Family Planning Stakeholder Meeting

September 29, 2021

10:00am – 12:00pm

Meeting Agenda

10:00 – 10:05	Welcome/Introductions
10:05 – 10:15	Action Items from previous meeting
10:15 – 10:30	DHCS Updates
10:30 – 10:45	Stakeholder Updates
10:45 – 11:15	DHCS Managed Care Quality Accountability: Dr. Lisa Albers
11:15 – 11:45	Evaluation & Management Billing: Dr. Michael Policar
11:45 – 12:00	Recap of Action Items and Closing Remarks

Welcome
&
Introductions

Proposed Agenda Items

Item No.	Requested by:	Requested Agenda Item	On Agenda?	Written response?
1	Roots Community Health Center	Coverage trichomonas testing for males	No	OFP will take this request under advisement. Any changes to benefits will be announced in a future Family PACT bulletin.
2	Roots Community Health Center	Coverage for BD Affirm testing under family PACT	No	OFP will take this request under advisement. Any changes to benefits will be announced in a future Family PACT bulletin.

Proposed Agenda Items

Item No.	Requested by:	Requested Agenda Item	On Agenda?	Written response?
3	Roots Community Health Center here	PrEP medication coverage under Family PACT - HIV is an STD and this is one of the best methods of prevention.	No	The coverage of PrEP is not under consideration at this time.
4	Sequoia Quality Health	With the large influx of immigrants coming to California, we are seeing a large increase in the incidence of Hepatitis B. In the past, FPACT covered Hepatitis B vaccination; is it possible to re-instate this due to the increase in incidence amongst immigrants?	No	The coverage of the Hepatitis B vaccination under the Family PACT Program is not under consideration at this time.

Proposed Agenda Items

Item No.	Requested by:	Requested Agenda Item	On Agenda?	Written response?
5	The Children's Clinic	Online FAMPACT Application – is this coming soon?	No	The Office of Family will be transitioning the Family PACT Provider Enrollment application to DocuSign in November. In addition, DHCS plans to leverage the Medi-Cal PAVE system and expand it to include the enrollment application process for providers seeking participation and recertification in Family PACT (target date of early 2022).

Proposed Agenda Items

Item No.	Requested by:	Requested Agenda Item	On Agenda?	Written response?
6	The Children's Clinic	Online FAMPACT inquiries ○ Application status, or active/inactive status by org name or site address ○ Provider Orientation Completion Status/Active/Inactive ○ Can this be made available sooner than later?	No	For questions regarding Family PACT provider enrollment and recertification, please contact ProviderServices@dhcs.ca.gov For questions regarding provider training and orientation, please contact OFPProviderTrainings@dhcs.ca.gov

Proposed Agenda Items

Item No.	Requested by:	Requested Agenda Item	On Agenda?	Written response?
7	The Children's Clinic	2022 Online Provider Orientation Orientations: ○ Based on existing conditions, will online/virtual trainings/orientation be the norm? ○ If so, will a schedule be made available for 2022, for planning/scheduling purposes of Providers' schedules & future site openings?	No	The Office of Family is currently in the process of scheduling dates for virtual provider orientations for 2022 and will release the 2022 Provider Orientation schedule by the end of 2021. For questions regarding provider training and orientation, please contact OFPProviderTrainings@dhcs.ca.gov

DHCS Updates

PAVE Update

- Integration of Family PACT into PAVE – the Medi-Cal provider enrollment system used by DHCS' Provider Enrollment Division (PED) – target completion is June 2022

- Future updates will be shared with the Family PACT Program provider community as it becomes available.

CalHEERS

The CalHEERS 24-Month Roadmap, 2021 Initiatives Draft includes an initiative entitled ***Explore Integration of Family Planning into CalHEERS***.

- Suggested Target Release Timeline is scheduled for 2022.
- Please refer to the AB 1296 & Eligibility Expansion Stakeholder Workgroup's webpage for the most up to date information.

Medi-Cal COVID Resources

DHCS

Services | Individuals | Providers & Partners | Laws & Regulations | Data & Statistics | Forms & Publications

DHCS COVID-19 Response

DHCS is working with our program partners and state and federal officials to ensure Medi-Cal beneficiaries have access to medically necessary COVID-19 testing and care. The resources below contain detailed information about our actions during the COVID-19 emergency.

Vaccines

View All »

- APL 21-010: Medi-Cal COVID-19 Vaccination Incentive Program – Updated September 1, 2021
- APL 21-010: Vaccination Incentive Program – Health Plan Outcome Metrics – Updated September 1, 2021
- Medi-Cal COVID-19 Vaccination Rates - Updated August 22, 2021
- APL 20-022 (Revised): COVID-19 Vaccine Administration - Updated August 9, 2021
- COVID-19 Vaccine Engagement - July 27, 2021
- DHCS COVID-19 Vaccine Administration FAQs for Beneficiaries - Updated July 1, 2021

Vaccines - CDPH Resources

- "30 Conversations in 30 Days" Campaign
- Pregnancy and the COVID-19 Vaccine
- My Vaccine Record
- Vaccinate all 58
- Employer Vaccination Toolkit
- COVID Response Toolkit

Remote Enrollment

- Remote enrollment flexibility still in effect until end of Public Health Emergency (PHE)
- Post PHE: Remote enrollment will be allowed under Family PACT
  - Draft remote enrollment policy will be released mid-late October for Public Comment
  - Post PHE remote enrollment policy guidance will be published in Family PACT Policies, Procedures and Billing Instructions (PPBI) manual

Family PACT Updates

- Provider Enrollment and Provider Responsibility policy
- Family PACT Regulations
- Prop 56 SPAs
- Medi-Cal RX

Stakeholder Updates

DHCS Managed Care Quality Accountability

Lisa Albers, MD, MC II, Chief Quality Improvement Section
Managed Care Quality and Monitoring Division
Department of Health Care Services

Outline

- Managed Care Accountability Set (MCAS)
  - How measures are chosen
  - Individual measure accountability
- DHCS accountability program
  - Quality Improvement work
  - Corrective Action
  - Sanctions
- Health Disparities Report & Equity Efforts

Goal of discussion:
Provide insights into Medi-Cal managed care program quality improvement and health equity efforts

Managed Care Quality Measurement Set

Managed Care Accountability Set (MCAS)

- MCPs report annually on a set of quality measures.
- Measures are selected primarily from Centers for Medicare and Medicaid Services (CMS) Adult and Child Core Sets, *as feasible.*

