New PCP Medical and Quality Orientation

November 2023

Detailed Notes

Introduction:

Partnership HealthPlan of California's mission is:

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

This dual focus – on both the individuals who are members of the health plan and the communities that we all live in – is rooted in our not-for-profit status and our governance structure. Our governing Board of Commissioners includes a diversity of representatives from all counties that we serve in Northern California.

Partnership's vision is:

"To be the most highly regarded health plan in California."

We strive to be highly regarded by our members, the provider network comprising our health care delivery system, our community partners, the state legislative and executive branches, other health plans (our peers), and by our employees. This requires engagement and communication with each of these groups.

Facilitator/Presenter

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Your Regional Medical Directors:

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Electronic versions of this orientation available at:
http://www.partnershiphp.org/Providers/HealthServices/Pages/Office-of-the-CMO.aspx

Land Acknowledgement: Partnership honors the ancestral stewards of the land on which we meet today and acknowledges the displacement and lost lives due to colonization and ongoing disparities among California Native Americans.

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Introducing Partnership HealthPlan of California

Origins of Partnership

Medicaid and Medicare were both authorized by the U.S. government in 1965 as title XIX of the Social Security Act. All states, the District of Columbia, and the U.S. territories have Medicaid programs designed to provide health coverage for low-income people. Although the Federal government establishes certain parameters for all states to follow, each state administers their Medicaid program differently, resulting in variations in Medicaid across the country.

California's version of Medicaid is the California Medical Assistance Program, known as Medi-Cal, also created in 1965 as a fee-for-service program. Costs of the program grew steadily over the ensuing years as the number of beneficiaries grew. The predecessor to modern Medi-Cal Managed Care was the for-profit prepaid health plan, first piloted in 1968, and then fully authorized in 1971 as the Medi-Cal Reform Act, signed by Governor Ronald Reagan with the goal of controlling costs. State oversight was lax, resulting in poor quality, poor access, high profits for health plans, as documented by the California State Auditor in 1976.

As an attempt to control this, in 1976 the U.S. Congress explicitly authorized states to purchase services under a prepaid capitation basis, but required that they follow the rules of the new Health Maintenance Organization (HMO) model, and limited their combined Medicaid and Medicare enrollment to no more than 50% of their membership. The policy rationale was that only reputable HMOs with provider networks sufficient to attract and retain at least half of their enrollees in the private sector would not pose a program integrity risk to Medicaid.

The Medicaid/Medicare maximum percentage of enrollment was increased to 75% in 1981, as part of an effort to give states greater flexibility. This legislation (OBRA 81) also allowed states to create Medicaid-only Managed Care organizations if they met certain rules, under a waiver of Medicaid rules (section 1915(b) waiver), which was the genesis of the steadily growing 1915(b) waivers used to allow CalAIM and a host of optional benefits in the decades to come. A 1915(b) waiver could also be sought to mandate enrollment into Medi-Cal Managed Care.

In 1982, California legislation authorized the first County Organized Health System (COHS) to deliver managed care services to Medi-Cal beneficiaries. The first such COHS was established in 1983 in Santa Barbara County, followed by San Mateo in 1987.

The third COHS was the Solano Health Partnership, founded in 1994 in Solano County by the Solano Coalition for Better Heath. With expansion into Napa County in 1998, the new name Partnership HealthPlan of California was adopted.

The COHS in California, with their current counties, are listed below, with the year they began operations.

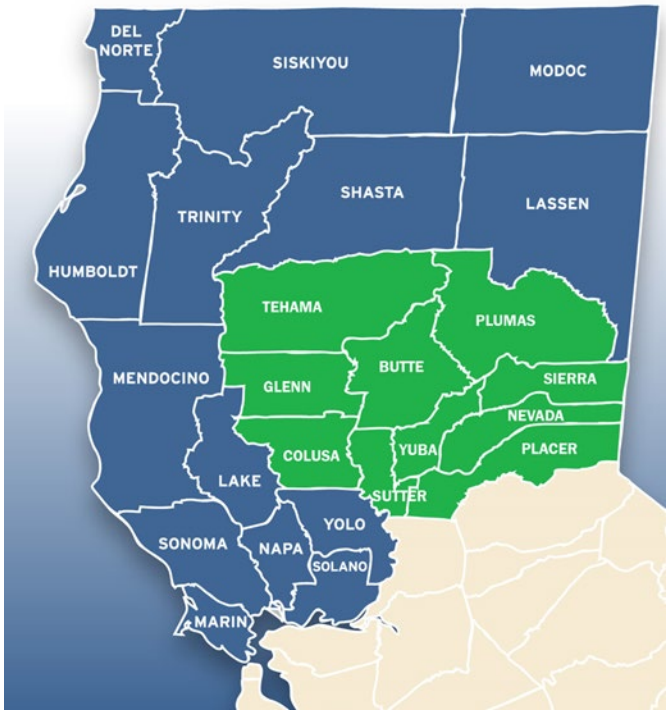
1. Cen Cal Health (Santa Barbara and San Luis Obispo) - 1983
2. Health Plan of San Mateo - 1987
3. Partnership Health Plan (see county list below) - 1994
4. Cal Optima (Orange), currently the largest COHS with about 900,000 members - 1995
5. Central California Alliance for Health (Monterey, Santa Cruz, Stanislaus) - 1996
6. Gold Coast Health Plan (Ventura) - 2011

The government of Contra Costa County formed its own managed care plan in 1973, with the county government itself running the health plan (a County *Sponsored* Health Plan) instead of having a separate commission. There were other statutory differences from a COHS, and in 1997 a commercial plan option was added to Contra Costa County, making Contra Costa into a two-plan model.

Of note, COHS health plans are regulated directly by DHCS, and are not required to be licensed and regulated by the Knox Keene Act which sets the regulatory infrastructure for commercial managed care plans in California. The DHCS contract contains many provisions found in the Knox Keene Act, so this difference is mainly reflected in a different appeals process.

By 2013, all counties in California had most Medi-Cal enrollees served by Medi-Cal Managed Care. Besides the COHS model, other models include the Two Plan Model, with counties serviced by a Community-based health plan and a commercial health plan; the Geographic Managed Care Model, with multiple plans service one county (Sacramento and San Diego), and the Regional Model with one to two commercial health plans providing coverage.

After a large scale re-procurement process by DHCS in 2022, the health plans covering different counties and the types of models will shift dramatically as of 2024. This includes an expansion of Partnership into 10 counties formerly in the Regional Model, a sharp reduction in the number of plans covered by commercial insurance companies with corresponding growth of other COHS and community-based plans, and allowing Kaiser Health Plan to cover their Medi-Cal members directly in the counties they serve (including 8 of Partnership's 24 counties).



In February 2022, DHCS announced that the 10 counties in green would become part of the Partnership County Organized Health System model in January 2024.

Partnership Geographic Expansion

Geographic Expansion of Partnership is listed below:

Date	Counties	Updated number of counties
1994	Began operations in Solano County	1
1998	Napa	2
2003	Yolo	3
2009	Sonoma	4
2011	Marin and Mendocino	6
2013	Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou	14
2024 (anticipated)	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba	24

Terminology

Partnership HealthPlan of California may be shortened to Partnership (capitalized) in this document.

Partnership HealthPlan of California Structure

A County Organized Health System is formally authorized by the County Board of Supervisors in each county in which they serve, which also approves its governance structure and selects representatives to serve on the Board of Commissioners. Partnership is a Commission of the State of California. It is a multicounty government joint organization, governed by many rules of government, with a contract with the State of California through the California Department of Healthcare Services (DHCS).

The Board of Commissioners meets six times per year in an open meeting governed by the California Open Meeting Act (Brown Act of 2003, updated by Bagley Keen Act of 2023 to allow certain types of virtual meeting participation). The Board of Commissioners hires and oversees Partnership's CEO, who is currently Sonja Bjork, JD. The current Board Chair is Alicia Hardy, the CEO of Communicare+Ole in Napa, Solano, and Yolo counties.

As of January, 2024, there will be 37 Commissioners altogether, including three Consumer At-Large Members from the North, South and Eastern Regions, and at least one representative from each of the 24 counties. The six counties with the largest number of Medi-Cal enrollees will have extra Board representation: Humboldt and Yolo counties will have 2 seats; Butte, Shasta, Solano, and Sonoma counties will each have 3 seats.

In October 2023, Partnership had 964 employees working in six buildings in four cities: Fairfield, Santa Rosa, Redding and Eureka. New offices will be opening in Auburn and Chico in the coming year.

Employees of Partnership fall into three groups of departments. The actual reporting relationships are not reflected in this list.

1. Health Services
    a. Office of the Medical Director
    b. Utilization Management
    c. Care Coordination
    d. Quality
    e. Pharmacy
    f. Population Health
    g. Health Equity
    h. CalAIM
    i. Behavioral Health
2. Health Plan Operations

a. Provider Relations
b. Member Services
c. Claims
d. Configuration
e. Transportation
f. Compliance and Regulatory Affairs
g. Regional Offices

3. Business Operations
    a. Administration
    b. Finance and Analytics
    c. Information Technology
    d. Human Resources
    e. Communications
    f. Operational Excellence/Project Management Office

The current Executive Leadership Team at Partnership is comprised of:

Chief Executive Officer	Sonja Bjork
Chief Operating Officer	Wendi West
Chief Financial Officer	Patti McFarland
Chief Medical Officer	Robert Moore
Chief Information Officer	Kirt Kemp
Chief Strategy & Government Affairs Officer	Amy Turnipseed
Chief Health Services Officer	Katherine Barresi
Behavioral Health Administrator	Mark Bontrager
Senior Director of Human Resources	Naomi Gordon

Partnership produces an annual Community Report and a triennial Strategic Plan, which can be found on our public website.

Partnership Coverage History

Currently, Partnership has just one line of business: Medi-Cal Managed Care.

Other coverage programs have been included in the past:

- 2002-2005 County Medical Services Program (CMSP) program (Solano and Napa counties).
- 2007-2014 PartnershipAdvantage, a Special Needs Plan Medicare Advantage program (D-SNP) (Yolo, Napa, Solano counties only)
- 2010-2013 Healthy Families, the California version of the federal Children's Health Insurance Program (Napa, Sonoma, Solano, Yolo counties only). In 2013, the Healthy Families Program was folded into Medi-Cal as part of the Affordable Care Act.
- 2005-2016 Healthy Kids. Partnership also offered a health insurance product called Healthy Kids to low income children not otherwise eligible

for Medi-Cal. In 2016, the Healthy Kids Program was folded into Medi-Cal under California's SB 75, passed in 2015.

Partnership Committee Structure

There are many opportunities for interested members of the public to participate in Partnership's activities. Meetings in which we are looking for clinicians from the Eastern Region to serve are in **bold**. Those for which we are looking for local quality leaders are *italicized*.

The following Partnership meetings are open to any member of the public:

- Board of Commissioners (selected by county boards of supervisors)
    - Subcommittees: Finance, Strategic Planning
- Consumer Advisory Committee (consumers and caregivers)
- **Physician Advisory Committee** (clinicians)
- **Quality Utilization Advisory Committee** (clinicians and consumers)

Other Partnership meetings with outside participants include the following:

- **Credentials Committee** (clinicians)
- **Peer Review Committee** (clinicians)
- **Pediatric Quality Committee (CCS directors and providers)**
- Substance Use Provider Advisory (SUD providers)
- **Pharmacy and Therapeutics Committee** (clinicians and pharmacists)
- ***QIP Advisory Groups***
- ***Optimizing the EMR for Quality Workgroup*** (PCP organizations)
- Family Advisory Committee (families of children with CCS)
- Provider Engagement Group
- *Quality Improvement and Health Equity Committee* (starting in 2024)

Partnership is especially looking for volunteers to serve on our Physician Advisory Committee, our Credentials Committee, and our Quality Utilization Advisory Committee. All these meetings are monthly on different Wednesday mornings.

In particular, we are looking for:

- Leaders of Primary Care Organizations
- Non-primary care specialists
- A hospitalist
- A psychiatrist, psychologist or LCSW.

If you know of any good candidates, please email a regional medical director or CMO at the email addresses on page 1.

Delegation

Unlike many managed care plans, Partnership delegates very little of its benefits to be administered by other entities. As of January, 2024, these consist of just:

1. Mild to moderate mental health benefits (Carelon, see below)
2. A few hospitals within the current 14 counties are delegated for certain activities, such as credentialing in tertiary care centers, or utilization management of inpatients.

Credentialing Primary Care Clinicians at Partnership

Detailed policies listing credentials requirements can be found in credentials policies retrievable on our website, particularly MCCR17.
For primary care physicians, they include:

- An unrestricted California license
- Either
    - Minimum 2 years of residency training in a primary care residency (Family Medicine, Internal Medicine, Pediatrics). Rotating internships may count, depending on content
    - The alternative pathway noted below.

The “alternative pathway” includes:

- One or both of the following:
    - Adult care - UC San Diego Retraining and Reentry Program
    - Pediatric care – University of Texas KSTAR/UTMB Health mini-residency in Pediatrics
- Even after completing one of these trainings, credentials may exclude prenatal care, and women’s health care
- Subscription to “UpToDate”
- Supervision x 12 months – with quarterly reporting
- Post-credentialing medical chart review by Partnership

Tribal Health Centers have some legally allowed flexibility in initial credentialing criteria, but additional monitoring is required.

Grievance and Appeals Process

Grievances and appeals are divided into **member** grievances/appeals, in which an individual member is involved, and **provider** grievances/appeals in which the member is not involved. When a provider files an appeal for a prior authorization denial, this is considered to be a **provider-on-behalf of a member** appeal.

Provider Grievances

Formal provider grievances that are not on behalf of the member are typically related to payment disputes. There is a formal provider grievance process with specific timelines. Informal complaints or inquiries not relating to member care are referred to the best person to respond, within Partnership departmental leadership, escalating to Executive Leadership as needed.

Member Grievance/Appeal

Partnership considers **any** expression of dissatisfaction from a member to be a grievance, i.e., any complaint is considered a grievance. However, investigation and documentation processes are less for complaints or exempt or informal grievances, compared to formal grievances.

All PCPs are required to provide access to Partnership grievance forms in their office. They can also be found on our website.

If a grievance involves a named provider organization or clinician, we may reach out to your organization and/or clinician, as part of our investigation, to get copies of medical records or to hear your side of the issue that was raised.

An appeal of a denied Prior Authorization request/TAR is tracked and handled as a sub-type of grievances from an administrative perspective. In other words, all appeals are considered formal grievances, but not all grievances are related to appeals of denied services. The most common types of grievances are related to:

1. Quality of Service, including disagreements over treatment plans, behavior issues with office staff, issues stemming from miscommunication between a provider and the Partnership member.
2. Access issues, including difficulty getting through to the office on the phone, a prolonged period of time before the member can be seen or cared for, and long waiting times in the office for appointments.
3. Billing issues, most commonly related to patients receiving bills for items covered by Medi-Cal.
4. Quality of Care concerns, including allegations of discrimination by a clinician, and any other concern about the quality of care provided, whether attributed to an individual provider or to the system itself.
5. Appeals of denied prior authorization requests

See the Prior Authorization/TAR topic and the Peer-to-peer sections for more details on the appeal process.

Potential Quality Issues and Peer Review

What is a Potential Quality Issue (PQI) and how are they identified?

A PQI is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern or opportunity for improvement exists. Partnership identifies PQIs through the systematic review of a variety of data sources, including but not limited to:

- Complaints, grievances, and appeals
- Utilization review
- Claims and encounter data
- Care coordination
- Medical record audits
- Facility site reviews
- Referrals from other health plan staff, providers, and members of the community

What happens when a PQI is identified?

A quality issue is defined as a confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process. The PQI investigation and Peer Review process provide a systematic method for the identification, reporting, and processing of a PQI to determine opportunities for improvement in the provision of care and services to Partnership members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity.

PQIs are processed by the Quality Assurance and Member Safety Team. All cases are initially reviewed by an RN and then forwarded to the CMO or Medical Director for Quality. Medical records and other supporting documentation are collected, and where issues are identified, the provider of concern may be given an opportunity to respond. The CMO/Medical Director for Quality review includes assessment of, but is not limited to, appropriate level of care, appropriate tests, therapy and treatment, technical expertise, referral, consultation, timeliness, and adequate documentation.

The Member Safety team, Pharmacist, and a designated group of Medical Directors review PQI cases at weekly PQI rounds. Severity ratings are designated to identify “Practitioner performance,” “System issues,” or both. Sometimes, multiple provider performance issues or system issues are identified in the same case and rated accordingly.

A request for input from a provider of concern or facility may be obtained and a final determination is made by the physician reviewer or sent to a specialist or Subject Matter Expert for an independent review; this is often a provider in the community or through a contracted medical review company.

After investigation, when a Partnership Medical Director determines that a significant lapse in quality has occurred, the case is referred for review to the Peer Review Committee (PRC). The PRC includes external practitioners (representing PCPs and board certified specialists) and internal Partnership physicians, nurses and pharmacists. The PRC investigates member or practitioner complaints about the quality of clinical care provided by Partnership contracted providers and makes recommendations for opportunities for improvement and/or corrective action plans. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

How can a PQI be referred?

