PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: Nov. 13, 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 – 9:10 a.m., Wednesday, Nov. 19, 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
H&HS Dept.,5730 Packard Ave., Suite 100, Marysville

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)
Gual, Kristine, Director of Quality Measurement, QI
Harriss, Vander, Sr Health Data Analyst, Finance
Innes, Latrice, Manager of Grievance & Appeals Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Jarrett-Lee, Kevin, RN, Associate Director, UM
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
Rudd, Janet, RN, Manager of Long Term Support Services, UM
Sackett, Anthony, Project Manager II, QI (MEGA)
Sharp, Tim, Regional Director, Northeast
Smith, Christine, Community Health Needs Liaison, Pop Health
Stark, Rebecca, Regional Director, Chico
Trosky, Renee, Manager of Provider Relations Compliance
Vaisenberg, Liat, Director of Health Analytics, Finance
Watson, Deanna, Project Manager (ECM QIP

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

Date: Nov. 19, 2025 **Time: 7:30 – 9:10 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
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H&HS Dept.,5730 Packard Ave., Suite 100, Marysville

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 Partnership locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* • Oct. 15 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	7 - 20
2	*Acknowledgment and acceptance of draft minutes of the* • Oct. 7 Internal Quality Improvement (IQI) Committee • Oct. 29 Over/Under Utilization Workgroup • Oct. 2 Population Needs Assessment (PNA) Committee • Sept. 4 Member Grievance Review Committee (MGRC)			21 - 44
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:37	45 - 53
2	HealthPlan Update	Robert Moore, MD	7:42	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:47	55
	2026 LTC QIP Measure Set – *PAC-approved Nov. 12: direct questions to Deanna Watson*			57 - 59
	G&A PULSE Report – Issue 19, November 2025 – *direct questions to Latrice Innes*			61 - 71
	UM Delegated Hospital Summary – *direct questions to Tony Hightower*			73
	CY2024 Carelon Oversight Final Audit Results – *direct questions to Gary Robinson*			75 - 78
HS Policies	**Care Coordination**			
	MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) – **ARCHIVE** – *See MPTP2501 effective 0/14/26*			79 - 90
	MCCP2029 – Emergency Medical Transportation – **ARCHIVE** – *See MPTP2502 effective 01/14/26*			91 - 93

	Item	Lead	Time	Page #
Health Services Policies	MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities *click here to review Attachments A-L (unchanged from 8/13/25)*			95 - 99
	MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services *(previously MCCP2019)*			101 - 125
	MPCP2023 – New Member Needs Assessment *(previously MCCP2023)*			127 - 141
	Quality Improvement			
	MCQG1015 – Pediatric Preventive Health Guidelines			143 - 156
	MCQP1021 – Initial Health Appointment *includes CLEAN Attachment B on p. x*			157 - 168
	MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines			169 - 177
	Utilization Management			
	MPUP3051 – Long Term Care SSI Regulation – **ARCHIVE** – *refer to MCUG3038*			179 - 180
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-H Facilities			181 - 187
	MCUP3003 – Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services			189 - 194
	MCUP3049 – Pain Management Specialty Services			195 - 199
	MCUP3102 – Vision Care			201 - 203
	MCUP3125 – Gender Dysphoria/Surgical Treatment			205 - 209
Non HS Policies	**Transportation**			
	MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) *(previously MCCP2016)*			211 - 223
	MPTP2502 – Emergency Medical Transportation *(previously MCCP2029)*			224 - 226
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	227 - 234
Health Services Policies	**Care Coordination**			
	MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Shannon Boyle, RN	7:52	235 - 242
	Population Health			
	MPNP9006 – Doula Services Benefit	Christine Smith	7:57	243 - 252
	Utilization Management			
	MCUG3038 – Review Guidelines for Member Placement in Extended Care Facilities (Custodial/Long Term Care, Skilled or Subacute) ***NEW Title*** *CLEAN policy copy begins on p. 271*	Janet Rudd, RN	8:03	253 - 280
	MCUP3020 – Hospice Services	Tony Hightower, CPhT	8:8	281 - 294
	MCUP3041 – Attachment A – Partnership TAR Requirements		8:13	295 - 302
	MCUP3106 – Waiver Programs		8:18	303 - 308
	MCUP3131 – Genetic Screening and Diagnostics		8:23	309 - 456
VI.	**Presentations**			
1	Member Experience Grand Analysis: Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Program 2024-2025 (NCQA ME 7C/7D Report) – *PowerPoint presentation begins on p. 501*	Anthony Sackett	8:28	457 - 516
2	Network Access Grand Analysis: Network Adequacy Report (NET 3, Element A, B: Assessment of Member Experience Accessing the Network & Opportunities to Improve Access to Non-Behavioral Healthcare Services) – *PowerPoint presentation begins on p. 563*	Renee Trosky, BSRRT, MOL	8:48	517 - 580

	Item	Lead	Time	Page #
3	2025 3rd Next Available & Next Available Survey	Vander Harris	9:00	581 - 608
VI. FYI & Close	CY 2026 QI Committees Meeting Schedules and Material Deadlines	*Refer any questions to Leslie Erickson*	--	609
	CY 2026 QI Committee Presentations Calendar		--	610
	Adjournment scheduled for 9:10 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Jan. 21, 2026 – THERE IS NO Q/UAC MTG IN DECEMBER			

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Oct. 15, 2025 / 7:33 a.m. – 8:54 a.m. - Napa/Solano Room, 1st Floor

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

Voting Members Absent: Brandy Lane, Consumer Member; Phuong Luu, MD

Partnership *Ex-Officio* Members Present:
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 & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care 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)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, 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 & Appeals

Partnership *Ex-Officio* Members Absent:
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Cotter, James, MD, Associate Medical Director
Guillory, Ledra, Senior Manager of Provider Relations Representatives

Guests:
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chiang, Yuen, Program Manager 1, Utilization Management
Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health
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)
Frankovich, Terry, MD, Associate Medical Director
Gaul, Kristine, PMO, CPHQ, Director of Quality Measurement, QI
Hendrix, Hillary, Executive Assistant, Behavioral Health
Jamali, Shahrzad, Improvement Advisor, QI (Chico)
Jarrett-Lee, Kevin, RN, Assoc. Dir., 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
Quichocho, Sue, Manager of Quality Measurement, QI
Robertello, Kimberly, PhD, Sr. Medicare QI Program Manager, QI
Romero, Liz, Improvement Advisor, QI
Tryan, Tiffany, Improvement Advisor, QI
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions – *none made* Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m. The Sept. 17 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Sept. 9 Internal Quality Improvement (IQI) Committee • Sept. 25 Substance Use Disorder Internal Quality Improvement (SUIQI) Committee Matt Goudy from MD Staffers came unannounced into the meeting. He introduced himself to Isaac Brown after the meeting.	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Robert Quon, MD *Approved unanimously* Motion to **accept the other minutes:** Robert Quon, MD Second: Steven Gwiazdowski, MD *Accepted unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Interim Senior Director of Quality and Performance Improvement, QI*	• About 200 students were vaccinated during recent immunization events held in Shasta County. Local community partners aided Partnership in this successful endeavor. • The Partnership Improvement Academy 2026 Improving Measure Outcomes webinar series has been finalized, with six sessions beginning on Feb. 11 with pediatric preventive care (0-30 months) and ending on April 22 with perinatal care. • Several Joint Leadership Initiative (JLI) sessions will happen in our Auburn and Chico regions in October, November and December 2025. • Twenty three of the original 26 provider organizations are continuing to participate in the Equity and Practice Transformation project. Several deliverables are due in November. The EPT program focuses on improving core foundational aspects of our practices (e.g., data policy and procedure, and team-based care) rather than working on specific measures. • Q/UAC members will recall we are now in a second phase of the Preventive Care Bridge Project (formerly known as the Locum Pilot Initiative) to ascertain what type of practices are best able to use locums with the greatest efficiency. We have been focused on well child visits and cervical cancer screenings and trying to understand if a locum is appropriate to help in these areas or whether we need to figure out something else to help increase access. Each of the four participating provider organizations has thus far had varying results successfully overcoming different barriers. Partnership will be sharing our best practices as soon as the pilot ends towards the end of this year. • Partnership in September began a project management training program with a pilot cohort of 20 county, provider, and community-based organization participants interested in learning about and applying project management principles to various interventions. The training curriculum is undergoing final edits, and a dedicated Toolkit Hub webpage is live on the Improvement Academy's website. The pilot ends in November. The full program launch is planned for first quarter 2026.	*For information only. There were no questions.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
2. HealthPlan Update *Robert Moore, MD, MPH, MBA* *Chief Medical Officer*	• Partnership has implemented the use of a mobile phone app, Kinetik, for our members' use in accessing their transportation benefit. To initiate individual use, the member should contact the Transportation department at 866-828-2303. The app empowers members to schedule stand-alone or recurring non-emergency medical transportation (NEMT) and non-medical transportation (NMT) rides. The app allows the member to share health conditions and accessibility needs, apply for gas mileage reimbursement, and view, call, and track the assigned driver. At this time, short notice (less than five days) trips and travel related expense requests are not supported. • Q/UAC members will recall that most CTs and MRIs no longer require a Treatment Authorization Request (TAR). A communication will be sent to network radiology providers before the end of October. Thereafter, another communication will be sent to the entire clinician network. • As a result of the federal H.R.1, as of Sept. 11 Partnership may no longer cover family planning services such as IUDs, birth control pills, and women's health exams provided to our members by Planned Parenthood and Women's Health Specialists. Interestingly, these providers can provide and be reimbursed for abortion services because those monies come from state, not federal, funding. We are watching the legal battles and will update Q/UAC as we learn more. Planned Parenthood has seven sites in Partnership's footprint: Chico, Clearlake, Eureka, Fairfield, Napa, Santa Rosa, and Ukiah. Women's Health Specialists has sites in Chico and Redding. • H.R. 1 rural health transformation grants purportedly designed to help keep rural hospitals from closing may not have that effect as the states get to decide "rural" criteria. Partnership is advocating that California focus on obstetric and general care in rural areas and not utilize these grants for other projects at the expense of cutting core health services. • Gov. Gavin Newsom has just signed both Senate Bill 669 and Assembly Bill 55. SB 669 requires the California Department of Public Health to establish a five-year pilot project to allow critical access and individual and small system rural hospitals to establish standby perinatal medical services. The bill, which took three years to get to the Governor's desk, was conceived by Partnership and marks the first time Partnership has championed health care legislation from beginning to end. This has nothing to do with being a managed care plan, although it does help our network. Partnership and our lobbying organization are "super happy." We are likewise pleased that AB 55 should ease some regulations around free-standing birth centers. • Word at the recent Coalition for Compassionate Care for California meeting is that the long-awaited statewide electronic Physician Orders for Life-Sustaining Treatment (POLST) registry may pilot this coming winter. Q/UAC members will recall that legislation passed several years ago, paving the way for emergency medical services and emergency rooms to access an electronic POLST registry in lieu of "relying on paper on the refrigerator." The state organization CalEMS is garnering data use agreements with the larger providers such as Kaiser, Dignity and Sutter to first upload the POLSTs as found in their electronic medical records. Q/UAC members are asked to please "bug" the right people at their organizations to say 'move along on the registry.'	*There were no questions.* • As directed, staff on Oct. 24 emailed this Kinetik information to Q/UAC voters. • For more information on preparing data sharing or use agreements to facilitate uploading POLST agreements into a statewide electronic registry, contact Kevin Chan, Branch Chief, EMSA, Health Information and Data Technologies, at kevin.chan@emsa.ca.gov.
III. Old Business – None		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set – *direct questions to Athena Beltran-Nampraseut* Proposed 2026 Enhanced Care Management (ECM) QIP Measure Set – *direct questions to Deanna Watson* Proposed 2026 Palliative Care QIP Measure Set – *direct questions to Eva Lopze, CPhT*		No questions were asked. Motion to **approve slate as presented:** Brian Montenegro, MD Second: Chris Swales, MD *Approved unanimously* Next Steps: The three proposed measure sets were approved at the Oct. 8 Physician Advisory Committee (PAC) meeting. All policies go to the Nov. 12 PAC
Health Services Policies Behavioral Health MCBP8015 – Coordination of Care for Child Welfare-Involved Members *(previously MCUP3103)* MPBP8007 – Screening and Treatment for Substance Use Disorders (*previously MCUP3101)* MPBP8013 – Eating Disorder Management Policy Care Coordination MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines **– ARCHIVE –** *see new Behavioral Health policy MPBP8011* Utilization Management MCUP3101 – Screening and Treatment for Substance Use Disorders – **ARCHIVE –** *see new Behavioral Health policy MPBP8007* MCUP3103 – Coordination of Care for Child-Welfare Involved Members – **ARCHIVE –** *see new Behavioral Health policy MCBP8015* MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3012 – Discharge Planning (Non-capitated Members) MCUP3050 – Medication Abortion in the First Trimester MCUP3052 – Medical Nutrition Services MCUP3115 – Community Based Adult Services MCUP3128 – Cardiac Rehabilitation MCUP3130 – Osteopathic Manipulation Treatment MPUP3078 – Second Medical Opinions MPUP3116 – Positron Emission Tomography Scants (PET Scans) **Non-Health Services Policies** Grievance & Appeals CGA022 – Member Discrimination Grievance Procedure		
V. New Business – Discussion Policies		Propose
Policy Owner: Behavioral Health – *Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	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)]** **III.A Definition added:** (BHP) Behavioral Health Plan: A county Behavioral Health Plan in Partnership's	Motion to **approve as amended:** Robert Quon, MD Second: John Murphy, MD *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	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). **VI.I.3 adds** Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization. *Footnotes:* Some mental health treatment services, such as TMS, may be available in both specialty mental health services (SMHS) and non-specialty mental health services (NSMHS) systems of care. Partnership's coverage of these treatment services through NSMHS 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. For Partnership Medi-Cal Members, County BHPs are responsible for covering administration of electro convulsive therapy (ECT). Hospital incurred medical costs for ECT (i.e., anesthesia) for Partnership Medi-Cal Members are covered by Partnership. **Per discussion at Oct. 7 IQI,** MCUP3041, Treatment Authorization Request (TAR) Review Process is added to the Related Policies list because TMS requires prior authorization. Also, APL 25-013 supersedes all APL 22-012 references. Many of you are aware that our previously delegated services that were going to Carelon for non-specialty mental health services. One subset has been brought in-house in Fairfield, which we are very excited about: we have a whole new team of behavioral access guides that are now fielding all of the member-facing phone calls. When you call the same Carelon number that you would call before, it's now reaching someone at Partnership. We are hoping this gives us an opportunity to be able to make more substantive changes on how referrals happen because we control the call center. There have been some policy language changes to keep it consistent with what the State uses, for example, "behavioral health programs" is meant to subsume both substance use and mental health services. The State has issued transitional tools to provide an objective measure that would help determine what level of care or what system of care – NSMHS or SMHS – would best suit an individual to receive their behavioral health services. APL 25-010 allows clinicians to override the finding of that screening tool should they feel it is in the patient's best interest, or they feel clinically that there is a more appropriate system of care than what the transitional tool tells them should be the case. In July, the State provided some information on its intention to have TMS covered by NSMHS. TMS is a non-invasive procedure that uses the externally mounted magnets to generate currents to treat depression. Traditionally, this was something that was seen more in SMHS, but the State also wants this to be available in NMSHS, so they added the billing codes 90867, 90868, and 90869 for the diagnosis codes 32.3 and 33.2. We are still working out the details, including developing policies because a TAR is required. In addition to TMS, the State is encouraging NSMHS to also provide Spravato, a brand name for esketamine	Next Steps: Nov. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	nasal spray, a prescription medication used to treat certain types of depression in adults. We are trying to figure out how these services can live in both systems and be non-duplicated. By providing TMS through NSMHS is not meant to supplant or replace TMS that may be provided through the county, but it does add an additional care coordination component to ensure that patients are receiving the services I the system of care that is most appropriate. ECT is another behavioral health intervention that lives in two worlds. There is a component of care that is covered by the managed care plan – hospital costs like anesthesia and whatnot associated with the administration of the ECT – but county specialty mental health is still responsible for paying for the actual procedure itself. The transitional tools issued by the State are included in today's packet. We don't have much editorial authority over them. Some of the language changes that we've made have already been approved by DHCS. Senior Director for Behavioral Health Mark Bontrager added that "our obligation is to triage these services" and he more closely enumerated the transitional tools' scoring results that point to the two systems of care, reiterating that the APL permits clinical judgment overrides. **Q/UAC voter Robert Quon, MD, suggested that versions of the tools themselves be referenced in the policy.** "The only thing that gets a little squishy for me is what do you have to write down and what do you have to document for an override?," Dr. Quon continued. "I read through this several time because I sit on our mental health committees at Kaiser. With mental health being such a laser focus right now, if somebody says 'I am going to override this', whether to up code or downcode it, what is the data that I need to include to do that versus 'it was just a clinician decision'? Can I feel that the patient's presentation is just of higher acuity and do it?, which from a policy standpoint a little bit open to interpretation." Dr. DeVido responded that as a psychiatrist he was not trained to differentiate, based on severity, in what sort of system of care the patient got treatment. This transitional tool is based off of what system of care do you go into? County or NSMS? Right there there's something that awkward about that for a mental health provider because we were trained to adjustment treatment based on the severity of the patient that's walking through the door. I hear what you are saying 'open for interpretation' can also mean you get your hands slapped later for doing something incorrectly or that somebody else deemed was not done correctly. Dr. DeVido continued: say you are a primary care doc and this persons scored low on the screening tool but you think they are more severe. At that point, there is a handoff that's happening between provider A and then system B. Ideally, there's communication 'hey, they scored this, this is what I think is happening and these are the additional factors going into my decision making.' I get a little worried when things get overly prescriptive when it comes to clinical judgment, especially in a somewhat subjective space, which behavioral health can be. **To your first point, absolutely we need to add the version numbers because the State will change that.** To your second point, I'm open to suggestions. Dr. Quon noted "You are protecting the floor. You are saying 'we are not going to go below: if they score a five I'm not going to provide then with a level of care than a five.' … Some of these policies are all about how do we protect our most vulnerable patients and how do we make sure that they are not getting left on	

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	the side of the road?" Mark Bontrager provided some clarification: there are two screening tools, adult and youth, that are to be used when a member contacts our call center, and our access guides actually conduct the 12 question screener. If, during the course of that screen, they have a sense that there may be an alternative outcome here, or even in a situation where a member might say 'I screened a 7 and should be directed to the county but I am sure as heck not going to go there. I had a bad experience,' that can be overwritten. There is no clinical coding in this scenario; it's just a way to direct to the right system of care. The transition of care tool is different and is used if a member commences services with a provider, which they can. They can go to one of our providers straight away: the screening tools don't apply. If during the course of treatment, the provider determines that they actually need a higher level of care, that's when they employ the transition of care tool: that's their passport into the specialty mental health system, and vice versa. That's the only time the TOC is completed. The only time the screening tools are utilized is if the member actually calls a call center. But none of our members have to call a call center. We have this 'no wrong door' policy that allows members to start anywhere and then go everywhere.	
MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines *(previously MPCP2017)*	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. **Section V. is updated to read:** 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, 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. **VI.B.3 now contains the following addition**: (Note that by Jan. 1, 2026, all California counties are expected to be compliant with SB43 which updates the Lanterman-Petris-Short (LPS) clinical definition of "Grave Disability." For more information: https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf)" **VI.C.4.i is added** 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.e., operating motor vehicles while intoxicated)." **References added:** 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. **Attachment A** 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. Dr. DeVido went through the synopsis. SB 43 allowed for the expansion of the definition of grave disability for LPS psychiatric holds. Historically, the criteria used on California for involuntary psychiatric holds was based off the LPS set of legislation. There were three dimensions: suicidality, homicidality, and grave disability. 'Grave disability' was the person was disabled due to a mental illness and could not be due to neurocognitive disorders such as dementia or substance use. So, SB 43is allowing for grave disability that is	Motion to **approve as presented:** Jennifer Wilson, MD Second: Robert Quon, MD *Approved unanimously* Next Steps: Nov. 12 PAC

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	caused by severe substance use, that can be a criteria for psychiatric hold. There have been questions: we can hold people. Now what? Where do we send them? Where are the appropriate placements for someone on an involuntary psychiatric hold for a substance use disorder? This presents some challenges. It's not a primary care provider's duty to do these evaluations; it's simply providing back drop. Associate Medical Director Dave Katz, MD, asked where a provider should best go to learn more. Dr. DeVido said https://www.dhcs.ca.gov/provgovpart/Documents/SB-43-FAQs.pdf) is "fairly digestible": SB 43 amends the LPS Act's definition of "gravely disabled" **in two ways**. "Gravely disabled" now means a condition in which a person: - as a result of a mental health disorder, impairment by chronic alcoholism, **severe substance use disorder, or a co-occurring mental health disorder and severe substance use disorder**, - is unable to provide for their basic personal needs for food, clothing, shelter, **personal safety, or necessary medical care.** There were no other questions or comments.	
Policy Owner: Enhanced Health Services – *Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services*		
MPAP7003 – CalAIM Community Supports (CS)	Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services: Deposits **[See VI.F.2.]** Short-Term Post Hospitalization Housing **[See VI.F.4.]** Recuperative Care **[See VI.F.5]** Medically Tailored Meals and Groceries (MTM/G) **[See new VI.F.6.]** Asthma Remediation – service will be added Jan. 1, 2026 **[See new VI.F.11.]** Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.) **Per discussion at Oct. 7 IQI,** "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.) **Section III Definitions added** for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent **III.J** - Transitional Rent: 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. **Section VI.C** Member Identification and Referral for Community Support Services is updated with track and trending provisions. **Section VII. References is updated** with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and	Motion to **approve as presented:** Brian Montenegro, MD Second: Steven Gwiazdowski, MD *Approved unanimously* Next Steps: Nov. 12 PAC Partnership in November will train our MTM providers on changes.

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	initial policy references to these APLs are hyperlinked. **Attachment A:** 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. Lisa noted that updates to DHCS Policy Guides Volumes 1 and 2 were made in April, then in June, and more are expected in January; so, this policy soon will come back. There were changes to deposits: they now do not allow for the first and last month's rent, only the security deposit or deposits. Short-term hospitalization housing and recuperative care now have a 182-day cap within a 12-month period. There were some changes in the medically tailored meals and we have met with the MTM providers as well as some RDNs to evaluate that. We will be adding asthma remediation on Jan. 1, 2026: it will leave CS and become a Medi-Cal benefit. Transitional rent will be its own policy once DHCS reviews it (effective) Jan. 1 for specific populations. Medical Director for Quality Mark Netherda, MD, asked about eligibility and oversight of both asthma education and remediation eligibility. Lisa said we will require that members first do asthma prevention services: education with a community health worker (CHW) and then the CHW will evaluate whether the member qualifies for remediation services. To begin with, the member must have poorly controlled asthma and meet criteria as follows: 1. An emergency department visit of hospitalization or two sick or urgent care visits due to asthma in the past 12 months **or** 2. Asthma control test core of 19 or lower **or** 3. Recommendation from a licensed health care provider. No treatment authorization request is required for the education services with the CHW. A TAR will be required for any remediation service. Lisa added that education will be under the contracted provider organization, which would provide and manage the CHWs. One statewide organization, Breathe Easy, is interested. Partnership is having an asthma remediation webinar Nov. 6 with RAMP (Regional Asthma Management and Prevention), another statewide organization that does asthma prevention. Remediation for such items as air filters and air purifiers could occur up to $7,500 during a member's lifetime. In response to a question whether remediation would cover mold and cockroaches, Lisa noted it could but "most licensed contractors in the state of California won't do anything for $7,500." Mold removal requests would be unusual because most of the people that would qualify don't own their own homes. Their landlords would need to be involved. Associate Medical Director Marshall Kubota, MD, asked whether remediation monies could be used for flood damage or smoke damage from house fires? Lisa said the same home ownership issues could apply, although RAMP has examples of how mold removal can be done without doing construction.	

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	Dave Katz, MD, asked if there will be tracking to see if such asthma control is cost effective? Dr. Moore noted we do have a general plan of looking at the cost effectiveness of our Community Supports in ECM; however, once it becomes a benefit, it doesn't matter: the State just says we have to do it.	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, Policy Analyst, UM*		
MCUP3015 – Family Planning By-Pass Services	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). **Section III.A:** Added end note 1 to the definition of Bypass Services: "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." **Section III.C:** Added Definition of Prohibited Entity **Sections VI.B., C., and E.:** Added end note message (same as described for III.A) regarding Prohibited Entities. **Section VI.G.7.:** 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." **Section VII.F. and G.:** 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) **Per Oct. 7 IQI discussion,** "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 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." Associate Director for UM Regulations Tony Hightower's attendance was delayed, so Anna Campbell presented. In this policy, we are addressing the federal H.R.1 bill, which DHCS covered in APL 25-011. We defined the term "prohibited entity" and then we added footnotes throughout to reference this bill and the fact that, although we say 'you can go wherever you want,' we will not be able to pay prohibited entities. There were no questions and no discussion. Dr. Moore acknowledged that the policy changes were approved without objection.	Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Nov. 12 PAC
MPUP3035 – Preoperative Day Review	During annual review, this policy was updated to remove old criteria. **Section I.B.:** Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management	Motion to **approve as presented:** Robert Quon, MD

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	Section III.: 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. **Section IV.:** Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead. **Section VI.B.2. – 2.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. **Section VIII.A.:** Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System. **APPENDIX:** Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews. This was an annual review, and UM decided to remove what was called Appendix A. For a long time, it said Partnership would look at criteria from the ASA to determine if someone needed a preoperative day, but now we have decided we are using the InterQual® criteria and other things, Anna noted. So, we deleted that appendix and referenced our policy MPUP3139, which defines all the criteria that we might use for management, and then we talked about using InterQual.® There were no questions or comments.	Second: Randy Thomas, MD *Approved unanimously* Next Steps: Nov. 12 PAC
VI. Presentation		
Health Equity Grand Analysis – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
This health disparity analysis compares 2024 performance to that of 2023, stratifying for race and no other demographics. We got the data from Health Analytics team, who did a plan wide assessment of many of our disparities. We then compared these stratifications against the minimum performance level (MPL). And from there were looked at the trending data. We recognize that there is an issue with data quality, so there are certain measures we did not include (e.g., FUM and FUA). We do have to look at where we have made improvement. The key ones are the Well Child Visits for the First 15 months and the 15-to-30 months, Lead Screening in Children (LCS), and even Blood Pressure Control. In the context of well child visits, a majority of our race groups actually improved in 2024 above 2023 and met what we were looking for; however, although the 15-month plan-wide composite at 67.05% exceeded the minimum performance level, only the Hispanic and Pacific Islander racial groups exceeded the MPL. When we look at Child and Adolescent Well Care Visits, we see that most groups improved in 2024 over 2023 performance; however, only Hispanics and those identified as "multi-racial" exceeded the MPL. This is an example where a systemic issue may be why a majority of all race groups are not able to attend these WCVs. Then there is the classic, even textbook, examples of a health disparity for LSC in Black children and in Immunizations for Adolescents (IMA), especially for our White or Caucasian members. In 2024, results actually trended down from 2023 in LCS for Black members and in IMA for White members. We may want to do an intervention to help address these concerns for these communities.		

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For Cervical Cancer (CCS) and Breast Cancer Screening (BCS), a majority of members are not at the MPL. (We do not have colorectal cancer screening data, so that is excluded from this analysis.) Tribal members, although showing a 7.66% gain in 2024 still remain below the BCS MPL. In 2024 BCS, Black members fell slightly below the MPL, while White members remained below the MPL fairly static to 2023 performance. We may want to prioritize BCS for the Tribal community.

We looked at the data regarding the prenatal and postpartum care measures. I do recognize that we didn't meet the minimum for both the prenatal and postpartum care, but I recognized too that we really barely met the minimum for the prenatal care measures, so those might be key priorities for us. And then this is another example where we found a specific disparity: our post-partum care measure composite was at 89.5 %, but then again, our Black members, who had the highest 2023 rates, fell below the MPL in 2024. We may want to do an intervention to address this disparity. (The Tribal community showed notable improvement, hovering at the MPL.)

Dr. Moore thanked Dr. Jalloh for "the quick and easy to absorb" presentation. Dr. Moore noted that we have previously looked at the LSC disparity in the Black community: because it tends to be concentrated in certain areas, it can be driven by provider performance, as he sees it within the Primary Care Provider Quality Incentive Program (PCP QIP) performance. Other providers, like La Clinica, CommuniCare+OLE, and Northbay, have "high" rates, he said, adding that in this case, the disparity is not a systemic issue as much as a provider targeted issue.

Dr. Jalloh thanked him for putting this in context. 'And that is one way we can approach a lot of these disparities," he said. "We recognize that while there's a big plan-wide measure, we recognize that there are certain health systems that are the big driver: a perfect example is that for African Americans, a majority of them are actually seen at Family Health Services in Solano County, so we recognize that if we do a targeted intervention there, that likely will have the impact at the plan wide measure versus trying to do something across all of our regions." In another caveat, Dr. Jalloh noted that 2023 results include only the 14 "legacy" counties, while the 2024 results cover Partnership's current 24 counties. Therefore, a comparison of 2025 data against 2024 could be more telling. Meanwhile, DHCS is still holding us accountable to the data for this year, he said.

Dr. Moore said low composite BCS in the Native American community is being driven by a certain provider. In 2023, all of our providers had an equally low rate but in 2024, although not enough to get the rate high, "a couple of providers did really well." Moore noted that the rates of the K'ima:w Medical Center, which serves the Hoopa, dramatically improved, as did those of the Sonoma County Indian Health Project. Round Valley actually scored the highest on the BCS of any provider for the Native American population, "which is a big victory as they struggled so much with quality," he said, inviting Q/UAC to "guess what the common denominator was?" It was the mobile mammography units going out to the rural areas. "I think that is a good example of a particular intervention eliminating a disparity, at least in a local area," Dr. Moore concluded.

Doctors Moore, Jalloh, and Associate Medical Director Marshall Kubota, MD, had a brief discussion on how "multi-racial" although not graphed in the presentation's WCV in the First 15 comparisons can present anomalies. This is something we continue to work on with Health Analytics as "the data from the State is frankly awful," Dr. Moore said. "We can look for broad trends and make some general conclusions but, to refresh everyone's memory, if someone picks 'Hispanic plus anything,' 'Hispanic' trumps, and everything else is ignored. If you're non-Hispanic, and you pick one race, then you'll see it. If you pick more than one race, some of them end up in 'multi-race,' some end up in 'unknown,' some end up in 'other' and it is completely uninterpretable. And the percentage of our members who are in those (categories) has been growing dramatically in the last few years. DHCS is planning to make some changes in the next few years as there are new federal requirements for changing the way race is done. The net effect, just so no one is surprised, will be a big decrease in the Hispanic population just because of data. So that will give us a new fresh start to look at it with a little better lens."

Q/UAC voter Robert Quon, MD, said he noticed that the Black demographic dropped in almost every single graph presented, whereas most of the others stayed about the same or climbed: the 10-county expansion alone or a single provider can't account for this. "We often talk about rural counties (with) mobile mammography, but for our working class people who can't get to wherever, childcare or whatever, do we think about those mobile resources for those communities that are not rural but are urban and just don't have access? With Medi-Cal, we provide transportation because these are people that don't have the same mobility."

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Dr. Jalloh thanked Dr. Quon for his comments. Dr. Moore added that although there are fewer Blacks in the new counties, they do perform worse than those in the Fairfield region, where most of our African Americans are located. Dr. Jalloh talked of a likely intervention. "One project that we are actually starting is trying to work with integrating community health workers into areas where a lot of African American community members attend," Dr. Jalloh said. "Key are barber shops for Black men and beauty salons for (many) Black women. And we're currently working in contracting to be actually able to train some of these barbers, these beauty salon people to be CHWs where they can provide a lot of that education so we can hopefully improve that."

Q/UAC voter John Murphy, MD, said "we have a mobile mammography van that Partnership helps us facilitate that is parked a 100 yards away from the Sutter mammography. It's an access and trust issue, and we get people in that way. We find value in bringing the (mobile) mammography very close and we appreciate Partnership's flexibility in granting us that."

Dr. Murphy also noted that for the American Indian Alaksa Native, "there were pediatric measure results that essentially doubled, which could be just a performance increase (but) it could also be a data issue. That would be interesting to hear more about. In some measures, there are important structural issues, and in some measures there's an important element of member choice or parent/guardian choice, especially around IMA. I don't mean to blame the member. We have to be careful about that. For lead screening, that seems more structural: I haven't had a parent yet say 'do not screen my child for lead.' I wonder how one would tailor an approach to disparity given that framework?"

Dr. Jalloh acknowledged this distinction, saying many "members feel a little bit more empowered to say, 'no, I don't want the flu shot.' That's where we may want to tailor our interventions to make sure ones that are more provider leaning" is "where we try to focus with more interventions. The ones that are more member driven, that's where we may want to focus more community engagement."

Dr. Jalloh added that data is improving with the recent advent of our new vendor, DataLink. Interim Senior Director for Quality and Process Improvement Isaac Brown added that our auditors allowed us to run a supplemental project to look at medical charts for our early well-child visits. "It was a major lift, but in talking to the providers, we felt like they were doing the work. We just weren't seeing it in the data; (with) the supplemental data project, we jumped from the 25th percentile to the 75th percentile."

Manager of Quality Measurement Sue Quichocho noted, in looking at the medical records, that in some cases if the child was brought in for a sick visit, there was enough documentation within that sick visit that met the WCV requirements. At the end of October, we are conducting a "kaizen" to go this because in some instances there were no claims filed.

Regional Medical Director Colleen Townsend, MD, said while we've seen access improvements in Solano County, "we are still struggling with some of those postpartum follow-ups in particular because the delivery hospital doesn't provide all the postpartum care. We've had a really great system in place for babies, but for the moms that's been a little bit more challenging. We need to look at that more carefully. We have seen some disparities in other counties where the population of Black members is smaller but still has impact in terms of noting the disparity and the decrease over time." Dr. Murphy concurred: "It would be hard to overstate the significance of the birthing center being across the hill. Even though it seems fairly close compared to a frontier county, that is a barrier, and where we run our data and where we have missing newborns and missing moms, it's for those patients that weren't assigned to us: we saw them for their prenatal care and mother and infant just kind of disappeared after they delivered somewhere else."

Q/UAC voter Randy Thomas, MD, said with regard to IMA that "I have seen more refusals, particularly of the HPV. We've had refusals or postponements in the White population for a good while and we've had a lot more refusals in the Black population recently. And some of those refusals aren't total refusals, it's just 'I don't want it now' and you know sometimes they might get the vaccine when they're 14 or 15, but that's not included in these statistics."

Dr. Kubota asked if birth order is a factor in postpartum visits. Dr. Townsend said some practices may have anecdotal evidence that they see more primiparous moms following up and fewer multiparous moms but that is not something Partnership has differentiated. Dr. Moore said "overall, the postpartum rate is our best measure

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across the board at Partnership. It's notable that there was a drop (from 97% to 76.56%) for the African American population. The adolescent vaccination rate is way lower than that."

Q/UAC voter Steven Gwiazdowski, MD, wondered if this is a "regression to the mean kind of thing going on because they (Blacks) were the highest performer there." Dr. Townsend added this may be an opportunity to better utilize doulas, "particularly in Solano County, (where) we probably have the largest network of doulas of color that may be able to engage differently to support that postpartum visit. Our doula network in 2024 was really just burgeoning, so to speak, and our network has completed a number of local trainings that may really support the educational pathway to help moms get back to their prenatal care provider for a postpartum visit within the first three months."

VII. Adjournment

Dr. Moore adjourned the meeting at 8:54 a.m.

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

Signature of Approval: _____ Date: _____

Robert Moore, MD, MPH, MBA
Chief Medical Officer

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Oct. 7, 2025 / 1:31 – 3:19 PM

Members Present:

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
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
Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI [1]
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Manager of Grievance & Appeals Compliance
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services
Klakken, Vicki, Regional Director (Northwest)
Leung, Stan, Pharm.D, Director of Pharmacy Services
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)
YoungStone, Kelly, RN, Director of Care Coordination, Care Coordination

Members Absent:

Andrews, Leigha, MBA, Regional Director (Southwest)
Bjork, Sonja, JD, Chief Executive Officer
Davis, Wendi, Chief Operating Officer
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Kerlin, Mary, Senior Director, Provider Relations
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
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

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)
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance
Bushey, Lindsey, Project Manager I, QI
Chiang, Yuen, Program Manager I, Utilization Management
Clark, Kristen, Manager, Quality & Training, Member Services
Conner, Maria, Improvement Advisory, QI (Auburn)
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Sr. Mgr. of Performance Improvement, QI (Redding)
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)
Escobar, Nicole, Sr. Mgr. of Behavioral Health, Behavioral Health
Flournoy, Candi, Project Manager II, QI
Hanusiak, Kenzie, Sr. Mgr., Regulatory Affairs & Compliance (RAC)
Harris, Vander, Senior Health Data Analyst I, Finance
Hendrix, Hillary, Exec. Asst. to the Sr. Dir. of Behavioral Health
Lee, Donna, Manager of Claims, Claims
Legere, James, Administrative Assistant I, Regional Administration (Chico)
Leung, Paul, Sr. Health Data Analyst I, Finance
O'Leary, Hannah, Manager of Population Health, Population Health
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
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Seale, J'aime, PR Lead, Network Services
Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Smith, Christine, Community Health Needs Liaison, Population Health
Thomas, Penny, Senior Health Data Analyst I, Finance
Trosky, Renee, Manager of Provider Relations Compliance, Network Services

[1] *Effective immediately, Kristine is now a voting IQI member, and her position title will be added to the IQI policy member matrix on its annual next review, March 2026.*

Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Tryan, Tiffany, Senior Improvement Advisor, QI (Redding)
Jamali, Shahrzad, Improvement Advisor, QI (Chico)	Vance, Brooke, Program Manager I, Network Services
Kubota, Marshall, MD, Associate Medical Director	Watson, Deanna, Program Manager I, QI (ECM QIP)
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance (RAC)	Yu, Fei, Senior Data Scientist I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Introductions • Approval / Acceptance of Minutes	Medical Director for Quality and IQI Vice Chair Mark Netherda, MD, called the meeting to order at 1:31 p.m. in the planned absence of Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA. RAC Senior Manager Kenzie Hanusiak introduced RAC Policy Analyst Shreya Kulkarni, JD, who is now training to look at policies for an enterprise-wide compliance review. Hillary Hendrix introduced herself as Mark Bontrager's executive assistant. • Approval of the Sept. 9, 2025 IQI Minutes • Acknowledgment and Acceptance of the draft minutes of the ○ Sept. 25, 2025 Substance Use Internal Quality Improvement (SUIQI) Committee	Motion to **approve IQI Minutes**: Issac Brown Second: Tony Hightower Motion to **accept SUIQI minutes**: Lisa O'Connell Second: Katherine Barresi, RN
II. Old Business - None		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies <u>Behavioral Health</u> MCBP8015 – Coordination of Care for Child Welfare-Involved Members *(previously MCUP3103)* MPBP8007 – Screening and Treatment for Substance Use Disorders *(previously MCUP3101)* MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines *(previously MPCP2017)* MPBP8013 – Eating Disorder Management Policy <u>Care Coordination</u> **ARCHIVE** MPCP2017 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines *(now MPBP8011)* <u>Utilization Management</u> **ARCHIVE** MCUP3101 – Screening and Treatment for Substance Use Disorders *(now MPBP8007)* **ARCHIVE** MCUP3103 **–** Coordination of Care for Child Welfare-Involved Members *(now MCBP8015)* MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3012 – Discharge Planning (Non-capitated Members) MCUP3050 – Medication Abortion in the First Trimester MCUP3052 – Medical Nutrition Services – ***pulled for comment by Anna Campbell*** MCUP3115 **–** Community Based Adult Services MCUP3128 – Cardiac Rehabilitation MCUP3130 – Osteopathic Manipulation Treatment MPUP3078 – Second Medical Opinion MPUP3116 – Positron Emission Tomography Scans (PET Scans) **Non-Health Services Policies** <u>Grievance & Appeals</u> CGA022 – Member Discrimination Grievance Procedure	Motion to **approve slate without MCUP3052**: Lisa O'Connell Second: Katherine Barresi, RN <u>Next Steps</u>: All policies will go to the Oct. 15 Quality/ Utilization Advisory Committee (Q/UAC) and to the Nov. 12 Physician Advisory Committee (PAC)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Anna Campbell **pulled MCUP3052** to discuss alongside MPAP7003 – CalAIM Community Supports (CS). IQI thereafter agreed that **MPAP7003 would be amended to define Registered Dietician (RD) or Registered Dietician Nutritionist (RDN)** and to see that MCUP3052's language jibed accordingly. **Motion to approve an altered MCUP3052**: Anna Campbell/Second: Lisa O'Connell. Kellie Muncy asked if the federal HR1 provisions affected MCUP3050, Medication Abortion in the First Trimester. Anna replied that they do not but they do affect MCUP3015 – Family Planning By-Pass Services, which is one reason that policy is on discussion today.	
IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeff DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	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]** Adds Transcranial Magnetic Stimulation (TMS) as a newly covered Non-Specialty Mental Health Services (NSMHS) benefit with prior authorization **[VI.I.3]** **Section III Definition** added for (BHP) county Behavioral Health Plan Footnotes: 1. Clarifies how ECT services are covered in Medi-Cal and Medicare Advantage 2. Identifies that TMS is a covered benefit in both systems of care, Specialty Mental Health Services (SMHS) and NSMHS Dr. DeVido noted that many of the language changes reflect the Carelon de-delegation for some call center activities Partnership has now brought in-house. TMS related to treatment of depression and other conditions is newly covered under NSMHS: the State has issued a fee schedule, and the Department of Health Care Services (DHCS) has approved our policy language. Partnership will continue to cover aspects of hospital-based care for electro convulsive therapy (ECT), although the procedure delivery itself is the responsibility of the counties under SMHS; thus, coordination between the two systems of care will be necessary. **Kenzie Hanusiak suggested adding MCUP3041 Treatment Authorization Request Review Process to the Related Policies list because TMS does require prior authorization**. Dr. DeVido had no objection to this addition, although he noted that a separate TMS TAR policy is in development. **The IQI Committee agreed to this amendment. Anna noted also that she will accordingly amend the TAR list (MCUP3041-A), bringing that to November committees for approval.** Dr. DeVido added that how we ensure we won't duplicate services across the two systems of care has yet to be determined and is made difficult because of claims lag with the counties. Very few counties, however, actually offer TMS because it involves purchasing a machine and training personnel in its operation and use. Marin County, for example, utilizes an outside vendor for this purpose, he said. Chief Health Services Officer Katherine Barresi, RN, commented that Partnership may need to impose attestation responsibility on the provider or refer to contracts. She cautioned against becoming "helicopter pilots for all things for all patients at all times."	Motion to **approve as amended**: Lisa O'Connell Second: Stan Leung, Pharm.D Next Steps: Oct. 15 Q/UAC Nov. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Kenzie noted that DHCS is telling us we have to report usage within 30 days or we can't keep the monies. Senior Director of Behavioral Health Services Mark Bontrager added that TMS became a NSMHS benefit because it wasn't being provided much under SMHS, adding that Partnership does do a retrospective review to make sure that there isn't duplication of services. Director of Pharmacy Services Stan Leung, Pharm.D, said **APL 25-013 (09/18/25) should supersede APL 22-012** in this and other policies. Anna responded she has been waiting to do this because we haven't done gene therapy yet. Dr. DeVido asked if this is inclusive of gene assays? Stan said no, this APL relates to sickle cell anemia therapies. **The Committee accepted this amendment too.**	
Policy Owner: Enhanced Health Service – *Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services*		
MPAP7003 – CalAIM Community Supports (CS) *(previously MCAP7003)*	Updates made because of changes made to DHCS Policy Guides Volume 1 and 2. Most changes made by DHCS were to the following services: • Deposits **[See VI.F.2.]** • Short-Term Post Hospitalization Housing **[See VI.F.4.]** • Recuperative Care **[See VI.F.5]** • Medically Tailored Meals and Groceries (MTM/G) **[See new VI.F.6.]** • Asthma Remediation – service will be added Jan. 1, 2026 **[See new VI.F.11.]** • Transitional Rent – services will be added Jan. 1, 2026 (Transitional Rent will be a separate, forthcoming policy.) **Section III Definitions added** for Electronic Visit Verification (EVV), Global Cap, Partnership Advantage (effect. Jan. 1, 2027), and Transitional Rent **III.J** - Transitional Rent: 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. **Section VI.C** Member Identification and Referral for Community Support Services is updated with track and trending provisions. **Section VII. References are updated** with the hyperlinked additions of DHCS APLs, 22-013 and 22-014, and initial policy references to these APLs are hyperlinked. **Attachment A:** 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. Lisa went through the synopsis. Partnership can no longer cover first and last month deposits; however, we can cover security deposits, she said in response to a question from Dr. Netherda. Members will need to find first and last through other sources.	Motion to **approve as amended**: Katherine Barresi, RN Second: Isaac Brown Next Steps: Oct. 15 Q/UAC Nov. 12 PAC Consider including this definition in any policy mentioning "registered dietician" as it renews: "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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Medically Tailored Meals sections are updated to allow more education time, so MTM themselves do not become a lifetime commitment. Metrics have been added for re-authorization. MTM has been removed from the Attachment A grid. **VI.F.4.a.3 is corrected to read "meeting of *any* of the following criteria:"**. Dr. Netherda noted that as this policy's added definition of Registered Dietician (RD) or Registered Dietician Nutritionist (RDN) be carried forward in Medical Nutrition, Lactation and other policies: that is, all policies going forward that only speak of RDs should also mention RDNs. Anna Campbell suggested that Credentialing staff and the Credentials Committee might be consulted. **RD/RDN definition is added at III.I for Q/UAC's consideration Oct. 15.** Associate Medical Director Marshall Kubota, MD, expressed concerns that the $7500 remediation limit for the relief of asthma wouldn't go very far, and Lisa said these monies will likely be used to pay for air filters, air circulation system, and the like, but licensed contractors cannot be found to work on such small projects. Anna wondered whether these provisions would need to be written into the asthma clinical practice guideline MPXG5001 (due for annual update in May 2026): no one had a ready answer.	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.)"
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3015 – Family Planning By-Pass Services	This policy is being updated to describe Prohibited Entities as per H.R.1. and APL 25-011 Revised H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025). **Section III.A:** Added end note 1 to the definition of Bypass Services to say: "Effective July 4, 2025, Prohibited Entities, as defined in III.C. above, cannot receive 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." **Section III.C:** Added Definition of Prohibited Entity **Sections VI.B., C., and E.:** Added end note message (same as described for III.A) regarding Prohibited Entities. **Section VI.G.7.:** 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." **Section VII.F. and G.:** 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) Tony went though the synopsis. "Prohibited entities" in Partnership's footprint include all Planned Parenthood clinics and three Women's Health Specialist clinics organizations. It does not include OB/Gyn practices, Tony said in response to a question from Dr. Kubota. Anna and Kenzie discussed some of the new federal prohibitions. Kenzie clarified that Planned Parenthood can at their own cost provide certain services to our members, but they may not charge Partnership for these services. Kenzie said that footnote 3 as written would seem to imply that Partnership would not reimburse prohibited entities at all when we actually still may reimburse contracted state supportive services using a limited set of codes and not using any federal dollars. **Mark Bontrager suggested inserting "federal" before "Medicaid" in all three end notes; both Tony and Kenzie agreed to that clarification. For end note 3 only, Kenzie**	Motion to **approve as presented**: Lisa O'Connell Second: Anna Campbell After further discussion, the **policy approval was amended (O'Connell/Campbell) with the changing of footnote 3** to read "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." Next Steps: Oct. 15 Q/UAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	recommended removing the second sentence "as such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members" for accuracy.	Nov. 12 PAC
MPUP3035 – Preoperative Day Review	During annual review, this policy was updated to remove old criteria. **Section I.B.:** Added Related Policy MPUP3139 – Criteria and Guidelines for Utilization Management **Section III.:** 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. **Section IV.:** Removed APPENDIX A. Deleted information on the Preoperative Day Review/ American Society of Anesthesiologists (ASA) Patient Classification System. Partnership currently uses InterQual® criteria instead. **Section VI.B.2. – 2.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. **Section VIII.A.:** Deleted Reference for the American Society of Anesthesiologists (ASA) Patient Classification System. **APPENDIX:** Deleted APPENDIX which shared the American Society of Anesthesiologists (ASA) Patient Classification System. This is no longer our main criteria for preoperative day reviews. Tony went through the synopsis. There were no questions.	Motion to **approve as presented**: Lisa O'Connell Second: Lisa Ward, MD Next Steps: Oct. 15 Q/UAC Nov. 12 PAC
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Interim Senior Director, Quality Improvement and Performance*		
• All are invited to participate in the Improvement Academy's 2026 Improving Measure outcome webinar series: o 2/11: Pediatric Preventive Care (0-30 months) o 2/25: Pediatric Preventive Care (3-17 years) o 3/11: Preventive Cancer Screenings o 3/25: Chronic Disease o 4/8: Sexual Health Screenings o 4/22: Perinatal Care • Joint Leadership Initiative (JLI) sessions are coming up in 2025 to help us raise our scores in the Eastern and Redding regions: o 10/14: WellSpace Health o 10/20: Oroville Hospital o 10/21: Shasta Community Health Center o 11/3: Ampla Health o 11/17: MCHC o 12/8: Western Sierra Medical Center • Twenty three of the original 26 providers organizations are still participating in the Equity & Practice Transformation Project. (Fairchild Medical Clinic, Lassen Indian Health Clinic and Northern Valley Indian Health dropped for limited band width or limited staff.) Partnership is proceeding with DHCS-approved option allowing us to submit self-produced quality measure rates using the California Technical Specifications (CATs) so that performance can be tracked for all EPT deliverables that include Healthcare	*For information only.* Dr. Netherda encouraged physicians and coding support personnel to attend Dr. Kermit Jones' Oct. 8 webinar addressing coding acuity for the Dual-eligible Special Needs Plans (D-SNP).

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Effectiveness Data Information Set (HEDIS®)-like measures. The HEDIS® team will move forward with preparing CATs rates for all EPT sites for Measurement Year 2024. • The Preventive Care Bridge Project continues with locum providers at four provider sites. Nearly 1,100 Partnership members have been seen by locums June 30 to date. • The Mobile Mammography program provided services to Partnership members during 21 event days plan-wide in the first quarter of Fiscal Year 2025-2026. • The QI Trilogy team is now reviewing subject matter experts' suggested opportunities for improvement re tools, resources and practices to enhance document preparation and submission for the upcoming FY 2025-2026 QI Trilogy season. • The Medicare Quality team is developing an approach to share a Stars analytic tool and DHCS measure information with key stakeholder in a centralized, cloud-based format. • The Site Review team conducted 23 facility site reviews (FSR) and 22 medical record reviews (MRR), issuing five FSR Corrective Actions Plans (CAPs) and 12 MRR CAPs across the HealthPlan between Aug. 25 and Sept. 26.	

Health Equity Grand Analysis – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*

This health disparity analysis utilizes Health Effectiveness Data Information Set (HEDIS®) we got in September, and compares 2024 performance to that of 2023, stratifying for race and no other demographic. The Health Analytics team did a plan wide assessment of many of our disparities. We then compared these stratifications against the minimum performance level. And from there were looked at the trending data. We recognize that there is an issue with data quality, so there are certain measures we did not include (e.g., FUM and FUA).

We do have to look at where we have made improvement. The key ones are the well child visits for the first 15 months and the 15-to 30 months, lead screening, and even blood pressure control. In the context of well child visits, a majority of our race groups actually improved in 2024 above 2023 and met what we were looking for; however, although the 15-month plan-wide composite at 67.05% exceeded the minimum performance level, only the Hispanic and Pacific Islander racial groups exceeded the MPL. When we look at Child and Adolescent Well Care Visits, we see that most groups improved in 2024 over 2023 performance; however, only Hispanics and those identified as "multi-racial" exceeded the MPL. This is an example where a systemic issue may be why a majority of all race groups are not able to attend these WCVs

Then there is the classic, even textbook, examples of a health disparity for Lead Screening (LSC) in Black children and in Immunizations for Adolescents (IMA), especially for our White or Caucasian members. In 2024 results actually trended down from 2023 in LCS for Black members and in IMA for White members. We may want to do an intervention to help address these concerns for these communities.

For Cervical Cancer (CCS) and Breast Cancer Screening (BCS), a majority of members are not at the MPL. (We do not have colorectal cancer screening data, so that is excluded from this analysis.) Tribal members, although showing a 7.66% gain in 2024 still remain below the BCS MPL. In 2024 BCS, Black members fell slightly below the MPL, while White members remained below the MPL fairly static to 2023 performance. We may want to prioritize BCS for the Tribal community.

We looked at the data regarding the prenatal and postpartum care measures. I do recognize that we didn't meet the minimum for both the prenatal and postpartum care, but I recognized too that we really barely met the minimum for the prenatal care measures, so those might be key priorities for us. And then this is another example where we found a specific disparity: our post-partum care measure composite was at 89.5 %, but then again, our Black members, who had the highest 2023 rates, fell below the MPL in 2024. We may want to do an intervention to address this disparity. (The Tribal community showed notable improvement, hovering at the MPL.)

In response to a question from Senior Manager for Regulatory Affairs and Compliance Kenzie Hanisiak, Dr. Jalloh said this information has been shared with the Community Advisory Committee (CAC) but not the Family Advisory Committee (FAC). Epidemiologist Folo Akintan, MBBS/MD, said many of the results looked close, and she suggested we utilize confidence intervals. Dr. Jalloh noted we could do this in future in year-over-year comparisons, although the State does not require it. (We do look at how NCQA wants us to approach disparities, and that informs our composites, he said.) Director of Quality Measurement Kristine Gual supported Dr. Akintan's suggestion, saying that many of our populations are not big: for some we are looking at no more than 400 medical records, and then we stratify from there.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Kenzie noted that not all races perform the same across each region. Dr. Jalloh, cautioning that this analysis looks only at race and not other issues such as linguistic preferences or housing status, asked for suggestions on what interventions to address first. Medical Director for Quality Mark Netherda, MD, suggested that WCV interventions in the Black community might also positively impact LCS and IMA. Dr. Jalloh liked this idea.		
Proposed 2026 Primary Care Provider Quality Incentive Program (PCP QIP) Measure Set – *Athena Beltran-Nampraseut, CPhT, Program Manager II, QI*		
There isn't much change in 2026 from 2025 apart from an age expansion in the Breast Cancer Screening (BCC) measure, a move of Chlamydia Screening from monitoring to an active clinical domain measure for both Family Practice and Internal Medicine, and the addition of a Kidney Health Evaluation for Patients with Diabetes (KED) in both Family and Internal Medicine. BCS now includes all persons 40-74 years old assigned female at birth. Chlamydia Screening is proposed as an active measure in Family Practice (16-24 y-o), Internal Medicine 21-24 y-o), and in Pediatrics (16-20 y-o) in all persons assigned female at birth or identifying as female. The 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 annually receive both an estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (uACR). There are no changes to the Pediatric Clinical Domain set. In the Unit-of-Service (UOS) measure set, both the Early Administration of the 1st HPC Dose and the Early Administration of Initial Flu Vaccine Series are being retired because there were no discernable differences in the completion rates of early administration. Dr. Kubota said so many practices have an overlap of patients that perhaps, in future, Partnership should put together program packages, rather than continuing to do "one-offs" in things such as cancer screening in children. Dr. Netherda liked the idea, particularly in patients with diabetes. Athena said this was discussed in 2025 workgroups and could be again in 2026 for MY 2027.		The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar. *Meeting Postscript*: PAC passed the proposal as presented.
Proposed 2026 Enhanced Care Managed (ECM) QIP Measure Set – *Deanna Watson, Program Manager, QI*		
No changes are proposed for 2026. Quarterly payouts on differing targets for full and partial points remain in effect for three measures: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare within 60 days; PHQ9 Depression Screening; and Controlling Blood Pressure (CBP) – Blood Pressure Screening. Dr. Netherda was curious how numbers are reported or counted. Isaac Brown said PointClickCare does the counting for us. He added that we are considering changing the payout to every six months, rather than quarterly because the process is so labor intensive. Auburn Regional Medical Director Matthew Mooris, MD, said that extending the reward farther out from the action can make persons forget why they are doing the action in the first place, and Chico Regional Medical Director Doug Matthews, MD, concurred.		The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar. *Meeting Postscript*: PAC passed the proposal as presented.
Proposed 2026 Palliative Care QIP Measure Set – *Deanna Watson, for QIP Program Manager Eva Lopez, CPhT*		
Deanna presented because Eva was away at a palliative care conference. No change is recommended on the utilization measure Avoiding Hospitalization & Emergency Room Visits: $240 PMPM if no inpatient or ED use per calendar month. Providers can still earn $120PMPM once a signed Physician Order for Life Sustaining Treatment (POLST) is completed. The quality measure Completion of a Palliative Care Survey is changing to a Completion of a Standardized Patient Symptom Assessment because the Palliative Care Quality Collaborative dissolved April 17, 2025, at which time palliative care providers confirmed they all use the Edmonton Symptom Assessment System (ESAS) and could submit ESAS data directly to Partnership. Providers can earn $120 PMPM if two standardized patient symptom assessments are completed will all essential data elements		The proposal will be put to PAC approval Oct. 8 and be acknowledged on the Oct. 15 Q/UAC consent calendar. *Meeting Postscript*: PAC passed the proposal as presented.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	included. Full and partial thresholds apply: 70% or more of all data elements are entered on the assessments equals full points. Partial points ($60 PMPM) are available for 50-69% of data elements entered.	
VI. Adjournment		
Dr. Netherda adjourned the meeting at 3:19 p.m. IQI will meet next Tuesday, Nov. 11, 2025.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* *Mark Netherda, MD* *Medical Director for Quality and Committee Vice Chair*		

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Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

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

Date: October 29th, 2025 **Time**: 3:00pm – 4:00pm

Location: Board Room **Owner:** Dr. Ribordy

Coordinator: Radha Chebolu (Health Analytics)

Attendees:

Partnership Health Plan	Partnership Health Plan	Partnership Health Plan
☒ Robert Moore	☒ Ledra Guillory	☒ Doreen Crume
☒ Jeff Ribordy	☒ Melissa Perez	☐ Sharon Hoffman-Spector
☒ James Cotter	☐ Wendi Davis	☒ Lisa Malvo
☒ Mary Kerlin	☐ Stan Leung	☐ Melanie Lam
☒ Margarita Garcia-Hernandez	☒ Nancy Steffen	☒ Cody West
☒ Dejene Bikila	☒ Brian Spiker	☒ Angela Guevarra
☒ Liat Vaisenberg	☒ Shivani Sivasankar	☐ Renee Trosky
☒ Kristine Gual	☒ Radha Chebolu	☒ Lisa O'Connell
☒ Amber Newell	☒ Tiphanie Salehi	☒ Jen Kung
☒ Athena Beltran-Nampraseut	☐ Kim Palfini	☒ James Devan
☒ Garnet Booth	☒ Mark Aguirre	☒ Isaac Brown
☐ Kim Fillette	☒ Shell Swift	☒ Amy McCune
☒ Lindsey Bushey	☐ Stephanie Nakatani Phipps	☒ Katherine Barresi
☐ Sarah Browning	☒ David Lopez	☒ Deanna Watson
☒ Emily Stoller	☒ Candis Broadhead	☐ Kristina Coester
☒ Monika Brunkal	☒ Alex Brito	☒ David Lavine
☐ Penny Thomas	☐ Ruth Hood	☒ Elijah Allen
☒ Christopher Triolo	☒ Derick Stacy	☐ Erin Hall
☒ Jeffrey DeVido	☒ Mark Bontrager	☐ Dominic Salido
☒ Anthony Sackett	☒ Greg Allen Friedman	☒ Mohamed Jalloh
☐ Tim Sharp	☐ Akshay Sharma	☒ Florentina Torres
☒ Rasitha Rathnayake	☒ Danielle Ogren	☒ Qi Yao
☒ DeLorean Ruffin	☒ Hanh Hoang	☒ Kareena Rodriquez
☒ Vander Harris	☐ Amber Acosta	☒ Jennifer Lopez
☐ Michelle Rodriguez	☐ Tasha Krongard	☐ Robert Ducay
☒ Cheng Saechao	☒ Heather Esget	☐ Kevin Jarrett-Lee
☒ Benjamin Amparo	☒ Amanda Federico	☐ Migdalia Liboy
☒ Heather Coronado	☒ Roudabeh Moraghebi	☒ Brandy Isola
☒ Jennifer Durst	☐ Ben Spencer	☒ Tom Nguyen
☒ Bethany Hannah	☐ Tony Sengdara	☒ Chloe Ungaro
☐ Troy Foster	☐ Eva Lopez	☐ Teresa Lugo
☐ Reza Far	☒ Jen Cockerham	☒ Kimberly Robertello
☒ Garvin Lum	☒ Brigid Gast	☒ Flower Sincheff
☒ Dorian Roberts	☒ Ben Spencer	☒ Eva Lopez

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Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Jeff Ribordy	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Jeff Ribordy	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner*:* HA	Discuss Findings The overall PCP office visit rate has been steadily increasing from 2024 Q3 through 2025 Q1 and across all office regions. The Santa Rosa office region had higher visit rate in 2025 Q1 compared to the other regions. In 2025, so far, Colusa, Del Norte, and Glenn counties had highest visit rates and Placer, Lassen, and Solano counties had lowest visit rates and have not met the target visit rate along with Sierra and Nevada counties, while the other counties were in line with the target are exceeded the target. Shasta Comm Health Center, Ampla Health Chico Medical, and Solano County Hlth Svcs are amongst the clinics in 2025 that didn't meet the target visit rate. The low visit rate of Solano County Health Services is impacting Solano County's visit rate, driving it down. The restructuring of Shasta Comm Health Svc led to changes in its visit rates. Wellspace Health Clinics' rates might be influenced by billing & access related issues.
2) Topical Fluoride Varnish Report Owner*:* QI	Measure Definition: The percentage of members 1-21 years of age who received at least two (2) fluoride varnish applications during the measurement year. • Importance of measure: DHCS sanctions • Important Measure background • Delay in Denti-Cal claims data as of 10/1 • Requirement of 2 applications The company is committed to the following performance improvement efforts – • Inclusion as a monitoring measure in QIP • Improvement coach technical assistance and connection to Dental Liaison • Presented and discussed through regional meetings and consortia's • Mass communications to provider network with coding guidance • Developed internal monitoring dashboards for Z29.3 code usage
3) ED utilization Report *Speaker:* HA	Discuss Findings

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	The overall ED utilization rate (visits PMPY per 1000 members) increased by 28% from 2023 to 2024. The Eureka office region had highest visit rate among all the regions in 2024, and Fairfield office region had notably higher visit rate between 2023 and 2024.Modoc County had highest visit rate that exceeded the national benchmark in 2024 followed by Yuba and Plumas counties. Glenn, Napa, and Butte counties had lowest visit rates that are below the benchmark. Yolo County had the highest growth trend between the 2 years, 2023 and 2024, among all counties. In 2024, Solano County Health Svc and Adventist Health Clearlake are amongst those that had observed visit rates exceed the national benchmark. Ole Health Hospital was in line with the benchmark, while Petaluma Health Center and Marin Comm Clinic San Rafael were amongst those that had visit rates lower than the benchmark. Summary on unhoused members- Overall, the unhoused members experienced an increase of 85% in utilization from 2023 to 2024. Humboldt, followed by Shasta and Butte counties, observed higher utilization and Modoc, Placer, and Plumas counties had lower utilization. Native American members had higher utilization amongst all the races. Amongst all age groups, 46-59 aged members had higher utilization than the other age groups. Unspecified chest pain, Suicidal ideations, and Unspecified abdominal pain were some of the primary reasons to visit ER in 2024.
4) ED with CT scan Report Owner*:* HA	Some of the top facilities that had notably higher increase in ED visits with CT scans between 2023 and 2024 are Oroville, Sierra Nevada Mem Miners, St Helena Adventist Health, and Kaiser Vacaville hospitals. Sutter Roseville, Tahoe Forest, and QVMA Med Ctr Hospitals observed a decrease in utilization for CT scans in ER from 2023 to 2024.
Overutilization Analysis Discussion Topics	
1) Hospital OB Quality Report	Summary on providers' performance in 2023 in the following metrics - Enloe Medical Center demonstrated strong and impressive performance in all the metrics, C-Section, Breastfeeding, Episiotomy, VBAC, Certified Nurse Midwife, and Early Elective Delivery rates. Marin Health Medical Center demonstrated notably higher performance in all metrics, except for Early Elective Delivery. Sutter Roseville and Dignity Health Sierra Nevada Memorial are amongst those hospitals whose C-Section rate was subpar. Breastfeeding rates are low/missing due to data entry issues.

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	Action items: • To compare C-Section rates with Prenatal/Postpartum rates, PHPS services and Doula Services • Dr. Moore to review the 2024 data with Maternal health dashboard - Doula and C-Section
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

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MEETING MINUTES

Meeting Name: Population Needs Assessment Committee

Date: October 2, 2025 **Time**: 4 - 5 p.m.

Location: Marin Conference Room; Webex

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

Virtual Attendees: Amanda Smith; Christine Smith; Folo Akintan; Greg Allen Friedman; Jeff Ribordy, MD; Jessica Null; Lilian "Lilly" Merino; Lisa O'Connell; Mark Bontrager; Matthew Morris, MD; Rachel Newman; Rhonda Schultz; Richard Matthews, MD; Rose Aarons; Sydni Aguirre; Wendy Starr

Absent: Colleen Townsend, MD; DeLorean Ruffin, DrPH; Denise Rivera; Jill Blake; Katherine Barresi, RN; Kathryn Power; Leigha Andrews; Liat Vaisenberg; Marshall Kubota, MD; Matt Hintereder; Mohamed Jalloh, PharmD; Priscila Ayala; Rebecca Stark; Robert Moore, MD; Tim Sharp; Vicky Klakken; Wendi Davis; Yolanda Latham

Agenda Topic	Minutes	Action Items
1. Intros *Time: 5 minutes* *Speaker: CHNL Team*	• Rhonda Schultz is Population Health's new Community Health Needs Liaison (CHNL) in Redding!	
2. CHA/CHIP updates *Time: 10 minutes* *Speaker: CHNL Team*	A PowerPoint presentation was shared (attached to these minutes). Each region's Community Health Needs Liaison (CHNL) typically speaks for when their assigned counties are being discussed. For more details, please refer to the PowerPoint. Status of Goals: • 16 counties have approved goals. Remaining county numbers are: 4 with goals drafted, 2 with a priority area identified, and 2 with no identified goal. ○ Note: Yuba and Sutter have multiple goals drafted.	

Agenda Topic	Minutes	Action Items
	Updated Goal for Discussion: Slides 5-6, Marin Goal: To improve preventative care measures for children ages 0-5 years of age in Marin County by implementing a Community Health Worker Hub (A coordinated program that organizes, trains, and supports a workforce of Community Health Workers (CHWs) to connect individuals and communities to health and social services, reduce health disparities, and improve health outcomes.) *SMART Objective:* By December 31, 2026, Partnership HealthPlan, Kaiser Permanente, and Marin County Public Health, in collaboration with First 5 Marin, will implement a Marin County CHW Hub to serve 30 Medi-Cal enrolled families with children ages 0-5, to achieve at least 90th percentile of completed Well Care Visits (WCV). • Lilly thanked the group for their feedback from the last August meeting. Unfortunately, Partnership brought a drafted goal with the group's feedback to the county, but after Marin's review, their updated version still includes the performance of well-child visits. Though they're doing well on the measure, they want to reach "excellent," and the 90th percentile. Marin was very firm on their decision to continue with this goal as is, and they have the final decision. ○ Marin is currently around 70th percentile. ○ CHNLs must support the county's work in their process, and work with the other MCP in the county (Kaiser). In this case, we couldn't convince them otherwise. • Concerns around CHWs: ○ Are the CHWs enrolled and set up to be a CHW hub? ▪ They appear to be enrolled. ○ Are CHWs allowed to provide education on childhood vaccines and vaccine hesitancy? They are non-clinical. ▪ According to page 9 of APL 24-006 (under "Covered CHW Services including Violence Prevention Services"), CHWs can be trained to do health education. • Concerns around the metric: ○ Making an impact on 30 families is only a pilot and doesn't meaningfully impact the measures. ▪ Within the 30 families, some will be Partnership members, while others will be with Kaiser.	

Agenda Topic	Minutes	Action Items
	○ There are 3 different WCV measures within the age group specified. The language of the goal should clarify the measures involved. Marin should understand that their time period of ages 0-5 spans different measures with different thresholds. Clarifying these details will get ahead of future headaches. If Marin has questions, QI would be happy to help explain. ▪ When the W30 visits are measured, most take place in the prior year, so this won't have much of an effect. • Concerns around wording: ○ Lilly can work with Marin to wordsmith some of the goal, but [the essence of the goal is likely to remain unchanged]. • No PCPs are involved in the planning of this goal.	• Lilly will take this back to Marin.
3. CHA/CHIP Grant Funding Update *Time: 5 minutes* *Speaker: Monika*	• LHJ Grant Funding status ○ Sierra's grant funding contract has been executed and a $100,000 check request is going for approvals. ○ Humboldt is at the contracting step with the Non-Provider Contracting team. ○ Siskiyou's application is with leadership for internal review. • RFA Addendum updated ○ The RFA has updated how counties can use grant funds. Now, part of the funding can be used toward implementation activities. As long as the primary use of funding is toward support of the upcoming CHA/CHIP cycle, counties are able to apply. ▪ The requirements for application (executed MOUs ≥50%) have not changed.	
4. Next steps *Time: 5 minutes* *Speaker: All*	• If attending a CHA/CHIP-relevant meeting, don't forget to send the CHA/CHIP team your notes at chachip@partnershiphp.org.	

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

MEETING MINUTES

Meeting Name: Member Grievance Review Committee

Date: September 4, 2025 **Time**: 2 p.m. to 2:50 p.m.

Location: *WebEx link in meeting invite*
Fairfield West | Board Room
Airpark | Burney Falls Conference Room
Avtech | Whiskeytown Conference Room

Attendees: Kory Watkins, Latrice Innes, Mori McLennan, Mark Netherda, Gary Robinson, Kenzie Hanusiak, Ajee'lon Boyd, Andrew Ivey, Cori Olney, Edna Villasenor, Heather Esget, Kevin Jarrett-Lee, Leigha Andrews, Lisa Rowand, Melissa Perez, Michela Englehart, Rebecca Stark, Shreya Kulkarni, Stephanie Nakatani Phipps, Tim Sharp, Tina Yarcia, Tony Hightower, Aaron Maxwell, Robert Bides, Lizzy Niccolai, Naz Sattari

Agenda Topic	Minutes	Action Items
Agenda Item #1: Introductions & Objective of Meeting *Speaker: Latrice Innes*		
Agenda Item #2: Review & approve minutes from last meeting	The minutes from the MGRC meeting on May 22, 2025 were reviewed and approved without changes. Motion to Approve: Gary Robinson Second: Mark Netherda	

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Speaker: Latrice Innes		
Agenda Item #3: Old Business *Speaker: Latrice Innes/Mori McLennan*	**Quality Assurance** • The Grievance Case Analysts (GCAs) are not consistently attaching relevant documentation to their cases. For example, there were cases missing translated copies of Resolution Letters, Acknowledgement Letters, relevant emails, or referral responses. The staff was given additional training during the monthly GCA Meeting on June 19, 2025. This issue is now closed. • The Grievance Case Analysts are not consistently closing cases in a timely manner once all required actions have been completed. For example, there were instances where all steps, including the resolution call and mailing of the Resolution Letter, were completed, but the case was not closed until the following day. The staff was given additional training during the monthly GCA Meeting on June 19, 2025. This issue is now closed.	
Agenda Item #4: Department Updates *Speaker: Kory Watkins*	**1. Department Updates** **DHCS** • DHCS has approved the corrective action plan (CAP) response for the 2024 audit finding and agrees with the proposed changes. The finding is about the number of Quality-of-Care (QOC) cases exceeding the 30-day mandatory time period for closure. ○ There will be an increase in audits for QOC grievances. The number of QOC audits has increased to 50% of the closed grievances with a minimum of 8 grievances audited per month. ○ A new internal process will consist of having two nurses review the grievance, and if both agree that additional information is required; the grievance will go into a "pended" status until that information is received. • G&A policy CGA024 has been revised to include the changes and will be going through IQI and Q/UAC then to DHCS for final approval. **NCQA**	

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	• We completed the internal Quarterly File Review on 8/15/25 and received 100%. • The UM12 Information Integrity Training was approved by our NCQA consultant, Managed Healthcare Resources (MHR) – the training must occur before June 2026. • The Information Integrity UM12 desktop (combined with UM, RX and G&A) was approved by MHR. **D-SNP** • G&A has met with a vendor for potential delegation of G&A for D-SNP. If delegated to a vendor, they will handle grievances, and first level appeals and state hearings. **JIVA** • UAT testing began 8/15/24 and is still underway. There were some delays due to the outage a couple of weeks prior, and most of G&A's testers did not have access to HRP. HRP access has been granted now so testing has commenced. • G&A is working with UM and RX to align the appeals process. Currently the appeals appear different when forwarded to the Medical Directors, depending on which department is processing the appeal. The process will be aligned once all three departments are operating in JIVA, making reviewing the appeal easier for the Medical Directors. • Finalized the template letters and assessments. The template letters will be embedded in JIVA making sending letters more efficient, today's process is all manual. **2. Staffing Updates** G&A has grown substantially and soon several new staff members will be joining G&A. There are new positions, including a G&A Nurse Supervisor who will have all the nurses and the state hearing representatives reporting directly to them. An additional Supervisor for the Operations team, currently the 2 supervisors have 14-15 direct reports reporting to them each. With the new supervisor they will each have about 10 direct reports under them. We will be adding a State Hearing Representative to have a total of 3 State Hearing Representatives in the near	

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	future. Another new position, Compliance Analyst, will be assisting Latrice with policies, reporting, the quarterly PULSE Report, and identifying trends proactively. Lastly there will be two (2) training/auditing specialists.	
Agenda Item #5: Case Statistics *Speaker: Latrice Innes*	**Case Statistics** There were 2,477 cases closed in 2Q25. Fourteen (14) cases were closed past 30 days, resulting in a 99.2% timeliness performance rate for 2Q25. Members were notified that their case was received within five (5) calendar days of receipt for all but 25 cases, resulting in a 98.6% timeliness rate. G&A's timeliness goal is 98.6%. There was one (1) lost State Hearing during 2Q25 regarding the denial of a specialty off-road wheelchair. The judge felt the member could only get what they needed with the specialty off-road wheelchair. The trends each year prove to be consistent with the highs and lows just with a higher case load. In the first quarter of the year, we noticed an increase in exempt grievances. Averaging to around 16 exempt grievances per week increased to 63 exempt grievances per week in the second quarter and the new average of 34 grievances per week in the third quarter. The increase in the second quarter was due to training in the Transportation department that required Transportation representatives to file an exempt grievance when they do not want to file a formal grievance.	
Agenda Item #6: Compliance & Strategy *Speaker: Latrice Innes / Mori McLennan*	**1. Delegation Oversight** **<u>Carelon</u>** Carelon was issued a CAP for not reporting any Exempt cases for Q1 or Q2 2025. Making us believe that Carelon is not capturing the Exempt grievances properly. The de-delegation of Carelon is on track for September 29, 2025. **<u>VSP</u>** The CAP for updates to VSP's policy regarding the previously contracted 25-day resolution time was approved with the new timeframe of 10 days and closed on May 28, 2025. And the CAP for the phone audit regarding call categorization was resolved and closed on July 22, 2025.	

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	2. Inter-Rater Reliability (IRR) Findings IRR assesses the accuracy of clinical decisions made by Grievance Nurse Specialist (GNS). The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides a clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 1Q25: • The Grievance Case Analyst did not review the member record in the case even though the member withdrew the grievance. The GCA should have requested the member records to be reviewed since the member stated the provider did not give the member their prescriptions. Staff were given additional training during the monthly GCA Meeting on August 27, 2025. This issue is now closed. • The Grievance Case Analysts are not consistently attaching relevant documentation to their cases. For example, there were cases missing translated copies of Resolution Letters, Acknowledgement Letters, relevant emails, or referral responses. The staff were given additional training during the monthly GCA Meeting on August 27, 2025. This issue is now closed. • The Grievance Case Analysts are not sending the Acknowlegement Letters on a timely basis. The Acknowledgment Letters are due 5 calendar days from the date the grievance/appeal is received. The staff were given additional training during the monthly GCA Meeting on August 27, 2025. This issue is now closed. **3. PULSE Report** The 3Q25 PULSE Report is due to be released September 2025. If you would like to be added to the email distribution list, please email Latrice. The report can also be found on the Grievance & Appeals page on Partnership4ME. A highlight to look for: • Statistics broken down by Region	

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Agenda Item #7: Investigation *Speaker: Mori McLennan*	**Case Spotlight** **1. PRA Process** **Issue** Member requested documentation through the Public Records Act (PRA). The Public Records Act is a law that gives the public the rights to access government records. This is when a member files a case requesting documentation of their public record (all internal communications, medical records, or documents within their Partnership account). **Process** Notify management of the member's request. A referral must be sent to the Regulatory Affairs and Compliance (RAC) Department advising them of the member's request as soon as possible. RAC will work with the applicable departments and compile the file. RAC will send the completed file requests to the member. RAC might schedule a meeting to verbally review the member's request and documents needed. **2. Frequent Flyers** **Issue** Member has submitted over 75 grievances for herself and her son, including DHCS inquiries and reporting to her Ombudsman. Member's initial issue was not having valid authorized representative (AR) paperwork for her son, although she stated she submitted Power of Attorney (POA) documents several times. However, once that was resolved, the member continued to file grievances for various reasons. **Background** The member has contacted Member Services multiple times a week often engaging in calls that extend for an hour or longer. Over time, her grievances have been processed by at least seven different GCAs, including several at the senior level. The member has subsequently filed grievances against each GCA citing concerns that range from mispronunciation of words during conversations to requests to reopen previously closed grievances in order to add addendums.	

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	Learning Opportunity For frequent flyers, G&A will begin meeting with the departments involved and appointing a senior level representative who will serve as dedicated point of contact for the member. In addition, we will hold a meeting to realign expectations and notify the member of their assigned team representative. The senior representative will be closely involved in the members coordination of care, calls into Partnership, and any grievances or appeals. They will also ensure duplicative complaints/requests are addressed appropriately and that any new grievances or appeals are thoroughly reviewed in collaboration with the member. This process will allow the member to avoid starting over each time they reach out and will provide consistency by ensuring they always speak with the same senior member when concerns arise.	
Next Meeting	November 20, 2025	

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
November 2025
Prepared by Isaac Brown
Interim Senior Director, Quality and Performance Improvement

Quality Incentive Programs (QIPs)

PROGRAM	UPDATE
General QIP Update	• There is a new annual requirement for a signed contract amendment to be able to participate in pay-for-performance programs. Signed amendments will be required by December 31st of each calendar year.
Primary Care Provider Quality Incentive Program (PCP QIP)	• 2026 PCP QIP measure set was approved at PAC in October. One (1) new measure for the 2026 measurement year: Kidney Health Evaluation for Patients with Diabetes • 2026 specifications in progress and will be posted to public website by 12/31/2025
Palliative Care Quality Incentive Program (Palliative Care QIP)	• 2026 Palliative QIP measure set was approved at PAC in October. One (1) new measure for the 2026 measurement year: Measure III: Completion of a standardized patient symptom assessment - this is a replacement measure in response to the dissolution of PCQC • January – June 2026 payment is in progress and will distribute by 11/30/2025
Perinatal Quality Incentive Program (PQIP)	• FY24/25 payment is set to be distributed by 11/30/2025 • Q1 FY25/26 reports will be distributed by 11/30/2025
Enhanced Care Management quality Incentive program (ECM QIP)	• Q2 2025 payment was distributed in October • 2026 ECM QIP measure set was approved at PAC in October, no changes to the measures for 2026
Hospital Quality Incentive Program (HQIP)	• FY24/25 payment is set to be distributed by 11/30/2025

Quality Data Tools

TOOL	UPDATE
Partnership Quality Dashboard (PQD)	• 2025 PQD was launched in October. Kick Off webinar has been posted to the PCP QIP webpage
eReports	• 2026 eReports development has begun in preparation for the March 2026 launch

Performance Improvement (PI)

ACTIVITY	UPDATE
State Mandated Work: *Performance Improvement Project (PIP) & Plan-To-Do-Study-Act (PDSA) Cycle*	• North Bay Region (formerly "Southern Region"): Work continues to work on the Children's Health Domain through work within Sonoma County to improve Lead Screening and Fluoride varnish. · • Rural Upper North (Formerly "Northern Region): Continues to work on multiple interventions within the Children's Health, Chronic Disease, Reproductive Health & Cancer Prevention Domains in the North, such as expediting newborn

	membership enrollment, academic detailing for medication-based measures like asthma and diabetes, increasing mammography access through mobile mammography and fixed-imaging, and more. • Next update to DHCS due October 31, 2025 • Non-Clinical PIP: The non-clinical Behavioral Health PIP submitted to Health Services Advisory Group (HSAG) in August will be resubmitted to include additional performance data beyond the originally submitted timeframe. No further updates are expected, and the next cycle will continue into 2026.
QUALITY MEASURE SCORE IMPROVEMENT	• **Pediatrics:** The workgroup has identified priority areas and selected activities across several QIP measures in preparation for upcoming implementation. o Child & Adolescent Well Child Visits, Childhood Immunization Series, and Immunizations for Adolescents: The workgroup has outlined a phased approach starting with data analysis and interviews of high-performing sites. Based on those findings, the workgroup will select activities for 2026. o Developmental Screening in Children: The workgroup will be developing and implementing one-on-one education for lower-performing providers. o Fluoride Varnish Application: Will continue with data investigation. o Lead Screening in Children: Will continue to focus on education and POC grants. o Well Child Visits under 30 months (6 by 15 months): Partnership will continue promotion of the Growing Together Program. o Well Child Visits under 30 months (2 between 15 – 30 months): The workgroup launched the implementation of a newborn pilot project with Fairchild on 09/01/2025 and will continue through the end of the calendar year. This project is an adaptation of the project previously completed with North Bay Health in 2024. • **Chronic Disease:** o Academic detailing continues at many health centers to provide education to prescribing providers regarding medication adherence and titration recommendations. The focus has been on Asthma, Hypertension, and Diabetes with additional topics covered upon request. o DHCS has proposed retiring the Asthma Medication Ratio measure in 2026 and replacing it with a new measure, Follow-up after an ED or Urgent care visit for Asthma. o Colorectal Cancer Screening is planned to be an accountable measure in 2026. • **Woman's Health and Perinatal:** o Partnership hosted a Doula Pathways Webinar on 09/09/2025, with 14 attendees. Provider Relations has held five onboarding sessions since

	July and brought in 20 new doulas. We now have doulas in 18 Partnership counties. o The Woman's Health and Perinatal workgroup is continuing to facilitate integration of the hrHPV self-collect across our network and offer providers one-on-one education. In 2025, 24 parent orgs with 93 total sites have completed training. Training and health education materials are being reviewed and updated to reflect current screening options. o New topic identified for Improvement Academy 2026 Improving Measure Outcome series focusing on sexual and reproductive health is scheduled for April 2026. • **Behavioral Health:** DHCS has proposed adding three new depression measures as accountable for 2026. Depression screening for Adolescents and Adults, Prenatal Depression Screening and Follow Up, and Postpartum Depression Screening and Follow Up. These screenings are not captured through administrative means like claims, so records have to be retrieved through Partnership's data aggregator, DataLink. • **Elder Care:** No updates
IMPROVEMENT ACADEMY	• Promotional materials (emails, flyers, website posts, and newsletter announcements) are now live for the 02/05/2026, ABCs of Quality Improvement training, which will be held in Fairfield. • Registration information can be found on our website: (https://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx)
JOINT LEADERSHIP INITIATIVE (JLI)	• No updates
REGIONAL IMPROVEMENT MEETINGS	• The **Auburn Region** Quality meeting was held on 10/06/2025, and the Chico Region Quality meeting was held on 10/28/2025. The topics were geared toward maximizing clinical resources when there are access constraints. • The first **Santa Rosa Region** Quality meeting was held on 10/07/2025, and focused on the topic of immunization measure improvement, covering strategies for vaccine hesitancy and immunization inventory management. A second meeting is planned for the smaller-sized health centers, which will focus on implementing strategies learned at the Regional Quality Meeting. • To be added to future Regional Quality Meeting invitations, please contact the Performance Improvement Team at PIT@partnershiphp.org

Note: Detailed information and recordings of Performance Improvement related webinars, virtual CME, Best Practice resources, and more are posted to the PHC Website:
https://www.partnershiphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 25/26 ORG GOALS	**CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey** • The CAHPS Program is on track for the next survey cycle (MY 2025 | RY 2026) with preparation activities scheduled to conclude by the end of the calendar year. **Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)** • Fiscal Quarter 2 (On-Track): Goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement. **NCQA Health Plan Accreditation Requirement Update** • The 2024 Member Experience Outcomes (ME7) was presented at the October NCQA Steering Committee, receiving strong engagement from Senior Leadership. o Priority Outcome: Enhancing Member Experience by improving member touchpoints, particularly interactions related to connecting with the plan (all member engagement customer service lines). o Key internal stakeholders are actively collaborating on a strategy with implementation targeted for the first quarter of 2026. The MY 2024 | RY 2025 Annual Member Experience Grand Analysis (ME7) will be presented formally at Committee (IQI and Q/UAC) in November.
PROMOTING COLORECTAL CANCER SCREENINGS	**Colorectal Cancer Web Page** A provider-facing webpage is available on Partnership's website to support colorectal cancer screening efforts. https://www.partnershiphp.org/Providers/Quality/Pages/Cologuard.aspx **Partnership Facilitated Order** • The next Facilitated Order is scheduled to launch on 01/19/2026 and is aligned with Colorectal Cancer Awareness Month in March.
EQUITY & PRACTICE TRANSFORMATION PROJECT	**PDPP Participation and Deliverables** • Twenty-three (23) provider organizations are working on completing their deliverables due 11/01/2025. • To continue participating in the EPT program, provider organizations are to follow the updated delivery requirements: o By November 2025, practices should complete the 2025 PhmCAT and at least one additional deliverable from program year 1.

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By May 2026, practices should complete the 2026 PhmCAT and successfully submit the following deliverables:

Data Policy & Procedure
Empanelment Policy & Procedure
Data Implementation Plan
Disparity Reduction Plan
One Model of Care deliverable

EPT MCP Reporting Requirements

In accordance with the APL 25-015 published on 10/02/2025, DHCS is asking Managed Care Plans (MCPs) to produce quarterly rolling quality measure rates using the California Technical Specifications (CaTS) so that performance can be tracked for all EPT deliverables that include HEDIS-like measures.

DHCS will allow MCPs to either submit self-produced rates using CaTS or utilize a third-party solution (Innovaccer) through the Pop Health Learning Center. Partnership will proceed with the self-produced CaTS submission, and the HEDIS team is preparing rates for all EPT sites to meet the 10/31/2025 deadline.
MCPs expected to submit practice-level rates on a quarterly basis moving forward.

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<td>Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)</td>
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Participating providers have completed or are nearing completion of the 12-week program. Close-out questionnaires are required of all providers and program evaluation will begin in early November.

Most recent visit data is included in the table below and the October Strategy Team Update is linked here for further details.

<table>
<tr><th>Provider Org</th><th>Total Visits</th><th>PHC Members</th><th>WCV</th><th>CCS</th><th>No-show Rate</th><th>Avg. Visit/Day (anticipated 16-20/day)</th></tr>
<tr><td>WSMC
Start: June 30</td><td>637</td><td>505</td><td>548</td><td>0</td><td>28.5%</td><td>12</td></tr>
<tr><td>Open Door
Start: July 14</td><td>511</td><td>446</td><td>337</td><td>47</td><td>13.2%</td><td>9</td></tr>
<tr><td>Shasta
Start: July 28</td><td>509</td><td>499</td><td>443</td><td>66</td><td>29.5%</td><td>9.5</td></tr>
<tr><td>Ampla
Start: Aug 18</td><td>268</td><td>245</td><td>90</td><td>177</td><td>32.2</td><td>6.5</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><td>Mobile Mammography Program</td><td>Current Event Days for FY 25/26 Q2 (October – December)

<table>
<tr><th colspan="4">Current Event Days
10/01/2025 – 12/30/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Chico</td><td>1</td><td>3</td><td>3</td></tr>
<tr><td>Eureka</td><td>6</td><td>6</td><td>6</td></tr>
<tr><td>Fairfield</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Redding</td><td>6</td><td>6</td><td>6</td></tr>
<tr><td>Santa Rosa</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Plan Wide</td><td>16</td><td>20</td><td>20</td></tr>
</table></td></tr>
<tr><td>Partnering for Pediatric Lead Prevention Program (PPLP)</td><td>• The Partnering for Pediatric Lead Prevention (PPLP) program continues to accept applications for either a LeadCare ll POC device or reimbursement for a lead analyzer within 3 months of application.
• Hill Country Community Clinic and Butte County Public Health received their devices (total of 3) and have been onboarded to the program. Pediatric Medical Associates has been approved to participate in the program (4 devices) with an MOU currently pending development.</td></tr>
<tr><td>QI Trilogy Program</td><td>• 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 received Board approval on 10/22/2025.</td></tr>
<tr><td>QI Project Training Program</td><td>No New Updates.</td></tr>
<tr><td>SAGE Grant</td><td>The Systems Advancement for General EHR (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. The grant application and review period ended 10/01/2025.

Of the three applications, Kimaw Medical Center was awarded $250,000 to aid in the replacement of their existing EHR (RPMS) with OCHN Epic with the goal to improve accuracy, coordination, and quality of care, while also increasing efficiency in healthcare delivery.</td></tr>
<tr><td></td><td></td></tr>
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D-SNP

ACTIVITY	UPDATE
Coding Intensity Webinar Series	• "Capturing Patient Acuity through Coding Part 2", a webinar addressing coding acuity for D-SNP, took place on 10/08/2025 at 12 p.m. The webinar was led by Dr. Kermit Jones, Deputy Medical Director at Partnership. The webinar was attended by 55 individuals from 26 organizations and are eligible for 0.75 CME/CE credits upon completing the post-webinar evaluation. Of those who evaluated the session content, 100% rated the webinar "good" or "excellent". • The D-SNP Team will be working with a Practicum student from Harvard's Master of Public Health program beginning in November. The student will assist in developing curriculum for various QI department teams to increase their knowledge of D-SNP specific to their current roles. • 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.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **09/30/2025 TO 10/23/2025**	• 23 PQI referrals were received with 16 coming from Grievance and Appeals, 2 from Utilization Management, 1 from a Regional Medical Director, 2 from an Associate Medical Director, and 2 from Care Coordination. • 13 PQI cases were processed and closed. • 88 PQI cases are currently open. • One case was discussed at Peer Review Committee (PRC) on 10/15/2025 • Two cases were sent to Medical Institute of America (MRIoA) for an expert opinion.

FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **09/29/2025 TO 10/17/2025**

- As of 10/23/2025, we have a total of 523 reviews including PCP, OB, Multiple check-ins and delegated reviews

Primary and OB Reviews:

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

New sites opened this period → None

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	• New for MY2025, the HEDIS team has launched its first ever Year-Round Medical Record Review project. This project will include the Well Child Visits Birth – 30 Months (W30) and other HEDIS measures. With the launch of this project, it will provide opportunities for the team to receive and review the records collected in a timelier manner to support the regulatory compliance deadlines for MY2025. • On October 16th, the HEDIS team hosted a Provider webinar focused on the medical record retrieval process. Thank you to those who attended, we truly appreciate the great questions that were asked. • Provider outreach began in October and will continue into the Annual Regulatory Medical Record Review Project. • Preparation is underway to launch the MY2025 Annual Regulatory project in January 2025.
HEDIS® Program Overall	• DHCS sent Partnership a Notice of Intent to Sanction for MY2024 county-level performance below the Minimum Performance Level benchmarks. The proposed sanctions totaled $260,000 for MY2024. Partnership has scheduled a Meet and Confer meeting with DHCS for 11/04/2025 to appeal $146,488 in sanctions for four (4) measures with significant data completeness issues: Topical Fluoride Varnish for Children (TFL-CH), Follow-Up After ED Visit for Mental Illness—30 days (FUM-30), Follow-Up After ED Visit for Substance Use—30 days (FUA-30), and Developmental Screening in the First Three Years of Life (DEV-CH).

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation	• The NCQA Program Management Team submitted our application for the 2026 HPA Renewal Survey and received confirmation from NCQA of the final survey dates: Survey submission date by 09/15/2026 and the two (2) day file review is scheduled for 11/02-11/03/2026. • The majority of Business Owners (BOs) reviewed and submitted the 2026 HPA Workbook and updated 2024-2026 HPA Report Schedule by the due date of 10/24/2025. The NCQA Program Management Team continues to work with the selected departments to complete their annual HPA Workbook and/or HPA Report schedule, and to ensure no issues are identified due to the late submission, such as any delay in producing evidence per the look-back period or at the frequency specified by NCQA. • Our NCQA Consultant, Managed Healthcare Resources (MHR), conducted a four (4) day HPA Mock Renewal Survey with Partnership, focusing on evidence within the Year One look-back period based on 2026 HPA Standards and Guidelines. The BOs will submit a completed Action Plan (AP) in December 2025 to address the recommendations by the applicable look-back period, timelines, and/or expectations by NCQA. Any revised or subsequent new evidence must be submitted to MHR for approval and in alignment with the timeline of committee meetings approval. No edits should be made without review and/or assessment by the NCQA Consultant.
NCQA Health Equity Accreditation	• NCQA shared the proposed updates for the 2026 HEA Standards and Guidelines in August 2025. NCQA will release the final Standards and Guidelines in December 2025. The new requirements will take effect for surveys scheduled on or after 07/01/2026. The NCQA Program Management Team has updated the HEA Key Activities and Milestones in alignment with the NCQA timeline for release of the new HEA Standards and Guidelines, along with our tentative HEA Renewal Survey submission date of 05/18/2028. Additional details will be shared with the key stakeholders at the November 2025 Business Owner Check-in meetings.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZAION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Nov. 19, 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)

		Pages
	2026 LTC QIP Measure Set – *direct questions to Deanna Watson* [1]	57 - 59
	G&A PULSE Report – Issue 19, November 2025 – *direct questions to Latrice Innes*	61 - 71
	UM Delegated Hospital Summary – *direct questions to Tony Hightower*	73
	CY2024 Carelon Oversight Final Audit Results – *direct questions to Gary Robinson*	75 - 78
Health Services Policies	**Care Coordination**	
	MCCP2016 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) – **ARCHIVE** – *See MPTP2501 effective 0/14/26*	79 - 90
	MCCP2029 – Emergency Medical Transportation – **ARCHIVE** – *See MPTP2502 effective 01/14/26*	91 - 93
	MCCP2036 – Memorandum of Understanding (MOU) Requirements for Medi-Cal Managed Care Plans and Third-Party Entities *click here to review Attachments A-L (unchanged from 8/13/25)*	95 - 99
	MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services *(previously MCCP2019)*	101 - 125
	MPCP2023 – New Member Needs Assessment *(previously MCCP2023)*	127 - 141
	Quality Improvement	
	MCQG1015 – Pediatric Preventive Health Guidelines	143 - 156
	MCQP1021 – Initial Health Appointment *includes CLEAN Attachment B on p. x*	157 - 168
	MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines	169 - 177
	Utilization Management	
	MPUP3051 – Long Term Care SSI Regulation – **ARCHIVE** – *refer to MCUG3038*	179 - 180
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-H Facilities	181 - 187
	MCUP3003 – Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services	189 - 194
	MCUP3049 – Pain Management Specialty Services	195 - 199
	MCUP3102 – Vision Care	201 - 203
	MCUP3125 – Gender Dysphoria/Surgical Treatment	205 - 209
Non-HS Policies	**Transportation**	
	MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) *(previously MCCP2016)*	211 - 223
	MPTP2502 – Emergency Medical Transportation *(previously MCCP2029)*	224 - 226

[1] Approved at the Nov. 12 Physician Advisory Committee

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Proposed 2026 LTC QIP Measurement Set

Key:

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

2023 Measures	Proposed 2026 Measures
Gateway Measure 1: CMS Five-Star Quality Rating Points: N/A Target: 2 or more stars to be eligible for other program measures	No changes
Gateway Measure 2: California Immunization Registry (CAIR) Enrollment Points: N/A Target: CAIR enrollment required to be eligible for other program measures	No changes
	Gateway Measure 3: Quality Assurance and Performance Improvement (QAPI) Plan Submission Points: N/A Target: Submission by 6/30/26: Full credit Submission between 7/1/26 - 12/31/26: 50% decrease Submission after 12/31/26, will result in gateway not met and ineligibility for other program measures.
Clinical Domain	
Measure 1: Percentage of long-stay high-risk residents with pressure ulcers Points: 10 Target: Full Points: < 5.1% Partial Points: 5.1 – 5.3% 2025 Natl AVG: 5.4% 2025 CA AVG: 5.1%	No changes
Measure 2: Percentage of long-stay residents who lose too much weight Points: 10 Target: Full Points: < 4.3% Partial Points: 4.3 – 5.4% 2025 Natl AVG: 5.5% 2025 CA AVG: 4.3%	No changes

Measure 3: Percentage of long-stay residents who needed and got a flu shot ~~*AND* successful entry into CAIR~~ Points: 10 Target: Full Points: > 98.4% Partial Points: 93.5 – 98.4% 2025 Natl AVG: 93.4% 2025 CA AVG: 98.4%	Remove CAIR entry requirement
Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia ~~*AND* successful entry into CAIR~~ Points: 10 Target: Full Points: > 98.5% Partial Points: 93.5 – 98.5% 2025 Natl AVG: 93.4% 2025 CA AVG: 98.5%	Remove CAIR entry requirement
Functional Status Domain	
Measure 5: Percentage of long-stay residents experiencing one or more falls with major injury Points: 10 Target: Full Points: < 1.7% Partial Points: 1.7 – 3.2% 2025 Natl AVG: 3.3% 2025 CA AVG: 1.7%	No changes
Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder Points: 10 Target: Full Points: < 1.2% No Partial Points 2025 Natl AVG: 1.2% 2025 CA AVG: 1.2%	No changes
Resource Use Domain	
Measure 7: Number of hospitalizations per 1,000 long-stay resident days Points: 15 Target: Full Points: < 1.83% Partial Points: 2.17 – 1.83 % 2025 Natl AVG: 1.83% 2025 CA AVG: 2.18%	No changes
Operations & Satisfaction Domain	
Measure 8: Health Inspection Star Rating Points: 10 Target: Full Points: 4 or more stars Partial Points: 3 stars	No changes

Measure 9: Staffing Rating Points: 15 Target: Full Points: 4 or more stars Partial Points: 3 stars	No changes
~~**Measure 10:** QI Training~~ ~~Points: 5~~ ~~Target: Full Points: Facilities attending PHC's Hospital Quality Symposium do not need to submit evidence of attendance. Facilities attending other trainings must submit evidence of training attendance by February 2023.~~ ~~No Partial Points~~	Remove measure due to concern with not meeting current criteria for a pay-for-performance measure
~~**Measure 11:** Health Equity~~ ~~Points: 5~~ ~~Full Points: Facilities will submit a project addressing Health Equity at the beginning of the measurement year. The submission will be an outline of their project that PHC will review and approve or reject.~~ ~~No Partial Points~~	Remove measure due to concern with not meeting current criteria for a pay-for-performance measure

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GRIEVANCE & APPEALS
Pulse Report

Our Mission

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



G&A PULSE REPORT

INSIDE THIS ISSUE

PG. 4
Breakdown of cases filed per 1,000 members by county

ISSUE 19 | NOVEMBER 2025

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings received in the Grievance & Appeals Department (G&A). The report contains data from the third quarter of 2025.

