that each patient has an individualized plan for continuing care, follow-up and/or rehabilitation. It can also be defined as planning for the appropriate continuing care of the patient upon discharge from an acute care facility.

**IV. ATTACHMENTS:**

- A. N/A

**V. PURPOSE:**

To define the process for Discharge Planning. Discharge Planning is part of admission certification and an integral part of daily inpatient utilization management.

**VI. POLICY / PROCEDURE:**

**A. OBJECTIVES OF DISCHARGE PLANNING**

- 1. To identify prior to or on admission, "high risk" patients with medical, surgical, or psychosocial problems which have potential for increased lengths of stay or possible readmission. Examples of “high risk” patients include Seniors and Persons with Disabilities, children in the California Children’s Services (CCS) program, or other populations as identified by Partnership HealthPlan of California (Partnership).

<b>Policy/Procedure Number:</b> MCUP3012 (previously UP100312)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Discharge Planning (Non-capitated Members)		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 05/27/1999		<b>Next Review Date:</b> <del>09/11/2025</del> 09/11/2511/12/2026 <b>Last Review Date:</b> <del>09/11/2024</del> 09/11/2411/12/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

2. To coordinate post discharge needs and alternative care
3. To ensure continuity of care throughout inpatient confinement and following discharge
4. To ensure appropriate utilization of inpatient facilities and services
5. To prevent iatrogenic complications that may require hospital readmission
6. To reduce length of stay by preventing unnecessary inpatient days

**B. PROCESS**

1. Assessment
  - a. Discharge planning begins **prior** to admission by assessing the following areas:
    - 1) The patient's living arrangements prior to hospitalization
    - 2) The expected living arrangements post-discharge
    - 3) Any significant others who would be available to provide assistance at home
    - 4) The assessment of patient/family psychosocial status
    - 5) Family, support group status
    - 6) The patient's socio-economic status
    - 7) Available community resources and the estimated cost and benefits
    - 8) The patient's ability to perform activities of daily living
    - 9) Special nursing procedures, medication administration, other special ancillary care services required
  - b. Determination of the need for discharge planning is also determined through use of goal-based criteria. Discharge planning should be considered for all patients admitted to an acute care facility.
  - c. The need of all patients for discharge planning should be identified and should commence at the time of admission.
2. Ongoing Assessment
  - a. Throughout the patient's confinement, the Nurse Coordinator, facility discharge planner, and/or social worker assess the following:
    - 1) The patient/family psychosocial, and emotional status
    - 2) Any change in the patient's physical status that may affect post-discharge well-being (i.e., physical progress or deterioration, new diagnosis, disease or procedure)
  - b. Once the alternate care setting has been selected and transfer has taken place, a request is made to the agency or provider for a written progress report when necessary.
3. Identification of Alternate Medical Services
  - a. Home health care, pediatric day nursing care, hospice, or a skilled nursing facility is for patients who may require intermittent professional nursing care outside the acute care facility. See Partnership HealthPlan of California's (Partnership's) policies MPEUG3011 Criteria for Home Health Services, MCCP2031 Private Duty Nursing under EPSDT, MCUP3020 Hospice Services Guidelines and MCUG3038 Review Guidelines for Member Placement in Long Term Care Facilities for authorization of these services.
4. Attending physician or hospital discharge planner must notify the Nurse Coordinator prior to patient discharge for precertification of that service as part of a patient's discharge plan.
5. An alternate notification process is for the service provider to call and request pre-certification of services for the patient being discharged.

**VII. REFERENCES:**

- A. Centers for Medicare & Medicaid Services (CMS) Standards
- B. Medi-Cal Provider Manual/ Guidelines

**VIII. DISTRIBUTION:**

<b>Policy/Procedure Number:</b> MCUP3012 (previously UP100312)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Discharge Planning (Non-capitated Members)		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 05/27/1999		<b>Next Review Date:</b> <del>09/11/2025</del> 09/11/2511/12/2026 <b>Last Review Date:</b> <del>09/11/2024</del> 09/11/2411/12/2025	
<b>Applies to:</b> <input checked="" type="checkbox"/> <b>Medi-Cal</b>		<input type="checkbox"/> <b>Employees</b>	

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:** 05/05/00; 05/16/01; 05/15/02; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 10/15/14; 01/20/16; 08/17/16; 08/16/17; \*09/12/18; 09/11/19; 09/09/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; 11/12/25

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

**PREVIOUSLY APPLIED TO:** N/A

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

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- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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.

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>Policy/Procedure Number:</b> MCUP3050 (previously UP100350)			<b>Lead Department:</b> Health Services <u>Business Unit: Utilization Management</u>	
<b>Policy/Procedure Title:</b> Medication Abortion in the First Trimester			<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 01/17/2001		<b>Next Review Date:</b> <del>10/09/2025</del> <u>11/12/2026</u> <b>Last Review Date:</b> <del>10/09/2024</del> <u>11/12/2025</u>		
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal		<input type="checkbox"/> Employees	
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	<input type="checkbox"/> OPERATIONS		<input type="checkbox"/> EXECUTIVE	
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD		<input type="checkbox"/> COMPLIANCE	
	<input type="checkbox"/> CEO	<input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALSING	<input type="checkbox"/> FINANCE
			<input checked="" type="checkbox"/> DEPARTMENT	
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <u>11/12/2025</u> <del>10/09/2024</del>	

**I. RELATED POLICIES:**

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

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

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

**IV. ATTACHMENTS:**

- A. [Mifepristone Patient Agreement Form for Danco Laboratories](#)
- B. [Mifepristone Patient Agreement Form for GenBioPro Inc.](#)
- C. [Mifepristone Prescriber Agreement Form for Danco Laboratories](#)
- D. [Mifepristone Prescriber Agreement Form for GenBioPro Inc.](#)
- E. [Mifepristone Pharmacy Agreement Form for Danco Laboratories](#)
- F. [Mifepristone Pharmacy Agreement Form for GenBioPro Inc.](#)

**V. PURPOSE:**

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

<b>Policy/Procedure Number: MCUP3050 (previously UP100350)</b>		<b>Lead Department: Health Services</b>	
<b>Policy/Procedure Title:</b> Medication Abortion in the First Trimester		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 01/17/2001		<b>Next Review Date:</b> <del>11/12/2025</del> <del>10/09/2025</del> <del>11/12/2025</del> <b>Last Review Date:</b> <del>11/12/2025</del> <del>10/09/2024</del> <del>11/12/2025</del>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

**VI. POLICY / PROCEDURE:**

**A. Medication Regimens:**

This policy describes Provider and Member considerations with regard to the medical management of abortion using mifepristone and/or misoprostol.

1. Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* “Governor’s Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx,” and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. Please refer to the State Medi-Cal Rx webpage which is found at <https://medi-calrx.dhcs.ca.gov/home/>
2. Mifepristone, an antiprogestin, has been approved by the U.S. Food and Drug Administration (FDA) for termination of intrauterine pregnancies through 70 days gestation. It is generally used with misoprostol, an E1 prostaglandin analog.
  - a. The usual dose is oral mifepristone 200 mg followed by misoprostol 800 mcg buccal 24 to 48 hours later. This leads to complete abortion in 94% to 98% of patients up to 63 days gestation and in 93% of patients between days 64 – 70 gestation.
  - b. For patients 9 to 11 weeks gestation, a second dose of misoprostol should be self-administered after 3 to 6 hours (see Reference VII.DE. It is noted that the FDA approval does not include usage after 10 weeks gestation or a second dose.
  - c. The primary complications are vaginal bleeding and crampy abdominal pain, which may be severe. Curettage may be needed to control bleeding or, after treatment failure, to terminate the pregnancy.
3. Misoprostol alone is endorsed by the World Health Organization (WHO), the American College of Obstetrics and Gynecology (ACOG) and the Society of Family Planning for medical abortions at < 11 weeks gestational age.
  - a. Dosing regimens include sublingual 800 mcg every 3 hours for 2-3 doses OR intravaginal or buccal 800 mcg every 3-12 hours 2-3 doses
  - b. Complications that may need follow up include heavy bleeding, pain or fever.
  - c. Primary side effects include nausea, vomiting, diarrhea and fever.

**B. Provider Requirements**

1. Under Federal law, the FDA Mifepristone REMS Program requirements were updated on January 3, 2023 as follows:
  - a. Mifepristone must be prescribed by a health care provider who meets certain qualifications and is certified under the Mifepristone REMS Program (see III.~~A~~ above).
  - b. In order to become certified to prescribe mifepristone, health care providers must complete a Prescriber Agreement Form. (see Attachments ~~CB~~ and ~~DE~~)
  - c. The Patient Agreement Form (Attachment A or B as applicable) must be reviewed with, and signed by, the patient and the health care provider, and the risks of the mifepristone treatment regimen must be fully explained to the patient before mifepristone is prescribed.
  - d. The Patient must be provided with a copy of the Patient Agreement Form (Attachment A or B as applicable) and Mifepristone Medication Guide (FDA approved information for patients).
  - e. Mifepristone may only be dispensed by, or under the supervision of, a certified prescriber, or by a certified pharmacy on a prescription issued by a certified prescriber.
  - f. To become certified to dispense mifepristone, pharmacies must complete a Pharmacy Agreement Form. (see Attachments ~~ED~~ and ~~FE~~)
  - g. Certified pharmacies must be able to ship mifepristone using a shipping service that provides tracking information.
  - h. Certified pharmacies must ensure mifepristone is dispensed to the patient in a timely manner.

<b>Policy/Procedure Number: MCUP3050 (previously UP100350)</b>		<b>Lead Department: Health Services</b>
<b>Policy/Procedure Title:</b> Medication Abortion in the First Trimester		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>
<b>Original Date:</b> 01/17/2001	<b>Next Review Date:</b> <del>11/12/2026</del> 10/09/202511/12/2025 <b>Last Review Date:</b> <del>11/12/2025</del> 10/09/202411/12/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

2. The following provider requirements must also be met for all medical abortions:
    - a. The prescriber must have the ability to assess the duration of pregnancy accurately.
    - b. The prescriber must have the ability to diagnose ectopic pregnancies.
    - c. The prescriber must be able to provide surgical intervention in cases of incomplete abortion or severe bleeding, or has made arrangements to provide such care through other appropriately trained and credentialed practitioners, and is able to assure patient access to medical facilities equipped to provide blood transfusion and resuscitation, if necessary.
    - d. When using Mifepristone, the prescriber has read and understood the prescribing information. Prescribing information is available on the manufacturers' websites as cited in [References](#) VII.B and C. below.
  3. Providers of medication abortions must be available to patients receiving this care for consultation after office hours and must have arrangements with a suitable facility for emergency surgical intervention when necessary, including after office hours.
  4. The prescriber must provide each patient with a Mifepristone Medication Guide. The prescriber must fully explain the procedure to each patient, provide the patient with a copy of the Mifepristone Medication Guide and Patient Agreement form (see Attachment A [or B as applicable](#)), give the patient an opportunity to read and discuss, obtain the patient's signature on the Patient Agreement form, and the prescriber must sign it.
  5. The prescriber should educate the patient on the importance of follow-up between 5 to 14 days after use of mifepristone to confirm that a complete termination of pregnancy has occurred and to address any complications. The prescriber must ensure there is access to schedule a follow up appointment after initiating treatment.
    - a. Telephonic follow up at 5 to 14 days for evaluation of patient experience and infection symptoms (cramping, vaginal bleeding, passage of tissue, fever or discharge) in combination with an in-home pregnancy test at 4 weeks can be considered adequate.
    - b. The prescriber must notify the manufacturer in writing as discussed in the Package Insert under the heading Dosage and Administration in the event of an on-going pregnancy which is not terminated subsequent to the conclusion of the treatment procedure.
    - c. While serious adverse events associated with the use of mifepristone are rare, the prescriber must report any hospitalization, transfusion, or other serious event to the manufacturer, identifying the patient solely by package serial number to ensure patient confidentiality.
  6. The provider must keep on file a signed Mifepristone Patient Agreement Form (Attachment A [or B as applicable](#)).
- C. Patient Requirements
1. The patient must read carefully and understand the Mifepristone Medication Guide, which will help in understanding how the treatment works.
  2. The patient must sign the Patient Agreement Form.
  3. The patient should agree to see their provider between day 7 and day 14 after receiving the medication.
- D. Partnership Requirements
1. Partnership will reimburse Medi-Cal providers for the service.
  2. Partnership does not require prior authorization or medical justification for medication abortion services, but does require authorization for inpatient hospital services for complications arising from medication abortions when such services are medically necessary (in agreement with Partnership policy MCUG3024 Inpatient Utilization Management).
  3. Abortions are considered sensitive services and as such are provided to Partnership Members in a timely manner through the Member's primary care provider (if appropriately qualified), obstetrics/gynecology (OB/GYN) specialist, or providers of family planning bypass services.
- E. Partnership monitors the quality of medical abortion services through the Member grievance and appeals

<b>Policy/Procedure Number: MCUP3050 (previously UP100350)</b>		<b>Lead Department: Health Services</b>	
<b>Policy/Procedure Title:</b> Medication Abortion in the First Trimester		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 01/17/2001		<b>Next Review Date:</b> <del>11/12/2026</del> <del>10/09/2025</del> <del>11/12/2025</del> <b>Last Review Date:</b> <del>11/12/2025</del> <del>10/09/2024</del> <del>11/12/2025</del>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

process or through the Plan’s Potential Quality Issue (PQI) process (see MPQP1016 Potential Quality Issue Investigation and Resolution policy).

**VII. REFERENCES:**

- A. U.S. Food and Drug Administration (FDA) [“Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation”](#) website content updated 03/23/2023
- B. Danco Mifeprex (mifepristone) manufacturer’s website, “For Health Professionals” tab: <https://www.earlyoptionpill.com/for-health-professionals/>
- C. GenBioPro Inc. Mifepristone manufacturer’s website, “Prescriber Resources” tab: <https://genbiopro.com/products/mifepristone/prescribers/abortion-resources/><https://genbiopro.com/resources-prescriber/>
- D. **UpToDate:** “Medication Abortion”
- E. UpToDate: Bartz D, Blumenthal P. [First-trimester pregnancy termination: Medication abortion](#) published online 27 June 2022
- F. American College of Obstetrics and Gynecology (ACOG), “Medication Abortion Up to 70 Days of Gestation” Practice Bulletin #225 Volume 136, No. 4, October 2020. <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/practice-bulletin/articles/2020/10/medication-abortion-up-to-70-days-gestation.pdf>
- G. Medi-Cal Provider Manual/ Guidelines: Abortions ([abort](#))
- H. World Health Organization (WHO) 2022 Abortion Care Guideline: <https://apps.who.int/iris/handle/10665/349316>
- I. International Federation of Gynecology and Obstetrics: Morris JL, Winikoff B, Dabash R, et al. [FIGO's updated recommendations for misoprostol used alone in gynecology and obstetrics](#). Int J Gynaecol Obstet 2017; 138:363.
- J. Department of Health Care Services (DHCS) All Plan Letter ([APL 22-012 Revised](#)) – Governor’s Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
- K. DHCS All Plan Letter [APL 24-003](#) Abortion Services (03/28/2024)

**VIII. DISTRIBUTION:**

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

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

**X. REVISION DATES:**

02/14/01 (Physician Advisory Committee); 09/19/01; 10/16/02, 10/20/04; 10/19/05, 10/18/06, 08/20/08; 11/28/12; 02/18/15; 02/17/16; 02/15/17; 11/15/17; \*02/13/19; 02/12/20; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24; 11/12/25

\*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

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

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

**Patient Agreement:**

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

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

**Patient Signature:** \_\_\_\_\_ **Patient Name (print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Provider Name (print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**PATIENT AGREEMENT FORM**

**Mifepristone Tablets, 200 mg**

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

**Patient Agreement:**

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

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

<b>Patient</b>	<b>Patient</b>	
<b>Signature:</b> _____	<b>Name (print):</b> _____	<b>Date:</b> _____

<b>Provider</b>	<b>Provider</b>	
<b>Signature:</b> _____	<b>Name (print):</b> _____	<b>Date:</b> _____

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



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

*Mifeprex*<sup>®</sup> (Mifepristone)  
Tablets, 200 mg

## PRESCRIBER AGREEMENT FORM

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

### **TO BECOME A CERTIFIED PRESCRIBER, YOU MUST:**

#### **If you submit Mifeprex prescriptions for dispensing from certified pharmacies:**

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

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

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

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

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

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

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

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

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

**If Mifeprex will be dispensed through a certified pharmacy:**

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

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

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

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

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical License # \_\_\_\_\_ State \_\_\_\_\_

NPI # \_\_\_\_\_

Practice Name(s): \_\_\_\_\_

Practice Setting Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred  email  phone

**Return completed form to: [Mifeprex@dancodistributor.com](mailto:Mifeprex@dancodistributor.com)  
or fax to 1-866-227-3343.**

*Mifeprex*<sup>®</sup>   
**(Mifepristone)**  
Tablets, 200 mg

**THE ORIGINAL EARLY OPTION PILL.**



\*MIFEPREX IS A REGISTERED TRADEMARK OF DANCO LABORATORIES, LLC.  
P.O. BOX 4816 · NEW YORK, NY 10185 1-877-4-EARLY-OPTION · (1-877-432-7596)  
WWW.EARLYOPTIONPILL.COM

Approved 03/2023

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

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

To **become a certified prescriber**, you must:

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

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

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

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

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

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

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

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

**PRESCRIBER AGREEMENT FORM**

**Mifepristone Tablets, 200 mg**

- o Obtain the NDC and lot number of the package of mifepristone the patient received in the event the prescriber becomes aware of the death of a patient.
- If mifepristone will be dispensed by you or by healthcare providers under your supervision:
  - o Ensure the NDC and lot number from each package of mifepristone are recorded in the patient’s record.

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

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical License #: \_\_\_\_\_ State: \_\_\_\_\_

NPI #: \_\_\_\_\_

Practice Name(s): \_\_\_\_\_

Practice Setting Address: \_\_\_\_\_

\_\_\_\_\_

Email: \_\_\_\_\_ Phone \_\_\_\_\_ Preferred:  Email  Phone

Return completed form to [RxAgreements@GenBioPro.com](mailto:RxAgreements@GenBioPro.com) or fax to 1-877-239-8036.



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

## PHARMACY AGREEMENT FORM

*Mifeprex*<sup>®</sup> (Mifepristone)  
Tablets, 200 mg

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

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

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

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

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

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

Authorized Representative Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred  email  phone

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

**Return completed form to [Mifeprex@dancodistributor.com](mailto:Mifeprex@dancodistributor.com) or fax to 1-866-227-3343.**



*Mifeprex*<sup>®</sup>  
 (Mifepristone) Tablets, 200 mg  
**THE ORIGINAL EARLY  
 OPTION PILL**



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

\*MIFEPREX is a registered trademark of Danco Laboratories, LLC.

**PHARMACY AGREEMENT FORM**

**Mifepristone Tablets, 200 mg**

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

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

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

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

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

Authorized Representative Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Preferred \_\_\_ email \_\_\_ phone

Pharmacy Name: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Return completed form to [RxAgreements@GenBioPro.com](mailto:RxAgreements@GenBioPro.com) or fax to 1-877-239-8036.



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

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>Policy/Procedure Number:</b> MCUP3052 (previously UP100352)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Medical Nutrition Services		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 05/16/2001		<b>Next Review Date:</b> <del>09/11/2025</del> 11/12/2026 <b>Last Review Date:</b> <del>09/11/2024</del> 11/12/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALING	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval Date:</b> <del>09/11/2024</del> 11/12/2025	

**I. RELATED POLICIES:**

- A. MCUP3113 - Telehealth Services
- B. ~~MP~~CP2026 - Diabetes Prevention Program
- C. ~~MCUP3145~~-~~MPBP~~8013 - Eating Disorder Management Policy

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. Medical Nutrition Therapy (MNT): An evidence-based application of the Nutrition Care Process. The provision of MNT (to a patient/client) may include one or more of the following: nutrition assessment/re-assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. [Academy of Nutrition and Dietetics (see latest edition)]
- B. Registered Dietician (RD) or Registered Dietician Nutritionist (RDN): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)
- C. Certified Diabetes Educator (CDE®): A health professional who possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention, and management. The CDE® educates and supports people affected by diabetes to understand and manage the condition. A CDE® promotes self-management to achieve individualized behavioral and treatment goals that optimize health outcomes. The Certification Examination for Diabetes Educators (Examination) is designed and intended for health professionals who have responsibilities that include the direct provision of diabetes self-management education (DSME), as defined by National Certification Board for Diabetes Educators.

**IV. ATTACHMENTS:**

- A. [Referral Guidelines for Children/Adolescents](#)
- B. [Referral Guidelines for Adults](#)
- C. [Adult Body Mass Index](#)

<b>Policy/Procedure Number: MCUP3052 (previously UP100352)</b>		<b>Lead Department: Health Services Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Medical Nutrition Services</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 05/16/2001</b>		<b>Next Review Date: <del>09/11/2025</del>11/12/2026</b> <b>Last Review Date: <del>09/11/2024</del>11/12/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

**V. PURPOSE:**

To define the criteria for medically necessary referrals and continuing services for medical nutrition therapy (MNT) and Diabetes education services for children and adults.

The Patient Protection and Affordable Care Act of 2010 requires all United States Preventive Services Task Force (USPSTF) recommendations with class A or B be covered. The USPSTF recommends intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians. Grade: B Recommendation. Children are also covered under this policy, as an enhanced benefit.

**VI. POLICY / PROCEDURE:**

- A. Medical nutrition therapy (MNT) must be provided by a Registered Dietitian (RD) or Certified Diabetes Educator (CDE®). The RD or CDE may either be working for a provider contracted with Partnership HealthPlan of California (Partnership) (including primary care, specialist, hospital, home health agency, or hospice) or may be an unaffiliated RD or CDE contracted individually with Partnership. In either case, the RD and/or CDE® documentation must be on file with the Provider Relations department of Partnership for claims to be paid. No accreditation of the provider’s overall diabetes self-management training program is required.
- B. MNT Services must meet state and federal standards of medical necessity. Diagnoses that are covered are listed in Attachments A and B. The frequency of services in Attachments A and B are guidelines, not maximum requirements. No Referral Authorization Form (RAF) nor Treatment Authorization Request (TAR) is required.
- C. The following codes should be used as applicable when submitting a claim for MNT services.
  - 1. 97802 - Initial Visit - Medical Nutritional Therapy (outpatient initial assessment, is limited to one initial visit per year per diagnosis grouping listed in the attached criteria. No RAF is required, although a clinician referral (Physician or Non-Physician Clinician) must be documented in the medical record.
  - 2. 97803 - Medical Nutrition Therapy- Individual follow-up outpatient nutritional counseling education
  - 3. 97804 - Medical Nutrition Therapy- Group reassessment and intervention. Must have an individual assessment prior to first group appointment.
  - 4. 99539 – Home/Telehealth Medical Nutrition Therapy – Nutritional Counseling/Education/Assessments
  - 5. 98970 thru 98972 - Monitoring Meal Plan Journals virtually between sessions. Registered Dietitians may bill Partnership for these codes 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 (as defined in Attachments A and B.)
  - 6. G0108 - Diabetes outpatient self-management training services, individual, per 30 minutes. Partnership allows up to 8 hours to be billed without a TAR in a rolling 12-month period. *(code may not be billed on same date of service as CPT codes 97802 thru 97804)*
  - 7. G0109 - Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes. *(may not be billed on same date of service as CPT codes 97802 thru 97804)*
  - 8. Z6200, Z6202, Z6204 - Medical nutrition therapy ante-partum/post-partum, individual, provided in a Perinatal Services Program based on perinatal services program guidelines
  - 9. Z6206, Z6208 - Medical Nutrition Therapy antepartum, group, recommendations/ limits based on Perinatal Services Program allowances
- D. Nutrition supplements
  - 1. Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership’s medical benefit and is not on [Partnership’s Medical Drug List \(MDL\)](#), or when the MDL indicates a prior authorization is required.

<b>Policy/Procedure Number: MCUP3052 (previously UP100352)</b>		<b>Lead Department: Health Services Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Medical Nutrition Services</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 05/16/2001</b>		<b>Next Review Date: <u>09/11/2025</u> <u>11/12/2026</u></b>	
		<b>Last Review Date: <u>09/11/2024</u> <u>11/12/2025</u></b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

2. Nutritional supplements provided by a Pharmacy must be submitted through the Medi-Cal Rx TAR process\* when not on the [Medi-Cal Rx Contract Drugs List \(CDL\)](#).
3. Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

\***NOTE:** Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in [APL 22-01225-013 “Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage”](#) and Revised, “[Governor’s Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx.](#)” Please refer to the State Medi-Cal Rx webpage which is found at <https://medi-calrx.dhcs.ca.gov/home/>

**VII. REFERENCES:**

- A. United States Preventive Services Task Force (USPSTF) recommendations
- B. Medi-Cal Provider Manual/ Guidelines: Medicine ([medne](#))
- C. DHCS All Plan Letter ([APL- 25-01322-012 Revised – “Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage”](#) Governor’s Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx – (12/30/2022/09/18/2025))

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

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

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

**PREVIOUSLY APPLIED TO:** N/A

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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.

**MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES  
FOR CHILDREN / ADOLESCENTS**

Nutrition Criteria/ ICD-10 Codes	Definition of Child/Adolescent Criteria	Recommended Number of Visits
<b>Diabetes</b> E10.10 – E11.9	Type 1 & Type 2	4 visits over 6 months
<b>Eating disorders</b> F50.00 - F50.029 F50.20 - F50.25, F50.8 – F50.9	Anorexia nervosa, bulimia or other feeding or eating disorder	4 visits over 2 months
<b>Lead poisoning</b> T56.0X1A – T56.0X4S	Blood Lead Level	4 visits over 6 months
<b>Obesity and Overweight</b> E66.0 – E66.3, E66.9	Ages 2 – 19 years: > 85 <sup>th</sup> percentile by weight for height OR by BMI, using the appropriate growth chart for age (NCHS)	8 visits over 1 year
<b>Pre-diabetes (impaired glucose tolerance)</b> R73.01 – R73.09	Impaired fasting glucose of $\geq$ 100 mg/dl, but <125 mg/dl. <b>and/or</b> impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of $\geq$ 140 mg/dl, but less than 200 mg/dl	2 visits over 6 months
<b>Pregnancy Related Conditions</b> O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34	All pregnant individuals with these diagnoses are eligible for MNT	see Perinatal Services visit recommendations OR 1-2 visits per month up to 12 months after delivery
<b>Severe anemia</b> D50.0 – D50.9 D53.0 – D53.9	Has received a trial of iron therapy for 2 months and <b>who still has a</b> Hemoglobin less than or equal to 9.0gm/dl <b>and a</b> hemoglobin electrophoresis which does not indicate hemoglobinopathy	3 visits over 6 months
<b>Severe food hypersensitivity</b> L27.2	Diagnosed food hypersensitivity to casein, gluten, or soy	2 visits over 6 months
<b>Short Stature</b> R62.0 R62.50 – R62.52	Measurement below the 5 <sup>th</sup> percentile <u>height for age</u> using the appropriate growth chart for age (NCHS)	3 visits over 6 months
<b>Under weight, and/or failure to thrive</b> R62.0 R62.50 – R62.52 R63.0	Measurement below the 5 <sup>th</sup> percentile <u>weight for height</u> using the appropriate growth chart (NCHS) <b>or</b> Dramatic drop on the growth curve from previous visit by two percentiles	3 visits over 6 months

**MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES  
FOR ADULTS**

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
<b>Cardiovascular disease/or risk of</b>  <b>E78.0 – E78.3, E78.5</b> <b>I70.0 – I70.249</b> <b>I70.261 – I70.299</b> <b>I70.401 – I70.419</b> <b>I70.501 – I70.519</b> <b>I70.8 – I70.92, I10 – I11.9</b>	Hypertension, hyperlipidemia <b>and/or</b> coronary artery disease	3 visits over 3 months
<b>Decubitus ulcer</b>  <b>L89.90 – L89.95</b> <b>L89.000 – L89.029</b> <b>L89.110 – L89.149 L89.200 –</b> <b>L89.329 L89.500 – L89.819</b>	Increased nutritional need due to wound	1 visit
<b>Pre-diabetes</b> <b>(impaired glucose tolerance)</b>  <b>R73.01, <u>R73.03</u> – R73.09</b>	Impaired fasting glucose of $\geq 100$ mg/dl, but $<125$ mg/dl. <b>and/or</b> impaired glucose tolerance (IGT), defined as oral glucose tolerance test value of $\geq 140$ mg/dl, but less than 200 mg/dl	2 visits over 6 months
<b>Diabetes</b> <b>E10.10 – E11.9</b>	Type 1 & Type 2	4 visits over 6 months
<b>Eating disorder</b>  <b>F50.00 – F50.029</b> <b>F50.20 – F50.25, F50.8 – F50.9</b>	Anorexia nervosa, bulimia or other feeding or eating disorder	4 visits over 2 months
<b>Gastrointestinal disease:</b>  <b>Crohn’s Disease</b> <b>K50.00, K50.10, K50.80, K50.90</b>  <b>Ulcerative colitis</b> <b>K51.00, , K51.20, K51.30, K51.40,</b> <b>K51.50, K51.80, K51.90 K52.9</b>  <b>Irritable bowel syndrome</b> <b>K58.9</b>  <b>Malabsorption, s/p GI surgery</b> <b>K90.0 – K90.3</b> <b>K90.81 – K90.9</b>	Need for dietary manipulation due to gastrointestinal condition	2 visits over 2 months
<b>HIV/AIDS</b> <b>B20</b>	Nutritional problems related to HIV/AIDS	4 visits over 3 months

**MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES  
FOR ADULTS**

Nutrition Criteria/ ICD-10 Codes	Definition of Adult Criteria	Recommended Number of Visits
<p><b>Liver disease</b> K70.0 – K70.31 K72.91, K73.0, K73.2, K73.9, K74.5 – K75.1, K75.4, K75.9, K76.3, K76.6 – K77</p>	<p>Need for dietary manipulation due to declining liver function</p>	<p>2 visits over 2 months</p>
<p><b>Obesity</b> <u>E66.0</u> - E66.9, <del>E66.2</del></p>	<p>BMI <math>\geq</math> 30 Kg/m<sup>2</sup> <b>and</b> at medical risk with concurrent medical problem(s) <b>or</b> BMI <math>\geq</math> 27 Kg/m<sup>2</sup> with CVD complications</p>	<p>2 individual appointments and group weight management program over 6 months</p>
<p><b>Overweight</b> E66.3</p>	<p>BMI between 25 and 29.9 Kg/m<sup>2</sup>, <b>and</b> Waist to Hip Ratio <math>\geq</math> .95 in men and <math>\geq</math> .85 in women</p>	<p>Group weight management program over 6 months</p>
<p><b>Pre-End Stage Renal and/or Chronic Kidney Disease</b> N01.0, N03.1 – N03.2, N03.5, N03.8 – N03.9, N04.0 – N04.2, N04.5, N04.8 - N04.9, N05.1 – N05.2, N05.5, N05.8 – N05.9, N08, N17.0 – N17.2, N17.8 – N17.9, N18.1 – N19</p>	<p>Need for dietary manipulation due to declining renal function (pre-dialysis)</p>	<p>2 visits over 2 months</p>
<p><b>Pregnancy Related Conditions</b> O09, O10-O16, O21, O24, O26.0 - O26.2, O26.8, O26.9, O30, O36.5, O36.6, O36.8, O36.9, O40, O48, Z34</p>	<p>All pregnant individuals with these diagnoses are eligible for MNT</p>	<p>see Perinatal Services visit recommendations <b>OR</b> 1-2 visits per month up to 12 months after delivery</p>
<p><b>Substance abuse</b> Z79, F10.10, F11.10, F11.20 – F11.21, F12.10, F12.20 – F12.21, F13.10, F13.20 – F13.21, F14.10, F14.20 – F14.21, F15.10, F15.20 – F15.21, F16.10, F16.20 – F16.21, F17.200, F18.20 – F18.21, F19.10, F19.20 – F19.21</p>	<p>Nutritional problems related to substance abuse</p>	<p>4 visits over 4 months</p>

**MEDICAL NUTRITION THERAPY REFERRAL GUIDELINES  
FOR ADULTS**

<b>Nutrition Criteria/ ICD-10 Codes</b>	<b>Definition of Adult Criteria</b>	<b>Recommended Number of Visits</b>
<p><b>Undernutrition or risk of related to dietary deficiency:</b></p> <p><b>E40 – E41, E43 – E51.12, E51.8, E52 – E56.1, E56.9, E58, E63.8 – E63.9, E64.3</b></p> <p><b>Poor dentition, poor appetite, unexplained weight loss</b></p> <p><b>R63.0, R63.3 - R63.6</b></p> <p><b>Cachexia</b></p> <p><b>R64</b></p>	<p>Poor nutritional status related to a variety of medical problems, including cancer, cancer treatment, frail elder, etc.</p>	<p>2 visits over 2 months</p>

## ADULT BODY MASS INDEX

Body weight in lb (kg)/height (m)<sup>2</sup>

Height in inches (cm)	BMI 25	BMI 27	BMI 30
58 (147.32)	119 (53.98)	129 (58.51)	143 (64.86)
59 (149.86)	124 (56.25)	133 (60.33)	148 (67.13)
60 (152.40)	128 (58.06)	138 (62.60)	153 (69.40)
61 (154.94)	132 (59.87)	143 (64.86)	158 (71.67)
62 (157.48)	136 (61.69)	147 (66.68)	164 (74.39)
63 (160.02)	141 (63.96)	152 (68.95)	169 (76.66)
64 (162.56)	145 (65.77)	157 (71.21)	174 (78.93)
65 (165.10)	150 (68.04)	162 (73.48)	180 (81.65)
66 (167.64)	155 (70.31)	167 (75.75)	186 (84.37)
67 (170.18)	159 (72.12)	172 (78.02)	191 (86.64)
68 (172.72)	164 (74.39)	177 (80.29)	197 (89.36)
69 (175.26)	169 (76.66)	182 (82.56)	203 (92.08)
70 (177.80)	174 (78.93)	188 (85.28)	207 (93.89)
71 (180.34)	179 (81.19)	193 (87.54)	215 (97.52)
72 (182.88)	184 (83.46)	199 (90.27)	221 (100.25)
73 (185.42)	189 (85.73)	204 (92.53)	227 (102.97)
74 (187.96)	194 (88.00)	210 (95.26)	233 (105.69)
75 (190.50)	200 (90.72)	216 (97.98)	240 (108.86)
76 (193.04)	205 (92.99)	221 (100.25)	246 (111.58)

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number: MCUP3115</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Community Based Adult Services</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 10/17/2012</b> (Effective 07/01/2012)		<b>Next Review Date: <del>10/09/2025</del>11/12/2026</b> <b>Last Review Date: <del>10/09/2024</del>11/12/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALING</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature: Robert Moore, MD, MPH, MBA</b>			<b>Approval Date: <del>10/09/2024</del>11/12/2025</b>

**I. RELATED POLICIES:**

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

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

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

**IV. ATTACHMENTS:**

- A. [CBAS Individual Plan of Care \(IPC\) Form \(DHCS 0020\)](#)

<b>Policy/Procedure Number: MCUP3115</b>		<b>Lead Department: Health Services Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Community Based Adult Services</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 10/17/2012</b>		<b>Next Review Date: 10/09/202511/12/2026</b>	
		<b>Last Review Date: 10/09/202411/12/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

**V. PURPOSE:**

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

**VI. POLICY / PROCEDURE:**

**A. CBAS Objectives**

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

**B. Eligibility Criteria**

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

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

C. CBAS Authorization Process

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

D. TAR Submission

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

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the IPC and clinical information submitted with the TAR.

- a. If Partnership or DHCS or its contractor(s) cannot determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses, then the initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by DHCS.
  3. Partnership will approve, modify or deny the requested CBAS services within five (5) business days of receipt of the TAR, in accordance with Health and Safety Code 1367.01. Decisions for requests on behalf of Members in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who are at high risk for admission to a hospital or SNF (e.g., an expedited or urgent request) will be made within 72 hours of receipt of the TAR, in accordance with CMS Letter Number 11-W100193/9 (CalAIM) Special Terms and Conditions (STCs). If the TAR is approved, the facility will be notified via copy of the authorization.
  4. If the TAR is modified or denied, a Notice of Action (NOA) letter will be sent to the Member and CBAS provider.
  5. If the plan does not have sufficient information to make a determination, Partnership will extend the time frame one time by up to 14 calendar days. The Member and the CBAS provider are notified immediately in writing of the extension and what additional information is required to complete the review. If no additional requested information is received, the TAR may be denied via the NOA letter. The letter will include appeal rights and responsibilities.
  6. CBAS providers can contact Partnership at (800) 863-4155 with all inquiries related to CBAS eligibility determinations, authorization requests, and care planning. The call will be triaged to the appropriate department, where the appropriate assigned Case Manager/Care Team will be identified and notified for follow-up. Partnership will coordinate with CBAS providers for the timely exchange of coordination of care information, including but not limited to:
    - a. Updates to Member's IPC and/or discharge plan
    - b. Reports of incidents that threaten the welfare, health, and safety of the Member
    - c. Significant changes in the Member's condition
- E. Reassessment and Reauthorization
1. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by Partnership to be clinically appropriate.
  2. A CBAS center requests reassessment and submits a request to begin the CBAS reassessment process.
    - a. Examples:
      - 1) Prior authorization end date is approaching
      - 2) Due to a change in level of service
  3. A TAR is created and sent to Partnership with an IPC and a Level of Service recommendation.
  4. Partnership receives the prior authorization request from the CBAS center, which includes a completed IPC and level of service recommendation. Partnership will handle the recommendation through existing TAR process which includes:
    - a. Partnership will approve, modify or deny prior authorization request within five (5) business days, in accordance with Health and Safety Code 1367.01.
    - b. If Partnership cannot make a decision within five (5) business days, a 14-day pend letter will be sent to the Member and center.
    - c. Partnership notifies the center within 24 hours of the decision. The plan notifies the Member within 48 hours of the decision.
  5. Denial in services or reduction in the requested number of days for services of ongoing CBAS by DHCS or by Partnership requires a face-to-face review.

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- a. Process must be completed in accordance with the Health and Safety Code 1367.01 and ensure timelines are met.
6. CBAS services continue.
- F. Emergency Remote Services (ERS)
  1. Pursuant to the CalAIM 1115 waiver authorized by Centers for Medicare and Medicaid Services (CMS) in January of 2022, CBAS Emergency Remote Services (ERS) are available to Members who are approved and participate in services delivered by a CBAS center.
    - a. ERS are defined as the temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, to allow for immediate response to a Member's needs when an emergency restricts or prevents them from receiving services at their CBAS center.
  2. Prior to delivery or approval of ERS services, CBAS centers are required to complete the necessary two-step process for obtaining approval from the California Department of Aging (CDA).
    - a. Prior to authorizing CBAS ERS services, Partnership shall track and ensure contracted CBAS providers have completed the approval process as required.
    - b. Partnership shall regularly check the CDA website for updated CBAS and ERS letters.
  3. Effective October 1, 2022, CBAS providers are required to provide ERS when Members experience emergencies as defined below:
    - a. Public Emergency: The CBAS center is located in a region that is impacted by state or local disaster(s), regardless of whether formally declared. These may include, but are not limited to: earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc., and/or
    - b. Personal Emergency: The Member is experiencing serious illness or injury, crises or care transition, which affects their ability to safely and appropriately participate in services at the CBAS center. For the purposes of ERS, DHCS has defined this as:
      - 1) Serious illness or injury that prevents the Member from receiving CBAS services within the facility and that providing medically necessary services/supports to the Member would protect life, address or prevent significant illness or disability, and/or alleviate pain.
      - 2) Crises means that the Member is experiencing or threatened with intense difficulty, trouble or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
      - 3) Care transitions occur when the Member is moving to or from care settings such as returning to home or another community setting after a hospital or nursing facility stay.
  4. Members who are hospitalized or admitted to a skilled nursing facility (SNF) are not eligible for ERS services while they are admitted or in those facilities.
  5. ERS provided during a care transition shall address service gaps and Member/caregiver needs but should not duplicate responsibilities assigned to intake or discharging entities.
  6. To request ERS services:
    - a. The Registered Nurse and Social Worker at the CBAS center must first assess the emergency and make updates to the Member's IPC above (Attachment A).
    - b. If there is no active TAR on file for CBAS services, the CBAS provider must submit a new TAR to Partnership requesting ERS services along with:
      - 1) A copy of the Member's IPC
      - 2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
      - 3) Anticipated time/duration of ERS services
    - c. If there is already an active TAR on file for CBAS services, the CBAS provider must submit a TAR modification request to Partnership requesting ERS services along with:
      - 1) An updated copy of the Member's IPC
      - 2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services

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- 3) Anticipated time/duration of the ERS services
- d. During the TAR review process for ERS services, Partnership staff shall work collaboratively with contracted CBAS providers regarding the method of ERS services.
7. ERS services are time-limited and may be authorized for up to three (3) consecutive months for Members who are experiencing a public or personal emergency.
  - a. Members may choose to cease ERS services at any time.
  - b. For Members who may require ERS beyond the initial three (3) consecutive months:
    - 1) The CBAS center shall complete a new assessment documenting the continued need for remote/telehealth delivery of CBAS services and supports at least every three (3) months. A TAR modification request shall be submitted to Partnership requesting a continuation of ERS along with the Member's updated IPC for review.
8. Through the TAR review process for ERS services, Partnership shall coordinate with the CBAS center(s) to ensure that Members have their service and support needs met throughout the duration of ERS services.
- G. CBAS Facility Selection
  1. The Member may choose any CBAS Center as long as it is within the selected facility's time and distance criteria for transportation.
- H. Reduction in Services or Discharge from CBAS Services
  1. If a Member is going to experience a reduction in CBAS or ERS services, the CBAS center must submit an updated IPC to Partnership.
  2. If the Member will be discharged from a CBAS center, the CBAS center must update the Member's IPC and/or complete a discharge plan for the Member. A copy of the revised IPC and/or discharge plan must be submitted to Partnership for review. The discharge plan must include the following:
    - a. The Member's name and ID number
    - b. The name(s) of the Member's physician(s)
    - c. If applicable, the date the NOA denying authorization for CBAS was issued
    - d. If applicable, the date the CBAS benefit will be terminated
    - e. Specific information about the Member's current medical condition, treatments, and medications
    - f. Potential referrals for medically necessary services and other services or community resources that the Member may need upon discharge
    - g. Contact information for the Member's case manager
    - h. A space for the Member or the Member's representative to sign and date the discharge plan or IPC
  3. If a Member has already been discharged, the CBAS center must submit the updated IPC and/or discharge plan to Partnership within 30 days.
  4. Partnership shall review the IPC and/or discharge plan to determine if the Member has additional needs.
    - a. For Members that possess additional needs, Partnership shall make a referral to appropriate care coordination or case management services.
    - b. Members who are discharged from a CBAS program involuntarily may file a grievance with Partnership or request a fair state hearing or independent medical review within 180 calendar days of the date of the involuntarily discharge.
      - 1) A Member who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
      - 2) A CBAS participant may file a grievance with Partnership as a written or oral complaint as described in Partnership policy CGA024 Medi-Cal Member Grievance System. The Member or their authorized representative may file a grievance at any time that they experience dissatisfaction with the services or quality of care provided to them.

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I. Unbundled Services

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

J. Quality and Monitoring

1. Licensing & Program Oversight: Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDA certifies licensed Adult Day Health Care (ADHC) centers as Medi-Cal CBAS providers. CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers, certification renewal, providing on-going training and technical assistance to centers, and initiating adverse certification actions against centers that are substantially out of compliance with program requirements.
  - a. Partnership's Provider Relations department shall review All Center Letters (ACL) issued by the CDA and ensure that contracted CBAS providers are meeting all requirements issued in those letters.
2. Credentialing: Partnership's Provider Relations department is responsible for ensuring that all CBAS providers are licensed pursuant to CDA and DHCS regulations, and verifying center credentials (see policy MPCR700 Assessment of Organizational Providers). Pursuant to Partnership policy MPCR500 Ongoing Monitoring and Interventions, Partnership's CBAS providers shall be monitored monthly to ensure they remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license.
  - a. In addition, Partnership's Network Services Provider Relations department shall review and monitor the CDA website for updates to contracted CBAS providers licensing and/or ERS approval status.
  - b. Partnership's Network Services Provider Relations department shall update Partnership Health Services staff when or if a CBAS provider loses their license(s) or ERS approval(s).
  - c. Partnership Provider Relations and Health Services departments will be responsible for providing written notification and training (if necessary) when substantive updates to CBAS-related policies and procedures are made.
3. In collaboration with Health Services (HS) staff, Partnership's Network Services Provider Relations department shall monitor the documentation and reporting requirements of CBAS providers, including but not limited to IPCs, discharge plans, on-going assessments, progress notes, discharge plans, timely completion of the CBAS Emergency Remote Services Initiation Form (CEIF or CDA 4000), etc.
4. Reporting: CBAS centers shall remit to Partnership all DHCS and/or CDA required reporting pursuant to the templates and frequencies requested by Partnership.
5. In addition to DHCS Quarterly reporting, Partnership Health Services staff shall monitor and track

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available performance and/or quality measures made available on the on the CDA website, such as the CBAS dashboard, to track, trend and/or evaluate CBAS provider performance and outcomes.

K. Darling vs. Douglas Settlement

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

**VII. REFERENCES:**

- A. Welfare and Institutions Code, Sections [14525](#) and [14526.1](#)
- B. California Health and Safety Code Section [1367.01](#)
- C. California Department of Aging (CDA) CBAS Branch All Center Letter ([ACL #19-02](#) Implementation of New CBAS Individual Plan of Care (IPC) (*Amended* 03/19/2019)
- D. Medi-Cal Provider Manual/ Guidelines: Community-Based Adult Services (CBAS) (*community*)
- E. Department of Health Care Services (DHCS) All Plan Letter ([APL 22-013 Revised](#) Provider Credentialing / Re-Credentialing and Screening / Enrollment (06/12/2019)
- F. DHCS [APL 22-020 Revised](#) Community-Based Adult Services Emergency Remote Services (11/02/2022)
- ~~F.G.~~ [DHCS APL 21-011 Revised Grievance and Appeal Requirements, Notice And “Your Rights” Templates \(08/31/2022\)](#)
- ~~G.H.~~ California Department of Aging (CDA) CBAS Branch All Center Letter ([ACL 22-04 Revised](#) Launch of New CBAS Emergency Remote Services (ERS) (10/03/2023)
- ~~H.I.~~ Centers for Medicare and Medicaid Services (CMS) [Letter Number 11-W-00193/9 \(CalAIM\) Special Terms and Conditions \(STCs\) \(Amended 11/28/2014\)](#)

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:** 08/20/14; 01/20/16; 11/16/16; 04/19/17; \*06/13/18; 06/12/19; 05/13/20; 05/12/21; 05/11/22; 05/10/23; 10/11/23; 10/09/24; [11/12/25](#)

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

**PREVIOUSLY APPLIED TO:** N/A

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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

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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

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

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>3E</b> Policy/Procedure Number: MCUP3128		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Cardiac Rehabilitation		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
Original Date: 02/18/2015 Effective Date: 08/01/2015		Next Review Date: <del>10/09/2025</del> 10/09/202611/11/2026 Last Review Date: <del>10/09/2024</del> 10/09/202511/12/2025	
Applies to:	<input type="checkbox"/> Employees	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Partnership Advantage
Reviewing Entities:	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
Approving Entities:	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA		Approval Date: <del>10/09/2024</del> 11/12/2025	

**I. RELATED POLICIES:**

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

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

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

**IV. ATTACHMENTS:**

- A. N/A

**V. PURPOSE:**

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

**VI. POLICY / PROCEDURE:**

- A. Eligibility
  - 1. Appropriately identified adults with full-scope Medi-Cal are eligible for Phase II Cardiac Rehabilitation services, with the following diagnoses:

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<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- a. Myocardial infarction within the past 12 months
- b. Coronary artery bypass surgery in the past 12 months
- c. Current stable angina pectoris
- d. Heart valve repair or replacement in the past 12 months
- e. Coronary angioplasty performed or coronary stent placed in the last 12 months
- f. A heart or heart-lung transplant in the last 12 months
- g. Intermittent claudication due to atherosclerotic disease, with current symptoms.
- h. Stable chronic heart failure with an ejection fraction of less than 35% and New York Heart Association (NYHA) class II to IV symptoms in spite of optimal therapy for at least 6 weeks.
- i. Other cardiac or major pulmonary surgery, in the past 12 months
- j. Sustained Ventricular Tachycardia, Ventricular Fibrillation or survivor of sudden cardiac death.
2. Partnership HealthPlan of California considers cardiac rehabilitation experimental and investigational for all other indications including:
  - a. Atrial Fibrillation (other than post Maze procedure)
  - b. Atrial Fibrillation with ablation (other than post Maze procedure)
  - c. Takotsubo (stress) Cardiomyopathy
  - d. Uncompensated congestive heart failure
  - e. Uncontrolled arrhythmias (other than PVCs and PACs)
3. Phase II services are only covered when ordered by a licensed physician and when performed in a facility/program meeting Medicare's standards for cardiac rehabilitation programs. These standards include:
  - a. The facility meets the definition of a hospital outpatient department or a physician-directed facility.
  - b. The facility has available for immediate use all the necessary cardio-pulmonary emergency and therapeutic life-saving equipment to perform defibrillation, administer oxygen and perform cardiopulmonary resuscitation.
  - c. The program is conducted in an area set aside for the exclusive use of the program while it is in session.
  - d. The program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
  - e. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area or immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself, provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible. The examples below are for illustration purposes only. They are not meant to limit the discretion of the contractor to make determinations in this regard.
  - f. The non-physician personnel are employees of either the physician, hospital, or facility conducting the program and their services are "incident-to" a physician's professional services.
4. Prior to referral for Phase II cardiac rehabilitation services, a cardiologist or primary care physician with experience and training in evaluation and assessment of cardiovascular disease must complete a diagnostic evaluation of the prospected cardiac rehabilitation participant. This will include:
  - a. Evaluation of chest pain and atypical chest pain. This may include performance of a cardiac stress test or review of a recent stress test
  - b. Pre or post-operative evaluation of cardiac operations (if applicable)

<b>Policy/Procedure Number: MCUP3128</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Cardiac Rehabilitation</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 02/18/2015</b> <b>Effective Date: 08/01/2015</b>		<b>Next Review Date: 10/09/202510/09/202611/11/2026</b> <b>Last Review Date: 10/09/202410/09/202511/12/2025</b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- c. Review and reconciliation of all medications
- d. Review of medical history, including social history, medical history, surgical history
- e. Specific recommendations for the exercise regimen to be used in the cardiac rehabilitation program. This can lead to either a prescription or a referral to cardiac rehabilitation. Partnership does not require submission of a Referral Authorization Form (RAF), but Phase II cardiac rehabilitation services do require a TAR as detailed in VI.A.5. below. Partnership may audit the clinical documents to ensure the criteria required in a. – e. have been met.
- 5. Requests for pediatric cardiac rehabilitation are reviewed on a case by case basis in accordance with our Treatment Authorization Request (TAR) Review Process described in policy MCUP3041. Pediatric cases require consultation with an appropriate specialist (e.g. pediatric cardiologist) and must take place at an appropriate facility for pediatric rehabilitation.
- 6. **A Treatment Authorization Request (TAR) is required for Phase II cardiac rehabilitation services.**
  - a. Current Procedural Terminology (CPT)-4 codes 93797 and 93798 may not be reimbursed in the same calendar month as Healthcare Common Procedure Coding System (HCPCS) codes G0422 and G0423, for any provider. Similarly, HCPCS codes G0422 and G0423 may not be reimbursed in the same calendar month as CPT-4 codes 93797 and 93798, for any provider.
  - b. Modifiers SA, U7, 24, 25 and 99 are all allowable for CPT-4 codes 93797 and 93798, as well as HCPCS codes G0422 and G0423.
  - c. Qualified Practitioners
    - 1) Licensed practitioners who are eligible for reimbursement of CPT-4 codes 93797 and 93798 include physicians, physician assistants, nurse practitioners and physical therapists.
    - 2) Licensed practitioners who are eligible for reimbursement of HCPCS codes G0422 and G0423 include physicians, physician assistants, nurse practitioners, psychologists, licensed clinical social workers, marriage and family therapists and physical therapists.
- 7. For all other indications (individuals who are too debilitated to exercise, and secondary prevention after transient ischemic attack or mild, non-disabling stroke), because of insufficient evidence in the peer-reviewed information, Partnership considers cardiac rehabilitation experimental and investigational and therefore not a benefit.
- B. Covered Services
  - 1. Phase I cardiac rehabilitation services are performed while the Partnership Member is in the acute hospital or acute rehab setting. They are integral to the inpatient care provided to Partnership Members for appropriate indications.
  - 2. Phase II cardiac rehabilitation services are performed in an outpatient setting. Services may include:
    - a. medically-supervised exercise program
    - b. nutritional counseling
    - c. stress management
    - d. smoking cessation counseling and support services
  - 3. Phases III and IV cardiac rehabilitation, by themselves, are not covered.
  - 4. Phase II cardiac rehabilitation services do not include the diagnostic evaluation that is required prior to referral to cardiac rehabilitation, which is covered separately.
  - 5. The medically necessary frequency and duration of cardiac rehabilitation is determined by the Member's level of cardiac risk stratification:
    - a. High-risk Members have any of the following:
      - 1) Decrease in systolic blood pressure of 15 mm Hg or more with exercise; or
      - 2) Exercise test limited to less than or equal to 5 metabolic equivalents (METs); or
      - 3) Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more

<b>Policy/Procedure Number: MCUP3128</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Cardiac Rehabilitation</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 02/18/2015</b> <b>Effective Date: 08/01/2015</b>		<b>Next Review Date: 10/09/202510/09/202611/11/2026</b> <b>Last Review Date: 10/09/202410/09/202511/12/2025</b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

- ST depression by electrocardiography (ECG); or
- 4) Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure; or
  - 5) Resting complex ventricular arrhythmia; or
  - 6) Severely depressed left ventricular function (ejection fraction less than 30 %); or
  - 7) Survivor of sudden cardiac arrest; or
  - 8) Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.
- b. Program Description for High-Risk Members:
- 1) 36 one-hour sessions (e.g., 3 times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring
  - 2) Create an individual out-patient exercise program that can be self-monitored and maintained
  - 3) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.
  - 4) If no clinically significant arrhythmia is documented during the first 3 weeks of the program, the provider may have the Member complete the remaining portion without telemetry monitoring.
- c. Intermediate-risk Members have any of the following:
- 1) Exercise test limited to 6-9 METS; or
  - 2) Ischemic ECG response to exercise of less than 2 mm of ST depression
- d. Program Description for Intermediate-Risk Members:
- 1) 24 one-hour sessions or less of exercise training with or without continuous ECG monitoring
  - 2) Geared to define an ongoing exercise program that is "self-administered."
  - 3) Educational program for risk factor/stress reduction; classes listed below in VI.B.6. c. – f. covered for up to 3 months.
- e. Low-risk Members have exercise test limited to greater than 9 METS
- f. Program Description for Low-Risk Members:
- 1) Six 1-hour sessions involving risk factor reduction education and supervised exercise to show safety and define a home program (e.g., 3 times per week for a total of 2 weeks or 2 sessions per week for 3 weeks).
  - 2) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.
- g. Intensive Cardiac Rehabilitation (ICR)
- 1) ICR is a Centers for Medicare & Medicaid Services (CMS) designation (through the National Coverage Determination [NCD] process) for certain programs demonstrated to have:
    - a) Accomplished one or more of the following for its patients:
      - i. Positively affected the progression of coronary heart disease
      - ii. Reduced the need for coronary bypass surgery, OR
      - iii. Reduced the need for percutaneous coronary interventions; AND
    - b) Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services:
      - i. Low density lipoprotein
      - ii. Triglycerides
      - iii. Body mass index
      - iv. Systolic blood pressure

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<b>Policy/Procedure Title: Cardiac Rehabilitation</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 02/18/2015</b> <b>Effective Date: 08/01/2015</b>		<b>Next Review Date: 10/09/202510/09/202611/11/2026</b> <b>Last Review Date: 10/09/202410/09/202511/12/2025</b>	
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- v. Diastolic blood pressure
- vi. The need for cholesterol, blood pressure, and diabetes medications
- 2) Proof of CMS designation should accompany the TAR
- 3) ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.
- 6. Procedure codes covered:
  - a. 93797 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG Monitoring (For intermediate-risk and low-risk Members)
  - b. 93798 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG Monitoring (for high-risk Members)
  - c. G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session (This code will only be paid to programs approved by CMS, as described above).
  - d. G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session (This code will only be paid to programs approved by CMS, as described above.)
  - ~~e. S9449 – Weight management classes, non-physician provider, per session~~
  - ~~f. S9451 – Exercise classes, non-physician provider, per session~~
  - ~~g. S9453 – Smoking cessation classes, non-physician provider, per session~~
  - ~~h. S9454 – Stress management, non-physician provider, per session~~
  - ~~i.e.~~ Nutrition Therapy services are also covered, as defined in policy MCUP3052 Medical Nutrition Services.