1. Partnership external website->Providers->Quality & Performance Improvement->Patient Safety-Potential Quality Issues

2. You can email PQI@Partnershiphp.org. Remember to encrypt any patient identifying information you send by email.

What is "carved-out" to DHCS or counties

1. Dental benefit (Partnership covers dental anesthesia, jaw MRI and a few oral maxillofacial services, such as jaw trauma and cancer-related services)
2. Serious mental illness, especially inpatient hospitalization (but Partnership partially covers eating disorder treatment, see below)
3. Substance use disorder treatment (outside the 7 county Wellness and Recovery pilot, see below; Partnership also covers medical problems caused by SUD and medical exams conducted in conjunction with admission to a SUD detox program)
4. Pharmaceutical and related supplies, provided through community pharmacies, such as blood glucose monitors and vaccinations (some exceptions are on our direct distribution program, see below). In addition, all medications specifically for HIV treatment or prevention and for hemophilia are carved out to DHCS, regardless of where administered.
5. CCS services for the 10 new counties for 2024 (Partnership has responsibility in current counties, through the Whole Child Model).
6. COVID vaccines are covered by DHCS for all settings.

Most Useful Resources for Primary Care:

Local Provider Relations Representative. Each primary care organization will be assigned a representative from our Provider Relations department who will visit or contact with the office management monthly, passing on timely information, noting changes in clinician staffing, coordinating trainings, and gathering any problems to be escalated. The Provider Relations team for the new counties is coming together now, so be on the lookout for your office's representative to reach out to set up an initial meeting.

Regional Leadership. Regional Manager and Regional Medical Director. In parallel with your local Provider Relations Representative, each of the five Partnership regions has an individual Regional Manager and a Regional Medical Director. Between them, they will interact with regional stakeholders and providers about larger policy and strategic issues.

As the Eastern Regional Manager gets hired and your individual Provider Relations Representative is assigned, keep their contact information readily available for escalating system issues that arise. For medical issues, preventive health issues, utilization management system issues, you should email your Eastern Region Medical Director, Richard "Doug" Mathews, MD, at rmatthews@Partnershiphp.org

Partnership Website Highlights for Clinicians

The Partnership website is packed with useful references and resources. We recommend bookmarking the launch page in your internet browser: PartnershipHP.org

Website highlights include:

- Links to the PCP QIP and all other pay for performance programs:
  - Providers>Quality>Quality-Improvement-Programs
- Links to all Partnership Policies
  - Providers>Providers>Provider Manual>Medi-Cal Provider Manual
  - Using our search function may find a particular policy faster
- Locating contracted specialists in our Provider Directory
  - Providers>Providers>Provider Directory
- Community Resources, by County
  - Community>(select your county)

Other website links will be given elsewhere in this document, related to specific programs.

Monthly Newsletter for PCP Clinical Leaders

The Partnership CMO, Robert Moore, MD, produces a monthly newsletter targeted to Clinical Leaders of Primary Care Practices, although others are welcome to subscribe. We have included an option to subscribe to the monthly newsletter on the sign-up sheet for the in-person orientation session. To sign up other clinical leaders in your organizations to the newsletter, email Dr. Moore at rmoore@Partnershiphp.org or Sarah Browning at sbrowning@Partnershiphp.org

Past newsletters can be perused on our website at: Partnership website.

Quarterly QIP Newsletters (and other communications)

Each of Partnership's pay for performance programs has its own quarterly newsletter.

PCP QIP:
Past newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx
Sign up through QIP@Partnershiphp.org

Perinatal QIP:
Past newsletters:
http://www.partnershiphp.org/Providers/Quality/Pages/Perinatal-QIP.aspx
Sign up through perinatalqip@Partnershiphp.org

(For other QIPs, for example Palliative Care, Enhanced Care Management, Hospital etc. see our website)

Primary Care Blog

Timeless lead articles from the Medical Director Newsletter are also put on the Partnership Primary care blog: http://phcprimarycare.org, Content goes back to 2012. You can review the older articles without subscribing, or you can subscribe if you want to be notified when new articles are posted. Comment posting is turned off, so if you have comments, send them directly to a Partnership Medical Director.

Major Benefits for Partnership Members

Pharmacy Services for Partnership Members

The state pharmacy carve-out, known as Medi-Cal Rx went live in January 2022. As a result, DCHS directly administers most of the pharmacy benefit, in conjunction with its Pharmacy Benefit Manager contractor, Magellan.

Here are some hints for the optimal use of Medi-CalRx:

Bookmark the hyperlink https://medi-calrx.dhcs.ca.gov/home/cdl/ to access the Contract Drug List to see what preferred drug is covered.

We also have many helpful links located at our Pharmacy website: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

Be sure any new clinicians who join your practice sign up for CoverMyMed and have access to the TAR processing system set up by Magellan/DHCS, to allow them to submit TARS more expeditiously. The primary methods for TAR submission is fax, the Magellan Provider Portal, and CoverMyMed (CMM), a commercial online platform for drug prior authorization. Most prescribers and pharmacies are using CMM as the platform for completing TARs. However, pharmacies can only initiate the TAR on CMM and are blocked from submitting the TAR to Medi-Cal. Under Medi-Cal Rx, only the prescriber can submit the TAR to Medi-Cal through CMM. If you receive a notification from CMM or the pharmacy to complete a TAR, please complete the TAR on CMM and submit to Medi-Cal. You can also print out the form and fax the TAR directly to Medi-Cal at 800-869-4325.

Magellan is responsible for fielding calls from both members and providers for problems they encounter. If you or your patients find this system is not working in individual cases, please contact Partnership to assist. Resolution through Magellan should always be pursued first. Here are some options:

1. If you as a prescriber want to have a conversation with Magellan about a TAR deferral to discuss the particulars of the case. Please call Magellan at 800-977-2273. This is especially important for urgent patient needs.

2. If an inappropriate denial of a medication is made, but it is not urgent, the standard process for appealing a denied TAR is to submit an appeal for the TAR adjudication results, clearly identified as appeals to: Medi-Cal CSC, Provider Claims Appeals Unit P.O. Box 610. Rancho Cordova, CA 95741-0610. Medi-Cal Rx will acknowledge each submitted TAR appeal within three days of receipt and make a decision within 60 days of receipt.

3. For patients who want to file a grievance related to the process, recommend that they call the Magellan customer support at 800-977-2273.

4. If these options are not yielding results, you can reach out to our Partnership pharmacy staff directly at 707-863-4155 to assist with getting Magellan to respond. Partnership does not have the ability to overturn Magellan/DHCS denials, but we have one additional escalation pathway we can use if the above are not successful.

Blood Pressure Devices and Cuffs through Community Pharmacies

In addition to the option of using Partnership's Medical Equipment Distribution Program (see below), blood pressure devices and cuffs are also available through community pharmacies. TARs will not be accepted for products not on the Medi-Cal Rx list. Covered items include standard blood pressure monitors, monitors with talking functions, and monitors with Bluetooth connectivity and remote patient monitoring capabilities. Please refer to the Medi-Cal Rx Covered Product Lists https://medi-calrx.dhcs.ca.gov/provider/forms/ for additional information.

Click here for a summary of which BP devices are covered.

For convenience, we recommend a generic phrase like: "BP Monitor-Large Cuff" and let the pharmacy see what they have in stock that Medi-Cal will cover and dispensing that. An exception: if you want a specific connected device you will want to specify the device exactly.

Note the options from the list above for devices compatible with remote patient monitoring programs.

For new or a different size BP cuffs only, the pharmacy TARs must indicate that the cuff is for a home use monitor and that the current cuff does not fit or is damaged. The indication of 'home use' is key. For questions regarding Medi-Cal Rx coverage or billing of blood pressure monitors and cuffs please contact Magellan at (800) 977-2273.

Glucose Monitors Currently Covered by Medi-Cal

A recently updated list of DHCS covered Blood Glucose monitors can be found here:

For continuous glucose monitors covered by DHCS, see this document:

See below for more details on coverage criteria and best practices for Continuous Glucose Monitor and Insulin Pump criteria.

Care Coordination Services at Partnership

Partnership offers comprehensive case management services to all of our members regardless of age or location. Partnership's Care Coordination department is comprised of RN Case Managers, Medical Social Workers, Health Care Guides, Behavioral Health Clinical Specialists, and Transportation Specialists ready to assist providers, members, and community partners coordinate care and access services.

These services are voluntary, provided at no cost to the member or provider, and the member can opt-out at any time.

Most of our teams' work is done telephonically, with the possibility of face-to-face engagement in select instances.

When we connect with members, we assign them an Acuity Level that best matches their needs and level of intensity for case management services.

The lowest level is for our members that need help accessing their benefits or providers. The highest levels are for those members that have multiple unmanaged complex conditions and/or for those whom have difficulty navigating the healthcare system without intensive support of a case manager.

If you believe you have a Partnership member that would benefit from the services available from our Care Coordination department, please refer them by calling (800) 809-1350 or by sending a secure email to cchelpdeskEA@partnershiphp.org

The Intensive Outpatient Palliative Care Benefit

The current Medi-Cal Palliative Care Benefit was based on Partnership's Palliative Care Pilot program, conducted about a decade ago. This pilot showed that intensive outpatient palliative care saved hospital costs at the end of life, compared to those not enrolled in such programs. Partnership's program is quite successful; we have more seriously ill patients in

outpatient palliative care programs than any other Medi-Cal Managed Care Plan in California.

Sutter and Dignity do not contract with Partnership to provide Palliative Care services, but they do have Home Hospice programs. They sometimes will enroll patients who are not yet ready for hospice in a less intense palliative care transition program, a different model of care than is covered through Partnership's palliative care program.

Covered conditions for Partnership's Intensive Outpatient Palliative Care program include advanced cancer, advanced liver disease, congestive heart failure, chronic obstructive lung disease, progressive degenerative neurologic disease, or other serious pre-terminal conditions that result in frequent hospitalizations. This benefit is designed for Partnership members with limitations in function and limited life expectancy who are at a late stage of illness who have received maximal member-directed therapy or therapy is no longer effective. As patient severity increases, they may become eligible for the more comprehensive Hospice benefit.

Palliative care local in-person resources vary by county.

Here is the contact information for new and likely Palliative Care Provider Organizations in our new Eastern Region. Contracts are pending for some; our website will have the most up-to-date listing in January, 2024. At the April/May Regional Medical Directors meeting, we will provide an update, as well.

Counties Served	Organization	Referrals (if contracted)
Plumas, Sierra, Tehama	Vynca	Phone: 707-442-5683
Butte, Glenn	MedZed (contract pending, new to PC in this region)	
Butte, Glenn	Butte Home Care and Hospice (not finalized)	
Butte	Enloe Hospice and Home Care (contract pending)	
Colusa	Yolo Care	Phone: 530-758-5566
Sutter, Yuba	Adventist Health (Contract pending)	
Nevada and Placer (Grass Valley, Nevada City, Auburn)	Hospice of the Foothills	Phone: 530-272-5739
Nevada and Placer (Truckee and North Lake Tahoe)	Tahoe Forest Hospice (Contract pending Network -new)	
Placer County (Roseville area)	Aspire/Carelon (contract pending)	

Eligible patients should have a year or less of life expectancy, not be a candidate for hospice, and be in a state of declining health, in spite of medical treatment.

Transportation Benefit Changes for Partnership Members

Briefly, what is covered? Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, physical therapy, dialysis, and substance use disorder appointments (including for opioid treatment centers), and to pick up prescriptions and medical supplies.

There are two types of transportation for medically necessary appointments.

- Non-emergency medical transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation.
- Non-medical transportation (NMT) is transportation by private or public vehicle for people who do not have another way to get to their appointment.

The plan's responsibility is to get members to their medically necessary Medi-Cal covered services using the least costly method of transportation that meets the member's needs.

Partnership manages the Transportation Benefit directly.

Patients/members may request transportation by calling our toll-free number for Transportation Services, **(866) 828-2303** or they can email us at mytrip@Partnershiphp.org .

If you as a **provider** are encountering problems or challenges providers can reach us by phone at 707-420-7863, or by email transportationhelpdesk@Partnershiphp.org. Please make sure your case managers and others that help members with transportation are aware of this method to arrange transportation! If you know of any transportation provider in your community interested in contracting with Partnership, you can also let us know through this email.

How does the request process work? Scheduler software is used to screen members, determine appropriate mode of transportation, make reservations and assign trips to providers. Included options include:

- Requests for travel expenses such as flights and lodging
- Member reimbursements for travel-related expenses and gas mileage reimbursement (GMR)
  - Driver/Payee credentials are managed in the software
  - Must supply current driver's license, registration and insurance
  - Members cannot be reimbursed directly
- Public transportation passes

Interpreter Services

Partnership provides interpreter services for members and our contracted provider network at no cost. Once the system is set up you may use it for non-Partnership members as well.

There are three options for accessing interpreter services for your patients.

1. Preferred Option: To use your own computers in exam rooms for interpreter services, have your IT technical support set up the app to access interpreter services on your desktop/laptop/iPad/iPhone/Android phone. Detailed instructions are found here VRI guidelines on our website. Each individual device will need to be registered, so having IT do this as a group process is most efficient. Only devices owned by the PCP practice may be registered.
2. Large volume users of interpreter services may qualify for our vendor to place some dedicated devices in your clinical setting (one device for every 5 translations per month at a specific site). There are several options, ranging from iPads on carts ("translation carts") to portable standalone devices that can be brought into the exam room. To learn more, a 2022 recorded webinar on our interpretive services can be accessed here.
3. If you have not set up the above options, and you have a patient requiring interpreter services, either the patient or the provider can contact us to arrange an interpreter: 800-863-4155. (Our main member services line).

AMN Resources:

- AMN Healthcare Training Video: https://bit.ly/3A7x8uM
- VRI Guidelines: https://bit.ly/3DjCF3z
- VRI Setup Form: https://bit.ly/3lchVEv
- Where to find your PHC #: https://bit.ly/2YpnruI

Telemedicine Services at Partnership

Partnership has a robust Telemedicine policy governing all aspects of telemedicine. Even before the COVID-19 pandemic, we covered a wide range of services, from eConsult to synchronous telemedicine, for all ages, and a variety of ancillary medical services. Highlights are listed below.

We have gathered together many resources about all aspects on Telemedicine into a single Toolkit, available on our website.

eConsult Options: ConferMED and Safety Net Connect

Partnership HealthPlan of California is pleased to offer primary care providers two options for electronic consultation between the PCP and the specialist.

The first is ConferMED, an innovative specialty network that supports our Medi-Cal members by providing e-consultations (eConsults). A primary care provider (PCP) can consult with a specialist about a patient electronically instead of referring the patient for a face-to-face visit. A referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist, with a complete consult returned within two business days.

Partnership also contracts with another e-consult vendor, Safety Net Connect, which will continue to offer services, as well. Our preferred telemedicine vendor for virtual visits (Telemed2u) is integrated with Safety Net Connect for a few specialties, which offers a nice continuity of care if you have Telemed2u set up.

All eConsult services are Health Insurance Portability and Accountability Act (HIPAA)-compliant, and do not require prior authorizations. Integration with a practice's Electronic Health Record system is not required, but improves the efficiency for your clinicians and makes the workflow smoother.

ConferMED has built interfaces to major electronic health record vendors, so integration with your electronic health record is relatively quick and seamless. ConferMED does not charge the PCP for an interface, although your EHR vendor may do so. If you want to use ConferMED with non-Partnership patients, they are able to bill Medicare and private insurance for these services. You would need to have an agreement with them to set it up.

All specialists are Board certified in a specialty or subspecialty, and licensed in California. ConferMED eConsult specialties include:

ConferMED eConsult offers the following specialties:	
Allergy*	Nephrology*
Cardiology*	Neurology*
Dermatology*	Obesity Medicine
Endocrinology*	Orthopedics*
ENT*	Pain Medicine
Gastroenterology*	Psychiatry*
Geriatric Medicine	Pulmonary*
Gynecology*	Retinal Reading
Hematology*	Rheumatology
Infectious Disease*	Urology*
Medical Oncology	
*Indicates specialty is available for pediatrics	

If your organization is already using ConferMED, no action is needed to continue using it after January 1, 2024. If you are not currently signed up with an eConsult platform, and you are interested in learning more about ConferMED, contact your local Partnership Provider Relations representative to set up a meeting, or send an email to the telemedicine team at Partnership: telemedicine@Partnershiphp.org.

Adult Specialty Telemedicine

In "traditional" synchronous telemedicine, the patient is physically located in the PCP office and the specialist is remote. The PCP office will coordinate the appointment, check vitals, and may have the PCP clinician step in to examine the patient or speak with the specialist.

Partnership will accept claims from any specialist conducting telemedicine visits. If your primary care center has an existing telemedicine vendor, you may continue to use them. Some FQHCs have put telemedicine into their PCP scope description, and can bill Partnership for these specialty services. There is some set-up involved to have a specialist working out of a PCP office; contact your PR representative for more information.

Another option is to use Partnership's contracted adult telemedicine specialty provider, called Telemed2U. They do have some ancillary providers, such as registered dieticians, available as well. To sign up to use Telemed2U, contact our telemedicine program manager at: telemedicine@Partnershiphp.org
Here are the specialties currently offered through Telemed2U:

- Endocrinology
- Gastroenterology/Hepatology**
- Infectious Disease (HIV, HEP-B, & HEP-C)
- Nephrology
- Neurology
- Nutrition (ages 3+)
- Physical Medicine & Rehabilitation**
- Psychiatry (ages 4+)
- Pulmonology
- Rheumatology
- Transgender Care

**Available only through Direct-to Member

Partnership has an incentive payment system to reward robust use of telemedicine, in the form of a biannual grant payment, depending on volume. The purpose of this is to cover some of the extra administrative cost associated with running a robust telemedicine program. Our telemedicine team will give full details when you reach out to them.