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

Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level. Membership totals are calculated using monthly snapshot data, averaged across the county by quarter. The scheduling and ride data for Transportation is sourced from the Transportation Dashboard in Tableau.

3Q25 HIGHLIGHTS

OVERALL NUMBERS

In 3Q25, G&A investigated 2,261 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 1,731 cases subject to DHCS-mandated timeframes, 99.2% were closed on time.

3Q25 TOTAL INVESTIGATED CASES		
	# of Cases	% Total
Grievance	1,460	64.6%
Exempt	465	20.6%
Appeal	271	12.0%
State Hearing	65	2.9%
Grand Total	**2,261**	**100.0%**



KEY POINTS & TRENDS BY CONCERN

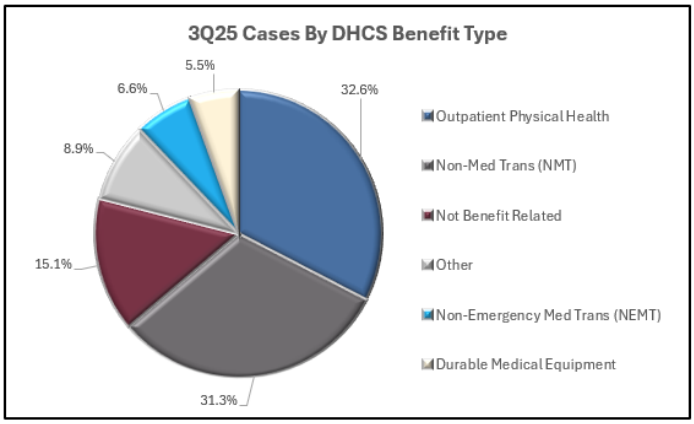
G&A cases are categorized by concern. There can be multiple concerns listed in one case.

Transportation – Transportation-related concerns were the most frequently reported concern at 40.0% of the total concerns reported. Missed rides account for 46.8% of all transportation related concerns. Having a preference of which transportation company is assigned to their rides accounts for 43.9% of transportation concerns reported. Members can express a preference in what company is assigned to their ride. However, it is never guaranteed that this choice can be used when a ride is scheduled. Drivers arriving late for a scheduled appointment accounted for 31.6% of reported transportation concerns.

Provider Service – Provider Service accounted for 25.5% of all reported concerns. The most frequently reported issue was communication challenges, followed by concerns related to poor attitude and customer service. Disputes regarding treatment plans ranked as the third most cited concern within this category.

DHCS CATEGORIES

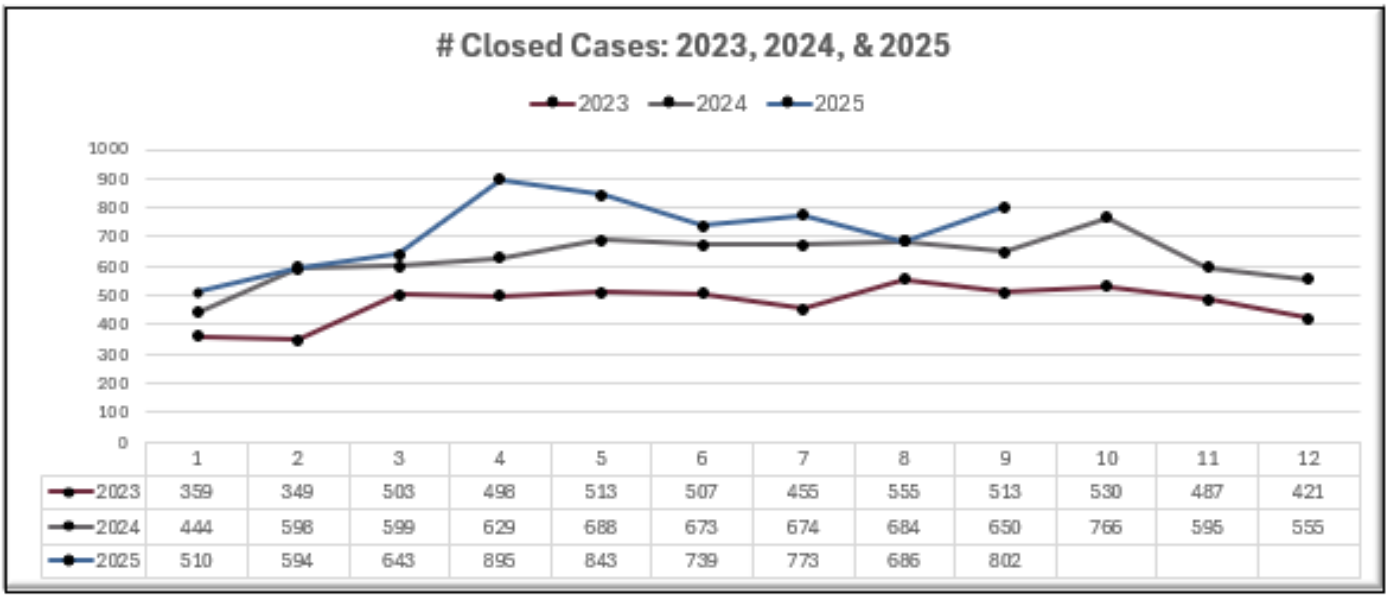
Outpatient Physical Health services were the most frequently reported Benefit Type which represented 32.6% of the reported concerns, followed by Non-Medical Transportation (NMT), which represented 31.3%. Cases that were Not Benefit Related accounted for 15.1% of the DHCS Benefit Type categories. Cases that fall under the Not Benefit Related category typically consist of reports of poor provider attitude and dissatisfaction with Partnership's customer service.



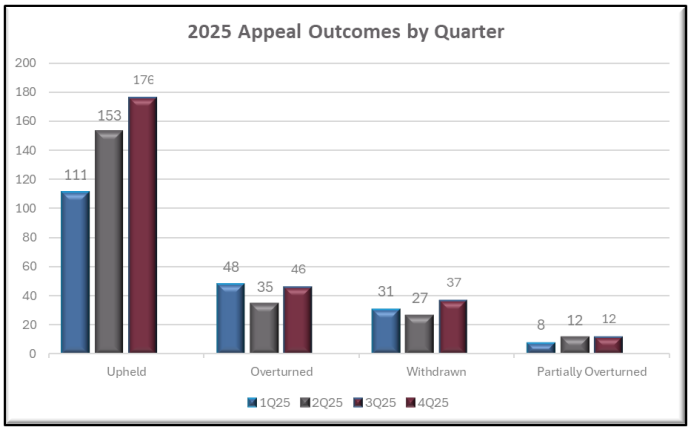
KEY STATISTICS

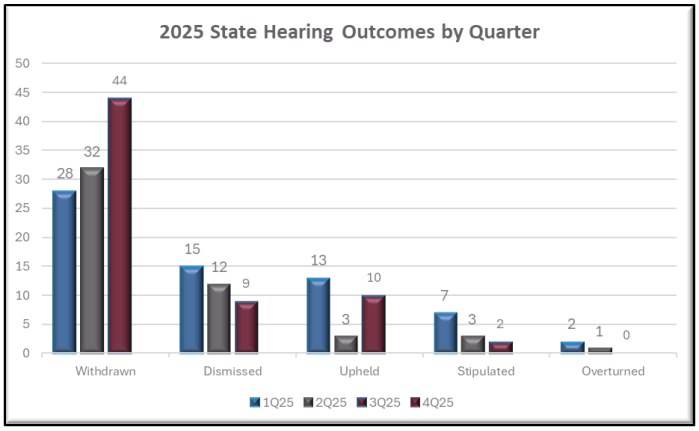
CHARTS OF KEY CASE TRENDS

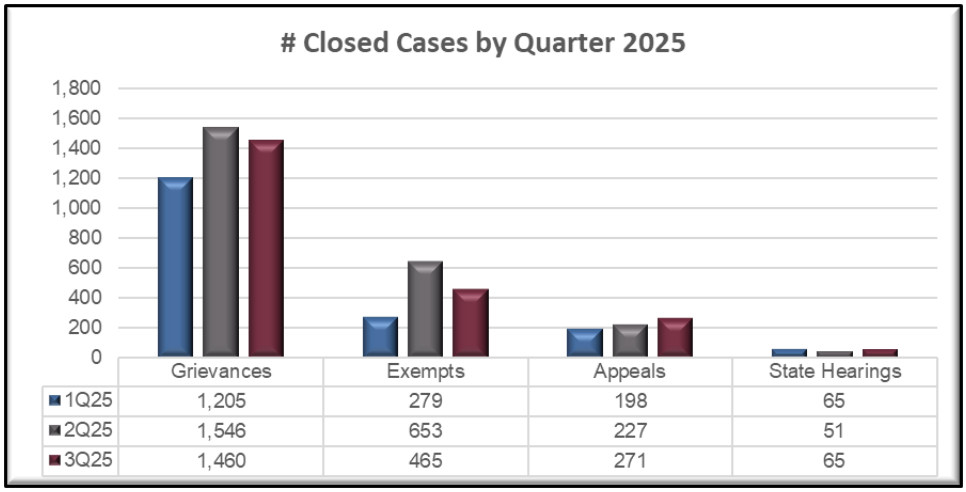
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	1	2	3	4	5	6	7	8	9	10	11	12
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	596	599	629	688	673	674	684	650	766	595	555
2025	510	594	643	895	843	739	773	686	802			







	Grievances	Exempts	Appeals	State Hearings
1Q25	1,205	279	198	65
2Q25	1,546	653	227	51
3Q25	1,460	465	271	65

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average membership, and the number of cases closed per 1,000 members for 3Q25.



3Q25 CASES BY COUNTY			
AUBURN			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	64	28,547	2.24
Placer	239	61,918	3.86
Plumas	10	5,716	1.75
Sierra	2	830	2.41
Total	315	97,011	3.25

3Q25 CASES BY COUNTY			
FAIRFIELD			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	323	102,904	3.14
Napa	29	27,677	1.05
Yolo	131	54,387	2.41
Total	483	184,968	2.61

3Q25 CASES BY COUNTY			
CHICO			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	185	84,450	2.19
Colusa	16	10,158	1.58
Glenn	22	13,668	1.61
Sutter	59	44,458	1.33
Yuba	69	37,512	1.84
Total	351	190,246	1.84

3Q25 CASES BY COUNTY			
SANTA ROSA			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	182	111,582	1.63
Marin	68	46,819	1.45
Total	250	158,401	1.58

3Q25 CASES BY COUNTY			
EUREKA			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	42	12,297	3.42
Humboldt	196	57,073	3.43
Lake	73	33,575	2.17
Mendocino	86	40,587	2.12
Total	397	143,532	2.77

3Q25 CASES BY COUNTY			
REDDING			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	22	8,441	2.61
Modoc	10	3,844	2.60
Shasta	269	64,845	4.15
Siskiyou	58	17,845	3.25
Tehama	78	29,740	2.62
Trinity	28	5,165	5.42
Total	465	129,880	3.58

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 3Q25.

3Q25 CASES BY AGE		
Member Age	% of Cases	% of Membership
Age 0-10	5.9%	18.4%
Age 11-19	4.0%	16.3%
Age 20-44	25.3%	34.1%
Age 45-64	45.5%	19.6%
Age 65+	19.3%	11.6%
Grand Total	100.0%	100.0%

"Robert worked diligently over the last few months helping me get a reimbursement check. Thank you, I really appreciate your help."

- *Partnership Member*

3Q25 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	92.5%	75.7%
Spanish	5.6%	20.8%
Other	1.3%	2.1%
Russian	0.3%	0.6%
Tagalog	0.2%	0.3%
Punjabi	0.0%	0.5%
Grand Total	100.0%	100.0%

3Q25 CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	63.1%	51.9%
Male	36.9%	48.1%
Grand Total	100.0%	100.0%

3Q25 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	56.8%	37.9%
Other/Unknown	16.0%	19.8%
Hispanic	15.2%	34.3%
Black	7.3%	3.6%
Asian	2.9%	2.5%
Native American	1.7%	1.7%
Hawaiian/Pacific Islander	0.1%	0.2%
Grand Total	100.0%	100.0%



TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 3Q25.

3Q25 STATISTICS

Transportation cases in 3Q25 accounted for 904 cases of the total 2,261 cases closed. This represented 40.0% of all cases closed in 3Q25. There were 82 Appeals, 821 Grievances (Exempt and Standard), and one (1) State Hearings.

The cases closed during this reporting period include cases with trips scheduled or completed in both 2Q25 and 3Q25. In 2Q25, there were 467,111 scheduled trips, of which 287,016 were completed. In 3Q25, there were 693,974 scheduled trips and 329,971 completed trips, based on data from the NMT and NEMT Tableau Dashboards.

TRENDING ISSUES

Lyft, North Bay transit, Budget Friendly, Silver Lining and Hey Taxi are the top five (5) providers that members grieved about in 3Q25. The top five (5) issues that members had were requesting a taxi company preference, missed rides, drivers arriving late, driver behavior and scheduling issues. There were 146 NEMT cases and 758 NMT cases closed in 3Q25.

There has been a decline in the number of State Hearings as compared to the previous quarter with eight (8) State Hearings in 2Q25. The one (1) State Hearing closed in 3Q25 was withdrawn by the member as there was a mistake by the provider in requesting the wrong type of transportation for the member.

G&A identified cases related to discrimination specific to transportation providers based on religion, race, gender and disability. In one discrimination case, the member complained about the driver speaking aggressively about his religious views and attempting to convert the member into his religion. This case was reported to the North Bay Transit Group for review. They confirmed training and education was provided to their staff regarding proper customer service.

There were three (3) cases involving potential HIPAA violations reported to RAC. The transportation providers reported that the drivers received retraining to ensure they do not share members' personal information. Additional cases resulted in driver education on professional communication with members, appropriate phone use, and defensive driving.

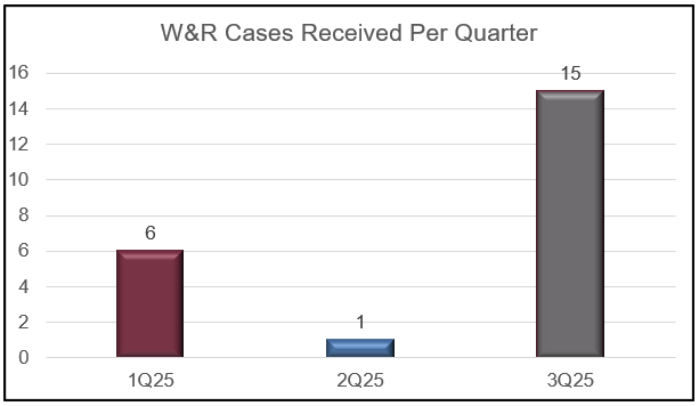
G&A identified multiple complaints against Transportation Services. The top two (2) complaints for 3Q25 included reimbursement of lodging/meals and scheduling issues.



W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 3Q25. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.



3Q25 NUMBERS

G&A received 15 Grievances and zero (0) Appeals, representing 0.6% of the total cases reported this quarter. Three (3) Grievances were closed in 3Q25. The rest of the cases will be resolved in 4Q25.

TRENDING ISSUES

Receiving 15 Grievances is a significant increase from the first half of the year. There were six (6) cases in the first quarter and one (1) in the second quarter. Part of this increase is due to one (1) member who filed eight (8) grievances against different providers. All eight (8) of those cases will be closed in 4Q25. The member expressed frustration that none of the facilities were able to accommodate him.



DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. The three (3) closed cases were closed within the 30-day DHCS regulatory timeframe.

3Q25 W&R Cases	
# of Grievance Received	15
# of Grievance Resolutions	3
# of Appeal Received	0
# of Appeal Resolutions	0

DHCS Grievance Categories	1Q25	2Q25	3Q25
Access to Care	2	0	9
Failure to Respect Enrollee's Rights	0	0	0
Interpersonal Relationship Issues	1	1	1
Program Requirements	2	0	3
Quality of Care	1	0	2
Other	0	0	0
Totals	6	1	15

CCS RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to California Children's Services (CCS) and Whole Child Model (WCM) during 3Q25.

3Q25 STATISTICS

During 3Q25, a total of 29 CCS-related cases were closed and reported to DHCS, representing 1.3% of the total of 2,261 closed cases for this quarter. These cases are divided into 17 Grievances and 12 Appeals.

TRENDING ISSUES

The most commonly reported issues involved Appeals for transportation-related services such as meals and lodging. Most cases were upheld because the member did not meet the eligibility criteria for these benefits at the time of the request. The criteria require that the members travel begin before 6:00 a.m., end after 10:00 p.m., or the total travel and appointment time exceed 12 hours.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There was one case of discrimination reported for CCS members during 3Q25. The member's mother alleged race and ethnicity discrimination due to the provider not scheduling appointments with the son. The provider shared the member has been seen by providers at that office five (5) times in 2025. The member changed to another provider office. After investigation, it was determined that discrimination was unlikely to have occurred.



ETHNICITY AND PREFERRED LANGUAGE

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

3Q25 CCS CASES BY ETHNICITY		
Member Ethnicity	**# of Cases**	**% of Cases**
Hispanic	9	31.0%
White	8	27.6%
No Response	6	20.7%
Other	4	13.8%
Alaskan Native or American Ind	1	3.4%
Other Asian	1	3.4%
Grand Total	**29**	**100.0%**

3Q25 CCS CASES BY LANGUAGE		
Member Language	**# of Cases**	**% of Cases**
English	25	86.2%
Spanish	4	13.8%
Grand Total	**29**	**100.0%**

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 3Q25. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

3Q25 DISCRIMINATION STATISTICS

G&A investigated 115 cases related to discrimination allegations in 3Q25. This represented 5.1% of all cases closed. Of the 115 cases, 76 fell under applicable federal or state civil rights law.

After investigation, it was determined that discrimination likely occurred in six (6) cases containing seven (7) discrimination categories.

In two (2) of the cases, there was discrimination due to a member's limited English skills. One (1) of those two (2) cases also had an instance of discrimination involving language assistance services.

In two (2) cases, there were issues related to religion. Both cases involved a driver who was actively trying to push their religious views onto the passenger.

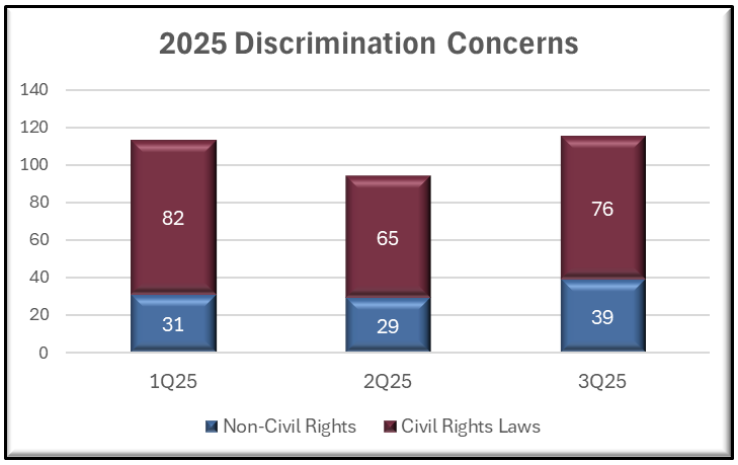
In the two (2) remaining discrimination cases, one was related to race, and the other was related to gender. For all cases, feedback and education were provided to the offending parties to prevent these issues from occurring again.

Discrimination allegations that did not fall under a civil rights law accounted for 39 of the 115 alleged discrimination cases filed. Members alleged discrimination based on reasons such as having specific medical coverage, retaliation, or being labeled a medication/drug seeker.

3Q25 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations has increased. There was a 22.3% increase in discrimination allegations compared to the last quarter. Notably, Placer county had zero (0) cases reported last quarter and eight (8) cases reported this quarter. Shasta went from two (2) cases last quarter to 13 cases this quarter.

Overall, the most commonly reported allegation for all cases was Disability, accounting for 25.2% of the cases followed by Race/Ethnicity accounting for 18.3%.



3Q25 CASES BY CATEGORY

The chart below shows a breakdown of cases where discrimination was found to be likely, categorized by civil rights law.

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Limited English Skills	2
Religion	2
Gender	1
Language Assistance Services	1
Race or Ethnicity	1
Total	7

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

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

THE RESULTS

Fifty Grievances were evaluated for the 3Q25 IRR review. These were Grievances that closed in 2Q25.

The Medical Director found one grievance that was valid and related to patient safety, specifically concerning the changing of gloves between patients. He advised that, although the provider reported the issue would be addressed, it could have also been referred to the Quality Department for PQI track and trending.

G&A leadership identified a couple of opportunities for improvement. The Grievance Case Analysts did not consistently attach relevant documentation to their cases. Relevant documents include resolution letters, referrals, emails, and attachments. There were also issues with timeliness (i.e. cases not closed on time or actions not closed on time), missing or incorrect case labelling and case categorization, not addressing some member issues involved in the cases, and lack of communication between case workers.



TIMELINESS

The target timeliness goal for closing cases and mailing acknowledgement letters is 98.6%. For 3Q25, 1,731 cases were subject to DHCS Turnaround Times (TAT). We achieved our goal for case timeliness, with 99.2% of cases closed within required timeframes. However, we fell slightly short of our goal for mailing acknowledgement letters, with 98.3% sent within five (5) calendar days. In total, 14 cases were processed late, and 29 acknowledgement letters were mailed after the required time frame.

Delays were primarily due to late responses from providers, time needed to request or obtain additional information or medical records, and cases not being submitted promptly by other departments.

3Q25 DHCS Timeliness Performance				
Performance Category	Performance Goal	# Late	Performance Result	Status
Investigations	98.6%	14	99.2%	
Ack-Letters	98.6%	29	98.3%	



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

CONTACT US

Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, CA 94534

2525 Airpark Drive
Redding, CA 96001

www.partnershiphp.org

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UM Delegated Hospitals Summary
November 2025

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

- **Adventist Health** (Adventist Clearlake, Adventist St. Helena, Adventist Ukiah Valley, Adventist Mendocino Coast, Howard Memorial)
  - Delegation Agreement in progress for update to reflect the 2026 standards.
  - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
  - CY2024 annual audit completed 03/06/2025. Adventist team had zero (0) identified deficiencies for program and file review audits. Partnership UM continues to monitor Adventist denials on a weekly basis for compliance and sustainability.

- **NorthBay Medical Center/ VacaValley Hospital**
  - Delegation Agreement in progress for update to reflect the 2026 standards.
  - Not currently operating on the Essette platform for prior authorizations, with no immediate plans to migrate. This poses a risk for DHCS and NCQA compliance for UM reviews and denials.
  - CY2024 annual audit completed 03/27/2025. NorthBay team had zero (0) identified deficiencies for program review and one (1) preliminary finding for file review audits. NorthBay was notified of the deficiency, a CAP was issued and resolved on 04/01/2025. Partnership UM continues to monitor NorthBay denials on a weekly basis for compliance and sustainability.

- **Queen of the Valley Medical Center (QVMC)**
  - Delegation Agreement in progress for update to reflect the 2026 standards.
  - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
  - CY2024 annual audit completed 03/04/2025. QVMC team had zero (0) identified deficiencies for program and file review audits. Partnership UM continues to monitor QVMC denials on a weekly basis for compliance and sustainability.

- **MarinHealth Medical Center (MHMC)**
  - Delegation Agreement in progress for update to reflect the 2026 standards.
  - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
  - CY2024 annual audit completed on 03/07/2025. Areas of improvement in the documentation of UM processes addressed through the preliminary CAP process. Partnership UM continues to monitor MHMC denials on a weekly basis for compliance and sustainability.

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2025 ANNUAL OVERSIGHT AUDIT
Carelon

August 4, 2025

NOTICE OF FINAL AUDIT RESULTS

January 1, 2024 – December 31, 2024

Attention:
Kaneisha Willis, AP Regional Operations

Dear Kaneisha,

Partnership Health Plan of California (PHC) writes this notice to advise you regarding the conclusion of this year's annual delegation compliance oversight audit. As a result of the supplemental documentation and feedback we received from your organization, you will find the final audit results on the next page. Each of the finalized CAP forms for the preliminary deficiencies we reviewed during the audit are also attached with this notice for your records.

This year's **audit scope** is outlined below:

SCOPE AREA	REVIEW TYPE	CURRENT CAP STATUS
Basic Case Management	**Program Review**	**0-CAP**
Care Coordination	**Program/File Review**	**1 CAP**
Claims/PDR	**Program Review/File Review**	**0-CAP**
Compliance (HIPAA/FWA)	**Program Review**	**0CAP**
Credentialing	**Program Review Special Review (Credentialing Timeliness)**	**0-CAP**
Cultural and Linguistics	**Program Review**	**1CAP**
DEI and Transgender	**Program Review**	**0CAP**
Grievance & Appeals	**Program Review/File Review**	**0 CAP**
Member Services	**Program Review**	**0CAP**
Mental Health Services	**Program Review/File Review**	**0-CAP**
Net Management	**Program Review**	**0-CAP**
QIHETP	**Program Review**	**1 CAP**
Quality Improvement/QIPQI	**Program Review /File Review** Special Review (Identification, Reporting and Processing of PQI)	**0-CAP**
Utilization Management	**Program/File Review**	**0-CAP**

Please be advised that the completion of this annual audit does not preclude any future PHC auditing or oversight activities and should not be construed as a substitute for any other reviews required by law, license, or accreditation. PHC values the services provided to our members by Carelon and we look forward to a continued partnership.

If you have any further questions or concerns, feel free to contact me directly.

Sincerely,

Charo Patio
Compliance Auditor
Regulatory Affairs and Compliance Department
Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534
Phone: (702)588-1214 |**FAX:** (70)450-7568
Email: cpatio@partnershiphp.org
Normal work hours: 8 a.m-5p.m Monday –Friday (note: I am off every other Friday)

APPROVED
By Robert Moore, MD MPH MBA at 5:24 pm, Aug 13, 2025

Our website: www.partnershiphp.org
PHC Mission: *To help our members, and the communities we serve, be healthy*
cc: Kenzie Hanusiak, Dani Ogren

2025 ANNUAL OVERSIGHT AUDIT
Carelon

August 4, 2025

FINAL AUDIT RESULTS REPORT
January 1, 2024 – December 31, 2024

RECOMMENDATIONS/COMMENTS: *The following description(s) address opportunities for improvement, as observed during audit, and does not represent a formal finding or request for corrective action plan. PHC will review cited opportunities for improvement through monitoring and future oversight audits. Recommendations that require collaboration will be initiated by PHC.*
N/A
N/A

ASSIGNED CAPs: *Any preliminary deficiencies, which have not been justified or corrected, result in a formal Corrective Action Plan (CAP). Every CAP listed below must be satisfied and closed by the given deadline. Should there be any justifiable reason that The Delegate needs additional time or would like to discuss a CAP further, please let us know immediately.*

SCOPE AREA	DEFICIENCY/CAP DESCRIPTION	INSTRUCTION TO CLOSE	DEADLINE
Care Coordination	The Q4 reporting shows data on TOC and it is not consistent with the reporting information from Q1-Q2-Q3. Please provide correct report for Q4 and explain the Q4 TOC report that was provided to PHC in this audit, is this a different report not related to the audit ask?	Further clarification is needed. Audit tool requires these values: Provide Reports for the audit review period (by quarter): a) Total # of Continuity of Care Requests, listed by county, including the total number of approved/denied requests b) Average # of days the Continuity of Care request was approved for, listed by county c) of members transitioned to Carelon Services, listed by county (moderate/mild) With the new Q4 reporting, what report values will mirror the ones above (a,b,c)?	**August 18,2025**
Cultural & Linguistics	Please submit examples of member materials in the two other PHC threshold languages, Tagalog and Russian to fully close this CAP.	The delegate must provide examples of member materials in Tagalog and Russian to fully close this CAP. Translation requests are not necessary in order to fulfill this CAP.	**August 18,2025**
QIHETP	The 2025 HE programs description was reviewed. In addition, the Corporate Quality Management program description was reviewed. Finally, the California Health Equity program description was reviewed. Key MCAS measures that the state is requiring is of FUM/FUA--which is listed in the Quality Management program. It was unable to identify which Race, Ethnicity, and Language groups (REAL) have FUM/FUA	Partnership respectfully acknowledges that they may be challenged with assessing FUA/FUM data. The FUA/FUM data was an example measure that was suspected to be measured by the organization. We are requesting at least ONE or any measure to be stratified to identify which Race, Ethnicity, and Language groups (REAL) have any related disparities. FUA/FUM was given as an example. Include a preliminary assessment and plan	**August 18,2025**

	related disparities.	regarding any specific (REAL/SOGI) group experiencing any related disparity (e.g. FUM/FUA/PHQ-9 Screening rates, et	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2016</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/21/2015</td><td colspan="4">Next Review Date: N/A~~01/08/2026~~
Last Review Date: 01/08/2025</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Archived Date: 01/14/2026~~Approval Date: 01/08/2025~~</td></tr>
</table>

Archived 01/14/2026- Refer to MPTP2501

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

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

I. California Driving Requirements: Defined by California Vehicle Code (VEH Section 12500, 4000, and 16020)
J. Round Trip: Transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.
K. Short Notice Request: Any request for transport not allowing five calendar day notice.
L. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional verbal consent when the prior verbal consent window of time has expired.

IV. ATTACHMENTS:

A. Provider Certification Statement (PCS) form

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. GENERAL TRANSPORTATION PROGRAM RULES

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

Archived on 1/14/2026- Refer to MM12501

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

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

5. All requests for transportation services made to Partnership must be submitted five (5) calendar days prior to the date of service.
   a. Partnership will review short notice requests on a case by case basis based on the following criteria:
      1) If the appointment is life threatening/sustaining, Partnership will attempt to secure transportation.
      2) If the appointment is not life threatening/sustaining, has been scheduled with the provider, but the Member waited to request transportation and did not allow five calendar days, the request will be denied.
      3) If the appointment was scheduled by the provider within 5 calendar days, Partnership will attempt to secure transportation.
   b. Exceptions for gas mileage reimbursement (GMR)
      1) Non-advance funds GMR requests will be accepted regardless of days' notice.
      2) Advance funds GMR requests must be made two (2) business days in advance. If the request is made with less than two (2) business days' notice, regular GMR can be requested.
      3) Retroactive requests will not be accepted.
6. All approved transports will be scheduled to ensure the Member is dropped off within 15 minutes of their scheduled appointment and Members will be informed of their pick-up/drop off time when the transport is scheduled.
   a. If the transportation provider does not arrive at the pick-up location in time to ensure the Member arrives at their appointment within 15 minutes of the scheduled appointment time, the Member can call Partnership and transport with an alternate transportation provider will be approved.
7. If an approved transport experiences any disruption due to the assigned Transportation Provider arriving late or failing to arrive, Partnership will provide urgent authorization for a replacement ride to be scheduled.
8. With the written consent of a parent or guardian, a minor between the ages of 12-18 may receive transportation unaccompanied as long as Partnership and the transportation provider accepts the necessary written consent forms and agrees to provide unaccompanied transport. Certain appointments will not require written consent or parent/legal guardian permission to travel unaccompanied as described below:
   a. All Members under age 21
      1) Pregnancy and pregnancy-related services
      2) Family planning services
      3) Sexual assault services

Archived 01/14/2026 Refer to MPTP2501

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

9. All requests for transportation to medical appointments are subject to appointment verification by Partnership.
10. Transportation for Partnership covered services to Out of Network (OON) providers will be provided with prior authorization and if all other utilization control requirements are met.
11. Transportation for Medi-Cal covered services, carved out of Partnership's responsibility, will be provided and are not subject to Partnership's utilization controls or time and distances standards related to reviewing requests for medical services. Transportation requests to carved out services will only be reviewed in accordance with the rules and regulations listed in this policy.
12. Partnership will store Transportation Provider information, including the name of the driver based on service date, time, pick-up/drop-off location, and Member name. If a Partnership Member files a grievance, this information will be made available to them.

B. NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

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

1. Transportation Providers are required to provide door-to-door or door-through-door service for all authorized NEMT services.
2. NEMT PRIOR AUTHORIZATION REQUIREMENTS
   a. Both a Treatment Authorization Request (TAR) and Partnership's DHCS approved Provider Certification Statement (PCS) (see Attachment A) are required for all NEMT services that have an identified TAR requirement in order to be processed. All TARs received without a PCS are subject to Partnership's standard Utilization Management (UM) TAR review process as outlined in
   policy MCUP3041 Treatment Authorization Request (TAR) Review Process. Once submitted to Partnership, prescribed NEMT services and the corresponding PCS form cannot be changed or altered.
      1) In urgent situations, when a PCS form cannot reasonably be obtained prior to the requested NEMT service, Partnership can authorize one-time NEMT and accept the PCS post-service. This authorization can be made via phone; however, the service still requires a Treatment Authorization Request (TAR) to be submitted by the Medi-Cal Certified NEMT Provider once a valid PCS can be obtained.
      2) A copy of the PCS form will remain on file for all Members receiving NEMT services.
      3) If needed, Partnership can provide a copy of the PCS to the Medi-Cal Certified NEMT Provider via fax or encrypted email.
   b. Providers and Members can call Partnership or any Medi-Cal Certified NEMT Provider directly to request NEMT services. Providers and Members can also call Partnership or the scheduled Medi-Cal Certified NEMT provider to receive status updates on NEMT rides.
   c. Only Partnership's DHCS approved PCS form (Attachment A) will be accepted and must include, at a minimum, the components listed below. All fields must be completed by the provider.
      1) Function Limitations Justification: For NEMT, the provider is required to document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

Archived 01/14/2026. Refer to MCP2501

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

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

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

Archived 01/14/2026 - Refer to MPTP2501

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

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

C. NON-MEDICAL TRANSPORTATION (NMT)

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

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

Archived 01/14/2026- Refer to MPTP2501

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

g. Additional passenger rules:
1) Members under the age of 21 are allowed two (2) additional passengers if the passengers are parents or legal guardians to the Member.
a) If the parent or legal guardian is a single caregiver, transport can be provided for additional minor children under the care of the parent or legal guardian. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.
2) All other Members are allowed one (1) additional passenger
a) If the Member is a single caregiver, transport can be provided for additional minor children under the care of the Member. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.

h. NMT services will be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the Member and consistent with applicable state and federal disability rights laws.

2. PARENT/LEGAL GUARDIAN-ONLY NMT
a. In emergent situations when a Member under the age of 21 is transferred to a facility via emergency medical transport, Partnership will authorize parent/guardian only transport services on a case-by-case basis.
1) If the request is for gas mileage reimbursement (GMR), Members and their guardians have 30 days from the date of service to request this type of reimbursement.
b. For Members under the age of 21, Partnership may authorize parent/guardian-only transport on a case-by-case basis upon hospital discharge from an inpatient setting if the medically necessary transport provided for the Member cannot also provide transport for one parent or guardian.
1) If the request is for GMR, Members and/or their guardians have 30 days from the date of service to request this type of reimbursement.
c. Further parent or guardian-only transports for Members under the age of 21 will be reviewed on a case-by-case basis and in compliance with provisions described under Partnership policy and procedure MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

3. NMT PRIVATE VEHICLE AUTHORIZATION REQUIREMENTS
a. GMR requires prior authorization Partnership.
1) Non-advance funds GMR requests will be accepted regardless of days' notice.
2) Advance funds GMR requests must be made 48 hours in advance. If the request is made with less than 48 hours' notice, regular GMR can be requested.
3) Retroactive requests will not be accepted.

Archived 01/14/2026 Refer to MPTP2501

b. In order to receive GMR for use of a private vehicle, the driver must be compliant with all California driving requirements, which include the following:
   1) Valid driver's license
   2) Valid vehicle registration
   3) Valid vehicle insurance
c. Partnership will only reimburse the driver.
d. Members may not receive reimbursement for driving themselves, unless the Member is eligible to CCS and legally allowed to drive.
e. Mileage reimbursement for gas is consistent with the Internal Revenue Service standard mileage rate for medical transportation when conveyance is in a private vehicle arranged by the Member.
f. The form of reimbursement offered is decided by Partnership and may be in the form of cash, check, gas cards, or other forms of prepaid cards.
g. In order for Partnership to issue payment for GMR requests, the Member or Member's parent/legal guardian must provide the following:
   1) Credentials verifying the driver/payee is in compliance with all California driving requirements as listed above in section VI.C.3.b.
   2) Attendance verification issued by the treating provider on facility letterhead or via the facility's online member portal or mobile application.
h. Partnership will allow the Member 90 calendar days from the date of service to submit all required credentials.

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

Archived 01/14/2026. Refer to MPTP2501

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

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

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

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

Archived 01/14/2026. Refer to MPP 2501

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

F. SCREENING & ENROLLMENT

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

G. REGULATORY REQUIREMENT

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

01/20/16; 08/16/17; *11/14/18; 02/12/20; 08/12/20; 08/11/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24; 01/08/25; ARCHIVED 01/14/2026

*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 01/14/2026- Refer to MPTP2501

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

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

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

The materials provided are guidelines used by 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.

Archived 01/14/2026- Refer to MPTP2501

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

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

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

3. Dates of Service (DOS)

From: _____ To: _____

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

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

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

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

Archived 01/14/2026- Refer to MPTP2501-A

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCCP2029			**Lead Department: Health Services**	
Policy/Procedure Title: Emergency Medical Transportation			☒ **External Policy** ☐ **Internal Policy**	
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)		**Next Review Date:** N/A ~~01/08/2026~~ **Last Review Date: 01/08/2025**		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Archived Date: 01/14/2026** ~~**Approval Date: 01/08/2025**~~	

Archived 01/14/2026 - Refer to MPTP2502

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

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

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

IV. ATTACHMENTS:
- A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. EMERGENCY MEDICAL TRANSPORTATION (EMT)

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

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

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 02/10/21; 02/09/22; 01/11/23; 01/10/24; 01/08/25; ARCHIVED 01/14/2026

PREVIOUSLY APPLIED TO:

This policy topic was separated from policy MCCP2016 Transportation Policy for Non-Emergency Medical

Archived 01/14/2026 - Refer to MPP 2502

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

(NEMT) and Non-Medical Transportation (NMT) as of 01/08/2020

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

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

The materials provided are guidelines used by 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.

Archived 01/14/2026 - Refer to MPTP2502

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="5">Policy/Procedure Number: MCCP2036</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="5">Policy/Procedure Title: Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="4">Original Date: 08/13/2025
Effective Date: 01/01/2024</td><td colspan="4">Next Review Date: ~~08/13/2026~~01/14/2027
Last Review Date: ~~08/13/2025~~01/14/2026</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td></td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="5">Approval Signature: Robert Moore, MD MPH MBA</td><td colspan="3">Approval Date: ~~08/13/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCCP2035 – Local Health Department (LHD) Coordination
B. MPBP8005 – Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services
C. ADM41 – PHC's Community Emergency Response Plan
D. MPBP8003 – Mental Health Services
E. MPUP3047 – Tuberculosis Related Treatment
F. MCCP2024 – Whole Child Model For California Children's Services (CCS)
G. MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program
H. MPCP2034 – Transitional Care Services (TCS)
I. MCUP3103 – Coordination of Care for Child Welfare-Involved Members

II. IMPACTED DEPTS:

A. Administration
B. Compliance
C. Health Services
D. Grievance and Appeals
E. Member Services
F. Provider Relations

III. DEFINITIONS:

A. Behavioral Health Plan (BHP): A county behavioral health plan that is responsible for providing behavioral health services outlined in Title 9 CCR and Title 22 CCR.
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. Managed Care Plan (MCP): Partnership HealthPlan of California (Partnership) is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). MCPs are required to provide and cover all medically necessary physical health and non-specialty mental health services.
D. Memorandum of Understanding (MOU): A formal written agreement between two or more

governmental entities or community-based organizations to outline and define roles and responsibilities. MOUs do not constitute a provider contract.

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

IV. ATTACHMENTS:

A. Base Memorandum of Understanding Template
B. In Home Supportive Services Memorandum of Understanding Template
C. Regional Center Memorandum of Understanding Template
D. Specialty Mental Health Services Memorandum of Understanding Template
E. Substance Use Disorder Treatment Services Memorandum of Understanding Template
F. Local Health Department Memorandum of Understanding Template
G. County Social Services Programs and Child Welfare Memorandum of Understanding Template
H. Women, Infant, & Children Memorandum of Understanding Template
I. County-Based Targeted Case Management Memorandum of Understanding Template
J. Drug Medi-Cal State Plan Memorandum of Understanding Template
K. First 5 Memorandum of Understanding Template
L. California Children's Services (CCS) Whole Child Model Program Memorandum of Understanding Template

V. PURPOSE:

To describe and define the intent of the Memorandum of Understanding (MOUs) required to be entered into by Partnership HealthPlan of California (as the Medi-Cal Managed Care Plan [MCP]) and Third Party Entities as defined below under the Medi-Cal Managed Care Contract with the Department of Health Care Services (DHCS).

VI. POLICY / PROCEDURE:

A. MOU OVERSIGHT & COORDINATION
   1. Partnership HealthPlan of California (Partnership) shall negotiate in good faith and execute an MOU with Third Party Entities as required under the Medi-Cal Managed Care Contract (MCP Contract) with the Department of Health Care Services (DHCS).
      a. Partnership will submit all executed MOUs to DHCS as required by the DHCS-MCP Contract Exhibit A, Attachment III, Subsection 5.6.1 (MOUs with Third Party Entities and County Programs).
      b. To the extent the plan does not execute an MOU required by the DHCS-MCP contract within four months of the effective date of the contract, Partnership must submit quarterly reports to their DHCS contract manager documenting the plan's continuing good faith efforts to execute the MOU, until such time as the MOU is executed. Documentation of good faith efforts to execute the MOU must include a justification for why the MOU has not been executed.
         1) All MOU reports must be submitted to DHCS via the MCOD-MCP (MCOD: Managed Care Operations Division) Submission Portal.
         2) The MCOD-MCP Submission Portal is available at: https://cadhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Home.aspx
      ~~b.~~c. Partnership is responsible for authorizing medically necessary covered services and coordinating care for Members provided by Partnership's Network Providers and other providers of carved-out programs, services, and benefits.

2. Partnership has a designated point of contact responsible for the oversight and supervision of the terms of all MOUs entered into by the plan.
   a. The appropriate level of leadership for both the parties to the MOU must be present at all engagements when defining the terms of the MOU.
   b. Partnership will notify the Third Party Entities of any changes to Partnership's designated MOU point of contact in writing as soon as reasonably practical but no later than the date of change.
   c. Partnership will notify DHCS within five working days of any change in the designated MOU point of contact.
3. All Partnership Subcontractors, Downstream Subcontractors, and Network Providers are required to comply with any applicable provisions for all MOUs entered into by the plan.
   a. Partnership provides training and orientation for its employees who carry out responsibilities under an MOU and on any provisions applicable to Subcontractors, Downstream Subcontractors, and Network Providers in any MOUs entered into by the plan, on an annual basis, at a minimum. The training must include information on MOU requirements, what services are provided or arranged for by each of the MOU parties, and policies and procedures outlined in the MOU.
   b. Partnership and Third Party Entities will work together to develop training and educational materials that covers services provided or arranged for by the MOU parties.
4. The MOU parties must work collaboratively to ensure Members are referred to appropriate programs and/or services. Referrals must be facilitated among the MOU parties for Members who potentially meet criteria or quality for such programs and/or services.
5. The MOU parties will coordinate Members' access to care and services that incorporate all the requirements noted in the MOU. Partnership would need to maintain collaboration with Third Party Entities and to identify strategies to monitor and assess the effectiveness of the MOU in place.
6. At a minimum, the plan must review its MOUs annually for any needed modifications or renewal of responsibilities and obligations outlined within.
   a. Partnership will submit evidence of the plan's annual review of MOUs to their DHCS contract manager, along with copies of any MOUs that have been modified or renewed as a result.
7. All executed MOU's are available on the Partnership website at: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx

B. MOU Meetings
   1. For each MOU entered into by the plan, Partnership will hold regular meetings with the MOU parties, at least quarterly, to address policy and practical concerns that may arise between MOU parties.
      a. For each regular meeting, appropriate representatives from both parties to the MOU, who are knowledgeable about the topics to be discussed, must:
         1) Be present, and
         2) Include at least one individual who directly interacts with the Member population being served.
      b. At each regular meeting, there will be an opportunity to discuss and address care coordination and MOU-related issues directly with county executives, when applicable.
      c. Partnership will report to DHCS updates from each regularly held MOU meeting in a manner and frequency specified by DHCS.

C. Quality Improvement (QI)
   1. The MOU parties may develop QI activities specifically for the oversight of the requirements of the MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member

engagement, and service utilization. Partnership must document these QI activities in its policies and procedures or the MOU parties may agree to additional requirements that involves adopting joint policies and procedures to establish and address QI activities for coordinating the care and delivery of services for Members.

D. Data Sharing, Exchange, and Confidentiality
   1. The MOU parties must ensure that the minimum necessary Member information and data for accomplishing the goals of the MOU are exchanged timely and maintained securely and confidentially.
   2. The MOU parties must support the timely and frequent exchange of Member information and data, which may include behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent.

E. Disaster and Emergency Preparedness
   1. The MOU parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the MOU parties' health care delivery system to ensure the continued coordination and delivery of the Third Party Entities programs and services and Partnership's Covered Services for impacted Members.
   2. Refer to Partnership policy ADM41 PHC's Community Emergency Response Plan for more details.

F. Dispute Resolution Process
   1. Partnership and MOU parties shall negotiate in good faith and execute memoranda of understanding (MOUs) to ensure coordination of Medi-Cal services, delineate the responsibilities of each respective party, and afford for a dispute resolution process.
   2. MOUs shall be entered into and maintained, consistent with any future-related DHCS guidance as communicated in writing.
   3. Emphasis on Timely~~,~~ and Collaborative Resolution
      a. The provision of medically necessary services for Members will not be delayed during the pendency of any dispute.
      b. Partnership and the MOU party staff will make a good faith effort to agree to resolutions that are in the best interest of Members and are agreeable to all parties involved.
      c. Proactive and timely communication is expected between Partnership and the MOU party.
   4. Partnership or the MOU parties may seek to remedy a dispute informally through discussion and dialogue. If this fails to resolve the dispute, either party may request, in writing, a formal meeting between the two parties to identify issues and possible solutions. The receipt of the written request will initiate the Plan Level Dispute timeline.
      a. A Request for Plan Level Dispute Resolution can be submitted via secure email to any of Partnership's respective MOU liaisons, Directors, Behavioral Health Administrator, or Chief Health Services Officer as applicable.
      b. Within 10 business days, the meeting will be conducted at a mutually agreeable time. Representatives from both Partnership and the MOU parties must participate in the meeting.
      c. Within 5 business days from the date of the meeting, Partnership will issue to the MOU party a written final position on the matter in dispute signed by the CEO or their designee.
      d. Partnership will maintain records of Plan Level Dispute Resolutions consistent with applicable Partnership record retention policy.
   5. Refer to Partnership policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services for more details on dispute resolution between Partnership and Behavioral Health Plans (BHPs) in delivery of mental health services. The receipt of the written request will initiate the Plan Level Dispute timeline in which the dispute must be resolved within 15

business days.

VII. REFERENCES:

A. DHCS Contract, Exhibit A, Attachment III, Section 5.6 (MOUs with Third Party Entities and County Programs)

B. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 08/11/2025~~01/08/2025~~)

- Base Memorandum of Understanding Template
- In Home Supportive Services Memorandum of Understanding Template
- Regional Center Memorandum of Understanding Template
- Specialty Mental Health Services Memorandum of Understanding Template
- Substance Use Disorder Treatment Services Memorandum of Understanding Template
- Local Health Department Memorandum of Understanding Template
- County Social Services Programs and Child Welfare Memorandum of Understanding Template
- Women, Infant, & Children Memorandum of Understanding Template
- County-Based Targeted Case Management Memorandum of Understanding Template
- Drug Medi-Cal State Plan Memorandum of Understanding Template
- First 5 Memorandum of Understanding Template

C. Title 9, California Code of Regulations (CCR) Sections §1810.370, §1850.505, §1850.520, §1850.525, and §1850.530

D. Template for Memorandum of Understanding between [MCP] Medi-Cal Managed Care Plans and [County] California Childrens Services (CCS) Whole Child Model Program (07/2024)

E. Partnership External Website Memoranda of Understanding (MOU) Documents: https://www.partnershiphp.org/About/Pages/MOU-Documents.aspx

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES: 01/14/26~~N/A~~

PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPC~~C~~CP2019 (previously MCCP2019, MCUP3117)			**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)		**Next Review Date:** ~~02/12/2026~~01/14/2027 **Last Review Date:** ~~02/12/2025~~01/14/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~02/12/2025~~01/14/2026	

I. RELATED POLICIES:

A. MCUP3012 – Discharge Planning (Non-capitated Members)
B. MPC~~C~~UP3039 – Direct Members
C. MPC~~C~~CP2007 – Complex Case Management
D. MPC~~C~~CP2023 – New Member Needs Assessment
E. MCCP2024 – Whole Child Model for California Children's Services (CCS)
F. MPCD2013 – Care Coordination Program Description
G. MCAP7002 – ~~MCCP2032~~ – CalAIM Enhanced Care Management (ECM)
H. MCAP7001 – ~~MCUP3143~~ – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
I. MPC~~C~~CP2014 – Continuity of Care ~~(Medi-Cal)~~

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Complex Case Management (CCM): The process of applying evidence-based practices to individual ~~member~~Members to assist them with the coordination of their care and promote their well-being.
B. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost ~~member~~Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.
C. Health Care Guide (HCG): A non-clinical Care Coordination staff ~~member~~Member who provides support and guidance to ~~member~~Members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting ~~member~~Members to available internal and external resources.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult ~~member~~Members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
E. Individualized Care Plan (ICP)~~: A~~: A ~~member~~Member-focused care plan designed to optimize the ~~member~~Member's health, function, and well-being.

Policy/Procedure Number: MPCCP2019 (previously MCCP2019, MCUP3117)			Lead Department: Health Services Business Unit: Care Coordination
Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)			**Next Review Date: 01/14/2027~~02/12/2026~~** **Last Review Date: 01/14/2026~~02/12/2025~~**
Applies to:	☐ **Employees**	☐ **Medi-Cal**	☒ **Partnership Advantage**

~~E.~~F. Interdisciplinary Care Team (ICT): ICT will only be applicable for Partnership Advantage (PA) Members. A group of key stakeholders including, at minimum, the Member, their Primary Care Provider (PCP), and the Case Manager. This core group is responsible for developing, implementing, and evaluating the Member's individualized care plan. This includes oversight and coordination of care for D-SNP Members and may include additional specialists and family ~~member~~Members if relevant to the Member's care needs. The extended ICT may also include other stakeholders who provide support as required across transitions and care settings.

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

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

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

IV. ATTACHMENTS:

A. Health Risk Assessment (HRA)
B. Pediatric HRA
C. HRA Stratification Matrix
D. PHRA Stratification Matrix

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

B. HRA/PHRA Process
1. All newly enrolled ~~member~~Members designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment A) or PHRA (Attachment B) via mail within 10 calendar days of enrollment

into the plan.

2. The HRA/PHRA forms are reviewed by the Chief Medical Officer, the Health Educator, and by the Consumer or Family Advisory Committee prior to implementation by the health plan, as are any and all revisions to the HRA/PHRA.
3. All newly enrolled SPD/CCS ~~member~~Members are contacted telephonically within 45 days of enrollment in order to encourage the ~~member~~Member to return the HRA/PHRA.
4. All questions on the HRA/PHRA forms are sent to each SPD/CCS beneficiary according to age upon enrollment. In no instance are any questions in the HRA/PHRA forms sent to a subset of the SPD/CCS population.
5. For those HRA/PHRAs completed, the ~~member~~Member's responses will be captured and evaluated as follows:
   a. Adult ~~member~~Member responses will be captured and evaluated utilizing the HRA Stratification Matrix (Attachment C) for adult ~~member~~Members. Adult ~~member~~Members will be placed in low- or high-risk categories~~:~~.
      1) Low-Risk – ~~member~~Members~~s~~ will benefit from basic case management; or
      ~~2) High-Risk – Member requires complex case management through an individualized care plan (ICP) to prevent adverse health outcomes.~~
      2)
   b. Pediatric Members who complete a PHRA are classified as high-risk in accordance with policy MCCP2024 Whole Child Model for California Children's Services (CCS). Other Members may also be identified as high-risk based on additional criteria outlined in the policy.
   ~~b. All pediatric member~~Members who complete a PHRA are treated as high- risk according to policy MCCP2024 Whole Child Model for California Children's Services (CCS).

C. Care Coordination
   1. Low-Risk ~~Member~~Members
      a. Adult ~~member~~Members who are stratified as low-risk based on their responses to the HRA will be contacted by a Health Care Guide (HCG) within 30 calendar days of the returned HRA.
      b. The role of the HCG is to identify barriers to care and safety and to carry out non-clinical interventions to eliminate those barriers. Examples include, but are not limited to:
         1) Work with the primary care provider and/or specialist's offices to coordinate appointments
         2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
         3) Work with community-based organizations to assist ~~member~~Members with access to psychosocial services
         4) Arrange transportation as appropriate
         5) Resolve any claims issues
         6) Provide support and encouragement to the ~~member~~Member and caregiver
         7) Evaluate the ~~member~~Member for need for additional case management services available through the health plan.
         8) Facilitate referrals for Long Term Support Services (LTSS) needs identified
      c. The HCG, Nurse Case Manager (NCM), and Social Worker (SW) work together. Any clinical issues will be the responsibility of a licensed clinician.
   2. High-Risk ~~Member~~Members
      a. Adult ~~Member~~Members stratified as ~~high risk~~high-risk, as well as all pediatric ~~member~~Members who complete a PHRA, will be contacted by a NCM or SW within 14 days of the returned HRA/PHRA, and the ~~member~~Member will be offered enrollment into Complex Case Management (CCM) (see policy MPCCP2007 Complex Case Management.) The NCM/SW collaborates with a ~~member~~Member's interdisciplinary care team and is responsible for the

development of the individualized care plan (ICP) for a ~~member~~Member stratified as ~~high risk~~high-risk. They are also responsible for providing education and clinical support, facilitating appropriate communication among the interdisciplinary care team, and working closely with outside agencies and available community resources.

b. The NCM/SW will discuss the HRA/PHRA results with the ~~member~~ Member and develop an ICP with interventions tailored to the particular needs of the M~~member~~Member. The care plan will include, but is not limited to, needs such as:
   1) The M~~member~~Member's identified medical care needs
   2) Access to primary and/or specialty care
   3) DME and/or medications
   4) Assessment of ~~member~~Member's current use of community resources as well as provision of referrals to appropriate resources and/or services outside of the Plan's benefits (i.e. mental health and behavioral health services, personal care, housing, meal delivery programs, energy assistance programs and services for individuals with intellectual and developmental disabilities)
   5) Identification of the ~~member~~Member's caregiver(s) and need for their involvement in the care plan
   6) Identification of an action plan to assist the ~~member~~Member with other activities or services needed to optimize their health status, including:
      a) Process/Plan for coordination of care across all settings, including those outside the provider network
      b) Process/Plan for referrals to resolve any physical or cognitive barriers to access care
      c) Process/Plan for helping to facilitate communication among the ~~member~~Member's health care providers
      d) Process/Plan for identifying a ~~member~~Member's need for other activities/services that would optimize their health status (e.g. self-management skills, health education classes, etc.)
      e) For the ~~member~~Member in a facility, a plan to ensure discharge planning and coordination is implemented
      f) Designated date of follow-up and reassessment as often as necessary, but not less than annually
      g) Referrals to LTSS services where applicable

c. For adult and pediatric ~~member~~Members stratified as high--risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible ~~member~~Members. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership. Refer to policies MCAP7002~~CP2032~~ CalAIM Enhanced Care Management (ECM) and MCAP7001~~UP3143~~ CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) for more details.

D. Assessment and Reassessment
   1. Populations required to receive an assessment as referenced in the Department of Health Care Services (DHCS) All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" (11/28/2022) and the latest version of the DHCS CalAIM: Population Health Management (PHM) Policy Guide include:
      a. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
      b. Those entering CCM, refer to policy MP~~C~~CP2007 Complex Case Management.
      c. Those entering ECM, refer to policy MCAP7002~~CP2032~~ CalAIM Enhanced Care Management (ECM)

d. Children with Special Health Care Needs (CSHCN)
e. Pregnant Individuals
f. Seniors and persons with disabilities who meet the definition of "high-risk" as established in existing APL requirements, namely:
    1) Members who have been authorized to receive:
        a) IHSS greater than, or equal to, 195 hours per month;
        b) Community-Based Adult Services (CBAS), and/or
        c) Multipurpose Senior Services Program (MSSP) Services
    2) Members who:
        a) Have been on oxygen within the past 90 days;
        b) Are residing in an acute hospital setting;
        c) Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
        d) Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
        e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
        f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
        g) Have cancer and are currently being treated;
        h) Are pregnant;
        i) Have been prescribed antipsychotic medication within the past 90 days;
        j) Have been prescribed 15 or more prescriptions in the past 90 days;
        k) Have a self-report of a deteriorating condition; and
        l) Have other conditions as determined by the Partnership, based on local resources.

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

E. Extended Continuity of Care (COC)
1. Newly enrolled SPD/CCS ~~member~~Members who request continued access to a provider who is not part of Partnership's network will be permitted to remain with that provider for up to 12 months as long as certain criteria are met. Partnership will begin processing requests for extended COC and will follow the COC process as described in policy MPCCP2014 Continuity of Care ~~(Medi-Cal)~~.

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

VII. REFERENCES:

A. Welfare and Institutions Code Section 14182
B. DHCS All Plan Letter 22-024: Population Health Management Program Guide (11/28/2022)
C. DHCS CalAIM: Population Health Management (PHM) Policy Guide (July 2025)

D. DHCS All Plan Letter 24-015: California Children's Services Whole Child Model Program (12/02/2024)
E. DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)
~~F.~~ DHCS Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2022-2023
F.
G. CalAIM Dual Eligible Special Needs Plan Policy Guide- Contract Year 2026 (June 2025)
~~G.~~H. Risk Stratification, Segmentation, and Tiering Transparency Document (July 2025)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2027)
01/14/26~~N/A~~

MCCP2019 (effective 02/15/17)
10/18/17; *11/14/18; 11/13/19; 09/09/20, 09/08/21; 10/12/22; 11/08/23; 10/09/24; 02/12/25; 01/14/26

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

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

****

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

- Consistent with sound clinical principles and processes

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

The materials provided are guidelines used by Partnership 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
Health Risk Assessment Form
Seniors and Persons with Disabilities (SPD)

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

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

If you have questions, please call Partnership at **(800) 809-1350**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call **(800) 735-2929**.

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

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

Name of Partnership Member: _____

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

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

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

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

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

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

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

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

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

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

10. Are you pregnant? ☐Yes ☐No

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

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

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

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

15. Do you use home oxygen? ☐Yes ☐No

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

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

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

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

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

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

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

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

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

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

21. Can you live safely and move easily around your home?

☐Yes ☐No ☐N/A

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

Good lighting	☐Yes	☐No	☐N/A
Good heating	☐Yes	☐No	☐N/A
Good cooling	☐Yes	☐No	☐N/A
Rails for any stairs or ramps	☐Yes	☐No	☐N/A
Hot water	☐Yes	☐No	☐N/A
Indoor toilet	☐Yes	☐No	☐N/A
A door to the outside that locks	☐Yes	☐No	☐N/A
Stairs to get into your home or stairs inside your home	☐Yes	☐No	☐N/A
Elevator	☐Yes	☐No	☐N/A
Space to use a wheelchair	☐Yes	☐No	☐N/A
Clear ways to exit your home	☐Yes	☐No	☐N/A

22. I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medications?	☐Yes	☐No	☐N/A
Do you need help filling out health forms?	☐Yes	☐No	☐N/A
Do you need help answering questions during a doctor's visit?	☐Yes	☐No	☐N/A

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

- ☐ I don't think it is necessary to do what my doctor says all of the time
- ☐ I don't understand my medical needs
- ☐ I feel confident that I know how to take care of what I need

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

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

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

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

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

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

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

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

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

Signature of person filling out the form: _____

Date: _____

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

Thank you for your time filling out this form.
CONFIDENTIAL

Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

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

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

If you have questions, please call Partnership at **(800) 809-1350** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the green envelope

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

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

Name of Partnership CCS Member: _____

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

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

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

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

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐Yes	☐No	☐N/A
Taking a bath or shower (bathing)	☐Yes	☐No	☐N/A
Getting dressed (dressing)	☐Yes	☐No	☐N/A
Going to the toilet (toileting)	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident" (continence)	☐Yes	☐No	☐N/A
Being active, like:			
Walking (mobility)	☐Yes	☐No	☐N/A
Getting out of a bed or a chair (transferring)	☐Yes	☐No	☐N/A
Going up or down stairs	☐Yes	☐No	☐N/A
Showing independence by:			
Going out to visit family or friends	☐Yes	☐No	☐N/A
Going to school or work	☐Yes	☐No	☐N/A
Making doctor or dentist appointments	☐Yes	☐No	☐N/A
Using the phone, tablet, or computer	☐Yes	☐No	☐N/A
Other _____	☐Yes	☐No	☐N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐Yes ☐No ☐Not sure
   What is the name of the center where you go?_____

5. Does your child receive any of the following services? (Check all that apply)
   ☐ Speech Therapy
   Where is this received? ☐Home ☐School ☐Medical Therapy Program (MTP) or Medical Therapy Unit (MTU)
   ☐Other _____
   ☐ Physical Therapy
   Where is this received? ☐Home ☐School ☐MTP/MTU
   ☐Other _____
   ☐ Occupational Therapy
   Where is this received? ☐Home ☐School ☐MTP/MTU
   ☐Other _____
   ☐ Respiratory Therapy
   Where is this received? ☐Home ☐School
   ☐Other _____
   ☐ Nursing Services
   Where is this received? ☐Home ☐School Hours/days per week? _____
   ☐Other _____
   ☐ Mental or Behavioral Therapy
   Where is this received? ☐Home ☐School
   ☐Other _____
   ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
   Which one(s)? ☐IEP ☐504
   ☐School Name_____
   ☐ Other supportive services (Respite Care, Palliative Care, etc.)
   Please explain _____
   Where is this received? ☐Home ☐School
   ☐Other_____

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

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

8. Does your child use durable medical equipment (DME) or supplies that were ordered for your child's specific needs?

☐ Yes (check all that apply)

☐ Glasses
☐ Hearing Aids
☐ Cochlear Implant
☐ Wheelchair
☐ Brace
☐ Orthotics
☐ Walker
☐ Car Seat
☐ Bed
☐ Ventilator/breathing machine
☐ Oxygen
☐ Percussion Vest
☐ Insulin Pump/Continuous Glucose Monitor
☐ Intravenous pump/Infusion device
☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)
☐ Other (please specify) _____

Who ordered it? _____

Date of last order _____

Who was the vendor? _____

Vendor Phone: _____

9. What is your child's current:

Height _____ Weight _____

10. Has your child ever had surgery?

☐ Yes ☐ No ☐ Don't Know

Please list each surgery	**Date or Year**

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

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

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

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

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

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

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

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Muscular Dystrophy	☐	☐
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Ostomy/G Tube /Colostomy/Urostomy	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI)/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐

	Current	Past
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
        - ☐ Which condition(s) _____
    - ☐ No – my child already has provider(s) for all his/her needs
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
    - ☐ No – my child does not need a specialist for his/her condition
16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
        - ☐ Do not have one
    - ☐ Provider Name: _____
    - ☐ Provider Phone: _____
    - ☐ Last Appointment: Date: _____
    - ☐ Next Appointment: Date: _____

◊ Specialty Care Center
- ☐ N/A
- ☐ Facility Name: _____
- ☐ Facility Phone: _____
- ☐ Last Appointment: Date:_____
- ☐ Next Appointment: Date:_____

◊ Regular Dental Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date:_____

◊ Regular Vision Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date:_____

◊ Ongoing care from Mental or Behavioral Health Specialist
- ☐ N/A
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Condition(s) being treated for:

_____

☐ My child does not get regular care from any provider

◊ Do you need help choosing a provider for your child?
☐ Yes ☐ No ☐ Don't know

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

_____

_____

_____

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

_____

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

Thank you for your time filling out this form.
CONFIDENTIAL

Adult Health Risk Assessment (HRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MPCCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

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

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

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

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

Pediatric Health Risk Assessment (PHRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MPCCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPC~~C~~CP2023 (previously MCCP2023)				**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: New Member Needs Assessment				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 08/16/2017			**Next Review Date: ~~02/12/2026~~01/14/2027** **Last Review Date: ~~02/12/2025~~01/14/2026**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: ~~02/12/2025~~01/14/2026**	

I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MPC~~C~~CP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Information Technology
C. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. Care Coordination (CC) Staff: Partnership's CC staff members have either experience in health care fields (e.g., Medical Assistant, Emergency Medical Technician, etc.) or are licensed and possess the appropriate skills and training to assist M~~m~~embers. All staff are trained in care coordination and motivational interviewing.
C. Health Information Form (HIF)/Member Evaluation Tool (MET): Screening tool sent to newly enrolled M~~m~~embers to identify M~~m~~embers needing expedited care.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult M~~m~~embers (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
~~D.~~E. 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.
F. Pediatric Health Risk Assessment (PHRA): An assessment form mailed to newly enrolled pediatric M~~m~~embers (under age 21) with corresponding Seniors and Persons with Disabilities (SPD) aid codes and/or California Children's Services (CCS) identifiers who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).

Policy/Procedure Number: MPCP2023 (previously MCCP2023)			Lead Department: Health Services Business Unit: Care Coordination
Policy/Procedure Title: New Member Needs Assessment			☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/16/2017			**Next Review Date: 01/14/2027~~02/12/2026~~** **Last Review Date: 01/14/2026~~02/12/2025~~**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

~~E.~~G. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.~~This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).~~

IV. ATTACHMENTS:

A. Health Information Form (HIF)/Member Evaluation Tool (MET)
B. Health Risk Assessment (HRA)
C. Pediatric HRA

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. New Member Outreach Process
   1. All newly enrolled M~~m~~embers designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment B) or PHRA (Attachment C) via mail within 10 calendar days of enrollment into the plan along with a postage-paid envelope for response. The HRA includes both questions from the HIF tool as well as additional questions appropriate for assessing the need for expedited services for high-risk M~~m~~embers. (See policy MPCP2019 for the full process of screening of Seniors and Persons with Disabilities and/or California Children's Services beneficiaries, and risk assignment process.)
   2. For more information on the assessment, outreach and case management activities for CCS M~~m~~embers, please see Partnership policy MCCP2024 Whole Child Model for California Children's Services.
   3. All newly enrolled M~~m~~embers who are designated with neither an SPD aid code nor a CCS identifier are sent the HIF/MET form (Attachment A) via mail within 10 days of enrollment into the plan along with a postage-paid envelope for response.
   4. Each new M~~m~~ember will also receive up to two telephone calls reminding them to review and return the assessment form. This telephonic outreach can be made to head of household for M~~m~~embers under the care of parents or other authorized representatives. At least two attempts will be made to contact the M~~m~~ember or their authorized representative within 45 days of enrollment.

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

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

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

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

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

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

X. REVISION DATES:
Medi-Cal
10/18/17; *11/14/18; 11/13/19; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 10/09/24; 02/12/25; 01/14/26

Partnership Advantage (Program effective January 1, 2027)
~~N/A~~01/14/26

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

PREVIOUSLY APPLIED TO: N/A

Health Information Form

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

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

If you have questions, please call Partnership at **(800) 863-4155** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the (yellow) envelope provided or mail to:

Q&A Research Inc
#357, 22052 W 66th Street
Shawnee KAS 66226-9905

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

Name of Partnership Member:_____

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

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

If yes, circle all that apply:

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

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

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

Signature:_____ Date: _____

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

CONFIDENTIAL

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

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

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

If you have questions, please call Partnership at **(800) 809-1350**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call **(800) 735-2929**.

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

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

Name of Partnership Member: _____

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

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

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

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

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

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

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

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

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

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

10. Are you pregnant? ☐Yes ☐No

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

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

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

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

15. Do you use home oxygen? ☐Yes ☐No

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

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

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

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

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

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

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

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

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

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

21. Can you live safely and move easily around your home?

	☐Yes	☐No	☐N/A
*If **no***, does the place where you live have: (Yes, No, or N/A to each individual item)			
Good lighting	☐Yes	☐No	☐N/A
Good heating	☐Yes	☐No	☐N/A
Good cooling	☐Yes	☐No	☐N/A
Rails for any stairs or ramps	☐Yes	☐No	☐N/A
Hot water	☐Yes	☐No	☐N/A
Indoor toilet	☐Yes	☐No	☐N/A
A door to the outside that locks	☐Yes	☐No	☐N/A
Stairs to get into your home or stairs inside your home			
	☐Yes	☐No	☐N/A
Elevator	☐Yes	☐No	☐N/A
Space to use a wheelchair	☐Yes	☐No	☐N/A
Clear ways to exit your home	☐Yes	☐No	☐N/A

22. I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medications?	☐Yes	☐No	☐N/A
Do you need help filling out health forms?	☐Yes	☐No	☐N/A
Do you need help answering questions during a doctor's visit?			
	☐Yes	☐No	☐N/A

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

- ☐ I don't think it is necessary to do what my doctor says all of the time
- ☐ I don't understand my medical needs
- ☐ I feel confident that I know how to take care of what I need

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

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

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

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

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

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

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

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

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

Signature of person filling out the form: _____

Date: _____

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

Thank you for your time filling out this form.
CONFIDENTIAL

Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

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

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

If you have questions, please call Partnership at **(800) 809-1350** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the green envelope

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

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

Name of Partnership CCS Member: _____

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

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

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

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

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐Yes	☐No	☐N/A
Taking a bath or shower (bathing)	☐Yes	☐No	☐N/A
Getting dressed (dressing)	☐Yes	☐No	☐N/A
Going to the toilet (toileting)	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident" (continence)	☐Yes	☐No	☐N/A
Being active, like:			
Walking (mobility)	☐Yes	☐No	☐N/A
Getting out of a bed or a chair (transferring)	☐Yes	☐No	☐N/A
Going up or down stairs	☐Yes	☐No	☐N/A
Showing independence by:			
Going out to visit family or friends	☐Yes	☐No	☐N/A
Going to school or work	☐Yes	☐No	☐N/A
Making doctor or dentist appointments	☐Yes	☐No	☐N/A
Using the phone, tablet, or computer	☐Yes	☐No	☐N/A
Other _____	☐Yes	☐No	☐N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐Yes ☐No ☐Not sure
   What is the name of the center where you go?_____

5. Does your child receive any of the following services? (Check all that apply)
   - ☐ Speech Therapy
     Where is this received? ☐Home ☐School ☐Medical Therapy Program (MTP) or Medical Therapy Unit (MTU)
     ☐Other _____
   - ☐ Physical Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other _____
   - ☐ Occupational Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other _____
   - ☐ Respiratory Therapy
     Where is this received? ☐Home ☐School
     ☐Other _____
   - ☐ Nursing Services
     Where is this received? ☐Home ☐School Hours/days per week? _____
     ☐Other _____
   - ☐ Mental or Behavioral Therapy
     Where is this received? ☐Home ☐School
     ☐Other _____
   - ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
     Which one(s)? ☐IEP ☐504
     ☐School Name_____
   - ☐ Other supportive services (Respite Care, Palliative Care, etc.)
     Please explain _____
     Where is this received? ☐Home ☐School
     ☐Other_____

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

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

8. Does your child use durable medical equipment (DME) or supplies that were ordered for your child's specific needs?

☐ Yes (check all that apply)

- ☐ Glasses
- ☐ Hearing Aids
- ☐ Cochlear Implant
- ☐ Wheelchair
- ☐ Brace
- ☐ Orthotics
- ☐ Walker
- ☐ Car Seat
- ☐ Bed
- ☐ Ventilator/breathing machine
- ☐ Oxygen
- ☐ Percussion Vest
- ☐ Insulin Pump/Continuous Glucose Monitor
- ☐ Intravenous pump/Infusion device
- ☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)
- ☐ Other (please specify) _____

Who ordered it? _____

Date of last order _____

Who was the vendor? _____

Vendor Phone: _____

9. What is your child's current:

Height _____ Weight _____

10. Has your child ever had surgery?

☐ Yes ☐ No ☐ Don't Know

Please list each surgery	**Date or Year**

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

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

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

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

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

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

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

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Muscular Dystrophy	☐	☐
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Ostomy/G Tube /Colostomy/Urostomy	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI)/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐

	Current	Past
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
        - ☐ Which condition(s) _____
    - ☐ No – my child already has provider(s) for all his/her needs
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
    - ☐ No – my child does not need a specialist for his/her condition
16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
        - ☐ Do not have one
    - ☐ Provider Name: _____
    - ☐ Provider Phone: _____
    - ☐ Last Appointment: Date: _____
    - ☐ Next Appointment: Date: _____

◊ Specialty Care Center
- ☐ N/A
- ☐ Facility Name: _____
- ☐ Facility Phone: _____
- ☐ Last Appointment: Date: _____
- ☐ Next Appointment: Date: _____

◊ Regular Dental Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date: _____

◊ Regular Vision Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date: _____

◊ Ongoing care from Mental or Behavioral Health Specialist
- ☐ N/A
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Condition(s) being treated for: _____

☐ My child does not get regular care from any provider

◊ Do you need help choosing a provider for your child?
☐ Yes ☐ No ☐ Don't know

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

_____

_____

_____

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

_____

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

Thank you for your time filling out this form.
CONFIDENTIAL

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE/ PROCEDURE

Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)			**Lead Department: Health Services** Business Unit: Quality Improvement		
Guideline/Procedure Title: Pediatric Preventive Health Guidelines			☒ **External Policy** ☐ **Internal Policy**		
Original Date: 04/25/1994		**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026			
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**		
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	☒ **PQC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**	
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**	
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**		
Approval Signature: *Robert Moore, MD MPH, MBA*			**Approval Date:** ~~01/08/2025~~01/14/2026		

I. RELATED POLICIES:

A. MCQP1021 - Initial Health Appointment
B. ~~MCUP3047~~ MPUP3047 – Tuberculosis Related Treatment
C. MC~~P~~QP1022 - Site Review Requirements and Guidelines
D. ~~MCCP2021~~ MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program
E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
F. MCCP2024 – Whole Child Model for California Children's Services (CCS)
G. ~~MCUP3101~~ MPBP8007 – Screening and Treatment for Substance Use Disorders
H. CMP-~~20~~ 30Records Retention and Access Requirements

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Adolescent: The American Academy of Pediatrics (AAP) defines adolescents as persons aged 11 up to 21 years of age.
B. Parent: For our purposes, a "parent" is the designated legal guardian for the pediatric member.
C. CHDP: The Child Health and Disability Prevention (CHDP) was a preventive program that delivered periodic health assessments and services to low income children and youth in California. CHDP provided care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. CHDP sunsetted July 1, 2024, consolidating care responsibilities for children/youth under the Medi-Cal managed care plans.
~~C.~~D. CDPH: New California Assembly Bill 144 establishes the California Department of Public Health as the source for immunizations and preventive services guidelines based on national medical organizations. The CDPH uses the Advisory Committee on Immunization Practices (ACIP) and the United States Preventive Services Task Force (USPSTF) recommendations as of Jan. 1, 2025 as its baseline and will issue updates as needed.

Guideline/Procedure Number: MCQG1015 (previously MPQG1015 & QG100115)			**Lead Department: Health Services** Business Unit: Quality Improvement
Guideline/Procedure Title: Pediatric Preventive Health Guidelines			☒ **External Policy** ☐ **Internal Policy**
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Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐**Partnership Advantage**

IV. ATTACHMENTS:

A. AAP Recommendations for Preventive Pediatric Health Care
B. TB Screening Recommendations (Flow Charts)
C. Blood Lead Testing Refusal Form
D. Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger

~~IV.~~V. PURPOSE:

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

~~V.~~VI. GUIDELINE / PROCEDURE:

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

B. Primary Care Providers (PCPs) must complete an Initial Health Appointment (IHA) on all new Members within 120 days of enrollment to Partnership or assignment to a PCP, or within 12 months prior to Plan enrollment. (See policy MCQP1021.) The IHA must include a history of the Member's physical and behavioral health, an identification of risks, an assessment of need for preventive screens or services, health education, and the diagnosis and plan for treatment of any diseases (~~Reference A~~See pp. 20-21, CalAIM Population Health Management Guide ~~(May 2024~~July 2025.)~~.~~ PCP office should request and review previous medical record(s) to show a complete history.

C. PCPs must provide immunizations~~ according to the *General Recommendations on Immunization: Recommendations of the* ACIP, AAP, the American Academy of Family Physicians (AAFP) and the~~.

~~Centers for Disease Control and Prevention (CDC).~~

1. Specific to DHCS All Plan Letter (APL) 24-008, providers must ensure timely provision of immunizations to Members ~~in accordance with the most recent schedule and recommendations published by ACIP~~, regardless of age, sex, or medical condition, including pregnancy. ~~[~~as clinically appropriate~~]~~. ~~This policy ensures coverage of all U.S. Food and Drug Administration (FDA) approved vaccines recommended by the ACIP and their administration, without cost sharing.~~
2. Vaccines for Children (VFC) is not mandatory if a provider site has less than 200 children assigned and refers out to appropriate facility. ~~following the ACIP recommended immunization schedule.~~ Referrals should be documented in the electronic health record (~~-~~EHR).
3. Providers must document each Member's need for ACIP recommended immunizations as part of all regular health visits. All provided immunizations must be reported within 14 calendar days to the California Immunization Registry (CAIR2).
4. When immunizations are provided at sites other than the PCP's office, that provider should enter the immunizations into CAIR2, according to the provisions of AB1797.

D. Screening for alcohol or drug or tobacco use and/or substance use disorders is considered part of the standard of primary care of Members aged 11 up to age 21. APL 21-014 stipulates that, consistent with United States Preventive Services Task Force (USPSTF) Grade A or B recommendations, AAP/Bright Futures, and the Medi-Cal Provider Manual, MCPs are required to provide SABIRT (Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment) for all Members aged 11 and older. PCPs must screen via validated screening tools. For more details, see MPBP8007~~MCUP3101~~ - Screening and Treatment for Substance Use Disorders.

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

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

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

H. Monitoring and Quality Management
   1. Timeliness and appropriateness of pediatric preventive health will be monitored annually by Healthcare Effectiveness Data and Information Set (HEDIS®) measures (including but not limited to Childhood Immunization, Adolescent Immunization, Well Child Visits in the third, fourth, fifth and sixth years of life, Adolescent Well Care Visits and Well Child Visits in the First 15 months.
   2. Partnership's Site Review team will periodically review PCPs' documentation of pediatric preventive services. (See MC~~P~~QP1022.)

I. Developmental Screening
   1. Before age 3, comprehensive developmental screening must be performed at least annually in accordance with the APP/Bright Futures periodicity schedule, using one of the standardized instruments listed below.
      a. Ages and Stages Questionnaire (ASQ) - 2 months to age 5
      b. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
      c. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
      d. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2

e. Brigance Screens-II - Birth to 90 months
f. Child Development Inventory (CDI) - 18 months to age 6
g. Infant Development Inventory - Birth to 18 months
h. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
i. Parents' Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
j. Or a standardized tool that follows CMS criteria per APL 23-016:
   1) Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional.
   2) Established Reliability: Reliability scores of approximately 0.70 or above.
   3) Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).

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

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

J. Trauma Screening – Adverse Childhood Experiences (ACEs) APL 23-017
1. PCPs may screen children annually up to age 19 for traumatic life events using the Pediatric ACEs and Related Life-events Screener (PEARLS), which includes screening for several social determinants of health.
   a. Coding results of screening will depend on the result of the screening. Codes will not be reported for non-qualifying ACE screening services or other services. Providers must calculate the Member's ACE screening score using the questions on the 10 original categories of ACE.

1) G9919: Screening performed and positive and provisions of recommendations (4 and greater)
2) G9920: Screening performed and negative (0 to 3)

2. DHCS develops recommendations for stratifying the risk, based on the screening, and tailoring interventions to this risk stratification. These recommendations are based on consensus of experts and have not yet been studied systematically. DHCS maintains provider resources for administering trauma screenings and provision of trauma informed care. More information is available on the DHCS website. See also ACESaware.org.
3. Providers must document the following in the Member's medical record and be available upon request by the Member and/or Member's parent in compliance with all relevant state and federal privacy requirements:
   - The tool that was used.
   - The completed screen was reviewed.
   - Results of the screen.
   - The interpretation of results.
   - What was discussed with the Member and/or parent.
   - Any appropriate actions that were taken.
   - (References: APL 23-017, Page 7-8)
4. Provider attestation of completion of DHCS-approved training (accessible through the ACESaware.org website) by individual clinicians performing the screening is required for payment for billing of trauma screening services.
5 Auditing: Use of an approved ACE Screening Tool will be audited Partnership through the site review process.

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

b. Partnership will train providers and laboratories as appropriate, regarding Partnership testing requirements and related claims procedures. This includes use of correct billing codes, claims forms, and reporting to Partnership and to the CLPPB as required.

5. Record Retention and Reporting
   a. Data, documentation, and information related to the processes described under this policy shall be maintained in compliance with Partnership policy CMP-30.
6. Claims and Validation
   a. Claims shall be submitted to Partnership using appropriate and current claims forms/format (CMS-1500/UB-04 claim forms, or their electronic equivalents (837-P/837-I)).
   b. Consistent with DHCS APLs 14-019 and 17-005 and the current DHCS Companion Guide for X12 Standard File Format, capitated encounters shall be validated, by Partnership, for completeness, accuracy, reasonableness, and timeliness when making payment and/or submission to DHCS.

VII. REFERENCES:

A. Department of Managed Health Care All Plan Letter (APL) 25-015 Assembly Bill 144 and Coverage of Preventive Care Services (Sept. 18, 2025)

~~A.~~B. CalAIM Population Health Management Policy Guide, (~~May 2024~~July 2025)

~~B.~~C. American Academy of Pediatrics (AAP)Recommendations for Preventive Pediatric Health Care Bright Futures/AAP (~~updated June 2024~~published February 2025)

~~C.~~D. AAP. Bright Futures Guidelines and Pocket Guide, 4th Edition. (April 26, 2022)

~~D.~~E. United State Preventive Services Task Force (USPSTF) A & B Recommendations

E. Centers for Disease Control and Prevention (CDC). 2024 Immunization Schedules (Aug. 9, 2024)

F. American Academy of Family Physicians (AAFP) Birth through Age 18 Immunization Schedule (June 27, 2024)

G. Advisory Committee on Immunization Practices (ACIP) Child and Adolescent Immunization Schedule by Age (June 27, 2024)

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

I. AAP publications on Health Supervision for Children with (disease/genetic condition) https://www.aappublications.org/search/policy/%20subject_collection_code%3A100 (Search should be done under the Policy tab)

J. DHCS APL 23-017 Directed Payments for Adverse Childhood Experiences Screening Services (June 13, 2023 supersedes APL 19-018)

K. DHCS APL 23-016 Directed Payments for Developmental Screening Services (June 9, 2023 supersedes APL 19-016)

L. DHCS APL 22-030 Initial Health Appointment (Dec. 27, 2022 supersedes APL 13-017)

M. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)

N. DHCS APL 20-016 *Revised:* Blood Lead Screening of Young Children (Nov. 2, 2020 supersedes APL 18-017)

O. DHCS APL 17-005 Reminder Regarding Requirement to Submit Specialty Referrals Report (July 28, 2017)

P. DHCS APL 14-019 Encounter Data Submission Requirements (Dec. 19, 2014 supersedes APL 13-006)

Q. DHCS Child Health and Disability Prevention Program (CHDP) Transition Plan (March 2024)

R. Title 17 CCR section 37100

S. California Assembly Bill 1797 Immunization Registry (March 27, 2022)

T. CHDP Provider Notice 23-04 Child Health and Disability Prevention Program Activities in Fiscal Year 2023-2024 (Dec. 13, 2023)

VII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

IX: REVISION DATES:

Medi-Cal
10/13/95; 10/10/97 (name change only); 03/11/98; 5/17/00; 02/20/02; 10/30/02 vs. 10/16/02; 10/20/04; 04/20/05; 10/19/05; 06/21/06; 09/19/07; 03/18/09; 02/17/10; 03/16/11; 10/17/12; 10/16/13; 11/19/14; 11/18/15; 10/19/16; 09/20/17; *06/13/18; 06/12/19; 02/12/20; 02/10/21; 05/12/21; 02/09/22; 03/08/23; 06/12/24; 01/08/25; 01/14/26

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

PREVIOUSLY APPLIED TO:

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

****

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

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

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

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

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

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

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

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

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

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

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

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

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

(continued)

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

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(continued)

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

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

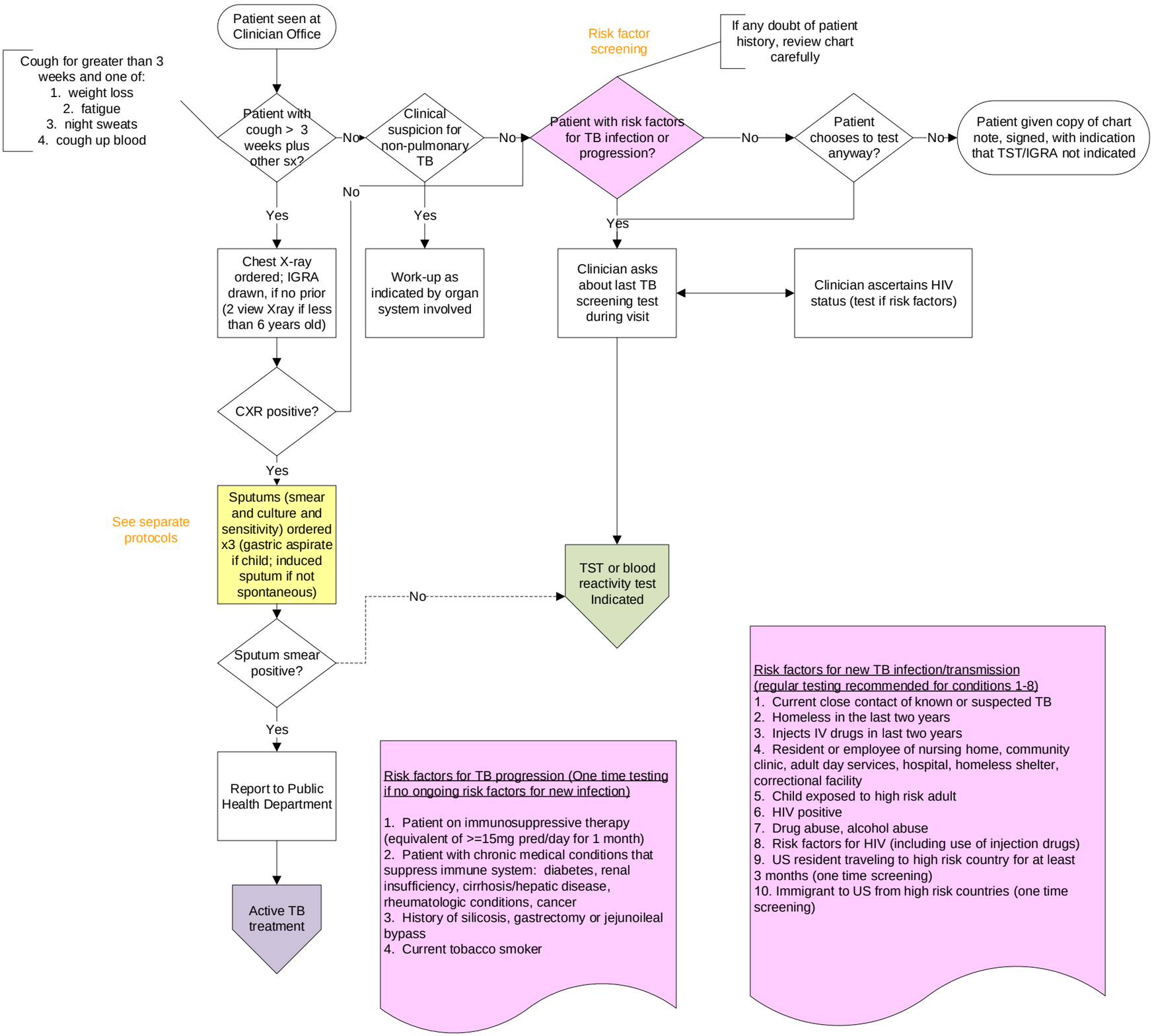
This schedule reflects recommendations approved in December 2024 and published in February 2025. For updates and a list of previous changes made, visit www.aap.org/periodicityschedule.

RECOMMENDATIONS APPROVED IN DECEMBER 2024

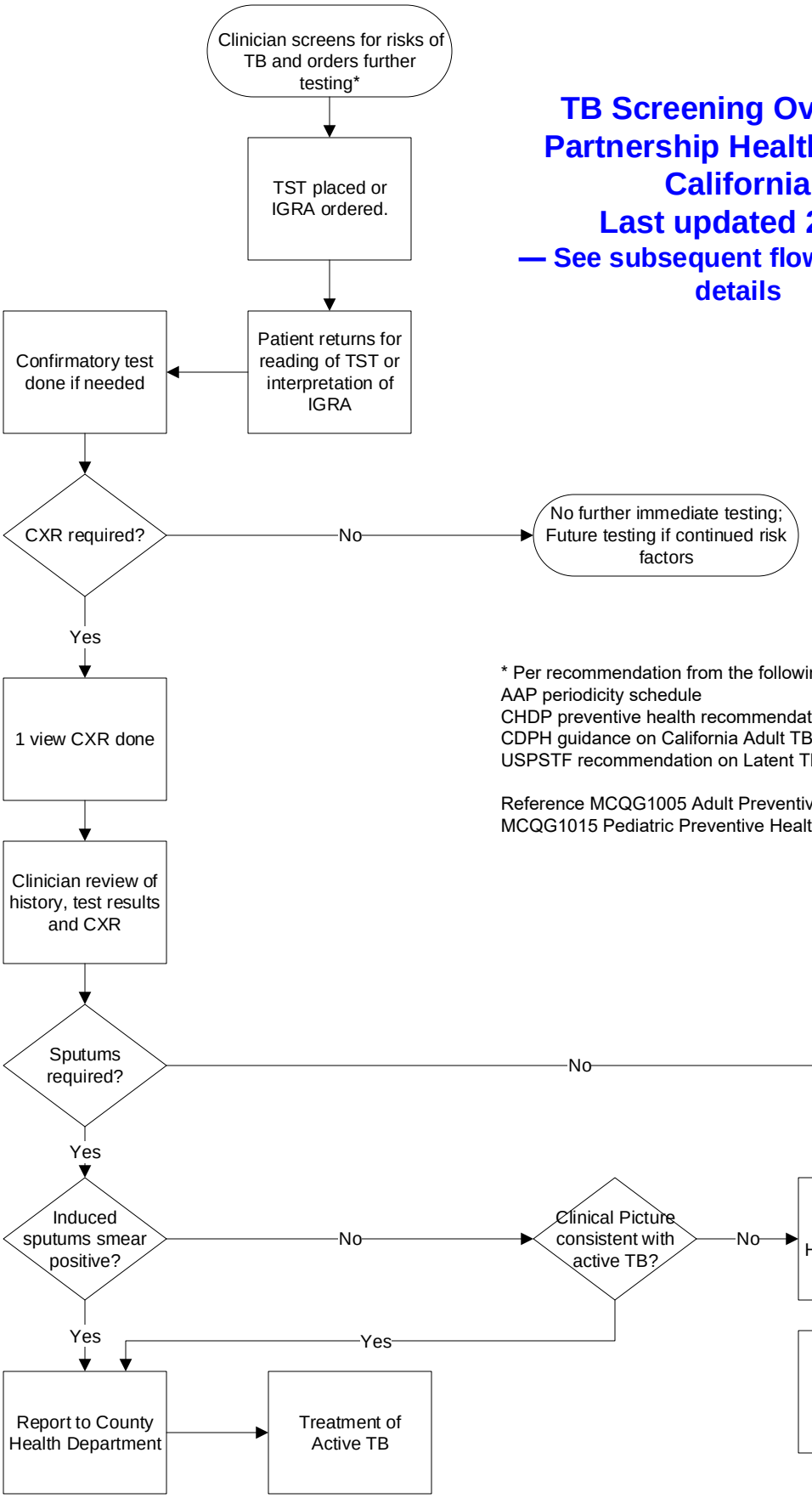
No changes have been made to clinical guidance or footnotes in the recommendations published in 2025.

HRSA
Health Resources & Services Administration
This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,566,000 with 0% financed with non-governmental sources. The contents of this document are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government.
For more information, please visit HRSA.gov.

