Medical Directors Forum

Primary Care Almanac (Leadership Version)

Detailed Notes

Spring 2026

Partnership HealthPlan of California's mission is **"To help our members, and the communities we serve, be healthy."** This dual focus – on both the individuals who are members of the health plan and the communities that we all live in – is rooted in our nonprofit status and our governance structure. Our governing Board of Commissioners includes a diversity of representatives from all counties that we serve in Northern California.

Partnership's vision is **"To be the most highly regarded health plan in California."** We strive to be highly regarded by our members, the provider network comprising our health care delivery system, our community partners, the state legislative and executive branches, other health plans (our peers), and by our employees. This requires engagement and communication with each of these groups.

Robert L. Moore, MD, MPH, MBA, FAAFP
Chief Medical Officer

Kermit Jones, MD, JD
Deputy Chief Medical Officer

Your Regional Medical Directors:
Lisa Ward, MD, Regional Medical Director, Santa Rosa office (Marin and Sonoma counties)
Colleen Townsend, MD, Regional Medical Director, Fairfield office (Napa, Solano and Yolo Counties)
Jeff Ribordy, MD, Regional Medical Director, Eureka office (Humboldt, Del Norte, Mendocino and Lake counties)
Brad Cox, DO, Regional Medical Director Redding Office (Trinity, Shasta, Tehama, Siskiyou, Modoc and Lassen counties)
Richard (Doug) Matthews, MD Regional Medical Director, Chico Office (Butte, Colusa, Glenn, Sutter, Yuba counties)
Matthew Morris, MD, Regional Medical Director, Auburn office (Placer, Nevada, Sierra, Plumas counties)

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

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

Table of Contents

Partnership Structure *6*
Six Regional Offices 6
Partnership Advisory Committees 6
Partnership Strategic Issues *7*
Partnership Advantage 7
Recent Enrollment Trends 7
Health Policy Updates *8*
State Budget Outlook 8
Federal Affairs 8
California Legislative Roundup 11
Selection of Public Health Bills 12
Ballot Initiatives 13
CMS Recommended Changes to Medicaid Quality Measures 14
Access to Safe Perinatal Services and Obstetrical Care 15
Rural Health Policy 21
Obstetrical related bills passed last year: 22
POLST Registry 27
CMA House of Delegates Asserts its Autonomy (2025) 28
Improving Health Outcomes in California Tribal Communities 29
Partnership Policy Reminders *30*
Grievance and Appeals Process 30
Potential Quality Issues and Peer Review 30
What's "Carved-Out" to DHCS or Counties? 32
Monthly Newsletter for PCP Clinical Leaders 33
Primary Care Blog 33
List of PPS Covered Services 33
Partnership Website Highlights for Clinicians 36
Benefits Updates for Partnership Members *37*

Blood Pressure Devices and Cuffs through Community Pharmacies 37
Medical Equipment Distribution Program 38
Care Coordination Services at Partnership 39
Intensive Outpatient Palliative Care Benefit 40
Hospice Provider Network 42
Telemedicine Services 43
Diabetes Education and Nutrition Counseling 47
Behavioral Health 48
Supplemental Benefits 52
Transportation Benefit 53
Medi-Cal Benefits: Recent Changes 54
CalAIM: Enhanced Care Management and Community Supports 54
GLP-1 Criteria and Fibroscanning for a Diagnosis of MASH. 57
Other Medi-Cal Rx Updates 60
Coverage for Community Health Workers 60
Genetic Testing 60
Partnership Updates 61
New Core Claims Processing System 61
Prior Authorizations in Primary Care 61
Mobile Mammography 62
Partnership Provider Recruitment Program (PRP) 63
Provider Retention Initiative (PRI) 64
Partnership Clinic Leadership Academy 65
Pearls on Referrals 65
Public Health Data Review 68
County Profiles and HEDIS Results from 2024 68
Advance Directive Completion 68
Smoking Rate 69
Adult Flu Vaccination 69
Tobacco screening and referral rates 69
Vaccination in Pregnancy: 71
CT Scan Usage by Emergency Departments: 72
Hospital Obstetrical Data: 73
Clinical Practice Guidelines and Best Practices 74
Preventive Services Updates 74

