AGENDA
Children’s Health Consultant Advisory Committee Meeting
Board of Governors
Tuesday, January 19, 2021, 8:30 a.m.
L.A. Care Health Plan, 1055 W 7th Street, 10th Floor, Los Angeles, CA 90017

California Governor issued Executive Order N-25-20, N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order N 33-20, ordering all residents to stay in their homes, except for specific essential functions. Accordingly, members of the public should now listen to this meeting via teleconference or videoconference as follows:

To join the meeting via videoconference please use the link below:
https://lacare.webex.com/lacare/onstage/g.php?MTID=e844125c95d4cb8c22c45344ec54c1fb0

To join the meeting via teleconference please dial:
+1-415-655-0002
Meeting Number:
146 451 6004

Members of the Board of Governors or staff may also participate in this meeting via videoconference or teleconference. The public is encouraged to submit its public comments or comments on Agenda items in writing by e-mail to boardservices@lacare.org, or by a text or voicemail to 213 628 6420.

The text, voicemail, or email should indicate if you wish to be identified or remain anonymous, and should also include the name of the item to which your comment relates.

Comments received by voicemail, email or text by 8:30 a.m. on January 19, 2021 will be provided in writing to the members of the Children’s Health Consultants Advisory Committee at the meeting. Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.

Public comments will be read for up to 3 minutes at the meeting.
All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to boardservices@lacare.org.

Welcome

Tara Ficek, MPH
Chair

1. Approve today’s Agenda

2. Public Comment

3. Approve November 19, 2020 Meeting Minutes P.3

4. Chairperson Report

5. Chief Medical Officer Report P.7

6. Dyadic Care/Family Therapy Guidance Implementation P.12

Richard Seidman, MD, MPH
Chief Medical Officer

Alex Briscoe, M.A.,
Principal, California Children’s Trust,
7. First 5 LA Impact Framework and 2020 Pathway to Progress Report  P.41

ADJOURNMENT

The next meeting is scheduled on March 16, 2021 at 8:30 a.m.

Please keep public comments to three minutes or less.

The order of items appearing on the agenda may change during the meeting.

If a teleconference location is listed at the top of this agenda, the public can participate in the meeting at that location or by calling the teleconference call in number provided. If teleconference arrangements are listed at the top of this Agenda, note that the arrangements may change prior to the meeting. To confirm details with L.A. Care Board Services staff prior to the meeting call (213) 694-1250, extension 4183 or 4184.

THE PUBLIC MAY ADDRESS THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY FILLING OUT A “REQUEST TO ADDRESS” FORM AND SUBMITTING THE FORM TO L.A. CARE STAFF PRESENT AT THE MEETING BEFORE THE AGENDA ITEM IS ANNOUNCED. YOUR NAME WILL BE CALLED WHEN THE ITEM YOU ARE ADDRESSING WILL BE DISCUSSED. THE PUBLIC MAY ALSO ADDRESS THE BOARD ON OTHER L.A. CARE MATTERS DURING PUBLIC COMMENT.

NOTE: THE CHILDREN’S HEALTH CONSULTANT ADVISORY COMMITTEE CURRENTLY MEETS ON THE THIRD TUESDAY EVERY TWO MONTHS AT 8:30 A.M. POSTED AGENDA AND PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT Board Services, 1055 W. 7th Street – 10th Floor, Los Angeles, CA 90017.

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at Board Services, L.A. Care Health Plan, 1055 W. 7th Street, 10th Floor, Los Angeles, CA 90017, during regular business hours, 8:00 a.m. to 5:00 p.m., Monday – Friday.

AN AUDIO RECORDING OF THE MEETING MAY BE MADE TO ASSIST IN WRITING THE MINUTES AND IS RETAINED FOR 30 DAYS.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notes, and meeting packet may contact L.A. Care’s Board Services Department at (213) 694-1250. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and related materials.
California Governor Newsom issued Executive Orders No. N-25-20 and N-29-20, which among other provisions amend the Ralph M. Brown Act. Members of the public can hear and observe this meeting via teleconference and videoconference, and can share their comments via voicemail, email or text.

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<thead>
<tr>
<th>AGENDA ITEM/ PRESENTER</th>
<th>MOTIONS / MAJOR DISCUSSIONS</th>
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<tr>
<td>CALL TO ORDER</td>
<td>Tara Ficek, MPH, Chair called the meeting to order at 8:34 a.m. without quorum.</td>
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<td>APPROVAL OF MEETING AGENDA</td>
<td>The Committee reached a quorum at 8:40 a.m.</td>
<td>Approved unanimously. 13 AYES (Aragon, Bloch, Chandler, Dudovitz, Ficek, Frederick, Knox, Kyle, Perez, Puffer, Ramos, Seidman, Shapiro)</td>
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<td>The Agenda for today’s meeting was approved as submitted.</td>
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<tr>
<td>APPROVAL OF THE MEETING MINUTES</td>
<td>The minutes of the August 18, 2020 meeting were approved as submitted.</td>
<td>Approved unanimously. 13 AYES</td>
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<td>CHAIRPERSON REPORT</td>
<td>There was no report from the Chairperson.</td>
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<td>CHIEF MEDICAL OFFICER REPORT</td>
<td>Richard Seidman, MD, MPH, Chief Medical Officer presented his report (A copy of the report can be obtained from Board Services).</td>
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<td>AGENDA ITEM/ PRESENTER</td>
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| Richard Seidman, MD, MPH | COVID-19 Update  
At the time of this writing, close to 50 million cases of COVID-19 were reported worldwide with more than 1.2 million deaths. The number of new infections reported are at the highest levels worldwide and in the United States since the beginning of the pandemic, and cases are increasing at rates as high as during the peak of the summer surge. Los Angeles remains in Tier 1, the most restrictive tier of the State’s Blueprint for a Safer Economy. He stated that he will be providing a verbal update highlighting the most current numbers and trends during the upcoming Board and Committee meetings.  

Influenza (Flu) Update  
Dr. Seidman stated that the flu season in Los Angeles typically ramps up in October, peaks sometime in January, and tails off by the end of March. The Los Angeles County Department of Public Health (DPH) recommends that everyone get their flu shot before the end of October. Due to the COVID-19 pandemic this year, it is widely recognized that the Fight the Flu efforts must be more effective than ever. The Department of Public Health has also noted the relatively light flu season in the Southern Hemisphere and the potential benefit of widespread masking and social distancing due to the COVID-19 pandemic. L.A. Care has successfully partnered with the DPH and other Medi-Cal managed care health plans in Los Angeles County to collaborate on efforts to Fight the Flu and lay the groundwork for successful COVID-19 vaccination efforts, once we have a licensed, safe and effective COVID-19 vaccine. Collaborative projects include a co-branded vaccine hesitancy provider education material created by HealthNet, a flu myths buster video developed by L.A. Care, and a clinician’s flu guidance letter by DPH.  