TB Screening Guidelines
Partnership HealthPlan of California
Last updated:2025



TB Screening Overview
Partnership HealthPlan of California
Last updated 2024
— See subsequent flow charts for details



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

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

Blood Lead Testing Refusal

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

Patient Medical Record Number: _____

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

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

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

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

Reason(s):

Parent/Guardian Signature: Date:

Clinic Use Only

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

Provider / clinic signature / stamp:

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

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

UNITED STATES 2024

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

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

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

How to use the child and adolescent immunization schedule

1. Determine recommended vaccine by age **(Table 1)**
2. Determine recommended interval for catch-up vaccination **(Table 2)**
3. Assess need for additional recommended vaccines by medical condition or other indication **(Table 3)**
4. Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**
5. Review contraindications and precautions for vaccine types **(Appendix)**
6. Review new or updated ACIP guidance **(Addendum)**

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

Report

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

Questions or comments

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

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

Helpful information

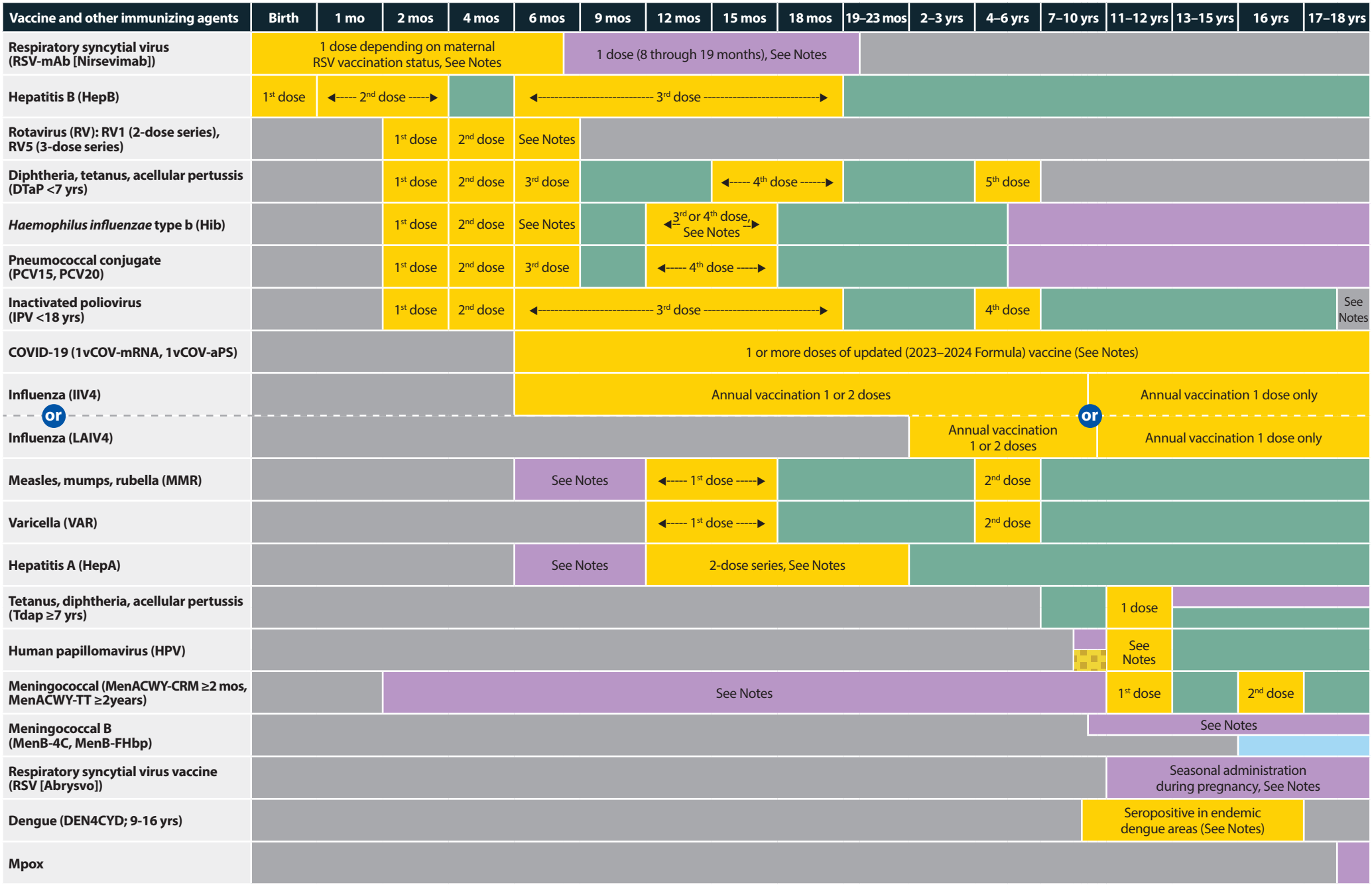
- Complete Advisory Committee on Immunization Practices (ACIP) recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- ACIP Shared Clinical Decision-Making Recommendations: www.cdc.gov/vaccines/acip/acip-scdm-faqs.html
- *General Best Practice Guidelines for Immunization* (including contraindications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

Scan QR code for access to online schedule

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

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

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



Range of recommended ages for all children

Range of recommended ages for catch-up vaccination

Range of recommended ages for certain high-risk groups

Recommended vaccination can begin in this age group

Recommended vaccination based on shared clinical decision-making

No recommendation/ not applicable

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1021 (previously QP100121)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Initial Health Appointment			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/18/2000		**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026		
Applies to:	☐~~☒~~ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~01/08/2025~~01/14/2026	

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. ~~MPQG1015~~ MCQG1015 – Pediatric Preventive Health Guidelines
C. ~~MCUP3101~~ MPBP8007 – Screening and Treatment for Substance Use Disorders
D. MCUG3118 – Prenatal and Perinatal Care
E. MC~~P~~QP1022 – Site Review Requirements and Guidelines
F. CMP36 – Delegation Oversight and Monitoring
G. MP~~C~~UP3039 – Direct Members
H. ~~MCCP2021~~ MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. PCP New Member Letter MC
B. IHA Applicable Visit Codes

C. Two- Attempt Outreach Tracker Template

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. To meet the Department of Health Care Services (DHCS) contractual requirements, an IHA is to be performed:
   1. Within 120 calendar days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 120 calendar days of a member's assignment to a PCP (whichever is most recent).
      a. Refer to Medi-Cal Managed Care Division policy letter APL 22-030 (Dec. 27, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003).
      b. Exceptions to this requirement are specified in Section E of this policy.

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

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

D. Preventive Services
   1. The IHA must bring members up to date with all currently recommended preventive services, including immunizations, or arrange to have the member brought up-to-date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.
   2. The IHA shall follow the United States Preventive Services Task Force (USPSTF) / Advisory Committee on Immunization Practices (ACIP) immunization protocols as set forth in DHCS' APL 24-008.
      a. If the Medi-Cal provider manual outlines less restrictive criteria than ACIP, immunizations are provided according to the less restrictive guidelines.
   3. For members under the age of 21 years, the IHA shall follow these requirements:
      a. The IHA shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et seq., and Title 17, CCR, Sections 6l842 through l6852, except that the PCP shall follow the most recent periodicity schedule (*aka* Bright Futures Recommendations for Periodic Preventive Health Care) recommended by the American Academy of Pediatrics (AAP) as noted in

Reference D of this document and in MCQG1015, the Pediatric Preventative Health Guidelines.

1) All active California Child Health and Disability Prevention Progran (CHDP) providers as of June 30, 2024 were automatically enrolled as CPE (Children's Presumptive Eligibility Program) providers on July 1, 2024.

b. For asymptomatic members 21 years and older, the IHA shall follow these guidelines:

1) The IHA shall include a history and physical examination sufficient to assess and manage the acute, chronic, behavioral, and preventive health needs of the member.

2) The PCP shall provide the core set of preventive services for adult screening of asymptomatic health members over the age of 21years consistent with MPQG1005, Adult Preventive Health Guidelines and the Guide to Clinical Preventive Services of the ~~U.S. Preventive Services Task Force (~~USPSTF~~)~~.

4. Perinatal Services

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

b. Pregnant and breastfeeding members must be referred to the Women, Infants, and Children (WIC) program. Infant feeding plans should be documented during the prenatal period, and infant/breastfeeding status is documented during the postpartum period. See MPNP9008 ~~MCCP2021~~ – Women, Infants and Children (WIC) Supplemental Food Program.

5. Members with Chronic and/or Complex Conditions

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

E. Excluded Members

1. Individual members may be excluded from the IHA requirement under the following circumstances:

a. The medical records contain documentation of prior health assessments within the 12 months prior to enrollment, and which the member's primary care services provider determines meets the requirements for documentation of the IHA.

b. Members who are not continuously enrolled in Partnership for 120 calendar days.

c. Members, including emancipated minors, or a member's parent(s) or guardian, who refuses an IHA. A declination should be documented in the member's medical record.

d. Members with certain restricted aid codes, except pregnancy, which limit the services to which members are entitled, or to members who are share-of-cost (SOC) Medi-Cal beneficiaries are exempted from the IHA.

e. The member was dis-enrolled from the plan before an IHA could be performed.

f. The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation

must include at least two attempts to outreach to the member.

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

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

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

I. Direct Members: ~~-~~Since Direct Members are not generally assigned to a PCP, providers primarily responsible for their care should perform the IHA per the requirements outlined in this policy. For more information on Direct Members, see MP~~C~~UP3039 – Direct Members.

~~J. Delegation of IHA monitoring functions~~
   ~~1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at Partnership discretion, to perform IHA monitoring functions as part of the Site Review Process. An organization or groups will perform these functions under a formal delegation agreement.~~
   ~~2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.~~
   ~~3. Delegated entities will perform IHA monitoring functions for all Primary Care Physician (PCP) sites no less than every three years.~~
   ~~4. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.~~
   ~~5. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight~~

~~Review Sub-Committee (DORS) for review and approval.~~

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-008 Immunization Requirements (June 21, 2024) supersedes APL 18-004
B. DHCS APL 22-030 Initial Health Appointment (Dec. 27, 2022 supersedes APL 13-017 and Policy Letters 13-001 and 08-003)
C. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021)
D. American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (~~June 2024~~February 2025)
E. DHCS APL 23-005 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21 (March 16, 2023 supersedes 19-010)
F. DHCS CHDP Provider Notice 22-06 Child Health and Disability Prevention Program Discontinuance (Oct. 21, 2022)
G. DHCS CHDP Transition Plan (March 2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 05/15/02; 04/20/05; 06/21/06; 06/20/07; 07/16/08; 10/21/09 11/17/10; 10/16/13; 02/19/14; 02/17/16; 02/15/17; *03/14/18; 06/13/18; 06/12/19; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 03/13/24; 06/12/24; 01/08/25; 01/14/26

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

PREVIOUSLY APPLIED TO:
N/A

To: Primary Care Providers

From: Partnership HealthPlan of California
Provider Relations Department

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

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

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

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

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

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

Thank you.

www.partnershiphp.org

SAMPLE WELCOME LETTER MEDI-CAL

Dear Partnership HealthPlan Member,

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

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

Let's work together for your health.

Sincerely,

Estimado miembro del Partnership HealthPlan:

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

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

Vamos a colaborar juntos para mantenerlo sano.

Atentamente,

ОБРАЗЕЦ ПРИВЕТСТВЕННОГО ПИСЬМА MEDI-CAL

Уважаемый участник плана Partnership HealthPlan,

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

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

Вместе мы сможем позаботиться о вашем здоровье.

С уважением,

HALIMBAWA NG WELCOME LETTER SA MEDI-CAL

Minamahal na Miyembro ng Partnership HealthPlan,

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

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

Magtulungan tayo para sa inyong kalusugan.

Taos-pusong sumasainyo,

INITIAL HEALTH APPOINTMENT (IHA)

MCQP1021- Attachment B rev. 01/14/2608/25

BILLING CODES

New Patient Age	CPT Code
0-12 Months	99381
1-4 Years	99382
5-11 Years	99383
12-17 Years	99384
18+ Preventative Visit	99385
18-64 Office Visit	99386
65+ Office Visit	99387
Tribal Health Visit	0520
Any Age During Pregnancy	59400, 59510, 59610, 59618

New Patient Visit Location	Visit Duration	CPT Code
Office Visit	15-29 Minutes	99202
Office Visit	30-44 Minutes	99203
Office Visit	45-59 Minutes	99204
Office Visit	60-74 Minutes	99205
Home Visit	30 Minutes	99342
Home Visit	60 Minutes	99344
Home Visit	75 Minutes	99345
SNF Visit	25 Minutes	99304
SNF Visit	35 Minutes	99305
SNF Visit	45 Minutes	99306

Established Patient Age	CPT Code
0-12 Months	99391
1-4 Years	99392
5-11 Years	99393
12-17 Years	99394
18+ Preventative Visit	99395
18-64 Office Visit	99396
65+ Office Visit	99397
Tribal Health Visit	0520

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

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

EDUCATIONAL RESOURCE

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

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

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

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

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

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

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

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

- A history of the Member's physical and mental health;
- An identification of risks;

~~Other administrative examinations~~	~~Z02.89~~

Screenings	CPT Code
Developmental Screening	96110
Health Risk Assessment	96160
Cognitive Health Assessment	99483

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

- An assessment of need for preventive screens or services;
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- A Member Risk Assessment

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Exam for insurance purposes	Z02.6
Pregnancy	Z1032
Other administrative examinations	Z02.89
ACEs High Risk	G9919
ACEs Low Risk	G9920
SDOH Risk Assessment	G0136

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

INITIAL HEALTH APPOINTMENT (IHA)

MCQP1021- Attachment B rev. 01/14/26

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Other administrative examinations	Z02.89
ACEs High Risk	G9919
ACEs Low Risk	G9920
SDOH Risk Assessment	G0136

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQG1011</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/31/1994</td><td colspan="4">Next Review Date: ~~01/08/2026~~01/14/2027
Last Review Date: ~~01/08/2025~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☐ IQI</td><td>☐ P & T</td><td colspan="2">☐ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MC~~P~~QP1022 – Site Review Requirements and Guidelines

B. MPCR301 – Non-Physician Medical Practitioner Credentialing Criteria & Non-Physician Medical Practitioner Re-Credentialing Criteria

II. IMPACTED DEPTS.:

A. Health Services

B. ~~Provider Relations~~Network Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP) are defined as nurse practitioners, physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM).

B. Nurse Practitioner (NP), by definition, shall be currently licensed as a registered nurse in California and be currently certified by a licensed Nurse Practitioner Program, which has met the requirements set forth and described in Title 16, Section H84 of the California Administrative Code.

C. Physician Assistant (PA) shall be currently licensed by the Physician Assistant Examining Committee/Medical Board of California.

D. Midwifery practice is the independent, comprehensive management of birthing individuals' health care in a variety of settings focusing particularly on pregnancy, childbirth, and the postpartum period.

1. A Certified Nurse Midwife (CNM) is licensed by the California Board of Registered Nursing. CNMs are registered nurses who acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives (ACNM).
2. A Licensed Midwife (LM) in an individual issued a license to practice midwifery by the Medical Board of California to attend cases of normal pregnancy and childbirth, and to provide prenatal, intrapartum and postpartum care, including family-planning care and immediate care (first 6 weeks) for the newborn.

E. Medical Assistants (MAs) are unlicensed persons who have received certificates indicating satisfactory completion of training requirements specified in Chapter 13, Title 16 of the California Code of Regulations.

F. "Protocols" refers to protocols that meet the requirements of the Physician Assistant Practice Act and Regulations of the Physician Assistant Examining Committee for Physician Assistants and standardized procedures for Nurse Practitioners and Certified Nurse Midwives.

IV. ATTACHMENTS:

A. Sample Non-Physician Medical Practitioners Agreement

Policy/Procedure Number: MPQG1011			Lead Department: Health Services
Policy/Procedure Title: Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines			☒External Policy ☐Internal Policy
Original Date: 10/31/1994			Next Review Date: ~~01/08/2026~~1/14/2027 Last Review Date: ~~01/08/2026~~1/14/2026
Applies to:	☐Employees	☒Medi-Cal	☐Partnership Advantage

V. PURPOSE:

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

VI. GUIDELINE / PROCEDURE:

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

B. Supervision:

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

C. Scope of Practice:

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

required by protocols, which references, or parts thereof, are to be used by the NPMP.

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

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

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

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

conflict with the aspect of care under the physician's management. Thus, collaborative management requires careful communication between the midwife and the physician, who assumes responsibility for overall provision of the patient's care.

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

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

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

physician, unless they meet specific requirements as outlined below:~~.~~

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

2. When authorized to do so by the supervising physician, the ~~nurse practitioner~~NP may perform the patient-related activities within the scope of practice defined by Title 16 and applicable Federal and State laws.
3. The ~~nurse practitioner~~NP may provide medical care which is either based upon direct consultation with the physician or contained within written medical policies and procedures (e.g., protocols) adapted by the supervising physician. The policies and procedures must be reviewed and approved by the supervising physician.
4. The ~~nurse practitioner~~NP will seek physician consultation as soon as possible for the following situations, and any others perceived as appropriate:
    a. Any conditions which have failed to respond to appropriate management or any unusual symptom
    b. Unexplained physical finding
    c. Potentially serious or life threatening condition where prompt initiation of appropriate care has a substantial impact on outcome
    d. All emergencies after initial patient stabilization.
    e. Any patient who desires physician consultation
    f. Before performing any invasive procedures, other than those outlined and agreed upon in established protocols.
5. The supervising physician shall be a physician licensed by the State of California.
    a. The Nursing Practice Act (NPA) does not require physician countersignature of nurse practitioner charts. However, other statutes or regulations, such as those for third party reimbursement, may require the physician countersignature. Additionally, some malpractice insurance carriers require physicians to sign NP charts as a condition of participation. Standardized procedures may require physicians to countersign charts.
    b. The ~~nurse practitioner~~NP will be responsible to communicate with the supervising physician regarding patient management and seek assistance or additional instructions in patient management as deemed necessary by the nurse practitioner including in unusual or non-routine cases.
    c. The supervising physician will be available for consultation or assistance at all times, either by physical presence or by electronic communications.
    d. A supervising physician shall not supervise more than four ~~nurse practitioners~~NPs with furnishing licenses at any one time. There is no limit to the number of supervised ~~nurse~~

~~practitioners~~NPs without furnishing licenses.

~~6.~~

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

I. Medical Assistant Guidelines:

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

examinations or procedures including positioning, draping, shaving and disinfecting treatment sites.

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

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

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

VII. REFERENCES:

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

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

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

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

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

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

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

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
10/14/95; 05/17/00; 08/15/01; 09/18/02; 10/20/04; 04/20/05; 04/19/06; 06/20/07; 07/16/08; 07/15/09; 09/15/10; 01/16/13; 01/15/14; 01/21/15; 08/17/16; 08/16/17; *08/08/18; 09/11/19; 10/14/20; 10/13/21; 10/12/22; 01/10/24; 01/08/25; 1/14/26

Partnership Advantage (eff. Jan. 1, 2027)
1/14/26

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

PREVIOUSLY APPLIED TO:

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

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

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

(S A M P L E)
Non-Physician Medical Practitioners Agreement

The following is an agreement between _____ and
(Clinician Name)
_____.
(Supervisory MD or Medical Director)

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

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

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

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

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

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

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

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

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

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3051 (previously MCUP3051, UP100351)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Long Term Care SSI Regulation (previously Long Term Care Admissions)			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 01/17/2001		**Next Review Date:** ~~05/14/2026~~N/A **Last Review Date:** 05/14/2025		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			~~**Approval**~~ **Archive Date:** ~~05/14/2025~~01/14/2026	

ARCHIVED 01/14/2026 - Refer to MCUG3038

I. RELATED POLICIES:
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities

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

III. DEFINITIONS:
A. LTSS: Long-Term Services and Supports
B. SSI: Supplemental Security Income
C. SSA: Social Security Administration
D. MC171 Form: Medi-Cal Long Term Care Facility Admission and Discharge Notification form

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To ensure that Long Term Care (LTC) facilities notify the Social Security Administration (SSA) and Partnership Health Plan of California of an admission to the LTC facility of a Partnership member with Supplemental Security Income (SSI).

VI. POLICY / PROCEDURE:
A. Notification to Social Security Administration
1. For Partnership members with SSI, the LTC facility is required to submit the MC171 form to the SSA within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
2. Partnership's Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form with all LTC Treatment Authorization Requests (TARs) as required per policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities.
   a. If a facility does not submit the MC171 form, the TAR is denied for "information requested not received" and the facility is notified.

VII. REFERENCES:
Medi-Cal Provider Manual/ Guidelines: Admissions and Discharges (*admis*)

Policy/Procedure Number: MPUP3051 (previously MCUP3051, UP100351)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Long Term Care SSI Regulation (previously Long Term Care Admissions)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/17/2001		**Next Review Date: 05/14/2026N/A** **Last Review Date: 05/14/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

X. REVISION DATES:
Partnership Advantage (Program effective January 1, 2027)
05/14/25; ARCHIVED 01/14/2026

Medi-Cal
02/20/02; 08/20/03; 02/08/05; 10/15/08; 11/18/09; 01/18/12; 01/20/16; 10/19/16; 10/18/17; *02/13/19; 03/11/20; 03/10/21; 05/11/22; 05/10/23; 05/08/24; 05/14/25; ARCHIVED 01/14/2026

*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.

ARCHIVED 01/14/2026 - Refer to MCUG3038

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3058 (previously UG100358)			**Lead Department:** Health Services **Business Unit**: Utilization Management	
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/19/2003		**Next Review Date:** ~~11/13/2025~~01/14/2027 **Last Review Date:** ~~11/13/2024~~01/14/2026		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIAL~~S~~ING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~11/13/2024~~01/14/2026	

I. RELATED POLICIES:

A. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, ~~(LTC)~~Subacute or Skilled) Facilities
B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
C. ~~MCCP2016~~ MPTP2501 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. BH: Bed Hold
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. 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.
D. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled. The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system.
E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
F. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
G. Form HS 231: State of California Department of Health Care Services form entitled "Certification for Special Treatment Program Services"
H. LOA: Leave of Absence
I. Managed Care Plan (MCP): Partnership HealthPlan of California 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.

IV. ATTACHMENTS:

A. Bed hold/TAR Process
~~A.~~B. Bed hold Form

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 11/13/202501/14/2027** **Last Review Date: 11/13/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in an ICF/DD for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. As a Managed Care Plan (MCP), Partnership provides all medically necessary covered services for Members residing in or obtaining care in an ICF/DD facility/home, including home services, professional services, ancillary services, and transportation services. Partnership also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 24-011~~23-023 Revised~~ and in adherence to DHCS contract requirements and the DHCS Population Health Management (PHM) Policy Guide.

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

1. Federal regulations require California to provide a program of independent professional review of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD-N) that provide services to Medi-Cal recipients. This process is referred to as utilization review. Its purpose is to control unnecessary utilization of services by evaluating patient needs and the appropriateness, quality and timeliness of service delivery.
2. Patient Placement Requirements
   a. Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures "as needed" are not appropriate for ICF/DD-H and ICF/DD-N placement.
   b. Please refer to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care (LTC) Facilities

~~3. Federal Requirements for monitoring utilization and quality of care include:~~
~~a. A review of the recipient's plan of care every 90 calendar days by the facility's interdisciplinary team.~~
~~b. A comprehensive medical and social evaluation of the recipient within 12 months prior to admission~~
~~c. A requirement that the recipient be seen by the attending physician at least every 60 calendar days.~~

~~4.~~3. Per Diem Services
   a. Services covered under the daily rate of an ICF/DD, ICF/DD-H and ICF/DD-N include:
      1) Services of the direct care staff
      2) Services of the facility's interdisciplinary team
      3) Services of qualified intellectual disabilities professional
      4) Case conference reviews
      5) Development of service plans
      6) In-service training of direct care staff and consultation on individual recipient needs
      7) Transportation services (see policy MPTP2501~~MCCP2016~~ - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
      8) Equipment and supplies necessary to provide appropriate care
      9) Room and Board

~~5.~~4. ICF/DD-H/DD-N TAR Submission

a. Submitting with a Treatment Authorization Request (TAR):
   1) Completed new TAR form 20-1
   ~~1)~~2) Submit form HS 231 with initial and reauthorization TARs within 15 business days from date of service.
b. Certification Period:
   1) For the ICF/DD-H or ICF/DD-N level of care, form HS 231 must be certified by the Regional Center director or designee.
   2) Certification may be granted for a period of twelve months at a time.
   3) The Regional Center director or designee assesses new patients within a reasonable amount of time.
   4) When the certified period expires, the Member must be re-assessed and a new form HS 231 must be filled out and signed by the Regional Center director or designee.

~~6.~~5. Readmission and New Certification:
a. ICF/DD-H or ICF/DD-N Member who is discharged and subsequently readmitted must be re-assessed. A new form HS 231 must be filled out and submitted with a new TAR.

C. Leave of Absence
1. Leave of Absence Qualifications
   a. A leave of absence (LOA) may be granted to a recipient in an ICF/DD-N or ICF/DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined below:
      1) A visit with relatives or friends
      2) Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons
2. Leave of Absence Maximum Time Period
   a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
      1) Developmentally disabled recipients can receive a leave of absence for relatives/friend visits or summer camp for up to seventy-three (73) days per calendar year.
         a) A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.
      3) These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the patient's bed (bed hold) as described below.

D. Bed Hold (BH) Qualifications
1. Partnership covers the stay when a recipient residing in a ICF/DD facility/ home is admitted to an acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then requires a return to an ICF/DD Home. Providers must bill bed hold (BH) days (see Attachment B). Reimbursement for bed hold days is limited to a maximum of seven days per hospitalization, subject to the following:
   a. The attending physician must order the acute hospitalization.
   b. The ICF/DD facility/home must hold a bed vacant when requested during the entire hold period, maximum of 7 days for each bed hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
2. General Leave of Absence and Bed Hold Requirements
   a. General requirements for LOA and BH are outlined below:
      1) Day of departure is counted as one day of LOA/BH, and the day of return is counted as one day of inpatient care.
      2) Facility holds the bed vacant during LOA/BH

3) LOA or BH (hospitalization) is ordered by a licensed physician
4) Recipient's return from LOA/BH must not be followed by discharge within 24 hours
5) LOA/BH must terminate on a recipient's day of death
6) Facility claims must identify the inclusive dates of leave

3. Additional Leave of Absence Requirements
   a. Requirements specific to LOA are listed below:
      1) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H, or ICF/DD-N.
      2) Re-admission TAR's are not necessary for recipients returning from a leave of absence if a valid TAR covering the return date exists.
      3) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
      4) Recipient's records maintained in an ICF/DD, ICF/DD-H, or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
   b. Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
   c. At the time of admission, if a recipient has not been an inpatient in any custodial/~~-~~long term care ~~(LTC)~~ facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations.
4. Patient Failure to Return from Leave of Absence
   a. If recipients have used their total leave days, they may still be allowed a leave of absence during the same calendar year. However, the facility will not receive reimbursement for those authorized leave days.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Sections 483.400 – 483.480
B. Title 22 California Code of Regulations (CCR) Section 51535
C. California Department of Developmental Services (DDS) Guidelines
D. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities *(util review)*; Leave of Absence, Bed Hold, and Room and Board *(leave)*; TAR for Long Term Care: 20-1 Form *(tar ltc)*
E. Lanterman Developmental Disabilities Services Act
F. DHCS APL ~~23-023 *Revised*~~24-011 Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care ~~(11/28/2023)~~(09/16/2024)
G. DHCS Population Health Management Guide
~~G.~~H. DHCS form HS 231 Certification for Special Treatment Program Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 10/20/04; 10/19/05, 08/20/08; 11/18/09; 01/18/12; 02/18/15; 03/16/16; 03/15/17; *06/13/18; 09/12/18; 09/11/19; 08/12/20; 08/11/21; 08/10/22; 09/13/23; 10/09/24; 11/13/24; 01/14/26

*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.

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 11/13/202501/14/2027** **Last Review Date: 11/13/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO: N/A

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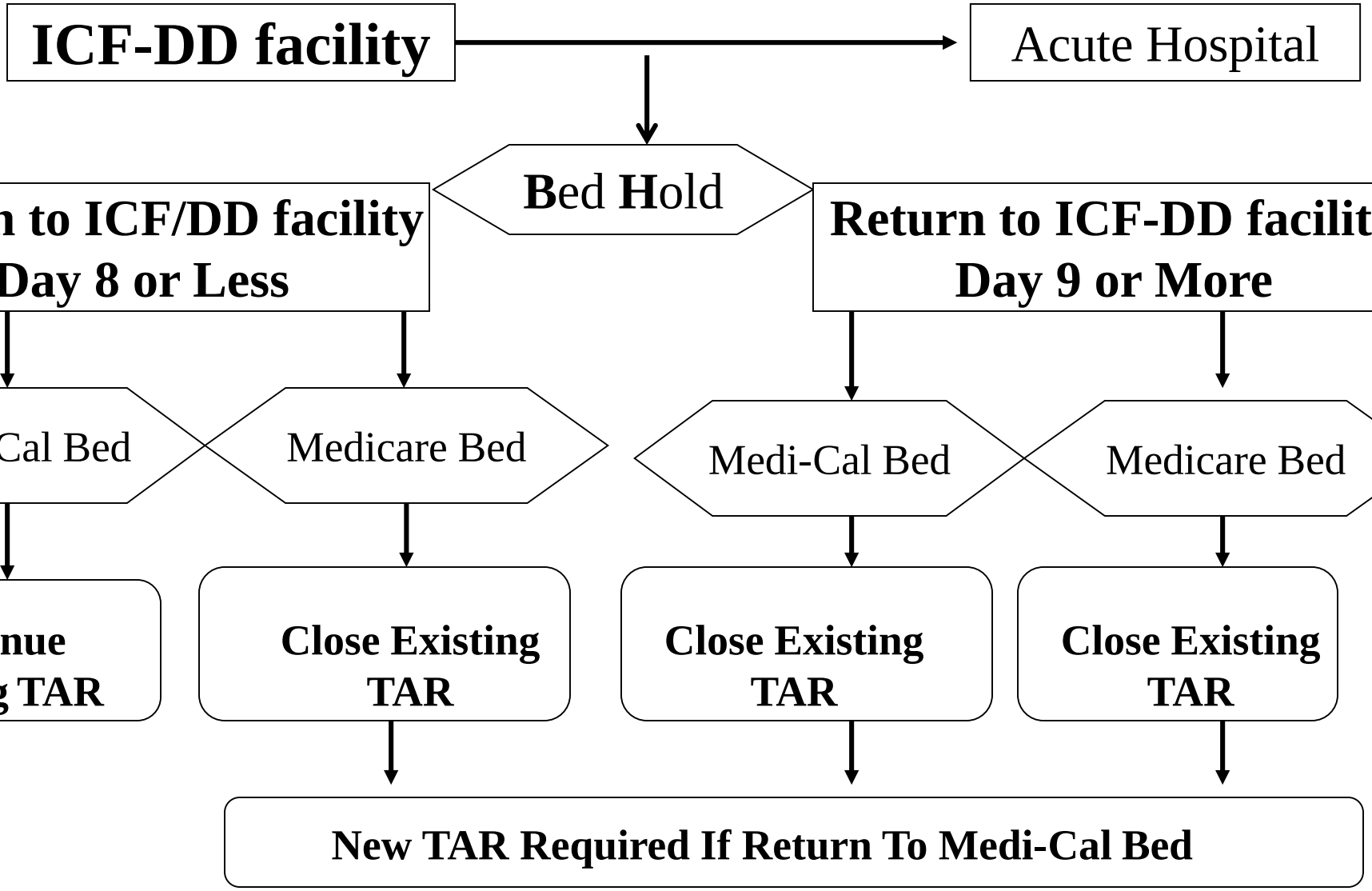
In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

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

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

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

Bed Hold / TAR Process After Acute Hospitalization



Partnership HealthPlan of California
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

MCUG3038 Attachment A 01/14/2026
MCUG3058 Attachment B 01/14/2026

BED HOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

NO.	MONTH -	DAY OF THE WEEK																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	NAME:																														
	TAR NUMBER:																														

Please note, member discharge /transfer to acute requires a MD order.

Fax to **707 - 863 - 4118**

REMARKS:

NO.	

LEGEND:

A - Discharge to Acute (use after 7 day BH)
B - Discharge to B & C
B/H - Bed Hold
E - Expired
E/A - Expired in Acute
TL - Therapeutic Leave
H - Discharge to Home
I - Discharge to ICF
M - Discharge to Medicare Bed
P - Discharge to Private Pay
R - Return to Medi-Cal Bed
S - Discharge to Other SNF
X - Discharge to Hospice

Prepared By: _____

Telephone #: _____

Fax #: _____

Date Prepared: _____

Please note, report will not be processed without a signed Physician's order

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3003 (previously UP100303)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~10/09/2025~~01/14/2027
Last Review Date: ~~10/09/2024~~01/14/2026</td></tr>
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<tr><td>☐ CEO ☐ COO</td><td>☐ CREDENTIALS~~LING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/09/2024~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUG3038 - Review Guidelines for Member Placement ~~in Long Term Care (LTC) Facilities~~in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities
C. MCUG3024 - Inpatient Utilization Management
D. MP~~C~~UG3011 - Criteria for Home Health Services
E. MCUP3114 - Physical, Occupational and Speech Therapies

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity - Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. UM Nurse Coordinator – This is the Partnership HealthPlan of California nurse in the Utilization Management department who is assigned to a case and who performs reviews for medical necessity and coordinates services covered by Partnership within the health plan and with the staff at the treating facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Overview

Policy/Procedure Number: MCUP3003 (previously UP100303)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: 10/09/202501/14/2027** **Last Review Date: 10/09/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

7. The written treatment plan must include the following:
   a. Date of onset of the illness
   b. Medical diagnosis necessitating the service, with severity and duration of condition
   c. Related medical conditions
   d. Impairments necessitating an inpatient or ~~LTC custodial care~~skilled nursing admission for rehabilitation services
   e. Functional limitations including cognitive abilities, mobility and self-care limitations, emotional problems, and communication difficulties
   f. History and results of previous rehabilitation services and outcomes of treatment
   g. Prognosis
   h. Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
   i. Types of services to be rendered by each discipline related to the problem
   j. Description of plan to instruct household members or other caregivers to provide needed care after discharge from the rehabilitation program.
   k. Documentation that the Member has sufficient strength and endurance to actively participate in the proposed treatment.
8. The UM Nurse Coordinator reviews the TAR for medical necessity and consults with the referring physician or rehabilitation staff as indicated. Definition of "medical necessity" states that necessary health care services are those needed to protect life and to prevent significant illness or significant disability, or to alleviate pain. The Chief Medical Officer or physician designee is the only individual who can deny TARs for inpatient or ~~LTC custodial care~~ skilled nursing rehabilitation services.
9. If additional days are needed beyond the initial TAR, a progress report must be submitted to Partnership documenting that significant improvement has occurred with the initial therapy and that continued therapy will further improve the Member's function, although not necessarily restoration of full capacity. The progress report must indicate plans for discharge and measured progress in each problem area being treated. In addition, the report must detail the Member's active participation in therapy and that the Member still requires close supervision in an ~~inpatient~~ inpatient or skilled ~~or LTC~~ setting.
10. Requests for extension of inpatient rehabilitation services are denied for medical necessity for the following reasons:
    a. Therapeutic goals have been attained or the prospect of further incremental improvement is so small that an additional expense is not justified
    b. Lack of progress toward attaining goals, with further progress unlikely
    c. Inability or unwillingness of Member or family to cooperate with the Member's program
    d. Goals can be achieved at a lower level of care

B. Admission Criteria

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

1. Patient Selection
   a. The patient must have a physical disability of which the medical condition and functional performance can be realistically improved through intensive, accepted rehabilitation measures.
   b. The patient must have the potential to be medically and emotionally stable for management on a rehabilitation nursing service and be capable of active participation in a rehabilitation program.
   c. The patient must be in need of close daily medical supervision by a physician with specialized training or experience in rehabilitation and must require 24-hour rehabilitation nursing or other rehabilitation services.

d. Primary admitting diagnosis must include one but not limited to ~~of~~ the following categories:
   1) Stroke
   2) Spinal cord injury
   3) Amputation
   4) Major multiple trauma
   5) Fracture of femur (hip)
   6) Brain injury
   7) Polyarthritis - including rheumatoid arthritis
   8) Neurological disorder, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's Syndrome
   9) Burns
   10) Other conditions requiring intensive rehabilitative care

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

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

D. DISCHARGE CRITERIA
1. Must meet either a., b., c., or d. below:
   a. The patient has met the goals established at, and subsequent to, the time of admission.
   b. The patient no longer requires rehabilitative nursing and is receiving treatment in only one therapy area, i.e., occupational therapy, physical therapy, speech therapy, psychology, neuropsychology.
   c. There is no evidence of progress toward documented goals.
   d. There are intercurrent medical conditions that require acute care and suspension of rehabilitative

services.

2. A weekend pass may be given the week prior to planned discharge to determine problems or issues that might exist that would need to be addressed before patient is sent home.

E. CASE REVIEW CONFERENCES

Partnership Members in acute rehabilitation facilities are reviewed in case review conferences.

1. Weekly review conferences are held to discuss select hospitalized Members.
2. Participants include, but are not limited to, Nurse Coordinators, Care Coordination staff, UM Team Manager, Chief Medical Officer and/or Regional Medical Director and the Associate Director of UM.
3. The purpose of the meeting is to collaborate and facilitate timely medical services and transition to the next level of care.
4. ~~UM Nurse Coordinators may also attend conferences at assigned hospitals upon request.~~
5.4. UM Nurse Coordinators are expected to follow the review guidelines outlined in policy MCUG3024 Inpatient Utilization Management, including, but not limited to, admission review and concurrent review.

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

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: TAR Criteria for Acute Inpatient Intensive Rehabilitation *(tar crit aiir)*

B. California Code of Regulations (CCR) Title 22 Health Care Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 03/23/95; 08/98; 06/21/00; 04/18/01; 01/16/02; 08/20/03; 09/15/04; 10/19/05; 08/20/08; 05/19/10; 11/28/12; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 08/14/19; 08/12/20; 08/11/21; 10/12/22; 10/11/23; 10/09/24, 01/14/26

*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:

Policy/Procedure Number: MCUP3003 (previously UP100303)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing Inpatient Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: 10/09/202501/14/2027** **Last Review Date: 10/09/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

- Consistent with sound clinical principles and processes
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3049 (previously UP100349)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Pain Management Specialty Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/20/2000</td><td colspan="4">Next Review Date: ~~11/13/2025~~01/14/2027
Last Review Date: ~~11/13/2024~~01/14/2026</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~SING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/13/2024~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MPCR13– Credentialing of Pain Management Specialist
D. MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
~~C.~~E. MCRP4068 – Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. Partnership Medical Necessity Criteria for Pain Management Procedures

V. PURPOSE:

To describe the specialty of Pain Management, the practitioners eligible to provide services as a Pain Management Specialist, and the reimbursement mechanism for this specialty.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) recognizes Pain Management as a specialty and will reimburse certain practitioners to perform services to Members as contracted Pain Management Specialists. These specialists are recognized by Partnership as experts in the medical management of acute and chronic pain, and may have expertise in the performance of invasive procedures designed to treat such conditions. Pain Management Specialists may also act as care coordinators for Partnership Members requiring a multi-disciplinary approach to their condition.
B. In order to be considered as a Pain Management Specialist, the practitioner must be credentialed by the Partnership Credentials Committee as a Pain Management Specialist.
C. The Primary Care Provider (PCP) must refer a Member~~s~~ by submitting an electronic or hardcopy Referral Authorization Form (RAF). If the Pain Management Specialist wants the Member to see another specialist, the physician must ensure that the Member's PCP completes a referral authorization request (RAF) for the consultation (see policy MCUP3124 Referral to Specialists (RAF) Policy).

D. The specialty of Pain Management is to be reimbursed based on provisions in the specialist's contract. Medications[1] dispensed or provided to Partnership Members as part of pain management services are reimbursed at the Medi-Cal rate. Revisions to the reimbursement schedule will be governed by the Specialty Contract of each provider.

E. TAR Requirements

1. The Pain Management Specialist must submit a Treatment Authorization Request (TAR) to Partnership for those procedures requiring a TAR. Please refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process - Attachment A (Partnership TAR Requirements) for a list of those pain management services that require a TAR.
2. Attachment A of this policy describes Partnership Medical Necessity Criteria for Pain Management Procedures.

VII. REFERENCES:
InterQual® Criteria

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

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

X. REVISION DATES: 12/19/01; 05/21/03, 10/20/04; 10/19/05; 10/18/06, 03/19/08, 07/15/09; 05/18/11; 03/20/13 – effective 04/01/13; 05/20/15; 04/20/16; 03/15/17; *06/13/18; 05/08/19; 05/13/20; 11/11/20; 10/13/21; 11/09/22; 11/08/23; 11/13/24; 01/14/26

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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.

[1] 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 25-013 "Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage" and Executive Order N-01-19 . Please refer to the State Medi-Cal Rx webpage which is found at https://medi-calrx.dhcs.ca.gov/home/ ~~Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in All Plan Letter (APL) 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS contracted pharmacy administrator instead of Partnership. This includes medications used for pain management.~~

Policy/Procedure Number: MCUP3049 (previously UP100349)		**Lead Department:** Health Services Business Unit: Utilization Management
Policy/Procedure Title: Pain Management Specialty Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 12/20/2000	**Next Review Date: 11/13/202501/14/2027** **Last Review Date: 11/13/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Necessity Criteria for Pain Management Procedures

22510, 22511, 22512, 22513, 22514, 22515 Percutaneous vertebroplasty and percutaneous vertebral augmentation	**InterQual® criteria followed.** **Subset:** *Vertebroplasty or Kyphoplasty* **Exception(s) to InterQual criteria:** None Well-controlled study shows no benefit over placebo for longstanding vertebral fractures/pain. (Reference: Treatment of Symptomatic Osteoporotic Spinal Compression Fractures, *Journal of the American Academy of Orthopedic Surgeons*, March 2011; Spine J. 2012 Nov; 12(11): 998-1005)
27096 SI joint injection	**InterQual® criteria followed.** **Subset:** *Sacroiliac (SI) Joint Injection* **Exception(s) to InterQual criteria:** • Imaging to confirm sacroiliac joint disease is not required
62263, 62264 Percutaneous lysis of epidural adhesions	**Requests are reviewed on a case-by-case basis** upon review of clinical information provided.
62290, 62291 Injection procedure for d~~D~~iscography - lumbar, thoracic, and cervical *(see also 72285, 72295 below)*	**InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.
62360, 62362 Implantable or replacement device for intrathecal or epidural drug infusion; subcutaneous reservoir	**InterQual® criteria followed.** **Subset:** *Epidural or Intrathecal Catheter Placement* **Exception(s) to InterQual criteria:** • Physician review required
63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688 Insertion, revision, or removal of spinal neurostimulator	**InterQual® criteria followed.** **Subset:** *Spinal Cord Stimulator (SCS) Insertion* **Exception(s) to InterQual criteria:** None **Note:** Revisions/Replacements may be considered when the Elective Replacement Indicator (ERI) reflects that replacement is required in ≤ 6 months.

64479, 64480, 64483, 64484 Transforaminal epidural injection	**InterQual® criteria followed.** **Subset:** *Epidural Steroid Injection* **Exception(s) to InterQual criteria:** 1. A minimum of 30 days conservative treatment is required before eligible for epidural steroid injection. 2. TFESI may be considered for cervical radicular pain with nerve root impingement confirmed by imaging or testing. 3. Repeat injections require a minimum of 50% improvement in pain symptoms lasting a minimum of 8 weeks from previous injection. 4. The interval between injections per site must be no more frequent than every 3 months, and the maximum number of injections per site is 3 per year.
64490, 64491, 64492, 64493, 64494, 64495 Paravertebral facet injections and medial branch blocks	**InterQual® criteria followed.** **Subset:** *Facet Joint Injection* **Exception(s) to InterQual criteria:** 1. The progress note should document a physical examination of the back, including pain elicited with movement. 2. Trial of physical therapy & NSAIDS/ acetaminophen is not required. 3. Imaging required only to rule out nerve root impingement for any radicular complaints. 4. No more than 3 levels will be approved, either 3 levels unilaterally or 3 levels bilaterally.
64633, 64634, 64635, 64636 Destruction by neurolytic agent, paravertebral facet joint	**InterQual® criteria followed.** **Subset:** *Neuroablation, Percutaneous* **Exception(s) to InterQual criteria:** None
72285, 72295 Radiological supervision and interpretation for discography - cCervical, tThoracic, lLumbar *(see also 62290, 92291 above)*	~~*Same as 62290 and 62291 above.*~~ **InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3102				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Vision Care				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/21/2010			**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIAL~~ING~~**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~01/08/2025~~01/14/2026	

I. RELATED POLICIES:
CMP36 – Delegation Oversight and Monitoring

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

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

IV. ATTACHMENTS:
A. N/A

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

VI. POLICY / PROCEDURE:
A. Provision of Services
   1. Partnership contracts with a vision care insurance organization, Vision Services Plan (VSP), for the provision of Medi-Cal vision care services to eligible Members. Members assigned to VSP must go to a VSP Medi-Cal participating provider for refraction services and eye glass frames.
   2. Members not assigned to VSP are billed directly to Partnership.
B. Examination
   1. Benefits include one eye examination with refraction every 24 months. A second eye examination with refraction will be covered if the Member has a sign or symptom indicating medical necessity. The reimbursement rates of optometric services shall not exceed charges made to the general public.
C. Eye Appliances
   1. A written prescription is required.
   2. The reimbursement rates for appliances shall not exceed charges made to the general public.

3. Lenses and frames are covered every 24 months. Lenses may be covered more often if medically necessary.
   a. Lost, stolen, broken or significantly damaged eye appliances may be replaced within 24 months if damage was beyond the recipient's control. Recipient must submit a signed statement describing the circumstances of replacement.
4. All fabrication of optical lenses is provided by the Prison Industry Authority (PIA) optical laboratories except ~~with~~when Member requires lenses ~~are~~ not available through PIA. The Department of Health Care Services (DHCS) is responsible for reimbursement for the fabrication of the ophthalmic lenses in accordance with the Interagency Agreement between DHCS and PIA.
5. Elective contact lenses are not a covered benefit.
   a. In certain cases, contact lenses may be covered if medically necessary. Prior authorization is required.
6. Optical low vision aids may be covered when medically necessary for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery and the subnormal vision interferes with the Member's ability to perform everyday activities. Prior authorization is required.

E. Delegation Oversight and Monitoring
1. Partnership delegates the administration of vision care services to a vision care insurance 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.

VII. REFERENCES:

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

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
03/21/12; 01/21/15 (effective 02/01/15); 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25; 01/14~~08~~/26

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

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MCUP3102			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Vision Care			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010		**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

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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

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3125</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Gender Dysphoria/Surgical Treatment</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/21/2013</td><td colspan="4">Next Review Date: ~~01/08/2026~~01/14/2027
Last Review Date: ~~01/08/2025~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MP~~C~~UP3039 - Direct Members
C. MCUP3114 - Physical, Occupational and Speech Therapies
D. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
E. MP~~C~~ND9002 - Cultural & Linguistic Program Description
~~E.~~F. MPQG1005 - Adult Preventive Health Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the criteria and process by which Partnership HealthPlan of California will provide benefits for the

surgical treatment of gender dysphoria.

VI. POLICY / PROCEDURE:

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

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

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

1. According to the APL 20-018 (excerpted):
   a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender or gender nonconforming beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body, to create a normal appearance to the extent possible" and for transgender Members, may consider gender dysphoria as a developmental abnormality. In the case of transgender or gender nonconforming beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.
   b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."
2. Gender reassignment/ affirming surgery is a covered benefit according to APL 20-018 and will be reviewed according to most recent WPATH criteria for the surgery. The requesting provider must submit evidence in demonstration of meeting either medical necessity or reconstructive surgery criteria consistent with WPATH criteria. This may include, but is not limited to:
   a. Persistent, well-documented gender dysphoria
   b. Capacity to make a fully informed decision and consent for treatment
   c. Consent for gender reassignment/ affirming surgery must be in compliance with current California consent policies and statutes.
   d. If significant medical or mental health concerns are present, they must be reasonably well controlled
3. The list of surgical procedures may include:
   a. For Male to Female (MtF, also known as transfeminine) patients or gender nonconforming patients desiring surgery for de-masculinization
      1) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
      2) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
   b. For Female to Male (FtM, also known as transmasculine) patients or gender nonconforming patients desiring surgery for de-feminization
      1) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)
      2) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses.
   c. It is suggested that health care professionals consider gender-affirming genital procedures in eligible transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired

surgical result unless hormone therapy is either not desired or is medically contraindicated).

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

4. Pharmaceutical treatment for gender dysphoria: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter ~~(APL) 22-012 *Revised*,~~(APL) 25-013 and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. This includes medications used for the treatment of gender dysphoria. Refer to the Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx
   The State Medi-Cal Contract Drugs List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://medi-calrx.dhcs.ca.gov/home/cdl/

D. Treatment Authorization Review (TAR)
   1. TARs must be submitted prior to any surgical procedure referenced in section VI.C.3. and should demonstrate either medical necessity or reconstructive surgery criteria that is consistent with WPATH criteria and the covered benefit according to DHCS APL 20-018.

2. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review and determination. Requests for surgical treatment of gender dysphoria shall be reviewed for reconstructive surgery criteria, the standard of care as advised by WPATH, and medical necessity requirements.
   a. Review of reconstructive surgery criteria and medical necessity are considered separate and distinct and may independently serve as the basis for approval of a request.
   b. Where medical necessity is not met, Partnership must review the TAR to determine if criteria for reconstructive surgery is met, taking into consideration the gender with which the Member identifies.
   c. Denial of a TAR, in whole or part, must describe the basis for denial for both reconstructive surgery criteria and medical necessity.

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

F. Statement of Non-Discrimination
1. Partnership does not discriminate against transgender individuals and treats beneficiaries in a manner consistent with their gender identity.
2. Partnership will not deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for any health services that are ordinarily or exclusively available to individuals of one sex, to a transgender or gender nonconforming individual based on the fact that an individual's sex assigned at birth, gender identity, or gender otherwise recorded is different from the one to which such health services are ordinarily exclusively available.
3. Partnership will not otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health services related to gender transition if such denial, limitation, or restriction results in discrimination against a transgender individual.
4. See also policy MPCND9002 Cultural & Linguistic Program Description for more information on Partnership's Diversity, Equity and Inclusion (DEI) training programs for contracted network providers.

VII. REFERENCES:

A. World Professional Association for Transgender Health (WPATH) criteria, current version. https://www.wpath.org/soc8
B. DHCS All Plan Letter (APL) 20-018: Ensuring Access to Transgender Services (10/26/2020)
C. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)
D. Title 42 United States Code (USC) Section 1396d(r)(5)
E. Insurance Gender Nondiscrimination Act (IGNA) Health and Safety Code (HSC) Section 1365.5
F. DHCS All Plan Letter (APL) 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)
~~F. DHCS APL 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx. (12/30/2022)~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Policy/Procedure Number: MCUP3125		Lead Department: Health Services
Policy/Procedure Title: Gender Dysphoria/Surgical Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 08/21/2013	**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

X. **REVISION DATES:** 01/20/16; 02/15/17; 04/19/17; *06/13/18; 09/11/19; 09/09/20; 01/13/21; 09/08/21; 10/12/22; 01/10/24; 01/08/25; 01/14/26

*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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- Evaluated and updated at least annually
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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCCP2016~~ MPTP2501 (previously MCCP2016)</td><td colspan="3">Lead Department: ~~Health Services~~Transportation</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/21/2015 (MCCP2016)</td><td colspan="3">Next Review Date: 01/14/2027~~01/08/2026~~
Last Review Date: 01/14/2026~~01/08/2025~~</td></tr>
<tr><td>Applies to:</td><td colspan="2">~~☒~~☐ Employees</td><td>☒Medi-Cal</td><td colspan="2">☒Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. ~~MCCP2030~~ MPTP2503 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
C. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCUG3118 – Prenatal & Perinatal Care
F. CMP09 – Investigating & Reporting Fraud, Waste and Abuse
G. CMP26 –Verification of Caller Identity and Release of Information
H. CGA024 – Medi-Cal Member Grievance System
I. CMP36 – Delegation Oversight and Monitoring
J. MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment
K. ~~MCUP3146~~ MPAP7005 – Street Medicine

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

Policy/Procedure Number: MPTP2501 *(previously MCCP2016)*		Lead Department: Transportation	
Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)		☒ External Policy ☐ Internal Policy	
Original Date: 10/21/2015 (MCCP2016)		**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026	
Applies to:	☒ Employee	☒ Medi-Cal	☒ Partnership Advantage

H. Private vehicle: Any motor vehicle, other than a motor truck, truck tractor, or a bus, and used or maintained for the transportation of persons (Defined by VEH Section 465)
I. California Driving Requirements: Defined by California Vehicle Code (VEH Section 12500, 4000, and 16020)
J. Round Trip: Transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.
K. Short Notice Request: Any request for transport not allowing five calendar day notice.
L. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain ~~protected~~ Personal H~~h~~ealth I~~i~~nformation (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a ~~designated person~~non-member. Verbal consent expires at close of business the following business day. The Member can give additional verbal consent when the prior verbal consent window of time has expired.

IV. ATTACHMENTS:

A. Provider Certification Statement (PCS) form

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. GENERAL TRANSPORTATION PROGRAM RULES

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

e. Transportation is covered for Members picking up medical supplies, prosthetics, orthotics and other equipment when said supplies and/or equipment is covered by Medi-Cal.
f. Transportation is covered to all Medi-Cal covered street medicine providers including those serving as Primary Care Providers (PCPs).
    1) Members using a street medicine provider as a Primary Care Provider will still be provided transport to a traditional Primary Care Provider if requested, provided the request meets all other applicable criteria.
g. Discharge from an inpatient stay at a hospital, long-term care, or any other Medi-Cal covered institutional setting to the Member's residence is covered.
    1) Requests for transport services of this nature must be made by the discharging or receiving facility.
    2) Transport to an alternate location can also be provided if permission from the alternate location has been granted and the alternate location is within the Member's county of residence.
    3) Requests for transport outside the Member's county of residence will be reviewed on a case by case basis.

5. All requests for transportation services made to Partnership must be submitted five (5) calendar days prior to the date of service.
    a. Partnership will review short notice requests on a case by case basis based on the following criteria:
        1) If the appointment is life threatening/sustaining, Partnership will attempt to secure transportation.
        2) If the appointment is not life threatening/sustaining, has been scheduled with the provider, but the Member waited to request transportation and did not allow five calendar days, the request will be denied.
        3) If the appointment was scheduled by the provider within 5 calendar days, Partnership will attempt to secure transportation.
    b. Exceptions for gas mileage reimbursement (GMR)
        1) Non-advance funds GMR requests will be accepted regardless of days' notice.
        2) Advance funds GMR requests must be made two (2) business days in advance. If the request is made with less than two (2) business days' notice, regular GMR can be requested.
        3) Retroactive requests will not be accepted.
6. All approved transports will be scheduled to ensure the Member is dropped off within 15 minutes of their scheduled appointment and Members will be informed of their pick-up/drop off time when the transport is scheduled.
    a. If the transportation provider does not arrive at the pick-up location in time to ensure the Member arrives at their appointment within 15 minutes of the scheduled appointment time, the Member can call Partnership and transport with an alternate transportation provider will be approved.
7. If an approved transport experiences any disruption due to the assigned Transportation Provider arriving late or failing to arrive, Partnership will provide urgent authorization for a replacement ride to be scheduled.
8. With the written consent of a parent or guardian, a minor between the ages of 12-18 may receive transportation unaccompanied as long as Partnership and the transportation provider accepts the necessary written consent forms and agrees to provide unaccompanied transport. Certain appointments will not require written consent or parent/legal guardian permission to travel unaccompanied as described below:
    a. All Members under age 21
        1) Pregnancy and pregnancy-related services
        2) Family planning services
        3) Sexual assault services

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

9. All requests for transportation to medical appointments are subject to appointment verification by Partnership.
10. Transportation for Partnership covered services to Out of Network (OON) providers will be provided with prior authorization and if all other utilization control requirements are met.
11. Transportation for Medi-Cal covered services, carved out of Partnership's responsibility, will be provided and are not subject to Partnership's utilization controls or time and distances standards related to reviewing requests for medical services. Transportation requests to carved out services will only be reviewed in accordance with the rules and regulations listed in this policy.
12. Partnership will store Transportation Provider information, including the name of the driver based on service date, time, pick-up/drop-off location, and Member name. If a Partnership Member files a grievance, this information will be made available to them.

B. NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

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

1. Transportation Providers are required to provide door-to-door or door-through-door service for all authorized NEMT services.
2. NEMT PRIOR AUTHORIZATION REQUIREMENTS
   a. Both a Treatment Authorization Request (TAR) and Partnership's DHCS approved Provider Certification Statement (PCS) (see Attachment A) are required for all NEMT services that have an identified TAR requirement in order to be processed. All TARs received without a PCS are subject to Partnership's standard Utilization Management (UM) TAR review process as outlined in
   policy MCUP3041 Treatment Authorization Request (TAR) Review Process. Once submitted to Partnership, prescribed NEMT services and the corresponding PCS form cannot be changed or altered.
      1) In urgent situations, when a PCS form cannot reasonably be obtained prior to the requested NEMT service, Partnership can authorize one-time NEMT and accept the PCS post-service. This authorization can be made via phone; however, the service still requires a Treatment Authorization Request (TAR) to be submitted by the Medi-Cal Certified NEMT Provider once a valid PCS can be obtained.
      2) A copy of the PCS form will remain on file for all Members receiving NEMT services.
      3) If needed, Partnership can provide a copy of the PCS to the Medi-Cal Certified NEMT Provider via fax or encrypted email.
   b. Providers and Members can call Partnership or any Medi-Cal Certified NEMT Provider directly to request NEMT services. Providers and Members can also call Partnership or the scheduled Medi-Cal Certified NEMT provider to receive status updates on NEMT rides.
   c. Only Partnership's DHCS approved PCS form (Attachment A) will be accepted and must include, at a minimum, the components listed below. All fields must be completed by the provider.
      1) Function Limitations Justification: For NEMT, the provider is required to document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or private vehicles.

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

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

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

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

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

C. NON-MEDICAL TRANSPORTATION (NMT)

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

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

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

g. Additional passenger rules:
1) Members under the age of 21 are allowed two (2) additional passengers if the passengers are parents or legal guardians to the Member.
a) If the parent or legal guardian is a single caregiver, transport can be provided for additional minor children under the care of the parent or legal guardian. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.
2) All other Members are allowed one (1) additional passenger
a) If the Member is a single caregiver, transport can be provided for additional minor children under the care of the Member. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.

h. NMT services will be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the Member and consistent with applicable state and federal disability rights laws.

2. PARENT/LEGAL GUARDIAN-ONLY NMT
a. In emergent situations when a Member under the age of 21 is transferred to a facility via emergency medical transport, Partnership will authorize parent/guardian only transport services on a case-by-case basis.
1) If the request is for gas mileage reimbursement (GMR), Members and their guardians have 30 days from the date of service to request this type of reimbursement.
b. For Members under the age of 21, Partnership may authorize parent/guardian-only transport on a case-by-case basis upon hospital discharge from an inpatient setting if the medically necessary transport provided for the Member cannot also provide transport for one parent or guardian.
1) If the request is for GMR, Members and/or their guardians have 30 days from the date of service to request this type of reimbursement.
c. Further parent or guardian-only transports for Members under the age of 21 will be reviewed on a case-by-case basis and in compliance with provisions described under Partnership policy and procedure MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

3. NMT PRIVATE VEHICLE AUTHORIZATION REQUIREMENTS
a. GMR requires prior authorization Partnership.
1) Non-advance funds GMR requests will be accepted regardless of days' notice.
2) Advance funds GMR requests must be made 48 hours in advance. If the request is made with less than 48 hours' notice, regular GMR can be requested.
3) Retroactive requests will not be accepted.

b. In order to receive GMR for use of a private vehicle, the driver must be compliant with all California driving requirements, which include the following:
   1) Valid driver's license
   2) Valid vehicle registration
   3) Valid vehicle insurance
c. Partnership will only reimburse the driver.
d. Members may not receive reimbursement for driving themselves, unless the Member is eligible to CCS and legally allowed to drive.
e. Mileage reimbursement for gas is consistent with the Internal Revenue Service standard mileage rate for medical transportation when conveyance is in a private vehicle arranged by the Member.
f. The form of reimbursement offered is decided by Partnership and may be in the form of cash, check, gas cards, or other forms of prepaid cards.
g. In order for Partnership to issue payment for GMR requests, the Member or Member's parent/legal guardian must provide the following:
   1) Credentials verifying the driver/payee is in compliance with all California driving requirements as listed above in section VI.C.3.b.
   2) Attendance verification issued by the treating provider on facility letterhead or via the facility's online member portal or mobile application.
h. Partnership will allow the Member 90 calendar days from the date of service to submit all required credentials.

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

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

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

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

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

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

F. SCREENING & ENROLLMENT

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

G. REGULATORY REQUIREMENT

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

~~IX.~~X. REVISION DATES:

Medi-Cal:
01/20/16; 08/16/17; *11/14/18; 02/12/20; 08/12/20; 08/11/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24; 01/08/25; 01/14/26

Partnership Advantage (effective Jan. 1, 2027):
01/14/26

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

Policy/Procedure Number: MPTP2501 *(previously MCCP2016)*			**Lead Department:** Transportation
Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/21/2015 (MCCP2016)		**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026	
Applies to:	☒ **Employee**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PREVIOUSLY APPLIED TO:
N/A

Policy/Procedure Number: MPTP2501 *(previously MCCP2016)*			**Lead Department:** Transportation
Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)			☒ **External Policy** ☐ **Internal Policy**
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Applies to:	☒ **Employee**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

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

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

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

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

3. Dates of Service (DOS)

From: _____ To: _____

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

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

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

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: ~~MCCP2029~~MPTP2502 (previously MCCP2029)</td><td colspan="3">Lead Department~~: Health Services~~: Transportation</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Emergency Medical Transportation</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)</td><td colspan="3">Next Review Date: ~~01/08/2026~~01/14/2027
Last Review Date: ~~01/08/2025~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐Employees</td><td>☒~~☐~~ Medi-Cal</td><td colspan="2">☒Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. EMERGENCY MEDICAL TRANSPORTATION (EMT)

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

Policy/Procedure Number: ~~MCCP2029~~MPTP2502 *(previously MCCP2029)*		**Lead Department: Transportation**	
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**	
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)		**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☒☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

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

VII. REFERENCES:

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

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
02/10/21; 02/09/22; 01/11/23; 01/10/24; 01/08/25; 01/14/26

Partnership Advantage (effective Jan. 1, 2027)

Policy/Procedure Number: ~~MCCP2029~~MPTP2502 *(previously MCCP2029)*		**Lead Department: Transportation**	
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**	
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)		**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☒☐ **Employees**	☒ **Medi-Cal**	☒**Partnership Advantage**

01/14/26

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

****

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.

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Nov. 19, 2025 Quality/Utilization Advisory Committee (Q/UAC).
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.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Department Name – *Presenter: Shannon Boyle, RN, Manager of Care Coordination Regulatory Performance*			
MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	235 – 242	**Policy Edits due to APL 25-008 Hospice Services (05/05/25) – added as new Reference J.** **Related Policies alphanumeric designations updated** for Medi-Cal and Medi-Cal/Medicare lines of business **Related Policies added:** MCUP3020 - Hospice Services Guidelines MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21 **Definitions added for** Hospice Care and Palliative Care **Whole Child Model (WCM)Definition updated:** A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership. **VI.P Hospice Services section added:** 1. Children receiving hospice care services for a terminal illness and life expectancy if six months or less may receive additional services than are available for adults. 2. Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under 21 years of age also may elect to receive concurrent curative treatment of the hospice-related diagnosis and concurrent palliative care. **3.** For more information, see Partnership policy MCUP3020 Hospice Service Guidelines and MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21.	Health Services Claims Member Services Provider Relations
Policy Owner: Population Health *Presenter: Christine Smith, Community Health Needs Liaison, Population Health*			
MPNP9006 – Doula Services Benefit (*previously MCNP9006*)	243 – 252	This annual policy update reflects language changes for added Reference E: Partnership's Partnership HealthPlan Perinatal Services (PHPS), a Comprehensive Perinatal Services Program-like equivalent or substantially similar to the California Department of Public Health's CPSP. **Related Policies alphanumeric designations updated** for Medi-Cal and Medi-Cal/Medicare lines of business and for recent policy migrations from Care Coordination and Utilization Management to Enhanced Health Services.	Provider Relations Member Services Network Services Health Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		III. Definitions – Updated CPSP definition and added Partnership HealthPlan Perinatal Services (PHPS) definition in alignment with MCUG3118 Prenatal & Perinatal Care. Added Dual-eligible Special Needs Plan (D-SNP). **VI.D.1 –** Added "Partnership Advantage enrollees" language. **VI.E.1** – Expanded eligibility for doula services to include Partnership Advantage members. Clarified that a recommending provider does not need to be enrolled in Medicare. **VI.K.2 –** Per IQI discussion Nov. 12, removed section clarifying that OON abortion services must be reimbursed at no less than the Medi-Cal Fee-For-Service rate. **VI.L.1.d –** Added D-SNP data reporting requirement. **VII. References** • Added: DHCS APL 23-020 Requirements for Timely Payment of Claims • Added: California Department of Public Health CPSP Program link (https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx). • Added: D-SNP Quality and Data Reporting - to support new data stratification and disparity analysis requirements.	
Policy Owner: Utilization Management *Presenter: Janet Rudd, RN, Manager of Long Term Support Services, UM*			
MCUG3038 – Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities – **NEW TITLE**	253 – 280 *CLEAN policy copy begins on p.271*	During the annual review, this policy and its title were updated to reflect use of the term "Extended Care Facility (ECF)" in lieu of previous Long Term Care (LTC), which was not always an appropriate term for all categories of extended care. Our LTSS team worked on extensive revisions to better describe our processes. **Section I Related Policies:** Removed Related Policy MCUP3051 Long Term Care SSI Regulations as the policy will be archived and language was moved into this policy MCUG3038. Also removed Related Policy MPPR210 Long Term Support Services Liaison because the policy has not been made public and includes errors that would confuse the reader. We now instead reference the external webpage that describes Partnership's LTSS Liaison at VI.G.5. Other policy numbers were updated to reflect transfers to other departments. and three new Related Policies were added as follows: • MPUP3139 – Criteria and Guidelines for Utilization Management • MCUP3020 – Hospice Services • MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions **Section II:** Four other departments were added as "Impacted": • Enhanced Health Services (EHS) • Transportation • Provider Relations	Claims Member Services Enhanced Health Services Quality Improvement Transportation Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		• Quality and Performance Improvement **Section III Definitions:** The definitions of Custodial Care Facility, Skilled Nursing Facility, and Subacute Contracting Unit were updated. Definitions of ICF and Long Term Care were removed. A new definition of Extended Care Facility was added as an all-inclusive term for facilities providing custodial, skilled and sub-acute services. The definition and purpose of DHCS' Subacute Contracting Unit (SCU) is added. **Section IV.B:** A new Attachment B was added "Skilled Nursing Facility Request Form" **Section V:** The Purpose statement was updated to use the term "Extended Care Facilities" in lieu of "Long Term Care Facilities." **Sections VI.A. – VI.G:** This policy was extensively reorganized to describe authorization requirements for three main Extended Care Classifications: • Custodial/ Long Term Care • Skilled Nursing Care • Subacute Care **Section VII:** References were updated as follows: A. Three new DHCS Provider Manual sections were added: • TAR for Long Term Care: 20-1 Form (*tar ltc)* • TAR for Long Term Care (Form 20-1): Inpatient Services (*tar ltc ip)* • TAR Completion for Long Term Care *(tar comp ltc)* I. All County Welfare Director's Letter was updated to current ACWD 25-02 J. APL 23-004 was updated to APL 24-009 for SNF Facilities K. APL 23-027 was updated to APL 24-010 for Subacute Facilities	
Policy Owner: Utilization Management *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUP3020 – Hospice Services	281 – 294	This policy has been updated for APL 25-008 Hospice Services and Medi-Cal Managed Care. **Section I.** Two Related Polices were added as follows: • MCCP2022 - EPSDT Services • MCCP2024 - Whole Child Model For California Children's Services (CCS) **Section III.A. B. & C.:** Definitions were added for Authorized Representative, California Children's Services (CCS), and Whole Child Model (WCM). **Section IV.** Two new DHCS forms were added as Attachments to this policy per APL 25-008: A. Medi-Cal Hospice Program Election Notice *DHCS 8052* (07/2023) B. Patient Notification of Hospice Non-Covered Items, Services, and Drugs *DHCS 8053* (07/2023) **Section V.:** The Purpose statement was updated**.**	Compliance Provider Relations Configuration Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		Section VI.A.1.b.: Updated statement to say that a member may elect hospice in lieu of curative care for terminal illness. **Section VI.A.2:** Updated to describe how hospice services may be elected using the new DHCS 8052 form and the how hospice election works with the other aspects of Medi-Cal enrollment. Specified that Partnership does not deny late referrals or completed election notices. **Section VI.B.1:** Defined hospice provider requirements include certification, CDPH licensing, and National Provider Identifier (NPI) for out-of-network providers. **Section VI.B.2:** Specified that Providers must submit DHCS 8052 form within 5 calendar days. Clarified liability for non-covered days due to late submission. Added prepayment review process to prevent fraud, waste, and abuse. **Section VI.C.1**: Specified that Members who elect hospice care are identified as Direct Members in Partnership's system. **Section VI.C.2.**: Made distinction between hospice and palliative care services. **Section VI.C.3.**: Specified that Partnership avoids unnecessary delays and complications when Members elect hospice care while also placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse. **Section VI.C.4:** Specified that Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness. **Section VI.C.5:** Described hospice and palliative care services available to Members under age 21. Also, information regarding hospice billing and Q codes was removed in this section as it will be moved to a more appropriate claims or configuration policy. **Section VI.C.6 –10.:** Updated list of services that are part of the hospice benefit. **Section VI.D.:** Added New section for "Services Not Covered by a Hospice Provider" **Section VI.E.:** Updated this section to specify hospice services that do NOT require a TAR, and to define the only circumstance when Hospice services do require a TAR, which is inpatient care. **Section VI.F.3:** Updated requirements in Hospice Period of Care **Section VI.G:** Added language regarding written certification statements and recertification. **Section VI.H.:** Revocation of Hospice Care Services has been edited/expanded **Section VI.I.:** References were updated to include • DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care • DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage • California Children's Services (CCS) Numbered Letter (NL) 06-1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice CCS NL 12-1119 Palliative Care Options for CCS Eligible Children (11/18/2019)	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
MCUP3041-A – TAR Requirements List	295 – 302	The TAR Requirements List was updated to include the following **Section HH:** Added Repetitive Transcranial Magnetic Stimulation (rTMS) Pain Management CPT Code List: **62290, 62291:** Clarified that these two codes are for "Injection procedure" for discography **63661, 63663, 63688:** Added these three codes for "Insertion or revision of spinal neurostimulator" **72285, 72295:** Clarified that these two codes are for "Radiological supervision and interpretation for" for discography	Provider Relations
MCUP3106 – Waiver Programs	303 – 308	During annual review of the Waiver Programs policy, we removed reference to In Home Operations Waiver, which has ended. **Section III.E** Removed Definition of In-Home Operations Waiver (IHO) program **Section VI.A.1**. Removal of IHO program **Section VI.B.1.** Added that Partnership monitors compliance with electronic visit verification (EVV) requirements through periodic audits and provider education. **Section VI.C.2.** Added reference to Title 22, CCR §51340; Welfare and Institutions Code §4684-4699 **Section VI.D.2** Reference added 42 CFR §441.301(c)(4); DHCS Policy Guidance, HCBS Waiver Enrollment Criteria, 2024 **Section VI.D.4:** Information for IHO program removed **Section VI.D.5**.: Updated office locations for Regional Centers **Section VI.6:** Updated language to specify that Sonoma County is currently the only county in Partnership's covered service area that is participating in Assisted Living Waiver (ALW) program. List of participating facilities link was updated. **Section VI.7** HCBA Code of Federal Regulations and application information cited 42 CFR §441.300-441.310. **Section VI.8** Welfare and Institution Code cited §9560 et seq **Section VII.:** Two References added: • Welfare & Institutions Code §4684-4699, 9560 et seq. • DHCS Home and Community-Based Services Waiver Program Overview (2024)	Compliance

Synopsis of Changes to Discussion Policies

MCUP3131 – Genetic Screening and Diagnostics	309 – 456	There were no major changes to the policy itself; however, attachments A and C were substantially updated.	Health Services Claims Member Services

MCUP3131 Attachment A Changes

Code	Gene	Comment
81226	CYP2D6	New code
81227	CYP2C9	New code
81228	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants, comparative genomic hybridization [CGH] microarray analysis	New code Dr. Townsend added a note to specify that this code cannot be billed if 81229 has been completed.
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic	New code
81349	Genome-wide analysis	Dr. Townsend chose to add this covered code to Attachment A because new code 81425 makes reference to 81349 (with no guidance) and we wanted the reader to be able to differentiate why they can't bill both. Also, we added a note that this code cannot be billed if 81229 is billed.
81403	Human Erythrocyte Antigen Gene Analyses –	Addition per DHCS guidelines to include these analyses for sickle cell
81403	RHD	Addition per DHCS guidelines
81403	VWF	Partnership is adding test for von Willebrand disease
81404	DYT-TOR1A	Partnership is adding test for Dystonia
81404	FSHD (third most common type of muscular dystrophy)	Added Facioscapulohumeral muscular dystrophy per Dr. Townsend
81404	SOD1	Addition per DHCS guidelines
81404	UGT1A1	Addition per DHCS guidelines
81405	DYT-TOR1A	Partnership is adding test for Dystonia
81405	FH	Addition per DHCS guidelines
81405	MYL2 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy
81405	MYL3 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy

Synopsis of Changes to Discussion Policies

81405	SLC2A1 (glucose transporter type 1 [GLUT 1] deficiency syndrome)	This code was on our list, but Dr. Townsend added ICD-10 codes G40-G47 for pediatric absence seizures.
81405	TPM1 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy
81405	Lysine and hydroxylysine errors of metabolism ICD-10-CM diagnosis code E72	Partnership added test
81406	RYR1	Addition per DHCS guidelines
81406	TNNT2 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy
81406	Lysine and hydroxylysine errors of metabolism ICD-10-CM diagnosis code E72	Partnership added test
81407	COL4A3,COL4A4, COL4A5 Alport Syndrome (ICD-10-CM diagnosis code Q87.81)	Partnership adding test for Alport Syndrome
81407	MYBPC3 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy
81407	MYH7 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49	Partnership adding test for hypertrophic cardiomyopathy
81407	Pediatric absence seizures ICD-10-CM diagnosis codes G40-G47	Partnership adding test for pediatric absences seizures
81408	COL4A3,COL4A4, COL4A5 Alport Syndrome (ICD-10-CM diagnosis code Q87.81)	Partnership adding test for Alport Syndrome
81408	RYR1	Addition per DHCS guidelines
81425	Whole Genome sequencing	New code, requires TAR, NOT Rapid Cannot be billed if 81349 has been billed.
81426	Genome sequencing, up to two comparators	New code, requires TAR, NOT Rapid Must be billed in conjunction with 81425 81349 cannot be billed with this code.
81427	Genome sequencing, re-evaluation	New code, requires TAR, NOT Rapid Must meet criteria for 81425
81436	Hereditary colon cancer disorders;	Code Deleted per DHCS 01/01/2025

Synopsis of Changes to Discussion Policies

MCUP3131 Attachment C Changes

Code	Gene	Comment
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing	New code
0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes,	DHCS guidelines updated frequency from N/A to "Once in a lifetime, except with valid TAR Override"
0340U	Oncology (pan-cancer), analysis of minimal residual disease	New code
0345U	Psychiatry (e.g., depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6	New code
0369U	Infectious agent detection by nucleic acid (dna and rna), gastrointestinal pathogens	Code Deleted per DHCS
0448U	Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection	Code Deleted per DHCS (see 0523U instead)
0488U	Obstetrics (fetal antigen noninvasive prenatal test),	Updated slightly per DHCS guidelines
0493U	Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA	New code
0494U	Red blood cell antigen (fetal RrhDd gene analysis),	Updated slightly per DHCS guidelines
0523U	Oncology (solid tumor), dna, qualitative, next generation sequencing (ngs) of single nucleotide variants (snv)	New code (Expanded test from 0448U)
0540U	Transplantation medicine, quantification of donor-derived cell-free DNA using nextgeneration sequencing analysis of plasma, reported as percentage of donor-derived cell free DNA to determine probability of rejection	New code
0543U	Oncology (solid tumor), next-generation sequencing of DNA	New code
0094U	Rapid Whole Genome Sequencing (rWGS) Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis	Existing code since AB133 passed and this became a benefit in 2022 for babies under one in ICU setting only. Dr. Townsend recommended adding to this Attachment for clarity.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCCP2022 (previously MCUP3065; UP100365)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="4">Original Date: 03/16/2005 (MCUP3065)</td><td colspan="3">Next Review Date: ~~02/12/2026~~01/14/2027
Last Review Date: ~~02/12/2025~~01/14/2026</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/12/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MC~~P~~UP3126 – Behavioral Health Therapy (BHT) for Members Under the Age of 21
D. MPTP2501~~MCCP2016~~ – Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)

E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
G. MPUP3048 – Dental Services (including Dental Anesthesia)
H. MP~~C~~UG3019 – Hearing Aid Guidelines
I. MCCP2031 – Private Duty Nursing Under EPSDT
J. MPBP8003~~MCUP3028~~ – Mental Health Services
K. MP~~C~~ND9002 – Cultural & Linguistic Program Description
L. MCCP2035 – Local Health Department (LHD) Coordination
M. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
N. MCUP3102 – Vision Care
O. MCUP3020 – Hospice Services Guidelines
~~N.~~P. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Ameliorate: To make more tolerable or to make better
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. DHCS: Department of Health Care Services
D. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment (*see also Medi-Cal for Kids and Teens below*)

E. FFS: Fee-for-Service
F. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
~~F.~~G. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course. For children, curative services may be provided concurrently with hospice services.
~~G.~~H. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
~~H.~~I. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
~~I.~~J. LEA: Local Education Agency
~~J.~~K. Maintenance Services: Services that sustain or support rather than cure or improve health problems
~~K.~~L. Medi-Cal for Kids and Teens: DHCS refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of Preventive Care and also a "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.
~~L.~~M. Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.
~~M.~~N. NCHCC: Northern California Hearing Coordination Center
O. Newborn Hearing Screening Program (NHSP): DHCS has implemented this statewide comprehensive program that helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills.
~~N.~~P. Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care can be provided as part of Hospice Care at the end of life, or as a set of supportive services for individuals with life-threatening conditions who have a life expectancy that is longer than 6 months.
~~O.~~Q. TCM: ~~-~~Targeted Case Management
R. Whole Child Model (WCM): A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.~~This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric members with a CCS-eligible condition(s).~~

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define Partnership HealthPlan of California's (Partnership's) responsibility to cover medically necessary services not covered under the Medi-Cal Program for individuals under the age of 21 under the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) supplemental services benefit, also referred to as "Medi-Cal for Kids and Teens."

VI. POLICY / PROCEDURE:

A. Partnership covers and ensures the provision of screenings and preventive and medically necessary diagnostic and treatment services for M~~m~~embers under the age of 21 in accordance with the EPDST program benefit.
B. Partnership provides information regarding EPSDT services for M~~m~~embers which can be found in the

Partnership Medi-Cal Member Handbook and in the "Medi-Cal for Kids and Teens" letter and education materials provided by DHCS and available on their website: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx . In addition, Partnership annually provides information to all M~~m~~embers, their families and/or caregivers about available EPSDT services through Partnership's website at http://www.partnershiphp.org/ and also through Member Newsletters which are mailed twice a year (summer and winter) and can also be accessed from this Partnership webpage: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Newsletter.aspx .

1. Partnership provides M~~m~~ember information in accordance with all language and accessibility standards as described in Partnership policy ~~MCND9002~~ MPND9002 Cultural & Linguistic Program Description.

C. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21. Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. Early and Periodic Screening, Diagnostic and Treatment services: These are services that are provided at intervals, which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services, at a minimum must include a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed exam; appropriate immunizations (according to Title 42 of USC Section 1396s(c)(2)(B)(i) for pediatric vaccines for age and health history); laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).
2. Vision services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses. For more information, see Partnership policy MCUP3102 Vision Care.
3. Dental services provided at intervals, which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services are carved out to the State, with the exception of medically necessary dental anesthesia.
4. Hearing services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids. For more information, see Partnership policy MP~~C~~UG3019 Hearing Aid Guidelines.
5. Other necessary health care, diagnostic services, treatment and other measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.
6. Partnership ensures that M~~m~~embers have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventative screening or other visit that identifies a need

for follow-up.

D. The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that "Early and periodic screening, diagnosis and treatment for any individual under the age of 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."

E. For ~~members~~Members under the age of 21, Partnership will provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule. For more information, see Partnership policy MCQG1015 - Pediatric Preventive Health Guidelines.

F. For M~~m~~embers under the age of 21, Partnership will provide and cover all medically necessary EPSDT service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of Partnership's contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

G. An EPSDT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are also covered under EPSDT because they 'ameliorate' a condition. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.

H. Additional services must be provided if determined to be medically necessary for an individual child (as per III.L above). Medical necessity determinations for services requested under EPSDT are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and are not permitted. Requests are reviewed on a case-by-case basis and take into account the particular needs of the M~~m~~ember:
   1. Children with mild to moderate mental health issues or conditions are the responsibility of Partnership and services for them are available through Carelon Behavioral Health's provider network ~~(formerly known as Beacon Health Options)~~ as Partnership's subcontractor. Referrals for services should be made to Partnership's behavioral health access line. ~~at (855) 765-9703.~~
   2. The supplies, items or equipment to be provided are medical in nature.
   3. The services are not requested solely for the convenience of the ~~member~~Member, family, physician or other provider of service(s).
   4. The services are not unsafe for the individual, and are not experimental.
   5. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the M~~m~~ember's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the M~~m~~ember's appearance.
   6. Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

I. EPSDT services must meet all of the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the ~~member~~Member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Available scientific evidence demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

5. The total cost of providing services and all other medically necessary Medi-Cal services to the beneficiary is not greater than the costs incurred in providing medically necessary equivalent services at the appropriate institutional level of care as outlined by State and Federal law.

J. Upon adequate evidence that a ~~member~~Member has a California Children's Services (CCS) eligible condition, Partnership will refer the M~~m~~ember to the local county CCS office for determination of CCS program eligibility. If the local CCS program does not approve eligibility, Partnership remains responsible for the provision of all medically necessary covered services for the ~~member~~Member. For more information, see Partnership policy ~~MCCP2024~~MCCP2024 Whole Child Model for California Children's Services (CCS).

K. Partnership is responsible for providing medically necessary Behavioral Health Treatment (BHT) under EPSDT. For more information, see Partnership policy ~~MPUP3126~~MCUP3126 Behavioral Health Therapy (BHT) for Members Under the Age of 21.

L. Partnership has the primary responsibility to provide medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agency (LEA) programs, Regional Centers (RCs), CCS, or local governmental health programs, and will not rely on these or other entities as the primary provider. Where another entity, such as an LEA, RC, or local governmental health program has overlapping responsibility for providing services to a ~~member~~Member under the age of 21, Partnership will:
   1. Assess what level of EPSDT medically necessary services the ~~member~~Member requires
   2. Determine what level of service (if any) is being provided by the other entities, and
   3. Coordinate the provision of services with the other entities to ensure that Partnership and the other entities are not providing duplicative services, and that the M~~m~~ember is receiving all medically necessary services in a timely manner.

M. Targeted Case Management (TCM)
   The EPSDT benefit includes case management and care coordination for all medically necessary EPSDT services. Partnership ensures the coverage of TCM services designed to assist the M~~m~~ember in gaining access to necessary medical, social and educational and other services. When the need for TCM services is identified, Partnership shall:
   1. Determine whether a M~~m~~ember requires Case Management (CM) or Targeted Case Management (TCM) services under EPSDT.
   2. For M~~m~~embers who are eligible for CM or TCM services, Partnership will either provide services or refer and collaborate with the appropriate agency, RC or local government health program where applicable.
   3. If a M~~m~~ember is currently receiving TCM services, Partnership will coordinate the M~~m~~ember's health care needs and EPSDT services with the TCM provider.
   4. If Partnership determines that an eligible M~~m~~ember is not accepted for TCM services, Partnership will ensure that the M~~m~~ember has access to services comparable to EPSDT TCM services.

N. Transportation
   1. Under the EPSDT benefit, for M~~m~~embers under the age of 21, Partnership:
      a. May provide medical (NEMT) and non-medical (NMT) transportation, meals and/or lodging to and from any medically necessary covered EPSDT appointment as outlined by Title 42 Code of Federal Regulations (CFR) Section 440.17 (a)(3).
      b. Shall provide appointment scheduling assistance to and from medical appointments for the medically necessary EPSDT services covered by Partnership.
   2. For more information, see Partnership policy ~~MCCP2016~~MPTP2501 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).

O. Dental Services
   1. Most dental services are carved-out of Partnership's contract with DHCS. Under EPSDT, for

M~~m~~ember under the age of 21 Partnership will:

a. Cover and ensure that dental screenings/oral health assessments for all M~~m~~embers are included as part of the initial health appointment.
b. Ensure providers perform a dental screening/oral health assessment as part of every periodic assessment
c. Encourage providers to make annual dental referrals no later than 12 months of age or when referral is indicated.
d. Cover and ensure that fluoride varnish and oral fluoride supplementation assessment and provision is consistent with AAP/Bright Futures periodicity schedule and anticipatory guidance.
e. Cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.
f. Ensure that providers refer M~~m~~embers to appropriate Medi-Cal dental providers.

2. For more information, see Partnership policy ~~MPUP3048~~MPUP3048 Dental Services (including Dental Anesthesia).

P. Hospice Services

1. Children receiving hospice care services for a terminal illness and life expectancy of six months or less may receive additional services than are available for adults.
2. Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under 21 years of age also may elect to receive concurrent curative treatment of the hospice-related diagnosis and concurrent palliative care.
3. For more information, see Partnership policy MCUP3020 Hospice Service Guidelines ~~or~~and MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21.

~~P.~~Q. Excluded Services

For M~~m~~embers under the age of 21, Partnership is required to cover all medically necessary EPSDT services except those services that are specifically carved out of Partnership's contract with DHCS. Carved-out services vary and can include, but are not limited to, dental services, specialty mental health services, non-medical services provided by the Regional Center(s), etc. In addition, Partnership does not reimburse families or caregivers for care.

~~Q.~~R. For services to be considered under the EPSDT benefit, a Treatment Authorization Request (TAR) must be accompanied by the following information:

1. The principal diagnosis and significant associated diagnoses
2. Prognosis
3. Date of onset of the illness or condition; and etiology if known
4. Clinical significance or functional impairment caused by the illness or condition
5. Specific types of services to be rendered by each discipline, and anticipated time for achievement of the goals
6. The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
7. Any other documentation available that may assist Partnership in making determinations related to medical necessity.

~~R.~~S. Newborn Hearing Screening Program (NHSP)

1. Partnership is responsible for case management services related to EPSDT and collaborates with the PCP and/or Specialist to ensure follow-up for missed EPSDT-related appointments, which includes follow-up with the families of babies that miss their hearing screening or diagnostic appointments. Partnership's Care Coordination department will receive referrals from the Northern California Hearing Coordination Center (NCHCC) to assist in case management services for access to care concerns and following up on missed hearing screening or diagnostic appointments.

2. Partnership providers can refer Mmembers who have missed or failed EPSDT-related appointments through the external referral form on the Partnership's website. Our Care Coordination staff may also reach out to the Mmember once the referral is received to assist with care coordination services and identify barriers.

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

1. For more information, refer to Partnership policy MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities and MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities.

VII. REFERENCES:

A. Title 42 United States Code (USC) Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
B. Title 22 California Code of Regulation (CCR) Section51340(e)
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Welfare and Institutions Code (WIC) Section 14132(v)
E. Mental Health Parity and Addiction Equity Act
F. Social Security Act Section 1905 (a) and (r)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
H. DHCS webpage with resources for "Medi-Cal for Kids and Teens": https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx
I. DHCS APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (*Revised* 11/28/2023)
~~I.~~J. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES:

MCCP2022 - (as of 02/15/17)
08/16/17; *06/13/18; 02/13/19; 11/13/19; 02/12/20; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 02/14/24; 06/12/24; 09/11/24; 02/12/25; 01/14/26

*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:
MCUP3065 (03/16/2005 to 02/15/2017)
10/18/06; 07/15/09; 01/18/12; 02/18/15; 02/17/16 to 02/15/2017

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Policy/Procedure Number: MCCP2022 (previously MCUP3065, UP100365)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/16/2005 (MCUP3065)			**Next Review Date: 01/14/2027~~02/12/2026~~** **Last Review Date: 01/14/2026~~02/12/2025~~**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MP~~C~~NP9006 *(previously MCNP9006)*			**Lead Department: Health Services** Business Unit: Population Health	
Policy/Procedure Title: Doula Services Benefit			☒ **External Policy** ☐ **Internal Policy**	
Original Date: ~~——~~01/10/2024 Effective Date: ~~——~~01/01/2023		**Next Review Date:** ~~01/08/2026~~01/14/2027 **Last Review Date:** ~~01/08/2025~~01/14/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒~~☐~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~08/13/2025~~01/14/2026	

I. RELATED POLICIES:

A. MP~~C~~ND9001 – Population Health Management Strategy & Program Description
B. MP~~C~~ND9002 – Cultural and Linguistic Program Description
C. MCUG3118 – Prenatal & Perinatal Care
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCUP3113 – Telehealth Services
F. MPCR15 – Doula Credentialing and Re-Credentialing Criteria
G. MPNET100 – Access Standards and Monitoring
H. MPPR200 – ~~PHC~~ Partnership Provider Contracts
I. MPPRO1102 – Contracted Provider Education
J. ~~MCCP2032~~ MCAP7002 – CalAIM Enhanced Care Management (ECM)
K. ~~MCUP3143~~ MCAP7001 – CalAIM Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. The Comprehensive Perinatal Services Program (CPSP): Has divided authority between ~~Developed by~~ the California Department of Health Care Services (DHCS) and the California Department of Public Health (CDPH). It is~~as~~ an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. The CPSP provider certification process is ~~locally~~ administered and approved by the CDPH~~county CPSP Coordinator with final approval by DHCS~~. *Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, ~~perinatal~~ providers to be CPSP certified in order to provide obstetrical and perinatal services, however obstetrics providers~~they~~ need to provide CPSP-like services or refer to another CPSP Provider for non-obstetric CPSP or CPSP-like services. *[Also see the Partnership HealthPlan Perinatal Services (PHPS) definition below.]*
B. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
C. Doulas are trained birth workers credentialed by Partnership to provide health education, advocacy, and

physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.

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

~~D. Partnership HealthPplan Perinatal Services (PHPS) : CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *[Also (ssee also the Comprehensive Perinatal Services Program (CPSP) definition above.])*~~

E. 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 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.

~~E.~~F. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *[Also see the Comprehensive Perinatal Services Program (CPSP) definition above.]*

IV. ATTACHMENTS:

A. Medi-Cal Doula Services Recommendation F~~f~~orm

B. Doula Crosswalk Coding Information~~Required ICD Codes for Doula Services~~

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

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

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

C. Informing providers about the D~~d~~oula B~~b~~enefit
   1. Partnership publicizes our current understanding of the regulatory framework for doulas with our provider network and CBOs in community meetings, provider meetings, and in Provider Newsletters as applicable.
   2. Partnership's Provider Relations department educates providers on doula services through the

Medical Director's Newsletter, quarterly Provider Newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

D. Informing members about the Ddoula Bbenefit
   1. Partnership's Health Education team crafts culturally and linguistically appropriate communication to explain doula services to our members.
      a. Members are informed of the Doula Services benefit in the Partnership Member Handbook, known as the Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services and is also available on the Partnership website at PartnershipHP.org in the Members section. Partnership Advantage enrollees (as defined in III.E.), are eligible for doula services under their Medi-Cal benefit as described in this policy.
      b. Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the Member Newsletter and that the Partnership webpage is updated with these new services. Members qualifying for doula services are given information about how doulas can provide support during pregnancy, postpartum, and after childbirth, during miscarriage, stillbirth, and abortion.

E. Eligibility for Ddoula Sservices
   1. Partnership Medi-Cal members and Partnership Advantage ~~Members~~ enrollees who are currently pregnant or have been pregnant in the last 365 days are considered eligible and are recommended to receive the doula services benefit.
      a. A licensed provider (a physician or other licensed practitioner of healing arts acting within their scope of practice under state law) may provide a recommendation for a Partnership Member to have doula services. This may be noted in the member's medical record and/or a written recommendation forwarded to the doula.
         1) The recommending provider does not need to be enrolled in Medi-Cal, Medicare or be a Partnership network provider.
         2) DHCS has created an optional Medi-Cal Doula Services Recommendation form that recommending providers may choose to use (see Attachment A).
      b. Doulas must verify that the member's Medi-Cal (or Partnership Advantage as applicable) eligibility for the month of services is valid by contacting Partnership to verify eligibility.
      c. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.
      d. Doulas must document in the records, the name/practice of a collaborating provider involved in the care of the member.
         1) A collaborating provider is a licensed practitioner of the healing arts who is involved in the member's care acting within their scope of practice (LCSW, MD, DO, NP, PA).
   2. The DHCS standing recommendation for doula services implemented on November 1, 2023 authorizes the following:
      a. One initial visit.
      b. Up to eight (8) additional visits (may be provided in any combination of prenatal and postpartum visits).
      c. Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
      d. Up to two extended three-hour postpartum visits after the end of a pregnancy (these two visits would not require the member to meet additional criteria or receive a separate recommendation)
         1) The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days.
      e. All visits are limited to one per day per member, and only one doula may bill for a visit provided to the same member on the same day (excluding labor and delivery).

1) On the day of labor/delivery, stillbirth, abortion, or miscarriage support:
   a) One doula may bill for labor and delivery, stillbirth, abortion or miscarriage support, and
   b) One prenatal *or* one postpartum visit may be provided, also. This visit may be billed by a different doula.

3. A Treatment Authorization Request (TAR) is required for additional visits (beyond eight) during the postpartum period [~~(~~see policy MCUP3041 Treatment Authorization Request (TAR) Review Process]~~)~~.
   a. A recommendation from a physician or other LPHA acting within their scope of practice under state law is required.
   b. The request for additional visits will be evaluated for medical necessity; the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits.
   c. The additional recommendation may authorize up to nine (9) additional postpartum visits.

F. Documentation Requirements
1. Doulas must document each visit with:
   a. National Provider Identifier (NPI)
   b. Date, time, and duration of services provided to the member
   c. Service(s) provided
   d. Length of time spent with member that day
   e. Initial visit records must include documentation of a collaborating or recommending perinatal provider (medical, behavioral health, or licensed CPSP provider)
2. Documentation should be integrated into the member's medical record from the recommending provider, and available for encounter data reporting. Doulas will share documentation with the perinatal providers.
3. Documentation must be accessible to Partnership and DHCS upon request.

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

H. Doula Services Provided
1. Refer to sections VI.E.2. for a description of doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization.
2. For pregnancy-related services that are available through Medi-Cal, doulas should work with the member's provider or with Partnership to refer the member to a network provider who is able to render the service. These Medi-Cal services include but are not limited to:
   a. Behavioral health services

b. Belly binding after cesarean section by clinical personnel
c. Clinical case coordination
d. Health care services related to pregnancy, birth, and the postpartum period
e. Childbirth education group classes
f. Comprehensive health education including orientation, assessment, and planning (CPSP services)
g. Hypnotherapy (non-specialty mental health services)
h. Lactation consulting, group classes, and supplies
i. Nutrition services (assessment, counseling, and development of care plan)
j. Transportation
k. Medically appropriate Community Supports services

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

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

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

K. Billing, Claims, and Payments
1. Partnership makes payments in compliance with the clean claims requirements and timeframes outlined in its ~~the~~ MCP Contract and ~~Timely Payments~~DHCS All Plan Letter (APL) 23-020 Requirements for Timely Payment of Claims ~~APL~~. These requirements apply to both Partnership and its Network Providers and Subcontractors.
~~2. If a member chooses to see an OON Provider for abortion services, Partnership will reimburse that provider no less than the Medi-Cal Fee-For-Service rate for the service provided. This also applies to eligible Partnership Advantage members for whom abortion services are covered through the Medi-Cal portion of their benefit. Providers may not charge Members any amount above the reimbursed rate for covered abortion services.the reimbursement rate must not be lower, and is not required to be higher, than the Medi-Cal Fee-For-Service~~

~~3.~~2. Doula services will be reimbursed in accordance with their Network Provider contract and per Medi-Cal guidelines for Doula Services.
   a. Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.

~~4.~~3. Encounter data
   a. Doulas must submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes.
   b. Partnership will submit data related to doula services utilization and provider network per DHCS requirements.

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

      ~~e.~~ .When applicable, ensure compliance with D-SNP state specific quality reporting requirements by monitoring quality measures – including but not limited to Emergency Department Behavioral Health (ED BH), Cognitive Health Assessment (CHA), and ~~Individualized Care Plan (ICP). Refer to the D-SNP Quality and Data Reporting~~Individualized Care Plan (ICP). Refer to the D-SNP Quality and Data Reporting documentation for the complete list of measures.
      d.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024 Doula Services (*Revised* 11/03/2023 *supersedes* APL 22-031)
B. DHCS APL 22-013 Provider Credentialing / Re-credentialing and Screening / Enrollment (*Revised* 08/24/2022)
~~B.~~C. DHCS APL 23-020 Requirements for Timely Payment of Claims (*Revised* 10/12/2023)
~~C.~~D. State Plan Amendment (SPA) 22-0002
~~D.~~E. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
F. Medi-Cal Provider Manual/Guidelines: Doula Services
G. -California Department of Public Health CPSP Program
~~E.~~H. D-SNP Quality and Data Reporting

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
01/08/25; 01/14/26

Policy/Procedure Number: **MPCNP9006 (previously MCNP9006)**			**Lead Department: Health Services** Business Unit: Population Health
Policy/Procedure Title: Doula Services Benefit			☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/10/2024 Effective Date: 01/01/2023			**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

Partnership Advantage (effective Jan. 1, 2027)
01/14/26~~N/A~~

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.

Medi-Cal Doula Services Recommendation

Support for healthy pregnancies and follow-up care

If you are a Medi-Cal beneficiary…



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



If you are a doula…

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



If you are a licensed provider[1]…

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

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

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

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

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

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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

- Ask for a State Hearing

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

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

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

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

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

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

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

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

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

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

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

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

Doula Crosswalk Coding Information

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

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

Doula Billing Code Crosswalk

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

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

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

To view the Medi-Cal Provider Bulletin, click here

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~11/13/2025~~01/14/2027
Last Review Date: ~~11/13/2024~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td>☐ Employees</td><td colspan="2"></td><td colspan="2">☒ Medi-Cal</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☒ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td>☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date:
~~11/13/2024~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~B. MCUP3051 – Long Term Care SSI Regulation~~
~~C.~~B. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
C. MPUP3139 – Criteria and Guidelines for Utilization Management
D. MCUP3020 – Hospice Services
~~D.~~E. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
F. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~E.~~G. MPTP2501 – Transportation ~~Guidelines~~Policy for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
~~F.~~H. MPQP1016 – Potential Quality Issue Investigation and Resolution
~~G.~~I. MCRP4068 – Medical Benefit Medication TAR Policy
~~H.~~J. ~~MCUP3142~~MPAP7003 – CalAIM Community Supports
~~I.~~K. ~~MCCP2032~~MCAP7002 – CalAIM Enhanced Care Management (ECM)
~~J. MPPR210 – Long Term Support Services Liaison~~

II. IMPACTED DEPTS:

A. Claims
B. Member Services
C. Enhanced Health Services (EHS)

D. Transportation
E. Provider Relations
F. Quality and Performance Improvement

III. DEFINITIONS:

A. Custodial Care Facilty: A n~~N~~on-medical facility (often referred to as a Long Term Ce~~a~~are (LTC) facility that provides basic assistance ~~helps Members~~ with ~~their~~ daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability. ~~basic care such as eating, bathing, and/or mobility~~.
~~B. Intermediate Care Facility (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.~~

~~C. Long Term Care (LTC) Facility: A health facility that provides rehabilitative, restorative and/or on-going skilled nursing care to patients in need of assistance with activities of daily living (ADLs).~~

~~D.~~B. Extended Care Facility (ECF): A healthcare institution that provides ~~rehabilitative, restorative and/or~~ on-going ~~skilled nursing care to patients in need of~~medical care, rehabilitation services, and assistance with activities of daily living ~~(ADLs).~~to individuals who require prolonged or specialized care. This is an all-inclusive term for facilities providing custodial, skilled and sub-acute services.

