Primary Care Provider Quality Incentive Program Specifications

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2026

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
- Hospital Utilization
- Primary Care Utilization
- 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 after the program period ends, in the month of June the following year.

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 PO, a site, a 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 for the PCP QIP, providers must have signed Partnership PCP QIP contract amendment no later than December 31, 2025, to be eligible for the 2026 measurement year which begins on January 1, 2026. Newly contracted providers within Partnership's 24 counties may be invited to participate in the PCP QIP 2026 measurement year if the provider has a signed Partnership contract (that includes PCP QIP details) no later than March 31, 2026. 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 and 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.

QIP Measure Set

PCP sites that join Partnership's network are eligible for participation in the full measure set of the QIP under the following scenarios:

- **Upon executive review and approval only -** PCP sites joining Partnership who have been invited to participate in the measurement year 2026 program without affiliation to an existing PCP QIP participant site (standalone new practice or new PCP PO): Must have a signed Partnership contract (that includes PCP QIP details) no later than March 31, 2026 and have at least nine (9) months of members assigned for the measurement year and will be admitted to the program **on an exception-based system** that involves review for approval by the Partnership Executive team.

- PCP sites joining Partnership as part of a PCP PO where members from an existing PCP 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 full measure set. 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. Please note: Visibility of measure performance does **not** guarantee eligibility for program nor payment.*

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 during the measurement year due to new information becoming available (i.e., a measure's retirement from the DHCS Managed Care Accountability Set). 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 within three days of Partnership's decision to remove the measure. Measure sets are approved in the third quarter of the prior measurement year and included in QIP contract amendments which are agreed upon by the PCP site prior to the start of the measurement year.

[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).

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 the appropriate steps to monitor this behavior. The processes utilized for decision making are based solely on the 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, the number of member months accumulated throughout the year and the calculated earned per member per month (PMPM). The calculated earned PMPM will vary by site, according to the principles noted below.

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

1. A base rate of $4 PMPM minimum
    1. A site adjusted supplemental rate (may range from an additional $0 to a maximum of approximately $23.25 PMPM). Only sites with at least 100 assigned members on December 1, 2026, are eligible for the adjustment.

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

- **Factors 1a and 1b (Core Adjustment-20% each)**
    - 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-20%)**
    - An adjustment for unfavorable socio-demographic mix of patient population
- **Factors 3a & 3b (Core Adjustment-10% each)**
    - An adjustment for the difficulty in hiring primary care clinicians at the site.
- **Factor 4 (Core Adjustment-20%)**
    - An adjustment for low practice resources
- **Factor 5 (Supplemental Adjustment- Not available to all PCPs)**
    - An adjustment for major disruptions in service related to natural disasters.
- **Factor 6 (Supplemental Adjustment- Not available to all PCPs)**
    - 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.

The calculation used to determine the actual incentive amount of the Core Measurement Set is: 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.

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.

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. Specific codes used 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 used for non-clinical measures are listed in non-clinical code sets which can be found within eReports, on the HELP page at the time of eReports launch (March of the measurement year). 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 11 – 29 (the last business day) 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 for services that should to be completed by the end of measurement year OR within the last 12 months of the member's birthday when service should be completed by. For example, using Well-Child Visits in the First 15 Months of Life, if the member turns

15 months old on June 1 of the measurement year, then outreach would need to be completed prior to the member turning 15 months old. If outreach is completed in the prior measurement year, it would be considered in this scenario.
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 site's choice with the date and type of outreach documented. Text message is also an acceptable form of outreach.

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 all PCP QIP providers, small denominator exclusions templates are due between **January 15 – 29**, 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.

***The small denominator exclusion request applies only to active clinical measures. Small denominator exclusion requests for monitoring measures will not be accepted for exclusion consideration.**

****Best Practice: Before submitting a Small Denominator Exclusion request, please consider the following:**

1) Will the request be beneficial to your site's final score. For example, consider whether removing a member(s) from the measure(s) denominator will result in a positive outcome.
2) Verify the members listed on the small denominator exclusion template at the time of submission remain in your denominator ***after*** continuous enrollment has been applied at the end of the measurement year.

Small Denominator Examples:

Provider 1: Diabetes-Retinal Eye Exam

Current QIP Score = 40%

Numerator/Denominator = 2/5

Partial Point Target (75th Threshold) = 59.41%

Full Point Target (90th Threshold) = 64.06%

Request from Provider: Remove 1 member from the Denominator

Outcome = New score: 2/4 X 100 = 50%

Impact: Although the score has improved from 40% to 50%, the new QIP score does not meet either Partial or Full Point Targets.