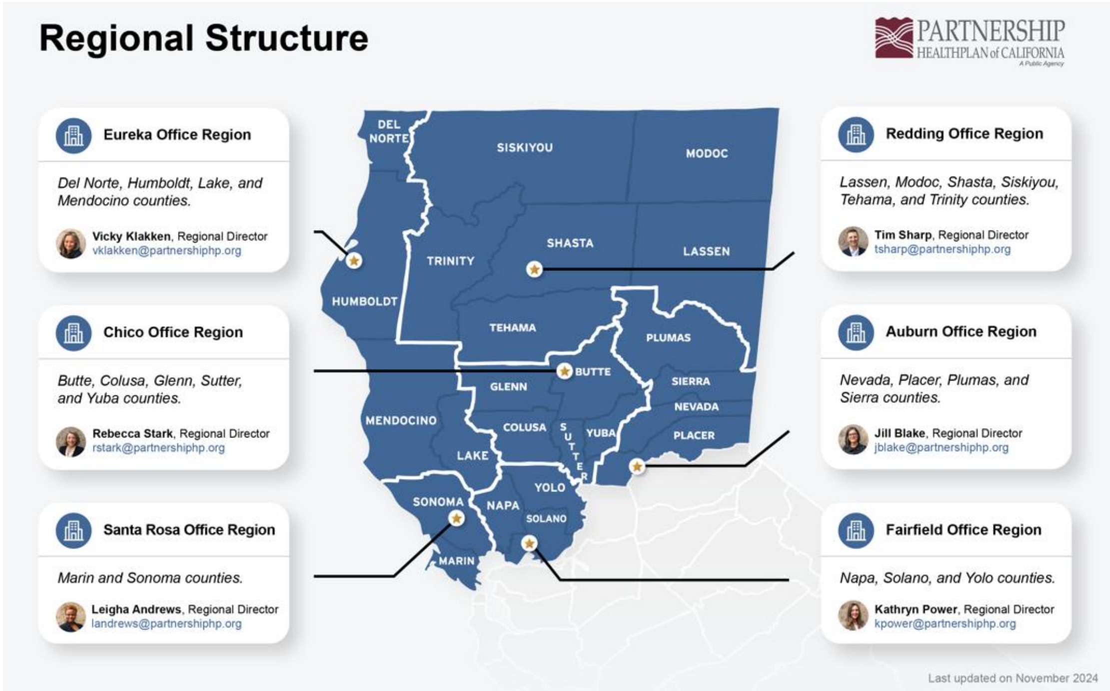
Clinical Practice Guidelines 75
Specific Pediatric Guidelines 76
Developmental Screening 83
Adult Guidelines 88
Reminder on Screening for Tuberculosis 91
Health Equity *92*
Mandatory CARES Training 92
Health Inequity Measurement 92
2024 Population Needs Assessment 95
Health Equity/Practice Transformation (EPT) Directed Payment Program 95
General Quality Updates *97*
How PCP QIP drives HEDIS 97
DHCS Quality Oversight 98
Withhold Measures 99
DataLink and ECDS Measures 100
Facility Site Review 101
Improving the Patient Experience 102
Quality Improvement Program Description, Evaluation, and Work Plan 111
Pay for Performance Program for Primary Care (PCP QIP) *111*
PCP QIP Overview 111
PCP QIP Measure Sets 112
Prioritization of PCP QIP measure interventions, by time of year. 115
Scheduling Well-Child Visits: Taking Demand for Acute Visits into Account 116
Online Tools for Quality Measurement and Reporting 119
eReports 120
Partnership Quality Dashboard (PQD) 121
Payment Methodology for Core Measure Set 122
Equity Adjustment of the Core Measure Set 122
Consequences of Poor Performance on the PCP QIP 124
Training Resources for Quality and Performance Improvement *125*
Pediatric Well Visits: Required Training 125
Improvement Academy Trainings 125
A Quick Guide to Starting Your Quality Improvement Projects 126
Improving the Patient Experience through Communication Workshops 126
Cologuard Care Gap Orders 127

Upcoming trainings *128*
ABCs of Quality Improvement Training 128
Suggested "To Do" List *129*
Medical Directors/Clinic Directors 129
Quality Leaders 130

Partnership Structure

Six Regional Offices

To better serve the needs of our large geographic area, Partnership has six regions, each with a regional office with a regional director, a regional medical director, and a regional multi-department team. The following graphic shows the counties in each region.