Flu Vaccine Clinics  
After months of planning in collaboration with multiple stakeholders, drive through flu clinics got underway beginning in October to provide free flu vaccines to L.A. Care’s communities. The primary goal is to maximize flu vaccine uptake this year to reduce the number of flu cases and avoid the risk of overwhelming the health care delivery system with both influenza and COVID-19 at the same time. Free flu shots were provided to all members of the community who showed up, regardless of insurance status, or health insurance plan. As of early November 2, there have been 186 vaccines administered during our first seven events of the season, with two additional events currently scheduled and more being planned. |
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<td>Other interventions to remind members include:</td>
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<td>1. Flu shot reminder postcards</td>
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<td>2. Live-agent member calls</td>
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<td>3. Instagram and Facebook campaigns</td>
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<td>Member Maria Chandler, MD, MBA, stated that the Pfizer vaccine can be administered to people as young as 12 years of age. The monoclonal antibodies are tested to 12 years of age. She noted that the Valencia State Lab has opened for processing tests, and tests results are available in under 24 hours. Dr. Seidman thanked Member Chandler for her comment and stated that the Valencia lab has opened and is testing at capacity.</td>
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**L.A. CARE HEALTHY MOMS**

Marina Acosta, MPH, Health Equities Program Director II, and Jacqueline Kalajian, MPH, Health Education Program Manager II, Health Education, Bettsy Santana, Manager, Quality Improvement Initiatives, Quality Improvement, gave a presentation on L.A. Care’s Healthy Moms and Babies Program (LAHMB) *(a copy of the presentation can be obtained from Board Services).*

Disparities Leadership Program

- L.A. Care is participating in national Disparities Leadership Program
- The project is focused around a high-risk pregnancy program in order to address disparities in prenatal and postpartum care, as well as overall health outcomes like infant and maternal mortality
- Presenting this information to get initial input and keep on this workgroup’s radar

The problem in Los Angeles County, is that Black babies are more than three times as likely as white babies to die before their first birthday. L.A. Care Black mothers and birthing parents have the lowest rates for timeliness of prenatal care and a postpartum visit compared to other races in the community.

L.A. Care is unable to quickly identify high-risk pregnancy through standard data collection methods due to untimely reporting and lack of uniform assessment, making success difficult for early interventions and timely service provisions.

A goal is to implement a high-risk pregnancy program to mitigate complications for high-risk pregnant L.A. Care members, ultimately addressing disparities.

**Next Steps**

- Identify providers in high need and volume practices to implement program
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<tr>
<td></td>
<td>- Current target sites: DHS, MLK Hospital, CPSP provider network</td>
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<td>- Reach out to March of Dimes and First 5 LA for assistance</td>
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<td>• Solicit Feedback</td>
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<td>- Solicit provider and community feedback on desired perinatal programs, resources, and ancillary services</td>
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<td></td>
<td>• Provider incentive</td>
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<td>- Determine incentive amount for provider participation in this program</td>
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**MEMBERSHIP**

Richard Seidman, MD, MPH  
Member Seidman presented the following motion for approval:  

**Motion CHC 100.1220**  
To appoint Susan Fleischman, MD, as member of Children’s Health Consultant Advisory Committee (CHCAC), for the L.A. Care Plan Partners seat effective December 3, 2020.  

Approved unanimously.  
13 AYES

**ADJOURNMENT**

Future potential Agenda items may include:  
• First 5 Inaugural Report  
• LAHMB Black Babies Efforts Outcome  
• ACEs Aware Update  

The meeting was adjourned at 9:50 a.m.

Respectfully submitted by:  
Malou Balones, *Board Specialist III, Board Services*  
Victor Rodriguez, *Board Specialist II, Board Services*  
Linda Merkens, *Senior Manager, Board Services*  

APPROVED BY:  
Tara Ficek, MPH, Chair: __________________________  
Victor Rodriguez, Board Specialist II, Board Services  
Linda Merkens, Senior Manager, Board Services  

Date Signed: __________________________
COVID-19 Update – By early January, the World Health Organization (WHO) reported over 83 million cases of COVID-19 worldwide and more than 1.8 million deaths. The numbers of new infections reported are at the highest levels worldwide and in the United States since the beginning of the pandemic with more than 4 million new cases per week worldwide for the fourth week in a row. California and Arizona have the highest rates of new infections in the Country and the healthcare delivery system in Los Angeles, with over 932,000 cases, is being pushed beyond its capacity to provide safe and effective care to everyone who needs it. The L.A. County Department of Public Health has asked people to avoid coming to Emergency Rooms for other than truly life threatening emergencies and ambulances have been asked not to transport patients with a low likelihood of survival (trauma and cardiac patients they are not able to resuscitate in the field) to emergency rooms. The three-day average number of COVID patients hospitalized in Los Angeles is now 10 times higher at 7,873 than it was on November 1, 2020 and some hospitals are preparing to declare crisis standards of care in which patients will be triaged to determine which patients are priorities for limited resources such as ICU beds and ventilators. L.A. Care has documented over 75,000 known cases among L.A. Care members, with nearly 13,000 admissions and over 2,000 deaths.

Even as we are facing the most difficult and challenging times thus far, over 130,000 doses have been administered of one of two COVID-19 vaccines approved by the FDA for Emergency Use Authorization. Frontline healthcare workers are beginning to get their second dose of vaccine. At this time, we are progressing through the various tiers of Phase 1a (healthcare workers and the residents and staff of LTC and Skilled Nursing Facilities (SNFs) and anticipate moving into Phase 1b by early February, which includes people 75 and older and frontline essential workers in its first tier. People 65 and older and a broader list of essential workers are prioritized in the second tier of Phase 1b before we are able to move on to Phase 1c, anticipated in late March or early April, which will include people 16 -64 with chronic health conditions and co-morbidities placing them at increased risk for serious disease and death.

Fortunately, influenza activity in the county remains relatively low, likely due to all of the precautions in place to reduce the spread of COVID, and due to enhanced flu vaccine efforts during the fall. L.A. Care collaborated with the Department of Public Health, the USC School of Pharmacy, and several community pharmacies to conduct 9 mobile flu vaccine clinics which provided 2500 members of the community with flu vaccines. Pharmacy staff are currently pursuing the opportunity to leverage these partnerships and experience to assist in the COVID vaccination effort.
Year End Activities
The end of the calendar year includes efforts to close clinical care gaps to optimize Healthcare Effectiveness Data and Information Set (HEDIS) performance, to tabulate and report incentive earnings for the prior measurement year, and to survey our members to meet regulatory and accreditation requirements and to identify opportunities to improve by gaining a better understanding of their experience during the past year. More detailed reports of these activities will be presented to the Board throughout the year.

Our HEDIS team completed outreach efforts to close care gaps with nearly 1,500 providers, over half of L.A. Care’s contracted network of PCPs.

The team is also leveraging the more than 2,000 annual wellness exam records that were collected by L.A. Care’s Risk Adjustment team, looking to close gaps for those CMC members. It is expected that approximately 1,800 gaps will be closed by this review.

In addition to surveying our members, L.A. Care offered a patient experience training series for providers that offered eight sessions between October - December 2020. Over 500 unique attendees participated, including 138 individuals who attended more than one session. Feedback from attendees has been very positive, resulting in exceptionally high Net Promoter Scores. We are developing the 2021 series with the vendor, SullivanLuallin Group.