Direct to Member Specialty Telemedicine

This alternative to having the patient in the PCP office became very popular during the COVID-19 pandemic. Patients are located at home or another location with broadband access and communicate directly with the specialist office. This is called Patient to Specialist ("Direct") Telemedicine Services.

Many community specialists have adopted direct to member telemedicine. Direct Specialty Telehealth Services are being provided by "TeleMed2U" for a select set of specialties. More Information can be found here

Now accepting New Patient specialty telehealth referrals for:

- Dermatology
- Endocrinology
- Infectious Disease
- Rheumatology
- Pulmonology
- Pediatric Dermatology also available for 17 and under

Pediatric Subspecialties

Pediatric Telemedicine and E-consult services. Partnership and UC Davis Health (UCD) have partnered to expand access to pediatric specialty care services which is now available through Partnership Telehealth Program. Thirty specialties, representing every major pediatric subspecialty area, are covered. For more information, please visit the Pediatric Telehealth Page, on our website. PCPs must sign up in advance to get systems in place to use this pediatric subspecialty network. Contact telemedicine@Partnershiphp.org to sign up.

Primary Care Telemedicine

Most primary care providers adopted telemedicine to care for their patients during the pandemic. Several have continued to use the flexibility and convenience offered by telemedicine to continue to provide such services now. DHCS and CMS have extended the ability to bill for video and telephone visits and be paid at the same rate as in-person visits.

Procedure code modifiers are required when virtual visits take place:

Telephone-only visits must use a .93 modifier.
Video visits must use a .95 modifier

Partnership does **not** contract with a separate virtual urgent care group (like

TeleDoc). Our existing provider network prefers to provide continuity for their patients by arranging urgent or same day care through its own infrastructure.

Certain services must be conducted in a face-to-face format. These include well child visits, and initial OB visits (at least the physical exam portion of these visits must be face to face). In addition, some same-day urgent visits are not appropriate to be addressed without a physical exam. Partnership has noted an increase in quality of care issues related to inappropriate use of virtual visits, when an in-person visit was needed. We encourage clinical leaders to set up protocols and trainings to avoid such poor quality care.

Diabetes Education and Nutrition Counseling for Patients with Diabetes

Diabetes education and nutrition counselling are a necessary component to diabetes care that gives patients an opportunity to better understand their condition and master the tools needed to manage nutrition, activity, and medications. The American Diabetes Association recommends that all people with diabetes participate in diabetes self-management and education to support better outcomes.[1] Patients with diabetes require these services to receive the support needed and gather knowledge that improve decision-making for diabetes self-care.

This aspect of diabetes management (DM) care is difficult to fit into the standard 15-minute PCP visit. Referrals to Registered Dietitians (RDs) and Certified Diabetes Educators (CDEs) offer your patients focused consultations to move the dial on glycemic control through health education and self-management using motivational interviewing and other standardized tools.

To support you and your patients' efforts to manage diabetes, Partnership covers Medical Nutrition Therapy for both diabetes and prediabetes. Please use Partnership resources to integrate Nutrition and Diabetes Education with RDs and CDEs from the Partnership network to optimize care and improve glycemic control in your patients with diabetes.

Medical Nutrition Therapy (with a Partnership credentialed CDE or RD) that takes place in the PCP office, with community RD or CDE in person or via telehealth, is a covered Partnership benefit. If your practice does not offer these services, your patient can access Medical Nutrition Therapy (MNT) within the Partnership network of specialty providers. Partnership Network providers for MNT include: *the Northern California Center for Wellbeing* in Sonoma County and *As You Are Nutrition* in Napa County. These practices may offer flexibility for in-person or telehealth visits. Some practices offer individual and/or group visits. Another option, TeleMed2U offers direct telehealth only visits for Partnership members over three years old. Direct telehealth visits for members are available with referral to TeleMed2U Nutrition through Partnership's Online Services. Referral coordinators can direct referrals via an eRAF or faxing for MNT using the Provider Directory and the Partnership Provider Portal. Please

have your referrals team contact your local Partnership Provider Relations representative for more information on details of referring to MNT if they are not familiar with these systems.

In addition, the Partnership Care Coordination department can assist your patients who need additional assistance navigating the health care system to ensure they are accessing prescribed medications and follow up on referrals to nutrition therapy and other specialty care. You can refer a Partnership member to Care Coordination by calling or having the patient call (800) 809-1350 or sending a secure email to CCHelpDeskEA@Partnershiphp.org.

If your patient continues to have challenges meeting glycemic targets in spite of a collaborative approach with medication and lifestyle management (MNT), a referral to an endocrinologist may be needed. A consultation with an endocrinologist may occur in person or via telehealth. The telehealth network is more readily accessible than in-person options. Be mindful that patients who are not collaborative with the treatment plan nor adherent to the medication regimen and MNT recommendations are not likely to benefit from endocrinology consultation. For these patients, continued work with diabetes education, self-management tools, and engagement toward adherence to the current medication and lifestyle regimen has better potential for benefit.

1. ADA Professional Practice Committee: Standards of Care in Diabetes December 2021, Vol.45, S1-S2. doi:https://doi.org/10.2337/dc22-Sint

Behavioral Health

Mild to Moderate Mental Health: Carelon

Partnership contracts with a third part Mental Health provider, Carelon Behavioral Health, to help manage mental health benefits for Partnership Medi-Cal members with mild to moderate mental health conditions in need of outpatient mental health services. Members with severe mental illness are managed by local County Mental Health Services."

Integrating mental health services with physical health services is a best practice for increasing access to mental health services. Partnership encourages PCPs to embrace the integrated behavioral health model of care.

Be sure all your mental health specialists (LCSW, PsychD, MFT, etc.) are credentialed with Carelon, so payment can occur without issues.

If you do not have internal mental health resources and need to make a referral, you can fill out a referral form to Carelon to connect the patient to services. Alternatively, patients may self-refer. In general, no prior authorization nor referral is required for treatment. Some specialized mental health services such as a comprehensive psychological screening do require a referral, but not prior authorization (see below).

A toolkit for PCPs around the mild to moderate mental health benefit can be found on our website.

Partnership's Wellness and Recovery Program

In 2020, Partnership began providing comprehensive substance use treatment (SUD) services through our new Wellness and Recovery Program in seven of our counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. **We expect additional counties to join this model in 2025.** We remain the only managed care plan in California to take on this benefit. For details see the Partnership website.

Certain SUD services are also within the realm of primary care or overlap with mild to moderate mental health issues and can be treated by Partnership PCPs or Carelon clinicians. Examples include office-based medication assisted therapy for opioid use disorder, alcohol use disorder, or other disorders. In such cases, SUD care can be provided by a different primary care clinician from the PCP that the member is assigned to. We request that the following diagnosis codes be used to allow payment without additional manual steps:

- F11.2x for Medication Assisted Therapy for Opioid Use Disorder
- F10.2x for Medication Assisted Therapy for Alcohol Use Disorder

Members with High Complexity Eating Disorders

Partnership has an internal team for case managing patients with complex eating disorders, for whom you are having difficulty finding treatment options.

If you have identified someone with an eating disorder for whom a higher level of care or intervention may be warranted, please complete the Eating Disorder Collaboration Request Form (posted with meeting materials) and send it to : ED_Collab@Partnershiphp.org Partnership will review the form and work with you to identify possible options.

Hints for Getting an Appointment with a Carelon Provider

Scenario: You are seeing a patient who is depressed and anxious and is receptive to mental health counseling. You give them the contact number for Carelon to call to request a referral to a local contracted mental health professional open to new patients. Your patient is given a list of three numbers to call. When they call all the numbers, none of the mental health professionals

are accepting new patients/appointments in the next month. The patient gives up, and her depression and anxiety become worse.

What can you do? Don't give up! Here are three options:

1. Fill out a "PCP Referral Form." This ensures that Carelon works directly with the client to link them to service and keeps you in the loop.
2. Coach your patient to specifically ask Carelon for assistance in contacting the Mental Health Professionals to make an appointment. Per our agreement with Carelon, patients who ask for this help will have Carelon staff do the legwork to find a mental health professional open to a new patient and make the appointment.
3. Have your patient contact Partnership's Care Coordination Department to get assistance.

Supporting Behavioral Health Needs in Children: UCSF's Child & Adolescent Psychiatry Portal

Do you have children and adolescents with mental health needs? Do you have difficulty finding local child psychiatry specialists to whom you can refer them? Are you looking for ways to increase your skills to handle common behavioral health challenges yourself?

UCSF has developed a Child & Adolescent Psychiatry Portal (CAPP) to help meet increasing needs of pediatric primary care with mental health in the youth population.

Resources:

- CAPP Services and FAQ
- CAPP Fact Sheet

Webinars on Topics Related to Substance Use Disorder

Past webinars on the following topics are available on the Partnership website:

- Medication treatment options for Methamphetamine Use Disorder
- Safety and Correct Disposition when Performing a Medical Clearance Exam for Alcohol Withdrawal
- Marijuana in Pregnancy
- Cannabis Use and Cannabis Use Disorder in the Setting of Legalization
- Trauma Informed Care and Addiction
- Inpatient Alcohol and Drug Detoxification Materials
- Pharmacology of Treating Alcohol Use Disorders
- Benzodiazepines
- ASAM Criteria Training
- Gabapentanoids: A Wolf in Sheep's Clothing

Obtaining Psychological and Neuropsychological Testing

Partnership covers psychological and neuropsychiatric testing though our mental health intermediary, Carelon.

To request this testing, the PCP should complete the "PCP Referral Form" and request testing for a member. Check the box at the bottom of the form, labeled "Request for Psychological or Neuropsychological testing." The "PCP Referral Form" is faxed to Carelon to conduct member outreach to assist with linkage to a psychologist. The psychologist will complete an intake assessment to determine if testing is indicated. Carelon will send a fax notification back to the PCP with the outcome of the request.

If your patient requires additional assistance in getting connected and coordinating their neuropsych evaluation, check the box "Referral for Local Care Management" for Beacon/Carelon Care Management assistance.

Bright Heart Health: On-Demand Behavioral Health

Bright Heart Health is an on-demand mental health, medication-assisted treatment, and pain management telemedicine program providing a wide range of services across the United States. All services are provided remotely.

Partnership Health and Carelon contract with Bright Heart Health for:

1. Mental health services;
2. Medication assisted treatment
3. Services related to eating disorders
4. Chronic Pain

In conjunction with County mental health plans, members may also receive intensive outpatient eating disorder services involving a team.

Partnership has contracted with Bright Heart Health to provide services in all 24 counties.

Bright Heart Health can be accessed by either patients or referring providers either by:

1. Calling 1-800-892-2695
2. Visiting the on-line virtual clinic at: https://www.brighthearthealth.com/contact-us/

After intake documentation is competed with a Care Coordinator, the patient will be scheduled to see a licensed physician or therapist through Zoom.

In addition to Partnership, Bright Heart Health accepts fee-for-service Medi-Cal, Medicare, most commercial insurances and self-pay.

Medical Equipment Distribution Services

Partnership's Medical Equipment Distribution Program offers the following types of monitoring and treatment medical equipment to Partnership members at no cost.

- Blood pressure monitors
- Small and Extra-large blood pressure cuffs
- Pulse Oximeters
- Digital thermometers
- Humidifiers
- Nebulizers (plug-in and battery-powered options)
- Scales (regular, bariatric, and infant scales available)
- Vaporizers
- Prescription Lock Boxes
- Enuresis alarms (coming soon)

To request equipment, providers are required to review the Medical Equipment Distribution guidelines, complete the request form, and submit the completed form to Partnership.

Best Practice: Integrate the fillable form into your EMR. One best practice in ECW: make the form into a letter, tagged with data fields. The provider then checks what they want and click send (which faxes). Partnership hopes to automate this process in 2024, but the current process will remain until then.

For more information on this program, see our website.

Supplemental Benefits

Partnership covers certain services that are not covered by other Managed Care Plans or covers them more expansively than is required by DHCS. Here is a reference list:

Covered by Partnership but not DHCS

- Neonatal circumcision
- Hospital Admission for induction of MAT for those on Fentanyl (UM criteria apply)
- Bone anchored hearing aids
- Medication Lock boxes (through medical equipment distribution system, see above)
- Humidifiers and Vaporizers (through medical equipment distribution system, see above)

Expanded Coverage

- Well child visits covered if at least 14 days apart
- Registered dietician visits covered for most diagnoses (see policy)
- Lactation consultation and education covered (see policy)
- Prenatal/CPSP appointments: no extra documentation until over 15 prenatal visits.
- CPSP codes covered to 12 months post-partum (DHCS only covers 2 months post-partum)
- Scales covered for any medical indication (through medical equipment distribution system)
- Eating disorder coverage (see mental health benefit section)

Special Topics for New Primary Care Providers

Partnership Provider Recruitment Program (PRP)

To help increase the supply of Primary Care providers seeing Partnership HealthPlan members, we offer a generous signing bonus program, plus other recruiting support. For new counties, this program begins on January 1, 2024.

Providers

- $100,000 signing bonus for physician candidates (Primary care specialties plus OB/GYN)
- $50,000 signing bonus for NP/PA/CNM candidates
- Enhanced bonus disbursed over a five-year term

Behavioral Health

- $20,000 signing bonus for licensed behavioral health professionals: licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical psychologists
- Must have unique skill/specialty (i.e. bilingual, or from/connected with a culturally, ethnically, or racially underrepresented community, or possess specialty training)
- Enhanced bonus amounts disbursed over a two-year term

Key Criteria

- Candidates must not have accepted an offer to practice at a partner site under the previous PRP version.
- If the candidate is currently practicing, they must be from outside of Partnership's 24 counties.
- Providers in training or residency programs within Partnership's 24 counties qualify for support.

- Requests for program support must be provided to Partnership before formal offers are made to candidates.

Organizations with an existing PRP grant agreement with Partnership must execute an amended agreement to participate with the updated incentives. Organizations not currently participating in the PRP must have executed a grant agreement to submit requests for grant funds.

Please contact the Workforce Development team with any questions or requests: wfd@Partnershiphp.org | (707) 430-4846

Kaiser Statewide Contract

In 2022, at the request of the Governor, the California legislature passed enabling legislation to allow Kaiser to have a state-wide contract for Medi-Cal, starting January 2024. Initially, Kaiser health plan will be assigned the members that they are already served by Kaiser medical foundation, and the transition of patients from Partnership will be limited to dual eligible members and foster children. Gradually, they are planning on expanding the number of Medi-Cal patients served, state-wide.

Kaiser Foundation has medical offices or hospitals in Marin, Sonoma, Napa, Solano, Yolo and Placer Counties. There are a few Kaiser patients in Yuba and Sutter counties, and DHCS is allowing Kaiser Health Plan to cover those counties as well.

Patients new to Medi-Cal in these 8 southern counties will be asked to select Partnership or Kaiser by a State organization called “Healthcare Options”, but many who select Kaiser will not meet the criteria that Kaiser has set forth (for example: previously a Kaiser member or a family member with Kaiser coverage), and so will ultimately be assigned to Partnership, regardless of their choice. We anticipate some confusion and dis-satisfaction by members due to this process, which we want all PCPs in the new counties to be aware of. Grievances about Healthcare Options will be directed through the state grievance mechanism, not through Partnership.

Implementation of New Core Claims Processing System

For a Health Plan, the claims processing system is the single most important IT software system in the organization. Tens of millions of claims are processed each year, over $3 billion worth at Partnership. All our providers count on that system to be paid accurately and timely.

After several delays, Partnership is on track to change from our legacy system, called Amysis, to a new system called Health Edge Health Rules

Payer (HRP) around July of 2024. All electronic data interfaces from PCPs and other providers will need to be re-directed to HRP and tested in Spring of 2024. If you use a claims clearinghouse, they will do this testing for you.

Health Equity/Practice Transformation Directed Payment Program

In the 2022-23 California Budget, $700 million was allocated for a directed payment program to be administered by DHCS, called Health Equity/Practice Transformation (HEPT). Many of you applied for this funding. The application review period is going on now, the organizations awarded grants will be announced in December.

The goals of this 5-year program are very ambitious. Partnership is committed to deeply engaging all primary care organizations that are participating, finding ways to work collectively where possible, and bringing targeted assistance when needed, to achieve as many of the practice transformation goals as possible, to maximize the resources that come to our PCP network.

Connecting to a Certified Health Information Organization

One note for those who applied for HEPT. The IT deliverable for having a two-way interface with a certified Health Information Organization is something every grantee will need to do. DHCS just released the list of Qualified Health Information Organizations. We plan to closely partner with Sac Valley Med Share, whose geographic footprint largely matches the Partnership footprint, to meet those HIE goals. There are substantial state grants available (up to $35,000 per “physician organization or medical groups”) to support organizations to join HIOs. These have the very bland name “Data Sharing Organization Signatory Grants.” This funding may dry up next year, so we recommend that all PCPs get a free consultation with CAHIE (the California HIE membership organization), which has funding to offer free consultations to health care providers to help them successfully apply for this grant funding. Link to CAHIE: https://cahie.org/initiatives/dsa-signatory-grants/

Of note, in addition to the carrot of HIO connection grants, there is a stick. California will begin enforcing the required California Data Sharing agreement (DSA) for all PCPs by January 31, 2026. Larger Medical Groups are required to comply by January 31, 2024.

For more information on the grants to help establish connections see the California Data Exchange Framework website.

Prior Authorizations in Primary Care

As a not-for-profit, community-based health plan, Partnership only uses the Prior Authorization (PA) process (also called the Treatment Authorization Request or TAR process) to ensure that the taxpayer resources that are given to Partnership from the State are spent responsibly, avoiding un-necessary expenses and un-necessary or harmful procedures and care. Both DHCS and NCQA regulate this process.