2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
0032	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
0033	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
0039	NCQA	Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	Survey
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)^	Administrative or EHR
2372	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR
Maternal and Perinatal Health			
0469/ 0469e	TJC	PC-01: Elective Delivery (PC01-AD)	Hybrid or EHR
1517*	NCQA	Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	Administrative or hybrid
2902	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
2903/ 2904	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative

2021 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Care of Acute and Chronic Conditions			
0018	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
0059	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Administrative, hybrid, or EHR
0272	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
0277	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
0283	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
1768*	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
1800	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
2082/ 3210e	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR

MCAS

- From the CMS Core Sets, as well as other national measure stewards such as the NCQA, DHCS selects measures that fall within the scope of the MCPs' contract.
  - Includes measures that reflect the MCPs work to coordinate care with the counties.
- Measure review:
  - NCQA: annually reviews all measures, may modify technical specifications, add new measures or retire measures (public comment)
  - CMS: annually reviews all measures, may add or remove measures, update tech specs to conform with NCQA changes

Principles for Quality Measure Selection

- **Clinically meaningful:**
  - Important for the public, beneficiaries, the State and health plans
  - Will improve the quality of care or services for beneficiaries
  - Poor quality with significant adverse outcomes for beneficiaries
- **High population health impact:**
  - Affecting large numbers of beneficiaries or having substantial impact on smaller, special populations
- **Alignment:**
  - With other national and state priority areas and initiatives; with other public purchasers

Principles for Quality Measure Selection

- Availability/feasibility
  - Standardized measures and data (leveraging validated measures, Medicaid-specific benchmarks, if possible, feasibility of data collection to avoid extra administrative burden)
- Evidence based:
  - Sufficient evidence base to guide development of measure and interventions to drive improvement
- Promotes health equity:
  - Stratifying data by social determinants of health

MCAS for Medi-Cal Managed Care Health Plans (MCPs) Measurement Year 2020 | Reporting Year 2021

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL
1	Antidepressant Medication Management: Acute Phase Treatment	AMM-Acute	Administrative	Yes
2	Antidepressant Medication Management: Continuation Phase Treatment	AMM-Cont	Administrative	Yes
3	Asthma Medication Ratio	AMR	Administrative	Yes
4	Breast Cancer Screening	BCS	Administrative	Yes
5	Cervical Cancer Screening	CCS	Hybrid/Adm	Yes
6	Child and Adolescent Well-Care Visits	WCV	Administrative	Yes
7	Childhood Immunization Status: Combination 10	CIS-10	Hybrid/Adm	Yes
8	Chlamydia Screening in Women	CHL	Administrative	Yes

MCAS

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL
9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	CDC-H9	Hybrid/Admin	Yes
10	Controlling High Blood Pressure CBP	CBP	Hybrid/Adm	Yes
11	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	SSD	Administrative	Yes
12	Immunizations for Adolescents: Combination 2	IMA-2	Hybrid/Admin	Yes
13	Metabolic Monitoring for Children and Adolescents on Antipsychotics	APM	Administrative	Yes
14	Prenatal and Postpartum Care: Postpartum Care	PPC-Pst	Hybrid/Admin	Yes
15	Prenatal and Postpartum Care: Timeliness of Prenatal Care	PPC-Pre	Hybrid/Admin	Yes
16	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	WCC-BMI	Hybrid/Admin	Yes

MCAS

#	MEASURE REQUIRED OF MCP	MEASURE ACRONYM	MEASURE TYPE METHODOLOGY	HELD TO MPL
17	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Nutrition	WCC-N	Hybrid/Admin	Yes
18	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Physical Activity	WCC-PA	Hybrid/Admin	Yes
19	Well-Child Visits in the First 30 Months of Life	W30	Administrative	Yes
20	Ambulatory Care: Emergency Department (ED) Visits	AMB-ED i	Administrative	No
21	Concurrent Use of Opioids and Benzodiazepines	COB	Administrative	No
22	Contraceptive Care—All Women: Long Acting Reversible Contraception (LARC) ii	CCW-LARC	Administrative	No
23	Contraceptive Care—All Women: Most or Moderately Effective Contraception ii	CCW-MMEC	Administrative	No

Performance Measure Accountability

- MCPs annually report performance measure rates in June of every year (based on data from the prior calendar year)
  - Rates are reported to NCQA and audited by DHCS' EQRO
  - MCQMD receives final, audited rates for prior measurement year (MY) in July of the reporting year (RY)

Accountability

- DHCS determines which measures MCPs will have to meet the DHCS mandated benchmark for
  - Known as “minimum performance level” or MPL
- DHCS requires MCPs to perform at least as well as 50% of Medicaid plans in the U.S., where that information is available and the services measured are delivered by MCPs
- DHCS may establish alternative benchmarks where that information is not currently available

Accountability

When MCPs do not meet MPL:

- Corrective actions plans (CAPs) may be imposed
- Sanctions will be imposed
- Quality improvement work will be required
  - Plan-Do-Study-Act (PDSA) cycles or performance improvement projects (PIPs)

Technical Assistance

- MCQMD provides technical assistance to MCPs
  - Ongoing one-on-one technical assistance
    - DHCS Nurse Consultants and Health Educators
  - MCP QI trainings - annual
  - Opportunities for the sharing of promising practices
  - QI Toolkit
  - Quality Improvement Highlights/QI Postcards
  - Quality Improvement Collaborative Calls
  - Quality Conference
  - Annual Innovation and Health Equity Awards
    - https://www.dhcs.ca.gov/Documents/Health-Equity-Proposal-Summaries.pdf
    - https://www.dhcs.ca.gov/Documents/Innovation-Award-Proposal-Summaries.pdf

MCP RESOURCES FROM DHCS

COLLABORATIVE MEETINGS WITH DHCS AND HSAG

Quarterly participation of MCPs in collaborative calls with DHCS and HSAG that allow sharing of best practices and opportunities among MCPs on selected quality improvement topics.

MCP QUALITY CONFERENCE

MCPs participate in multiple topic sessions from expert QI speakers in one day face-to-face meeting. The event allows learning and networking among MCP staff.

ANNUAL INNOVATION and HEALTH EQUITY AWARD

MCPs submit to DHCS innovative interventions to improve health equity and the quality of health care for Medi-Cal beneficiaries. MCPs vote on an Innovation Award Winner, while DHCS chooses the Health Equity Winner. Highlighted innovative interventions are published on the DHCS website: http://www.dhcs.ca.gov/services/Pages/QualityAwards.aspx

MCP RESOURCES FROM DHCS

DHCS' MCAS QUALITY IMPROVEMENT HIGHLIGHTS

Released quarterly featuring resources, facts, figures, and/or video clips' regarding selected MCAS measures.