Provider 2 (Family Practice): Lead Screening in Children

Current QIP Score = 16.67%

Numerator/Denominator = 1/6

Partial Point Target (75th Threshold) = 71.11%

Full Point Target (90th Threshold) = 79.51%

Family Practice Full Points = 6 Points

Request from Provider: Remove 5 members from the Denominator

Outcome = New score: 1/1 X 100 = 100%

Impact: By removing the 5 non-compliant members and keeping the necessary compliant member the score has improved to 100% and the provider would earn Full Points. This approach is considered a best practice versus removing all members from the denominator including the numerator. This strategy is best for the provider as the work performed for the members remains incentivized and is best for Partnership's HEDIS rates.

Provider 3: Diabetes-Retinal Eye Exam

Current QIP Score 30%

Numerator/Dominator= 3/10

Partial Point Target (75th Threshold) = 59.41%

Full Point 90th Threshold= 64.06%

Request from Provider: Remove 6 members from the Denominator

Outcome = New Score: 3/4 x 100 = 75%

Impact: Based upon the new score of 75%, the provider would earn Full Points

Non-clinical measures: For PCP sites with less than 500 (<500) assigned members, the follow-up within seven 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.

PCP Parent Organizations with Very Low PCP QIP scores

Organizations with over 500 assigned members as of December 1 of the year prior earning the fewest QIP points will be required to participate in additional performance improvement activities as determined in collaboration with a performance improvement advisor on an individualized improvement plan.

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 Preliminary reviews 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. In addition, providers will be given one week for the non-clinical measures validation period, to review data and report any discrepancies they may see.
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 set in the third quarter of the prior measurement year and included in QIP contract amendments which are agreed upon by the PCP site prior to the start of the measurement year. Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year.

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 advice 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

2026 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 50th percentile target to be eligible for RI points on the measure

  AND

- **Have an RI score of 15% or higher**, compared to the previous year's performance. **New for 2026: Providers scoring between the 50th and 75th percentile will earn partial points, while those scoring above the 75th percentile and up to (but not exceeding) the 90th percentile will earn full points.**
    - **RI Score >15% and provider score between 50th-75th percentile = Partial Points**

      OR
    - **RI Score >15% and provider score above 75th percentile but not exceeding the 90th percentile = Full Points**

3. 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 2024 as targets.

2026 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			5	N/A
Cervical Cancer Screening			5	3
Child and Adolescent Well Care Visits			9	6
Childhood Immunization Status: Combo 10			5	3
Chlamydia Screening (16-24yo)			3	N/A
Colorectal Cancer Screening			5	3
Comprehensive Diabetes Management: HbA1c Good Control			5	3
Comprehensive Diabetes Management - Retinal Eye Exams			5	3
Controlling High Blood Pressure			5	3
Lead Screening in Children			5	3

Kidney Health Evaluation for Patients with Diabetes (KED)			3	N/A
Immunizations for Adolescents – Combo 2			5	3
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	8
NON-CLINICAL DOMAIN: HOSPITAL UTILIZATION[2]				
Ambulatory Care Sensitive Admissions	60th Percentile (9.17)	70th Percentile (11.91)	5	3
Follow-Up within 7 Days after Hospital Discharge	>=33% of members with a follow-up visit within 7 days of hospital discharge	28-32% of members with a follow-up visit within 7 days of hospital discharge	5	3
Avoidable ED Visits	60th percentile (13.14)	70th percentile (16.28)	5	3
PCP Office Visits	Greater than 2.1 visits per member per year on average	Between 1.8 and 2.1 visits per member per year on average	5	3
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	>=50th Percentile (Access 49.14%) **and** >=50th Percentile (Communication 75.83%)	>=25th Percentile (Access 40.00%) **and** >=25th Percentile (Communication 65.84)	9	6
Patient Experience (Survey Option)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				

Topical Fluoride in Children *Monitoring Measure*		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*			0	0
		TOTAL POINTS	**100**	

Topical Fluoride in Children is not a HEDIS measure and is measured based on the CMS, calculated national median, which serves as the MPL.

