



# Medical Directors Forum

## Primary Care Almanac (Clinician Version)

### Detailed Notes

Spring 2025

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.

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Electronic versions of these notes 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.

## ***Table of Contents***

<b><i>Health Policy Updates</i></b> .....	4
Access to Maternity Care.....	4
Rural Health Policy .....	11
<b><i>Partnership Policy Reminders</i></b> .....	13
Grievance and Appeals Process .....	13
Potential Quality Issues and Peer Review .....	14
What's "Carved-Out" to DHCS or Counties? .....	15
Partnership Website Highlights for Clinicians.....	16
Monthly Newsletter for PCP Clinical Leaders.....	16
Primary Care Blog.....	16
<b><i>Benefits Updates for Partnership Members</i></b> .....	17
Blood Pressure Devices and Cuffs through Community Pharmacies .....	17
Medical Equipment Distribution Program.....	17
Care Coordination Services at Partnership .....	19
Intensive Outpatient Palliative Care Benefit .....	19
Transportation Benefit.....	21
Diabetes Education and Nutrition Counseling.....	22
Behavioral Health.....	23
Supplemental Benefits .....	27
<b><i>Medi-Cal Benefits: Recent Changes</i></b> .....	28
Genetic Testing .....	28
Genetic Testing for Pregnant People: What is covered?.....	28
<b><i>Partnership Updates</i></b> .....	33
Prior Authorization Changes for CT/MRI.....	33
Prior Authorization for PT, ST, and OT.....	33
Prior Authorizations in Primary Care.....	34
Pearls on Referrals .....	35
Non-invasive Assessment for Liver Fibrosis:.....	37
Electro-diagnostic Studies .....	39
Advance Directive Completion.....	39
Tobacco screening and referral rates .....	40

CT Scan Usage by Emergency Departments: .....	41
Hospital Obstetrical Data: .....	43
<i>Clinical Practice Guidelines and Best Practices</i> .....	44
Preventive Services Updates .....	44
Clinical Practice Guidelines .....	45
Specific Pediatric Guidelines .....	45
Developmental Screening .....	51
Adult Guidelines .....	54
New Mandates on Tuberculosis .....	56
<i>Health Equity</i> .....	57
National Changes in Categorization of Race/Ethnicity .....	57
Mandatory Diversity-Equity-Inclusion Training – Coming soon .....	62
Health Inequity Measurement .....	62
<i>Pay for Performance Program for Primary Care (PCP QIP)</i> .....	64
PCP QIP Overview .....	64
PCP QIP Measure Sets .....	65
Prioritization of PCP QIP measure interventions, by time of year .....	67
<i>Training Resources for Quality and Performance Improvement</i> .....	68
Performance Improvement Online Trainings .....	68
A Quick Guide to Starting Your Quality Improvement Projects .....	68
Partnership Measure Best Practices Documents .....	68
<i>Upcoming trainings</i> .....	69
Improving Measure Outcomes Webinar Series .....	69
Sierra Nevada Conservation & Wilderness Medicine Conference .....	69

## Health Policy Updates

### Access to Maternity Care

Last year, another Northern California hospital maternity ward closed in the Partnership service area. The closure of the Mad River Hospital in Arcata (Humboldt County), leaves just 23 non-Kaiser hospitals with open maternity units in our 24-county service area. Now, there are 24 hospitals without maternity services across rural Northern California.

Last spring, Advancing Health in Rural California [published a research paper](#) by Harvard MPH student Sara Howard, describing the underlying drivers of the steadily worsening maternity care access crisis in rural California:

1. Birth volume has decreased by 20% in the past decade, which has cascading impacts on financing and operations for hospitals providing obstetric (OB) services.
2. Financial stability of rural hospitals is decreasing due to a variety of factors besides OB volume.
3. A trend toward RN training programs that focus on specialized care limits the foundation of cross-training experiences, which subsequently limits nurses' abilities to pivot into OB care when needed.
4. Regulatory barriers prevent flexibility in staffing models that could optimize the capacity for low volume rural hospitals to meet the local service needs
5. Statutory regulations on Alternative Birthing Centers prevent most of these centers from billing Medi-Cal, and consequently they are unable to serve the Medi-Cal population.
6. A pervasive shortage of trained maternity care providers, especially obstetrician-gynecologists (OB/GYNs), midwives, family physicians who do obstetrics (FP-OBs).

In Partnership's service area, 40% of births are covered by Medi-Cal. This rate grows to over 60% in smaller and rural counties. Partnership has a responsibility to participate in and lead actions that address this issue and help ensure our members receive the care they need.

Partnership has a wide range of working relationships with a diverse group of stakeholders whose collaboration can drive policy change and local initiatives to meet the maternity care needs of rural communities. The stakeholders include: county and state public health entities, hospitals, health centers, tribal health centers, Department of Health Care Services (DHCS) and our government regulators, elected government representatives, community-based organizations, the mental health delivery system, the trade organizations serving hospitals, health centers and Tribal health, and public-school systems.

Partnership holds a unique position to address complex, multi-faceted challenges like OB access and quality, with multiple interventions and projects across different domains, all working towards a common goal. Over the years, Partnership has had a key role of cross-sector collaboration and innovation to enact change, in order to improve health outcomes of the communities we serve. Our experiences in addressing opioid overuse, palliative care, substance use disorder treatment, transportation, pay for performance, social determinants of health, complex care management, and more, can be leveraged to address the large and complex maternal health problems in our service area.

Expanding access to safe and high-quality obstetrical care aligns with Partnership's mission: to help our members, and the communities we serve, be healthy. Safe, accessible, local maternity care serves the entire community. Building key local and regional partnerships improves both the quality of care and member satisfaction. These are foundational components of Partnership's strategic plan.

Improving access to high-quality maternity services in our service area requires a portfolio of synergistic interventions in these broad categories:

1. Policy changes: governmental, health plan, and local health systems
2. Educational programs that optimize local health care workforce capacity
3. Adjustment of reimbursement models to support diverse settings of care
4. Deepening community partnerships that reinforce collaboration
5. Better data collection and analysis to guide thoughtful decision making

Much has been accomplished in the two years since Partnership's focus on obstetrical access and quality began. This article summarizes key developments and activities, so our partners can see how they all fit together.

## Policy Activities

**CMA House of Delegates:** Thanks to the efforts of the medical societies representing rural Northern California, the 2024 House of Delegates of the California Medical Association focused on two major policy issues: rural health equity and access to quality obstetrical services. The final list of [19 recommendations](#) can be found on the CMA website.

There was general support for activities to support the rural health care delivery system and to improve rural OB access. Nonetheless, statements from some urban based physicians on the floor of the House of Delegates illustrated the lack of understanding of rural health care delivery systems, including the role of family physicians in providing obstetrical services in rural areas.

While strong evidence across several countries shows that closing hospital maternity units in rural hospitals increases adverse neonatal outcomes, some urban-based medical leaders and policy makers express ambivalence to

closure of rural OB units, believing that the safest place to deliver any baby is at a larger volume facility. The reality of long distances in rural areas and the effect of inclement weather on transportation may not be fully appreciated by urban-based physicians and policymakers. This is an important opportunity for medical societies in rural areas to speak up on issues affecting rural health care.

## **State Regulatory Activities**

In February 2025, DHCS unveiled their “Birthing Care Pathway” framework, which lists several current and proposed interventions to improve quality and access to high quality OB services. One new activity to note is that dyadic services (mental health services provided to both the mother and baby/infant) are a reimbursable fee-for-service in all primary care settings, including health centers.

Also in the beginning of the year, DHCS was awarded a 10-year federal grant to reduce maternal mortality and improve health outcomes in several San Joaquin valley counties. The initiative, called “Transforming Maternal Health” will test the hypothesis that maternal outcomes can be dramatically improved with a new payment model that pays for quality outcomes instead of services provided.

## **Partnership Activities**

### **Provider Recruitment**

In late 2024, a survey of the Partnership network found that 33% of all positions for maternity care providers (including physicians, midwives, and nurse practitioners) are currently vacant and under active recruitment. This is higher than the vacancy rate for primary care in general, which is 26%. A vacancy is defined as a job opening in which active recruitment is underway, with exam room capacity and funding available to pay the clinician, if one is found.

Maternity care providers are eligible for Partnership’s recruitment incentive program. During 2024, three obstetrician/gynecologists, two family physicians with a focus on obstetrics, seven midwives/nurse practitioners, and two women’s health physician assistants (a total of 14 individuals) received signing bonuses.

While Partnership supports efforts to integrate midwives into hospital and community-based care for Medi-Cal members, midwifery workforce development efforts are stymied by external factors. Unfortunately, one of the two California training programs for nurse midwives (UC San Francisco) converted its program from a master’s program into a doctorate program (a longer, more expensive training program) and paused admission of new students for a year to prepare for the transition. This will lead to a decrease in new nurse midwives who complete training in California in the next few years.

The only remaining nurse midwife master's program is at California State University, Fullerton. Advocacy that reinforces existing training programs and expands training for midwifery and other obstetrics providers is vitally needed in California to meet the workforce needs of our communities.

### **Rural Nursing Education**

In the summer of 2024, Christi Myers, the director of the registered nurse training program at Lassen College, highlighted the way that the program provides a well-rounded, hands-on training experience for registered nurses. Graduates of the program can practice in multiple hospital settings in rural hospitals. She presented this program at Partnership's annual Hospital Quality Symposium in August. Meyers stated that a close partnership between Lassen College and nearby Banner Lassen Hospital was a key to the strength of the program. Another highlight is a high-quality simulation lab for teaching hands-on skills using mannequins before trying them on patients. Partnership hopes that RN training programs in other rural community colleges will collaborate with nearby rural hospitals with the same goal: to produce well-trained nurses who are able to work in multiple settings in the hospital.

Several other community colleges in the Partnership region are working to develop such programs. Support by local medical societies and hospitals will be key.

### **Building Skills and Teamwork to Provide Safe OB and Newborn Care in Rural Areas**

Partnership has identified three training programs related to obstetrical/newborn care, which are rarely available but important to be accessible in rural areas: Advanced Life Support in Obstetrics, Basic Life Support in Obstetrics, and custom neonatal airway training.

Advanced Life Support in Obstetrics (ALSO), developed by the American Academy of Family Physicians, is taught around the world. This intensive course offers teams actively providing obstetrical care the current knowledge and skills for managing obstetrical emergencies, including hands-on practice of manual skills that are needed in obstetrical emergencies, such as shoulder dystocia, vaginal breech delivery, and post-partum hemorrhage. The target audience is family physicians that provide active OB services, nurse midwives, licensed midwives, as well as nurses who work in a labor and delivery setting. This is a 6 to 10 hour online training is followed by 7.5 hours of in-person training. Inviting any local OB/GYNs to participate can build team communication skills and is encouraged.

Basic Life Support in Obstetrics (BLSO) is a variation of ALSO that targets first responders, doulas, physicians, and nurses that practice in the emergency department or outpatient setting. These individuals may be the only medical personnel available to assist with delivery in rural areas. The training includes material covering normal delivery and routine newborn care, as well as the basics of managing uncommon obstetrical emergencies. This is a 4 to 8 hour

online training followed by 7.5 hours of in-person training. The focus of the practice sessions can be adapted to meet the specific scope of the trainees.

Neonatal Airway Training is a custom advanced training for pediatricians, family physicians, emergency physicians, respiratory therapists, and inpatient pediatric physician assistants/nurse practitioners. This training builds on the foundations of the Neonatal Resuscitation Program (widely available) and includes hands-on practice mastering complex neonatal airway challenges that can be encountered in term and premature infants. The training focuses on using bag-valve mask, laryngeal mask airway, and video-enabled laryngoscopes. The training lasts about 2.5 hours. Partnership provides the hospital with a state-of-the-art video laryngoscope and includes a supply of disposable laryngoscope blades.

Partnership offers all three training programs in our rural service area, training physicians, midwives, doulas, nurse practitioners, and respiratory therapists. If you are interested in scheduling a training course in your community or hospital, please reach out to your local Partnership Regional Medical Director to be connected to our training coordinator.

### **Support for Doulas**

Doula services became a Medi-Cal benefit in January 2023, with the number of contracted doulas in our region growing steadily. Doulas provide support and education for those who are to give birth. These services are especially important for pregnant individuals without their own support system or who need extra advocacy to gently assure that patient-doctor communication is optimized. Studies show that birthing persons from the vulnerable population (groups with higher rates of maternal mortality and serious maternal morbidity) who have doula care have better outcomes than those without doulas. Partnership aims to provide doula access for our perinatal members in each of the 24 counties we serve.

Partnership has three parallel strategies to develop a robust doula network: contracting with existing trained doulas, enhancing the integration of high-quality doula care into maternity care teams, and supporting efforts to train new doulas.

To connect with currently practicing doulas, Partnership staff reach out to individual doulas and doula groups to schedule information meetings that introduce the doulas to Partnership, the doula benefit, and other perinatal services offered by Partnership. These sessions provide a step-by-step overview of the process to contract and credential with Partnership. To expedite the enrollment process in the Medi-Cal system to onboarding doulas, the application for contracting and credentialing are processed simultaneously within Partnership.

Once contracting and credentialing are complete, Partnership schedules monthly trainings for doulas to learn about Partnership benefits and how to submit a claim. The Partnership Claims team works closely with newly

contracted doulas to facilitate timely and smooth claims and reimbursement processing.

In addition to direct outreach to doulas, we partner with community-based organizations, public health departments, clinical practices and hospitals to share information regarding the doula benefit. Partnership has sponsored informational doula gatherings and doula trainings on different clinical topics. Since Medi-Cal coverage of doula services is new, both Medi-Cal beneficiaries and hospitals/maternity care professionals are learning how doulas fit into the birthing care team. Partnership provides educational awareness activities directed at members, hospitals, and maternity care teams and collaborates with several county-based organizations to recruit and train new doulas.

### **Tribal Perinatal Support**

Maternal and neonatal outcomes for American Indians in California are worse than outcomes for other ethnic groups. Partnership members who identify as single-race American Indians are more likely to reside in rural areas. Many reside in remote frontier areas with limited access to health care services. The closure of obstetrical units in many rural hospitals especially impacts our Tribal communities.

The Partnership service area includes 21 Tribal Health Clinics serving 51 federally recognized Tribes, more than any other managed care plan in California. Tribal health leaders and clinicians serve on Partnership's Board of Commissioners, Physician Advisory Committee, Quality Utilization Advisory Committee, and Community Advisory Committee.

As part Partnership's CalAIM portfolio, we launched a Tribal Perinatal Initiative, which provides grants to Enhanced Care Management (ECM) programs to support the case management needs of pregnant and post-partum Tribal members living in our service area. Major activities include grants to start new ECM programs with a focus on Tribal health and wellness, educational offerings targeting community health workers and case managers, and supporting local community collaboratives that connect Tribal members and hospitals to build a more responsive, understanding, and welcoming health system for Tribal members who are pregnant. Many Tribal health centers are participating, but the work has only just begun.

### **Quality Improvement Activities**

Partnership's pay-for-performance programs that focus on prenatal and post-partum care quality are the longest standing and most effective perinatal incentive programs in California.

Until recently, the reimbursement rates for non-Health Center maternity care have been far below rates in Federally Qualified Health Centers, rural health centers, and Tribal health centers, which are reimbursed with different mechanisms. Matching a trend seen in primary care services in the Partnership

region, most prenatal and post-partum care has migrated to Federally Qualified Health Centers.