Another way Partnership prevents fraud, waste and abuse is through the configuration of our claims processing system, which is configured to deny claims exceeding logical or reasonable limits. When such denials are appealed, on the basis that the claim represented a medically necessary service, the resulting review is retrospective, sometimes called a retro-TAR. Since the service was already provided, a denied retro-TAR results in a service being provided that will not be reimbursed.

Almost no TARS come from primary care practices. Even for services that are ordered by a PCP, the TAR is generated by the organization that will actually be providing the service and billing for it. If your practice has specialists, each specialist should become familiar with the procedures that they do that require prior authorization. The services and procedure codes that generally require a TAR can be found on the Partnership website.

Some services *sometimes* associated with primary care that require a TAR are listed here. If your organization participates in these programs, ensure a staff person has expertise on completing TARS properly.

- Enhanced Care Management
- Community Supports
- Physical Therapy
- Chiropractic Services if more than 2 per month
- Acupuncture services if more than 2 per month
- Any procedure which may be performed for either cosmetic reasons or reconstructive purpose

Certain procedures and supplies ordered by the PCP will need sufficient information documented so that when medical records are sent to the service provider to submit with the TAR, these records are adequate and complete enough to justify medical necessity when the ancillary provider submits them with the TAR. We recommend extra diligence in clinical documentation when one of these is ordered by the PCP. The most commonly ordered by PCPs include:

- CT Scans
- MRI Scans
- Certain genetic blood tests, most commonly cancer screening tests
- Circumcision in children over 4 months of age
- Facility-based sleep studies
- Hospice and Palliative Care

Prior Authorization Denials

The most common reason for a denial of a prior authorization request is that insufficient information was submitted to justify the requested service. In some cases, no progress notes or explanation at all is attached to the TAR, in other cases the progress notes are sent but are missing the history or physical exam elements related to the requested service. If the denial is for insufficient supporting information, and you believe the service to be necessary, we recommend resubmitting with the medical records, or potentially a short note with an explanation.

Unlike the commercial plans you had previously, Partnership is not subject to any oversight by the Department of Managed Health Care (DMHC). If you don't agree with the medical rational for a denial, you may first appeal (on behalf of your patient) to Partnership. If you still disagree, your patient must request a State Fair Hearing through DHCS, as described in the letter that goes out with an upheld denial. They may not request a hearing until *after* an appeal has been upheld. See the section on grievances and appeals above for more detail on that process.

Since Partnership is not regulated by DMHC, all independent medical reviews are conducted within the context of our usual UM process, ordered by the Partnership Medical Director reviewing the case. You cannot request an Independent Medical Review (IMR) in lieu of an appeal or a state hearing. If you feel that specialty expertise is needed to fully understand the nuances of a case, we recommend including that with your explanation in an appeal or you can talk to a Partnership Medical Director directly through a Peer-to-Peer discussion. They have a low threshold to submitting cases for review to outside specialty reviewers. However, we interpret the judgment of the reviewer in the context of our policies and Medi-Cal policy (something the DMHC IMR process does not do).

If the particular case is complex or you are not sure you understand the rationale for denial, you can have a conversation with a Partnership Medical Director about the prior authorization request through our "Peer-to-Peer" process.

Peer-to-peer Discussions

A peer-to-peer discussion is a discussion of a utilization management issue between the ordering clinician and a Partnership medical director. It can happen at any point in the prior approval/appeal timeline, but is most common after an initial UM denial.

Since having a peer to peer discussion of a particular case is only fruitful if both you and the Partnership medical director have the information in front of them, we have a process for requesting the peer-to-peer, scheduling it, and gathering up the information needed.

For TARs related to equipment, lab testing, hospitalizations, have your staff call our Utilization Management department: 707-863-4118.
For TARs related to a provider administered drug (a medication provided through your office, not through a commercial pharmacy), have your staff call our Pharmacy department: 707-863-4144.

When contacting us to request a peer-to-peer, here is the information we will be collecting:

1. Standard or Urgent: If urgent, give reason for urgency:
2. TAR #:
3. Member Name:
4. CIN#:
5. DOB:
6. Name of Requesting Provider P2P (MD, PA, NP):
7. Availability of Requesting Provider (MD, PA, NP): *Days/Times*
8. Name of Contact/Scheduler:
9. Phone Number of Contact/Scheduler
10. Partnership Medical Director who issued the denial
11. Brief summary of the Reason for Denial

The time frame for peer-to-peer responses is generally within a few days, to allow time to gather the materials and coordinate with the schedule of the specific Medical Director most familiar with the case. You can request an urgent peer-to-peer, if a patient's condition or the clinical situation warrants it. We will find an available medical director, who may not be quite as familiar with the specific case.

Our assistants have a process for reviewing the request, calling back, scheduling etc.

Specialty Referrals

In general, Partnership members needing specialty care should be referred to the appropriate specialist by the Primary Care Practice. Most practices designate a referral coordinator who becomes expert in the local nuances of this process, to complete the electronic referral authorization process. This referral coordinator takes the clinical and demographic information from your electronic health record, and enters it into Partnership's Electronic Referral Authorization (RAF) system.

If a contracted PCP refers a Partnership member to a contracted Partnership specialist, no further review by Partnership staff is needed; the referral is auto-approved, and the specialist will be paid for any services provider to the referred member (subject to the TAR requirements mentioned earlier).

Partnership nurses and medical directors only review referrals for assigned members who are referred to non-contracted specialists, especially out of state specialists. In this case, we evaluate the medical necessity of the referral and the availability of contracted specialists within a reasonable distance who could provide comparable care. We will look for documentation for this in the RAF itself, with the medical record as a backup.

The list of specialists in the network is updated very frequently, and is available through the Partnership website in a searchable format, as well as a printable directory.

Some Partnership members are in a status called “Direct Members,” which means that technically they do not need prior authorization to see any Medi-Cal provider willing to see them. This includes members of Indian tribes, children on CCS, those with Medicare insurance primary, and other categories.

Most CCS children will still be assigned to a PCP medical home to coordinate their care. We recommend that the PCP complete a RAF for any new problem that comes up, so the specialist is confident that the patient had some screening for the appropriateness of the referral, and that they will be paid by Partnership.

This same principle applies to unassigned Partnership members who may be seen in your PCP office. Specialists appreciate that you screen patients for appropriateness and the RAF is reassurance that they will be paid. Thus it is best practice to use the RAF system for both assigned and unassigned Partnership Patients needing a new referral.

One quick note on tertiary care centers in Northern California. Partnership is contracted with all tertiary care centers in Northern California **except for Stanford University for Adults**. Patients needing tertiary care should be referred to any Sacramento Hospital including Sutter, Dignity or Shriners, and UC Davis, to a San Francisco based hospital including UCSF, or California Pacific Medical Center, or to Children’s Hospital Oakland. This is especially true for transplants.

Strategies for Difficult Referrals

Partnership strives to contract with every willing specialist in our geographic area. Over the last 20 years, there has been a steady decrease in the number of specialists available in rural and many suburban areas. To preserve the specialty network we have, and prevent them from burning out, it is critically

important to ensure that referrals are judicious and the referral process is completed efficiently and respectfully. Here are some best practices and hints:

1. Avoid unnecessary referrals to in-person specialists. This has an immediate result of increasing access for patients who really need the specialist. Ways to do this include:
    - Start with using e-Consult wherever appropriate to begin the workup before sending the patient to the specialist. As many as 60% of eConsults that are done result in a workup that does not need an in-person visit.
    - Use telemedicine for cognitive specialties, such as rheumatology, endocrinology, or specialties that lend themselves to transmission of digital images, like dermatology.
    - Use UpToDate or other references to narrow down your diagnosis and drive your initial workup. Use your primary care training to do as much as you can for your patient! This can often be combined with eConsult to excellent effect.
    - If you have a colleague at your office with some specialized expertise have a patient see your internal expert before deciding if an external referral is needed.
    - If you have new providers, especially Nurse Practitioners or Physician Assistants, review their referrals before they are sent. In our review, the percentage of inappropriate referrals is higher from NPs and PAs than from physicians.

2. Ensure your communication to the specialist is clear, either from your progress note or from your referral note. If you are willing to manage the patient after the diagnosis and treatment plan is made by the specialist, let them know that you would happy to manage the patient with their guidance. If you need them to take over care, indicate that on the referral. If you just want a second opinion, note that. If you are trying to sort out between two different diagnoses, let them know what you have done so far.

    Nothing justifiably irritates a specialist as much as a cryptic note as to the purpose of the referral with complete lack of appropriate workup done before referral.

3. Local specialists will develop their own rules about pre-reviewing and approving referrals. This is usually done because inappropriate referrals have been made in the past, so PCPs should honor the requests of the specialists and try to re-earn trust in appropriateness of referrals.

4. The medical director or CMO should make an effort to engage with specialists on referral appropriateness on a regular basis.

5. If you have a patient that you feel really needs a specialty referral and your referral coordinator is having difficulty, contact the Partnership Care Coordination Department for assistance (see section on Care Coordination, above). Be sure they really need this referral, that you have done step 1 above. It is a waste of everyone's time to activate this care coordination step for an inappropriate referral.

Other, Relatively New Medi-Cal Benefits

CalAIM Update

California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the DHCS to implement overarching policy changes across all Medi-Cal delivery systems with these objectives:

a. Reduce variation and complexity across the delivery system;
b. Identify and manage member risks and needs through population health management strategies
c. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Two components of CalAIM that began in January 2022 are Enhanced Care Management (ECM) and Community Supports (CS), formerly known as In Lieu of Services). We encourage primary care health centers to consider becoming ECM providers. If you are not an ECM or CS provider, your clinicians and case managers should become familiar with the populations of focus, so referrals can be made for your patients with more complex needs.

For documents and presentations related to the ECM and CS programs, see our website:
http://www.Partnershiphp.org/Community/Pages/CalAIM.aspx

The current categories proposed for populations covered by ECM and the potential services covered by Community Support Services are listed here:

ECM target populations:

The following populations are currently approved:

1. Adults and children at risk for institutionalization with serious mental illness (SMI), substance use disorder (SUD) with co-occurring chronic health conditions, or children with serious emotional disturbance (SED),

2. Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
3. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
4. Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
5. Individuals at risk for institutionalization who are eligible for long-term care services.
6. Nursing facility residents who want to transition to the community.

In January 2024, additional populations will be added:

7. Perinatal population of African American, Native American and Pacific Islander ethnicity.
8. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. (Note: many individuals in this population may qualify sooner if they have one of the above other conditions.)

Community Support Services covered by Partnership include the following:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Meals/Medically Tailored Meals
- Personal Care and Homemaker Services

If you are not an ECM provider and wish to learn more about becoming one, please reach out to our ECM team through CalAIM@Partnershiphp.org

If you wish to refer a patient for consideration for ECM or CS services, have your care coordinator contact our Care Coordination team by securely emailing us at: CareCoordination@Partnershiphp.org.

The Population Health Management part of CalAIM began in January 2023 with many components. Partnership has a population health management strategy that includes initial and ongoing assessments of risk and need, leverage risk stratification in care planning, consider social determinants of health, ensure smooth transitions of care, and focus on data collection and reporting.

These last two have implications for our primary care network.

For the new transitions of care requirement, DCHS expects Partnership to be more actively involved in the discharge planning of all inpatients. Partnership is testing several options to achieve this, including the option of partnering with primary care providers to provide more robust hospital discharge transition services than they many have done in the past. **If you already have a program for monitoring your practice's inpatients and ensuring that they have appropriate hospital discharge plans, please reach out to our Care Coordination leadership to see if you are a good candidate for some additional financial support to boost this program to meet the DHCS deliverables.**

For the data collection and reporting, DHCS has convened a technical advisory committee to work on the data and risk assessment models. At some point, DHCS plans to require health plans to absorb this risk data and act upon it, including passing it on to our PCP network to act upon. This will be a large IT lift in the future, probably in 2024 or 2025.

Additional components of CalAIM scheduled for the future include the following. See the DHCS website for details.
https://www.dhcs.ca.gov/CalAIM/Pages/calaim.aspx

1. *Behavioral Health:* Proposal to steadily integrate behavioral health services with the rest of the health care system.
2. *NCQA Accreditation* (including NCQA Health Equity Accreditation) will be required for all Medi-Cal managed care plans as of 2026.
3. *Requirement all Managed Care Plans to implement a Medicare-Medi-Cal* joint health plan product (also known as a Dual-Special Needs Plan or a D-SNP) by 2026. Partnership has begun planning for this.

Coverage for Community Health Workers

Community Health Workers (CHWs) began to be covered on July 1, 2022. State policy details can be found here.

Some highlights:

1. CHW services require a written recommendation by a certified health care provider. The supervising provider must be an approved Medi-Cal provider.
2. Encounters must be documented in a medical record system of some sort, including the topics discussed and the duration of the encounter.
3. CHW must meet minimum requirements by either a certification pathway or a work experience pathway. Six hours of annual continued education is required. Partnership will establish a process to credential CHWs, according to these criteria. Generally, the organization employing the CHW will submit claims, and thus will need to be a Medi-Cal provider.

4. DHCS specified covered and non-covered services in their policy document.
5. The only billing codes that are acceptable are for face-to-face self-management education and training: 98960 for individuals and 98961 or 98962 for groups of patients.

Special note for FQHCs, RHCs, and Tribal Health Centers: CHWs are not considered PPS-providers by the state. This means that although services can be provided, they would be considered part of the current scope of an FQHC or Rural Health Center. If CHWs are added, they may be counted in a future scope change request, which could incorporate the cost of CHW service into the overall PPS rate. Tribal health centers are eligible for a FFS payment for CHWs, but not their OMB rate.

This reimbursement challenge has led to a rather limited availability of CHWs in the Partnership region, thus far. As a result of this, Partnership is exploring other options for implementing CHWs in our service area.

Coverage for Doulas

Per new DHCS guidelines, doula services for perinatal education and birth support is now a covered Medi-Cal and Partnership benefit. Doulas' services offer personal support to birthing patients and families throughout pregnancy, childbirth, and post-partum experience. This includes education, emotional support, and physical support provided during pregnancy, labor, birth, and the post-partum period. Partnership is building a network of qualified doulas to contract with Partnership and offer our members these services.

Please contact Partnership if you have questions about this benefit and/or know of a contact in the doula network in your community: Dr. Colleen Townsend (ctownsend@Partnershiphp.org).

Dyadic Services

Dyadic services are preventive behavioral health services for recipients ages 0 to 20 years and/or their caregivers. Medi-Cal reimburses the following dyadic services for recipients ages 0 to 20 years, when billed to the child's Medi-Cal ID with the U1 modifier: Dyadic Behavioral Health (DBH) Well-Child Visits (H1011)

A dyad refers to a child and their parent(s) or caregiver(s). Dyadic care refers to serving both parent(s) or caregiver(s) and child together as a dyad and is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. It is provided within pediatric primary care settings whenever possible and can help identify behavioral health interventions and other behavioral health issues, provide referrals to services, and help guide the parent-child or caregiver-child relationship. Dyadic care fosters team-based approaches to meeting family needs, including addressing

mental health and social support concerns, and it broadens and improves the delivery of pediatric preventive care.

A pilot of dyadic services done at Zuckerberg-San Francisco General Hospital used mental health professionals (psychologists and licensed clinical social workers) and similar interventions done at other settings (such as the HealthySteps program have found positive outcomes for the children.

The California legislature therefore passed a law in 2021 requiring Dyadic Services be a Medi-Cal benefit starting in January 2023. In a recent update to the policy, pediatric medical providers may also provide dyadic services and bill for them. Recently DHCS ruled that Dyadic services could be paid at the fee-for-service rate, in addition to the usual PPS rate for the well child visit, for PPS-eligible providers, and that they could keep this extra payment at the time of PPS reconciliation. This is still not sufficient to completely cover the cost of the same day visit for PPS providers, and probably also not for private providers. Follow up visits (which must be separated by at least a week from the well-child visit to be reimbursable), can be reimbursed at the PPS/OMB rate.

A major challenge is the workforce shortage of mental health professionals in general, such that dyadic services are functionally competing with other mental health service needs. For this reason, Partnership leaves the decision about provision of dyadic services to the individual PCP/Health Center, based on an analysis of their individual capacity and need.

For more details, see the full state policy.

Street Medicine

Street Medicine is defined as medical care provided by a licensed medical provider where the patient lives, when a patient is unhoused (i.e., not living in a shelter, home or apartment).

Primary care providers may provide such services for their assigned members, as part of those members' primary care services.

An organization or individual who does not routinely provide primary care may contract with Partnership as a Street Medicine Provider. In this case, they may provide medical services to any Partnership member they come across, **regardless of their assigned PCP**. Such Street Medicine Providers are expected to communicate with the assigned PCP about the activities performed.

Whether street medicine services are provided by a PCP or a Street Medicine Provider, **please let your billing departments and providers know that we need them to use the place of service code "16" when services are**

provided outside a usual health care facility, where the patient lives. You may need a special workflow (like a separate schedule) with this place of service code assigned to make this happen.

COVID Vaccines and Home Test Kits

DHCS decided to carve out COVID vaccination during the 2023-24 winter season. Both commercial pharmacies and office practices should bill DHCS directly for COVID vaccination, plus a more generous than usual administration fee. For children, VFC can provide COVID vaccine; the request would go through the usual VFC ordering process.