2026 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			7	N/A
Cervical Cancer Screening			10	7
Chlamydia Screening (21 – 24 years old)			6	N/A
Colorectal Cancer Screening			12	8
Comprehensive Diabetes Management: HbA1c Good Control			10	7
Comprehensive Diabetes Management - Retinal Eye Exams			10	7
Controlling High Blood Pressure			10	7
Kidney Health Evaluation for Patients with Diabetes (KED)			6	N/A
Reducing Healthcare Disparity *Optional Measure*	(7% of QIP Baseline)	(3% of QIP Baseline)	N/A	N/A
NON-CLINICAL DOMAIN: HOSPITAL UTILIZATION[3]				
Ambulatory Care Sensitive Admissions	60th Percentile (9.17)	70th Percentile (11.91)	5	3
Follow-Up within 7 Days after Hospital Discharge	>=33% of members with a follow-up visit within 7 days of hospital discharge	28-32% of members with a follow-up visit within 7 days of hospital discharge	5	3
Avoidable ED Visits	60th percentile (13.14)	70th percentile (16.28)	5	3
PCP Office Visits	Greater than 2.1 visits per member per year on average	Between 1.8 and 2.1 visits per member per year on average	5	3

NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	>=50th Percentile (Access 49.14%) **and** >=50th Percentile (Communication 75.83%)	>=25th Percentile (Access 40.00%) **and** >=25th Percentile (Communication 65.84%)	9	6
Patient Experience (Survey Option)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEAURES				
			TOTAL POINTS	**100**	

2026 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			11	8
Childhood Immunization Status: Combo 10			11	8
Chlamydia Screening (16-20yo)			9	6
Lead Screening in Children			9	6
Immunizations for Adolescents – Combo 2			11	8
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	8
Well-Child Visits in the First 15-30 Months of Life			9	6
NON-CLINICAL DOMAIN: PRIMARY CARE UTILIZATION [4]				
Avoidable ED Visits	60th percentile (13.14)	70th percentile (16.28)	10	7
PCP Office Visits	Greater than 2.1 visits per member per year on average	Between 1.8 and 2.1 visits per member per year on average	10	7

[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.

NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CG-CAHPS)	>=50th Percentile (Access 49.14%) **and** >=50th Percentile (Communication 75.83%)	>=25th Percentile (Access 40.00%) **and** >=25th Percentile (Communication 65.84%)	9	6
Patient Experience (Survey Option)	Submits Parts 1 and 2	Submits Part 1 or 2		
MONITORING MEASURES				
Topical Fluoride in Children *Monitoring Measure*		N/A - New monitoring measure. Will not qualify for partial points in first active measurement year	0	0
		TOTAL POINTS	**100**	

Topical fluoride in children is not a HEDIS measure and is measured based on the 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 **OR** • $100 per advance directive/POLST For a **maximum** incentive payment of $10,000 per site
Clinician Education on Improving Medication Management	$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) and QI Department and Partnership pharmacist/medical director present. There is a two-part meeting requirement for the incentive: **First** meeting to review the data ($2,500) and **second** meeting to follow-up for feedback ($1,000). If a pharmacy academic meeting is scheduled with only one medical director at the first initial meeting, only $500 will be given.
Extended Office Hours	**(If specified in contract amendment)** Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter and an additional 8 hours per week or more beyond the normal business hours (reference measure specification).
PCMH Certification	$1,000 yearly per site, for achieving or maintaining PCMH accreditation.
Peer-led & Pediatric Group Visits	$1,000 per group, either new or existing. (Maximum of 15 groups per parent organization).
Health Information Exchange	One-time $3,000 incentive for signing on with a local or regional health information exchange; Annual $1,500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.

Health Equity	$2,000 per parent organization for submission of health equity implementation initiative or an annual updated health equity report.
Tobacco Screening	$5 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) **Important Note: This will become a gateway measure in 2027, so all sites are encouraged to participate in 2026.**	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, 2026. Agreements signed after September 30, 2026, will be eligible for half payment ($1,000) through December 31, 2026. 2. An additional $3,000 per parent organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2026, and the Parent Organization responds timely to request for verification.

IV. Clinical Domain

Measure 1. Breast Cancer Screening

Description

The percentage of continuously enrolled Medi-Cal members assigned female at birth 40 – 74 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.

*Denominator

The number of continuously enrolled assigned members assigned female at birth 42 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1952, and December 31, 1984). For full details, please review QIP specifications manual via eReports.