Partnership Advisory Committees

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

In particular, we are looking for:

- Non-primary care specialists
- A hospitalist
- A psychiatrist or psychologist

We are especially looking for clinicians who reflect the diversity of our communities and can bring diverse views to the committees. If you know of any good candidates, please email your Partnership regional medical director or chief medical officer.

Partnership Strategic Issues

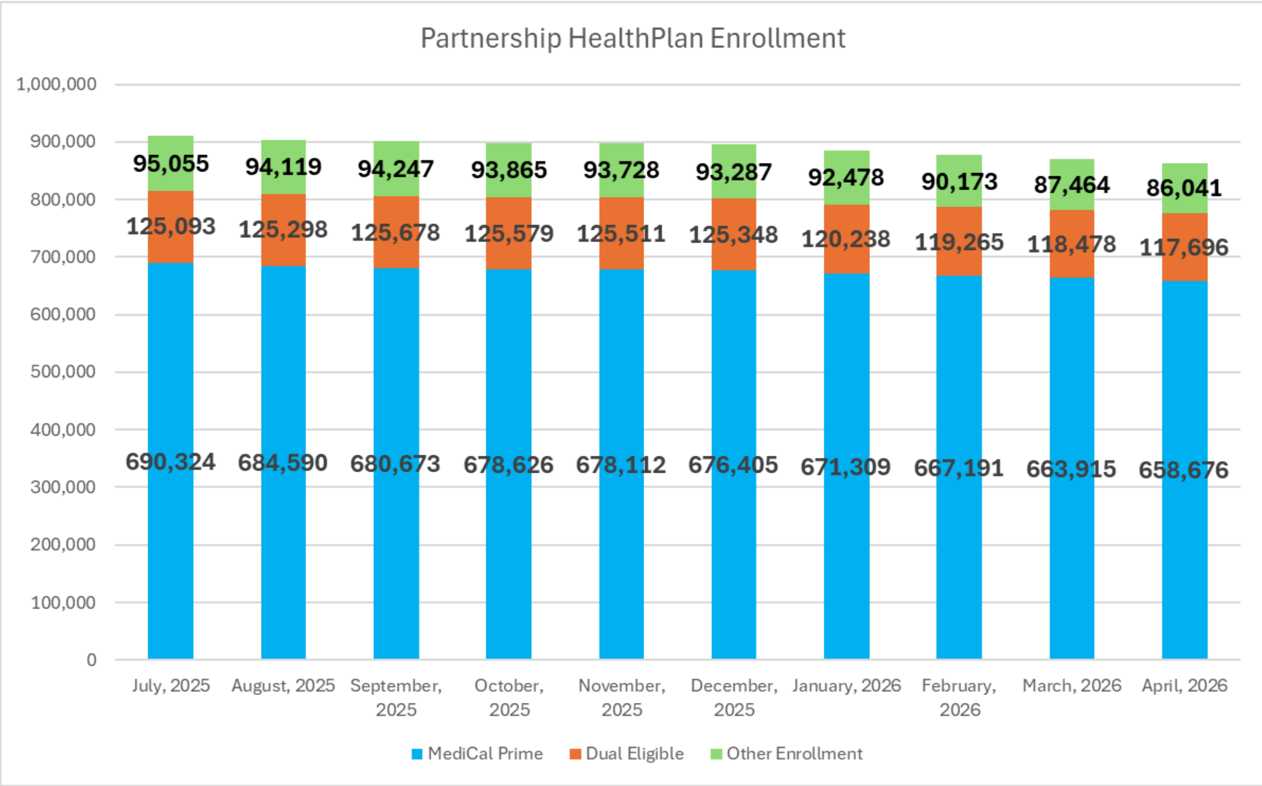
Partnership Advantage

Background

In January 2023, the California Department of Health Care Services (DHCS), mandated that Medi-Cal managed care plans operate a Medicare Advantage Dual Special Needs Plan (D-SNP) designed to coordinate care and benefits for Medi-Cal members who qualify for Medicare. In pursuance of this mandate, Partnership HealthPlan of California began the application process to the state and federal Centers for Medicare and Medicaid Services (CMS) to have a D-SNP plan called Partnership Advantage.

The original go-live planned for eight coastal counties in January 2026 was delayed. Our new target date is January 2028. A final readiness assessment will be completed in early Spring 2027, before a bid is submitted to CMS.