Partnership's Perinatal Quality Incentive Program (Perinatal QIP) incentivizes timely prenatal care, depression screening, vaccinations recommended in pregnancy, timely post-partum visits, and electronic clinical data exchange systems. Perinatal QIP staff visit prenatal practices regularly to provide individual feedback and information on perinatal programs and improvement activities. Educational content for perinatal providers includes in-person, real-time webinar, recorded webinar, and written materials, available on the Partnership website.

In addition, Partnership's Hospital Quality Incentive program (HQIP) includes many hospital quality metrics related to maternity and newborn care. A new measure incentivizes hospitals to implement or continue to include family physicians and midwives into the medical staff. A diverse medical staff model leads to a more sustainable workforce and allows community members more options in their care providers. As a result of these robust efforts, perinatal quality measures are among the highest performing in California.

### **Introducing Partnership HealthPlan Perinatal Services (PHPS)**

Over the last several years, the California Department of Public Health has pulled back from overseeing the California Perinatal Services Program (CPSP). As a result in 2024, with significant input from our provider network, Partnership launched Partnership HealthPlan Perinatal Services (PHPS). This is an updated, nimble version of the CPSP program, that builds on the core strengths inherent to CPSP, while adding flexibility to expand access to perinatal services.

Building a stable, modern perinatal case management system offers a platform for high quality and optimal maternal care outcomes. Key changes include telehealth services for health education/case management, nutrition, behavioral health and medical care. We have expanded the types of eligible providers and are building the network of participating providers for services that are difficult to access, such as nutrition.

We are rolling out PHPS to the network, with perinatal provider meetings, review of applications, and updating our site review process. After this phase is complete, we will be aiming to fill network gaps for perinatal case management and setting up the infrastructure for ongoing enhancement of quality of care provided by the network.

### **Future Activities**

Stabilizing access and quality of obstetrical services is a major strategic initiative of Partnership, as is evident from the host of high-impact activities noted above. While some great groundwork has been laid, much remains to be done on these projects.

We are committed to working with our partners to create new solutions and fortifying and spreading current successful practices to build safer, accessible maternal care services across Northern California.

## Rural Health Policy

### Inequitable Policies for Rural Californians: Structural Urbanism

Between 85-95% (depends on definition used) of all Californians live in an urban or suburban setting, including individuals who develop the regulations in various state departments, so much of the legislation and policy in California is written with an urban or suburban point of view. Inequitable health outcomes associated with rural residence are currently of equal or greater magnitude than ethnicity-associated inequities. Although poverty exists in both cities and rural areas, a higher-density of clinicians, patients, and support services provide urban/suburban areas with more governmental and community resources and funding to help address underlying economic drivers of inequitable health outcomes.

Health policies and funding streams written to apply to both urban and rural areas of California are often written to be not implementable in rural areas, leading to exacerbation of rural inequities. Health outcomes of American Indians in rural California have the highest rates of inequity, so that any policy that is inequitable from a rural perspective, is also inequitable from a California Indian perspective, with an effect that multiplies their historic trauma and discriminatory policies.

Health-related policies that systematically, if unintentionally, disadvantage residents and health care providers in rural areas are a reflection of “Structural Urbanism,” which lead to poorer health outcomes.

Just as intentionality and awareness of implicit bias is needed to address Structural Racism, so too is intentional policy analysis needed to ensure that health policy and regulations are not perpetuating inequities for rural Californians, including Native Americans.

### Key Framing Messages for Rural Health

1. People living in rural areas deserve high quality health care and good health outcomes.
2. In rural areas and frontier areas, Medicaid patients get services from the same providers as everyone else. Access and quality of care for everyone living there is the goal.
3. The needs of people in frontier areas are very different from those in cities with surrounding rural areas (like Redding and Eureka and Chico).

4. Policy-makers from urban areas/backgrounds often have implicit bias against those living in rural areas, leading to discrimination and structural inequities, sometimes called Structural Urbanism. Some aspects of this
  - a. Statewide policies that work in urban settings but not rural or small county settings
  - b. Not getting input of stakeholders from rural areas in the policy-making process.
  - c. Lack of awareness of the sociodemographic differences of populations outside urban and suburban areas.
5. In just about all areas of the health care delivery system, the relatively low volume of services means that fixed costs per services are higher than in urban areas. Thus, equal payments for the same service are inherently inequitable, whether these assumptions are at the federal, state or local level.

#### Actions to address Structural Urbanism in health care

1. Join and be active in advocacy groups that represent organized health care professionals and organizations. For physicians, it is essential that state-wide organizations, like the California Medical Association consider and account for a Rural Health perspective as part of their legislative and regulatory advocacy activities. The same is true for organized nursing, physician assistants, midwives, hospital associations, etc.
2. Work with your local legislators to support specific State legislation requiring the following:
  - a. As State departments develop regulation, a rural analysis must be performed that identifies any challenges in applying the policy equally and equitably in rural communities. This analysis should include direct feedback from key advisors and associations that represent rural communities.
  - b. If a challenge affecting rural application is identified, the policy shall be amended to equitably impact rural areas, with accommodations in regulations and requirements that remedy these challenges. When necessary, this may include a higher level of funding for rural areas compared to urban areas so that the policy can be applied equitably.
  - c. The documentation of each policy that is promulgated attests that the above process has been followed.

#### Rural Health was Focus of 2024 CMA House of Delegates

The California Medical Association's 2024 House of Delegates made 14 recommendations related to rural health (see below). Notably missing was a recommendation to create a new rural health section or other grouping of

rural physicians to directly advise the Board of Trustees. There was notable support for this idea, and further advocacy is warranted. Nonetheless, in an organization dominated by urban and suburban physician members, the passage of the 14 recommendations demonstrates a dedication to supporting physicians practicing in rural areas.

## Partnership Policy Reminders

### 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
6. A report of discriminatory practices. Partnership is required to review grievances related to discrimination to consider if the member was treated differently due to race/ethnicity, language, sexual orientation, gender or disability status. In cases of grievances in which the information available shows that discrimination was likely to have occurred, Partnership will send a letter to the practice/provider and also must report this to DHCS.

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.

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 any provider or facility caring for a Partnership member and makes recommendations for opportunities for improvement and/or corrective action plans. The definition and description of Corrective Action Plan (CAP) was recently redefined for clarity: "A CAP is a directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. 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 Health Plan external website->Providers->Quality & Performance Improvement->Patient Safety-Potential Quality Issues
2. You can email [PQI@Partnershiphp.org](mailto:PQI@Partnershiphp.org). Remember to encrypt any patient identifying information you send by email.

#### **What's "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. Pharmaceuticals 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.

## 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:

<http://Partnershipphp.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 [rmoores@Partnershipphp.org](mailto:rmoores@Partnershipphp.org) or Sarah Browning at [sbrowning@Partnershipphp.org](mailto:sbrowning@Partnershipphp.org) or have them [subscribe](#) at <http://eepurl.com/gjHOxb>.

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

## Benefits Updates for Partnership Members

### 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. The link to the download of the Excel spreadsheet with the 34 different BP monitor options is [here](#).

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 Medi-Cal Rx at (800) 977-2273.

### Medical Equipment Distribution Program

The Partnership's Medical Equipment Distribution Services (PMEDS) program was developed in response to COVID-19, starting as a pilot to offer providers access to medical devices that could be used to treat and care for patients while they remained at home. The program initially included blood pressure monitors, oximeters, and thermometers. Over the past few years, the program has grown to include over a dozen devices. In general, these are items that are covered by Medi-Cal and/or Partnership, but which are relatively inexpensive and therefore with low profit margins leading to lack of access to these devices from contracted, storefront medical equipment vendors and pharmacies.

Providers contracted with Partnership can request equipment from the PMEDS program without the need of a TAR, pharmacy fulfillment, or any cost to the

member. The ordering clinician simply completes the [request form](#) by providing some basic member demographic information, equipment selection(s), diagnosis code(s), and clinic contact information, then fax or securely email the form to us. Requests can be submitted 24 hours a day, 7 days a week. Orders received by 3 p.m. on a business day are processed that same business day and ship the following business day via USPS Certified Mail. Equipment is typically received by the member within 5-7 days of the date the request was submitted for processing. [Program Guidelines](#) are found on the Partnership website.

**Equipment available includes:**

<b>Blood Pressure Monitors and Accessories</b>	
Blood Pressure Monitor (with medium cuff)	Small Cuff
Talking Blood Pressure Monitor (for low vision members)	Large Cuff
	Extra-Large Cuff
<b>Scales</b>	
Digital smart scale (max weight 330 pounds)	Smart baby scale (infant must be under 40 pounds)
Heavy duty smart scale (330 to 550 pounds)	Talking Digital Scale (for low vision members)
<b>Respiratory-Related</b>	
Pulse oximeter Nebulizer (plug-in electric)	Adult replacement nebulizer mask and tubing kit
Warm Steam Vaporizer	Pediatric replacement nebulizer mask and tubing kit
Cool Mist Humidifier	Portable Nebulizer (for unhoused members)
<b>Other items</b>	
Digital Thermometer	Safer Lock Medication Lock Box
Enuresis Alarm	

Partnership is committed to ensuring our members have access to these small personal medical devices. Every effort is made to process request quickly and accurately. We thank the providers that participate and submit request on behalf of their Partnership members. If you have any questions, please reach out to the PMEDS team at [request@partnershiphp.org](mailto:request@partnershiphp.org).

## 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, Social Workers, Health Care Guides, and Behavioral Health Clinical 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 from high-risk populations that transition from one care setting to another, have multiple unmanaged complex conditions, and/or for those who have difficulty navigating the health care 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:

**Southern Region Office**

Fairfield, CA

[CCHelpDeskSR@partnershiphp.org](mailto:CCHelpDeskSR@partnershiphp.org)

**Northern Region Office**

Redding, CA

[CCHelpDeskNR@partnershiphp.org](mailto:CCHelpDeskNR@partnershiphp.org)

**Eastern Region Office**

[CCHelpDeskEA@partnershiphp.org](mailto:CCHelpDeskEA@partnershiphp.org)

## 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.

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 patients' health declines, they may become eligible for the more comprehensive Hospice benefit. Other types of palliative care are also covered: primary palliative care covered as a routine part of primary care, and episodic specialty palliative care (fee for service).

Palliative care local in-person resources vary by county. Here is the contact information for current and pending Intensive Outpatient Palliative Care programs.

<b>Counties Served</b>	<b>Organization</b>	<b>Referrals (if contracted)</b>
Del Norte, Humboldt, Lassen, Modoc, Placer County (Roseville area), Plumas, Sierra, Siskiyou, Shasta, Solano, Trinity, Tehama, Sutter, Yuba	Vynca/Resolution Care	Phone: 707-442-5683
Butte, Glenn	Adobe Ca Medical Group	Phone: 1-877-633-9331
Butte (Chico area)	Butte Home Care and Hospice	Phone: 530-895-0462
Colusa, Yolo	Yolo Care	Phone: 530-758-5566
Humboldt	Hospice of Humboldt	Phone: 707-267-9880
Lake	Hospice Services of Lake County	Phone: 707-263-6270 ext. 140
Mendocino	Madrone Care Network	Phone: 707-380-5080
Napa, Sonoma, Solano (Vallejo)	Providence Palliative Care Napa Valley	Phone: 707-258-9080
Marin, Sonoma	By the Bay Health	Phone: 415-444-9210
Marin	MarinHealth Medical Network	Pending
Sonoma	St. Joseph Home Care Network	Phone: 707-522-4307
Nevada and Placer (Grass Valley, Nevada City, Auburn)	Foothills Compassionate Care	Phone: 530-272-5739
Nevada and Placer (Truckee and North Lake Tahoe)	Tahoe Forest Hospice (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

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. Importantly, members who drive themselves or own cars are not eligible.

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.

**Members** may request transportation by calling our toll-free number for Transportation Services, **(866) 828-2303**.

If you as a **provider** are encountering problems or challenges, you can reach us by phone at **(866) 828-2303** (option 3), or by email [transportationhelpdesk@Partnershiphp.org](mailto: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:

- Member reimbursements for travel expenses such as lodging, meals, parking and tolls
- Driver reimbursements for gas mileage reimbursement (GMR)
  - Driver/Payee credentials are managed in the software
  - Must supply current driver's license, registration, insurance and proof of attendance on facility letterhead (we also match trips to medical claims in lieu of proof of attendance documents)
  - Members cannot be reimbursed directly and GMR is intended for transport via a private vehicle (Taxi rides, including Lyft and Uber, do not qualify for GMR)
- Taxi transportation (including Lyft)
- Wheelchair, Gurney/Litter, Ambulance or Air ambulance
  - These options require a Provider Certification Statement (PCS)

- The PCS must be signed by the physician overseeing care and be fully completed
- A copy of our PCS can be requested via email at [transportationhelpdesk@Partnershiphp.org](mailto:transportationhelpdesk@Partnershiphp.org)

## Diabetes Education and Nutrition Counseling

Diabetes education and nutrition counselling are important components of diabetes care that give 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.

Patients with diabetes require these services to receive the support needed and gather knowledge that improve decision-making for diabetes self-care. 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. A new telemedicine nutrition vendor, *FoodSmart* will be contracted soon. 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.

For health centers (FQHCs, RHCs, and Tribal Health Centers), registered dietitians are covered by the CPSP program, and payable under the all-inclusive (PPS or OMB) rate.

## Behavioral Health

### Follow Up Visits for Patients Seen at ED's with Mental Health or Substance Use Diagnoses

Partnership encourages PCPs to communicate on a regular basis with local ED's to support well-coordinated transitions of care and post-ED follow up care for all members.

PCPs should follow up with all assigned members who were seen in an ED with a Mental Health or Substance Use Diagnosis within 7 days of their ED event. Please schedule these members with appropriate follow-up services with a clinician who can address their mental health or substance use treatment needs. It is important to code these visits appropriately on claims and encounters, using a mental health or substance use diagnosis aligned with their ED event, so that your work can be counted towards NCQA and DHCS behavioral health quality measures reported by Partnership and County Departments of Behavioral Health.

Many EHR's now include real-time Admission, Discharge, and Transfer (ADT) feeds which makes it possible for PCP's to monitor their assigned members' ED events and follow up in a timely manner. The Compass Rose module in Epic OCHIN is an example of this tool in an EHR. ADT feeds also include up-to-date contact information for members seen at the ED, which can streamline contacting for follow-up care.

### Mild to Moderate Mental Health: Carelon Behavioral Health

Partnership contracts with a third party Mental Health administrator, Carelon Behavioral Health, to help manage mental health benefits for Partnership Medical 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.

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. 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](#).

### 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.

### 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 remain the only managed care plan in California to administer 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.x for Medication Assisted Therapy for Opioid Use Disorder
- F10. x for Medication Assisted Therapy for Alcohol Use Disorder

## 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](mailto:ED_Collab@Partnershiphp.org). Partnership will review the form and work with you to identify possible options.

## Supporting Behavioral Health Needs in Children

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](#)

## Online Behavioral Health Resources for Caregivers and Youth

Free Online Behavioral Health Resources for Caregivers and Youth are now available through the state's Children and Youth Behavioral Health Initiative (CYBHI).

**BrightLife Kids** (<https://www.hellobrightline.com/ca-families/>) - provides free behavioral health coaching to all California kids ages 0–12.

- No costs attached
- No insurance required
- No referrals needed
- Video or chat-based
- 1:1 coaching (diverse, bilingual coaches)
- On-demand digital tools
- Care Guides to manage complex needs and provide referrals

**Soluna** (<https://solunaapp.com>) - is the all-in-one mental health app for California youth and young adults to de-stress, reset, and seek support.