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2024, and December 31, 2026

Exclusions

- Members who had a bilateral mastectomy any time during their member history through December 31 of the measurement year. Members have a diagnosis of palliative care during the measurement year.
- Members who had an encounter for palliative care at any time during the measurement period.
- Members have had gender-affirming chest surgery with a diagnosis of gender dysphoria at 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.
- Members who have had sex assigned at birth of male at any time in the member 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 cancer 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 assigned female at birth 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 members assigned female at birth 24 – 64 years of age as of December 31 of the measurement year (DOB between January 1, 1962, and December 31, 2002).

Numerator

The number of assigned members 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, of the measurement year.
- Members who have had cervical agenesis or acquired absence of cervix any time during their history through December 31, of the measurement year.
- 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 sex assigned at birth of male at any time in the member'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 acceptable for this measure in 2026.

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, 2009, and December 31, 2023).

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 and December 31, 2026). 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 2024 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), all children should have an annual wellness visit and physical exam annually. 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 pediatricians, parents, and children. 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 health care 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, 2024, and December 31, 2024).

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)

American Academy of Pediatrics (AAP): Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, 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 American Academy of Pediatrics. 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 assigned female at birth 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. Pediatric: 16 – 20 years old
Family Practice: 16 – 24 years old
Internal Medicine: 21 – 24 years old

*Denominator

The number of continuously enrolled members assigned female at birth for whom screening is indicated 16 – 24 years of age as of December 31 of the measurement year (DOB between January 1, 2002, and December 31, 2010).
For full details, please review QIP specifications manual via eReports.

Numerator

The number of members assigned female at birth from the eligible population in the denominator with at least one (1) test for chlamydia during the measurement year (January 1, 2026 – December 31, 2026)

Exclusions

- Members receiving palliative care any time during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
- Members with sex assigned at birth of male at any time in the member's history.

Measure Rationale and Source

The PCP QIP Chlamydia Screening measure focuses on increasing rates for chlamydia screening for individuals who are assigned female at birth and under the age of 24 years, reflecting the USPSTF recommendations. We support universal screening of all individuals assigned females at birth in the age range where chlamydia infection rates are highest. Screening all individuals in this age group ensures screening for the highest risk individuals and prevents missing individuals whose sexual activity may not be known by the PCP practice. Currently, systems are unable to effectively identify individuals who are sexually active, placing individuals at risk for complications due to undetected infection. Screening all individuals in this age range captures those seeking care who, based on age are at highest risk for infections and complications of chlamydia. Furthermore, the HEDIS measure denominator identifies sexual activity based on administrative data such as a pregnancy test outside of the PCP practice (urgent care or emergency room), or a prescription /treatment with contraception regardless of the condition for which they are prescribed.

This measure does focus specifically on females assigned at birth as the USPSTF concludes there is insufficient evidence to determine the balance of benefits and harms of screening males for chlamydia and therefor do not recommend they do not make a recommendation for or against screening this population. Please note: The PCP QIP chlamydia screening measure is not intended to represent the full practice of sexual health related screenings.

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.

Denominator

The number of continuously enrolled assigned members 46 – 75 years of age by December 31 of the measurement year (DOB between January 1, 1951, and December 31, 1980).

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 at 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 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, 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, 1951, and December 31, 2008). For full details, please review QIP specifications manual via eReports.

Numerator

The number of people with diabetes 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, 2025 – December 31, 2026), 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.
- At least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81) **AND one (1) of the following:**
- Advanced illness on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). **OR**
- Dispensed dementia medication during the measurement year or the prior measurement year.

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, 1951, and December 31, 2008) with diabetes identified as of December 31 of the measurement year.
For full details, please review QIP specifications manual via eReports.

Numerator

The number of people with diabetes 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.
- At least two indications of frailty with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81) **AND one (1) of the following:**
- Advanced illness on at least two different dates of service. Do not include laboratory claims (claims with POS code 81) **OR**
- Dispensed dementia medication during the measurement year or the prior measurement year.

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, 1941, and December 31, 2008) 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, 2025 – June 30, 2026). 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.
For full details, please review QIP specifications manual via eReports.

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 December 31 of the measurement year.
- 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 December 31 of the measurement year.
- 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 66 – 80 years of age as of December 31 of the measurement year with frailty and advanced illness.

- Members 81 years of age and older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

Measure Rationale and Source

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

- Nearly one in three 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 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 cardiovascular conditions, MCAS, NQF Controlling High Blood Pressure (#0018), and UDS Controlled Hypertension (CMS165v7).