**VII. REFERENCES:**

- A. Medi-Cal Provider Manual/ Guidelines: Rehabilitative Services ([rehab](#))
- B. Up-To-Date: Lynne T Braun, PhD, RN, CNP, Nanette K Wenger, MD, Robert S Rosenson, MD, [“Cardiac Rehabilitation Programs”](#) updated 5/15/2024.

**VIII. DISTRIBUTION:**

- A. Partnership Provider Manual
- B. Partnership Department Directors

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

**X. REVISION DATES:** 06/17/15; 05/18/16; 05/17/17; \*08/08/18; 09/11/19; 09/09/20; 09/08/21; 09/14/22; 10/11/23; 10/09/24; 11/12/25

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

**PREVIOUSLY APPLIED TO:** N/A

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with

<b>Policy/Procedure Number: MCUP3128</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Cardiac Rehabilitation</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 02/18/2015</b> <b>Effective Date: 08/01/2015</b>		<b>Next Review Date: 10/09/202510/09/202611/11/2026</b> <b>Last Review Date: 10/09/202410/09/202511/12/2025</b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

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**

<b>Policy/Procedure Number:</b> MCUP3130		<b>Lead Department:</b> Health Services <u>Business Unit: Utilization Management</u>	
<b>Policy/Procedure Title:</b> Osteopathic Manipulation Treatment		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 06/17/2015 <b>Effective Date:</b> 10/01/2015		<b>Next Review Date:</b> <u>09/11/202411/12/2026</u> <b>Last Review Date:</b> <u>09/11/202409/11/202511/12/2025</u>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS <b>SING</b>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval Date:</b> <u>09/11/202411/12/2025</u>	

**I. RELATED POLICIES:**

MPCR13C - Osteopathic Manipulation Treatment Credentialing

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

- A. Osteopathic medicine is a branch of the medical profession in the United States, whose physicians are known as Doctors of Osteopathy (DO).
- B. Osteopathic physicians are trained in Osteopathic Manipulative Treatment (OMT), also known as Osteopathic Manipulative Medicine (OMM), a core set of manual manipulative techniques used to treat somatic dysfunction.
- C. Somatic dysfunction means an impaired or altered function of related components of the somatic system, which is the part of the peripheral nervous system associated with the voluntary control of body movements via skeletal muscles.

**IV. ATTACHMENTS:**

- A. N/A

**V. PURPOSE:**

This policy describes the conditions under which osteopathic manipulation treatment (OMT) services are a covered benefit.

**VI. POLICY / PROCEDURE:**

Osteopathic Manipulation Therapy (OMT) Coverage

- A. OMT services should only be provided by physicians skilled, trained and experienced in providing these services. This includes Doctors of Osteopathic Medicine, but may include other medical doctors (MDs) who have completed supplementary training and are certified by the Osteopathic Medical Board of California.
- B. Authorization:
  - 1. No treatment authorization is required to perform OMT, if it is performed by a primary care clinician or a Doctor of Osteopathic Medicine credentialed by Partnership HealthPlan of California

<b>Policy/Procedure Number: MCUP3130</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>
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<b>Original Date:</b> 06/17/2015	<b>Next Review Date:</b> <del>09/11/211/12/2026</del> 09/11/202409/11/2024	
<b>Effective Date:</b> 10/01/2015	<b>Last Review Date:</b> <del>09/11/2511/12/2025</del> 09/11/202409/11/2025	
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- (Partnership) AND with documentation of skill, training and experience in providing OMT services. Non-credentialed providers will not be eligible for payment for OMT.
2. Only one OMT service should be billed per day. A maximum of 12 treatments may be billed per rolling 12-month period. Reimbursement for OMT services beyond 12 treatments per rolling 12-month period requires a Treatment Authorization Request (TAR) for medical necessity.
  3. Codes covered. The following CPT® codes are covered under this OMT policy when billed in conjunction with ICD-10 diagnosis codes M99.01, M99.02, M99.03, M99.04, or M99.05:
    - a. 98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved
    - b. 98926 Osteopathic manipulative treatment (OMT); 3-4 body regions involved
  4. Evaluation and Management (E&M) services may be billed on the same day as OMT services, when medically necessary, using modifier 25 in the following conditions:
    - a. If the patient's condition requires a separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the procedure
    - b. If a new condition occurs or the patient's condition has changed substantially, necessitating an overall assessment
- C. OMT is a proven medical therapeutic option for treatment of musculoskeletal disorders, including acute and chronic lower back pain.
- D. OMT is unproven and not medically necessary in the following circumstances/diagnoses:
  1. The patient's condition has returned to the pre-symptom state.
  2. Little or no improvement is demonstrated within 30 days of the initial visit despite modification of the treatment plan.
  3. Concurrent chiropractic manipulative therapy, for the same or similar condition, provided by another health professional whether or not the healthcare professional is in the same professional discipline.
  4. When documentation of somatic dysfunction is absent from the patient's medical record
  5. Manipulative therapy under anesthesia.
  6. Non-musculoskeletal disorders (e.g. asthma, otitis media, infantile colic, etc.)
  7. Prevention/maintenance/custodial care
  8. Internal organ disorders (e.g., gallbladder, spleen, intestinal, kidney, heart or lung disorders)
  9. Scoliosis correction
  10. Craniosacral therapy (cranial manipulation)
  11. Manipulative services that utilize nonstandard techniques
- E. All OMT services conducted should be documented in the medical record, including the diagnosis, any disability that is present, the treatment used, the length of the treatment, and the effectiveness of the treatment.

## VII. REFERENCES:

- A. [Spinal Manipulative therapy for chronic low-back pain](#). Cochrane abstract. February 13, 2011
- B. [Spinal Manipulative therapy for acute low-back pain](#). Cochrane abstract. September 12, 2012
- C. Medi-Cal Provider Manual/ Guidelines: Osteopathic Manipulation Treatment ([osteo](#))
- D. American Osteopathic Association
- E. Christopher L Knight, MD et al. [Treatment of acute low back pain](#); UpToDate. Accessed 05/01/2023
- F. Roger Chou, MD et al. [Subacute and chronic low back pain: Nonpharmacologic and pharmacologic treatment](#); UpToDate. Accessed 05/01/2023

## VIII. DISTRIBUTION:

- A. Partnership Provider Manual
- B. Partnership Department Directors

<b>Policy/Procedure Number: MCUP3130</b>		<b>Lead Department: Health Services</b> <b><u>Business Unit: Utilization Management</u></b>	
<b>Policy/Procedure Title: Osteopathic Manipulation Treatment</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 06/17/2015	<b>Next Review Date:</b> <del>09/11/211/12/2026</del> <del>09/11/2024</del> <del>09/11/2024</del>	<del>09/11/2024</del> <del>09/11/2025</del>	
<b>Effective Date:</b> 10/01/2015	<b>Last Review Date:</b> <del>09/11/2511/12/2025</del> <del>09/11/2024</del> <del>09/11/2025</del>		
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

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

**X. REVISION DATES:** 05/18/16; 05/17/17; \*09/12/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 08/09/23; 09/11/24; [11/12/25](#)

\*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:

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- 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~~**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.

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number: MPUP3078</b>		<b>Lead Department: Health Services</b>	
		<b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: -Second Medical Opinions</b>		<input checked="" type="checkbox"/> <b>External Policy</b>	
		<input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 04/20/2016 – Medi-Cal</b>		<b>Next Review Date: <del>09/11/2025</del> <u>11/12/2026</u></b>	
		<b>Last Review Date: <del>09/11/2024</del> <u>11/12/2025</u></b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature: -Robert Moore, MD, MPH, MBA</b>		<b>Approval Date: <u>11/12/2025</u><del>09/11/202</del></b>	

**I. RELATED POLICIES:**

- A. MCUP3124 – Referral to Specialists (RAF) Policy
- B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- D. CGA024 – Medi-Cal Member Grievance System

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services
- D. Grievance and Appeals

**III. DEFINITIONS:**

- A. 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 licensed health care 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:**

To define the indications and process for Second Medical Opinions.

**VI. POLICY / PROCEDURE:**

- A. When a second medical opinion is requested by a Member, a Member’s authorized representative and/ or health professional, the request will be reviewed. The Member does not need permission from Partnership HealthPlan of California (Partnership) for a second opinion from a network provider. If there is no provider in the Partnership network who can provide the second opinion, a prior authorization will be required and if approved, Partnership will pay for the second opinion from an approved out-of-network provider who is certified by Medi-Cal. Reasons for second opinions include, but may not be limited to the following:

<b>Policy/Procedure Number: MPUP3078</b>		<b>Lead Department: Health Services</b> <a href="#">Business Unit: Utilization Management</a>	
<b>Policy/Procedure Title: Second Medical Opinions</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 04/20/2016 – Medi-Cal</b>		<b>Next Review Date: <del>09/11/2025</del>11/12/2026</b> <b>Last Review Date: <del>09/11/2024</del>11/12/2025</b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

1. The Member has questions concerning the reasonableness or necessity of a recommended surgical procedure or treatment.
  2. The Member questions the diagnosis or course of treatment for a condition that threatens loss of life, limb, bodily function or impairment, including but not limited to a serious chronic condition.
  3. The diagnosis is in doubt due to conflicting test results, or the treating practitioner is unable to make an accurate diagnosis of the situation.
  4. The current treatment plan is not improving the medical condition within an appropriate period of time for the known diagnosis.
  5. The Member has attempted to follow the course of treatment or consulted with the initiating professional and still has serious doubts about the diagnosis or treatment plan.
- B. An appropriately qualified health care professional, qualified to render a second opinion, is considered to be a primary care provider or specialist acting within the scope of practice and who possesses a clinical background including training and expertise related to the particular illness, disease or condition associated with the request for a second opinion.
- C. The Plan reserves the right to limit a Member’s choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The Member shall be referred outside the network to a Medi-Cal certified provider when there is not a qualified network/contracted professional available (see discussion of out of network referrals in policy MCUP3124 Referral to Specialists [RAF] Policy.) Note that any out of network treatments recommended would be subject to the treatment authorization (TAR) process as per policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
- D. Timeframes for out-of-network second opinions will be as follows:
1. If a Member’s request requires an urgent review, a determination will be made within 72 hours after receipt of the request.
  2. For a non-urgent request, the Member will be notified within 5 business days as to whether or not the provider he/she requested for a second opinion was approved.
- E. If a Member’s request for second opinion is not granted by the primary care provider, the Member may contact the Grievance Coordinator at Partnership HealthPlan and file a grievance.
- F. If the health plan denies a request for a second opinion, the Member will be notified in writing of the reasons for the denial, the Member’s right to appeal or file a grievance, and information on how to file an appeal and how to file a grievance.

**VII. REFERENCES:**

- A. DHCS Contract Exhibit A, Attachment III, Section 2.3. C.
- B. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 202~~5~~4) -UM 5 Timeliness of UM Decisions Element E

**VIII. DISTRIBUTION:**

- A. Partnership Provider Manual
- B. Partnership Department Directors

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

**X. REVISION DATES:**

Medi-Cal:  
04/20/16 initial; 04/19/17; \*06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; [11/12/25](#)

<b>Policy/Procedure Number: MPUP3078</b>		<b>Lead Department: Health Services</b> <a href="#">Business Unit: Utilization Management</a>	
<b>Policy/Procedure Title: Second Medical Opinions</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 04/20/2016 – Medi-Cal</b>		<b>Next Review Date: <del>09/11/2025</del>11/12/2026</b> <b>Last Review Date: <del>09/11/2024</del>11/12/2025</b>	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

\*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.

*Note – Policy initially developed under the Healthy Kids Program 11/16/2005*

**PREVIOUSLY APPLIED TO:**

Healthy Kids – MPUP3078, KK UM115 (Healthy Kids program ended 12/01/2016):  
11/16/05; 11/21/07; 11/19/08; 10/01/10; 08/19/15; 04/20/16 to 12/01/2016

Healthy Families:

MPUP3078 - 10/01/2010 to 03/01/2013

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

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

The materials provided are guidelines used by 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.

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPUP3116		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Positron Emission Tomography Scans (PET Scans)		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 09/19/2012 Effective 01/01/2013		<b>Next Review Date:</b> <del>11/13/2025</del> 11/12/2026 <b>Last Review Date:</b> <del>11/13/2024</del> 11/12/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIAL <u>SING</u>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <del>11/13/2024</del> 11/12/2025

**I. RELATED POLICIES:**

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- ~~B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions~~
- ~~B-C. MPUP3139 – Criteria and Guidelines for Utilization Management~~

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. Medical Necessity - Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
- B. Standard of Care – The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstances.

**IV. ATTACHMENTS:**

- A. N/A

**V. PURPOSE:**

To adopt evidence based criteria from the National Comprehensive Cancer Network (NCCN) for use in evaluating the medical necessity of positron emission tomography (PET) scans for Members diagnosed with a malignancy. This policy will also address the use of PET Scans in other areas besides oncology.

**VI. POLICY / PROCEDURE:**

- A. Treatment Authorization Requests (TARs) for PET scans for those Members diagnosed with cancer or being evaluated for possible diagnosis of cancer are reviewed using the current guidelines from the National Comprehensive Cancer Network which may be found on these webpages:  
[https://www.nccn.org/professionals/physician\\_gls/default.aspx](https://www.nccn.org/professionals/physician_gls/default.aspx) or  
<https://www.NCCN.org/professionals/imaging/content>  
 If the clinical situation is not covered in NCCN, InterQual® Positron Emission Tomography (PET) Whole Body is a reliable resource.
  - 1. Requests for PET Scans related to cancer can be approved by Utilization Management Nurse

<b>Policy/Procedure Number: MPUP3116</b>		<b>Lead Department: Health Services Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 09/19/2012 Effective 01/01/2013</b>		<b>Next Review Date: 11/13/202511/12/2026 Last Review Date: 11/13/202411/12/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

Coordinators without referral to the Chief Medical Officer ([CMO](#)) or Physician Designee for further evaluation in the following circumstances:

- a. The request is part of the initial work up for a malignancy and there has been a biopsy that is positive for a malignancy. This is part of the initial staging for a malignancy.
  - b. The request is part of a re-staging of a malignancy following treatment such as chemotherapy or radiation therapy or post-operative after resection of a tumor. There must be a minimum of three months between PET Scans and there must have been active treatment during that time.
  - c. The request is part of a routine screening for a malignancy following treatment. There must have been at least six months of time elapsed since the end of treatment.
  - d. Requests for PET Scans that do not fit these criteria will be referred to the ~~CMO~~[Chief Medical Officer](#)/Physician Designee for review.
- B. PET Scan authorization requests for clinical problems other than malignancies will be reviewed on a case by case basis by the Partnership ~~Chief Medical Officer or CMO~~/Physician Designee.
1. Decisions about appropriate use of PET Scans will be based on existing Standard of Care and/or reasonableness of the procedure for advancing the diagnosis and treatment of a clinical problem. Standard of Care can be developed using policies from other healthcare providers and consultation with experts in the field as well as review of current and relevant medical literature and on-line references including UpToDate.
  2. Review decisions will be based on the definition of Medical Necessity.
- C. For any request, denials for medical necessity will only be made by a physician. All medical necessity denials are subject to Partnership's appeals process ([see policy MCUP3037 Appeals of Utilization Management/Pharmacy Decisions](#)).
- D. When a PET Scan is paired with another imaging modality, such as Three Dimensional Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), the associated modality will be reviewed along with the PET Scan.

#### VII. REFERENCES:

- A. National Comprehensive Cancer Network ([NCCN](#)) criteria
- B. InterQual® Criteria
- C. [Medi-Cal Provider Manual/Guidelines](#)
- D. [UpToDate](#): (*Topic specific to the disease process being evaluated*)

#### 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](#)  
01/20/16; 11/11/16; 11/15/17; \*02/13/19; 02/12/20; 01/13/21; 01/12/22; 11/09/22; 11/08/23; 11/13/24;  
[11/12/25](#)

\*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 MPUP3116 \(Healthy Kids program ended 12/01/2016\)](#)  
01/20/16; 11/11/16 to 12/01/2016

<b>Policy/Procedure Number: MPUP3116</b>		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>
<b>Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>
<b>Original Date: 09/19/2012</b> Effective 01/01/2013	<b>Next Review Date: 11/13/202511/12/2026</b> <b>Last Review Date: 11/13/202411/12/2025</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

Partnership Advantage

MPUP3116 – 09/19/2012 to 01/01/2015

Healthy Families

MPUP3116– 09/19/2012 to 03/01/2013

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

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

The materials provided are guidelines used by 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.

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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY/ PROCEDURE**

<b>Policy/Procedure Number: CGA022</b>			<b>Lead Department: Grievance &amp; Appeals</b>	
<b>Policy/Procedure Title: Member Discrimination Grievance Procedure</b>			<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 11/08/2016</b>		<b>Next Review Date: 11/12/2026</b> <b>Last Review Date: 11/12/2025</b>		
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>	
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input checked="" type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>		<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b>
	<input checked="" type="checkbox"/> <b>CEO</b>	<input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input checked="" type="checkbox"/> <b>PAC</b>
<b>Approval Signature: Robert Moore, MD, MPH, MBA</b>			<b>Approval Date: 11/12/2025</b>	

**I. RELATED POLICIES:**

- A. CGA024 Medi-Cal Member Grievance System
- B. CMP10 Confidentiality
- C. CMP13 Permitted Use, Disclosure, and Minimum Necessary Use of Member Information
- D. CMP15 Amendment of Member’s Protected Health Information
- ~~D~~.E. [CMP26 – Verification of Caller Identity and Release of Information](#)
- E,F. MC305 Distribution of Member Rights and Responsibilities
- F,G. MCNP9004 Regulatory Required Notices [and Taglines](#)
- G,H. MP316 Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior
- H,I. MPPR200 [PartnershipHC](#) Provider Contracts
- I,J. MPQP1053 Peer Review Committee

**II. IMPACTED DEPTS:**

- A. All Departments

**III. DEFINITIONS:**

- A. Adverse Benefit Determination (ABD): is generally a benefit that has been denied, limited, or stopped. This also includes not paying for covered benefits. The Department of Healthcare Services (DHCS) formally defines it as encompassing all previously existing elements of “Action” under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability which includes the following:
  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’s request to obtain services outside the network.
  7. The denial of a Member’s request to dispute financial liability.
- B. Civil Rights Coordinator: is a specialized Grievance Case Analyst trained in Civil Rights Laws. This person is responsible for handling end-to-end investigations of all Member Discrimination Grievances. This person answers questions related to State and Federal Civil Rights Laws, including disability related questions, for Partnership HealthPlan of California (Partnership) staff and Members.
- C. Civil Rights Laws: includes section 1557 of the Patient Protection and Affordable Care Act (ACA).

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Section 1557 incorporates and enforces other Federal civil rights laws such as Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, California State laws that protect Members from Discrimination include California Government Code Section 12926, California Government Code Section 11135, and California Penal Code 422.56.

- D. Complaint: is the same as a Grievance.
- E. Discrimination: is when a person is treated unfairly, differently, or unequally from others, because of the reasons described in the Civil Rights Laws definition.
- F. Grievance: is generally a Complaint about the experience or services received while using your Partnership Medi-Cal plan. DHCS formally defines it as an expression of dissatisfaction about any matter that is not an Adverse Benefit Determination.
- G. Member: is a person who is eligible for Medi-Cal receives health care benefits through Partnership.
- H. Provider: is a ~~person, group, or facility that is licensed, accredited, or certified to treat or offer health care services to Partnership Members. Some examples are a physician, a hospital, lab, ambulance, skilled nursing facility, or pharmacy.~~ physician, mid-level clinician, pharmacist, other licensed clinician or other individual providing medical care to a Partnership member, physician’s staff member, or authorized billing representative of a physician.

**IV. ATTACHMENTS:**

A. N/A

**V. PURPOSE:**

To ensure that all Members are aware of their discrimination rights, how to report a violation, and the investigation process. The sections below outline the various components to the Grievance System as well as the process for Discrimination Grievances. Allegations identified in section VI.B.1 will be subject to these processes. This policy is written in accordance with Partnership’s contract with the DHCS: 23-30236 Exhibit A, Attachment III – 4.6 Member Grievance and Appeal System and sections III (A)-(C) of All Plan Letter (APL) 21-011.

**VI. POLICY / PROCEDURE:**

A. How Partnership Communicates Member’s Rights

- 1. Partnership includes out notice of non-discrimination in the Partnership Member Handbook. The Partnership Member Handbook is available on our website 24 hours a day 7 days a week at [www.partnershiphp.org](http://www.partnershiphp.org). It is also available by calling Partnership Member Services department at 1-800-863-4155 (TTY: (800)735-2929 or 711).
- 2. Partnership expects our Members to be treated fairly and to treat their providers fairly. “Your Rights” and “Your Responsibilities” are outlined in the Partnership Member Handbook. It is also explained in Partnership Policy MC305 titled Distribution of Member Rights and Responsibilities.

B. How Partnership Practices Non-Discrimination

- 1. Partnership follows all State and Federal Civil Rights Laws. Partnership does not discriminate, exclude people, or treat them differently because of any reasons listed below.
  - a. *Disability* – a person with a physical or mental problem that limits major life activities. Some examples are seeing, hearing, and sleeping.
  - b. *Basis of Sex* – a person’s gender identity and sex stereotypes. It also includes a person who is or has a medical condition related to pregnancy, false pregnancy, abortion, or childbirth.
  - c. *Gender* – a person who is male, female, neither, or both.
  - d. *Gender Identity* – a person’s belief about their gender. This could be different from a person’s gender assigned at birth.

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- e. *Gender Expression* – a person’s appearance and behavior whether or not it is commonly accepted according to the gender they were born with.
  - f. *Sex Stereotypes* – a person who represents or communicates their masculinity or femininity in uncommon ways.
  - g. *Sexual Orientation* – a person who is heterosexual, homosexual, or bisexual.
  - h. *Nationality* – where a person is born, their citizenship, cultural, or language characteristics.
  - i. *Race or Ethnicity* – a person’s ancestry, color, or ethnic background.
  - j. *Religion* – a person’s religious belief, practice, or things observed.
  - k. *Language Assistance Services* – interpretation services that help people with a Limited English Proficiency communicate in English.
  - l. *Limited English Proficiency* – a person whose first language is not English and has trouble reading, writing, speaking, or understanding English.
  - m. *Group or Character Association* - a person who identifies with or is associated with a specific group or club. The person or group has characteristics protected under Disability, Gender, Nationality, Race, Ethnicity, Religion, or Sexual Orientation.
  - n. *Auxiliary Aids & Services* – services used by a person who is deaf, blind, hard of hearing or seeing to help them communicate. These services include sign language, test telephones, or other such devices to get information. This also includes any effective method to improve reading such as large print.
  - o. *Age* - a person because of how old they are.
  - p. *Genetic Information* – a person or family members requesting genetic tests, receiving genetic tests, or ~~joining~~ participating in a clinical research about genetic tests. This also includes symptoms of a disease or disorder in a family member.
2. Partnership investigates all allegation(s) of discrimination because Members should ~~but~~ not have unlawful barriers to healthcare while using their Partnership Medi-Cal benefits.
  3. Partnership Members have the right to receive healthcare services through Partnership Medi-Cal plan free from discrimination.
    - a. A Member should not be denied any covered services or availability of a service because of a reason defined in Section VI.B.1, except where medically indicated.
    - b. A Member should not be provided any covered service differently from another Member because of a reason defined in Section VI.B.1, except where medically indicated.
    - c. A Member should not be separated from others or subjected to a different treatment in order to receive any covered service because of a reason defined in Section VI.B.1, except where medically indicated.
    - d. A Member should not be restricted in receiving any covered service because of a reason defined in Section VI.B.1, except where medically indicated.
    - e. A Member should not be treated differently from others to determine whether they satisfy any requirement or condition to be provided any covered service because of a reason defined in Section VI.B.1, except where medically indicated.
    - f. A Member should not be assigned a time or place to receive covered services because they have characteristics associated with any reason defined in Section VI.B.1, except where medically indicated.
    - g. A Member should not be discriminated against because of their health status during enrollment, re-enrollment, disenrollment, or termination.
  4. It is against the law for Partnership to retaliate against any person who files a Grievance or participates in the investigation of a Grievance.
- C. What a Member Should Do If Discrimination Occurs
1. As a Member, you will file a Grievance if you believe Partnership or a provider discriminated

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<b>Original Date:</b> 11/08/16		<b>Next Review Date:</b> 11/12/2026 <b>Last Review Date:</b> 11/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

against you.