- Always free
- Always anonymous

- Scheduled or drop-in 1:1 coaching (diverse, bilingual coaches)
- Interactive and engaging tools • Moderated community forum, self-support guides, and articles

## 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 through 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 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.brighthousehealth.com/contact-us/>

After intake documentation is completed 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.

## 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)
- Non-custom compression garments

### 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)

## Medi-Cal Benefits: Recent Changes

### 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).

### Genetic Testing for Pregnant People: What is covered?

Over the last few decades, antenatal testing for genetic disorders has grown from screening for Down syndrome (introduced in 1986) to screening for a variety of disorders. For our members, some are covered by DHCS, some are covered by Partnership, and others are not covered by either. State policy documents related to prenatal diagnosis are unclear in certain aspects. Here are some hints for sorting this out:

#### Universal Screening of Pregnant Persons:

(Lab bills DHCS, not Partnership)

By California law, every prenatal provider must offer every pregnant patient

before 21 weeks gestation the option of participating in the California Prenatal Genetic Testing Program. This program covers screening tests, as well as counselling and follow-up studies if the screening test is positive. There is a specific “California Prenatal Screening Program Patient Booklet” that should be given to every pregnant patient to assist with their choice, as this booklet contains the privacy statement related to the test and a consent form, which must be brought to the lab that is drawing the test with the lab order (see below).

With appropriate counselling, most pregnant MediCal patients will accept prenatal testing. It is incorrect for providers to counsel patients to only do prenatal tests if they would consider getting an abortion if a genetic abnormality is encountered.

Routinely covered by the state prenatal screening program (detailed regulation can be found [here](#)).

- a. Maternal Serum Alpha-fetoprotein MSAFP screening
  - i. These test for Trisomy 21, Trisomy 18, Trisomy 13, Neural tube defects
  - ii. Fetal translucency (ultrasound) in first trimester
- b. Cell-free DNA (cfDNA) screening **CPT Code 81420**, Includes:
  - i. Trisomy 21, Trisomy 18, Trisomy 13
  - ii. Sex chromosome aneuploidies: Turner syndrome (XO), Klinefelter syndrome (XXY), Trisomy X, XYY.
- c. If screening positive, covers amniocentesis or CVS procedure and resulting lab tests.

Additional notes on these tests:

- a. Maternal Serum Alpha-fetoprotein MSAFP screening must be ordered with state-required on-line requisition form/consent; do NOT just order an Alpha Feto Protein (AFP) from your local lab; it is the wrong test. The MSAFP is ordered via an on line form (Cal Genetics portal) (takes 10 minutes for staff to fill out), then the form needs to be printed out form on special paper with bar codes, and handed to patient to bring to lab. We recommend against giving the form to the patient too early, as may lose the form or the test may be drawn too early. Thus, you will need a process to not miss the window 15-21 weeks. Results of the MSAFP are mailed; abnormal results are followed up with a phone call within a week.

An electronic interface option is available with your electronic health record. You will need to apply to the CDPH-Prenatal Screening Program to get the process rolling. [pns@cdph.ca.gov](mailto:pns@cdph.ca.gov)

Fetal translucency (ultrasound) in first trimester is covered, but in

reality, but with the cell-free DNA as a backup to the SMAFP, if the two tests are normal then the first trimester ultrasound is primarily used for dating; there isn't much additional sensitivity gained by doing the fetal translucency. Later a 20 week ultrasound screening for anomalies is standard of care.

Cell-free DNA (cfDNA) screening **CPT Code 81420, no TAR required (ordered through Quest, or drawn by any lab and sent to Quest or Natera; NOT Lab Corps). Can be ordered through portal in the process above.**

There are a few special cases in which a specific cfDNA test is recommended as summarized in this chart:

## Singleton vs Twins Screenability Guide

	Singleton		Twins	
<b>Ovum Donor = No</b>	<b><u>Trisomies</u></b>	All labs - YES	<b><u>Trisomies</u></b>	Quest & Natera - YES Revy - NO
	<b><u>SCAs</u></b>	All labs - YES	<b><u>SCAs</u></b>	Quest and Revity – NO and will show on mailer as “Not Reportable”  Natera – YES if Monozygotic. NO if Dizygotic and will show on mailer as “Not Reportable”
<b>Ovum Donor = Yes</b>	<b><u>Trisomies</u></b>	All labs - YES	<b><u>Trisomies</u></b>	Quest – YES Natera & Revity – NO
	<b><u>SCAs</u></b>	All labs - YES	<b><u>SCAs</u></b>	All labs – NO and will show on mailer as “Not Reportable”

**Last updated 5/6/2024**

### Other reasons patients cannot have cfDNA

- Malignancies
- Organ transplant
- Bone Marrow Transplant
- Triplets
- Any type of failed pregnancy (with a current viable fetus)—blighted ovum, vanishing twin, empty sac, twin demise.

Note- A patient with a known SCA is eligible for screening; however, there would be a higher rate of “inconclusive” results because it is unclear how to distinguish if the SCA is of maternal or fetal origin.

In some cases, a different cfDNA test can be ordered directly from a lab that carries these tests, instead of the tests that are part of the state Genetic Screening program

1. triplet pregnancies
2. mosaic aneuploidies

For advice on what test to order in these circumstances, we recommend you consult a skilled, state-certified genetic counsellor.

The lab will bill Partnership with the same 81420 code if this is required (no TAR is required, but overuse of commercial 81420 may trigger an audit of the ordering provider. Using a commercial cfDNA as a routine screening test or as a diagnostic test, reserving the Prenatal Screening Program for those who test positive but the financial viability of the Prenatal Screening Program at risk.

Coming changes: In the spring of 2025, ACOG is expected to recommend adding DeGeorge syndrome to the recommended group of disorders screened for with cfDNA. CDPH and DHCS are expected to promptly make this addition to the state Prenatal Screening Program.

State Genetic Counselling Program. Patients with complex genetic histories or family histories of disorders should be seen by a Licensed, Certified Genetic Counsellor under the state prenatal diagnosis program. If they recommend specific testing that is not normally covered by DHCS or Partnership, they will assist with the prior authorization request process to facilitate approval by Partnership.

**Partnership Covered Prenatal Genetic Tests:** The four most common recessive carrier traits are covered without a TAR. Because there are several tests that sound similar, it is easy to accidentally order a test that is not covered. Here is a list, with the correct codes:

1. Cystic Fibrosis (CF) Screening: The correct code for screening for CF carrier status in a person with no known history of CF or family history of CF is **81220**, which screens for the most common variants. If there is a known family history of CF or a personal history, one of three different codes would be appropriate (81221, 81222, 81223), depending on the scenarios (consulting a genetic counsellor is recommended).
2. Spinal Muscular Atrophy (SMA) Screening: The correct code for screening for SMA carrier status in a person with no known history or family history is **81329**. If there is a known family history of SMA or a personal history of SMA, one of two different codes would be appropriate (81336 and 81337), depending on the scenario (consulting a genetic counsellor is recommended).
3. Hemoglobinopathy screening (for sickle cell trait and thalassemia): For diseases of the alpha subunit of hemoglobin gene (alpha thalassemia), use **81257**. For diseases of the beta subunit of the hemoglobin gene (sickle cell trait or beta thalassemia), use **81361**.

4. Fragile X syndrome has some phenotypic symptoms, like mental delay, mental impairment, autism, or tremor/ataxia. Anecdotally, the rate is higher in sex workers and those who are incarcerated, associated with the underlying mental impairment. Unlike other genetic disorders, in which a specific base pair mutation is tested for, the test for fragile X is more specialized and more expensive (the CPT code which Partnership accepts without a TAR to test phenotypically abnormal individuals for Fragile X syndrome is **81243**). According to ACOG, testing for fragile X should only be considered if there is a known family history of fragile X syndrome, or if the patient has an underlying neuropsychiatric disorder has been fully evaluated by a neurologist or other specialist with experience in neuropsychiatric evaluations. A blood test for Fragile X is a once in a lifetime test, and considering that the patient has intellectual impairment, they often don't know if they have been tested before. Previous medical records should be requested and reviewed if the patient or relative has care for their condition by another provider. State genetic counselors can assist with the decision making and if consulted they can order the Fragile X test.

Not covered by Partnership:

1. Other tests for autosomal recessive genes: Some lab vendors are recommending a broader screening of pregnant patients, covering a host of rarer recessive traits. There are a number of codes for these. They are currently NOT covered by Partnership or MediCal. There are some CPT codes for panels with many recessive traits, (**81443** for a very comprehensive screen and **81412** for Ashkenazi Jewish disorder analysis), but neither is covered by MediCal, and the price for 81443 is about \$2500, getting close to the price for a whole genome sequence! There are other fishing expedition tests: **81349**, **81228**, **81229**, "genome-wide analysis for constitutional chromosomal abnormalities"; none are covered by MediCal.

2. Tay Sachs disease is more common in these of Ashkenazi Jewish or French Canadian/Creole origin. Screening for Tay Sachs or other Ashkenazi Jewish disorders are not covered by Partnership or Medi-Cal, so a patient with a risk factor **should be seen by a state genetic counsellor first to fully assess the risk and for them to make a recommendation** for consideration of an exception, to cover the test although not ordinarily covered. Potential tests they might order include: 1. **81255**: for Tay Sachs itself; 2. **81412** for Ashkenazi Jewish disorder Analysis, Medicare cost about \$2500; 3. **81443** the screening for over 100 recessive disorders, which does happen to include Tay Sachs and costs about \$2500 (interesting that the price is the same with so many more tests).

3. Paternity testing is also never covered by Medi-Cal or Partnership. There are two options for paternity testing: a blood test and an amniocentesis. A blood test using cell free fetal DNA from the mother can now be used as early as 10-12 weeks, comparing the nonsense chromosomal patterns to determine paternity testing; the cost is \$2000 (1-800-DNA center is one example). If an amniocentesis

sample is used (if the patient is getting an amniocentesis for another reason, and an extra sample is collected at the same time) the cost of the analysis is \$500. Again, the patient would be responsible for the cost of either test.

4. Test for mutations in the gene for Methyl Tetrahydrofolate Reductase (MTHFR). MTHFR gene analysis shows mutations in about 60% of the population (so really variations of normal), so is not particularly diagnostic. Medical geneticists never recommend this test for screening, and believe the psychiatrists who order the test do not understand the genetics of MTHFR tests.

Locations of Genetic Testing in Northern California: Kaiser, Sutter, UC Davis, Marwan Ali (Folsom), UCSF

## Partnership Updates

### Prior Authorization Changes for CT/MRI

Treatment authorization requests (TARs) are no longer required for certain radiologic studies:

**For adults aged 21 years and older:**

- No TARs are required for CT scans of extremities, head, neck, or spine, for CT angiograms, or for screening CT colonograms.
- TARs continue to be required for CT scans of the chest, abdomen, and/or pelvis.
- No TARs are required for other MRI scans of the extremities, head, neck, or spine, for MR elastography, or for breast MRIs.
- TARs continue to be required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis.

**For children aged 20 and younger:**

TARs continue to be required for all CT and MRI scans. No changes noted.

For a detailed list of codes covered by this change, please see the [important provider notice](#) on the Partnership website.

### Prior Authorization for PT, ST, and OT

No referral authorizations (RAFs) are required for Physical Therapy, Speech Therapy, or Occupational Therapy (PT, ST, and OT). However, a written order from the referring clinician is needed.

A therapist contracted with Partnership will not need to submit a prior treatment authorization (TAR) for members age 21 and over, for up to 12 visits in a rolling 12 month period. A TAR is required if more than 12 visits are requested, and

will be evaluated based on progress and potential for further improvement after the first 12 visits.

TARs are still required for therapy services for children (under age 21) and for services provided in the home.

## 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/Occupational Therapy/Speech 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
- Facility-based sleep studies
- Hospice and Palliative Care

## Pearls on Referrals

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.

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**. This is especially true for transplants. Adults needing tertiary care should be referred to any Sacramento Hospital including Sutter, Dignity, or UC Davis, to a San Francisco based hospital including UCSF or California Pacific Medical Center. Children may be referred to Shriner’s Hospital in Sacramento (for problems requiring specialized surgery), Children’s Hospital Oakland, UC Davis, Lucille Packard Children’s Hospital, or UCSF.

## 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 be 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. Which specialists want what type of review before referrals varies by community. Often these are communicated at Partnership-sponsored referral roundtables. Be sure your referral coordinator attends these (and potentially office manager and a clinician leader as well).
4. The medical director or CMO should make an effort to engage with specialists on referral appropriateness on a regular basis. Please let your Partnership Regional Medical Director know of any specific specialists or specialties which are a challenge in your area, so we can assist.
5. If you are able to secure a needed in-person specialty appointment further away from the patient's home, keep the transportation

benefit in mind to help the patient go to that appointment. Closer care or virtual care is preferred to seeing a specialist located far away, but that is sometimes the only option.

6. 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.

## Non-invasive Assessment for Liver Fibrosis:

While the definitive test for liver fibrosis is liver biopsy, these are uncomfortable, relatively expensive, and occasionally have serious complications. As a result, there are a number of algorithms for evaluating the likely severity of liver disease to predict who can be presumptively assumed to have minimal fibrosis or severe fibrosis, and who needs a biopsy to be sure. See the section of UpToDate "[Noninvasive assessment of hepatic fibrosis: Overview of serologic tests and imaging examinations](#)" for full details.

Who needs evaluation? Assessing level of fibrosis in patients with

- Chronic Hepatitis C
- Alcoholic Liver Disease
- Fatty Liver/Hepatic steatosis
- Other Liver Disease

The level of fibrosis determines best treatment options (like urgency for Hep C treatment), indicated surveillance (like for liver cancer), and prognosis.

The first step will generally be some sort of serologic test:

- Some level of abnormality of liver enzymes (AST, ALT, GTT) and liver biosynthesis (Platelets, Prothrombin time, Cholesterol level)
- Nonproprietary tests/panels: AST/Platelet Ratio, AST/ALT ratio, many others.
- Other (proprietary) serologic tests: FibroTest, Fibrosure, ActiTest.

Broadly, these tests will indicate one of the following:

- Probably no fibrosis
- Probably extensive fibrosis
- Intermediate result

These interpretations are then compared to the global clinical scenario to decide if a radiologic study would be helpful.

There are two types of radiologic studies to evaluate the level of fibrosis:

- Ultrasound-based tests, three variations, but generally use the term elastography and billed with code: 91200
- MRI-based test, called MR Elastography, billed with code 76391.

In both cases, special equipment is needed (a regular ultrasound machine or MRI scanner by itself cannot be used)

No prior authorization (TAR) is required for either test.

Within the hospitals contracted by Partnership, only a few offer either ultrasound-based elastography and/or MRI-based elastography. This list was confirmed a few months ago; please send us any updates you become aware of.