IV. Clinical Domain

Measure 10. Kidney Evaluation in Patients with Diabetes

Description

The percentage of persons 18 – 85 years of age with diabetes (type 1 or type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) ***and*** a urine albumin-creatinine ratio (uACR), during the measurement period.

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, 1941 – December 31, 2008).

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

Numerator

The number of diabetics in the eligible population who received both an eGFR and a uACR during the measurement year (January 1, 2026 – December 31, 2026) on the same or different dates of service.

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 with a diagnosis of ESRD any time during the member's history on or prior to December 31 of the measurement year.
- Members who had dialysis any time during the member's history on or prior to December 31 of the measurement year.
- 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.
- Members 81 years of age or older as of December 31 of the measurement year with at least two indications of frailty with different dates of service during the measurement year.

Measure Rationale and Source

Chronic kidney disease (CKD) is a common and serious complication of diabetes, affecting up to 40% of adults with the condition. It also is a contributor for higher rates of cardiovascular events, kidney disease or failure, and even early mortality. The Kidney Health Evaluation for Patients with Diabetes (KED) measure promotes early detection in adults aged 18-85 with type 1 or type 2 diabetes who received a kidney health evaluation during the measurement year and incentives intervention by ensuring patients receive both an estimated glomerular filtration rate (eGFR) **and** urine albumin-to-creatinine ratio (uACR) annually. Despite strong evidence and clear clinical

guidelines, fewer than half of adults with diabetes receive both tests each year, highlighting a significant care gap.

According to the NCQA – State of Health Care Quality report for KED, “Diabetic kidney disease is one of the most common adverse outcomes of diabetes, affecting 20% – 40% of patients with diabetes. CDC simulation studies showed that uACR screening for early detection of CKD was cost-effective in patients with diabetes, at $50 thousand per quality-adjusted life-year.” Adoption of this measure drives an evidence-based and cost-effective practice which supports better long-term outcomes for patients with diabetes.

https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/kidney-health-evaluation-for-patients-with-diabetes-ked/

IV. Clinical Domain

Measure 11. Lead Screening in Children

Description

The percentage of continuously enrolled children two 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, who turn two years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2024, and December 31, 2024).

Numerator

The number of assigned children who had at least one lead capillary or venous blood test on or before their second birthday. For full details, please review QIP specifications manual via eReports.

Exclusions

This measure does not have any exclusions.

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. The 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 12. 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 13th 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, 2013, and December 31, 2013).

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.

American Academy of Pediatrics (AAP): Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, 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 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, and NQF Immunizations for Adolescents (#1407).

IV. Clinical Domain

Measure 13. 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 2,400 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 2 and March 6, 2026.** 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, 2026**.

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 2026. 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 MY2026. 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 that 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. The 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 14. 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, 2024, and October 2, 2025).

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

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.

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

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 pediatricians, parents and children. 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 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 15. Well-Child Visits in the First 15-30 Months of Life (W30-2)

Description

The percentage of continuously enrolled Medi-Cal members who turned 30 months old during the measurement year and had two (2) or more well-child visits between the age of 15 months and one (1) day and 30 months.

Points and Thresholds by Practice Type

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

This measure has an age group(s) included as a monitoring measure for 2026

*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 5, 2023, and July 4, 2024)

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

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.

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

Exclusions

This measure does not have any exclusions.

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. Hospital Utilization

Measure 16. Ambulatory Care Sensitive Admissions

Description

Admission rate of assigned members with any of the principal 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 measurement. 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 the 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 hospitalization 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. Hospital Utilization

Measure 17. Hospital Follow-Up Within 7 Days After 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 seven 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 measurement.

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 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

The number of members in the denominator who had a follow-up visit within seven calendar days of hospital 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
- 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 conditions
- Members who have had perinatal conditions
- LTC/SNF Members who have been discharged back into long-term care/SNFs
- Outpatient in bed stays
- Transition to a swing bed and transferred to another hospital for a higher level of care
- Inpatient hospital visit
- Inpatient psychiatric facility visit

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. Primary Care Utilization

Measure 18. Avoidable Emergency Department (ED) Visits/1,000 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 one year of age or older during the measurement year.

Numerator

The number of assigned members one 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 health care measurement entities.

VI. Primary Care Utilization

Measure 19. 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, urgent care 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, including urgent care services 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 20. Patient Experience

Description

This measure aims to improve patient experiences. 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/MY2026NonClinicalPatientExperience_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 29 following the measurement year.

No submissions required for CG CAHPS participants. Final CG CAHPS results will be available in late Fall of the measurement year and sent out via email.

