Primary Care Provider Quality Incentive Program Detailed Specifications

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2025

MEASUREMENT YEAR

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I. Quality Incentive Program Contact Information

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II. Program Overview

The Primary Care Provider Quality Incentive Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers sizable financial incentives and technical assistance to primary care providers so they can make significant improvements in the following areas:

- Preventative Screening
- Chronic Disease Management
- Pediatric Access
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience
- Advance Care Planning

Although the PCP Quality Incentive Program evaluates performance on Partnership's Medi-Cal line of business, Partnership encourages high quality, cost-efficient care for all your patients. Incentives are based on meeting specific performance thresholds in measures that address the above areas.

Guiding Principles

The QIP uses nine (9) guiding principles to build and strengthen its provider network through value-based program management that promotes the delivery of high-quality, affordable, and equitable care to our members.

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

The guiding principles outlined above are used to select measures for improvement. These measures are selected in areas that are not addressed under PCP contracts, such as population-level screening targets and other population-level preventive care services. The QIP serves to increase health plan operational efficiencies by prioritizing areas that drive high quality care and have potential to reduce overall healthcare costs.

Program Timeline: Calendar Year

The measurement year begins on January 1 and ends on December 31 of the current year. Please see Appendix VI for details on deadlines specific to any measures. Payment is sent out 120-150 days after the program period ends, in the month of April-May the following year. Partnership HealthPlan of California reserves the right to adjust QIP payment timelines due to holidays and extensive validation processes.

Definitions

Parent Organization (PO): A health providing organization (e.g., a health center, an integrated health system, or a health care administrative entity that owns and oversees the operations of one or more sites in a defined administrative region) that may or may not operate multiple sites.

Primary Care Provider site (PCP site): A clinic location with a designated unique PCP ID who has members actively assigned by Partnership HealthPlan of California. Eligibility and requirements for primary care provider sites are listed in the Partnership's policy MPQP1023, (Access Standards and Monitoring), subject to California Health and Safety Code 1206(h) and HRSA regulations on intermittent sites. All primary care provider sites are listed in the Provider Directory.

Provider: A term that may refer to a PCP PO, a PCP Site, a PCP Clinician, or any other entity or professional that is contracted to provide health care services to Partnership members.

Eligibility for Partnership Program

To be eligible, providers must have a Partnership contract within the first three (3) months of the measurement year. The provider must remain contracted through the end of the measurement year to be eligible for payment.

Eligible providers must be in good standing continuously from the beginning of the measurement year to the month the payment is to be disbursed.

Definition of Good Standing:

Partnership has the sole authority to determine if a provider is in good standing based on the criteria set forth below.

1. Provider is open for services for Partnership members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, Partnership will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against Partnership.

5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with Partnership on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following Partnership policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement, or overbilling.
9. Provider is not conducting other activities adverse to the business interests of Partnership.

Clinical Measures
PCP sites that join Partnership's network mid-year are eligible for payment for the clinical measures of the QIP under the following circumstances:

- PCP sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice or new PCP PO):
  - Must be contracted within the first three (3) months of the measurement year and have at least nine (9) months of members assigned for the measurement year.
- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
  - Must be contracted with members assigned by October 1.
  - New PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP parent organization will be used to support continuous enrollment requirements for clinical measures.

PCP sites who were not contracted within the first three (3) months of the measurement year and did not have at least nine (9) months of members assigned for the measurement year but contracted by October 1 of the measurement year, will still be given visibility of their measure performance with access to eReports and PQD. Please note: Visibility of measure performance does* ***not *guarantee eligibility for program nor payment.*

Non-Clinical Measures
PCP sites that join Partnership's network mid-year are eligible for measures in the non-clinical domains under the following circumstances:

- All PCP sites, regardless of any affiliation with a PCP PO:
  - Must be contracted within the first three (3) months of the measurement year and have at least nine (9) months of members assigned for the measurement year.

Eligible Member Population
The eligible population used to calculate the final scores for all measures is defined as capitated or assigned medical home Medi-Cal members. These members are eligible to be included in PCP sites'

denominator lists assuming other denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

For measures in the clinical domain, the member must be continuously enrolled within a PCP parent organization, with continuous enrollment defined as member assignment for nine (9) out of the 12 months between January 1 and December 31 of the current measurement year (assignment to a site occurs on the first of the month). For multi-site PCP parent organizations, the continuous enrollment criterion is applied at the parent organization level. The anchor date of assignment within a PCP site's final denominator is December 1. This means that members must be assigned as of December 1 to be included in the final denominator lists used to calculate payment. Members who are dually enrolled in Medicare and Medi-Cal, or have other health care coverage are excluded from all measures. Cases in which continuous enrollment criteria negatively affect a site's final rate (compared to the rate calculated in eReports prior to continuous enrollment being applied) should be presented to the QIP Team. Each case will be screened by QIP internal governance for consideration. Sites will be notified of all results prior to final payment.

For measures in the non-clinical domain, continuous enrollment criteria is included within each measure's specifications.

Measure Development and Selection

The measurement set for the QIP is reviewed and developed annually. To maintain a clinically relevant alignment with key external healthcare measurement entities, and a stable measurement set, major changes occur only when significant changes are made across a majority of the key external healthcare measurement entities measurement sets.[1] With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, specifications are developed and the finalized set for the next year is shared with the network. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e., a measure's retirement from the Department of Health Care Services Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's quarterly newsletter.

Measures may evaluate a PCP site's utilization of a certain service or provision of treatment. Partnership recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the

[1] Key External Healthcare Measurement Entities: Healthcare Effectiveness Data and Information Set (HEDIS); National Committee for Quality Assurance - Health Plan Accreditation (NCQA); National Quality Forum (NQF); Patient-centered medical home (PCMH) and Uniform Data System (UDS).

appropriateness of care and services and existence of coverage. Partnership does not offer incentives or compensation to providers, consultants, or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

Payment

The PCP QIP is comprised of two (2) measurement sets, each with its own payment methodology. The PCP QIP Core Measurement Set includes measures in the Clinical, Non-Clinical, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. The amount per member per month (PMPM) available in the PCP QIP will vary by site, according to the principles noted below. The number of member months is multiplied by the site's PMPM then the sum is multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

The methodology for calculating the PCP site PMPM amount will have two (2) components:

1. A base rate of a $4 PMPM minimum
2. A site adjusted supplemental rate (may range from an additional $0 to a maximum of approximately $20 PMPM).

The following six (6) factors will be used to generate the site adjusted supplemental rate:

- **Factors 1a & 1b (Core Adjustment)**
  - An adjustment for the severity of the patient mix of the site, based on an estimate of the additional workload of caring for that patient population
- **Factor 2 (Core Adjustment)**
  - An adjustment for unfavorable socio-demographic mix of patient population
- **Factors 3a & 3b (Core Adjustment)**
  - An adjustment for the difficulty in hiring primary care clinicians at the site
- **Factor 4 (Core Adjustment)**
  - An adjustment for low practice resources
- **Factor 5 (Supplemental Adjustment)**
  - An adjustment for major disruptions in service related to natural disasters
- **Factor 6 (Supplemental Adjustment)**
  - An adjustment to support pediatric access for sites meeting certain criteria

For additional information including recorded presentations and a payment methodology specifications document, please visit our PCP QIP webpage section: Equity Adjustment.

For the unit of service measurement set, the payment is independent of, and distinct from, the financial incentives a site receives from the core measurement Set. A PCP site receives payment according to the measure specifications if the requirements for at least one (1) unit of service measure is met.

Partnership HealthPlan of California reserves the right to adjust QIP payment timelines due to holidays and extensive validation processes.

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. Specific codes for clinical measures are listed in measure specific code sets specified within each measure and can be found in the diagnosis crosswalk in eReports. Specific codes for non-clinical measures are listed in non-clinical specific Code Sets and specified within each measure. These codes are not wholly representative of all reimbursable codes of Partnership.

Any codes outside of the clinical and non-clinical Code Sets are not used for measure evaluation and credit.

eReports

eReports is an online application by which PCP sites can monitor their own performance within the QIP Clinical measures and submit supplemental data to Partnership. The eReports portal may be accessed at https://qip.partnershiphp.org/. The launch date of eReports typically falls within the first quarter of the measurement year to ensure availability of data throughout the year. PCP sites have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e., January 9 – 31 following the measurement year, and is intended to allow for final data collection and uploads.

Small Denominators

All providers, regardless of membership size, will have measures compared against the specified measure thresholds. We are aware that small denominators may negatively impact the overall performance of a particular measure.

Clinical measures: If a provider has 1) Less than 15 members (<15) in the denominator for any clinical measure after continuous enrollment is applied, and 2) Does not meet the threshold, there will be an additional opportunity to submit evidence of outreach efforts to non-responsive members conducted during the measurement year.
Providers with denominators of less than 15 members (<15) must provide evidence of three (3) targeted outreach attempts when requesting a member be excluded from the denominator.

The three (3) outreach attempts must include:

1. One (1) written outreach attempt
2. One (1) verbal outreach attempt
3. A third outreach attempt of the sites choice with the date and type of outreach documented

Evidence of documentation must be submitted on a **Small Denominator Exclusion Template**. This template will be provided by the QIP Team. Please send a request to the QIP Inbox: qip@partnershiphp.org. Documentation must be clear and can be submitted to the QIP team via email or fax. For Modified QIP providers, small denominator exclusions templates are due between January 1-15th, the following measurement year. For all other PCP QIP providers, small denominator exclusions templates are due between **January 15 – 31,** the following measurement year.
Note: Guardian/patient refusal is not an acceptable exclusion. In addition, members who were seen at their assigned PCP or at another PCP within the same parent organization at any point during the current measurement year will not be considered for exclusion.

Non-clinical measures: For PCP sites with less than 500 (<500) assigned members, the Follow-Up within 7 Days after Hospital Discharge and Ambulatory Care Sensitive Admission measures will not apply.

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

Modifications of PCP QIP for PCP Parent Organizations with Very Low PCP QIP scores
PCP Parent Organizations with greater than 1000 assigned members and very low clinical measure scores in the *prior* measurement year are subject to the Modified QIP in the new measurement year and subsequent years until significant performance improvement is achieved.

The modified QIP includes a narrower set of measures, intensive quality coaching with the Partnership Performance Improvement team, a report to the governing board of the organization, and a change in structuring of incentive payments available to the parent organization.

The overall goal of the modified QIP is to find alternative mechanisms, relative to the traditional PCP QIP, to enhance provider engagement in improving member outcomes. Individual parent organization circumstances and assessment of needs inform and customize ongoing quality coaching. Parent organizations initially falling subject to the Modified QIP are notified in the first quarter of the measurement year. Parent organizations failing to actively engage with Partnership on improvement efforts or who demonstrate continued year-over-year low performance are subject to subsequent actions, including, but not limited to: suspension from the PCP QIP, a formal corrective action plan, and termination of its contract with Partnership.

The PCP QIP team, in coordination with a Partnership supplied quality coach, will work closely with each Modified QIP participant to support tracking ongoing measure performance, on-boarding provider staff in program tools and any other requested support. The PCP QIP team will communicate separately with these organizations about timelines and deliverables unique to the Modified QIP.

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and during the validation period following the end of the measurement year. Providers are strongly encouraged to review their year-end data closely during the Preliminary Report Review and eReports validation periods as this data is used to finalize point earnings. If a provider does not notify Partnership of a calculation or point attribution error during these periods, resulting in a potential under or over payment, the error may be corrected by Partnership post-payment through a formal appeal process. The formal appeal process is available for **up to 30 days after the PCP has received their final payment statement**. Additionally, Partnership may recoup overpayments any time after payment is distributed.