2. As a Member, you will file a Grievance if you believe Partnership or a provider did not treat you fairly.
3. As a Member, you will file a Grievance by phone, writing, online, or in person.
  - a. *Phone* – Call Partnership Member Services at 1-800-863-4155. TTY/TDD 1-800-735-2929 or 711.
  - b. *Writing* – Write and mail a letter to:  
Partnership HealthPlan of California  
ATTN: Grievance & Appeals Department  
4665 Business Cener Drive  
Fairfield, CA 94534
  - c. *Online* – Visit Grievance & Appeals section under Members at [www.partnershiphp.org](http://www.partnershiphp.org)
  - d. *In person* – Visit your doctor’s office or a Partnership local office. Say you want to file a Grievance.
4. Your Grievance must describe how you were discriminated against, the result of the discrimination, and how you want it fixed.
5. As a Member, you have the right to submit any evidence.
6. As a Member, you will support the Grievance process by sharing your experience with the Civil Rights Coordinator. You will be available for any questions.
7. As a Member, you have the right to pursue other legal or administration remedies, while filing a Discrimination Grievance with Partnership. This includes filing a Grievance with the U.S. Department of Health and Human Services, Office for Civil Rights.

Office for Civil Rights  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

1-800-368-1019  
TDD Toll-Free 1-800-537-7697  
Email: [1557@hhs.gov](mailto:1557@hhs.gov)  
Website: [www.hhs.gov/ocr](http://www.hhs.gov/ocr)

8. Any person filing a Discrimination Grievance on behalf of a Member
    - a. Any person who believes a Partnership Member has been subjected to discrimination may file a Grievance. Per Partnership Policy CMP15 titled Amendment of Member’s Protected Health Information, Partnership will ask the Member for their authorization in order to begin the investigation.
    - b. Partnership has the right to open a Grievance on the Member’s behalf if we suspect discrimination has occurred.
    - c. A Member has the right to withdraw their Grievance case.
    - d. If the case is withdrawn, Partnership reserves the right to continue the investigation. This may occur if Partnership decides the allegation(s) is dangerous, grossly inappropriate, threatening, or unlawful.
- D. Understanding the Investigation Process
1. Free assistance with communication
    - a. Partnership offers free aids and services to a person with a disability to help them communicate better so they can participate in the Grievance process.

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- b. Partnership offers free language services to a person whose primary language is not English so they can participate in the Grievance process.
2. Storing and Safeguarding your information
- a. Partnership will monitor the confidentiality of all files and records. Our practice is defined in Partnership Policy CMP10 titled Confidentiality.
- b. Partnership will share information only with those who have a need to know during the investigation process. Our practice follows the requirements identified in Partnership Policy CMP13 titled Permitted Use, Disclosure, and Minimum Necessary Use of Member Information.
- ~~b.c.~~ All Grievance records shall be maintained by Partnership for no less than ten (10) years. Grievance records include, but not limited to: the name and contact information of the complaint, if provided, the alleged discriminatory action and alleged basis of discrimination, the date the Grievance was filed, the date the Grievance was resolved, the Grievance resolution, and any other pertinent information.
3. The investigation process for alleged Discrimination
- a. Discrimination Grievances follow the investigation process defined in Partnership Policy CGA024 titled Medi-Cal Member Grievance System, with a few additional steps.
- b. All Discrimination Grievances are assigned a Civil Rights Coordinator who oversees the investigation of the case.
- c. The Civil Rights Coordinator will assess the allegation(s) to determine if the Member's Rights and Responsibilities were violated. As defined in the Partnership Member Handbook. If the investigation finds the Member was unfairly treated, the offending party will be educated on Partnerships Member's Rights and Responsibilities. Furthermore, Partnership will request the supervisor of the employee be notified of the Grievance and take appropriate corrective action, in accordance with the organization's human resources policy.
- d. The Civil Rights Coordinator will further assess the allegation(s) to determine if it falls under any category identified in Section VI.B.1. If so, the case will be referred to Partnership's Health Equity department to review the case details and offer an additional opinion if discrimination was likely or unlikely. The Civil Rights Coordinator will review the Health Equity Department's perspective and if their determination differs the case will be escalated to a three-person panel for review and determination. To comply with All Plan Letter (APL) 21-004, the Civil Rights Coordinator will forward the following information to DHCS within 10 calendar days of mailing the Notice of Resolution Letter:
- i The Civil Rights Coordinator's contact information
  - ii The contact information of the Member
  - iii The problem as stated by the member or authorized representative
  - iv The accused party's response to the Grievance and their contact information
  - v All correspondence to and from the member including the final Notice of Resolution Letter
  - vi Copies of any corrective action plan(s) taken in response to the Grievance
- e. The Member will receive a Notice of Resolution Letter describing the results of the investigation. It will include additional information about their rights to pursue further administrative or legal solutions. ~~in the event the Member is dissatisfied with Partnership's outcome of the discrimination Grievance, the Member can ask for a Second Level Grievance. A different Civil Rights Coordinator, who was not involved in the original decision, will reinvestigate the case. A new decision will be made and communicated to the Member in a second Notice of Resolution Letter.~~
- f. In the event that Partnership determined that discrimination likely occurred, the Civil Rights Coordinator will send a letter to the provider. This letter will inform the provider that a member

<b>Policy/Procedure Number: CGA022</b>		<b>Lead Department: Grievance &amp; Appeals</b>	
<b>Policy/Procedure Title:</b> Member Discrimination Grievance Procedure		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 11/08/16		<b>Next Review Date:</b> 11/12/2026 <b>Last Review Date:</b> 11/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Partnership Advantage</b>

has alleged discrimination against them, with a brief explanation of the category of discrimination. The letter also offers support to the provider by supplying information on trainings to improve interactions with patients to avoid similar incidents in the future. The G&A department tracks discrimination allegations against our providers. In the event a provider receives a second discrimination allegation within a rolling three-year period, the Civil Rights Coordinator will send an additional letter to the provider, including follow-up training requirements. Additionally, the G&A department will notify the Credentialing team upon confirmation of the second incident.

g. Allegations of discrimination against any Partnership provider are subject to review by Partnership's Peer Review Committee. Information about this committee can be found in Partnership Policy MPQP1053 titled Peer Review Committee.

**VII. REFERENCES:**

- A. 45 CFR 92 et. seq.,(Section 1557 of ACA);
- B. California Government Code Section 12926 (sex, gender expression);
- C. California Government Code Section 11135 (sex, race, color, disability, national origin, age);
- D. California Penal Code Section 422.56;
- E. 42 U.S.C. § 2000d et seq., Title VI of the Civil Rights Act of 1964 (race, color, national origin);
- F. 20 U.S.C. § 1681 et seq., Title IX of the Education Amendments of 1972 (sex);
- G. 42 U.S.C. § 6101 et seq., the Age Discrimination Act of 1975 (age);
- H. 42 U.S.C. § 1211 et seq., Americans with Disabilities Act of 1990
- I. 29 U.S.C § 794, Section 504 and 508 of the Rehabilitation Act of 1973 (disability);
- J. DHCS Contract ~~22-20196~~ 23-30236, Exhibit A Attachment III 4.6 Member Grievance and Appeal System
- ~~J.~~K. DHCS APL 21-011 Grievance and Appeals Requirements Notice and "Your Rights" Templates (revised 08/31/22)

**VIII. DISTRIBUTION:**

- A. [www.partnershiphp.org](http://www.partnershiphp.org)
- B. Partnership Provider Manual
- C. Partnership Department Directors

**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:**

Director, Grievance & Appeals

**X. REVISION DATES:**

03/14/18; 06/12/19; 10/14/20; 10/13/21; 01/11/24; 11/13/24; 11/12/25

**PREVIOUSLY APPLIED TO:** N/A

## Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the October 15, 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 #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i> )	External Documentation (Notice required outside of originating department)
<b>Policy Owner: Behavioral Health</b> – <i>Presenter: Jeff DeVido, MD, Clinical Director, Behavioral Health</i>			
MPBP8003 – Mental Health Services	197 – 232	<p>Updates made to align with new All Plan Letter (APL) 25-010 Adult and Youth Screening and Transition Tools for Mental Health Services, which allows for a clinician to override the result of the screening tool if it is inconsistent with the clinical presentation of the member. [VI.B.3.c.3]</p> <p><b>III.A Definition added:</b> (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnership’s service area. BHPs are required to provide and cover all medically necessary Specialty Mental Health Services (SMHS) and Substance Use Disorder (SUD) treatment services in accordance with their contracts with the Department of Health Care Services (DHCS).</p> <p><b>VI.I.3 adds</b> Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization.</p> <p><i>Footnotes:</i></p> <ol style="list-style-type: none"> <li>2. Some mental health treatment services, such as TMS, may be available in both SMHS and NSMH systems of care. Partnership’s coverage of these treatment services through NSMH is, therefore, not intended to duplicate, supplant, or exclude the potential of those treatment services being offered in the SMHS system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMHS systems of care to ensure Members receive clinically indicated care in the most appropriate mental health system of care.</li> <li>3. For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of electro convulsive therapy (ECT). Hospital incurred medical costs for ECT (<i>i.e.</i>, anesthesia) for Partnership Medi-Cal Members are covered by Partnership.</li> </ol> <p><b>Per discussion at Oct. 7 IQI, MCUP3041, Treatment Authorization Request (TAR) Review Process</b> is added to the Related Policies list because TMS requires prior authorization. Also, APL 25-013 supersedes all APL 22-012 references.</p>	Health Services Claims Member Services
MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral	233 – 240	<p>This policy update reflects changes necessitated by the de-delegation of Carelon for triage and referral services: Partnership began handling these calls in-house on Sept. 29.</p> <p><b>Section V. is updated to read:</b> The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and</p>	Health Services Claims Member Services

## Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i> )	External Documentation (Notice required outside of originating department)
Guidelines (previously MPCP2017)		<p>2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership HealthPlan of California, and for referral to County Behavioral Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between Primary Care Providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.</p> <p><b>VI.B.3 now contains the following addition:</b> (Note that by Jan. 1, 2026, all California counties are expected to be compliant with SB43 which updates the LPS clinical definition of “Grave Disability.” For more information: <a href="https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf">https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf</a>)”</p> <p><b>VI.C.4.i is added</b> to the risk factor list of what PCPs should assess: “Risk to self or community due to high risk behaviors and/or impaired judgment (<i>i.e.</i>, operating motor vehicles while intoxicated).”</p> <p><b>References added:</b> APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (June 3, 2025), supersedes APL 22-028. Also, APL 25-013 supersedes APL 22-012.</p> <p><b>Attachment A</b> Partnership Behavioral Health Referral Form has been modified to reflect the changed relationship with Carelon as these referrals will now be sent directly to Partnership.</p>	
<b>Policy Owner: Enhanced Health Services – Presenter: Lisa Brundage O’Connell, MHA, Director, Enhanced Health Services</b>			
MPAP7003 (previously MCAP3142)	241 – 268	<p>Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services:</p> <ul style="list-style-type: none"> <li>• Deposits [See VI.F.2.]</li> <li>• Short-Term Post Hospitalization Housing [See VI.F.4.]</li> <li>• Recuperative Care [See VI.F.5]</li> <li>• Medically Tailored Meals and Groceries (MTM/G) [See new VI.F.6.]</li> <li>• Asthma Remediation – service will be added Jan. 1, 2026 [See new VI.F.11.]</li> <li>• Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.)</li> </ul> <p><b>Per discussion at Oct. 7 IQI</b>, “Registered Dietician (RD) or Registered Dietician Nutritionist” is added to the Definition section here because a RDN assessment is required for an individual to qualify for MTM. (This definition is also added to UM’s Medical Nutrition policy on today’s consent calendar.)</p> <p><b>Section III Definitions added</b> for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent</p>	<p style="text-align: center;">Health Services Claims Finance Member Services Provider Relations Administration</p>

## Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i> )	External Documentation (Notice required outside of originating department)
		<p><b>III.J - Transitional Rent:</b> Effective Jan. 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.</p> <p><b>Section VI.C</b> Member Identification and Referral for Community Support Services is updated with track and trending provisions.</p> <p><b>Section VII. References is updated</b> with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and initial policy references to these APLs are hyperlinked.</p> <p><b>Attachment A:</b> Deleted the matrix as this information is in the DHCS Policy Guides and codes are listed on our website in other materials. Information changes frequently so decision to delete matrix was made since information is provided in other materials. Updated information and made changes to Deposits, Short-Term Post Hospitalization Housing, Recuperative Care, Medical Tailored Meals/Groceries and added new service, Asthma Remediation.</p>	
<b>Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations</b>			
MCUP3015 – Family Planning By-Pass Services	269 – 272	<p>This policy is being updated to describe Prohibited Entities as per H.R.1. and All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025).</p> <p><b>Section III.A:</b> Added end note 1 to the definition of Bypass Services: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive <b>federal</b> Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p> <p><b>Section III.C:</b> Added Definition of Prohibited Entity</p> <p><b>Sections VI.B., C., and E.:</b> Added end note message (same as described for III.A) regarding Prohibited Entities.</p> <p><b>Section VI.G.7.:</b> To the list of requirements for a family planning provider to be reimbursed, added, “The provider must not be a Prohibited Entity as defined in III.C. above.”</p> <p><b>Section VII.F. and G.:</b> Added References for APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) and Public Law No. 119-21, H.R.1, 119th Congress. (2025)</p> <p><b>Per Oct. 7 IQI discussion,</b> “federal” was added to all end note descriptions of “Medicaid reimbursement.” End note 3 relating to VI.E. Abortion-related services was further altered: “Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal</p>	<p>Member Services Claims Compliance Regulatory Affairs Config Provider Relations Providers Network Services</p>

## Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i> )	External Documentation (Notice required outside of originating department)
		<p>Medicaid reimbursement. <del>As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members.</del> Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.”</p>	
MPUP3035 – Preoperative Day Review	273 – 276	<p>During annual review, this policy was updated to remove old criteria.</p> <p><b>Section I.B.:</b> Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management</p> <p><b>Section III.:</b> In the Definition of Preoperative Day, description was generalized to refer to “patients admitted before surgery,” without reference to the number of days. Also removed language describing “InterQual®” and specified “medical necessity criteria” instead. Remove language about UM Leadership being involved in the review.</p> <p><b>Section IV.:</b> Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead.</p> <p><b>Section VI.B.2. – 2.b.:</b> Updated language describing how a nurse coordinator reviews a preoperative day request. Removed direct reference to InterQual and added reference to policy MPUP3139 Criteria and Guidelines for Utilization Management.</p> <p><b>Section VIII.A.:</b> Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System.</p> <p><b>APPENDIX:</b> Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews.</p>	Provider Relations

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPBP8003 (previously MCUP3028, UP100328)		<b>Lead Department:</b> -Health Services Business Unit: Behavioral Health	
<b>Policy/Procedure Title:</b> Mental Health Services		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> <del>06/11/2026</del> 11/12/2026 <b>Last Review Date:</b> <del>06/11/2025</del> 11/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> Employees	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Partnership Advantage
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS <u>SING</u>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval Date:</b> <del>06/11/2025</del> 11/12/2025	

**I. RELATED POLICIES:**

- A. [MPBP8011 MPCP2017](#) – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
- B. 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. MPUP3014 – Emergency Services
- F. [MPBP8007MCUP3101](#) – 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
- J. [MCUP3041– Treatment Authorization Request \(TAR\) Review Process](#)

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

- A. (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnership’s service area. BHPs are required to provide and cover all medically necessary- [Specialty Mental Health Services \(SMHS\)](#) and Substance Use Disorder (SUD) treatment services in accordance with their contracts with [the Department of Health Care Services \(DHCS\)](#).
- 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.
- C. 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.
- D. 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

<b>Policy/Procedure Number: MPBP8003</b> (previously MCUP3028, UP100328)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Mental Health Services		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> 06/11/2026 <b>Last Review Date:</b> 06/11/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

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.

- E. (MBHO) Managed Behavioral Healthcare Organization: Partnership HealthPlan of California’s delegated managed behavioral healthcare organization is Carelon Behavioral Health
- F. (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.
- 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<sup>1</sup>, supplies, and supplements
- J. Partnership Advantage: Effective January 1, 2027, 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-enrollees 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.
- L. Specialty Mental Health Services (SMHS): aka Serious and Persistent Mental Health Services  
County Behavioral Health Plans (BHPs) 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

<sup>1</sup> As per [APL 25-01322-012 Revised](#), the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. 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, 2027, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

<b>Policy/Procedure Number: MPBP8003</b> (previously MCUP3028, UP100328)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Mental Health Services		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> 06/11/2026 <b>Last Review Date:</b> 06/11/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

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.

- M. Wellness & Recovery Program: Partnership’s regional Drug Medi-Cal Organized Delivery System waived 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, 2027, 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.
- 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 served by contacting 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 Behavioral Health Plan in the Member’s county of responsibility. The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each County Behavioral Health Plan (BHP), consistent with California statutes and regulations.
  - 3. DHCS requires MCPs and BHPs 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 BHP 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 BHP 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

<b>Policy/Procedure Number: MPBP8003</b> (previously MCUP3028, UP100328)		<b>Lead Department: Health Services</b> <b>Business Unit: Behavioral Health</b>	
<b>Policy/Procedure Title:</b> Mental Health Services		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 04/25/1994		<b>Next Review Date:</b> 06/11/2026 <b>Last Review Date:</b> 06/11/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

- 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 BHP 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 [unless the MCP overrides the score consistent with the guidance outlined in DHCS APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services](#).
      - 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 BHPs or directly to BHP providers delivering SMHS. MCPs may only refer directly to a BHP provider of SMHS if policies and procedures have been established and MOUs are in place with the BHP to ensure a timely clinical assessment with an appropriate in-network provider is made available to the Member.
    - 3) [MCPs may override the Screening Tool score when the result is inconsistent with Member's clinical presentation \(e.g. the Screening Tool does not capture the need for SMHS in Members who are unable to respond to the Screening Tool questions due to serious mental health symptoms\)](#).
      - a) [Overriding the Screening Tool score must be conducted only by qualified practitioners of](#)

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NSMHS. MCP practitioner types that may override the Screening Tool score include Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists, Licensed Psychologists, Psychiatric Physician Assistants, Psychiatric Nurse Practitioners, Licensed Physicians, and waived Registered, or Clinical Trainee counterparts. MCPs are responsible for ensuring that all Practitioners deliver services within their scope of practice under California law.

- b) MCP Practitioners must provide their rationale and information supporting the rationale for overriding the Screening Tool score based on the following:
    - i. Information provided during screening indicates a higher level of services than NSMHS in needed. MCP should refer members to BMHP for a timely assessment.
    - ii. Information provided during screening indicates a lower level of services than SMHS in needed. BMHP should refer members to MCP for a timely assessment.
  - c) MCP must record overrides as well as the Practitioner’s rationale through the MCP’s preferred monitoring system (EHR, Excel spreadsheet) and share this information when referring a member to the appropriate Medi-Cal mental health delivery system following the administration of the Screening Tool. Overrides of the Screening Tool are subject to auditing and MCPs must provide the records, including the override rationale, to DHCS upon request.
  - d. The Adult and Youth Screening Tools are administered by Partnership’s ~~staff-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 designated staff, licensed and unlicensed, who are trained by the MCP to administer the Screening Tools in alignment with MCP protocols and in accordance with APL 25-010, 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.
  - f.g. The Screening Tools are also not required to be used when a Practitioner refers a member specifically to the MCP for NSMHS based on an understanding of the member’s needs and using their own clinical judgment. If a Practitioner refers a member directly to the MCP for NSMHS, the MCP should follow existing protocols for referrals in these scenarios.
  - g.h. 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.i. Completion of the Adult or Youth Screening Tool is not considered an assessment. Once a Member is referred to the MCP or BHP, they must receive an assessment from a provider in that system to determine medically necessary mental health services.
  - h.j. 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 BHPs for all Members, including adults age 21 and older and youth under age 21, when their service needs change, unless the member is currently receiving mental health

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services through the MCP or BMHP; or referred directly to a mental health delivery system by Practitioner based on an understanding of the Member's needs and using their own clinical judgment; or the member reaches out directly to the mental health delivery system.—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.

j.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.

k.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.

l.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

m.d. Following the completion of the Transition of Care Tool, Partnership ~~or its delegate, Carelon Behavioral Health,~~ shall:

- 1) Refer the Member to the BHP, or directly to a BHP provider delivering SMHS if appropriate processes have been established in coordination with BHPs.
- 2) Coordinate Member care services with BHPs 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.B.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 BHP.

n.e. The determination to transition services to and/or add services from the BHP 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

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accordance with accepted standards of clinical practice

e.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
- 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.
- 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.
- F. The County Behavioral Health Plan's (BHP's) role in providing mental health services:
1. County BHPs 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

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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.
- 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 MPBP8011 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 BHP'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.
- H. Managed Care Plan's responsibility for providing NSMHS:
1. Partnership is responsible for the delivery of NSMHS (as defined in III.I.) 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.) to correct or ameliorate health conditions for Members under the age of 21 shall be in accordance with the

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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.
- 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 APL 25-013](#) 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/>
  - 2.3. [Partnership covers Transcranial Magnetic Stimulation \(TMS\) under NSMHS with prior authorization.](#)<sup>2</sup>
- 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 MCUGP3118 Prenatal & Perinatal Care*)
- 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 BHP, 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.
- 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

<sup>2</sup> Note that some mental health treatment services, such as TMS, may be available in both SMHS and NSMH systems of care. Partnership’s coverage of these treatment services through NSMH is, therefore, not intended to duplicate, supplant, or exclude the potential of those treatment services being offered in the SMHS system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMHS systems of care to ensure Members receive clinically indicated care in the most appropriate mental health system of care.

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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
- 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.
- 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 MPBP8007 Screening and Treatment for Substance Use Disorders*)
- 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 Screening and Treatment for Substance Use Disorders.*)
- 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](http://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

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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.

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- 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

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<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

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 Behavioral Health Plan (BHP) and Partnership HealthPlan of California (Partnership) or its delegated managed behavioral healthcare organization, Carelon Behavioral Health, the BHP and Partnership will participate in a dispute resolution process as defined in Partnership Policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services.
  - a. Partnership does not delegate the responsibility of MCP and BHP dispute resolution to any

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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, 2027)

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-enrollees](#) 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-enrollees](#) 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-enrollees](#) 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-enrollees](#) 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, [hospital incurred medical costs for ECT \(i.e., anesthesia\)](#),

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- partial hospitalization and intensive outpatient treatment.<sup>3</sup>
- 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-enrollees~~ in need of this level of care will be provided care coordination and referral to their county BHP for services.

## 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) — Superseded.~~
- ~~N.M. DHCS [APL 22-029 Revised](#) Dyadic Services & Family Therapy Benefit (03/20/2023)~~
- ~~O.N. California Welfare and Institutions Code section [14132.755](#), Dyadic Behavioral Health Visits~~
- ~~P.O. Behavioral Health Information Notice ([BHIN](#)) [21-073](#)~~
- ~~Q.P. California Health Care Foundation explanation of [The Drug Medi-Cal Organized Delivery System](#)~~
- ~~R.Q. DHCS [APL 24-012](#) Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements (09/17/2024)~~
- ~~R. DHCS [APL 24-019](#) Minor Consent to Outpatient Mental Health Treatment or Counseling (12/31/2024)~~
- ~~S. DHCS [APL 25-010](#) Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (6/3/2025) *Supersedes APL 22-028*~~
- ~~S-T. DHCS All Plan Letter (APL) 25-013 “Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage” (09/18/2025)~~
- ~~T.U. California [Family Code](#) section [6924](#)~~
- ~~U.V. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in~~

<sup>3</sup> ~~Note that the administration of ECT is covered by Partnership for Partnership Advantage members. For Partnership members who are not Partnership Advantage members, the county BH Plans (SMH) are responsible for covering administration of ECT. Hospital incurred medical costs for ECT (i.e., anesthesia) for Partnership members are covered by Partnership regardless of whether the member has Partnership Advantage or not.~~  
For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of ECT. Hospital incurred medical costs for ECT (i.e., anesthesia) for Partnership Medi-Cal Members are covered by Partnership.

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draft (2025).

~~W.~~ 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\(c\)\(1\)\(iii\)](#)

~~W-X.~~ [Medicare Managed Care Manual, Ch. 4 § 110.1.1](#)

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

**X. REVISION DATES:**

MPHP8003  
06/11/2025; [11/12/2025](#)

**PREVIOUSLY APPLIED TO:**

MCUP3028: 10/18/2006 – 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: 04/25/1994 – 10/18/2006

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

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

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

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

[Note that some mental health treatment services, such as TMS, may be available in both SMH and NSMH systems of care. Partnership’s coverage of these treatment services through NSMH is, therefore, not intended to duplicate, supplant, or](#)

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exclude the potential of those treatment services being offered in the SMH system of care. As with all mental health treatment services, Partnership will coordinate care with the relevant SMH systems of care to ensure members receive clinically indicated care in the most appropriate mental health system of care.

# 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.<sup>1</sup>

## 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.

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<sup>1</sup> 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: <b>NOTE: If age 20 or younger, switch to the “Youth Screening Tool for Medi-Cal Mental Health Services.”</b>	
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation?  <b>NOTE: If yes, do not finish the screening and handle according to existing emergency or crisis protocols.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> 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?          <b>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.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <sup>1</sup>  <i><b>NOTE:</b> If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.</i>	2	0
12. Have you recently engaged in any self-harming behavior like cutting or hurting yourself?	2	0

Question	Yes	No
<p>13. Are you concerned about your current level of alcohol or drug use?<sup>2</sup></p> <p><i><b>NOTE:</b> If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.</i></p>	—	—
<p>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.)?<sup>2</sup></p> <p><i><b>NOTE:</b> If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.</i></p>	—	—
<p><b>Total Score:</b></p> <p><b>If score is 0 – 5, refer to the MCP per instruction #8</b></p> <p><b>If score is 6 or above, refer to the MHP per instruction #8</b></p>		
<p><sup>1</sup> 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.</p> <p><sup>2</sup> 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.</p>		

# 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.<sup>1</sup>

## 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.”

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<sup>1</sup> 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.<sup>2</sup>
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.