All Final MY2026 Patient Experience scores will be available during preliminary period via Preliminary Statement in March of the following measurement year.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to the 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. Unit of Service

Measure 1. Clinician Education on Improving Medication Management
$2,500 Maximum per Parent Organization

Description

This measure is to incentivize the parent organizations to host 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 and hosting academic detailing meetings with at least one of their PCP clinicians per site, a pharmacist (where applicable) and at least one (1) QI staff along with Partnership's 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 1,000 assigned members.
- The first meeting must be scheduled and completed by July 1, 2026, and second meeting must be completed by December 15, 2026, to be eligible for the full incentive.
- At least one of their PCP clinicians per site, a pharmacist (where applicable) and 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. Unit of Service

Measure 2. Advanced Care Planning **$10,000 Maximum per Site**

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 advanced 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

  OR

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

For a **maximum** incentive payment of $10,000 per site.

Measure Requirements

ACP discussions which may include the completion of an Advance Directive and/or POLST, must take place between January 1 and December 31 of the measurement year to be eligible for this measure.

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 29 following the close of the measurement year.

Measure Rationale and Source

According to the 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 advanced directive on record (Jones 2011).
- Even among severely or terminally ill patients, fewer than 50 percent had an advanced directive in their medical record (Kass-Bartelmes 2003).
- Between 65 and 76 percent of physicians whose patients had an advanced directive were not aware that it existed (Kass-Bartelmes 2003).

VIII. Unit of Service

Measure 3. Extended Office Hours **10% of Capitation**

Description

Only if specified in PCP QIP Contract Amendment. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter
Definition of regular business hours:
Total open office hours are equal 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

Measure 4. Patient-Centered Medical Home Recognition (PCMH) $1,000 per site

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

$1,000 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 29 of the following measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

Exclusions

Submission(s) received after the close of the "grace period" that ends on January 29 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 ensure 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

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

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 must have a minimum of 50 assigned Partnership members to be eligible for this Unit of Service measure.

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 29 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 29 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

Measure 6. Health Information Exchange Participation
$3,000 Maximum per Parent Organization

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 either of the following participation:

- Establishing first time linkage: During the measurement year, first year HIE connection is established are eligible to earn $3,000.
- Continued utilization of the HIE: Year 2 and beyond of utilization of the HIE are eligible to earn $1,500.

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 29 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

Measure 7. Health Equity Implementation **$2,000 Maximum Per Parent Organization**

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 the submission template.
2. An updated annual report based on HE implementation as outlined in the submission template, 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 Health Care 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 on the Health Equity Implementation Template (Add appendix # and link) by January 29 following the measurement year via email to qip@partnershiphp.org or fax to (707) 863-4316.

VIII. Unit of Service

Measure 8. Tobacco Use Screening **$5 Per 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, 2005, and December 31, 2015)

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

Measure 9. Electronic Clinical Data Systems (ECDS)
Maximum of $5,000 Per Parent Organization

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 can 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. Note: this is a one-time Unit of Service incentive. PO will only be incentivized using the following thresholds for the measurement year they successfully contract with DataLink.

1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2026. Agreements signed after September 30, 2026, will be eligible for half payment ($1,000) through December 31, 2026. Data agreements do **not** term. Contract renewal is **not** required.
2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 30, 2026, and the Parent Organization responds timely to request for verification.

Note: The ECDS measure is also included in the Perinatal QIP. If your 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.

**Partnership's goal is to have all participating PCP QIP sites contracted with DataLink by January 2027. This goal supports DHCS's migration of HEDIS measures to electronic clinical data system (ECDS) capture. Datalink contracting will allow Partnership to retire all upload capability in eReports.

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

4665 Business Center Drive
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 29 following the measurement year** and send to:

- Email: QIP@partnershiphp.org
- Fax: (707) 863-4316
- Mail: Attention: Quality Improvement, 4665 Business Center Drive, 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:

_____
_____
_____
_____
_____
_____

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

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

4665 Business Center Drive
Fairfield, CA 94534

Please complete all of the following fields on this form by January 29 following the measurement year and send to:

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

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure programs 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 a minimum of 16 PARTNERSHIP patient visits, via list of attendees with DOB and date of group.