~~E.~~C. Skilled Nursing ~~Facilities (SNFs~~Facility (SNF): A ~~special~~ facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to complete a course of treatment that is not available in lower levels of care and support an increase in function, safety and independence with activities of daily living.

~~F.~~D. Subacute Care Facility: A facility with a level of care that is less intensive than acute care~~,~~ but ~~is~~ more intensive than skilled nursing care (e.g. Members who require ventilators,~~-~~ tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).

~~G.~~E. Subacute Contracting Unit (SCU): A unit within the California Department of Health Care Services (DHCS), responsible for contracting with providers to offer Medi-Cal subacute care services. Contracted facilities may be reimbursed for subacute care services provided to Medi-Cal subacute beneficiaries who meet subacute care criteria as defined in Medi-Cal Manual of Criteria R-15-98E (adult beneficiaries) and Welfare and Institutions Code, section 14132.25 (pediatric beneficiaries). Specific reimbursement rates have been developed for providers of subacute care who have contracted with the DHCS' SCU.

IV. ATTACHMENTS:

A. Bed Hold/Change of Status Report form
B. Skilled Nursing Facility Request Form

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Extended Care Facilities ~~Long Term Care (LTC) facilities~~ for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate ~~Long Term~~Extended Care Facilities (ECFs)
   1. Partnership ensures access to licensed ~~long-term~~ care facilities, irrespective of location in or out-of-network, to Members in need of ~~long-term~~extended care services. These facilities may include:
      a. Custodial/Long Term Care Facilities
      ~~a.~~b. Skilled Nursing Facilities (SNF) ~~as defined in III.D~~
      ~~b.~~c. Subacute Care Facilities (pediatric and adult) ~~as defined in III.E.~~
      ~~c. Intermediate Care Facilities (ICF) as defined in III.B.~~
   2. A Member in need of ~~long-term~~extended care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the Member to the appropriate type of facility.
   3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and Partnership Utilization Management (UM) team identifies the most appropriate level of care for the Member and assures that the Member is placed in a health care facility that provides the level of care most appropriate to the Member's medical needs.
      a. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120,

51335.5, 51334, 51335.6, and referenced sections of 51003 (e). ~~These~~

~~.~~b. DHCS Title 22 ~~Medi-Cal guidelines~~regulations, as well as CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* are ~~used~~utilized by Partnership UM Nurse Coordinators when performing reviews of authorization requests to determine the medical necessity for continued placement in ~~a long-term~~an extended care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended. ~~Classification categories include the following:~~

4. Extended Care Classification categories include the following:
   a. Custodial/Long Term Care: These facilities assist members in meeting their activities of daily living (ADLs) such as eating, bathing, grooming, etc. Members must meet criteria showing need for this level of care. Following admission to the facility, members will continue to be reevaluated periodically to ensure medical necessity is met for continued placement.
   b. Skilled Nursing Care: The Member may need a short-term stay for a skilled nursing care need or short-term rehab services and is expected to return to their previous living arrangement or alternate level of care. Facility staff, including case managers, are responsible for coordinating discharge planning for the member.
   ~~a.~~c. Subacute Care: The Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care either can either be short term, where there is potential for the Member eventually being transferred to a lower level of care; or custodial/long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these Members are authorized for time intervals based on the characteristics of the Member's medical condition.
   ~~b. Short Term Care: The Member may need a short term stay for a skilled nursing care need or short term rehab services and expected to return to his/her previous living arrangement or alternate level of care.~~
   ~~c. Long Term Care: When a Member is admitted for custodial care, the TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments.~~

~~4.~~5. The choice of ~~a long term care facility~~an ECF for a patient is a decision that should include consideration of the following:
   a. ~~If~~What are the medical/ rehabilitation needs for the member and does the facility have the services available to meet the Member's needs?
   ~~a.~~b. Is the facility ~~is~~ a licensed Medi-Cal provider?
   ~~b.~~c. ~~If~~Is the facility ~~is~~ contracted with Partnership?
   ~~c.~~d. ~~If~~Are there ~~are~~ beds available?
   ~~d.~~e. If more than one choice is available, ~~the family's choice of facility~~is there a family preference (e.g. geographical location) that can be reasonably accommodated?
   ~~e.~~f. ~~Benefit~~Are there any benefit coverage limitations?

~~5. A Long Term Care (LTC) facility must be a licensed institution (other than a hospital).~~

6. ~~-~~Facility Requirements
   a. An ~~LTC facility~~ECF must meet all of the following requirements:
      1) It must be a licensed institution
      ~~1)~~2)It must be qualified as a provider of services under Medi-Cal
      ~~2)~~3)It must maintain, on the premises, all facilities necessary for medical care and treatment
      ~~3)~~4)It must provide such services under the supervision of ~~physicians~~a physician
      ~~4)~~5)It must provide services given by or supervised by a registered nurse AND
      ~~5)~~6)~~It~~The facility must keep medical records on all patients
   b. For Members approved for subacute services, based on availability, Partnership verifies those

services are received from a provider that has a contract with the ~~Department of Health Care Services' (~~DHCS'~~)~~ Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

~~B. Short Term Skilled Nursing and Rehab Programs~~

~~1. Skilled level nursing is a covered level of care for Partnership's Members. Usually this level of care is short term and follows hospitalization at an acute care facility during the acute rehabilitation stage of treatment for an illness or injury.~~

~~a. Admission to a skilled nursing facility must be coordinated with a contracted, Medi-Cal licensed facility by the discharge planner. If the Member is not currently confined, or the hospital discharge planner is unavailable, the Partnership Nurse Coordinator is the appropriate contact for referral to a skilled nursing level facility.~~

~~b. The attending physician should also be aware that a history and physical are needed by the skilled nursing facility that is accepting the Member. Orders are generally accepted over the telephone for an immediate placement and a written history and physical must then be completed and sent to the accepting facility.~~

~~2. Specialized Rehabilitative Services~~

~~a. Specialized rehabilitative services in skilled nursing facilities shall be covered in accordance with the standards of medical necessity. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either:~~

~~1) A sustained higher level of self-care and discharge to home or~~

~~2) A lower level of care~~

~~b. Specialized rehabilitation service shall be covered contingent upon compliance with the following requirements:~~

~~1) The services shall be ordered by the beneficiary's attending physician.~~

~~2) The physician's signed order, specifying the care to be given, shall be on the beneficiary's chart.~~

~~3) A copy of the order shall be made available for departmental review upon request.~~

~~c. The services require prior authorization by the Partnership Nurse Coordinator prior to admission to a skilled nursing facility. The authorization request shall be accompanied by a treatment plan, signed by the attending physician, which shall include the following:~~

~~1) Principal and significant diagnoses~~

~~2) Prognosis~~

~~3) Date of onset of illness or injury~~

~~4) Specific type, number, and frequency of services to be performed by each discipline~~

~~5) Therapeutic goals of the service provided by each discipline and anticipated duration of treatment~~

~~6) Extent of and benefits or improvements demonstrated by any previous provision of physical therapy, occupational therapy, speech pathology or respiratory services~~

~~d. Professional therapy necessary to establish maintenance program services under treatment programs not requiring the skills of a qualified therapist shall not be separately payable or authorized.~~

~~C. Admission to a LTC Facility~~

B. Members with Other Healthcare Coverage

1. When Members have other healthcare coverage (e.g., Medicare) Partnership will work to coordinate benefits as applicable.

C. Treatment Authorization Requests (TARs) for Admission to an Extended Care Facility (ECF)

1. In alignment with ~~Manual of Criteria R-15-98E,~~Manual of Criteria R-15-98E, an initial Treatment

Authorization Request (TAR) is required with each admission~~. A LTC Treatment Authorization Request (~~ to an ECF. A TAR~~)~~ is required when the Member:

a. Is a new admission to the facility
b. Has exhausted ~~his/her~~their Medicare benefits
c. Has received a denial from Medicare or other insurance ~~denies LTC~~for extended care
d. Is readmitted to ~~LTC~~an ECF from an acute care hospital ~~or did not return to the LTC facility on or before day eight (8) of "bed hold days"~~
e. Returns to ~~the LTC facility~~an ECF from an approved leave of absence beyond the approved return date
f. Is newly eligible with Partnership while residing in the ~~LTC facility~~ECF
g. Changes level of care (e.g. ~~ICF level~~Skilled to ~~SNF level, SNF~~Custodial, Custodial to ~~ICF level of care, SNF to~~ Skilled, Subacute to Skilled)

~~2. The physician/ facility submits the TAR to the Partnership UM Department with the following documentation:~~

~~a. A completed Pre-admission Screening and/or a Preadmission Screening and Resident Review (PASRR) form indicating appropriateness for placement~~
~~b. The Minimum Data Set (MDS) and relevant medical record documentation supporting the medical necessity for the level of care requested which must have been completed within the last 90 calendar days to request for custodial care or re-authorization~~
~~c. A Medicare or other insurance denial, if applicable~~

~~3.~~2. A UM Nurse Coordinator reviews the authorization request for medical necessity and level of care utilizing DHCS Title 22 regulations and/or CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria* *and* ~~level of care.~~*Guidelines for Utilization Management*.

a. Cases not meeting criteria for medical necessity are referred to ~~one of~~ the Chief Medical ~~Directors~~Officer (CMO) or Physician Designee for review and determination.
b. ~~Upon determination of medical necessity, an approval~~Upon review, a UM Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity. Only the CMO/ Physician Designee can deny a TAR for reasons of medical necessity.

~~b.~~c. A determination will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.

~~c.~~d. Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what Partnership ~~actually~~ approves.

~~d.~~e. The facility is responsible for verifying the Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.

~~e. Acute Care to Long Term Care Facility~~

~~The transfer must be coordinated by the hospital discharge planner or case worker to Partnership inpatient concurrent review nurse prior to admission to the LTC facility. The hospital discharge planner or case worker will notify the Partnership inpatient concurrent review nurse when the Member needs to be transferred to a LTC facility.~~

~~1) The Partnership inpatient concurrent review nurse will discuss the case with the Partnership Nurse Coordinator. If the transfer meets the Partnership guidelines, verbal approval is given for admission to the skilled nursing facility.~~
~~2) If a Member is capped to a hospital, the discharge planner at the hospital will directly notify the Partnership Nurse Coordinator to initiate a referral to a skilled facility.~~

~~f. Admission from Home to Long Term Care Facility~~

~~1) A LTC facility is required to notify Partnership before any elective admission. Prior~~

~~authorization is required for all elective admissions from home.~~

~~2) The following information must be submitted with the prior authorization request via TAR:~~

~~a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in a long term care facility and the physician's certification that placement in the long term care facility is the appropriate level of care for the Member.~~

~~b) If placement follows an acute hospital stay within the past 30 calendar days, please submit the hospital history and physical and discharge summary.~~

~~c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, please submit the Primary Care Provider's progress notes for the past six (6) months.~~

~~d) Please Note: If the admission from home occurs without prior approval from Partnership and the Member's condition and services do not meet criteria, Partnership will issue a denial to the facility.~~

~~g. Admissions on Weekends and Outside normal business hours~~

~~g.a. For an admission to LTC facility on the weekend or outside normal business hours, facility is to contact Partnership as soon as possible to identify the Partnership Member, reason for admission, and name of facility.~~

~~g.a. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.~~

~~h. Transfer to an Acute Care Facility~~

~~1) The transfer of a Member to an acute care facility must be reported through the Bed Hold & Change of Status Report form (Attachment A) weekly. When appropriate, the Partnership Nurse Coordinator places the Member in a "bed hold" status for up to 7 calendar days. (see VI.G.4)~~

~~h.a. The LTC facility must notify Partnership when the Member is readmitted to the LTC facility. Claims will not be paid if the readmission is not appropriately reported to Partnership.~~

~~i. Discharge or Death~~

~~1) All discharges or deaths must be reported on a weekly basis. (Attachment A "Bed Hold & Change of Status Report" form is recommended for reporting.)~~

~~2) Notification of a Member's death should include whether the death occurred within the LTC or in an acute care facility.~~

~~j. Medicare/Medi-Cal Members~~

~~1) Members with both Medi-Cal and Medicare coverage become the financial responsibility of Partnership when the Member has exhausted their Medicare skilled days benefit.~~

~~2) The SNF must submit the Medicare denial letter showing non-coverage of services to Partnership along with a completed TAR and required medical documentation for review. Partnership's Nurse Coordinator reviews the case to determine the medical necessity of continued authorization.~~

~~3) Note: Partnership follows Title 22 criteria for admission and continuing care for LTC facilities.~~

~~D. Denials and Coordination of Care~~

~~1. Cases determined to not meet LTC guidelines based on Title 22 Medi-Cal Guidelines and the information available at the time of review, are managed as follows:~~

~~a. If the Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.~~

~~b. The Nurse Coordinator contacts the attending physician to discuss concerns regarding patient's acuity, treatment plan or length of stay (LOS), or to obtain any additional pertinent information~~

~~that might assist with the level of care determination.~~

~~c. Denials of medical necessity are determined only by the Partnership Chief Medical Officer (CMO) or Physician Designee.~~

~~d. UM staff ensures the Member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights.~~

~~E. Continuing Care Determinations~~

3. Extensions of Stay

~~.~~a. Extensions of stay in ~~SNF~~extended care facilities for Medi-Cal Members require re-authorization by Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6 ~~for newly admitted Members who may be eligible to return home~~.

b. Extension requests will be reviewed based on the facility's documentation of the Member's current clinical status and medical need of requested extension, including current services required, anticipated duration of services and progress towards goals of therapy in the prior approved stay, and current discharge disposition/ planning as noted by the facility's team.

4. Admissions on Weekends and Outside Normal Business Hours

a. If a member is transferred to a facility on a weekend, or outside normal business hours, Partnership must be notified via phone or the Online Services (OLS) portal on the next business day for immediate review of the TAR.

b. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.

5. Custodial (Long Term Care) TAR Submission Requirements:

a. Custodial care services require prior authorization by a Partnership UM Nurse Coordinator before admission to a Custodial facility, otherwise, the stay may be denied for not meeting medical necessity.

b. A custodial care authorization request shall be initiated by the ECF, and the following documentation must be submitted with the initial Custodial Care TAR:

1) Completed TAR form.

a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.

b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.

2) MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)

a) For Partnership members with Supplemental Security Income (SSI), the ECF is required to submit the MC171 form to the Social Security Administration (SSA) within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.

b) Partnership's Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form for all Partnership members with SSI. If a facility does not submit the MC171 form, the TAR will be sent to the CMO/Physician Designee for review and denied for "information requested not received." The facility will be notified.

3) Medicare or other Insurance denial letter (if applicable)

4) Completed Minimum Data Set (MDS) dated within the past 90 days

5) PASRR (Preadmission Screening and Resident Review)

c. When a member is admitted for custodial care, a TAR submission may be approved up to a six (6) month period.

d. The Member's condition will be re-evaluated upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

e. Continued Care (Reauthorization) with a new TAR must include the following:

1) Completed new TAR form
2) Current MDS dated within 90 days of TAR start date
3) Social Services annual review/quarterly assessment and progress notes

6. Skilled Nursing Facility (SNF) TAR Submission Requirements:
   a. Skilled level nursing is a covered level of care for Partnership Members. This level of care is short-term for the acute rehabilitation stage of treatment following an illness or injury.
   b. Admission to a SNF must be coordinated with a contracted Medi-Cal licensed facility by the discharge planner.
   c. Skilled nursing services require prior authorization by Partnership before a Member's admission to a SNF.
   d. The following documents must be submitted with the initial SNF TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) PASRR (Preadmission Screening and Resident Review)
      3) Acute notes
      4) Medicare or other health coverage denial letter
      5) Eligibility must be "No Other Insurance"
      6) Skilled Nursing Facility Request form (Attachment B)
      7) MD orders as applicable to facility type (see VI.C.8. and 9. below)
   e. The following documents must be submitted for a SNF TAR extension:
      1) MD orders from SNF
      2) Nurse and attending physician/ medical provider notes showing medical need for SNF care (e.g. wound care, IV antibiotics) and anticipated duration of need
      3) Therapy progress report indicating current level of participation, progress notes and goals of treatment
      4) Discharge planning documents
7. Subacute Care Facility TAR Submission Requirements:
   a. The following documents must be submitted with the initial Subacute Care Facility TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      3) Acute notes to include therapy notes (e.g. physical therapy, speech therapy, occupational therapy, respiratory therapy)
   b. Note: For Members approved for sub-acute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
   c. The following documents must be submitted for a Subacute TAR extension:
      1) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services (if dates are applicable)
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200

2) Facility progress notes
3) MD orders

~~.~~d. Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of ~~four months. Extensions are based on the same criteria as initial authorizations.~~six months.

~~3. When a Member is admitted for custodial care, a TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments upon submission of a new TAR within 15 days of the expiration date of the previous TAR.~~

~~F. Continuity of Care Requirements~~

~~1. Effective January 1, 2024, and through June 30, 2024, for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, Partnership will automatically provide 12 months of continuity of care for the Subacute Care Facility placement. Automatic continuity of care means that if the Member is currently residing in a Subacute Care Facility, they do not have to request continuity of care to continue to reside in that facility. While Members must meet medical necessity criteria for adult or pediatric subacute care services, continuity of care must be automatically applied.~~

~~a. Consistent with Health and Safety Code section 1373.96, application of automatic continuity of care allows for the completion of covered services provided by a nonparticipating provider to a newly covered Partnership Member who, at the time that coverage became effective, was receiving services from that provider, irrespective of contracting status with Partnership.~~

~~b. Members are allowed to stay in the same Subacute Care Facility, irrespective of location in or out-of-network, under continuity of care only if all of the following applies:~~

~~1) The facility is contracted or actively in the process of being contracted by DHCS SCU.~~
~~2) The facility is enrolled and licensed by the California Department of Public Health (CDPH)~~
~~3) The facility is enrolled as a Medi-Cal Provider~~
~~4) The Subacute Care Facility and Partnership agree to payment rates that meet state statutory requirements; and~~
~~5) The facility meets Partnership's applicable professional standards and has no disqualifying quality-of-care issues.~~

~~c. Partnership will determine if a Member is eligible for automatic continuity of care before the transition by identifying the Member's Subacute Care Facility residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the Member or provider. A pre-existing relationship means that the Member has resided in the Subacute Care Facility at some point during the 12 months prior to the date of the Member's enrollment with Partnership.~~

~~d. Following their initial 12-month automatic continuity of care period, a Member may request an additional 12 months of continuity of care, following the process established by APL 23-022, "Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023."~~

~~e. A Member newly enrolling with Partnership and residing in a Subacute Care Facility on or after July 1, 2024, does not receive automatic continuity of care and must instead request continuity of care following the process established by APL 23-022.~~

~~2. A Member residing in a SNF who newly enrolls with Partnership on or after July 1, 2023 does not receive automatic continuity of care and must request continuity of care following the process established by APL 23-022.~~

~~G. Monitoring and Review~~

~~1. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue,~~

~~the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.~~

1) Extensions are reviewed based on medical need for the care that is provided. Facilities must provide current records showing the Member's current clinical status, participation in therapies, progress toward goals and discharge planning.

8. Authorizations for Transfers from Acute Care to an Extended Care Facility (ECF)
   a. Please Note: If admission from acute care occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. The ECF is required to notify Partnership before any admission. Prior authorization is required for all admissions.
   ~~.~~c. UM Nurse Coordinator ~~also assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies~~will review documents and provide initial determination approval.

~~H. TAR Submission Requirements:~~

~~The authorization request shall be initiated by the facility with all required attachments as noted below. TAR should be submitted within 15 business days from the date of service. (Note that the TAR must also be submitted within 60 calendar days from the date that the Member established eligibility with Partnership.)~~

~~1. Initial TAR must include the following:~~
   ~~a. Completed new TAR form~~
   d. ~~MC171 (Medi-Cal Long Term Facility~~ The transfer must be coordinated by the hospital discharge planner or case worker.

~~6.~~9. Admission ~~and Discharge notification)~~from Home to an Extended Care Facility
   ~~0)~~1)~~Medicare or other Insurance denial letter (if applicable)~~
   ~~d. Minimum Data Set (MDS)~~

~~2. Continued Care with a new TAR must include the following:~~
   a. Please Note: If the admission from home occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. An ECF facility is required to notify Partnership before any admission. Prior authorization is required for all admissions from home.
      1) The following information must be submitted with the TAR:
         a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in an ECF and the physician's certification that placement in the particular ECF is the appropriate level of care for the Member.
         b) If placement follows an acute hospital stay within the past 30 calendar days, the hospital history and physical and discharge summary must be submitted.
         c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months must be submitted.
   ~~a. Completed new TAR form~~
   ~~b. Current MDS (or most recent quarterly MDS)~~
   ~~c. Social Services notes and evaluation~~

~~3. Post-service Retrospective TAR must include the following:~~
   ~~a. Completed new TAR form~~
   ~~b. MC171 (Medi-Cal LTC Facility Admission and Discharge Notification form)~~

~~c. PASSR (Preadmission Screening and Resident Review Medicaid form)~~
~~d. Minimum Data Set (MDS)~~
~~e. Medicare or other health coverage denial letter (as applicable)~~
~~f. Social Services notes and evaluation~~

10. Bed ~~hold TAR (When~~Hold Change of Status Reporting
~~.~~a. This occurs when a Member residing in ~~a nursing facility or subacute care facility~~an ECF is transferred to an acute care hospital or has an approved leave of absence~~)~~., which must be reported through the Bed Hold/ Change of Status Report form (Attachment A).
~~a. Bed hold TARs must include the following:~~
~~1) Doctor's order~~
~~2) Completed new TAR~~
~~a.~~b. ~~b. Maximum~~The maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
c. The following documents must be submitted when reporting a Bed Hold change of status:
1) MD orders
2) Bed Hold/Change of Status Report form (Attachment A)
~~.~~d. When a custodial Member returns to the ~~LTC facility~~ ECF prior to or on the 8th calendar day, the ~~current~~existing ECF TAR is still valid.
~~.~~e. If a Partnership Member returns to ~~a~~ an ~~LTC facility~~ECF after 8 calendar days, a new ECF TAR and all required attachments must be submitted (see ~~VI.H.1. TAR Submission Requirements, Initial TAR).~~initial TAR submission requirements described above according to facility type.)
f. NOTE: The ECF must notify Partnership when a Member is readmitted to the ECF. Claims will not be paid if the readmission is not appropriately reported to Partnership.

~~5. Short Term TAR (Less than 90 calendar days in a LTC facility) must include the following:~~
~~a. Doctor's order~~
~~b. Completed new TAR form~~

D.
1. Cases determined not to meet ECF admission criteria or continued stay criteria based on DHCS Title 22 regulations, CMS regulations, other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* and the information available at the time of review, are managed as follows:
a. If the UM Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
b. Denials of medical necessity are determined only by the Partnership CMO/ Physician Designee.
c. UM staff will ensure the Member, provider, and facility are notified verbally and/or in writing as appropriate. Notice of Action letters will include the applicable appeal rights as described in policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions*.
~~c. Medicare or other health coverage denial letter (as applicable)~~
~~d. Eligibility must be No Other Insurance~~

~~I.~~E. Criteria for Ending or Modifying an ~~Existing~~Active TAR
1. ~~With written or electronic (via Partnership ePortal) notification,~~ Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
~~1.~~ Member's death
~~.a. Exhausted 7 calendar day bed hold~~

~~3. Discharge to Medicare, Health Maintenance Organization (HMO) or other insurance bed~~
~~4. Discharge to hospice care~~
~~5. Discharged to home or transfer to other LTC facility~~

~~J. Procedures for Discharge from LTC Facilities~~
~~1. Discharge summary should be sent to the Member's PCP upon discharge.~~
~~2. Day of Discharge or Death Same as Day of Admission Reimbursement Policy~~
a. ~~When a patient receiving skilled nursing or intermediate care expires or is discharged from a LTC facility, the facility must notify~~ (Partnership ~~via the Bed Hold & Change of Status Report form (Attachment A).~~must be notified within 24 hours of Member expiring)
~~0)~~1)If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable~~.~~
2) Notification of a Member's death should include whether the death occurred within the ECF or in an acute care facility.
b. Exhausted 7 calendar day bed hold
c. Discharge to other health insurance payor (e.g., Medicare)
d. Discharge to hospice care (see policy MCUP3020 Hospice Services for requirements)
e. Discharged to home or transfer to another ECF
f. Change in level of care (e.g. Custodial to Skilled or Skilled to Custodial)
2. For all of the above, Partnership recommends that the ECF submits a Bed Hold/Change of Status Report form (Attachment A).
a. For all circumstances except death (which requires notification within 24 hours), a Bed Hold/Change of Status form (Attachment A) should be submitted within seven (7) days.

F. Quality Monitoring and Review
1. The UM Nurse Coordinator assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies as requested.
~~1.~~2. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue, the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.
~~3.~~1. ~~Durable Medical Equipment (DME)~~
a. ~~For requests for DME for residents residing in a LTC facility, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, regarding provision of wheel chairs for patients residing in a skilled nursing facility.~~
~~b.~~c. ~~The LTC facility is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.~~

~~K.~~G. Policies for Other Services or Supports
1. Facility Therapy Services
a. Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately

reimbursable.

~~0~~1) Therapy services ~~provide~~provided to the ~~recipient~~Member that are covered by the per diem rate include, but are not limited to:

- ~~)~~a) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
- ~~)~~b) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
- ~~)~~c) Care to prevent formation and progression of decubiti, contractures and deformities, including:
  - ~~.~~i. Changing position of bedfast and chairfast recipients
  - ~~.~~ii. Encouraging and assisting in self-care and activities of daily living
  - ~~.~~iii. Maintaining proper body alignment and joint movement to prevent contractures and deformities

2. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in an ECF, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, *Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components*, regarding provision of wheel chairs for Members residing in a skilled nursing facility.
   b. The ECF is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.

~~2.~~3. Transportation
   a. For all transportation needs, please refer to Partnership's policy ~~MCCP2016~~MPTP2501 Transportation ~~Guidelines~~Policy for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).

~~3.~~4. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to Partnership policy ~~MCCP2032~~MCAP7002 CalAIM Enhanced Care Management (ECM) for further details.
   b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For Members currently in a LTC setting who may benefit from Community Supports, please refer to Partnership policy ~~MCUP3142~~MPAP7003 CalAIM Community Supports (CS)

~~2.~~5. Partnership has a Long-Term Services and Supports (LTSS) Liaison who assists facilities in addressing claims and payment inquiries and coordinates support for LTSS providers to best meet Members' needs. Contact information for Partnership's LTSS Liaison can be found on this webpage: https://www.partnershiphp.org/Providers/Medi-Cal/Pages/DHCS%20Directed-Payments-Programs.aspx

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual:
   1. Subacute Care Programs: Level of Care for Adults and Children (*subacut lev~~);~~)*
   2. Subacute Care Programs: Adult *(subacute adu)~~:~~*
   3. Subacute Care Programs: Pediatric (*subacut ped~~);~~)*

~~0.~~4. Leave of Absence, Bed Hold, and Room and Board *(leave)*
5. TAR for Long Term Care: 20-1 Form *(tar ltc)*
6. TAR for Long Term Care (Form 20-1): Inpatient Services *(tar ltc ip)*
7. TAR Completion for Long Term Care *(tar comp ltc)*

B. InterQual® criteria
C. ~~DHCS~~Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services
D. Title 22 California Code of Regulations (CCR) Sections 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51134, 51335, 51335.5, 51335.6, 51321(h), 51535, 51535.1, 72520
E. Title 42 Code of Federal Regulations (CFR) Section 483.15e
F. Welfare and Institutions Code (WIC) §14132.25
~~A.~~G. Health and Safety Code (HSC) § 1373.96
~~G.~~H. DHCS All Plan Letter (APL) 15-018 dated 07/09/2015 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components
~~H.~~I. All County Welfare Director's Letter ~~ACWD 97-07 1997~~ACWD 25-02 2025 Statewide Average Private Pay Rate ~~(APPR)~~ for Nursing Facility Services (~~02/27/1997~~01/22/2025)
~~I.~~J. ~~Department of Health Care Services (~~DHCS~~) All Plan Letter (APL) 23-004~~ APL 24-009 Skilled Nursing Facilities ~~–~~ Long Term Care Benefit Standardization and Transition of Members to Managed Care (~~03/14/2023~~09/16/2024)
~~J. DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023. (08/15/2023)~~
K. ~~DHCS APL 23-027:~~DHCS APL 24-010 Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/~~26/2023~~16/2024)
L. DHCS Subacute Care Program and Manual of Criteria R-15-98E

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

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

X. REVISION DATES: 06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24; 11/13/24; 01/14/26

*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:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

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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

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)		**Lead Department: Health Services** **Business Unit: Utilization Management**	
Guideline/Procedure Title: Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~11/13/2025~~01/14/2027 **Last Review Date:** ~~11/13/2024~~01/14/2026	
Applies to:	☐ **Employees**		☒ **Medi-Cal**

- 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
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

BED HOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

NO.	MONTH -	DAY OF THE WEEK																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	NAME:																														
	TAR NUMBER:																														

Please note, member discharge /transfer to acute requires a MD order.

Fax to **707 - 863 - 4118**

REMARKS:

NO.	

LEGEND:

A - Discharge to Acute (use after 7 day BH)
B - Discharge to B & C
B/H - Bed Hold
E - Expired
E/A - Expired in Acute
TL - Therapeutic Leave
H - Discharge to Home
I - Discharge to ICF
M - Discharge to Medicare Bed
P - Discharge to Private Pay
R - Return to Medi-Cal Bed
S - Discharge to Other SNF
X - Discharge to Hospice

Prepared By: _____

Telephone #: _____

Fax #: _____

Date Prepared: _____

Please note, report will not be processed without a signed Physician's order

Skilled Nursing Facility Request Form

Member Information

First Name:_____ MI:_____ Last Name:_____

Partnership Member ID:_____ Date of Birth:_____

Requestor Information

Facility:_____ NPI Number:_____

Facility Contact Name:_____ Phone Number:_____

Reason for Admission:_____

Admission Date:_____ Requested Length of Service:_____

Anticipated Discharge Plan:_____

Requested Services (Check all that apply)

Custodial Services Only: ☐

Requested Skilled Therapy Code (check specific modalities below):_____

Was a verbal authorization given for this request? Yes ☐ No ☐

	Ordered	Frequency	Duration (Days)	Additional Information
Physical Therapy				
Occupational Therapy				
Speech Therapy				
IV Antibiotics				
Wound Care				
Additional Therapies				

Additional Comments:

clean version of UM's MCUG3038 begins next page

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)</td><td colspan="3">Lead Department: Health Services
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<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td></td><td colspan="3">☒ Medi-Cal</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td colspan="2">☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td colspan="2">☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
C. MPUP3139 – Criteria and Guidelines for Utilization Management
D. MCUP3020 – Hospice Services
E. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
F. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
G. MPTP2501 – Transportation Policy for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
H. MPQP1016 – Potential Quality Issue Investigation and Resolution
I. MCRP4068 – Medical Benefit Medication TAR Policy
J. MPAP7003 – CalAIM Community Supports
K. MCAP7002 – CalAIM Enhanced Care Management (ECM)

II. IMPACTED DEPTS:

A. Claims
B. Member Services
C. Enhanced Health Services (EHS)
D. Transportation
E. Provider Relations
F. Quality and Performance Improvement

III. DEFINITIONS:

A. Custodial Care Facility: A non-medical facility (often referred to as a Long Term Care (LTC) facility) that provides basic assistance with daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability.
B. Extended Care Facility (ECF): A healthcare institution that provides on-going medical care, rehabilitation services, and assistance with activities of daily living to individuals who require prolonged or specialized care. This is an all-inclusive term for facilities providing custodial, skilled and sub-acute services.
C. Skilled Nursing Facility (SNF): A facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to complete a course of treatment that is not available in lower levels of care and support an increase in function, safety and independence with activities of daily living.

D. Subacute Care Facility: A facility with a level of care that is less intensive than acute care but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
E. Subacute Contracting Unit (SCU): A unit within the California Department of Health Care Services (DHCS), responsible for contracting with providers to offer Medi-Cal subacute care services. Contracted facilities may be reimbursed for subacute care services provided to Medi-Cal subacute beneficiaries who meet subacute care criteria as defined in Medi-Cal Manual of Criteria R-15-98E (adult beneficiaries) and Welfare and Institutions Code, section 14132.25 (pediatric beneficiaries). Specific reimbursement rates have been developed for providers of subacute care who have contracted with the DHCS' SCU.

IV. ATTACHMENTS:

A. Bed Hold/Change of Status Report form
B. Skilled Nursing Facility Request Form

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Extended Care Facilities for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Extended Care Facilities (ECFs)
   1. Partnership ensures access to licensed care facilities, irrespective of location in or out-of-network, to Members in need of extended care services. These facilities may include:
      a. Custodial/Long Term Care Facilities
      b. Skilled Nursing Facilities (SNF)
      c. Subacute Care Facilities (pediatric and adult)
   2. A Member in need of extended care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the Member to the appropriate type of facility.
   3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and Partnership Utilization Management (UM) team identifies the most appropriate level of care for the Member and assures that the Member is placed in a health care facility that provides the level of care most appropriate to the Member's medical needs.
      a. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e).
      b. DHCS Title 22 regulations, as well as CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* are utilized by Partnership UM Nurse Coordinators when performing reviews of authorization requests to determine the medical necessity for continued placement in an extended care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended.
   4. Extended Care Classification categories include the following:
      a. Custodial/Long Term Care: These facilities assist members in meeting their activities of daily living (ADLs) such as eating, bathing, grooming, etc. Members must meet criteria showing need for this level of care. Following admission to the facility, members will continue to be reevaluated periodically to ensure medical necessity is met for continued placement.

b. Skilled Nursing Care: The Member may need a short-term stay for a skilled nursing care need or short-term rehab services and is expected to return to their previous living arrangement or alternate level of care. Facility staff, including case managers, are responsible for coordinating discharge planning for the member.
c. Subacute Care: The Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care either can either be short term, where there is potential for the Member eventually being transferred to a lower level of care; or custodial/long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these Members are authorized for time intervals based on the characteristics of the Member's medical condition.

5. The choice of an ECF for a patient is a decision that should include consideration of the following:
   a. What are the medical/ rehabilitation needs for the member and does the facility have the services available to meet the Member's needs?
   b. Is the facility a licensed Medi-Cal provider?
   c. Is the facility contracted with Partnership?
   d. Are there beds available?
   e. If more than one choice is available, is there a family preference (e.g. geographical location) that can be reasonably accommodated?
   f. Are there any benefit coverage limitations?
6. Facility Requirements
   a. An ECF must meet all of the following requirements:
      1) It must be a licensed institution
      2) It must be qualified as a provider of services under Medi-Cal
      3) It must maintain, on the premises, all facilities necessary for medical care and treatment
      4) It must provide such services under the supervision of a physician
      5) It must provide services given by or supervised by a registered nurse AND
      6) The facility must keep medical records on all patients
   b. For Members approved for subacute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

B. Members with Other Healthcare Coverage
1. When Members have other healthcare coverage (e.g., Medicare) Partnership will work to coordinate benefits as applicable.

C. Treatment Authorization Requests (TARs) for Admission to an Extended Care Facility (ECF)
1. In alignment with Manual of Criteria R-15-98E, an initial Treatment Authorization Request (TAR) is required with each admission to an ECF. A TAR is required when the Member:
   a. Is a new admission to the facility
   b. Has exhausted their Medicare benefits
   c. Has received a denial from Medicare or other insurance for extended care
   d. Is readmitted to an ECF from an acute care hospital
   e. Returns to an ECF from an approved leave of absence beyond the approved return date
   f. Is newly eligible with Partnership while residing in the ECF
   g. Changes level of care (e.g. Skilled to Custodial, Custodial to Skilled, Subacute to Skilled)
2. A UM Nurse Coordinator reviews the authorization request for medical necessity and level of care utilizing DHCS Title 22 regulations and/or CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*.
   a. Cases not meeting criteria for medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for review and determination.

b. Upon review, a UM Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity. Only the CMO/ Physician Designee can deny a TAR for reasons of medical necessity.
c. A determination will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
d. Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what Partnership approves.
e. The facility is responsible for verifying the Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.

3. Extensions of Stay
   a. Extensions of stay in extended care facilities for Medi-Cal Members require re-authorization by Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
   b. Extension requests will be reviewed based on the facility's documentation of the Member's current clinical status and medical need of requested extension, including current services required, anticipated duration of services and progress towards goals of therapy in the prior approved stay, and current discharge disposition/ planning as noted by the facility's team.
4. Admissions on Weekends and Outside Normal Business Hours
   a. If a member is transferred to a facility on a weekend, or outside normal business hours, Partnership must be notified via phone or the Online Services (OLS) portal on the next business day for immediate review of the TAR.
   b. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.
5. Custodial (Long Term Care) TAR Submission Requirements:
   a. Custodial care services require prior authorization by a Partnership UM Nurse Coordinator before admission to a Custodial facility, otherwise, the stay may be denied for not meeting medical necessity.
   b. A custodial care authorization request shall be initiated by the ECF, and the following documentation must be submitted with the initial Custodial Care TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
         a) For Partnership members with Supplemental Security Income (SSI), the ECF is required to submit the MC171 form to the Social Security Administration (SSA) within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
         b) Partnership's Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form for all Partnership members with SSI. If a facility does not submit the MC171 form, the TAR will be sent to the CMO/Physician Designee for review and denied for "information requested not received." The facility will be notified.
      3) Medicare or other Insurance denial letter (if applicable)
      4) Completed Minimum Data Set (MDS) dated within the past 90 days
      5) PASRR (Preadmission Screening and Resident Review)
   c. When a member is admitted for custodial care, a TAR submission may be approved up to a six

(6) month period.

d. The Member's condition will be re-evaluated upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

e. Continued Care (Reauthorization) with a new TAR must include the following:
   1) Completed new TAR form
   2) Current MDS dated within 90 days of TAR start date
   3) Social Services annual review/quarterly assessment and progress notes

6. Skilled Nursing Facility (SNF) TAR Submission Requirements:
   a. Skilled level nursing is a covered level of care for Partnership Members. This level of care is short-term for the acute rehabilitation stage of treatment following an illness or injury.
   b. Admission to a SNF must be coordinated with a contracted Medi-Cal licensed facility by the discharge planner.
   c. Skilled nursing services require prior authorization by Partnership before a Member's admission to a SNF.
   d. The following documents must be submitted with the initial SNF TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) PASRR (Preadmission Screening and Resident Review)
      3) Acute notes
      4) Medicare or other health coverage denial letter
      5) Eligibility must be "No Other Insurance"
      6) Skilled Nursing Facility Request form (Attachment B)
      7) MD orders as applicable to facility type (see VI.C.8. and 9. below)
   e. The following documents must be submitted for a SNF TAR extension:
      1) MD orders from SNF
      2) Nurse and attending physician/ medical provider notes showing medical need for SNF care (e.g. wound care, IV antibiotics) and anticipated duration of need
      3) Therapy progress report indicating current level of participation, progress notes and goals of treatment
      4) Discharge planning documents
7. Subacute Care Facility TAR Submission Requirements:
   a. The following documents must be submitted with the initial Subacute Care Facility TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      3) Acute notes to include therapy notes (e.g. physical therapy, speech therapy, occupational therapy, respiratory therapy)
   b. Note: For Members approved for sub-acute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
   c. The following documents must be submitted for a Subacute TAR extension:

1) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services (if dates are applicable)
   a) Adult form: DHCS 6200A
   b) Pediatric form: DHCS 6200
2) Facility progress notes
3) MD orders

d. Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of six months.
   1) Extensions are reviewed based on medical need for the care that is provided. Facilities must provide current records showing the Member's current clinical status, participation in therapies, progress toward goals and discharge planning.

8. Authorizations for Transfers from Acute Care to an Extended Care Facility (ECF)
   a. Please Note: If admission from acute care occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. The ECF is required to notify Partnership before any admission. Prior authorization is required for all admissions.
   c. UM Nurse Coordinator will review documents and provide initial determination approval.
   d. The transfer must be coordinated by the hospital discharge planner or case worker.
9. Admission from Home to an Extended Care Facility
   a. Please Note: If the admission from home occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. An ECF facility is required to notify Partnership before any admission. Prior authorization is required for all admissions from home.
      1) The following information must be submitted with the TAR:
         a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in an ECF and the physician's certification that placement in the particular ECF is the appropriate level of care for the Member.
         b) If placement follows an acute hospital stay within the past 30 calendar days, the hospital history and physical and discharge summary must be submitted.
         c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months must be submitted.
10. Bed Hold Change of Status Reporting
    a. This occurs when a Member residing in an ECF is transferred to an acute care hospital or has an approved leave of absence, which must be reported through the Bed Hold/ Change of Status Report form (Attachment A).
    b. The maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
    c. The following documents must be submitted when reporting a Bed Hold change of status:
       1) MD orders
       2) Bed Hold/Change of Status Report form (Attachment A)
    d. When a custodial Member returns to the ECF prior to or on the 8th calendar day, the existing

ECF TAR is still valid.

e. If a Partnership Member returns to an ECF after 8 calendar days, a new ECF TAR and all required attachments must be submitted (see initial TAR submission requirements described above according to facility type.)

f. NOTE: The ECF must notify Partnership when a Member is readmitted to the ECF. Claims will not be paid if the readmission is not appropriately reported to Partnership.

D. Denials

1. Cases determined not to meet ECF admission criteria or continued stay criteria based on DHCS Title 22 regulations, CMS regulations, other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* and the information available at the time of review, are managed as follows:
   a. If the UM Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
   b. Denials of medical necessity are determined only by the Partnership CMO/ Physician Designee.
   c. UM staff will ensure the Member, provider, and facility are notified verbally and/or in writing as appropriate. Notice of Action letters will include the applicable appeal rights as described in policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions*.

E. Criteria for Ending or Modifying an Active TAR

1. Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
   a. Member's death (Partnership must be notified within 24 hours of Member expiring)
      1) If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable
      2) Notification of a Member's death should include whether the death occurred within the ECF or in an acute care facility.
   b. Exhausted 7 calendar day bed hold
   c. Discharge to other health insurance payor (e.g., Medicare)
   d. Discharge to hospice care (see policy MCUP3020 Hospice Services for requirements)
   e. Discharged to home or transfer to another ECF
   f. Change in level of care (e.g. Custodial to Skilled or Skilled to Custodial)
2. For all of the above, Partnership recommends that the ECF submits a Bed Hold/Change of Status Report form (Attachment A).
   a. For all circumstances except death (which requires notification within 24 hours), a Bed Hold/Change of Status form (Attachment A) should be submitted within seven (7) days.

F. Quality Monitoring and Review

1. The UM Nurse Coordinator assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies as requested.
2. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue, the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.

G. Policies for Other Services or Supports

1. Facility Therapy Services
   a. Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases,

however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.

1) Therapy services provided to the Member that are covered by the per diem rate include, but are not limited to:
   a) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
   b) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
   c) Care to prevent formation and progression of decubiti, contractures and deformities, including:
      i. Changing position of bedfast and chairfast recipients
      ii. Encouraging and assisting in self-care and activities of daily living
      iii. Maintaining proper body alignment and joint movement to prevent contractures and deformities

2. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in an ECF, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, *Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components*, regarding provision of wheel chairs for Members residing in a skilled nursing facility.
   b. The ECF is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.
3. Transportation
   a. For all transportation needs, please refer to Partnership's policy MPTP2501 Transportation Policy for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
4. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM) for further details.
   b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For Members currently in a LTC setting who may benefit from Community Supports, please refer to Partnership policy MPAP7003 CalAIM Community Supports (CS)
5. Partnership has a Long-Term Services and Supports (LTSS) Liaison who assists facilities in addressing claims and payment inquiries and coordinates support for LTSS providers to best meet Members' needs. Contact information for Partnership's LTSS Liaison can be found on this webpage: https://www.partnershiphp.org/Providers/Medi-Cal/Pages/DHCS%20Directed-Payments-Programs.aspx

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual:
   1. Subacute Care Programs: Level of Care for Adults and Children (*subacut lev*)
   2. Subacute Care Programs: Adult *(subacute adu)*

3. Subacute Care Programs: Pediatric (*subacut ped*)
4. Leave of Absence, Bed Hold, and Room and Board *(leave)*
5. TAR for Long Term Care: 20-1 Form *(tar ltc)*
6. TAR for Long Term Care (Form 20-1): Inpatient Services *(tar ltc ip)*
7. TAR Completion for Long Term Care *(tar comp ltc)*

B. InterQual® criteria
C. Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services
D. Title 22 California Code of Regulations (CCR) Sections 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51134, 51335, 51335.5, 51335.6, 51321(h), 51535, 51535.1, 72520
E. Title 42 Code of Federal Regulations (CFR) Section 483.15e
F. Welfare and Institutions Code (WIC) §14132.25
G. Health and Safety Code (HSC) § 1373.96
H. DHCS All Plan Letter (APL) 15-018 dated 07/09/2015 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components
I. All County Welfare Director's Letter ACWD 25-02 2025 Statewide Average Private Pay Rate for Nursing Facility Services (01/22/2025)
J. DHCS APL 24-009 Skilled Nursing Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/16/2024)
K. DHCS APL 24-010 Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/16/2024)
L. DHCS Subacute Care Program and Manual of Criteria R-15-98E

VIII. DISTRIBUTION:
M. Partnership Department Directors
N. Partnership Provider Manual

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

X. REVISION DATES: 06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24; 11/13/24; 01/14/26

*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:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

****

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

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)			**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994		**Next Review Date: 11/13/2025** **Last Review Date: 11/13/2024**	
Applies to:	☐ **Employees**		☒ **Medi-Cal**

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3020 (previously UP100320)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Hospice Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/12/1995</td><td colspan="4">Next Review Date: ~~11/13/2025~~01/14/2027
Last Review Date: ~~11/13/2024~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~ING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/13/2024~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MP~~C~~UP3039 - Direct Members
C. MP~~C~~UP3137 - Palliative Care: Intensive Program (Adult)
D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
E. MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
~~D.~~F. MCCP2024 - Whole Child Model For California Children's Services (CCS)

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. 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.
~~A.~~C. Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.
~~B.~~D. Whole Child Model (WCM): This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California pediatric Members with a CCS-eligible condition(s).

IV. ATTACHMENTS:

A. ~~N/A~~Medi-Cal Hospice Program Election Notice *DHCS 8052* (07/2023)
B. Patient Notification of Hospice Non-Covered Items, Services, and Drugs *DHCS 8053* (07/2023)

Policy/Procedure Number: MCUP3020 (previously UP100320)		**Lead Department: Health Services** **Business Unit: Utilization Management**	
Policy/Procedure Title: Hospice Services		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 12/12/1995		**Next Review Date: 11/13/202501/14/2027** **Last Review Date: 11/13/202401/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**	

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for a Member to be admitted to a ~~authorization of~~ hospice ~~services~~ program and to outline compensation structures~~the reimbursement mechanisms~~ for ~~this~~ hospice services.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program

1. A patient will be admitted to the hospice program when the following conditions are met:
   a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course.
      1) The patient's physician or the hospice medical director must certify that the Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
   b. ~~Cure of the disease process is no longer the goal of treatment.~~A member may elect hospice services in lieu of curative care for the terminal illness. (For specific pediatric hospice guidelines, please see VI.C~~B~~.~~43~~. below.)
   c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
   d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient and family.
   e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
   f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal from the hospice program is possible at any time.
2. Election of hospice care for Partnership Medi-Cal Members occurs when the Member (or authorized representative ~~guardian~~) voluntarily completes and signs the Department of Health Care Services (DHCS) Medi-Cal Hospice Program Election Notice ~~Form~~ *DHCS 8052* (Attachment A) and selects a hospice provider. ~~-~~ Signing this form indicates the Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.
   a. Members who qualify for and elect to receive hospice care services, remain enrolled in Partnership while receiving hospice services.
   b. Hospice care services may be initiated or continued in a home or clinical setting. Partnership will remain responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the Member's primary care physician.
   c. A Member who is a resident of a skilled nurse facility (SNF) or an Intermediate Care Facility (ICF) may elect hospice care, and Partnership will provide payment to the hospice for hospice care services at the appropriate level of care.
   d. Partnership does not deny any completed Hospice Program Election Notices nor deny any late referrals to hospice.
   e. Upon receipt of a completed hospice election form, or the member is flagged by DHCS in data sent to the health plan that the member is receiving hospice services, the member is placed into ~~a~~ HP 6; a restricted Direct Member d~~D~~esignation category. This designation in Partnership's system and online provider portal informs the M~~m~~ember's primary care provider and/or other contracted providers, that the member is currently enrolled in hospice and receiving those services. For more information, see Partnership policy MPUP3039 Direct Members.

B. Hospice Provider Requirements

1. Consistent with contractual requirements for covered Medi-Cal benefits, and Continuity of Care provisions, hospice coverage is restricted to hospice providers who are contracted with Partnership. If medically necessary services are not available in-Network, or if a member is currently receiving hospice care at the time they become a Partnership member, Partnership will seek an agreement with an out-of-network provider to cover hospice services.
   a. An agreement with an out-of-network hospice provider will require the hospice provider to submit necessary documentation for Partnership to ensure that hospice services are provided in accordance with coverage policy, including medical necessity.
   b. For out-of-network hospice providers, Partnership will ensure the hospice provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier (NPI) prior to payments of claims.
   c. To avoid possible delays in hospice services with out-of-network hospice providers, while Partnership confirms hospice provider qualifications and enters into an agreement with the serving hospice provider, Partnership shall ensure the agreement start date commences with the start of services for those providers who meet necessary criteria.
      1) For providers who are not deemed eligible, a referral to Partnership's Care Coordination department shall occur so that M~~m~~embers are referred timely to an in-network hospice provider.
   d. A Partnership M~~m~~ember who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MP~~C~~UP3137 Palliative Care: Intensive Program (Adult).
2. The hospice Provider is responsible for the coordination of hospice services. To ensure proper hospice claim processing and reimbursement, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form *DHCS 8052* (Attachment A) to Partnership **within five calendar days** of a Medi-Cal Member's certification and election of hospice services.
   a. In instances where the hospice provider does not timely submit the election form to Partnership, Partnership is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to and accepted by Partnership. These non-covered days are a hospice provider's liability, and the hospice provider cannot bill the Member for them.
   b. DHCS and Partnership may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of our claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.
   c. While no Treatment Authorization Request (TAR) is required to elect hospice care, Partnership will conduct a prepayment review of each claim to verify that the appropriate documentation has been received in order to avoid fraud, waste, and abuse.
      1) See section VI.E. below for further clarification of TAR requirements for inpatient care.

C. Hospice Benefit
1. Members who elect hospice become case managed Direct Members at Partnership as described in policy MPUP3039 Direct Members. ~~When the Partnership HealthPlan of California (Partnership) Claims Department receives the first claim for hospice related services from the hospice provider, the claim will be routed to the Health Services/Utilization Management Team. The Utilization Management (UM) Designee will contact the hospice provider to obtain a copy of the hospice election form signed by the Member or legal representative.~~
   a. The status change effective date is the date the hospice election form was signed by the Member or Authorized~~legal~~ R~~r~~epresentative.
2. All services related to the terminal illness must then be provided or authorized by the hospice

provider.

a. Note that palliative items or services in the context of medical hospice benefits are defined separately from palliative care services as referenced in the DHCS Palliative Care guidelines *(palli care)* or as defined in DHCS APL 18-020 *Palliative Care* (or subsequent revisions).

3. Partnership facilitates Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, while also placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse.

~~1.~~4. Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness. Services not related to the terminal illness are the responsibility of Partnership. The Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)

5. A Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018. For more information on services under EPSDT see Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

a. Hospice and palliative care is available for California Children's Services (CCS)-eligible children as detailed in CCS Numbered Letter (NL) 06- 1011 AuthorizatioC.1.n of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care and in CCS NL 12-1119 Palliative Care Options for CCS Eligible Children.

1) For more information on CCS services for Partnership Members, see policy MCCP2024 Whole Child Model For California Children's Services (CCS).

2) For more information on pediatric palliative care services, see policy MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21

3) Partnership will facilitate Continuity of Care as described in policies MCCP2024 Whole Child Model For California Children's Services (CCS) and MCCP2014 Continuity of Care.

b. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between Partnership (the Managed Care Plan), local CCS programs (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition and will be provided as part of hospice care services as described below at VI.C.6.

~~2. The following services are billable by the hospice agency, however only one service may be billed for each day:~~

~~3. Routine Home Care (code Q5001) is provided in the Member's home but it is not continuous home care. Payment is made on an all-inclusive per diem basis without regard to the volume or intensity of routine home care provided on any given day.~~

~~4. Continuous Home Care (code Q5009) consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours only during a brief crisis period. Any Member of the hospice team may provide these services, including home health aide and homemaker services. The hospice provider is responsible for determining the medical necessity for this type of care and will bill the hourly continuous home care rate for each hour of the service.~~

~~5. Respite Care (code Q5006) occurs when the Member receives care in an approved Long Term Care (LTC) facility on a short-term basis to provide relief for family Members or others caring for the individual. The hospice provider is responsible for determining the medical necessity for this type of care. Each episode is limited to no more than 5 days. The hospice provider will pay the LTC per diem rate as agreed upon in the LTC/hospice contract.~~

~~6. Inpatient Care (code Q5005) related to the terminal illness for pain control or acute/symptom management that cannot be managed in other settings. Acute inpatient hospital services are subject~~

~~to approval by the hospice provider. The hospice provider pays the acute, subacute or LTC facility and then bills Partnership for inpatient care related to the terminal illness code (Q5005). The hospice provider pays the hospital or subacute facility per diem at the rate agreed upon in the hospital/hospice contract. While the Member is in the inpatient facility, the Hospice is responsible for payment to the LTC facility for a bed hold day for up to 7 days (if included in the Hospice/LTC contract) and will bill Code 658 to Partnership for a Member who resides in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF). If responsibility for payment of bed hold days is not included in the Hospice/LTC facility contract, the LTC facility will not be able to obtain payment for the bed hold.~~

~~7. If the Member chooses to revoke his/her hospice enrollment and the Member remains in a LTC facility, it is the responsibility of the facility to obtain a new TAR from Partnership for these services.~~

~~Physician services for the Member are coordinated between the attending physician, the hospice team, and the hospice medical director as indicated.~~

~~Physician services include:~~

~~General supervisory services of the hospice medical director~~

~~Participation in the establishment of plans of care~~

~~Supervision of care and services~~

~~Periodic review and updating of plans of care~~

~~Establishment of governing policies by the physician of the hospice interdisciplinary team.~~

~~Billing of physicians services occurs as follows:~~

~~The attending physician bills Partnership using the regular Medi-Cal codes. The hHospice physician fees are included in the hospice per diem rate.~~

~~Other physician services not described above [VI.C.6.f.1) a)-e)] must be billed to Partnership separately. This includes services of the Member's attending physician or consulting physician(s) if they are not an employee of the hospice or providing services under arrangement with the hospice.~~

~~The attending physician bills Partnership using the regular Medi-Cal codes.~~

~~If specialist consultation is necessary to evaluate a complication related to the terminal condition, the specialist physician bills the hospice and the hospice should bill Partnership using code Q5010.~~

~~8.~~

~~9.~~6. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness. Physician, and or other Medi-Cal benefits and services not described below must be billed to Partnership separately.

a. Nursing services
b. Physical, occupational, and speech therapy
c. Medical social services under the direction of a physician
d. Home health aide and ~~attendant care~~homemaker services
e. Medical supplies and durable medical equipment
f. Medications and infusion therapy (based on the Hospice Formulary)
g. Hospice physician services
h. Counseling services related to the adjustment of the Member's approaching death, including bereavement, grief, dietary, and spiritual counseling
i. Continuous Nursing services which may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill Member at home.
j. Inpatient r~~R~~espite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, SNF or hospice facility

k. Short-term i~~I~~n-patient care for pain control or symptom management in a ~~at~~ hospital, SNF or hospice ~~subacute~~ facility (Note that general inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit)
l. Nutritionist services
m. Medical transportation

7. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group to plan, provide, and/or supervise the care and services offered by the hospice provider.
8. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting.
9. Hospice services are not categorized as long term care (LTC) services, regardless of the Member's expected or actual length of stay in a nursing facility while also receiving hospice care.
10. Payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider.

D. Services Not Covered by a Hospice Provider

1. Private pay room and board or residential care
2. Acute in-patient hospitalization unrelated to the terminal illness
3. Level A or Level B Nursing Facility for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice
5. Other necessary services for conditions unrelated to the terminal illness

~~D.~~E. Treatment Authorization Requests (TARs) for Inpatient Care

1. A Partnership TAR is not required for the following services~~:~~;
   a. Hospice physician services
   ~~a.~~b. Routine home care
   ~~b.~~c. Continuous home care*
   ~~c.~~d. Respite Care*
   ~~d.~~e. Hospice Care room and board provided in a SNF or ~~Intermediate Care Facility (~~ICF~~)~~
      1) If a Member currently resides in an ~~Independent~~ Intermediate Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, Partnership continues to be financially responsible for the ICF-DD per diem payment.

   *Note: Although no TAR is required, Partnership may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care. If documentation does not support the levels of care, reimbursement may be reduced to the rate for routine home care, in which case the hospice provider may submit an appeal for reconsideration of payment with additional documentation of the medical necessity for the increased level of care.
2. Only general inpatient care is subject to prior authorization, regardless of whether the services are to be rendered by an in-network and out-of-network provider, and the following documents must be submitted to Partnership with the TAR:
   a. A written prescription signed by the Member's attending physician
   b. Justification for the general inpatient care level of care
   c. A copy of the certification of the Member's terminal condition
   d. A copy of the written initial plan of care; AND
   e. A copy of the Member's signed election form
3. Because the Medi-Cal Fee-For-Service (FFS) program does not permit prior authorization of hospice services, except for inpatient admissions, as outlined in state law, Partnership adheres to the same

utilization review standards as required by federal law. Hospice providers must submit the Medi-Cal Hospice Program Election form DHCS 8052 (Attachment A) and addendum forms containing the necessary information and appropriate signatures to Partnership as previously outlined at VI.B.2.

3.4. For nNon-emergency inpatient care related to the terminal illness, ~~requires preauthorization by Partnership.~~ tThe Hospice provider must submit a TAR using an appropriate inpatient code ~~(Q5005)~~ and attach a copy of the Hospice Inpatient Information Form.

4.5. Emergency admission related to the terminal illness is reviewed for medical necessity by the Partnership Utilization Management (UM) nurse and if appropriate, a length of stay assigned. Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using an appropriate inpatient code ~~(Q5005)~~ and attach a copy of the Hospice Inpatient Information Form.

a. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
b. Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.

6. For Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the Member resides in a LTC facility (bed code 658 for SNF or ICF). The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.

~~c.~~a. For Members with Medicare/Medi-Cal coverage, the hospice provider must submit the Medi-Cal Hospice Program Election form *DHCS 8052* (Attachment A) and addendum forms containing the necessary information and appropriate signatures to both DHCS and Partnership when a dual eligible Member elects the Medicare hospice benefit.

5.7. For Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

~~E.~~F. Hospice Periods of Care

1. Hospice is a covered Medi-Cal benefit with the following periods of care:
   a. Two 90-day periods, beginning on the date of hospice election
   b. Followed by unlimited 60-day periods
2. A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.

~~2.~~3. A Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.

~~F.~~G. Patient Certification and Recertification Required

1. After a Member has met criteria for admission to a hospice program (section VI.A. above), the hospice provider must maintain an initial certification for the first 90-day period that the patient is terminally ill. Written certification statements must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group, AND the Member's

[1] 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 25-0122-012 *~~Revised~~*, "~~Governor's Executive Order N-01-19 Regarding Transitioning~~ Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage ~~from Managed Care to Medi-Cal Rx~~," and all medications (Rx and OTC) which are dispensed from pharmacies and covered under Medi-Cal Rx must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

primary care physician)

2. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the patient is terminally ill. For recertification, a written certification statement must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group.
   a. No more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter, a hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. When an NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less.

~~G.~~H. Revocation of Hospice Care Services

1. An individual's voluntary election may be revoked or modified at any time during ~~an election~~a benefit period.
   a. To revoke the election of hospice care, the ~~the individual~~Member or ~~individual's~~ Authorized R~~r~~epresentative must file a signed statement with the hospice agency revoking the individual election for the remainder of the ~~election~~ benefit period, including the effective date of the revocation. ~~-~~The effective date may not be retroactive.
   b. The hospice provider must submit the Member's signed hospice revocation statement to Partnership within five calendar days.
   c. At any time after revocation or a discharge by the hospice for cause, a~~n~~ ~~individual~~ Member may execute a new election, if they meet hospice coverage eligibility requirements, and ~~for any remaining election period.~~ the 90/90/unlimited 60-day benefit periods of care will restart.
      1) ~~-~~If the Member re-elects hospice care, the hospice provider must submit a new hospice election form to Partnership.
   d. A~~n~~ ~~individual~~ Member or Authorized R~~r~~epresentative may change the designation of a hospice provider once in each benefit~~election~~ period; this is not a revocation of the hospice benefit.
   e. Members who move their legal residence out of Partnership's service area must notify the hospice provider and shall be disenrolled from Partnership.
      1) If members are transferring care to a new managed care plan, Hospice providers must provide transferring members with a transfer summary, including essential information relative to the members' diagnoses, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician.
      ~~1)~~2)Consequently, upon enrollment in a new managed care plan, a "change in designated hospice" must be initiated. This may be done only once per benefit period.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care (*hospic*)
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511
D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)
I. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
J. California Children's Services (CCS) Numbered Letter (NL) 06-1011 Authorization of Medically

Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care (10/07/2011)

~~G.~~K. CCS NL 12-1119 Palliative Care Options for CCS Eligible Children (11/18/2019)

~~H.~~L. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 06/21/00; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 01/14/26

*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.

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

Medi-Cal Hospice Program Election Notice

Email to: MCHospiceClerk@DHCS.CA.GOV **Questions, call: (916) 552-9200**

Section 1			
Recipient Name:			
Email:	Phone Number:	Medi-Cal ID:	Date of Birth:
Address:	City:	State:	Zip Code:

Section 2	
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above understand the following:	
I have a terminal illness with a life expectancy of six months or less if the illness were to run its normal course.	Initials:
Hospice care services alleviate pain and suffering and are intended to treat symptoms rather than to cure illness. Recipients younger than 21 years of age may concurrently receive both hospice care and curative treatments of the hospice-related diagnosis. The Medi-Cal Hospice Services and benefits have been explained to me and/or my legal representative. I understand that only recipients younger than 21 years of age may receive both hospice services and curative treatment concurrently.	Initials:
By choosing hospice, I waive my right to payment for all Medi-Cal services, except for: 1) services provided by my elected hospice, 2) services provided by another hospice through an arrangement made by my elected hospice provider, 3) services provided by my attending physician if that physician is not employed by my elected hospice, or receiving any compensation from the hospice for those services. 4) services that are unrelated to my terminal diagnosis.	Initials:
I understand that for recipients ages 21 and over: 1) All my care will be provided by my elected hospice provider for my terminal diagnosis and related conditions. 2) I am not eligible to receive services for my terminal diagnosis and related conditions from providers other than my elected hospice provider or attending physician. 3) I am still eligible for services needed for conditions not related to my terminal diagnosis, and related conditions, such as provider examinations, drugs, or other medical care.	Initials:
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above, understand that I may revoke my hospice election at any time by signing a statement to that effect, and that both I and/or the Legal Representative/Agent and the hospice provider must inform DHCS by submitting the hospice revocation form signed by me. I understand my rights to other Medi-Cal services will resume on that date if I continue to be Medi-Cal eligible. (This revocation is not to be pre-dated or post-dated).	Initials:
I understand that if I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medi-Cal benefits as long as I am eligible for Medi-Cal.	Initials:

I understand that the elected Hospice provider is responsible for any Home Health, Private Duty Nursing, or Personal Care Services, if related to my terminal diagnosis, and related conditions. Medi-Cal benefits will cover care for treatments not related to the terminal diagnosis and related conditions.	Initials:

Section 3

Admitting Terminal Diagnosis and related conditions ICD-10 Code(s):		
Recipient is currently being admitted from a medical facility.	☐ Yes ☐ No	
Facility Name:		NPI Number:
Recipient is currently being admitted from home.	☐ Yes ☐ No	
Home Address:		NPI Number:
Recipient is transferring from another Home Hospice Agency.	☐ Yes ☐ No	
Agency Name:		NPI Number:
Recipient and/or the Legal Representative/Agent choice of attending physician.		
Attending Physician:		NPI Number:
I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician. Therefore, the hospice physician is my choice as an attending physician.		Initials:

Section 4

Services currently being provided to recipient by other Agencies:

Home Health Services	☐ Yes ☐ No	Agency Name & NPI:
Private Duty Nursing Services	☐ Yes ☐ No	Agency Name & NPI:
Personal Care Services	☐ Yes ☐ No	Agency Name & NPI:
Elected Hospice Provider Name:		NPI Number:

Recipient and/or Legal Representative/Agent Statement
I, (Recipient's Name) _____, have read and understand the statements in this document. Recipient Signature: _____ Date: _____
I, (Legal Representative/Agent Name) _____, as the Legal Representative/Agent for (Recipient's Name) _____, have read and understand the statements in this document. Relationship to Recipient: _____ Legal Representative/Agent Signature: _____ Date: _____
Hospice Provider Statement
I, (Hospice Representative Name) _____, Hospice Representative for (Hospice Provider's Name) _____, understand that the The hospice provider is responsible for the coordination of services to ensure that there are no duplication of services. Hospice Representative Title: _____ Signature: _____ Date: _____

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

Patient Notification of Hospice Non-Covered Items, Services, and Drugs

Patient Name: _____ **MRN:** _____

Hospice Agency: _____ **Date Furnished:** _____
(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services, and drugs):

1.	4.
2.	5.
3.	6.

Diagnoses Unrelated to Terminal Illness and Related Conditions:

1.	4.
2.	5.
3.	6.

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Note: The hospice provider makes the decisions whether or not conditions, items, services, and drugs are related to the terminal diagnosis for each beneficiary. This addendum should be shared with other healthcare providers from whom you seek items, services, or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy
You have the right to appeal the decision of the hospice agency on items not being covered because the hospice provider has determined they are unrelated to the individual's terminal illness and related conditions. If you are enrolled in a managed care plan, you have the right to contact the Managed Care Ombudsman at (888) 452-8609. Email: MMCDOmbudsman@dhcs.ca.gov.

Acknowledgement of non-covered items services, and drugs not related to my terminal illness and related conditions.

The purpose of this addendum is to notify the beneficiary (or representative) in writing of those conditions, items, services, and drugs that hospice will not be covered because the hospice provider has determined they are unrelated to the individual's terminal illness and related conditions not being covered by hospice.

Signing this addendum (or its updates) is only an acknowledgement of the receipt of the addendum (or its updates) and is not necessarily in agreement with the hospice provider's determinations.

Beneficiary/Representative Signature (Date signed)

The beneficiary is unable to sign (reason):

Witness Signature (Date signed)

PARTNERSHIP TAR REQUIREMENTS

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

A. **Acupuncture** *(see policy MPUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Behavioral Health Treatment** *(see policy MCUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21)*

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

D. **Chiropractic Services** *(see policy MPUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MPAP7004 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCAP7003 CalAIM Community Supports (CS) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

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

H. **Diagnostic Studies**

A. MRA (MR Angiogram)
B. MSI
C. MEG
D. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
E. Transcranial Doppler
F. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MPUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
G. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

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

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)

1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)
2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MPUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
5. Oxygen and related supplies
6. Positive Airway Pressure (PAP) devices - No TAR is required for PAP supplies for a PAP machine owned

by the member (as per Medi-Cal guidelines for ordering/quantity limits).

7. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
8. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
9. Purchase of any wheelchairs for Medi-Medi members
10. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

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

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MPUP3136 Fecal Microbiota Transplant)*

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

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

P. **Hearing Aids** *(see policy MPUG3019 Hearing Aid Guidelines)*

Q. **Home Health Care** *(see policy MPUG3011 Criteria for Home Health Services)*

R. **Home Infusion Therapy**

S. **Hysterectomy**

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

U. **Hospitalization**

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

PARTNERSHIP TAR REQUIREMENTS

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

V. **Hyperbaric Oxygen Pressurization**

W. **Intermediate Care Facility for developmentally disabled services** *(see policy MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities*)

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

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

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

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

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

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

PARTNERSHIP TAR REQUIREMENTS

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

AA. **Occupational Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

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

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

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

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

GG. **Pulmonary Rehabilitation** *(see policy MPUP3111 Pulmonary Rehabilitation)*

~~GG.~~HH. **Repetitive Transcranial Magnetic Stimulation (rTMS)** *(see policy MPBPXXXX)*

~~HH.~~II. **Speech Therapy** *(see policy MPUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for ST services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

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

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

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

PARTNERSHIP TAR REQUIREMENTS

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

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28292, 28296, 28297, 28298, 28299, 28899	Correction Of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below

PARTNERSHIP TAR REQUIREMENTS

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

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC 's
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure

PARTNERSHIP TAR REQUIREMENTS

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

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

PARTNERSHIP TAR REQUIREMENTS

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

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
22510, 22511, 22512, 22513, 22514, 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62290, 62291	Injection procedure for Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level
72285	Radiological supervision and interpretation for Cervical and Thoracic Discography
72295	Radiological supervision and interpretation for Lumbar discography

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3106</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Waiver Programs</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~01/08/2026~~01/14/2027
Last Review Date: ~~01/08/2025~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIAL~~S~~ING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
</table>

I. RELATED POLICIES:
MP~~C~~UG3011 – Criteria for Home Health Services

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

III. DEFINITIONS:
A. DDS: California D~~D~~epartment of Developmental Services
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. DHCS: California Department of Health Care Services
D. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies ~~in~~the date, time, and type of in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
E. HCBS: Home and Community Based Services
~~IHO: In-Home Operations Waiver~~
F. Personal Care Services (PCS): Services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer homemaker services support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

IV. ATTACHMENTS:
A. N/A

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

Policy/Procedure Number: MCUP3106		Lead Department: Health Services
Policy/Procedure Title: Waiver Programs		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. The Department of Health Care Services (DHCS) administers a number of HCBS Waiver Programs. These waiver programs include:
   ~~1. In-Home Operations Waiver (IHO)~~
   ~~2.~~1. Medi-Cal Waiver Program (MCWP) (formerly known as the AIDS Medi-Cal Waiver Program)
   ~~3.~~2. Home and Community Based Services Waiver for the Developmentally Disabled (HCBS-DD)
   ~~4.~~3. Self-Determination Program (SDP)
   ~~5.~~4. Assisted Living Waiver (ALW)
   ~~6.~~5. Home and Community-Based Alternatives (HCBA) Waiver (formerly Nursing Facility/Acute Hospital (NF/AH)Waiver)
   ~~7.~~6. Multipurpose Senior Services Program (MSSP) Waiver

B. Electronic Visit Verification (EVV) Requirements:
   1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa. Partnership monitors compliance with EVV requirements through periodic audits and provider education.
   2. Please refer to policy MP~~C~~UG3011 Home Health Services for further information on EVV requirements.

C. Criteria Used for Identification
   1. ~~The~~ Primary Care Providers (PCP), Specialists, and/or Partnership Care Coordination/ Utilization Management Departments refer Members to Waiver Programs.
   2. ~~Persons~~ Members with intellectual and developmental disabilities are identified through coordination with the Regional Centers and in the course of utilization and case management services. (Title 22, CCR §51340; Welfare and Institutions Code §4684-4699.) Members with developmental disabilities who may meet the requirements for participation in this waiver are referred to the HCBS administered by the State Department of Developmental Services (DDS).

D. Referrals and Authorization
   1. The PCP requests prior authorization for services from the appropriate State Waiver Program and provides all appropriate medical information. –The PCP may request assistance from the Care Coordination department for the following:
      a. Facilitating authorization from appropriate Waiver Program(s)
      b. Completion of the Waiver Program application
      c. Follow up on status of acceptance to appropriate Waiver Program(s)
      d. Medical care coordination of Member while awaiting acceptance and/or placement into a Waiver Program
   2. No Member may be enrolled in more than one HCBS Waiver Program at a time. 42 CFR §441.301(c)(4); DHCS Policy Guidance, HCBS Waiver Enrollment Criteria, 2024.)
   3. Partnership maintains the responsibility to provide comprehensive care management and authorize all medically necessary covered services for Members including those accepted into the Waiver Programs. The PCP will continue to treat and coordinate treatment for the Member.
   ~~4. Referrals for the In-Home Operations Waiver Program are made via telephone or mail:~~
      ~~In-Home Operations Branch Intake Unit~~
      ~~Department of Health Care Services~~
      ~~MS 4502~~
      ~~P.O. Box 997437~~
      ~~Sacramento, CA 95899-7437~~
      ~~(916) 552-9105 in Sacramento~~

~~5.~~4. For the Medi-Cal Waiver Program (MCWP), patients should be referred to a MCWP Provider in their county (or if their county does not have an MCWP provider, they may be referred to a nearby county that participates in the MCWP). A list of MCWP Providers can be found here: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_MCWP_Provider_List.aspx
Information for the Office of AIDS Medi-Cal Waiver Program is posted on this website: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx
Through this waiver program, local agencies provide home and community based services as an alternative to nursing facility care or hospitalization. The agencies are under contract with the
California Department of Public Health
Office of AIDS
(916) 449-5900

~~6.~~5. Members who may qualify for services through the Home and Community Based Services Waiver for the Developmentally Disabled or the Self-Determination Program are referred to the Regional Center responsible for their geographic area as follows:

a. Alta California Regional Center (provides services in Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra , Sutter, Yolo, and Yuba counties)

4151 E. Commerce Way, Suite 100~~2241 Harvard Street, Suite 100~~
Sacramento, CA 9583~~4815~~
(916) 978-6400

b. Far Northern Regional Center (provides services in Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity counties)

Redding Office
1900 Churn Creek Road, Suite 114
Redding, CA 96002
(530) 222-4791

Chico Office
1377 E. Lassen Avenue
Chico, CA 95973
(530) 895-8633

c. Golden Gate Regional Center (provides services in Marin county)
4000 Civic Center Drive, Suite 310
San Rafael, CA 94903
(415) 446-3000

d. North Bay Regional Center (provides services in Solano, Napa, and Sonoma counties)

Solano/ Napa
610 Airpark Road
Napa, CA 94558
(707) 256-1100

Sonoma
520 Mendocino Avenue
Santa Rosa, CA 95401
(707) 569-2000

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

Del Norte County
1301-A Northcrest Drive
Crescent City, CA 95531
(707) 464-7488

Humboldt County
525 2nd Street, Suite 300
Eureka, CA 95501
(707) 445-0893

Lake County

180 3rd Street
Clearlake, CA 9545322

14888 Olympic Drive
Clearlake, CA 95422

(707) 262-0470

(707) 621-6169

Mendocino County
1116 Airport Park Blvd
Ukiah, CA 95482
(707) 462-3832

270 Chestnut Street, Suite A
Fort Bragg, CA 95437
(707) 964-6387

f. Contact information for the State agency is as follows:
California Department of Developmental Services (DDS)
1215 O Street
Sacramento, CA 95814
Mailing Address:
P. O. Box 944202
Sacramento, CA 94244-2020
Info: (833) 421-0061
TTY: 711

~~7.~~6. The Assisted Living Waiver (ALW) program is only offered in certain counties. Sonoma County is currently the only county ~~which~~in Partnership's covered service area that is participating in the ~~serves that provides~~ ALW ~~services. are available.~~ A list of all participating facilities can be found at this webpage: https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-RCFE-ARF.aspx~~https://www.dhcs.ca.gov/services/ltc/Documents/List-of-RCFE-ARF-facilities.pdf~~
Additional downloadable forms related to the ALW program can be found at this website:
http://www.dhcs.ca.gov/services/ltc/Pages/Assisted-Living-Waiver-Provider-Resources.aspx

a. How to enroll: Medi-Cal Members do not submit applications. Medi-Cal Members are enrolled through Care Coordination Agencies, which are providers within the ALW program. Full scope Medi-Cal Members must contact a Care Coordination Agency, which determines each individual's care needs. Assessments are done by registered nurses employed by a Care Coordination Agency (CCA). A list of these agencies by county can be found on this webpage:
https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-CCAs.aspx

~~https://www.dhcs.ca.gov/services/ltc/Documents/Care-Coordination-Agencies.pdf~~

b. Contact Information for State Program:
Department of Health Care Services
Long-Term Care Division, Monitoring & Oversight Section
Assisted Living Waiver Program
1501 Capitol Avenue, MS 4503
PO Box 997437
Sacramento, CA 95899-7437
ALW Hotline (916) 552-9322~~Based on information shared by DHCS confirmed by the Care Partnership Care Coordination Agency, and/or otherwise verified by Partnership Care Coordination, ALW shall confirm ALeligibility and status will be with the Care Coordination Agency and documented outcomes in the Member record.~~

7. The Home and Community-Based Alternatives (HCBA)Waiver (previously titled Nursing Facility/Acute Hospital Waiver) provides care management services at home to Medi-Cal beneficiaries with high level needs who would otherwise receive care in a facility. Some of the services that may be provided to support Waiver participants in the community include, but are not limited to: in-home nursing services, waiver personal care services, family/caregiver training, home

or facility respite, habilitation services, community transition services, environmental accessibility adaptation, medical equipment operating expenses, personal Emergency Response System (PERS) installation, testing, and operation. (42 CFR §441.300-441.310.) Application information for the program can be found here: https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

8. Referrals for the Multipurpose Senior Services Program (MSSP) Waiver program are made by sending the Medi-Cal Member (who is 65 years or older) to a local MSSP site in the county where the Member resides. (Welfare and Institutions Code §9560 et seq.) MSSP site staff will make a certification determination based upon Medi-Cal criteria. A list of MSSP sites can be found here: https://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III Subsections 4.3.15 *(Services for Persons with Developmental Disabilities)*, 4.3.20 (*Home and Community-Based Services Programs*), 4.4.2 E. (*Populations of Focus for Enhanced Care Management*)
B. Medi-Cal Provider Manual/Guidelines: Home and Community-Based Services (HCBS) *(home)*
C. Partnership Memoranda of Understandings (MOUs) with Regional Centers for specific geographical areas
D. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
E. Welfare & Institutions Code §4684-4699, 9560 et seq.
F. DHCS Home and Community-Based Services Waiver Program Overview (2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 11/28/12; 01/20/16; 11/16/16; *06/13/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25; 01/1408/26

*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

Policy/Procedure Number: MCUP3106		Lead Department: Health Services
Policy/Procedure Title: Waiver Programs		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/08/202601/14/2027** **Last Review Date: 01/08/202501/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3131</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Genetic Screening and Diagnostics</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/19/2015</td><td colspan="4">Next Review Date: ~~01/08/2026~~01/14/2027
Last Review Date: ~~01/08/2025~~01/14/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIAL~~SING~~</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/08/2025~~01/14/2026</td></tr>
</table>

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

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

III. DEFINITIONS:
A. Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment.
B. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Multianalyte Assays with Algorithmic Analyses (MAAA): Procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays and non-nucleic acid-based assays (for example, proteins, polypeptides, lipids, carbohydrates).
D. Proprietary Lab Analyses (PLA): A range of proprietary laboratory services and tests which may include, but is not limited to, multianalyte assays with algorithmic analyses (MAAA) and genomic sequencing procedures (GSP).

IV. ATTACHMENTS:
A. Genetic Testing Requirements
B. Family History Screening Tool
C. Proprietary Laboratory Analyses (PLA) Requirements

V. PURPOSE:
To provide criteria for medical necessity and benefit coverage of genetic testing. Genetic testing is a rapidly expanding aspect of medical care which can be useful for diagnosing disease, guiding treatment, and/or identifying possible genetic risks for development of disease. Given the rapid evolution of this field, it is impossible to establish guidelines to reliably inform when genetic testing is appropriate which will remain

valid for a significant time frame. Therefore, the purpose of this policy is to describe the criteria for evaluating requests for genetic testing, and to cite the external professional resources on which we will rely to make coverage determination.

VI. POLICY / PROCEDURE:

A. Genetic testing generally aims to achieve one of the following goals:
   1. Confirm the diagnosis of a genetic disease
   2. Identify genetic factors which significantly increase an individual's risk for developing a disease
   3. Determine whether a high-risk couple's genetic makeup increases the risk of their children having a genetic disease
   4. Help determine prognosis, effectiveness of various treatment options, and guide management of appropriate diseases
   5. Prenatal or newborn genetic testing to identify diseases in high-risk situations

B. Partnership HealthPlan of California's intent is to follow National Comprehensive Cancer Network (NCCN) guidelines. Decisions about which genetic tests to approve will rely on the most up-to-date recommendations provided by the Centers for Disease Control and Prevention, the National Comprehensive Cancer Network, and the American College of Medical Genetics and Genomics. See Section VII. for URLs for these guidelines.

C. A Treatment Authorization Request (TAR) is required for certain genetic testing as outlined in Attachments A and C. Please note Partnership requirements may differ from California Department of Health Care Services (DHCS) Requirements. Please use Partnership's grids entitled Genetic Testing Requirements (Attachment A) and Proprietary Laboratory Analyses (PLA) Requirements (Attachment C) for Partnership M~~m~~embers.
   1. When a TAR is required, medical necessity will be determined upon TAR submission and the following factors will be considered for genetic testing requests:
      a. A definitive diagnosis cannot be made without performing the genetic test being requested AND the results of the genetic testing will influence the treatment or medical management of the patient.
      b. There are identifiable reasons to perform the genetic tests being requested, including a relevant family history or the presence of a clinical condition which suggests a genetic component is relevant to diagnosis or management.
      c. Genetic testing is needed to help guide family planning decisions.
      d. The accuracy of the test has been established, with low proportions of false positive and false negative results.
      e. If a common single gene test is likely to be the cause of the genetic issue in question, a multi-gene test will not be approved until after the single gene test result is negative.
         1) Multi-gene testing may be considered for those who have tested negative (or indeterminate) for one particular syndrome but whose personal and family history is suggestive of an inherited susceptibility.
         2) Multi-gene testing may be considered in cases where more than one pathogenic or likely pathogenic variant could influence a condition.
         3) Clinical documentation indicating clinical impact of the testing that supports medical necessity will be required.
      f. In performing genetic testing of parents to determine risk of an autosomal recessive disease in their offspring, one parent will be tested initially. The other parent will only be tested if the first parent's test indicates the genetic abnormality is present.
      g. The test will be ordered by a clinician who has familiarity with the genetic testing being requested and who has the appropriate expertise to understand the implications of the test and how to follow-up the results.

h. Testing for any specific gene mutation will only be approved once for the lifetime of any individual person except with a valid TAR override.
i. Non-disease specific gene panel testing will not be approved (e.g. ancestral testing).
j. Testing solely for the purposes of determining paternity or familial relationships will not be approved.
k. Genetic testing needed for forensic purposes is not covered.
l. Genetic testing will not be approved if the results or outcome may pose a harm to the individual.
m. Genetic testing will not be approved if the only purpose for ordering the testing is one of the following:
   1) As part of a research project
   2) For general screening purposes where there are no high-risk factors indicating that genetic testing may be useful
n. Where the results of the genetic testing have no therapeutic or medical management implications: If expert guidance is not available to validate the appropriateness of a particular genetic test, Partnership reserves the right to request the patient see a geneticist prior to approving the test.

2. In accordance with state law, effective July 1, 2022, no prior authorization is required for medically necessary cancer biomarker testing for M~~m~~embers diagnosed with, or being monitored for progression or recurrence of, advanced or metastatic stage 3 or 4 cancer when the treatment is associated with an FDA-approved cancer therapy.
   a. No prior authorization is required, however, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
   b. Partnership may still require prior authorization for biomarker testing for such M~~m~~embers if the biomarker test is not associated with an FDA-approved cancer therapy.
   c. In a prepayment review of each claim, Partnership's Chief Medical Officer or Physician Designee will access the FDA's approved drug database at https://www.accessdata.fda.gov/scripts/cder/daf/ to verify that the treatment plan includes documentation of an agent that is an FDA-approved treatment in the setting of advanced or recurrent cancer and for which the biomarker test (for which the claim is submitted) is medically necessary to determine treatment options.
3. Rapid Whole Genome Sequencing (rWGS) is a covered benefit for any M~~m~~ember who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit (ICU).
   a. This includes individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing.
   b. rWGS is an emerging method of diagnosing conditions in time to affect ICU care of children one year of age or younger. rWGS is not a benefit for other ages or settings.
   b. No prior authorization is required, however, a prepayment review after the service has been provided may review the submitted documents to ensure that the documentation reflects medical necessity.

D. Certain genetic tests are not covered by Partnership, however, if ordered by a medical geneticist with appropriate supporting documents attached to the TAR, the request will be considered on an individual basis.
E. For Hereditary Cancer Testing, it is recommended that the provider complete a Family History Screening Tool (Attachment B).
F. For genetic tests related to pregnancy and newborns, please refer to Medi-Cal guidelines in the Genetic Counseling and Screening section *gene coun* 1 – 8.