Appeals received regarding any of the following five scenarios below will not be considered by the Partnership Executive Team. Final payment appeals must fall outside the following descriptions to be considered for review:

1. **QIP Scores on eReports:** eReports refreshes data twice per week and providers have access to eReports through the well-published grace period (i.e., several days following the close of the measurement year) to check for data discrepancies. Additionally, providers have access to eReports during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, Partnership may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.
2. **Exclusions on eReports:** Some approved exclusions involve a manual process by Partnership staff. Providers are responsible for checking if members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests, which need to be executed by the QIP Team, is January 15 following the measurement year.
3. **Data Reported on the Year-End Preliminary Report:** At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the earnings for Unit of Service measures. Providers will be given one week, commonly referred to as Preliminary Report Review Period, to review this report for calculation discrepancies.

4. **Practice Type Designations:** Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.
5. **Thresholds:** Thresholds are generally set at the beginning of the measurement year and only changed based on unusual circumstances, on input from the QIP governance structure. Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on quantified circumstances as reviewed by QIP governance and approved by Partnership's Executive Team. Post-payment disputes related to thresholds, however, cannot be accommodated.

Should a provider have a concern that does not fall in any of the categories above (i.e., the score on your final report does not reflect your eReports data at the conclusion of the validation period), a Payment Dispute Form must be completed ***within 30 days of receiving the final statement****. All payment adjustments will require approval from Partnership's Executive Team. Please reach out to the QIP team for a Payment Dispute Form at* qip@partnershiphp.org*.*

Governance Structure

The QIP and its measurement set are developed collaboratively with internal and external stakeholders and receive feedback and approval from the following parties:

- ***PCP Provider Network*****:** PCP Providers provide feedback on program structure and measures throughout the measurement year. During the measure development cycle, proposed changes are released to the network for public comment.
- ***QIP Technical Workgroup*****:** The QIP internal workgroup comprised of representatives from Quality Improvement, the Office of the CMO, Finance, Provider Relations, Regional Offices, and IT Departments reviews program policies and proposes measure ideas.
- ***QIP Advisory Group*****:** The QIP external advisory group is comprised of physicians and administrators from all practice types and counties. Their purpose is to provide recommendations on measures and advise on QIP operations.
- ***Partnership Physician Advisory Committee*****:** The Brown Act committee with board certified physicians is responsible for approving measures.
- ***Partnership Board of Commissioners*****:** The Partnership Board approves the financial components of the QIP and reviews and approves the actions of the Physician Advisory Committee, including the QIP measures.

III. Summary of Measures

2025 Primary Care Provider Quality Improvement Program Summary of Measures

For the tables below, please refer to these notes:

1. For most existing clinical measures, the full-point target is set at the 90th percentile performance of all Medicaid health plans reporting to the National Committee for Quality Assurance (NCQA); sites can receive partial points on these measures if the 75th percentile performance is met. For most new clinical measures, the full-point target is set at the 50th percentile performance, with no partial points available. No points through relative improvement are available for new measures.
2. For most existing clinical measures, sites can also earn points based on relative improvement (RI). Please note that if a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement in the current measurement year. Relative improvement measures the percentage of the distance the provider has moved from the previous year's rate toward a goal of 100 percent. The method of calculating relative improvement is based on a *Journal of the American Medical Association* article authored by Jencks et al in 2003, and is as follows:

$$\frac{\text{(Current year performance)} - \text{(previous year performance)}}{\text{(100 – Previous year performance)}} \times 100$$

The formula is widely used by the Integrated Healthcare Association's commercial pay-for-performance program as well as by the Center for Medicare and Medicaid Services.

- A site's performance on a measure must meet the 75th percentile target to be eligible for RI points on the measure
- **Have an RI score of 15% or higher**, as compared to the previous year's performance, ending up thereby achieving performance equal to or exceeding between the 75th percentile and not exceeding the 90th percentile, to earn full points.

3. Non-Clinical targets will be communicated to the provider network in spring 2025.
4. Most of the clinical measures use performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2023 as targets.

2025 Primary Care Provider Quality Improvement Program Summary of Measures

Core Measurement Set – Family Medicine

To view the actual targets for Clinical measures, please refer to the QIP Specifications Manual via eReports

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening			6	4
Cervical Cancer Screening			6	4
Child and Adolescent Well Care Visits			9	7
Childhood Immunization Status: Combo 10			6	4
Colorectal Cancer Screening	**75th Percentile**	**50th Percentile**	5	4
Comprehensive Diabetes Care: HbA1c Control			6	4
Comprehensive Diabetes Care - Retinal Eye Exams			5	4
Controlling High Blood Pressure			6	4
Lead Screening in Children			6	4
Immunizations for Adolescents – Combo 2			6	4
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
Well-Child Visits in the First 15 Months of Life			9	7
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	**TBD**	**TBD**	5	4
Follow-Up within 7 Days after Hospital Discharge	**TBD**	**TBD**	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	**TBD**	**TBD**	5	4
PCP Office Visits	**TBD**	**TBD**	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 44.55%) 50th Percentile (Communication 74.70%)	25th Percentile (Access 36.39%) 25th Percentile (Communication 64.70%)	10	9

Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				
Breast Cancer Screening (40-49yo) *Monitoring Measure*	**50th Percentile**	N/A – New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
Chlamydia Screening in Women (16-24yo) *Monitoring Measure*	**50th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
Topical Fluoride in Children *Monitoring Measure*	**25th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
Well-Child Visits in the First 15-30 Months of Life *Monitoring Measure*	**50th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
		TOTAL POINTS	**100**	**75**

Topical Fluoride in Children is not a HEDIS measure and is measured based on the Centers for Medicare & Medicaid Services (CMS) calculated national median, which serves as the MPL.

2025 Core Measurement Set – Internal Medicine

To view the actual targets for Clinical measures, please refer to the QIP Specifications Manual via eReports

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening			15	11
Cervical Cancer Screening			15	11
Colorectal Cancer Screening	**75th Percentile**	**50th Percentile**	12	9
Comprehensive Diabetes Care: HbA1c Control			12	9
Comprehensive Diabetes Care - Retinal Eye Exams			6	4
Controlling High Blood Pressure			10	7
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
NON-CLINICAL DOMAIN:APPROPRIATE USE OF RESOURCES[3]				
Ambulatory Care Sensitive Admissions	**TBD**	**TBD**	5	4
Follow-Up within 7 Days after Hospital Discharge	**TBD**	**TBD**	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	**TBD**	**TBD**	5	4
PCP Office Visits	**TBD**	**TBD**	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 44.55%) 50th Percentile (Communication 74.70%)	25th Percentile (Access 36.39%) 25th Percentile (Communication 64.70%)	10	8

Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEAURES				
Breast Cancer Screening (40-49yo) *Monitoring Measure*	**50th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
Chlamydia Screening in Women (21-24yo) *Monitoring Measure*	**50th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
		TOTAL POINTS	**100**	**75**

2025 Core Measurement Set – Pediatrics

*****To view the actual targets for Clinical measures, please refer to the QIP Specifications Manual via eReports*****

Measure Name	Full Point Target 90th Percentile (unless otherwise indicated)	Partial Point Target 75th Percentile (unless otherwise indicated)	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Child and Adolescent Well Care Visits			14	12
Childhood Immunization Status: Combo 10			11	9
Chlamydia Screening (16-20yo)	**50th Percentile**	N/A – New measures do not qualify for partial points in the first measurement year	5	N/A
Lead Screening in Children			9	7
Immunizations for Adolescents – Combo 2			11	9
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
Well-Child Visits in the First 15 Months of Life			11	9
Well-Child Visits in the First 15-30 Months of Life	**50th Percentile**	N/A – New measures do not qualify for partial points in the first measurement year	5	N/A
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	**TBD**	**TBD**	11	9
PCP Office Visits	**TBD**	**TBD**	11	9
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	50th Percentile (Access 44.55%) 50th Percentile (Communication 74.70%)	25th Percentile (Access 36.39%) 25th Percentile (Communication 64.70%)	12	11
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				

[5] For any measure, if "Partnership" is the only data source, Providers may not submit uploads for the measure through eReports. Partnership uses administrative data (Claims/Encounter/RxClaims) for these measures only.

Topical Fluoride in Children *Monitoring Measure*	**25th Percentile**	N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
		TOTAL POINTS	**100**	**75**

Topical Fluoride in Children is not a HEDIS measure and is measured based on the Centers for Medicare & Medicaid Services (CMS) calculated national median, which serves as the MPL.

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000 per site • $100 per Advance Directive/POLST, maximum payment $10,000 per site
Extended Office Hours	**For Capitated PCPs only**. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). Non-capitated PCPs will have additional funding added to the core measure set.
PCMH Certification	$1000 yearly per site, for achieving or maintaining PCMH accreditation.
Peer-led & Pediatric Group Visits	$1000 per group, either new or existing. (Maximum of 15 groups per parent organization).
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of Health Equity implementation initiative or an annual updated Health Equity report.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.

Electronic Clinical Data System (ECDS)	Maximum of $5,000 per parent organization. Allowance of data exchange from Provider Electronic Health Records to Datalink to capture clinical screenings, follow-up care and outcomes. Participation to include data collection of specific clinical components for all Partnership members within your organization. 1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2025. Agreements signed after September 30, 2025 will be eligible for half payment ($1,000) through December 31, 2025 2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2025 and the Parent Organization responds timely to request for verification.
Early Administration of First HPV Dose	Administer the first HPV dose by the age of 12 to have the required 6-month pause between the first and 2nd dose and another 6 months to administer the 2nd HPV dose before the 13th birthday $50 per HPV dose given before age 12 after 5% threshold of assigned members completed administration.
Early Administration of Initial Flu Vaccine Series (two doses)	Early administration of influenza *and* to complete administration of the 2nd dose within 60 calendar days of the 1st dose. $50 per two dose series completed by 15 months of age, with the 2 doses up to 60 days apart after 5% threshold of assigned members completed administration.
Academic Detailing	$2,500 bonus for scheduling and hosting academic detailing meetings with at least one provider for each site, with a minimum of one Medical Director, one Pharmacist (where applicable) & QI team and Partnership HealthPlan pharmacist/medical director present. There is a two-part meeting requirement for the incentive: **First** meeting to review the data ($2500) and **Second** meeting to follow-up for feedback ($1000). If a pharmacy academic meeting is scheduled with only one medical director at the first initial meeting,

IV. Clinical Domain
Measure 1. Breast Cancer Screening

Description

The percentage of continuously enrolled Medi-Cal members 50-74 years of age were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

This measure has an age group included as a monitoring measure for 2025**

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

***Denominator**

The number of continuously enrolled assigned members 52 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1951 and December 31, 1973).

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2023 and December 31, 2025

Exclusions

- Member who had a bilateral mastectomy any time during their member history through December 31 of the measurement year. Member has a diagnosis of palliative care during the measurement year.
- Members who had an encounter for palliative care any time during the measurement period.
- Member has had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.
- Members aged 66 and older by the end of the measurement period, with frailty and advanced illness.
  Member with Sex Assigned at Birth (LOINC code 76689-9) or Male (LOINC code LA2-8) at any time in the patient's history.

Measure Rationale and Source

According to JAMA Network's Jill Jin, MD, MPH (2014), screening for breast cancer means looking for signs of breast cancer in all women, even if they have no symptoms (Jin, 2014). The goal of screening is to catch cancers early (Jin, 2014). Early-stage cancers are easier to treat than later-stage cancers, and the chance of survival is higher (Jin, 2014). Routine screening for breast cancer lowers one's risk of dying of breast cancer (Jin, 2014).