Partnership is exploring an option for an ancillary services provider to work with PCPs to purchase and manage the inventory of adult vaccinations, to alleviate the financial burden for PPS providers (FQHCs, RHCs, and Tribal Health Centers) in which any income for providing such vaccines disappears at reconciliation.

The California Primary Care Association (CPCA) is also advocating to allow adult vaccines to be carved out of PPS reconciliation, like dyadic services, ACES screening and developmental screening. Stay tuned on this effort.

While the requirement for Medicare and commercial insurance to cover home COVID tests end when the federal Public Health Emergency expired on May 11, 2023, the American Rescue Plan Act included a provision extending coverage for Medicaid for one year after the end of the state of emergency.

Genetic Testing

The number of genetic tests available is growing rapidly, as is the complexity of deciding which test to order and how to interpret the results. While the prices are starting to drop, many cost several thousand dollars, and we find that many clinicians are ordering the wrong tests for the wrong reasons. Thus, these lab tests often require a Treatment Authorization Request (TAR) to be paid.

While most are typically ordered by specialists, tests for hereditary conditions and pediatric developmental disorders are increasingly being ordered by primary care clinicians. Note that prenatal screening tests are covered directly by the California Prenatal Screening program.

To view the list of tests that require prior authorization and to view the most recent form for screening for familial genetic syndromes, see the genetic testing policy addendum.

Another resource for the large majority of our network that uses Quest

Diagnostics is to contact Quest's genetic counselors to get advice on the correct test to order for a patient's particular circumstances. The phone number is: 1-866-GENE-INFO (1-866-436-3463).

Mobile Mammography Program

Partnership contracts with a Mobile Mammography Company to bring Mobile Mammography to locations within the Partnership service area where Mammography access is constrained, and mammography rates are low.

If your organization meets the following criteria, contact us to discuss sponsorship opportunities:

- Located in Partnership regions and counties below the 50th percentile benchmark for breast cancer screening
- Provider locations far below the 50th percentile benchmark
- Provider locations in imaging center "deserts"
  (Patients' travel to imaging center is unusually long or difficult.)
- Provider locations with lack of access at nearby imaging centers
  (More than one month to Third Next Available Appointment.)
- Provider locations with Partnership care gaps to support desired event
  (A full day event would require at least 60 - 90 Partnership members with mammogram care gaps. Providers can also consider partnering with nearby provider organizations in the Partnership network to meet the volume needed for a successful event. The majority of patients served at a Partnership-sponsored event should be Partnership members.)

For further information, contact**:** mobilemammography@Partnershiphp.org

Clinical Practice Guidelines and Best Practices

Preventive Services Covered

The Affordable Care Act mandates that Medicaid cover all services rated by the U.S. Preventive Services Task Force (USPSTF) as Grade A or B recommendations. The 47 recommendation categories (some with more than one recommendation) currently meeting this criteria can be found on the USPSTF's website. All of these services are covered by Partnership and Medi-Cal without prior authorization. DHCS goes further in its oversight, categorizing not following USPSTF recommendations and specialty society preventive recommendations (like Bright Futures for children) as a deficiency in quality.

Adoption of the USPSTF recommendations is not comprehensive. Some recommendations are widely followed, for example the Grade A recommendations for ocular prophylaxis for gonococcal ophthalmia

neonatorum. Others are highly aspirational, like the Grade B recommendation that all low-income pregnant individuals receive preventive counseling from a mental health specialist. Some recommendations can be met with a cursory template documentation (like counseling on skin cancer prevention and STD prevention), but it is the quality of such counseling interventions that really make a difference, and this is not documented in a medical record notation.

How does a clinical leader systematically address this volume of guidelines in a meaningful way? Occasionally the approach is to educate clinicians on the guidelines, with the hope that they will remember this information when the relevant situation arises in the course of clinical care, for example recommending barrier contraception to prevent STDs in sexually active youth.

However, in most cases, systems and templates need to be built to increase the rate of adoption of USPSTF recommendations. Routine prenatal panels that include all recommended lab work for pregnant individuals is one example of a very effective systematic way to increase appropriate prenatal screening, with a backup system needed for those arriving to a hospital with no prenatal care.

Since systematic approaches are mostly needed, clinical leaders need to take a systematic approach to increasing adoption of USPFST recommendations. This should include:

1. Review new or updated recommendations as they are released from USPSTF. Review them carefully at that time and determine if any education or system changes are needed. The Journal of the American Medical Association (JAMA) and American Family Physician journal do a nice job of reviewing and analyzing new and updated recommendations, related to primary care, as they are released. Each practice should assign someone to review these and bring the actionable educational or systematic aspects to their clinical leadership team for prioritization and implementation.

2. Periodic Comprehensive Review of USPSTF: Every 3-5 years, have someone at the PCP practice perform a comprehensive review of the entire list of USPSTF recommendations.

3. Periodic Comprehensive Review of Preventive Guidelines. Guidelines for preventive care released annually by Partnership and specialty organizations such as the American Academy of Pediatrics, and the American Academy of Family Medicine embed the USPSTF recommendations into their larger scope of recommendations.

Whether doing a comprehensive review or a review of new/updated recommendations, evaluate each guideline in light of your individual clinical setting and categorize as:

    a. Systems in place and high levels of adoption: continue to monitor

b. Systems in place but adoption medium, consider Quality Improvement interventions

c. No systems in place, or system in place with low adoption

   i. Explore what has worked elsewhere. Research systems used elsewhere to successfully address this issue in the practice setting, applying a critical eye to the quality of the research, the scalability and generalizability.

   ii. Major health system or policy constraints to adoption. Work with community partners including Partnership to address

   iii. Time and/or resource constraints to widespread adoption beyond what is possible in the current configuration of your PCP practice. Focus first on practice transformation.

Clinical Practice Guidelines

Partnership has posted clinical practice guidelines for depression, chronic pain management, diabetes management, lactation management, and asthma management on our website at: http://www.Partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Specific Pediatric Guidelines

The following guidelines are of particular interest to the California Legislature, DHCS and Partnership.

Lead Screening

DHCS added the HEDIS measure of blood lead screening by age 2 to its Managed Care Accountability Set (MCAS). Performance on this measure was low before COVID and dropped during COVID. In spite of educational interventions, sharing lists of patients due for lead screening with providers, and posting comparative data, the rates remained low.

Here are the MY 2022 HEDIS rates for lead screening between 1-2 years of age for the Anthem Blue Cross/California Health and Wellness Region 1, which includes 9 of the 10 new counties in Partnership's new Eastern Region. Partnership's overall rate and the National Medicaid Health Plan average rate are shown for comparison.

Health Plan/Geography	Lead Screening Rate Between ages 1 and 2
Anthem Blue Cross (Region 1)	53%
California Health and Wellness (Region 1)	40%
Partnership HealthPlan (overall)	40%
National NCQA Medicaid Health Plan average	63%

In 2023, DHCS issued an audit finding against Partnership for the persistent low rate of lead screening in our network.

As a result of this, Partnership is instituting a number of additional measures to support more universal lead screening:

1. Moving blood lead screening to the core measure set for the PCP QIP. This will incentivize primary care providers towards systematic efforts to increase screening rates.
2. Supporting providers who wish to move to providing lead testing on site, using point of care devices.
3. Doing more follow up with providers on their efforts to reach out to children overdue for screenings, with potential corrective action plans if actions are not taken by PCPs.

For a detailed, recorded presentation on the clinical, public health and regulatory aspects of the lead screening (with CME available): see our website.

If you do not yet have Point of Care Lead testing units in your office, there may be some grant funding available to supporting staring this testing. Contact us at: leadPOC@partnershiphp.org

Pediatric Well-Child Care Screening Tools

Staying Healthy Assessment no longer required; DHCS has removed the requirement for a specific Staying Healthy Assessment to be completed, but still requires the collection of screening information as recommended by Bright Futures for children and USPSTF for adults. While you must choose your own tool that meets the requirements of DHCS, we offer these recommendations.

Screening questions should include evaluation of physical health (including medical history, growth/nutrition, safety, physical activity, oral health, immunizations and age-appropriate lead testing). In addition, quality preventive care also includes evaluation of development, social/emotional health, mental health, and risk behaviors, using age-appropriate screening tools.
Ideally the EMR will have functionality to push screening forms (patient portal)

to the patient before the appointment or in the waiting room, and then the results are integrated into the EHR.

Recommendations for Adults: Combination of the brief alcohol and drug use screening, depression screening, anxiety screening, tobacco use, ACES screening (all discussed in this document in other locations). Additionally, a screening for intimate partner violence, such as HITS, some form of screening for physical activity, and screening for symptoms of tuberculosis (such as cough lasting longer than 3 weeks, lymphadenopathy, weight loss) are advisable on at least an annual basis.

Recommendation for Children:
As part of its well child care toolkit, the American Academy of Pediatrics (AAP) provides a listing of "Instruments for Recommended Universal Screening at Specific Bright Futures Visits." Although it is not a comprehensive list, it does include a number of commonly used instruments. We encourage you to visit this site if you are looking for screening tools for your practice. The ideal tool will be well-tested, available in multiple languages, and easy to use when seeing children and adolescents. The two most common strategies are listed below. Each practice should choose one to implement into their EHR.

Child screening strategy 1: Bright Futures Tool and Resource Kit plus Supplemental tools
The Bright Futures Tool and Resource kit is the well-established AAP comprehensive toolkit for well child care. Each WCC visit template includes an age appropriate history, physical exam, nutrition questions and developmental milestone checklist, as well as safety and social determinants of health-related questions. The template prompts the provider to use screening tools as appropriate for age, such as those listed below. The screening tools themselves are not built into the visit template. Parental handouts are available in 14 languages. The Bright Futures Tool and Resource Kit is available for a fee. Specific recommendations from the Bright Futures Toolkit are these additional recommended screenings:

i. ASQ Developmental screening
ii. M-CHAT
iii. Socio emotional questionnaire
iv. PEARLS trauma screening

Screening Strategy 2: The Survey of Well-being of Young Children (SWYC)
This tool is included on the AAP screening tool list for children 0-65 months. It contains general developmental screening (Milestones portion), Behavioral Screening (Baby Pediatric Symptom Checklist and Preschool Pediatric Symptom Checklist) and Autism screening (Parents Observation of Social Interactions portion), in a single screening tool. In addition, it includes Edinburgh screening questions for post-partum depression and a few ACES-related questions around substance use in the home and parental discord. It is available in 19 languages and is available free-of-charge. This tool would not provide full PEARLS trauma screening.

Additional screening for Adolescents:

a. Patient Health Questionnaire-A (PHQ-9 Modified for Teens)

This tool is included on the AAP screening tool list for depression in children 11-21 years of age. It contains 13 questions and is simple to score. It is free and available in more than 30 languages.

b. Car, Relax, Alone, Forget, Trouble Questionnaire (CRAFFT 2.1+N)

This tool is included on the AAP screening tool list for children 11-21 years of age. It screens for substance use including tobacco, alcohol and other drugs. It also includes vaping. The tool is available in more than 30 languages and is free of charge.

c. Other recommendations made by different specialty organizations but not grade A or B by USPSTF include screening for teen dating violence, bullying, sexual activity

Coding for Pediatric Screening

Screening	*Code*
Screening for drug use disorder (other than tobacco and alcohol))	*H0049*
Alcohol Misuse Screening	*G0042*
Tobacco Screening	*4004F*
ACES: Negative Screen	*G9920*
ACES: CPT G9919 - positive (4+) and recommended f/u	*G9919*
Developmental Screening	*96110*
Autism Screening	*96110 w/ modifier KX*
Mental Health/Depression Screening	*96127*

ACEs Screening

Payments took effect on January 1, 2020. FQHCs, RHCs, and Tribal Health centers are eligible, but they MUST bill with a Type 1 (individual NPI) in one of the available fields (rendering, ordering, prescribing, or billing) or they will not be paid! This incentive is paid through claims; the incentive payment will

supplement the usual fee for these services.

a. ACEs screening:
    i. Rate: $29 each
    ii. Paid based on use of the following code:
        1. G9919: Screening performed and positive and provisions of recommendations (4 and greater)
        2. G9920: Screening performed and negative (0 to 3)
    iii. Children up to age 19
b. PEARLS (Pediatric ACEs and Related Life-events Screener; includes screening for several social determinants of health) – child tool (0-11) and adolescent tool (12-19)
    1. Up to every 1 year
    2. Parents/caregiver may complete age 0-19; adolescent may answer self-report version of adolescent tool, ages 12-19
c. Adults ages 18 to age 65: ACES screening tool, once in a lifetime per provider per patient; OK to repeat for new provider.
d. Age 18 and 19: either tool can be used.
e. DHCS has posted translations of these tools.
f. Providers must complete a 2-hour training and attest to completion of the training to be eligible to be paid the supplemental payment! Training available at: www.acesaware.org

Unlike other incentive programs, all provider types, including Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs) and Tribal Health Centers, are entitled to keep the incentives for ACEs ($29 each) and Developmental screening ($59 each), which started on January 1, 2020.

We strongly encourage PCPs caring for children who are not fully taking advantage of these screening dollars to look at their systems and see if they can adapt them to capture this source of revenue.

Flu vaccination is key to improving CIS-10 vaccination rates!

Everyone involved in pediatric care knows how challenging it is to meet the current immunization measures. Across the Partnership network, Childhood Immunization Status (CIS-10) rates are low, sometimes in the teens.

Upon analyzing our own data, the most challenging immunization requirement to meet is the two influenza vaccinations. A sample of our data (just under 10,000 members under two years old) found only 30.59% of our members fully met the CIS-10 measure. An additional 4.3% would have met the CIS-10 measure with only one additional influenza vaccination and another 7.7% needed two influenza vaccinations to meet the CIS-10 measure. Certainly, COVID made these measures more challenging (combined with the lack of an actual flu season in 2020-21) but influenza vaccination rates have always

lagged behind other vaccines.

Our analysis also showed some other interesting findings. Only 3% of pediatric members received all required vaccines except for one Hep B vaccination dose! Another 4.5% were missed due to only lacking sufficient Rotavirus vaccinations. Just under 1% each were missing the full DTaP or PCV series. Some best practices that may help with some of these rates:

- If you have not already switched to the newer Vaxelis vaccine, this may be a good time to do so. Vaxelis is similar to the Pentacel and Pediarix, except it includes BOTH HepB and Hib. This may help with those missed HepB doses.
- It may also be time to switch to the 2-dose rotavirus vaccine, Rotarix. This will give some flexibility in catching up on a missed dose.
- Lastly, use the Immunization Dose Reports from our Partnership Quality Dashboard (PQD) throughout the measurement years and focus on the 18- to 2-month population to ensure they have received all four PCV and DTaP immunizations.

Testing for Streptococcal Pharyngitis

The standard of care for treatment of streptococcal pharyngitis is to confirm infection with a rapid strep test or throat culture prior to prescribing antibiotics, or at the latest concurrent with antibiotic treatment. Both UpToDate and the Cochrane Library summary support this standard.

NCQA has a HEDIS measure that looks at the lack of any strep test associated with antibiotic prescription for strep pharyngitis, called “Appropriate Testing for Pharyngitis” or CWP. Nationally, the 33rd percentile for this measure is 73% percent in Medicaid.

The rate of testing is far lower for Partnership members. The overall rate is just 53%, which is far below the 33rd percentile. The rate did drop about 20% during the COVID pandemic, likely a product of the increased use of virtual visits, and hesitation to send patients to the office or a lab for confirmatory testing. We ask you all to create processes to allow strep testing even if visits are done virtually.

Referral for Routine Dental Care

Denti-Cal payment rates were stabilized about 10 years ago, so dental access is better than it was before that. MediCal covers two dental hygiene visits per year; this is especially important for children and pregnant women. When dental hygienists apply topical fluoride varnish at their preventive visits with children (and bill for this on their claim), this can count towards a PCP QIP unit of service measure (see below).

To locate Denti-Cal dentists with offices near you, you can search here.

Developmental Screening

FQHCs, RHCs, Tribal Health and other PPS providers are eligible, for supplemental payments for developmental screening of children in certain age ranges, but they **MUST bill with a Type 1 (individual NPI) in one of the available fields (rendering, ordering, prescribing, billing) or they will not be paid!** This incentive is paid through claims, but the incentive payment will supplement the usual fee for these services.

g. Developmental screening:
    i. Paid based on use of CPT code: 96110, without a modifier, once for each age group: 2 months -1 year old, 1 - 2 years old, and 2 - 3 years old.
    ii. Rate: $59.50
    iii. Nine standardized tool options as defined in CMS Core Measure Set Specifications (not the same as AAP). Most commonly used is the Ages and Stages Questionnaire (ASQ). Any claim for 96110 without a KX modifier MUST be for the use of one of these nine specified tools.
    iv. Any other tool used (such as the MCHAT for autism screening), must add a KX modifier. These will be paid the usual claim rate, but not be eligible for the bonus payment. **Early audits are showing that many providers are neglecting to use the KX modifier for autism screening.**
    v. **Early audits also indicate many providers continue using the MCHAT screening tool, which is not approved for use by DHCS for billing with 96110 without a modifier. The approved tools include the following:**
        1. Ages and Stages Questionnaire (ASQ) - 4 months to age 5
        2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
        3. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
        4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
        5. Brigance Screens-II - Birth to 90 months

6. Child Development Inventory (CDI) - 18 months to age 6
7. Infant Development Inventory - Birth to 18 months
8. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

Misuse of Developmental Screening Code

Four years ago, DHCS set new rules around the use of CPT Code 96110 to document comprehensive developmental screening. More than half of pediatric and family medicine providers had not performed a comprehensive developmental screening when the 96110 code was used. While several developmental screening tools are allowed, the most commonly used is the Ages and Stages Questionnaire (ASQ).