VII. REFERENCES:

A. Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/genomics-and-

health/about/genetic-counseling.html

B. National Comprehensive Cancer Network (NCCN): NCCN Guidelines for Treatment by Cancer Type
C. American College of Medical Genetics and Genomics (ACMG) guidelines: Genetics in Medicine
D. Medi-Cal Provider Manual/ Guidelines: Pathology: Molecular Pathology *(path molec)*, Genetic Counseling and Screening *(gene coun)* and Proprietary Laboratory Analyses (PLA) *(prop lab)*
E. Lynch Syndrome PREMM5 Model: Prediction Model for MLH1, MSH2, MSH6, PMS2, and EPCAM Gene Mutations: http://premm.dfci.harvard.edu/ Kastrinos F, Uno H, Alvero C, McFarland A, Yurgelun MB, Kulke MH, Schrag D, Meyerhardt JA, Fuchs CS, Mayer RJ, Ng K, Steyerberg EW, Syngal S. Development and Validation of the PREMM5 Model for Comprehensive Risk Assessment of Lynch Syndrome. Journal of Clinical Oncology. 2017 Jul 1;35(19):2165-2172. doi: 10.1200/JCO.2016.69.6120. Epub 2017 May 10.
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010 Cancer Biomarker Testing (06/22/2022)
G. Assembly Bill (AB) 133, 2021-2022 Regular Session, Rapid Whole Genome Sequencing
H. California Department of Public Health (CDPH) California Genetic Disease Screening Program (GDSP) https://sis2-prod.powerappsportals.us/homepage/

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

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

X. REVISION DATES:
8/19/15; 11/18/15; 06/15/16; 02/15/17; 08/16/17; *05/09/18; 09/12/18; 03/13/19; 08/14/19; 11/13/19; 05/13/20; 08/12/20; 05/12/21; 09/08/21; 10/12/22; 10/11/23; 01/08/25; 01/14/2026

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

PREVIOUSLY APPLIED TO:
MCUP3108 BRCA - Gene Sequence Analysis was archived 08/19/2015

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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.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81105 – 81112 **Human Platelet Antigen Genotyping**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): D69.51 or P61.0	Once-in-a-lifetime, any provider, except with valid TAR override	
81120 **IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble), common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C71.0 – C71.9 or C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81121 **IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial), common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C71.0 – C71.9 or C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81161 **DMD (dystrophin) deletion analysis, and duplication analysis, if performed**	No	ICD-10-CM diagnosis code G71.00 (muscular dystrophy) G71.01, G71.02 or G71.09 is required on the claim.	Once-in-a-lifetime, any provider, except with valid TAR override	
81162 **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	A TAR for code 81162 requires documentation as follows: 1) The patient has personal or family history that suggests an inherited cancer susceptibility based on a standard assessment tool: See Attachment B for an example or one of the following tools: • Ontario Family History Assessment Tool • Manchester Scoring System • Referral Screening Tool • Pedigree Assessment Tool	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third-degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. (*Cont'd)*

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	• 7-Question Family History Screening Tool • International Breast Cancer Intervention Study instrument • Brief versions of BRCAPRO; AND 2) The patient is willing to talk with a health professional who is suitably trained to provide genetic counseling and interpret test results; AND 3) The test results will aid in the decision-making Additionally, a TAR for code 81162 requires documentation of *one or more* of the following numbered criteria Per NCCN Guidelines Version 1.2020 Hereditary Cancer Testing Criteria, testing is clinical indicated in the following scenarios: 1) An individual from a family with a known pathogenic /likely pathogenic variant in cancer susceptibility gene mutation; OR 2) Individuals meeting criteria below and previously tested NEGATIVE in single gene analysis desiring multiple gene sequencing 3) Personal history of cancer • Diagnosed at ≤45 years of age; OR • Diagnosed at 46 - 50 yo with: - An unknown or limited family history; OR - An additional breast cancer primary at any age - One or more close blood relatives with breast, ovarian, pancreatic or prostate cancer (Gleason score ≥7) • Diagnosed at ≤60 years of age with triple negative breast cancer; OR • Diagnosed at any age with: – One or more close blood relatives with: o breast cancer diagnosed at ≤50 years of age; or o Ovarian carcinoma; or	Once-in-a-lifetime, any provider, except with valid TAR override *	Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer. See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis** *Continued below*	Yes	○ Male breast cancer; or ○ Metastatic prostate cancer; or ○ Pancreatic cancer – 2 or more additional diagnoses of breast cancer at any age in patient and/or in close blood relatives; or • Ashkenazi Jewish ancestry; OR • Personal history of Male Breast Cancer; or • Personal history of Ovarian carcinoma (includes fallopian tube cancer and peritoneal cancer); or • Personal history of pancreatic cancer; or • Personal history of metastatic prostate cancer (biopsy-proven and/or with radiographic evidence; include distant metastasis and regional bed or nodes; not biochemical recurrence); or • Personal history of high-grade prostate cancer (Gleason score ≥7) at any age with: – Ashkenazi Jewish ancestry; or – One or more close blood relatives with ovarian carcinoma, pancreatic cancer or metastatic prostate cancer at any age or breast cancer under 50 years of age; or – 2 or more close blood relatives with breast or prostate cancer (any grade) at any age • A mutation identified on tumor genomic testing that has clinical implications if also identified in the germ line • To aid in systemic therapy decision-making 4) Family History of Cancer • An affected or unaffected individual with first- or second degree-blood relative meeting any criteria above (except those meeting criteria ONLY for systemic therapy decisions)	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81162** **BRCA1, BRCA2 gene analysis; full sequence analysis and full duplication/deletion analysis**	Yes	• An affected or unaffected individual who does NOT meet criteria but has a probability of greater than or equal to 5% of at BRCA 1 / 2 pathogenic variant based on prior probability models For BRACAnalysis CDx testing for breast cancer, all of the following TAR criteria must be met: • Patient has metastatic breast cancer. • Patient is human epidermal growth factor receptor 2 (HER2)-negative. • Patient has previously been treated with chemotherapy in the neoadjuvant, adjuvant or metastatic setting. • Patient's additional treatment is contingent on the test results. * An approved TAR that meets the necessary criteria listed below to override the once-in-a-lifetime frequency is required: In Advanced Ovarian Cancer: For patients with previous germline BRCA test (blood sample), additional somatic BRCA testing (tumor sample) may be necessary when treatment with Lynparza™ (olaparib) is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override *	See Attachment B – Family History Screening Tool which is suggested for use prior to ordering BRCA testing Note that for the purpose of this policy, a "close blood relative" is defined as a first-degree, second-degree or third degree blood relative. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer. Olaparib has FDA approval for use in some Ovarian Cancer diagnosis where there is a mutation in the germline or somatic BRCA.
81163 **BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81164 **BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) gene analysis; full duplication/deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81165 **BRCA1 (BRCA1, DNA repair associated) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81166 **BRCA1 (BRCA1, DNA repair associated) gene analysis; full duplication/ deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81167 **BRCA2 (BRCA2, DNA repair associated) gene analysis; full duplication/ deletion analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81168 **CCND1/IGH (t[11;14])(eg. mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.10 thru C83.19	Once-in-a-lifetime, any provider, except with valid TAR override	
81170 **ALB1 gene analysis, variants in the kinase domain**	Yes	Requires documentation on the TAR that the recipient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81171 **AFF2 (AF4/FMR2 family, member 2 [FMR2]) gene analysis evaluation to detect abnormal alleles**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): F70, F71, F80.0 – F89, H93.25, R48.0, R62.0 – R62.59, F82, F88, R48.2	Once-in-a-lifetime, any provider, except with valid TAR override	
81172 **AFF2 (AF4/FMR2 family, member 2 [FMR2]) gene analysis; characterization of alleles**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): F70, F71, F80.0 – F89, H93.25, R48.0, R62.0 – R62.59, F82, F88, R48.2	Once-in-a-lifetime, any provider, except with valid TAR override	
81173 **AR (androgen receptor) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81173 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81174 **AR (androgen receptor) gene analysis; known familial variant**	Yes	A TAR for CPT code 81174 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81175 **ASXL gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C93.10 – C93.12, D46.0 – D46.C, D47.1	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81176 **ASXL gene analysis, targeted sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C93.10 – C93.12, D46.0 – D46.C, D47.1	Once-in-a-lifetime, any provider, except with valid TAR override	
81177 **ATN1 (atrophin 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81177 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for dentatorubral pallidoluysian atrophy, and • The patient requires the service as a confirmatory test for dentatorubral pallidoluysian atrophy	Once-in-a-lifetime; any provider, except with valid TAR override	
81178 **ATXN1 (ataxin 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81178 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 1 (SCA1), and • The patient requires the service as a confirmatory test for SCA1	Once-in-a-lifetime, any provider, except with valid TAR override	
81179 **ATXN2 (ataxin 2) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81179 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 2 (SCA2), and • The patient requires the service as a confirmatory test for SCA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81180 **ATXN3 (ataxin 3) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81180 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 3 (SCA3), and • The patient requires the service as a confirmatory test for SCA3	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81181 **ATXN7 (ataxin 7) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81181 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 7 (SCA7), and • The patient requires the service as a confirmatory test for SCA7	Once-in-a-lifetime, any provider, except with valid TAR override	
81182 **ATXN8OS (ATXN8 opposite strand [non-protein coding]) gene analysis, evaluation to detect abnormal**	Yes	A TAR for CPT code 81182 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 8 (SCA8), and • The patient requires the service as a confirmatory test for SCA8	Once-in-a-lifetime, any provider, except with valid TAR override	
81183 **ATXN10 (ataxin 10) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81183 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 10 (SCA10), and • The patient requires the service as a confirmatory test for SCA10	Once-in-a-lifetime, any provider, except with valid TAR override	
81184 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81184 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81185 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81185 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81186 **CACNA1A (calcium voltage-gated channel subunit alpha1 A) gene analysis; known familial variant**	Yes	A TAR for CPT code 81186 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2	Once-in-a-lifetime, any provider, except with valid TAR override	
81187 **CNBP (CCHC-type zinc finger nucleic acid binding protein) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81187 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Myotonic dystrophy type 2 (MD2), and • The patient requires the service as a confirmatory test for MD2	Once-in-a-lifetime, any provider, except with valid TAR override	
81188 **CSTB (cystatin B) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81188 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81189 **CSTB (cystatin B) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81189 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81190 **CSTB (cystatin B) gene analysis; known familial variant(s)**	Yes	A TAR for CPT code 81190 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81191 **NTRK1 (neurotrophic receptor tyrosine kinase 1) (eg, solid tumors) translocation analysis**	Yes	A TAR for CPT code 81191 requires documentation of the following criteria: Adult and pediatric patients with solid tumors with any one of the following clinical scenario: • Metastatic tumor or where surgical resection is likely to result in severe morbidity, or • Have no satisfactory alternative treatments or have progressed following treatment	N/A	
81192 **NTRK2 (neurotrophic receptor tyrosine kinase 2)(eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81193 **NTRK3 (neurotrophic receptor tyrosine kinase 3)(eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81194 **NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis**	Yes	See CPT code 81191 for TAR criteria and billing requirements.	N/A	
81201 **APC** **gene analysis; full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, D12.0 – D12.9, K63.5, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
81202 **APC** **gene analysis; known familial variants**	Yes	Requires documentation on the Treatment Authorization Request (TAR) of a family history of familial adenomatous polyposis that includes a relative with a known deleterious APC mutation	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81203 **APC** **gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, D12.0 – D12.9, K63.5, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
81204 **AR (androgen receptor) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81204 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once-in-a-lifetime. any provider, except with valid TAR override	
81206 **BCR/ABL1 translocation analysis; major breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81207 **BCR/ABL1 translocation analysis; minor breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81208 **BCR/ABL1 translocation analysis; other breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02 or C92.10 – C92.12	N/A	
81210 **BRAF (B-Raf proto-oncogene, serine/threonine kinase)**, gene analysis, **V600 variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C18.9, C19, C20, C33, C34.00 – C34.92, C43.0 – C43.9, C79.2 or D03.0 – D03.9	Once-in-a-lifetime, any provider, except with valid TAR override	
81212 **BRCA1, BRCA2 gene analysis; variants**	Yes	Requires documentation on the TAR of the following: • An individual is of an ethnicity associated with the Ashkenazi Jewish population No additional family history may be required	Once-in-a-lifetime, any provider, except with valid TAR override	See Attachment B - Family History Screening Tool which is suggested for use prior to ordering BRCA testing

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81215 **BRCA1 (breast cancer 1) gene analysis; known familial variant**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81216 **BRCA2 (breast cancer 2) gene analysis; full sequence analysis**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81217 **BRCA2 (breast cancer 2) gene analysis; known familial variant**	Yes	See CPT code 81162 for TAR criteria and billing requirements.	See CPT code 81162	
81218 **CEBPA (CCAAT/enhancer binding protein [C/EBP], alpha) gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02, C92.40 – C92.42 or C92.50 – C92.52	Once-in-a-lifetime, any provider, except with valid TAR override	
81219 **CALR (calreticulin) gene analysis, common variants in exon 9**	No	One of the following ICD-10-CM codes is required on the claim: C92.10 – C92.12, D45, D47.3 or D75.81	Once-in-a-lifetime, any provider, except with valid TAR override	
81220 **CFTR (cystic fibrosis transmembrane conductance regulator) gene analysis; common variants**	No	When used to bill for cystic-fibrosis screening requires ICD-10-CM codes E84, O09.00 thru O09.93, X38.49, Z31.430, Z31.440, Z31.5, Z34.00 thru Z34.03, Z34.80 thru Z34.83, Z34.90 thru Z34.93 Not reimbursable with code 81224 for same date of service, recipient and provider May be billed separately with an appropriate National Correct Coding Initiative (NCCI) associated modifier Refer to the *Genetic Counseling and Screening* section in the Medi-Cal Manual for additional information	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81221 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; known familial variants	No	The following criteria should be documented: • The Patient has a strong clinical presentation suspicious of CF, and • Family with known variant not included in the test for common variants	Once-in-a-lifetime any provider, except with valid TAR override	
81222 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; duplication/deletion variants	No	The following criteria should be documented: • The patient has a strongclinical presentation suspicious of CF, and • Gene test for common variants did not result in twodisease-causing variants in CFTR	Once-in-a-lifetime any provider, except with valid TAR override	
81223 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cysticfibrosis) gene analysis; full gene sequence	Yes	TAR requires documentation of the following criteria: • Patient has intermediate sweat chloride result, or • Patient with confirmed or suspected CF, with unknowngenotype, and additional treatment or assessment of prognosis is contingent on the result of the test, or • Patient with normal sweat chloride results despite a strong clinical suspicion of CF	Once-in-a-lifetime, any provider, except with valid TAR override	
81224 CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-T analysis (eg, male infertility)	No	When used to bill for cystic-fibrosis testing requires ICD-10-CM diagnosis code N46.9	Once-in-a-lifetime, any provider, except with valid TAR override	
81225	No	Billable with any valid ICD-10-CM diagnosis code.	Once-in-a-lifetime,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19), gene analysis, common variants			any provider, except with valid TAR override	
81226 **CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6), gene analysis, common variants**	Yes	A TAR requires documentation that: • The member is being treated with Tetrabenazine and requires a dose above 50 milligrams per day, or • The member has Gaucher disease type 1 and is being considered for treatment with Eliglustat	Once-in-a-lifetime, any provider, except with valid TAR override	
81227 **CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)**	Yes	A TAR requires documentation that the member has a diagnosis of multiple sclerosis and is being considered for treatment with Siponimod	Once-in-a-lifetime, any provider, except with valid TAR override	
81228 **Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants, comparative genomic hybridization [CGH] microarray analysis**	Yes	A TAR requires documentation of all of the following criteria for each indication: For Prenatal Testing of Fetus: 1. Member has received pre-test genetic counseling and will receive post-test genetic counseling, and 2. One of the following criteria must be met (a thru c): a. Prenatal ultrasound identified one or more structural abnormalities in the fetus, or b. Member is undergoing invasive diagnostic fetal testing for a risk factor (for example, positive or inconclusive non-invasive prenatal screening test, advanced maternal age, family history of chromosomal or genetic abnormality, etc.), or c. Member has experienced intrauterine fetal death in the second or third trimester and testing of fetal cells/products of conception is needed to inform future pregnancies	Once-in-a-lifetime, any provider, except with valid TAR override	This codes is a benefit for the Presumptive Eligibility for Pregnant People (PE4PP) program. 81228 cannot be completed if an 81229 has been completed.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		For All Other Testing Indications: 1. Member has received pre-test genetic counseling and will receive post-test genetic counseling, and 2. Member's clinical phenotype does not fit a well-described syndrome for which single-gene or targeted panel testing is available, and 3. One of the following criteria must be met (a thru e): a. Intellectual disability or developmental delay with no identifiable cause, or b. Multiple congenital anomalies without an established diagnosis, or c. Autism spectrum disorder with no identifiable cause, or d. Findings suggestive of primary immunodeficiency, or e. Congenital heart disease		
81229 **Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants, comparative genomic hybridization (CGH) microarray analysis**	Yes	A TAR requires documentation of all of the following criteria for each indication: For Prenatal Testing of Fetus: 1. Member has received pre-test genetic counseling and will receive post-test genetic counseling, and 2. One of the following criteria must be met (a thru c): a. Prenatal ultrasound identified one or more structural abnormalities in the fetus, or b. Member is undergoing invasive diagnostic fetal testing for a risk factor (for example, positive or inconclusive non-invasive prenatal screening test, advanced maternal age, family history of chromosomal or genetic abnormality, etc.), or c. Member has experienced intrauterine fetal death in the second or third trimester and testing of fetal cells/products of conception is needed to inform future pregnancies	Once-in-a-lifetime, any provider, except with valid TAR override	This codes is a benefit for the Presumptive Eligibility for Pregnant People (PE4PP) program.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		For All Other Testing Indications: 1. Member has received pre-test genetic counseling and will receive post-test genetic counseling, and 2. Member's clinical phenotype does not fit a well-described syndrome for which single-gene or targeted panel testing is available, and 3. One of the following criteria must be met (a thru e): a. Intellectual disability or developmental delay with no identifiable cause, or b. Multiple congenital anomalies without an established diagnosis, or c. Autism spectrum disorder with no identifiable cause, or d. Findings suggestive of primary immunodeficiency, or e. Congenital heart disease		
81232 **DPYD (dihydropyrimidine dehydrogenase) gene analysis, common variant(s)**	Yes	A TAR requires documentation of the following criteria: • Patient had severe and unexpected toxicity (such as myelosuppression, mucositis, diarrhea, neurotoxicity, cardiotoxicity) during treatment with Fluorouracil or Capecitabine chemotherapy.	Once-in-a-lifetime, any provider, except with valid TAR override	
81233 **BTK (Bruton's tyrosine kinase) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D80.0 – D80.6, C91.10 – C91.12, C83.00 – C83.09	Once-in-a-lifetime, any provider, except with valid TAR override	
81234 **DMPK (DM1 protein kinase) gene analysis;**	Yes	A TAR for CPT code 81234 requires documentation of the following criteria:	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
evaluation to detect abnormal alleles		• The patient has clinical signs or symptoms suspicious for myotonic dystrophy type 1 (MD1), and • The patient requires the service as a diagnostic test for MD1.	valid TAR override	
81235 **EGFR (epidermal growth factor receptor) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim: C33, C34.00 – C34.92	Once-in-a-lifetime, any provider, except with valid TAR override	
81236 **EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) gene analysis, full gene sequence**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D47.1, D47.3, C83.30 – C83.39	Not more than once per month	
81237 **EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) gene analysis, common variant(s)**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): D47.1, D47.3, C83.30 – C83.39	Not more than once per month	
81238 **F9 (coagulation factor IX) full gene analysis sequence**	No	ICD-10-CM code D67 is required on the claim (except with valid TAR)	Once-in-a-lifetime, any provider, except with valid TAR override	
81239 **DMPK (DM1 protein kinase) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81239 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myotonic dystrophy type 1 (MD1), and • The patient requires the service as a diagnostic test for MD1.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81243 **FMR1 (fragile X mental retardation 1) gene analysis; evaluation to detect abnormal alleles**	No	One of the following ICD-10-CM codes is required on the claim: F70, F71 – F73, F78, F80.0 – F84.2, F88, F89, H93.25, R48.2, R62.0, R62.50 – R62.59	Once-in-a-lifetime, any provider, except with valid TAR override	
81244 **FMR1 (fragile X mental retardation 1) gene analysis; characterization of alleles**	No	One of the following ICD-10-CM codes is required on the claim: F70, F71 – F73, F78, F80.0 – F84.2, F88, F89, H93.25, R48.2, R62.0, R62.50 – R62.59	Once-in-a-lifetime, any provider, except with valid TAR override	
81245 **FLT3 (fms-related tyrosine kinase 3), gene analysis; internal tandem duplication (ITD) variants**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02, C92.60 - C92.62 or C92.A0 – C92.A2	Once-in-a-lifetime, any provider, except with valid TAR override	
81246 **FLT3 (fms-related tyrosine kinase 3), gene analysis; tyrosine kinase domain (TKD) variants**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02, C92.60 - C92.62 or C92.A0 – C92.A2	Once-in-a-lifetime, any provider, except with valid TAR override	
81250 **G6PC (glucose-6-phosphatase, catalytic subunit) gene analysis, common variants**	Yes	The patient has clinical features suspicious for, or requires the laboratory service as a diagnostic test for glycogen storage disease, type 1a	Once-in-a-lifetime, any provider, except with valid TAR override	
81256	No	One of the following ICD-10-CM codes is required on the claim:	Once-in-a-lifetime,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
HFE (hemochromatosis) gene analysis, common variants		E83.10, E83.110 or E83.118 – E83.119	any provider, except with valid TAR override	
81257 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; common deletions or variant**	No	N/A	Once-in-a-Lifetime, any provider, except with valid TAR override	
81258 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; known familial variant**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81259 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; full gene sequence**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81260 **IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinas complex-associated protein) gene analysis, common variants**	No	Indicated for: • Hypotonia in infancy • Decreased or absent deep tendon reflexes • Decreased taste and absence of fungiform papillae of the tongue • Absence of overflow tears with emotional crying (alacrima) • Absence of axon flare response after intradermal histamine injection • Pupillary hypersensitivity to parasympathomimetic agents	Once-in-a-lifetime, any provider, except with valid TAR override	While DHCS requires a TAR for this test, PHC has chosen to have no TAR requirement.
81265	No	One of the following ICD-10-CM codes is required on the claim:	Once-in-a-lifetime, any	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Comparative analysis using Short Tandem Repeat markers		C81.00 – C96.9, D45, T86.00 – T86.09 or T86.5	provider, except with valid TAR override	
81266 **Comparative analysis using Short Tandem Repeat markers; each additional specimen**	No	One of the following ICD-10-CM codes is required on the claim: C81.00 – C96.9, D45, T86.00 – T86.09 or T86.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81267 **Chimerism (engraftment) analysis, post transplantation specimen; without cell selection**	No	One of the following ICD-10-CM codes is required on the claim: T86.01, T86.02, T86.09 or T86.5	N/A	
81268 **Chimerism (engraftment) analysis, post transplantation specimen; with cell selection**	No	One of the following ICD-10-CM codes is required on the claim: T86.01, T86.02, T86.09 or T86.5	N/A	
81269 **HBA1/HBA2 (alpha globin 1 and alpha globin 2), gene analysis; duplication/ deletion variants**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81270 **JAK2 (Janus kinase 2) gene analysis, p. Val617Phe (V617F) variant**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 – C91.02, D45, D47.1 or D47.3	Once-in-a-lifetime, any provider, except with valid TAR override	
81271	Yes	A TAR for CPT code 81271 requires documentation of the following criteria:	Once-in-a-lifetime, any provider,	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
HTT (huntingtin) gene analysis; evaluation to detect abnormal alleles		• For adults, the patient has unequivocal motor signs of Huntington's disease (HD) and requires the service to confirm the diagnosis • For children, the patient has a family history of HD and develops symptoms that raise the suspicion for juvenile-onset HD as exemplified by two or more of the following: – Declining school performance – Seizures – Oral motor dysfunction – Rigidity – Gait disturbance	except with valid TAR override	
81272 **KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog), gene analysis, targeted sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C43.70 - C43.72, C92.00 – C92.02, C92.40 – C92.42, C92.50 – C92.52, D03.70 – D03.72, D47.01, D47.02 or D48.1	Once-in-a-lifetime, any provider, except with valid TAR override	
81273 **KIT (v-kit Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog), gene analysis, D816 variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C96.20 – C96.29, D47.01, D47.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81274 **HTT (huntingtin) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81274 requires documentation of the following criteria: • For adults, the patient has unequivocal motor signs of Huntington's disease (HD) and requires the service to confirm the diagnosis • For children, the patient has a family history of HD and develops symptoms that raise the suspicion for juvenile-onset HD as exemplified by two or more of the following: – Declining school performance – Seizures – Oral motor dysfunction	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		– Rigidity – Gait disturbance		
81275 **KRAS (Kirsten rat sarcoma viral oncogene homolog) gene analysis; variants in exon 2**	No	One of the following ICD-10-CM codes is required on the claim: C18.0 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81276 **KRAS (Kristen rat sarcoma viral oncogene homolog) gene analysis; additional variant(s)**	No	One of the following ICD-10-CM codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81278 **IGH @/BLC2 (t[4; 18]) (eg, follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative**	Yes	A TAR for CPT code 81278 requires documentation of the following criteria: The patient has clinical features suspicious for, or requires the service as a diagnostic test for follicular lymphoma	Once-in-a-lifetime, any provider, except with valid TAR override	
81279 **JAK2 (Janus kinase 2)(eg, myeloproliferative disorder) gene analysis, (eg, exons 12and 13)**	No	One of the following ICD-10-CM codes is required on the claim: C91.00 thru C91.02, D45, D47.1 or D47.3	N/A	
81283 **IFNL3 (interferon, lambda 3), gene analysis, rs12979860 variant**	No	ICD-10-CM code B18.2 is required on the claim (except with valid TAR)	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81284 **FXN (frataxin) gene analysis; evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81284 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81285 **FXN (frataxin) gene analysis; characterization of alleles**	Yes	A TAR for CPT code 81285 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81286 **FXN (frataxin) gene analysis; full gene sequence**	Yes	A TAR for CPT code 81286 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81287 **MGMT (0-6 methylguanin-DNA methyltransferase) methylation analysis**	No	Indicated for: • The patient has the diagnosis of glioblastoma multiforme, and • Treatment strategy will be contingent on the test results • Reimbursable when billed with ICD-10: C71.9.	Once-in-a-lifetime, any provider, except with valid TAR override	While DHCS requires a TAR for this test, PHC has chosen to have no TAR requirement when billed with ICD-10 code C71.9
81288 **MLH1 gene analysis; promoter methylation analysis**	Yes	Document the following criteria on the TAR: • Patient with cancer(s) associated with Lynch Syndrome, and • The tumor demonstrates microsatellite instability or immunohistochemistry results indicating loss of MLH1 protein expression	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
			valid TAR override	
81289 **FXN (frataxin) gene analysis; known familial variant(s)**	Yes	A TAR for CPT code 81289 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once-in-a-lifetime, any provider, except with valid TAR override	
81292 **MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81293 **MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious MLH1 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81294 **MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81295 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81296 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious MSH2 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81297 **MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81298 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also reimburse for these ICD-10 codes: C56.1 – C56.9
81299 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious MSH6 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/
81300 **MSH6 (mutS homolog 6 [E. coli]) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81301 **Microsatellite instability analysis of markers for mismatch repair deficiency includes comparison of neoplastic and normal tissue, if performed**	No	Reimbursable for patients who meet one of the following criteria: the patient is diagnosed with one of the Lynch syndrome-associated cancers; or, the patient is diagnosed with an unresectable or metastatic solid tumor and the treatment will be contingent on the test result.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81305 **MYD88 (myeloid differentiation primary response 88) (gene analysis, p.Leu265Pro (L265P) variant**	No	The following ICD-10-CM code is required on the claim (except with valid TAR): C88.0	Once-in-a-lifetime, any provider, except with valid TAR override	
81306 **NUDT15 (nudix hydrolase 15) gene analysis, common variant(s)**	Yes	A TAR for CPT code 81306 requires documentation of the following criteria: • The patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also authorize 81306 for the purpose of predicting toxicity to azathioprine prior to initiation of treatment for SLE and other recognized conditions when treatment with long term azathioprine is being considered.
81309 **PIK3CA gene analysis, targeted sequence analysis**	Yes	A TAR/SAR for CPT code 81309 requires documentation of the following criteria: • The patient has confirmed diagnosis of breast cancer • Treatment is contingent on the result of the test	Once-in-a-lifetime, any provider, except with valid TAR override	
81310 **NPM1 (nucleophosmin) gene analysis, exon 12 variants**	No	One of the following ICD-10-CM codes is required on the claim: C92.00 – C92.02	Once-in-a-lifetime, any provider, except with valid TAR override	
81311 **NRAS (neuroblastoma RAS viral [v-ras] oncogene homolog) gene analysis, variants in exon 2 and exon 3**	No	One of the following ICD-10-CM codes is required on the claim: C18.0, C18.2 – C20, D01.1, D01.2, D01.40, D01.49, D37.4 or D37.5	Once-in-a-lifetime, any provider, except with valid TAR override	
81312 **PABPN1 (poly[A] binding protein nuclear 1) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81312 requires documentation of the following criteria: • The patient has symptoms of ptosis and dysphagia, and	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• The patient requires the service as a confirmatory test for Oculopharyngeal Muscular Dystrophy		
81314 **PDGFRA (platelet-derived growth factor receptor, alpha polypeptide), gene analysis, targeted sequence analysis**	No	ICD-10-CM code D48.1 is required on the claim.	Once-in-a-lifetime, any provider, except with valid TAR override	
81315 **PML/RAR-alpha (promyelocytic leukemia/retinoic acid receptor alpha) translocation analysis; common breakpoints**	No	One of the following ICD-10-CM codes is required on the claim: C92.40 – C92.42	N/A	
81316 **PML/RAR-alpha (promyelocytic leukemia/retinoic acid receptor alpha) translocation analysis; single breakpoint**	No	One of the following ICD-10-CM codes is required on the claim: C92.40 – C92.42	N/A	
81317 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; full sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81318 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; known familial variants**	Yes	Document on the TAR family history of Lynch Syndrome that includes a relative with a known deleterious PMS2 mutation	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81319 **PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) gene analysis; duplication/deletion variants**	No	One of the following ICD-10-CM codes is required on the claim: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81320 **PLCG2 (phospholipase C gamma 2) gene analysis, common variants**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C91.10 – C91.12	Once-in-a-lifetime, any provider, except with valid TAR override	
81321 **PTEN (phosphatase and tensin homolog) gene analysis; full sequence analysis** *Continued below* *Continued from above* **81321** **PTEN (phosphatase and tensin homolog) gene analysis; full sequence analysis**	Yes *Continued* Yes	A TAR for CPT-4 code 81321 requires documentation of one or more of the following numbered criteria: 1. Individual with a personal history of: • Bannayan-Riley-Ruvalcaba syndrome, or • Adult Lhermitte-Duclos disease, or • Autism spectrum disorder AND macrocephaly, or • Two or more biopsy-proven trichilemmomas, or • Two or more major criteria (one macrocephaly), or • Three major criteria without macrocephaly, or • One major and three or more minor criteria, or • Four or more minor criteria (please see list below) 2. At-risk individual: With a relative who has a clinical diagnosis of Cowden syndrome or Bannayan-Riley-Ruvalcaba syndrome for whom testing has not been performed AND who has any one major criterion or two minor criteria Major Criteria • Breast cancer • Mucocutaneous lesions • One biopsy-proven trichilemmoma • Multiple palmoplantar keratosis • Multifocal or extensive oral mucosal papillomatosis	Once-in-a-lifetime, any provider, except with valid TAR override Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• Multiple cutaneous facial papules (often verrucous) • Macular pigmentation of glans penis • Macroencephaly (megalocephaly, ie, ≥97th percentile) • Endometrial cancer • Non-medullary thyroid cancer • Multiple GI tract hamartomas or ganglioneuromas Minor Criteria • Other thyroid lesions (adenoma, nodule, goiter) • Mental retardation (IQ ≤75) • Autism spectrum disorder • Single GI tract hamartoma or ganglioneuroma • Fibrocystic disease of the breast • Lipomas • Fibromas • Renal cell carcinoma • Uterine fibroids		
81322 **PTEN gene analysis; known familial variant**	Yes	Requires documentation on the TAR that patient is from a family with a known PTEN mutation	Once-in-a-lifetime, any provider, except with valid TAR override	
81323 **PTEN gene analysis; duplication/deletion variant**	Yes	Requires documentation on the TAR of a negative result in the full sequence analysis in PTEN (CPT-4 code 81321), and that patient meets one or more criteria listed under code 81321	Once-in-a-lifetime, any provider, except with valid TAR override	
81329 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; dosage/deletion analysis, includes SMN2 (survival of motor neuron**	No	One of the following ICD-10-CM diagnosis codes is required on the claim (except with valid TAR): O09.00 thru O09.93, Z31.430, Z31.440, Z34.00 - Z34.03, Z34.80 - Z34.83, Z34.90 - Z34.93	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
2, centromeric) analysis, if performed				
81331 **SNRPN/UBE3A methylation analysis**	Yes	Document the following age-specific criteria on the TAR • Birth to 2 years: Hypotonia with poor suck • 2 – 6 years: Hypotonia with history of poor suck and global development delay • 6 – 13 years: History of hypotonia with poor suck (hypotonia often persists); global development delay; and excessive eating (hyperphagia; obsession with food) with central obesity if uncontrolled • 13 years – adult: Cognitive impairment – usually mild mental retardation; excessive eating (hyperphagia; obsession with food) with central obesity if uncontrolled; and hypothalamic hypogonadism and/or typical behavior problems (including temper tantrums and obsessive-compulsive features)	Once-in-a-lifetime, any provider, except with valid TAR override	
81334 **RUNX1 (runt related transcription factor 1), gene analysis, targeted sequence analysis**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): C92.00 – C92.02, C92.40 – C92.A2	Once-in-a-lifetime, any provider, except with valid TAR override	
81335 **TPMT (thiopurine S-methyltransferase), gene analysis, common variants**	Yes	The service requires a TAR with documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, any provider, except with valid TAR override	PHC will also authorize 81335 for the purpose of predicting toxicity to azathioprine prior to initiation of treatment for SLE and other recognized conditions when treatment with long term azathioprine is being considered.
81336 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; full gene sequence**	No	The following criteria should be documented: • The patient has clinical signs or symptoms suspicious for spinal muscular atrophy, and • The patient requires the service as a confirmatory test for spinal muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81337 **SMN1 (survival of motor neuron 1, telomeric) gene analysis; known familial sequence variant(s)**	No	The following criteria should be documented: • The patient has clinical signs or symptoms suspicious for spinal muscular atrophy, and • The patient requires the service as a confirmatory test for spinal muscular atrophy	Once-in-a-lifetime, any provider, except with valid TAR override	
81338 **MPL (MPL proto-oncogene, thrombopoietin recepter) (eg, myeloproliferative disorder) gene analysis; common variants (eg, W515A,W515K, W515L, W515R)**	Yes	A TAR for CPT code 81338 requires documentation of the following criteria: The patient has clinical features suspicious for, or requires the service as a diagnostic test for, myeloproliferative disorder	N/A	
81339 **MPL (MPL proto-oncogene, thrombopoietin recepter) (eg, myeloproliferative disorder) gene analysis; sequenceanalysis, exon 10**	Yes	A TAR for CPT code 81339 requires documentation of the following criteria: The patient has clinical features suspicious for, or requires the service as a diagnostic test for, myeloproliferative disorder	N/A	
81340 **TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)**	Yes	A TAR for CPT code 81340 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	Once-in-a-lifetime, any provider, except with valid TAR override	
81341 **TRB@ (T cell antigen receptor, beta) (eg, leukemia and lymphoma),**	Yes	A TAR for CPT code 81341 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, Southern blot)		service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	valid TAR override	
81342 **TRG@ (T cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)**	Yes	A TAR for CPT code 81342 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for lymphoma and requires the service as a confirmatory test for lymphoma; or • The test is used to aid in classification of lymphomas	Once-in-a-lifetime, any provider, except with valid TAR override	
81343 **PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81343 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 12 (SCA12), and • The patient requires the service as a confirmatory test for SCA12	Once-in-a-lifetime, any provider, except with valid TAR override	
81344 **TBP (TATA box binding protein) gene analysis, evaluation to detect abnormal alleles**	Yes	A TAR for CPT code 81344 requires documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for spinocerebellar ataxia type 17 (SCA17), and • The patient requires the service as a confirmatory test for SCA17	Once-in-a-lifetime, any provider, except with valid TAR override	
81345 **TERT (telomerase reverse transcriptase) gene analysis, targeted sequence analysis**	Yes	Document the following criteria on the TAR: The patient has the diagnosis of grade II, III or IV glioma.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81347 **SF3B1 (splicing factor[3b] subunit B1) (eg, myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (eg, A672T, E622D, L833F, R625C, R625L)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81348 **SRSF2 (serine and arginine-rich splicing factor 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg,P95H, P95L)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81349 **Genome-wide analysis**	Yes	A TAR requires documentation of all of the criteria for 81425 shown below.		Typically used for rare diseases. Request should include specific gene requested. Cannot be billed if 81229 or 81425 is billed.
81351 **TP53 (tumorprotein 53) (eg, Li- Fraumeni syndrome) gene analysis; fullgene sequence** *Continued Below* *Continued from above* **81351** **TP53 (tumorprotein 53) (eg, Li- Fraumeni syndrome) gene analysis; fullgene sequence**	Yes Yes	A TAR for CPT code 81351 requires documentation for one of the following numbered criteria: 1. All of the following conditions: • The patient has sarcoma diagnosed before 45 years of age,and • A first-degree relative with any cancer before 45 years of age,and • A first or second-degree relative with any cancer before 45 years ofage, or a sarcoma at any age; or 2. All of the following conditions: • A tumor belonging to the Li- Fraumeni Syndrome (LFS) tumorspectrum (soft tissue sarcoma, osteosarcoma, pre-menopausal breast cancer, brain tumor, adrenocortical carcinoma, leukemia or lung	N/A N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		bronchoalveolarcancer) before 46 years of age, and • At least one first or second-degreerelative with an LFS tumor (exceptbreast cancer if the patient has breast cancer) before 56 years of age or with multiple tumors; or 3. The patient has multiple tumors (except multiple breast tumors), two of which belong to the LFS tumor spectrum, and the first occurred before 46 years of age; or 4. The patient is diagnosed with adrenocortical carcinoma or choroidplexus tumor.		
81352 **TP53 (tumor protein53) (eg, Li-Fraumenisyndrome) gene analysis; targeted sequence analysis (eg, 4 oncology)**	Yes	See CPT code 81351 for TAR criteria and billing requirements.	N/A	
81353 **TP53 (tumor protein53) (eg, Li-Fraumenisyndrome) gene analysis; known familial variant**	Yes	See CPT code 81351 for TAR criteria and billing requirements.	N/A	
81357 **U2AF1 (U2 small nuclear RNA auxiliaryfactor 1) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (eg S34F, S34Y, Q157R,Q157P)**	No	One of the following ICD-10-CM codes is required on the claim C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.	N/A	
81360	No	One of the following ICD-10-CMcodes is required on the claim	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/argine-rich 2) (eg, myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (eg, E65fs, E122fs, R448fs)		C92.00 thru C92.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.A, D46.B, D46.C, D46.4, D46.Z, D46.9.		
81361 **HBB (hemoglobin, subunit beta); common variant(s) (e.g., HbS, HbC, HbE)**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81362 **HBB (hemoglobin, subunit beta); known familial variant(s)**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81363 **HBB (hemoglobin, subunit beta); duplication/deletion variant(s)**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81364 **HBB (hemoglobin, subunit beta); full gene sequence**	No	N/A	Once-in-a-lifetime, any provider, except with valid TAR override	
81370 – 81383 **Human Leukocyte Antigen Typing**	No TAR required	CPT-4 codes 81370 – 81380, 81382 and 81383 (human leukocyte antigen typing) are reimbursable only with an ICD-10-CM diagnosis in the range of Z94.0 – Z94.9.	Once-in-a-lifetime, any provider, except with	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		CPT-4 code 81381 (HLA Class I typing, high resolution, one allele or allele group, each) is only reimbursable with an ICD-10-CM diagnosis of B20, F31.0 – F31.9, G40.001 – G40.919, G50.0, R75, Z01.812, Z21, Z94.0 – Z94.9.	valid TAR override	
81400 **Molecular Pathology Procedure, Level 1** *Continued below* *Continued from above*	Yes	Providers are required to document one of the following on the TAR: • CCR5 (chemokine C-C motif receptor 5): – Initial test: ❖ The use of a CCR5 inhibitor is being considered, or ❖ The patient exhibits virologic failure on a CCR5 inhibitor – Subsequent tests: ❖ A previous Trofile test was performed including the test date and the results showing that the patient has a CCR5 virus, and, ❖ The patient's previous Trofile test was not less than 90 days from subsequent request, and, ❖ The patient has clinical scenario such as, but not limited to the following: • The treatment with CCR5 antagonist drug therapy was interrupted and the clinician wishes to reinstitute CCR5 antagonist drug therapy, or, • The patient had a Trofile test performed previously that showed that the recipient had the CCR5 virus, but the CCR5 antagonist drug therapy was never initiated. Claims without documentation showing the preceding criteria have been met will be denied.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81401 **Molecular Pathology Procedure, Level 2**	Yes	Coverage for CPT-4 code 81401 (molecular pathology procedure, Level 2) is limited to the listed services. Reimbursement for code 81401 requires an approved TAR and requires providers to document one of the following on the TAR: • ABCC8 (familial hyperinsulinism): – The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI), failed medical therapy, and – The patient is under evaluation for surgical intervention • ABL (c-abl oncogene 1, receptor tyrosine kinase) – The patient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy • ABL1 (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib resistance), T315I variant – The patient has chronic myeloid leukemia (CML) and failed tyrosine kinase inhibitor (TKI) therapy • APOE (apolipoprotein E) (for example, hyperlipoproteinemia type III, cardiovascular disease, Alzheimer disease), common variants (for example, 2, 3, 4) – The patient has clinical signs and symptoms consistent with Alzheimer Disease, and – Medical treatment strategy will be contingent on the test results. • DEK/NUP214 (t [6; 9])(e.g., acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed – The patient has acute myeloid leukemia and the test is intended for the process of risk stratification	Once-in-a-lifetime, any provider, except with valid TAR override	
Continued below	*Continued*	• E2A/PBX1 (acute lymphocytic leukemia):		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81401** **Molecular Pathology Procedure, Level 2** *Continued below*	Yes *Continued*	– The patient has the diagnosis of acute lymphocytic/lymphoblastic leukemia, and – Treatment or monitoring strategy will be contingent on the test results • ETV6/RUNX1 (acute lymphocytic leukemia) – The patient has the diagnosis of acute lymphocytic or lymphoblastic leukemia, and requires the test for assessment of cancer prognosis • H19 (Beckwith-Wiedemann syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Beckwith-Wiedemann syndrome • KCNQ1OT1 (Beckwith-Wiedemann syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Beckwith-Wiedemann syndrome • MLL/AFF1 (acute lymphoblastic leukemia): – The patient has the diagnosis of acute lymphoblastic leukemia, and – Treatment or monitoring strategy will be contingent on the test results • MLL/MLLT3 (acute myeloid leukemia): – The patient has the diagnosis of acute myeloid leukemia, and – Treatment or monitoring strategy will be contingent on the test results • MUTYH (MYH-associated polyposis) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for MUTYH- associated polyposis • MT-ATP6 (neuropathy with ataxia and retinitis pigmentosa [NARP], Leigh syndrome) – The patient has clinical features suspicious for, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81401** **Molecular Pathology Procedure, Level 2**	Yes	requires the service as a confirmatory test for NARP or Leigh syndrome • PRSS1 (hereditary pancreatitis): – An unexplained documented episode of acute pancreatitis in childhood, or – Recurrent acute attacks of pancreatitis of unknown cause, or – Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or – A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance • PYGM (glycogen storage disease type V, McArdle disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type V • RUNX1/RUNX1T1 (t[8;21]) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute myeloid leukemia Claims without documentation showing the preceding criteria have been met will be denied.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81402 **Molecular Pathology Procedure, Level 3**	Yes	Coverage for CPT-4 code 81402 (molecular pathology procedure, Level 3) is limited to the listed services. Reimbursement for code 81402 requires an approved TAR and requires providers to document one of the following on the TAR: • Chromosome 1p-/19q- (e.g. glial tumors), deletion analysis – Patient with diagnosis of grade II, III or IV glioma • MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants: – The patient has clinical signs and symptoms suspicious for familial MEFV, and – The patient requires the service as a confirmatory test for familial MEFV	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81403 **Molecular Pathology Procedure, Level 4** *Continued below*	Yes	Coverage for CPT-4 code 81403 (molecular pathology procedure, Level 4) is limited to the listed services. Reimbursement for code 81403 requires an approved TAR and requires providers to document one of the following on the TAR: • DNMT3A (acute myeloid leukemia): – The patient has diagnosis of acute myeloid leukemia, and – The treatment strategy will be contingent on test results • EPCAM (Lynch syndrome) – The patient has one of the following: – Colon cancer – Uterine cancer – Lynch syndrome – Family history of colorectal cancer, uterine cancer or Lynch syndrome – Presence of synchronous, metachronous colorectal or other Lynch-associated tumors • Human Erythrocyte Antigen Gene Analyses – TAR may be approved based on one of the following criteria: – The member has sickle cell disease or other medical condition requiring chronic transfusions, or – The member has autoantibodies, interfering antibodies/therapies, or other serologic reactivity that impedes the exclusion of clinically significant alloantibodies, or – The member has a serologic antigen typing discrepancy requiring further investigation, or – The member has a suspected antibody against an antigen for which typing antisera is not available, or	Once-in-a-lifetime, any provider, except with valid TAR override	Prediction model calculator suggested for use prior to ordering Lynch syndrome testing: http://premm.dfci.harvard.edu/

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81403** **Molecular Pathology Procedure, Level 4**	Yes	– For paternal genotyping to assess risk for hemolytic disease of the fetus and newborn (HDFN): ❖ The paternal individual is a Medi-Cal member, and ❖ The paternal member's serologic typing result is either inconclusive for zygosity or unknown, and ❖ The paternal member's pregnant partner is antigen negative and alloimmunized to the antigen, or – For genotyping of fetal cell specimen (for example, amniocentesis) to assess risk for HDFN: ❖ The pregnant member is antigen negative and alloimmunized to the antigen, and ❖ The paternal antigen status is either heterozygous or unknown. • KCNC3 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • KCNJ11 (familial hyperinsulinism): For persistent hyperinsulinemic hypoglycemia of infancy (PHHI) ❖ The patient has PHHI and failed medical therapy, and ❖ The patient is under evaluation for surgical intervention For suspected developmental delay, epilepsy and neonatal diabetes (DEND) syndrome: ❖ The patient has developmental delay, epilepsy and neonatal diabetes	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		❖ The confirmation of the diagnosis and the treatment strategy is contingent on the test result • KIR (killer cell immunoglobulin-like receptor for hematopoietic stem cell transplantation): – The patient has diagnosis of acute myeloid leukemia or multiple myeloma, and The test is used for donor search process for patients considering hematopoietic stem cell transplantation • Known family variant not otherwise specified, for gene listed in Molecular Pathology Procedure Levels 1 - 3 or identified during a genomic sequencing procedure (GSP), DNA sequence analysis, each variant exon: – Documentation of the specific gene listed in Molecular Pathology Procedure Levels 1 - 3 or GSP for which further analysis is being requested • MICA (solid organ transplantation): – The patient is undergoing evaluation for kidney transplantation, or – The patient is post kidney transplantation *Continued*		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81403** **Molecular Pathology Procedure, Level 4**	Yes	• NDP (Norrie disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Norrie disease • RHD (Rh blood group, D antigen) – TAR may be approved based on one of the following criteria: – The member is pregnant or of childbearing potential and has a serologic weak D phenotype, or – For paternal genotyping to assess risk for HDFN: ❖ The paternal individual is a Medi-Cal member, and ❖ The paternal member's serologic typing result is either RhD positive or unknown, and ❖ The paternal member's pregnant partner is RhD negative and alloimmunized to RhD, or – For genotyping of fetal cell specimen (for example, amniocentesis) to assess risk for HDFN: ❖ The pregnant member is RhD negative and alloimmunized to RhD, and ❖ The paternal antigen status is either heterozygous or unknown. • SH2D1A (X-linked lymphoproliferative syndrome) – The patient has a single X chromosome with the diagnosis of: – Common variable immune deficiency, or – Hypogammaglobulinemia, or – Hemophagocytic lymphohistiocytosis, or – Severe infectious mononucleosis, or – Lymphoma, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		– Family history of X-linked lymphoproliferative syndrome • VHL (von Hippel-Lindau tumor suppressor), deletion/duplication analysis – The patient has clinical features suspicious for, or requires the service as a diagnostic test for von Hippel-Lindau syndrome • vWF (von Willebrand factor) Suspected von Willebrand disease type 2b or 2M, Thrombophilia, Epistaxis. Test requested must be Sequence Analysis of vWF exon 28 to detect germline variants associated with VWB 2B or 2M. Claims without documentation showing the preceding criteria have been met will be denied.		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81404 **Molecular Pathology Procedure, Level 5**	Yes	Coverage for CPT-4 code 81404 (molecular pathology procedure Level 5) is limited to the listed services. Reimbursement for code 81404 requires an approved Treatment Authorization Request (TAR) and requires providers to document one of the following on the TAR: • ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain), targeted sequence analysis: – The patient has elevated C4-C on newborn screening test, and – Confirmation (urine acylglycines or urine organic acids) that C4 (butyrylcarnitine) and/or ethylmalonic acid (EMA) are elevated • CD40LG (X-linked hyper IgM syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for hyperimmunoglobulin M syndromes • DYT-TOR1A (Dystonia)) ICD-10-CM diagnosis code G24.1 and G24.9 • EMD (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • EPM2A (progressive myoclonus epilepsy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for progressive myoclonus epilepsy • FHL1 (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • FSHD1/ FSHD2 (Facioscapulohumeral muscular dystrophy) ICD-10-CM diagnosis code G71.02	Once-in-a-lifetime, any provider, except with valid TAR override	
Continued below	*Continued*			

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81404** **Molecular Pathology Procedure, Level 5** *Continued below*	Yes *Continued*	• MEFV (Mediterranean fever) (eg, familial Mediterranean fever), common variants: – The patient has clinical signs and symptoms suspicious for familial MEFV, and – The patient requires the service as a confirmatory test for familial MEFV • NDP (Norrie disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Norrie disease • PDX1 (pancreatic and duodenal homeobox 1) • The patient requires the service as a diagnostic test for (maturity onset diabetes of the young) MODY, and • Is younger than 25 years of age, and • Has a family history of diabetes, and • Has negative islet of autoantibodies • PRNP (genetic prion disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for genetic prion disease • PRSS1 (hereditary pancreatitis): • An unexplained documented episode of acute pancreatitis in childhood, or • Recurrent acute attacks of pancreatitis of unknown cause, or • Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or • A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81404** **Molecular Pathology Procedure, Level 5**	Yes	unknown cause consistent with autosomal dominant inheritance • RET (ret proto-oncogene), common variants • The patient has a personal history of primary C cell hyperplasia, Medullary Thyroid Carcinoma (MTC), or Multiple Endocrine Neoplasia (MEN), type 2B, or • The patient has a family history consistent with MEN, type 2B or MTC, and at risk for autosomal dominant inheritance of the syndrome • SH2D1A (X-linked lymphoproliferative syndrome) – The patient has a single X chromosome with the diagnosis of: • Common variable immune deficiency, or • Hypogammaglobulinemia, or • Hemophagocytic lymphohistiocytosis, or • Severe infectious mononucleosis, or • Lymphoma, or • Family history of X-linked lymphoproliferative syndrome • SOD1 (superoxide dismutase 1, soluble) (e.g., amyotrophic lateral sclerosis), full gene sequence: – The member requires the service as a confirmatory test for Amyotrophic Lateral Sclerosis (ALS) when the diagnosis is not clear, or – The member has a diagnosis of ALS and is being considered for treatment with Tofersen. • SPINK1 (hereditary pancreatitis):	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81404 Molecular Pathology Procedure, Level 5		• An unexplained documented episode of acute pancreatitis in childhood, or • Recurrent acute attacks of pancreatitis of unknown cause, or • Chronic pancreatitis of unknown cause, particularly with onset younger than 25 years of age, or • A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance • UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (e.g., hereditary unconjugated hyperbilirubinemia [Crigler-Najjar syndrome]) full gene sequence – The member has clinical features suspicious for or requires the service as a confirmatory test for Crigler-Najjar syndrome • VHL (von Hippel-Lindau tumor suppressor), full gene sequence - the patient has clinical features suspicious for, or requires the service as a diagnostic test for von Hippel-Lindau syndrome • Lysine and hydroxylysine errors of metabolism ICD-10 E72 Claims without documentation showing the preceding criteria have been met will be denied.		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81405 **Molecular Pathology Procedure, Level 6**	Yes	Coverage for CPT-4 code 81405 (molecular pathology procedure, level 6) is limited to the listed services. Reimbursement for code 81405 requires an approved TAR and requires providers to document one of the following on the TAR: • ABCD1 (adrenoleukodystrophy): – The patient has clinical features suspicious for adrenoleukodystrophy, and – Measurement of plasma concentration of very long chain fatty acids (VLCFA) is inconclusive, and – The service is required as a confirmatory test for the diagnosis of adrenoleukodystrophy • ACADS (acyl-CoA dehydrogenase, C-2 to C-3 short chain), full gene sequence: – The patient has elevated C4-C on newborn screening test, and – Confirmation (urine acylglycines or urine organic acids) that C4 (butyrylcarnitine) and/or ethylmalonic acid (EMA) are elevated • CPOX (coproporphyrinogen oxidase), full gene sequence: – The patient has elevated urinary and fecal coproporphyrin III, and – The patient requires the service as a confirmatory test for hereditary coproporphyria • CTRC (chymotrypsin C) (e.g, hereditary pancreatitis), full gene sequence: – The patient has an unexplained documented episode of acute	Once-in-a-lifetime, any provider, except with valid TAR override	
Continued below	*Continued*			

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes *Continued*	pancreatitis in childhood, or – Recurrent acute attacks of pancreatitis of unknown cause, or – Chronic pancreatitis or possible chronic pancreatitis (ie, does not meet diagnostic criteria but clinical evidence of chronic pancreatitis is noted) of unknown cause, particularly with onset younger than 25 years of age, or – A family history of recurrent acute pancreatitis, chronic pancreatitis of unknown cause, and/or childhood pancreatitis of unknown cause consistent with autosomal dominant inheritance – Evidence of pancreatitis related disorders (male infertility or bronchiectasis) • DYT-TOR1A (Dystonia)) ICD-10-CM diagnosis code G24.1 and G24.9 • EMD (Emery-Dreifuss muscular dystrophy) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Emery-Dreifuss muscular dystrophy • FH (fumarate hydratase) (for example., fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence: – The member presents with clinical symptoms and history suspicious for Hereditary Leiomyomatosis and Renal Cell Cancer (HLRCC), which may include one of the criteria below:	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes *Continued*	❖ Multiple cutaneous leiomyomas, with at least one histologically confirmed lesion ❖ Solitary cutaneous leiomyoma and family history of HLRCC ❖ Presentation of severely symptomatic uterine fibroids before age 40 ❖ Presentation of Type II papillary renal cell cancer before age 40 ❖ Family history of first-degree family member meeting one of the above-mentioned criteria; and – The member requires the service as a confirmatory test for HLRCC • GDF2 (Growth/Differentiation Factor 2) – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD-10-CM diagnosis code dx I78.0) with concern for mutations in GDF2 and/or RASA1 • GLA (galactosidase alpha [for example, Fabry disease]), full gene sequence: – The patient has a family member with documented disease-causing mutation, and – The decision whether to initiate enzyme replacement therapy will be contingent on the results • HNF1A (HNF1 homeobox A) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*	Yes	– Has a family history of diabetes, and – Has negative islet of autoantibodies • HNF1B (HNF1 homeobox B) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • LAMP2 (Danon disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease IIb (Danon disease) • MYL2 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • MYL3 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • NF2 (neurofibromatosis, type 2): – The patient has clinical features suspicious for, or requires the service as a confirmatory test for type 2 neurofibromatosis, OR – The patient is at high risk for neurofibromatosis with one or more of the following: – A first-degree relative with type 2 neurofibromatosis – Multiple spinal tumors (schwannomas, meningiomas) – Cutaneous schwannomas – Sporadic vestibular schwannoma younger than	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*		30 years of age, or spinal tumor or meningioma younger than 20 years of age • NPHS2 (steroid resistant nephrotic syndrome [SRNS]) – The patient has clinical diagnosis of SRNS, and – Treatment will be contingent on the test results • OTC (ornithine transcarbamylase deficiency) – The patient has clinical signs and symptoms of urea cycle disorders with positive biochemical laboratory results and requires the service as a confirmatory test for ornithine transcarbamylase deficiency • PKLR (pyruvate kinase, liver and RBC), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for pyruvate kinase deficiency • RASA1 – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD-10-CM diagnosis code I78.0) with concern for mutations in GDF2 and/or RASA1 • RET (multiple endocrine neoplasia [MEN], type 2A and familial medullary thyroid carcinoma [MTC]) – exons 10, 11, 13 – 16:		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81405** **Molecular Pathology Procedure, Level 6** *Continued below*		– The patient has a personal history of MTC, or MEN, type 2A, or – The patient has pheochromocytoma and a family history of MTC or pheochromocytoma, or – The patient has sporadic MEN2-related tumors and is younger than 35 years of age, multicentric tumors in one organ, and/or two different organs affected, or – The patient has a family history consistent with MEN, type 2A • RET (ret proto-oncogen), targeted sequence analysis: – The patient has a personal history of primary C cell hyperplasie, MTC, or MEN, type 2A, or – The patient has a family history consistent with MEN, type 2A or MTC, and at risk for autosomal dominant inheritance of the syndrome • SLC2A1 (glucose transporter type 1 [GLUT 1] deficiency syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for GLUT 1 deficiency syndrome and/or pediatric absence seizures ICD-10-CM diagnosis codes G40- G47 • SLSLC22A5 (for carnitine deficiency or carnitine uptake defect) – allowable when the newborn screen is positive for low carnitine levels or when there is clinical suspicion		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above		• SPRED1 (Legius syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Legius syndrome • TCF4 (Pitt-Hopkins syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • THRB (Thyroid Hormone Receptor, Beta) (e.g., thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of more than 5 exons – The patient has clinical presentation suspicious for Resistance to Thyroid Hormone-beta (RTH-beta) with any one of the following: – Elevated free T4 and/or free T3 with normal or mildly elevated TSH – Goiter or tachycardia regardless of other clinical signs and symptoms of thyroid dysfunction – Requiring high doses of T4 or T3 to reduce the TSH secretion or to induce the appropriate responses in peripheral tissues		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		– No evidence of thyroid hormone binding abnormalities or pituitary adenoma – Family history of thyroid disease or RTH-beta • The test is needed to confirm the diagnosis of RTH-beta • TPM1 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • TSC1 (tuberous sclerosis complex 1) – duplication/deletion analysis - The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • WT1 (Wilms tumor 1) – full gene sequence – The patient has suspected or confirmed acute myeloid leukemia, and the result of the test will influence the diagnosis, prognosis and/or therapeutic management • Lysine and hydroxylysine errors of metabolism ICD-10-CM diagnosis code E72		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81406 **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81406 (molecular pathology procedure, Level 7) is limited to the listed services. Reimbursement for code 81406 requires an approved TAR and requires providers to document one of the following on the TAR: • ACADVL (very long chain acyl-coenzyme A dehydrogenase deficiency) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for ACADVL • AFG3L2 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • ATP7B (Wilson disease): – The patient has clinical features suspicious for Wilson disease, and – Diagnosis cannot be made based on the results of biochemical testing and liver biopsy, and – The patient requires the service as a confirmatory test for Wilson disease • BTK (X-linked agammaglobulinemia): • Patient with a single X chromosome has clinical features suspicious for X-linked agammaglobulinemia, and • Patient with a single X chromosome has less than two percent CD19+ B cells • CDH1 (hereditary diffuse gastric cancer): – Two gastric cancer cases in family, one confirmed diffuse gastric cancer younger than 50 years of age, or – Three confirmed diffuse gastric cancer cases in first or second degree relatives, regardless of age, or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**	Yes *Continued*	– Diffuse gastric cancer diagnosed younger than 40 years of age, or – Personal or family history of diffuse gastric cancer and lobular breast cancer, one diagnosed younger than 50 years of age • CNTNAP2 (Pitt-Hopkins-like syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • DSP The patient has clinical features suspicious for Arrhymogenic Right Ventricular Myopathy ICD 10 code I42. • GCK (glucokinase [hexokinase 4]) – The patient requires the service as diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • GDF2 (Growth/Differentiation Factor 2) – The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • GLUD1 (familial hyperinsulinism): – The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI) and failed medical therapy, and – The patient is under evaluation for surgical intervention	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	• HMBS (hydroxymethylbilane synthase), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute intermittent porphyria • HNF4A (hepatocyte nuclear factor 4, alpha) – The patient requires the service as a diagnostic test for MODY, and – Is younger than 25 years of age, and – Has a family history of diabetes, and – Has negative islet of autoantibodies • IDUA (iduronidase, alpha-L) (eg, mucopolysaccharidosis type I), full gene sequence. – The patient has clinical signs and symptoms consistent with mucopolysaccharidosis type I, and – Treatment option (allogeneic transplantation or gene therapy) will be contingent on the test results • JAG1 (Alagille syndrome) – duplication/deletion – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Alagille syndrome • KCNQ2 (potassium voltage-gated channel, KQT-like subfamily, member 2 [e.g. epileptic encephalopathy], full gene sequence) – The patient has clinical symptoms and electroencephalogram (EEG) patterns consistent with early infantile epileptic encephalopathy, and	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	– Treatment is contingent on test results • MUTYH (MYH-associated polyposis) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for MUTYH-associated polyposis • NF2 (neurofibromatosis, type 2): – The patient has clinical features suspicious for, or requires the service as a confirmatory test for type 2 neurofibromatosis, or – The patient is at high risk for neurofibromatosis with one or more of the following ▪ A first-degree relative with type 2 neurofibromatosis ▪ Multiple spinal tumors (schwannomas, meningiomas) ▪ Cutaneous schwannomas ▪ Sporadic vestibular schwannoma younger than 30 years of age, or spinal tumor or meningioma younger than 20 years of age • PCSK9 (proprotein convertase subtilisin/kexin type 9) (e.g., familial hypercholesterolemia), full gene sequence – Patient has coronary artery disease (CAD) or has risk factors for CAD – The intention to treat or not to treat with PCSK9 inhibitors will be contingent, at least in part, on the test results	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7** *Continued below*	Yes *Continued*	• PHEX (phosphate-regulating endopeptidase homolog, X-Linked) (e.g. hypophosphatemic rickets), full gene sequence – The patient is undergoing evaluation for X-Linked Hypophosphatemia (XLH); and – Diagnosis was not able to be established based on biochemical testing, which included the following tests: • Serum calcium, phosphate and alkaline phosphatase, and • PTH, 25 hydroxyvitamin D, and 1,25 dihydroxyvitamin D, and • Urinary calcium excretion; and • The confirmation of the diagnosis and the treatment strategy is contingent on the test result. • POLG (polymerase [DNA directed], gamma [e.g., Alpers-Huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia], full gene sequence). TAR may be approved based on one of the following numbered criteria: – The patient is undergoing consideration for treatment using valproic acid, or – The patient is undergoing evaluation for potentially having any one of the following conditions: ▪ Alpers-Huttenlocher syndrome	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**	Yes	▪ Ataxia neuropathy spectrum (ANS), previously known as mitochondrial recessive ataxia syndrome (MIRAS) and sensory ataxia neuropathy, dysarthria and ophthalmoplegia (SANDO) ▪ Autosomal dominant progressive external ophthalmoplegia ▪ Autosomal recessive progressive external ophthalmoplegia – Childhood myocerebrohepatopathy spectrum – Myoclonic epilepsy myopathy sensory ataxia • PPOX (protoporphyrinogen oxidase), full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for acute variegate porphyria • PRKCG (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • PYGM (glycogen storage disease type V, McArdle disease) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type V (McArdle disease) • RASA1	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81406** **Molecular Pathology Procedure, Level 7**		– The member has suspected hereditary hemorrhagic telangiectasia (HHT) aka Rendu-Osler-Weber- syndrome (ICD 10 dx I78.0) with concern for mutations in GDF2 and/or RASA1 • RPE65 (retinal pigment epithelium-specific protein 65kDa) – Patient has a clinical diagnosis of retinal dystrophy, and – The decision for gene therapy is contingent on the test results • RYR1 (ryanodine receptor 1, skeletal) (e.g., malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations: – The member has a clinical history suspicious for malignant hyperthermia, or – The member has a positive contracture test for malignant hyperthermia, or – The member has a family member who had a positive contracture or genetic test for malignant hyperthermia • SCNN1A (pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for pseudohypoaldosteronism • SCNN1B (Liddle syndrome, pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Liddle syndrome, pseudohypoaldosteronism • SCNN1G (Liddle syndrome, pseudohypoaldosteronism) – The patient has clinical features suspicious for, or requires		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		the service as a confirmatory test for Liddle syndrome, pseudohypoaldosteronism • SLC37A4 (glycogen storage disease, type Ib) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease, type Ib • TCF4 (Pitt-Hopkins syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Pitt-Hopkins syndrome • TNNT2 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • TSC1 (tuberous sclerosis complex 1) – full gene sequence – The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • TSC2 (tuberous sclerosis complex 2) – duplication/deletion analysis – The patient has signs or symptoms of tuberous sclerosis complex but a diagnosis cannot be clinically confirmed • UMOD (glomerulocystic kidney disease with hyperuricemia and isosthenuria) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glomerulocystic kidney disease with hyperuricemia and isosthenuria • WAS (Wiskott-Aldrich syndrome) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Wiskott-Aldrich syndrome • Lysine and hydroxylysine errors of metabolism ICD-10-CM diagnosis code E72		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81407 **Molecular Pathology Procedure, Level 8** *Continued below*	Yes *Continued*	Coverage for CPT-4 code 81407 (molecular pathology procedure, Level 8) is limited to the listed services. Reimbursement for code 81407 requires an approved TAR and requires providers to document ~~one of the following on the TAR:~~if~~:~~ Member's record shows one the following diagnoses or indicates medical necessity for tests for one of the following conditions. • ABCC8 (familial hyperinsulinism): − The patient has persistent hyperinsulinemic hypoglycemia of infancy (PHHI) who failed medical therapy, and − The patient is under evaluation for surgical intervention • AGL (glycogen storage disease type III) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for glycogen storage disease type III	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81407 **Molecular Pathology Procedure, Level 8**	Yes	• COL4A3,COL4A4, COL4A5 Alport Syndrome (ICD-10-CM diagnosis code Q87.81) • JAG1 (Alagille syndrome) – full gene sequence – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Alagille syndrome • MYBPC3 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • MYH7 (hypertrophic cardiomyopathy) ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49 • NOTCH (notch 1) – full gene sequence – The patient has suspected or confirmed acute lymphoblastic leukemia, and the result of the test will influence the diagnosis, prognosis and/or therapeutic management • NPHS1 (congenital Finnish nephrosis) • The patient has clinical diagnosis of steroid-resistant nephritic syndrome (SRNS)/congenital Finnish nephrosis, and • Treatment will be contingent on the test results • SCN1A – The patient has clinical features suspicious for, or requires the service as a confirmatory test for Dravet syndrome • SPTBN2 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • TSC2 (tuberous sclerosis complex 2) – full gene sequence – The patient has signs or symptoms of tuberous sclerosis complex	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		but a diagnosis cannot be clinically confirmed • Pediatric absence seizures ICD-10-CM diagnosis codes G40- G47		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81408 **Molecular Pathology Procedure, Level 9**	Yes	Coverage for CPT-4 code 81408 (molecular pathology procedure, Level 9) is limited to the listed services. Reimbursement for code 81408 requires an approved Treatment Authorization Request (TAR) explaining that the following criteria have been met: • COL1A1, COL1A2 (Osteogenesis Imperfecta) ICD-10-CM diagnosis code: Q78 • COL4A3,COL4A4, COL4A5 Alport Syndrome (ICD-10-CM diagnosis code Q87.81) • ITPR1 (spinocerebellar ataxia) – The patient has clinical features suspicious for, or requires the service as a confirmatory test for spinocerebellar ataxia • DMD (dsytophin), full gene analysis • Patient has a clinical diagnosis of dystrophinopathy based on the history, physical examination and elevated creatine kinase (CK) level • Result of the DMD (dystrophin) deletion or duplication is negative • NF1 (neurofibromatosis 1) • The patient has clinical features suspicious for NF1 and requires genetic testing to confirm the diagnosis (one or more signs of NF 1 present, but not enough to make clinical diagnosis), OR • Asymptomatic individual with a first, second, or third-degree relative with established diagnosis of NF1. • RYR1 (ryanodine receptor 1, skeletal) (e.g., malignant hyperthermia), full gene sequence:	Once-in-a-lifetime, any provider, except with valid TAR override	First degree relatives are biological parents, siblings, and children. Second-degree relatives are biological grandparents, aunts, uncles, nephews, nieces, grandchildren and half-siblings. Where third degree blood relatives are mentioned, they include great-grandparents, great-aunts, great-uncles, great-grandchildren, and first cousins.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		– The member has a clinical history suspicious for malignant hyperthermia, or • The member has a positive contracture test for malignant hyperthermia, or • The member has a family member who had a positive contracture or genetic test for malignant hyperthermia		
81412 **Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least nine genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1**	Yes	A TAR requires documentation of the following criteria: • Patient is considering pregnancy or is currently pregnant, and • Patient reports they are of Ashkenazi Jewish descent (family history with one Ashkenazi Jewish grandparent or more, or more immediate family members), and • The panel includes only the conditions specified by American College of Obstetricians and Gynecologists (ACOG) (e.g., [ACOG] Carrier Screening for Genetic Conditions) and/or by American College of Medical Genetics and Genomics [ACMG] for individuals of Ashkenazi Jewish descent	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81413 **Cardiac Ion Channelopathies genomic sequence analysis panel, must include sequencing of at least 10 genes**	Yes	Reimbursement for CPT-4 code 81413 must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A. The required TAR must document a copy of the report of the physician-interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause	Once-in-a-lifetime, any provider, except with valid TAR override	
81414 **Cardiac ion channelopathies; genomic sequence analysis panel, must include sequencing of at least 2 genes**	Yes	Reimbursement for CPT-4 code 81414 must include sequencing of at least 2 genes, including KCNH2 and KCNQ1. The required TAR must document a copy of the report of the physician-interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81419 **Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9AG, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2**	Yes	The required TAR must document the following: • Patient has specific epilepsy syndrome of unknown cause for which a number of genetic etiologies exist. • The test is needed for identifying the underlying diagnosis • The diagnostic or treatment strategy will be contingent on test results	N/A	
81420 **Fetal chromosomal aneuploidy genomic sequence analysis panel, must include analysis of chromosomes 13, 18, and 21**	No	N/A	Payable no more than once per pregnancy	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81425 **(Genome [eg, unexplained constitutional or heritable disorder or syndrome]; sequence analysis) is used for whole genome sequencing of the member**	Yes	A TAR requires documentation of all of the following criteria (1 thru 9): 1. Member's history and family history have been evaluated by a board-certified or board-eligible medical geneticist, and the medical geneticist has determined a genetic etiology is a plausible explanation for the member's clinical phenotype, and 2. Member has received pre-test genetic counseling including discussion of potential for incidental and secondary findings (as defined by the American College of Medical Genetics and Genomics [ACMG]), and informed consent will be obtained by the time of testing and post-test genetic counseling will be performed, and 3. Alternative etiologies for the member's condition (for example, environmental exposures, injury, prematurity or infection) have been considered and ruled out when possible, and 4. Member's clinical phenotype does not fit a well-described syndrome for which single-gene or targeted panel testing is available, and 5. If performed, genetic, molecular, cytogenetic, newborn screening panel or other laboratory tests did not yield a causative etiology relevant to the member's clinical phenotype, and 6. Test results are predicted to improve and/or guide the medical management of the member's condition, and 7. The test is not being used for prenatal screening or prenatal evaluation of fetus, and	Once in a lifetime. No TAR override allowed.	This code is for outpatient genetic testing only and cannot be used for inpatient billing. This code does not qualify for rapid or ultra rapid whole genome sequencing in the outpatient setting. 81425 cannot be billed if 81349 has been billed. Focused disease or condition-specific tests or panels should be considered prior to WGS.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		8. Member has not received another whole genome sequencing or rapid/ultra-rapid whole genome sequencing test during their lifetime, and 9. At least one of the following criteria must be met (a thru g): a. One or more congenital anomalies (for example, structural and/or functional) with onset prior to one year of age, or b. Global developmental delay with onset prior to five years of age with no identifiable cause and member has been evaluated by developmental pediatrician or neurologist, or c. Moderate, severe or profound intellectual disability with onset prior to 21 years of age with no identifiable cause and member has been evaluated by developmental pediatrician or neurologist, or d. Epilepsy of unexplained etiology with onset at any age, or e. Confirmed bilateral sensorineural hearing loss of unknown etiology with onset at any age, or f. Findings suggestive of inborn error of immunity (for example, infections requiring hospitalizations and/or intravenous antibiotics), or g. At least two of the following criteria (i thru vii) must be met: i. Abnormality affecting at minimum a single organ system and genetic etiology is the likely explanation ii. Autism spectrum disorder		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		iii. Severe neuropsychiatric condition (for example, schizophrenia, bipolar disorder, Tourette syndrome, self-injurious behavior, reverse sleep-wake cycle) iv. Symptoms of a complex neurological condition (for example, dystonia, spasticity, hypotonia, myopathy, muscular dystrophy, cerebral palsy) v. Family history is strongly suggestive of a genetic etiology, such as consanguinity vi. Period of unexplained developmental regression that is unrelated to epilepsy or autism spectrum disorder vii. Laboratory findings suggestive of an inherited metabolic disorder (for example, acidemia, hyperammonemia, mitochondrial disorders, etc.)		
81426 **Genome [eg, unexplained constitutional or heritable disorder or syndrome]; sequence analysis; comparator genome testing**	Yes	A TAR requires documentation of all of the following criteria (1 thru 9): • For testing of comparator(s), Member must meet TAR criteria for 81425	Maximum of two	Each comparator genome [eg, parents, siblings]) is used for sequencing of up to two comparators and is billed under the member. 81426 must be billed in conjunction with 81425 if providers choose to test the comparator(s). Per DHCS, 81349 cannot be billed when analysis for chromosomal abnormalities is performed by sequence analysis included in 81425 and 81426 This code is for outpatient genetic testing only and cannot be used for inpatient billing. This code does not qualify for rapid or ultra rapid whole genome sequencing in the outpatient setting.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81427 **Genome [eg, unexplained constitutional or heritable disorder or syndrome];** **Re-evaluation of previously obtained genome sequence [eg, updated knowledge or unrelated condition/syndrome]) is used to re-interpret previously performed whole genome sequencing for the member.**	Yes	A TAR requires documentation of all of the following criteria (1 thru 3): 1. Member must meet TAR criteria for 81425, and 2. Member received previous whole genome sequencing or rapid/ultra-rapid whole genome sequencing analysis, and 3. One of the following criteria must be met (a thru c): a. Previous whole genome sequencing analysis did not yield a causative genetic etiology relevant to the member's clinical phenotype and at least 1.5 years have passed since the initial analysis, or b. There is new clinical phenotype information for the member, or c. There has been a birth or diagnosis of a similarly affected first-degree relative	Once-in-a-lifetime, any provider, except with valid TAR override	81427 cannot be billed if the analysis is being performed solely for incidental findings, which are defined by American College of Medical Genetics and Genomics (ACMG). This code is for outpatient genetic testing only and cannot be used for inpatient billing. This code does not qualify for rapid or ultra rapid whole genome sequencing in the outpatient setting.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81432 **Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes** *Continued below*	Yes	A TAR with documentation of one or more the following criteria is required: 1. An individual from a family member with a known deleterious BRCA mutation; or 2. Personal history of breast cancer (invasive or ductal carcinoma in situ) plus one of more of the following: • Diagnosed at ≤45 years of age, or • Diagnosed at 46 – 50 years of age with: – An additional breast cancer primary at any age – One or more close blood relatives with breast cancer at any age – One or more close blood relatives with prostate cancer (Gleason score ≥7) – An unknown or limited family history; or • Diagnosed at ≤60 years of age with a triple negative breast cancer; or • Diagnosed at any age with: – One or more close relatives with: ❖ Breast cancer diagnosed at ≤50 years of age; ❖ Ovarian carcinoma; or ❖ Male Breast cancer; or ❖ Metastatic prostate cancer; or ❖ Pancreatic cancer – Two or more additional diagnosis of breast cancer at any age in patient and/or in close blood relatives; or – Ashkenazi Jewish ancestry: or **3.** Personal history of ovarian carcinoma (includes fallopian tube and primary peritoneal cancers); or	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Continued from above **81432** **Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes**		**4.** Personal history of male breast cancer; or **5.** Personal history of pancreatic cancer, or **6.** Personal history of metastatic prostate cancer (biopsy-proven and/or with radiographic evidence; includes distant metastasis and regional bed or nodes; not biochemical recurrence); or **7.** Personal history of high-grade prostate cancer (Gleason score ≥7) at any age with: • One or more close blood relatives (first, second or third-degree) with ovarian carcinoma, pancreatic cancer or metastatic prostate cancer at any age or breast cancer under 50 years of age; or • Two or more close blood relatives (first, second, or third-degree relatives on the same side of family) with breast or prostate cancer (any grade) at any age; or • Ashkenazi Jewish ancestry; or **8.** BRCA1/2 pathogenic/likely pathogenic variant detected by tumor profiling on any tumor type in the absence of germline pathogenic/likely pathogenic variant analysis; or **9.** For an individual without history of breast or ovarian cancer, but with one or more first or second-degree blood relative meeting any of the above criteria		

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81434 **Hereditary retinal disorders (e.g., retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR and USH2A**	Yes	A TAR is required with the following documentation: • Patient has a clinical diagnosis of retinal dystrophy (retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy) and • The decision for gene therapy is contingent on the test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81435 **Hereditary Colon Cancer Disorders; Genomic sequence analysis panel, must include sequencing of at least 10 genes**	No	Reimbursement for CPT-4 code 81435 must include analysis of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4 and STK11. Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030 - Z85.038, Z85.040 - Z85.048, Z85.42, Z86.010	Once-in-a-lifetime, any provider, except with valid TAR override	
~~**81436**~~ ~~**Hereditary colon cancer disorders; genomic sequence analysis panel, must include sequencing of at least 5 genes**~~	~~No~~	~~Reimbursement for CPT-4 code 81436 must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11.~~ ~~Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes:~~ ~~C17.0 – C20, C24.0 – C25.9, C54.0 – C54.9, C65.1 – C66.9, C71.0 – C71.9, D23.0 – D23.9, Z80.0, Z80.49, Z85.030 – Z85.038, Z85.040 – Z85.048, Z85.42 or Z86.010~~	~~Once-in-a-lifetime, any provider, except with valid TAR override~~	

MCUP3131- A Genetic Testing Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full descriptions of codes.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81439 **Inherited Cardiomyopathy Genomic sequence analysis panel, must include sequencing of at least 5 genes**	No	Reimbursement for CPT-4 code 81439 must include sequencing of at least 5 genes, including DSG2, MYBPC3, MYH7, PKP2, and TTN. Reimbursable only when billed in conjunction with ICD-10-CM diagnosis codes: I42.0 – I42.5 or Z82.41 – Z82.49. A TAR may override the frequency limit and required ICD-10-CM diagnosis codes.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81445 **Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, 5 to 50 genes**	Yes	A TAR for CPT code 81445 requires documentation of the following criteria: • For Somatic Testing: – The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and – The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of canceror repeat testing using the same NGS test only when anew primary cancer diagnosis is made by the treating physician, and – The decision for additional cancer treatment is contingent on the test results. • For Germline Testing: – Ovarian or breast cancer,and – Clinical indication for germline (inherited) testingfor hereditary breast or ovarian cancer (i.e., American College of – Obstetrician Gynecologists'criteria for further genetic evaluation for hereditary [germline] breast and ovarian cancer), and – A risk factor for germline (inherited) breast or ovariancancer, and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick), and – Has not been previously tested with the same germline test using NGS forthe same germline genetic content. • Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a Companion Diagnostic Device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81448 **Hereditary peripheral neuropathies, genomic sequence analysis panel, must include sequencing of at least 5 neuropathy-related genes**	No	One of the following ICD-10-CM codes is required on the claim (except with valid TAR): G11.4, G60.0	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81455 **Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (e.g., ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET),**	Yes	A TAR for CPT code 81455 requires documentation of the following criteria: For Somatic Testing: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing: • Ovarian or breast cancer,and • Clinical indication for germline (inherited) testingfor hereditary breast or ovarian cancer (i.e., American College of Obstetrician Gynecologists'criteria for further genetic evaluation for hereditary [germline] breast and ovarian cancer), and • A risk factor for germline (inherited) breast or ovarian cancer, and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick), and • Has not been previously tested with the same germline test using NGS forthe same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is FDA-approved as a Companion Diagnostic Device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81457 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, microsatellite instability**	Yes	A TAR for CPT code 81457 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81458 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis, copy number variants and microsatellite instability**	Yes	A TAR for CPT code 81458 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81459 **Solid organ neoplasm, genomic sequence analysis panel, interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants, microsatellite instability, tumor mutation burden, and rearrangements**	Yes	A TAR for CPT code 81459 requires documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For Germline Testing • The patient has ovarian or breast cancer, and • The patient has a clinical indication for germline (inherited) testing for inherited breast or ovarian cancer, and • The patient has a risk factor for germline (inherited) breast or ovarian cancer, and • The patient has not been previously tested with the same germline test using NGS for the same germline genetic content. Independent of the above criteria, either Somatic or Germline testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.	Once-in-a-lifetime, any provider, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81462 **Solid organ neoplasm, genomic sequence analysis panel, cell-free nucleic acid (e.g., plasma), interrogation for sequence variants; DNA analysis or combined DNA and RNA analysis, copy number variants and rearrangements**	Yes	A TAR for CPT code 81462 requires documentation of the following criteria: 1. The patient has a diagnosis of non-small cell lung cancer, and 2. The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and 3. Management is contingent on the test results	Once-in-a-lifetime, any provider, except with valid TAR override	
81479 **Unlisted Molecular Pathology Procedure**	Yes	Specific service being requested under this code must be defined and clinical documentation must be included for diagnosis and treatment recommendation.	N/A	Frequency will be determined by the clinical information submitted.
81500 **Oncology (ovarian), biochemical assays of two proteins**	No	Reimbursable for members who meet the following criteria: • 18 years of age or older • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist ICD-10-CM diagnosis code R19.09 is required for reimbursement	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81503 **Oncology (ovarian), biochemical assays of five proteins**	No	Reimbursable for members who meet the following criteria: • 18 years of age or older • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist CPT code 81503 is reimbursable only when billed in conjunction with at least one of the following ICD-10-CM diagnosis codes: D39.10 – D39.12, N83.00 – N83.02, N83.10 – N83.12, N83.201, N83.202, N83.209, N83.291, N83.292, N83.299, R19.00, R19.03 – R19.05, R19.07 or R19.09.	N/A	
81507 **Fetal aneuploidy (trisomy 21, 18 and 13)** **DNA sequence analysis of selected regions**	No	N/A	Payable no more than once per pregnancy	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.
81508 **Fetal congenital abnormalities, biochemical assays of two proteins**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81509 **Fetal congenital abnormalities, biochemical assays of three proteins**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81510 **Fetal congenital abnormalities, biochemical assays of three analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81511 **Fetal congenital abnormalities, biochemical assays of four analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	
81512 **Fetal congenital abnormalities, biochemical assays of five analytes**	No	Reimbursable only when billed in conjunction with one of the following ICD-10-CM diagnosis codes: O09.00 – O09.73, Z34.00 – Z34.93, Z36.0, Z36.81, or Z36.83 – Z36.89. Reimbursable in pregnancy only.	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81517 **Liver disease, analysis of 3 biomarkers (hyaluronic acid [HA], procollagen III amino terminal peptide [PIIINP], tissue inhibitor of metalloproteinase 1 [TIMP-1]), using immunoassays, utilizing serum, prognostic algorithm reported as a risk score and risk of liver fibrosis and liver related clinical events within 5 years**	No	N/A	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81518+ **Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes** +See note at the end of this table	Yes	Requires a *Treatment Authorization Request* (TAR) with documentation of the following criteria: • The recipient is estrogen and/or progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative or lymph node positive with up to three positive nodes. • The recipient has stage I or stage II breast cancer. • The recipient is disease-free (or no evidence of metastasis). • Test results will be used in determining treatment management of the patient for chemotherapy and/or extended endocrine therapy. Use CPT code 81518 when billing for Breast Cancer Index.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81519+ **Oncology (breast), mRNA, gene expression profiling by real time RT-PCR of 21 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is premenopausal and lymph node negative or has 1-3 positive lymph nodes (no distant metastasis) • OR when the recipient is post-menopausal 0 - 3 positive lymph nodes(no distant metastasis) • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81519 when billing for Oncotype Dx.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81520+ **Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative. • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81520 when billing for Prosigna.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81521+ **Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient has high clinical risk per MINDACT categorization. • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative or lymph node positive. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81521 when billing for MammaPrint. As noted in the 2017 ASCO guideline, the Adjuvant! Online website was not functional. As an alternative, clinicians can determine a patient's clinical risk status by using the printed version of the Adjuvant! Online clinical risk criteria found in the Data Supplement of the MINDACT publication.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81522+ **Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes** +See note at the end of this table	Yes	Requires a TAR with documentation of the following criteria: • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2-receptor negative. • The recipient is lymph node negative. • The recipient has stage I or stage II breast cancer. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT 81522 when billing for EndoPredict.	Once-in-a-lifetime +See note at the end of this table	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81523+ **Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis** +See note at the end of this table	No	For reference, here are the criteria outlined by DHCS: • The recipient has high clinical risk per MINDACT categorization. • The recipient is estrogen and progesterone receptor (ER/PgR)-positive. • The recipient is HER2- receptor negative. • The recipient is lymph node negative or lymph node positive. • The recipient is a candidate for chemotherapy. • The assay is used within six months of diagnosis. • The recipient is under consideration for adjuvant systemic therapy. Use CPT code 81523 when billing for MammaPrint. As noted in the 2017 ASCO guideline, the Adjuvant! Online website was not functional. As an alternative, clinicians can determine a patient's clinical risk status by using the printed version of the Adjuvant! Online clinical risk criteria found in the Data Supplement of the MINDACT publication.	Once in a lifetime	
81528 **Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers**	No	Reimbursable for recipients 45 – 75 years of age. For recipients outside this age range, providers must submit a TAR documenting medical necessity. * For recipients requiring additional tests within a year, providers must submit a TAR documenting medical necessity.	No more than once every two years *	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81541 **oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score** *Cont'd*	Yes	The following criteria must be documented on the TAR: 1. For identification of patients with Prostate Cancer who are most likely to benefit from active surveillance or treatment. • Coverage is limited to Decipher®, Prolaris® and ProMark. Gene expression profiling for prostate cancer may be billed as follows: – Decipher® Prostate – Use CPT code 81542 – Prolaris® – Use CPT code 81541 – ProMark – Use CPT code 81599 • The patient must have one of the following: – Higher volume Grade Group 1 – Favorable intermediate risk (e.g., Grade Group 2, percentage of positive biopsy scores, 50 percent and no more than on NCCN intermediate-risk factor) – Discordant features in their risk stratification (e.g., palpable mass with Grade Group 1) – Other features associated with progression while on active surveillance (e.g., high PSA density and certain germline or somatic mutations) – Unfavorable intermediate-risk when considering decisions to proceed with treatment (i.e. add androgen deprivation therapy to radiation) • Result of the test, when considered as a whole with routine clinical factors, is	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Cont'd from above **81541** **oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score**		likely to influence the decision to proceed with surveillance or treatment 2. For post-prostatectomy patients who seek guidance on adjuvant vs. salvage radiation: • Coverage is limited to Decipher Genomic Classifier • Result of the test, when considered as a whole with routine clinical factors, is likely to affect treatment		
81542 **oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score**	Yes	See CPT code 81541 for TAR criteria and billing requirements.	Once-in-a-lifetime, any provider, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
81546 **Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)**	Yes	The following numbered criteria must be documented on the TAR: 1. The patient is under evaluation for thyroid nodule(s) 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: • Follicular lesion of undetermined significance (FLUS), Bethesda III, or • Atypia of undetermined significance (AUS), Bethesda III, or • Follicular neoplasm, Bethesda IV. 3. The diagnostic or treatment strategy will be contingent on test results	N/A	
81552 **Oncology (uveal melanoma), mRNA, gene expression profiling by real -time RT-PCR of 15 genes**	No	An ICD-10-CD diagnosis code from the following ranges must be documented: C69.30 – C69.32 or C69.40 – C69.42	Once-in-a-lifetime, any provider, except with valid TAR override	
81596 **Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays**	No	The following ICD-10-CM code is required on the claim (except with valid TAR): B18.2	N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
88261 – 88269 88280 **Karyotype (aka Cytogenetic Studies)**	No	Karyotype testing for codes 88261-3 may be ordered once in a lifetime in children with phenotype of syndrome most commonly associated with a chromosomal abnormality. For perinatal indication, see Medi-Cal guidelines in the Genetic Counseling and Screening section gene coun 2.	Once-in-a-lifetime, any provider, except with valid TAR override	

+**Note:**
These benefits are limited to EndoPredict, Oncotype Dx, Prosigna (PAM50 risk of recurrence score) and Breast Cancer Index.
Use CPT code 81518 when billing for Breast Cancer Index.
Use CPT code 81519 when billing for Oncotype Dx.
Use CPT code 81520 when billing for Prosigna.
Use CPT code 81521 when billing for MammaPrint.
Use CPT code 81522 when billing for EndoPredict.

These once-in-a-lifetime benefits may be billed for the same recipient and any provider. Providers need an approved TAR and documentation showing that the recipient has a new second primary breast cancer that meets the necessary criteria as listed above to override the once-in-a-lifetime frequency.

Concurrent use of more than one test is not recommended as there is no data to support that ordering multiple assays in an individual patient would be beneficial in guiding treatment decisions.

We are committed to your health through cancer prevention.

Please fill out this brief questionnaire as thoroughly as possible so that we are better prepared to help you.

If you filled out this form within the last 6 months and nothing has changed, please initial here:

_____

TURN OVER



Screening: Your Personal and Family History of Cancer

Patient Name: _____ Date of Birth: _____

If you have a **personal or family history** of the following cancers, please indicate **WHO** and **AGE at diagnosis**. Include parents, children, brothers, sisters, grandparents, aunts, uncles, nieces, nephews, great aunts/uncles, great grandparents and cousins.

			You (age of diagnosis)	Siblings / Children (age of diagnosis)	Mother's Side (age of diagnosis)	Father's Side (age of diagnosis)
(Y)	N	**EXAMPLE:** *Breast Cancer*	_____	_____	*Aunt 53*	*Grandmother 45*
Y	N	**Breast Cancer**				
Y	N	**Ovarian cancer** *(Peritoneal/Fallopian Tube)*				
Y	N	**Are you of Ashkenazi Jewish descent?**				
Y	N	**Colon/Rectal cancer**				
Y	N	**Endometrial (uterine) cancer**				
Y	N	**10 or more colon polyps in a lifetime** *(Specify #)*				
Y	N	**Prostate Cancer (HBOC)**				
Y	N	**Melanoma (HBOC)**				
Y	N	**Pancreatic Cancer (HBOC/Lynch)**				
Y	N	**Other Cancers**				
Y	N	**Have you or anyone in your family had genetic testing for a cancer syndrome?** **If YES, WHEN: _____ RESULTS:_____**				

Breast Cancer Risk Model Information for FEMALES only:

Your current height (ft/in) _____

Your current weight (lbs) _____

Your menopausal status:

- ☐ Pre-menopausal
- ☐ Peri-menopausal (time before menopause marked by irregular cycles)
- ☐ Post-menopausal (permanent cessation of period for 12 months or longer)
  - Age of onset _____

Your age at time of first menstrual period _____

Your age at time of first live birth: _____

Did you ever use Hormone Replacement Therapy? ☐ Yes ☐ No

If yes, type: ☐ Combined ☐ Estrogen only ☐ Progesterone only ☐ Don't know

If yes, are you a: ☐ Current user: How many years ago did you start? _____ How many more years do you intend to use? _____

☐ Past user: How many years ago did you stop using? _____

Have you ever had a breast biopsy? ☐ Yes ☐ No

If yes, do you know your diagnosis? _____

Number of daughters _____

Number of sisters _____

Number of maternal aunts (mother's sisters) _____

Number of paternal aunts (father's sisters) _____

Patient's Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Patient meets guidelines for testing: ☐ YES ☐ NO CLINICIAN SIGNATURE: _____

IF YES: ☐ ACCEPTED ☐ DECLINED If Declined: Counseling Provided and Patient Signed:_____

HBOC: Personal or Family History

ONE person with (out to 2nd degree):
- *Breast Cancer under 50
- *Ovarian Cancer any age
- *Male Breast Ca any age
- *Triple Negative Breast Ca at or under 60
- *Metastatic Prostate Cancer
- *Breast Cancer any age and Ashkenazi
- *Pancreatic Cancer any age and Ashkenazi Jewish heritage

TWO persons with (out to 3rd degree):
- *Breast Ca, 1 at or under 50
- *Breast Ca and Ovarian Ca any age

THREE persons with (out to 3rd degree):
- *Breast and/or Pancreatic and/or Ovarian and/or Prostate (Gleason > 6) any age

LYNCH: Personal or Family History**

ONE person with (out to 2nd degree):
- *Endometrial Ca at or under 50
- *Colon Ca at or under 50

TWO persons with (out to 2nd degree):
- *Endo or Colon Ca over 50 and a Lynch cancer < 50

THREE persons with (out to 3rd degree):
- *Lynch cancers, 1 being Endo or Colon, any age

FAP/AFAP: Personal or Family History

ONE person with (out to 2nd degree):
- *10 or more colon polyps in a lifetime

**Lynch cancers: Endo, CRC, Ovarian, Stomach, Brain, Pancreas, Small Bowel, Biliary Tract, Ureter/Renal Pelvis, Sebaceous Adenoma

1st degree: parents, siblings, children. 2nd degree: grandparents, aunts/uncles, nieces/nephews, ½ siblings. 3rd degree: great grandparents, great aunts/uncles, 1st cousins.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
Proprietary Laboratory Analyses (PLA) codes represent proprietary laboratory services. The following codes may include a range of laboratory tests including, but not limited to multianalyte assays with algorithmic analyses (MAAA) and genomic sequencing procedures (GSP). MAAAs are procedures that utilize multiple results derived from assays of various types, including molecular pathology assays, fluorescent in situ hybridization assays and non-nucleic acid-based assays (for example, proteins, polypeptides, lipids, carbohydrates). Consistent with CPT® coding guidelines, when a PLA code is available, the specific PLA code takes precedence.				
0017M **Oncology (diffuse large b-cell lymphoma [dlbcl]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffin embedded tissue, algorithm reported as cell of origin**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39	Once in a lifetime, except with valid TAR override	
0001U **Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported**	No	Ordered by hematologist/oncologist	N/A	
0003U **Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score**	No	The following ICD-10-CM diagnosis code is required on the claim: R19.09 Reimbursable for females who meet the following criteria: • 18 years of age or older and • Ovarian adnexal mass present for which surgery is planned, and not yet referred to an oncologist	Once in a lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0016U **Oncology (hematolymphoid neoplasia), RNA, NCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.10 thru C92.12	Once per year	
0017U **Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report pf JAK2 mutation not detected or detected**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: D45, D47.1 or D47.3	Once per year	
0018U **Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy** *Continues* *Cont'd from above* **0018U** **Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy**	Yes Yes	The service requires a TAR with documentation of the following criteria: 1. The patient is under evaluation for thyroid nodules(s) and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV And the diagnostic or treatment strategy will be contingent on test results.	Once-in-a-lifetime, except with valid TAR override Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0022U **Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider.**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has a diagnosis of non-small cell lung cancer (NSCLC). • Treatment is contingent on test results	Once in a lifetime, except with valid TAR override	
0023U **Oncology (acute myelogenous leukemia), DNA, gentotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0026U **Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")** *Continues* *Cont'd from above* **0026U** **Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of**	Yes Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s) and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV And the diagnostic or treatment strategy will be contingent on test results	Once-in-a-lifetime, except with valid TAR override Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
malignancy" or "Negative, low probability of malignancy").				
0027U **JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: D45, D47.1 or D47.3	Once per year	
0034U **TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(e.g., thiopurine metabolism), gene analysis, common variants (ie, TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5).**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression	Once-in-a-lifetime, except with valid TAR override	
0035U **Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative** *Continues* *Cont'd from above* **0035U** **Neurology (prion disease), cerebrospinal fluid, detection of prion protein by quaking-induced conformational conversion, qualitative**	Yes Yes	The service requires a TAR with documentation of the following criteria: 1. Rapidly progressive dementia with at least two out of the following four clinical features: a. Myoclonus b. Visual or cerebellar signs c. Pyramid/extrapyramidal signs d. Akinetic mutism 2. And a positive result on at least one of the following tests: a. Characteristic changes in an EEG (periodic sharp wave complexes) during an illness of any duration b. High signal in caudate/putamen in magnetic resonance imaging (MRI) brain scan or at least two cortical regions	Once-in-a-lifetime, except with valid TAR override Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		(temporal, parietal occipital) either on diffusion-weighted imaging (DWI) or fluid attenuated inversion recovery (FLAIR) 3. And routine investigations do not indicate an alternative diagnosis		
0037U **Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden.**	As Noted	A TAR is not required when the following criteria are met: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. A TAR is required for all other cancer diagnosis that are not advanced. Required Documentation: diagnosis and stage of malignancy and the chart notes, must show the medical necessity for this test for therapeutic decisions.	N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0040U **BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative**	No	The following ICD-10-CM diagnosis code is required on the claim: C92.10.	Once per year, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0046U **FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0047U **Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score** *(continues)*	Yes	The coverage policy for Gene Expression Profile (GEP) for prostate cancer is based on the 2019 American Society of Clinical Oncologist (ASCO) Guideline titled, "Molecular Biomarkers in Localized Prostate Cancer: ASCO Guideline. For identification of patients with prostate cancer who are most likely to benefit from active surveillance or treatment: • Coverage is limited to Oncotype Dx Prostate – Use PLA code 0047U The service requires a TAR with documentation of the following criteria: 1. The patient must have one of the following: a. Higher volume Grade Group 1 or b. Favorable intermediate risk (e.g., Grade Group 2, percentage of positive biopsy cores, 50 percent, and no more than one NCCN intermediate-risk factor) or c. Discordant features in their risk stratification (e.g., palpable mass with Grade Group 1) or d. Other features associated with progression while on active surveillance (e.g., high PSA density and certain germline or somatic	Once-in-a-lifetime, except with valid TAR override	
(continued from above) **0047U** **Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score**	Yes		Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		mutations) or e. Unfavorable intermediate-risk when considering decisions to proceed with treatment (i.e. add androgen deprivation therapy to radiation). 2. Result of the test, when considered as a whole with routine clinical factors, is likely to influence the decision to proceed with surveillance or treatment. For post-prostatectomy patients who seek guidance on adjuvant vs. salvage radiation: 1. Coverage is limited to Decipher Genomic Classifier 2. Result of the test, when considered as a whole without routine clinical factors, is likely to affect treatment		
0049U **NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0050U **Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00 thru C92.02, C92.60 thru C92.62, C92.A0 thru C92.A2	Once per year	
0058U **Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C4A.0, C4A.10 thru C4A.12, C4A.20 thru C4A.22, C4A.30 thru	Once-in-a-lifetime, except	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
cell polyoma virus oncoprotein (small T antigen), serum, quantitative		C4A.39, C4A.51 thru C4A.59, C4A.60 thru C4A.62, C4A.70 thru C4A.72, C4A.8, C4A.9	with valid TAR override	
0059U **Oncology (Merkel cell carcinoma), detection of antibodies to the Merkel cell polyoma virus capsid protein (VP1), serum, reported as positive or negative**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C4A.0, C4A.10 thru C4A.12, C4A.20 thru C4A.22, C4A.30 thru C4A.39, C4A.51 thru C4A.59, C4A.60 thru C4A.62, C4A.70 thru C4A.72, C4A.8, C4A.9	Once-in-a-lifetime, except with valid TAR override	
0081U **Oncology (uveal melanoma), mRNA, gene-expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C69.30 thru C69.32, C69.40 thru C69.42 Repeat testing requires chart notes that show results will direct treatment	Once per year, except with valid TAR override	
0084U **Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens**	No	Hematology must order	N/A	
0087U **Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score**	No	The following ICD-10-CM diagnosis code is required on the claim: Z94.1	Once per year	
0088U **Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue,**	No	The following ICD-10-CM diagnosis code is required on the claim: Z94.0	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
algorithm reported as a probability score for rejection				
0118U Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell free DNA in the total cell-free DNA	Yes	A TAR requires documentation of the following criteria: For kidney transplant recipients • There is clinical suspicion for acute kidney allograft rejection and the member has not been tested with another donor-derived cell-free DNA test for the same episode, and • The test must be ordered by a nephrologist or kidney transplant surgeon, and • Member is at least one month post-kidney transplant, and • Member is 18 years of age or older, and • Member is not pregnant, and • Member has not received a kidney transplant from their twin, has not undergone multiple organ transplants, and has not undergone bone marrow transplantation	N/A	Partnership would consider for heart, lung and liver transplant with MD review for medical necessity.
0120U **Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C83.30 thru C83.39, C85.20 thru C85.29	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0154U **Oncology (urothelial cancer), RNA, analysis by real-time RT-PCR of the FGFR3 (fibroblast growth factor receptor 3) gene analysis (ie, p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C67.0 thru C67.9	Once-in-a-lifetime, except with valid TAR override	
0155U **Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (e.g., breast cancer) gene analysis (i.e., p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C50.011 thru C50.929	Once-in-a-lifetime, except with valid TAR override	
0157U **APC (APC regulator of WNT signaling pathway) (e.g., familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C18.0 thru C18.9, D12.0 thru D12.9, K63.5, Z86.010	Once-in-a-lifetime, except with valid TAR override	
0158U **MLH1 (mutL homolog 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0159U **MSH2 (mutS homolog 2) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0160U **MSH6 (mutS homolog 6) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0161U **PMS2 (PMS1 homolog 2, mismatch repair system component) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0162U **Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once-in-a-lifetime, except with valid TAR override	
0165U **Peanut allergen-specific quantitative assessment of epitopes using enzyme-linked immunosorbent assay (ELISA), blood, individual epitope results and probability of peanut allergy.**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: Z01.82, Z91.010 Repeat testing requires chart notes that show results will direct treatment.	Once per year except with valid TAR override with clinical justification	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0169U **NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism) gene analysis, common variants**	Yes	The service requires a TAR with documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression.	Once-in-a-lifetime, except with valid TAR override	
0171U **Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C92.00, C92.01, C92.02, C92.10 thru C92.22, C95.10, D45, D46.0, D46.1, D46.20 thru D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.1, D47.3.	Once per year	
0172U **Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score**	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has advanced ovarian, fallopian tube or primary peritoneal cancer and 2. Treatment is contingent on the result of the test	Once-in-a-lifetime, except with valid TAR override	
0177U **Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status**	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has confirmed diagnosis of breast cancer and 2. Treatment is contingent the result of the test	Once-in-a-lifetime, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0178U **Peanut allergen-specific quantitative assessment of multiple epitopes using enzyme-linked immunosorbent assay (ELISA), blood, report of minimum eliciting exposure for a clinical reaction.**	No	DX code Z91.01, CPT 95180 Ordered by Allergist TAR override if >50 /day above ICD-10 codes with clinical notes showing the medical necessity	50/day, except with valid TAR override	
0180U **Red cell antigen (ABO blood group) genotyping (ABO), gene analysis Sanger/chain termination/ convent-ional sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyl-transferase and alpha 1-3-galactosyltransferase) gene, including subtyping, 7 exons**	No	Ordered by hematologist	Once per year	
0181U **Red cell antigen (Colton blood group) genotyping (CO), gene analysis, AQP1 (aquaporin 1 [Colton blood group]) exon 1**	No	Ordered by hematologist	Once per year	
0182U **Red cell antigen (Cromer blood group) genotyping (CROM), gene analysis, CD55 (CD55 molecule [Cromer blood group]) exons 1-10**	No	Ordered by hematologist	Once per year	
0183U **Red cell antigen (Diego blood group) genotyping (DI), gene analysis, SLC4A1 (solute carrier family 4 member 1 [Diego blood group]) exon 19**	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0184U Red cell antigen (Dombrock blood group) genotyping (DO), gene analysis, ART4 (ADP-ribosyltransferase 4 [Dombrock blood group]) exon 2	No	Ordered by hematologist	Once per year	
0185U Red cell antigen (H blood group) genotyping (FUT1), gene analysis, FUT1 (fucosyltransferase 1 [H blood group]) exon 4	No	Ordered by hematologist	Once per year	
0186U Red cell antigen (H blood group) genotyping (FUT2), gene analysis, FUT2 (fucosyltransferase 2) exon 2	No	Ordered by hematologist	Once per year	
0187U Red cell antigen (Duffy blood group) genotyping (FY), gene analysis, ACKR1 (atypical chemokine receptor 1 [Duffy blood group]) exons 1-2	No	Ordered by hematologist	Once per year	
0188U Red cell antigen (Gerbich blood group) genotyping (GE), gene analysis, GYPC (glycophorin C [Gerbich blood group]) exons 1-4	No	Ordered by hematologist	Once per year	
0189U Red cell antigen (MNS blood group) genotyping (GYPA), gene analysis, GYPA (glycophorin A [MNS blood group]) introns 1, 5, exon 2	No	Ordered by hematologist	Once per year	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0190U **Red cell antigen (MNS blood group) genotyping (GYPB), gene analysis, GYPB (glycophorin B [MNS blood group]) introns 1, 5, pseudoexon 3**	No	Ordered by hematologist	Once per year	
0191U **Red cell antigen (Indian blood group) genotyping (IN), gene analysis, CD44 (CD44 molecule [Indian blood group]) exons 2, 3, 6**	No	Ordered by hematologist	Once per year	
0192U **Red cell antigen (Kidd blood group) genotyping (JK), gene analysis, SLC14A1 (solute carrier family 14 member 1 [Kidd blood group]) gene promoter, exon 9**	No	Ordered by hematologist	Once per year	
0193U **Red cell antigen (JR blood group) genotyping (JR), gene analysis, ABCG2 (ATP binding cassette subfamily G member 2 [Junior blood group]) exons 2-26**	No	Ordered by hematologist	Once per year	
0194U **Red cell antigen (Kell blood group) genotyping (KEL), gene analysis, KEL (Kell metallo-endopeptidase [Kell blood group]) exon 8**	No	Ordered by hematologist	Once per year	
0195U **KLF1 (Kruppel-like factor 1), targeted sequencing (ie, exon 13)**	No	Ordered by hematologist	Once per year	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0196U **Red cell antigen (Lutheran blood group) genotyping (LU), gene analysis, BCAM (basal cell adhesion molecule [Lutheran blood group]) exon 3**	No	Ordered by hematologist	Once per year	
0197U **Red cell antigen (Landsteiner-Wiener blood group) genotyping (LW), gene analysis, ICAM4 (intercellular adhesion molecule 4 [Landsteiner-Wiener blood group]) exon 1**	No	Ordered by hematologist	Once per year	
0198U **Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis Sanger/chain termination/ conventional sequencing, RHD (Rh blood group D antigen) exons 1-10 and RHCE (Rh blood group CcEe antigens) exon 5**	No	Ordered by hematologist	Once per year	
0199U **Red cell antigen (Scianna blood group) genotyping (SC), gene analysis, ERMAP (erythroblast membrane associated protein [Scianna blood group]) exons 4, 12**	No	Ordered by hematologist	Once per year	
0200U **Red cell antigen (Kx blood group) genotyping (XK), gene analysis, XK (X-linked Kx blood group) exons 1-3**	No	Ordered by hematologist	Once per year	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0216U **Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, G11.3, G11.9, G11.10, G11.11, G11.19, R26.0, R27.0.	Once per year except with valid TAR override	
0217U **Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, G11.3, G11.9, G11.10, G11.11, G11.19 R26.0, R27.0.	Once per year, except with valid TAR override	
0218U **Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has a clinical diagnosis of dystrophinopathy based on the history, physical examination and elevated creatinine kinase (CK) level and • Result of the DMD (dystrophin) deletion or duplication is negative	N/A	
0219U **Infectious agent (human immunodeficiency virus), targeted viral next-generation sequence analysis (ie, protease [PR], reverse transcriptase [RT], integrase [INT]), algorithm**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: B20, Z21. TAR override with above ICD 10 and Clinical notes showing medical necessity for repeat testing	Once per year, except with valid TAR override	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
reported as prediction of antiviral drug susceptibility				
0221U **Red cell antigen (ABO blood group) genotyping (ABO), gene analysis, next-generation sequencing, ABO (ABO, alpha 1-3-N-acetylgalactosaminyltransferase and alpha 1-3-galactosyltransferase) gene**	No	Ordered by hematologist	Once per year	
0222U **Red cell antigen (RH blood group) genotyping (RHD and RHCE), gene analysis, next-generation sequencing, RH proximal promoter, exons 1-10, portions of introns 2-3**	No	Ordered by hematologist	Once per year	
0230U **AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for bulbar muscular atrophy, and • The patient requires the service as a confirmatory test for spinal and bulbar muscular atrophy	Once in a lifetime	
0231U **CACNA1A (calcium voltage-gated channel subunit alpha 1A) (e.g., spinocerebellar ataxia), full gene analysis, including small sequence**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Episodic	N/A	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions		ataxia type 2 (EA2), and • The patient requires the service as a confirmatory test for EA2		
0232U **CSTB (cystatin B) (e.g., progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for myoclonic epilepsy type 1 and requires the service as a confirmatory test for myoclonic epilepsy type 1, and • Treatment will be contingent on test results	Once in a lifetime	
0233U **FXN (frataxin) (e.g., Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Friedreich ataxia (FRDA), and • The patient requires the service as a confirmatory test for FRDA	Once in a lifetime	
0234U **MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element**	Yes	The service requires a TAR with documentation of the following criteria: • The patient has clinical signs or symptoms suspicious for Rett syndrome, and	Once in a lifetime	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
insertions, and variants in non-uniquely mappable regions		• The patient requires the service as a confirmatory test for Rett syndrome		
0235U **PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions** *(continues)*	Yes	The service requires a TAR with documentation of the following criteria: 1. Individual with a personal history of: a. Bannayan-Riley-Ruvalcaba syndrome, or b. Adult Lhermitte-Duclos disease, or c. Autism spectrum disorder AND macrocephaly, or d. Two or more biopsy-proven trichilemmomas, or e. Two or more major criteria (one macrocephaly), or f. Three major criteria without macrocephaly, or g. One major and three or more minor criteria, or h. Four or more minor criteria (please see list of major and minor criteria below) 2. At-risk individual a. With a relative who has a clinical diagnosis of Cowden syndrome or b. Bannayan-Riley-Ruvalcaba syndrome for whom testing has not been performed AND who has any one major criterion or two minor criteria **Clinical Criteria:** Major Criteria • Breast Cancer • Mucocutaneous lesions • One biopsy-proven trichilemmoma • Multiple palmoplantar keratosis • Multifocal or extensive oral mucosal papillomatosis • Multiple cutaneous facial papules (often verrucous)	N/A	
(continued from above) **0235U** **PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions**	Yes		N/A	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• Macular pigmentation of glans penis • Macroencephaly (megalocephaly, ie, ≥97th percentile) • Endometrial cancer • Non-medullary thyroid cancer • Multiple GI tract hamartomas or ganglioneuromas **Minor Criteria** • Other thyroid lesions (adenoma, nodule, goiter) • Mental retardation (IQ ≤75) • Autism spectrum disorder • Single GI tract hamartoma or ganglioneuroma • Fibrocystic disease of the breast • Lipomas • Fibromas • Renal cell carcinoma • Uterine fibroids		
0236U **SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (e.g., spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions, and mobile element insertions**	Yes	The service requires a TAR. One of the following ICD-10-CM diagnosis codes is required on the claim: O09.00 thru O09.93, Z31.430, Z31.440, Z34.00 thru Z34.03, Z34.80 thru Z34.83,]Z34.90 thru Z34.93.	Once in a lifetime, except with valid TAR override	
0237U **Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia),**	Yes	The service requires a TAR. The TAR must document a copy of the report of the physician interpreted 12-lead electrocardiogram (ECG) with pattern consistent with or suspicious for prolonged QT	Once in a lifetime, except with valid TAR override	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions		interval. The TAR must also have clinical documentation of one or more of the following: 1. Torsade de pointes in the absence of drugs known to prolong QT interval 2. T-wave alternans 3. Notched T-wave in three leads 4. Syncope 5. Family members with long QT syndrome 6. Sudden death in family members less than 30 years of age without defined cause		
0238U **Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C17.0 thru C20, C24.0 thru C25.9, C54.0 thru C54.9, C65.1 thru C66.9, C71.0 thru C71.9, D23.0 thru D23.9, Z80.0, Z80.49, Z85.030, Z85.038, Z85.040, Z85.048, Z85.42	Once in a lifetime	
0239U **Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient has a diagnosis of either: – Non-small cell lung cancer (plasma), or – Metastatic castrate resistant prostate cancer 2. And treatment is contingent on the test result.	N/A	
0242U **Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence**	Yes	The service requires a TAR with documentation of the following criteria: • Patient has diagnosis of either – Non-small cell lung cancer, or – Hormone receptor-positive, Human	Once in a lifetime	