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<sup>2</sup> 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:	<b>NOTE:</b> <i>If age 21 or older, switch to the “Adult Screening Tool for Medi-Cal Mental Health Services.”</i>
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NOTE:</b> <i>If yes, do not finish the screening and handle according to existing emergency or crisis protocols.</i>	
2. Are you calling about yourself or about someone else? • If calling about someone else, who are you calling about and what is your relationship to them?	<input type="checkbox"/> Self <input type="checkbox"/> Someone else
<b>NOTE:</b> <i>If someone else, please switch to the “Respondent on Behalf of Youth” version of the tool.</i>	
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>NOTE:</b> <i>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.</i>	
5. When was the last time you saw your pediatrician or primary care doctor?	
<b>NOTE:</b> <i>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.</i>	

Question	Yes	No
6. Are you currently or have you ever been in juvenile hall, on probation, or under court supervision? <sup>1</sup>  <i>NOTE: If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
7. Are you currently in foster care or involved in the child welfare system? <sup>1</sup>  <i>NOTE: If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
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? <sup>1</sup>  <i>NOTE: If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
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? <sup>2</sup>  <i>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.</i>	—	—

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? <sup>3</sup>  <i>NOTE: If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.</i>	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? <sup>3</sup>  <i>NOTE: If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.</i>	2	0
21. Do you have plans to hurt others? <sup>3</sup>  <i>NOTE: If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.</i>	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:**

**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: <b>NOTE: If age 21 or older, switch to the “Adult Screening Tool for Medi-Cal Mental Health Services.”</b>	
Medi-Cal Number (CIN):	
1. Is this an emergency or crisis situation?  <b>NOTE: If yes, do not finish the screening and handle according to existing emergency or crisis protocols.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you calling about yourself or about someone else? • If calling about someone else, who are you calling about and what is your relationship to them?  <b>NOTE: If calling about themselves, switch to the “Youth Respondent” version of the tool.</b>	<input type="checkbox"/> Self <input type="checkbox"/> Someone else
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?  <b>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.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. When was the last time the child/youth saw their pediatrician or primary care provider?  <b>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.</b>	

Question	Yes	No
6. Is the child/youth currently or have they ever been in juvenile hall, on probation, or under court supervision? <sup>1</sup>  <i><b>NOTE:</b> If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
7. Is the child/youth currently in foster care or involved in the child welfare system? <sup>1</sup>  <i><b>NOTE:</b> If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
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? <sup>1</sup>  <i><b>NOTE:</b> If yes, stop the screening and refer to the MHP for clinical assessment.</i>	—	—
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? <sup>2</sup> <i><b>NOTE:</b> If yes, continue the screening and coordinate referral to the county behavioral health plan for substance use disorder assessment after the screening is completed.</i>	—	—
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? <sup>3</sup> <i><b>NOTE:</b> If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.</i>	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? <sup>3</sup> <i><b>NOTE:</b> If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of suicidality after the screening is completed.</i>	2	0
21. Does the child/youth have plans to hurt others? <sup>3</sup> <i><b>NOTE:</b> If yes, continue the screening and immediately coordinate referral to a clinician for further evaluation of homicidality after the screening is completed.</i>	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
<b>Total Score:</b>  <b>If score is 0 – 5, refer to the MCP per instruction #11</b> <b>If score is 6 or above, refer to the MHP per instruction #11</b>		

- 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

<b>REFERRING PLAN INFORMATION</b>	
<input type="checkbox"/> County Mental Health Plan <input type="checkbox"/> Managed Care Plan	
Submitting Plan:	
Plan Contact Name:	Title:
Phone:	Email:
Address:	
City:	State:      Zip:
<b>BENEFICIARY INFORMATION</b>	
Beneficiary's Name:	Date of Birth:
Beneficiary's Preferred Name:	
<input type="checkbox"/> Beneficiary or Legal Representative is in Agreement with Referral or Transition of Care	<b>Gender Identity:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Non-Binary <input type="checkbox"/>
	<b>Pronouns:</b> <input type="checkbox"/> He/Him <input type="checkbox"/> She/Her <input type="checkbox"/> They/Them <input type="checkbox"/>
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:
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**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:
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County Mental Health Plan:

County Mental Health Plan Contact Information

Fax:	Phone:	Toll Free:	TTY:
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**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> <del>MPBP8011 MPCP2017</del> (previously <del>MPCPCP2017</del> , MPQP1024, MPQG1024, QG100124) <del>MPBP8011</del>		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> 11/12/2026 <b>Last Review Date:</b> <del>02/12/2025</del> 11/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> Employees	<input checked="" type="checkbox"/> Medi-Cal	<input checked="" type="checkbox"/> Partnership Advantage
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIAL <u>SING</u>	<input checked="" type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <del>2/12/2025</del> 11/12/2025

**I. RELATED POLICIES:**

- A. ~~MCUP3101-MPBP8007~~ - Screening and Treatment for Substance Use Disorders
- B. ~~MCQG1005-MPOG1005~~ -- Adult Preventive Health Guidelines
- C. ~~MCUP3028-MPBP8003~~ - Mental Health Services
- D. ~~MCPUP3126~~ - Behavioral Health Treatment (BHT) for Members Under the Age of 21

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

- A. 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<sup>1</sup>, supplies, and supplements
- B. Specialty Mental Health Services (SMHS) aka Serious and Persistent Mental Health Services are those provided by County Mental Health Plans, generally 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.

**IV. ATTACHMENTS:**

- A. ~~Carelon/~~ Partnership Behavioral Health ~~Care Management~~ Referral Form (including Authorization for ~~Carelon Behavioral Health, Inc. Partnership to Release Confidential Information~~)

~~B.~~

**V. PURPOSE:**

<sup>1</sup> As per APL 22-012 Revised APL 25-013, this does not include medications covered by Medi-Cal Rx.: <https://medi-calrx.dhcs.ca.gov/home/education/>

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<b>Applies to:</b>	<input type="checkbox"/> <input checked="" type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <input type="checkbox"/> <b>Partnership Advantage</b>

The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership Health Plan of California's (Partnership's) delegated managed behavioral health organization, Celeron Behavioral Health (formerly known as Beacon Health Options) (855) 765-9703, and for referral to County Mental Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between Primary Care Providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.

The purpose of this guideline is to 1) Define the scope of primary care practice regarding behavioral health and/or substance use disorder conditions and 2) To define appropriate situations for referral for Non-Specialty Mental Health Services (NSMHS) to Partnership Health Plan of California, and for referral to County ~~Menta~~ Behavioral Health Plans and/or County Substance Use Disorder Services as appropriate. The guideline is intended to facilitate communication between Primary Care Providers (PCPs) and behavioral health specialists and to help identify educational opportunities for the Partnership provider network.

## VI. POLICY / PROCEDURE:

- A. Partnership utilizes this guideline to generally define the services and responsibilities of PCPs and behavioral health providers. PCPs are responsible for all services within the scope of primary care required by the patient except when clinical circumstances preclude the PCP role. The PCP's services are personal, and their responsibility is continuous. The scope of the responsibility is comprehensive, (i.e., all required services including preventive services). The PCP should provide those services which can be provided within their competence and should obtain consultation when additional knowledge or skills are required. Partnership recognizes that differences in skill level exist among PCPs; this document serves as a general guideline to define the scope of services and the indications for specialty referrals. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation. Consultation includes advice received from a specialist and the referral of a patient to a specialist for services. When care by specialists is required, it is the responsibility of the PCP and the specialists to coordinate all services.
- B. The PCP should be responsible for providing the following in regards to basic behavioral health conditions:
  1. Obtain developmental and psychosocial histories and perform mental status examinations when indicated by psychiatric or somatic presentations.
  2. Routinely screen for common behavioral health and substance use disorder conditions.
    - a. The plan has adopted, and Partnership contracted providers are expected to follow, the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Routine screening for depression is recommended by the USPSTF. Please refer to Partnership's Adult Preventive Health Guidelines policy MPQG1005 for further details.
    - b. Additionally, current versions of behavioral health and substance use disorder screening forms may be found on the Partnership Celeron Behavioral Health (formerly known as Beacon) website at this address: <https://www.celeronbehavioralhealth.com/providers/resources/provider-toolkit> <https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/default.aspx>
    - c. Screening for alcohol misuse is also required. Please refer to policy MCUP3101 (MPBP8007) Screening and Treatment for Substance Use Disorders for details.
  3. Ascertain whether individuals are experiencing symptoms that would warrant emergent or urgent psychiatric evaluation, such as significant suicidal or homicidal ideation and/or grave disability as defined by the Lanterman-Petris-Short Act (LPS) (see this web page: <https://ajud.assembly.ca.gov/sites/ajud.assembly.ca.gov/files/Kim%20Lewis%2C%20National%20Health%20Law%20Program%20slides.pdf>), active substance intoxication/withdrawal/use disorder, or disorganized thinking or psychomotoric agitation, and making appropriate referrals to complete

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these evaluations as clinically indicated. [Note that by January 1, 2026, all California counties are expected to be compliant with SB43 which updates the LPS clinical definition of “Grave Disability.” For more information: https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf)

4. Evaluate and provide ongoing management for the following:
  - a. Psychiatric factors affecting a medical condition and psychiatric symptoms precipitated by medications being used to treat medical conditions
  - b. Personality disorders that meet (or do not meet) the full criteria for a Diagnostic and Statistical Manual, Fifth Edition (DSM-5) diagnosis and ~~the severity of which does not necessitate SMHS~~ ascertain whether it may be beneficial for (and facilitate connection for) further specialty evaluation and/or management.
  - c. Medical assessments of members to evaluate and treat general medical conditions causing or exacerbating psychiatric symptoms.
  - d. Initial diagnosis and treatment of dementia. Differentiate dementia from other disorders effecting cognition, such as delirium, schizophrenia, substance misuse, and depression. Manage general medical factors that improve or worsen dementia. (See policy MCQG1005 - Adult Preventive Health Guidelines for more information on cognitive health assessments for members who are 65 years of age or older)
- C. The PCP should be responsible for the initial evaluation and referral for behavioral health services as follows:
  1. Medi-Cal only Members (with no Medicare):
    - a. All mental health services for these members are provided either by Carelon Behavioral Health’s network of providers (now accessed through Partnership HealthPlan call center) for Non-Specialty Mental Health Services (mild to moderate behavioral health conditions) or by County Mental Behavioral Health Plans for Specialty Mental Health services (aka serious and persistent mental health services).
    - b. Substance use disorder and substance misuse services for members in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties are ~~provided administered on behalf of these counties~~ by Partnership HealthPlan. Substance use disorder and substance misuse services for members in other counties are provided by each individual county’s Substance Use Programs. In all counties, substance use disorder and substance misuse treatment services may also be provided within the Partnership network through the prescribing of Medications for Addiction Treatment (MAT); see policy MPBP8007 MCUP3101 Screening and Treatment for Substance Use Disorders for further information.
  2. PCP may determine a diagnosis or provisional diagnosis for the following behavioral health conditions, as appropriate: schizophrenia/psychotic disorder, bipolar depression, depression, anxiety disorder, impulse control disorder, adjustment disorder, personality disorder (except anti-social), eating disorder, pervasive developmental disorder, disruptive behavior/attention deficit disorder, feeding and eating/elimination disorders, other disorders of infancy, childhood, or adolescence, somatoform disorders, factitious disorders, dissociative disorders, paraphilias, gender dysphoria, substance-related and addictive disorders.
  3. PCP should determine the level of functional impairment in the following life domains resulting from the behavioral health condition:
    - a. Independent living skills
    - b. Social relations
    - c. Physical condition (chronic medical condition)
    - d. Vocational/ Employment
    - e. Sexual Functioning
    - f. Self-care
    - g. Decision making

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<b>Applies to:</b>	<input type="checkbox"/> <input checked="" type="checkbox"/> Employees	<input checked="" type="checkbox"/> <u>Medi-Cal</u>	<input checked="" type="checkbox"/> <input type="checkbox"/> <u>Partnership Advantage</u>

- h. Legal
- i. Residential instability
- 4. PCP should assess risk factors linked to the further deterioration of behavioral health conditions such as:
  - a. Psychiatric hospitalization
  - b. Criminal behaviors and criminal justice system involvement
  - c. Suicidal/homicidal ideations and behavior
  - d. Experiencing psychotic or mood symptoms (especially in youth and transitional aged youth)
  - e. Self-injurious behavior (especially that which required medical attention)
  - f. Sexual aggression with risk of re-offending
  - g. Inability to adequately self-care
  - h. Ongoing substance misuse
  - ~~h-i.~~ Risk to self or community due to high risk behaviors and/or impaired judgment (i.e., operating motor vehicles while intoxicated)
- 5. For mental health conditions, PCP should refer Medi-Cal only members to Partnership Care ~~on Behavioral Health~~ when a provisional diagnosis is present or the diagnosis is uncertain, where functional impairment is considered to be in mild to moderate range, and where there are no deterioration/risk factors.
  - a. When Member's needs are outside PCP scope, PCP may refer for Outpatient Behavioral Health Services for therapy or medication management via Carelon's network of providers by providing the member with the Carelon Partnership Behavioral Health access line referral number (855) 765-9703. PCP can also fax a Carelon/Partnership PCP Behavioral Health Referral Form (Attachment AB) to Carelon Partnership at fax: ~~(877) 321-1787~~ (707) 914-0453 or use secure email to: medi-cal.referral@carelon.com BH-Access@partnershiphp.org. ~~Licensed Mental Health Providers at Carelon Behavioral Health Access Guides at Partnership~~ will utilize DHCS Screening and Transition of Care Tools as per APL 22-02825-010 to determine the appropriate mental health delivery system referral, including coordination with county BMHP if necessary (see policy ~~MPBPCUP30288003~~ Mental Health Services for more information).
  - b. PCP may request PCP Decision Support, which allows consultative peer discussion related to member diagnostic and medication clarification; the PCP may request a telephone consultation with a Carelon psychiatrist, ~~using the Carelon/Partnership PCP Referral Form (Attachment B)~~. Before phone consult with Carelon, PCP should fax medication list and last 2 PCP progress notes for Psychiatrist review. Fax: (877) 321-1787 or secure email: medi-cal.referral@carelon.com
  - c. PCP may refer for Local Care Management to help link members to mental health providers, support their transition between levels of care, or engage members with history of non-compliance and link them to community services by sending the Carelon/Partnership Behavioral Health Care Management Referral Form (Attachment A) to Carelon Partnership Fax: ~~(855) 371-2279~~ (707) 914-0453 or email: MediCal\_PHP@carelon.com BH-Access@partnershiphp.org.
  - d. Primary care sites with integrated behavioral health, whose mental health professionals are credentialed with Carelon, may co-manage patients who would qualify for the NSMHS mental health benefit.
  - e. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership member based on their current clinical competence and in collaboration with the behavioral health specialist as appropriate.
- 6. PCP should refer members to County Mental Behavioral Health Plans when a provisional diagnosis is present and when functional impairment is considered to be in the SMHS (moderate to severe) range, and/or when any risk factor is present.

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<b>Applies to:</b>	<input type="checkbox"/> <del>Employees</del>	<input checked="" type="checkbox"/> <u>Medi-Cal</u>	<input checked="" type="checkbox"/> <u>Partnership Advantage</u>

- a. The process of accessing mental health services in each county may be different. For initial telephone contacts, PCPs can refer to this webpage for County [Mental Behavioral Health](#) contact information: <http://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Mental-Health-Services.aspx>.
  - b. Patients with emergency psychiatric conditions should be referred for emergency evaluation, calling the county-designated crisis phone number to arrange for services: [https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/CrisisLines\\_Final\\_MH.pdf](https://www.partnershiphp.org/Providers/BehavioralHealth/Documents/CrisisLines_Final_MH.pdf).
  - c. After initial evaluation and/or referral, the PCP may continue to follow and treat a Partnership member based on [his/hers/their](#) current clinical competence and in collaboration with the behavioral health specialist as appropriate.
  - d. Federally qualified health centers (FQHCs) with integrated mental health may provide outpatient services for patients who would otherwise qualify for County Specialty Mental Health Services. These services are billed directly to the state.
7. PCP should screen and refer Medi-Cal only Members with substance use disorders and misuse as follows:
- a. Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) should be performed by PCP.
  - b. The process of accessing substance use disorder services in each county may be different.
    - 1) For Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano counties, members should be referred to [Carelon Behavioral HealthPartnership](#) (855) 765-9703 for [eall centeraccess](#) assistance to identify substance use disorder service providers.
    - 2) In all other counties, the first point of telephone contact for substance use disorder referrals for each county can be located on the Partnership website on this webpage under the heading “Alcohol and Drug Treatment (Substance Use Services)”: <http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx>
  - c. For details on substance use disorder and alcohol misuse screening and referral, see policy ~~MPBP8007 MCUP3101~~ Screening and Treatment for Substance Use Disorders.
  - d. Provide ongoing follow-up as jointly determined by the PCP and Substance Use Disorder treatment provider for members whose substance use disorder conditions have reached a high degree of stability.
8. Psychiatric manifestations of neurologic disorders, developmental neurologic disorders, traumatic brain injury, and cognitive impairment: A specialist in neuropsychiatry is ideally suited to assist with these cases. Providers can refer to [Carelon Behavioral HealthPartnership](#) to refer members for this service. Providers may also request [ease managementcare coordination](#) from [Carelon Partnership](#) to assist in establishing connections for these services using the [Carelon/Partnership Behavioral Health Care Management](#) Referral Form (Attachment A).
9. Behavioral Health Treatment (BHT) for Medi-Cal only Members Under the Age of 21 ([autism specific treatment](#)): BHT is covered by Partnership for members under the age of 21 through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services benefit. A Treatment Authorization Request (TAR) is required. See policy ~~MCPUP3126~~ - Behavioral Health Treatment (BHT) for Members Under the Age of 21.
10. School aged children may also have some assessment and treatment covered through their schools. School-based mental health services include a broad range of services, settings, and strategies. These services may include academic counseling, brief interventions to address behavior problems, family counseling, suicide prevention, and assessment and referral to other systems. Further information is available through your county mental health department.

## VII. REFERENCES:

<b>Policy/Procedure Number:</b> <u>MPBP8011 MPCP2017</u> (previously <u>MPCP2017, MPQP1024, MPQG1024, QG100124</u> )		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> <u>11/12/2026</u> <b>Last Review Date:</b> <del>02/12/2025</del> <u>11/12/2025</u>	
<b>Applies to:</b>	<input type="checkbox"/> <input checked="" type="checkbox"/> Employees	<input checked="" type="checkbox"/> <u>Medi-Cal</u>	<input checked="" type="checkbox"/> <input type="checkbox"/> <u>Partnership Advantage</u>

- A. Latest USPSTF Guide to Clinical Preventive Services
- B. County specific Mental Health Plan Memoranda of Understandings (MOUs)
- C. Welfare and Institutions Code Sections 14132.03 and 14189
- D. Title 9 of the California Code of Regulations, Chapter 11
- E. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (10/11/23)
  - Specialty Mental Health Services Memorandum of Understanding Template
  - Substance Use Disorder Treatment Services Memorandum of Understanding Template
  - Drug Medi-Cal State Plan Memorandum of Understanding Template
- F. DHCS All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
- ~~J. DHCS All Plan Letter (APL) 22-028 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (12/27/2022) DHCS APL 25-010 Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (6/3/2025) Supersedes APL 22-028~~
- K. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (Sept. 18, 2025 supersedes APL 22-012)

**VIII. DISTRIBUTION:**

- A. Partnership Provider Manual
- B. Partnership Department Directors

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

**X. REVISION DATES:**

Medi-Cal:

04/19/17; \*06/13/18; 06/12/19; 06/10/20; 06/09/21; 06/08/22; 06/14/23; 02/14/24; 2/12/25; MPBP8011: 11/12/25

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:**

Medi-Cal - MPQP1024

Original Date: 02/18/2004

Revision dates: 05/18/05; 04/19/06; 04/18/07; 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15

Healthy Kids - MPCP2017, MPQP1024 (Healthy Kids Program ended 12/01/2016)

Original Date: 04/18/2007

Revision dates: 04/16/08; 03/18/09 11/17/10; 01/16/13; 02/19/14; 05/20/15 to 12/01/2016

Partnership Advantage:

MPQG1024 – 04/18/2007 to 11/17/2010

MPQP1024 – 11/17/2010 to 01/01/2015

<b>Policy/Procedure Number:</b> <u>MPBP8011 MPCP2017</u> (previously <u>MPCP2017</u> , MPQP1024, MPQG1024, QG100124)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Behavioral Health	
<b>Policy/Procedure Title:</b> Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 02/18/2004 (QG100124)		<b>Next Review Date:</b> <del>02/12/2026</del> <u>11/12/2026</u> <b>Last Review Date:</b> <del>02/12/2025</del> <u>11/12/2025</u>	
<b>Applies to:</b>	<input type="checkbox"/> <input checked="" type="checkbox"/> Employees	<input checked="" type="checkbox"/> <u>Medi-Cal</u>	<input checked="" type="checkbox"/> <input type="checkbox"/> <u>Partnership Advantage</u>

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

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

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

The materials provided are guidelines used by 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 Behavioral Health Referral Form

Email: BH-Access@partnershiphp.org or Fax: (707) 914-0453

### Member Information:

Referral Date: \_\_\_\_\_ Member Name: \_\_\_\_\_ Medi-Cal CIN ID#: \_\_\_\_\_

Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (member's cell) Best day/time to reach the member: \_\_\_\_\_

### Youth/ Adolescent Services:

Member is under the age of 18  Yes  No

Parent/Guardian Name: \_\_\_\_\_

Parent/guardian's phone number: \_\_\_\_\_ Best day/ time to reach the parent/guardian: \_\_\_\_\_

Does the minor (12 and older) have capacity to give consent to services?  Yes  No

Youth's phone number: \_\_\_\_\_ Best day/ time to reach the youth: \_\_\_\_\_

### Referring Provider:

PCP Clinic/Agency: \_\_\_\_\_ Name of PCP: \_\_\_\_\_ PCP Phone #: \_\_\_\_\_

To receive confirmation of this referral's outcome, please check the box below noting preferred method & contact details:

Email address: \_\_\_\_\_  Fax Number: \_\_\_\_\_

### PCP Request

**Reason for referral:** (select the appropriate referral reason(s) below)

- Mental Health Services
- Substance Use Disorder Services
- Medication for Addition Treatment
- Eating Disorder Services
- Neurological Testing
- Maternal Mental Health
- Other, please specify: \_\_\_\_\_

**Symptoms:** (check all that apply):

- |                                                                                |                                                       |                                       |
|--------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Depression                                            | <input type="checkbox"/> Perinatal depression/anxiety | <input type="checkbox"/> PTSD/Trauma  |
| <input type="checkbox"/> Poor self-care due to mental health                   | <input type="checkbox"/> Violence/Aggressive behavior | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Psychosis (auditory/visual hallucinations, delusions) | <input type="checkbox"/> Psychological testing        | <input type="checkbox"/> Anxiety      |
| <input type="checkbox"/> Adverse Childhood experiences (ACEs)                  | <input type="checkbox"/> Neuropsychological testing   |                                       |
| <input type="checkbox"/> Substance use, please specify: _____                  |                                                       |                                       |
| <input type="checkbox"/> Other BH symptoms: _____                              |                                                       |                                       |

**Impairments:**

- Difficulties/Unable to complete ADLs
- Difficulties maintaining relationships
- Legal
- CPS
- Difficulties/Unable to go to work/school
- Other: \_\_\_\_\_

Submission of this form confirms member is aware of this referral.

For members 12 and older, in certain situations under privacy law AB1184 a written ROI may be required to share sensitive information with anyone including parents and guardians. If possible, please send this referral form along with a completed release of information for anyone who may be involved in the member's care.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPAP7003 (previously MCUP3142)		<b>Lead Department:</b> Health Services Business Unit: EHS	
<b>Policy/Procedure Title:</b> CalAIM Community Supports (CS)		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 03/09/2022 (MCUP3142) <b>Effective Date:</b> 01/01/2022 (MCUP3142)		<b>Next Review Date:</b> 11/11/2026 <b>Last Review Date:</b> 11/12/2025	
<b>Applies to:</b>	<input type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> <b>IQI</b>	<input type="checkbox"/> <b>P &amp; T</b>	<input checked="" type="checkbox"/> <b>QUAC</b>
	<input type="checkbox"/> <b>OPERATIONS</b>	<input type="checkbox"/> <b>EXECUTIVE</b>	<input type="checkbox"/> <b>COMPLIANCE</b> <input type="checkbox"/> <b>DEPARTMENT</b>
<b>Approving Entities:</b>	<input type="checkbox"/> <b>BOARD</b>	<input type="checkbox"/> <b>COMPLIANCE</b>	<input type="checkbox"/> <b>FINANCE</b> <input checked="" type="checkbox"/> <b>PAC</b>
	<input type="checkbox"/> <b>CEO</b> <input type="checkbox"/> <b>COO</b>	<input type="checkbox"/> <b>CREDENTIALS</b>	<input type="checkbox"/> <b>DEPT. DIRECTOR/OFFICER</b>
<b>Approval Signature:</b> <i>Robert Moore, MD, MPH, MBA</i>			<b>Approval Date:</b> 11/12/2025

**I. RELATED POLICIES:**

- A. MCAP7002 – CalAIM Enhanced Care Management (ECM)
- B. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
- C. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
- D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- E. ~~MCUP3103 – Coordination of Care for Members in Foster Care~~ – MCBP8015 Coordination of Care for Child Welfare-Involved Members
- F. [MPUG3011 – Home Health Services](#)
- G. MPCR100 – Credential and Re-credential Decision Making Process
- H. MPPR200 – Partnership Provider Contracts
- I. CMP36 – Delegation Oversight and Monitoring

**II. IMPACTED DEPTS:**

- A. Health Services
- C. Claims
- D. Finance
- E. Member Services
- F. Provider Relations
- G. Administration

**III. DEFINITIONS:**

- A. Community-Based Organizations (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
- B. 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).
- C. Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
- D. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services

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- and home health care services for in-home visits by a provider. In California, this is known as CalEVR
- E. 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.
- F. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports
- G. Global Cap: Recuperative Care and Short-Term Post Hospitalization Housing (STPHH) cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services. This means a member may not receive more than a combined six months of STPHH and Recuperative Care services during any rolling 12-month period.
- H. Partnership Advantage: Effective January 1, 2027, Partnership HealthPlan of California will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (DSNP) 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. Registered Dietician (RD) or Registered Dietician Nutritionist (RDN): An individual who has met current minimum (Baccalaureate) academic requirements with successful completion of both specified didactic education and supervised-practice experiences through programs accredited by The Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics and who has successfully completed the Registration Examination for Dietitians. To maintain the RD credential, the RD must comply with the Professional Development Portfolio (PDP) recertification requirements (accrue 75 units of approved continuing professional education every five years.)
- ~~H.~~J. In Home Supportive Services (IHSS) Program: The In-Home Supportive Services (IHSS) program is a Medi-Cal program funded by federal, state, and county dollars to provide in-home assistance to eligible aged (over the age of 65), blind and disabled individuals as an alternative to out-of-home care.
- ~~I.~~K. Transitional Rent: Effective January 1, 2026, Partnership will add a DHCS mandatory Community Supports Service for members meeting the Behavioral Health Population of Focus (PoF) within the overall eligible population. To be eligible for Transitional Rent, members must meet at least one requirement in each of the three domains: Clinical, Social, and Transitioning Risk Factors.
- ~~J.~~L. Whole Person Care (WPC): A five-year pilot program under California’s 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. Partnership counties participating in the WPC pilot program include Marin, Mendocino, Napa, Shasta, and Sonoma.