In most cases, the charts associated with use of the 96110 code documented a screening for autism with a tool such as the M-CHAT, neglecting to use the required KX modifier. Prior to 2019, the modifier was not required for autism screening.

When autism screening is provided **in addition to** a comprehensive developmental assessment, both 96110 without a modifier and 96110.KX may be billed together.

A comprehensive developmental screen is considered standard of care by the American Academy of Pediatrics, the American Academy of Family Physicians, CMS, NCQA, and DHCS. Please ensure your well-child visit process and templates include the use of a comprehensive tool such as the ASQ and documents this appropriately with 96110.

Like ACES screening, developmental screening is carved out of the PPS reconciliation process, so an additional $59.50 is paid when a comprehensive developmental screen is done, regardless of provider type. Many FQHCs are not billing 96110 at all, meaning either that they are doing developmental screening but giving up the revenue from doing so, or they are not following standard of care for pediatric preventive care. In either case, a remedy is needed. We ask Medical Directors and CEOs to take a lead in this.

Adult Guidelines I: Diabetes

Requirements for Continuous Glucose Monitors and Insulin Pump therapy for Diabetes

<u>Part I: Glucose Monitoring: When is Continuous Glucose Monitors Indicated?</u>

Clinical Scenario: A 57-year-old patient with type 2 DM (T2DM), with a Hemoglobin A1c of 8.2, taking metformin they report seeing an advertisement on television for a Continuous Glucose Monitor (CGM). She checks her blood sugar twice a day (once fasting, and the other time at various times in the day) and has no recorded episodes of hypoglycemia. She requests a prescription for a CGM. Is a CGM clinically indicated in this patient?

Glucose monitoring is a controversial aspect of diabetes care. The ADA Standard of Medical Care in Diabetes suggests that glucose monitoring allows patients to evaluate their individual response to therapy and assess whether glycemic targets are being safely achieved. Integrating results into diabetes management can be a useful tool for guiding medical nutrition therapy and physical activity, preventing hypoglycemia, or adjusting medications (particularly with insulin dosing). Blood Glucose Monitoring (BGM) is most effective when used in conjunction with a treatment plan that adjust treatments based on BGM values. Individual patient's needs and goals should dictate frequency and timing of BGM use.

For individuals with T1DM and insulin treated T2DM, frequent BGM is an essential component of glycemic management. The BGM readings are used throughout the day to limit hyperglycemia and prevent hypoglycemic episodes. Individual BGM routines are based on insulin regimen, activities and food or drink intake. Patients work closely with medical providers and RDs/CDEs to drive treatment adjustments that improve blood sugar control.

In the setting of T2DM managed with oral agents only, the role of using BGM has not demonstrated significant impact on overall A1C control. However, one can see the benefit of using BGM in patient education to demonstrate the mechanics of diabetes, nutrition and activity on blood sugar levels. For these patients, frequent daily blood sugar testing is not needed unless there are circumstances that place them at risk for hypoglycemia.

Glucose meters meeting FDA guidance for accuracy provide the most reliable data to support glycemic management. Partnership members can access blood glucose monitors and supplies through the Medi-Cal Rx medication program.

A Continuous Glucose Monitor (CGM) is a device that continuously measures and stores glucose levels. It can be used for short periods to answer a diagnostic question, or long term for home blood glucose management.

A short-term (7-14 day) monitor can be set up in the clinician office and used to understand an individual's trends and patterns in glycemic control for this period. This "snap shot" of information is used by the clinician and patients to develop the treatment plan. There are specific CPT codes for billing professional services associated with this approach.

Long-term CGMs are used to direct day-to-day management of blood sugar levels in the setting of intensive insulin management plans. The medical

provider, RD/CDE and individual use CGM readings to track trends and patterns to direct the overall treatment plan. Research-based evidence suggests the most impactful use of CGM occurs in the setting of intensive insulin treatment regimens or with insulin pumps, which is most commonly used in patients who have T1DM. For most of those with type 1 diabetes, frequent testing of glucose levels is necessary to achieve A1C targets safely without frequent or severe hypoglycemia. Self-monitoring allows adjustments of doses and timing of insulin as well as the timing and content of meals and snacks based on immediate feedback of glucose results. Many people with type 1 diabetes use a combination of blood glucose monitoring (BGM) by finger stick with a glucose meter in addition to CGM, when available.

Whatever the device used, all patients with diabetes should be taught how to use BGM data to adjust food intake, physical activity, or pharmacologic therapy to achieve their specific goals. The ongoing need for and frequency of BGM should be reevaluated at each routine visit to ensure its effective use.

Part II: Continuous Insulin Infusion

Continuous Subcutaneous Insulin Infusion (CSII) aims to provide a near physiologic insulin replacement using a pump. It requires close monitoring for dose adjustments and relies on frequent glucose monitoring. Insulin pumps are small computerized devices that deliver insulin as steady continuous basal dosing and insulin boluses as needed. Insulin pumps are a tool for managing diabetes in individuals with intensive insulin regimens, such as found in T1DM but rarely in T2DM. Some insulin pumps can receive glucose data from CGM devices.

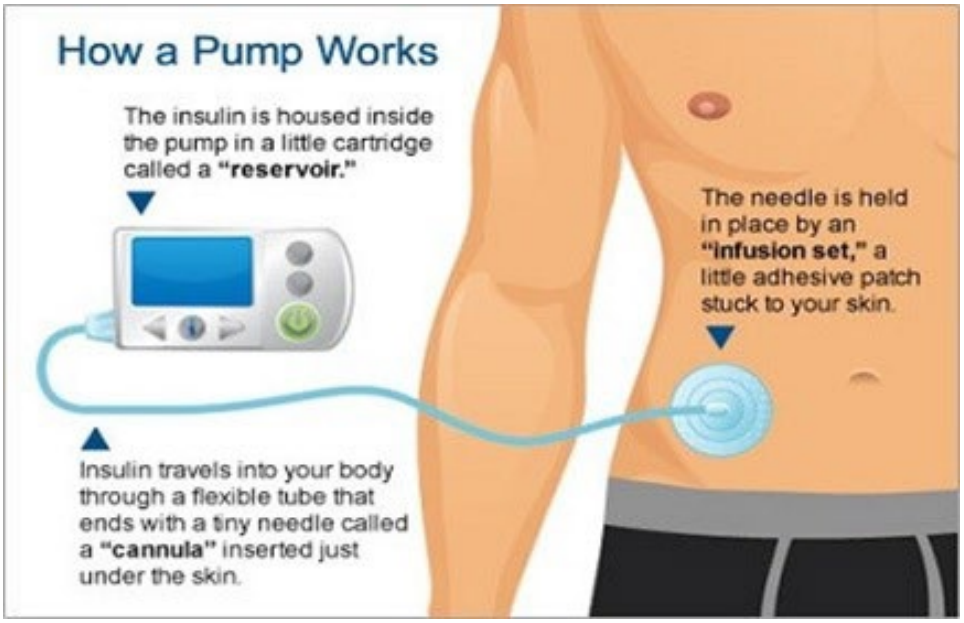


Figure 1 Photo Courtesy of NHS Chelsea and Westminster Hospital – NHS Foundation Trust

TAR Requests for CGMs and Insulin Pumps

When ordering a Continuous Glucose Monitor or Insulin Pump for a Partnership members with diabetes, a treatment Authorization Request (TAR) will be reviewed by Partnership staff for medical necessity. Please submit the following information for a TAR at Partnership:

- Clinician Order from the treating provider: NP/PA/MD/DO
- Most recent HgbA1C result
- Chart notes:
- From the clinician managing the member's diabetes: PCP, Diabetologist, Endocrinologist and CDE where applicable.
- Include diagnosis with the type of diabetes.
- Must include chart notes stating the need and justification for insulin pump or continuous glucose monitor as part of the member's plan of care in managing his/her DM.
- Should address the member's level of engagement in self-management and diabetes care – BGM testing should be at least 3 to 4 times per day.
- Recent Blood Sugar Log for 30 days of self-testing OR documentation from provider that member checks blood glucose at least 3 to 4 times per day.
- For member with T1DM, documented adherence to a clinician-ordered diabetic treatment plan.

For T2DM, documentation of the frequency of severe hypoglycemia, nocturnal hypoglycemia, or poor diabetes control in spite of good adherence to medication therapy.

Back to the patient…

The patient presented above is not a good candidate for either a short term or long term Continuous Glucose Monitor. She has type 2 DM, is not using insulin, and while the A1C is suboptimal, this does not indicate poor control. There is no mention of episodes of extreme hyperglycemia or hypoglycemia. She is a good candidate for additional diet/lifestyle education (RD or CDE) and optimization of the medication therapy.

Foot Care for Patients with Diabetes:

Using Partnership Benefits to Decrease Amputations and Ulcerations

Comprehensive foot care is essential to maintaining mobility and activity in the setting of chronic diabetes management. Individuals with poor foot care are at high risk for ulcers, infection and amputation. Most preventive foot care can take place during routine visits with exams and foot filament testing. Stock orthopedic shoes can be used to prevent complications in individuals with diabetes. Partnership covers stock orthopedic shoes for member with diabetes

when these are medically necessary especially in the following circumstances: neuropathy (noted with foot filament testing), current or past foot ulcers, amputation or foot deformity. Custom orthopedic shoes may be considered when the patients' footwear needs cannot be met with stock orthopedic shoes. Stock or custom orthopedic shoes can be ordered through Partnership contracted vendors who submit a TAR with a prescription and chart notes from a medical or podiatry provider showing the medical need for these items.

For patients whose foot care needs cannot be managed in the primary care office, referral to podiatry may be needed for management of callouses, ulcers and nail care. Additionally, many communities have wound care specialists who specialize in the care of complex and poorly healing wounds. The Partnership network of contracted podiatrists and wound care specialists in your area may be found in the Partnership Provider Directory on the Partnership website: http://www.Partnershiphp.org/Providers/Medi-Cal/Pages/Provider-Directory.aspx

Adult Guidelines II: Other

COPD Exacerbation Management

Key Points from the 2022 Global Initiative for Chronic Obstructive Lung Disease (GOLD) report for management of exacerbations include:

- Systemic corticosteroids can improve lung function (FEV1), oxygenation and shorten recovery time and hospitalization duration. Duration of therapy should not be more than 5-7 days.
- Short-acting inhaled bronchodilators (usually a combination of beta adrenergic agent like albuterol with a muscarinic antagonist like ipratropium) are recommended as initial treatment of an acute exacerbation. Long acting bronchodilators should be continued if the patient is using them at baseline, but GOLD does not recommend adding long acting bronchodilators for acute exacerbations of COPD. This is in contrast with asthma exacerbations, in which quick acting but long-lasting formoterol containing MDIs are an option.
- Maintenance therapy with long-acting bronchodilators should be initiated as soon as possible before hospital discharge.

Statin Therapy in Patients with Cardiovascular Disease or Diabetes

In 2022, about 36% of Partnership members with diabetes were not being prescribed recommended cholesterol-lowering medications. For patients with diagnosed cardiovascular disease, about 19% had not received statin therapy.

In formal studies of other populations, the patients not on statins (where statin therapy was indicated:

1. 60% of those not taking statins were not offered them by their doctor/clinician. This study found that women and African American/Black patients were less likely to have been offered statin therapy, suggesting possible underlying bias.
2. 30% had been on treatment and discontinued therapy. Most of these expressed a willingness to reconsider therapy with another medication.
3. 10% had declined statin therapy.

The Partnership Pharmacy team is meeting with PCP sites with a list of patients who are not taking statin therapy, part of our focused academic detailing program. If you are interested in having the pharmacists visit, please contact your regional medical director who will pass on the request to the pharmacy team.

Here is a summary of best practices for adding appropriate statin therapy and improving adherence for patients with diabetes and/or cardiovascular disease:

1. Members who do not tolerate one statin may be able to tolerate a different statin.
2. Consider statins with fewer drug interactions, such as rosuvastatin, pravastatin, and fluvastatin.
3. Review medication lists to confirm a statin has been prescribed when indicated.
4. Provide patient education: explaining goals of statin therapy and need for adherence.
5. Prescribe statins as 90 day supplies, once therapy is stable.
6. Ask your patients open-ended questions to monitor for adverse drug reactions, drug-drug interactions, and other obstacles that may hinder medication adherence.
7. Collaborate with dispensing pharmacies to identify and address medication adherence gaps.
8. Specific medication recommendations:
    a. For high intensity statin therapy (lowers LDL-C by >50%), consider atorvastatin 40-80 mg or rosuvastatin 20-40 mg.
    b. For moderate intensity statin therapy (lowers LDL-C by 30% to <50%), consider atorvastatin 10-20 mg, rosuvastatin 5-10 mg, or simvastatin 20-40 mg.

Cognitive Health Assessments Required Annually for Patients over age 65

The California Legislature passed a bill requiring that all patients age 65 or older receive an annual cognitive health screening to detect early dementia. This went into effect on July 1, 2022. DHCS released policy language about this requirement. Here are some highlights.

1. For Medi-Cal beneficiaries over the age of 65 who do not have Medicare, a CPT2 code (1494F) has been designated to be used to indicate that such a cognitive screening was performed. If billed with the visit, an enhanced payment will be paid on a fee for service basis.
2. DHCS has a mandatory training that must be completed by clinicians wishing to be paid for billing 1494F. This training can be accessed at: www.dementiacareaware.org . Few primary care clinicians in our 24 counties have completed this training, so far.
3. DHCS has added additional options for which cognitive assessment tools may be used. Early options presented included the mini mental status exam (MMSE) and the St. Louis University Mental Status Exam. The draft policy change added the General Practitioner Assessment of Cognition (GPCOG), the Mini-cog, the Informant Interview to Differentiate Aging and Dementia, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

Thus far, we have not received any claims for dementia screening.

Health Equity

According to the World Health Organization, equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation). Health is a fundamental human right. Health equity is achieved when everyone can attain their full potential for health and well-being.

Health Equity: What it Means for Primary Care

There are three pillars to Health Equity work: 1. Workforce diversity and cultural responsiveness, 2. Data Collection and Stratification, and 3. Reducing Healthcare Disparities, with examples. See the August 2022 Newsletter for details.

Mandatory Health Equity Training – Coming soon.

DHCS is requiring Medi-Cal Managed Care Plans to mandate and monitor regular health equity trainings for all patient-facing staff working in the primary care and specialty setting. This will begin in 2024. Online options will be available. More details will be coming in the months ahead.

Measuring Health Inequities

Partnership can use two primary sources to look for plan-wide health inequities:

1. HEDIS data includes more measures (approximately 50 measures), but Hybrid measures have small denominators making statistical significance for disparities harder to find.
2. PCP QIP data is a smaller set of measures, but achieves statistical significance on HEDIS hybrid measures.

In both cases, inequities are identified by finding statistically significant differences between a historically disadvantaged population versus the historically favored population. At this point in time, we have only completed analyses of inequities based on self-identified race/ethnicity (based on U.S. census criteria) and language data. There are many other likely inequities present which deserve analysis in the future:

a. Disability
b. Gender
c. Gender identity
d. Sexual orientation
e. Income
f. National origin
g. Geography, especially rural vs. suburban/urban and neighborhood-based
h. Educational attainment

Major findings: Individuals self-identifying as Native American/Alaska Natives have disparities in 11 of 12 PCP QIP measures. The Black/African American population had about a 3% disparity in three PCP QIP measures.

Partnership is addressing these inequities with a series of interventions, as outlined in our Quality Improvement, Health Equity, and Population Health program documents.

General Quality Updates

DHCS Quality Oversight of Managed Care Plans

The measures in the DHCS Managed Care Accountability Set (MCAS) for reporting year RY2023 (measurement year MY2022) are noted below:

2022 MCAS Measure Abbreviations	
Measure Abbreviation	**Measure Name**
Children's Health Domain	
CIS–10	Childhood Immunization Status—Combination 10
IMA–2	Immunizations for Adolescents—Combination 2
LSC	Lead Screening in Children
W30–6	Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits
W30–2	Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits
WCV	Child and Adolescent Well-Care Visits—Total
Reproductive Health Domain	
CHL–Tot	Chlamydia Screening in Women—Total
PPC–Post	Prenatal and Postpartum Care—Postpartum Care
PPC–Pre	Prenatal and Postpartum Care—Timeliness of Prenatal Care
Cancer Prevention Domain	
BCS	Breast Cancer Screening—Total
CCS	Cervical Cancer Screening
Chronic Disease Management Domain	
CBP	Controlling High Blood Pressure—Total
HBD–H9	Hemoglobin A1c (HbA1c) Control for Patients With Diabetes—HbA1c Poor Control (>9.0 Percent)
Behavioral Health Domain	
FUA–30Day	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total
FUM–30Day	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total

New Accountable Measures being added for MY 2023 are:

1. DEV: Developmental Screening in the First Three Years of life (non-HEDIS Measure)
2. TFL-CH: Topical Fluoride applied at least twice in the measurement year for children aged 1-20 (non-HEDIS measure)

Draft additions for MY 2024 (Final decision pending)

1. COL-E: Colorectal screening starting at age 45, using only electronic data)
2. POD: Pharmacotherapy for Opioid Use Disorder

2022 Performance on MCAS Measures in Eastern Region

MCP Name	MCAS Measures														
	Children's Health Domain						Reproductive Health Domain			Cancer Prevention Domain		Chronic Disease Management		Behavioral Health Domain	
	CIS–10	IMA–2	LSC	W30–6	W30–2	WCV	CHL–Tot	PPC–Post	PPC–Pre	BCS	CCS	CBP	HBD–H9[8]	FUA–30Day	FUM–30Day
Blue Cross of California Partnership Plan, Inc., DBA Anthem Blue Cross Partnership Plan	29.93%	29.68%	53.04%	49.10%	69.45%	45.49%	49.66%	87.60%	89.60%	43.35%	49.39%	61.56%	33.58%	34.23%	59.71%
California Health & Wellness Plan	31.14%	28.95%	39.66%	51.10%	66.10%	44.61%	53.23%	82.19%	92.24%	47.67%	52.80%	62.63%	32.22%	33.93%	51.28%
NCQA 2023 50th percentile	30.90%	34.30%	63%	58.38%	66.76%	48.07%	56.04%	78.10%	84.23%	52.20%	57.11%	61.31%	37.96%	36.34%	54.87%

Summary analysis: Chronic disease management and perinatal care are current strengths. Pediatric measures, cancer prevention and follow up from the ED for behavioral health issues need extra attention.