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
variants, gene copy number amplifications, and gene rearrangements		Epidermal Growth Factor Receptor 2 (HER2)-negative breast cancer • Treatment is contingent on test result		
0244U **Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue** *Continues*	As Noted	The service may require a TAR For Somatic Testing (tumor) when specific testing is aimed at identifying therapeutic targets, a TAR is not required when: • The patient has either recurrent, relapsed, refractory, metastatic or advanced stages III or IV cancer, and • The patient either has not been previously tested using the same Next Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. For somatic testing in the setting of cancers at stage 1 -2, TAR is required to include the diagnosis, stage and chart notes to show how results will direct treatments For Germline Testing a TAR is required with the following documentation: • Ovarian or breast cancer; and • Clinical indication for germline (inherited) testing for hereditary breast or ovarian cancer (ie, American College of Obstetrician and	N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
Cont'd from above **0244U** **Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue**	As Noted		N/A	As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		Gynecologists' criteria for further genetic evaluation for hereditary (germline) breast and ovarian cancer) and • A risk factor for germline (inherited) breast or ovarian cancer; and (BRCAPRO, Myriad, Claus, Boadicea, or Tyrer Cuzick) and • Has not been previously tested with the same germline test using NGS for the same germline genetic content.		prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0245U **Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage** *Continues* *Cont'd from above* **0245U** **Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage**	Yes Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s) 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV. 3. And the diagnostic or treatment strategy will be contingent on test results	Once in a lifetime Once in a lifetime	
0246U **Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups**	No	Ordered by hematologist	Once	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
with phenotype prediction of at least 51 red blood cell antigens				
0268U Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid	Yes	The service requires a TAR with documentation of the following criteria: 1. The patient has clinical signs of symptoms for atypical hemolytic uremic syndrome (aHUS), and 2. The patient requires the service as a diagnostic test for aHUS	Once in a lifetime	
0269U Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid	Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient has clinical signs of symptoms suspicious for autosomal dominant congenita thrombocytopenia, and 2. The patient requires the service as a diagnostic test for autosomal dominant congenital thrombocytopenia	Once in a lifetime	
0271U Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid	No	One of the following ICD-10-CM diagnosis codes is required on the claim: D70.0, D70.1, D70.2, D70.3, D70.4, D70.8, and D70.9. TAR over-ride allowed for ICD-10 codes	Once in a lifetime, except with valid TAR override	
0276U Genomic sequence analysis of 42 genes for detection of abnormalities associated with inherited thrombocytopenia (low platelet count)	Yes	The service requires a TAR A TAR requires documentation of the following criteria: 1. The patient has clinical signs or symptoms suspicious for inherited thrombocytopenia, and 2. The patient requires the service as a	Once in a lifetime	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		diagnostic test for inherited thrombocytopenia		
0282U **Red blood cell antigen typing, dna, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes**	No	Ordered by hematologist	Once per year	
0286U **CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants**	Yes	The service requires a TAR A TAR requires documentation of the following criteria: • That the patient is undergoing thiopurine therapy, and • The patient has severe or prolonged myelosuppression	N/A	
0287U **Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)**	Yes	The service requires a TAR. A TAR requires documentation of the following criteria: 1. The patient is under evaluation for thyroid nodule(s), and 2. The cytopathology result from fine needle aspiration is indeterminate, defined as one of the following: a. Follicular lesion of undetermined significance (FLUS), Bethesda III, or b. Atypia of undetermined significance (AUS), Bethesda III, or c. Follicular neoplasm, Bethesda IV. 3. And the diagnostic or treatment strategy will be contingent on test results	~~N/A~~ Once in a lifetime, except with valid TAR override	
0314U **Oncology (cutaneous melanoma),**	Yes		One unit per day,	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant		Ordered by Dermatology or Oncologist ICD-10 C43 and clinical notes showing medical necessity for repeat testing	except with valid TAR override	
0326U Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden	Yes	A TAR is required for malignancy diagnosis. Clinical information must be submitted showing diagnosis, staging and medical necessity where the treatment is directed by the results.	Once after recurrence, MORE frequently if there is a recurrence or progression with TAR override for medical necessity where treatment is directed by results	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0327U Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma,	Yes	A TAR is required with clinical information indicating pregnancy and not previously tested in this pregnancy.	Once per pregnancy, consider repeat with TAR	Reimbursement will be limited to one of the following Noninvasive Prenatal Tests per

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
algorithm reported as a risk score for each trisomy, includes sex reporting, if performed			override for medical necessity showing indication for repeat testing and treatment is directed by results	pregnancy: PLA code 0327U or CPT code 81420 or CPT code 81507. Concurrent or repeat use of these services during the same pregnancy is not covered unless there is documentation of medical necessity.
0329U **Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations**	Yes	A TAR is required with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and The decision for additional cancer treatment is contingent on the test results.	Once per year and /or after recurrence or progression with TAR override for medical necessity where treatment is directed by results	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0333U **Oncology (liver), surveillance for hepatocellular carcinoma (hcc) in highrisk patients, analysis of methylation patterns on circulating cell-free dna (cfdna) plus measurement of serum of afp/afp-l3 and oncoprotein des-gammacarboxy-prothrombin (dcp), algorithm reported as normal or abnormal result**	Yes	TAR Required with Dx of High risk for hepatocellular carcinoma, notation that standard surveillance AFP and imagining is insufficient or inconclusive and subsequent treatment options contingent on results	Once in a lifetime	Of note this testing is NOT supported in the 2023 NCCN guidelines
0334U **Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin embedded (ffpe) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden**	Yes	A TAR is required with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results.	Once in a lifetime	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
				metastatic stage 3 or 4 cancer.
0339U **Oncology (prostate), mrna expression profiling of hoxc6 and dlx1, reverse transcription polymerase chain reaction (rt-pcr), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C61, D07.5. Allow TAR/SAR override.	Once in 36 months, except with valid TAR override	
0340U **Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease burden correlation, if appropriate**	Yes	NCCN guideline recommendations will be reviewed. A TAR requires documentation of all of the following criteria (1 thru 3): 1. The member is not receiving other molecular testing for minimal residual disease analysis concurrently with this test, and 2. One of the following criteria must be met (a or b), and: a. Monitoring is needed to diagnose cancer recurrence, relapse or progression and member has a diagnosis of one of the following: muscle-invasive bladder cancer, stage II to IV ovarian cancer, stage II to IV breast cancer, non-small cell lung cancer, Merkel cell carcinoma, or stage II to IV colorectal cancer, or b. Monitoring of response is needed and member is receiving immune checkpoint inhibitor therapy for a diagnosis of any solid tumor	Based on NCCN guidelines	

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CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0340U cont'd Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease burden correlation, if appropriate		3. One of the following criteria must be met (a thru d): a. Member is currently being treated for cancer and the test has not been previously performed for this cancer diagnosis, or b. Member is currently being treated for cancer and there is clinical suspicion that the molecular profile of the member's tumor has changed, or c. Member is not currently being treated for their cancer (i.e. when there is no clinical, radiographical or other biological evidence that tumor cells remain post treatment and the member is no longer being subjected to therapeutic interventions for cancer) and the test has not been performed in the last 12 months, or d. Member is not currently being treated for their cancer and now there is a clinical suspicion for tumor recurrence		
0341U **Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid**	Yes	TAR required with Prenatal Care diagnosis and clinical information showing medical necessity including explanation of why the covered code 0327U cannot be used	Once per pregnancy	
0345U Psychiatry (e.g., depression, anxiety, attention deficit hyperactivity disorder	Yes	A TAR requires documentation of all of the following criteria: • Member is 18 years of age or older, and	Once in a lifetime	Consider for evaluation of a Member's genetic predisposition to a CYP450

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
[ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6 0345U Psychiatry (e.g., depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6		• Diagnosis of major depressive disorder of at least moderate severity, and • Non-pharmacologic treatment has been tried and failed or member's condition is not appropriate for non-pharmacological treatment, and • Prior inadequate response and/or significant adverse reaction to at least two psychotropic drugs must be documented in the medical record, and • Psychotropic drug(s) being considered for treatment has a known and clinically actionable gene-drug interaction based on one of the following: – Clinical Pharmacogenetics Implementation Consortium (CPIC) final Level A or B https://cpicpgx.org/genes-drugs/ or, – The U.S. Food and Drug Administration (FDA) Section 1 Table "Pharmacogenetic Associations for which the Data Support Therapeutic Management Recommendations, or – The current FDA-approved prescribing label for the drug.	No TAR override allowed	enzyme interaction, which may pose a risk for adverse drug reaction. Clinical Pharmacogenetics Implementation Consortium Guideline from the FDA can be found here: https://cpicpgx.org/genes-drugs/
0359U **Oncology (prostate cancer), analysis of all prostate-specific antigen (PSA) structural isoforms by phase separation and immunoassay, plasma, algorithm reports risk of cancer**	No	Reimbursable for males who meet the following criteria: • 40 years of age or older • One of the following ICD-10-CM diagnosis codes is required on the claim: N40.0, N40.1, N40.2, N40.3, Z12.5, Z80.42	Twice per year, except with valid TAR override	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0364U **Oncology (hematolymphoid neoplasm), genomic sequence analysis using multiplex (pcr) and next-generation sequencing with algorithm, quantification of dominant clonal sequence(s), reported as presence or absence of minimal residual disease (mrd) with quantitation of disease burden, when appropriate**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: C90.00, C90.01, C90.02, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12.	N/A Allow TAR override	
~~**0369U**~~ ~~**Infectious agent detection by nucleic acid (dna and rna), gastrointestinal pathogens, 31 bacterial, viral, and parasitic organisms and identification of 21 associated antibiotic resistance genes, multiplex amplified probe technique**~~	~~No~~	~~TAR Diagnosis of Gastrointestinal infection and documentation showing that testing is required to direct treatment~~	~~Once per year, except with valid TAR override~~	
0371U **Infectious agent detection by nucleic acid (dna or rna), genitourinary pathogen, semiquantitative identification, dna from 16 bacterial organisms and 1 fungal organism, multiplex amplified probe technique via quantitative polymerase chain reaction (qpcr), urine**	Yes	TAR required with diagnosis of Urinary Tract infection and documentation showing that testing is required to direct treatment	N/A	
0372U **Infectious disease (genitourinary pathogens), antibiotic-resistance gene detection, multiplex amplified probe technique, urine, reported as an antimicrobial stewardship risk score**	Yes	Documentation of genitourinary tract infection and risk for antibiotic resistance ICD 10 Z16, Z16.24	N/A	
0373U **Infectious agent detection by nucleic acid (dna and rna), respiratory tract infection, 17 bacteria, 8 fungus, 13 virus, and 16**	Yes	Documentation of respiratory tract infection and risk for antibiotic resistance ICD 10 Z16, Z16.24	Two times per year,	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
antibiotic-resistance genes, multiplex amplified probe technique, upper or lower respiratory specimen			except with valid TAR override	
0374U **Infectious agent detection by nucleic acid (dna or rna), genitourinary pathogens, identification of 21 bacterial and fungal organisms and identification of 21 associated antibiotic-resistance genes, multiplex amplified probe technique, urine**	Yes	Documentation of genitourinary tract infection and risk for antibiotic resistance	N/A	
0378U **Rfc1 (replication factor c subunit 1), repeat expansion variant analysis by traditional and repeat-primed pcr, blood, saliva, or buccal swab**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: G11.0, G11.2, G11.3, G11.4, G11.8, G11.9, G11.10, G11.11, G11.19, G32.81, G60.2, G80.4, R26.0, R27.0.	Once in a lifetime, except with valid TAR override	
0379U **Targeted genomic sequence analysis panel, solid organ neoplasm, dna (523 genes) and rna (55 genes) by next-generation sequencing, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability, and tumor mutational burden**	Yes	A TAR is required with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and The decision for additional cancer treatment is contingent on the test results.	Once in a lifetime, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
				prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0381U **Maple syrup urine disease monitoring by patient-collected blood card sample, quantitative measurement of allo-isoleucine, leucine, isoleucine, and valine, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E71.0, E71.2	Allow TAR override for tests of more than 20 per year with documentation demonstrating medical need for more frequent testing	
0382U **Hyperphenylalaninemia monitoring by patient-collected blood card sample, quantitative measurement of phenylalanine and tyrosine, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E70.0 and E70.1	N/A Allow TAR override	
0383U **Tyrosinemia type i monitoring by patient-collected blood card sample, quantitative measurement of tyrosine, phenylalanine, methionine, succinylacetone, nitisinone, liquid chromatography with tandem mass spectrometry (lc-ms/ms)**	No	One of the following ICD-10-CM diagnosis codes is required on the claim: E70.20, E70.21, E70.29	N/A Allow TAR override	
0388U **Oncology (non-small cell lung cancer), next-generation sequencing with**	Yes	TAR requires documentation of the following criteria:	Once in a lifetime,	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
identification of single nucleotide variants, copy number variants, insertions and deletions, and structural variants in 37 cancer-related genes, plasma, with report for alteration detection		• The patient has a diagnosis of non-small cell lung cancer • The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible • Management is contingent on the test results	except with valid TAR override	
0391U **Oncology (solid tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded (FFPE) tissue, 437 genes, interpretive report for single nucleotide variants, splice-site variants, insertions/deletions, copy number alterations, gene fusions, tumor mutational burden, and microsatellite instability, with algorithm quantifying immunotherapy response score**	Yes	A TAR is required with documentation of the following criteria: For Somatic Testing • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results.	Once in a lifetime, except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity. As per APL 22-010 Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4 cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0409U **Oncology (solid tumor), DNA (80 genes) and RNA (36 genes), by next-generation sequencing from plasma, including single**	Yes	A TAR is required with documentation of the following criteria:	Once in a lifetime	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
nucleotide variants, insertions/deletions, copy number alterations, microsatellite instability, and fusions, report showing identified mutations with clinical actionability		• The patient has a diagnosis of non-small cell lung cancer, and • The patient is medically unable to undergo invasive biopsy or tumor tissue testing is not feasible, and • Management is contingent on the test results	except with valid TAR override	
~~**0448U**~~ ~~**Oncology (lung and colon cancer), DNA, qualitative, next-generation sequencing detection of single-nucleotide variants and deletions in EGFR and KRAS genes, formalin-fixed paraffin-embedded (FFPE) solid tumor samples, reported as presence or absence of targeted mutation(s), with recommended therapeutic options**~~	~~Yes~~	~~A TAR is required with documentation of the following criteria:~~ ~~• The patient has been diagnosed with either non-small cell lung cancer (NSCLC) or colorectal cancer, and~~ ~~• Management is contingent on the test results~~	~~Once in a lifetime~~ ~~except with valid TAR override~~	
0471U **Oncology (colorectal cancer), qualitative real-time PCR of 35 variants of KRAS and NRAS genes (exons 2, 3, 4), formalin-fixed paraffin-embedded (FFPE), predictive, identification of detected mutations**	Yes	A TAR is required with documentation of the following criteria: • The patient has been diagnosed with colorectal cancer, and • Management is contingent on the test results	Once in a lifetime except with valid TAR override	
0473U **Oncology (solid tumor), next-generation sequencing (NGS) of DNA from formalin-fixed paraffin-embedded (FFPE) tissue with comparative sequence analysis from a matched normal specimen (blood or saliva), 648 genes, interrogation for sequence variants, insertion and deletion alterations, copy number variants, rearrangements, microsatellite instability, and tumor-**	Yes	A TAR is required with documentation of the following criteria: <u>For Somatic Testing</u> • The patient has recurrent, relapsed, refractory, metastatic or advanced stage III or IV cancer, and • The patient either has not been previously tested using the same Next-Generation Sequencing (NGS) test for the same primary	Once in a lifetime except with valid TAR override	NCCN guideline recommendations will be reviewed for medical necessity. As per <u>APL 22-010</u> Cancer Biomarker Testing (06/22/2022), no prior authorization is required for cancer biomarker testing for members with advanced or metastatic stage 3 or 4

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
mutation burden		diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and • The decision for additional cancer treatment is contingent on the test results. Independent of the above criteria, somatic testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.		cancer for whom an FDA approved treatment is considered. The intent is to remove barriers for members with late-stage cancer. Although no prior authorization is required, a prepayment review after the service has been provided may review the submitted documents to ensure that the records reflect advanced or metastatic stage 3 or 4 cancer.
0475U **Hereditary prostate cancer-related disorders, genomic sequence analysis panel using next-generation sequencing (NGS), Sanger sequencing, multiplex ligation-dependent probe amplification (MLPA), and array comparative genomic hybridization (CGH), evaluation of 23 genes and duplications/deletions when indicated, pathologic mutations reported with a genetic risk score for prostate cancer**	Yes	A TAR requires documentation of the following criteria: For Germline Testing • The patient has prostate cancer, and • The patient has a clinical indication for germline (inherited) testing for hereditary cancer (e.g., NCCN Guidelines for Prostate Cancer), and • The patient has a risk factor for germline (inherited) cancer (e.g., NCCN Guidelines for Prostate Cancer), and • The patient has not been previously tested with the same germline genetic content.	Once in a lifetime except with valid TAR override	
0488U **Obstetrics (fetal antigen noninvasive prenatal test), cell-free dna sequence analysis for detection of fetal presence or absence of 1 or more of the Rr~~r~~h, Cc~~e~~, c, Dd~~d~~, Ee, Dd~~d~~uffy (Ff~~f~~ya) or Kk~~k~~ell (Kk~~k~~)**	Yes	A TAR requires documentation of the following criteria: For fetal RhD antigen status • The patient is currently pregnant, and • The pregnant patient is RhD negative, and	Reimbursement will be limited to once per pregnancy unless there is documentation	~~Reimbursement will be limited to once per pregnancy.~~

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
antigen in alloimmunized pregnancies, reported as selected antigen(s) detected or not detected		• The pregnant patient has not been tested with another cell-free DNA test for fetal RhD status during the same pregnancy. • The paternal RhD status is either heterozygous or unknown, and • The pregnant member is not alloimmunized to RhD during a shortage of anti-D immune globulin, or the pregnant is alloimmunized to RhD. For fetal status of non-RhD red blood cell (RBC) antigens • The patient is currently pregnant, and • The pregnant patient ~~has alloantibodies~~is alloimmunized to one or more non-RhD RBC antigens, and • The paternal non-RhD RBC antigen status is either heterozygous or unknown, and • The pregnant patient has not been tested with another cell-free DNA test to determine fetal status of non-RhD RBC antigens during the same pregnancy.	of medical necessity.~~N/A~~	
0493U Transplantation medicine, quantification of donor-derived cell-free DNA (cfDNA) using next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA	Yes	A TAR requires documentation of the following criteria: For kidney transplant recipients • There is clinical suspicion for acute kidney allograft rejection and the member has not been tested with another donor-derived cell-free DNA test for the same episode, and • The test must be ordered by a nephrologist or kidney transplant surgeon, and	N/A	Partnership would consider for heart, lung and liver transplant with MD review for medical necessity.

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• Member is at least one month post-kidney transplant, and • Member is 18 years of age or older, and • Member is not pregnant, and • Member has not received a kidney transplant from their twin, has not undergone multiple organ transplants, and has not undergone bone marrow transplantation		
0494U **Red blood cell antigen (fetal R~~r~~hD~~d~~ gene analysis), next-generation sequencing of circulating cell-free DNA~~dna~~ (cfDNA~~dna~~) of blood in pregnant individuals known to be R~~r~~hD~~d~~ negative, reported as positive or negative**	Yes	A TAR is required with documentation of the following criteria: For fetal RhD antigen status • The patient is currently pregnant, and • The pregnant patient is RhD negative, and • The pregnant patient has not been tested with another cell-free DNA test to determine fetal RhD status during the same pregnancy, and~~.~~ • The paternal RhD status is either heterozygous or unknown, and • The pregnant member is not alloimmunized to RhD during a shortage of anti-D immune globulin, or the pregnant member is alloimmunized to RhD.	Reimbursement will be limited to once per pregnancy, unless there is documentation of medical necessity.~~N/A~~	~~Reimbursement will be limited to once per pregnancy, unless there is documentation of medical necessity.~~
0523U **Oncology (solid tumor), dna, qualitative, nextgeneration sequencing (ngs) of singlenucleotide variants (snv) and insertion/deletions in 22 genes utilizing formalin-fixed paraffin-embedded tissue, reported as presence or absence of mutation(s), location of mutation(s), nucleotide change, and amino acid change**	Yes	A TAR requires documentation of the following criteria: • The member has been diagnosed with either non-small cell lung cancer (NSCLC) or colorectal cancer, and • Management is contingent on the test results	Once in a lifetime	Previously 0448U

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
0540U Transplantation medicine, quantification of donor-derived cell-free DNA using next generation sequencing analysis of plasma, reported as percentage of donor-derived cell free DNA to determine probability of rejection		A TAR requires documentation of the following criteria: For kidney transplant recipients • There is clinical suspicion for acute kidney allograft rejection and the member has not been tested with another donor-derived cell-free DNA test for the same episode, and • The test must be ordered by a nephrologist or kidney transplant surgeon, and • Member is at least one month post-kidney transplant, and • Member is 18 years of age or older, and • Member is not pregnant, and • Member has not received a kidney transplant from their twin, has not undergone multiple organ transplants, and has not undergone bone marrow transplantation.	N/A	Partnership would consider for heart, lung and liver transplant with MD review for medical necessity.
0543U Oncology (solid tumor), next-generation sequencing of DNA from formalin-fixed paraffin-embedded (FFPE) tissue of 517 genes, interrogation for single- nucleotide variants, multi-nucleotide variants, insertions and deletions from DNA, fusions in 24 genes and splice variants in 1 gene from RNA, and tumor mutation burden	Yes	A TAR requires documentation of the following criteria: For Somatic Testing • The member has recurrent, relapsed, refractory, metastatic, or advanced stage III or IV cancer, and • Either the member has not been previously tested using the same next-generation sequencing (NGS) test for the same primary diagnosis of cancer or repeat testing using the same NGS test only occurs when a new primary cancer diagnosis is made by the treating physician, and	Once in a lifetime	

MCUP3131-C Proprietary Lab Analyses Requirements: Providers should refer to the CPT or HCPCS code book, as appropriate, for full code descriptions.

CPT Code Description	PHC TAR Required	TAR and/or Billing Requirements	Frequency Limit	BENEFIT COMMENTS
		• The decision for additional cancer treatment is contingent on the test results. Independent of the above criteria, somatic testing may be approved if the test is approved by the U.S. Food and Drug Administration (FDA) as a companion diagnostic device, and the decision for additional treatment is contingent on the test results.		
0094U **Rapid Whole Genome Sequencing (rWGS)** **Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis**	No	Per Assembly Bill (AB) 133 (2021-2022 Regular Session), Rapid Whole Genome Sequencing, including individual sequencing, trio sequencing for a parent or parents and their baby, and ultra-rapid sequencing, is a covered benefit for any Medi-Cal beneficiary who is: • One year of age or younger AND • Is receiving inpatient hospital services in an intensive care unit.	Once in a lifetime	This is not an outpatient benefit. Medi-Cal does not cover rapid or ultra-rapid whole genome sequencing in the outpatient setting.

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS & SYSTEMS (CAHPS®) PROGRAM

2024-2025

MEMBER EXPERIENCE GRAND ANALYSIS (NCQA ME 7C/7D REPORT)

PERIOD
(JULY 1, 2024 – JUNE 30, 2025)

PRODUCTION DATE
SEPTEMBER 2025

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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QUALITATIVE ANALYSIS & STRATEGIC PRIORITIES

CAHPS® PROGRAM

MEMBER EXPERIENCE OVERVIEW

In FY 2024–2025, Partnership HealthPlan of California ("Partnership") achieved two (2) transformative milestones in its mission to help our members live healthy lives. These achievements reflect not only organizational growth, but a deepened commitment to access, culturally responsive care.

In January 2024, Partnership expanded its service area from 14 to 24 counties, significantly enhancing healthcare access across Northern California. This expansion introduced new opportunities and challenges in member experience, as assessed in our Member Experience Grand Analysis (ME 7). Building on this momentum, in August 2025, Partnership earned NCQA Health Equity Accreditation, affirming our dedication to delivering culturally responsive, equitable care across our expanded service region.

This narrative sets the stage for a deeper exploration of the qualitative outcomes that underpin our ME 7 performance and inform the data-driven insights that follow. From operational alignment to member-centered innovation, the following outcomes illustrate how strategic intent translated into measurable impact shaping both the experience and expectations of the communities we serve.

ANALYSIS OF MEMBER EXPERIENCE BARRIERS AND STRATEGIC RESPONSE

Our analysis of member experience, drawn from both Grievance & Appeals (G&A) reporting and CAHPS survey results, aligns with NCQA's required assessment categories while revealing opportunities to enhance overall member experience across 24 counties, serving nearly one-million-members:

1. **NCQA CATEGORY: ACCESS**
   - G&A Data: Access complaints (2.83 per 1,000 members, exceeding threshold)
     - **Key Focus:** Access and Transportation related issues, collectively representing the highest volume of access-related grievances
   - CAHPS® Data: Getting Needed Care (5th percentile) and Getting Care Quickly (11th percentile)

   BARRIERS:
   - **Regional Growth Impact**
     - Expansion into 10 new counties resulting in 33% membership growth
   - Limited PCP and specialty provider availability within our rural counties
   - Members reported PCP scheduling challenges and timely appointment availability
   - **Operational Systems Integration**
     - Lack of systematic real-time tracking between transportation complaints and specific drivers
     - Manual complaint management process limiting timely response
     - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management

2. **NCQA Category: Quality of Practitioner Office Site**
   - G&A Data: Quality of Provider's Office concerns (Threshold Status: Increased from 0.003 to 0.006 per 1,000 members, exceeding threshold range)
     - **Key Focus:** PCP provider office cleanliness

Barriers:

- **No barriers identified**
  - 40% of reported cases (2 of 5) could not be validated due to absence of appointment verification
  - Limited sample size (5 cases) affects statistical significance of rate increase
  - Complaint categorization may not accurately reflect actual facility quality issues, as verified cases demonstrated appropriate cleaning protocols

3. **NCQA Category: Attitude and Service**
   - G&A Data: attitude and service complaints (2.84 per 1,000 members, threshold met)
     - **Key Focus:** Transportation service delivery barriers, and health plan customer service
   - CAHPS® Data: Customer Service performance at 12th percentile for Adult and 74th percentile for Child populations, highlighting significant variation in service experience

Barriers:

- **Regional Growth Impact**
  - Expansion into 10 new counties resulting in 33% membership growth
  - Transportation drivers providing unsatisfactory service
  - Extended hold times while seeking support from the plan
  - Members not satisfied with phone/call tree system
  - Transportation coordination and lack of benefit awareness and reimbursement processes
- **Operational Systems Integration**
  - Lack of systematic real-time tracking between transportation complaints and specific drivers
  - Manual complaint management process limiting timely response
  - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management
  - Plan main phone number / auto attendant not providing ease of access to route members directly to the transportation department

Impact on Member Experience:

Our data demonstrates that focused improvements in Access and Attitude/Service categories directly influence broader member experience measures, including:

- Health Plan ratings
- Health Care satisfaction
- Overall service delivery perception

This analysis informs our prioritized improvement strategies detailed in Table III, while recognizing these efforts are part of Partnership's comprehensive approach to quality enhancement. While this report focuses on specific member experience measures, it complements other organizational initiatives detailed in separate analyses (such as Network Adequacy Assessment Report (NET 3) and Population Health Management reports).

Our prioritized improvement strategies (Table III) align interventions across these categories:

High Priority Areas

- Access and Transportation
- Attitude and Service
- Member Experience Enhancement

Supporting Priorities

- Health Equity integration
- Dental benefit awareness and data collection
- Customer service enhancement

These priorities directly align with our data findings: High Priority areas address our most significant challenges shown in both G&A data (Access at 2.83 per 1,000 members) and CAHPS® results (Getting Needed Care at 5th percentile), while Supporting Priorities target additional improvement opportunities identified in our analysis. This prioritization framework acknowledges that sustainable improvement requires coordinated effort across multiple organizational workstreams and reports.

With these identified barriers and priorities established, the following sections provide a deeper exploration of the qualitative and quantitative analyses that underpin our ME 7 performance. This comprehensive assessment demonstrates how our strategic focus on Access and Service/Attitude improvements influences measurable impact across member experience initiatives, while shaping both the experience and expectations of the communities we serve.

QUALITY IMPROVEMENT

The Quality Improvement Department's Consumer Assessment of Healthcare Providers & Systems (CAHPS®) program provides programmatic structure and resource commitment to effectively administer National Committee for Quality Assurance (NCQA) requirements and influence organizational change to improve member experience and the health plan rating.

Our approach and discipline in leveraging team strengths equip us with the necessary skills to implement a mixed methodology, including quality improvement tools and program management principles such as plan-do-study-act (PDSA), lean, root-cause analysis, data analytics, and both qualitative and quantitative analysis. As the team identifies new opportunities or lessons learned, we continuously explore and develop pathways for improvement. The established program is designed to be flexible, allowing us to adapt and pivot, each fiscal year.

GRIEVANCES

Grievance and Appeals reporting evaluates member experience year-over-year to assess member dissatisfaction across five (5) NCQA-defined categories, including: Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. The reporting triggers a threshold alert when case numbers per 1,000 members increase by more than 10% compared to the previous period.

Partnership's expanded county coverage drove membership to a record high of 905,570 members by the end of 2024, a 33.5% increase from 678,546 members in 2023. Despite this substantial membership growth, Grievances showed only a modest increase (from 5.79 to 6.05 per 1,000 members, Table VI), while both Appeals and Second Level Grievances demonstrated favorable decreases. Most notably, Second Level Grievances declined from 1.02 to 0.74 per 1,000 members (Table VII).

Further analysis of the 6,149 total cases closed in 2024 (compared to 4,261 in 2023) reveals specific patterns in member concerns. Of these cases, 5,477 were Grievances and 672 were Appeals and Second Level Grievances (Tables VI and VII). Access and Attitude/Service remain the most frequently reported concerns, accounting for 2,567 and 2,569 cases, respectively.

The number of Grievances filed per 1,000 members increased from 2.25 to 2.83 for access-related issues. More missed rides were reported, resulting in access issues to appointments. In 2023, there were two (2) cases related to the Quality of a Provider's Office, while in 2024, this number increased to five (5) cases. When adjusted for membership growth, this represents an increase from 0.003 to 0.006 cases per 1,000 members, exceeding the threshold range of 0.00 to 0.01.

APPEALS & SECOND LEVEL GRIEVANCES

Appeals and Second Level Grievances showed a year-over-year decrease from 689 to 672 cases. All five (5) categories (Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office) remained within the 10% threshold target. However, notable changes occurred in two (2) categories: Access increased by 26.3% (from 350 to 442 cases), while Quality of Care decreased by 88.9% (from 9 to 1 case), as shown in Table VII.

CAHPS® MEASURE YEAR 2024 | REPORTING YEAR 2025 PLAN PERFORMANCE

Patient experience measures substantially influence NCQA Health Plan Ratings through key rating and composite scores. The MY 2024 CAHPS® survey performance analysis evaluates these measures across Adult and Child populations, examining current performance, identified barriers, and planned interventions for Fiscal Year (FY) 2025-2026.

The CAHPS® survey measures member experience performance through the HEDIS (Healthcare Effectiveness Data and Information Set) QC (Quality Compass) national percentile rankings, comparing performance against other Medicaid plans. Performance targets include Partnership's internal benchmark

(≥33rd percentile ranking) and Department of Health Care Services (DHCS) Minimum Performance Level requirement (≥50th percentile ranking).

ADULT SURVEY

Analysis of MY 2024 Adult CAHPS® measures reveals seven (7) of nine (9) measures performing below the plan's 33rd percentile benchmark target. Comparative year-over-year assessment demonstrates ranking decreases in five (5) measures, with detailed performance measures presented in Table I.

Table: I HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	19th	Not Met	Improvement
Rating of Health Care (% 8, 9, 10)	35th	Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	30th	Not Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	96th	Met	Improvement
Getting Needed Care (% Always or Usually)	5th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	11th	Not Met	Improvement
Care Coordination (% Always or Usually)	9th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	8th	Not Met	Decline
Customer Service (% Always or Usually)	12th	Not Met	Decline

CHILD SURVEY

For the Child population, MY 2024 CAHPS® measures indicate four (4) of nine (9) measures performing below the plan's 33rd percentile benchmark target. Year-over-year analysis shows ranking decreases in five (5) measures, with comprehensive performance measures outlined in Table II.

Table: II HEDIS Quality Compass (QC) Benchmarks

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	44th	Met	Decline
Rating of Health Care (% 8, 9, 10)	21st	Not Met	Improvement

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Personal Doctor (% 8, 9, 10)	73rd	Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	31st	Not Met	Improvement
Getting Needed Care (% Always or Usually)	13th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	13th	Not Met	Improvement
Care Coordination (% Always or Usually)	52nd	Met	Improvement
How Well Doctors Communicate (% Always or Usually)	36th	Met	Decline
Customer Service (% Always or Usually)	74th	Met	Decline

IDENTIFICATION OF OPPORTUNITIES AND PRIORITY

The QI CAHPS® framework continues to drive a coordinated, multi-disciplinary approach to enhance member experience through targeted initiatives and health equity integration. As part of a recent strategic realignment, Access initiatives have been separated from Member Experience and placed under the HR Workforce Development team to lead the FY 24-25 Access Strategic and Tactical plans in alignment with Organizational Goal #2: Network Optimization. Concurrently, the QI Department remains focused on advancing Member Experience improvements through the Strike-Team Pilot - an initiative designed to identify, prioritize, and eliminate service delivery barriers in real time.

Building on these structural improvements and our FY 2024-25 progress, (detailed in Appendix B), the Member Experience teams will advance our continuous improvement efforts through FY 2025-26. This includes enhancing member education, strengthening dental coverage initiatives, and integrating health equity perspective into service delivery. These strategic initiatives, as outlined in Appendix A, address evolving challenges while ensuring our interventions reflect our diverse member population's needs.



MEMBER EXPERIENCE – PRIORITY

Building on the organizational changes detailed earlier, this analysis examines Partnership's member experience measures within the context of our expanded service area and increased membership base. The data reflects our transition from a 14-county to 24-county service area, with MY2024 results capturing feedback from our broader membership population.

Member Experience Measures (Not Included in NCQA Scoring)

These supplementary measures evaluate three (3) key drivers of member satisfaction: *How Well Doctors Communicate* (doctor communication) quality, *Care Coordination* effectiveness, and *Customer Service* performance. These measures provide critical insights into how well our healthcare delivery system serves our members' needs.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Care Coordination showed positive gains in both populations (Adult: **+2.5** points, Child: **+4.3** points).
- Doctor Communication maintained strong performance above 90% for both populations.
- Customer Service sustained high member satisfaction levels, particularly in Child population (90.5%).

Adult Population Performance:

- Doctor Communication: 92.6% to 90.6% (↓ **-2.0** points)
- Care Coordination: 78.8% to 81.3% (↑ **+2.5** points)
- Customer Service: 96.4% to 86.5% (↓ **-9.9** points)

Child Population Performance:

- Doctor Communication: 93.0% to 93.3% (↑ **+0.3** points)
- Care Coordination: 80.4% to 84.7% (↑ **+4.3** points)
- Customer Service: 91.2% to 90.5% (↓ **-0.7** points)

Rating Measures

These rating measures reflect members' overall satisfaction with their healthcare experience, focusing on ratings of 9 or 10 on a 10-point scale. High scores indicate strong satisfaction with healthcare delivery systems.

What Changed Last Year (MY2023-MY2024)

Notable Improvements:

- Both populations showed improved Health Plan ratings (Adult: **+1.3** points, Child: **+4.8** points).
- Health Care ratings increased significantly (Adult: **+9.1** points, Child: **+7.5** points).
- Child population demonstrated improvements across all rating measures.

Adult Population Performance:

- Health Plan: 54.5% to 55.8% (↑ **+1.3** points)
- Health Care: 46.3% to 55.4% (↑ **+9.1** points)
- Personal Doctor: 70.0% to 65.7%

Child Population Performance:

- Health Plan: 68.1% to 72.9% (↑ **+4.8** points)
- Health Care: 58.9% to 66.4% (↑ **+7.5** points)
- Personal Doctor: 75.5% to 78.6%

(↓ **-4.3** points)
- Specialist: 69.5% to 70.3% (↑ **+0.8** points)

(↑ **+3.1** points)
- Specialist: 63.8% to 73.8% (↑ **+10.0** points)

ACCESS TO CARE MEASURES - PRIORITY

These measures evaluate members' ability to receive timely care and necessary services, providing crucial indicators of healthcare accessibility.

❖ GETTING NEEDED CARE (GNC)

This measure assesses members' ability to obtain necessary treatments and specialist appointments.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Both populations showed improved composite scores (Adult: **+0.5** points, Child: **+0.8** points).
- Care/Tests/Treatment access improved for both populations.
- Child population maintained stable specialist appointment access.

ADULT POPULATION PERFORMANCE:

- GNC Composite Score: 74.0% to 74.5% (↑ **+0.5** points)
  - *Care/Tests/Treatment: 76.1% to 78.6% (↑ **+2.5** points)*
  - *Specialist Appointments: 71.9% to 70.5% (↓ **-1.4** points)*

CHILD POPULATION PERFORMANCE:

- GNC Composite Score: 77.1% to 77.9% (↑ **+0.8** points)
  - *Care/Tests/Treatment: 81.3% to 82.7% (↑ **+1.4** points)*
  - *Specialist Appointments: 72.8% to 73.1% (↑ **+0.3** points)*

❖ GETTING CARE QUICKLY (GCQ)

This measure evaluates timely access to urgent and routine care.

WHAT CHANGED LAST YEAR (MY2023-MY2024)

NOTABLE IMPROVEMENTS:

- Both populations showed improved composite scores.
- Adult urgent care access showed significant improvement (**+9.1** points).
- Both populations maintained strong urgent care performance above 78%.

ADULT POPULATION PERFORMANCE:

- GCQ Composite Score: 68.1% to 74.0% (↑ **+5.9** points)
  - *Urgent Care: 69.8% to 78.9% (↑ **+9.1** points)*

CHILD POPULATION PERFORMANCE:

- GCQ Composite Score: 78.9% to 80.0% (↑ **+1.1** points)
  - *Urgent Care: 83.7% to 84.2% (↑ **+0.5** points)*

- *Routine Care: 66.3% to 69.2% (↑ **+2.9** points)*
- *Routine Care: 74.2% to 75.9% (↑ **+1.7** points)*

What Are New County Members Reporting - County Expansion

The 2025 CAHPS survey results for Partnership's expanding service regions show notable variations between child and adult populations. Child survey respondents (29.8% of 783 total) consistently reported higher satisfaction rates compared to adult respondents (30.7% of 511 total), particularly in Health Plan Ratings and Access Measures.

Tehama County demonstrated the widest performance variance between populations, while the Chico Region maintained the most consistent performance. Detailed analysis of regional performance and specific measures available for review here, *2024 CAHPS® Survey Plan Performance.*



Health Equity and Member Experience Analysis

Our analysis of CAHPS® MY 2024 Survey results reveal compelling insights into member experience across diverse populations, highlighting critical areas where health equity initiatives can make a meaningful impact. The data presents a nuanced picture of how different demographic groups experience healthcare services, from plan satisfaction to access barriers.

Key Findings

- **Health Status Correlation:** MY 2024 members reporting poor or fair physical or mental health consistently showed lower satisfaction scores across multiple domains, including health plan ratings, customer service, and provider communication. This correlation suggests these vulnerable populations may require enhanced support services.
- **Age-Based Disparities:** Notable variations emerged in access satisfaction among age groups, with members aged 18-34 expressing greater challenges. This younger demographic's preferences for digital engagement and remote services contrast sharply with older members who prefer in-person care, highlighting the need for multi-channel access strategies.

Cultural and Ethnic Variations:

American Indian/Native American populations reported significant challenges with form completion
Hispanic members showed notably higher satisfaction levels across both adult and child services compared to other demographic groups. These variations underscore the importance of culturally tailored approaches to healthcare delivery

For additional insights into these findings, please refer to the detailed *CAHPS® MY 2024 Survey Results* section that follows.

QUALITATIVE ANALYSIS

During this period of organizational change, member experience data revealed distinct differences across populations and service regions. Our CAHPS® survey and member feedback show how service delivery evolved during these transitions.

The intent of this report is to meet the requirements of NCQA Standard ME 7 Elements C and D. Its objectives are to assess member experience through Grievance & Appeals data and CAHPS® survey results. Qualitative analyses are conducted by the QI Department and opportunities for improvement are identified and prioritized.

The primary ME 7 report contributors include:

1. Isaac Brown, Director of Quality and Performance Improvement
2. Barbara Selig, Manager of Quality Improvement Programs
3. Anthony Sackett, Program Manager II, Quality Improvement Programs
4. Andrea Thomas, Project Manager I, Quality Improvement Programs
5. Kory Watkins, Director of Grievance & Appeals
6. Latrice Innes, Manager of Grievance & Appeals Compliance
7. Bonnie Thompson, Certified NCQA Survey Vendor, VP, Strategic Consulting

MEMBER FEEDBACK OVERVIEW

Survey results across our service areas show varying experiences between adult and child members:

- Child services maintained strong performance, with 90.5% satisfaction with customer service.
- Adult services saw improvements in Health Care ratings (**+9.1** points).
- Getting care quickly improved for both adults (**+5.9** points) and children (**+1.1** points).

WHAT MEMBERS TOLD US

Member feedback through grievances and appeals provided key insights:

- Total feedback increased proportionally with growth (5,477 cases in 2024, up from 3,572).
  Main concerns focused on:
  - Getting rides to appointments (49% of cases)
  - Access to care (42% of cases)
  - Provider services (24% of cases)
  - Partnership services (10% of cases)

SERVICE DELIVERY IMPACT

Key factors influencing member experience included:

- Network adjustments, including Dignity Health contract changes (April 2024)
- Ongoing regional healthcare workforce constraints
- Adapting service delivery systems for scale

Regional Understanding

Our expanded service area revealed important insights about how healthcare needs and experiences vary across Northern California communities. CAHPS® survey results highlighted differences in how adult and child populations experience care across regions, with Tehama County demonstrating the most significant variations. These regional differences deepen our understanding of how service delivery and member satisfaction interact across diverse geographic areas.

These service delivery challenges reflect broader healthcare system constraints, as California continues to experience workforce shortages across clinical and non-clinical positions. This staffing environment, combined with Partnership's significant growth, likely will continue ongoing pressure on appointment availability and service delivery.

Looking ahead, additional external factors may significantly influence member experience. The implementation of H.R.1, the One Big Beautiful Bill Act (HR1) changes are expected to impact Medi-Cal eligibility and coverage transitions, in particular Adults 19 years of age or older. These mandates, coupled with ongoing redetermination processes, could affect how adult members perceive and access healthcare services. As communities navigate these changes, member satisfaction scores may reflect both system-wide adjustments and individual challenges in maintaining continuous care.

For comprehensive analysis of 2024 network capacity and access standards during this expansion period, reference the *NCQA Network Adequacy Assessment Report (NET 3)* or the *2024 Grievance And Appeals Annual Report.*

Summary of FY 2024-2025 Activities and Interventions

The detailed activities for the FY 2024-2025 Organizational Goal 4: Access to Care and Member Experience Improvement is available in Appendix B, while Tables III and XV demonstrate cross-department action focused on interventions.

Organizational Goal #5 | FY 2025-2026

Member Experience

Building on our FY 2024-25 progress, the Member Experience teams will advance our continuous improvement efforts through FY 2025-26, implementing strategic initiatives to address evolving challenges and achieve the key milestones outlined below.

It is important to note that Access to Care interventions will now align under FY 25-26 Organizational Goal 2*: Network Optimization, sponsored by Wendi Davis, Chief Operating Officer. This strategic realignment fosters enhanced collaboration among key operational departments, strengthening our ability to address Access barriers that impact both clinical outcomes and member experience. While Access continues to be measured through CAHPS® performance, this realignment will support improved member experience outcomes through focused organizational goal achievements.

The summary table below includes improvement focus based on the outcome of MY 2024-2025 quantitative, qualitative, causal analysis, and highlights organization priority of member barriers identified through the mentioned Table III.

Table: III

Intervention & Improvement Status	Improvement Focus	Goal Milestone #	Interdepartmental Collaboration		Definitions
			Yes / No	# of Depts.	
Continue	*Access	--	--	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	All	Yes		
New	Health Equity	5			
Continue	Customer Service	All			
Continue	Attitude/Service	1			
Continue	Health Care Rating	All	Yes		
Continue	Health Plan Rating	All			

- **Milestone 1: MX Strike Team | Transportation Services:** The Transportation Department will continue its FY 2024-2025 pilot program, which connects member Grievance and Appeal cases with driver performance to enhance service quality and member satisfaction while developing data-driven improvement targets.
- **Milestone 2: MX Strike Team | Quality Improvement (QI):** The QI Consumer Assessment of Healthcare Providers and Systems (CAHPS®) team will lead the MX Strike Team pilot by leveraging real-time internal influence drivers to identify and address sources of member dissatisfaction (e.g., line staff engagement, causal factors), to enhance service delivery and effectiveness.
- **Milestone 3: Enhancement & Member Education | Member Services (MS):** The MS Department will lead activities to initiate one new initiative to improve member experience (MX) through operational and/or service delivery enhancements.
- **Milestone 4: Enhancement & Member Education | QI CAHPS® Team:**
  The QI CAHPS® team will advance dental coverage initiatives to improve MX through enhanced education, access, and service delivery.
- **Milestone 5: Integration of Health Equity into MX Initiatives** The Population Health Management (PHM) Department, in partnership with the Health Equity (HE) team, will lead collaborative workgroup activities aimed at advancing equitable member engagement and integrating diverse perspectives into the design and delivery of member experience (MX) initiatives. These efforts will reflect our diverse member population's cultural, linguistic, and social needs.

The comprehensive activities and implementation strategy for FY 2024-2025 Organizational Goal 5: Member Experience Goal Statement can be found in Appendix A, which outlines milestone outcomes and deliverables.

MEMBER EXPERIENCE & QUANTITATIVE ANALYSIS

2024-2025 GRAND ANALYSIS

OBJECTIVE

The intent of this report is to meet the requirements of NCQA Standard ME 7 Elements C and D. Its objectives are to assess member experience through Grievance & Appeals data and CAHPS® survey results. Quantitative analyses is conducted by the QI Department and opportunities for improvement are identified and prioritized.

The primary ME 7 report contributors include:

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DEPARTMENT OVERVIEW:

GRIEVANCE AND APPEALS

The Grievance and Appeals (G&A) Department is responsible for the execution of Department of Healthcare Services (DHCS) APL 21-011, also known as the "Final Rule," which mandates that members have a right to report any problem(s) while using their Partnership Medi-Cal plan and Partnership has an obligation to investigate objectively.

The G&A analysts are responsible for investigating, monitoring, and reporting on members' dissatisfaction experiences related to Partnership, health plan delivery, and services provided within a clinical and non-clinical setting. The role G&A serves on behalf of our members is to advocate, mediate, educate, and ensure each member receives high-quality healthcare services across the healthcare continuum. The G&A Department performs quarterly and annual reporting, and, through their analyses, they provide insight into service dissatisfaction. Through continuous monitoring and reporting, the G&A Team makes data-driven decisions to address, improve, and transform member dissatisfaction into innovative system-wide changes with the purpose to improve the overall member experience.

QUALITY IMPROVEMENT | CAHPS® PROGRAM

The Quality Improvement Department - CAHPS® Program manages the contract administration of conducting an annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®) regulated survey, designed and governed by the Agency of Healthcare Research and Quality (AHRQ). The team is also responsible for:

- Leading the ME 7 report production, performing quantitative and qualitative analyses on survey results and other plan delivery data aligned with NCQA Standard ME 7 Elements C and D intended to drive continuous improvement activities and interventions.

- CAHPS® programmatic alignment with two (2) of the five (5) FY 24-25 Organizational Metrics, 1) Achieve a 4.0 Star NCQA Health Plan Rating (HPR), 2) Achieve a 2.5 Star NCQA, Patient Experience (CAHPS®) HPR.
- Presenting annual survey results, HEDIS Quality Compass benchmarks, and NCQA reportable measures.
- Leading goal activities, discussion, and collaboration with program charter members.

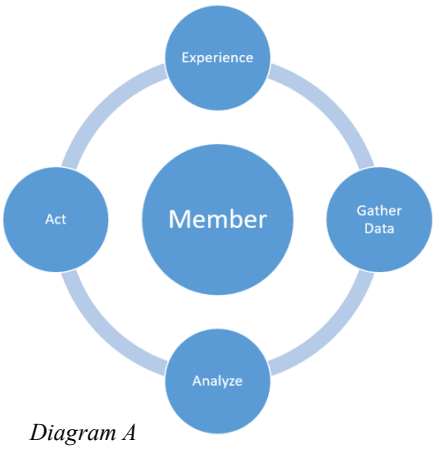


Diagram A

PROGRAM FRAMEWORK

The CAHPS® programmatic framework is rooted in the principles of continuous quality improvement (CQI) and is designed to be member-centered as shown in *Diagram A*, the framework emphasizes listening to member feedback, collecting and analyzing data, and implementing data-driven improvements. These efforts target key drivers of member experience, health outcomes, perceptions of the health plan, and performance scores. The outcomes of this continuous improvement process directly support Partnership's mission and vision.

METHODOLOGY

ANALYSIS WORKGROUP

As noted in the NCQA Standard ME 7 Elements C and D, the health plan is required to conduct a side-by-side annual quantitative and qualitative analysis of our data sources and make recommendations for interventions to ultimately improve our healthcare delivery system and most importantly, overall member experience. Partnership established internal thresholds and benchmarks as a strategy to set realistic goals for underperforming measures.

The QI CAHPS® Team leads ongoing activities and organizational efforts focused on improving CAHPS® score. Partnership relies on various internal and external data sources, including Grievance & Appeals (G&A) reports and CAHPS® results, to elevate member satisfaction and measure the effectiveness of improvement initiatives. The CAHPS® programmatic framework is guided by two (2) key documents: 1) the CAHPS® Program Charter and 2) the Organizational Goal #4 Charter. These documents are used to drive stakeholder commitment, outline specific actions to improve service delivery and member experience, and serve as core communication and strategic guidance tools.

DATA SOURCES

GRIEVANCE AND APPEALS: Partnership utilized NCQA's required data sources, which include G&A reporting and CAHPS® scores. The G&A analysts provided reporting for the period of January 1, 2024, through December 31, 2024, with 2023 data included for trending comparison. It's important to note that multiple reporting categories may apply to a single grievance, appeal, or second-level grievance. Therefore, the metrics presented here reflect the number of concerns expressed by our members during

the reporting periods, rather than unique case counts. In addition, please note that internally, Partnership refers to a member's dispute of a denied grievance as a "Second Level Grievance." For clarity, throughout this document, we will reference appeals as "Appeals" and "Second Level Grievances."

CAHPS® SURVEY: Partnership contracts with NCQA-certified vendor, Press Ganey, to administer the annual regulated survey and provide results of our CAHPS® survey on an annual basis. The CAHPS® regulated survey results are one of several sources used to complete the ME 7 analysis for MY 2024-2025 and include findings from the last two survey cycles (MY 2024 and MY 2023).

DATA MAPPING

GRIEVANCE AND APPEALS: NCQA Standard ME 7 Elements C and D requires organizations to aggregate G&A data into five (5) specific categories; Quality of Care, Quality of Practitioner Office Site, Attitude and Service, Billing/Financial Issues, and Access. Because Partnership's internal categorization is structured to meet DHCS requirements, a cross-departmental team (with representatives from Member Services, Health Services, G&A, Quality Improvement, and Communications) mapped Partnership's reporting categories to align with the five (5) NCQA-required categories.

CAHPS® SURVEY: Partnership reports on the eight (8) CAHPS® NCQA rating and composites measures including: Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service.

THRESHOLDS & BENCHMARKS

As part of the NCQA process and to better evaluate member experience, thresholds and benchmarks have been set to measure our performance.

- GRIEVANCES AND APPEALS
  For each category, a ratio of the number of grievances per 1,000 members is used as a performance metric. Our numerator will be the total amount of Grievances or Appeals/Second Level Grievances for the reporting period, and our denominator will be the monthly average member base of each reporting period. If we see a 10% increase in any of the five (5) categories, it is flagged for discussion based on the number of grievances per 1,000 members.

- CAHPS® SURVEY
  The CAHPS® Team, in collaboration with program charter stakeholders, established methods to measure member satisfaction through continuous monitoring, analysis and targeted improvement activities and interventions. Each year, Partnership evaluates the effectiveness of these improvements using both quantitative and qualitative analysis. To guide this work, Partnership relies on the Healthcare Effectiveness Data and Information Set (HEDIS) Quality Compass benchmarks and internal performance targets.

In addition to the eight (8) NCQA rating and composite summary measures, see Table IV, the CAHPS® program also includes, *How Well Doctors Communicate* as an additional monitoring and performance

measure. The CAHPS® program evaluates measure set performance at or above the 33rd percentile target or better, see Table IV. Summary measures performing below the 33rd percentile target are flagged for review and discussion.

Table: IV

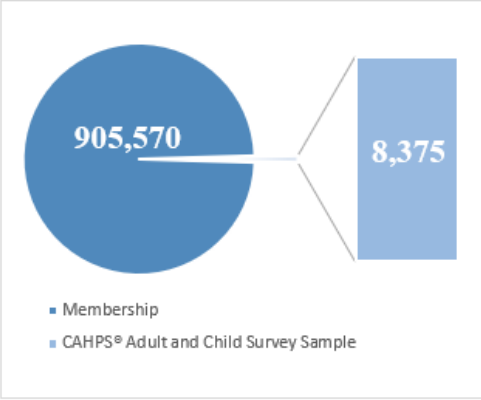
CAHPS® Composite Measures	CAHPS® Program Target
Getting Needed Care	Rating and composite measures ≥ 33rd percentile
Getting Care Quickly	
Getting Care Coordination	
Customer Service	
CAHPS® Rating Measures	
Rating of Health Plan	
Rating of All Health Care	
Rating of Specialist Seen Most Often	
Rating of Personal Doctor	

Survey Methodology

The CAHPS® survey is administered to capture accurate and complete information about HealthPlan member-reported experiences and specifically aims to measure how well plans are meeting member expectations. It also determines which areas of service have the greatest influence on overall member satisfaction and identifies areas of opportunity to improve the quality of care and service delivery.

Survey Sample Size

Survey sample size includes Adult and Children populations based on NCQA member sample frame eligibility requirements. The annual survey results provide a retrospective performance on key NCQA ratings and composite measures. Typically, the regulated survey is conducted in February of each calendar year, and members are asked to share their experiences over the past six (6) months that consists of dates-of-service between the months of July 1st and December 31st of the prior year. Survey questions target member experiences and engagement with a physician, non-emergent clinical setting, health plan, and health plan delivery of covered benefits within Partnership's twenty-four (24) county service area.



Oversample Strategy

In alignment with our county expansion, the QI CAHPS® Team implemented an enhanced oversampling strategy to exceed minimum requirements. For the Adult population, we maintained a 150% oversampling rate, while increasing the Child population rate from 150% to 200%. This strategy helps mitigate the risk of falling below the minimum threshold of 100 survey responses required for core CAHPS®/NCQA scoring measurements. The QI CAHPS® Team has successfully sustained this strategy across multiple survey cycles. As of December 2024, the combined Adult and Child sample size reached 8,375 participants, representing 0.92% of

DHCS-eligible members (905,570). Table V provides a detailed comparison of minimum sample requirements, oversampling percentages, and total sample sizes for each measurement year.

Table: V

Measure Year	Minimum Sample Size	Oversample %	Survey Sample Size		Minimum Sample Size	Oversample %	Survey Sample Size
	Adult				Child		
2024-2025	1,350	150%	3,375		1,650	200%	5,000
2023-2024		150%	2,700			150%	4,125

2024 Annual Assessment of Non-behavioral Healthcare Grievances and Appeals

Grievances | Appeals & Second Level Grievances

The G&A data and quantitative analysis encompass two (2) main components: 1) Grievances and 2) Appeals & Second Level Grievances (SLG). This analysis tracks total cases filed for both current and prior reporting periods, with data stratified across five defined NCQA service categories. Threshold calculations (category/average monthly member base) determine whether each category meets established targets.

The Member Experience Report monitors case volumes across these NCQA categories: Access, Attitude/Service, Billing/Financial, Quality of Care, and Quality of Provider's Office. A 10% increase in any category signals significant change, helping identify trends related to membership growth and case filing patterns.

Performance thresholds for 2024, based on prior year's data, are established for each NCQA category of grievances and appeals. Tables VI and VII provide comprehensive summaries of these annual performance metrics for all member filings throughout the calendar year.

In 2024, a total of 6,149 Grievances and Appeals were closed, as compared to 4,261 in 2023. Of these, Grievances represented 5,477 cases, while Appeals and Second Level Grievances accounted for 672 cases. During this period, membership grew by approximately 33.5%, from 678,546 to 905,570 members.

Table: VI

Grievances Only Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg PHC Mship	Grievances p/1,000	Grievances	Avg PHC Mship	Grievances p/1,000	Threshold	Threshold Met?
Access	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No
Attitude/Service	1,752		2.58	2,569		2.84	2.84	Yes
Billing/Financial	106		0.16	140		0.15	0.17	Yes
Quality of Care	186		0.27	196		0.22	0.30	Yes
Quality of Provider Office	2		0.00	5		0.01	0.00	No
TOTAL	3,572		5.26	5,477		6.05	5.79	No

RESULTS & THRESHOLDS – GRIEVANCES ONLY

The trending data in Table VI above covers annual reporting periods between January 1, 2023, through December 31, 2023, as compared to January 1, 2024, through December 31, 2024.

In 2024, Partnership closed a total of 5,477 grievances, compared to 3,572 in 2023. When adjusted for the membership growth (from 678,546 in 2023 to 905,570 in 2024), the overall grievance rate rose from 5.26 to 6.05 per 1,000 members, exceeding the established threshold of 5.79.

Among the categories, Access and Attitude/Service were the most frequently reported concerns, accounting for 2,567 and 2,569 cases respectively, which together accounted for over 90% of all grievances filed in 2024.

Access and Quality of Provider Office did not meet the established thresholds in 2024. Access-related grievances increased from 2.25 to 2.83 per 1,000 members, while Quality of Provider Office grievances rose slightly from 0.00 to 0.01 per 1,000 members. In contrast, Attitude/Service, Billing/Financial and Quality or Care remained within thresholds.

Transportation-related concerns fall under NCQA Category Attitude/Service. In 2024, member-reported grievances related to transportation, including missed rides, driver arrival times, driver behavior, scheduling issues, and vehicle conditions represented 49% of total cases. In the context of transportation services, Partnership provided 1,166,701 rides in 2024, with transportation-related concerns representing just 0.4% of total rides, down from 0.6% in 2023.

Table: VII

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs. Annual 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Appeals & SLG	Avg PHC Mship	Appeals & SLGs p/1,000	Threshold	Threshold Met?
Access	350	678,546	0.52	442	905,570	0.49	0.57	Yes
Attitude/Service	33		0.05	18		0.02	0.05	Yes
Billing/Financial	297		0.44	211		0.23	0.48	Yes
Quality of Care	9		0.01	1		0.00	0.01	Yes
Quality of Provider Office	0		0.00	0		0.00	0.00	Yes
TOTAL	689		1.02	672		0.74	1.12	Yes

RESULTS & THRESHOLDS – APPEALS & SECOND LEVEL GRIEVANCES

Note: Following 2023 DHCS Audit findings, this analysis represents the final annual reporting period including Second Level Grievances. Effective January 1, 2025, this process will transition to a streamlined appeal system with enhanced member notification and documentation requirements.

The trending data in Table VII above compares annual reporting periods from January 1, 2023, to December 31, 2023, to January 1, 2024, through December 31, 2024.

In 2024, total Appeals and Second Level Grievances decreased from 689 in 2023 to 672 in 2024. Despite the significant membership growth (678,546 to 905,570), the overall rate of cases per 1,000 members decreased from 1.02 to 0.74 in 2024, indicated positive performance.

All categories met their thresholds in 2024. Access and Billing/Financial remained the primary reporting categories, with 442 and 211 cases respectively. Other categories showed lower volumes: Attitude/Service (18 cases), Quality of Care (1 case), and Quality of Provider's Office (0 cases). G&A met all threshold requirements across categories for 2024.

Future reporting periods will likely reflect several changes under APL 21-011, including simplified categorization with the removal of Second Level Grievances, new compliance metrics for notification timelines, potential shifts in case volumes due to the streamlined process, and enhanced monitoring of member communication requirements.

Analysis of NCQA Categories Not Meeting Thresholds

Based on the quantitative data presented in Tables VI and VII, the analysis of MY 2024 grievance data identified two categories exceeding established thresholds, requiring focused barrier analysis:

1. **NCQA Category: Access**
   - G&A Data: Access complaints (2.83 per 1,000 members, exceeding threshold)
     - **Key Focus:** Access and Transportation related issues, collectively representing the highest volume of access-related grievances
   - CAHPS® Data: Getting Needed Care (5th percentile) and Getting Care Quickly (11th percentile)

   Barriers:
   - **Regional Growth Impact**
     - Expansion into 10 new counties resulting in 33% membership growth
   - Limited PCP and specialty provider availability within our rural counties
   - Members reported PCP scheduling challenges and timely appointment availability
   - **Operational Systems Integration**
     - Lack of systematic real-time tracking between transportation complaints and specific drivers
     - Manual complaint management process limiting timely response
     - High volume of trips versus complaints creates challenge in pattern identification and transportation provider management

2. **NCQA Category: Quality of Practitioner Office Site**

- G&A Data: Quality of Provider's Office concerns (Threshold Status: Increased from 0.003 to 0.006 per 1,000 members, exceeding threshold range
    - **Key Focus:** PCP provider office cleanliness

BARRIERS:

- **No barriers identified**
    - 40% of reported cases (2 of 5) could not be validated due to absence of appointment verification
    - Limited sample size (5 cases) affects statistical significance of rate increase
    - Complaint categorization may not accurately reflect actual facility quality issues, as verified cases demonstrated appropriate cleaning protocols

These identified barriers inform our improvement priorities discussed in the Member Experience Overview section and intervention strategies detailed in Appendix A: 2025-2026 Organizational Goal #5.

SUMMARY HIGHLIGHTS

GRIEVANCES AND APPEALS & SECOND LEVEL GRIEVANCES

GRIEVANCES

In 2024, grievances increased in volume with membership growth, reaching 6.05 per 1,000 members and exceeding the 5.79 threshold. Access and Quality of Provider Office did not meet thresholds, while Attitude/Service, Billing/Financial and Quality of Care remained within acceptable limits. Access and Attitude/Service together accounted for the vast majority of grievance cases.

APPEALS & SECOND LEVEL GRIEVANCES

Despite significant membership growth, Appeals and Second Level Grievances decreased slightly to 672 cases, with the overall rate improving from 1.02 in 2023 to 0.74 in 2024 (per thousand members). All categories met threshold requirements.

IDENTIFICATION OF OPPORTUNITIES

- Transportation remains a primary concern, representing 49% of total cases, though the rate of this concern decreased from 0.6% to 0.4% of total rides provided.

GRIEVANCES AND APPEALS BY NCQA CATEGORY

- Access and Attitude/Service continued to account for the majority of grievances.
- Quality of Provider Office cases remain relatively low but did exceed threshold in 2024.
- All other categories met thresholds.

EXPANSION/PLAN CHANGES

- Membership: 33.5% growth from prior year (678,546 to 905,570 members)
- Future Changes: Following DHCS Audit findings, Second Level Grievances will transition to a streamlined appeal process effective January 1, 2025 (APL 21-011).

PLAN PERFORMANCE

The CAHPS® Program evaluates health plan performance using HEDIS® MY 2024 Quality Compass benchmark targets set at the 33rd percentile for both rating and composite measures. The plan benchmark targets differ from NCQA-ratable measures in two key aspects:

1. CAHPS® Rating Measures: The program includes both summary rates (percentage of 9 or 10 responses) and supplemental ratings (percentage of 8, 9, or 10 responses) for team goal-setting activities.
2. NCQA Star Rating Measures: These exclusively use summary rates, consisting of:
   - Percentage of 9 or 10 responses for rating measures
   - Percentage of "Always" or "Usually" responses for composite measures

The CAHPS® survey plan performance for MY 2023-2024 / MY 2024-2025, and comparable analyses are included in each section by population and illustrated within Table VIII and Table IX.

ADULT CAHPS® PLAN PERFORMANCE

The comparison table illustrates Adult CAHPS® survey scores by MY 2023 and MY 2024.

Table: VIII

	ADULT CAHPS Composite	2023-2024 (15.3.% Response Rate) Sample Size 3,375 Total Returns 510	2023 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?	2024-2025 (15.3.% Response Rate) Sample Size 3,375 Total Returns 511	2024 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	68.4%	<5th	PHC ≥ 33rd	No	73.7%	19th	PHC ≥ 33rd	No
	Rating of Health Care (% 8, 9, 10)	66.9%	5th	PHC ≥ 33rd	No	73.9%	35th	PHC ≥ 33rd	Yes
	Rating of Personal Doctor (% 8, 9, 10)	82.8%	51st	PHC ≥ 33rd	Yes	81.3%	30th	PHC ≥ 33rd	No
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.0%	41st	PHC ≥ 33rd	Yes	88.0%	6th	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	74.0%	7th	PHC ≥ 33rd	No	74.5%	5th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	68.1%	<5th	PHC ≥ 33rd	No	74.0%	11th	PHC ≥ 33rd	No
	Care Coordination (% Always or Usually)	78.8%	11th	PHC ≥ 33rd	No	81.3%	9th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	92.6%	48th	PHC ≥ 33rd	Yes	90.6%	8th	PHC ≥ 33rd	No
	Customer Service (% Always or Usually)	87.0%	18th	PHC ≥ 33rd	No	86.5%	12th	PHC ≥ 33rd	No

WHAT CHANGED LAST YEAR (MY2023-MY2024): The CAHPS® survey results reflect changes in member experience across rating and composite measures.

RATING MEASURES

Overall Performance:

- Rating of Health Plan: Increased by 5.3 percentage points (68.4% to 73.7%), below benchmark
- Rating of Health Care: Increased by 7.0 percentage points (66.9% to 73.9%), exceeded benchmark

- Rating of Personal Doctor: Decreased by 1.5 percentage points (82.8% to 81.3%), below benchmark
- Rating of Specialist Seen Most Often: Increased by 7.0 percentage points (81.0% to 88.0%), below benchmark

Benchmark Analysis:

- Health Care ratings exceed the target benchmark.
- The remaining three (3) rating measures remained below benchmark.

COMPOSITE MEASURES

Overall Performance:

- Getting Needed Care increased by 0.5 percentage points (74.0% to 74.5%)
- Getting Care Quickly increased by 5.9 percentage points (68.1% to 74.0%)
- Care Coordination increased by 2.5 percentage points (78.8% to 81.3%)
- Doctor Communication decreased by 2.0 percentage points (92.6% to 90.6%)
- Customer Service decreased by 0.5 percentage points (87.0% to 86.5%)

Benchmark Analysis:

- No composite measures reached benchmark targets

CHILD CAHPS® PLAN PERFORMANCE

The comparison table illustrates Child CAHPS® survey scores by measure years; MY 2023, and MY 2024.

Table: IX

	CHILD CAHPS Composite	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	2023 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?	2024-2025 (15.8% Response Rate) Sample Size 5,000 Total Returns 783	2024 HEDIS Percentile Ranking	Partnership Benchmark Target	Benchmark Target Met?
Rating Measure	Rating of Health Plan (% 8, 9, 10)	86.5%	45th	PHC ≥ 33rd	Yes	86.0%	44th	PHC ≥ 33rd	Yes
	Rating of Health Care (% 8, 9, 10)	76.9%	<5th	PHC ≥ 33rd	No	84.5%	21st	PHC ≥ 33rd	No
	Rating of Personal Doctor (% 8, 9, 10)	89.9%	55th	PHC ≥ 33rd	Yes	91.4%	73rd	PHC ≥ 33rd	Yes
	Rating of Specialist Seen Most Often (% 8, 9, 10)	81.5%	21st	PHC ≥ 33rd	No	85.6%	31st	PHC ≥ 33rd	No
Composite Measure	Getting Needed Care (% Always or Usually)	77.1%	14th	PHC ≥ 33rd	No	77.9%	13th	PHC ≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	78.9%	9th	PHC ≥ 33rd	No	80.0%	13th	PHC ≥ 33rd	No
	How Well Doctors Communicate (% Always or Usually)	93.0%	40th	PHC ≥ 33rd	Yes	93.3%	36th	PHC ≥ 33rd	Yes
	Care Coordination (% Always or Usually)	80.4%	22nd	PHC ≥ 33rd	No	84.7%	52nd	PHC ≥ 33rd	Yes
	Customer Service (% Always or Usually)	91.2%	89th	PHC ≥ 33rd	Yes	90.5%	74th	PHC ≥ 33rd	Yes

WHAT CHANGED LAST YEAR (MY2023-MY2024): The Child CAHPS® survey results demonstrate changes in member experience across rating and composite measures.

RATING MEASURES

Overall Performance:

- Health Plan ratings remained stable with slight decrease of 0.5 percentage points (86.5% to 86.0%), maintaining above benchmark performance.
- Health Care ratings increased by 7.6 percentage points (76.9% to 84.5%).
- Personal Doctor ratings increased by 1.5 percentage points (89.9% to 91.4%), exceeding benchmark target.
- Specialist ratings increased by 4.1 percentage points (81.5% to 85.6%).

Benchmark Analysis:

- Personal Doctor ratings exceeded target at the 73rd percentile.
- Health Plan ratings maintained above benchmark at the 44th percentile.
- Two (2) rating measures remained below benchmark.

COMPOSITE MEASURES

Overall Performance:

- Getting Needed Care increased by 0.8 percentage points (77.1% to 77.9%).
- Getting Care Quickly increased by 1.1 percentage points (78.9% to 80.0%).
- How Well Doctors Communicate increased by 0.3 percentage points (93.0% to 93.3%), maintaining above benchmark.
- Care Coordination increased by 4.3 percentage points (80.4% to 84.7%), achieving benchmark target.
- Customer Service decreased slightly by 0.7 percentage points (91.2% to 90.5%), maintaining strong performance.

Benchmark Analysis:

- Three (3) measures exceeded benchmark: Customer Service (74th percentile), Care Coordination (52nd percentile), and How Well Doctors Communicate (36th percentile).
- Two (2) measures remained below benchmark targets.

COVID IMPACT ANALYSIS MY2020-MY2024

The COVID era triggered sharply divergent trends in CAHPS® Health Plan and Health Care performance. While Child measures show marked improvements in key ratings, Adult measures reveal substantial declines, particularly in access to care. This stark contrast, observed during the expansion beyond our original 14-county service area, illuminates the varying impact of COVID-era changes across populations.

KEY FINDINGS:

ADULT POPULATION

Most significant declines in access measures:

- Specialist appointments (**-10.6** points)
- Routine care access (**-9.4** points)
- Care coordination (**-7.3** points)

Areas of stability/improvement:

- Health Plan ratings (**+0.9** points)
- Doctor Communication (**+0.1** points)
- Customer Service (**+0.9** points)

CHILD POPULATION

Areas of significant improvement:

- Specialist ratings (**+10.2** points)
- Personal Doctor ratings (**+7.4** points)
- Health Plan ratings (**+5.8** points)

Persistent challenges:

- Routine care access (**-6.3** points)
- Getting needed care (**-2.8** points)

NCQA HEALTH PLAN RATING: CAHPS® PATIENT EXPERIENCE PERFORMANCE QUANTITATIVE ANALYSIS

The NCQA Health Plan Rating (HPR) methodology evaluates plan performance through a comprehensive scoring system that combines CAHPS® patient experience measures (weighted at 25%) and HEDIS® clinical quality measures (weighted at 75%).

This analysis focuses on the CAHPS® component, examining summary rates that reflect members' experiences with their health plan and healthcare services, as detailed in Tables X and XI for Adult and Child populations, respectively.

Summary rates, as defined by NCQA's HEDIS 2024 CAHPS® 5.1H guidelines, represent the percentage of most favorable responses:

- Rating Measures: Percentage of members rating 9 or 10 on a 0-10 scale
- Composite Measures: Percentage of members responding "Always" or "Usually"

Star ratings are assigned based on percentile distributions of plan performance:

- 5 Stars: ≥90th percentile
- 4 Stars: 75th to 89th percentile
- 3 Stars: 50th to 74th percentile
- 2 Stars: 25th to 49th percentile
- 1 Star: <25th percentile

Composite measure star ratings (such as Getting Care) represent weighted averages of their component questions, with statistical significance of year-over-year changes factored into trend analysis. Final Patient Experience ratings are calculated by averaging the star ratings across all CAHPS® measures, with results rounded to the nearest half-star.

The following analysis examines three-year trends across key domains using MY 2024 data and percentiles for commercial, Medicaid HEDIS/CAHPS®, and Medicare HEDIS measures. Table X presents Adult HEDIS/CAHPS® measures, while Table XI details Child HEDIS/CAHPS® measures, both evaluated against national benchmarks. These tables provide comprehensive trending of summary rates from RY 2023 through RY 2025, along with year-over-year comparisons and estimated star ratings.

Table: X

ADULT HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend					
Patient Experience	RY 2023	RY 2024	RY 2025	RY 24 | RY 25 Comparison	MY 2024 Estimated Star Rating
	Summary Rate Performance				
Getting Care					**1.5**
Getting Needed Care (% Always or Usually)	76.4%	74.0%	74.5%	**0.5%**	1
Getting Care Quickly (% Always or Usually)	69.5%	68.1%	74.0%	**5.9%**	2
Satisfaction with Plan Physicians					**2**
Rating of Personal Doctor (% 9 + 10)	66.9%	70.0%	65.7%	**-4.3%**	2
Satisfaction with Plan and Plan Services					**2.5**
Rating of Health Plan (% 9 + 10)	56.8%	54.4%	55.8%	**1.4%**	2
Rating of Health Care (% 9 + 10)	55.7%	46.3%	55.4%	**9.1%**	3

ADULT NOTABLE FINDINGS FOR RY 2025

- Adult oversampling strategy contributed to meeting the 100-survey response threshold for all NCQA Reportable measures.
- RY 2025 Patient Experience Star Rating Estimate: 2.0, ***showing improvement from prior year.***
- Getting Care (% Always or Usually): ***Mixed performance in Access measures with notable improvement in Getting Care Quickly***
    - Getting Needed Care - Slight improvement of +0.5% compared to RY 2024
    - Getting Care Quickly - Significant improvement of +5.9% compared to RY 2024
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Notable decline of -4.3% compared to RY 2024
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Modest improvement of +1.4% compared to RY 2024
    - Rating of Health Care - Significant improvement of +9.1% compared to RY 2024

Table: XI

CHILD HEDIS/CAHPS® Measures Required for Health Plan Accreditation Quality Compass Reporting Year Summary Rate Trend					
Patient Experience	**RY 2023**	**RY 2024**	**RY 2025**	**RY 24 | RY 25 Comparison**	**MY 2024 Estimated Star Rating**
	Summary Rate Performance				
Getting Care					**2**
Getting Needed Care (% Always or Usually)	76.7%	77.0%	77.9%	0.9%	2
Getting Care Quickly (% Always or Usually)	76.3%	78.9%	80.0%	1.1%	2
Satisfaction with Plan Physicians					**4**
Rating of Personal Doctor (% 9+10)	74.4%	75.5%	78.6%	3.1%	4
Satisfaction with Plan and Plan Services					**2.5**
Rating of Health Plan (% 9 + 10)	68.0%	68.1%	72.9%	4.8%	3
Rating of Health Care (% 9 + 10)	64.2%	58.8%	66.4%	7.6%	2

CHILD NOTABLE FINDINGS FOR RY 2025:

- Child oversampling strategy contributed to meeting the 100-survey response threshold for all NCQA reportable measures.
- RY 2025 Patient Experience Star Rating Estimate: 2.8, ***showing continued improvement from prior year.***
- Getting Care (% Always or Usually): ***Consistent improvement in Access measures continues to positively impact overall satisfaction***
    - Getting Needed Care - Modest improvement of +0.9% compared to RY 2024
    - Getting Care Quickly - Continued improvement of +1.1% compared to RY 2024
- Satisfaction with Plan Physicians (% 9+10):
    - Rating of Personal Doctor - Strong improvement of +3.1% compared to RY 2024, achieving 4-star performance
- Satisfaction with Plan and Plan Services (% 9 + 10):
    - Rating of Health Plan - Significant improvement of +4.8% compared to RY 2024
    - Rating of Health Care - Substantial improvement of +7.6% compared to RY 2024

ANALYSIS OF CAHPS® MEMBER EXPERIENCE BARRIERS

The analysis of barriers impacting CAHPS® performance below benchmark draws from comprehensive causal analysis detailed throughout this report. Key findings from our examination of root causes include:

Adult Population Measures

- **Getting Needed Care (5th percentile)**
  Root causes analyzed in Service Delivery Impact and Member Feedback sections include:
  - Network adequacy challenges during expansion period
  - Workforce constraints affecting appointment availability
  - Transportation coordination barriers (49% of member feedback)
  - Regional healthcare delivery system adaptations
- **Getting Care Quickly (11th percentile)**
  Primary barriers identified through member experience analysis include:
  - Clinical workforce shortages across service regions
  - System adaptation challenges in expanded counties
  - Service delivery constraints detailed in Network Assessment
- **Customer Service (12th percentile)**
  Causal factors examined in Service Delivery sections include:
  - Service system adaptation needs during expansion
  - Regional variation in service delivery
  - Resource allocation challenges across expanded territory

Child Population Measures

- **Getting Needed Care and Getting Care Quickly (13th percentile)**
  Root causes identified through Health Equity and Service Delivery analysis include:
  - Regional variations in pediatric service availability
  - Healthcare workforce distribution challenges
  - Service delivery adaptation needs in expansion areas
  - Cultural and linguistic service coordination requirements

For detailed discussion of these barriers and their impacts, refer to Service Delivery Impact, Member Feedback, and Health Equity analysis sections. These identified root causes inform improvement strategies detailed in Appendix A: 2025-2026 Organizational Goal #5.

HEALTH EQUITY AND MEMBER EXPERIENCE QUANTITATIVE ANALYSIS

Member Experience at Partnership integrates two (2) important frameworks that inform our approach to equitable healthcare delivery. Our Member Experience assessment incorporates HE CAHPS® survey data and Culturally and Linguistically Appropriate Services (CLAS) supplemental questions to assess plan and interpreter service experiences. The survey results provide insights into how members feel about our healthcare and service delivery.

The CAHPS® survey captures members' direct feedback on access, communication, and satisfaction, while our NCQA (HE 6) CLAS standards implementation ensures culturally responsive care delivery across provider and plan touchpoints.

Together, these measures support our successful NCQA Health Equity (HE 6) accreditation, demonstrating our systematic approach to reducing health disparities and improving care quality for all members.

MY 2024 Survey Response Analysis

Partnership's annual CAHPS® Adult and Child Surveys provide critical insights into member experiences and representation across our diverse populations. The data reveals significant variations in both demographic participation and satisfaction with services.

Demographic Representation

The surveys show marked differences in participation across populations. Hispanic/Latino representation is notably stronger in child surveys (68.6%) compared to adult surveys (42.7%). White respondents comprise the majority in both surveys (adult: 65.0%, child: 62.8%), highlighting persistent gaps in representation from other racial and ethnic groups.

Asian members represent 12.0% of adult responses and 10% of child responses, while Black/African American members show higher participation in child surveys (8.1%) compared to adult surveys (5.3%). American Indian/Alaska Native participation is similar across both populations (adult: 7.2%, child: 6.5%), and Native Hawaiian/Pacific Islander members maintain consistent but low representation (adult: 2.3%, child: 2.2%).

Language Services Experience

Members utilizing interpreter services reported varying experiences between provider interactions and health plan services. In adult surveys, 68.6% gave top ratings (9-10) to interpreter services during provider visits, while 58.1% gave similar high ratings to health plan interpreter services. This 10.5 percentage point difference suggests more effective communication through interpreters during direct provider interactions.

Families using interpreter services for their children's healthcare reported higher satisfaction overall. Top ratings for interpreter services reached 78.8% for provider visits and 74.7% for health plan interactions. While families still rated provider interpreter services more favorably, the gap between provider and plan services was smaller (4.1 percentage points) than in the adult population.

Notable Findings for RY 2025

1. Demographic Representation
    - Stronger Hispanic/Latino engagement in child surveys
    - Consistent underrepresentation of most communities of color in both surveys
    - Similar participation patterns across most racial groups between adult and child populations

2. Language Services
    - Consistently higher satisfaction with provider interpreter services compared to health plan services

- Notably higher satisfaction rates in pediatric settings
- Substantial gap between adult and child populations' experiences (16.6 percentage points higher for child survey respondents with health plan services)

These findings suggest opportunities for improving both member representation and language access services, particularly in adult services where satisfaction rates lag behind pediatric care. The data points to the need for targeted strategies to enhance engagement across all demographic groups while strengthening language support services, especially at the health plan level.

For detailed insights into our health equity achievements and opportunities, please refer to the NCQA Health Equity (HE 6) Grand Analysis Report. This integrated assessment framework allows us to identify gaps, implement targeted improvements, and measure the impact of our health equity initiatives across our expanded service area.

APPENDIX

MEMBER EXPERIENCE

APPENDIX A

APPENDIX OVERVIEW

This appendix outlines the FY 25/26 Member Experience organizational goals and their implementation framework. These goals are strategically designed to address identified member barriers through comprehensive data analysis, including CAHPS® Survey results and other member experience metrics. The status tracking system detailed in Table III demonstrates our systematic approach to monitoring interventions and improvements across departments.

Each milestone within Goal 5 directly corresponds to specific improvement focuses identified through member experience analysis, ensuring a coordinated approach to addressing member barriers through interdepartmental collaboration.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	*Access	--	--	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	All	Yes		
New	Health Equity	5			
Continue	Customer Service	All			
Continue	Attitude/Service	1			
Continue	Health Care Rating	All	Yes		
Continue	Health Plan Rating	All			

**Access priority aligns with Org. Goal #2: Network Optimization*

FY 25/26 ORGANIZATIONAL GOAL 5: MEMBER EXPERIENCE

Goal 5: Member Experience	
GOAL OWNER:	Isaac Brown, Director of Quality and Performance
GOAL SPONSOR:	Dr. Robert Moore, Chief Medical Officer
GOAL LEAD:	Anthony Sackett, Program Manager II

Goal Statement
The goal for Member Experience in FY 25-26 is to drive meaningful improvements in member satisfaction by fostering collaboration across departments, boosting CAHPS® scores, embedding Health Equity into member experience initiatives, and enhancing overall quality.

Milestones	
Milestone 1 – MX Strike Team | Transportation Services: The Transportation Department will continue its FY 2024-2025 pilot program, which connects member Grievance and Appeal cases with driver performance to enhance service quality and member satisfaction while developing data-driven improvement targets. **Outcome(s)/Deliverable(s):** • Design and implement one (1) operational pilot improvement initiative • Establish specific ridership improvement targets based on NCQA quality measures • Complete the full PDSA (Plan-Do-Study-Act) cycle with comprehensive analysis	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No
Milestone 2 – MX Strike Team | Quality Improvement (QI): The QI Consumer Assessment of Healthcare Providers and Systems (CAHPS®) team will lead the MX Strike Team pilot by leveraging real-time internal influence drivers to identify and address sources of member dissatisfaction (e.g., line staff engagement, causal factors), to enhance service delivery and effectiveness. **Outcome(s)/Deliverable(s):** • Develop recommendations and implement proposed improvements based on the outcome of root cause analysis and PDSA results.	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☐ Yes ☒ No
Milestone 3 – Enhancement & Member Education | Member Services (MS): The MS Department will lead activities to initiate one new initiative to improve member experience (MX) through operational and/or service delivery enhancements. **Outcome(s)/Deliverable(s):** • Implement and measure the impact of the new MX-focused initiative through defined metrics. (i.e. member satisfaction scores, reduced inquiries about covered benefits, or other indicators).	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No
Milestone 4 – Enhancement & Member Education | QI CAHPS® Team: The QI CAHPS® team will advance dental coverage initiatives to improve MX through enhanced education, access, and service delivery. **Outcomes/Deliverables:**	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No

• Measure and report on implementation progress using defined metrics for dental service utilization and member dental awareness	
Milestone 5 – Integration of Health Equity into MX Initiatives: The Population Health Management (PHM) Department, in partnership with the Health Equity (HE) team, will lead collaborative work group activities aimed at advancing equitable member engagement and integrating diverse perspectives into the design and delivery of member experience (MX) initiatives. These efforts will reflect our diverse member population's cultural, linguistic, and social needs. **Outcomes/Deliverables:** • Co-develop at least three (3) improvement strategies and actionable interventions/initiatives that incorporate member-informed health equity perspectives into the evaluation and enhancement of MX initiatives. • Implement at least two (2) developed strategies to improve visibility into barriers to care and service delivery.	**Target Completion Date:** June 30, 2026 **Required Milestone?** ☒ Yes ☐ No

APPENDIX B

APPENDIX OVERVIEW

This appendix documents FY 2024-2025's Goal 4 achievements and improvement tracking methodology. Through Table III's systematic status indicators and comprehensive milestone outcomes, it demonstrates Partnership's continuous improvement journey in member experience and access to care. The completed initiatives, strategic realignment, and ACAP CAHPS® Collaborative findings established the foundation for FY 2025-2026's Goal 5 initiatives, ensuring sustained progress in member experience enhancement.

Table: III

INTERVENTION & IMPROVEMENT STATUS	IMPROVEMENT FOCUS	GOAL MILESTONE #	INTERDEPARTMENTAL COLLABORATION		DEFINITIONS
			YES / NO	# OF DEPTS.	
Continue	Access	1,2	Yes	4	• **Adjust:** a lean approach or pivot. A continued focus and intent. • **Continue:** a continuation of intervention or improvement activity and focus. • **Maintain:** score or intervention met. • **Monitor:** intervention or improvement assessment period. • **New:** a new action or intervention.
Continue	Member Experience	2,3,4,5,6,7	Yes		
Continue	Customer Service	3,8			
Continue	Attitude/Service	3,5			
Continue	Health Care Rating	1,2,4,5,6,7	Yes		
Continue	Health Plan Rating	All	Yes		

2024-2025 ORGANIZATION GOAL #4

Goal 4: Access to Care and Member Experience Improvement. The Access to Care/Member Experience Improvement organizational goal will focus on three (3) main areas:

1. Understanding the landscape of our specialty provider network, identifying gaps, and developing targeted action plans
2. Understanding the landscape of our primary care provider network, identifying gaps, and developing targeted action plans
3. Expanding the "Your Partner in Health" branding campaign and implementing an action plan to improve and increase member awareness

CAHPS® SCORE IMPROVEMENT (CSI) PARTICIPANTS

The FY 2024-2025 QI Department CSI Goal cross-department workgroup participants illustrate organization-wide participants involved in a multi-disciplinary approach focused on improvement activities and strategic CSI planning during the reporting and evaluation period, Table: XII.

Table: XII

ORG. GOAL 4: ACCESS TO CARE AND MEMBER EXPERIENCE IMPROVEMENT	
WORKGROUP PARTICIPANTS	**DEPARTMENT | NAME**
GOAL CO-SPONSORS: DR. ROBERT MOORE *CHIEF MEDICAL OFFICER* WENDI DAVIS *CHIEF OPERATING OFFICER* **GOAL CO-OWNERS:** DAVID LAVINE *ASSOC. DIRECTOR OF WORKFORCE DEVELOPMENT* DUSTIN LYDA *DIRECTOR OF COMMUNICATIONS* **GOAL LEAD:** ANTHONY SACKETT *PROGRAM MANAGER II*	**COMMUNICATIONS:** Dustin Lyda, Amanda Bernal
	FINANCE HEALTH ANALYTICS: Liat Vaisenberg, Dejene Bikila, Shivani Sivasankar
	GRIEVANCE & APPEALS: Kory Watkins, Latrice Innes
	HEALTH EQUITY: Dr. Jalloh
	HR/WORKFORCE DEVELOPMENT: Cody Thompson, Arielle Tello
	IT WEB APPS TEAM: Shankar Reddy
	MEMBER SERVICES: Edna Villasenor, Maria Cabera, Melissa Shumann, Ryan Ciulla
	POPULATION HEALTH MANAGEMENT: Monika Brunkal, Nicole Curreri, Ruth Hood
	PROVIDER RELATIONS: Ledra Guillory, Garnet Booth, Stephanie Nakatani
	QI: Andrea Thomas, Amy McCune, Athena Beltran-Nampraseut, Barb Selig, Isaac Brown,
	TRANSPORTATION SERVICES: Melissa McCartney, Michelle Mootz, Brandi Walker

Goal Overview and Impact Summary

Improving access to care and enhancing member experience are pivotal for fostering a healthcare system that prioritizes both quality and member experience.

The CAHPS® regulated survey measures adult and child (member/patient) experience or perception of key aspects of their care. As an accredited health plan, we may designate which CAHPS® survey we want scored, either adult or child population. Last measure year, we chose child survey results that earned us 2.0 Patient Experience (CAHPS®) rating and an overall NCQA 3.5 Star Health Plan rating. This measure year, Partnership designated adult survey results to be included in the scoring.

This fiscal year Partnership aims to achieve or exceed a 2.5 Star NCQA Patient Experience (CAHPS®) rating and achieve or exceed a 4.0 Star NCQA Health Plan rating. The Goal #4 Team will continue to build on the prior year's interventions and improvement activities. The established FY 2024-2025 goals are intended to impact or influence positive change on the key focus areas:

Access to Care: Improving access to care serves as the gateway to improve patient/member experience and health outcomes. As an organization, Partnership must plan to navigate through access obstacles linked to ever-changing membership levels, clinical staffing shortages, and economic climate at state, county and federal levels. Over the next fiscal goal period, our plan is to broaden our approach with the

stewardship of Workforce Development leadership. In scope is to incorporate the past four (4) years of implemented access improvements and lessons learned through the 5-Star Quality Strategic and Tactical Plans, and, where applicable, adjust them as we develop a comprehensive Access Strategy and Tactical Plan fully dedicated to access moving forward.

Member Experience: Advancing the Quality Improvement (QI) CAHPS® programmatic framework will require implementing interventions rooted in present barriers and before eligible members participate in the regulated CAHPS® survey. Lessons learned through CSI activities over the past two (2) fiscal goal periods have paved the path forward. The plan is to leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide Goal #4 Team more real-time opportunities to measure intervention effectiveness against targeted barriers.

Positive Reputation and Brand Identity: Continue to distinguish Partnership as a Managed Care Plan leader that is committed to member-centered care, leading to a positive reputation and member awareness, "our story" within the communities we serve.

Effective Communication: Enhance member communication through texting, email, and Partnership mobile application designed to centralize and simplify all member-facing online websites/tools/platforms. This will help drive usability and value by engaging members through various communication modalities in delivering proactive resources that promote health education, covered benefits literacy, wellness, and preventative care resources.

Member Engagement and Adherence: Empower members with knowledge and resources intended to lead to greater engagement in their own care and increased adherence to treatment plans, resulting in better long-term health outcomes.

Enhanced Digital Experience: Develop a user-friendly mobile app and enhance member portal functionality and methods to empower members to self-serve and inform Partnership how they would prefer to engage with us. The plan is to build upon member demographic collection integration through existing C-Square enhancements.

ORGANIZATIONAL GOAL #4 | FY 2024-2025 OUTCOMES

Below are the milestone outcomes for the Access and Member Experience workgroups, organized sequentially and showing requirement status and goal completion.

Final Goal Status		
☒ **Goal Completed at Full Credit**	☐ Goal Completed at Partial Credit	☐ Goal Not Completed

Milestone 1: Access Strategy Development

The Access Workgroup successfully completed Milestone 1 of developing a comprehensive multi-year Access Strategy for specialty and primary care provider networks. Key accomplishments included creating a strategic framework with defined metrics, implementing advanced network visualization tools, and engaging 15 departments through 22 stakeholder interviews. The team delivered technical solutions including provider exit scoring, network gap analysis tools, and enhanced data reporting capabilities. The strategy incorporated critical elements such as workforce retention, telehealth integration, health equity, and transportation services, while establishing the foundation for tactical implementation in Milestone 2. This milestone met all requirements for framework development, stakeholder validation, and technical infrastructure establishment.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 2: Access Tactical Plan

The Access Workgroup successfully executed Milestone 2 by developing a comprehensive tactical plan for improving specialty and primary care network access. Through extensive stakeholder engagement across eight (8) key departments, the team produced a detailed multi-year implementation framework with defined timelines and success metrics. Key deliverables included a Provider Gap Analysis Tool, resource allocation framework, and integration strategies for existing services. The plan incorporated lessons from existing quality initiatives while addressing critical implementation factors such as staff capacity, technological infrastructure, and community partnerships. This milestone successfully established the operational blueprint for enhancing provider network accessibility.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 3: Member Experience Improvement Strike Team

The Member Experience Workgroup successfully implemented the CAHPS® Score Improvement (CSI) initiative through a Strike-Team approach, focusing on transportation services and benefit awareness enhancement. Key achievements included implementing Kinetik trip tracking, analyzing 154 grievances, and establishing NCQA-aligned incident thresholds for transportation services. The team strengthened benefit awareness through comprehensive staff training, enhanced communication channels, and strategic partnerships, particularly with DHCS's Smile, California program. Significant improvements were made in data analysis, G&A reporting, and cross-departmental collaboration, resulting in enhanced member service delivery and monitoring capabilities. The milestone exceeded original deliverables across stakeholder engagement, operational enhancement, data analysis, transportation provider accountability, and system-wide benefit awareness.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 4a: Digital Platform Enhancements

The Member Experience Workgroup completed preliminary planning for digital communication enhancements through the Member Portal platform. While the team successfully completed initial requirements gathering, system testing, and stakeholder engagement for sexual orientation and gender identity (SOGI) data collection and Community Advisory Committee (CAC), application integration, implementation has been strategically postponed to align with the upcoming HRP/JIVA platform launch.