DHCS requires Partnership to report this as part of the annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Breast Cancer Screening (#2372), and UDS Breast Cancer Screening (CMS125v8).

IV. Clinical Domain
Measure 2. Cervical Cancer Screening

Description
The percentage of continuously enrolled members 21–64 years of age who were recommended for routine cervical cancer screening.

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator
The number of continuously enrolled assigned women 24 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1961 and December 31, 2001).

Numerator
The number of assigned women in the eligible population who were appropriately screened according to evidence-based guidelines.

For full details, please review QIP specifications manual via eReports.

Exclusions
- Members who have had a hysterectomy with no residual cervix any time during their history through December 31, 2025
- Members who have had cervical agenesis or acquired absence of cervix any time during their history through December 31, 2025.
- Members who have had a diagnosis of palliative care during the measurement year.
- Members who have had an encounter for palliative care any time during the measurement period.
- Members who have had with Sex Assigned at Birth or Male at any time in the patient's history.

Measure Rationale and Source
According to American College of Obstetricians and Gynecology (ACOG), it usually takes 3–7 years for high-grade changes in cervical cells to become cancer (Cervical Cancer Screening, n.d.). Cervical cancer screening may detect these changes before they become cancer (Cervical Cancer Screening, n.d.). Women with low-grade changes can be tested more frequently to see if their cells go back to normal (Cervical Cancer Screening, n.d.). Women with high-grade changes can get treatment to have the cells removed (Cervical Cancer Screening, n.d.)
DHCS requires Partnership to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Cervical Cancer Screening (#0032), and UDS Cervical Cancer Screening (CMS124v7).

Partnership acknowledges that the American Cancer Society updated their guidelines to recommend cervical cancer screening via HPV testing starting at age 25 years. Partnership continues to follow the USPSTF and NCQA standards as written above. We also note that self-collection is likely to become acceptable for this measure sometime in 2025; specifications will be updated if needed when this occurs.

IV. Clinical Domain

Measure 3. Child and Adolescent Well-Care Visits

Description

The percentage of members continuously enrolled 3 - 17 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Here are some helpful links for information regarding Partnership's pediatric preventive care:

- For the Medical Staff, Partnership's Pediatric Preventive Health Guidelines (MCQG1015) is available in Partnership's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31 of the measurement year (DOB between January 1, 2008 and December 31, 2022).

Numerator

The number of children in the eligible population with at least one (1) well-care visit with a PCP or OB/GYN during the measurement year (January 1, 2025 and December 31, 2025). The services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2023 n.d). Services that occur over multiple visits may be counted, if all services occur in the time frame specified by the measure.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015).
Here are some of the benefits of well-care visits:

- Prevention: Children are scheduled immunizations to prevent illness. Providers can provide parent/guardian(s) with nutrition and safety education in the home and at school.
- Tracking growth and development. Documenting how much a child has grown in the time since their last visit and talking with parent/guardians(s) about their child's development. Providers can have a discussion with parent/guardian(s) about the child's milestones, social behaviors and learning.
- Raising concerns. Ask the child parent/guardian(s) to provide a list of topics they want to talk about with their child's pediatrician such as development, behavior, sleep, eating or relations with other family members. The parent/guardian(s) can provide the top three (3) to five (5) questions or concerns to the pediatrician at the start of the visit.
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires Partnership to report this as part of the annual report of MCAS measures. Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, and MCAS.

IV. Clinical Domain

Measure 4. Childhood Immunization Status – Combo 10

Description

The percentage of children continuously enrolled, 2 years of age who had four (4) diphtheria, tetanus and acellular pertussis (DTaP); three (3) polio (IPV); one (1) measles, mumps and rubella (MMR); three (3) *haemophilus* influenza type B (HiB); three (3) hepatitis B (HepB), one (1) chicken pox (VZV); four (4) pneumococcal conjugate (PCV); one (1) hepatitis A (HepA); two (2) or three (3) rotavirus (RV); and two (2) influenza (flu) vaccines by their second birthday.
Here are some helpful links for information regarding Partnership's Pediatric Preventive Care:

- For the Medical Staff, Partnership's Pediatric Preventive Health Guidelines (MCQG1015) is available in Partnership's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2023 and December 31, 2023).

Numerator

The number of assigned children who have had all of the following vaccines by their second birthday:

- Four dose (4) diphtheria, tetanus and acellular pertussis (DTaP)
- Three dose (3) polio (IPV)
- One dose (1) measles, mumps and rubella (MMR)
- Three dose (3) *Haemophilus influenzae* type B (HiB)
- Three dose (3) hepatitis B (HepB)
- One dose (1) chicken pox (VZV)
- Four dose (4) pneumococcal conjugate (PCV)
- One dose (1) hepatitis A (HepA)
- Two dose (2) or three dose (3) rotavirus (RV)
- Two dose (2) influenza (flu)

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2025. For full details, please review QIP specifications manual via eReports.

Exclusions (only if not numerator hit)

Exclude children who had a medical contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), diseases that used to be common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, rotavirus and Haemophilus influenzae type b (Hib) can now be prevented by vaccination (Why are Childhood Vaccines So Important? n.d.). Thanks to a vaccine, one of the most terrible diseases in history – smallpox – no longer exists outside of the laboratory (Why are Childhood Vaccines So Important? n.d.). Over the years, vaccines have prevented countless cases of disease and saved millions of

lives (Why are Childhood Vaccines So Important? n.d.) DHCS requires Partnership to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, MCAS, NQF Childhood Immunization Status (#0038), and UDS Childhood Immunizations (CMS117v7).

IV. Clinical Domain

Measure 5. Chlamydia Screening

Description

The percentage of continuously enrolled Medi-Cal members for whom screening is indicated 16-20 years of age who had at least one test for chlamydia during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.
Pediatric: 16-20yo (New for MY25)

This measure has an age group(s) included as a monitoring measure for 2025

*Denominator

The number of continuously enrolled assigned members for whom screening is indicated 16-20 years of age as of December 31 of the measurement year (DOB between January 1, 2005 and December 31, 2009).

Numerator

The number of members from the eligible population in the denominator with at least one (1) test for chlamydia during the measurement year (January 1, 2025 - December 31, 2025)

Exclusions

Member with Sex Assigned at Birth or Male at any time in the patient's history.

Measure Rationale and Source

The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: "Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV". Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

IV. Clinical Domain

Measure 6. Colorectal Cancer Screening

Description

The percentage of continuously enrolled assigned members 45–75 years of age who had appropriate screening for colorectal cancer.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Please note: For MY2025, Partnership has increased the Colorectal Cancer Screening benchmark targets. PARTNERSHIP is now using NCQA MediCaid standards and 2025 targets are set at the 50th percentile for partial points and 75th percentile for full points. Targets will be set at 75th percentile for partial points and 90th percentile for full points in the following QIP measurement year.

Denominator

The number of continuously enrolled assigned members 46-75 years of age by December 31 of the measurement year (DOB between January 1, 1950 and December 31, 1979).

Numerator

The number of assigned members 46–75 years of age who had one or more screenings for colorectal cancer. For full details, please review QIP specifications manual via eReports.

Exclusions (only if not numerator hit)

Members who have had either of the following any time during their history through December 31 of the measurement year:

- Colorectal cancer.
- Total colectomy.
- Diagnosis of palliative care **during the measurement year.**
- Members who had an encounter for palliative care **any time during the measurement year.**
- Members aged 66 and older by the end of the measurement period, with frailty and advanced illness.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC), colorectal cancer screening saves lives (Colorectal Cancer Awareness, n.d.). The U.S. Preventive Services Task Force (USPSTF) expanded the recommended ages for colorectal cancer screening to 45 to 75 years (previously, it was 50 to 75 years). If the member is older than 75, screening is to be determined by the physician (Colorectal Cancer Screening, n.d.). DHCS requires Partnership to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, NQF Colorectal Cancer Screening (#0034), and UDS Colorectal Cancer Screening (CMS130v7).

IV. Clinical Domain

Measure 7. Comprehensive Diabetes Management – HbA1C Good Control

Description

The percentage of continuously enrolled assigned members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold. For Partnership's Clinical Practice Guidelines for diabetes mellitus: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled assigned members 18-75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1950 and December 31, 2007).

Numerator

The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1 ≤9.0% during the measurement year.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2024 – December 31, 2025), and who meet either of the following criteria:

- Members who have received palliative care any time during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
  Members aged 66 and older by the end of the measurement period, with frailty and advanced illness.

Measure Rationale and Source

Diabetes is a complex group of diseases marked by high blood glucose (blood sugar) due to the body's inability to make or use insulin (National Diabetic Statistics Report, 2020). Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death (National Diabetic Statistics Report, 2020). Many interventions intended to prevent/control diabetes are cost saving or very cost-effective and supported by strong evidence (Li et al., 2010).

DHCS requires Partnership to report a comparable diabetic measure as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure CDC: Comprehensive Diabetes Care, MCAS, and NQF Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (#0059), and Diabetes Poor Control (CMS122v7).

IV. Clinical Domain

Measure 8. Comprehensive Diabetes Management – Retinal Eye Exam

Description

The percentage of continuously enrolled members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy. For Partnership's Clinical Practice Guidelines for diabetes mellitus: http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1950 and December 31, 2007) with diabetes identified as of December 31 of the measurement year.

Numerator

The number of diabetics in the eligible population with evidence of an eye screening for diabetic retinal disease. For full details, please review QIP specifications manual via eReports.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and who meet either of the following criteria:

- Members who have received palliative care any time during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
- Members aged 66 and older by the end of the measurement period, with frailty and advanced illness.

Measure Rationale and Source

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Respiratory Conditions, MCAS, and NQF Comprehensive Diabetes Care: Eye Exam (#0055).

IV. Clinical Domain

Measure 9. Controlling High Blood Pressure

Description

The percentage of continuously enrolled assigned members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled assigned members 18-85 years of age as of December 31 of the measurement year (DOB between January 1, 1940 and December 31, 2007) who had at least (2) outpatient visits, telephone visits, e-visits or virtual check-ins on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year (DOS between January 1, 2024 – June 30, 2025). Visit type need not be the same for the (2) visits.

Numerator

The number of assigned members population whose most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year. The BP reading must occur **on or after** the date of the second (2nd) diagnosis of hypertension.

The member is numerator compliant if the BP is <140/90 mm Hg. The member is **not compliant** if the BP is ≥140/90 mm Hg, or if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

Exclusions

- Members who have had a diagnosis that indicates end-stage renal disease (ESRD, any time during the member's history on or prior to 12/31/2025.
- Members who have had a procedure that indicates ESRD: dialysis, nephrectomy or kidney transplant any time during the member's history on or prior to 12/31/2025.
- Female members with a diagnosis of pregnancy during the measurement year.
- Member who had a diagnosis of palliative care during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
- Members aged 66-80 years of age as of December 31 of the measurement year with frailty and advanced illness.

Measure Rationale and Source

According to the Centers for Disease Control and Prevention (CDC) 2012 Vital Signs report:

- Nearly 1 in 3 adults (about 67 million) have high blood pressure
- About 36 million adults with high blood pressure don't have it under control
- High blood pressure contributes to nearly 1,000 deaths a day (Getting Blood Pressure Under Control, 2012).