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

Appendix III: Submission Template for Pediatric Group Visits

4665 Business Center Drive
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 29 following the measurement year** and send to:

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

You may submit elements 1-7 prospectively for review and feedback before groups start, to ensure programs 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. The 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 a 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

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

Appendix IV: Submission Template for HIE

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

4665 Business Center Drive
Fairfield, CA 94534

If your organization is linked to an HIE during or prior to the 2026 Measurement year, you may qualify for an incentive for the 2026 PCP QIP. Please complete all of the following fields on this form and submit by **January 29 following the measurement year** and send to:

Email: QIP@partnershiphp.org
Fax: (707) 863-4316
Mail: Attention: Quality Improvement, 4665 Business Center Drive, 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* 2026 (list date) _____
   - ☐ Maintenance: First joined HIE *prior to* 2026 (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: Submission Template for Health Equity Implementation

4665 Business Center Drive
Fairfield, CA 94534

Please complete all of the following fields on this form by **January 29 following the measurement year** and send to:

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

5) Name of Parent Organization and Site(s) or PCP ID#(s) :
_____

6) Identified Health Equity Problem or Community Need:
_____
_____
_____
_____
_____
_____
_____
_____

7) Root Cause Analysis or History of Problem/Community Need or Barrier Discussion:
_____
_____
_____
_____
_____
_____
_____
_____

8) Health Equity Project (check one that applies):

☐ Community event coordination for disparity seen in community

☐ QI intervention conducted for disparity seen in community

☐ Plan for upcoming QI intervention or community event per root-cause analysis

☐ Project for improving recruitment and diversity of workforce

☐ Project for REAL/SOGI data collection

☐ IHI Framework Score Tool Completion with Plan

☐ NCQA Health Equity Accreditation Designation

☐ Other: (please specify)

_____

9) Time frame of project: (please include development and/or implementation dates)

_____

10) Impact of Intervention or Plans for Future Intervention:

- Specify in detail the impact of interventions (e.g. # of Hispanics screened for Breast Cancer Screening before and after intervention, Blood Pressure control in Tribal Community before and after intervention)
- Specify in detail planning for future intervention

_____
_____
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_____
_____
_____

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

Appendix V: Submission Template for Health Equity Implementation – EXAMPLE

4665 Business Center Drive
Fairfield, CA 94534

Please complete all 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 Drive, Fairfield, CA 94534

1) Name of Parent Organization and Site(s) or PCP ID#(s):
   Example: Partnership Care, PCP#123456

2) Identified Health Equity Problem or Community Need:
   Example: Improve Prenatal visits Control by at least 5% in the Latino / Hispanic community in Solano County within 12 months.

3) Root Cause Analysis or History of Problem/Community Need or Barrier Discussion:
   Example: "Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Hispanic members in the Northeast and Northwest regions for Timeliness of Prenatal Care.

   For postpartum care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups — namely Hispanic / Latino American patients

   Currently, Hispanic/Latino women are at least two times more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care.

   In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management"

4) Health Equity Project (check one that applies):

☐ Community event coordination for disparity seen in community

☐ QI intervention conducted for disparity seen in community

☒ Plan for upcoming QI intervention or community event per root-cause analysis

☐ Project for improving recruitment and diversity of workforce

☐ New Partnership with an local entity to provide CHW services (health education, health navigation, screening and assessment, individual support/advocacy)

☐ Project for REAL/SOGI data collection

☐ IHI Framework Score Tool Completion with Plan

☐ NCQA Health Outcomes Accreditation Designation

☐ Other: (please specify)

_____

5) Time frame of project: (please include development and/or implementation dates that align with measurement year)
Example: April 1st to December 31st of Measurement Year

6) Impact of Intervention or Plans for Future Intervention:

- Specify in detail the impact of interventions (i.e., number of Hispanic members screened for Breast Cancer Screening before and after intervention, Blood Pressure control in Tribal Community before and after intervention)

- Specify in detail planning for future intervention

Example: During 2025, we seen 18% of Hispanic mothers within Solano County attending their PRE-PPC visits and 15% attending their POST-PPC visit compared to 2024 rates of only 7% attending their PRE-PPC visits and 4% attending their POST-PPC visit. In 2026, we plan to promote doula services within our clinics and flyers that are tailored to our local Hispanic community. We will continue to educate all patients on the importance of PPC visits during pregnancy and after. We also plan to onboard a new doula within the next year to expand services. To measure impact, we will track the Hispanic mothers, who receive our outreach efforts and assess whether they complete their subsequent visit afterwards. A measure of success will be at least a 5% PRE-PPC improvement and 3% POST-PPC improvement.