Electronic Clinical Data Systems (ECDS) Measures

ECDS is a HEDIS reporting standard for health plans collecting and submitting quality measures to NCQA. This reporting standard defines the data sources and types of structured data acceptable for use for a measure. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

ECDS reporting is part of NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. ECDS measures are indicated by a "-E" after the measure name.

The following ECDS measures require data to be extracted from the Electronic Health Record:

- Several Depression Related Measures: (DMS-E, DSF-E, DRR-E, PDS-E, and PND-E), including screening for depression in prenatal and postpartum periods, depression screening rates, appropriate follow up for depressed individuals, and improvement depression symptoms.
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)

There is an ECDS Unit of service measure in the 2024 PCP QIP, focusing on just the depression measures and the Alcohol Use Screening and Follow-up measures.

Partnership has developed a package of specifications for generating and transmitting files for the following measures (part of the PCP and Perinatal QIPs)

1. Depression Screening and Follow Up
2. Alcohol Use Screening

Full specifications for generating reports on these ECDS measures are available to PCPs on the eReports part of the Partnership website. Here are

some configuration considerations:

Depression Screening: The PHQ-2 and PHQ-9 can be used for all depression screening measures (with a modified version for adolescents called the PHQ-A). Other screening tools may be used for one of the depression screening measures, but they will not scale to other measures. Most important is to capture the actual score associated with a PHQ2 or PHQ9 as a discrete field that can be extracted from the electronic health record, along with the interpretation (positive or negative) of this numerical result. If a warm handoff is used in your practice for those who screen positive, you will need to keep track of the codes used for this warm handoff to set up the future QIP measure.

Alcohol Use Screening: The two most common screening tests are the single question screen and the AUDIT-C. Ensuring that the numerical value of the AUDIT-C the interpretation of this result are in discrete fields will position the EMR well for the ECDS programming.

See the PCP QIP part of the Partnership websites to see a recorded webinars on ECDS and the related topic of Primary Source Verification.

Facility Site Review

There are three types of site review: Facility Site Reviews, Medical Record Reviews, and Disability Accessibility Reviews. The third type of review will not be covered in this overview. For the detailed policy on Site Reviews, see the Site Review Policy, with related Attachments A, B, C, D, and E.

If you have not had a Site Review in the past year or two, please note that DHCS increased the requirements of Site Reviews to be much more challenging, as of 2022. Even if you passed easily in the past, we recommend your compliance team review the requirements carefully now to begin preparing for your next review well before it happens, to increase the probability of passing on the first review.

Facility Site Review

The Facility Site Review or FSR is an assessment of the physical site. It is done at the time of initial credentialing and then a maximum of every three years thereafter.

Partnership's team of Site Review nurses are DHCS certified along with a certified Master Trainer on staff. They attend meetings with the DHCS staff to stay up-to-date on current regulations and guidelines.

There are 6 domains (components including Accessibility/Safety, Personnel, Office Management, Clinical Services, Preventive Services, Infection Control) of the FSR. Each domain is assessed during the review.

The site needs to maintain an 80% overall score in order to pass the review.

There are some questions that are weighted at 2 points instead of 1 point. These are called Critical Elements. DHCS deems these to be of higher importance. Sites have 10 days to rectify any deficiencies that are Critical Elements.

Medical Record Review or MRR

A Medical Record Review is done at the time of initial site credentialing (or shortly thereafter) and then repeated every three years (or less). The patients are chosen at random and provided to the site prior to the review.

- For sites with 1-3 providers= 10 records reviewed
- 4-6 providers= 20 records
- More than 7 providers= 30 records

NPs and PAs are factored into this calculation if they are assigned member panels.

New DHCS requirements state that records should be maintained for a minimum of 10 years.

The medical records have their own domains:

- Format
- Documentation
- Continuity of Care
- Pediatric Preventative Care
- Adult Preventative Care
- OB Preventative and CPSP if applicable.

General Information

We work with the site to help with any deficiencies.

We offer training on any topics covered in our tools and within the site review. Please feel free to contact us with any questions.

If you are interested in a more elaborate training related to all the site review changes as of 7/2022 please email the FSR inbox at FSR@partnershiphp.org. Other contact information:

Pay for Performance Program for Primary Care (PCP QIP)

PCP QIP Program Overview

Partnership's PCP Quality Incentive Program (QIP) has been in place for more than 25 years, and has evolved over that time period. Designed in collaboration with our PCP provider network, the goal is to align Partnership and our Primary Care Providers on Quality Goals, and to transfer substantial resources to PCPs that they can leverage to improve quality.

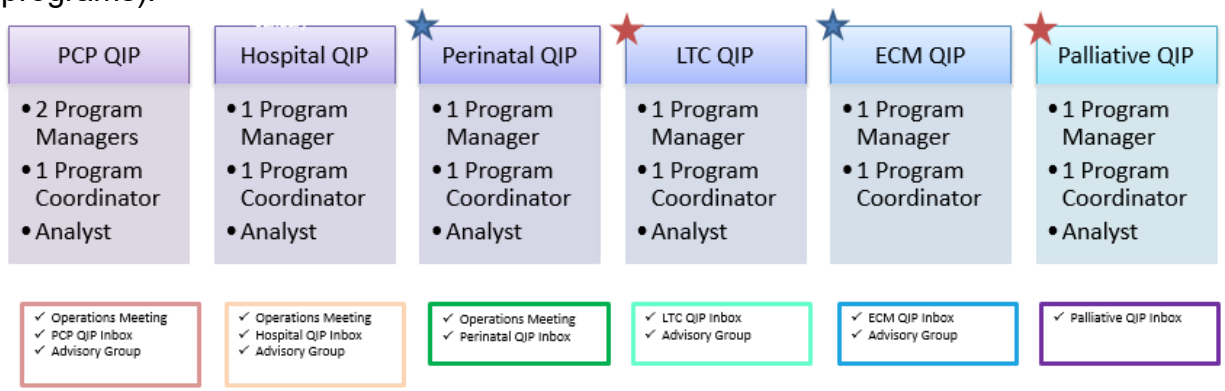
The QIP uses nine (9) guiding principles for measure development and program management to ensure our members have high quality care and our providers are able to be successful within the program.

1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The detailed specifications for the 2023 version of the PCP QIP can be found here. The material below is an abbreviated version.

Administering the PCP QIP

Partnership's Quality Improvement Department administers six different pay-for-performance programs, with staffing as noted below (some shared between programs).



We are Partnership are proud of the robust structure of these pay for performance programs. All are built on a set of core principles.

The QIP uses nine (9) guiding principles for measure development and program management to ensure our members have high quality care and our

providers are able to be successful within the program.

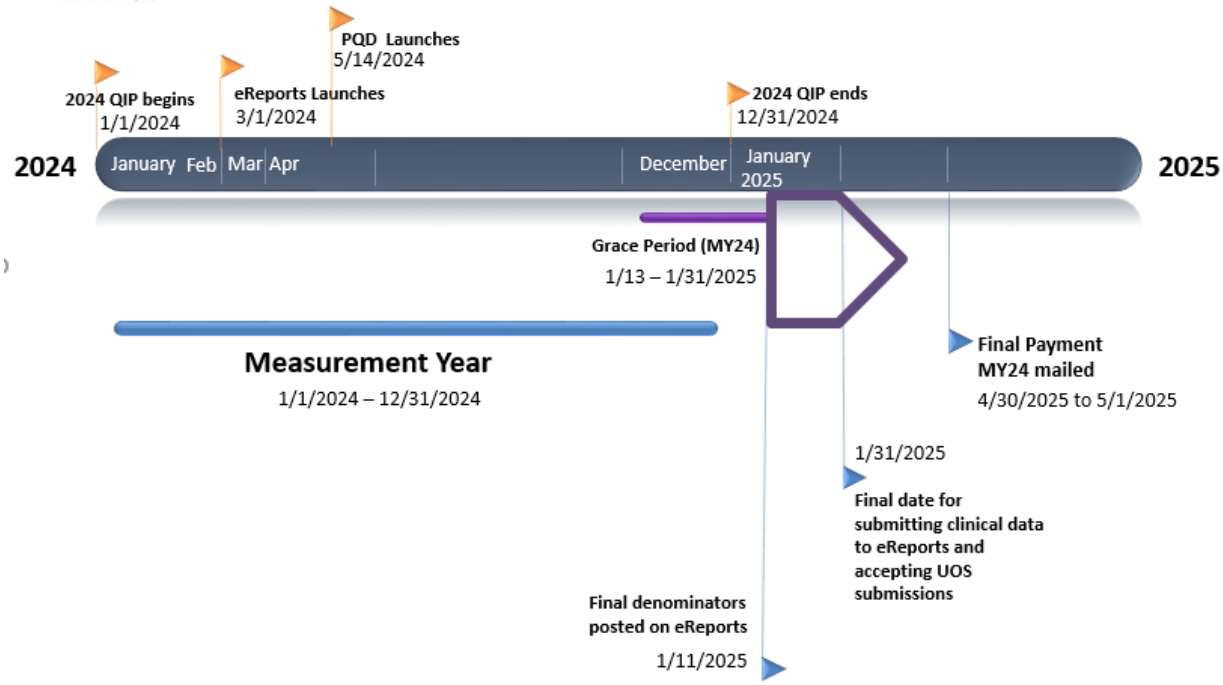
1. Pay for outcomes, exceptional performance, and improvement
2. Offer sizeable incentives
3. Actionable measures
4. Feasible data collection
5. Collaboration with providers
6. Simplicity in the number of measures
7. Comprehensive measurement set
8. Align measures that are meaningful
9. Stable measures

The guiding principles outlined above are used to select measures for improvement.

PCP QIP Yearly Timeline

The PCP QIP is on a calendar year cycle, with the measurement year running from January 1 to December 31. Payment is sent out the following May.

There are a series of deadlines related to the PCP QIP throughout the year. It is important to designate a staff member to track these activities and disseminate this information to the appropriate individuals at your PCP office. This timeline will be reviewed at the webinar introducing the 2024 PCP QIP measurement set. Here is a high level overview:



PCP QIP Measure Sets

There are two measure sets in the PCP QIP: The Core Measure Set and the Unit of Service measure set.

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Clinical Measures

Family Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Care: HbA1c Control 7. Diabetes Management: Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children (Blood Lead Screening)
Internal Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Colorectal Cancer Screening 4. Comprehensive Diabetes Care: HbA1c Control 5. Controlling High Blood Pressure 6. Diabetes Management: Eye Exams
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children (Blood Lead Screening)

Non-clinical Measures

Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)
All Practice Types: 1. Avoidable ED Visits 2. PCP Office Visits
All Sites: 1. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

All Sites:

1. Advance Care Planning Attestations
2. Extended Office Hours (Capitated sites only)
3. PCMH Certification
4. Peer-led Self-Management Support Groups
5. Health Information Exchange
6. Health Equity
7. Dental Fluoride Varnish Use
8. Tobacco Use Screening
9. Electronic Clinical Data Systems (ECDS)
10. Early Administration of the 1st HPV Dose
11. Early Administration of Initial Flu Vaccine Series

Core Measure Set: Program Specific Criteria

1. Continuous Enrollment

   For measures in the Clinical domain, the member must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 1 and December 31 of the current measurement year (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1st. This means that members must be assigned as of December 1st to be included in the final denominator lists used to calculate payment.

2. Relative Improvement

   For most existing clinical measures, sites can also earn points based on relative improvement (RI). Please note that if a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement in the current measurement year. Relative improvement measures the percentage of the distance the provider has moved from the previous year's rate toward a goal of 100 percent. The method of calculating relative improvement is based on a Journal of the American Medical Association article authored by Jencks et al in 2003.

   For clinical measures in Eastern Region, improvement cannot be determined. Partnership makes new clinical measures payable at the 50th percentile for the first year they are introduced. In subsequent years, when improvement can be measured, full credit will require

achieving a benchmark higher than the 50th percentile (75th or 90th percentile, with points also available for improvement.

2024 Core Measure Descriptions

Full details can be found on the Partnership website. The MY 2023 specifications are currently available; the 2024 specifications will be added in the coming weeks. To register for our January 24, noon to 1 p.m. PCP QIP Launch webinar, register here.

1. Preventive Screening Measures
    a. Cervical Cancer Screening: Percentage of women 21–64 years of age who were screened for cervical cancer.
    b. Breast Cancer Screening: The percentage of continuously enrolled Medi-Cal women 50-74 years of age who had a mammogram to screen for breast cancer.
    c. Childhood Immunizations (CIS-10): The percentage of children 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) *haemophilus* influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday.
    d. Adolescent Immunizations: The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one (1) dose of meningococcal conjugate vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two (2) doses of the human papillomavirus (HPV) vaccine by their 13th birthday.
    e. Colorectal Cancer Screening: The percentage of assigned members 45–75 years of age who had appropriate screening for colorectal cancer.
    f. Lead Screening in Children (Blood Lead Screening) – New in 2024 for FP & Peds
        i. BLS is currently a Partnership 2023 Unit of Service measure for children ages 24 to 72 months and incentivized at the Parent Organization level. The 2024 proposal is to move BLS to the Core Measure set and use the HEDIS measurement of completing at least one blood lead test by the age of 2 years and to incentivize at the PCP practice level.
2. Chronic Disease Management
    a. DM HbA1c-Good Control: The percentage of assigned members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold.
    b. DM-Retinal Eye Exam: The percentage of members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.
    c. Controlling Blood Pressure: The percentage of assigned members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the

measurement year.

3. Utilization
    a. Well child visits in the first 15 months of life: The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life.
    b. Well child visits from age 3 to 17: The percentage of members 3 - 17 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
4. Non Clinical Measures
    a. Appropriate Use of Resources
        i. Ambulatory Care Sensitive Admissions: Admission rate of assigned members with any of the principle diagnoses from Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) listed in the numerator, during the measurement year. Sites must have a minimum of 500 eligible members by December of the measurement year to be eligible for incentive.
        ii. Risk Adjusted Readmission: For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Sites must have a minimum of 500 eligible members by December of the measurement year to be eligible for incentive.
    b. Access and Operations
        I. Avoidable ED visits: The rate of assigned members with an "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by Partnership.
        II. PCP Office Visits: The number of Primary Care Provider visits per member per year by Partnership eligible members with participating QIP providers.
    c. Patient Experience: This measure aims to improve the patient experience. There are two (2) ways in which to earn points: Partnership contracts with a vendor to conduct the Consumer Assessment of Healthcare Providers and System (CAHPS) survey once during the measurement year OR PCP conducts a survey to understand the patient experience and reports results and findings using the submission template.

Unit of Service Measures

The detailed specifications list the financial details behind these measures (for MY 2023. An update will be posted in the coming months.

1. Advanced Care Planning: This measure encourages the PCP to provide annual awareness to Partnership members 18 years or older understand

the how the advance care plan (ACP) can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision-making challenges facing the individual and his or her caregivers. An advance care plan can be used at any stage of life and should be updated as circumstances change.

2. Extended Office Hours: **(Capitated Sites Only)** Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter. Definition of regular business hours: Total open office hours equals at least nine (9) hours between the hours of 8 a.m. and 5 p.m. OR 9 a.m. and 6 p.m., Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours. The site must be open to scheduled visits during the extended office time to receive credit. **Note: Non-capitated sites will have an equivalent amount put into their equity adjusted QIP pool.**

3. Patient Centered Medical Home (PCMH): This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.

4. Peer Led Support Groups: This measure encourages the PCP organization to host peer-led self-management groups for Partnership member and non-Partnership members focused a variety of conditions, or focused on specific diseases or conditions, such as Diabetes, Rheumatoid Arthritis, Chronic Pain, Hepatitis C, Cancer, Congestive Heart Failure, COPD, Asthma, Depression, Anxiety/Stress, and Substance use.

5. Health Information Exchange: This measure encourages the PCP parent organizations to establish and maintain a continued linkage to a recognized community health information exchange (HIE) organizations.

6. Health Equity: Partnership is actively engaged in HE initiatives that bring about equitable awareness and result driven change within the counties we serve and we highly encourage provider organizations to join our efforts. This unit of service measure allows PCPs to use their own data to identify a health inequity and then to develop a QI project to address this inequity.

7. Dental Fluoride Varnish Use: The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

8. Tobacco Use Screen: This measure uses the base logic of the National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of beneficiaries 18 years of

age and older screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Note that the Partnership measures focus on a younger age group than the NQF measure, to align with DHCS focus on monitoring preventive health in pediatric patients. Tobacco use includes any type of tobacco and aligns with U.S. Preventive Services Task Force (USPSTF) recommendations with regards to screening/counseling for tobacco. While these measures do not include screening for non-tobacco nicotine products, Partnership recommends also combining screening for these products, while screening for tobacco products, in support of the recommendations by the AAP and AAFP.