Additional training offerings include the final QI webinar for 2020 focused on risk adjustment for Cal-Medi Connect (CMC). The November session on Proposition 56 payments was our highest attended session to date. Webinars continue to be well received and attendance is increasing. The 2021 schedule is being developed.

Quality Improvement
• Childhood Immunization Performance Improvement Project (PIP) - The childhood immunization improvement initiative launched November 2, 2020 at St. John’s Well Child and Family Center -Dr. Louis C. Frayer Health Center. St. John's is contacting patients for telehealth appointments (when appropriate) for their well care visit then a face-to-face appointment for vaccinations. L.A. Care is supporting St. John's in this effort by providing a list of members due for vaccines, stamps for outreach, and coloring books for members.
• The Disparities Performance Improvement Project proposal was submitted and approved by Health Services Advisory Group (HSAG) in November 2020. The project focuses on African American members that are non-compliant for the Comprehensive Diabetes Control (CDC) measure of lower than 9.0% A1c.
• 2020-2021 Plan-Do-Study-Act (PDSA) for Well Child Visits is in the process of working with both providers and members to help ensure children complete their well care visits. The Department of Health Services (DHS) is providing support to L.A. Care for their assigned members by reaching out to their members and scheduling a well-child visit. The QI team will also be calling members.
Direct Network Support

Transform L.A.
In the past two months, Transform LA has doubled the number of actively engaged Direct Network practices from 7 to 14 and completed baseline practice assessments with the new “cohort 2” practices. We continue to use a virtual coaching model throughout the public health emergency to remotely work with 14 Direct Network (DN) practices representing 136 providers, 3,181 DN members, and 30,037 L.A. Care members. After completion of the baseline practice assessment, L.A. Care staff works with the practice to select improvement efforts such as access to care, quality improvement to improve member experience and outcomes.

Personal Protective Equipment (PPE) Distribution Collaboration
L.A. Care collaborated with the California and Los Angeles County Medical Associations (CMA and LACMA) to distribute PPE supplies to solo and small group practices in L.A. Care’s Direct Network. The collaboration resulted in the distribution of 50 pound boxes of PPE including masks, gowns and face shields to 385 practices.

Virtual Care Strategy
L.A. Care has developed a virtual care strategy and is moving forward with implementation to support further adoption of telehealth, and the introduction of eConsult within L.A. Care’s Direct Network. While there has been widespread adoption of telehealth services as an alternative for patients with clinical needs appropriately served virtually, eConsult between primary care and specialty providers has not yet been widely adopted in L.A. Care’s network outside of some closed systems such as the LA County Department of Health Services (DHS) and within the Kaiser system. Health Care LA IPA contracted providers also utilize the eConsult platform on a voluntary basis. Both telehealth visits and eConsult provide additional access to care and can improve quality of care, outcomes, and member and provider satisfaction.

Health Equity
- L.A. Care partnered with Los Angeles County Human Relations Commission (LACHRC) on LA Vs Hate: for the inaugural United Against Hate Week, November 30 – December 6. L.A. Care’s CEO participated in a press conference event. L.A. Care engaged in a social media campaign during the week, and our Communications department supported a larger media outreach plan for the week on behalf of LACHRC.
- Equity efforts continue with councils focused on our members, employees, and our provider network and contracted vendors. The Consumer Equity Council has been established as another forum to provide information to and gather input from L.A. Care’s members. Dr. Parrish presented at the Equity Council Kick-Off event in December on maternity benefits.
- L.A. Care Healthy Moms and Babies (LAHMB) program presented at the CHCAC meeting and L.A. Care continues to focus on efforts to improve birth outcomes for African American newborns.

Provider Quality Review (PQR) for Potential Quality Issues (PQI)
- As of November 30, 2020, after months of effort to reduce a backlog, all but one of the 2020 PQI cases have been processed timely (within six months).
- The year-end PQI trending analysis identified providers meeting the established threshold over the past 12 months. PQR has started discussions with the providers to improve identified
gaps in an effort to continue enhancing current processes and explore solutions to improve monitoring of patient safety.

- The PQR team conducted an analysis which identified opportunities to improve its operations by implementing a new secure and efficient electronic solution, continued interdepartmental partnerships to monitor patient safety, enhanced PQR in-service to increase understanding of how and when to report quality of care issues.
- Ongoing monitoring of PQR referral volume, staffing levels and timely review will continue to assure compliance with required timelines.

**Initial Health Assessment (IHA)**

- All 2019 IHA Corrective Action Plans (CAPs) have been closed. Work continues to revise the reports, enhance training and create a coordinated monitoring program with Facility Site Review (FSR), Delegation Oversight (DO), and internal audit team to improve the IHA monitoring process. The IHA requirement is on hold during the COVID emergency and the audit is postponed until summer 2021, however all IHAs will need to be completed after, so work to get L.A. Care’s monitoring process in place continues. We are encouraging providers to complete IHA encounters through virtual health methods as much as possible.
  - L.A. Care conducted an internal audit of the IHA process with a focus on the 2019 CAP findings and no issues were identified.
  - Managed Long Term Support Services (MLTSS) developed documentation for Institutions for Mental Diseases (IMDs) to document skipping or refusing the Staying Healthy Assessment (SHA).
  - Evaluating the feasibility of adding an incentive for IHA completion and surveying other health plans to identify best practices.

**Facility Site Review (FSR)**

- California Department of Health Care Services (DHCS) sent an All Plan Letter, APL 20-011, to officially delay the July 1, 2020 implementation date of APL 20-006 until six months after the end of this public health emergency. FSR will continue to train sites and staff on the new APL updates.
- FSR is conducting virtual visits for Initial FSRs for the Direct Network, Relocations and Corrective Action Plan (CAP) Follow Up visits until the public health emergency is lifted. To date 28 virtual audits have been conducted. Eight sites are in the virtual audit preparation phase.
- L.A. Care FSR is working with the LA County Collaborative:
  - To address the DHCS requirement to perform an onsite verification visit for every virtual visit conducted during the public health emergency, once onsite visits are resumed. The Collaborative has proposed a verification visit not be warranted if a site has had a full FSR virtual audit.
  - To request ability to add PCPs to sites that are in good standing (passing scores on FSR and MRR) that have expired FSR/MRR due to COVID.
- Provider Training Work Group—L.A. Care is working with the County Collaborative Provider Training Work Group to prepare training for PCP sites to assist in their implementation of the new APL 20-006.
Health Homes Program (HHP) Update
L.A. Care has now exceeded 13,000 members ever enrolled in the HHP served by 34 Community Based Care Management Entities (CB-CMEs). The Year 1 program report is nearing completion and will be brought to the Board later this year. Work continues with the State to provide input into the development of the Enhanced Care Management benefit proposed under CalAIM which would incorporate the HHP and elements of the Whole Person Care (WPC) Program currently administered by the Los Angeles County DHS.

