PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPQP1006 (previously QP100106)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Clinical Practice Guidelines</td><td colspan="2">☒External Policy
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 05/14/2025</td></tr>
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I. RELATED POLICIES:

A. MPXG5001 - Clinical Practice Guidelines Diagnosis and Management of Asthma
B. MPXG5002 - Clinical Practice Guidelines for Diabetes Mellitus
C. MPXG5003 - Major Depression in Adults Clinical Practice Guidelines
D. MPXG5008 - Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
E. MPXG5009 - Lactation Clinical Practice Guidelines
F. MCCP2020 – Lactation Policy and Guidelines

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Clinical Practice Guidelines (CPGs) are evidence-based strategies for clinical management of Partnership HealthPlan of California (Partnership) members who are at risk for, or who have, certain clinical conditions. The objectives of implementing CPGs are:
   1. To educate providers regarding comprehensive current evidence-based management practices for a given condition with the intent of improving quality of care.
   2. To minimize inter-practitioner variation in an attempt to reduce the use of out-of-date or sub optimal approaches to care.
   3. To define the objective clinical criteria against which provider and health plan performance will be measured in the areas covered by CPGs.
   4. To define best practices to be used in care coordination programs and to specify the clinical content to be used in Partnership health education programs.
   5. To help practitioners and members make decisions about appropriate health care for specific clinical circumstances and behavioral health services.

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

receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define, describe, and guide the process for Partnership's Clinical Practice Guideline (CPG) development, adoption, implementation, and performance evaluation.

VI. POLICY / PROCEDURE:

A. CPG Development and Implementation
   1. Determination of need:
      a. Suggested topics for clinical practice guidelines will be elicited from the following areas:
         1) Clinical committees: Physician Advisory Committee (PAC), Quality/Utilization Advisory Committee (Q/UAC), and Pharmacy & Therapeutics Committee (P&T)
         2) Partnership providers and practitioners
         3) Partnership staff
      b. CPG topics may be chosen because of the high frequency of the condition among health plan members, excessive morbidity or mortality as determined by retrospective review of health plan data, wide variations in practice patterns among health plan practitioners, potential risk for over- or under-utilization of services, or high cost of care for the condition.
      c. Partnership will develop at least two non-preventive acute or chronic care clinical guidelines and at least two guidelines related to behavioral conditions. There may be a clinical guideline that includes both the medical and behavioral components and where this occurs; the second behavioral guideline will address a separate condition or an aspect of a behavioral condition distinctly different from the behavioral guideline adopted by Partnership.
   2. Recommendations for new topics are forwarded to the Q/UAC, along with background information regarding the frequency of the condition among health plan members, the rates of morbidity and mortality arising from the condition, the availability of nationally recognized guidelines, and other pertinent materials. The Q/UAC determines which topics are scheduled for CPG development.
   3. Partnership Health Services staff conducts a literature search to determine whether any professionally recognized organization has developed an applicable guideline or expert consensus statement that is available to the public. If so, this "source guideline," per the recommendation of the Physician Advisory Committee, will be referenced in the CPG and appropriate internet sites will be listed. If a source guideline has not been developed or is not publicly available, Partnership staff develops a draft CPG based upon available objective peer-reviewed medical literature. When Partnership contracted provider groups have a CPG on the topic, an effort is made to make Partnership's CPG consistent with that of the provider group.
   4. The draft CPG will include:
      a. Brief introduction to the specific CPG, defining why it is an important clinical condition to manage (e.g., incidence, morbidity, social impact).
      b. Key points in diagnosis and management:
         1) Key issues in accurate diagnosis/differential diagnosis.
         2) Key issues in treatment and follow-up.
      c. Indicators monitored by Partnership to measure compliance with the CPG.
      d. References, which will either include the specific CPG adopted by Partnership or, in the case where nationally recognized guidelines are not available, the sources used to develop the CPG.
   5. A CPG may be drafted by any medically licensed Partnership provider or staff member or subject

matter expert. The draft is reviewed and initially approved by the Medical Director for Quality, the Chief Medical Officer, or medically licensed designee.