High blood pressure is a major risk factor for heart disease and stroke, both of which are leading causes of death in the US (Getting Blood Pressure Under Control, 2012). Nearly one-third of all American adults have high blood pressure and more than half of them don't have it under control (Getting Blood Pressure Under Control, 2012). Blood

pressure control means having a systolic blood pressure less than 140 mmHg and a diastolic blood pressure less than 90 mmHg, among people with high blood pressure (Getting Blood Pressure Under Control, 2012). Many with uncontrolled high blood pressure don't know they have it. Millions are taking blood pressure medicines, but their blood pressure is still not under control (Getting Blood Pressure Under Control, 2012). There are many missed opportunities for people with high blood pressure to gain control (Getting Blood Pressure Under Control, 2012). Doctors, nurses and others in health care systems should identify and treat high blood pressure at every visit (Getting Blood Pressure Under Control, 2012).
DHCS requires Partnership to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure cardiovascular conditions, MCAS, NQF Controlling High Blood Pressure (#0018), and UDS Controlled Hypertension (CMS165v7).

IV. Clinical Domain
Measure 10. Lead Screening in Children

Description
The percentage of continuously enrolled children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator
The number of continuously enrolled Medi-Cal members within last 365 days, who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2023 and December 31, 2023).

Numerator
The number of assigned children who had at least one lead capillary or venous blood test on or before their second birthday.

Exclusions
Members who have received Palliative Care during the measurement year.

Measure Rationale and Source
Lead is a common environmental contaminant present in all areas of the United States, and all children are at risk for lead's toxic effects. Within the United States approximately half a million children ages one to five years have blood lead levels (BLLs) greater than five mcg/dL. Lead exposure is one of the most common and preventable environmental diseases among California children. (Blood Lead Testing and Anticipatory Guidance – DHCS July 2023). No level of lead (Pb) in the body is recognized as safe. Lead toxicity is associated with impaired cognitive, motor, behavioral, and physical abilities. In 2021, the Centers for Disease Control and Prevention (CDC) lowered the blood lead reference value (BLRV) to 3.5 micrograms per deciliter (mcg/dL) to identify children with BLLs that are higher than most children's levels. The BLRV is the level at which health care providers are recommended to provide retesting and follow-up (Blood Lead Testing and Anticipatory Guidance – DHCS July 2023).

The only way to know if a child is lead poisoned is to obtain a BLL. Young children from six months to six years (particularly those at one and two years) are at greatest risk. Under California regulations, providers must give anticipatory guidance on lead poisoning prevention at each periodic health assessment from the age of six months up to 72 months. California statute requires that health care providers inform parents and guardians about the risks and effects of childhood lead exposure, the requirement that children enrolled in Medi-Cal receive blood lead tests, and the requirement that children not enrolled in Medi-Cal who are at high risk of lead exposure receive blood lead tests. The provider must order BLLs at the ages of one and two years and whenever a child under six years is identified as having missed the required tests, a change in circumstances has put the child at risk, or if requested by the parent or guardian and medically indicated. (Blood Lead Testing and Anticipatory Guidance – DHCS July 2023).

IV. Clinical Domain
Measure 11. Immunizations for Adolescents

Description
The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series by their 13 birthday. Here are some helpful links for information regarding Partnership's Pediatric Preventive Care:

- For the Medical Staff, Partnership's Pediatric Preventive Health Guidelines (MCQG1015) is available in Partnership's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator
The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2012 and December 31, 2012).

Numerator
The number of assigned adolescents who had at least one (1) dose of meningococcal vaccine; at least one (1) tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday. Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2025

Exclusions
Exclude adolescents who had a contraindication for a specific vaccine from the denominator for all antigen rates and the combination rates. The denominator for all rates must be the same. Contraindicated adolescents may be excluded only if administrative data does not indicate that the contraindicated immunization was given.

Measure Rationale and Source
Thirty-five million American adolescents fail to receive at least one recommended vaccine (Schaffer et al., 2005). This gap exists despite specific adolescent immunization recommendations from the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) (Schaffer et al., 2005). Low immunization rates in adolescents have a wide array of implications—outbreaks of vaccine-preventable diseases, negative effects on quality of life and increased disease associated costs (Schaffer et al., 2005). Importantly, low immunization rates establish reservoirs of disease in adolescents that can affect others, including high-risk infants, elderly persons and persons with underlying medical conditions (Schaffer et al., 2005).

DHCS requires Partnership to report this as part of annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Immunizations for Adolescents (#1407).

IV. Clinical Domain

Measure 12. Reducing Healthcare Disparity

Description

Partnership is actively engaged in Health Equity (HE) initiatives that bring equitable awareness and result in improved quality performance within the 24 counties we serve. We highly encourage provider organizations to partner with us in these efforts. Together, we can help move our communities toward equitable access to healthcare. In reviewing the performance of our clinical measures, we recognize there are underlying disparities among our member populations based on location, access and Social Determinants of Health (SDOH). To help our provider organizations with identifying and addressing disparities in their member populations, we have created the Disparity Analysis dashboard housed within eReports which promotes the identification of disparities across all PCP QIP clinical measures based on race/ethnicity groups.

This new clinical measure will incentivize participating sites with set dollar amounts if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the primary focus, followed by Breast Cancer Screening, Controlling High Blood Pressure & Colorectal Cancer Screening).

Participation Requirements

Parent Organizations that have sufficient Partnership assigned member volume can earn up to a maximum of 7% of a designated PCP site's total baseline PCP QIP payment for meeting performance thresholds in certain race/ethnicity groups. Sufficient member assignment volume is defined as having at least one visit by 2400 unique Partnership members between January and December of the prior measurement year.

If a Parent Organization does not meet the criteria for sufficient member assignment volume or, **they do not wish to participate in the Reduction of Inequity Adjustment measure**, they may still participate in the Unit of Service – Health Equity Implementation measure. However, **a Parent Organization must indicate which measure they choose for participation.**

Intent to Participate

All qualifying Parent Organizations will be notified of qualification status via email **between March 3 and March 7, 2025.** Upon notification, qualifying Parent Organizations must indicate intent to participate by notifying the PCP QIP team at qip@partnerhsiphp.org **by end of business, March 31, 2025**.

Measure of Focus and Race/Ethnicity Assignment Criteria

The PCP QIP team will work with the Health Equity Medical Director to determine which site(s) meet measure and race/ethnicity denominator criteria for measure incentive.

Once all PCP sites have been evaluated and approval has been received from the Partnership's Health Equity Officer, measure and race/ethnicity group assignments will be shared via email by the PCP QIP team in May 2025. For full details, please review QIP specifications manual via eReports.

Incentive Payment

A 3% or 7% bonus can be earned and will be calculated on the providers base pay from MY2025. For full details, please review QIP specifications manual via eReports.

Measure Rationale and Source

According to the National Institute on Minority Health and Health Disparities (NIMHD), racial and ethnic health disparities cost the U.S. economy $451 billion, a 41% increase from the previous estimate of $320 billion in 2014 (LaVeist et al, 2023) . This is based upon the idea people experience high levels of poor health, chronic diseases, and disabilities—coupled with low access to quality health care—resulting in excessive medical care costs, lower labor market productivity, and premature deaths. Currently, many health systems are limited to

effectively address health disparities due to current financial constraints to implement programs and services designed to reach underserved populations and close key quality gaps. A systematic literature review by Conway and Satin found that Pay-for-Performance (P4P) and Value-Based Payment (VBP) can be effective to address health disparities if the right set of design features and the right payment context are utilized. Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including Agency for Healthcare Research and Quality (AHRQ).

IV. Clinical Domain

Measure 13. Well-Child Visits in the First 15 Months of Life

Description

The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life. Here are some helpful links for information regarding Partnership's Pediatric Preventive Care:

- For the Medical Staff, Partnership's Pediatric Preventive Health Guidelines (MCQG1015) is available in PARTNERSHIP's Provider Manual at: http://www.partnershiphp.org/Providers/Policies/Pages/QualityMonitoringandImprovement.aspx
- Training materials for the clinician: http://www.partnershiphp.org/Providers/Medi-Cal/Pages/Well-Child-Visits-Training-Materials.aspx

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of continuously enrolled Medi-Cal members who turn 15 months old between January 1 and December 31 of the measurement year (DOB between October 3, 2023 and October 2, 2024).

Numerator

The number of children in the eligible population with at least six (6) well-child visits with a PCP by the date of age 15 months.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), parents know who they should go to when their child is sick. But pediatrician visits are just as important for healthy children (Sturgeon, 2015). Here are some of the benefits of well-child visits:

- Prevention: Children are scheduled immunizations to prevent illness. Providers can provide parent/guardian(s) with nutrition and safety education in the home and at school.
- Tracking growth and development. Documenting how much a child has grown in the time since their last visit and talking with parent/guardians(s) about their child's development. Providers can have a discussion with parent/guardian(s) about the child's milestones, social behaviors and learning.
- Raising concerns. Ask the child parent/guardian(s) to provide a list of topics they want to talk about with their child's pediatrician such as development, behavior, sleep, eating or relations with other family members. The parent/guardian(s) can provide the top three to five questions or concerns to the pediatrician at the start of the visit.
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires Partnership to report this as part of annual MCAS reporting.
Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, and NQF Well-Child Visits in the First 15 Months of Life (#1392).

IV. Clinical Domain
Measure 14. Well-Child Visits in the First 15-30 Months of Life (W30-2)

Description
The percentage of continuously enrolled Medi-Cal members who turned 15 months and one day - 30 months old during the measurement year and had two (2) or more well-child visits.

Points and Thresholds by Practice Type
Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Pediatric: 15 months-30 months (New for MY 2025)

This measure has an age group(s) included as a monitoring measure for 2025

*Denominator
The number of continuously enrolled assigned members who turn 30 months old during January 1 and December 31 of the measurement year (DOB between July 1, 2022 and July 30,2023)

Numerator
The number of children in the eligible population with two (2) or more well-child visits on different dates of service between the child's 15-month birthday plus one (1) day and the 30 month birthday.

Exclusions
- Members who have received hospice services or elect to use a hospice benefit any time during the measurement year.
- Member who became deceased any time during the measurement year.

Measure Rationale and Source
According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits.

V. Appropriate Use of Resources

Measure 15. Ambulatory Care Sensitive Admissions

Description

Admission rate of assigned members with any of the principle diagnoses from Agency for Healthcare Research and Quality (AHRQ), Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI) listed in the numerator, during the measurement year.

****Existing Sites*** (contracted in the prior and new measurement year) must have a minimum of 500 eligible members by December 1 of the prior measurement year to be eligible for this measure.

****New Sites*** (contracted during the current measurement year) must have a minimum of 500 eligible members by December 1 of the current measurement year to be eligible for this measure. Points and Thresholds by Practice Type

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

Total hospital days for all admissions for eligible population during the measurement period.

Numerator

Total hospital days for inpatient admissions with a qualifying diagnosis from the provided list of PQIs and PDIs. The PQI and PDI principle diagnoses for each are located on AHRQ resource page.

Preventive Quality Indicators (PQI)	Pediatric Quality Indicators (PDI):
• PQI 01 – Diabetes Short-term Complications • PQI 03 – Diabetes Long-term Complications • PQI 05 – COPD or Asthma in Older Adults Admission Rate • PQI 07 – Hypertension • PQI 08 – Heart Failure • PQI 11 – Community Acquired Pneumonia Admission Rate • PQI 12 – Urinary Tract Infection • PQI 14 – Uncontrolled Diabetics • PQI 15 – Asthma in Younger Adults • PQI 16 – Lower-Extremity Amputation among Patients with Diabetes	• PDI 14 – Asthma Admissions Rate • PDI 15 – Diabetes Short-term Complications • PDI 16 – Gastroenteritis • PDI 18 – Urinary Tract Infection

For full details, please review QIP specifications manual via eReports.