Individuals Experiencing Homelessness
Staff assessed the current state of street medicine in LA County in order to inform our contracting strategy. Interviews were held with Housing for Health, CCALAC, and internal staff to get a better understanding of current models and providers that offer this service. L.A. Care will continue its efforts to expand the network of providers serving members experiencing homelessness.

- **Los Angeles Housing Policy Leadership Academy** - Erika Granados successfully completed the 8-week Academy. The intensive program provided an overview of the current housing crisis and focused on partnerships and policy solutions to address challenges impacting local communities.
- **Housing for a Healthy CA** – SNI, Social Services and Housing For Health (HFH) are preparing for a soft launch of Housing for a Healthy CA in December, starting by housing up to 50 Los Angeles County Department of Health Services (DHS)-assigned members at two project-based supportive housing sites.
- **Health Homes Program (HHP) Capacity Building** – SNI and HHP consultant, Deborah Maddis, finalized work plan for housing and homelessness coaching & technical assistance for CB-CMEs.
- **L.A. Care and LAHSA Participated in Kickoff CHCS Learning Community** – Alison Klurfeld, Jessica Jew, Delia Mojarro, and Becky Lee from L.A. Care and Daniel Reti from LAHSA completed 1st kickoff session of 12-month learning community focused on collective learning across housing and homelessness/housing sectors. Discussion topics will include data-sharing & CalAIM.
- **LAHSA Data Match for Project Roomkey (PRK) and HHP Coordination** – SNI and HHP teams worked together to refine messaging on how to best partner with LAHSA/PRK Staff to conduct outreach and enroll L.A. Care or Plan Partner members residing in PRK. Goal is to connect eligible members with Health Homes and other health plan benefits and services.
- **Higher Level of Care placements (HLOC) Project Roomkey (PRK) Collaboration** – In November, SNI continued to monitor and participate in planning meetings with various county partners on how best to address the needs of members in PRK who need SNF, LTC, or various other in-home supports. SNI held meetings with LADHS and HCLA familiarize them with PRK HLOC needs.
- **Housing for Health and Brilliant Corners grant program** – As of November 2020, a total of 286 households are actively enrolled in the grant, 263 of those have secured housing, and 208 of those housed (79%) are L.A. Care members. The total number of households ever housed via this grant is 323. All enrolled participants have also been connected to services through the Housing for Health (HFH) Division at the Los Angeles Department of Health Services (DHS).
SCALING AND SUSTAINING DYADIC MODELS OF CARE IN PEDIATRIC PRIMARY CARE:
UCSF/CHC DYADIC THERAPY PILOT AND DHCS FAMILY THERAPY GUIDANCE

LA Care Children’s
January 2021
AGENDA

• The Well Child Visit and Context for Dyadic Care
• The Children’s Health Center and Healthy Steps
• The Journey Toward Sustainability
• Babies Don’t Go To The Doctor By Themselves Proposal
• DHCS and The Family Therapy Benefit
• What’s Next
ACKNOWLEDGMENTS

6MBHT Kathy Stanton, Amanda Wagstaff, Katie Mason, Nelly Pino, Liliana Ramos, Cesia Zelaya, Blanca DiDonato, Kathryn Hallinan, Kate Dube, Amanda Wallin, Ana Galdamez, Anna Harrison, John Fernandez, Sharece Francis, ICAP MCTP Interns

ZSFG Peds Amy Whittle, Shon Jain, Ellen Laves, Christine Mayor, Susan Fisher-Owens, Maggie Gilbreth, Pallavi Sheth, Eleanor Chung, Raul Gutierrez, Dave Gordon

Solid Start Melanie Thomas, Kate Dube

Center for Child and Community Health Anda Kuo, Baylee DeCastro, Dayna Long, Adam Davis

SFDPH SDOH Working Group Ben Lui, Matt Pantell

UCSF SIREN Laura Gottlieb

Health Advocates Phil Herrera, Laura Gottlieb, Laurie Rothstein, Anais Amaya

First Five Theresa Vergara, Nadia Thind

SFGH Foundation & Funders Solid Start, Stupski, John and Lisa Pritzker, Clinton Foundation, Kaiser

Zero to Three & Healthy Steps National Office

SFHP Medical Director and Executive Leadership, Jim Glauber MD

Anthem Blue Cross Dennis McIntyre MD

Philanthropic Funders including Heising Simmons, Kaiser, Susie Sarlo Genentech, Packard, Zellerbach, WBT, MHSA OAC

California Children’s Trust staff and partners

Project CLIMB Team/Children’s Hospital Colorado HealthySteps, Ayelet Talmi, PhD & Melissa Buchholz, PsyD
FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE

Federal Government
Distributed through Federal departments with funding authorized by Congress (FFP/Match)

State of CA
Acting as pass through, enhancer, or reconciler of funding—sometimes providing it, sometimes certifying (CPE)

Health Plans (MCO) CAPITATION
County Mental Health Dept’s (MHP) CPE
School Districts (LEAs/SELPAs) CPE
Community Health Centers FQHC PPS
Dept. of Heath (LGA) CPE
Hospital UC/PH IGT
Regional Center CPE
WHAT DRIVES THIS WORK?

Macro System Change

Dissemination

CHC Clinical Care Innovation
### Early Intervention Systems: Current State

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<tr>
<th>Ages</th>
<th>Pediatric Sector: Child Only Focused</th>
<th>Education Sector: Child Only Focused</th>
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<tr>
<td>0-1</td>
<td>7 Well Visits Per Year</td>
<td>Pre-k Opportunities Limited; Voluntary</td>
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<td>1-2</td>
<td>4 Well Visits Per Year</td>
<td>Early Pre-k Opportunities Limited; Voluntary</td>
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<td>1 Well Visits Per Year</td>
<td>Entry Into K-12 Compulsory Education System</td>
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</table>

**Family-Focused Systems:** Push in, Run Parallel

**Source:** Albany Promise Cradle to Career Partnership adapted by First 5 San Francisco
## EARLY INTERVENTION SYSTEMS: WHAT IF…

<table>
<thead>
<tr>
<th>Ages</th>
<th>Pediatric Sector: Child Focused</th>
<th>Education Sector: Child Focused</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1</td>
<td>7 Well Visits Per Year</td>
<td>Parent/Caregiver support was Intentional, Integrated, and Financed where most accessible and when most needed</td>
</tr>
<tr>
<td>1-2</td>
<td>4 Well Visits Per Year</td>
<td>Early Pre-k Opportunities Limited; Voluntary</td>
</tr>
<tr>
<td>2-3</td>
<td>2 Well Visits Per Year</td>
<td>Early Pre-k Opportunities Limited; Voluntary</td>
</tr>
<tr>
<td>3-4</td>
<td>1 Well Visits Per Year</td>
<td>Pre-k Opportunities Growing; Voluntary</td>
</tr>
<tr>
<td>4-5</td>
<td>1 Well Visits Per Year</td>
<td>Entry Into K-12 Compulsory Education System</td>
</tr>
<tr>
<td>5+</td>
<td>1 Well Visits Per Year</td>
<td></td>
</tr>
</tbody>
</table>