Submitted by: Dr. Mohamed Jalloh Date: 12/11/2025
Title: Health Equity Officer Phone: 707-777-1111
Email: mjalloh@partnershiphp.org

Appendix VI: 2026 PCP QIP Submission and Exclusion Timeline

2026 QIP Uploads, Patient Experience (Survey Option Only) and Unit of Service Submissions

DEADLINE DATES	QIP MEASURES	REPORTING TEMPLATES
January 29, 2027, by 5 p.m.	All Clinical Domain Measures and Advanced Care Planning	Found in eReports
July 31, 2026	Patient Experience – Survey Option, Part 1	Appendix VIII
January 29, 2027	Patient Experience – Survey Option, Part 2	Appendix VIII
January 29, 2027	PCMH Recognition	Appendix I
January 29, 2027	Peer-led Self-Management Support Group	Appendix II & III
January 29, 2027	Health Information Exchange	Appendix IV
January 29, 2027	Health Equity Implementation Plan	Appendix V
September 30, 2026 (Full Incentive) or December 30, 2026 (Half Incentive)	ECDS – DataLink Agreement Due	N/A
October 31, 2026	ECDS – Successful HEDIS data extraction from EMR	N/A

2026 QIP Exclusions

SUBMISSION DATES	APPLICABLE MEASURES
January 15 – 29, 2027	Small Denominators for all PCP QIP Providers
January 1, 2026 – January 15, 2027	All measures from the Clinical Domain

Appendix VII: 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. Cervical Cancer Screening	Family and Internal			
3. Child and Adolescent Well Care Visits	Family and Pediatrics			
4. Childhood Immunization Status Combination 10	Family and Pediatrics			
5. Chlamydia Screening (16-24 years old)	Family, Internal, Pediatrics			
6. Colorectal Cancer Screening	Family and Internal			
7. Comprehensive Diabetic Care – HbA1c Control	Family and Internal			
8. Comprehensive Diabetic Care – Eye Exams	Family and Internal			
9. Controlling High Blood	Family and Internal			
10. Kidney Health Evaluation for Patients with Diabetes (KED)	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			

[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.

PCP QIP Core Measures	Practice Type	Data Source[6]	System Used for Data Monitoring	System Used for Data Submission
	Hospital Utilization Domain			
1. Ambulatory Care Sensitive Admissions	Family and Internal			
2. Follow-Up within 7 days after Hospital Discharge	Family and Internal	Partnership	PQD	Claims
	Primary Care Utilization Domain			
1. Avoidable ED Visits	Family, Internal, Pediatrics			
2. PCP Office Visits	Family, Internal, Pediatrics	Partnership	PQD	Claims
	Patient Experience Domain	Partnership	PQD	Claims
1. Survey Option (sites not qualified for CAHPS)	Family, Internal, Pediatrics	Partnership and Providers	PQD	Submission Template
2. CAHPS Survey (sites qualified for CAHPS)	Family, Internal, Pediatrics	Partnership Vendor	PQD	Partnership Vendor

[6] 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.

Appendix VIII: Patient Experience Survey 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 29 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 not to 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 29 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. ***Must take place during the same measurement year***

2. Provide descriptions for the following for your re-measurement period: ***Must take place during the same measurement year***
   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 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, 2026, and May 1, 2026, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2026. 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, 2026 (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. ***Must take place during the same measurement year***
   We had a consultant train our site over a two-month period (June- July 2026) 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: ***Must take place during the same measurement year***
   - 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 and November 1, 2026, 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, 2027 (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 and May 30, 2026, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2026. 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 a 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 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, 2026 (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. ***Must take place during the same measurement year***
   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: ***Must take place during the same measurement year*
   - 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, 2026, 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 felt 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 exceptions to this new rule based on the members' unique circumstances.

Submitted by Jim Ropes (QI Manager) (Name & Title) **on** January 08, 2027 (Date)

X. Monitoring Measurement Set for the MY2026

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. Topical Fluoride for 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 MY2026)

Family Practice: (Monitoring for MY2026)

*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 January 1, 2022, and December 31, 2025).

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

This measure does not have any exclusions.

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 applications.

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

Description

The percentage of continuously enrolled Medi-Cal members who turned 30 months old during the measurement year and had two (2) or more well-child visits between the age of 15-months and (1) day and 30-months.

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 2026)

*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 5, 2023, and July 4, 2024)

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

This measure does not have any exclusions.

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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