Key preparatory work included C2 platform testing, SOGI module development, and CAC application framework design. This milestone established the technical groundwork and documentation necessary for future implementation while ensuring seamless integration with the new HRP system.

Required Milestone: ☑ No ☐ **Status:** Not Complete

Milestone 4b: Mobile Application Assessment

The Member Experience Workgroup completed a comprehensive assessment for Partnership's mobile application initiative through extensive stakeholder engagement and strategic analysis. The team gathered valuable insights from Family Advisory Committee (FAC), CAC, and Member Services, resulting in a detailed operational assessment framework and requirements inventory. Key deliverables included developing vendor evaluation criteria, establishing feature prioritization methodology, and creating implementation recommendations based on member feedback. This milestone successfully laid the groundwork for mobile application development by aligning stakeholder needs with operational feasibility and integration requirements.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 5: Member Informative Session (MIS) Program

The Member Experience Workgroup successfully established the Member Informative Session (MIS) program framework, securing both executive approval and resources for regional implementation. Key achievements included creating five (5) new positions (4 Member Engagement Specialists and 1 CAC Coordinator), developing partnerships across 24 counties, and implementing a comprehensive cross-departmental collaboration system. The team completed the initial phase by staffing four (4) regional offices (Fairfield, Redding, Auburn, and Chico) and establishing the infrastructure for 48 annual sessions. The milestone delivered a scalable framework for future expansion to Eureka and Santa Rosa offices, supported by robust event tracking systems and sustainable budget planning.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 6: Text Messaging Program Implementation

The Member Experience Workgroup successfully implemented Year 1 of the text messaging program, establishing comprehensive infrastructure, and launching multiple targeted campaigns. The team created a cross-departmental texting workgroup, developed operational parameters, and successfully executed campaigns reaching approximately 100,000 members with remarkably low opt-out rates (0.013%). Notable achievements included rapid emergency response deployment for the Park Fire, implementation of the Welcome Campaign, and execution of multiple health initiative campaigns across three (3) quarters. The program established robust KPI tracking mechanisms and demonstrated operational success through high delivery rates and engagement metrics. This milestone created a scalable foundation for future messaging campaigns while proving the effectiveness of text-based member communication.

Required Milestone: ☑ Yes **Status:** ☑ Completed

Milestone 7: Partnership Awareness Communications Strategy

The Member Experience Workgroup launched the "Your Partner in Health" branding campaign, establishing a comprehensive grassroots communications strategy. Working with NKE Strategies, the

team developed and secured executive approval for a Strategic Communications Plan focused on community-centered messaging. Key achievements included creating targeted messaging for Congressional visits, advancing immigration-focused communications, and establishing a grassroots engagement framework. The milestone successfully delivered messaging architecture and presentation materials while laying the groundwork for Year One implementation. With strategic planning and executive approval phases completed, the initiative is positioned to move into active implementation.
Required Milestone: ☐ No **Status:** ☑ Completed

Milestone 8: CAHPS® Integration Strategy
The Member Experience Workgroup successfully established an integrated approach to patient experience measurement by connecting clinic-level CG-CAHPS® with health plan CAHPS® scoring. Working with the Quality Improvement Pay-for-Performance team, the group developed unified measurement standards and specific improvement targets, which were successfully incorporated into the 2025 PCP specifications. Key achievements included gaining Technical Work Group consensus on measure modifications, creating comprehensive resource documentation, and establishing clear connections between provider and health plan performance metrics. The milestone completed all planned implementation steps through July 2024, positioning the program for ongoing stakeholder education and support.
Required Milestone: ☑ Yes **Status:** ☑ Completed

LESSONS LEARNED

ACAP CAHPS® Collaborative: Year 2 Summary
The CAHPS® Team partnered with 10 sister plans through the Association for Community Affiliated Plans (ACAP) CAHPS® Collaborative to improve survey performance and member experience.

KEY INITIATIVES AND FINDINGS

1. Member Experience Projects: The cornerstone of our work was knowledge sharing between sister plans. Through collaboration, we developed solutions to optimize access to care, enhance needed care scores, and streamline durable medical equipment access.

2. Health Plan Operational Assessment: Our operational assessment uncovered key insights about structure and performance. Through systematic evaluation, we identified organizational strengths in quality metrics and cross-functional collaboration, while noting opportunities to enhance member contact systems, provider experience, and regional access consistency. Priority improvement areas emerged in pharmacy services, healthcare access, and transportation.

3. Enhanced Engagement: To facilitate ongoing learning and collaboration, the team implemented monthly "Office Hours" sessions. These forums proved value by offering real-time problem-solving and best practice sharing among peer organizations.

4. Benefit Literacy Initiative: Perhaps the most significant finding from our MY 2023/RY 2024 surveys was the widespread challenge in benefit comprehension. The most common areas of confusion included transportation, vision, behavioral health, and dental services. This discovery prompted a series of targeted interventions in FY 24/25, including.

- **Targeted Interventions:**
    - **Transportation:** Improved tracking tools, data analysis, and alignment with NCQA standards.
    - **Dental:** Formed a dedicated work group, expanded member education, and planned outreach events.
    - **Organizational Support:** Increased staff training, multilingual communication efforts, and digital engagement strategies.

LOOKING AHEAD

The initiatives implemented through this collaborative have laid a strong foundation for continued improvement in member experience. The combination of structural changes, enhanced communication channels, and targeted service improvements positions us to better serve our member population. Moving forward, we will continue to monitor these initiatives' effectiveness and adapt our strategies based on member feedback and performance measures.

FY 24-25 ORG. GOAL CONCLUSION

The FY 2024–2025 Quality Improvement Evaluation reflects Partnership's continued commitment to advancing member experience, access to care, and health outcomes through data-driven, cross-functional collaboration. This year's findings reaffirm the importance of listening to member voices—whether through survey results, grievances, or community engagement—and translating those insights into targeted, meaningful action.

Despite challenges such as workforce shortages, regional access disparities, and growing member needs, the organization has made measurable progress. Improvements in provider ratings and select CAHPS® measures, alongside successful interventions in benefit literacy, transportation, and dental access, underscore the impact of our collective efforts.

Looking ahead, Partnership remains focused on equity, responsiveness, and continuous learning. The insights gained from this evaluation will shape the next cycle of strategic priorities, with an emphasis on sustained improvement, community trust, and alignment with our organizational mission to help the members of our communities be healthy.

2024 Member Experience Outcomes

Presented by

Anthony Sackett, QI CAHPS® Program Manager II



Agenda

- The ***Consumer Assessment of Healthcare Providers and Systems*** (CAHPS®) Survey
- Review of MY2024 / RY2025 CAHPS® Survey Results
- Active listening -- what members are saying
- Member Experience Outcomes / Interventions
- Q&A

QI CAHPS® Program Framework

Retrospective



Active Listening



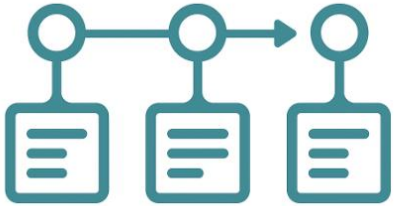
Analysis / Interventions



Member Experience Improvement

CAHPS® Survey





Survey period: February - May

Mixed survey methodology:

- ✓ Mailers
- ✓ Online
- ✓ QR codes
- ✓ Phone

Using any number from 0 to 10, what number would you use to rate your child's health plan?

Rating Questions:

- Rating of all healthcare
- Rating of personal doctor
- Rating of specialist seen most often
- Rating of health plan

Composite Questio

- Getting care quickly
- Getting needed care
- Customer service
- **How well doctors communicate**

Did your doctor:
1. Explain things well
2. Listen carefully
3. Show respect
4. Spend enough time with you

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

CAHPS® Performance

Measure Year 2024 / Report Year 2025
CAHPS® CHILD Survey Results

Patient Experience | CHILD Measure Year 2024 | Reporting Year 2025							
CAHPS Summary Rates	Reporting Year(s)			HEDIS | NCQA Quality Compass Benchmarks			
Survey Domains	2023	2024	2025	10th	33rd	66th	90th
Getting Care (Usually + Always)							
Getting Needed Care	76.7%	77.1%	77.9%	76.8%	81.1%	85.7%	89.4%
Getting Care Quickly	76.3%	78.9%	80.0%	78.9%	84.6%	89.4%	92.1%
Satisfaction with Plan Physicians (9 + 10)							
Rating of Personal Doctor	74.4%	75.5%	78.6%	70.7%	74.4%	78.5%	82.6%
Satisfaction with Health Plan Services (9 + 10)							
Rating of Health Care	64.2%	58.9%	66.4%	62.3%	67.5%	71.9%	76.3%
Rating of Health Plan	68.0%	68.1%	72.9%	64.0%	69.0%	73.8%	78.2%

Measure Year 2024 / Report Year 2025
CAHPS® CHILD Survey Results

Patient Experience | CHILD Measure Year 2024 | Reporting Year 2025							
CAHPS Summary Rates	Reporting Year(s)			HEDIS | NCQA Quality Compass Benchmarks			
	2023	2024	2025	10th	33rd	66th	90th
Influencing Measures							
Rating of Specialist	69.5%	63.8%	73.8%	64.0%	72.0%	74.6%	80.5%
Coordination of Care	81.1%	80.4%	84.7%	76.8%	82.2%	85.7%	89.1%
How Well Doctors Communicate	92.7%	93.0%	93.3%	90.5%	93.0%	95.1%	96.5%
Customer Service	89.9%	91.2%	90.5%	84.2%	87.3%	89.9%	92.2%

Measure Year 2024 / Report Year 2025
CAHPS® ADULT Survey Results

Patient Experience | ADULT Measure Year 2024 | Reporting Year 2025							
CAHPS Summary Rates	**Reporting Year(s)**			**HEDIS | NCQA Quality Compass Benchmarks**			
Survey Domains	**2023**	**2024**	**2025**	**10th**	**33rd**	**66th**	**90th**
Getting Care (Usually + Always)							
Getting Needed Care	76.4%	74.0%	74.5%	75.5%	79.8%	83.7%	86.1%
Getting Care Quickly	69.5%	68.1%	74.0%	73.3%	78.8%	83.0%	86.4%
Satisfaction with Plan Physicians (9 + 10)							
Rating of Personal Doctor	66.9%	70.0%	65.7%	63.0%	67.3%	71.1%	74.4%
Satisfaction with Health Plan Services (9 + 10)							
Rating of Health Care	55.7%	46.3%	55.4%	50.0%	55.1%	59.5%	63.4%
Rating of Health Plan	56.8%	54.5%	55.8%	53.4%	59.4%	64.1%	68.5%

Measure Year 2024 / Report Year 2025
CAHPS® ADULT Survey Results

Patient Experience | ADULT Measure Year 2024 | Reporting Year 2025							
CAHPS Summary Rates	Reporting Year(s)			HEDIS | NCQA Quality Compass Benchmarks			
	2023	2024	2025	10th	33rd	66th	90th
Influencing Measures							
Rating of Specialist	64.4%	69.5%	70.3%	62.2%	65.1%	69.8%	74.0%
Coordination of Care	86.6%	78.8%	81.3%	81.4%	83.6%	86.7%	90.6%
How Well Doctors Communicate	92.9%	92.6%	90.6%	90.7%	92.2%	93.8%	95.6%
Customer Service	88.6%	87.0%	86.5%	86.5%	87.9%	90.2%	92.0%

Key Population Insights



- CHILD | GCQ, GNC
- CHILD | Personal Doctor
- CHILD | Health Plan, Health Care
- CHILD | Influence Measures

Voices of Our Newest Members



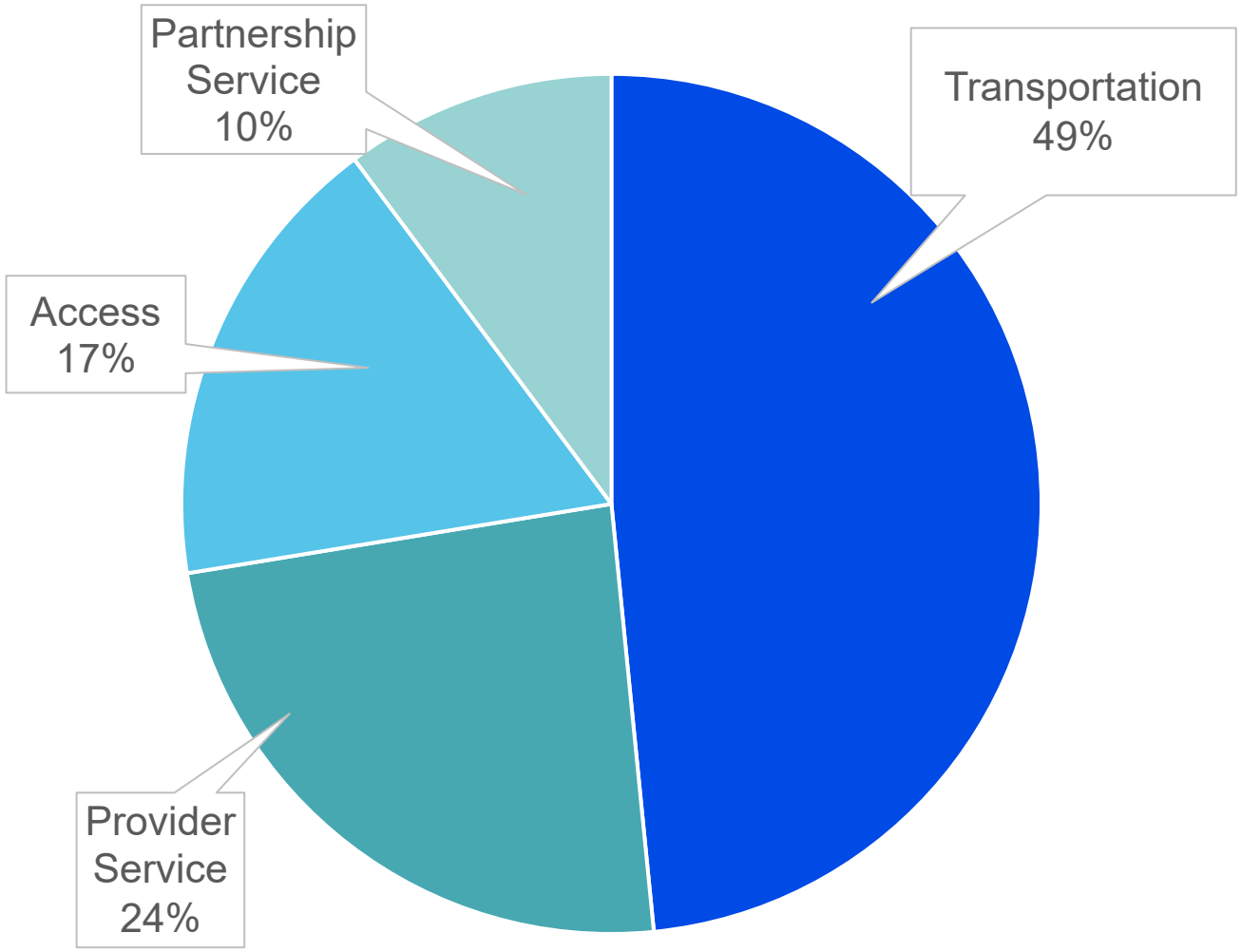
- Nearly 30% participation
- Auburn Region
- Chico Region

Active Listening

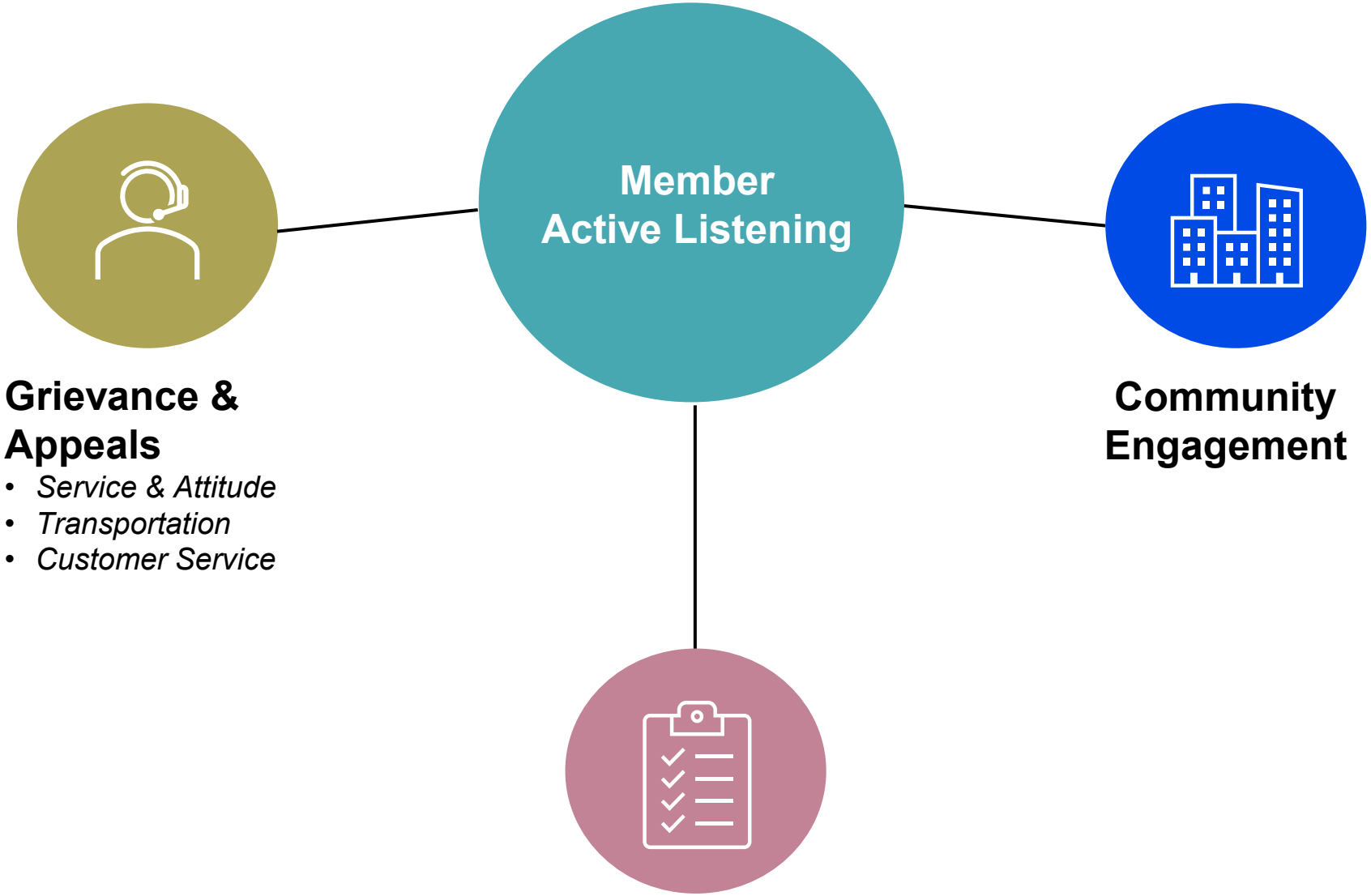




Top Grievance Concerns by Category



Comprehensive Approach



Process Improvement



Organizational Goals

FY 2024 - 25 Goal 4
Access to Care & Member Experience Improvement

- Access Strategy & Tactical Plans
- Member Experience Improvement Strike Team
- Digital Platform Enhancements
- Mobile Application Assessment
- Member Informative Session Program
- Text Messaging Program Implementation
- Partnership Awareness Communications Strategy

FY 2025 - 26 Goal 5
Member Experience Improvement

- Strike Team Pilot Continuation
  - Benefit Literacy – Top Four
- Member Service Improvement
- Dental Focus
- Integration of Health Equity

NETWORK ADEQUACY REPORT

ASSESSMENT OF NETWORK ADEQUACY

NET 3, ELEMENT A, B: ASSESSMENT OF MEMBER EXPERIENCE ACCESSING THE NETWORK & OPPORTUNITIES TO IMPROVE ACCESS TO NON-BEHAVIORAL HEALTHCARE SERVICES

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Section 1: Objective

The purpose of this report is to evaluate all aspects of data related to Network Adequacy to ensure Partnership HealthPlan of California (Partnership) provides members with adequate network access for needed healthcare services. The provider types covered include primary care clinicians, medical specialists, and hospitals. Partnership follows the NCQA Network Management Standard requirements, and this report will present those findings.

Partnership HealthPlan of California (PARTNERSHIP) is a managed Medi-Cal Health Plan in Northern California. PARTNERSHIP expanded from 14 counties in 2023 to 24 counties in 2024. Our service area is divided into 6 regions with 13 counties designated as rural, 7 designated as small, and 4 designated as medium by DHCS.

Utilizing access data from our current network, this report evaluates and summarizes the following:

- Member Grievance (Complaints) appeals and member experience about network adequacy for non-behavioral healthcare services from ME7: Element C and D.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results from the ME 7 report.
- Utilization of out-of-network services.
- Practitioner Availability summarized results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in (Net 1 Element A Cultural Needs and Preferences).
- High Volume and High Impact specialty geographic distribution and Practitioner Ratios (NET 1 Practitioner Availability of Services - Elements B and C).
- Routine Primary Care, Urgent Care, Non- Urgent Specialty Care Practitioner (NET 2 - Accessibility of Services - Elements A and C).
- Analysis from factors 1-3 to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.

The Network Services Manager of Compliance, Associate Directory of Workforce Development, and the Workforce Development Liaison, are responsible for conducting and summarizing the qualitative analysis.

The report is reviewed and approved by a multi-disciplinary team made up of the Chief Medical Officer, Senior Director of Provider Relations, Senior Director of Member Services, Director of Grievance and Appeals, Senior Director of Quality and Performance HS Quality Improvement, Network Services Director, Network Services Manager of Compliance, and Network Services Compliance Program Managers.

Opportunities for improvement are identified by the Chief Medical Officer, Associate Director of Workforce Development, and the Workforce Development Liaison. Decisions and actions are reviewed and approved by the Quality Committee.

Section 2: Methodology

The following data sources were used to evaluate Network Adequacy:

***MEMBER GRIEVANCE*:** From the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. Grievance category used was “access”, which includes all grievances related to appointment access or availability within the network.

MEMBER APPEALS: Member appeals and second level grievances data.

2023-2024 CAHPS: Survey results from the ME 7 report for Adult and Child.

***OUT OF NETWORK (OON) REQUEST/REFERRAL AND UTILIZATION*:** Partnership has two distinct types of members, Direct and Non-Direct. For Non-Direct Members, a request for a referral to see an OON specialist must be submitted and prior authorization (approval) are required prior to seeing the specialist. Direct Members do not need to submit a request for a referral or receive prior authorization (approval) before seeing an OON specialist. The ability of Direct Members to self-refer accounts for the number of OON requests and approved referrals being lower than the number of OON claims. Claims data is pulled to determine utilization. Out of network request and claims are analyzed per 1, 000 members. Requests and claims counts are analyzed at the Plan level.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES): Partnership collects data every year on language, culture and ethnicity/race of our members and compares the data against practitioners to determine if there is adequate practitioner coverage to meet our members’ needs. Member Ethnicity/Race – all self-reported member race/ethnicity is identified and assessed against provider ethnicity/race. Provider Ethnicity/Race – data from the Medical Board of California's Physician Survey of allopathic physicians and surgeons (licensees) is to analyze practitioner ethnicity/race. Member Grievance Reports: data is collected and analyzed for member concerns regarding discrimination and linguistic needs. Cultural Preference is assessed utilizing the Health Education and Cultural and Linguistic Population Needs Assessment (PNA). The PNA investigates member health status and behavior, cultural and linguistic needs, community health education and cultural and linguistic programs and resources, health disparities, and gaps in services.

PRACTITIONER AVAILABILITY: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS):

Partnership obtained data for contracted primary care, high volume, and high impact specialties from our Data Warehouse which then populates Quest Analytics software to evaluate geographic distribution compared to our established geographic standards set forth in policy (MPNET 100) that were in effect at the time of production. Additionally, practitioner ratios were evaluated for primary

care, high volume, and high-impact specialty practitioners. The analysis is based on a comparison to our established standards.

PRACTITIONER ACCESSIBILITY: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE):

The Third Next Available (3NA) survey is a cross-sectional, one-time call during business hours, to provider offices, to evaluate access. This survey is used to evaluate primary care and high volume/high impact specialty appointment access using the following performance standards:

Routine Primary Care Appointments	**< 10 Business Days of Request**
Prenatal Care Appointments	**< 10 Business Days of Request**
Newborn Appointments	**< 48 hours of Discharge of Request**
Urgent Care Appointments	**< 48 hours of Request of Request**
Non-Urgent Specialty Care Appointments	**< 15 Business Days of Request**

The survey is administered by Partnership's provider relations staff annually during the months of February and March and includes all PCP sites and identified high volume/high impact specialists that meet a set threshold of 200 unique member visits a year. The 2022 3NA surveyed 254 primary-care provider sites, 255 specialty provider sites, and 110 prenatal provider sites. Partnership's Well-managed benchmark analysis to evaluate specialty use trends within our network.

Member Grievances: from the full volume of member grievances evaluated annually, this analysis includes a subset of those grievances that are specifically focused on network adequacy or access to care. The grievance category is used as the "access" category, which includes all grievances related to appointment access for primary care and specialty care providers. Grievance data utilized for the analysis is data from January 1, 2023, through December 31, 2023.

***BEHAVIORAL HEALTH PRACTITIONER AVAILABILITY AND ACCESSIBILITY*:** Behavioral health data is analyzed in the Annual Behavioral Health Report. Additionally, Carelon Health Options is Partnership's delegated entity, and are NCQA accredited.

Section 3: Quantitative Analysis:

MEMBER GRIEVANCES:

TOTAL ACCESS MEMBER GRIEVANCES:

The trending data includes reporting periods; January 1, 2024 – December 31, 2024, and the previous year, January 1, 2023 – December 31, 2023.

In 2024, there were a total of 5,477 grievances submitted by our members. The analysis attributes 42% of all cases to Access.

In comparison to the 2023 reporting period, there were a total of 3,572 grievances submitted by our members. The analysis attributes 43% of all cases to Access.

Grievances Only Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg Mship	Grievances p/1,000	Grievances	Avg Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No

- **Notable Findings:** Partnership did not meet the established 2.47 grievances per 1,000 member threshold, having 2.83 grievances per 1,000 members in 2024. This number represented an increase in grievances per 1,000 members when compared to the 2.25 grievances per 1,000 members in 2023.

MEMBER APPEALS:

The trending data includes reporting periods; January 1, 2023 – December 31, 2023, and the previous year, January 1, 2022 – December 31, 2022.

In 2024, the health plan received 674 Appeals and Second Level Grievance cases, a 2% decrease in case filings from 2023, with Access contributing 34% of the total.

In comparison to the 2023 reporting period, the health plan received a total of 689 Appeals and Second Level Grievances cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	350	678,546	0.52	442	905,570	0.49	0.57	Yes

Notable Findings: Partnership met the access Appeals and Second Level Grievances threshold for 2024.

There were 6,149 Grievances, Second Level Grievances, and Appeals closed in 2024 compared to 4,261 in 2023. These cases are broken into two (2) groups – Grievances accounted for 5,477 and Appeals and Second Level Grievances accounted for 672.

Our membership experienced a 33.5% growth, rising from 678,546 in 2023 to 905,570 members in 2024. Alongside our membership increase, there was a rise in Grievances received in 2024, leading to an increase in access related Grievances filed per 1,000 members from 2.25 to 2.83. We saw a decrease in the number of Appeals and Second Level Grievances filed in 2024.

With an increase in membership and a 28.5% increase in Grievances filed, three thresholds for Grievances were not met, one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed ride issues.

Partnership was able to meet the minimum threshold for Appeals & SLGs regardless of a 31% increase from 2023. The total number of cases filed per 1,000 members decreased from 0.52 to 0.49 and was well within the threshold.

In 2023, DHCS eliminated Second Level Grievance as a case type. Effective January 1, 2025, the process was replaced with the appeal process to satisfy DHCS guidelines.

PRIMARY CARE ACCESS MEMBER GRIEVANCE

Partnership analyzes total access grievances by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Partnership had 14 counties and two distinct regions in 2023

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Northern	29	0	0	30
Southern	51	1	8	60
Totals	81	1	8	90

Partnership had 24 counties and six distinct regions in 2024

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	18	0	4	22
Chico	23	1	2	26
Eureka	13	0	2	15
Fairfield	65	0	13	78
Redding	18	1	4	23
Santa Rosa	17	0	2	19
Totals	154	2	27	183

The threshold for review is based on the total number of grievances of two or more in any one category and a rate of 4/1000 members.

Primary Care Access Grievance Data (January 1, 2024 – December 31, 2024)								
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**Total Members Assigned to Provider**	**Rate per 1000 Members**
Auburn	Placer	Wellspace Health Roseville	3			3	7,985	0.37
Chico	Butte	Ampla Health Chico Medical & Pediatric	3			3	15,536	0.19
Fairfield	Solano	Jayesh Patel, MD			3	3	927	3.31
Fairfield	Solano	Solano County Health & Social Service	7			7	31,098	0.23
Redding	Shasta	Shasta Community Health Center	2		1	3	18,773	0.16

Member Complaints Primary Care (Everest Data, 2024)

Notable findings: In 2024, the access to primary care member complaints increased from 90 to 183. The increase is not surprising with the inclusion of 10 new counties. Appointment availability remains the most common type of grievance.

- Jayesh Patel, MD had the highest telephone availability grievances and a rate of 3.31 per 1000 members. However, the rating is within the standard and requires no further action.
- Solano County Health and Social Service had the most grievances in appointment availability as well as overall. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is currently required.

A trend could not be established due to the low number of member grievances over the course of a year. No further action is currently required.

SPECIALTY CARE MEMBER GRIEVANCE:

Partnership analyzes total access complaints by region and practitioner group to determine if there are access trends. Grievance data utilized for the analysis is for the calendar year, January 1st - December 31st.

Partnership had 14 counties and two distinct regions in 2023

Region	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**
Northern	2			2
Southern	2			2
Totals	4			4

Member Complaints Specialty Care (Everest Data, 2023)

Partnership had 24 counties and six distinct regions in 2024

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	2			2
Chico	6			6
Eureka	1			1
Fairfield	4			4
Redding	2			2
Santa Rosa	1			1
Totals	16			16

Member Complaints Specialty Care (Everest Data, 2024)

The threshold for review is based on the total number of grievances of two or more in any one category.

Specialty Care Access Grievance Data (January 1, 2024 – December 31, 2024)							
Region	**County**	**Provider Name**	**Appt. Availability**	**Office Availability**	**Telephone Availability**	**Total**	**High Volume or High Impact Specialty**
Chico	**Butte**	Ampla Health Chico Medical	**2**			**2**	**High Volume Specialty** Pediatrics
Santa Rosa	**Sonoma**	Santa Rosa Orthopedic Medical Group	**2**			**2**	**High Volume Specialty** Physical Therapy
Santa Rosa	**Sonoma**	Santa Rosa Orthopedic Medical Group	**2**			**2**	**High Volume Specialty** Orthopedic Surgery

Specialty Care Access Grievance Data (Everest, 2024)

Notable findings: In 2024, the access to specialty care member complaints increased from 4 to 16. The increase is not surprising with the inclusion of 10 new counties. Appointment availability remains the most common type of grievance. Twelve high-volume specialties had one appointment complaint each for the reporting year and two had two appointment complaints.

- Ampla Health: Despite having two grievances for appointment availability, Ampla was within appointment standards with the 3NA survey. A trend could not be established. No further action is currently required.
- Santa Rosa Orthopedic: Despite having two grievances for appointment availability in physical therapy and orthopedic surgery, Santa Rosa Orthopedic was within the standards with the 3NA survey. A trend could not be established. No further action is currently required.

CULTURAL, ETHNIC, RACIAL, LGBTQ+ DISCRIMINATION GRIEVANCES

Partnership looks at network adequacy for issues pertaining to race, ethnicity, and language to ensure practitioners are meeting member needs. This report identifies member-reported grievances

which are classified into four discrimination categories which include: Cultural, Ethnic, Racial, and LGBTQ+. For Language grievances, we identify language discrimination and language barriers.

The table below outlines the summary of discrimination grievances for 2023

Discrimination Grievances (January 1, 2023 - December 31, 2023)							
Region	County	Provider	Specialty	Discrimination Grievances			
				CE&R Discrim	Language Discrim	Language Barrier	LGBTQ+ Discrim
South	Mendocino	Adventist Health Ukiah Valley	Nutrition Services	1	0	0	0
South	Solano	DaVita Dialysis - Napa	Renal Dialysis Clinic	1	0	0	0
South	Lake	Elhakim, Samer MD	Family Medicine	0	1	0	0
South	Solano	La Clinica - Vallejo	Pediatrics	1	0	0	0
South	Mendocino	North Coast Family Health Center-Clinic	Pain Management	1	0	0	0
South	Solano	Solano County Health & Social Services	Internal Medicine	1	0	0	0
South	Solano	Sutter Medical Foundation	Orthopedic Surgery	0	1	0	0
South	Sonoma	Sutter Medical Group of the Redwoods	General Surgery	0	1	0	0
South	Solano	Sutter Solano Medical Center	General Medicine	1	0	0	0
South	Marin	Marin Health Network	ENT (Family Practice)	0	1	0	0
South	Solano	Vacaville Urgent Care Medical Group	Urgent Care	1	0	0	0
North	Shasta	Fletscher, Walter Lyle, MD	Cardiovascular Disease/Internal Medicine	0	1	0	0
North	Lassen	Lassen Indian Health Center	Family Practice	2	0	0	0
North	Shasta	Mercy Medical Center-Redding	Emergency Medicine	0	1	0	0
North	Trinity	Meredith, Randall John, MD	Family Medicine	0	0	0	1
North	Shasta	Shasta Regional Medical Center	Psychiatry	0	2	0	0
North	Humboldt	Southern Humboldt Community Clinic	Family Practice	0	0	1	0

Source: 2023 Discrimination Grievances Data: 1Q24 Grievance and Appeals PULSE Report

The table below outlines the summary of discrimination grievances for 2024. The 2023 categories of language and language barrier were combined into one category of linguistic.

Discrimination Grievances (January 1, 2024 - December 31, 2024)						
Region	County	Provider	Specialty	Discrimination Grievances		
				CE&R	Linguistic	LGBTQ+
Auburn	Placer	Baird, Rowan Chantel MD	Family Medicine		1	
Auburn	Placer	Jahangir Mahmoudi, MD	Endocrinology	1		
Chico	Yuba	Angeli Duran, MD	Internal Medicine	1		
Chico	Butte	Enloe General & Colorectal Surgery	Multi-Specialty Group		1	
Fairfield	Solano	Bay Area Ortho Surgery	Orthopedic Surgery		1	
Fairfield	Solano	Rashid Iqbal Gastro Office	Gastroenterology	1		
Redding	Siskiyou	Nicholas Schulack, DO	Emergency Medicine	1		
Redding	Shasta	Hill Country – Center of Hope	Family Medicine		1	
Redding	Shasta	Lassen Medical Center-Red Bluff	Family Medicine			1

Source: 2024 Discrimination Grievances Data: 1Q25 Grievance and Appeals PULSE Report

- **Notable Findings:** The most common reported problem was alleged discrimination due to race or ethnicity. The second most common was alleged discrimination due to language. All concerns were addressed by the usual grievance process. Further action is not required.

  An examination of discrimination cases from 2023 to 2024 showed a significant reduction of 47%. This decline is particularly noteworthy given the overall year-over-year increase of 28.5% in total grievance cases. This follows the same pattern from 2022 to 2023.

  One contributing factor to this decline could be attributed to our comprehensive approach in handling cases of alleged discrimination. Upon identifying instances where discrimination is likely to have occurred by a provider, G&A initiates a proactive measure of implementing a Soft-Warning Letter aimed at fostering awareness and corrective action within the provider community. These letters serve as a formal communication channel providing educational resources that are tailored to assist in understanding and implementing practices that promote inclusiveness and prevent discrimination against our members.

2022- 2023 CAHPS Composite Scores:

CAHPS Results from ME7 Report: Adult Response

Below is a year-by-year comparison of the Composite scores for measurement year 2022 and measurement year 2023 for the Adult Survey. In Year 2023-2024, we received 130 more complete surveys than in Year FY 2022-2023. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th percentile for measurement period 2023-2024.

	ADULT CAHPS Composite	2022-2023 (14.3% Response Rate) Sample Size 2700 Total Returns 380	2022 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?	2023-2024 (15.3% Response Rate) Sample Size 2700 Total Returns 510	2023 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	76.4%	14th	≥ 25th	No	74.0%	7th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	69.5%	5th	≥ 25th	No	68.1%	<5th	≥ 33rd	No

Notable Findings: The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark.

The Adult survey response relative to Partnership covered members indicates we continue to have dissatisfaction with member access which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures and Rating of Health Plan would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2024-2025.

CAHPS Results from ME7 Report: Child Response

Below is a year-by-year comparison of the Composite scores for measurement year 2022 and measurement year 2023 for the Child Survey. In Year 2023-2024, we received 48 more complete surveys than in Year FY 2022-2023. All questions met the 100 sample size criteria for both measurement periods. The CAHPS program raised the plan performance benchmark to the 33rd percentile from the 25th.

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Rate	Partnership Benchmark	Benchmark Met?	2022-2023 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?
Composite	Getting Needed Care (% Always or Usually)	76.7%	10th	≥ 25th	No	77.1%	14th	≥ 33rd	No

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Rate	Partnership Benchmark	Benchmark Met?	2022-2023 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?
	Getting Care Quickly (% Always or Usually)	76.3%	<5th	≥ 25th	No	78.9%	9th	≥ 33rd	No

- **Notable Findings:** The Child composite score for Getting Needed Care increased from 76.7% to 77.1% and Getting Care Quickly increased from 76.3% to 78.9%. However, both measures failed to meet the benchmark.

  The Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2024-2025.

QUALITATIVE ANALYSIS FOR MEMBER SATISFACTION: GRIEVANCE, APPEALS, AND CAHPS

The healthcare system in California and throughout the country has continued to grapple with workforce shortages for both clinical and non-clinical staff. This has resulted in greater difficulty in obtaining timely appointments. Access and Attitude/Service remain the most frequently reported concerns. In 2023, there were two cases related to the Quality of a Provider's Office, while in 2024, this number increased to five cases. Members reported 181 concerns against their primary care provider (PCP) or provider's office staff regarding access to appointments in person or by phone, compared to 139 in 2023. Members expressed dissatisfaction with long wait times for appointments, difficulties in reaching staff when calling, a lack of return calls from providers, and instances where providers refused to see them.

The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field, and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

• **COUNTY EXPANSION - HEALTHPLAN GROWTH:** In January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.

• **REGIONAL SERVICE DISRUPTION:** In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

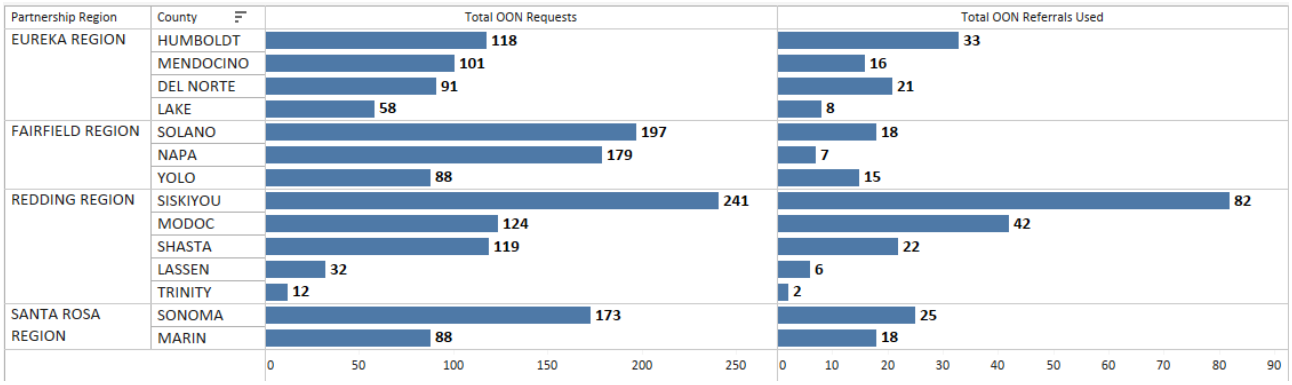
Barriers identified: Partnership is aware there is a national and regional shortage of clinical professionals and aging clinical professionals retiring. The fluctuation of Access measure performance identified coupled with performance not improving to pre-COVID, indicates inconsistency with access to care and service delivery.

Out-of-Network Requests:

The out of network requests per 1,000 members' threshold is less than or equal to 20. The Threshold for out of network utilization is less than or equal to 10 per 1,000 members.

Partnership had 14 counties in 2023.

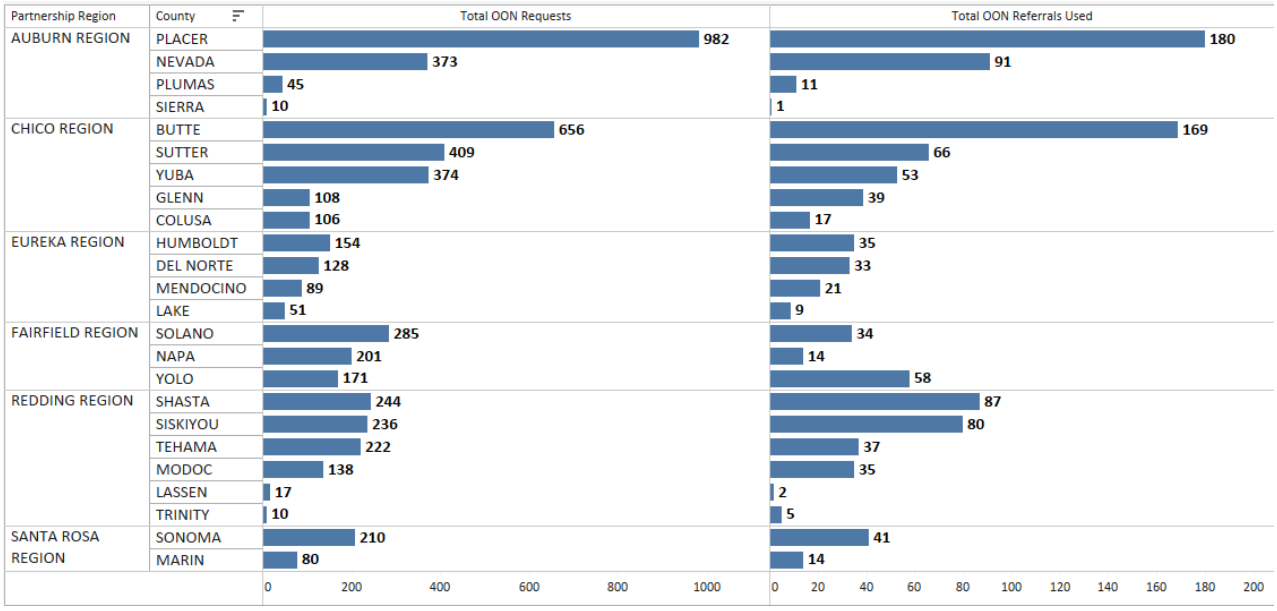
	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	147,060	229,942	108,230	178,592	663,824
Total OON Requests	368	464	528	261	1,621
OON Requests per 1,000 Members	2.5	2.0	4.9	1.5	2.4
Approved OON Requests	163	296	374	110	943
Approved OON Requests per 1,000 M..	1.1	1.3	3.5	0.6	1.4
Denied OON Requests	205	168	154	151	678
Denied OON Requests per 1,000 Members	1.4	0.7	1.4	0.8	1.0
Total OON Referrals Used	78	40	154	43	315
Total OON Claims	525	323	802	253	1,903
OON Claims per 1,000 Members	3.6	1.4	7.4	1.4	3
Approved OON Claims	383	226	671	145	1,425
% Approved OON Claims	73.0%	70.0%	83.7%	57.3%	74.9%
Denied OON Claims	142	97	131	108	478
% Denied OON Claims	27.0%	30.0%	16.3%	42.7%	25.1%



Notable findings: For the period of January 2023 – December 2023, Partnership met performance goals for requests and utilization.

Partnership had 24 counties in 2024

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	95,974	189,666	146,315	183,081	133,122	158,709	906,867
Total OON Requests	1,410	1,653	422	657	867	290	5,299
OON Requests per 1,000 Members	14.7	8.7	2.9	3.6	6.5	1.8	5.8
Approved OON Requests	996	1,089	268	508	672	166	3,699
Approved OON Requests per 1,000 M..	10.4	5.7	1.8	2.8	5.0	1.0	4.1
Denied OON Requests	414	564	154	149	195	124	1,600
Denied OON Requests per 1,000 Members	4.3	3.0	1.1	0.8	1.5	0.8	1.8
Total OON Referrals Used	283	344	98	106	246	55	1,132
Total OON Claims	1,546	1,341	538	466	1,426	339	5,656
OON Claims per 1,000 Members	16.1	7.1	3.7	2.5	10.7	2.1	6
Approved OON Claims	1,126	1,075	322	386	729	219	3,857
% Approved OON Claims	72.8%	80.2%	59.9%	82.8%	51.1%	64.6%	68.2%
Denied OON Claims	420	266	216	80	697	120	1,799
% Denied OON Claims	27.2%	19.8%	40.1%	17.2%	48.9%	35.4%	31.8%



Notable findings: For the period of January 2024 – December 2024, Partnership met performance goals for requests and utilization.

The number of OON Requests increased from 1,621 in 2023, to 5,299 in 2024. The number of OON Claims increased from 1,903 in 2023, to 5,656 in 2024. An increase was expected due to the addition of 10 counties to the service area.

January 2023 – December 2023:

Requests: Partnership met the goal of less than 20 per 1,000 members for requests. Out of the 1,621 OON Requests submitted (2.4 per 1,000 members) in 2023, 943 (58%) were approved and 678 (42%) of requests were denied. The counties with the highest number of requests included Solano County with 12%, Siskiyou County with 15%, and Sonoma County with 11%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied.

Utilization: There was 1,903 OON Claims submitted (3 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. Of the 1,902 OON Claims submitted, 1,425 (75%) were approved and 478 (25%) were denied. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. Of the 943 approved requests Plan wide, 315 (33%) were used. The three specialties with the highest OON requests included: Cardiovascular Disease/Internal Medicine with 48% of requests used, Gastroenterology with 15% of requests used, and Rheumatology with 44% of requests used. Analysis of data on paid claims did not reveal additional insights related to the practitioner network.

January 2024 – December 2024:

Requests: As a plan, Partnership met the goal of less than 20 per 1,000 members for requests. Out of 5,299 OON Referral submitted (5.8 per 1,000 members) in 2024, 3,699 (70%) were approved. The counties with the highest number of requests included Placer County with 19%, Butte County with 12%, and Sutter County with 8%. Some requests were due to excessive appointment wait times or excessive driving distance, and approvals were allocated in those instances. Where services were available in network, those requests were denied. Of the 5,299 requests submitted, 1,600 (30%) of requests were denied.

Utilization: There was 5,656 OON Claims submitted (6 per 1,000 members) meeting the 10 or less per 1,000 members performance goal for utilization. This appears to demonstrate that authorization review processes are effectively identifying and redirecting out-of-network requests to qualified in-network providers and practitioners. The three specialties with the highest OON requests included: Oncology/Hematology with 48% of requests used, Dermatology with 7% of requests used, and Optometry with only .8% of requests used. Of the 5,656 OON Claims submitted, 3,857 (68%) were approved and 1,799 (32%) were denied. Of the 3,699 approved requests Plan wide, 1,132 (31%) were used. A closer look at the Auburn Region shows that Placer County had the highest

utilization with the total OON Claims per 1.000 members at 17.7. The most requested referral was Gastroenterology with 3.7% being Out of Network.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT A: CULTURAL AND LINGUISTIC NEEDS AND PREFERENCES)

Availability standards and detailed analysis are provided in the annual Network Adequacy Report Availability of Practitioners reports. For this grand analysis, we have summarized the results for practitioner ethnicity/race to member ethnicity/race data and provider to member ratio for the top three threshold languages identified in 2024. Practitioner to member ratios and geographic distribution data for primary care, high volume specialties, and high impact specialties.

ETHNICITY/RACE COMPARISON:

Partnership collects race and ethnicity information on both members and practitioners. However, the collection of that information is voluntary. Since Partnership implemented the collection of race and ethnicity information through the credentialing process, the voluntary disclosure of that information has been very low with the majority of practitioners declining to answer leaving the organization with an incomplete and non-useful data set. In order to get an idea of what the race/ethnicity comparison is in our network, Partnership utilized the information gathered by the Medical Board of California for physicians licensed in the counties we serve.

The table below summarizes our findings in 2023

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report				
Race/Ethnicity	**PHC Members 686,844**	**Physician 14,283**	**Physician to Member Ratio**	**Goal 1:2000**
White	37.5%	60.97%	1:30	Met
Hispanic	30.9%	7.62%	1:195	Met
Other	11.1%	2.01%	1:265	Met
Unknown	8.8%	2.01%	1:199	Met
Black	5.3%	4.44%	1:50	Met
Native American	2.2%	1.17%	1:90	Met
Filipino	1.8%	4.52%	1:15	Met
Asian/Pacific Islander	1.0%	1.17%	1:27	Met
Asian Indian	0.8%	6.37%	1:6	Met
Vietnamese	0.6%	1.42%	1:21	Met

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Amysis Data, April 2023 / Medical Board of California Data, June 2021)

- **Notable Finding:** The self-reported ethnicity/race comparison indications plan wide we met our ratio performance goal of 1:2000

The table below summarizes our findings in 2024

PHC Member Data Ethnicity/Race Percentages to Physician/Surgeon Ethnicity/Race Percentages and Ratio Report				
Race/Ethnicity	**PHC Members 902,734**	**Physician 14,608**	**Physician to Member Ratio**	**Goal 1:2000**
White	39.1%	60.97%	1:40	Met
Hispanic	33.6%	7.62%	1:272	Met
Other	4.4%	2.01%	1:135	Met
Unknown	13.3%	2.01%	1:408	Met
Black	3.6%	4.44%	1:50	Met
Native American	1.8%	1.17%	1:95	Met
Asian	2.5%	4.52%	1:34	Met
Asian Indian	1.5%	1.17%	1:79	Met
Native Hawaiian or other Pacific Islander	0.2%	6.37%	1:2	Met

PHC Member Data Ethnicity/Race Comparison Analysis to Physician/Surgeon Ethnicity/Race (Tableau Data, June 2024 / Medical Board of California Data, June 2021)

- **Notable Findings:** The self-reported ethnicity/race comparison indicates that plan-wide we met our ratio performance goal of 1:2000.

Partnership Assessing Practitioner and Member Language:

Partnership has applied a general standard for PCP to member ratio, which is 1:500 for all threshold languages to establish a point of comparison. The standard is considered compliant if the member to provider ratio is less than 1:500 for each threshold language. For this study, we will look at Partnership 's top three (3) threshold languages, which are Spanish, Tagalog, and Russian.

The following table summarizes our findings for 2023

Practitioner Language					
Threshold Language	**Provider**	**Member**	**2023 Ratio**	**Performance Goal**	**Goal Met?**
Spanish	360	135,827	1:377	1:500	Met
Tagalog	71	3,269	1:46	1:500	Met
Russian	29	2,205	1:76	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, April 2023)

The following table summarizes our findings for 2024

Practitioner Language					
Threshold Language	Provider	Member	2023 Ratio	Performance Goal	Goal Met?
Spanish	1943	186,842	1:96	1:500	Met
Tagalog	113	2,319	1:21	1:500	Met
Russian	80	5,237	1:65	1:500	Met

Practitioner Language to Member Language (SUGAR Data, Amisys Data, December 2024)

- **Notable Finding:** As a plan Partnership met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog and Russian).

To further assess how Partnership is meeting member language needs, we looked at office staff languages spoken at provider sites as it compares to the top three (3) threshold languages of Spanish, Tagalog, and Russian.

The following table summarizes our finds for 2023

Practitioner Office Staff Language				
Threshold Language	Provider Sites	Member	Performance Goal	2023 Ratio
Spanish	326	135,827	1:500	1:416
Tagalog	96	3,269	1:500	1:34
Russian	28	2,205	1:500	1:78

Practitioner Language to Member Language (SUGAR Data, Amysis Data, April 2023)

The following table summarizes our findings for 2024

Practitioner Office Staff Language					
Threshold Language	Provider Sites	Member	Ratio	Performance Goal	Goal Met?
Spanish	402	186,842	1:464	1:500	Met
Tagalog	108	2,319	1:21	1:500	Met
Russian	32	5,237	1:163	1:500	Met

Practitioner Language to Member Language (SUGAR Data, December 2024)

- **Notable Finding:** Provider site language to member language ratios meets the performance goal. Office staff capabilities for threshold languages are sufficient to meet member needs.

LINGUISTIC NEEDS

As a plan, Partnership met the overall ratio of 1:500 (provider to member) standard for all three threshold languages (Spanish, Tagalog, and Russian). When comparing our linguistic data to grievances, there was a decrease in language discrimination from eight in 2023 to four in 2024. Shasta, Solano, and Placer Counties had the highest reported grievances, however, none of the providers within the counties had more than one grievance, and therefore, there is no trend to address.

Partnership offers no-cost linguistic services which include, oral interpreters, and sign language interpreters. Many practices have providers and medical staff who speak languages spoken by plan members. Written informing materials are fully translated into the threshold languages upon request.

PRACTITIONER AVAILABILITY RESULTS: (NET 1, ELEMENT B, C: PRACTITIONERS PROVIDING PRIMARY CARE & SPECIALTY CARE RATIO, GEOGRAPHIC DISTRIBUTION OF PRACTITIONERS

The following table summarizes the findings for Primary Care practitioners for 2023.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**833**	**616,313**	**Primary Care Practitioner to Member (adult and children)**	**1:739**	**1:≤ 2,000**	**MET**
Family or General Practice	**517**	**616,313**	**Family or General Practice Practitioner to Member (adult and children)**	**1:1,192**	**1:≤ 2,000**	**MET**
Pediatrics	**171**	**193,201**	**Pediatricians to Members (children)**	**1:1,129**	**1:≤ 2,000**	**MET**
Internist	**145**	**423,112**	**Internists to Members (adult)**	**1:2,918**	**1:≤ 3,000**	**MET**

Practitioner Ratios: Primary Care (April 2023)

The following table summarizes the findings for Primary Care practitioners for 2024.

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1,272	915,046	Primary Care Practitioner to Member (adult and children)	1:719	1:≤ 2,000	MET
Family or General Practice	741	915,046	Family or General Practice Practitioner to Member (adult and children)	1:1,235	1:≤ 2,000	MET
Pediatrics	296	334,640	Pediatricians to Members (children)	1:1,130	1:≤ 2,000	MET
Internist	235	580,406	Internists to Members (adult)	1:2,469	1:≤ 3,000	MET

Practitioner Ratios: Primary Care (April 2024)

Notable findings: The Plan met the standard for all Primary Care Practitioners in 2024 without any significant changes from 2023. Interventions are not currently indicated

- The primary care overall ratio exceeded the performance goal. There was slight improvement from 2023.
- The family or general practice care ratio exceeded the performance goal. There was a slight decrease from 2023.
- The pediatric primary care ratio exceeded the performance goal without change from 2023 to 2024.
- The internal medicine ratio exceeded the performance goal. There was an improvement from 2023.

The DHCS standard for primary care is a provider to member ratio of 1:2000 that combines Family Medicine with Internal Medicine for adults and Family Medicine with Pediatric Medicine for children. NCQA looks at all three types of primary care providers separately.

Partnership expanded into 10 new rural counties in 2024 and experienced a 38.8% increase in total membership compared to 2023. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network.

The following table summarizes the findings for High Volume Specialists for 2023.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	479	254,936	OB-GYN to Member	1:287	1:≤ 5,000	MET
Cardiology	574	616,313	Cardiologist to Member	1:1,074	1:≤ 10,000	MET
General Surgery	427	616,313	General Surgery to Member	1:1,443	1:≤ 10,000	MET
Orthopedic	335	616,313	Orthopedic Surgeon to Member	1:1,840	1:≤ 10,000	MET
Ophthalmology	248	616,313	Ophthalmologist to Member	1:2,485	1:≤ 10,000	MET
Dermatology	204	616,313	Dermatologist to Member	1:3,021	1:≤ 15,000	MET

Practitioner Ratios: Tableau Dashboard -High Volume Specialist (April 2023)

The following table summarizes the findings for High Volume Specialists for 2024.

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	523	379,253	OB-GYN to Member	1:725	1: ≤ 5,000	MET
Cardiology	459	915,046	Cardiologist to Member	1:1,994	1: ≤ 10,000	MET
General Surgery	413	915,046	General Surgery to Member	1:2,216	1: ≤ 10,000	MET
Orthopedic	356	915,046	Orthopedic Surgeon to Member	1:2,570	1: ≤ 10,000	MET
Ophthalmology	261	915,046	Ophthalmologist to Member	1:3,506	1: ≤ 10,000	MET
Dermatology	212	915,046	Dermatologist to Member	1:4,316	1: ≤ 15,000	MET

Practitioner Ratios: Tableau Dashboard - High Volume Specialist (April 2024)

- **Notable findings**: The six high-volume specialties remained unchanged from 2023. Partnership comfortably met the provider ratio standards for all high-volume specialist providers. Interventions are not currently indicated.

- The obstetrics/gynecology provider ratio exceeded the performance goal despite a decrease from 2023.
- The cardiology provider ratio exceeded the performance goal despite a decrease from 2023.
- The general surgery provider ratio exceeded the performance goal despite a decrease from 2023.
- The orthopedic provider ratio exceeded the performance goal despite a decrease from 2023.
- The ophthalmology provider ratio exceeded the performance goal despite a decrease from 2023.
- The dermatology provider ratio exceeded the performance goal despite a decrease from 2023.

The following table summarizes the findings for High Impact Specialists for 2023.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	**428**	**616,313**	**Oncology Hematology to Member**	**1:1,440**	**1: ≤ 25,000**	**MET**

The following table summarizes the findings for High Impact Specialists for 2024.

Practitioner Ratio: High Impact Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Oncology Hematology	**230**	**915,046**	**Oncology Hematology to Member**	**1:3,978**	**1: ≤ 25,000**	**MET**

Practitioner Ratio: Tableau Dashboard -High Impact Specialists (April 2024)

- **Notable findings:** The provider ratio for oncology/hematology dropped plan wide as well as the total number of network practitioners. Despite this drop, the practitioner -to- member ratio for oncology/hematology practitioners stayed comfortably within the performance standard. No plan-wide interventions are currently indicated.

GEOGRAPHIC DISTRIBUTION: PRIMARY CARE PRACTITIONERS

The following table summarizes the 2023 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**1 within 10 miles or 30 minutes from the member's residence**	**97.9%**	**≥ 95%**	**MET**
Family Medicine or General Practitioner	**1 within 10 miles or 30 minutes from the member's residence**	**99.8%**	**≥ 95%**	**MET**
Pediatrics	**1 within 10 miles or 30 minutes from the member's residence**	**97.4%**	**≥ 95%**	**MET**
Internist	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, December 2023)

The following table summarizes the 2024 findings for Primary Care Practitioners

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	**1 within 10 miles or 30 minutes from the member's residence**	**97.59%**	**≥ 95%**	**MET**
Family Medicine or General Practitioner	**1 within 10 miles or 30 minutes from the member's residence**	**99.9%**	**≥ 95%**	**MET**
Pediatrician	**1 within 10 miles or 30 minutes from the member's residence**	**96.0%**	**≥ 95%**	**MET**
Internal Medicine	**1 within 10 miles or 30 minutes from the member's residence**	**96.6%**	**≥ 95%**	**MET**

Geographic Distribution of Primary Care (Quest Analytics, December 2024)

- **Notable findings:** Partnership met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty. No interventions are currently indicated.
  - The primary care practitioner overall geographic distribution remained stable from 2023 to 2024 without significant change.
  - The family medicine practitioner geographic distribution remained stable from 2023 to 2024 without significant change.
  - The pediatrician geographic distribution had a 1.4% decrease while meeting the standard.
  - The internal medicine geographic distribution remained stable without any change.

Geographic Distribution of Primary Care by County – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Lassen	Primary Care	1 within 10 miles or 30 minutes	89.3%	≥ 95%	Not MET
	Modoc	Primary Care	1 within 10 miles or 30 minutes	99.0%	≥ 95%	MET
	Shasta	Primary Care	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
	Siskiyou	Primary Care	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
	Trinity	Primary Care	1 within 10 miles or 30 minutes	98.4%	≥ 95%	MET
	Tehama	Primary Care	1 within 10 miles or 30 minutes	99.9%	≥ 95%	MET
Eureka	Humboldt	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Del Norte	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Mendocino	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Lake	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
Chico	Butte	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sutter	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Yuba	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Glenn	Primary Care	1 within 10 miles or 30 minutes	99.7%	≥ 95%	MET
	Colusa	Primary Care	1 within 10 miles or 30 minutes	99.7%	≥ 95%	MET
Auburn	Placer	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Nevada	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Plumas	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sierra	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
Fairfield	Napa	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Solano	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Yolo	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
Santa Rosa	Marin	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET
	Sonoma	Primary Care	1 within 10 miles or 30 minutes	100%	≥ 95%	MET

Geographic Distribution of Primary Care by County (Quest Analytics, December 2024)

- Notable findings: A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 8219 Partnership members in Lassen County, 879 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:663.

County	Family Medicine	Pediatrics	Internal Medicine
Modoc	99.0%	0%	68.4%
Siskiyou	99.9%	86.3%	60.3%
Trinity	98.4%	12.8%	13.5%
Plumas	100%	1.1%	39.5%
Sierra	100%	75.3%	88.4%

Geographic Distribution of Primary Care by County (Quest Analytics, December 2024)

- **Notable findings:** A deeper dive into the three categories of Primary Care shows that despite a ≥95% coverage by Family Practice Physicians, there are five counties that lack Pediatricians and Internal Medicine providers. This is indicative of a rural county, where the population is widely dispersed, and the providers are in, or near, towns and cities.

  Rural areas generally have family physicians that serve as primary care physicians, as the population is not sufficient to sustain pediatric and internal medicine specialists. Taking the presence of family physicians into account, there is sufficient access to primary care physicians.

  Continued general support of the primary care workforce, like our primary care recruitment program and our primary care Quality Incentive Program, are prudent to maintain and grow our current primary care network.

PART V: GEOGRAPHIC ACCESS: SPECIALISTS

County Size Categories by Population			
Size Category	**Population Density**	**# of Counties**	**PARTNERSHIP Counties**
Rural	≤50 people per square mile	13	Colusa, Del Norte, Glenn, Humboldt, Lassen, Mendocino, Modoc, Plumas, Shasta, Sierra, Siskiyou, Tehama, and Trinity
Small	51 to 200 people per square mile	7	Butte, Lake, Napa, Nevada, Sutter, Yolo, and Yuba
Medium	201 to 599 people per square mile	4	Marin, Placer, Solano, and Sonoma

County Size Categories by Population (DHCS, Standard for County Size by Population, 2024)

The following table summarizes the 2023 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		100%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		100%	≥90%	MET
Ophthalmology		98.5%	≥90%	MET
Orthopedics		100%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		97.8%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, May 2023)

The following table summarizes the 2024 findings for High Volume and High Impact Specialists

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		100%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		99.9%	≥90%	MET
Ophthalmology		99.3%	≥90%	MET
Orthopedics		99.3%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		99.1%	≥80%	MET

Geographic Distribution of Specialty Care - High Volume and High Impact (Quest Analytics, Nov 2024)

➢ **Notable findings:** The geographic distribution of all High Volume and High Impact Specialties met the access standard plan wide. Interventions are not currently indicated.

- The geographic distribution for cardiology remained at 100% exceeding the standard
- The geographic distribution for dermatology remained at 100% exceeding the standard
- The geographic distribution for general surgery remained at 100% exceeding the standard
- The geographic distribution for obstetrics/gynecology was 99.9% exceeding the standard. This represented a decline from 2023 of 0.1%.
- The geographic distribution for ophthalmology was 99.3% exceeding the standard. This represented a increase from 2023 of 0.8%.
- The geographic distribution for orthopedics was 99.3% exceeding the standard. This represented a decline from 2023 of 0.7%.
- The geographic distribution for oncology/hematology was 99.1%. exceeding the standard. This represented an increase from 2023 of 1.3%.

When the data is broken down to the county level, one rural county did not meet the 60 miles, or 90 minutes standard for access to specialists.

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Modoc	Ophthalmology	Rural standard: % of members' residence is 60 miles or 90 minutes from a specialist's office.	14.1%	≥ 80%	Not MET
	Modoc	Hematology/Oncology		0.8%	≥ 80%	Not MET
	Modoc	Physical Medicine and Rehabilitation		0.9%	≥ 80%	Not MET

Geographic Distribution of Specialty Care - Not Met Score by County (Quest Analytics, Nov 2024)

Partnership contracts with all available high-volume specialists that practice within Modoc county. Modoc is sparsely populated and has an insufficient population to sustain a practice for many specialties. Currently, there are no qualified specialists who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership will assist members in making appointments and arrange transportation for members to see a specialist that is outside of the time or distance standards.

Partnership continues to review all sources of data related to access to specialty care, for monitoring trends and implementing focused strategies on the area of greatest need. This includes a robust telemedicine and e-Consult program. Many telehealth specialties are available to members via video appointments arranged at primary care offices. In addition, direct-to-member video telehealth between specialist providers and members is available through Partnership's contract with TeleMed2U.

PRACTITIONER ACCESSIBILITY RESULTS: (NET 2 ELEMENT A, C: ACCESS TO PRIMARY CARE & SPECIALTY CARE)

The data for assessing regular and routine care, urgent care, and after-hours care is collected by Partnership's Provider Relations staff using the Third Next Available (3NA) methodology for appointment access and the after-business hours' survey for telephone and triage services. All PCPs are surveyed (no sampling).

Third Next Available (3NA) Survey Results - Primary Care Routine Appointment Accessibility The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt.			Percentage of Clinics Meeting PCP Standards			Goal	2023 Goal Met?
		North	South	Plan	North	South	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94%	91.7%	92.9%	≥ 90%	Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	3.0	3.0	94.4%	90.4%	92.4%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	96.9%	100.0%	98.5%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	0.0	0.0	0.0	95.3%	96.9%	96.1%	≥ 90%	Met

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	Standard	Median Days for Established PCP Appt.				Percentage of Clinics Meeting PCP Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	3.0	5.0	2.5	3.0	94.4%	78.7%	91.3%	86.2%	≥ 90%	Not Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	3.0	4.0	2.5	3.0	93.6%	85.1%	96.4%	91.3%	≥ 90%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	1.0	1.0	1.0	1.0	100%	99.0%	93.2%	97.4%	≥ 90%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	1.0	1.0	0.0	0.0	97.9%	97.4%	95.4%	96.9%	≥ 90%	Met

Third Next Available (3NA) Primary Care Survey Findings (PR Reps Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan we did not meet our 2024 performance goal across all areas.

- Non-urgent Adult Primary Care Provider appointments fell short of the goal with a 6.7% decrease from 2023.
- Non-urgent Pediatric appointment access exceeded the performance goal despite a 1.1% decrease from 2023.
- Newborn appointment access exceeded the performance goal despite a 1.1% decrease from 2023.
- Urgent primary care access exceeded the performance goal. There was 0.8% improvement from 2023.

THIRD NEXT AVAILABLE (3NA) SURVEY RESULTS - PRIMARY CARE TELEPHONE ACCESSIBILITY:

Third Next Available (3NA) Survey Findings (Primary Care)												
Measurements	Standard	Median Performance Rates				Percentage of Clinics Meeting PCP Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
# Rings before phone answered	≤ 5 rings	2.0	1.0	1.0	1.0	100%	100%	100%	100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	0.0	1.0	1.0	0.0	100%	92.8%	94.5%	95.2%	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	10.0	10.0	10.0	10.0	100%	100%	99.1%	99.7%	≥ 90%	Met
Return call within 30 minutes	≤ 30 minutes	Yes	Yes	Yes	Yes	98.9%	100%	96.4%	98.6	≥ 90%	Met

Third Next Available (3NA) Primary Care Telephone Accessibility (PR Rep Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan we met our 2024 performance goal of 90% telephone accessibility and wait time measurements.

SURVEY RESULTS - PRIMARY CARE AFTER BUSINESS HOURS

After Business Hours Survey Findings Primary Care																
Measurements	Standard	Q1 2024			Q2 2024			Q3 2024			Q4 2024			Goal	Goal Met?
		North	South	East	North	South	East	North	South	East	North	South	East		
Answering Machine/ Answering Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Instructions to call 911/ER	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	≥ 90%	Met

After Business Hours Survey Findings Primary Care																
Measurements	Standard	Q1 2024			Q2 2024			Q3 2024			Q4 2024			Goal	Goal Met?
		North	South	East	North	South	East	North	South	East	North	South	East		
Instructions to reach MD or Advice Nurse	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	≥ 90%	Met
Wait time for screening or triage services	≤ 30 minutes	100%	100%	99%	100%	100%	99%	100%	100%	99%	100%	100%	100%	≥ 90%	Met

Survey Results Primary Care After Business Hours (PR Rep Survey, 2024).

- **Notable findings:** The 3NA survey results show that as a plan Partnership met 2024 goals for Primary Care After Business Hours Accessibility measurements.

3NA SURVEY RESULTS - ACCESS TO PRIMARY CARE BY COUNTY

The data for assessing access to care by county is pulled from the 3NA survey results. The 2024 3NA findings below summarize the access by county.

The following table summarizes the findings of the Third Next Available Survey for 2024.

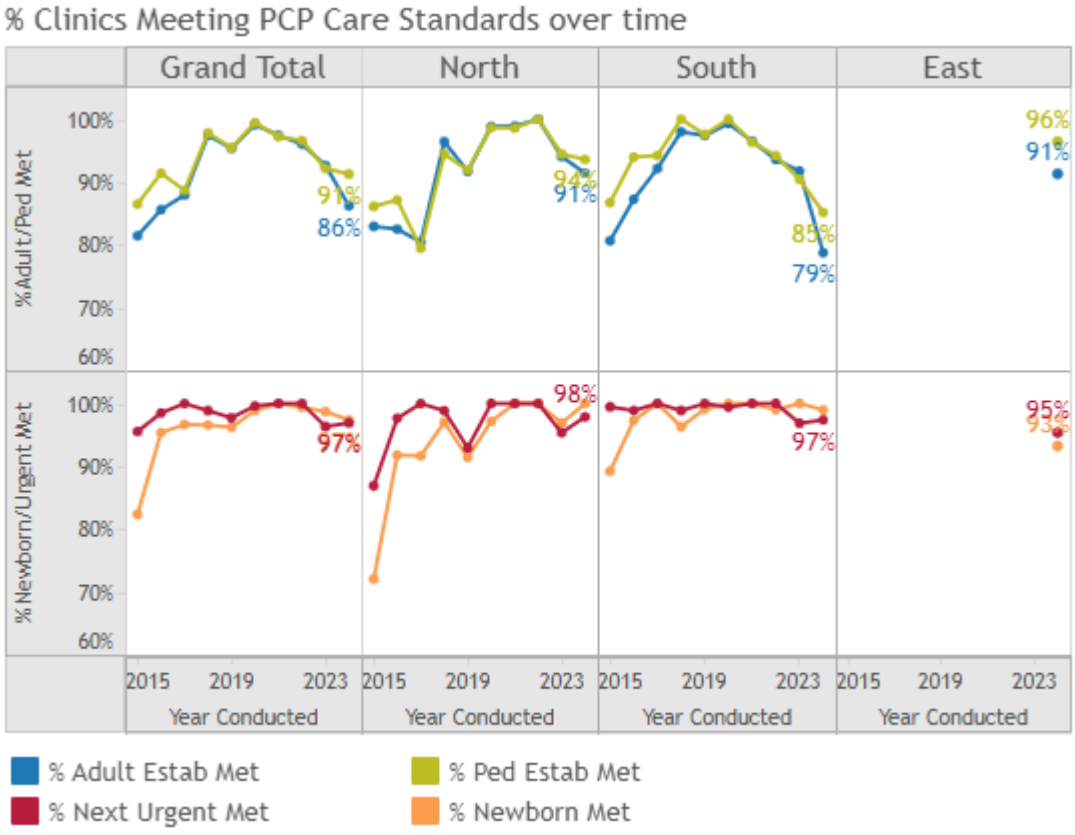
Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Adult Primary Care
Chico	Butte	Ampla Health Chico	18
		Oroville Premier Health Practice	13
	Sutter	Harmony Health Medical Clinic	19
		Sutter North Medical Group	12
		Peach Tree Healthcare	11
Eureka	Humboldt	UIHS Potawot Health Village	13
		Fortuna Family Medical Clinic	12
	Mendocino	Adventist Health Ukiah Valley	37
		Hillside Health Center	22
		Dora Street Health Clinic	21
		Point Arena Community Health Clinic	19
		Adventist Health Ukiah Valley – Hospital Dr.	11
	Lake	Adventist Health Clear Lake	11
Redding	Siskiyou	Karuk Tribal Health Clinic	35
		Staszel, Michael Zbigniew	11

Primary Care Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Adult Primary Care**
	Lassen	Westwood Family Practice	22
		Northeastern Rural Health Clinic	12
Fairfield	Napa	Ole Health – Hartle Clinic	30
		Ole Health – Pear Tree Clinic	28
	Solano	Solano County Health	40
		Ole Health Fairfield	37
		La Clinica – Vallejo	21
		La Clinica – N Vallejo	14
		Community Medical Centers – Vacaville	11
Santa Rosa	Marin	Marin Community – Campus Clinic	52
		Marin Community – S Novato	39
		Marin Community – Greenbrae	29
		Marin Community – Larkspur	23
	Sonoma	Sutter Medical Group of the Redwoods	19

- **Notable Findings:** When the 3NA data is broken down by county we find 29 sites failed to meet the appointment standards. All sites that failed to meet the standard were surveyed 30 days later. 20 passed upon resurvey, 9 were escalated to the Chief Medical Officer.
  - Marin Community Clinics-Larkspur Clinic- The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. They have 12 open positions for Physicians and 6 open positions in the call center. They passed the resurvey for urgent appointment but are still under cap for 3na Adult appointment. Provider was escalated to CMO.
  - Marin Community Clinics-Greenbrae The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. The have 12 open positions for Physicians and 6 open positions in the call center. Provider was escalated to CMO
  - Marin Community – Campus Clinic- The Compliance director stated MCC is actively recruiting and participating in our physician recruitment program. The have 12 open positions for Physicians and 6 open positions in the call center. Provider was escalated to CMO
  - Solano County Family Health & Social Service: Provider in process of clinician recruitment. Escalated to CMO

- Adventist Health Ukiah Valley PCP-260 Hospital Dr Ste 103 Family Med Response from Kristi Adams, office manager stated that Adventist has lost quite a number of providers and is actively recruiting. Escalated to CMO
- Adventist Health Ukiah Valley PCP (850 Sequoia Circle, Fort Bragg) – Received email from the interim director of the clinic. They will be having a new provider start in the next few months which will help alleviate the backlog. Resurveyed and provider failed standards. Provider was escalated to CMO.
- Point Arena Community Health Center- Followed up with Maryann Watts, clinic manager, on April 3. They are doing their best to accommodate everyone but are currently having longer wait times than normal. Escalated to CMO
- Dora Street Health Center-Clinic PCP- CAP response from the clinic manager stated they have a lack of providers and are actively recruiting. Resurveyed on and provider failed standards. Provider escalated to CMO
- Westwood Family Practice CAP response stated they currently only have one provider and are actively recruiting for more. Escalated to CMO.

Trends for PCP Appointments Meeting Targets



- **Notable Finding:** There has been a downward trend for adult and pediatric PCP appointments across the Partnership service area since 2020. A baseline for the expansion counties was established in 2024.

3NA SURVEY RESULTS - ACCESS TO PRENATAL CARE[1]

The data for assessing access to prenatal care by county is also pulled from the 3NA survey results.

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	Standard	Median Days for Established PCP Appt			% of Clinics Meeting Prenatal Standards			Goal	Goal Met?
		North	South	Plan	North	South	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	Standard	Median Days for Established PCP Appt				% of Clinics Meeting Prenatal Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Prenatal Care	Appointments within 10 business days of request	2.5	5.0	3.0	3.0	96.9%	73.7%	90.6%	82.9%	≥ 90%	Not Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2024)

- **Notable Findings:** The 3NA survey results show that as a plan we did not meet the 2024 performance goal for prenatal care appointments with the southern counties experiencing a 19.5% decrease from 2023.

Prenatal Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	County	Service Location	Days to Prenatal Appointment
Chico	Butte	Enloe Women's Services - Esplanade	15
		Oroville Women's Health-Midwifery	14
Eureka	Humboldt	UIHS-Potawot Health Village	20
	Lake	Adventist Health Clearlake	19
	Mendocino	Adventist Health Ukiah Valley	37
		Adventist Health Ukiah Valley-1050 N State	18
		Hillside Health Center	13
		Little Lake Health Center	16

Prenatal Appointment Access by County- 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Prenatal Appointment**
		Point Arena Community Health Center	19
Fairfield	Solano	Center for Primary Care-Vacaville	37
		Community Medical Centers-Vacaville	14
		NorthBay Women's Health - Fairfield	43
	Yolo	Sutter Medical Group Yolo-2020 Sutter Pl Ste 203	20
		Woodland Clinic-1321 Cottonwood St	16

- **Notable Findings:** When breaking down Prenatal Appointment Access by County we find that fourteen providers failed to meet the standard within 10 business days. All sites were re-surveyed and were found to be compliant. No further action was taken

ACCESS TO SPECIALTY CARE

The data for assessing access to specialty care is collected by Partnership's Provider Relations staff using the 3NA methodology for appointment access and the After Business Hours survey for telephone and triage services. Data results for urgent care and after business hours' survey findings are not required by NCQA, however, they are included in this report to meet DHCS requirements. The 3NA high-volume, high-impact specialists are selected from a list of all specialty offices that served 200 or more unique members in the measurement year. If a county does not meet the 200 unique members seen, the provider with the highest unique members seen is selected to ensure we account for all counties.

The following tables summarize the findings for specialty care providers.

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	**Standard**	**Median Days for Established Specialty Appointment**			**% of Sites Meeting Specialty Care Standards**			**Goal**	**2023 Goal Met?**
		North	**South**	**Plan**	**North**	**South**	**Plan**		
Specialty Care	Non-urgent specialty care appointments within 15 business days	9.0	8.0	7.0	78.8%	82.0%	80.4%	≥ 80%	Met
Specialty Care	Next urgent appointment ≤ 48 hours	0.0	1.0	1.0	92.9%	95.8%	94.4%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2023)

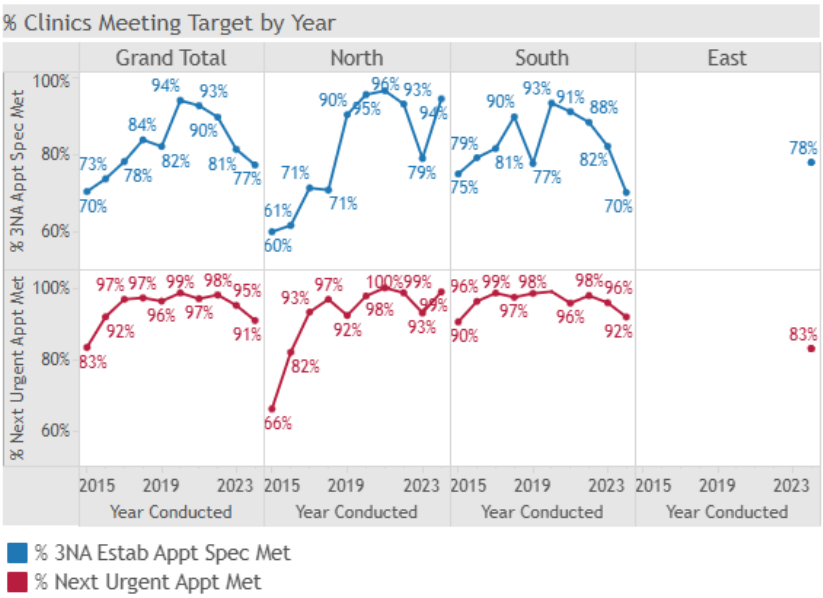
The following table summarizes the findings of the Third Next Available Survey for 2024.

Third Next Available (3NA) Survey Findings											
Provider Type	Standard	Median Days for Established Specialty Appointment				% of Sites Meeting Specialty Care Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
Specialty Care	Non-urgent specialty care appointments within 15 business days	7.0	10.0	5.0	8.0	94.3%	70.0%	77.8%	77.8%	≥ 80%	Not Met
Specialty Care	Next urgent appointment ≤ 48 hours	1.0	1.0	1.0	1.0	98.9%	91.8%	82.9%	90.8%	≥ 90%	Met

3NA Survey Specialty Care Overall (PR Rep Survey, 2024)

- **Notable Finding:** As a Plan, we did not meet the 2024 goal for non-urgent and urgent specialty care appointments. Partnership met the goal in 2023, but data also showed that all regions had suffered an overall decrease in the number of sites meeting both the non-urgent and urgent appointment goal. In 2024 we experienced further decreases that dropped us below the overall goal.

Trends for Specialty Appointments Meeting Targets



- Notable Finding: There had been a downward trend for routine and urgent specialty care appointments across the Southern and Northern regions between 2020 and 2023. In 2024 we saw improvement in the Northern Region while the Southern Region has continued to decrease. A baseline was established for the expansion counties of the Eastern Region.

High Volume Specialties Third Next Available Survey Results

The following table summarizes the findings of the Third Next Available Survey for 2023.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)								
High Volume Specialties	Median Days for Established Specialist Appointment			% of Clinics Meeting Specialty Care Standards			Goal	2023 Goal Met?
	North	South	Plan	North	South	Plan		
Cardiology	7	8	7	63%	81%	77%	≥ 80.0%	Not Met
Dermatology	9.5	17	12	100%	50%	67%	≥ 80.0%	Not Met
General Surgery	7	5	5	100%	89%	93%	≥ 80.0%	Met
Obstetrics Gynecology	5	6	4	100%	90%	94%	≥ 80.0%	Met
Ophthalmology	18	9	8	60%	78%	73%	≥ 80.0%	Not Met
Orthopedic Surgery	7.5	7.5	7.5	89%	93%	92%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2023)

The following table summarizes the findings of the Third Next Available Survey for 2024.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)										
High Volume Specialties	Median Days for Established Specialist Appointment				% of Clinics Meeting Specialty Care Standards				Goal	Goal Met?
	North	South	East	Plan	North	South	East	Plan		
Cardiology	8	10	2	5	89%	71%	86%	80%	≥ 80.0%	Met
Dermatology	3	27	15	14	100%	33%	75%	57%	≥ 80.0%	Not Met
General Surgery	5	5	7.5	5	100%	95%	83%	95%	≥ 80.0%	Met
Obstetrics Gynecology	7	9.5	9	8	100%	61%	67%	71%	≥ 80.0%	Not Met
Ophthalmology	5	9	10	8.5	83%	85%	85%	85%	≥ 80.0%	Met
Orthopedic Surgery	5	8	5	7	100%	90%	80%	90%	≥ 80.0%	Met

3NA Survey High Volume Specialties (PR Rep Survey, 2024)

Notable finding: As a plan, two high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to 3 in 2023.

- Cardiology met the 2024 goal with a 3% increase from 2023
- Dermatology did not meet the goal two years in a row with a 10% decrease from 2023
- General Surgery met the 2024 goal and had a 2% increase from 2023
- Obstetrics Gynecology did not meet the 2024 goal with a decrease of 23% from 2023
- Ophthalmology met the 2024 goal with a 12% improvement from 2023
- Orthopedic Surgery met the 2024 goal despite a 2% decrease from 2023

High Volume: Cardiology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Cardiology Appointment**
Redding	Shasta	Dignity Health Medical Group North State-Eureka Way	25
Eureka	Mendocino	Adventist Health Ukiah Valley	41
	Lake	Adventist Health Clearlake-15230 Lakeshore Dr	19
Fairfield	Solano	Sutter Medical Group Solano-2720 Low Ct	27
	Yolo	Sutter Medical Group Yolo-2030 Sutter Pl Ste 1000	86
	Napa	Adventist Health Physicians Network-475 N Forbes St	25
Santa Rosa	Sonoma	Providence Medical Group, Sonoma-141 Lynch Creek Way Ste C	65
		Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 103	19
Auburn	Plumas	Adventist Health Physicians Network-481 Plumas Blvd Ste 201	40
Chico	Butte	Enloe Cardiology Services & Structural Heart & Valve Center	20
		Northstate Cardiology Consultants	44

- **Notable finding:** When breaking down the Cardiology Appointment Access by County we found that eleven providers failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except one.
  - Providence Medical Group failed to meet the standard upon resurvey. Office staff reported there are a total of 3 MDs and 1NP at the office, the reason for appointments being pushed back is not all MDs are in office every day and NP only sees patients for intake. The Provider CAP and reported barrier to timely access was shared with the CMO and the information was taken to the Partnership Specialty Access Group for discussion.

High Volume: Dermatology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Dermatology Appointment**
Santa Rosa	Marin	Marin Health Medical Network Dermatology- 5000 Civic Center	56
	Sonoma	Redwood Family Dermatology-Santa Rosa	35
Chico	Colusa	Oroville Dermatology	37
Fairfield	Napa	Loftis, Brent, DO	28
	Yolo	Woodland Clinic-2440 W Covell Blvd Ste 100	45
		Sutter Medical Group Yolo-2030 Sutter Pl Ste 2200	112
	Solano	Solano Dermatology Associates-Vallejo	18
		Jiva Health, Inc-Vacaville	26
		Sutter Medical Group Solano-2720 Low Ct Dermatology	96

- **Notable finding:** When breaking down the Dermatology Appointment Access by County we find that two providers in the Santa Rosa region, one provider in the Chico region, and three

providers in the Fairfield region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all passing except 1 site.

- Sutter Medical Group Yolo failed to meet the standard upon resurvey. The staff did not offer a specific reason for the appointment backlog. The CAP for timely access was shared with the CMO and the information was taken to the Partnership Specialty Access Group for discussion.

High Volume: General Surgery 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to General Surgery Appointment**
Chico	**Butte**	**Oroville Surgical Specialists**	**26**

- **Notable finding:** When breaking down the General Surgery Appointment Access by County we find that one provider in the Chico region failed to meet the standard within 15 business days. The provider was re-surveyed and found to be compliant with the access standard. No further action was taken.

High Volume: Obstetrics Gynecology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Obstetrics Gynecology Appointment**
Fairfield	**Napa**	**Adventist Health Physicians Network**	**60**
	Solano	**NorthBay Women's Health**	**45**
	Yolo	**Sutter Medical Group Yolo**	**32**
		Woodland Clinic	**26**
Sonoma	**Marin**	**Marin Health Medical Network**	**29**
Eureka	**Lake**	**Little Lake Health Center**	**16**
		Adventist Clearlake	**19**
Chico	**Butte**	**Enloe Women's Services**	**36**
		Oroville Women's Health-Midwifery	**39**
	Yuba	**Sutter North Medical Group-969 Plumas St Ste 103**	**37**

- **Notable finding:** When breaking down the OB GYN Appointment Access by County we find that 10 providers failed to meet the standard of 15 business days. All sites that failed were re-surveyed after 30 days with all but 4 having passed.
  - Adventist Health Physicians Network staff stated that the reason for the appointment backlog is the fact that they do not have as many physicians in their office as other Adventist locations within the county. CAP and barrier reported the CMO.
  - NorthBay Women's Health reported there are a high number of referrals to the office, however the referrals are appropriate. The provider is in the process of recruiting. CAP and barrier reported to the CMO
  - Little Lake Health Center CAP response stated they have a lack of providers and are actively recruiting. The provider stated they are also working with staff processes as they felt there might be a scheduling issue. CAP and barrier reported to the CMO

- Enloe Women's Services CAP response stated that they are currently experiencing a shortage of providers. CAP and barrier reported to the CMO.

High Volume: Ophthalmology 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Ophthalmology Appointment**
Redding	Tehama	Northridge Eye Care	56
	Shasta	Robert C. Fox MD, Inc	21
Chico	Butte	Kirstiane Ransbarger MD	92
		Oroville Premier Health Center	38

- **Notable finding:** When breaking down the Ophthalmology Appointment Access by County we find that two providers in the Redding Region and two providers in the Chico region failed to meet the standard within 15 business days. All sites that failed were resurveyed after 30 days with all 4 having passed. No direct barriers were identified.

High Volume: Orthopedic Surgery 3NA Results (Outside Performance Standards)			
Region	**County**	**Service Location**	**Days to Orthopedic Surgery Appointment**
Chico	Yuba	Adventist Health Physicians Network-370 Del Norte Ave Ste 201	53
Auburn	Placer	Sutter Medical Group Placer-3 Medical Plaza Dr Ste 110	19

- **Notable finding:** When breaking down the Orthopedic Surgery Appointment Access by County we find that one provider in the Chico Region and one provider in the Auburn region failed to meet the standard within 15 business days. Both sites were resurveyed after 30 days with both having passed. No direct barriers were identified.

HIGH IMPACT SPECIALTY THIRD NEXT AVAILABLE SURVEY RESULTS

The following table summarizes the findings of the Third Next Available Survey for 2023.

Third Next Available (3NA) Survey Findings									
Provider Type	**Standard**	**Median Days for Established PCP Appt**			**% of Clinics Meeting Prenatal Standards**			**Goal**	**2023 Goal Met?**
		North	**South**	**Plan**	**North**	**South**	**Plan**		
Prenatal Care	Appointments within 10 business days of request	2.5	3.9	3.2	87.1%	93.2%	90.2%	≥ 90%	Met

3NA Survey Results Prenatal Care Region and Plan (PR Rep 3NA Survey, 2023)

- **Notable Findings:** The 3NA survey results show that as a plan we met the 2023 performance goal for prenatal care appointments.

The following table summarizes the findings of the Third Next Available Survey for 2024.

3NA Survey Results – Specialty Care: Routine Non-Urgent Care (Standard = 15 Days)										
High Impact Specialty	Median Days for Established Specialist Appointment				% of Clinics Meeting Specialty Care Standards				Goal	Goal Met?
	North	South	East	Plan	North	South	East	Plan		
Oncology Hematology	5.5	4.5	2	4	100%	93%	75%	89%	≥ 80.0%	Met

3NA Survey High Impact Specialty (PR Rep Survey, 2024)

Notable finding: The 3NA survey results show that as a plan we met the 2024 performance goal for prenatal care appointments despite a 1.2% decrease from 2023.

3NA SURVEY RESULTS: SPECIALTY CARE ACCESSIBILITY

Specialty Care Accessibility Survey Findings											
Measurements	Standard	Median Performance Rates				% of Sites Meeting Standards				Goal	Goal Met?
		North	South	East	Plan	North	South	East	Plan		
# rings before phone answered	≤ 5 rings	2	2		2	100%	100%		100%	≥ 90%	Met
Minutes on hold	≤ 5 minutes	0.0	1.0		1.0	100%	98.9%		99.2	≥ 90%	Met
Average wait time before seeing a provider	≤ 30 minutes	5	10		10	100%	100%		100%	≥ 90%	Met
Return call	≤ 30 minutes	1	1		1	100%	99.5%		99.6%	≥ 90%	Met

3NA Survey Specialty Care Accessibility Survey Results (PR Rep Survey, 2024)

- **Notable Findings:** As a plan, we met our 2023 goal for appointments and telephone access to specialty care providers.

Survey Results: After Business Hours Specialty Care

The after-business hour's survey includes all specialty care providers (no sampling).

After-Business Hours Survey Findings Specialty Care															
Measurements	Standard	Q1 2024			Q2 2024			Q3 2024			Q4 2024			Goal	Goal Met?
		North	South	East	North	South	East	North	South	East	North	South	East		
Answering Machine/ Answering Services	100%	100%	100%		100%	100%		99%	100%		100%	100%		≥ 90%	Met
Instructions to call 911/ER	100%	100%	99%		100%	100%		100%	100%		100%	100%		≥ 90%	Met

Instructions to reach MD or Advice Nurse	**100%**	**100%**	**99%**		**100%**	**100%**		**94%**	**99%**		**100%**	**99%**		**≥ 90%**	**Met**
Wait times for screening or triage services	**≤ 30 minutes**	**100%**	**99%**		**100%**	**100%**		**90%**	**99%**		**100%**	**99%**		**≥ 90%**	**Met**

Table 1: Survey Results: After Business Hours Specialty Care Accessibility (PR Rep Survey, 2024)

- **Notable Findings:** Partnership met the After Business Hours Accessibility Specialty Care goals for each quarter in 2023. No action is currently required.

Section 4: Qualitative Analysis

ACCESS TO PRIMARY CARE

As a plan, Partnership met the ≥90% performance goal for all Primary Care Provider appointments including, adult, pediatrics, newborn, prenatal, and urgent care. When breaking down the primary care access standard 3NA survey data by percentages of clinics in the county that meet the standard we find one county in the northern region, one in the eastern region, and two in the southern region had lower percentages of appointment compliance. This is a decrease from seven counties last year. All sites that fail to meet the standard were resurveyed and issued a corrective action plan if needed.

The total number of member complaints regarding access increased between 2023 and 2024 with appointment availability being the most common type of access grievance. Primary care grievances increased by 32% compared to 2023. However, an increase is to be expected with the addition of 10 new counties. Despite the number of grievances, the rating per 1000 members was within the standard. No further action is currently required.

ACCESS TO SPECIALTY CARE

As a Plan, we met our ≥ 80% appointment access performance goal for four of the six identified high-volume specialties and the identified high-impact specialty. Two high-volume specialties fell below the established median 15-day appointment goal in 2024 as compared to 3 in 2023. Dermatology demonstrated a 10% decrease while Ophthalmology demonstrated a 12% improvement. Obstetrics Gynecology had the largest decrease with a drop of 23%. Providers who failed re-survey were issued a CAP and their reported barrier to timely access was shared with the CMO for Specialty Access Group discussion.

Access to specialty care member complaints were low. Twelve high-volume specialties had one appointment complaint each for the reporting year and three had two appointment complaints. A trend could not be established due to low member complaints. No further action is currently required.

Section 5: Summary of Findings

Partnership is meeting access standards for primary care (adult/pediatrics, newborn, urgent appointments, and telephone and after-hours accessibility) and four of six specialty care, high-volume

and high-impact (urgent, telephone, and after hours), based on data from our provider surveys and additional internal analysis.

Partnership has experienced a downward trend for adult and pediatric primary care as well as specialty care appointments meeting the appointment standard across both regions since 2020. This coincides with the start of the pandemic. We are experiencing a continued trend of decreasing numbers of providers for multiple reasons including retirement of the baby boomer generation, decreased enrollment into medical schools across the nation, and higher burnout of physicians leading to reduction in available office hours.

While Partnership failed to meet the 15-day appointment standard for Dermatology and Obstetrics Gynecology, this is not due to a lack of contracting with an available service provider. Currently there are no additional qualified providers who are enrolled in Medi-Cal practicing in these geographic areas with whom to contract. Partnership monitors appointment access each quarter and works with individual providers who fail to meet the standard to identify strategies for improvement.

The 2024 CAHPS data from the ME7 (Member Experience) report indicates performance below the thirty-third percentile benchmark for getting care quickly and getting care needed for Adult and Child. This is a decrease from 2023. The benchmark was raised from the twenty-fifth in 2022 to the thirty-third in 2023. The previously noted performance tables demonstrate a continuation of member dissatisfaction. The CAHPS® Team concludes that while the survey is structured as a retrospective, it is hypothesized there is a high probability that experiences whether satisfactory or unsatisfactory may influence survey results by present experiences. Highlighted below are events that occurred while the regulated survey was in the field and likely led to member dissatisfaction and subsequent declines in NCQA rating and composite measures.

- County Expansion – HealthPlan Growth: Previously noted in January of 2024, Partnership expanded into ten (10) new counties, now serving twenty-four (24) Northern California counties. *It is relevant to note the new county members were not included in the HEDIS CAHPS® sample frame member for MY 2023*. The membership growth coupled with the below disruption created unforeseen operational delays that impacted members requiring plan or service support during this period.

- Regional Service Disruption: In April of 2024, contract negotiations and renewal was not reached with Dignity Health. This matter is presently resolved, but while the CAHPS® survey was in the field, thousands of members were impacted through the initial notification and subsequent actions of provider reassignment among many others.

There were 6,149 Grievances, Second Level Grievances, and Appeals closed in 2024 compared to 4,261 in 2023. These cases are broken into two (2) groups – Grievances accounted for 5,477 and Appeals and Second Level Grievances accounted for 672.

Our membership experienced a 33.5% growth, rising from 678,546 in 2023 to 905,570 members in 2024. Alongside our membership increase, there was a rise in Grievances received in 2024, leading

to an increase in access related Grievances files per 1,000 members from 2.25 to 2.83. We saw a decrease in the number of Appeals and Second Level Grievances filed in 2024.

With an increase in membership and 28.5% increase in Grievances filed, three thresholds for Grievances were not met, one of which was Access. Access issues mainly consisted of long wait times for providers and transportation issues such as the driver arriving late and missed ride issues.

Partnership was able to meet the minimum threshold for Appeals & SLGs regardless of a 31% increase from 2023. The total number of cases filed per 1,000 members increased from 0.52 to 0.49 and was well within the threshold.

There were no identified gaps in the provider ratios overall. Although Partnership experienced an 38.8%% increase in total membership compared to 2023 due to our expansion into 10 additional counties. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network. The Provider Recruitment Program provides incentives for Primary Care practitioners to join our network and Partnership is continuously recruiting for all categories of Primary Care, specifically in our rural counties that traditionally have a lower number of providers.