DHCS' HEALTH EQUITY INFORMATION FEED

Released every 6 months featuring new educational information about Health Equity in a FAQ format.

DHCS' QUALITY IMPROVEMENT TOOLKIT

An interactive toolkit that is housed in one document. MCPs are able to access information, resources, educational materials and training in a common document.

DHCS' QUALITY IMPROVEMENT POSTCARD AND COVID-19

An interactive document that is released monthly to MCPs. Provides information specific to providers and members on various topics and COVID-19.

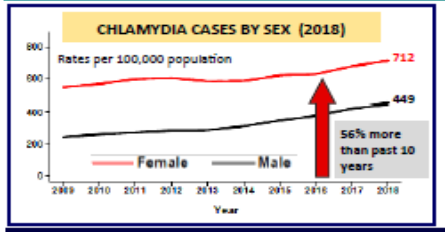
QUALITY IMPROVEMENT HIGHLIGHTS

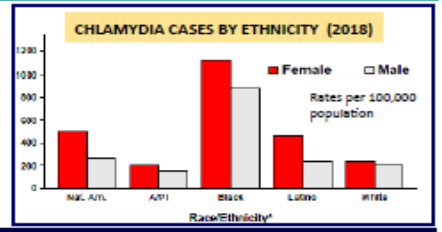
A Quality Improvement brief brought to you by the Managed Care Quality and Monitoring Division

VOL. 1, ISSUE 10 3.9.2020

IMPROVING CHLAMYDIA (CHL) SCREENING

DISPARITY OF CHL INFECTIONS IN CALIFORNIA (CA)





CHL and Gonorrhea cases in CA are at highest reported levels since 1990.

Affects ages 15 to 24 — **5 OUT OF 10 CHL CASES**

Black/African American communities experience a higher burden of CHL and gonorrhea infection compared to other ethnic groups.

- Higher incidence of CHL in females (2018)
- Higher incidence of gonorrhea in males (2018)
- Untreated CHL: Risk of HIV, infertility

40 TO 90% (MALES) CHL infection is asymptomatic in males and females. **70 TO 95% (FEMALES)**

Incarcerated individuals, military recruits and public STD clinic patients demonstrated higher rate of CHL and gonorrhea infection.

583 (CA) 540 (US) California CHL rate is higher than the national rate per 100,000 for all age groups, races and sexes.

San Francisco had the sharpest increase of CHL infections in 2018.

Screening for CHL reduces the incidence of Pelvic Inflammatory Disease by 60%.

EVIDENCE-BASED PRACTICES FROM A PEER REVIEWED JOURNAL

POPULATION: Females ages 14-18

INTERVENTION: 4 Stage Clinical Improvement Initiative

- Development of Clinic Flow Chart
- Promotional materials
- Monthly team meetings
- Use of performance indicators

* Universal urine specimen collection at registration prior to examination.

Result: **65%** Increase in testing was achieved within a few months and sustained for 12 months.

POPULATION: Clinic setting serving a wide range of age groups

INTERVENTION: Use of External Advisor

- Raised awareness of chlamydia in the clinic.
- Trained staff on chlamydia guidelines

Result: **176%** Increase in the number of CHL tests performed in females during a six month period.

POPULATION: Clinic setting

INTERVENTION: Point of Care (POC) Computer Reminders

- Conducted on-screen computer reminders on processes and outcomes of care in comparison to passive prompts of attaching a reminder sticker to medical records or including CHL information on laboratory form results.

Result: **3.8%** Median improvement in CHL test ordering for POC computer reminders versus passive prompts.

(click on images above for more information)

QUALITY IMPROVEMENT HIGHLIGHTS

A Quality Improvement brief brought to you by the Managed Care Quality and Monitoring Division

VOL. 1, ISSUE 10 3.9.2020

UTILIZING SOCIAL MEDIA TO PROMOTE CHL TESTING

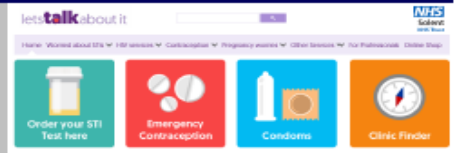
POPULATION: Adolescents and young adults

INTERVENTION: Sexual Health Promotion Campaign using Facebook linked to a website

USE OF A GRAPHIC INTERCHANGE FORMAT(GIF) MESSAGING ANIMATION

You are unique
You are important
Your sexual health matters to us

CHLAMYDIA TEST ONLINE



(GIF animation lasts 10 seconds on a loop x 7 weeks)

- Users click on website link to order CHL test kits
- CHL test kits delivered to the address of choice

41%

Result: Increase in CHL test kit orders compared to the baseline period before the intervention.

PRACTICES FROM HEALTH PLANS TO INCREASE CHL SCREENING

Provider-related	Physician profiles on measures compared to peers		Newsletters to providers on CHL screening rates.		Academic detailing from Medical Directors
Member-related	Annual preventive magazines for members		Birthday letters to members		Educational brochures or self-help pamphlets to members

FIND OUT MORE
(click on images above and below for more information)

OTHER USEFUL RESOURCES ON CHL

Screening Guidelines	USPSTF Screening Guidelines	Helps clinicians identify the right clinical preventive services for their patients with CHL.	CHL Treatment Guidelines (2015)	CHL treatment guidelines, management and follow-up considerations
CHL screening resources	Provider - Engagement Resources	Includes case studies and tips that can be utilized by providers to improve CHL screening	Promoting Member Engagement	Article assessing the preferences of young women in receiving sexual health information via social media
Economic Burden and Health Impact	Economic Impact	Compares the economic impact of CHL infection to other sexually transmitted	Health Impact	Provides information on the impact of CHL re-infection following initial diagnosis

COVID-19 Reporting Impact

- For Reporting Year (RY) 2020, COVID-19 impacted health plan retrieval of complete medical records and decreased accuracy for hybrid quality measures
  - DHCS did not hold MCPs to the MPL for RY 2020 due to difficulties in data collection/reporting.
- For RY 2021, COVID-19 impacted utilization of all health care services
  - DHCS did not hold MCPs to the MPL for RY 2021 due to stay at home orders, sheltering in place and the resulting decrease in health care utilization
- For RY 2022, DHCS will hold the MCPs accountable to the MPL

Value Based Payments

- DHCS managed care Value Based Payment (VBP) Program
  - Provides incentive payments to managed care providers for meeting specific measures aimed at improving care for certain high-risk, or high-cost populations
    - Targets providers for specific achievement on measures in 4 domains:
      - Behavioral health integration
      - Early Childhood Development
      - Prenatal and Postpartum Care, including postpartum contraception
      - Chronic Disease Management
  - Additional information can be found here: https://www.dhcs.ca.gov/provgovpart/Pages/VBP_Measures_19.aspx