Bay Area Counties:

- Sutter Santa Rosa: (Sonoma) the outpatient imaging clinic only (not the hospital) for Fibroscan/Liver elastography
- Queen of the Valley Hospital (Napa): has ultrasound elastography only
- Sutter Davis (Yolo); has both ultrasound elastography and MRI elastography.
- Sutter Lakeside (Lake): has ultrasound elastography only

Northern Counties: the following two Oregon hospitals have ultrasound elastography:

- Asante in Medford, OR, for ultrasound elastography
- Asante in Grants Pass, OR, for ultrasound elastography
- Sky Lakes Medical Center in Klamath Falls, OR (unclear which)
- DDA/Enloe GI office in Chico for ultrasound elastography “referral for FibroScan”

Eastern Counties:

- Sutter Roseville (Placer County) has both ultrasound elastography and MRI elastography.
- Tahoe Forest (Nevada County): has ultrasound elastography only
- Rideout (Yuba County): has ultrasound elastography only

Tertiary Care Centers:

- UC Davis has both ultrasound elastography and MRI elastography.
- UCSF has both ultrasound elastography and MRI elastography.
- Mercy Sacramento: all Sacramento-based hospitals have ultrasound elastography; MRI elastography only at Elk Grove Location

## Electro-diagnostic Studies

Electro-diagnostic studies such as Electro-encephalograms (EEGs), Nerve Conduction Studies, and Electro-myelograms (EMGs) are important diagnostic tools for different neurologic and other conditions.

It is ideal to make a *referral* to a specialist that conducts the actual test, asking for evaluation of the patient with consideration of performing an electro-diagnostic test if indicated (such as a neurologist or physical medicine/rehab specialist, for example). This allows the specialist to also bill for and be paid for their expert evaluation of the patient, for the purposes of ordering the correct test.

If the actual *test* is ordered without the referral, an incorrect test for that patient's specific condition may be ordered. For example, a patient with fibromyalgia usually does not need an EMG for diagnosis. If the EMG is ordered without a specialist referral, the specialist doing the study might determine that the EMG is not needed, but have no mechanism for reimbursement given the lack of a RAF.

If an eConsult, curbside consult, or telemedicine specialist - such as a neurologist - confers on the case and requests an electro diagnostic test, there is not a need for a second referral, but the prior consultation should be noted for the benefit of the staff doing the test and the specialist interpreting the test.

Your local specialists (where available) may have different preferences; you may want to reach out to them to determine what they prefer and let your clinical staff know. For example, if your local neurologist has shared a protocol for criteria for ordering a nerve conduction study with your office, you may be able to order the test directly if you follow that protocol.

## Advance Directive Completion

Data source: CG-CAHPS supplemental Data, from 2023 survey (Legacy counties only)

County - Advanced Directive									
County	Q32 Did you fill out and sign an Advance Directive?			Q33 Did you talk about your <u>Advance Directive</u> with your medical decision maker or family?*			Q34 Did you give a copy of your <u>Advance Directive</u> to your doctor or your local hospital?*		
	Yes	No	Not Sure or Don't Remember	Yes	No	Not Sure or Don't Remember	Yes	No	Not Sure or Don't Remember
Del Norte	27.5%	58.0%	14.5%	63.2%	36.8%	0.0%	47.4%	31.6%	21.1%
Modoc	9.1%	81.8%	9.1%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%
Humboldt	13.3%	66.5%	20.2%	69.0%	27.6%	3.4%	64.3%	25.0%	10.7%
Marin	28.4%	54.2%	17.4%	52.3%	29.5%	18.2%	15.9%	61.4%	22.7%
Mendocino	8.3%	63.6%	28.1%	77.8%	0.0%	22.2%	33.3%	33.3%	33.3%
Trinity	21.6%	56.9%	21.6%	90.9%	0.0%	9.1%	90.9%	9.1%	0.0%
Yolo	22.6%	55.0%	22.4%	68.7%	13.1%	18.2%	38.4%	27.3%	34.3%
Napa	34.9%	45.6%	19.5%	80.4%	13.7%	5.9%	56.9%	35.3%	7.8%
Sonoma	26.3%	51.7%	22.0%	58.4%	28.0%	13.7%	30.7%	51.8%	17.5%
Siskiyou	26.7%	54.5%	18.8%	70.1%	27.8%	2.1%	55.6%	33.3%	11.1%
Lake	33.6%	52.7%	13.6%	62.9%	22.9%	14.3%	40.0%	34.3%	25.7%
Solano	25.1%	52.8%	22.1%	69.9%	21.3%	8.7%	55.7%	24.6%	19.7%
Lassen	18.2%	56.1%	25.7%	61.8%	27.6%	10.5%	65.7%	15.7%	18.6%
Shasta	23.8%	58.5%	17.7%	67.8%	20.0%	12.2%	51.3%	26.5%	22.2%

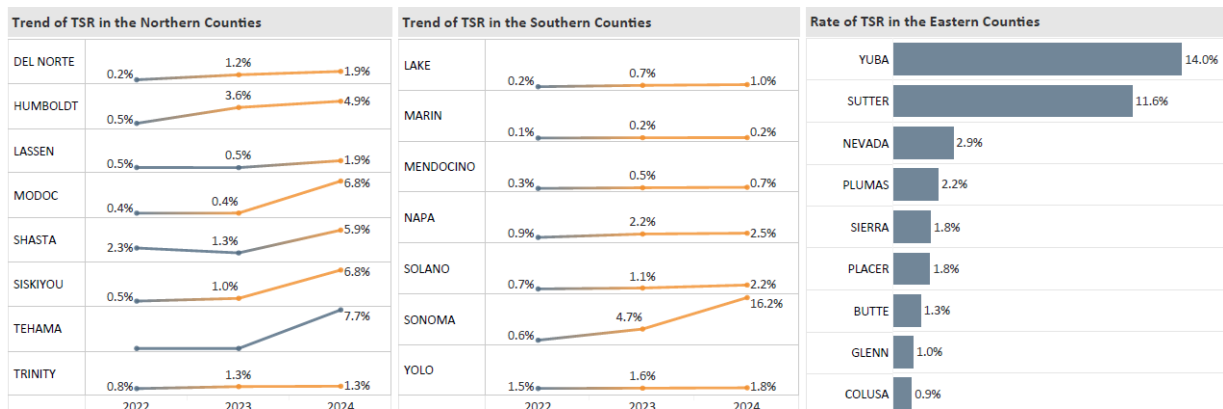
## Tobacco screening and referral rates

Data source: Partnership Claims data for Calendar Year 2024

Screening for tobacco use and vaping, for well-child visits aged 12 and above. This should be linked to the CPT II code: 4004F. In practice this should be a screening for both tobacco and non-tobacco nicotine delivery devices (vaping), with appropriate counseling and referral afterwards but CPT codes only exist for tobacco use screening/counseling referral. This measure remains a PCP QIP as a unit of service measure.

Of the many codes that could be used for tobacco screening, DHCS has selected four for tracking this: 99406, 99407, 4004F and 1036F. The .25 modifier is needed when 99406 or 99407 are provided in the same visit that an E&M code is used. Of these 4 codes, the **4004F is the most appropriate for use** in a typical well child visit, starting at age 12 and in adults well adult template or MA template.

- 99406.25: Smoking + tobacco use cessation counseling visit: 3-10min
- 99407.25: Smoking + tobacco use cessation counseling visit: >10 min
- 1036F: Current tobacco non-user.
- **Preferred: 4004F:** Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy or both) if identified as a tobacco user



Top PCPs with increased TSR rate from last year							Top PCPs with decreased TSR rate from last year						
	2022		2023		2024			2022		2023		2024	
	Members with TSR	%	Members with TSR	%	Members with TSR	%		Members with TSR	%	Members with TSR	%	Members with TSR	%
PEACH TREE HEALTHCARE					5,745	36.2%	FULL CIR CTR FOR INTEGRATIV	2	3.2%	9	12.3%	5	7.5%
BUTTE VALLEY HEALTH CENTER	1	0.1%	0	0.0%	261	34.1%	CONCEPCION MARC	94	14.9%	94	14.4%	82	11.0%
SRCH CARITAS CAMPUS	5	0.6%	126	14.0%	528	47.3%	REDWOOD RURAL HEALTH CENTER	8	0.3%	266	9.8%	263	7.8%
HARMONY HEALTH MEDICAL CLINIC					1,570	29.1%	VIDA FAMILY HEALTH CENTER	6	3.2%	43	3.5%	38	1.6%
MT SHASTA HEALTH CENTER	2	0.6%	1	0.3%	132	29.3%	HUMBOLDT OPEN DOOR CLINIC	25	0.5%	9	1.7%		
VISTA FAMILY HEALTH CENTER	29	0.3%	863	8.6%	3,902	37.0%	SCOTT VALLEY RURAL HEALTH	3	0.5%	19	3.4%	10	2.0%
BURNEY HEALTH CENTER	9	1.0%	10	1.1%	231	29.4%	LIZARRAGA MIGUEL	73	16.9%	48	14.8%	29	13.4%
FALL RIVER VALLEY HC	7	0.8%	6	0.7%	256	27.4%	NORTH COUNTRY CLINIC	28	0.5%	152	3.3%	6	2.3%
LASSEN MEDICAL CLINIC	29	1.4%	30	1.4%	1,791	27.5%	PATEL JAYESH	116	20.8%	233	31.0%	315	30.1%
TULELAKE HEALTH CENTER	0	0.0%	2	0.2%	302	25.8%	LOFFLER-BARRY CHRISTINE	0	0.0%	5	3.0%	4	2.2%
SRCH LOMBARDI CAMPUS	16	0.2%	641	6.1%	4,188	30.5%	WILLOW CREEK COMM HLTH CTR	6	0.4%	44	2.7%	57	1.9%
SRCH DUTTON CAMPUS	32	0.3%	699	7.3%	3,117	30.7%	ROBERT RUSHTON MED OFFICES	0	0.0%	1	0.7%	0	0.0%
BIG VALLEY HEALTH CENTER	1	0.3%	5	1.4%	87	24.4%	HARVEST PEDIATRICS	0	0.0%	15	1.5%	8	0.8%
WEED HEALTH CENTER	3	0.2%	1	0.1%	318	20.6%	CORRELL ALICIA	46	9.2%	98	15.3%	126	14.8%
SRCH PEDIATRIC CAMPUS	8	0.1%	151	2.6%	1,031	18.7%	SHASTA FAMILY CARE	0	0.0%	2	0.6%	0	0.0%
MED ASSOC INC CAMPOS TRAN	0	0.0%	1	4.2%	4	15.4%	NORTHERN VLY INDIAN HEALTH	7	1.6%	4	0.8%	47	0.3%
PROVIDENCE MED GROUP HUMBOLDT	1	0.4%	63	29.2%	95	39.6%	MERCY LAKE SHASTINA COMM	3	0.5%	3	0.5%	0	0.0%

## CT Scan Usage by Emergency Departments:

Data source: Partnership Claims Data, comparing 2022 to 2023

Trends: The trend has changed over the years; currently the highest rates are UC Davis Medical Center, Sutter Santa Rosa, and several Dignity hospital emergency rooms. The lowest rates were in Adventist system Emergency Rooms, Queen of the Valley Hospital, and several small rural hospitals.

Top 50 Hospitals by Number of ER Visits

Facility	% Visits with CT scan					% Change in % Visits with CT scan from Previous Year				
	2019	2020	2021	2022	2023	2019	2020	2021	2022	2023
MEDICAL CENTER UC DAVIS	14.9	17.8	19.0	18.6	20.9		19.82%	6.42%	-2.00%	12.48%
ROSA REG HOSP SUTTER SANTA	14.5	15.2	16.3	16.2	17.6		4.84%	7.43%	-0.55%	8.15%
HOSPITAL MERCY SAN JUAN	14.6	20.4	15.7	15.6	16.8		40.16%	-23.40%	-0.58%	8.15%
HOSPITAL MERCY GENERAL	14.6	15.3	14.2	14.5	14.4		4.93%	-7.34%	2.09%	-0.48%
COMMUNITY HOSP ST ELIZABETH	8.5	10.2	10.6	14.3	12.3		20.83%	3.65%	34.74%	-13.93%
CENTER REDDING MERCY MEDICAL	8.9	11.9	12.7	14.2	13.4		32.75%	7.18%	11.85%	-5.56%
SUTTER DAVIS HOSPITAL	10.7	12.5	12.9	13.5	13.6		17.35%	3.47%	4.03%	1.08%
HOSPITAL VACAVALLEY	10.8	12.2	14.0	13.2	14.7		12.42%	15.11%	-6.18%	11.89%
JOSEPH HOSP PROVIDENCE ST	10.9	12.5	12.6	12.9	14.1		14.14%	1.15%	2.63%	8.53%
HEALTH ENLOE	13.9	13.2	14.5	12.9	15.3		-4.86%	9.97%	-10.95%	18.26%
VALLEY HOSP PETALUMA	10.3	12.2	12.8	12.4	15.0		17.93%	4.83%	-2.86%	20.98%
MEDICAL CENTER NORTHBAY	9.4	11.0	12.9	12.2	14.6		15.97%	17.48%	-5.07%	19.45%
UCSF MEDICAL CENTER	4.7	12.2	13.0	12.2	10.7		156.88%	6.54%	-5.83%	-12.35%
MEMORIAL HOSP WOODLAND	9.8	11.0	12.8	12.2	10.1		12.26%	16.53%	-5.11%	-16.75%
KAISER VACAVILLE	11.0	10.3	10.9	11.8	6.6		-6.25%	5.19%	8.33%	-43.61%
KAISER S. SACRAMENTO	9.7	12.3	13.3	11.8	10.5		26.69%	7.74%	-11.46%	-10.80%
CENTER SAC SUTTER MEDICAL	10.4	10.5	12.1	11.6	12.0		0.26%	15.64%	-4.05%	3.25%
KAISER FOUND HSP SACRAMENTO	7.0	8.6	13.4	11.2	10.2		22.57%	55.88%	-15.89%	-9.53%
SONOMA VALLEY HOSPITAL	8.3	11.5	11.2	11.1	11.0		38.66%	-2.14%	-0.94%	-1.30%
LAKESIDE HOSP SUTTER	8.7	9.4	11.4	10.8	11.7		8.43%	21.24%	-5.28%	7.79%
MEDICAL CENTER MARINHEALTH	7.4	8.5	11.2	10.7	12.0		15.20%	31.58%	-4.48%	12.38%
MEDICAL CENTER FAIRCHILD	8.1	11.2	11.5	10.0	9.9		36.93%	3.24%	-13.37%	-0.57%
CTR MT SHASTA MERCY MEDICAL	8.9	10.4	8.9	9.7	10.3		16.18%	-14.32%	9.01%	5.72%
KAISER FOUND HOSP OAKLAND	10.0	9.2	11.4	9.2	7.5		-7.83%	23.42%	-19.43%	-18.74%
COMMUNITY HOSP MAD RIVER	8.0	9.0	10.5	9.0	9.9		12.87%	16.89%	-14.11%	9.69%
WOOD MEM HOSP PROVIDENCE RED	7.8	9.5	9.8	9.0	10.1		22.32%	2.82%	-7.82%	11.77%
COAST HOSPITAL SUTTER	10.5	11.7	12.9	8.8	10.1		10.92%	10.41%	-31.38%	14.35%
MEDICAL CENTER SKY LAKES	7.6	10.6	12.7	8.7	11.9		40.44%	19.58%	-31.37%	36.19%
CLEARLAKE ADVENTIST HLTH	6.3	8.6	9.2	8.4	9.4		36.74%	6.69%	-8.16%	11.53%
SUTTER SOLANO MEDICAL CENTER	5.7	7.2	7.6	8.4	9.3		27.58%	4.90%	10.71%	11.31%
KAISER MED CTR SANTA ROSA	6.4	5.2	7.7	8.4	8.4		-18.18%	47.24%	9.52%	-0.05%
HOSPITAL NOVATO COMMUN	5.9	8.2	8.4	8.4	8.9		38.94%	2.45%	-0.66%	6.33%
HOSPITAL TRINITY	7.4	10.3	8.3	8.3	6.6		38.51%	-19.73%	0.08%	-20.77%
MEMORIAL HOSP PROVIDENCE SR	7.5	7.8	8.4	8.2	10.2		3.99%	8.49%	-2.56%	24.29%
MEDICAL CENTER BANNER LASSEN	7.1	6.6	7.1	8.2	8.4		-6.86%	8.04%	14.56%	2.39%
MENDO COAST ADVENTIST HLTH	6.2	6.3	7.5	8.1	8.0		2.31%	19.21%	7.20%	-0.45%
ST HELENA ADVENTIST HLTH	7.0	8.7	9.7	7.8	6.3		24.75%	11.07%	-19.10%	-19.46%
MEDICAL CENTER SHASTA REG	6.4	7.7	8.7	7.8	7.1		19.42%	12.94%	-10.12%	-8.58%
KAISER VALLEJO	6.2	4.4	7.0	7.4	7.8		-28.52%	57.17%	5.36%	6.04%
KAISER FOUND HOSP SANRAFAEL	7.7	8.7	8.1	7.0	6.2		12.72%	-7.23%	-13.65%	-10.81%
QVMA MED CTR PROVIDENCE	6.6	7.1	8.3	6.9	9.3		7.79%	17.04%	-16.97%	33.88%
HOWARD MEM ADVENTIST HLTH	4.0	6.2	7.4	6.9	7.7		52.77%	19.89%	-7.22%	12.17%
UKIAH VALLEY ADVENTIST HLTH	5.8	6.8	7.3	6.7	7.7		18.51%	6.60%	-8.69%	14.91%
MEMORIAL HOSP MAYERS	6.9	5.8	6.8	6.5	6.3		-15.46%	16.86%	-4.53%	-3.76%
HEATH RIDEOUT ADVENTIST	13.6	15.5	11.7	6.2	5.6		13.49%	-24.57%	-46.91%	-9.24%
CENTER MODOC MEDICAL	5.4	5.0	5.3	5.9	5.7		-8.01%	5.18%	11.60%	-2.38%
HOSPITAL HEALDSBURG	7.1	6.4	7.8	5.7	6.4		-10.08%	22.15%	-27.05%	12.42%
MEDICAL CENTER ALAMEDA COUNTY	8.4	6.0	4.3	4.0	3.7		-28.48%	-28.57%	-6.86%	-6.51%
CHILDRENS HOSP OAKLAND	2.6	2.0	3.5	2.2	1.9		-23.06%	75.72%	-35.30%	-13.48%