Recent Enrollment Trends



Health Policy Updates

State Budget Outlook

Late 2025, the Legislative Analyst Office (LAO) made some stark budget projections ahead of the Governor's January budget. The LAO estimated an $18 billion budget deficit for the year, which contrasted with the Governor's $3 billion deficit estimate. Governor Newsom and the LAO both acknowledge a $20-$33 billion structural budget deficit in 2027, but the January Budget did not take significant action to address this shortfall. Instead, the Governor is relying on the avoidance of a significant stock market drop. According to the Department of Finance February Finance Bulletin, the economy has remained steady, with January General Fund cash receipts $3.4 billion, or 14.2%, above the Governor's January budget forecast, and $6.9 billion, or 5.4%, above the fiscal year-to-date forecast.

California's tax structure historically leads to boom-and-bust budget cycles aligned with the stock market. In an economic downturn, lawmakers would be forced to reckon with a significant loss of tax receipts AND the loss of federal funding from the provisions of H.R.1. Lawmakers appear to be following the Governor's lead and are waiting for the May Revise before taking action to address the structural deficits identified by state agencies. However, there are several revenue generation bills and ballot initiatives, discussed later, that would backfill funding losses created by H.R.1. The initiative getting the most attention is a one-time 5% wealth tax on taxpayers and trusts with assets valued over $1 billion. This proposal would allocate 90% of these revenues for healthcare and 10% for food assistance and education-related programs. Billionaires for their part are introducing counter ballot initiatives that would eliminate the value of the wealth tax and are spending heavily to defeat the proposal.

Federal Affairs

On February 3, 2026, President Trump signed the Consolidated Appropriations Act of 2026, which included funding for Labor-HHS, into law. The HHS section of the bill included major reforms to the way Pharmacy Benefit Managers may operate, prevents Disproportionate Share Hospital Payment cuts through 2027, extends Medicare telehealth flexibilities through 2027. The bill also increased funding for the Community Health Clinics but limited the extender to just one year of funding. Missing from the bill was an extension of the Enhanced Premium Tax Credits.

While states continue to operationalize the provisions of H.R. 1 over the next few years, Partnership is focused on how revenue and enrollment declines will impact rural health systems. Fewer Medicaid enrollments mean rising uncompensated care costs, while the loss of provider taxes means already tight margins in rural communities get even tighter. The State has indicated that it does not have the resources to backfill for the loss of federal funding, making new revenue much more important. Resources from the Rural Health Transformation Program are still pending but will not

be sufficient to replace lost federal funds.

H.R.1 Implementation

DHCS released its **Implementation Plan** for New Federal Eligibility and Enrollment Changes Under H.R. 1. The guidance outlines the state's approach to implementing new federal requirements under H.R. 1, which start as early as October 2026. These include work reporting requirements (January 2027), 6-month renewal cycles (January 2027), and adjustments to immigrant eligibility criteria (October 2026).

Work Requirements – DHCS intends to use automated systems to verify work or volunteer hours for Medi-Cal eligibility. DHCS has the flexibility to consider monthly income (80 hours x federal minimum wage=$580/mo.) in lieu of the 80-hour work requirement. At California's minimum wage ($16.90/hr), Medi-Cal members would meet the $580 income after about 35 working hours a month. DHCS reported that Medi-Cal members in 22 counties may be eligible for a hardship exemption based on county unemployment rates, most of these counties are located in the San Joaquin Valley.

MCO Tax - On January 30, CMS issued a Final Rule that allows states with managed care organization (MCO) taxes that were approved within two years of April 3, 2026, to retain MCO tax revenues through the end of the 2026 calendar year. California is among these states. Prior to the final rule, the language appeared to limit California's MCO Tax revenue to June of 2026.

Federal Bills

HR 7981 (Lawler, Republican from New York) would exempt physicians from the $100,000 H1B fee, which is impacting the number of foreign medical graduates matching in US residencies.