Health Disparity Reports

- The purpose is to assess potential differences in health outcomes between groups within a population EQRO uses annual quality measures to conduct a health disparities study of Medi-Cal MCPs
- Stratifications were made based on race/ethnicity, primary language, age, and sex. Statistical analysis was performed using race and ethnicity data
- EQRO aggregated results from the MCP for a statewide interpretation
- There are currently five reports available to view for measurement years 2015 - 2019

https://www.dhcs.ca.gov/dataandstats/reports/Pages/MgdCareQualPerfDisp.aspx

2019 Metrics Breakdown

- Indicators based on the 10 administrative MCAS measures
- Measures were stratified into seven racial/ethnic groups (White, American Indian/Alaska Native, Asian, Black/African American, Hispanic/Latino, Native Hawaiian/other Pacific Islander, and other) for statistical analysis
- Measures were stratified by primary language derived from current threshold languages for Medi-Cal Managed Care (MCMC) counties; number of languages assessed varies from measure to measure due to potential small numbers and data suppression

2019 Metrics Breakdown (Cont.)

Indicators
Antidepressants Medication Management - Effective Acute Phase Treatment and Effective and Continuation Phase Treatment
Asthma Medication Ratio - Total
Breast Cancer Screening
Chlamydia Screening in Women – Total
Contraceptive Care – All Women – Most or Moderately Effective Contraception – Age 15 – 20 Years and Ages 21 – 44 Years
Contraceptive Care – Postpartum Women – Most or Moderately Effective Contraception – 60 Days – Ages 21 – 44 Years
Developmental Screening in the First Three Years of Life – Total
Plan All-Cause Readmissions – Observed Readmission Rate - Total

2019 Report Findings

- Overall, compared to the reference, the White group:
  - American Indian/Alaskan Native group, Black/African American group, and Native Hawaiian/Other Pacific Islander group had the highest number of disparities identified with four performing below the reference.
  - Asian and Hispanic/Latino group had 3 identified disparities
  - The Other group had one disparity identified

2019 Report Findings Highlight

- The Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 15–20 Years indicator measures the percentage of women 15 to 20 years of age at risk of unintended pregnancy who were provided a most effective or moderately effective method of contraception
  - Five health disparities were identified compared to the White group reference rate 25.6%:
    - Asian group 9.7%
    - Black or African American 17.9%
    - Hispanic or Latino 14.0%
    - Native Hawaiian or Other Pacific Islander group 10.6%
    - Other group 19.6%

2019 Report Findings Highlight (Cont.)

- The Contraceptive Care—All Women—Most or Moderately Effective Contraception—Ages 21–44 Years (CCW–MMEC–2144) indicator measures the percentage of women 21 to 44 years of age at risk of unintended pregnancy who were provided a most effective or moderately effective method of contraception.
  - Two health disparities were identified compared to the White group reference rate 24.8%
    - Asian group 19.8%
    - Native Hawaiian or Other Pacific group 17.7%

2019 Report Findings Highlight (Cont.)

- The Contraceptive Care—Postpartum Women—Most or Moderately Effective Contraception— 60 Days—Ages 21–44 Years (CCP–MMEC60–2144) indicator measures the percentage of women 21 to 44 years of age who had a live birth and were provided a most effective or moderately effective method of contraception within 60 days of delivery
  - Two health disparities were identified for the White group reference rate 34.3%:
    - Asian group 27.7%
    - Black or African American group 27.8%

Oversight, Monitoring & Interventions

- DHCS uses reports to help drive internal projects and develop focus studies for a closer examination of the data
  - Tobacco cessation focus study
  - Long-acting reversible contraceptive focus study
  - Asian subpopulation focus study
  - Methodology for homelessness identification focus study
- DHCS is currently exploring how to best use the reports to drive targeted disparity reductions across the state

Oversight, Monitoring & Interventions (Cont.)

- Reporting of unit level data is shared with MCPs to identify disparities among their members
  - Adjust quality improvement (QI) resources and practices to mitigate disparities
  - MCPs are required to use the health disparity data to help develop the strategic plan for MCPs' annual PNA
  - MCPs can use the data to help determine the metric to target for their health disparity PIP

Oversight, Monitoring & Interventions (Cont.)

- MCPs are required to conduct a health equity performance improvement project (PIP)
- MCPs participate in quarterly PIP collaborative calls and presentations addressing three domains (child/adolescent health, women's health, and disease management/behavioral health), and health equity is addressed through each domain.
- PNAs are required to be conducted by MCPs addressing specific needs, such as members with disabilities, children with special health care needs, as well as members with diverse cultural and ethnic backgrounds.
  - Findings from the assessment are to be used to help drive improvements for achieving health equity

https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-017.pdf
https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2019/APL19-011.pdf

Thank you for your time!

Questions

Family PACT Stakeholder's Meeting
September 29, 2021

Update in Coding and Billing for Family PACT Services
New Family PACT Benefits in 2021

Michael S. Policar, MD, MPH
Professor Emeritus of Ob, Gyn, RS
UCSF School of Medicine
michael.policar@ucsf.edu

Outline

- How E/M billing has changed for non-clinician counselor services
- Discuss the new contraceptive products that have been added to the Family PACT formulary (like the Annovera 1-year vaginal ring)
- Define the Family PACT benefit for sampling for GC and chlamydia at more than one site per visit (e.g., genital, throat, rectum)
- Changes in the PPBI relative to the 2021 CDC STI Treatment Guidelines

Learning Objectives

01

List at least six activities that can be counted in the "total time" of a visit when computing E/M level

02

List each of the 3 elements used in medical decision making, and give examples of each

03

Explain how to use the 3 elements of medical decision making in computing the level of an E/M visit

04

Describe the Family PACT policy for coding for a clinician visit and counselor services on the same date of service

Review:
Fundamentals of Coding

What Is the *Fundamental* Objective of Coding?