Source: Albany Promise Cradle to Career Partnership adapted by First 5 San Francisco
Children’s Health Center

- Pediatric Ambulatory Care Hub within the San Francisco Health Network
- Primary Care
- Urgent Care for children throughout SFHN
- Subspecialty Care in partnership with UCSF Benioff Children’s Hospital
- 30,000 annual visits, 13,000 patients birth-24
- Located on ZSFG Campus
Healthy Steps at a Glance

I. Universal Services

- Child developmental, social-emotional, and behavioral screening
- Screening for family needs
- Education and anticipatory guidance

II. Short-term Supports

- Developmental and behavior consults

III. Comprehensive Services

- Team-based well-child visits, care coordination, systems navigation

III. Long-term Supports

- Screening for family needs
- Education and anticipatory guidance

CORE COMPONENTS AND COMMUNITY CONNECTIONS

- IPV & Substance Misuse Services
- Food/WIC, Lactation, Housing
- Early Intervention, Child Care, Head Start
- Home Visiting, Peer Support, Parent Ed
- Health & Mental Health Specialists

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Pilot Proposal to SF Health Plan & Anthem

Babies Don’t Go to the Doctor By Themselves:
Innovating a Dyadic Behavioral Health Payment Model to Serve the Youngest Primary Care Patients and Their Families

AUTHORS
Kate Margolis, PhD Assistant Professor, UCSF kathryn.margolis@ucsf.edu
Alex Briscoe Principal, California Children’s Trust alex@cachildrenstrust.org
Jennifer Tracey Senior Director of Growth and Sustainability for HealthySteps, Zero to Three jtracey@zerotothree.org

Proposal Summary
The caregiving and family context is the most

A statewide demonstration project to align reimbursement with clinical best practices in early childhood mental health

Essential support for proven dyadic models

Improving health outcomes for young children and their caregivers

Pioneering clinical best practices to inform state-level guidance

Demonstrating partnership with safety-net clinical leadership
STRATEGY 1:
USE THE WELL CHILD VISIT AS PRIMARY
REPLICATE SFHP PRACTICE

Credentialed non-specialty behavioral health providers may submit as a billable primary diagnosis, the Z-code for a well-child visit, as the primary ICD-10 code attached to any allowable CPT code under the mild to moderate benefit. (Approved Z-codes include, Z00.11, Z00.12).
## Non-specialty Mental Health Encounter Form

### INTERVENTIONAL PROCEDURES

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Billable Code</th>
<th>Rate Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy 30 (16-37) Min</td>
<td>90832</td>
<td>79960639</td>
</tr>
<tr>
<td>Psychotherapy 45 (38-52) Min</td>
<td>90834</td>
<td>79960654</td>
</tr>
<tr>
<td>Psychotherapy 60 (53+) Min</td>
<td>90837</td>
<td>79960670</td>
</tr>
<tr>
<td>Psychotherapy W/EM 30 (16-37) Min</td>
<td>90833</td>
<td>79960647</td>
</tr>
<tr>
<td>Psychotherapy W/EM 45 (38-52) Min</td>
<td>90836</td>
<td>79960662</td>
</tr>
<tr>
<td>Psychotherapy W/EM 60 (53+) Min</td>
<td>90838</td>
<td>79960688</td>
</tr>
</tbody>
</table>

### Paternal Health CPT Code for Level of Service

- **Well Child Visit Z-code**

### Indicate BH Dyadic Visit occurring same day as WCV

- **X**

### Notes

- **DO NOT CREATE ANOTHER ACCOUNT - REVISE CURRENT ACCOUNT**
- Patient has SFHP M-CAL send to Eligibility to revise IPC to 329 Beacon
- Patient does not have SFHP M-CAL - Patient checked in

- **ICD 10:** __Z100.11__

---

Zuckerberg San Francisco General
STRATEGY 2:
LEVERAGE THE NEW FAMILY THERAPY BENEFIT

- Leverage new Family Therapy Benefit that opens Z codes and redefines Medical Necessity criteria.
- There is no cap on the number of family therapy visits billed with ICD-10 code Z65.9 in place of a mental health diagnosis ICD-10 code. However, for children without a specified risk factor who are suspected of having a mental health disorder, no diagnosis is required until after the 5th visit.
- Benefit still on accessible by credentialled providers (license eligible)
- **We want DHCS to Add Z13.39 “Encounter for Screening Examination for Other Mental and Behavioral Disorders” to the family therapy benefit** as an ICD-10 code accepted in addition to Z65.9.
A DEEPER DIVE: DHCS FAMILY THERAPY BENEFIT

1 You can find the Medi-Cal Bulletin article here: https://filessysdev.medi-cal.ca.gov/pubsdoco/bulletins/artfull/gm202006.aspx#a11

2 The full policy, found on pages 4-6 of the Psychological Services section of the provider manual is can be accessed via this link: https://filessysdev.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psychol_a07.doc.

3 The reimbursement rates can be found in the Psychological Services: Billing Codes and Reimbursement Rates section of our provider manual via this link: https://filessysdev.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/psycholcd_a07.doc
STRATEGY 3: CREATE A NEW BENEFIT

Seek parity for preventative behavioral health services by....

Open code H0025 (Behavioral health prevention education service) to be accessible for behavioral health prevention to all infants and young children ages birth to 5 similar to how routine encounters for wellness exams are available to all children in physical health. Pair H0025 with the diagnosis: Z13.39 “Encounter for Screening Examination for other Mental and Behavioral Disorders” or a similar Z code that does not specify criteria for medical necessity.
What does success look like?

Short Term:
- Dyadic service model meets fidelity & is scalable
- CHC reports on HS cost savings metrics & plan QI metrics
- Meet enrollment goals for T2 & T3
- Solid partnership with plans: innovation & data feedback
  - Claims data, total cost of care per family

Long Term:
- Movement towards DHCS adoption of pilot strategies
- Plans’ pilot expenditures considered in look-back period for future rate setting
- Healthcare reform → payment of primary care based dyadic BH models in early childhood
- BH/Development Well Child Visits = Parity with Physical Health
Eligible Medi-Cal recipients may receive psychological services when medically necessary. The information found in this section does not apply to specialty mental health services delivered by county Mental Health Plans (MHPs). For additional information regarding coverage of mental health services, refer to the Specialty Mental Health Services section of this manual. For additional help, refer to the Psychological Services: Billing Examples section of this manual.

Eligibility

An adult recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health disorder as defined by the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional or behavioral functioning. A child recipient obtains eligibility for mental health services if the recipient is diagnosed with a mental health condition as defined by the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5) regardless of level of severity. Adults and children are also eligible for central nervous system tests and assessments when medically necessary.

Exceptions:

Recipients under age 21 may receive up to five sessions of a combination of individual or family therapy before a mental health diagnosis is required.

Recipients under age 21 who have risk factors for mental health disorders as specified in the “Family Therapy” section below, are eligible for family therapy.
Pregnancy and Postpartum-Related Services

Policy for screening for depression in pregnant or postpartum recipients may be found in the Evaluation and Management (E&M) section of the appropriate Part 2 Manual.