Exclusions

Factors and indicators qualifying for exclusion:

- See the PQI and PDI numerator details section for exclusions from the individual composite indicators
- Hospitalizations for obstetrics
- Hospice
- Acute hospital transfers

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), the PQIs are a set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions" (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease (Guide to Prevention Quality Indicators, 2001). The Pediatric Quality Indicators (PDIs) focus on potentially preventable complications and iatrogenic events for pediatric patients treated in hospitals and on preventable hospitalizations among pediatric patients, taking into account the special characteristics of the pediatric population (Pediatric Quality Indicators Overview, n.d.). Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including Agency for Healthcare Research and Quality (AHRQ) PQI and PDI Measures.

V. Appropriate Use of Resources

Measure 16. Follow-Up Within 7 Days After Hospital Discharge

Description

The percentage of discharges for members 18 to 64 years of age who received a clinical follow-up with a primary care provider, a hospital-based provider or specialist provider within 7 days of discharge. Follow-up visits may include in-person, telephone, and telehealth visits. Clinical visits by a qualified medical professional include those with a patient's primary care provider, other specialist, mental health professional, PA, NP, RN, CNM or a hospitalist/hospital-based clinician in a hospital discharge visit. Visits with a case manager (non-RN) would not count towards the numerator for this measure.

****Existing Sites*** (contracted in the prior and new measurement year) must have a minimum of 500 eligible members by December 1 of the prior measurement year to be eligible for this measure.

****New Sites*** (contracted during the current measurement year) must have a minimum of 500 eligible members by December 1 of the current measurement year to be eligible for this measure.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of acute or non-acute inpatient discharges on or between January 1 and December 1 of the measurement year for members 18 to 64 years of age continuously enrolled from the date of discharge through 30 days after discharge (31 days)

Numerator

Patient engagement provided within seven days after discharge. Do not include patient engagement that occurs on the date of discharge. The following meets criteria for patient engagement:

- An outpatient visit, telephone visit, telehealth visit.
- Transitional care management services.
- Place of service
- Service provider specialty
- Service provider category

Exclusions

- Members who have used hospice services or elect to use a hospice benefit any time during the measurement year
- Members who have died any time during the measurement year
- Members who have had discharges for death
- Members who have had pregnancy condition
- Members who have had perinatal condition
- LTC/SNF Members who has been discharged back into long-term care/SNFs

Measure Rationale and Source

According to National Committee for Quality Assurance (NCQA), a "readmission" occurs when a patient is discharged from the hospital and then admitted back into the hospital within a short period of time (Plan All-Cause Readmission, n.d.). A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination (Plan All-Cause Readmission, n.d). Unplanned readmissions are associated with increased mortality and higher health care costs (Plan All-Cause

Readmission, n.d). They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d).

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768).

A follow up with a hospitalist, a primary care clinician or a specialist within a week after discharge from the hospital can help reduce readmissions back to the hospital. While this can be a struggle, a good strategy to attain this goal is to have a proper discharge summary which can be communicated with the follow-up provider.

VI. Access and Operations

Measure 17. Avoidable Emergency Department (ED) Visits/1000 Members per Year

Description

The rate of assigned members with “avoidable ED visits” with a primary diagnosis that matches the diagnosis codes selected by Partnership.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The number of assigned members 1 year of age or older with an emergency department visit anytime during the measurement year.

Numerator

The number of assigned members 1 year of age or older with “avoidable ED visits” with a primary diagnosis that matches the diagnosis codes selected by Partnership. For full details, please review QIP specifications manual via eReports.

Exclusions

- Members who are less than one (1) year of age at the time of the visit.
- ED claims with at least one (1) diagnosis code not considered avoidable will deem the visit as not avoidable.

Measure Rationale and Source

ED visits are a high-intensity service and a cost burden on the health care system, as well as on patients (Measures of Care Coordination, 2015). Some ED events may be attributed to preventable or treatable conditions (Measures of Care Coordination, 2015). A high rate of ED utilization may indicate poor care management, inadequate access to care or poor patient choices, resulting in ED visits that could be prevented (Dowd, et al., 2014). Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities.

VI. Access and Operations

Measure 18. PCP Office Visits

Description

The number of Primary Care Provider visits per member per year by Partnership eligible members with participating QIP providers. Partnership will extract the total number of Partnership office visits, telephone visits, and video visits from claims and encounter claims data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site.

Thresholds

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Denominator

The average number of months per year a member is assigned to a participating QIP PCP.

Numerator

The total number of visits during the measurement year with any PCP in Partnership's network. PCP Visits include face-to-face, video or telephonic services in provider's office, or patient's home or private residence settings. For full details, please review QIP specifications manual via eReports.

Codes Used

- Codes to identify office visit location: OV Inclusion – Location Code on Code List
- Codes to identify office visits: OV Inclusion – Procedure Code on Code List
- Codes to identify void or denied claims in exclusions: OV Exclusion – Explain Code on Code List

Exclusions

Medicare-Medi-Cal dual capitated members

VII. Patient Experience

Measure 19. Patient Experience

Description

This measure aims to improve the patient experience. Partnership's strategic focus is to improve member health care and health plan experience. For additional measure resources, please refer to the links below:

Measure Resource:
https://phcwebsite.partnershiphp.org/Providers/Quality/Documents/QIP%202024/MY2025NonClinicalPatientExperience_COMSFINAL_clean.pdf
Member Benefits: https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx

There are **two** ways in which to earn points:

- Partnership contracts with a vendor to conduct the Clinician-Group Consumer Assessment of Healthcare Providers and System (CG-CAHPS) survey once during the measurement year;
- PCP conducts a survey to understand the patient experience and reports results and findings using the submission template

Patient feedback can help providers capture the patient's voice, gain more understanding of the patient population, and target specific improvement areas to improve the overall quality of health service delivery. PCP contracts do not account for this. This measure can incentivize providers to understand more about patients' needs and save future costs by identifying patient concerns and utilizing resources efficiently.

Thresholds

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.
There are two ways in which to earn points:

1) **CG-CAHPS**
   Providers that have sufficient PARTNERSHIP patient volume can earn up to a maximum of 10 points for meeting performance thresholds in key measures in the Clinician & Group CAHPS 3.0 survey. The validated tool can be found here: http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/downloadsurvey3.0.html.

2) **Survey Option**
   Sites that do not meet the patient volume threshold can conduct an internal survey and report results using the template found in Appendix VII There are two (2) parts to this option. Please follow the steps below accordingly. Sites can describe existing survey efforts, such as the NCQA PCMH survey.

For full details, please review QIP specifications manual via eReports

Submission Process

Only for sites who must use the Survey Option (i.e., sites that do not meet the patient volume threshold), please submit the Patient Experience Submission Template (Appendix VII) via fax or e-mail to QIP@partnershiphp.org. Part I is due on July 31 of the measurement year and Part II January 31 following the measurement year.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right (Why Improve Patient Experience, n.d.). But good patient experience also is associated with important clinical processes and outcomes (Why Improve Patient Experience, n.d.). Measures of patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency (Why Improve Patient Experience, n.d.).

Patient experience is correlated with key financial indicators, making it good for business as well as for patients (Why Improve Patient Experience, n.d.). For example:

- Good patient experience is associated with lower medical malpractice risk. A 2009 study found that for each drop in patient-reported scores along a five-step scale of "very good" to "very poor," the likelihood of a provider being named in a malpractice suit increased by 21.7 percent;
- Efforts to improve patient experience also result in greater employee satisfaction, reducing turnover. Improving the experience of patients and families requires improving work processes and systems that enable clinicians and staff to provide more effective care. A focused endeavor to improve patient experience at one hospital resulted in a 4.7 percent reduction in employee turnover;
- Patients keep or change providers based upon experience. Relationship quality is a major predictor of patient loyalty; one study found patients reporting the poorest-quality relationships with their physicians were three (3) times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships (Why Improve Patient Experience, n.d.)

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NQF CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005).

VIII. Units of Service $2,500 Maximum per Parent Organization

Measure 1. Academic Detailing

Description

This measure is to incentivize the Parent Organizations for hosting a two-part academic detailing meeting with Partnership's Pharmacy Team/Medical Director. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. Pharmacy academic detailing meetings will focus on discussing improving medication management through pharmacy claims analysis within the following disease states:

- CBP: Controlling High Blood Pressure
- HbA1c Good Control
- AMR: Asthma Medication Ratio
- Statin therapy in:
  - Cardiovascular disease
  - Diabetes
- Opioid Disorder Measure (only if providers are interested in opioids and MAT)

Thresholds

A $2,500 bonus for scheduling & hosting academic detailing meetings with at least one Medical Director, one Pharmacist (where applicable) & QI team/Partnership Healthplan pharmacist/medical director present. For full details, please review QIP specifications manual via eReports

Measure Requirements

- Incentivize at the Parent Organization level with a minimum of 1000 assigned members.
- First meeting must be scheduled & completed by July 1st, 2025 and second meeting must be completed by December 15, 2025 to be eligible for the full incentive.
- At least one of their PCP clinicians per site, a Pharmacist (where applicable) & at least one (1) QI staff are expected to attend **OR** attendance at the Medical Director level (all Medical Directors must attend within the entire Parent Organization) with expectation of them relaying the information back to their reporting staff.

For full details, please review QIP specifications manual via eReports

Submission Process

Partnership's Pharmacy Team will track all meeting dates and attendees who were present at both Academic Detailing meetings. No submission is required for this measure. These details will be shared with the PCP QIP team at the end of the measurement year.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

Medication management is an important component of disease state management, such as diabetes, hypertension, and asthma. Effective medication management requires the clinician and care team to have complete, accurate, and current data on pharmacy claims. Partnership Pharmacy Academic Detailing partners clinicians with the PHC clinical staff to provide a review of actionable pharmacy claims data to address gaps in care such as medication non-adherence, suboptimal asthma medication therapy, and gap in statin therapy for people with diabetes and/or cardiovascular disease. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients

VIII. Units of Service $20,000 Maximum per Site
Measure 2. Advanced Care Planning

Description

This measure encourages the PCP to provide annual awareness to Partnership members 18 years or older regarding how Advance Care Planning (ACP) can help alleviate unnecessary suffering, improve quality of life and provide better understanding of the decision-making challenges facing the individual and his or her caregivers (Advance Care Planning, n.d.). An advance care plan can be used at any stage of life and should be updated as circumstances change (Advance Care Planning, n.d.).

Thresholds

Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for:

- $100 per Attestation, maximum payment $10,000.
- $100 per Advance Directive/POLST, maximum payment $10,000

Measure Requirements

ACP discussions must take place between January 1 and December 31 of the measurement year in order to be eligible for this measure. For full details, please review QIP specifications manual via eReports

Submission Process

Providers must utilize the templates found within eReports to submit documentation for individual patients.

Exclusions

ACP is a covered benefit and can be reimbursed using CPT codes, 99497 or 99498. If any of these two CPT codes are billed via Claims, then the upload will be excluded. Submission(s) received after the close of the "grace period" that ends on January 31 following the close of the measurement year.

Measure Rationale and Source

According to Centers for Disease Control and Prevention (CDC):

- Most people say they would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care (Pew 2006, AARP 2008). Among those 60 and older, that number rises to about half of older adults completing a directive (Advance Care Planning, n.d.).
- Only 28 percent of home health care patients, 65 percent of nursing home residents and 88 percent of hospice care patients have an advance directive on record (Jones 2011).
- Even among severely or terminally ill patients, fewer than 50 percent had an advance directive in their medical record (Kass-Bartelmes 2003).
- Between 65 and 76 percent of physicians whose patients had an advance directive were not aware that it existed (Kass-Bartelmes 2003).