- Provider
  - To prepare a standardized “bill” for services given to a patient
- Payer
  - To determine the amount to be paid to the provider (based on contracted rates)….
  - For medically necessary services….
  - That are a benefit of the payer’s health plan…
  - And supported by documentation

Code Numbers Tell A Story

- To establish medical necessity, for every *what* there must be a *why*
- Unusual circumstances explained with *modifier*

	Encounter content	Code book
What	• Services performed • Drugs, supplies provided	• CPT • HCPCS II
Why	• Diagnoses	• ICD-10-CM
Additional Explanation	• Modifier	• CPT

Procedure Codes – The "What"

CPT: Current Procedural Terminology©

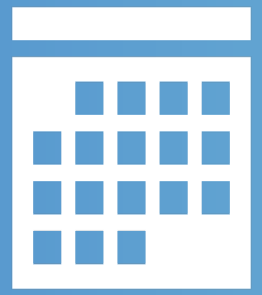
- Procedures: IUD/implant placement, lesion removals
- Point-of-care
  - Lab tests: pregnancy test, microscopy, rapid HIV 1+2
  - Diagnostic imaging (office ultrasound)
- Evaluation and Management (E/M) codes
- Modifiers

HCPCS Level II Codes

- Clinic administered or dispensed drugs, devices (i.e., insertion kits)

E/M: Which Series Have Changed?

- Problem-Oriented Visits: symptoms or complaints
  - 99202-5, 99211-5 (new/established)
- Preventive Medicine Services: “well person” visit
  - 99384-7, 99394-7 (new/established, age)
- Preventive Medicine, Individual Counseling
  - 99401-4 (time intervals)



Assigning an E/M Level *Before* January 1, 2021

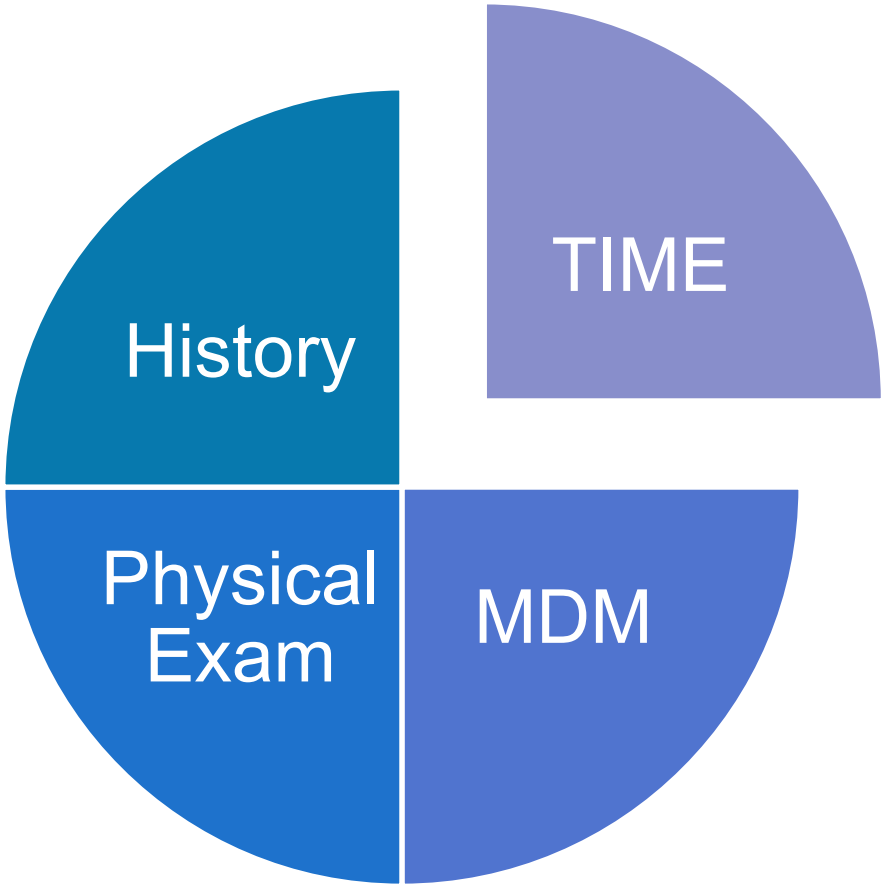
Two Methods to Calculate E/M Level

- Composite of 3 key components

or

- TIME, when greater than 50% of face-to-face clinician time is spent in counseling / coordination of care

1 method doesn't fit all visits



E/M Rules Beginning January 1, 2021

Problem Oriented Visit E/M Selection

- Delete code 99201: new patient, straightforward
- E/M codes 99202-99215 were revised
  - Select E/M levels using *either*
    - Total time, or
    - Medical decision-making (MDM)
  - Remove history and exam as a E/M coding component
    - Did not adequately capture the actual work of the physician or other QHP in an E/M visit

E/M Code: Total Time

- Removes “50% threshold” for counseling time
- Changes time intervals associated with each code
- Time redefined *from* face-to-face time to total time spent on the day of the encounter
  - Specific criteria for total time
  - Guideline added to clarify when > 1 provider is involved

2021 E/M Intervals

NEW	Minutes
~~99201~~	deleted
99202	15-29
99203	30-44
99204	45-59
*99205	60-74

ESTABLISHED	Minutes
99211	<10
99212	10-19
99213	20-29
99214	30-39
*99215	40-54

* Not family PACT benefits

E/M Codes: Time Defined

- Prepare to see the patient (e.g., review test results)
- Obtain and/or review separately obtained history
- Perform medically appropriate exam and/or evaluation
- Counsel and educate the patient/family/caregiver
- Document clinical information in the health record
- Independently interpret results (if not separately reported) and communicating results to the patient/family/caregiver
- Care coordination

MDM Selection

January 1, 2021

From	To
# of Diagnoses or Management Options	# and Complexity of Problems Addressed
Amount and/or Complexity of Data to be Reviewed	Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications and/or Morbidity or Mortality	Risk of Complications and/or Morbidity or Mortality of Patient Management

MDM: *Number and Complexity of Problems*

Level	Number, complexity of problems
Minimal	• 1 self-limited or minor problem
Low	• 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury
Moderate	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury
High	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment or • 1 acute or chronic illness or injury that poses a threat to life or bodily function

MDM: *Number and Complexity of Problems*

Level	Examples in Family Planning
Minimal	• Follow-up visit, straightforward • Refill of a contraceptive Rx • Prepregnancy visit • STI counseling visit
Low	• ≥ 2 of the above problems on same date of service • Healthy patient presenting for contraception • Follow up visit after genital wart treatment • New c/o vaginal discharge • Hormonal contraceptive user with c/o unscheduled bleeding
Moderate	• Recurrent vaginitis with new episode(s) • ≥2 chronic infections managed on same date of service • Acute pelvic pain • Solitary breast mass • PID with fever or chills
High	• Ectopic pregnancy • Hemorrhage from ovarian cyst • DVT in combined hormonal contraceptive user