Pregnant and postpartum women with one or more of the following risk factors for perinatal depression are also eligible for individual and group counseling: a history of depression, current depressive symptoms (that do not reach a diagnostic threshold), certain socioeconomic risk factors such as low income, adolescent or single parenthood, recent intimate partner violence, or mental health-related factors such as elevated anxiety symptoms or a history of significant negative life events. Up to a total of 20 individual counseling (CPT® codes 90832 and 90837) and/or group counseling (CPT code 90853) sessions are reimbursable when delivered during the prenatal period and/or during the 12 months following childbirth. Modifier 33 must be submitted on claims for counseling given to prevent perinatal depression.

For information about other pregnancy-related services, providers may refer to the Pregnancy: Early Care and Diagnostic Services section of the appropriate Part 2 manual.

Mental Health Services Delivery Systems

Eligible Medi-Cal recipients may receive Medi-Cal mental health services through all Medi-Cal delivery systems including, but not limited to, Managed Care and fee-for-service delivery systems. Recipients that meet medical criteria for specialty mental health services will receive mental health services via county MHPs.

Mental Health Services

Recipients who are eligible for Medi-Cal mental health services may receive the following:

- Individual and group mental health evaluation and treatment (psychotherapy) rendered by a psychologist, LCSW, LPCC or MFT
- Family therapy rendered by a psychologist, LCSW, LPCC, or MFT
- Psychological testing when clinically indicated to evaluate a mental health condition
- Development of cognitive skills to improve attention, memory and problem solving
- Outpatient services for the purposes of monitoring drug therapy
- Outpatient laboratory, drugs, supplies and supplements
- Psychiatric consultation
- Specialty mental health services provided by County Mental Health Plans

Treatment Authorization Requests (TARs) are not required for psychology services for Medi-Cal recipients that meet eligibility criteria for mental health services.
Program Coverage

Medi-Cal covers psychological services only when provided by persons who meet the appropriate requirements specified by the California Code of Regulations.

Marriage and family therapist interns, registered associate clinical social workers and psychology assistants may render psychotherapy services under a supervising clinician. The claim must list the intern, associate or assistant’s name in the Additional Claim Information field (Box 19) or in an attachment, along with the supervising clinician’s National Provider Identifier number as the “billing provider.”

Psychological services are not covered under the County Medical Services Program (CMSP).

“Service” Defined

“Service” means all care, treatment or procedures provided to a recipient by an individual practitioner on one occasion.

Eligibility Requirements

Providers should verify the recipient’s Medi-Cal eligibility for the month of service.

Authorization

A Treatment Authorization Request (TAR) is not required for psychological services. Psychological services are covered services when ordered by a primary care physician.

Place of Service Codes

Psychologist, LCSWs, LPCCs and MFTs may only bill Place of Service codes for the following: office, home, outpatient hospital, community mental health center, comprehensive rehabilitation facility, state or local public health clinic, rural health clinic or other.

When using Place of Service code “99” (other), indicate the full name and address of the testing location in the Additional Claim Information field (Box 19) or on an attachment and leave the Service Facility Location Information field (Box 32) blank.
Family Therapy

Family therapy that is evidence-based or incorporates evidence-based components is reimbursable in an outpatient setting for adults with a mental health condition and for children under age 21 who meet at least one the following criteria:

- The child has a diagnosis of a mental health condition as defined by DSM or as defined by the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). If DC: 0-5 is used for the diagnosis, the corresponding ICD-10 code, which can be found at www.zerotothree.org, must be entered on the claim form.

- The child under age 21 has a history of at least one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  - Separation from a parent/guardian due to incarceration or immigration
  - Death of a parent/guardian
  - Foster home placement
  - Food insecurity, housing instability
  - Exposure to domestic violence or other traumatic events
  - Maltreatment
  - Severe and persistent bullying
  - Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences or disability
• The child under age 21 has a parent/guardian with one of the risk factors below. Claims for family therapy for these children must be billed with ICD-10 code Z65.9:
  – A serious illness or disability
  – A history of incarceration
  – Depression or other mood disorder
  – PTSD or other anxiety disorder
  – Psychotic disorder under treatment
  – Substance use disorder
  – A history of intimate partner violence or interpersonal violence
  – Is a teen parent

• The medical provider suspects a mental health disorder and has referred the recipient under age 21 for evaluation. A specific diagnosis is not required for the first five sessions for recipients under age 21. Claims for these visits must be billed with ICD-10 code F99.

Some examples of evidence-based family therapy are:
  • Child-Parent Psychotherapy (ages 0 thru 5)
  • Triple P Positive Parenting Program (ages 0 thru 16)
  • Parent Child Interactive Therapy (ages 2 thru 12)

Family therapy must be composed of at least two family members. Mental health providers must bill for family therapy using the Medi-Cal ID of only one family member per therapy session for CPT codes 90846, 90847 and 99354. Mental health providers must bill for multiple-family group therapy using the Medi-Cal ID of only one family member per family.

**Inpatient Family Therapy**

Family therapy is reimbursable on an inpatient basis only for infants hospitalized in a neonatal intensive care unit. Claims for these therapy sessions must be billed with ICD-10 code P96.9.

**Billing Newborn Infant Family Therapy with Mother’s ID**

Family therapy rendered to an infant who has not yet been assigned a Medi-Cal ID number may be billed with the mother’s ID for the month of birth and the following month only.
Billing Codes

Reimbursement of family therapy is limited to a maximum of 50 minutes when the patient is not present (CPT code 90846) or a maximum of 110 minutes when the patient is present (CPT code 90847 plus CPT code 99354).

When billing family therapy (CPT codes 90846, 90847, 90849 and 99354), providers should use the appropriate code, based on the following descriptions and direct patient care time frames:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90846</td>
<td>Family psychotherapy (without the patient present), 50 minutes</td>
</tr>
<tr>
<td>90847</td>
<td>Family psychotherapy (with patient present), 50 minutes</td>
</tr>
<tr>
<td>90849</td>
<td>Multiple-family group therapy</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged psychotherapy service requiring direct patient contact beyond the usual service; first hour</td>
</tr>
</tbody>
</table>

CPT code 99354 is only reimbursable when billed on the same date of service as CPT code 90847.

CPT codes 90846, 90847, 90849 and 90853 may not be billed on the same day for the same beneficiary.

Group Therapy

Group therapy is defined as counseling of at least two but not more than eight persons at any session. There is no restriction as to the number of Medi-Cal-eligible persons who must be included in the group’s composition. For example, if there are five patients in the group, and only one is a Medi-Cal recipient, then Medi-Cal should be billed using CPT code 90853, once per session.

Group therapy sessions of less than one and one-half hours are not reimbursable.
**Individual Therapy**

Individual therapy is limited to a maximum of one and one-half hours per day by the same provider.