VIII. Units of Service 10% of Capitation
Measure 3. Extended Office Hours

Description

For Capitated PCPs only. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter. **Non-capitated PCPs** are not invited to participate in this measure. Definition of regular business hours: Total open office hours equals to at least nine hours between the hours of 8 a.m. and 5 p.m. OR 9 a.m. and 6 p.m., Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours. The site must be open to scheduled visits during the extended office time to receive credit.

Thresholds

Providers will receive quarterly payments, equal to 10% of capitation, if the site holds extended office hours for a full quarter.

Measure Requirements

PCP sites must have at least eight extended office hours for a full quarter listed in the Partnership Provider Directory for Provider Relations to confirm. For full details, please review QIP specifications manual via eReports

Submission Process

Partnership's Provider Relations department keeps track of extended office hours. No submission is required for this measure. Payment is in accordance with information listed on the Provider Directory. Payment is paid throughout the year on a Quarterly basis by Provider Relations and
is not included in the PCP QIP Final Payment.

Exclusions

This measure excludes PCP sites who do not meet the measure requirements.

Measure Rationale and Source

Continuity of care is a central goal of primary care improvement efforts nationwide, because physician's offices with office hours during the weekends and evenings allow patients more opportunities to be seen, yielding opportunities for improved health outcomes, more patient satisfaction, and lower healthcare costs. Efforts in this area are not addressed in routine PCP contracts.

VIII. Unit of Service $1,000 per site

Measure 4. Patient-Centered Medical Home Recognition (PCMH)

Description

This measure encourages PCP sites to create a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand (What is Patient-Centered Medical Home, n.d.) Primary care provider sites with a minimum of 50 assigned Partnership members.

Thresholds

$1000 yearly incentive for achieving or maintaining PCMH accreditation from NCQA, or equivalent from AAAHC or JCAHO.

Measure Requirements

PCP sites must receive accreditation, maintain accreditation, or re-certify within the measurement year from NCQA, or equivalent from AAAHC or JCAHO.

Submission Process

All documentation must be submitted on the Patient-Centered Medical Home Recognition template (Appendix I) by January 31 of the following measurement year via email to gip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Submission(s) received after the close of the "grace period" that ends on January 15 following the close of the measurement year.

Measure Rationale and Source

According to the American College of Physicians (ACP), the objective of PCMH is to have a centralized setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family (What is Patient-Centered Medical Home, n.d.). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner (What is Patient-Centered Medical Home, n.d.).

VIII. Unit of Service $15,000 Maximum per Parent Organization
Measure 5. Peer-Led and Pediatric Group Visits

Description

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

For Family Medicine and Pediatric Practices, this measure can also be used to promote the formation and implementation of cohorts by age that are devoted to a group's timely completion of pediatric well-child visits (W15 & W30). In these cohorts, groups may overlap more than one measurement year. In these cases, sites can start the group in one measurement year and still claim credit for the group's completion of required visits under W15 & W30 in the subsequent measurement year.

Primary care provider sites with a minimum of 50 assigned Partnership members are eligible.

Thresholds

The parent organization is eligible to earn $1,000 per group, maximum 15 groups, to the parent organization. For full details, please review QIP specifications manual via eReports

Measure Requirements

Qualifying peer groups must have a peer-facilitation component and a self-management component via face-to-face, telephonic, or video meetings. For full details, please review QIP specifications manual via eReports.

Submission Process

All documentation must be submitted on the Peer-led Self-Management Support Group (Appendix II) or Pediatric Group Visit template (Appendix III) by January 31 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Unapproved groups that do not meet the measure requirements, as determined by Partnership's CMO or physician designee. Submission(s) received after the close of the "grace period" that ends on January 31 following the measurement year.

Measure Rationale and Source

Studies suggest peer-led self-management training improves chronic illness outcomes by enhancing illness management self-efficacy (Jerant, Moore-Hill, and Franks, 2009). Interventions to help patients manage health conditions have potential as cost-effective ways to improve chronic illness outcomes (Jerant, Moore-Hill, and Franks, 2009). The peer-led group aims to enhance self-efficacy or confidence to execute illness management behaviors, regardless of specific diagnosis (Jerant, Moore-Hill, and Franks, 2009). Hosting and leading support groups for various health needs is not part of routine PCP contracts.

Studies suggest pediatric group well childcare results in higher parental satisfaction with longer provider face-time without increasing time spent in the practice (Pediatric Practice Redesign with Group Well Child Care Visits: A Multi-Site Study – PubMed, 2021 Aug). It is also observed that the group environment increases knowledge retention of parents and enhances social supports (Redesigning Primary Care Well Child Visits: A Group Model | American Academy of Pediatrics, January 1, 2018).

VIII. Unit of Service $3,000 Maximum per Parent Organization
Measure 6. Health Information Exchange Participation

Description

This measure encourages the PCP parent organizations to establish and maintain a continued linkage to a recognized community health information exchange (HIE) organization.

Thresholds

The PCP parent organizations will be reimbursed for the following participation:

- Establishing first time linkage: During the measurement year, first year HIE connection is established are eligible to earn $3000.
- Continued utilization of the HIE: Year 2 and beyond of utilization of the HIE are eligible to earn $1500.

Measure Requirements

To qualify for the incentive Partnership will validate the data exchange by working directly with the specified HIE to confirm the linkage. For full details, please review QIP specifications manual via eReports

Submission Process

All documentation must be submitted on the HIE Attestation template (Appendix IV) by January 31 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Unapproved HIE connections that do not meet the measure requirements.

Measure Rationale and Source

According to the Office of the National Coordinator for Health Information Technology (ONC), electronic exchange of clinical information is vital to improving health care quality, safety, and patient outcomes (Why is health information exchange important, n.d.). Health information exchange (HIE) can help your organization:

- Improve Health Care Quality: Improve health care quality and patient outcomes by reducing medication and medical error
- Make Care More Efficient: Reduce unnecessary tests and services and improve the efficiency of care by ensuring everyone involved in a patient's care has access to the same information
- Streamline Administrative Tasks: Reduce administrative costs by making many administrative tasks simpler and more efficient
- Engage Patients: Increase patient involvement in their own health care and reduce the amount of time patients spend filling out paperwork and briefing providers on their medical histories; and
- Support Community Health: Coordinate with and support public health officials to improve the health of your community (Why is health information exchange important, n.d.).

Electronic exchange of clinical information allows doctors, nurses, pharmacists, other health care providers, and patients to access and securely share a patient's vital medical information electronically improving the speed, quality, safety, coordination, and cost of patient care (Why is health information exchange important, n.d.).

VIII. Unit of Service $2,000 Maximum Per Parent Organization
Measure 7. Health Equity Implementation

Description

Partnership is actively engaged in Health Equity (HE) initiatives that bring about equitable awareness and drive changes within the 24 counties we serve. We highly encourage provider organizations to join our efforts. At Partnership, we believe in diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff. Together, we can help move our communities toward equitable access to healthcare.

Thresholds

$2,000 per Parent Organization for either:

1. Submission of an initial HE report based on identifying health disparities as outlined in measure requirements below.
2. An updated annual report based on HE implementation for sites who were incentivized in the prior measurement year.

Measure Requirements

Submission shall demonstrate HE characteristics PCPs can successfully integrate as a core strategy. Should include how best practices apply to internal domains such as: Access, Referral Processes, Avoidable ED Visits, Community Partnerships, and Staff Education.

*** **If participating in the Reducing Healthcare Disparity Measure,** Parent Organizations will **not** be able to participate in the Health Equity Unit of Service Measure. If a Parent Organization does not qualify to participate in the Reduction of Inequity Adjustment Measure, they are then able to participate in the Health Equity Unit of Service Measure.

For full details, please review QIP specifications manual via eReports

Submission Process

All reports must be submitted by January 31 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

VIII. Unit of Service $5.00 Per Screening

Measure 8. Tobacco Use Screening

Description

This measure uses the base logic of the National Committee for Quality Assurance (NCQA) #226 (National Quality Forum (NQF) 0028), which assesses the percentage of members 18 years of age and older screened for tobacco use AND who received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F). Note that the Partnership measure focuses on a younger age group than the NQF measure, to align with DHCS focus on monitoring preventive health in pediatric patients. Tobacco use includes any type of tobacco and aligns with U.S. Preventive Services Task Force (USPSTF) recommendations with regards to screening/counseling for tobacco use. While these measures do not include screening for non-tobacco nicotine products, Partnership recommends also combining screening for these products, while screening for tobacco products, in support of the recommendations by the AAP and AAFP.

Eligible Population

Assigned members aged 11– 21 years of age during the measurement year. (DOB between January 1, 2004 and December 31, 2014)

Thresholds

Incentive to improve early detection of and intervention toward tobacco use. For full details, please review QIP specifications manual via eReports

Measure Requirements

Partnership will extract claims data within the measurement year recognizing codes affiliated with Tobacco Use Screening: HCPCS: 4004F. No other code will be accepted.

VIII. Unit of Service $50 Per Early Admin with Completion of Series
Measure 9. Early Administration of the 1st HPV Dose

Description

In 2022, 58% of Partnership's members turning 13 did not complete the 2-dose series for HPV vaccinations. The CDC recommends 1st HPV doses start between ages 11 and 12 (and can start at age 9). Partnership's data indicates that members completing their 1st HPV dose by 12 years are much more likely to complete their 2nd by 13, as compared to members who completed their 1st dose after 12. The purpose of this new UOS measure is to incentivize providers to administer the first HPV dose by the age of 12 years in order to complete the two-dose series before the 13 birthday. This allows for the minimum 6-month interval between doses.

Eligible Population

Assigned members who turn 9 - 12 years of age during the current measurement year (DOB between January 1, 2013 and December 31, 2016).

Thresholds

Incentive for early administration of the 1st HPV dose. For full details, please review QIP specifications manual via eReports

Measure Requirements

Partnership will extract claims data within the current and prior measurement year recognizing codes affiliated with HPV vaccine Administered: CPT: 90649, 90650, 90651 & CVX: 118, 137, 165, 62. No other code will be accepted.

VIII. Unit of Service $50 Per Early Admin with Completion of Series
Measure 10. Early Administration of the Initial Flu Vaccine Series

Description

In 2022, 57% of Partnership's members turning 2 years of age did not complete the two-dose series of influenza vaccinations. The ACIP recommends two influenza vaccinations, at least four weeks apart starting in children aged six (6) months. This initial two dose series provides protection for children under 2 years of age, all of whom are considered at high risk for serious influenza infections. The purpose of this new UOS measure is to incentivize early administration of the first influenza vaccine *and* administration of the second influenza vaccine, within 60 calendar days of the first.

Eligible Population

Assigned members who turn 7 months to 15 months of age during the current measurement year (DOB between October 2, 2024 and May 31, 2025).

Thresholds

Incentive to increase the number of children under two years of age who have completed the initial influenza vaccine series early. For full details, please review QIP specifications manual via eReports

Measure Requirements

Partnership will extract claims data within the current and prior measurement year recognizing codes affiliated with Influenza Vaccine Administered: CPT: 90655, 90657, 90661, 90673, 90674, 90685-90689, 90756; CVX: 140, 141, 150, 153, 155, 158, 161, 171, 186, 88; HCPCS: G0008. No other code will be accepted.

VIII. Unit of Service Maximum of $5000 Per Parent Organization
Measure 11. Electronic Clinical Data Systems (ECDS)

Description

This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures, this process will continue to increase in emphasis and could potentially become a gateway measure to the PCP QIP. Partnership has partnered with DataLink (a qualified HEDIS data aggregator) who has the ability to pull a much larger scope of measures than what is currently required for the PCP QIP.