#### IV. ATTACHMENTS:

- A. [Community Supports Criteria](#)
- B. [Community Supports \(CS\) Release of Information \(ROI\)](#)

#### V. PURPOSE:

To describe how Partnership HealthPlan of California administers Community Supports (CS) for Partnership members and to outline the collaboration between members, Partnership, providers, county agencies,

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community resources, and Community Based Organizations (CBOs). Pursuant to the Department of Health Care Services (DHCS) All Plan Letter ([APL 21-017 Revised](#)), Community Support services are not plan benefits, but are instead optional services that Partnership may authorize for members to save health care costs while promoting better health outcomes for the member. Community Supports builds upon the design and learning from California’s Whole Person Care (WPC) and Health Homes Program (HHP) and are a part of DHCS’ waiver under CalAIM. The goals of Community Supports are:

- A. To place members in the least restrictive setting possible and keep them in the community.
- B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community resources to improve medical health outcomes and healthcare costs.

## VI. POLICY / PROCEDURE:

### A. PARTNERSHIP ADMINISTRATION OF COMMUNITY SUPPORTS:

1. Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are 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).
2. Effective January 1, 2022, Partnership offers the following DHCS approved CS services:
  - a. Housing Transition Navigation Services
  - b. Housing Deposits
  - c. Housing Tenancy and Sustaining Services
  - d. Short-Term Post-Hospitalization Housing
  - e. Recuperative Care (Medical Respite)
3. Medically Tailored Meals/Groceries Effective January 1, 2023, Partnership offers the additional DHCS approved CS services:
  - a. Respite Services
  - b. Personal Care and Homemaker Services
4. Effective January 1, 2025, Partnership offers the additional DHCS approved CS Services:
  - a. Day Habilitation Program
  - b. Sobering Centers
5. Effective January 1, 2026, Partnership offers the additional DHCS approved CS Services:
  - a. Asthma Remediation
  - b. Transitional Rent
6. Upon approval by DHCS, Partnership may elect to add additional CS services to their network every six (6) months.

### B. COMMUNITY SUPPORTS ELIGIBILITY CRITERIA:

1. To be eligible to receive a CS service, the member and/or CS provider must demonstrate that the service will result in:
  - a. A decrease in utilization and/or cost for a subsequent Medi-Cal benefit. Examples include, but are not limited to:
    - 1) Hospitalization (Medical or Behavioral Health conditions)
    - 2) Nursing Facility care
    - 3) Emergency Department use
2. CS services must be reviewed and pre-authorized as per policy MCAP7001 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
3. CS services are optional services that Partnership may offer and services that a member can decline or end at any time.
  - a. The CS service provider is responsible for obtaining the member’s consent for service and data sharing (when required by federal law) and remitting the consents to Partnership along with

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<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

other documents pursuant to policy MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

4. Please see Attachment A for Partnership’s methodology to ensure an appropriate, equitable, and non-discriminatory approach when reviewing and authorizing CS services. This includes eligibility requirements as outlined by DHCS.
    - a. In the event Partnership identifies the CS service authorization has an inappropriate, inequitable, and/or discriminatory effect, Partnership will take immediate action and set a Correction Action Plan (CAP), one-on-one meetings, and follow-ups to guarantee CS services providers and/or delegates adhere and align to Partnership policies and procedure; if a provider fails to adhere to the Corrective Action Plan, it may be decided to terminate the provider’s contract.
- C. MEMBER IDENTIFICATION AND REFERRAL FOR COMMUNITY SUPPORT SERVICES:
1. Partnership shall utilize a variety of methods to identify members who may benefit from CS, including:
    - a. Working with ECM Providers to identify members receiving ECM who could benefit from CS
    - b. Proactively identifying members who may benefit from the Partnership’s CS services, through the use of information such as:
      - 1) Enrollment data
      - 2) Utilization/claims data
      - 3) Screening or assessment data, when available (ex: HRA, IHA, HIF, ACEs, etc.)
      - 4) Clinical information on physical and/or behavioral health
      - 5) Severe Mental Illness (SMI)/Substance Use Disorder (SUD) data, when available
      - 6) Risk stratification information for children in Partnership’s Whole Child Model (WCM)
      - 7) Other cross-sector data and information, including housing, social services, foster care, criminal justice history, and other relevant information
    - c. Identification and referral by internal Partnership departments (ex: Care Coordination, Claims, Utilization Management, Quality, Member Services, Population Health Management, etc.)
  2. Partnership encourages direct referrals for members to access CS services. These direct referrals can come from a multitude of sources, including but not limited to:
    - a. PCPs, specialists, ECM providers, and/or CBOs via phone, secure electronic mail, mail or fax.
    - b. Members and/or their family member(s), guardian, Authorized Representative (AR), caregiver, and/or authorized support person(s) via phone, mail, or Partnership member portal.
  3. Upon internal identification or direct referral for a member who may potentially benefit and/or be eligible for a CS service, a referral shall be sent to Partnership’s Enhanced Health Services (EHS) department. The staff in the EHS department shall attempt to contact the member, CS provider, and/or the member’s caregiver, AR, or Lead Care Manager to refer the member to the CS service within ten (10) business days. Once a member is referred to a CS provider, the CS provider has two (2) business days to:
    - a. Notify Partnership that they received and accept the referral, and
    - b. Attempt to contact the member or their representative to begin services, or
    - c. Notify Partnership that the CS provider is at full capacity pursuant to their contract with Partnership so that the member can be re-referred to an alternative provider
  4. Partnership’s EHS department shall document and track the CS referral in the appropriate system.
    - a. If the member is receiving ECM, their Lead Care Manager shall document, coordinate and ensure closed-loop referrals and service delivery of the CS service(s) per the member’s Individualized Care Plan. For more information, see MCAP7002 CalAIM Enhanced Care Management (ECM).
  5. Members may be referred more than once for CS Services; members must engage with Partnership and/or CS providers to qualify for services.
    - a. Members who do not engage or are unresponsive to the CS Provider and/or Partnership may not be

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<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Employees</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input checked="" type="checkbox"/> <b>Partnership Advantage</b>

- authorized for CS Services again until the member is willing to engage and maintain communication.
- b. The member is responsible for a means to communicate with the CS Provider and/or Partnership.
6. If referral lacks required information, Partnership will make one (1) attempt to contact the referring party (e.g. case worker, lead care manager, etc.) or member to gather more information, however, member will be responsible to continue communication with Partnership and/or CS provider to prevent cancelation of services.
  7. Partnership will track and monitor all referrals to ensure complete and necessary information is shared securely and efficiently.
  8. Partnership will maintain timely data on referral status and intervene in support of individual referrals to improve member connections to services.
  9. Partnership will collect the data on a monthly basis from the service providers.
- D. DISCONTINUATION OF COMMUNITY SUPPORT SERVICES:
1. The CS provider shall notify Partnership, and the inter-disciplinary care team (e.g., PCP, Lead Care Manager, etc.) when a member discontinues CS services. Examples of discontinuation include, but are not limited to:
    - a. The member has met their goals for the service and/or their service limitations pursuant the approved CS Treatment Authorization Request (TAR)
    - b. The member expresses that they no longer wish to receive the CS service
    - c. The member is unresponsive or unwilling to engage with the CS provider and/or attempts from an ECM provider or Lead Care Manager (when applicable). Providers must make a minimum of three (3) outreach attempts. If no response, the CS provider must contact Partnership immediately for further direction.
    - d. The member is deceased
    - e. The member loses Partnership Medi-Cal eligibility
    - f. The member moves out of Partnership’s service area
    - g. The member becomes incarcerated for more than 30 days
    - h. The CS provider can no longer provide services (e.g.: patient behavior, unsafe environment, etc.)
  2. The CS provider may submit other reasons to request that the member discontinue services, for which Partnership will review on a case-by-case consideration.
  3. If a member was not informed at the beginning of the service delivery via the provider, portal or Treatment Authorization Request (TAR), Partnership will send a Notice of Action (NOA) letter to inform a member when the CS service is ending or discontinuing. NOAs are not required if the member has opted out of the CS service.
- E. COMMUNITY SUPPORTS PROVIDERS:
1. Partnership shall contract with both traditional and/or non-traditional providers for the provision of CS services. CS Providers can include, but are not limited to, those listed in the [Medi-Cal Community Supports, or In Lieu of Services \(ILOS\) Policy Guide](#) – under “Licensing/Allowable Providers.”
  2. Providers must communicate with Partnership and provide weekly updates through email, phone calls, meetings, etc. until the member is engaged and participating. When the member is engaged, a TAR should be submitted to authorize services for a specified period of time, which will allow the provider to submit claims for their services.
  3. All CS providers must have experience and expertise with the services they provide. To demonstrate such, all CS providers must complete Partnership’s CS Provider “Readiness Assessment” prior to contracting.
  4. All CS providers must have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition.

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5. Partnership will ensure members receive CS services within a timely manner. All CS providers shall prioritize referrals for Partnership members in a non-discriminatory manner and shall not, without the expressed consent of Partnership, keep or maintain “waitlists” for members referred or approved for a CS service.
    - a. To the extent possible, Partnership shall prioritize the member’s preference for a CS provider.
  6. Pursuant to their contracts, CS providers must maintain their stated capacity/volume levels for the provision of the CS service. CS providers must communicate to Partnership within five (5) business days if they have changes to their organization’s capacity or staffing levels. All CS providers must be enrolled with Medi-Cal pursuant to relevant DHCS APLs including [APL 22-013](#) [APL 22-013](#) Revised Provider Credentialing/Recredentialing and Screening/Enrollment.
    - a. For providers that do not have a pathway to state-level enrollment, Partnership requires that they meet and adhere to Partnership’s contract standards. See policies MPPR200 Partnership Provider Contracts and MPCR100 Credential and Re-credential Decision Making Process.
- F. **COMMUNITY SUPPORTS CORE SERVICE COMPONENTS:**  
The following CS services shall be offered pursuant to the definitions and standards set forth by DHCS in the CalAIM Waiver and per the DHCS contract for the following Partnership approved CS services:
1. **Housing Transition Navigation Services (HTNS):**
    - a. Conducting tenant screening(s) and/or assessment(s) to identify the member’s preferences and barriers related to a successful tenancy.
    - b. Development of an individualized housing support plan that contains both short-term and long-term goals, as well as a housing support crisis plan that includes how the member will sustain housing.
    - c. Assist searching for housing, presenting options, and assisting with requests for reasonable accommodations if necessary.
    - d. Assistance in securing housing via direct support with applications, documentation requirements, advocacy, etc.
    - e. Landlord education and engagement including advocacy on behalf of a member when necessary.
    - f. Ensuring that the living environment is safe and ready for move-in.
    - g. Assisting in, arranging for and supporting the details of the move.
    - h. Identification and coordination of benefits and resources to secure costs such as security deposits, moving costs, adaptive aids, environmental modifications, and/or other one-time expenses. These services do not assist members with ongoing rental costs.
    - i. Identification, coordination, and/or securing non-emergency, non-medical transportation (NMT).
    - j. Members that are referred for HTNS should be offered enrollment in ECM, if not already enrolled.
    - k. A member cannot receive HTNS and Housing Tenancy and Sustaining Services (HTSS) at the same time.
  2. **Housing Deposits:**
    - a. Housing deposits may be approved based on the individualized assessment of need and documented in the member’s individual housing support plan. Deposit TARs must be accompanied by a Housing Support Plan, a lease agreement or similar document and confirmation that the landlord has been contacted and the HTNS or Housing Deposit provider has seen the living environment to ensure it is safe and ready for move-in.
      - 1) The housing deposit may be used to secure a one-time service/funding to enable a person to establish a basic household that does not constitute room and board or ongoing rental cost.
        - a) Housing Deposits can only be approved one additional time with documentation demonstrating what has changed and how this service would be more successful on the second attempt.

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- 2) If approved, members may use the one-time benefit, per waiver period, for a subset of the services below:
  - a) Security deposits required to obtain a lease on an apartment or home in alignment with California Civil Code section 1950.5.
  - b) Set-up fees/deposits for utilities or service access and utility arrears.
  - c) First month coverage of utilities (e.g.: telephone, gas, electricity, heating, and water).
  - d) Services necessary for the individual’s health and safety, such as pest eradication and one-time cleaning prior to occupancy.
  - e) Application fees to cover the cost of the lease application.
3. Housing Tenancy and Sustaining Services (HTSS)
  - a. Tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include, but are not limited to:
    - 1) Early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
    - 2) Education and training on the role, rights, and responsibilities of the tenant and landlord.
    - 3) Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
    - 4) Coordination with landlord and/or case management provider(s).
    - 5) Development of a plan to mitigate risk to housing such as assistance in resolving disputes with landlords/neighbors, repayment plans for damage to unit or back rent, etc.
    - 6) Assisting with benefits advocacy, including assistance with obtaining identification and documentation for Supplemental Security Income (SSI) eligibility and supporting the SSI application process.
    - 7) Assistance with the annual housing recertification process.
    - 8) Health and safety visits, including unit habitability inspections.
    - 9) Providing independent living and life skills including assistance with and training on budgeting, financial literacy, and connection to community resources.
4. Short-Term Post-Hospitalization Housing (STPHH – Room and Board Service):
  - a. Members are eligible if they meet all of the following criteria:
    - 1) Exiting an inpatient hospital setting such as:
      - a) An acute or psychiatric or Chemical Dependency and Recovery hospital
      - b) Residential substance use disorder treatment or recovery facility
      - c) Residential mental health treatment facility
      - d) Correctional facility, or
      - e) Nursing facility AND
    - 2). Experiencing or at risk of homelessness AND
    - 3). Meeting ~~one~~any of the following criteria:
      - a) Are receiving ECM
      - b) Have one or more serious chronic conditions
      - c) Have a serious mental illness, or
      - d) Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for STPHH.
  - b. These services are intended to provide ongoing support necessary for recuperation and recovery (e.g. gaining or re-gaining the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation, etc.).
  - c. STPHH cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services including Recuperative Care.
5. Recuperative Care (Medical Respite – Room and Board Service):

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- a. At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual’s ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring, etc.).
- b. An individual need not be exiting an institution to qualify but must have been determined by a contracted network provider or a clinical provider at Partnership to have medical needs significant enough to result in ED visits, hospital administration or other institutional care.
- c. Recuperative Care cannot exceed a duration of six months (182 days) per rolling 12-month period and is subject to the six-month global cap on room and board services including STPHH.
- d. Based on individual needs, the service may also include:
  - 1) Limited or short-term assistance with Instrumental Activities of Daily Living and/or Activities of Daily Living (ADLs).
  - 2) Coordination of transportation to post-discharge appointments.
  - 3) Connection to any other on-going services an individual may require including mental health and substance use disorder services.
  - 4) Support in accessing benefits and housing.
  - 5) Gaining stability with case management relationships and programs.
6. Medically Tailored Meals/Groceries (MTM/G)
  - a. MTM/MTG may only be reimbursable when provided by an MTM/G vendor contracted and in good standing with Partnership.
  - b. MTM/MTGs must include an individual assessment of the member’s condition and nutritional needs conducted or overseen by a Registration Dietitian Nutritionist (RDN).
  - c. Each MTM/G must be tailored by a RDN or appropriate clinician to ensure the food provided adheres to established, evidence-based nutrition guidelines to prevent, manage or reverse the targeted health condition.
  - d. MTMGs must meet at least two-thirds of the daily nutrient and energy needs of an average individual.
  - e. Members receive no more than two meals a day for MTM and no more than one delivery per week for MTG.
  - f. Members should receive no less than one documented nutritional education session from a RDN within the first 30 days and a total of three (3) other touches from program staff within the 12-week period.
  - g. Per DHCS, MTM/G is not covered to respond to or address food insecurities and/or food disparities. Members experiencing food insecurities, shortages or disparities shall be referred to the appropriate community program. (ex-CalFresh, Meals on Wheels, etc.)
  - h. For members meeting criteria, MTM/G may be authorized for up to 12 weeks. Providers can request additional services via a new authorization. Additional services will require a report from the nutritionist or registered dietician outlining:
    - 1) The educational interventions to date identifying any member improvements to date,
    - 2) An explanation of why the member could not achieve stated goals during the initial authorization period,
    - 3) Any changes of medical condition(s) the member may have as documented by a medical provider if applicable, and
    - 4) How additional services would likely lead to member success and/or completion of goals.
  - i. Request for additional services beyond the 12-week period will not be approved if one or more of the following apply:
    - 1) The member and/or the member’s authorized representative was unable or unwilling to engage with the MTM/G staff and/or RDN,
    - 2) No progress towards document goals,
    - 3) Meals and/or groceries are not being consumed by the member,

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- 4) As applicable, referrals to appropriate community programs for food insecurity or disparity are not made, and/or
- 5) Other requirements of the program pursuant to DHCS Community Support policy guidance are not being met in the initial period.
- j. MTM/Gs are tailored to the medical needs of the member by a RDN or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes:
7. Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders. Respite Services (Effective January 1, 2023)
  - a. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals. Services are provided in the member's own home or in an approved out-of-home location.
  - b. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
  - c. Services cannot be provided virtually, or via telehealth.
  - d. Services that attend to the participant's basic self-help needs and other activities of daily living.
  - e. Hours approved by the plan will be based on the individual's assessment of needs.
  - f. Service limit is up to 336 hours per calendar year.
  - g. Subsets may include children who were previously covered under:
    - 1) Pediatric Palliative Care
    - 2) Foster Care Programs
    - 3) California Children's Services (CCS)
    - 4) Genetically Handicapped Persons Program (GHPP)
    - 5) Clients with complex care needs
    - 6) Individuals who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement
  - h. Effective January 1, 2023, as per [APL 22-014](#), EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
    - 1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
    - 2) Please refer to Policy [MPUG3011 Home Health Services](#) for further information on EVV requirements.
8. Personal Care and Homemaker Services (Effective January 1, 2023)
  - a. Above and beyond any approved county In-Home Supportive Services (IHSS) hours, when additional hours are required and if IHSS benefits are exhausted; and
  - b. As authorized during any IHSS waiting period (member must be already referred to IHSS); this approval time period includes services prior to and up through the IHSS application date.
  - c. For members not eligible to receive IHSS, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days). Authorization should include information and the need for short term stay in a skilled nursing facility in the absence of PCHS being available.

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- d. Services can only be utilized if appropriate and if additional hours/supports are not authorized by IHSS.
- e. Total number of awarded IHSS hours for the member will be requested to ensure adequate hours for the individual's needs.
- f. Services cannot be utilized in lieu of referring to the IHSS Program. Member must be referred to the IHSS program when they meet referral criteria.
- g. Personal Care and Homemaker Services are only allowed four (4) hours a day for up-to 20 hours a week, or as determined by the intake assessment.
- h. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
  - 1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
  - 2) Please refer to Policy [MPUG3011 Home Health Services](#) for further information on EVV requirements.
9. Sobering Centers (Effective July 1, 2024)
  - a. Will provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counselling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.
  - b. CS provider is required to provide direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services are strongly encouraged.
  - c. Service will also include screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options where applicable.
  - d. CS providers will be required to partner with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
  - e. CS providers must be prepared to identify members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
  - f. CS providers will utilize best practices for members who are experiencing homelessness and who have complex health and/or behavioral health conditions including housing first, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care.
  - g. Eligible members are 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a sobering center.
  - h. Service is covered for a duration of less than 24 hours.
10. Day Habilitation Program (Effective January 1, 2025)
  - a. Provide in a member's home or an out-of-home, non-facility setting training on:
    - 1) The use of public transportation
    - 2) Personal skills development in conflict resolution
    - 3) Community participation
    - 4) Developing and maintaining interpersonal relationships
    - 5) Daily living skills (cooking, cleaning, shopping, money management)

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- 6) Community resource awareness such as police, fire, or local services to support independence in the community.
- b. Programs may include assistance with, but not limited to:
  - 1) Selecting and moving into a home
  - 2) Locating and choosing suitable housemates
  - 3) Locating household furnishings
  - 4) Settling disputes with landlords
  - 5) Managing personal financial affairs
  - 6) Recruiting, screening, hiring, training, supervising, and dismissing personal attendants
  - 7) Dealing with and responding appropriately to governmental agencies and personnel
  - 8) Asserting civil and statutory rights through self-advocacy
  - 9) Building and maintaining interpersonal relationships, including a circle of support
  - 10) Coordination with Partnership to link member to any CS or ECM for which the member may be eligible
  - 11) Referral to non-CS housing resources if member does not meet HTNS eligibility criteria
  - 12) Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if member is not receiving these services through CS or ECM
  - 13) Coordination with Partnership to link member to health care, mental health services, and substance use disorder services based on the individual needs of the member for members who are not receiving this linkage through CS or ECM
- c. The services provided should utilize best practices for members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
- d. Members eligible are individuals who are experiencing homelessness, who exited homelessness and entered housing within the last 24 months, and those at risk of homelessness or institutionalization while housing stability could be improved through participation in a day habilitation program.
- e. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
  - 1) Providers of Community Supports (including Personal Care and Homemaker Services, Respite Services, and Day Habilitation Programs) must complete a self-registration process to gain access to the state-sponsored EVV system and EVV Aggregator.
  - 2) Please refer to Policy [MPUG3011 Home Health Services](#) for further information on EVV requirements.
11. Asthma Remediation (Effective January 1, 2026)
  - a. Provide interventions to help manage acute asthma episodes which consist of supplies and/or physical modifications to a home environment that are necessary to ensure health, welfare, and safety of a member, or to enable a member to function in the home with reduced likelihood of experiencing acute asthma episodes.
  - b. Supplies and/or physical modifications included but not limited to:
    - 1) High-Efficiency Particulate Air (HEPA) filtered vacuums
    - 2) Allergen-impermeable mattress and pillow dustcovers
    - 3) Integrated Pest Management (IPM) services

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- 4) De-humidifiers
  - 5) Mechanical air filters/air cleaners
  - 6) Other moisture-controlling interventions
  - 7) Minor mold removal and remediation services
  - 8) Ventilation improvements
  - 9) Asthma-friendly cleaning products and supplies
  - 10) Other interventions identified to be medically appropriate for the management and treatment of asthma.
- c. Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments
  - d. When authorizing physical modifications and supplies for Asthma Remediation as a Community Support, Partnership must receive and document that an assessment is completed.
  - e. Asthma Remediation will supplement the Asthma Prevention Services (APS) benefit. If another State Plan service beyond the APS, such as Durable Medical Equipment (DME), is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations, the State Plan service should be accessed first.
  - f. The services are available in a home that is owned, rented, leased, or occupied by the member or their caregiver.
  - g. Services provided to a member need not be carried out at the same time but maybe spread over time, subject to lifetime total maximum of \$7,500.
  - h. Member must have poorly controlled asthma and criteria is as follows:
    - 1) An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
    - 2) Asthma Control Test score of 19 or lower **OR**
    - 3) Recommendation from a licensed health care provider
  - i. Documentation required:
    - 1) An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
    - 2) Asthma Control Test score of 19 or lower **OR**
    - 3) Recommendation from a licensed health care provider
  - j. Along with an in-home environmental trigger assessment performed within the last 12 months, the following information is required:
    - 1) Date of Home Visit
    - 2) Date of Scheduled Home Visit
  - k. An in-home environmental trigger assessment is defined as the identification of environmental asthma triggers commonly found in and around the home, including allergens and irritants within the last 12 months. This assessment identifies medically appropriate Asthma Remediation such as the supplies, home modifications, and/or asthma self-management education about actions to mitigate or control environmental exposures offered to the member.
  - l. Asthma remediations must be conducted in accordance with applicable State and local building codes.
  - m. Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, Partnership must provide the owner and member with written

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documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuum, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.

- n. Physical adaptation to a residence covered by Asthma Remediation must be performed by an individual holding a California Contractor’s License.
- o. Partnership shall monitor the provision of all the Asthma Remediation services.
- p. All allowable providers must be approved by Partnership to ensure adequate experience and appropriate quality of care standards are maintained
- q. Asthma Remediation Providers must enroll in the Medi-Cal program to continue providing in-home trigger assessments and asthma self-management education under the APS benefit.

**G. CONTINUITY OF CARE**

1. Members transitioning to Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently receiving a CS service that is currently being offered by Partnership, shall automatically be authorized for CS services. For these members:

- a. Partnership shall use available utilization data to proactively identify any new members who are in receipt of a CS service within the previous 90 days of their assignment to Partnership, and initiate continued CS authorization.
- b. Newly assigned Partnership members or their AR may contact Partnership directly to request continued CS Services, and Partnership shall expedite this request.
- c. Partnership is not obligated under DHCS continuity of care requirements to keep the member assigned to the same CS provider, however, whenever possible Partnership shall make a good faith effort to keep the member’s CS provider the same.
- d. Partnership shall contact and work with the member’s previous health plan and/or CS provider to obtain access to the member’s ICP and ensure services are connected appropriately.
- e. Partnership intends to adhere to Continuity of Care guidelines for transitioning members receiving CS services not offered by Partnership but offered by a previous MCP. Members who have an active prior authorization for services not offered by Partnership at the time of the transition will be authorized for a six-month span of the service. Requests for additional date spans will be reviewed on a case-by-case basis.