## Hospital Obstetrical Data:

Data source: California Hospital Quality Compare (data from CMQCC), 2023

				NTSV C-Section Rate			Breastfeeding Rate (CDPH)			Episiotomy Rate			VBAC Rate			Routinely Available	Certified Nurse Midwife Delivery Rate	Early Elective Delivery			
	Partnership Regional Office	County	City	Denominator	Score (%)	Rating	Denominator	Score (%)	Rating	Denominator	Score (%)	Rating	Denominator	Score (%)	Rating	Yes/No	Denominator	Score (%)	Denominator	Score (%)	Rating
Marin Health Medical Center	Santa Rosa	Marin	Greenbrae	520	17.9	Superior	1357	84.3	Above Average	1091	0.5	Above Average	194	40.2	Superior	Yes	1453	46.2	46	2.1	Below Average
Santa Rosa Memorial Hospital	Santa Rosa	Sonoma	Santa Rosa	258	20.5	Above Average				529	0.8	Above Average	134	39.6	Superior	Yes	767	45.4	66	7.58	Below Average
Sutter Santa Rosa	Santa Rosa	Sonoma	Santa Rosa	501	23.4	Average				976	1.1	Average				No	1451	0.8			
Dignity Health Woodland Memorial Hospital	Fairfield	Yolo	Woodland	172	22.1	Average	449	80.4	Above Average	332	0.9	Above Average				No	489	0	34	0	Above Average
NorthBay Medical Center	Fairfield	Solano	Fairfield	398	25.4	Below Average				875	0.7	Above Average	219	18.3	Average	Yes	1326	0	97	0	Above Average
Providence Queen of the Valley Medical Center	Fairfield	Napa	Napa	234	20.5	Above Average	574	71.95	Average	544	1.5	Average	143	28.7	Above Average	Yes	797	0	51	1.96	Below Average
Sutter Davis	Fairfield	Yolo	Davis	449	14.5	Superior				989	1.4	Average	151	31.8	Above Average	Yes	1240	60.2			
Tahoe Forest Hospital	Auburn	Nevada	Truckee	147	16.3	Superior				246	1.2	Average				No	359	0	5	0	Above Average
Sutter Roseville	Auburn	Placer	Roseville	867	25.7	Below Average				1723	3	Average	336	15.5	Average	Yes	2477	0			
Dignity Health Sierra Nevada Memorial Hospital	Auburn	Nevada	Grass Valley	110	30	Below Average	313	90.1	Superior	215	4.2	Average				No	324	4.9			
Adventist Health Clear Lake	Eureka	Lake	Clearlake	38	15.8	Superior				92	2.2	Average				No	131	0	99	0	Above Average
Adventist Health Ukiah Valley	Eureka	Mendocino	Ukiah	228	18.9	Above Average	714	77.17	Above Average	501	1	Average	105	14.3	Average	Yes	701	50.1	44	0	Above Average
Sutter Coast	Eureka	Del Norte	Crescent City	63	17.5	Superior				146	2.1	Average				No	209	0			
Sutter Lakeside	Eureka	Lake	Lakeport	54	25.9	Below Average				138	1.4	Average				No	200	0			
Providence St. Joseph Hospital Eureka	Eureka	Humboldt	Eureka	217	24	Below Average	610	85.25	Above Average	457	5	Below Average	91	15.4	Average	Yes	660	15.6	53	0	Above Average
Mad River Community Hospital (closed Oct 31)	Eureka	Humboldt	Arcata	141	19.9	Above Average				255	1.6	Average				No	356	19.4	14	0	Above Average
Banner Lassen Medical Center	Redding	Lassen	Susanville	68	14.7	Superior				141	6.4	Below Average				No	197	0	23	0	Above Average
Dignity Health Mercy Medical Center Mount Shasta	Redding	Siskiyou	Mount Shasta	53	18.9	Above Average	102	80.39	Above Average	116	2.6	Average				No	156	0	11	9.09	Below Average
Dignity Health Mercy Medical Center Redding	Redding	Shasta	Redding	546	22.2	Average	1519	78.54	Above Average	1126	2.3	Average				No	1688	0	89	2.25	Below Average
Dignity Health St. Elizabeth Community Hospital	Redding	Tehama	Red Bluff	189	21.7	Above Average	519	74.95	Average	380	2.4	Average				No	540	16.1	53	0	Above Average
Fairchild Medical Center	Redding	Siskiyou	Yreka	49	32.7	Below Average				89	4.5	Average	27	22.2	Average	Yes	156	0	8	12.5	Below Average
Adventist Health Rideout Hospital	Chico	Yuba	Marysville	504	24.4	Below Average				1127	1.6	Average	275	10.5	Average	Yes	1705	0.1			
Oroville Hospital	Chico	Butte	Oroville			Not Rated			Not Rated			Not Rated					~500				Not Rated
Enloe Medical Center - Esplanade Campus	Chico	Butte	Chico	648	18.2	Superior	1729	87.45	Above Average	1408	0.5	Above Average	285	25.3	Above Average	Yes	1913	14.3	45	0	Above Average

### 2023 Partnership HealthPlan Hospital OB Quality Data

	NTSV C-section	Early Elective Delivery	Breastfeeding at discharge	Episiotomy Rate	VBAC rate	CNM delivery rate
Above Avg	<21.9%	<1%	>75%	<1.2%	>25%	>10%
Avg	22-23.6%	1-2%	70-75%	1.5 - 5.0%	10 - 25%	
Below Avg	>23.6%	>2%	<70%	>5.0%	<10%	<10%

## Clinical Practice Guidelines and Best Practices

### Preventive Services Updates

Each year Partnership's Quality Utilization Advisory Committee reviews the adult preventive care recommendations of various organizations and updates [Attachment A](#) of our Adult Preventive Services Guideline. The updated version will be posted to our website in April. Here are the major changes:

Each year Partnership's Quality Utilization Advisory Committee reviews the adult preventive care recommendations of various organizations and updates [Attachment A](#) of our Adult Preventive Services Guidelines. The updated version will be posted to our website in March. Here are the major changes:

In anticipation of Partnership Advantage, added references to Preventive Care for Medicare recipients. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.

All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.

The following services are available to both Medicare and Medi-Cal recipients:

- Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
- Diabetes Prevention Services (DPP) as outlined in Partnership policy MCCP2026 – Diabetes Prevention Services.

Required Medicare-specific preventive care visits as outlined on the Medicare website at <http://www.medicare.gov/coverage/preventive-screening-services>.

Updated existing guidelines include:

- Breast Cancer Screening by Mammography: The USPSTF (April 2024) recommends biennial mammography for persons with breasts and assigned female at birth ages 40 to 74 years (Grade B).
- Osteoporosis in Postmenopausal Persons Assigned as Female at Birth, Screening: USPSTF Recommendation (January 2025) - Screen persons assigned as female at birth age 65 years and older with bone measurement testing to prevent osteoporotic fractures (Grade B). For postmenopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at: <https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9> to determine the appropriate need for bone measurement testing (Grade B).

## 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 Requirements

Pediatric lead poisoning occurs throughout California and continues to present a health risk, particularly for infants and young children. The Department of Health Care Services (DHCS) requires lead prevention education at every well-child visit between 6 months and 6 years of age and lead testing for all Medi-Cal enrolled children at 12 and 24 months, with catch-up testing to be performed up to the age of 6 (for those who were not previously tested or do not have lead testing results available).

The single most important strategy to get all your age-appropriate pediatric patients tested for lead exposure, is obtaining a capillary specimen in the exam room. Once the specimen is collected (ideally by the individual rooming the patient, through a standing order), it can be run with a point of care testing device on-site (LeadCare II) or sent to a public health or commercial lab.

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

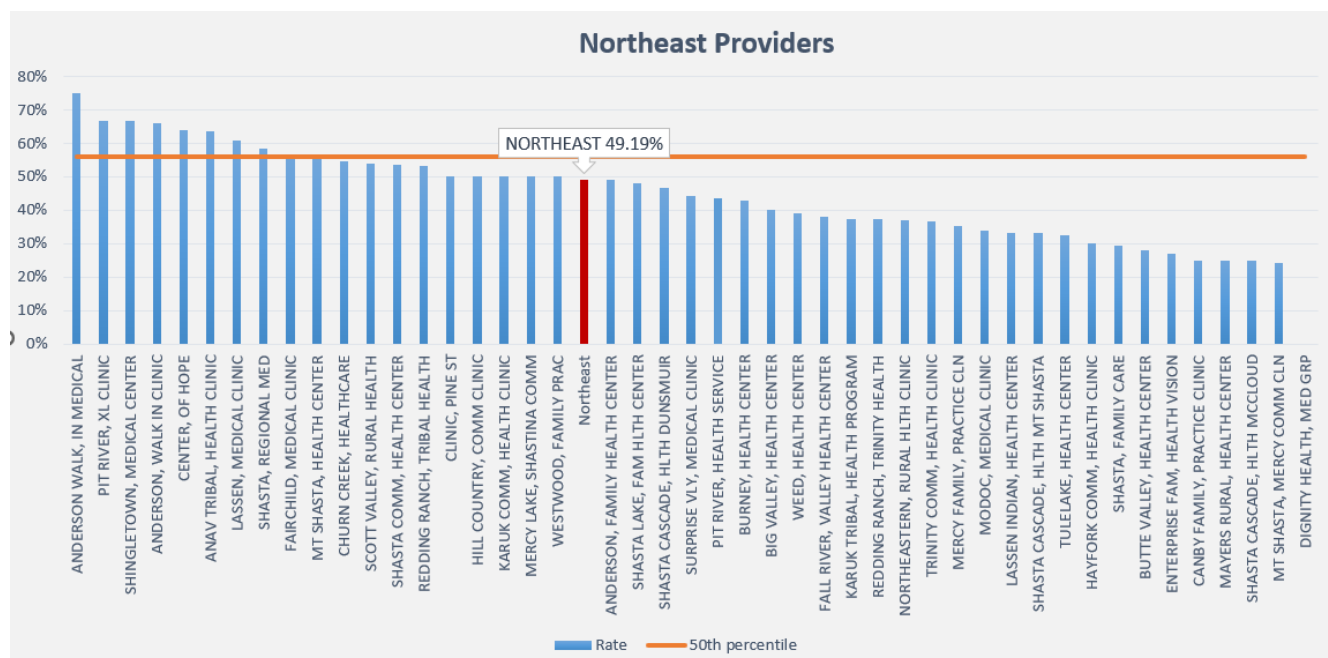
If you do not yet have Point of Care Lead testing units in your office, there may be some grant funding available within the Partnering for Pediatric Lead Prevention program. Contact us at [leadPOC@partnershiphp.org](mailto:leadPOC@partnershiphp.org) or visit our [website](#) for more information.

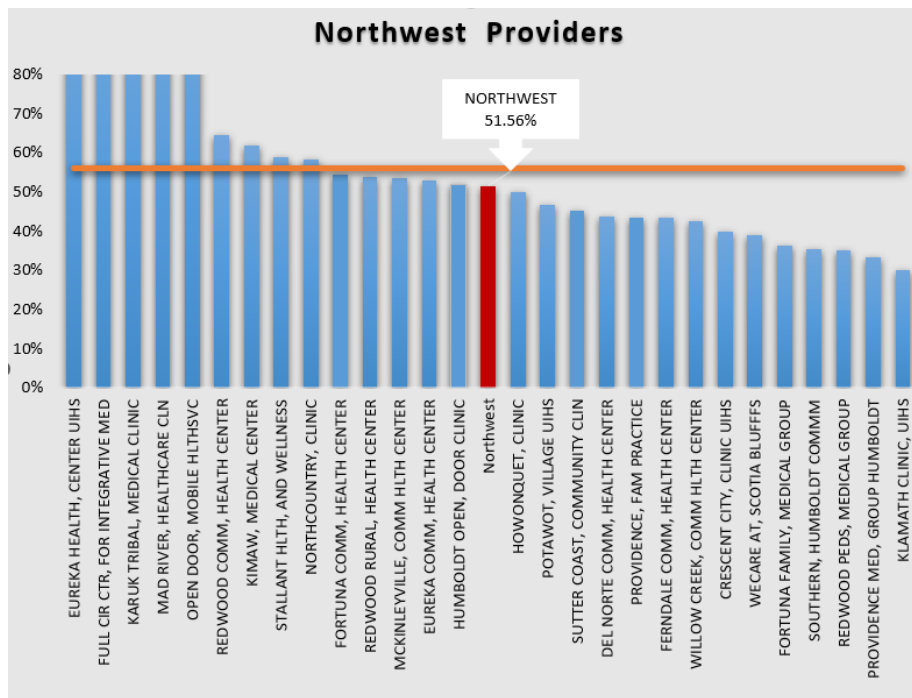
### Chlamydia Screening

Chlamydia screening is being added to the Partnership pay for performance program in MY 2025, given ongoing DHCS sanctions for low Chlamydia screening rates in our Northeast and Northwestern regions. Within the PCP QIP, it is included in the core measure set for Pediatric practices and as a monitoring only measure for Family Medicine and Internal Medicine practices.