Thresholds

Incentive can be achieved by completing Electronic Clinical Data System (ECDS) requirements by the end of the measurement year and is paid at the Parent Organization (PO) level.

1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2025. Agreements signed after September 30, 2025 will be eligible for half payment ($1,000) through December 31, 2025
2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2025 and the Parent Organization responds timely to request for verification.

Note: The ECDS measure is also included in the Perinatal QIP. If your Parent Organization (PO) participates in both the PCP and Perinatal QIP, **your PO will only qualify for the ECDS incentive for one program**.

Measure Requirements

Incentive requires multiple steps in four (4) phases:

Phase 1: DataLink's Interoperability Specialist will coordinate outreach with providers to schedule Discovery Meetings with targeted providers. Discovery Meetings will be to discuss connectivity, benefits of the data extraction and the extraction process

Phase 2: DataLink's Interoperability Specialist will work one-on-one with each practice to set up the Data Generation and Data Upload via sFTP

Phase 3: DataLink will parse and ingest the provider's Continuity of Care Documents (CCD) and create the output file for both quality and risk.

Phase 4: DataLink will deliver to Partnership via sFTP the output file for validation and processing.

Submission Process

Incentive for the ECDS measure includes a multi-step process and can be achieved by participating and completing all of the necessary steps. For full details, please review QIP specifications manual via eReports

IX. Appendices
Appendix I. Patient-Centered Medical Home Documentation Template

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

1. Name of Recognition entity (NCQA, JCAHO or AAAHC):
2. Recognition status (First time, Maintenance or Re-certification):
3. Date of recognition received:
4. Level accomplished (if applicable):
5. How often is recognition obtained?
6. Attach a copy of PCMH recognition documentation provided by the recognizing entity (must contain a date of recognition within the measurement year).

Additional Notes/Comments:

Appendix II: Submission Template for Peer-led Self-Management Support Group Visits

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by January 31 following the measurement year and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure program will be eligible for the bonus paid to the parent organization, not the individual sites.

1. Name of group
2. Name and background information/training of group facilitator for peer-lead group.
3. Site where group visits took place
4. Narrative on the group process that includes location and frequency of the group meetings.
5. List of major topics/themes discussed at each meeting
6. A description of the way that self-management support is built into the groups
7. An assessment of successes and opportunities for improvement of the group
8. Documentation of minimum of 16 PARTNERSHIP patient visits, via list of attendees with DOB and date of group

Appendix III: Submission Template for Pediatric Group Visits

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

4665 Business Center Dr.
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 31 following the measurement year** and send to:

- Email: QIP@partnershiphp.org
- Fax: 707-863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure program will be eligible for the bonus paid to the parent organization, not the individual sites.

1. Name of group
2. Name and background information/training of Pediatric Group Well-Visit Coordinator.
3. Site where group visits took place
4. Narrative on the group process that includes location and frequency of the group meetings.
5. List of major topics/themes discussed at each meeting
6. A description of Well-Care Visit Cohort.
7. An assessment of successes and opportunities for improvement of the group
8. Documentation of minimum of 16 Partnership patient visits, via list of attendees with DOB and date of group.

Please note: Pediatric well-care visits should be billed administratively (Dates of service must also appear as they occurred in eReports). Completion of this UOA template does not guarantee credit in the W15/W30 QIP Clinical Measure

Appendix IV: Submission Template for HIE

4665 Business Center Dr.
Fairfield, CA 94534

If your organization is linked to an HIE during or prior to the 2025 Measurement year, you may qualify for an incentive for the 2025 PCP QIP. Please complete all of the following fields on this form and submit by **January 31 following the measurement year** and send to:

Email: QIP@partnershiphp.org
Fax: 707-863-4316
Mail: Attention: Quality Improvement, 4665 Business Center Dr. Fairfield, CA 94534

Partnership will verify the following information with the HIE specified. The parent organization, not the individual sites, will qualify for an incentive based on **either** HIE linkage (as a first time user) or HIE maintenance (as a continuing user). Please refer to the Measure Specifications for details.

1) Name of Parent Organization and Site(s) or PCP ID#(s) linked to the HIE:
_____

2) Type of linkage established (check at least one that applies):

☐ Sending HL7/ Patient Visit Information history to the HIE
☐ Sending CCD document to the HIE
☐ Retrieving clinical information such as labs from the HIE

3) Type of incentive
   - ☐ Linkage: First joined HIE *during* 2025 (list date) _____
   - ☐ Maintenance: First joined HIE *prior to* 2025 (list date) _____

4) Name of the HIE linked to (check the option that applies):

☐ Sac Valley Med Share
☐ North Coast Improvement and Information Network (NCHIIN)
☐ Jefferson HIE
☐ Other, include contact information (Name of HIE and Contact Name & Email/Phone #):
_____

Submitted by: _____ Date: _____
Title: _____ Phone: _____
Email: _____

Appendix V: 2025 PCP QIP Submission and Exclusion Timeline

2025 QIP Uploads and Unit of Service Submissions

DEADLINE DATES	QIP MEASURES	REPORTING TEMPLATES
January 31 2026, by 5 p.m.	All Clinical Domain Measures and Advanced Care Planning	Found in eReports
January 31, 2026	PCMH Recognition	Appendix I
January 31, 2026	Peer-led Self-Management Support Group	Appendix II & III
January 31, 2026	Health Information Exchange	Appendix IV
January 31, 2026	Health Equity Implementation Plan	N/A
September 30, 2025 (Full Incentive) or December 31, 2025 (Half Incentive)	ECDS- DataLink Agreement Due	N/A
October 31, 2025	ECDS – Successful HEDIS data extraction from EMR	N/A

2025 QIP Exclusions

SUBMISSION DATES	APPLICABLE MEASURES
January 1-15, 2026	Small Denominators for Modified Providers
January 15-31, 2026	Small Denominators for all other PCP QIP Providers
January 1, 2025 – January 15, 2026	All measures from the Clinical Domain

Appendix VI: Data Source Table

PCP QIP Core Measures	Practice Type	Data Source[5]	System Used for Data Monitoring	System Used for Data Submission
	Clinical Domain			
1. Breast Cancer Screening	Family and Internal	Partnership and Providers		eReports
2. Breast Cancer Screening (40-49 yr.) *Monitoring*	Family and Internal			
3. Cervical Cancer Screening	Family and Internal			
4. Child and Adolescent Well Care Visits	Family and Pediatrics			
5. Childhood Immunization StatusCombination 10	Family and Pediatrics			
6. Chlamydia Screening (16-24 yr.) *Monitoring for Family and Internal*	Family, Internal, Pediatrics			
7. Colorectal Cancer Screening	Family and Internal			
8. Comprehensive Diabetic Care – HbA1c Control	Family and Internal			
9. Comprehensive Diabetic Care – Eye Exams	Family and Internal			
10. Controlling High Blood	Family and Internal			
11. Lead Screening in Children	Family and Pediatrics			
12. Immunization for Adolescents – Combination 2	Family and Pediatrics			
13. Reducing Healthcare Disparities*Optional*	Family, Internal, Pediatrics			
14. Topical Fluoride in Children *Monitoring*	Family and Pediatrics			
15. Well-Child Visits in the First 15 Months of Life	Family and Pediatrics			
16. Well-Child Visits in the First 15-30 Months of Life *Monitoring for Family*	Family and Pediatrics			
	Appropriate Use of Resources Domain			
1. Ambulatory Care Sensitive Admissions	Family and Internal	Partnership	PQD	Claims
2. Follow-Up within 7 days after Hospital Discharge	Family and Internal			

[5] For any measure, if "Partnership" is the only data source, Providers may not submit uploads for the measure through eReports. Partnership uses administrative data (Claims/Encounter/RxClaims) for these measures only.

	Access/Operations Measures Domain			
3. Avoidable ED Visits	Family, Internal, Pediatrics	Partnership	PQD	Claims
4. PCP Office Visits	Family, Internal, Pediatrics	Partnership	PQD	Claims
	Patient Experience Domain			
Survey Option (sites not qualified for CAHPS)	Family, Internal, Pediatrics	Partnership and Provider	PQD	Submission Template
CAHPS Survey (for qualified sites)	Family, Internal, Pediatrics	Partnership Vendor		Partnership Vendor

Appendix VII: Patient Experience Survey Option Submission Template

Quality Improvement Program – Patient Experience

Survey Option Submission Template and Example

Due Date for Part I Submission: July 31 of the measurement year.
Due Date for Part II Submission: January 31 following the measurement year

Below you will find the submission template and examples for the Survey Option. This is a guide for your submission, and if you decide to not use it, points will still be rewarded if all areas are addressed in your submission. For detailed instructions, please refer to the Measure Specification.

Survey: Part I Submission Template

(Due July 31 of the measurement year)

1. Attach a copy of the survey instrument administered (Survey must include at least two questions on access to care. For examples of access questions, please refer to the CAHPS questions listed on the last page of this document)
2. Provide descriptions for the following:
   - Population surveyed:
   - How the survey was administered (via phone, point of care, web, mail, etc.):
   - The time period for when the surveys were administered:
   - Total number of surveys distributed:
   - Total number of survey responses collected/received:
   - Response Rate:
3. Based on the results from your survey, what specific measure(s) have you selected to improve?
4. For each measure or composite of questions selected for improvement, what is your specific objective?
5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

Submitted by _____ (Name & Title) **on** _____ (Date)

Survey: Part II Submission Template

(Due January 31 following the measurement year)

1. Describe specific changes/actions/interventions you implemented to improve your performance in the measures you selected in Part I. Include specific timelines, who implemented the changes, and how changes were implemented.

2. Provide descriptions for the following for your re-measurement period:
   a. Population surveyed:
   b. How the survey was administered (via phone, point of care, web, mail, etc.):
   c. The time period for when the surveys were administered:
   d. Total number of surveys distributed:
   e. Total number of survey responses collected/received:
   f. Response Rate:

3. Comparing your re-measurement period(s) to baseline and other sources of data, did you observe improvements in the measures targeted? Did you meet your stated objectives within your improvement plan? Please describe the changes in performance and which changes you believe contributed to the improvements observed.

4. What challenges did you experience and how did you overcome these?

Submitted by _____ (Name & Title) **on** _____ (Date)

EXAMPLE 1
Note: Sample text is provided in blue **font**
Survey: Part I Submission

1. Attach a copy of the survey instrument administered: See below

Dear Patient,

We want every patient to have a positive experience every time when they come to our clinic. We would like to know how you think we are doing. Please take a few minutes to fill out this survey and drop it off at the comment box on your way out. Thank you so much.

Please rank the following statements based on your visit today:

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The non-clinical staff at this office (including receptionists and clerks) were as helpful as I thought they should be.				
2. The non-clinical staff at this office were friendly to me.				
3. The non-clinical staff at this office addressed my concerns adequately.				
4. I was given more than one option in terms of how and when to schedule the next appointment.				
5. I felt comfortable asking the non-clinical staff questions.				
6. When I called for an appointment, the wait time was reasonable.				
7. I was given an appointment when I wanted it.				
8. I feel confident that my personal information is kept private.				
9. Charges were explained to me clearly.				

2. Provide descriptions for the following

   a. Population surveyed:

   b. How the survey was administered (via phone, point of care, web, mail, etc.):

   c. The time period for when the surveys were administered:

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between March 1, 2025 and May 1, 2025, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2025. The first mailing was sent on March 1, followed by a second mailing on April 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate.

3. Based on the results from your survey, what specific measures in the survey have you selected to improve?

   "I was given an appointment when I wanted it."

4. For each selected measure or composite of measures selected for improvement, what is your specific objective?

   80% of patients surveyed will select "strongly agree".