When billing individual psychotherapy (CPT codes 90832, 90837, 90839 and 90840), providers should use the appropriate code, based on the following direct patient care time frames:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90832</td>
<td>Psychotherapy, 30 minutes with patient</td>
</tr>
<tr>
<td>90837</td>
<td>Psychotherapy, 60 minutes with patient</td>
</tr>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes</td>
</tr>
<tr>
<td>90840</td>
<td>Psychotherapy for crisis each additional 30 minutes</td>
</tr>
</tbody>
</table>

**Case Conference**

Case conference allowances (CPT codes 99366 and 99368) are limited to conferences with persons immediately involved in the case or recovery of the client.

**Central Nervous System Assessments/Tests**

Claims for central nervous system assessments/tests (CPT procedure codes 96105, 96110, 96112, 96113, 96116, 96121, 96130 thru 96133, 96136 thru 96139 and 96146) must include an itemization of the tests performed. Providers must list the tests performed either in the Additional Claim Information field (Box 19) or on an attachment.

Claims billed with CPT codes 96105, 96116 and 96121 must include an attachment specifying the amount of time spent completing each of the following:

- Administration of test(s)
- Interpretation of test results
- Preparation of the report
## Frequency Limitations/Additional Billing Instructions

Frequency limitations and additional billing instructions apply to the following central nervous system assessments/tests:

«Central Nervous System Assessments Tests Codes Table»

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Frequency Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>96105</td>
<td>Assessment of aphasia, per hour.</td>
<td>Two episodes per year (≤3 hours each), any provider. All hours for each episode must be billed on the last day of service.</td>
</tr>
<tr>
<td>96110 *</td>
<td>Developmental screening, per standardized instrument</td>
<td>Two per year, any provider</td>
</tr>
<tr>
<td>96112</td>
<td>Developmental test administration; first hour</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96113</td>
<td>Developmental test administration; each additional 30 minutes</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral status exam; first hour</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96121</td>
<td>Neurobehavioral status exam; each additional hour</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96130</td>
<td>Psychological testing evaluation services; first hour</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96131</td>
<td>Psychological testing evaluation services; each additional hour</td>
<td>Two per year, any provider</td>
</tr>
</tbody>
</table>
### Neuropsychological Tests Codes Table

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Frequency Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>96132 †</td>
<td>Neuropsychological testing evaluation services; first hour</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96133 †</td>
<td>Neuropsychological testing evaluation services; each additional hour</td>
<td>Two per year, any provider</td>
</tr>
<tr>
<td>96136 †</td>
<td>Psychological or neuropsychological test administration and scoring, two or more tests; first 30 minutes</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96137 †</td>
<td>Psychological or neuropsychological test administration and scoring, two or more tests; each additional 30 minutes</td>
<td>Nine per year, any provider</td>
</tr>
<tr>
<td>96138 †</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests; first 30 minutes</td>
<td>One per year, any provider</td>
</tr>
<tr>
<td>96139 †</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests; each additional 30 minutes</td>
<td>Nine per year, any provider</td>
</tr>
<tr>
<td>96146 †</td>
<td>Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only</td>
<td>One per year, any provider</td>
</tr>
</tbody>
</table>

**Note:** A TAR override is allowed for CPT codes 96105, 96110, 96112, 96113, 96116, 96121 96130 thru 96133, 96136 thru 96139 and 96146.
Medical Necessity Criteria for Neuropsychological Testing

Neuropsychological testing (CPT codes 96132, 96133, 96136 thru 96139 and 96146 [when billing for neuropsychological testing]) is considered medically necessary:

- When there are mild deficits on standard mental status testing or clinical interview, and a neuropsychological assessment is needed to establish the presence of abnormalities or distinguish them from changes that may occur with normal aging, or the expected progression of other disease processes; or

- When neuropsychological data can be combined with clinical, laboratory and neuroimaging data to assist in establishing a clinical diagnosis in neurological or systemic conditions known to affect CNS functioning; or

- When there is a need to quantify cognitive or behavioral deficits related to CNS impairment, especially when the information will be useful in determining a prognosis or informing treatment planning by determining the rate of disease progression; or

- When there is a need for pre-surgical or treatment-related cognitive evaluation to determine whether it would be safe to proceed with a medical or surgical procedure that may affect brain function (for example, deep brain stimulation, resection of brain tumors or arteriovenous malformations, epilepsy surgery, stem cell transplant) or significantly alter a patient’s functional status; or

- When there is a need to assess the potential impact of adverse effects of therapeutic substances that may cause cognitive impairment (for example, radiation, chemotherapy, antiepileptic medications), especially when this information is utilized to determine treatment planning; or

- When there is a need to monitor progression, recovery and response to changing treatments, in patients with CNS disorders, in order to establish the most effective plan of care; or

- When there is a need for objective measurement of patients' subjective complaints about memory, attention, or other cognitive dysfunction, which serves to inform treatment by differentiating psychogenic from neurogenic syndromes (for example, dementia vs. depression), and in some cases will result in initial detection of neurological disorders or systemic diseases affecting the brain; or

- When there is a need to establish a treatment plan by determining functional abilities/impairments in individuals with known or suspected CNS disorders; or

- When there is a need to determine whether a member can comprehend and participate effectively in complex treatment regimens (for example, surgeries to modify facial appearance, hearing, or tongue debulking in craniofacial or Down syndrome patients; transplant or bariatric surgeries in patients with diminished capacity), and to determine functional capacity for health care decision making, work, independent living, managing financial affairs, etc.; or

Part 2 – Psychological Services
• When there is a need to design, administer, and/or monitor outcomes of cognitive rehabilitation procedures, such as compensatory memory training for brain-injured patients; or

• When there is a need to establish treatment planning through identification and assessment of neurocognitive conditions that are due to other systemic diseases (for example, hepatic encephalopathy; anoxic/hypoxic injury associated with cardiac procedures); or

• Assessment of neurocognitive functions in order to establish rehabilitation and/or management strategies for individuals with neuropsychiatric disorders; or

• When there is a need to diagnose cognitive or functional deficits in children and adolescents based on an inability to develop expected knowledge, skills or abilities as required to adapt to new or changing cognitive, social, emotional or physical demands.

Neuropsychological testing is not considered medically necessary when:

• The patient is not neurologically and cognitively able to participate in a meaningful way with the requirements necessary to successfully perform the tests; or

• Used as screening tests given to the individual or general populations; or

• Used as a screening test for Alzheimer’s dementia; or

• Administered for educational or vocational purposes that do not inform medical management; or

• Performed when abnormalities of brain function are not suspected; or

• Used for self-administered or self-scored inventories, or screening tests of cognitive function such as AIMS, or Folstein Mini Mental Status Exam (MMSE); or

• Repeated when not required for medical decision making, (for example, to make a diagnosis, or to start or continue rehabilitative or pharmacological therapy); or

• Administered when the patient has a substance abuse background and any one of the following apply:
  – the member has ongoing substance abuse such that test results would be inaccurate, or
  – the member is currently intoxicated; or

• The member has been diagnosed previously with brain dysfunction, and there is no expectation that the testing would impact the member’s medical management.
Test Scoring/Written Test Report
The appropriate test scoring or written test report procedure code must be billed on the same claim as the test administration. Claims with a test score or written report code billed without a test administration code will be denied.