While some members were outside the time or distance standards for primary care, specialty care, and hospital services, this is not due to lack of contracting with available service providers. There are no new provider sites in these geographic areas with whom to contract as the geography and lack of larger towns limits the ability to reduce time or distance to a provider office. Partnership requests and receives approval for Alternative Access Standards (AAS) from the Department of Health Care Services on an annual basis for the geographical areas that fail to meet the standard. If a member lives in an area where services are not covered, Partnership will help those members with making the appointment and arrange transportation to see the specialists that are not within the time or distance standard.

Section 5: Opportunities for Improvement

Partnership operates in a broad service area encompassing urban, suburban, and rural settings. Improving member access to care is consistently the number one opportunity for improvement and top priority for leadership. Partnership's provider network is challenged by a national shortage of providers, competition from other entities, and an aging provider community. Because of this, Partnership has developed a multi-pronged approach to recruit and retain providers.

Effectiveness of Prior Actions: Partnership started a sponsored workforce development program that offered a sign-on bonus for providers when they contracted with Medi-Cal for the first time, and if they came from a county outside of the 14 counties that partnership served. The updated program took place between January 2021 and January 2024 with the bonuses being paid out over multiple payments over a 36-month period for physicians, nurse practitioners, physician assistants and 12 months for licensed behavioral health clinicians including substance use disorder counselors. The result of the program was an increase in accepted offers with 84 the first year and 89 the second with Family Medicine being the majority provider specialty. Partnership was able to recruit 66 new primary care practitioners to the network between May 1 2023 and December 1 2023 with 27 of those practicing in 6 of the Partnership's most rural northern counties.

The results of increased primary care recruitment resulted in a 0.4% increase in non-urgent primary care access in our rural northern region.

Opportunity: Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

Partnership has chosen primary care and women's health provider recruitment as equal high priority opportunities.

- *Planned Action:* Partnership has updated the Provider Recruitment Program (PRP) that offers a sign-on bonus for providers that are new to the Partnership network. If they are a currently practicing provider, they must come from outside of the Partnership 24 county service area. Providers completing a training program within the Partnership service area qualify for consideration for an award from the program. This updated program is active between January 2024 – June 2025 with the bonuses being paid out over multiple payments over a 60-month term for physicians, NPs, and PAs, 24 months for behavioral health clinicians, and 12 months for certified SUD counselors. The strategy is to recruit and hold providers in place longer term.
    - Effectiveness of Action: To date there has been an increase in accepted offers with 168 awards approved on average over 12 months, (as compared to a historical average going back to 2014 of 86 awards per year). Family Medicine has been the majority provider specialty awarded, representing nearly 57% of the program awards to date. Partnership was able to recruit 208 new primary care practitioners to the network between January 2024 – April 2025, with 5 of them recruited to 4 of our most rural counties, including Sierra, Modoc, Plumas, and Trinity, whose geographic area is 75% or more rural (according to the US Census Bureau definition). Initial recruitment and retention details look favorable, but we may not know completely until the 60-month time period and further payments take place.
- Planned Action: Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 PRP.

    Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.

- Planned Action: Partnership launched a provider retention initiative (PRI) pilot in January 2024. The PRI is intended to recognize primary care clinicians, those who offer perinatal services (including labor and delivery) and/or obstetrics/gynecology, who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. Our hope is that the PRI will help preserve institutional knowledge and clinical

leadership and mentorship within our network, while an emerging generation of providers can learn from and train with these committed health professionals.

- Effectiveness of Action: Since January 2024, 65 providers have been awarded and have committed to practice for 3 additional years.

Opportunity: Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- Planned Action: To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers



Grand Analysis: Network Access

Assessment of Network Adequacy

Standards for Network Management

Availability of Practitioners

- Primary Care Practitioners
- Specialty Care Practitioners

Accessibility of Services

- Primary Care Practitioners
- Specialty Care Practitioners

Assessment of Network Adequacy



Network Adequacy Data Elements

- **Member Grievances (ME7)**
  NCQA "Access" Category
- **CAPHS Survey (ME7)**
- **The Population Needs Assessment (PNA)**
- **Out of Network Requests and Utilization (UM)**
- **Practitioner Availability Ratio**
  & Geographic Distribution (Net 1 B, C)
- **Accessibility of Services (Net 2 A, C)**

Data: Member Grievances ME7

In 2024, our members submitted 5,477 grievances. The analysis attributes 42% of all cases to Access.

In comparison to the 2023 reporting period, there were a total of 3,572 grievances. Similarly, analysis attributes 43% of all cases to Access.

Grievances Only Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Grievances	Avg Mship	Grievances p/1,000	Grievances	Avg Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	1,526	678,546	2.25	2,567	905,570	2.83	2.47	No

Notable findings: Partnership did not meet the access grievance threshold in 2024.

Data: Grievances ME7
Appeals and Second Level Grievances

In 2024, the health plan received 674 Appeals and Second Level Grievance cases, a 2% decrease in case filings from 2023, with Access contributing 34% of the total.

In comparison to the 2023 reporting period, the health plan received a total of 659 Appeals and Second Level Grievance cases with Access contributing 43% of the total.

Appeals & Second Level Grievances Reporting Period: Annual 2023 vs 2024								
	Previous Period: 2023			Current Period: 2024				
NCQA Category	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Appeals & SLG	Avg Mship	Appeals & SLG p/1,000	Threshold	Threshold Met?
ACCESS	350	678,546	0.52	442	905,570	0.49	0.57	Yes

Notable findings: Partnership met the access Appeals and Second Level Grievances threshold for 2024.

CAHPS Composite Scores
Adult

	ADULT CAHPS Composite	2022-2023 (14.3% Response Rate) Sample Size 2700 Total Returns 380	2022 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?	2023-2024 (15.3% Response Rate) Sample Size 2700 Total Returns 510	2023 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	76.4%	14th	≥ 25th	No	74.0%	7th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	69.5%	5th	≥ 25th	No	68.1%	<5th	≥ 33rd	No

Notable findings: The Adult Composite score for getting needed care decreased, and getting care quickly decreased with both failing to meet the benchmark.

CAHPS Composite Scores
Child

	CHILD CAHPS Composite	2022-2023 (14.9% Response Rate) Sample Size 4,125 Total Returns 611	MY 2022 Percentile Rate	Partnership Benchmark	Benchmark Met?	2022-2023 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	76.7%	10th	≥ 25th	No	77.1%	14th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	76.3%	<5th	≥ 25th	No	78.9%	9th	≥ 33rd	No

Notable findings: The child composite score for Getting Needed Care increased from 76.7% to 77.1% and Getting Care Quickly increased from 76.3% to 78.9%. However, both measures failed to meet the benchmark.

The Adult and Child survey responses relative to Partnership covered members indicate we continue to have dissatisfaction with member access and correlating impact to member experience which influences health plan ratings. Stakeholders determined that continued intervention focused on; Getting Needed Care and Getting Care Quickly composite measures would be in scope for the CAHPS® Score Improvement (CSI) Goal for FY 2024-2025.

Data: Out of Network Requests (OON Report)

Out-of-Network Requests January 2023 – December 2023:

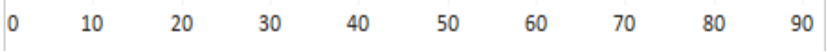
The out of network requests per 1,000 members' threshold is less than or equal to 20. The Threshold for out of network utilization is less than or equal to 10 per 1,000 members.
Partnership had 14 counties in 2023.

	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	147,060	229,942	108,230	178,592	663,824
Total OON Requests	368	464	528	261	1,621
OON Requests per 1,000 Members	2.5	2.0	4.9	1.5	2.4
Approved OON Requests	163	296	374	110	943
Approved OON Requests per 1,000 M..	1.1	1.3	3.5	0.6	1.4
Denied OON Requests	205	168	154	151	678
Denied OON Requests per 1,000 Members	1.4	0.7	1.4	0.8	1.0
Total OON Referrals Used	78	40	154	43	315
Total OON Claims	525	323	802	253	1,903
OON Claims per 1,000 Members	3.6	1.4	7.4	1.4	3
Approved OON Claims	383	226	671	145	1,425
% Approved OON Claims	73.0%	70.0%	83.7%	57.3%	74.9%
Denied OON Claims	142	97	131	108	478
% Denied OON Claims	27.0%	30.0%	16.3%	42.7%	25.1%

Data: Out of Network Requests (OON Report)

Partnership Region	County	Total OON Requests	Total OON Referrals Used
EUREKA REGION	HUMBOLDT	118	33
	MENDOCINO	101	16
	DEL NORTE	91	21
	LAKE	58	8
FAIRFIELD REGION	SOLANO	197	18
	NAPA	179	7
	YOLO	88	15
REDDING REGION	SISKIYOU	241	82
	MODOC	124	42
	SHASTA	119	22
	LASSEN	32	6
	TRINITY	12	2
SANTA ROSA REGION	SONOMA	173	25
	MARIN	88	18





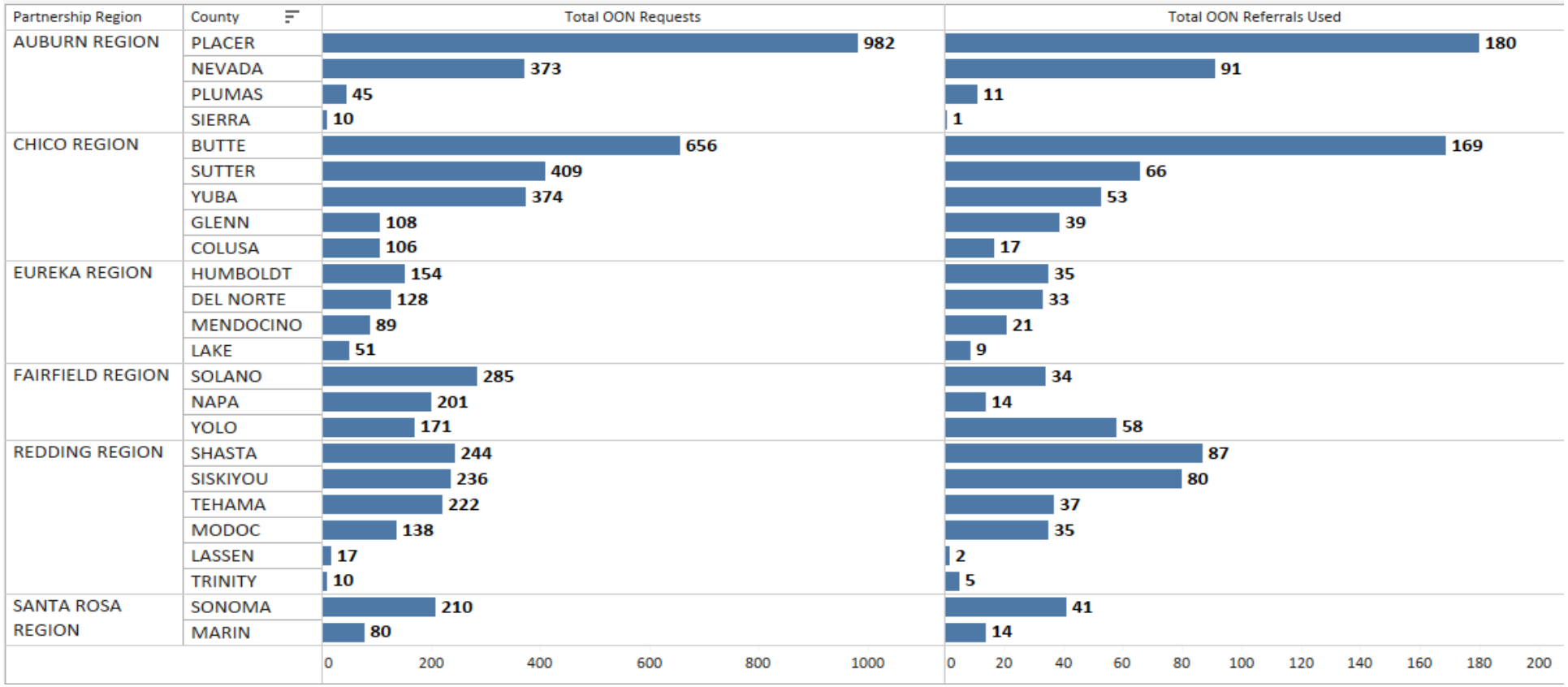
Notable finding: For the period of January 2023 – December 2023, Partnership met performance goals for requests and utilizations.

Data: Out of Network Requests (OON Report)

Partnership had 24 counties in 2024.

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	95,974	189,666	146,315	183,081	133,122	158,709	906,867
Total OON Requests	1,410	1,653	422	657	867	290	5,299
OON Requests per 1,000 Members	14.7	8.7	2.9	3.6	6.5	1.8	5.8
Approved OON Requests	996	1,089	268	508	672	166	3,699
Approved OON Requests per 1,000 M..	10.4	5.7	1.8	2.8	5.0	1.0	4.1
Denied OON Requests	414	564	154	149	195	124	1,600
Denied OON Requests per 1,000 Members	4.3	3.0	1.1	0.8	1.5	0.8	1.8
Total OON Referrals Used	283	344	98	106	246	55	1,132
Total OON Claims	1,546	1,341	538	466	1,426	339	5,656
OON Claims per 1,000 Members	16.1	7.1	3.7	2.5	10.7	2.1	6
Approved OON Claims	1,126	1,075	322	386	729	219	3,857
% Approved OON Claims	72.8%	80.2%	59.9%	82.8%	51.1%	64.6%	68.2%
Denied OON Claims	420	266	216	80	697	120	1,799
% Denied OON Claims	27.2%	19.8%	40.1%	17.2%	48.9%	35.4%	31.8%

Data: Out of Network Requests (OON Report)



Partnership Region	County	Total OON Requests	Total OON Referrals Used
AUBURN REGION	PLACER	982	180
	NEVADA	373	91
	PLUMAS	45	11
	SIERRA	10	1
CHICO REGION	BUTTE	656	169
	SUTTER	409	66
	YUBA	374	53
	GLENN	108	39
	COLUSA	106	17
EUREKA REGION	HUMBOLDT	154	35
	DEL NORTE	128	33
	MENDOCINO	89	21
	LAKE	51	9
FAIRFIELD REGION	SOLANO	285	34
	NAPA	201	14
	YOLO	171	58
REDDING REGION	SHASTA	244	87
	SISKIYOU	236	80
	TEHAMA	222	37
	MODOC	138	35
	LASSEN	17	2
	TRINITY	10	5
SANTA ROSA REGION	SONOMA	210	41
	MARIN	80	14

Notable findings: For the period of January 2024 – December 2024, Partnership met performance goals for requests and utilization.

Ratios

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Measure: Ratio**	**Performance Goal**	**2023 Results**	**Goal Met?**	**2024 Results**	**Goal Met?**
Primary Care Practitioner Overall	Primary Care Practitioner to Member (adult and children)	1:≤ 2,000	1:739	MET	1:719	MET
Family or General Practice	Family or General Practice Practitioner to Member (adult and children)	1:≤ 2,000	1:1,192	MET	1:1,235	MET
Pediatrics	Pediatricians to Members (children)	1:≤ 2,000	1:1,129	MET	1:1,130	MET
Internist	Internists to Members (adult)	1:≤ 3,000	1:2,918	MET	1:2,469	MET

Partnership expanded into 10 new rural counties in 2024 and experienced a 38.8% increase in total membership compared to 2023. We have been able to maintain access to primary care for all ages by having a stable Family Medicine network.

Geographic Distribution of Primary Care

Geographic Distribution of Primary Care – Standards and Performance Goals						
Practitioner Type	**Standard: Geographic Distribution**	**Performance Goal**	**2023 Results**	**Goal Met?**	**2024 Results**	**Goal Met?**
Primary Care Practitioner Overall	1 within 10 miles or 30 minutes from the member's residence	≥ 95%	97.9%	MET	97.59%	MET
Family Medicine or General Practitioner	1 within 10 miles or 30 minutes from the member's residence	≥ 95%	99.8%	MET	99.9%	MET
Pediatrics	1 within 10 miles or 30 minutes from the member's residence	≥ 95%	97.4%	MET	96.0%	MET
Internist	1 within 10 miles or 30 minutes from the member's residence	≥ 95%	96.6%	MET	96.6%	MET

Partnership met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty .

Third Next Available Survey

Provider Type	Standard	Goal	Plan Wide	Goal Met?	Plan Wide	Goal Met?
Primary Care Adult	Non-urgent care primary care appointments within 10 business days of request	≥ 90%	92.9%	Met	86.2%	Not Met
Primary Care Pediatrics	Non-urgent care primary care appointments within 10 business days of request	≥ 90%	92.4%	Met	91.3%	Met
Newborn Appointments	Newborn appointments within 48 hours of discharge	≥ 90%	98.5%	Met	97.4%	Met
Primary Care Urgent Care	Urgent care appointments within 48 hours of request	≥ 90%	96.1%	Met	96.9%	Met

Non-urgent Adult Primary Care Provider appointments fell short of the goal in 2024 with a 6.7% decrease from 2023.

Data: Grand Analysis Reports



2024 Summary

2023-2024 PHC Availability and Accessibility Adequacy Report

Measure or Description	Performance Standard Met for Plan?	Notes
Grievance Data: Member Complaints NCQA Access Category & Appeals and Second Level Grievances	Partially Met	*Partnership failed to meet the access grievance threshold however, met the Appeals and Second Level Grievances threshold.
Member Experience: CAHPS Composite Results	Did Not Meet	.
Out of Network Requests	Met	
Net 1A: Language, Ethnicity, Gender, Cultural Preference	Met	
Net 1B: Ratio Practitioner	Met	
Net 1C: Geographic Distribution	Partially Met	*Met Plan-Wide distribution, however, Lassen did not meet the goal for Primary Care and Modoc County fell below the standard for Ophthalmology, Physical Medicine and Rehabilitation, and Hematology/Oncology.
Net 2: Third Next Available (3NA)	Partially Met	*Partnership failed to meet the Non-Urgent Primary Care Adult appointment standard but met the Non-Urgent Pediatric, Newborn, and Primary Urgent Care appointment standard

Opportunity and Intervention

Opportunity: Appointment access to non-urgent primary care decreased by 13% in the southern region. Appointment access for obstetrics and gynecology in the southern region decreased by 19.5%. Partnership has identified the need to increase the number of contracted primary care and women's health specialty care practitioners to the network, particularly in the southern region.

- **Planned Action:** Partnership continued to expand its efforts to strengthen recruitment for specialty providers, including obstetrics providers (physicians, women's health nurse practitioners, certified nurse midwives) whose clinical care focuses on perinatal care, including labor and delivery, to the 2024 Provider Recruitment Program.
  - Effectiveness of Action: Fifteen obstetrics providers have been awarded since January 2024.

Opportunity: Partnership has identified a need to improve member experience associated with access to care. The Adult Composite score for getting needed care decreased from 76.4% to 74.0% and getting care quickly decreased from 69.5% to 68.1%. Both failed to meet the benchmark for the second year in a row.

- **Planned Action:** To leverage more real time data (i.e., Grievance & Appeals [G&A] and Population Health Management [PHM] community engagement responses) on a quarterly basis to examine and respond timelier to topical themes identified directly from our members, including complaints about the health plan and providers. This enhanced method will provide the CAHPS Goal Team more real-time opportunity to measure intervention effectiveness against targeted barriers

Questions



2025 3rd Next Available & Next Available Survey

Provider Relations & Health Analytics

November 2025

Overview - 3rd Next Available Survey

The survey is used to assess Partnership's compliance with the Accessibility standards annually

- The survey monitors appointment availability, telephone access and appointment wait time among primary care providers and high volume and high impact specialists

Standards are set forth by the Department of Health Care Services (DHCS), to ensure access to and availability of services for our members

Survey Objectives:

- Assess compliance with Partnership access standards
- Review trends and identify opportunities to improve
- Assist providers to ensure standards are met

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Methodology

The survey is administered by Partnership's Provider relations staff. One-time call to provider offices to request appointment information, providing a snapshot of access

Surveyed providers: Primary Care Providers (Family Practice, Internal Medicine and Pediatrics) and High-Volume/High-Impact Specialists

Telephonic survey: Telephonic survey by Provider Relations team during business hours in Q3 2025, asking specific appointment availability using the "third next available appointment" methodology

Data Entry: Sugar Database with fields constructed to align with the survey questions which allows uniformity of data entry across interviewers

Data Validation and Analysis: Completed by Health Analytics using Tableau

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3rd Next Available Surveyed Sites

Total of **808** sites survey across all regions and multiple specialties

Primary Care Access:

- Surveyed **304** providers

Specialty Providers:

- Surveyed **270** providers

Prenatal Providers:

- Surveyed **117** providers

Response Rate:

- **87%** of surveyed providers



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Criteria/Targets

ALL REGIONS PRIMARY CARE PROVIDERS	Standard
Days to 3NA Adult Appt	<= 10 business days
Days to 3NA Pediatric Appt	<= 10 business days
Time to Next Available Newborn Appt	<= 48 Hours
Time to Next Available Urgent Appt	<= 48 Hours
HIGH-VOLUME SPECIALISTS	**Standard**
Days to 3NA Specialty appt	<=15 business days
Time to Next Available Urgent Appt	<= 48 Hours
PRENATAL CARE	**Standard**
Days to 3NA Prenatal Care (PCP & Specialists)	<= 10 days



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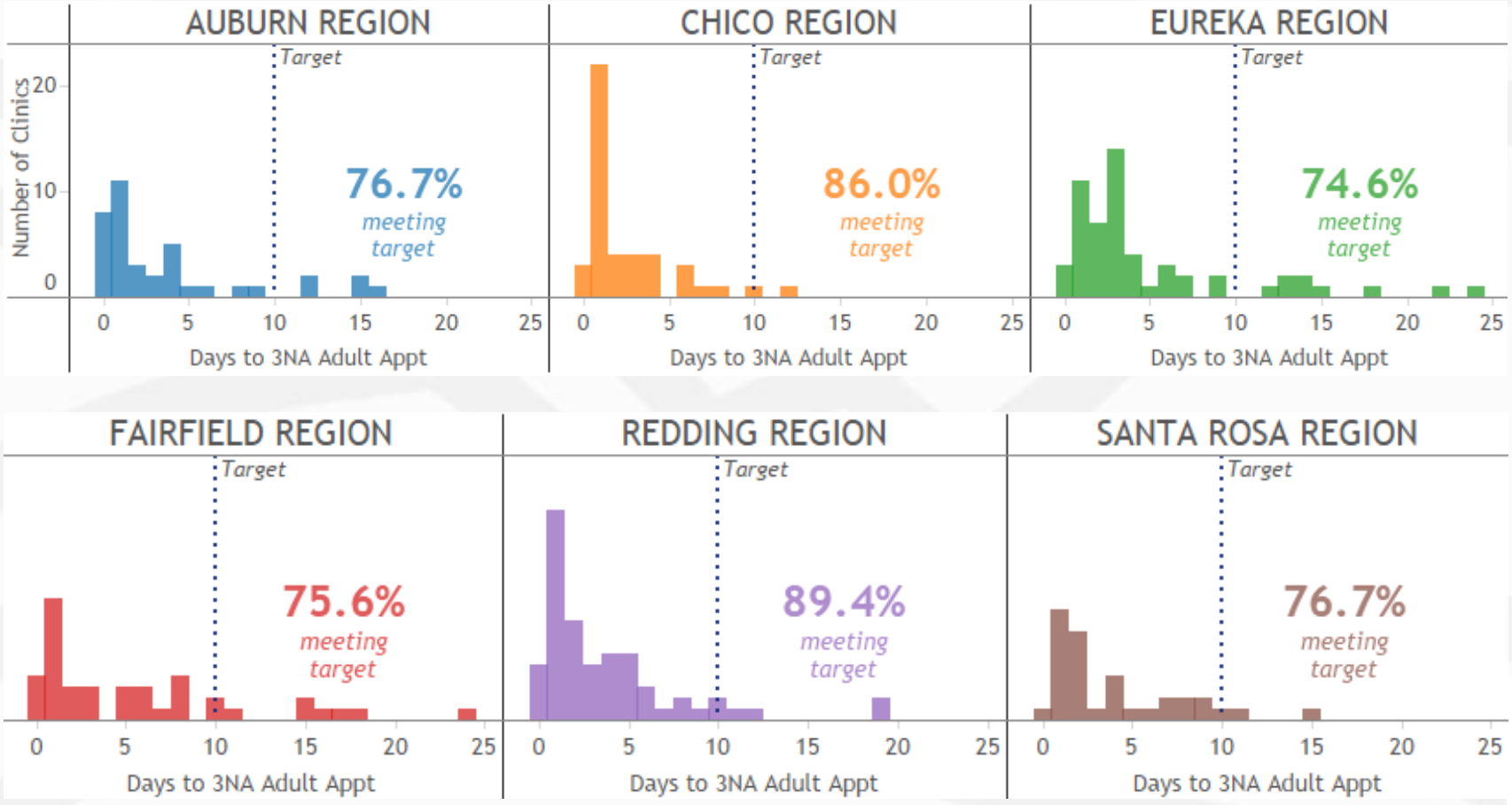


PCP Appointments

Adult PCP Appointments

Distribution of Clinics by Days to 3rd Next Available Appointment for Adults

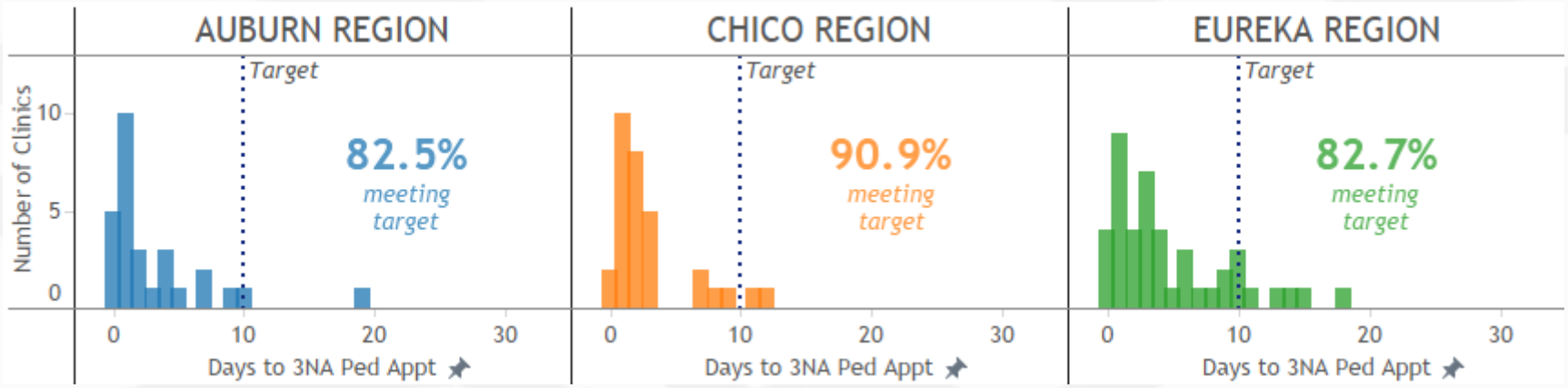
Target for Adult Appointments:
<= 10 days

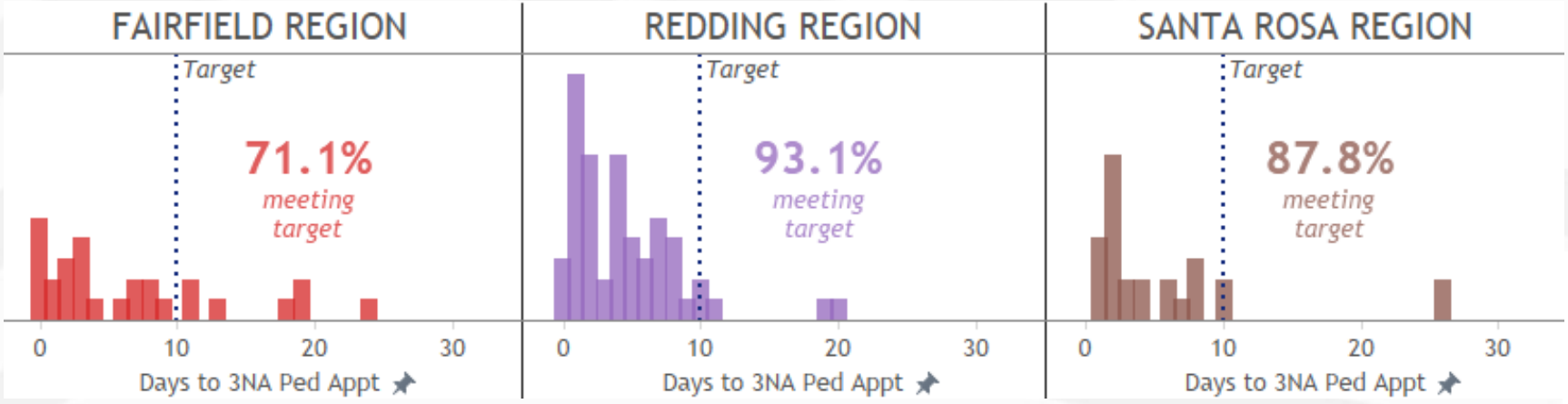


Pediatric PCP Appointments

Distribution of Clinics by Days to 3rd Next Available Pediatric Appointment

Target for Pediatric Appointments:
<= 10 days



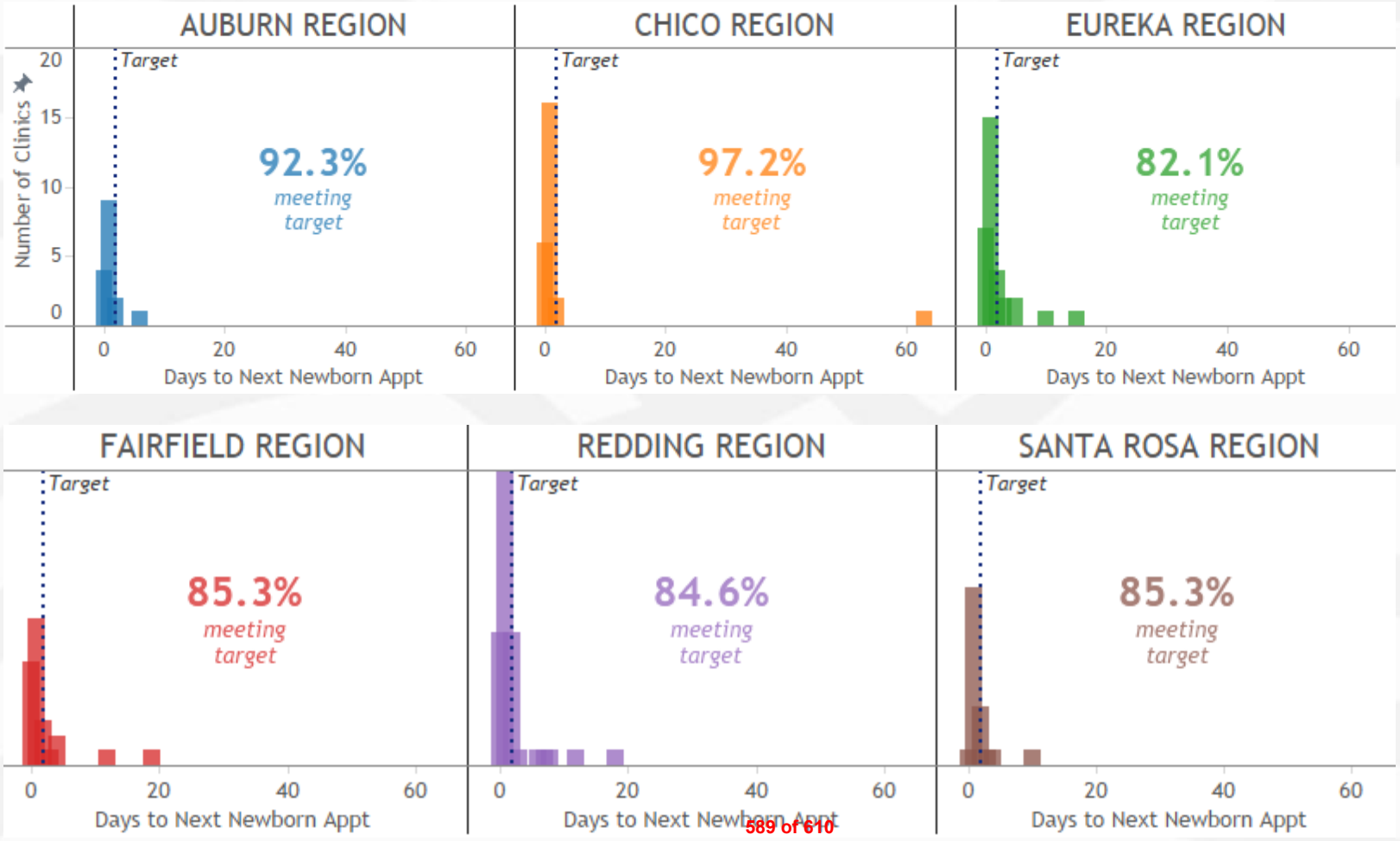


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Newborn PCP Appointments

Distribution of Clinics by Days to Next Available Appointment for Newborns

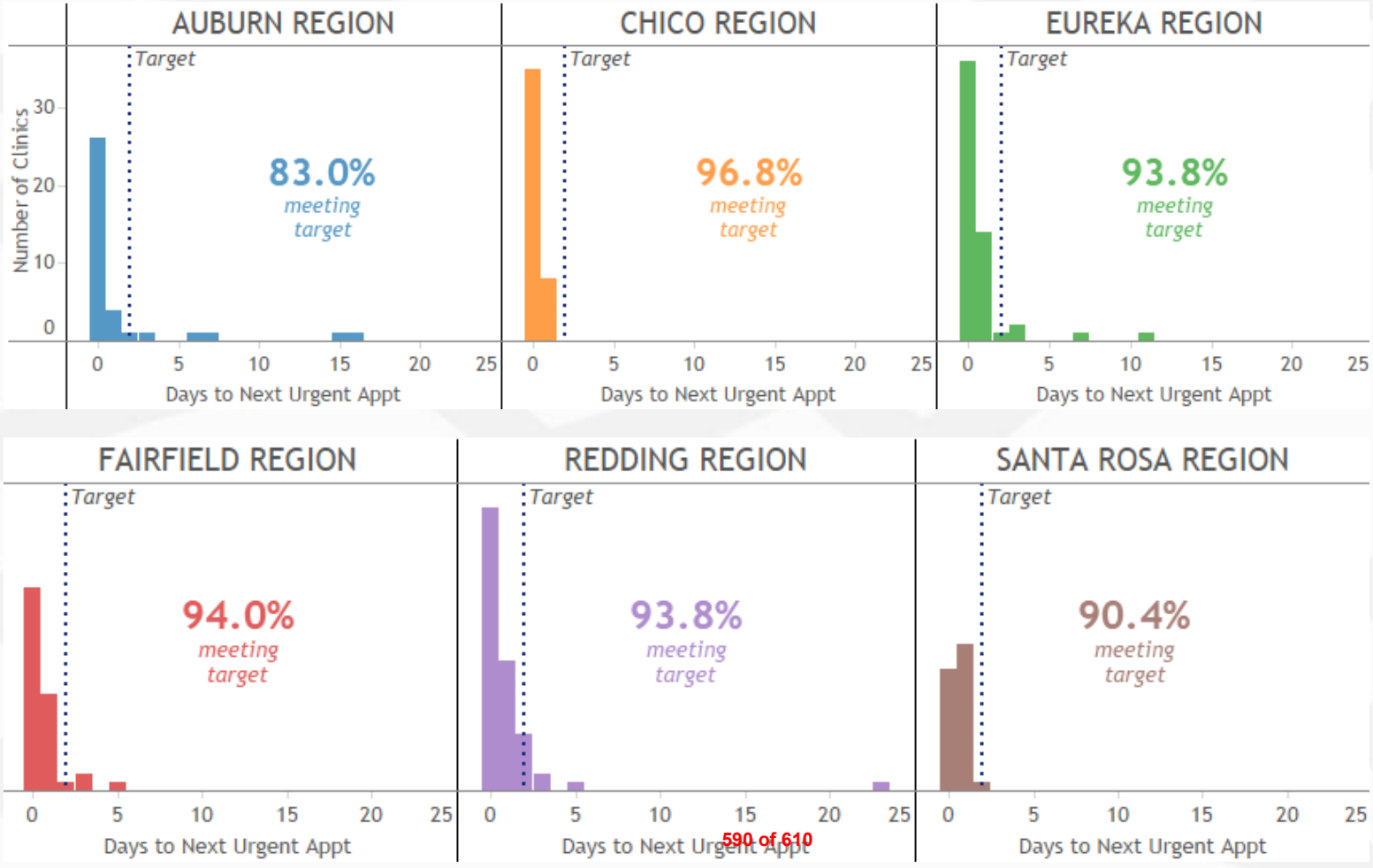
Target for Newborn Appointments:
<= 48 hours



Urgent PCP Appointments

Distribution of Clinics by Days to Next Available Urgent Appointment

Target for Urgent Appointments:
<= 48 hours

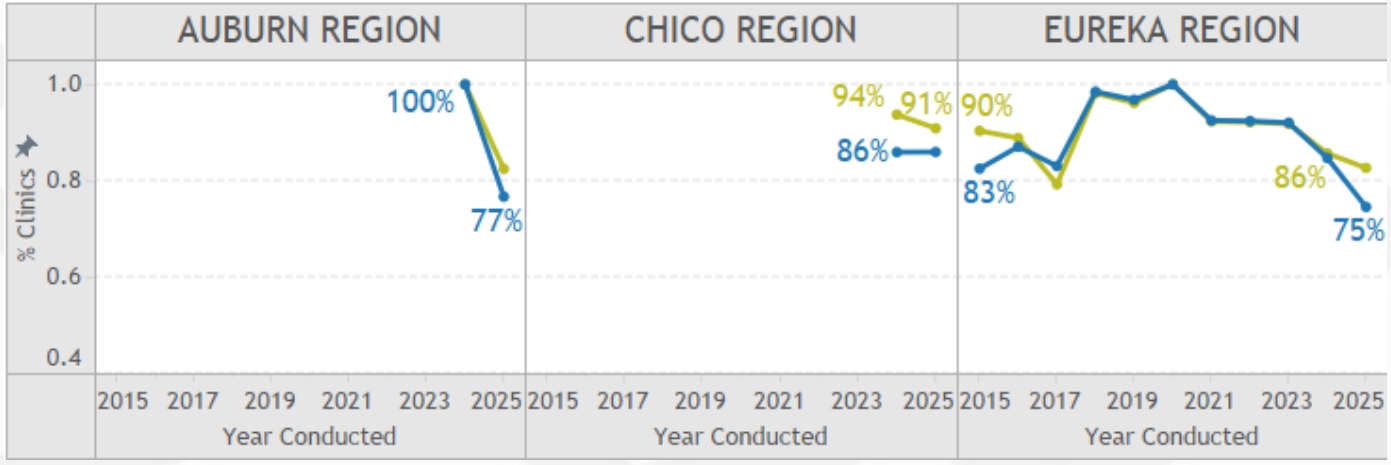


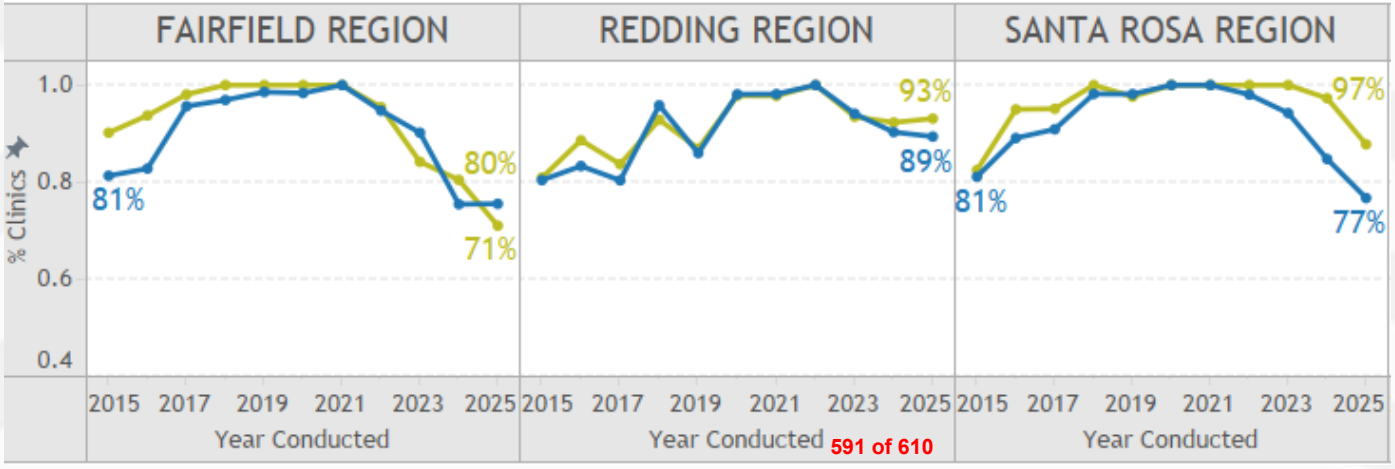
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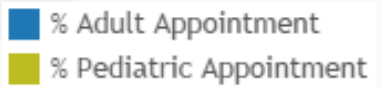
Trends for PCP Appointments Meeting Targets

Share of Clinics Meeting Adult/Pediatric Care Targets by Year

Target for Adult and Ped. Appointments: **<= 10 days**





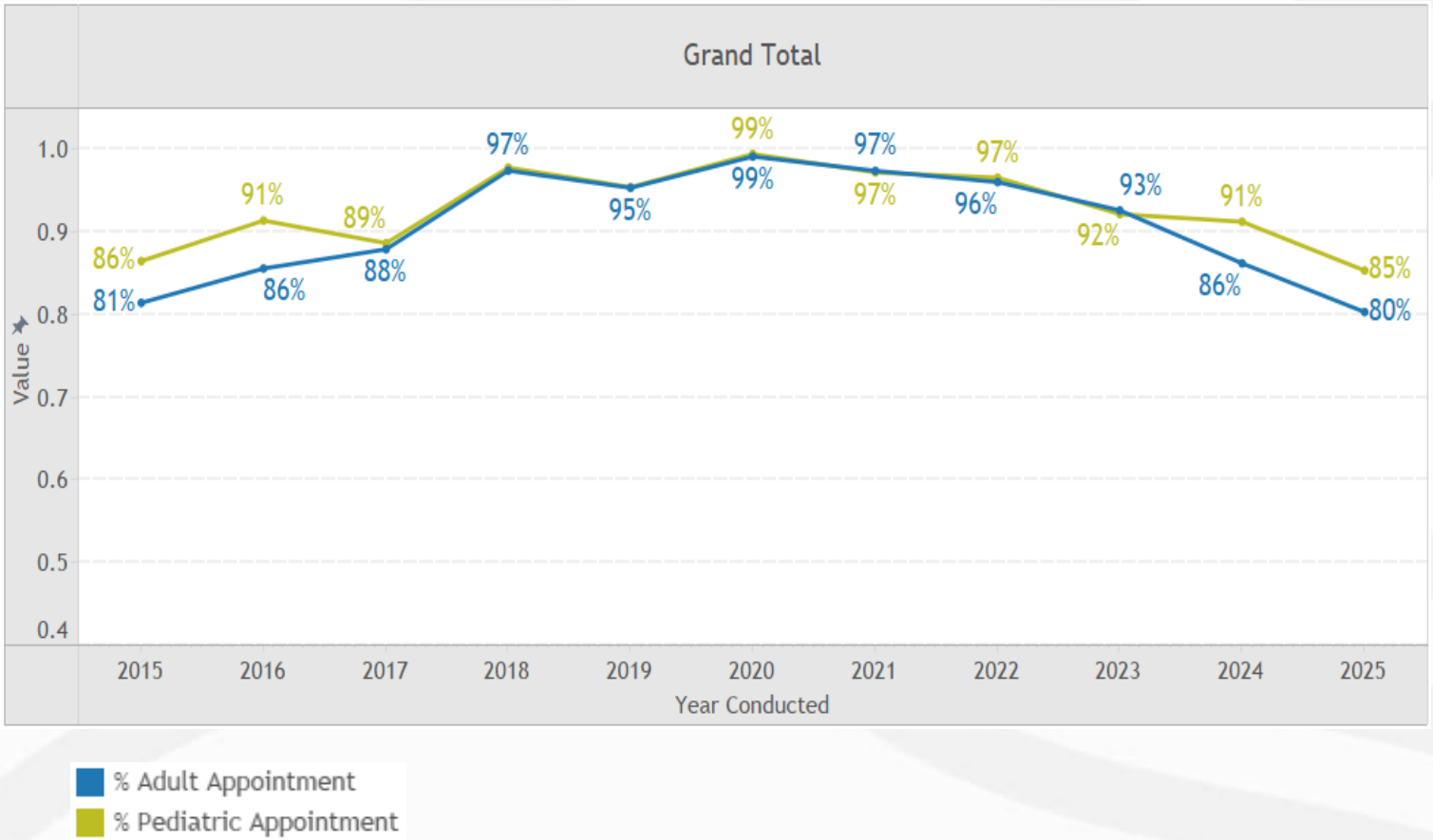


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Trends for PCP Appointments Meeting Targets

Share of Clinics Meeting Adult/Pediatric Care Targets by Year

Target for Adult and Ped. Appointments: **<= 10 days**



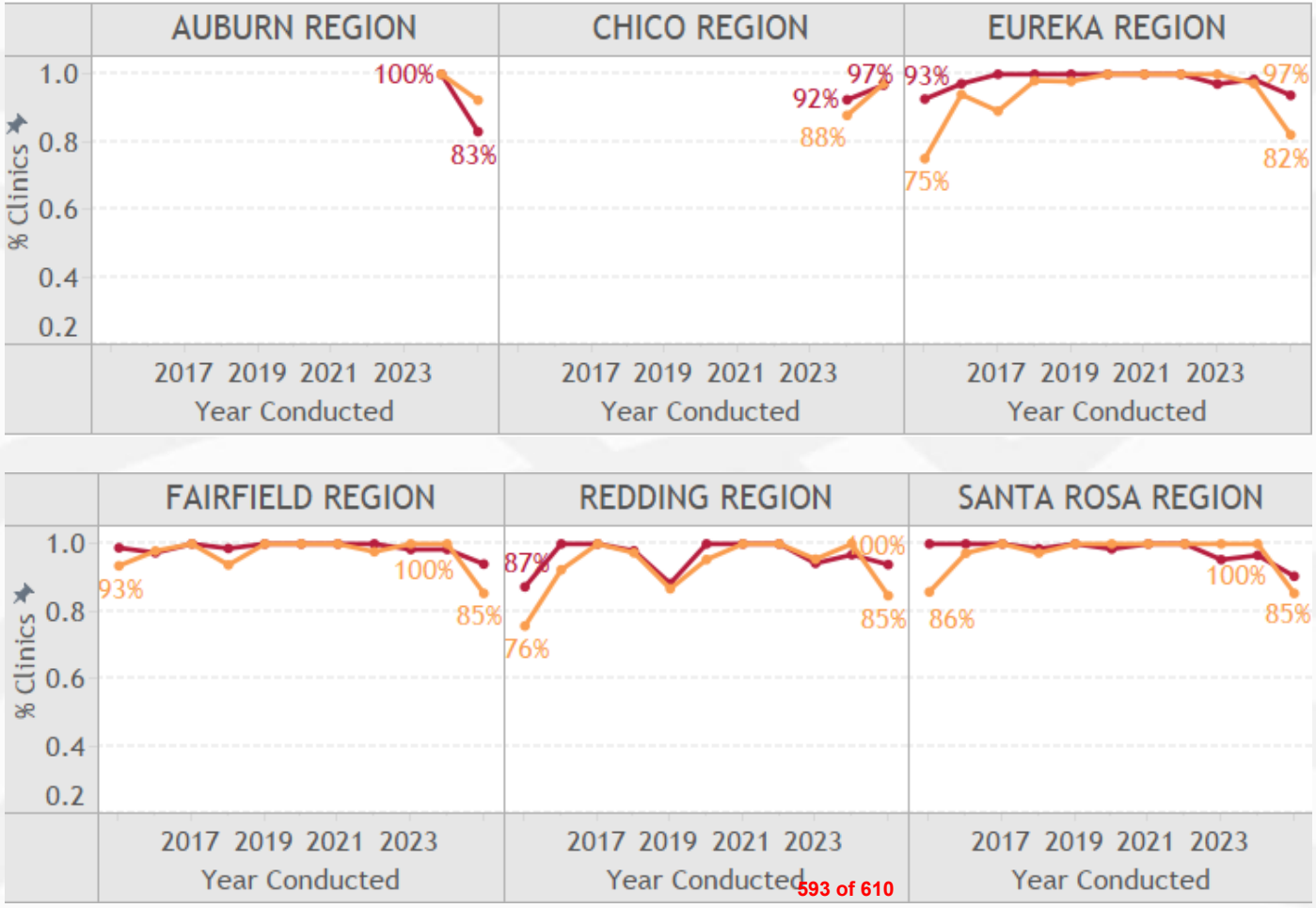
- Overall recent ~6% decrease for Adult and Pediatric appointment access

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Trends for PCP Appointments Meeting Targets

Share of Clinics Meeting Newborn/Urgent Care Targets by Year

Target for Urgent and Newborn Appts: **<= 48 hours**

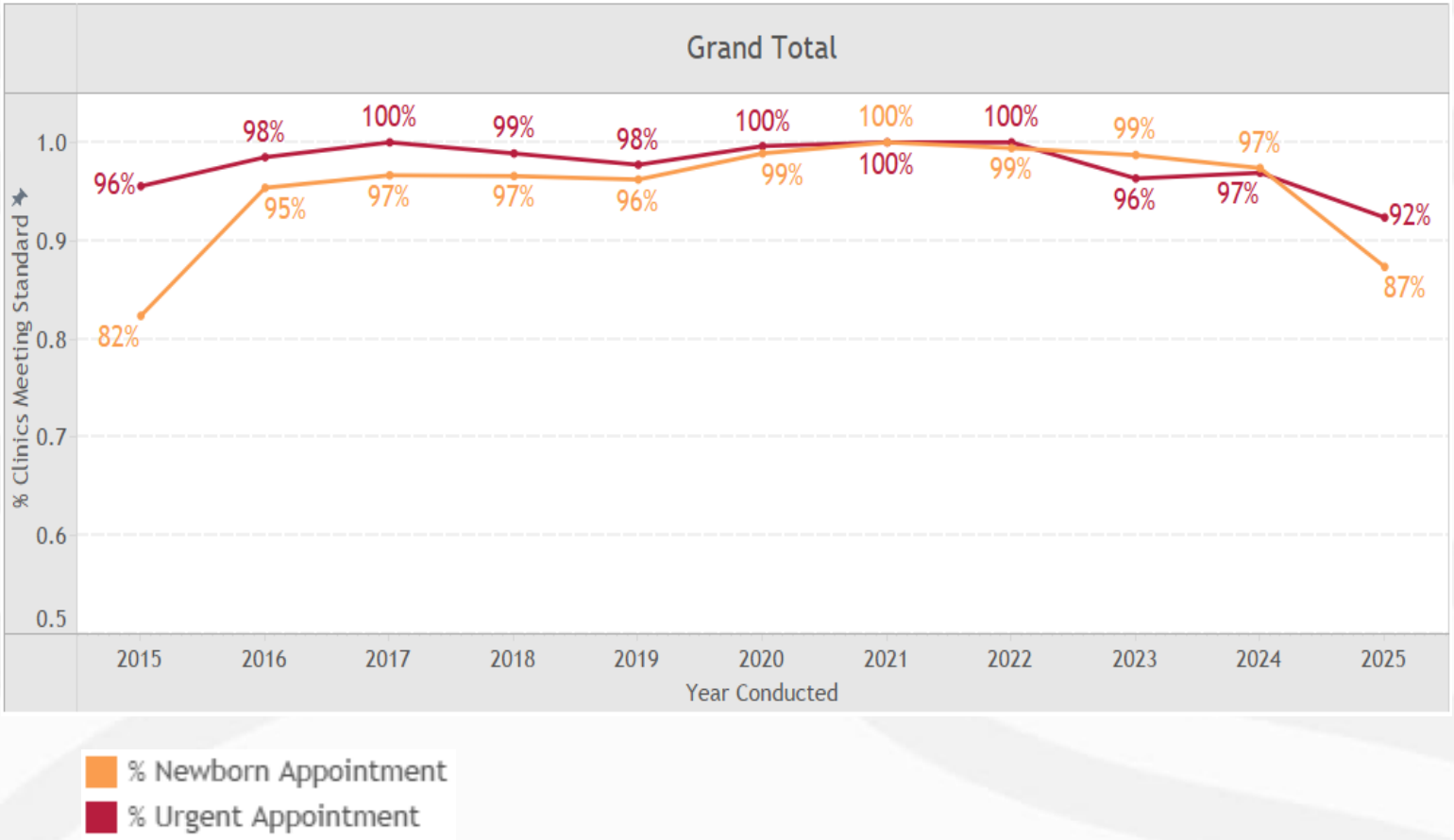


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Trends for PCP Appointments Meeting Targets

Share of Clinics Meeting Newborn/Urgent Care Targets by Year

Target for Urgent and Newborn Appts: **<= 48 hours**



- Overall 5-10% decline across Newborn and Urgent appointment access

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PCP Appointments Meeting Targets by County

% of Clinics Meeting PCP Standards by County

		Adult	Pediatric	Newborn	Urgent
AUBURN REGION	Placer	60%	76%	89%	72%
	Nevada	100%	89%	100%	100%
	Plumas	100%	100%		100%
	Sierra	100%	100%	100%	100%
CHICO REGION	Butte	73%	100%	100%	91%
	Sutter	100%	100%	88%	100%
	Yuba	78%	88%	100%	100%
	Glenn	88%	83%	100%	100%
	Colusa	100%	75%	100%	100%
EUREKA REGION	Humboldt	84%	89%	100%	96%
	Mendocino	65%	76%	69%	90%
	Lake	55%	70%	71%	92%
	Del Norte	100%	100%	100%	100%
FAIRFIELD REGION	Solano	81%	64%	75%	91%
	Yolo	87%	79%	85%	94%
	Napa	44%	70%	100%	100%
REDDING REGION	Shasta	92%	90%	84%	92%
	Siskiyou	100%	100%	92%	88%
	Tehama	83%	100%	80%	100%
	Trinity	100%	100%	75%	100%
	Modoc	75%	75%	100%	100%
	Lassen	50%	75%	67%	100%
SANTA ROSA REGION	Sonoma	88%	89%	81%	100%
	Marin	63%	86%	92%	77%

Summary

- **Adult and Pediatric** appts have the lowest number of counties meeting target
- **Newborn** appts have higher share of counties meeting target with Chico Region leading with 100% meeting standard
- All regions have high share of counties meeting **Urgent** target
- Generally Adult, Ped, and Newborn percentages have declined and Urgent appts are stable

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Clinics not Meeting Targets for PCP Appointments

Office Region	Clinic Location	3NA Adult Appt	3NA Ped Appt	Next Newborn Appt	Next Urgent Appt
AUBURN REGION	Elica Health Centers-Franklin	16			16
	Elica Health Centers-Mack Road	35	15		35
	Elica Health Centers-Marysville	35	18		35
	Elica Health Centers-North Highlands	43	38	64	
	Elica Health Centers-V Street Medical Center	46			42
	Sacramento Community Clinic-Del Paso	15			15
CHICO REGION	Adventist Health Physicians Network-Tharp Rd	1	2	63	1
	Adventist Health-Paradise Clinic-PCP	26			26
	Ampla Health Lindhurst Medical	127	34		0
	Ampla Health Oroville Medical	61			0
	Ampla Health South Chico Medical	51			1
	Oroville Family Practice-Ste 9A	93			14
EUREKA REGION	Adventist Health Clearlake-487 South Main St P..	76			0
	Adventist Health Clearlake-15230 Lakeshore Dr ..	1	36	15	1
	Lakeview Health Center	77	36	5	1
FAIRFIELD REGION	Elica Health Centers-15th St	37	41		
	Elica Health Centers-Halyard Medical Center	5	19	19	5
REDDING REGION	Canby Family Practice Clinic	42	42	2	2
	Dignity Health Medical Group North State-Court ..	1			23
	Lassen Indian Health Center	46	2	27	1
	Rolling Hills Clinic-Corning Peach	49	3	3	1
	Rolling Hills Clinic-Red Bluff 2526 Sister Mary Co..	1	8	18	1
SANTA ROSA REGION	Marin Community Clinics-Campus Clinic	42	15	2	11
	Marin Community Clinics-Greenbrae	27			25

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Summary

- 65% of clinics missed at least one PCP next appointment target
- Maximum waits for next appt. can be exceedingly long

Targets:
Adult & Pediatric <= 10 days
Newborn & Urgent <= 48 hours

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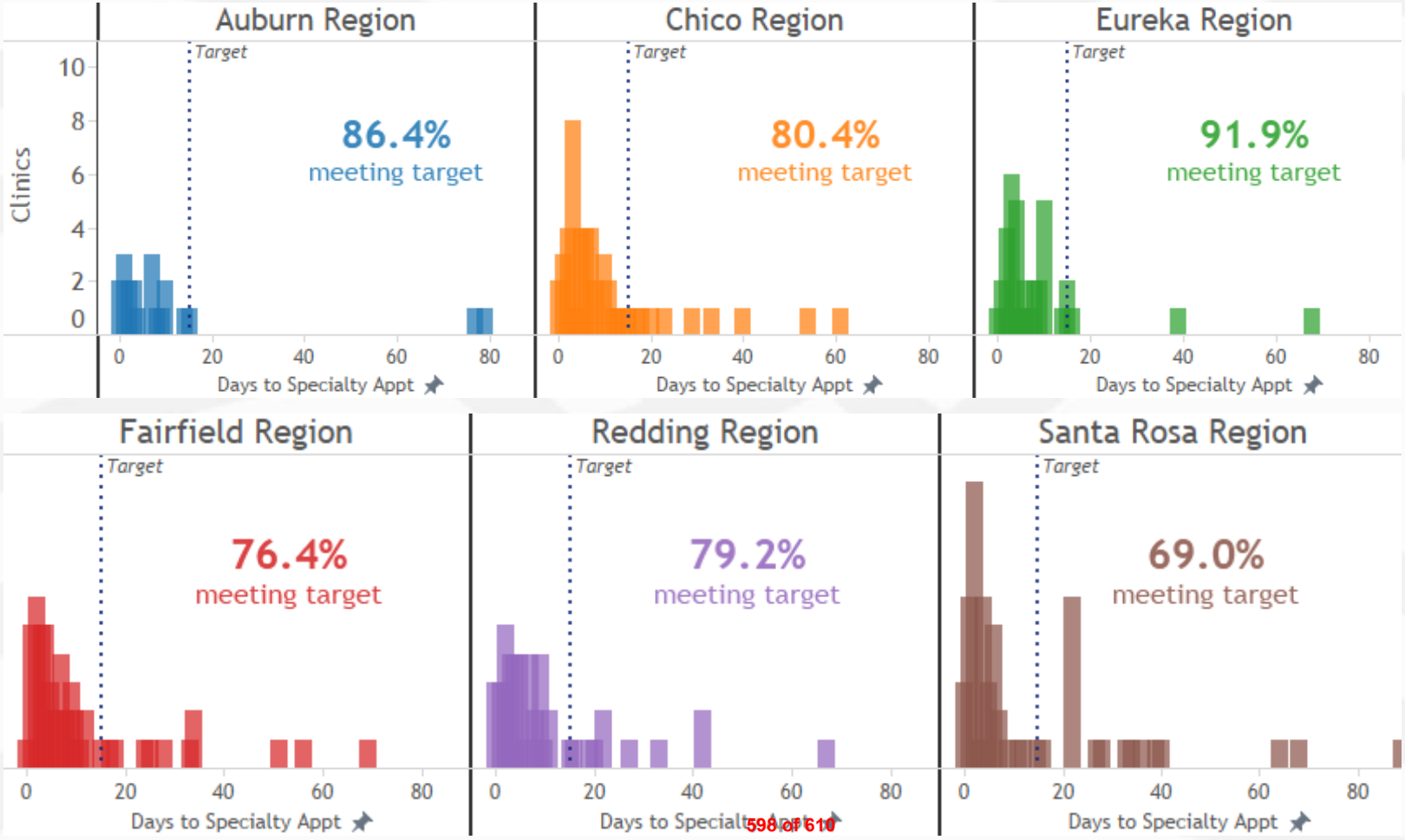
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Specialty Appointments

Specialty Appointments

Distribution of Specialty Clinics by Days to 3rd Next Available Non-Urgent Specialty Appointment

Target for Specialty Appointments:
<= 15 Days

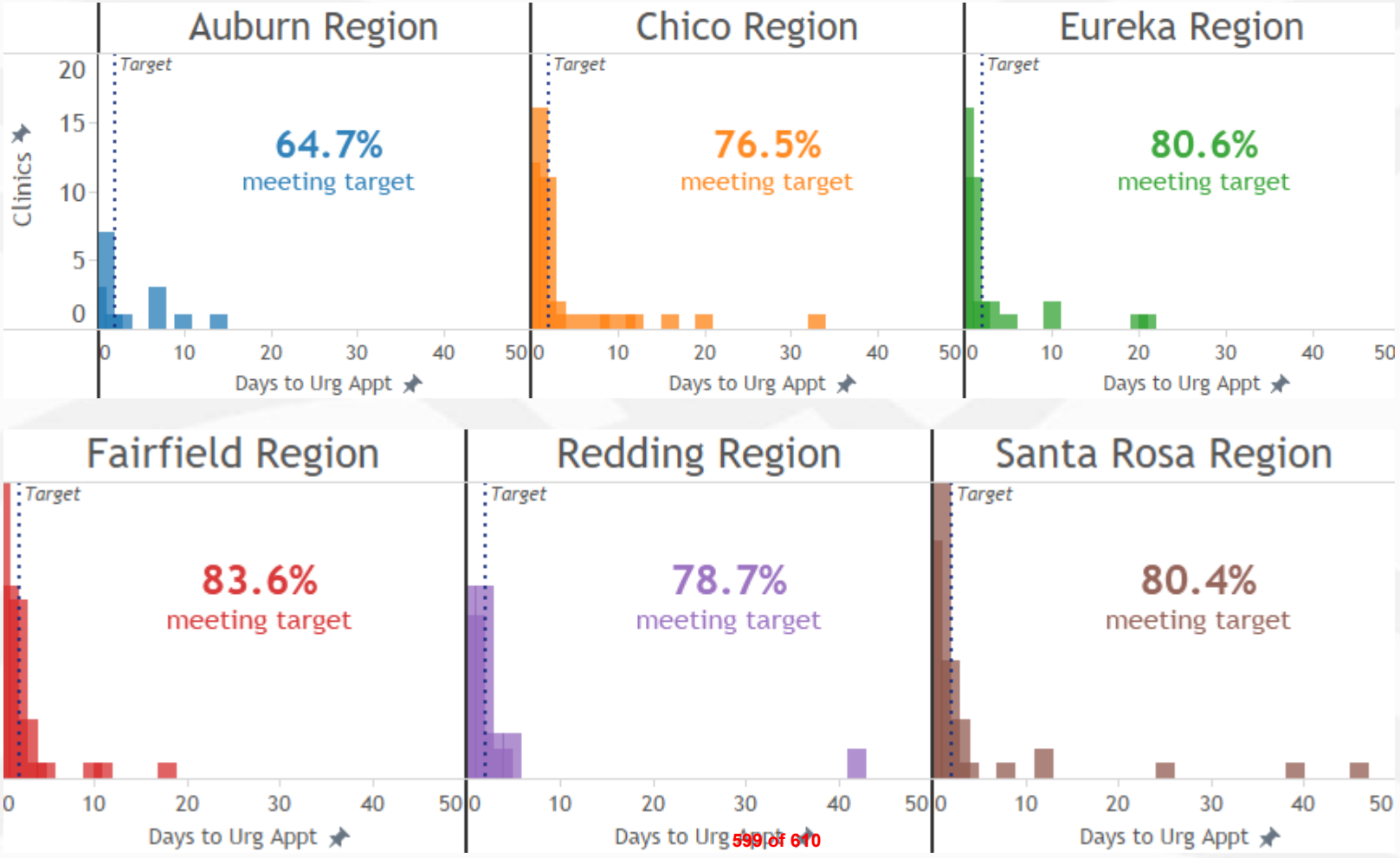


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Specialty Appointments

Distribution of Specialty Clinics by Days to 3rd Next Available Urgent Specialty Appointment

Target for Urgent Specialty Appts: **<= 48 hrs**

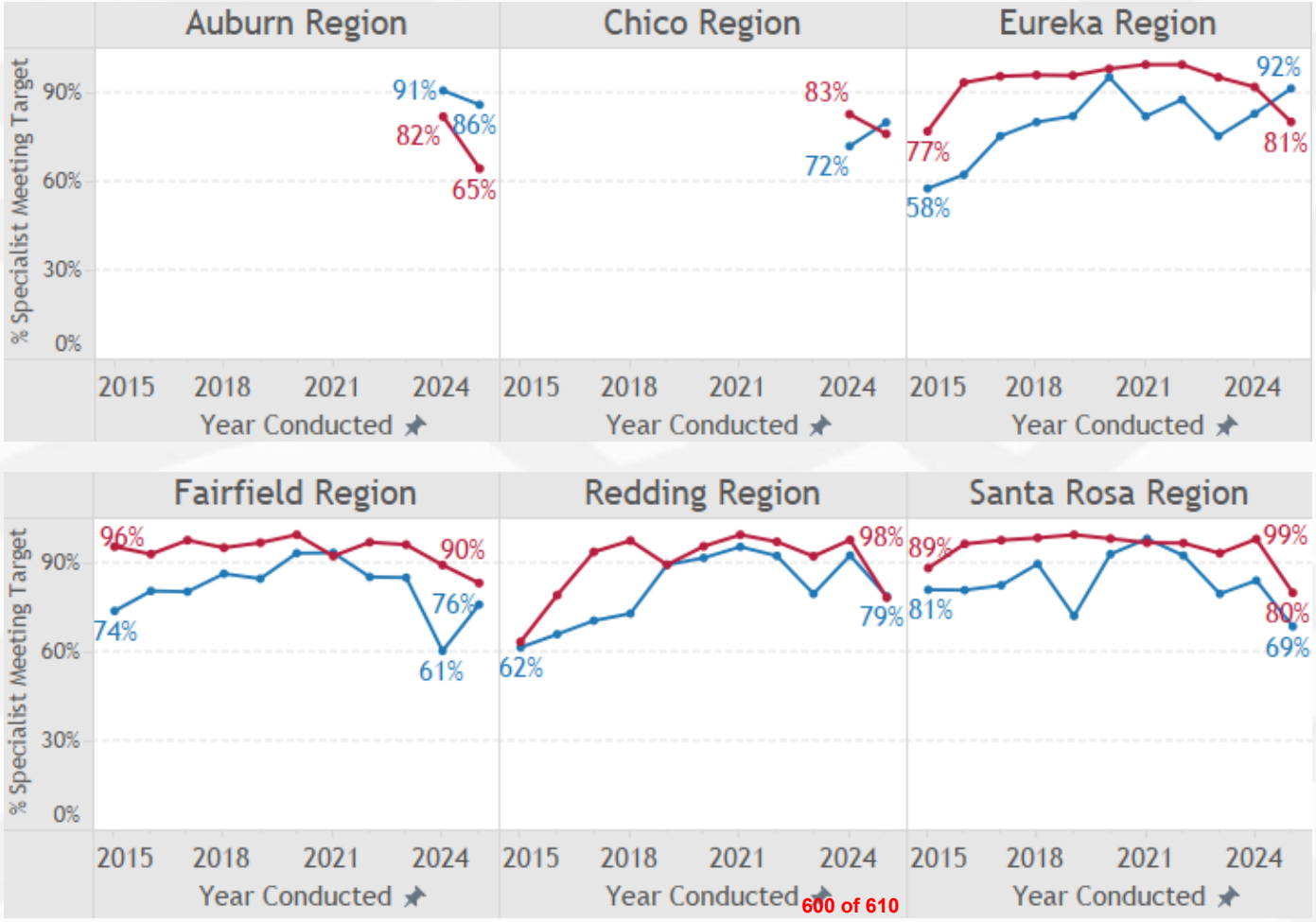


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Trends for Specialty Appointments Meeting Targets

Share of Clinics Meeting Targets by Year and Appointment Type

Specialty Appts: **<= 15 days**
Urgent Appts: **<= 48 hrs**

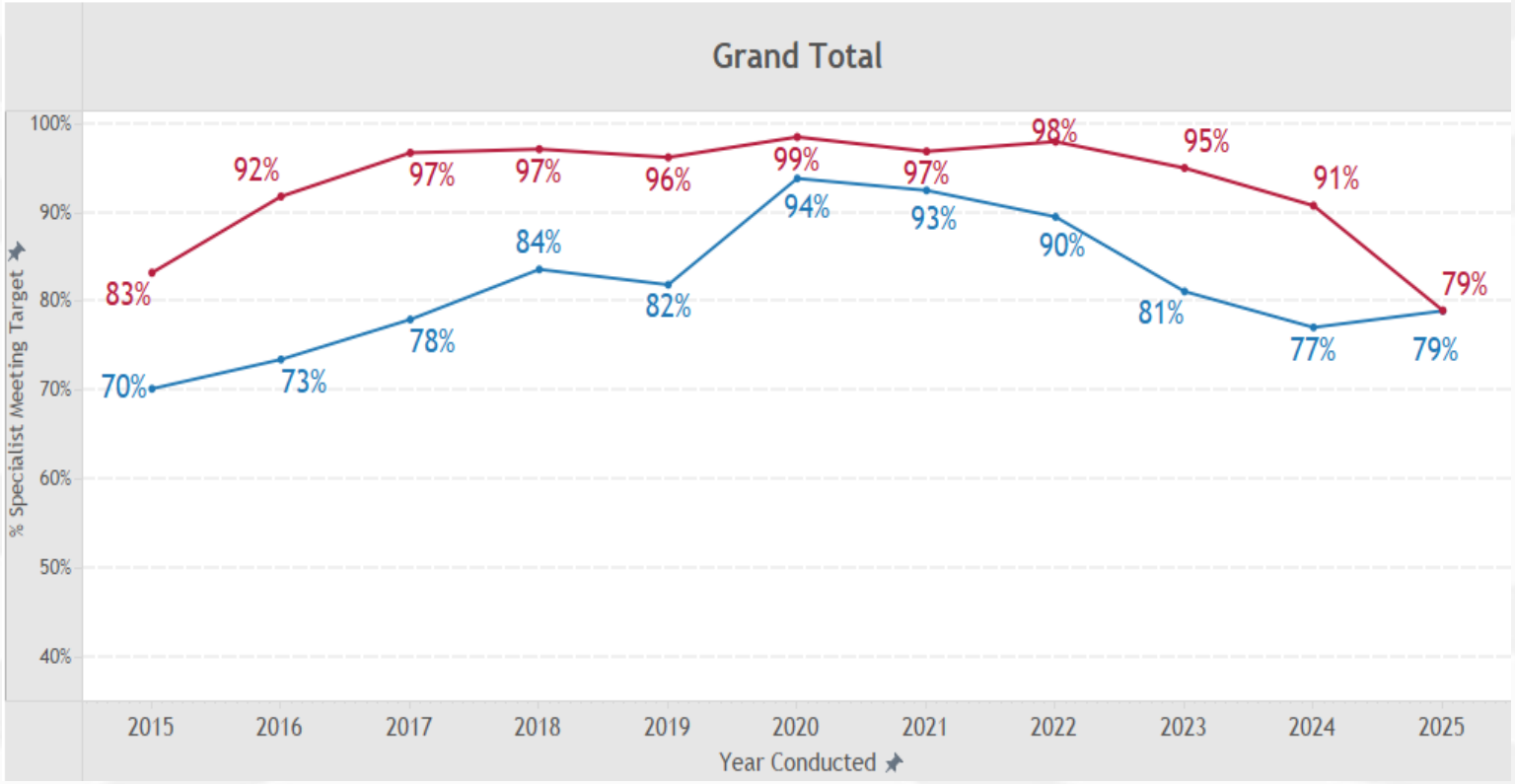


PARTNERSHIP HEALTHPLAN of CALIFORNIA
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Trends for Specialty Appointments Meeting Targets

Share of Clinics Meeting Targets by Year and Appointment Type

Specialty Appts:**<= 15 days**
Urgent Appts:**<= 48 hrs**



- Overall >10% decline across Urgent Spec appt and 2% increase for Non-Urgent Spec appt

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Share of Clinics Meeting Targets by Specialty

% of Clinics Meeting Standards by Specialty, 2025

	Auburn Region	Chico Region	Eureka Region	Fairfield Region	Redding Region	Santa Rosa Region	Grand Total
CARDIOVASCULAR DISEASE	80%	80%	100%	57%	100%	60%	76%
DERMATOLOGY	100%*	100%	100%	75%	33%	0%	64%
ENDOCRINOLOGY	0%*					0%	0%
GASTROENTEROLOGY	100%	33%	100%	60%	50%	0%	56%
GENERAL SURGERY	100%*	100%	88%	100%	100%	100%	97%
INFECTIOUS DISEASES		100%*	100%	100%*	100%*	100%*	100%
NEPHROLOGY		75%	100%	100%	0%*	100%	84%
NEUROLOGY	50%	50%	100%*	66%	100%	75%	71%
OBSTETRICS/ GYNECOLOGY	100%	80%	71%	85%	87%	90%	84%
OPHTHALMOLOGY	100%*	100%*	100%	77%	85%	50%	75%
ORTHOPAEDIC SURGERY	100%	100%	100%	83%	83%	75%	85%
OTOLARYNGOLOGY		50%	100%	50%	50%	100%*	66%
PHYSICAL MEDICINE AND REHABILITATION	100%	0%*	100%*	100%*	0%		66%
PULMONARY DISEASE	100%*	100%	100%*	66%	0%*	100%	83%

Summary

- Specialties with highest % of clinics meeting standards: ***Infectious Disease, General Surgery, Orthopedic Surgery***
- Specialties with lowest % of clinics meeting standards: ***Endo., Gastroenterology, Dermatology.***
- The **Eureka Region** has greatest # of specialties meeting standards.
- **Fairfield Region** has lowest # of specialties meeting standards.
- Across all specialties **80.5%** met standard

* single provider

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Clinics not Meeting Targets for Specialty Appointments

19.5% of Surveyed Clinics do not meet the 3NA Specialist Appointment Target

Auburn & Chico Region Specialty Providers

Specialty Group	Provider Name	
CARDIOVASCULAR DISEASE	Adventist Health Physicians Network-414 G St Ste 106	18
	Adventist Health Physicians Network-414 G St Ste 108	61
	Tahoe Forest MultiSpecialty Clinics-10978 Donner Pass Rd	77
ENDOCRINOLOGY	Tahoe Forest MultiSpecialty Clinics-Pulm/Endo	79
GASTROENTEROLOGY	Enloe Digestive Diseases Clinic	29
	Oroville Gastroenterology	20
NEPHROLOGY	Jon Ferguson DO Corp	17
OBSTETRICS/ GYNECOLOGY	Enloe Women Services - 2nd Ave	33
	Enloe Women's Services - South	54
OTOLARYNGOLOGY	Enloe Ear, Nose, & Throat Clinic	40
PHYSICAL MEDICINE AND REHABILITATION	Enloe Physical Medicine & Rehabilitation Clinic	23

Fairfield & Santa Rosa Region Specialty Prov.

Specialty Group	Provider Name	
CARDIOVASCULAR DISEASE	MarinHealth Medical Network Cardiology-75 Rowland Way Ste 250	64
	NorthBay Health Wound Care-Vacaville	33
	NorthBay Heart and Vascular Center-Fairfield Business Center Dr	34
	NorthBay Heart and Vascular Center-Fairfield Pennsylvania Ave	34
	Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 103	68
DERMATOLOGY	Santa Rosa Community Health-Vista Campus	28
	Solano Dermatology Associates-Vallejo	51
ENDOCRINOLOGY	MarinHealth Medical Network Endocrinology-900 S Eliseo Drive Ste 201	36
	Providence Medical Group, Sonoma-1162 Montgomery Dr Endocrinology	39
GASTROENTERO..	MarinHealth Medical Network Gastroenterology-200 Tamal Plaza Ste 200	33
	Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 205	40
NEUROLOGY	Integrated Neurology & Pain Management PC	28
OBSTETRICS/ GYNECOLOGY	Santa Rosa Community Health-Lombardi Campus	27
OPHTHALMOLO..	North Bay Eye Associates Inc.-Santa Rosa	89
	Woodland Clinic-1321 Cottonwood St Ste 202	69
ORTHOPAEDIC SURGERY	Weiss Orthopaedics-Sonoma	34
OTOLARYNGOL..	Woodland Clinic-2440 W Covell Blvd Ste 100	56

Eureka & Redding Region Specialty Providers

Specialty Group	Provider Name	
DERMATOLOGY	Lassen Medical Clinic-Red Bluff	42
	Reece, Ronald E, MD	67
GASTROENTERO..	Redding Endoscopy Center-Sonoma St	42
GENERAL SURGERY	Cobb, Luther Fuson, MD	68
NEPHROLOGY	Shasta Critical Care Specialists	20
OBSTETRICS/ GYNECOLOGY	Adventist Health Clearlake-15230 Lakeshore Dr	39
	Fairchild Medical Clinic-Spec	22
	Little Lake Health Center	16
OPHTHALMOLO..	Riverside EyeCare Professionals	33
ORTHOPAEDIC SURGERY	Guthrie, Todd Bruce, MD	19
OTOLARYNGOL..	Gary Buxa, MD	27
PHYSICAL MEDICINE AND ..	Redding Spine and Sports Medicine	22
PULMONARY DISEASE	Shasta Critical Care Specialists	16

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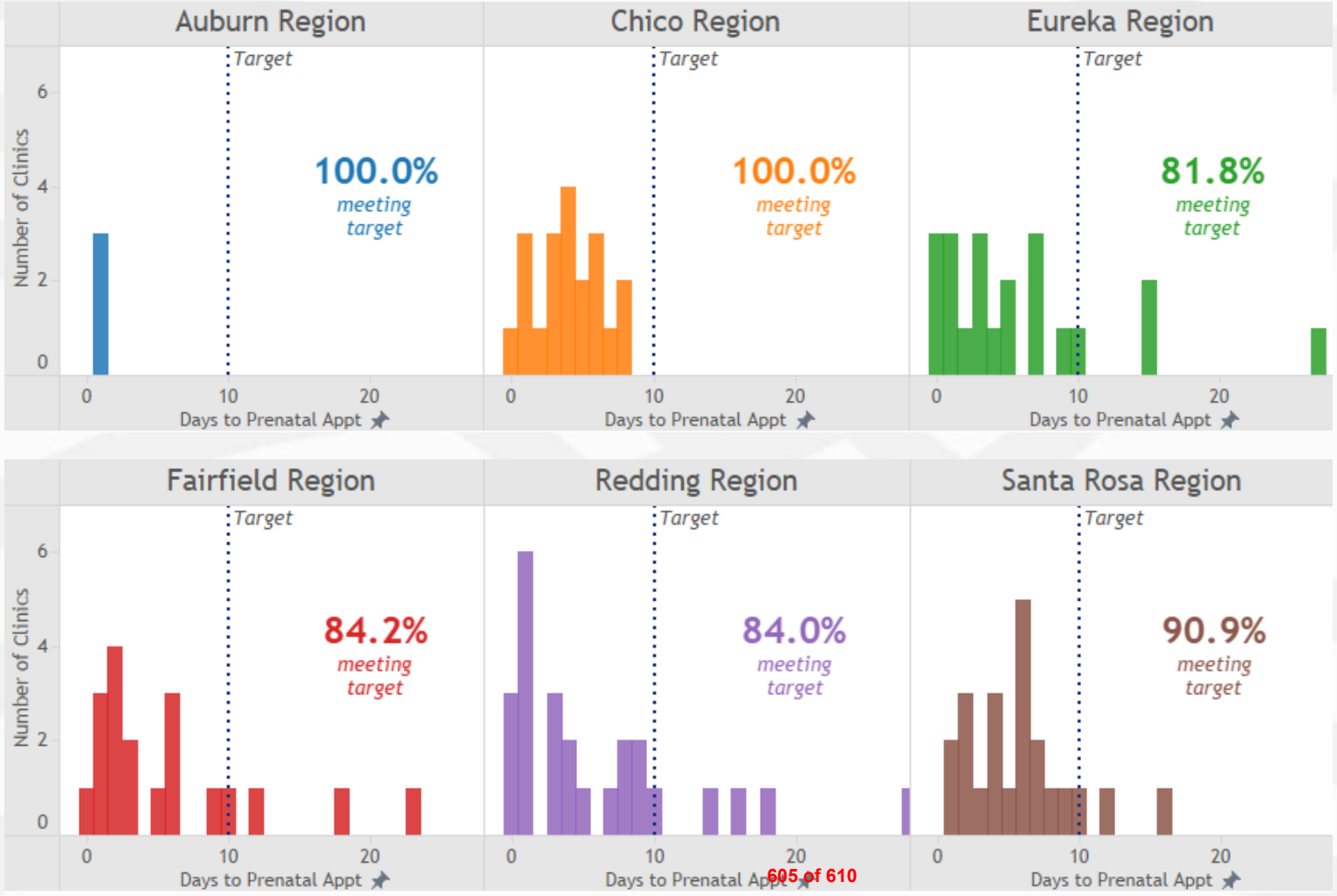


Prenatal Appointments

Prenatal Appointments Meeting Targets

Distribution of Clinics by Days to Next Prenatal Appt

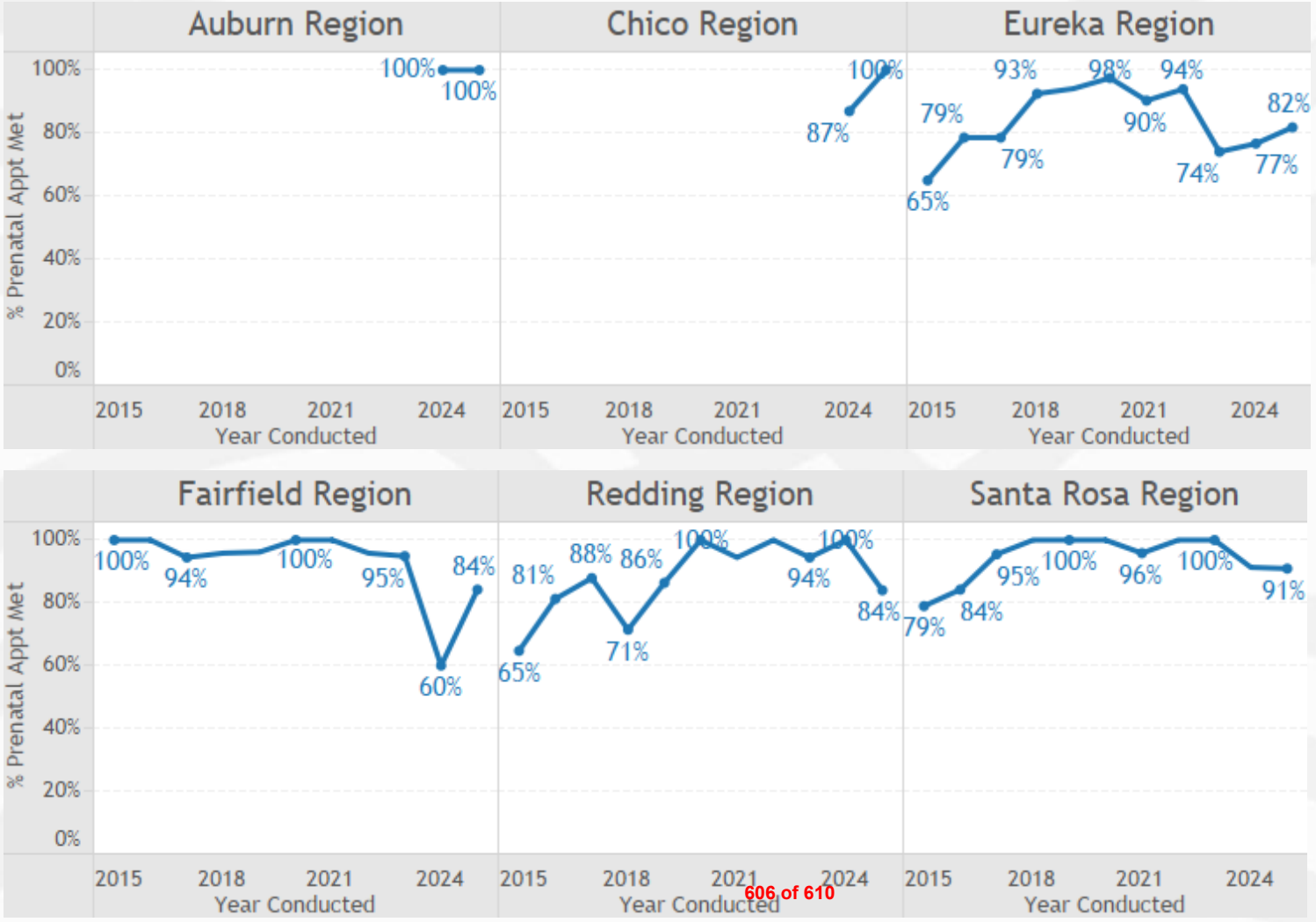
Target 3NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days



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Trends for Prenatal Appointments Meeting Targets

Share of Clinics Meeting Prenatal Care Targets by Year



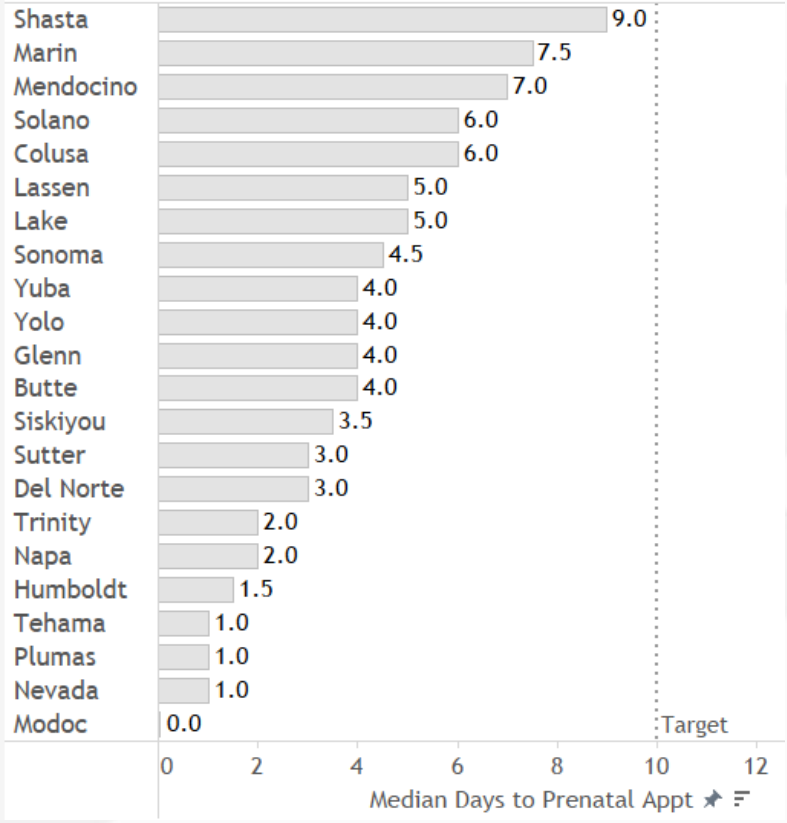
Target 3NA Appointment Prenatal Care
PCP <= 10 days
Specialist <= 10 days

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Prenatal Appointments Meeting Targets

The median wait for all counties was within the target but individual sites may have exceeded target greatly

Days to Prenatal Appts by County



Clinics that Missed Prenatal Target

Region	County	Location	
Eureka Region	Lake	Adventist Health Clearlake-15230 Lakeshore Dr Peds	15
	Mendocino	Adventist Health Ukiah Valley-260 Hospital Dr Ste 103..	27
		Hillside Health Center	33
		Point Arena Community Health Center	15
Fairfield Region	Solano	Communicare OLE-Travis	18
	Yolo	Northern Valley Indian Health-Woodland 175 W Court..	23
		Winters Healthcare Foundation, Inc.-Winters	12
Redding Region	Shasta	Pit River Health Service	16
		The Women's Babies' & Children's Center-OB/GYN	28
	Siskiyou	Scott Valley Rural Health Clinic	14
		Tulelake Health Center	18
Santa Rosa Region	Marin	MarinHealth Medical Network Ob/Gyn-75 Rowland W..	16
	Sonoma	Alliance Medical Center - Healdsburg	12

Target
3NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days

Thank You!

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2026 QI Committees Meeting Schedules and Material Deadlines

Policies and Presentations (usually) due last Tuesday of preceding month:
Dec. 30, 2025; Jan. 27, 2026; Feb. 24; March 24; April 28; May 26; July 28; Aug. 25; Sept. 29; Oct. 27

Internal Quality Improvement (IQI) Committee

All meetings are held 2nd Tuesdays from 1:30 to 3:30 PM; July and December are tentative*
*Note: * April 7 is a first Tuesday **

Jan. 13, 2026	**April 7, 2026**	July 7, 2026	**Oct. 10, 2026**
Feb. 10, 2026	**May 12, 2026**	**Aug. 11, 2026**	**Nov. 10, 2026**
March 10, 2026	**June 9, 2026**	**Sept. 8, 2026**	Dec. 8, 2026

Per MPQP1004, Standing Committee Members are required to appoint and send a designee if unable to attend:
Administration: CEO; COO; Chief Strategy & Government Affairs Officer;
Regional Directors; Compliance Manager, Grievance & Appeals
Configuration: Configuration Department Leadership / ***Finance:*** Director, Health Analytics
Health Services *(i.e., BH, CC, EHS, HE, Pharmacy, PHM, QI, and UM):* Chief Medical Officer – Committee Chair;
Medical Director for Quality – Vice Chair; Medical Director for Medicare Services; Chief Health Services Officer;
Director of Health Equity (Health Equity Officer);
Senior Directors of Behavioral Health, Care Management, and Quality & Performance Improvement;
Directors of Enhanced Health Srvcs, Pharmacy, Population Health, Quality Management, Quality Measurement, Utilization Mgmt;
Associate Director(s), Care Coordination, Population Health and Utilization Management;
Manager of Care Coordination Regulatory Performance; Manager of Member Safety – Quality Investigations;
Manager, Clinical Compliance – Quality Inspections; Senior Health Educator; Policy Analyst, Health Services
Regional Directors; Regional Medical Director(s); Associate Medical Director(s)
Member Services: Senior Director of Member Services & Grievance
Provider Relations: Director, Provider Relations; Director of Network Services

Quality/Utilization Advisory Committee (Q/UAC)

All meetings are held 3rd Wednesdays from 7:30 to 9:00 AM; July and December are tentative
CONFIDENTIAL Peer Review Committee meets immediately thereafter: 9 to 10 AM and may need to meet in July and December, depending on caseload.

Jan. 21, 2026	**April 15, 2026**	July 15, 2026	**Oct. 21, 2026**
Feb. 18, 2026	**May 20, 2026**	**Aug. 19, 2026**	**Nov. 18, 2026**
March 18, 2026	**June 17, 2026**	**Sept. 16, 2026**	Dec. 16, 2026

Per MPQP1002, the following Partnership staff, excluding the CMO and Medical Directors, serve as non-voting members:
Administration: Director, Grievance and Appeals
Health Services: Chief Medical Officer – Committee Chair; Medical Director for Quality – Vice Chair;
Medical Director for Medicare Services; Clinical Director of Behavioral Health; Chief Health Services Officer;
Senior Director of Quality and Performance Improvement; Director of Health Equity (Health Equity Officer);
Directors of Population Health, Enhanced Health Services, and Pharmacy Services;
Director(s) and Associate Director(s) of Care Coordination and Utilization Management;
Manager, Member Safety – Quality Investigations; Manager, Clinical Compliance – Quality Inspections; Senior Health Educator;
Regional Directors; Regional Medical Director(s); Associate Medical Director(s)
Provider Relations: Senior Provider Relations Rep Manager

Meetings are held at Fairfield (West), with video connection to remote callers and to Partnership's Redding (Airpark) and Santa Rosa offices.

2026 QI Committee Presentations Calendar

As of Nov. 12, 2025 (subject to change)

The Internal Quality Improvement (IQI) and Quality/Utilization Advisory Committee (Q/UAC) will not meet in July and December.

Non-footnoted topics are scheduled for full presentations at both IQI and Q/UAC.

January – *due Tuesday, Dec. 30, 2025* 2025 Referral Follow-up (Robert Moore, MD) [1] 2025 CG-CAHPS Analysis (Amber Newell) [1a] 2024-25 Hospital QIP Evaluation (Troy Foster) [1a] QI Initiative: DataLink Pilot (Kristine Gual) [8]	**February** – *due Tues., Jan. 27, 2026* 2025 PQI/PPC Annual Report (Robert Bides) PARS Report (Rachel Newman) Care Coordination Grand Analysis (Kelly Youngstone) 2024-25 Perinatal QIP Evaluation (Troy Foster) [1a] Perinatal Portfolio (Colleen Townsend, MD) [8]
March – *due Tues., Feb. 24, 2026* D-SNP Model of Care (Kermit Jones, MD/K. Robertello) Site Review Report (Rachel Newman) Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 2025-2026 QI Work Plan Update (Isaac Brown) [2a] ***C&L Trilogy*** [3] (Hannah O'Leary): 2025 C&L Program Evaluation, 2026 C&L Program Description, 2026 C&L Work Plan	**April** – *due Tues., March 24, 2026* UM Program Description (Tony Hightower) [3] UM/Pharmacy Evaluation/Grand Analysis (UM/Pharm Team) [3] Pharmacy Operations Update (Stan Leung) [2a] Population Needs Assessment (Hannah O'Leary) [3] Proposed 2026-27 HQIP & PQIP Measures Summaries (Troy Foster) [1] Audit in April Potentially
May – *due Tues., April 28, 2026* IHA – Claims & Encounters Summary (Rachel Newman) [1] Grand Analysis: Behavioral Health Coord (Nicole Escobar) [3] Behavioral Health Overview (Mark Bontrager/J. DeVido, MD)[7] QI Initiative: Mobile Measures (Areli Carrillo) [8]	**June** – *due Tues., May 26, 2026* InterQual® Annual Review (UM Team) [3] Annual Grievance & Appeals (Kory Watkins) [3] 2025-2026 PHM Work Plan Final Update [2a, 3] ***PHM Package*** [3] (DeLorean Ruffin): 2026-2027 Strategy & Program Description, Grand Analysis with Segmentation Report and Impact Analysis
August – *due Tues., July 28, 2026 (Q/UAC minutes to NCQA HPA)* HEDIS® Annual Performance (Kristine Gual) [4] PQI/PPC 1st & 2nd Qtr 2026 (Robert Bides) [2] 2025-2026 QI Work Plan Final Update (Isaac Brown) [3, 4, 5] ***QI Trilogy*** [3, 4, 5] (Isaac Brown): 2025-2026 QI Evaluation, 2026-2027 QI Work Plan, 2026-2027 QI Program Description	**September** – *due Tues., due Aug. 25, 2026* Grand Analysis: Network Access/Adequacy (Renee Trosky) Proposed 2027 PCP QIP Measure Set (Athena Beltran-Nampraseut)[1] Proposed 2027 ECM Measure Set (Deanna Watson) 1st/2nd Qtr UM/Pharmacy IRR/Timeliness (UM Team/Stan) [1, 3] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 5-Star QI Strategy Plan / Tactical Plan Update (Isaac Brown) [2a]
October – *due Tues., Sept. 29, 2026* Grand Analysis: Health Equity (Moe Jalloh, Pharm.D) [9] 2025 PCP QIP Program Evaluation (A. Beltran-Nampraseut) Proposed 2027 Palliative Care QIP Measure Set (Eva Lopez) [1] Proposed 2027 LTC QIP Measure Set (Deanna Watson) [1] Oversight Audit: CY2025 Carelon (Gary Robinson) [2] Year-long medical record review (Maybe)	**November** – *due Tues., Oct. 27, 2026* Grievance & Appeals PULSE Quarterly (Latrice Innes) [2, 6] Grand Analysis: Member Experience (Anthony Sackett) [6] 3NA Survey Results (Vander Harris) UM Delegated Hospitals Summary (Tony Hightower) [2] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2]
January 2027 – *due Tues., Dec. 29, 2026* 2026 Referral Follow-up (Robert Moore, MD) [1] QI Initiative: TBD [8]	2025-26 Hospital QIP Evaluation (Troy Foster)[1a] 2025-26 Perinatal QIP Evaluation (Troy Foster) [1a] 2026 CG-CAHPS Analysis (Amber Newell)

[1] Short presentation at IQI; on Q/UAC consent calendar for acceptance (no presentation)
[1a] Short presentation at IQI; FYI handout at Q/UAC (no vote required)
[2] On both IQI & Q/UAC consent calendars for acceptance (no presentation)
[2a] FYI handouts at both IQI and Q/UAC (no presentation; no vote required)
[3] Timed for NCQA considerations
[4] to include HEDIS® Activity Update
[5] QI Trilogy documents to be approved at Q/UAC in August, PAC in September, Board in October (Q/UAC & PAC minutes included in NCQA evidence for QI 1 Element D)
[6] includes analysis of annual CAHPS data
[7] includes Wellness & Recovery Benefit components
[8] Short presentation at IQI. Will be presented at Q/UAC if time allows; otherwise, will be included as FYI in the Q/UAC packet. 2025 topic may not repeat in 2026.
[9] to include HEDIS® & PCP/QIP data