5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

   To improve the appointment wait times, our clinic will test adding same day appointments and extending visit intervals for well controlled patients with chronic conditions to improve the time it takes to get a routine appointment.

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** July 10, 2025 (Date)

EXAMPLE 1
Note: Sample text is provided in blue **font**
Survey: Part II Submission

1. Describe specific changes/actions/interventions you implemented to improve your performance in the measure(s) you selected in Part I. Include specific timelines and who implemented the changes and how changes were implemented.

   We had a consultant train our site over a two-month period (June- July 2025) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every three months, we now bring them in every six months.

2. Provide descriptions for the following for your re-measurement period:

   - Population surveyed:
   - How the survey was administered (via phone, point of care, web, mail, etc.):
   - The time period for when the surveys were administered:
   - Total number of surveys distributed:
   - Total number of survey responses collected/received:

   • Response Rate:

   Between October 15, 2025 and November 1, 2025, our site mailed a survey to all our adult patients who came in for an office visit between September 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

3. Comparing your re-measurement period (s) to baseline and other sources of data, did you observe improvements in the measures targeted? Did you meet your stated objectives in your improvement plan? Please describe changes in performance and which changes you believe contributed to improvements observed.

   In the question, "I was given an appointment when I wanted it," we exceeded our goal in that 83% of our patients reported "Strongly agree," compared to our goal of 80% and our baseline score of 72%.

4. What challenges did you experience and how did you overcome these?

   We learned a lot while facing many challenges. The most important lesson was that patients were very skeptical about getting appointments "same day". It took a lot of educating our patients on this change. There was also a lot of resistance from some of the providers as they were concerned that the no-show rate would increase. We started collecting no show rate data to monitor this in combination with appointment availability (3NA). We encountered challenges with reducing the number of appointment types. We had to re-train our scheduling staff and in the end, they preferred this as it was simple and they were more efficient with scheduling.

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** January 10, 2026 (Date)

EXAMPLE 2

Note: Sample text is provided in blue **font**

Survey: Part I Submission

1. Attach a copy of the survey instrument administered: See below

Dear Patient,

We want every patient to have a positive experience every time they come to our clinic. We would like to know how you think we are doing. Please take a few minutes to fill out this survey and drop it off at the comment box on your way out. Thank you so much.

Please rank the following statements based on your visit today:

	Never	Sometimes	Usually	Always	Does not apply
1. How often were you able to make an appointment and be seen by your personal doctor within a decent timeframe?					
2. How often were you able to get an appointment as soon as you needed it for health care services, tests or treatments?					
3. How often did your personal doctor spend enough time with you during your visit?					
4. How often did your personal doctor answer all questions to your satisfaction?					
5. How often did your personal doctor encourage you to talk about all health problems or concerns?					
6. How often did your personal doctor speak to you in a way that was easy to understand?					
7. How often did your personal doctor use medical words you did not understand?					
8. How often did you have problems communicating with your doctor or health care provider because of different cultural, personal, or religious beliefs?					

9. How often did you have a hard time speaking with or understanding your doctor or other health care provider because you spoke different languages?					

2. Provide descriptions for the following
    - Population surveyed:
    - How the survey was administered (via phone, point of care, web, mail, etc.):
    - The time period for when the surveys were administered:
    - Total number of surveys distributed:
    - Total number of survey responses collected/received:
    - Response Rate:

    Between February 1, 2025 and May 30, 2025, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2025. The first mailing was sent on February 1, followed by a second mailing on May 30th. 800 surveys were mailed and 500 surveys were returned; yielding a 62.5% response rate.

3. Based on the results from your survey, what specific areas in the survey have you selected to improve?

    "How often did your personal doctor spend enough time with you during your visit?" – 65% of responses answered sometimes

4. For each selected area or composite of measures selected for improvement, what is your specific objective?

    80% of patients surveyed will select "always".

5. For the measures selected for improvement, describe the specific changes/interventions/actions you believe will improve your performance.

    To improve the appointment timeframes, our clinic will only allow 15 minute grace period of late appointments and reschedule appointments if patients arrive later than 15 minutes pass their scheduled appointment. This will allow acceptable time in between appointments so patients are have protected time to share their medical concerns with their doctor and doctor have sufficient time to thoroughly examine and counsel the patient.

Submitted by Jim Ropes (QI Manager) (Name & Title) **on** July 15, 2025 (Date)

EXAMPLE 2
Note: Sample text is provided in blue **font**
Survey: Part II Submission

1. Describe specific changes/actions/interventions you implemented to improve your performance in the measure(s) you selected in Part I. Include specific timelines and who implemented the changes and how changes were implemented.

   In August, our office implemented a late appointment rule with a 15-minute grace period. The medical staff checked all visit rooms to ensure they had working and visible clocks so providers could easily keep track of time. We also revisit of time blocks for the various types of appointments so there is adequate time blocked for the patient's needs.

2. Provide descriptions for the following for your re-measurement period:

   - Population surveyed:
   - How the survey was administered (via phone, point of care, web, mail, etc.):
   - The time period for when the surveys were administered:
   - Total number of surveys distributed:
   - Total number of survey responses collected/received:
   - Response Rate:

   On October 15, 2025, our site mailed a survey to all our adult patients who came in for an office visit between August 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. 200 surveys were mailed and 90 surveys were returned; yielding a 45% response rate.

3. Comparing your re-measurement period (s) to baseline and other sources of data, did you observe improvements in the measures targeted? Did you meet your stated objectives in your improvement plan? Please describe changes in performance and which changes you believe contributed to improvements observed.

   In the question, "How often did your personal doctor spend enough time with you during your visit," we exceeded our goal with 83% of our patients reported "Always," compared to our goal of 80% and our baseline score of 65%

4. What challenges did you experience and how did you overcome these?

   There were challenges with implementing the 15-minute appointment rule since there was an associated fee for rescheduling if the patient did not arrive within the 15-minute grace period window. Patients feel it was a fair cost to them and thought it was an additional way for our clinic to earn money. We had to educate our patients on the importance of provider's schedules staying within a specific timeframe and explaining the potential effects if they did not. We did make a few exception to this new rule based on the member's unique circumstances.

Submitted by Jim Ropes (QI Manager) (Name & Title) **on** January 08, 2026 (Date)

X. Monitoring Measurement Set for the MY2025

Partnership wants to emphasize that the measures not included in the payment group remain clinically important. Therefore, we are including this Monitoring Measurement Set.

The Monitoring Measurement Set is a separate and distinct measurement set that **does not have any points assigned to each measure**. The intent of this set is to provide visibility to your performance and access to the member gap-in-care list throughout the
measurement year.

Monitoring Measure 1. Breast Cancer Screening (40-49yo)

Description

The percentage of continuously enrolled Medi-Cal members 40-49 years of age were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Internal Medicine: (Monitoring for MY2025)

Family Practice: (Monitoring for MY2025)

*Denominator

The number of continuously enrolled assigned members 40-49 years of age as of December 31 of the measurement year (DOB between January 1, 1976 and December 31, 1983).

Numerator

The number of members from the eligible population in the denominator with one (1) or more mammograms any time on or between October 1, 2023 and December 31, 2025

Exclusions

- Members who have had a bilateral mastectomy any time during their history through December 31 of the measurement year. Member who have had a diagnosis of palliative care during the measurement year.
- Members who had an encounter for palliative care any time during the measurement period.
- Members who have had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement period.

Measure Rationale and Source

According to JAMA Network's Jill Jin, MD, MPH (2014), screening for breast cancer means looking for signs of breast cancer in all women, even if they have no symptoms (Jin, 2014). The goal of screening is to catch cancers early (Jin, 2014). Early-stage cancers are easier to treat than later-stage cancers, and the chance of survival is higher (Jin, 2014). Routine screening for breast cancer lowers one's risk of dying of breast cancer (Jin, 2014).

DHCS requires Partnership to report this as part of the annual MCAS reporting.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and Screening, MCAS, NQF Breast Cancer Screening (#2372), and UDS Breast Cancer Screening (CMS125v8).

Partnership acknowledges that the USPSTF is in the process of drafting new guidelines that may change the recommended age range for Breast Cancer Screening from ages 50 - 74 years to ages 40 - 74 years. For the purposes of this measurement year, at least, the eligible age range will remain constant at 50-74 years. Providers may choose to start screening women at the younger ages now, but only those in the 50-74 years range, meeting all eligibility requirements, will be included in the calculations for this measure.

Monitoring Measure 2. Chlamydia Screening (16-24yo)

Description

The percentage of continuously enrolled Medi-Cal members for whom screening is indicated 16-24 years of age who had at least one (1) test for chlamydia during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Family Practice: 16-24yo (Monitoring for MY2025)

*Denominator

The number of continuously enrolled assigned members for whom screening is indicated 16-24 years of age as of December 31 of the measurement year (DOB between January 1, 2001 and December 31, 2009).

Numerator

The number of members from the eligible population in the denominator with at least one (1) test for chlamydia during the measurement year (January 1, 2025 - December 31, 2025)

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: “Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV”. Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

Monitoring Measure 3. Chlamydia Screening (21-24yo)

Description

The percentage of continuously enrolled Medi-Cal members for whom screening is indicated 16-24 years of age who had at least one test for chlamydia during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Internal Medicine: 21-24yo (Monitoring for MY25)

*Denominator

The number of continuously enrolled assigned members for whom screening is indicated 21-24 years of age as of December 31 of the measurement year (DOB between January 1, 2001 and December 31, 2004).

Numerator

The number of members from the eligible population in the denominator with at least one (1) test for chlamydia during the measurement year (January 1, 2025 - December 31, 2025)

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: “Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV”. Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

Monitoring Measure 4. Topical Fluoride in Children

Description

The percentage of members 1-4 years of age who received at least two fluoride varnish applications during the measurement year.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Pediatric: (Monitoring for MY2025)

Family Practice: (Monitoring for MY2025)

*Denominator

The number of continuously enrolled Medi-Cal members between 1-4 years of age as of December 31 of the measurement year (DOB between December 31, 2021 and December 31, 2024).

Numerator

The number of assigned children who had two (2) or more fluoride varnish applications during the measurement year, on different dates of service.

Exclusions

- Members who have used hospice services or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year.
- Members who have died any time during the measurement year.

Measure Rationale and Source

Topical fluoride varnish (TFV) application is recognized as one of the most effective strategies for preventing dental caries and improvement of oral health in all children (8). In addition to prevention, TFV has the potential to re-mineralize existing caries and halt the progression from caries to cavities. According to the CDC, the prevalence of untreated cavities (tooth decay) in the primary teeth of children (aged 2 to 5) from low-income households is about three times higher than that of children from higher income households. Young children are seen in primary care settings earlier and more frequently than in dental offices, making well child visits an ideal opportunity for early detection of caries and varnish application.

Monitoring Measure 5. Well-Child Visits in the First 15-30 Months of Life (W30-2)

Description

The percentage of continuously enrolled Medi-Cal members who turned 15 months and 1 day-30 months old during the measurement year and had two or more well-child visits.

Points and Thresholds by Practice Type

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria.

Family Practice: 15 months-30 months (Monitoring for MY 2025)

*Denominator

The number of continuously enrolled assigned members who turn 30 months old during January 1 and December 31 of the measurement year (DOB between July 1, 2022 and July 30,2023)

Numerator

The number of children in the eligible population with two (2) or more well-child visits on different dates of service between the child's 15 month birthday plus (1) day and the 30 month birthday.

Exclusions

- Members who have received hospice services or elect to use a hospice benefit any time during the measurement year.
- Members who have died any time during the measurement year.

Measure Rationale and Source

According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits.

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