**H. DATA SHARING TO SUPPORT COMMUNITY SUPPORTS**

- 1. Partnership shall support CS providers to access systems and processes allowing the CS provider to obtain and document member information including eligibility, CS authorization status, member authorization for data sharing (to the extent required by federal law), and other relevant demographic and administrative information, and to support notification to the member’s PCP and/or interdisciplinary care team when a referral has been fulfilled. Examples include but are not limited to:
  - a. Encounter / claims data
  - b. Physical, behavioral, administrative, and SDOH data (e.g., HMIS data).
  - c. Quality Reports
- 2. Partnership has an IT and data analytic infrastructure to support the delivery of CS services. Key features of Partnership’s systems include, but are not limited to:
  - a. Securely share data between Partnership, the CS provider, the member, and other providers in support of the CS service
  - b. The ability to receive, process, and send encounters from CS providers to DHCS

<b>Policy/Procedure Number: MPAP7003</b> (previously MCUP3142)		<b>Lead Department: Health Services</b> <b>Business Unit: EHS</b>	
<b>Policy/Procedure Title:</b> CalAIM Community Supports (CS)		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 03/09/2022 (MCUP3142) <b>Effective Date:</b> 01/01/2022 (MCUP3142)		<b>Next Review Date:</b> 11/11/2026 <b>Last Review Date:</b> 11/12/2025	
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- c. The ability to receive and process supplemental reports from CS providers
- d. The ability to receive and process electronic claims and/or invoices from a CS provider
- e. The ability to track CS grievances and appeals for Partnership
- f. Partnership will support CS Provider access to systems and processes allowing them to track and manage referrals for CS and member information.
- 3. Partnership will use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with CS Providers and with DHCS, to the extent practicable.
- 4. Effective September 1<sup>st</sup>, 2023, Partnership will follow guidance provided by DHCS in the most current version of the document “CalAIM Data Guidance: Community Supports Member Information Sharing.”
  - a. Partnership will share the required CS Authorization Status File (CS-ASF) data elements with contracted providers monthly using a Secure File Transfer Portal (s-FTP)
  - b. CS contracted Providers will share the required CS Provider Return Transmission File (CS-RTF) data elements with Partnership monthly using a Secure File Transfer Portal (s-FTP)
- I. COMMUNITY SUPPORTS PROVIDER OVERSIGHT AND QUALITY MONITORING
  - 1. Partnership will perform oversight of CS providers, holding them accountable to all applicable requirements contained in the DHCS Contract amendment and DHCS [APL 21-017 Revised](#).
    - a. Partnership will perform quarterly audits, or more frequently as needed, to evaluate CS provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following will be reviewed:
      - 1) Partnership internal monitoring reports
        - a) Utilization Reports
        - b) Cost Reports
        - c) Referral Reports
      - 2) Quality reports (e.g. Member Experience surveys)
      - 3) CS TARs to ensure they are equitable and non-discriminatory and have not had an inequitable effect
      - 4) Required documentation such as member file, a Housing Support Plan, updated notes on services and member encounters, etc.
    - b. Data and outcomes concerning CS services will be aggregated quarterly and reported at Partnership’s Over/Under Utilization Review Committee and/or other Committees deemed appropriate.
  - 2. Partnership has developed its CS provider contracts using the DHCS ILOS Provider Standard Terms and Conditions and incorporated all of its CS provider requirements, including all monitoring and reporting expectations and criteria.
  - 3. CS providers are responsible for timely and accurate submission of data to Partnership for the purposes of reporting to DHCS.
  - 4. Partnership shall provide and make available CS training and technical assistance to CS providers, including in-person sessions, webinars, and/or calls, as necessary, in addition to Network Provider training requirements described in Partnership’s contract with DHCS in Exhibit A, Attachment 7, Provision 5, Network Provider Training.
- J. PAYMENT TO COMMUNITY SUPPORTS PROVIDER
  - 1. To the extent possible, Partnership encourages all of its CS providers to submit electronic claims to Partnership for payment.
    - a. When a CS provider does not have the ability to submit a claim electronically, Partnership shall accept an invoice via mail.
      - 1) CS providers shall make a good faith attempt when remitting invoices to Partnership for the purposes of reimbursement of approved CS services to use the necessary billing and

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member-specific encounter information for DHCS Partnership validation and DHCS reporting purposes.

- 2) Invoices sent via mail shall be processed in the same time frames as electronic claims.
- 3) In the event of a request for expedited claim payment, the plan will review the request on a case-by-case basis.
- 4) For more information on how to submit claims, refer to Partnership’s Provider Manual, Section 3: Claims at <http://www.partnershiphp.org/Providers/Policies/Pages/Section3.aspx>

**K. DHCS COMMUNITY SUPPORTS REPORTING**

1. Partnership will submit the following data and reports to DHCS to support DHCS’ oversight of CS:
  - a. Encounter data
    - 1) Partnership shall submit all CS encounters to DHCS using national standard specifications and code sets to be defined by DHCS.
    - 2) Partnership shall be responsible for submitting to DHCS all CS encounter data, including encounter data for CS generated under subcontracting arrangements.
    - 3) In the event the CS Provider is unable to submit CS encounters to Partnership using the national standard specifications and code sets to be defined by DHCS, Partnership shall be responsible for converting CS Providers’ invoice data into the national standard specifications and code sets for submission to DHCS.
  - b. Supplemental reporting
    - 1) Contractor shall submit supplemental reports on a schedule and in a format to be defined by DHCS.
  - c. In the event of underperformance by Partnership in relation to its administration of CS, DHCS may administer sanctions as set out in the DHCS Contract Exhibit E, Provision 1.1.19, Sanctions.

**VII. REFERENCES:**

- A. Title 42 Code of Federal Regulations ([CFR](#)) 438.3(e)(2)
- B. DHCS All Plan Letter ([APL](#)) 21-017 [Community Supports Requirements](#) (Revised 03/01/2022)
- C. DHCS Contract Exhibit A, Attachment III, 2.3 Utilization Management; 4.5 Community Supports
- D. DHCS Contract Exhibit E, Provision 1.1.19, Sanctions.
- E. DHCS [Medi-Cal Community Supports, or In Lieu of Services \(ILOS\), Policy Guide, Volume 1 and Volume 2](#) (April 2025)
- F. [CalAIM Data Guidance - Community Supports Member Information Sharing](#) (December 2024)
- G. DHCS [APL 22-013](#) Provider Credentialing/Re-credentialing and Screening/Enrollment (July 19, 2022)
- H. DHCS [APL 22-014](#) Electronic Visit Verification Implementation Requirements (July 21, 2022)
- I. DHCS [APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements](#) (09/14/2023)

**VIII. DISTRIBUTION:**

- A. Partnership Department Directors
- B. Partnership Provider Manual

**IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:** Chief Health Services Officer, Director of Enhanced Health Services

**X. REVISION DATES:**

Medi-Cal  
MCAP7003 (02/12/2025)

<b>Policy/Procedure Number: MPAP7003</b> (previously MCUP3142)		<b>Lead Department: Health Services</b> <b>Business Unit: EHS</b>	
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11/12/25

Partnership Advantage (Effective Jan. 1, 2027)  
N/A

**PREVIOUSLY APPLIED TO:**  
MCUP3142 (Archived 02/12/2025)  
01/11/23; 06/14/23; 01/10/24

\*\*\*\*\*

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 needs 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.

## Community Supports Criteria

### Housing Transition/Navigation Services

#### Eligibility Criteria

- Are prioritized for a permanent supportive housing unit or rental subsidy resource through a local Coordinated Entry System (CES).
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the definition of an individual experiencing chronic homelessness.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

#### Restrictions and Limitations

- Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

### Housing Deposit

#### Eligibility Criteria

- Received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services.
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CBO.
- Meet the Housing and Urban Development (HUD) definition of homeless.
- Meet the HUD definition of at risk of homelessness.
- Are determined to be at risk of experiencing homelessness.
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness."

#### Restrictions and Limitations

- Only available in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.
- Must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.
- Individuals must also receive at a minimum, the associated tenant screening, housing assessment and individualized housing support plan in conjunction with this service.
- The housing deposit may be used to secure a one-time service/funding to enable a person to establish a basic household that does not constitute room and board (ie first and last month's rent) or payment of rental assistance.

Security deposit in alignment with California Civil Code section 1950.5.

MCAP7001 Attachment A  
MPAP7003 Attachment A  
Rev. 11/12/25

## Housing Tenancy & Sustaining Services

### Eligibility Criteria

- Received Housing Transition/Navigation Services Community Supports in counties that offer Housing Transition/Navigation Services (but this is not a requirement)
- Are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CBO.
- Meet the Housing and Urban Development (HUD) definition of homeless
- Meet the definition of an individual experiencing chronic homelessness
- Meet the HUD definition of at risk of homelessness
- Are determined to be at risk of experiencing homelessness
- Meet the State's No-Place-Like-Home definition of "at risk of chronic homelessness"

### Restrictions and Limitations

- These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed.
- These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.
- Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

## Short-Term Post-Hospitalization Housing (STPHH - Room and Board Services)

### Eligibility Criteria

- Members are eligible if they meet all the following criteria:  
Exiting an inpatient hospital stay such as an acute or psychiatric or chemical dependency and recover hospital; residential substance use disorder (SUD) treatment or recovery facility; residential mental health treatment facility; correction facility; or nursing facility.

AND

- Experiencing or at risk of homelessness.

AND

- Meet on of the following criteria:  
Are receiving ECM  
have one or more serious chronic conditions  
have a serious mental illness, or  
Are at risk of institutionalization or requiring residential services as a result of SUD

AND

- Have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for STPHH.

## Restrictions and Limitations

- Limited to six months (182 days) within a rolling 12-month period under the global cap. Member may not receive more than a combined six months (182 days) of STPHH and recuperative care services during any rolling 12-month period.

## Recuperative Care (Room and Board Services)

### Eligibility Criteria

- Individuals requiring recovery in order to heal from an injury or illness AND
- Experiencing or at risk of homelessness
- An individual need not be exiting an institution to qualify but must have been determined by a contracted Partnership provider or by clinical Partnership staff to have medical needs significant enough to result in ED visit, hospital admissions or other institutional care.

### Restrictions and Limitations

- Limited to six months (182 days) within a rolling 12-month period under the global cap. Member may not receive more than a combined six months (182 days) of STPHH and recuperative care services during any rolling 12-month period.

## Medically Tailored Meals/Groceries (MTM/Gs)

### Eligibility Criteria

- Individuals who have chronic or other serious health conditions that are nutrition sensitive, such as (but not limited to): cancer(s), cardiovascular disorders, chronic kidney disease, chronic lung disorders or other pulmonary conditions such as asthma/COPD, heart failure, diabetes or other metabolic conditions, elevated lead levels, end-stage renal disease, high cholesterol, human immunodeficiency virus, hypertension, liver disease, dyslipidemia, fatty liver, malnutrition, obesity, stroke, gastrointestinal disorders, gestational diabetes, high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders

### Restrictions and Limitations

For member's meeting criteria:

- MTM/MTG can be authorized for up to 12 weeks.
- Providers can request additional services via a new authorization. Additional services will require a report from the nutritionist or registered dietician outlining:
  - The educational interventions to date identifying any member improvements to date,
  - An explanation of why the member could not achieve stated goals during the initial authorization period,
  - Any changes of medical condition(s) the member may have as documented by a

- medical provider if applicable, and
  - How additional services would likely lead to member success and/or completion of goals.
- Requests for additional services beyond the 12-week period will not be approved if one or more of the following apply:
    - The member and/or the member's authorized representative were unable or unwilling to engage with MTM/G staff and/or RDNs,
    - No progress towards document goals,
    - Meals and/or groceries are not being consumed by the member,
    - As applicable, referrals to appropriate community programs for food insecurity or disparity are not made, and/or
    - Other requirements of the program pursuant to DHCS Community Support policy guidance are not being met in the initial period.
  - Members should receive no less than one documented nutritional education session from an RDN within the first 30 days and a total of three (3) other touches from program staff within the 12-week period.
  - Meals, food, payments, and nutrition services that are eligible for or reimbursed by alternate programs for the Member cannot be funded or counted by MCPs as an MTM/MSF.
  - Per DHCS, MTM/G is not covered to respond to or address food insecurities and/or food disparities. Members experiencing food insecurities, shortages or disparities shall be referred to the appropriate community program. (ex CalFresh, Meals on Wheels, etc.)

## Respite Services (Effective January 1, 2023)

### Eligibility Criteria

- Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.
- Other subsets may include children who previously were covered for Respite Services under the Pediatric Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

### Restrictions and Limitations

- In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.
- Service limit is up to 336 hours per calendar year.
- This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

## Personal Care & Homemaker Services (Effective January 1, 2023)

### Eligibility Criteria

- Individuals at risk for hospitalization, or institutionalization in a nursing facility.
- Individuals with functional deficits and no other adequate support system.
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: <http://www.cdss.ca.gov/In-Home-Supportive-Services>.

### Restrictions and Limitations

- This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.
- If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker services during this reassessment waiting period.

## Sobering Centers (Effective July 1, 2024)

### Eligibility Criteria

- Individuals ages 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who otherwise can be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center

### Restrictions and Limitations

- This service is covered for a duration of less than 24 hours.
- This service shall supplement and not supplant services received by the Member through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions (STCs) and federal DHCS guidance.

## Day Habilitation Program (Effective January 1, 2025)

### Eligibility Criteria

- Individuals experiencing homelessness
- Individuals who exited homelessness and entered housing in the last 24 months
- Individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in day habilitation program

### Restrictions and Limitations

- This service shall supplement and not supplant services received by the Member through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal DHCS guidance.

## Asthma Remediation (Effective January 1, 2026)

### Eligibility Criteria

- Member must have poorly controlled asthma and criteria is as follows:
  - An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
  - Asthma Control Test score of 19 or lower **OR**
  - Recommendation from a licensed health care provider
- Documentation required:
  - An emergency department visit or hospitalization or two sick or urgent care visits due to asthma in the past 12 months **OR**
  - Asthma Control Test score of 19 or lower **OR**
  - Recommendation from a licensed health care provider

- Along with an in-home environmental trigger assessment performed within the last 12 months, the following information is required:
  - Date of Home Visit
  - Date of Scheduled Home Visit

### **Restrictions and Limitations**

- Supplies and/or physical modifications included but not limited to:
  - High-Efficiency Particulate Air (HEPA) filtered vacuums
  - Allergen-impermeable mattress and pillow dustcovers
  - Integrated Pest Management (IPM) services
  - De-humidifiers
  - Mechanical air filters/air cleaners
  - Other moisture-controlling interventions
  - Minor mold removal and remediation services
  - Ventilation improvements
  - Asthma-friendly cleaning products and supplies
  - Other interventions identified to be medically appropriate for the management and treatment of asthma.
- Asthma Remediation home modifications are limited to those that are of direct medical or remedial benefit to the member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments
- The services are available in a home that is owned, rented, leased, or occupied by the member or their caregiver.
- Services provided to a member need not be carried out at the same time but maybe spread over time, subject to lifetime total maximum of \$7,500.
- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, Partnership must provide the owner and member with written documentation that the modifications are permanent and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers, high-efficiency particulate air (HEPA) filtered vacuum, de-humidifiers, portable air filters, and asthma-friendly cleaning products and supplies.
- Physical adaptation to a residence covered by Asthma Remediation must be performed by an individual holding a California Contractor's License.



# COMMUNITY SUPPORTS (CS) SERVICES

Authorization for Use, Exchange, and/or Disclosure  
of my Confidential Health Care and Personal Information

## Purpose

Health care providers, health payers, and social services agencies have joined together to provide **Community Supports (CS) Services** to help promote your health and well-being. To allow Partnership HealthPlan of California (“**Partnership**”) and/or other entities to share your health care and other personal information with each other to help provide you with these CS Services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in CS (“**CS Entities**”): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit CS Entities to use and release your health care and other personal information for the following purposes (“**Purposes**”): to allow these entities to address your health-related social needs, including housing transition navigation services; housing deposits; short-term post-hospitalization housing; short-term residential care including housing, meals, and ongoing medical monitoring; caregiver services; day habilitation programs; assistance transitioning from a nursing facility to an assisted living facility or private residence; in-home support services; home adaptations or modifications; medically tailored meals; and sobering centers (“**Purposes**”). The information that you authorize for use and release may be shared in a secure electronic format, in writing, or verbally to coordinate CS Services for you.

## Member Information

First Name:	Last Name:
Address:	
Phone Number: (    )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California and participating CS Entities named in Attachment A** to use and share any of my health care or other personal information with each other for the reason stated in this Authorization.

Choose ONE of the following options:

<i>INITIAL HERE</i>	<p><b>Consent for communication by CS Program:</b> By putting my initials here, I am allowing ALL of the CS Entities listed in <b>Attachment A</b> to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide CS Services. The types of health and other confidential information that I am authorizing between CS Entities include:</p> <p>(a) Protected health information (PHI), including information regarding my health</p>
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	<p>care, medical history, lab test results, and current or future conditions and treatment;</p> <p>(b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form;</p> <p>(c) Individualized Education Program information and other information about social services provided in school;</p> <p>(d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits;</p> <p>(e) Housing/homelessness information, including my housing status, history, and supports; and</p> <p>(f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.</p>
<p><i>INITIAL HERE</i></p>	<p><b>Decline to participate in CS:</b> I understand that the CS program allows CS Entities to be in contact with each other to coordinate my care. I decline to participate in the CS program. I can ask to participate in case management programs for which I am eligible.</p>

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically allow it)

<p><i>INITIAL HERE</i></p>	<p>Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes which are only shared if I sign a separate consent form.</p>
<p><i>INITIAL HERE</i></p>	<p>HIV Test Results (Health &amp; Safety Code § 120980 (g))</p>

**Substance Use Disorder Information**

Substance use disorder (“SUD”) records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing CS Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain CS Entities, including health care providers, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

<i>INITIAL HERE</i>	Initial here to allow the CS Entities in <b>Attachment A</b> to use and share your SUD information as described above, excluding SUD counseling notes.
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**Expiration of Form**

Choose ONE of the following options:

<i>INITIAL HERE</i>	<b>Standard expiration:</b> This form will expire 1 year from today’s date; OR
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<i>INITIAL HERE</i>	<b>Expiration:</b> This form will expire on:_____. This date may not be less than 6 months (to participate in CS services), but may be more than 1 year from today’s date.
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I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:
 

Partnership HealthPlan of California  
Attn: Enhanced Health Services  
4665 Business Center Drive  
Fairfield, CA 94534
- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose not to sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. However, my ability to participate in CS Services may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the CS Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release may be re-shared by CS Entities, but only in compliance with this Authorization and applicable law.
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all CS Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

*[signature on next page]*

### Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MCUP3015 (previously UP100315)		<b>Lead Department:</b> Health Services <b>Business Unit:</b> Utilization Management	
<b>Policy/Procedure Title:</b> Family Planning Bypass Services		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 03/08/1995		<b>Next Review Date:</b> <del>10/09/2025</del> <u>11/12/2026</u> <b>Last Review Date:</b> <del>10/09/2024</del> <u>11/12/2025</u>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIAL <u>SING</u>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA			<b>Approval Date:</b> <del>10/09/2024</del> <u>11/12/2025</u>

**I. RELATED POLICIES:**

MCUP3050 - Medication Abortion in the First Trimester

**II. IMPACTED DEPTS:**

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

**III. DEFINITIONS:**

A. Bypass Services: Members may receive services from any family planning provider, including those not contracted with Partnership HealthPlan of California, without prior authorization.<sup>1</sup>

B. Medi-Cal Minor Consent Program: The Minor Consent program provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.

B-C. Prohibited Entity: According to H.R. 1, a bill passed by the United States Congress on July 3, 2025, and enacted on July 4, 2025, a Prohibited Entity is an entity, including its affiliates, subsidiaries, successors, and clinics, that is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code, and is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and related medical care; and provides for abortions, other than an abortion if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal

<sup>1</sup> Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.

<b>Policy/Procedure Number: MCUP3015</b> (previously UP100315)		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title:</b> Family Planning Bypass Services		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date:</b> 03/08/1995		<b>Next Review Date:</b> 10/09/202511/12/2026 <b>Last Review Date:</b> 10/09/202411/12/2025	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded \$800,000.

**IV. ATTACHMENTS:**

A. N/A

**V. PURPOSE:**

To describe and define “family planning bypass” services as implemented and managed by Partnership HealthPlan of California.

**VI. POLICY / PROCEDURE:**

- A. Partnership provides Members with direct access to the full range of family planning services and providers without prior authorization.
- B. Federal law, Title 42 U.S. Code Section [1396a\(a\)23\(B\)](#), states that "enrollment of an individual eligible for medical assistance in a primary care case-management system [described in section 1396n(b)(1)], a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such services under Section 1396d(a)(4)(C) of this title." Partnership must allow Members the freedom of choice with family planning providers. Members may receive services from any family planning provider, including those not contracted with Partnership, without prior authorization.<sup>2</sup>
- C. Partnership notifies its Members regarding the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider.<sup>2</sup> Members are encouraged to use their primary care provider (PCP) for family planning services, when appropriate.
- D. Family planning services are defined as:
  1. Health education and counseling necessary to understand contraceptive methods and make informed choices
  2. History and physical examination as indicated
  3. Laboratory tests, if medically indicated, as part of decision making process for choice of contraceptive methods. This includes cervical cancer screening methods recommended by the United States Preventative Services Task Force (USPSTF): For ages 21 – 29 cervical cytology every 3 years and for ages 30 to 65 years old cervical cytology every 3 years OR high risk human papillomavirus (HPV) testing every 5 years, OR high risk HPV testing in combination with cytology every 5 years. For Members under 21 years, cervical cancer screening is not recommended.
  4. Diagnosis and treatment of sexually transmitted infections (STIs) when medically necessary.
  5. Screening, testing and counseling of individuals at risk for human immunodeficiency virus (HIV) and referral for treatment
  6. Provision of contraceptive pills/devices/supplies
  7. Tubal ligation
  8. Vasectomy
  9. Pregnancy testing and counseling

<sup>2</sup> Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members. Please see the Department of Health Care Services (DHCS) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.

<b>Policy/Procedure Number: MCUP3015</b> (previously UP100315)		<b>Lead Department: Health Services</b> <b>Business Unit: Utilization Management</b>	
<b>Policy/Procedure Title: Family Planning Bypass Services</b>		<input checked="" type="checkbox"/> <b>External Policy</b> <input type="checkbox"/> <b>Internal Policy</b>	
<b>Original Date: 03/08/1995</b>		<b>Next Review Date: 10/09/2025</b> <b>Last Review Date: 10/09/2024</b>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>	

- E. Abortion-related services are available to Members from the provider of their choice without prior authorization.<sup>3</sup>
1. Partnership covers all medical services and supplies incidental or preliminary to an abortion, as per requirements stated in Medi-Cal Provider Guidelines: [Abortions](#)
  2. Partnership is prohibited from imposing annual or lifetime limits on coverage of outpatient abortion services.
  3. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.
- F. The following services are NOT included under family planning bypass services:
1. Routine infertility studies or procedures
  2. Reversal of voluntary sterilization
  3. Hysterectomy for sterilization purposes only
  4. Evaluation and treatment of gynecological problems
  5. Evaluation and treatment of breast problems
- G. To be reimbursed for services, the family planning provider must meet the following requirements:
1. The provider is qualified to provide family planning services based on his/her scope of practice.
  2. The provider must submit claims on the appropriate billing form.
  3. The provider must maintain medical records that contain information regarding the eligible services rendered. Partnership reserves the right to request copies of records prior to paying a claim or for quality improvement audits.
  4. The provider must obtain appropriate consent for contraceptive methods including voluntary sterilization, consistent with the requirements of Title 22 CCR, Sections 51305.1 and 51305.3.
  5. The bypass provider should coordinate services with the PCP, by requesting the Member's consent to share information and sending a copy of pertinent medical records to the PCP.
  6. The provider should refer the Member to return to the PCP for all non- family planning related services.
  - 6-7. ~~The provider must not be a Prohibited Entity as defined in III.C. above.~~
- H. Access to Services to Which Contractor or Subcontractor Has a Moral Objection:  
Unless prohibited by law, Partnership providers shall arrange for the timely referral and coordination of covered services including abortion services and family planning bypass services when the hospital, clinic or other provider may have religious or ethical objections to the request/ required service(s). The provider shall support and shall demonstrate ability to arrange, coordinate and ensure provision of abortion and family planning bypass services. If the provider is unwilling to arrange for or coordinate the provision of such services, the provider must refer the Member to Partnership Member Services Department for assistance.

## VII. REFERENCES:

- A. United States Preventive Services Task Force:  
<https://uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>
- B. Title 42 U.S. Code Sections [1396a\(a\)23\(B\)](#), [1396n\(b\)\(1\)](#), [1396d\(a\)\(4\)\(C\)](#)
- C. Title 22 California Code of Regulations (CCR) Sections [51305.1](#) and [51305.3](#)
- D. Medi-Cal Provider Manual/ Guidelines: Abortions ([abort](#)), Minor Consent Program ([minor](#))
- E. DHCS [APL 24-003](#) Abortion Services (03/28/2024)
- F. [DHCS APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities \(09/17/2025\)](#)

<sup>3</sup> [Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. Please see the Department of Health Care Services \(DHCS\) All Plan Letter APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities \(09/17/2025\) for further information. Members may also contact Partnership's Member Services department for assistance \(800\) 863-4155.](#)

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E.G. [Public Law No. 119-21, H.R.1, 119th Congress. \(2025\)](#)

**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  
 10/10/97 (name change only); 06/14/00, 10/17/01; 8/20/03; 10/20/04; 10/19/05, 08/20/08; 11/19/08;  
 11/18/09; 08/15/12; 01/21/15; 01/20/16; 02/15/17; 11/15/17; \*02/13/19; 02/12/20; 11/11/20; 10/13/21;  
 10/12/22; 10/11/23; 10/09/24; 11/12/25

\*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.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA  
POLICY / PROCEDURE**

<b>Policy/Procedure Number:</b> MPUP3035 (previously UP100335)		<b>Lead Department:</b> Health Services <u>Business Unit: Utilization Management</u>	
<b>Policy/Procedure Title:</b> Preoperative Day Review		<input checked="" type="checkbox"/> External Policy <input type="checkbox"/> Internal Policy	
<b>Original Date:</b> 05/28/1999		<b>Next Review Date:</b> <u>10/09/202511/12/2026</u> <b>Last Review Date:</b> <u>10/09/202411/12/2025</u>	
<b>Applies to:</b>	<input checked="" type="checkbox"/> Medi-Cal	<input type="checkbox"/> Employees	
<b>Reviewing Entities:</b>	<input checked="" type="checkbox"/> IQI	<input type="checkbox"/> P & T	<input checked="" type="checkbox"/> QUAC
	<input type="checkbox"/> OPERATIONS	<input type="checkbox"/> EXECUTIVE	<input type="checkbox"/> COMPLIANCE <input type="checkbox"/> DEPARTMENT
<b>Approving Entities:</b>	<input type="checkbox"/> BOARD	<input type="checkbox"/> COMPLIANCE	<input type="checkbox"/> FINANCE <input checked="" type="checkbox"/> PAC
	<input type="checkbox"/> CEO <input type="checkbox"/> COO	<input type="checkbox"/> CREDENTIALS <u>SING</u>	<input type="checkbox"/> DEPT. DIRECTOR/OFFICER
<b>Approval Signature:</b> Robert Moore, MD, MPH, MBA		<b>Approval Date:</b> <u>10/09/202411/12/2025</u>	

**I. RELATED POLICIES:**

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- A-B. MPUP3139 – Criteria and Guidelines for Utilization Management

**II. IMPACTED DEPTS:**

- A. Health Services
- B. Claims
- C. Member Services

**III. DEFINITIONS:**

Preoperative Day – The planned admission of a member to the acute hospital ~~one or more days~~ prior to a scheduled (elective) procedure.