18-Month Outlook for Medi-Cal Changes

Impact Date	Federal/State	Policy Change	Scope of Impact
Jan. 1, 2026	State Policy	Froze Medi-Cal enrollment for adults with Unsatisfactory Immigration Status (UIS)	UIS adults ages 19 - 64
	State Policy	Reinstated Medi-Cal asset limits - $130k for individuals and $195k for couples	Older adults age 65 and older, people with disabilities, and long-term care recipients
July 1, 2026	State Policy	Replaces PPS rate with FFS rate at FQHC and RHC for UIS population	Clinics providing services to UIS adults and certain other groups of immigrants
	State Policy	Eliminates Medi-Cal dental benefits for UIS adults	UIS adults and certain other groups of immigrants
Oct. 1, 2026	Federal Policy	Reduces federal match for emergency Medi-Cal	California state budget
	Federal Policy	Eliminates Medi-Cal and CHIP for many immigrant populations	About 200,000 refugees, asylees and other immigrants will be impacted
Jan. 1, 2027	Federal Policy	Introduces new restrictions on provider tax rates	Entire Medi-Cal program
	Federal Policy	Increases eligibility checks for the ACA expansion adults	About 400,000 adults could lose Medi-Cal
	Federal Policy	Limits Medi-Cal retroactive coverage for adults	ACA Adults receive 1 month of retroactive coverage instead of 3 mos.
	Federal Policy	Institutes work reporting requirements for ACA adults	About 1.4 million adults could lose Medi-Cal
July 1, 2027	State Policy	Imposes a $30 monthly Medi-Cal premium for certain groups of immigrants	Undocumented adults and certain other groups of immigrants ages 19-59
Oct. 1, 2027	Federal Policy	Lowers the allowable provider tax rate	Entire Medi-Cal program

SB 912 (Cervantes) Comprehensive Perinatal Services
This bill would require DHCS to oversee a statewide comprehensive community-based perinatal services program and enroll health care providers to deliver these services to Medi-Cal members. The bill would require DHCS to develop training on administering comprehensive perinatal services, require all perinatal providers providing perinatal care to Medi-Cal members to attend the training, and require all Medi-Cal managed care plans to ensure providers receive the training. This bill requires Medi-Cal members to be informed about the availability comprehensive perinatal services. **No sooner than January 1, 2027, the bill would prohibit a PPS billable visit from including an encounter with a comprehensive perinatal practitioner who is not otherwise a PPS billable health professional.** The bill would authorize the department to implement an alternative payment methodology for FQHCs and RHCs to obtain reimbursement for encounters with community health workers at no less than the applicable Medi-Cal fee-for-service rate. After input from CPCA, the bolded section above is likely to be removed.

SB 1088 (Blakespear) POLST Modernization and Prehospital DNR.
Sponsored by the Coalition for Compassionate Care in California, this bill would:

- Change the name of the form from "Physician Orders for Life Sustaining Treatment (POLST)" to "POLST (portable medical orders)."
- Authorize nurse practitioners and physician assistants/associates to also sign the prehospital DNR form.
- Specify who, exactly, is a "legally recognized decisionmaker" who can sign a POLST on behalf of an incapacitated patient.
- Emphasize that POLST is entirely voluntary and the provision of care or admission to a facility cannot be conditioned on completion of or refusal to complete a POLST or prehospital "do not resuscitate" order.
- Authorize electronic signature of POLST for electronic health records and the POLST eRegistry.
- Require the form to be dated!
- Honor POLSTs and POLST-like forms and prehospital DNRs executed in other states.

SB 1422 (Durazo) Medi-Cal: Eligibility: immigration status. With an astounding 19 co-authors and hundreds of organizational supporters, this bill would restore the ability for the UIS population to obtain full scope Medi-Cal. This would require significant financial resources which are not generated as part of this bill, placing the fate of the bill in the hands of the appropriations committee, which must generate a balanced budget, and the governor, who may remove it.

Selection of Public Health Bills

Social Media Addiction

AB-1700 (Lowenthal) Covered platforms: age restriction: e-Safety Advisory Commission.

Would require covered platforms – based on the "addictive internet-based service or application" definition from the Protecting Our Kids from Social Media Addiction Act to prevent minors under age 16 from having accounts, using the device-based age verification system created by the Digital Age Assurance Act. The bill does not prevent minors from accessing social media to find information and resources; it simply prohibits them from having a personalized account. The bill would require the eSafety Commission to craft regulations to enforce the ban. The commission would be established within the State Department of Justice and advise the Attorney General on which platforms are covered under the law.

Youth Nicotine Use

AB-1884 (Hadwick) Interscholastic athletics: drug testing: suspensions: nicotine use.