9. Electronic Clinical Data Systems (ECDS): This measure supports the allowance of data exchange from Provider Electronic Health Records to Partnership in order to capture clinical screenings, follow-up care and outcomes. ECDS implementation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA plans to convert most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable to several ECDS measures, this process will continue to increase in emphasis.

10. **New** Early Administration of 1st HPV Dose
    The purpose of this new UOS measure is to incentivize providers to administer the first HPV dose by the age of 12 in order to have the required 6-month pause between the first and 2nd dose and another 6 months to administer the 2nd HPV dose before the 13th birthday.

11. **New** Early Administration of Initial Flu Vaccine Series (Two Doses)
    The purpose of this new UOS measure is to incentivize early administration of influenza *and* to complete administration of the 2nd dose within 60 calendar days of the 1st dose.

Online Tools for Quality Measurement and Reporting

Partnership offers two primary online tools for monitoring quality performance at your sites: eReports and the Partnership Quality Dashboard. For our new counties, assess will begin in the late Spring, 2024. We will hold online trainings for new sites on how to use these two tools at that time. Below is a brief description of each.

Important note: do not wait until you have access to eReports and PQD to begin working on quality improvement, in particular, several measures depend on activities being done early in the year; you should start focusing on these immediately using your existing EMR or population health management tool!

High priorities for Fall, 2023:

1. Children turning 2 years old in January through May: looking for opportunities to get their vaccines caught up, especially to offer the primary series of two flu vaccines.
2. Adolescents turning 13 years old in January through May: looking for opportunities to get their vaccines caught up, especially the second HPV vaccine.
3. Infants turning 15 months old in January through May, to ensure they are being scheduled for regular well child exams, catching up with some shorter time intervals if needed.

eReports

eReports is an online application by which PCP sites can monitor their own performance within the QIP Clinical measures and submit supplemental data to Partnership. The eReports portal may be accessed through Provider Online Services, which has a link at the top of the main Partnership webpage. Provider Online Services is a pass-word protected part of the Partnership webpage, allowing access to Patient-specific information related to billing and quality.

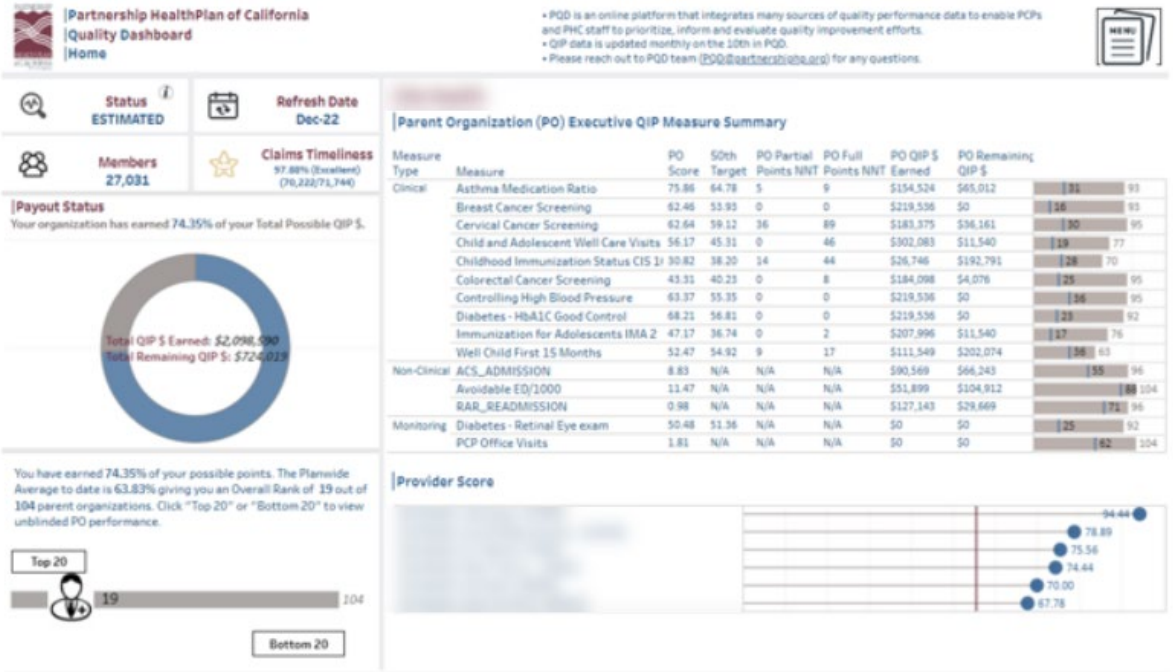
Generally one person at each PCP site (often someone from the billing or IT department) is the administrator for Partnership's Provider Online Services, and this administrator manages access and assignment of passwords for other staff at their organization. Access for PCPs will be arranged in late December.

The launch date of eReports typically falls within the first quarter of the measurement year to ensure availability of data throughout the year. PCP sites have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 9th – 31st following the measurement year, and is intended to allow for final data collection and uploads.

Partnership Quality Dashboard (PQD)

The Partnership Quality Dashboard (PQD) is a Tableau dashboard that is integrated into eReports and designed to visualize Primary Care Provider Quality Incentive Program (PCP QIP) data. The PQD dashboard is designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Performance data in PQD can be rolled up, in executive summary views and in drilldown views to the patient demographic level.

Below is the **Home View**, one example of many pages that available on PQD:



Features found on the **Home View**:

- Claims Timeliness score – the percentage of claims at the parent organization level that are received by Partnership within 90 days of the date of service. This is to encourage timely billing and data capture through claims. Providers can export a drill-down report of claims received outside of 90 days.
- Projected QIP payout at the parent organization level. This snapshot shows a donut chart of Total QIP $ Earned and Total dollars the org stands to earn if performance was 100%.
- Number of patients needed to treat at the parent organization level to meet Full Points targets.
- Highest and Lowest performing providers identified. Based on overall, year- to-date QIP score. The Top and Bottom 20 ranked organizational providers are displayed.

Once launched in the spring, we highly recommend that CMOs/Medical Directors and CEOs/Executive Directors/Office Managers log on to PQD every one to two months to track your progress on all measures, and to see what actions can improve PCP QIP performance in the current year.

Payment Methodology for Core Measure Set

How much payment can you expect from the PCP QIP?

Partnership's PCP QIP program is one of the most generous pay for

performance or pay for value programs in California.

The Core measure set represents an average of about 90 percent of the annual incentive earned. Since the payment associated with the Unit of Service Measures is evident from the specifications of each measure, we won't cover that in more detail.

Conceptually, payment for the Unit of service measures can be thought of as four steps:

1. The dollars put into the QIP pool depends first on the monthly assigned members for each PCP site. This $4 per assigned member per month (or $4 PMPM) is put into the pool for all primary care sites.
2. *Additional* dollars are put into the pool, as an "equity adjustment." The details of the components of the equity adjustment are listed in the next section. The range of additional funds are projected to range from $0 to about $14 PMPM for 2023. Added to the $4 PMPM base rate, the range of projected payouts is estimate to range from $4 to $18 PMPM.
3. At the end of the year, a score is calculated on the Core Measure set, from 0% to 100%, based on the performance of each measure. In 2022, the weighted average score was 62%, with the range from 0% to 100% per site.
4. The total dollars in the pool (1 and 2 above) are multiplied by the quality performance on the Core Measure set, giving the amount that each site is paid. This payment will be sent out during the month of May, in the year after the close of the measurement year.

Equity Adjustment of the Core Measure Set

Here are the components of the additional dollars in the Equity Adjustment:

- Gateway
  - Must have at least 100 assigned members as of December 1, 2023
- Core adjustments
  - Acuity of patient panel
  - Socio-demographic risk, at patient level, rolled up to PCP site level
  - Site difficulty in recruiting PCP physicians
  - Lower than average baseline per visit resources available to PCP
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year

Here is the weighting of the four core adjustments:

Percentage Weight	Equity Factor
20%	Acuity Adjustment a: Average number of diagnoses/encounter
20%	Acuity Adjustment b: Average engagement of population
20%	Socio-demographic risk of assigned patients
10%	Frontier location
10%	PCP to population ratio
20%	Below average practice resources

Factors under the control of the practice

Factors more intrinsic to the practice setting/population served

Here is the detail on the thresholds used for each component:

Weight	Factor	Description	Level of adjustment	Adjustment Method	Zero Adjustment	Max Adjustment	Data Source
20%	1a	Acuity: Number of diagonses	PCP Site	Continuous	<2.5 diagnoses/ encounter	>4 diagnoses/ encounter	PHC Claims Data; Denominator=claims from PCP site
20%	**1b**	Acuity: Non Utilizer rate	PCP site	Continuous	>20%	<10%	PHC Claims Data; Denominator=assigned patients with some utilization in past 2 years
20%	**2**	Sociodemographic Factors	Rolled up member risk to PCP site	Continuous	>0.8	< -0.4	Address of each Resident (homeless patients assigned to PHC location for address)
10%	**3a**	Physician Shortage area- Frontier Location	Location of PCP Site (Frontier)	full credit for frontier level 2 (all or nothing)	Non-frontier	Frontier Level 2	USDA
10%	**3b**	Physician Shortage area PCP density in county	County of PCP site (physicians/1000 residents	Continuous	Greater than 3 physicians/1000 residents	0.6 or less physicians/1000 residents	County Health Rankings
20%	**4**	Structurally unfavorable per visit reimbursement	Site level	Continuous	> $220	< $120	DHCS, PHC contracts

Hint: Focus on improving Acuity Adjustment

Partnership recommends you immediately use your EMR to measure your baseline number of diagnosis codes per encounter, and working to improve this number through provider trainings and system changes.

Additionally, once you get your list of assigned patients from Partnership in January, we recommend you compare that list to patients you have seen in the past year, and begin outreaching to those you have not seen in the past year.

A recorded webinar with more detail on the Equity Adjustment Process can be found here.

Consequences of Poor Performance on the PCP QIP

PCP Parent Organizations who score less than 33% on the PCP QIP Core Measure Set may be put into a modified QI and subject to additional requirements, collectively called Enhanced Provider Engagement. The main components of this are:

1. A reduced set of measures in the PCP QIP
2. A practice coach is assigned to the practice
3. The CMO or Director of Quality will meet with the governing board to give a presentation on the quality performance of the organization

Training Resources for Quality and Performance Improvement

Customizing your Electronic Health Record for Quality

Each summer, Partnership updates a white paper entitled "Optimizing the Configuration of the Electronic Health Record for Quality." It contains 41 specific, detailed recommendations for how the electronic health record should be configured to optimize the capture of quality measures and improve the quality of care provided.

The 2023 white paper, can be accessed through our website. A webinar overview of the white paper is scheduled for

Monday, November 27, from 1 p.m. to 2 p.m.
Register here.

We recommend your EMR configuration clinician and non-clinician experts attend.

Quality & Performance Improvement Online Training

Looking for more educational opportunities? The Quality & Performance Improvement department has many pre-recorded, on-demand courses available to you. Trainings include:

- ABCs of Quality Improvement: An introduction to the basic principles of quality improvement.
- Accelerated Learning Educational Program: An overview of clinical measures including improvement strategies and tools.
- Advanced Access Webinar Series for Primary Care Providers.
- The Role of Leadership in Quality Improvement Effort: Leaders from top performing organizations share how they were able to build a culture of quality.

- PCP QIP High Performers – How'd They Do That? Learn how other PCPs accelerated in their QIP performance.
- Project Management 101 – An introduction to the basic principles and tools used in project management.

You can find these on-demand courses, and more, on our Webinars Webpage.

Improving the Patient Experience through Communication Workshops

Does your staff need training to improve their communication with patients? Are you worried about how they will perform on the Partnership CG-CAHPS survey in April?

Consider a communication training workshop!

One California-based option we have found to be very effective is EM Consulting, which has a variety of workshops available:

1. Trauma informed de-escalation
2. Motivational interviewing Part 1 and Part 2
3. Helping people with Addictive Disorders
4. Building Trust
5. Enhancing Trust
6. Empathic Communication at Home and at Work
7. Telehealth: best practices for communication
8. Custom Communication Workshops

For more information email: contact@emorrisonconsulting.com

A Quick Guide to Starting Your Quality Improvement Projects

The Performance Improvement Team at Partnership is pleased to share with you our newest resource, A Quick Guide to Starting Your Quality Improvement Projects. This 10-step guide covers inception to implementation of a quality improvement (QI) project. The guide includes concrete steps on meeting preparation, development of a project charter, how to develop change ideas for QI project, and the use of the PDSA cycle. Additionally, each section includes example documents and links to templates. There are tips throughout the guide for the project lead to successfully manage projects.

You can find the guide on the Partnership's Partnership Improvement Academy webpage, under resources.

Recommended Actions for PCP Clinical Leaders

Between now and December 31, 2023

1. Meet with your front-line clinicians to cover highlights from theses detailed notes
2. If you or another clinician leader is interested in joining a Partnership committee, let us know.
3. If one of your current clinicians doesn't meet the residency training requirements to be credentialed by Partnership, start having them pursue the Alternative Pathway.
4. Send an introductory email to your Eastern Regional Medical Director, Dr. Doug Matthews: rmatthews@Partnershiphp.org to introduce yourself and your team. Consider setting up a time for a virtual or in-person visit to your site.
5. When the new Eastern Region Manager starts, send an email introduction to them with your contact information.
6. Sign up the clinical leaders for your organization for the monthly Partnership Medical Directors Newsletter. If you send a list of those you would like to sign up to Dr. Moore at rmoore@Partnershiphp.org and Sarah Browning at sbrowning@Partnershiphp.org we will sign you up.
7. Assign someone to set up the Partnership computer interpreter service on all computers in your office that are used for in-person and video visits.
8. Have your intranet administrator set up commonly used resources for convenient access by our clinicians and support staff, including pharmacy resources.
9. In conjunction with your leadership, select one of the two eConsult service options and communicate this to Partnership's telemedicine team.
10. In conjunction with your leadership, review the different options for adult and pediatric subspecialty telemedicine, and reach out to Partnership to select which ones fit for your organization.
11. Check with your credentialing department to be sure your in-house behavioral health specialists are credentialed with Carelon so they can be paid for mental health services they provide.
12. Have your EMR configuration liaison integrate the Partnership form for Medical Equipment Distribution into your EMR, for ease of access. Train your staff on what equipment is available through this program and how to access the form and send it in.
13. Ask your director of recruiting to sign up for the Partnership Provider Recruitment program ASAP, so it can be used for new recruits.
14. Ensure that your referral coordinator is thoroughly trained in the process of submitting referral authorizations to Partnership.
15. Improve your Acuity Score! Have your billing team calculate the average number of diagnosis codes per encounter for all your clinical staff. If the overall average is below 4 diagnoses per encounter, formulate a provider and billing department training to improve this, using materials from Partnership to help.

After January 1, 2024

1. Update the list of Outpatient Palliative Care Providers in your geographic area, and distribute this information to your clinicians and case managers.
2. Designate a clinician to perform regular reviews of USPSTF guidelines and other specialty society guidelines, developing a prioritization process for implementing system changes.
3. Ensure the compliance team responsible for site reviews has some time to fully review the 2022 requirements, doing a mock survey to look for opportunities for improvement before Partnership performs its official audit.
4. Support your Quality Department leader's for staffing and analytic support to optimize revenue from the PCP QIP.

Recommended Actions for PCP Quality Leaders

Between now and December 31, 2023

1. Sign up for the PCP QIP email distribution list and PCP QIP newsletter by sending an email to QIP@Partnershiphp.org.
2. Attend (and have your EMR configuration specialist attend) Dr. Moore's November 27 training on "Optimizing the EMR for Quality"
3. Using your existing system, pull a list of members who are turning 2 years old from January 1, 2024 through May 31, 2024. If their vaccines are not up to date, bring them in to update them (with special attention to 2 flu doses).
4. Using your existing system, pull a list of members turning 13 years old from January 1, 2024 through May 31, 2024, evaluating for completion of their adolescent vaccinations, with special attention to the second HPV vaccine. Bring them in if they are not up to date.
5. Using your existing system, pull a list of members turning 15 months old from January 1, 2024 through May 31, 2024 to ensure they are getting their well child visits on time. If they are behind, bring them in more frequently for catch up well child visits.
6. If you do not have lead testing Point of Care devices, and are interested in seeing if you quality for a grant to get such a device, contact us at leadPOC@partnershiphp.org

After January 1, 2024

1. Ensure key quality staff and senior leaders (like a Medical Director of Quality and the CMO) have usernames and passwords assigned for the Provider Online Service/eReports module.
2. If your practice is in a location far from hospital mammogram access or your local access is constrained, if you are interested in being considered for a local Mobile Mammography event, reach out to the coordinating team.
3. Ensure that the quality team at your PCP office is sufficiently staffed fully trained on the PCP QIP, using the materials from the Partnership website.
4. Plan activities to monitor and improve the patient experience of care at your organization, in preparation for the CG-CAHPS survey to be done by Partnership in April (for large organizations) or for your custom customer experience project, for smaller organizations.
5. Plan which Unit of Service measures you plan to focus on for 2024. Develop a project plan for these.
6. Plan clinician trainings to gradually review the PCP QIP core measures in depth, so they can actively participate in achieving better outcomes.