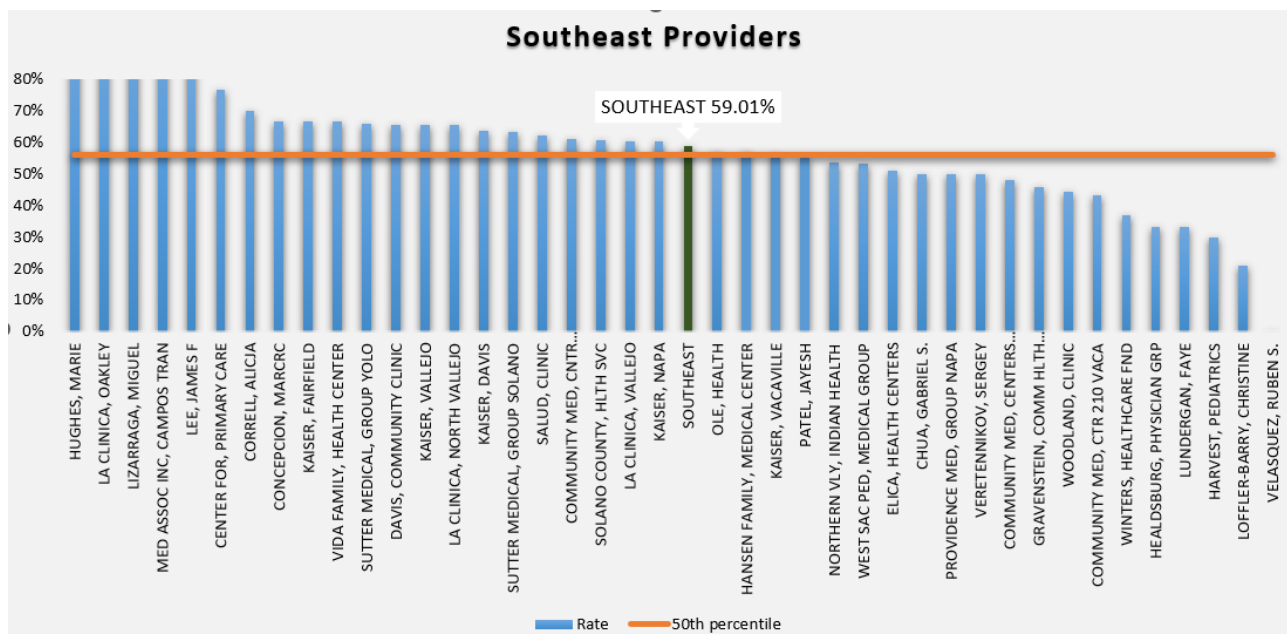
The NCQA HEDIS measure is defined as the percentage of women 16-24 years of age who were identified as sexually active and completed at least one test for chlamydia during the measurement year. Of note, there is significant variation in screening, indicating that provider behavior influences this rate. In particular, the screening rate in teenagers varies widely, with some providers clearly not routinely screening teenagers, suggesting discomfort in talking with teens or parents about potential sexual activity.

Here are the rates of screening for all PCPs in the 14 legacy counties, by region. If your screening rate is low, we ask that you discuss this with your providers and consider template changes or alerts that will increase the screening rate. Remember to consider screening for HIV and syphilis at the same time, if appropriate.

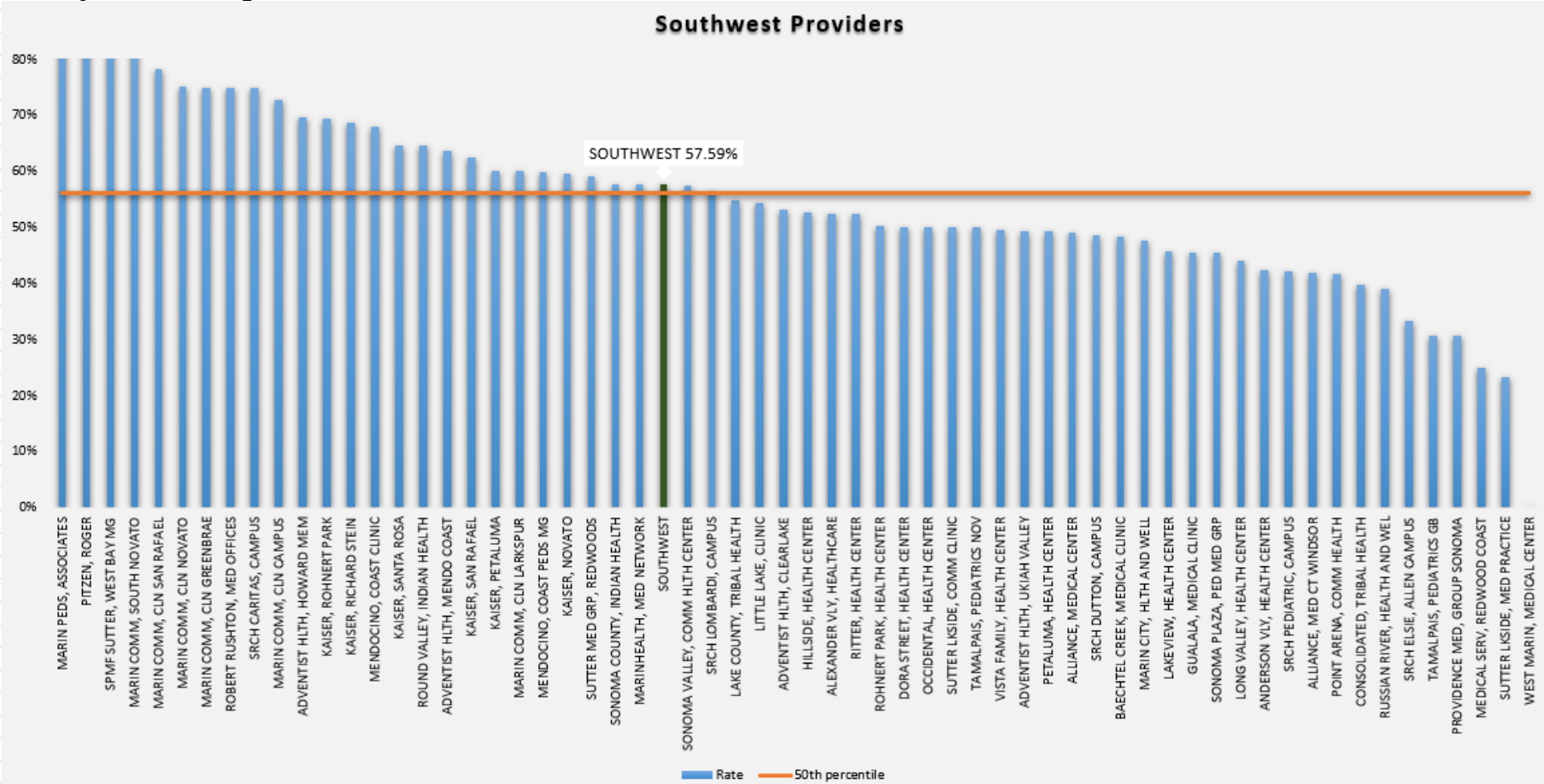




## Chlamydia Screening Rates.



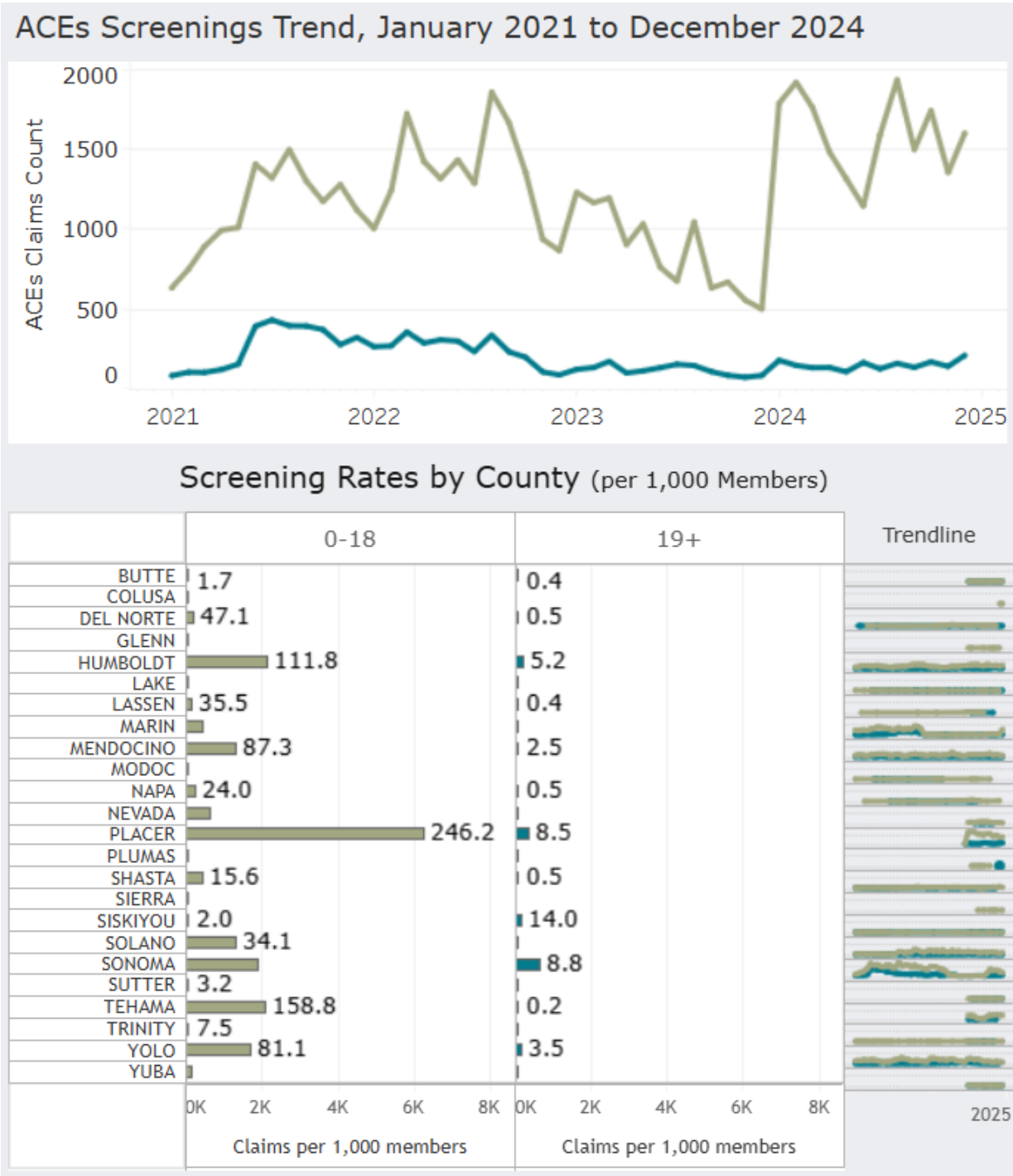
Chlamydia screening rates:



ACEs Screening

Screening for Adverse Childhood Events (ACEs) is a separately reimbursable service, to help gather data on the number of ACEs through billing data.

ACEs screening peaked in 2022 and has been declining since then.



FQHCs, RHCs, and Tribal Health centers are eligible for the supplemental payment for screening, 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](http://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.

### 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 33<sup>rd</sup> percentile for this measure was 69% percent in Medicaid in 2023.

The overall rate for Partnership was 71% in 2023, which is between the 33<sup>rd</sup> and 66<sup>th</sup> percentile. We ask you all to create processes to allow strep testing even if visits are done virtually, such as sending them to a lab for testing, or dropping into the office for testing only.

### 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. Medi-Cal covers two dental hygiene visits per year; this is especially important for children and pregnant women.

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

In 2019, 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.

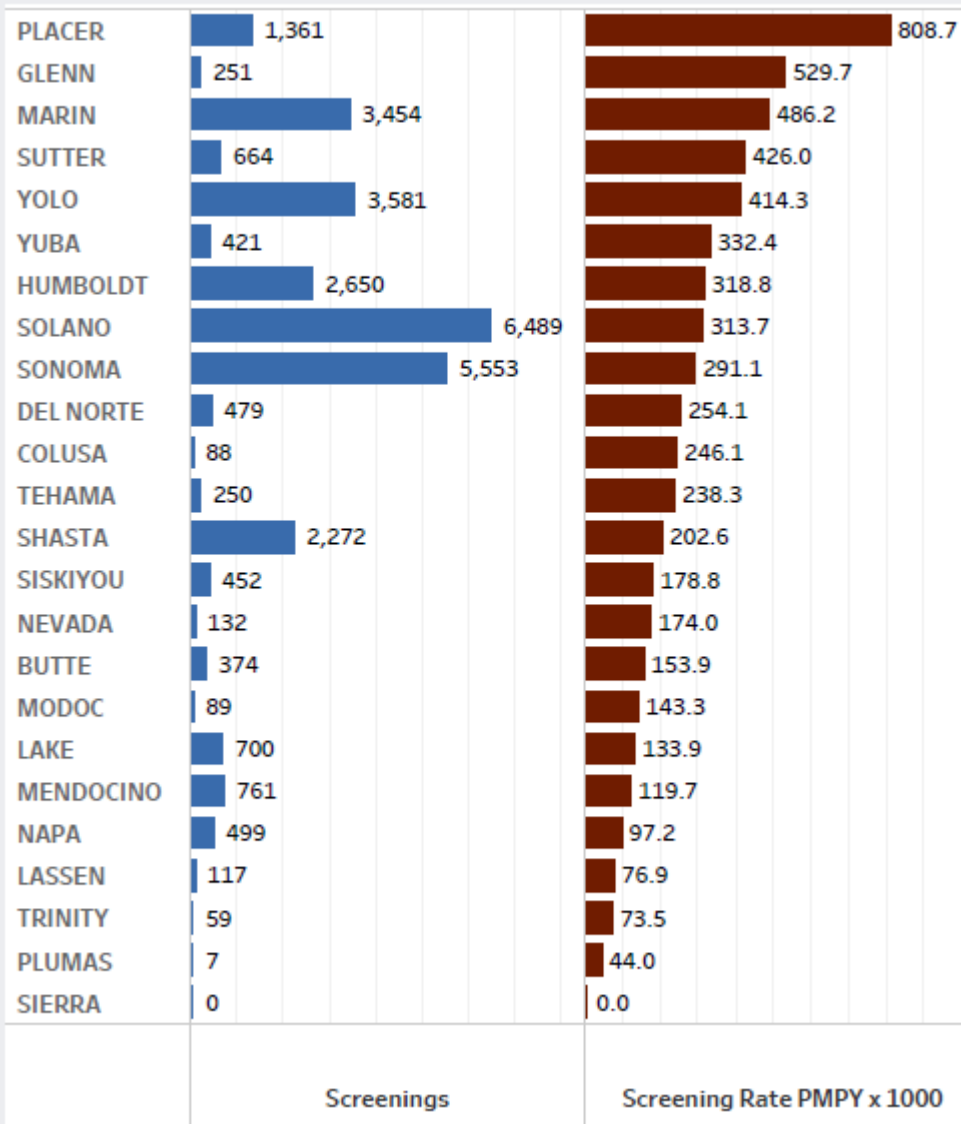
A comprehensive developmental screen is considered standard of care by the American Academy of Pediatrics, the American Academy of Family Physicians, CMS, NCQA, and DHCS. Please ensure your well-child visit process and templates include the use of a comprehensive tool such as the ASQ and documents this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