2021 E/M Revisions: *Data Element*

Level	Amount and/or Complexity of Data to be Reviewed and Analyzed
Minimal	Minimal or none
Limited	Any combination of 2 from the following • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test
Moderate (Must meet requirements of at least 1 out of 3 categories)	Category 1: any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s), or Cat 2: Independent interpretation of tests by another MD,QHP, or Cat 3: Discussion of management or test result with external physician or QHCP

2021 E/M Revisions: *Data Element*

Level	Examples in Family Planning
Minimal	• No tests ordered or results reviewed • No review of external records
Limited	Any combination of 2 from the following • Review of note(s) from provider in a distinct group or different specialty • Review of each unique test result ordered by an external provider • Each unique test ordered today, not including billed point-of-care tests (Examples: GC, CT, CBC, Hgb A1c) • Additional history required from a partner, parent, guardian, caregiver
Moderate (Must meet requirements of at least 1 out of 3 categories)	• Category 1: any combination of 3 of the above items • Category 2: Review of pelvic sonogram or CT images from an imaging center • Category 3: – Discussion with pathologist about biopsy result – Discussion with radiologist about mammogram result

In the Weeds: MDM Data Element

- If you code and bill for a (point-of-care) test, you can't count it as "data" at all
- If you *order* a test, it includes *review* of the result as 1 point, whether you review the result today or next week
- “Review of test results” can be counted only for tests that you didn't order
- Each unique “test” has a CPT code; a “panel” counts as 1 unique test

2021 E/M Revisions: *Risk of Complications*

Level	Risk of Complications and/or Morbidity or Mortality of Patient Management
Minimal	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate risk of morbidity from testing or treatment. Examples • Prescription drug management • Decision re: minor surgery with patient or procedure risk factors • Decision re: major surgery without patient or procedure risk factors • Diagnosis or treatment limited by social determinants of health

2021 E/M Revisions: *Risk of Complications*

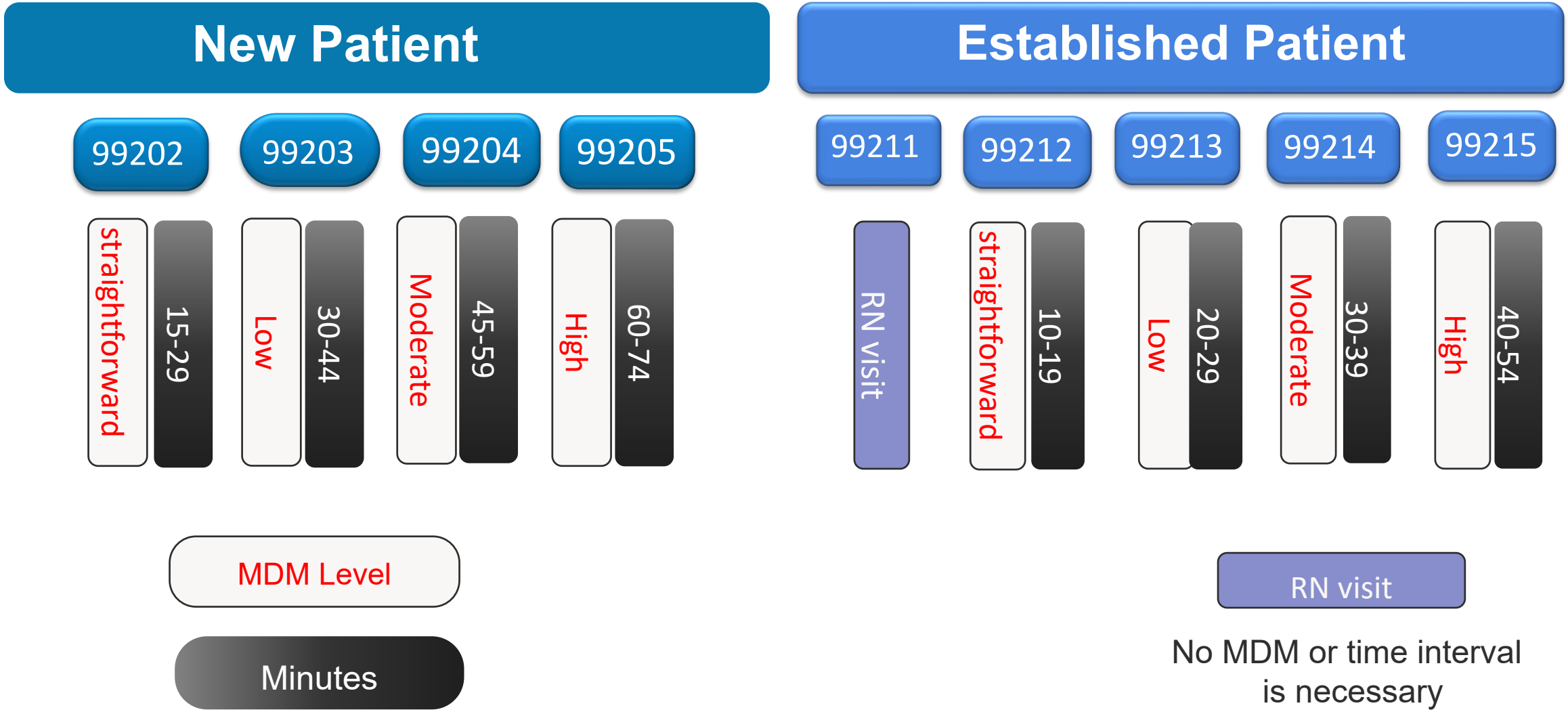
Level	Examples in Family Planning
Minimal	• No diagnostic studies or treatment
Low	• Point-of-care tests done • Venous blood drawn for a serologic test • Condoms, spermicides dispensed • Treatment with an OTC NSAID (e.g., ibuprofen, naproxen sodium)
Moderate	• Prescription of any contraceptive or antibiotic • Discussion and consent for IUD or implant placement, endometrial biopsy, or colposcopy • Discussion and consent for laparoscopic tubal occlusion or extraction of translocated IUD • Individual experiencing homelessness having challenges with maintaining treatment recommendation(s) [social determinant must be addressed and increases risk of complication]

Level of MDM *based on highest 2 of 3 elements*

Number, complexity of problems	Amount or complexity of data reviewed	Risk of complications or morbidity	MDM Level	E/M code
Minimal	Minimal	Minimal	Straightforward	99202 99212
Low	Limited	Low	Low	99203 99213
Moderate	Moderate	Moderate	Moderate	99204 99214
High	Extensive	High	High	*99205 *99215