1. As part of the precertification review process, patients are identified for Preoperative Day Review when the reasons for and the timing of admissions are submitted by the provider of service.
2. Preoperative Day Review is initiated for ~~a patients who must be admitted on the day prior to to be admitted before surgery, the planned procedure.~~ If the admitting physician requests that the patient be admitted ~~the day~~ before surgery, all patient information is reviewed to determine if it meets medical necessity compared to InterQual<sup>®</sup> -criteria for an elective admission ~~and to the anesthesia staging criteria.~~ If necessary, the clinical information is referred to the Utilization Management (UM) leadership team or to the Chief Medical Officer (CMO) or Physician Designee.

**IV. ATTACHMENTS:**

- ~~APPENDIX~~
- A. ~~N/A Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System~~

**V. PURPOSE:**

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

**VI. POLICY / PROCEDURE:**

- A. Objective
  1. To determine the appropriateness of a patient’s admission to the hospital prior to the day of surgery. Whenever possible, early morning admission on the day of a proposed surgical procedure should be utilized. If the patient's problem precludes such utilization, special certification consideration by the

<b>Policy/Procedure Number: MPUP3035</b> (previously UP100335)		<b>Lead Department: Health Services</b>
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<b>Original Date:</b> 05/28/1999	<b>Next Review Date:</b> 10/09/2025 <b>Last Review Date:</b> 10/09/2024	
<b>Applies to:</b>	<input checked="" type="checkbox"/> <b>Medi-Cal</b>	<input type="checkbox"/> <b>Employees</b>

~~CMO/hief Medical Officer~~, Physician Designee ~~or UM leadership team~~ may be given through the prior authorization process.

B. Procedure

1. Admissions for elective surgical procedures are identified during the precertification review process.
2. If the admitting physician requests the patient be admitted prior to the day ~~prior to of~~ surgery, a Nurse Coordinator reviews all pertinent clinical information is compared to to see if it meets medical necessity InterQual® criteria for a preoperative day admission, and to the anesthesia staging criteria. The authorization request must clearly explain the medical necessity of the requested preoperative day.
  - a. If medical necessity any one of the criteria elements are met, for anesthesia staging criteria class IV-V is met (see Appendix A), the Nurse Coordinator approves the admission for the day prior to the planned procedure.
  - b. If none of the criteria elements are met, or the medical need for the request is not clear, the case is referred ~~to the UM leadership team or~~ to the ~~CMO/hief Medical Officer or~~ Physician Designee for medical necessity review using criteria as described in policy MPUP3139 Criteria and Guidelines for Utilization Management.
3. The CMO hief Medical Officer or Physician Designee are the only individuals who can deny a request based on lack of medical justification.

VII. REFERENCES:

- A. ~~American Society of Anesthesiologists (ASA) Standards and Guidelines~~
- B.A. InterQual® criteria

VIII. DISTRIBUTION:

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

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

X. REVISION DATES:

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

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

\*\*\*\*\*

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

<b>Policy/Procedure Number: MPUP3035</b> (previously UP100335)		<b>Lead Department: Health Services</b>
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- Consistent with sound clinical principles and processes
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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.

**APPENDIX**  
**Preoperative Day Review**

**AMERICAN SOCIETY OF ANESTHESIOLOGISTS (ASA)  
PATIENT CLASSIFICATION SYSTEM**

~~CLASS I — The patient has no organic, physiologic, biochemical, or psychiatric disturbance. The pathologic process for which the surgery is to be performed is localized and does not entail a systemic disturbance.~~

~~Examples — A fit patient with an inguinal hernia; fibroid uterus in an otherwise healthy person.~~

~~CLASS II — Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.~~

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

~~CLASS III — Severe systemic disturbance or disease from whatever cause even though it may not be possible to define the degree of disability with finality.~~

~~Examples — Severely limiting organic heart disease, severe diabetes with vascular complications, moderate to severe degrees of pulmonary insufficiency, angina pectoris, or healed myocardial infarction.~~

~~CLASS IV — Indicative of the patient with severe systemic disorders that are already life-threatening, not always correctable by surgery.~~

~~Examples — Patients with organic heart disease showing marked signs of cardiac insufficiency, persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency.~~

~~CLASS V — The moribund patient who has little chance of survival but is submitted to surgery in desperation.~~

~~Examples — The burst abdominal aneurysm with profound shock, major cerebral trauma with rapidly increasing intracranial pressure, massive pulmonary embolus. Most of these patients require surgery as a resuscitative measure with little if any anesthesia.~~

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

<b>Policy/Procedure Number:</b> MPUP3035 (previously UP100335)		<b>Lead Department:</b> Health Services
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~~Emergency Operation (E)—Any patient in one of the classes listed previously who is operated upon as an emergency is considered to be in poorer physical condition. The letter "E" is placed beside the numerical classification. Thus, the patient with a hitherto uncomplicated hernia now incarcerated and associated with nausea and vomiting is classified "I. E".~~

# Annual Health Disparities Review

**Mohamed Jalloh, Pharm.D**

Health Equity Officer

October 2025

# About Us

## Regional Offices



## Mission:

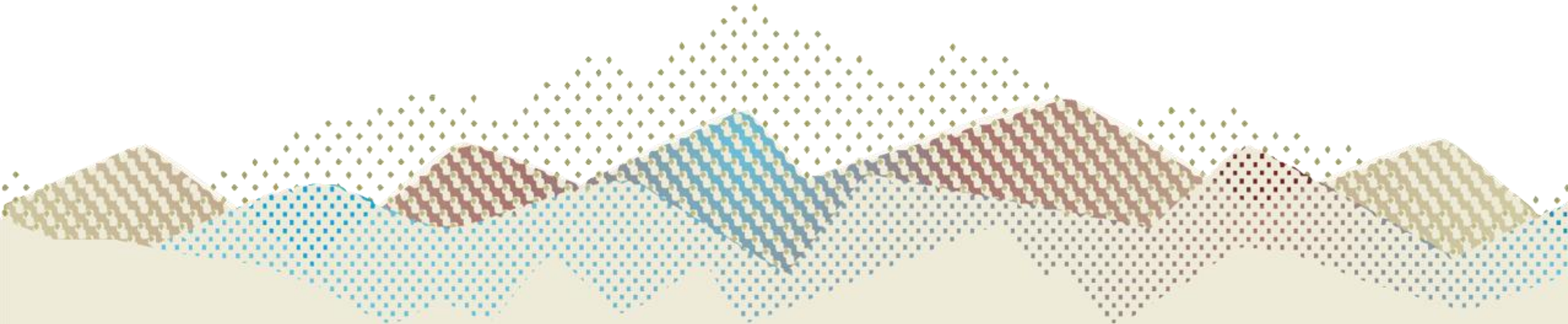
*To help our members, and the communities we serve, be healthy.*

## Vision:

*To be the most highly regarded managed care plan in California.*

# Background

## Definitions



# Membership Demographics

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**898,094** Members (As of 09/2025)

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**51.9%** Female

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**52.2%** Aged 21 to 64

---

**37.9%** White, 34.2% Hispanic, 13.2% Unknown

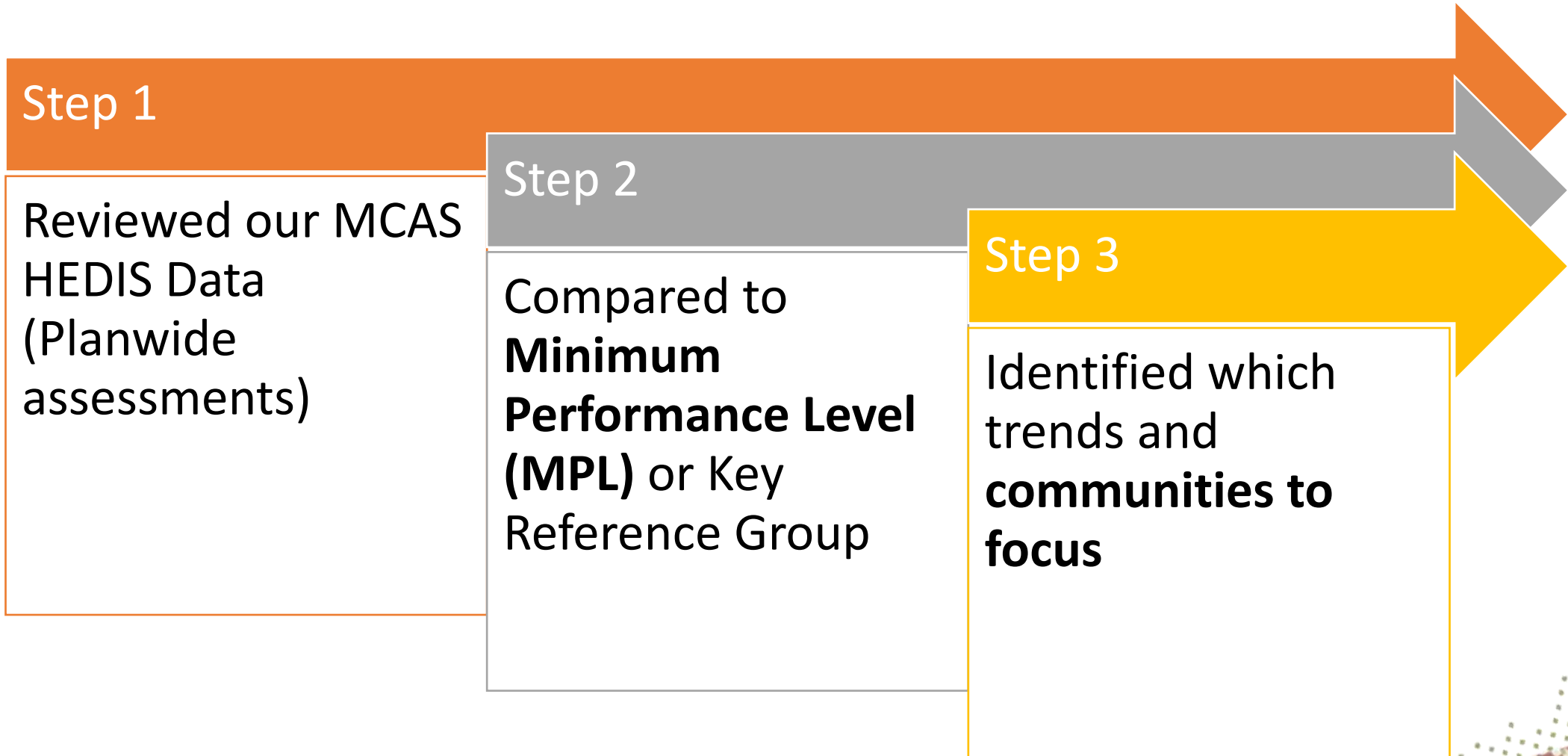
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**10,458** CCS Kids

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**Sonoma, Solano, Butte, Shasta, and Placer** have largest number of members

# Data Evaluation



# Data Exclusions

- Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (**FUM**)
- Follow-Up After Emergency Department Visit for Substance Use - 30 Days (**FUA**)

# Overall Significant Improvements



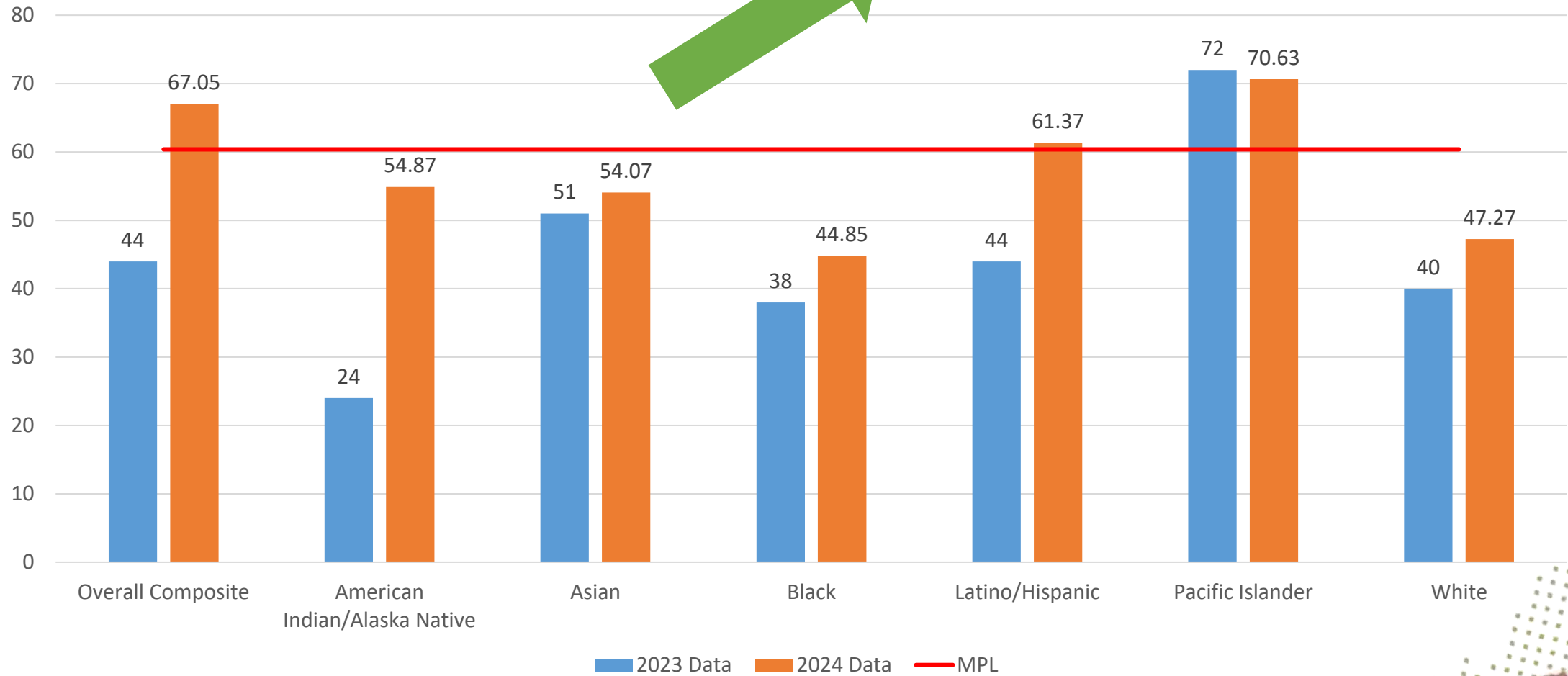
**Well-Child  
Visits** first  
15 and 15 to  
30 months

**Lead  
Screening**

**Controlling  
High Blood  
Pressure**



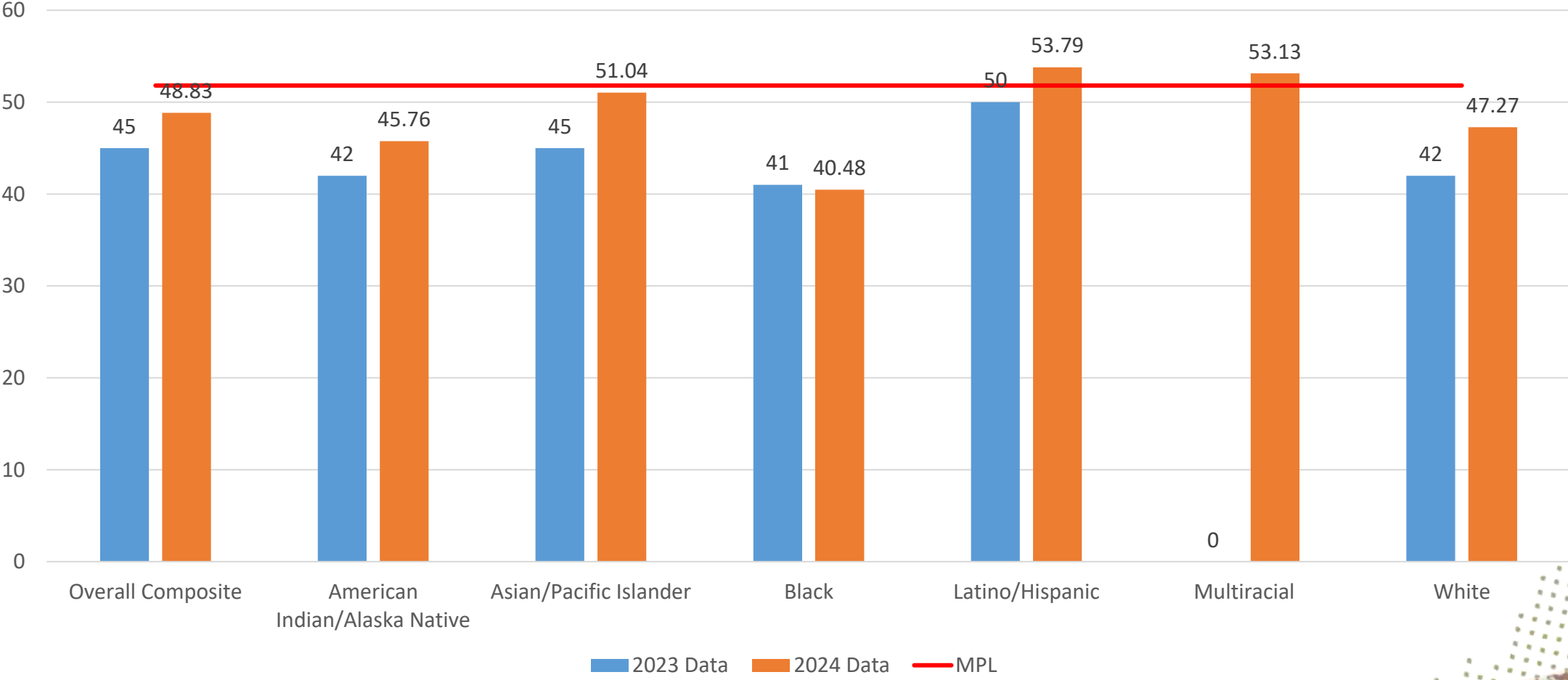
# Well-Child Visits in First 15 months



# Trends for Child and Adolescent Measures

- **Well-Care Visits (WCV) and Childhood Immunizations (CIS-10)** continue to remain below Minimum performance level (MPL) for majority of race groups
- **Lead Screening in Children (LSC)** is lower in Black members
- **Immunizations for Adolescents (IMA)** is significantly lower for White members

# Child and Adolescent Well Care Visits (WCV)

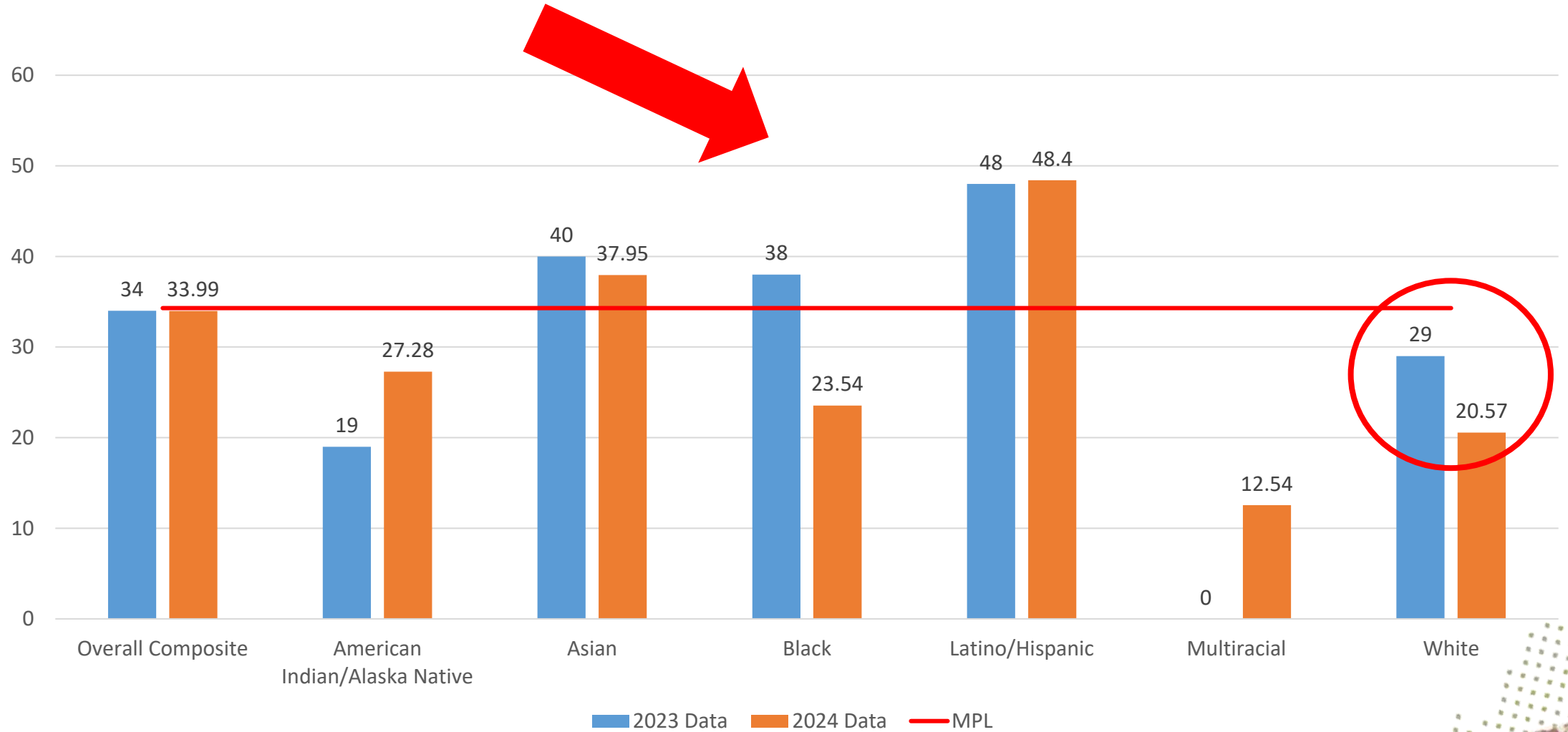




# Lead Screening in Children (LSC)



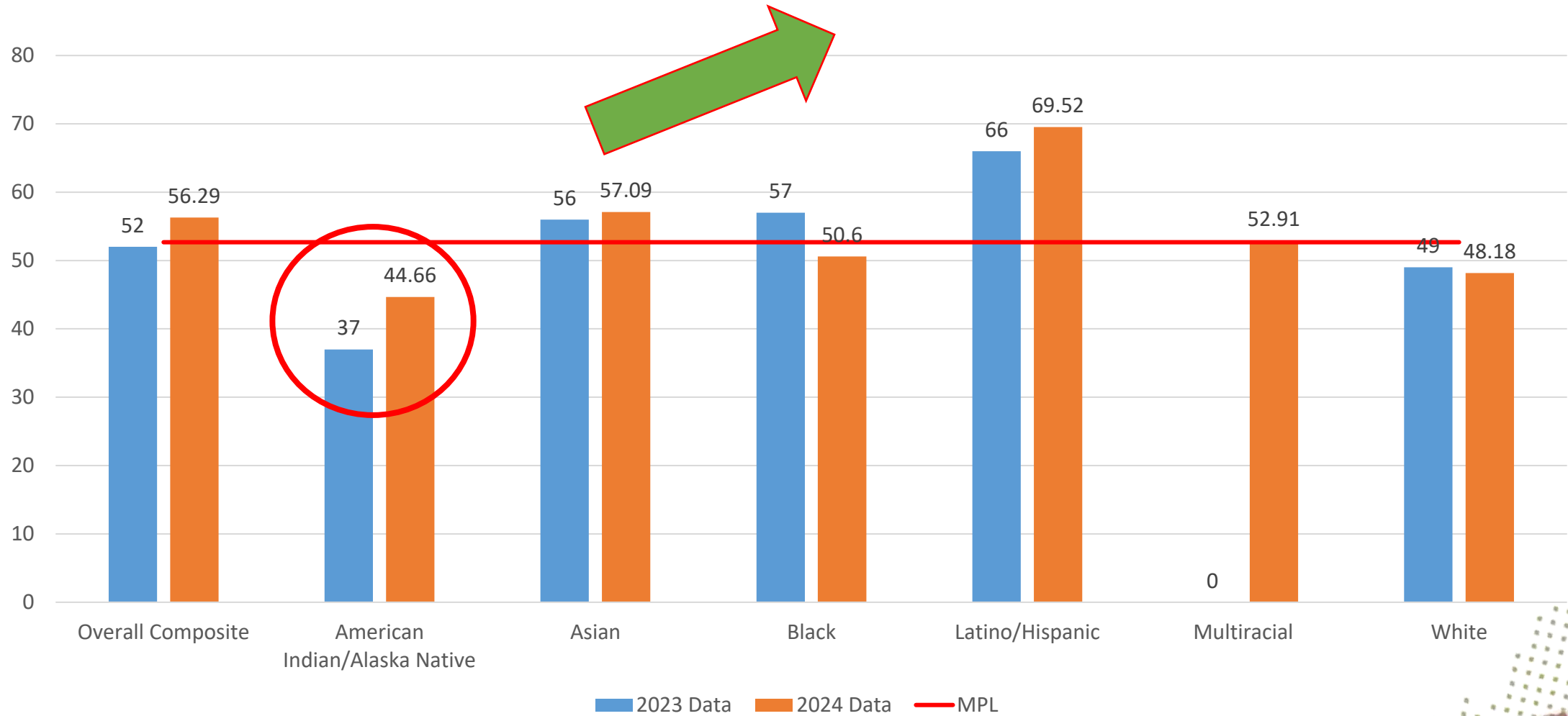
# Immunizations for Adolescents(IMA)



# Trends for Cancer Screening Measures

- **Cervical Cancer Screenings (CCS)** rates continue to remain below MPL for majority of race groups
- **Breast Cancer Screenings (BCS)** rates continue to have multiple groups below MPL with **Tribal members** having the lowest rate
- **Colorectal Cancer Screenings (CCS)** evaluation Not included

# Breast Cancer Screenings (BCS)



# Trends for Prenatal and Postpartum Measures

- **Timeliness of Prenatal Care Measures** remain competitive above 85% completion rate
- **Postpartum Care Measures** significantly high with 89.54% completion rate
  - **Black** group below MPL when compared to other races
  - **Tribal** community had notable improvement

# Postpartum Care (PPC)