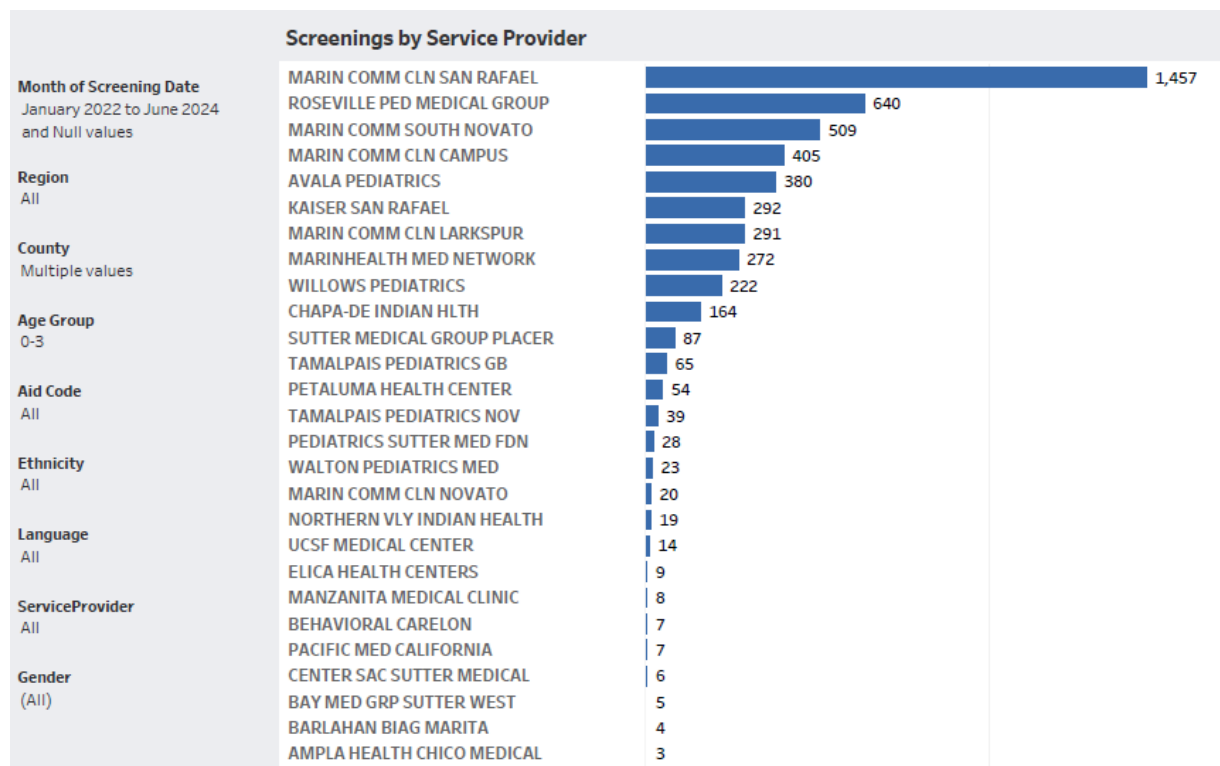
Like ACES screening, developmental screening is carved out of the PPS reconciliation process, so an additional \$59.50 is paid when a comprehensive developmental screen is done, regardless of provider type. Many FQHCs are not billing 96110 at all, meaning either that they are doing developmental screening 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.

### Developmental Screening Rate Data

Data source: Partnership Claims Data plus historical data file for expansion counties, January 2022 to June 2024

## Screening by County





## Adult Guidelines

### Colorectal Cancer Screening

Screening for colorectal cancer remains on the Managed Care Accountability Set (MCAS) along with the Primary Care Provider Quality Improvement Program, although Partnership's PCP QIP is now utilizing the NCQA MediCaid standards resulting in an increase in the benchmark targets. 2025 targets are currently set at 50<sup>th</sup> percentile for partial points and 75<sup>th</sup> percentile for full points, with the following measurement years benchmarks set to rise to 75<sup>th</sup> and 90<sup>th</sup> respectively. Members between the ages of 45 – 75 need to have an appropriate screening done for colorectal cancer.

While colonoscopies are ideal as they are good for every 10 years, access to colonoscopies continues to be limited while cases continue to rise in young adults. FIT testing can be done annually, and FIT/DNA (Cologuard) is good for every 3 years. To discuss bulk ordering for Cologuard, you can reach out to Exact Sciences at [phc@exactsciences.com](mailto:phc@exactsciences.com).

### COPD Exacerbation Management

Key Points from the 2025 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. The duration of therapy should not normally be more than 5 days.
- Short-acting inhaled beta2-agonists, with or without short acting anticholinergics are recommended as initial treatment of 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.

Antibiotics, when indicated (increased sputum purulence plus increased dyspnea or sputum volume), can shorten recovery time, reduce the risk of early relapse, treatment failure, and hospitalization duration. Duration of therapy should normally be 5 days.

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 pharmacy consultation 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.**

## 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](http://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.

Of note, Cognitive Health Assessments are required for Medicare-Medi-Cal covered patient enrolled in a Medicare advantage plan, so everyone caring for patients over age 65 should complete the trainings on the dementia care aware website.

## New Mandates on Tuberculosis

Starting January 1, 2025, [AB 2132](#) will generally require a health care provider to offer a tuberculosis risk assessment and screening (if appropriate) to all adult patients seen in a setting where primary care services are provided.

These publications serve as helpful guides for tuberculosis screening and treatment:

- The California Department of Public Health (CDPH) –
  - [Prevent Tuberculosis \(TB\) in 4 Steps: A Guide for Medical Providers](#)
  - [Risk Assessments](#)

The first step of the risk assessment is to evaluate for potential symptoms of active TB:

1. Cough lasting longer than 2 weeks
2. Fevers or night sweats
3. Unexplained weight loss

An individualized diagnostic evaluation is needed to ensure that the patient

does not have active TB.

The four risk factors for latent TB are:

1. Birth, travel, or residence of at least 1 month in a country with elevated TB rate
2. Immunosuppression
3. Close contact to someone with known active TB during lifetime
4. Homelessness or incarceration, current or past

Treatment is strongly recommended for patients diagnosed with latent TB infection.

## 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.

## National Changes in Categorization of Race/Ethnicity

Two years ago, Partnership first stratified Quality Outcome data based on the race/ethnicity we received from DHCS. As noted in prior newsletters, this data showed that outcomes were much worse for the self-identified American Indian/Alaska Native (AIAN) population than for any other racial group. This prompted Partnership to launch a Tribal Engagement Strategy to build relationships with the 21 Tribal Health Centers and their associated 51 individual tribes, so that we can work together on improving health and wellness for the AIAN population.

Two months ago, while preparing a presentation for the Medi-Cal Managed Care Advisory Group about Partnership's Tribal Health Liaison, Yolanda Latham, I was looking through race/ethnicity data on our members, and comparing it to the official California Census data, and discovered something very concerning: The number of AIAN enrolled in Partnership seemed very low. After a little digging (details below), I discovered that the magnitude of the undercounting is somewhere between 213% and 900%, and may be even higher.

The reason for this is the way DHCS takes the race/ethnicity/tribal affiliation data from the official Medi-Cal application and uses an algorithm to assign a single race. The Medi-Cal application encourages individuals to choose all

racess that apply, in accordance with federal recommendations going back to 2000.

Page 4 of the Medi-Cal application:

**Tell us about your race** *This information is confidential and will only be used to make sure that everyone has the same access to health care. It will not be used to decide what health insurance you qualify for.*

What is your race? (optional; check all that apply)

<input type="checkbox"/> White	<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Cambodian	<input type="checkbox"/> Korean	<input type="checkbox"/> Samoan
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Chinese	<input type="checkbox"/> Laotian	<input type="checkbox"/> Other
	<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	
	<input type="checkbox"/> Hmong	<input type="checkbox"/> Native Hawaiian	

Are you of Hispanic, Latino, or Spanish origin? (optional) ☐ Yes ☐ No

**If yes, check which ones:**

<input type="checkbox"/> Mexican, Mexican American, Chicano
<input type="checkbox"/> Salvadoran <input type="checkbox"/> Guatemalan
<input type="checkbox"/> Cuban <input type="checkbox"/> Puerto Rican
<input type="checkbox"/> Other Hispanic, Latino, or Spanish origin: _____

★ ☐ Check here if you are an American Indian or Alaska Native, and fill out Attachment A on pages 20 and 21.

Page 20 of the Medi-Cal application

Is this person a member of a federally recognized American Indian or Alaska Native tribe? ☐ Yes ☐ No

If yes, write the name of the tribe: \_\_\_\_\_ and the state of the tribe: \_\_\_\_\_

The mechanism that DHCS uses to convey membership information to Partnership and other Medi-Cal Managed Care Plans is a file called the 834 file or membership file. This file lists just one single race-ethnicity category per enrollee. DHCS uses an algorithm to translate the application race and ethnicity responses to this single category.

While the exact algorithm is not publicly posted, it seems likely that if an AIAN also identifies as Hispanic or Latino, this trumped their AIAN status and they were assigned a Latino ethnicity. Additionally, if an enrollee identified both AIAN and any other racial status, they were classified as “other” or “mixed race,” a category with poor outcomes similar to the AIAN population, but as it is mixed with all other mixed-race individuals is completely non-actionable.

Here are three mechanisms used to estimate the scope of this undercounting:

### 1. Census Data

One way to estimate the scope of undercounting is to compare the proportion the Medi-Cal enrolled population identified as AIAN compared to California census data on AIAN ethnicity.

Official MediCal statistics show a total of 55,302 (**only 0.4% of all beneficiaries**) individuals enrolled in Medi-Cal as of July 2023 identified as AIAN ([Medi-Cal Fast Facts](#)).

In contrast, in the 2020 census, 1.6% of the California population identified as

American Indian and Alaska Native race alone and an additional 2% of the population identified as American Indian or Alaska Native in combination with some other race, for a total of 3.6% of the population categorized as AIAN alone or in combination. Even if we assume that the proportion of the AIAN population of California with Medi-Cal is the same as the non-Medi-Cal population (a highly unlikely assumption), **Medi-Cal is undercounting the AIAN population by as much as 9-fold**. Put another way, the true number is 900% higher.

Extrapolating the scope of the undercounting based on census data, as many as 495,000 Medi-Cal beneficiaries would be categorized as AIAN alone or in combination, instead of just 55,302.

## 2. Tribal Health Centers

Confirmatory evidence of racial mis-categorization comes from the subset of Tribal Health Centers which **only** allow enrolled tribally affiliated members to be served. Of those Medi-Cal members served at these tribal health centers, 53% were categorized by Medi-Cal 834 data as **not** being AIAN. Meaning that the true number is 213% greater than the identified AIAN at Native-run health centers.

Extrapolating this underestimate would mean that the actual number of AIAN receiving Medi-Cal is about 118,000 individuals.

### Why such a broad range?

The range of undercounting (from 213% to 900%) is so large partly because the U.S. Census groups together indigenous populations from Central American (such as the Maya and Aztec), South America and Canada into its totals. Of these groups, those who identify as indigenous from Central America is large and growing, resulting in a shift from the Latino Category to the indigenous/AIAN category. In contrast, indigenous people from outside the United States are not generally eligible to receive care at tribal Health Centers that are limited to tribal members.

The American Community Survey assesses race and ethnicity differently, in a way that likely does not include indigenous individuals from Central America in the AI/AN count, which lowers that count relative to the census estimate.

### Impact of Undercounting

Official methods of categorizing race have a centuries-long history of being built on racist assumptions and bias. While I would like to think that the algorithm decisions that led to the undercounting of the AIAN in Medi-Cal were not intended to harm AIAN, such large scale undercounting has several important impacts.

First, it reinforces the perception that American Indians are no longer present in

California, “erasure” is the term used by American Indian scholars and activists. In fact, in the past century, erasure was official U.S. government policy, as tribes were “terminated” in the 1950s and 1960s, children kidnapped and taken away to boarding schools to “save the child by killing the Indian,” so the residual evidence of erasure reflects a lack of acknowledgement and sensitivity of this historical trauma.

Second, such profoundly faulty data leads to faulty analysis of health inequities. If the racial data used to calculate rates of quality indicators is biased and faulty, then the inferences drawn by stratifying data by race are hints of the underlying reality, but any sanctions or penalties tied to reducing such inequities by any specified quantity are statistically invalid.

Lastly, such significant undercounting impacts public health prioritization based on population affected, and thus potentially impacts funding allocated proportional to the AIAN population affected.

#### Major changes in the new U.S. Office of Management and Budget (OMB) Standards

The Updated 2024 OMB Standards for categorizing race/ethnicity move Latino/Hispanic to be a co-equal race/ethnicity category, instead of a carved-out ethnicity category. The Middle-eastern/north African population was carved out of the White category, so there will now be 7 major race/ethnicity categories, one of which is American Indian or Alaska Native, with a box to fill in details with the following language: “Enter, for example Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya etc.”

The most concerning aspect of the new OMB standard is the list of options for handling individuals who identify more than one race/ethnicity category. The three options identified are:

1. The “alone or in combination” approach mentioned earlier related to census data. There is some complexity to using this approach, but it substantially resolves the undercounting of the AIAN population and should be the starting point of data sharing and equity analysis. A key feature of this approach is that the total of all categories is greater than 100% as one individual may be two or more categories; this requires special statistical methods to avoid errors.

2. The “most frequent multiple responses” approach, in which the top combined categories are each presented with individual data. For example, in addition to each race ethnicity category alone, each combination is listed with the number of individuals. Some may be simple two-race categories (like black-asian) but more complex combinations are possible (like latino-black-white). This allows the most granular data analysis, and the numbers can be folded into the “alone or in combination” category. The sum of all individuals in all categories will total 100%.

3. The “multiracial” approach in which any individual who chooses more than one race/ethnicity category is categorized as either “other” or “mixed.” This grouped category is impossible to analyze, so the “pure” race/ethnicity categories end up being the only way to look for health disparities. This appears to be the method currently used by DHCS, and it should be abandoned as soon as possible.

Partnership has urged DHCS should share the current detailed enrollment race/ethnicity/tribal affiliation data with all Medical Managed Care plans so they can better analyze and understand the inequities in their members. We request either the “alone or in combination” approach or the “most frequent multiple responses” approach (which can be combined to create “alone or in combination” groups. These two approaches would stop the undercounting of the AIAN population.

This granular race/ethnicity/tribal affiliation data will allow Managed Care Plans to re-run our disparity analyses and release an analysis of our findings. In addition, we can pass on this information to primary care practices to give them the complete and accurate data they need to identify and address health inequities.

As unintentional as it may be, the DHCS racial categorization algorithm is an example of structural racism that deserves to be addressed. With the increased emphasis on Health Equity at DHCS and CDPH, there should be a heightened sense of urgency to definitively address this issue. DHCS alignment with the OMB’s updated race and ethnicity data standards creates an opportunity to correct an issue that obscures AIANs and other small populations from the data.

One additional wrinkle is a recent increase in the willingness of individuals applying for MediCal to embrace their multiracial background. In the past, there were significant social and administrative pressures for individuals to self-identify one race on the Medi-Cal application. In contrast, newly eligible newborns now have “other/multiple race” as the largest single category of race even before the new OMB standards are implemented.