* Not family PACT benefits

Summary of 2021 E/M Levels



Family PACT E/M Policy Modifications (Feb 2021)

- Adopt CMS/ AMA changes to office visit E/M coding rules
- Delete old policy for E/M visit with clinician and counselor
  - Add clinician time and counselor time in computing E/M level
- *Replace with*
  - E/M code for office visit based on *clinician* "total time"
  - E&C by counselor, billed separately with "individual preventive medicine counseling" code, based on F-to-F counselor time
    - 99401-U6: up to 15 minutes
    - 99402-U6: 16-30 minutes
    - 99403-U6: 31-45 minutes

Case Studies

The Coding Framework

	Codes	Examples
Procedure	CPT	IUD, implant, colposcopy, vulvar biopsy
Drug and supplies	NDC ± HCPCS	IUD kits, implant kits, condoms, spermicides, clinic-dispensed medications
Point of care lab + imaging	CPT	• On-site lab tests: preg test, microscopy • Office ultrasound: abdominal, vaginal
E/M	CPT	• Problem-oriented visits • Preventive medicine visits
Modifiers	CPT	-25, -51, -95,
Diagnosis	ICD-10	Z-codes, N-codes

NDC: National drug code

Case Study: Janae (she/her/hers)

- Janae is 24-year-old established patient who presents with concerns about STI and requests testing
- STD and contraceptive counseling done; wants a 3-year LNg IUD
- Office urine pregnancy test: negative
- Point of care HIV 1+2 antibody test: negative
- Vaginal sample sent to lab for CT/GC NAAT
- Bimanual exam performed; then IUD inserted easily
  - Pelvic ultrasound with vaginal probe to check placement
- Total time (excluding IUD placement)
  - Face-to face time: 18 minutes
  - Total time: 26 minutes

Coding this Visit by Time

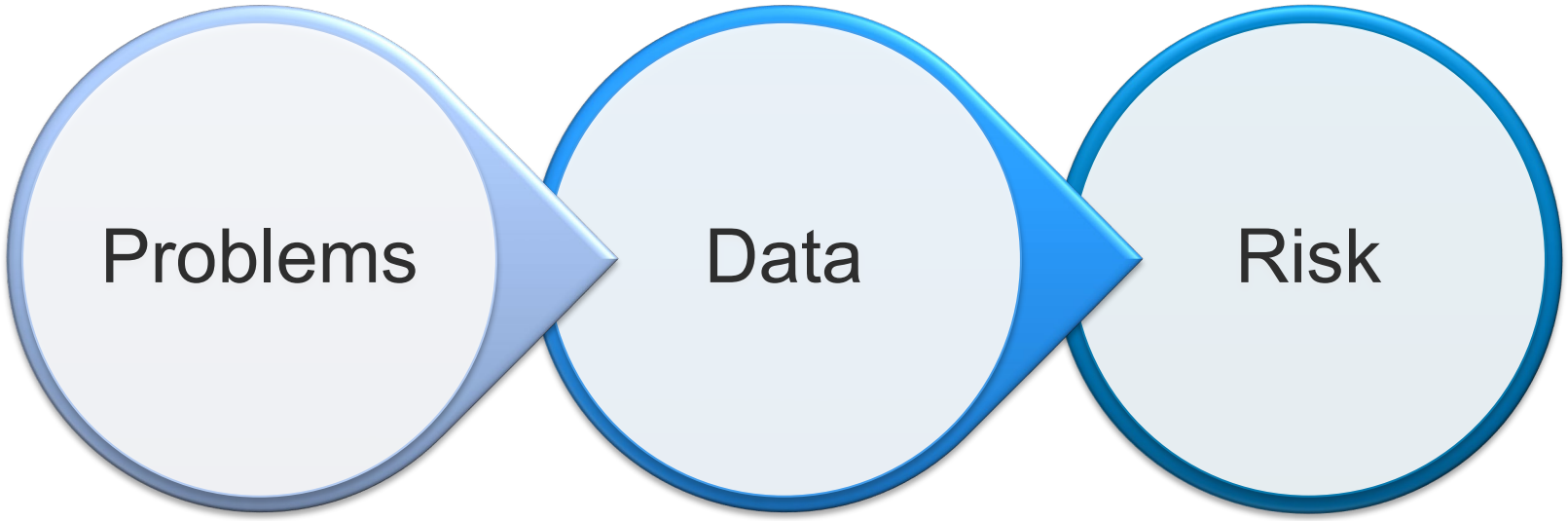
- **Total time (excluding IUD placement): 26# minutes (not 18!!)**

New	Time
deleted	
99202	15-29
99203	30-44
99204	45-59
*99205	60-74

Established	Time
99211	N/A
99212	10-19
99213	20-29
99214	30-39
*99215	40-54

* Not family PACT benefits

Level of MDM
(*based on highest 2 of 3 elements)*



Janae received STI and contraceptive counseling

– 1 acute, uncomplicated illness = LOW

Level	Problems
Straightforward	Minimal • 1 self-limited or minor
Low ✓	Low • 2 or more self-limited or minor OR • 1 stable chronic OR • 1 acute, uncomplicated illness or injury
Moderate	Moderate • 1 or more chronic illness with exacerbation OR • 2 or more stable chronic illnesses OR • 1 undiagnosed new problem with uncertain prognosis OR • 1 acute illness with systemic symptoms OR • 1 acute complicated injury

- Tests: office urine pregnancy test, point of care HIV 1+2 test, samples sent for CT and GC NAAT
- 2 unique tests: 2 points

Level	Amount and/or Complexity of Data
Minimal	Minimal or none
Limited ✓	Any combination of 2 from the following • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*
Moderate	Category 1: any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test • Ordering of each unique test • Assessment requiring an independent historian(s)

A 3-year LNg IUD inserted

MDM Level	Risk of treatment or management
Straightforward	Minimal risk of morbidity
Low	Low risk of morbidity
Moderate 	Moderate risk of morbidity • Prescription drug management • Decision regarding minor surgery with identified risk factors • Decision regarding elective major surgery without identified risk factors • Diagnosis or treatment significantly limited by social determinants of health

Level of MDM
(*based on highest 2 of 3 elements)*

Problems	Data	Risk	E/M Code
Minimal	Minimal or none	Minimal risk of morbidity	99202 99212
Low ✓	Limited ✓	Low risk of morbidity	99203 99213
Moderate	Moderate	Moderate risk of morbidity ✓	99204 99214
High	Extensive	High risk of morbidity	99205 99215