When billing Place of Service code “99” (other), the full name and address of the testing location must be documented in the Additional Claim Information field (Box 19) or on an attachment or the claim will be denied.

Cognitive Skills Development
When billing for cognitive skills development providers should use HCPCS code G0515 (development of cognitive skills to improve attention, memory, problem solving [includes compensatory training], direct [one-on-one] patient contact, each 15 minutes). The frequency limit is two units (30 minutes) per day, any provider.

Medicare/Medi-Cal Crossovers
If Medicare denies payment because the following requirements are not met, payment will also be denied by Medi-Cal.

Requirements
Medicare covers both psychotherapy and central nervous system assessments/tests. Claims for testing and therapy must first be submitted to Medicare before billing Medi-Cal for Medicare-eligible recipients. When billing Medi-Cal, providers must submit an Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN) with the claim for services rendered to a Medicare/Medi-Cal recipient.

Diagnostic Testing Covered by Medicare When Ordered by a Physician
Diagnostic testing performed by a psychologist practicing independently of an institution, agency or physician’s practice is covered by Medicare only when the service is ordered by a physician. When submitting a claim, Medicare requires the psychologist to include a copy of the report sent to the physician who ordered the testing and the name and address of the referring physician.
<Legend>

Symbols used in the document above are explained in the following table.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>«</td>
<td>This is a change mark symbol. It is used to indicate where on the page the most recent change begins.</td>
</tr>
<tr>
<td>»</td>
<td>This is a change mark symbol. It is used to indicate where on the page the most recent change ends.</td>
</tr>
<tr>
<td>*</td>
<td>Refer to the Preventive Services section in the appropriate Part 2 manual for more information.</td>
</tr>
<tr>
<td>†</td>
<td>Neuropsychological tests require medical necessity as explained in this section.</td>
</tr>
</tbody>
</table>
FIRST 5 LA'S IMPACT FRAMEWORK
Purpose of the Conversation

- Introduce the Impact Framework and the 2020 Pathway to Progress Report
- Highlight Impact Framework indicators that speak to health disparities in L.A. County
Our Pathway for Systems Change

Our North Star
By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.

We Want Systems To Be
- Accessible
- Quality
- Aligned
- Sustainable

We Change Systems By
- Policy change
- Practice change
- Will building

Results for Children and Families
- Families optimize their child’s development.
- Children receive early developmental supports and services.
- Children are safe from abuse, neglect, and other trauma.
- Children have high-quality early care and education experiences.

Our Strategic Priorities
- Strengthen public & community systems
- Advance & build on community experience
- Expand influence & impact with data
- Optimize our effectiveness

Our Values
- Collaboration
- Integrity
- Learning
- Diversity, Equity and Inclusion

Our Investment Guidelines
- Equity
- Sustainability
- Partnership
- Prevention
- Systems Change
- Evidence and Innovation
What is the Impact Framework?

By 2028, all children in L.A. County will enter kindergarten ready to succeed in school and life.

**Types of Indicators**

<table>
<thead>
<tr>
<th></th>
<th>What They Are</th>
<th>How We Will Use Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>Results for Children and Families</td>
<td>The child and family conditions that reflect progress toward the North Star</td>
<td>To gauge how well systems are working for children and families</td>
</tr>
<tr>
<td>Long-Term System Outcomes</td>
<td>The improvements needed in systems so that they work for children and families</td>
<td>To measure the progress of our systems change strategies</td>
</tr>
<tr>
<td>Short-Term Markers of Progress</td>
<td>The early improvements in systems expected from our strategies</td>
<td>To guide course-correction and serve as early markers of progress</td>
</tr>
<tr>
<td>Context</td>
<td>Conditions within L.A. County which inform our work</td>
<td>To understand the context and inform our objectives</td>
</tr>
</tbody>
</table>
2020 Pathway to Progress Inaugural Report

Pathway to Progress:
Indicators of Young Child Well-being in Los Angeles County
Document the conditions of L.A. County children and families prior to the launch of the 2020-2028 Strategic Plan

Share the Impact Framework and how we will measure the progress of our Strategic Plan

Encourage the use of indicator data internally and externally

Provide a resource with population and subgroup data
### Key Findings for the Result Indicators

<table>
<thead>
<tr>
<th>Title</th>
<th>Trend</th>
<th>Equity</th>
<th>Access</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High-Quality ECE</td>
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<td>2. Publicly Funded ECE</td>
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<td>3. Early Intervention Services</td>
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<td>4. Average Age of Students in Special Education</td>
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<td>5. CPS Involvement</td>
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<td>6. Family Engagement With Child</td>
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<td>7. Home Visiting Participation</td>
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<td>8. Safety Net Program Eligibility</td>
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<td>9. Social Support</td>
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<td>10. Access to Parks</td>
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</tbody>
</table>

**Key:**
- Blue: Mostly positive
- Black: Mixed or modestly good
- Yellow: Mostly negative
- Grey: Unknown
Result Indicator: A greater proportion of Latino & Multiracial young children are identified early.

Receipt of Early Intervention Services among California Children birth through age 5

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Rate Receiving Early Intervention Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino</td>
<td>5.9%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>5.6%</td>
</tr>
<tr>
<td>Black</td>
<td>4.4%</td>
</tr>
<tr>
<td>North American</td>
<td>3.7%</td>
</tr>
<tr>
<td>White</td>
<td>3.4%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

Rate Receiving Early Intervention Services by Race/Ethnicity, 2018-19
Result Indicator: Delays in enrollment of Asian/Pacific Islander students in Special Education

Average Age of L.A. County Students Enrolled in Special Education for Speech or Language Impairment

- **Latino**: 6.7
- **Black**: 7.2
- **White**: 7.3
- **Asian/Pacific Islander**: 7.5

- [Legend: Average age of students enrolled in special education]
Result Indicator: More Latino & Black families with an infant participate in First 5 LA-funded home visiting

Participation in Home Visiting Services

- Latino: 17.6%
- Black: 14.5%
- Asian/Pacific Islander: 3.9%
- White: 2.7%

Rate of Families with Infants Participating in Home Visiting
Contextual Indicators highlight context of significant disparities in health of L.A. County young children

The mortality rate of infants born to Black mothers is nearly three times the mortality rate of infants born to White mothers.

The rate of preventable death was four times higher among young Black children than among young Latino and White/Other children.

Infants born to Black mothers had nearly twice the rate of low birth weight as infants born to mothers from all other racial or ethnic groups.

Over the past 16 years, 4-year-old children with Latina mothers have consistently had the lowest rate of healthy weight.
Contextual Indicators also highlight a context of significant disparities in maternal health in L.A. County

- 76% of Black mothers receive prenatal care compared to 88% of White mothers.
- 87% of Black mothers have postpartum checkups compared to 94% of White mothers.
- Black and Latina mothers experience higher rates of both prenatal and postpartum depression compared to Asian/Pacific and White mothers.
Next Steps

• Utilize data in the report to inform discussions and decisions that impact child and family serving systems

• Collaborate to address data access and data limitations
Thank you!