According to DHCS, one option for generating more accurate MediCal race data is to have beneficiaries individually go on-line to update their race selection. This is done through CalHEERS and BenefitsCal. Partnership has not confirmed that this will work, so if one of your patients uses this system to update their race, please let us know how it goes.

## Mandatory Diversity-Equity-Inclusion Training – Coming soon.

DHCS is requiring Medi-Cal Managed Care Plans to mandate and monitor regular trainings on Diversity-Equity-Inclusion (DEI) for all patient-facing staff working in the primary care and specialty setting. This will begin in late 2025. Online options will be available. More details will be coming in the months ahead.

## Health Inequity Measurement

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:

- A. The most important administrative measures for detecting racial inequities (compared to the white population) are the following HEDIS measures:
  - a. Mammogram
  - b. Colorectal Cancer
  - c. Well Child Visit

### Mammogram Inequities:

In all 4 regions of 2023, **American Indians** had lower rates of screening. In just the Southeast region, **Pacific Islanders** also had low rates.

### Colorectal Cancer:

In all 4 regions in 2023, **American Indians** had lower rates of screening.

In just the Northeast, the **Black** population had lower rates.

In just the Southwest, the **Pacific Islander** had lower rates.

### Well Child Visits in 2023:

Northeast: Inequity in **Pacific Islander** population

Northwest: Inequity in **Pacific Islander and American Indian** populations

Southeast: Inequity in **Pacific Islander and Black** populations

Southwest: Inequity in just the **American Indian** population.

Other notable trends are evident in the CIS-10 Childhood immunization Measure:

Northeast: Inequity in **American Indian** population (0%) vs. 5% in white population. Rates in all ethnic groups very low with highest in Hispanic population (14%)

Northwest: No inequities

Southeast: No inequities

Southwest: Inequity in just the **American Indian** population (0%) vs. 26% in white population.

## B. PCP QIP Equity Analysis

In 2024 there were 11 clinical measures; here are the plan-wide consolidated results (QIP denominator only)

- Breast Cancer screening: Only American Indian rate (45%) lower than white rate (47%)
- Cervical Cancer screening: Only American Indian rate (41%) lower than white rate (46%)
- Well Child/Adolescent Visits: Only the Black rate (45%) lower than the white rate (47%)
- Childhood Immunization (CIS-10): Only American Indian rate (7%) is lower than the white rate (13%)
- Colorectal Cancer Screening: American Indian (27%) and Black (32%) rates less than white rate (35%)
- Blood Pressure Control: American Indian (54%) and Black (60%) rates less than white rate (62%)
- Diabetes Good Control: American Indian (56%) and Black (59%) rates less than white rate (64%)
- Diabetes Retinal Eye Exam: Only American Indian rate (45%) is below white rate (46%)
- Adolescent Immunization (IMA-2): No inequities noted: white population performs the worst with just 22% complete.
- Lead Screening in Children: No inequities noted: white population performs the worst with 62% complete.

- Well child visit in the first 15 months of life: Only American Indian rate (36%) is below white rate (42%)

#### Summary by Race:

- Native American: Improvement in inequities from 10/11 have worse outcomes than the white population in 2022 to 8/11 in 2024
- Black/African American: Improvement in inequities from 5/11 have worse outcomes than the white population in 2022 to 4/11 in 2024
- No statically significant disparities: Hispanic, South Asian, East Asian, Southeast Asian, and Pacific Islanders.

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

## Pay for Performance Program for Primary Care (PCP QIP)

### PCP QIP 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 abridged specifications for the 2025 PCP QIP measurement year can be found [here](#). The detailed specifications are housed in eReports. You can also request the detailed version from the PCP QIP team who will send the document via Secure email.

## PCP QIP Measure Sets

### PCP QIP Measurement Year 2025 Changes and Updates

#### **Clinical Domain:**

- **New** for **Pediatrics:**
  - Chlamydia Screening (16-20yo)
    - The purpose of this new clinical measure is to incentivize providers for completing at least one chlamydia test for members 16-20 years of age during the measurement year.
  - Well-Child Visits in the First 15-30 Months of Life
    - The purpose of this new clinical measure is to incentivize providers for completing two or more well child visits between the child's 15 month and one (1) day birthday and 30-month birthday for members who turn 30 months of age during the measurement year.
- **New** for **Family Practice, Internal Medicine, and Pediatrics:**
  - Reduction of Healthcare Disparity (Participation is optional)
    - The purpose of this new clinical measure is to incentivize providers to reduce disparity in a race/ethnicity group within an assigned measure of focus during the measurement year.
- **New Monitoring Measures for Family Practice & Internal Medicine:**
  - Breast Cancer Screening (40-51yo)
    - The purpose of this new monitoring measure is to visualize the completion rate of mammograms for members 40-51 years of age on or between October 1, 2023, and December 31, 2025. The target is one or more mammograms per year.
  - Chlamydia Screening (FP: 16-24yo) (IM: 21-24yo)
    - The purpose of this new monitoring measure is to visualize the completion rate of chlamydia tests for members 16-24 years of age (FP) and 21-24 years of age (IM) during the measurement year. At least one test/member is the target.
- **New Monitoring Measures for Family Practice:**
  - Well-Child Visits in the First 15-30 Months of Life
    - The purpose of this new monitoring measure is to visualize the completion of well child visits between the child's 15 month and one (1) day birthday and 30-month birthday for members who turn 30 months of age during the measurement year. The target is at least two visits annually.
- **New Monitoring Measures for Pediatrics and Family Practice:**
  - Topical Fluoride in Children

- The purpose of this new monitoring measure is to visualize the completion rate of fluoride varnish applications in members 1-4 years of age during the measurement year. The target is at least two applications annually.

### **Non-Clinical Domain**

- **Retired** from **Family Practice & Internal Medicine** – Risk Adjusted Readmission Rate (RAR)
  - Measure was retired due to the implementation of the new follow-up within seven days after Hospital Discharge measure.
- **New** for **Family Practice & Internal Medicine** – Follow-up within seven days after Hospital Discharge
  - The purpose of this new non-clinical measure is to incentivize providers to complete a clinical follow-up for members 18-64 years of age with a primary care provider, a hospital-based provider or specialist provider within seven days after discharge.
- **Change** for **Family Practice, Internal Medicine & Pediatrics** – Patient Experience
  - Added links to measure resources and member benefits located on the PCP QIP webpage.
  - Added a second survey and results example focusing on the member experience directly with their personal doctor.

### **Unit of Service**

- **New** for **Family Practice, Internal Medicine & Pediatrics** – Academic Detailing
  - Providers can earn a \$2500 incentive for scheduling and hosting academic detailing meetings with Partnership's Pharmacy team.
- **Change** from **Family Practice & Pediatrics** – Peer-Led Pediatric Group Visits
  - Expanded the qualifying pediatric well-child group visit to include both Well-Child Visits in the First 15 months of Life and Well-Child Visits in the First 15-30 Months of Life.

### **Targets**

- **Change** for **Family Practice, Internal Medicine & Pediatrics**
  - Partial Points raised to the 75<sup>th</sup> Percentile
  - Full Points raised to the 90<sup>th</sup> Percentile
  - Colorectal Cancer Screening thresholds increased to the 50<sup>th</sup> percentile for partial points and the 75<sup>th</sup> percentile for full points
  - New measures are the exception and targets for full points are set at the 50<sup>th</sup> percentile. New measures are not eligible for partial points.

Prioritization of PCP QIP measure interventions, by time of year.



## Timeline for Addressing 2025 and 2026 PCP QIP Measures

2025				2026
Quarter 1 January – March	Quarter 2 April – June	Quarter 3 July - September	Quarter 4 October – December	Quarter 1 January – March
Year-round: On-call system to reduce emergency visits, hospital follow-ups to prevent readmissions, and control of congestive heart failure and chronic obstructive pulmonary disease to reduce admissions.				
<div> <div>Annual Measures</div> <div>Multi-Year Measures</div> <div>Early Measures</div> </div>				
<ul style="list-style-type: none"> <li>Childhood Immunization Status (0-2 years)</li> <li><b>Updated:</b> Well-Child Visits (0-30 months)</li> <li>Lead Screening in Children (0-2 years)</li> <li>Controlling High Blood Pressure (18-85 years)</li> <li>Diabetes Management: HbA1C good control (18-75 years)</li> <li>Child (3-11 years) and Adolescent (12-17 years) Well Care Visits</li> <li><b>New:</b> Chlamydia Screening (16-24 years)</li> <li><b>New:</b> Reducing Healthcare Disparity Improve performance in a specific group in one of the following measures, in order of priority: <ul style="list-style-type: none"> <li>Child and Adolescent Well Care Visits</li> <li>Breast Cancer Screening</li> <li>Controlling High BP</li> <li>Colorectal Cancer Screening</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li><b>Updated:</b> Breast Cancer Screening (40-75 years)</li> <li>Cervical Cancer Screening (21-64 years)</li> <li>Colorectal Cancer Screening (45-75 years)</li> <li>Adolescent Immunization (10-12 years)</li> <li>Diabetes Management: Retinal Eye Exams (18-75 years)</li> </ul>	<ul style="list-style-type: none"> <li>Well-Child Visits (0-30 months)</li> <li>Lead Screening in Children (0-2 years)</li> </ul> <p>*Schedule those with January – March birthdays</p> <ul style="list-style-type: none"> <li>Childhood Immunization Status (0-2 years)</li> <li>Adolescent Immunization (13 years)</li> </ul> <p>Annual measures <del>gap</del> are closed using <del>eReports</del> uploads before CE and RI are applied in January.</p> <ul style="list-style-type: none"> <li>Controlling High Blood Pressure</li> <li>Diabetes Management: HbA1C good control</li> <li>Child and Adolescent Well Care Visits</li> </ul>	<p><b>Grace Period: January 12-30</b></p> <ul style="list-style-type: none"> <li>Review <del>eReports</del> data after CE and RI applied.</li> <li>Upload missing data in <del>eReports</del> for prior measurement year.</li> </ul>
Revised 3/10/2025				

## Training Resources for Quality and Performance Improvement

### Performance Improvement Online Trainings

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.
- 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.
- Improving Measure Outcomes Webinar Series: An overview of clinical measures including improvement strategies and tools.
- Incorporating Patient Experience in Quality Improvement Projects and Plans.
- 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](#).

### 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.

### Partnership Measure Best Practices Documents

Each year Partnership updates and publishes [measure best practices documents](#) that cover the important details in each of the PCP QIP. Topics include Partnership tools available, supporting programs, outreach strategies, clinical process tips, and equity strategies. The documents were just updated for 2025 and now include the new chlamydia and dental fluoride measures.

## Upcoming trainings

### Improving Measure Outcomes Webinar Series

**Target Audience:** Clinicians, practice managers, quality improvement teams, and staff who are responsible for participating and leading quality improvement efforts within their organization.

The ***Improving Measure Outcomes Webinar Series*** allows Quality Improvement teams to make knowledge actionable, improving quality service and clinical outcomes around specific measures of care.

These learning sessions will cover Partnership's Primary Care Provider Quality Incentive Program measures. Content will focus on direct application on best practices including eliminating health disparities with examples from clinical quality improvement teams who are doing the work.

#### **Remaining 2025 sessions:**

- April 23, 2025 - Diabetes Control

Registration:

[http://www.partnershiphp.org/Providers/Quality/Pages/Quality\\_Events.aspx](http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx)

Contact: [improvementacademy@partnershiphp.org](mailto:improvementacademy@partnershiphp.org)

### Sierra Nevada Conservation & Wilderness Medicine Conference

We are excited to announce that the 2025 Sierra Nevada Conservation & Wilderness Medicine Conference will be held on September 5th-7th, at the UC Berkeley Forestry Camp in Meadow Valley, California! This is a remote venue. Cell service and Wifi are largely inaccessible. A landline is available for emergencies only.

We encourage all participants to stay in the rustic cabins (Gender separate bunk/dorm room style logging) or bring a tent and camp on site, though you can make other accommodations if you choose. RV and Trailer camping is not available at the conference venue.

This year's conference theme is ***THE HEAT IS ON: Wilderness Medicine's Response to Rising Temperatures***. Join us as we delve into the unique, pressing healthcare challenges posed by climate-induced migration, including issues related to public health, infectious disease, mental health, and cross-cultural competency. As always, our conference will also feature world class

speakers and workshops on core wilderness medicine topics such as wound care, sports medicine, ultrasound in remote environments, and many more!

The schedule will feature world-class presenters, a keynote speaker, lectures and workshops relating to wilderness medicine and patient care in remote settings. This high-quality educational event is supported through the combined efforts of Plumas District Hospital, Plumas Health Care Foundation, and The UC Berkeley Forestry Camp. The conference is open to both healthcare and non-healthcare professionals, including students and residents. CME details will be released upon approval.

### **Tuition**

We are a non-profit 501c3. We remain committed to making this event affordable for all registrants, in particular for medical students, residents and paramedics/EMTs with our sliding tuition scale, while preserving the quality experience that you have come to expect from our conference. **(2025 Conference details coming soon!)** These additions will not only enhance the learning experience but also provide more opportunities for hands-on training, skill development, and CME credits. The Tuition Fee is based on a sliding scale and includes all materials, \*key note presentation, 4 lectures, interactive & hands on breakout sessions, and CME Credits (Excluding Non-Conference Attendees)\*. The Facility Fee includes all lodging and camping fees, facilities, and six meals. The Facility Fee is a flat rate of \$230, for each attendee (Our Cost).

Please see the facility & tuition rates for each registrant category below.

- **Physician or Doctoral Level** (\$230 Facility Fee + \$315 Tuition Fee)
- **Non-Doctoral Professional** (\$230 Facility Fee + \$215 Tuition Fee)
- **Resident Physician** (\$230 Facility Fee + \$65 Tuition Fee)

**Student** (Full-Time Current) (\$230 Facility Fee + \$15 Tuition Fee)

- **EMT or EMS professional** (\$230 Facility Fee + \$15 Tuition Fee)
- **Non-Conference Attendee** (Lodging and Meals only) (\$230 Facility Fee)
- **Presenter/Faculty**

Camping and gender separate bunkhouse/dormitory style lodging will be available at the UC Berkeley Forestry Camp, conference venue. Registrants that choose to camp will be responsible for bringing their own camping equipment (Tent, sleeping bag, pads, lights). Conference attendees are also free to pursue and organize their own outdoor activities during free time on Saturday afternoon. Pets are not allowed. Credit or debit card transactions will be processed through Stripe. To pay by cash or check, mail to: Plumas Health Care Foundation, c/o Wilderness Conference, 1065 Bucks Lake Road, Quincy, CA 95971. **Cancellation Policy:** Cancellations received in writing more than four weeks prior to event will receive a full refund minus a refund processing fee. Cancellations received in writing two to four weeks prior will receive a refund minus a \$100.00 administrative fee. There will be no refunds for

cancelations received within two weeks of the event. Please remember that canceling your registration does not automatically cancel your hotel and travel arrangements. Individuals are responsible for canceling their own hotel and travel reservations.

**Registration coming soon!**

CME DETAILS PENDING This event is fiscally sponsored by the Plumas Health Care Foundation with facilitation support from Plumas District Hospital. We depend on sponsors to help keep Conference tuitions affordable. We want to extend a big thank you to our Sponsors (More details coming soon) for partnering with us for 2025!

Questions? Contact us at [information@pdh.org](mailto:information@pdh.org)  
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[www.facebook.com/SierraNevadaCWMC](https://www.facebook.com/SierraNevadaCWMC)