6. The draft CPG is then reviewed by Partnership's Associate Director of Utilization Management, Medical Director for Quality, Pharmacy Services Director, Associate Director of Network Services, and a member of Population Health's Cultural and Linguistics team to ensure that the CPG is consistent with UM criteria, member education, benefit interpretation, QI program goals, and practitioner communications. When indicated, the Director of Grievance & Appeals and Member Services and/or Behavioral Health Clinical Director may also be asked to review a CPG.
7. If the draft CPG was created due to a lack of "nationally recognized guidelines," then an "expert workgroup" is convened to review the draft and make further recommendations regarding its content.
    a. The workgroup will include at least one, but two if available, board-certified practicing physicians of the specialty area to which the guideline applies, as well as at least one primary care provider if the condition is one typically managed by primary care providers.
    b. Depending upon the complexity of the subject or length of the draft CPG, the workgroup may be asked to meet in person or may communicate by telephone or email.
8. The draft CPG is then forwarded to the Q/UAC for consideration. The draft can be:
    a. Approved as presented, or,
    b. Modified by the Q/UAC and approved, or,
    c. Referred back to the "expert workgroup" for further modification in the case of a CPG created due to no "source guidelines." Once acted upon by the "expert workgroup," the draft can be resubmitted to the Q/UAC.
    d. After approval by the Q/UAC, the CPG is then submitted to the PAC, which may approve, modify or refer back to the "expert workgroup" for further consideration.
9. Once approved by the PAC, the CPG will be disseminated in the following manner:
    a. The CPG is used in making utilization management determinations, quality of care, benefit interpretations, care coordination decisions, and designing health educational materials.
    b. The CPG is incorporated into the Provider Manual, viewable on the Partnership Website.
10. Review and updating CPGs
    a. CPGs will be reviewed annually from the approval date and updated as appropriate.
    b. If a significant new intervention (e.g., diagnostic test, drug, or surgical intervention) becomes available before the next scheduled revision of the CPG, staff consults with Chief Medical Officer (CMO) and, if the CMO recommends modifications of the CPG, the updated CPG will be referred to the Q/UAC and PAC for approval. Experts in the focus area will be consulted as appropriate.

B. Monitoring Use of CPGs
1. Once a CPG is approved by the PAC, a copy of the CPG is forwarded to a designated physician at the provider site. The site may adopt the Partnership CPG, or submit its CPG to Partnership for approval.
2. Partnership audits practice site adherence to CPGs through the annual collection of data using standardized measures such as Healthcare Effectiveness Data and Information Set (HEDIS®) measures. Data collection occurs through HEDIS® and Partnership's Primary Care Provider Quality Incentive Program (PCP QIP).

C. MEDICATIONS
1. The pharmacy benefit is carved-out to Medi-Cal Fee-for-Service (Medi-Cal Rx) as described in the Department of Health Care Services' All Plan Letter (APL) 22-012 and the Governor's Executive Order N-01-19 effective Jan. 1, 2022.
2. For Partnership Advantage members. pharmacy is a covered Medicare Part D benefit that will be administered by Partnership and our delegated Pharmacy Benefits Manager (PBM).

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VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (revised Dec. 30, 2022 supersedes APL 20-020)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
06/21/00; 08/15/01; 08/20/03; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 05/18/11; 02/15/12; 02/20/13; 02/19/14; 02/18/15; 02/17/16; 04/19/17; *03/14/18; 03/13/19; 03/11/20; 04/14/21; 05/11/21; 05/10/23; 05/08/24; 05/14/25

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

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

PREVIOUSLY APPLIED TO:

Healthy Kids - MPQP1006 (Healthy Kids program ended 12/01/2016)
03/21/07; 02/20/08; 03/18/09; 05/18/11; 02/15/12; 02/20/13; 02/19/14; 02/18/15; 02/17/16 to 12/01/2016
PartnershipAdvantage:
MPQP1006 - 03/21/2007 to 01/01/2015
Healthy Families:
MPQP1006 - 05/18/11 to 03/01/2013