Janae: Coding Framework

	CPT/ HCPCS II Code	ICD-10-CM Code
Procedure	58300 Insert IUD	Z30.430 Insertion of IUD
Drug	J7301 LNG-IUS, 13.5 mg	Z30.430 Insertion of IUD
Point of care lab + imaging	81025 UPT 86703 HIV 1+2	Z32.02 Preg test, neg Z11.4 Screen for HIV
E/M	99213-25	Z30.09 Other FP advice Z11.3 Screen for STD

-25 indicates that a significant and separately identifiable E/M was provided on the same date of service as a procedure

Case Study: Wendy

- 17-year-old new client seen for STI screening after learning that her boyfriend was diagnosed with genital warts
- She has no symptoms
- Using oral contraceptives for contraception
- Physical exam
  - Genital skin exam shows normal genital skin with no warts
  - Screening tests for GC, CT, syphilis and HIV picked up by lab
- Total time for clinician: 26 minutes
- Afterwards, meets with health educator for 10 minutes to discuss STI prevention and safer sex

Coding this Visit by Time

- Total time: 26 minutes

New	Time
deleted	
99202	15-29
99203	30-44
99204	45-59
*99205	60-74

Established	Time
99211	N/A
99212	10-19
99213	20-29
99214	30-39
*99215	40-54

* Not family PACT benefits

Wendy: MDM
(*based on highest 2 of 3 elements)*

Problems	Data	Risk	E/M Code
Minimal	Minimal or none	Minimal risk of morbidity ✓	99202 99212
Low ✓	Limited	Low risk	99203 99213
Moderate	Moderate (4 tests ordered) ✓	Moderate	99204 99214
High	Extensive	High risk	99205 99215

MDM level is Low

Wendy

	CPT Code	ICD-10-CM Code
Procedure	none	
Drug/supply	none	
Point of care lab + imaging	none	
E/M code	99203	1º Z20.2 (contact with or exposure to STI) 2º Z30.41 (surveillance of OC user)
E&C code	99401-U6	Z20.2 (contact with or exposure to STI)

- Total time: 99202 (new patient, 15-29 minutes)
- 99203 chosen because it is the higher of MDM or total time
- E&C code 99401-U6 is an updated Family PACT benefit

New Family PACT Contraceptive Benefits

Phexxi® Vaginal gel (July 2021)

- 1 box (12 single-use applicators); 3 dispensings per any 75-day period
- Restricted to NDC labeler code 69751.

DMPA-SQ 104 mg as a permanent pharmacy benefit (June, 2021)

- Earliest refill: 80 days

Contraceptive vaginal rings (November 1, 2020)

- J7303 U2 CVR (segesterone and EE; Annovera) $2,090.00 each
  - One ring per dispensing; maximum of two dispensings in a 12-month period
- J7303 U1 CVR (etonogestrel and EE; NuvaRing) $121.62 each
  - Up to 13 rings; maximum of two dispensings in a 12-month period
- TAR is required for 3rd supply of the same product requested within a year

Common STI Management Questions

Does Family PACT cover expedited partner therapy for the prevention of reinfection from chlamydia, gonorrhea, and trichomoniasis?

Does Family PACT cover multi-site screening GC and Ct, as clinically indicated?

- Are there any limits on how often this will this be covered?

Expedited Partner Treatment (EPT)

CDC, 2021: Responsibility for discussing partner treatment rests with diagnosing provider and the patient

Bring Your Own Partner (“BYOP”)

- Bring her partner(s) at the time of her treatment

Patient-delivered partner therapy (“PDPT”)…in order

- Provide patient with drugs intended for partners
- Prescribe extra doses in the index patients’ name
- Write prescriptions in the partners’ names
  - Ideally with written instructions for the partner(s)

Family PACT Coverage of PDPT

- Partner(s) may opt to obtain Family PACT eligibility, or
- If a client is diagnosed with GC, CT and/or trichomoniasis and EPT is medically necessary to prevent reinfection of the client, the provider may either
  - Dispense medication directly to the client to provide to his/her partner(s), or
  - Provide the client with a prescription (in the *enrolled client's name*) for medications with a quantity and duration of therapy sufficient to treat the acute infection in the client and partner(s)
- Reimbursement for client dose and up to 5 partner doses per dispensing

PPBI, ben fam rel, page 23. August 2020

MSM: Multi-site GC and CT Screening

- 70% of GC/CT infections might be missed with urogenital-only testing as most pharyngeal and rectal infections are asymptomatic
- Test men who during the preceding year have had
  - Insertive intercourse: urethral GC/CT (with urine NAAT)
  - Receptive anal intercourse: rectal GC/CT NAAT
  - Receptive oral intercourse: pharyngeal GC NAAT
  - Testing for pharyngeal CT is not recommended
- Testing can be offered to MSM who do not report exposure at these sites after a detailed explanation, due to known underreporting of risk behaviors.

Females: Multi-site GC and CT Screening

- Screen females based on sexual history during the preceding year …not routinely
  - Receptive anal intercourse: rectal GC/CT NAAT
  - Receptive oral intercourse: pharyngeal GC/CT NAAT
  - *Based on a shared clinical decision* (CDC, 2021)

Family PACT Benefits
Multi-site GC and CT Screening and Testing

- Family PACT (and Medi-Cal) frequency limits for GC/CT are up to three tests per recipient, per day (as of Sept, 2018)
- Use separate NAAT test kits regardless of genital, anal, or oropharyngeal sample site
  - CPT codes are the same, so label samples clearly
- Don’t forget to include ICD-10 diagnosis codes on lab slips!

AMA Documents

E/M Services Guidelines

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

E/M MDM Chart

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

AMA Online Modules

- Office Evaluation and Management (E/M) CPT Code Revisions: https://edhub.ama-assn.org/cpt-education/interactive/18057429
- Revisions to the CPT E/M Office Visits: New Ways to Report Using Medical Decision Making (MDM) https://edhub.ama-assn.org/cpt-education/interactive/18461932
- Revisions to the CPT E/M Office Visits: New Ways to Report Using Time: https://edhub.ama-assn.org/cpt-education/interactive/18461930

Thank you for your time!

Questions

Recap of Action Items

Program Assistance

To better serve providers and Stakeholders, the Family PACT Program has established the following email boxes:

- For questions regarding Family PACT provider enrollment and recertification, please contact ProviderServices@dhcs.ca.gov
- For questions regarding provider training and orientation, please contact OFPProviderTrainings@dhcs.ca.gov
- For all Stakeholder related inquiries, please contact OFPStakeholder@dhcs.ca.gov
- For questions regarding provider reviews, please contact OFPcompliance@dhcs.ca.gov

Next OFP Stakeholder Meeting: 2022