Would require the governing boards of school districts to establish drug testing programs for pupils in grades 7 to 12, as part of their policies regarding participation in extracurricular and cocurricular activities. The bill requires programs to include nicotine testing for athletic extracurricular activities, authorizes testing to also include alcohol and other controlled substances, and authorizes testing to apply to other non-athletic extracurricular activities.

AB-2667 (Hadwick) Vape products: household hazardous waste: advertising

Prohibits the sale of cannabis or tobacco vape products that conceal the nature of the vape product, use branding known to appeal to minors, or include interactive videogame capabilities; requires the Department of Toxic Substances Control (DTSC) to evaluate and make recommendations relating to the confiscation of vape products from students by schools; and authorizes household hazardous waste (HHW) collection facilities to disassemble vape products.

Bike Safety

AB-2346 (Wilson) Vehicles: electric bicycles and speed limits.

This bill would require all class 1 and class 2 electric bicycles manufactured, sold, or offered for sale on or after January 1, 2029, to be equipped with a speedometer. The bill would also require all electric bicycles on or after January 1, 2029, to be equipped with an integrated front lamp and a rear lamp. The bill would also require manufacturers and distributors of electric bicycles to include a written description of California's electric bicycle laws with the bicycle's packaging to be provided to the consumer. The bill would also require sellers and distributors of electric

bicycles to provide specified disclosures at or before the point of sale. The bill would make a violation of these provisions punishable by a civil penalty not to exceed $15,000 for a first violation and not to exceed $50,000 for each subsequent violation. This bill would authorize a local authority to set a speed limit on a bicycle path of 15 or 20 miles an hour or on a multiuse trail to 10, 15, or 20 miles per hour, subject to specified signage requirements. The bill would also prohibit a person under 16 years of age from riding an electric bicycle at a speed greater than 15 miles per hour on a highway or a bicycle path.

Ballot Initiatives

Revenue Initiatives

The 2026 Billionaire Tax Act (**25-0024A1**)
Imposes one-time tax of up to 5% on taxpayers and trusts with covered assets valued over $1 billion; covered assets include businesses, securities, art, collectibles, and intellectual property, but exclude real property and some pensions and retirement accounts. Allocates 90% of these tax revenues for health care, 10% for food assistance or education-related programs; prohibits using revenues to replace existing funding for these purposes. It further exempts such tax revenues from constitutional requirements for school funding, budget reserves, and state spending limit. This is not an income tax but instead is tax on wealth and assets. It is supported and sponsored by SEIU-UHW and opposed by Governor Newsom. As of Feb. 27, this initiative has not yet qualified for the ballot.

The California Children's Education and Health Care Protection Act of 2026 (**25-0016**.)
Makes permanent the existing 2012 voter-approved tax rates for high-income Californians, currently set to expire in 2031. Voters approved Proposition 30 in 2012 to temporarily increase income tax rates on high-income taxpayers in order help dig the state out of perpetual multi-billion budget deficits. In 2016, voters approved Proposition 55 to extend these higher rates until 2030. The top 2 percent of California taxpayers pay these higher rates. These taxpayers pay about half of all state income taxes accounting for $5-$15 billion of revenues. This measure is supported by the California Teachers Association and other state public employee unions.

Health Care Initiatives
The Clinic Funding Accountability and Transparency Act (25-0008A1.)
Requires nonprofit Federally Qualified Health Centers to spend at least 90% of their revenue on program services rather than management and overhead. This proposal was also found in AB 1113 (M. Gonzalez) which was introduced in the 2025 legislative session. That bill failed to advance due to the stiff opposition from community clinics and their allies.

The Health Care Executive Compensation Act of 2026 (25-0009A1.)

Prohibits certain hospitals and medical entities from paying executives, managers, and administrators more than $450,000 in total annual compensation (salary, paid time off, bonuses, stock options, company vehicle, etc.) or severance payment and limits any increases to 3.5% annually. This proposal is a heavy-handed threat to the healthcare industry and its executives and aimed at trying to coerce the hospital industry to capitulate on broad labor and organizing negotiations.

Revenue and Labor Opposition Initiatives

The Local Taxpayer Protection Act to Save Proposition 13 (25-0006A1.)
Limits voters' ability to pass voter-proposed local special taxes by raising the vote approval threshold requirement for such ballot measures from a simple majority (over 50%) to two-thirds. This measure would invalidate court decisions that allows local governments to raise special taxes with a majority vote instead of two-thirds vote as long as the measure is officially spearheaded by a citizens group. The Howard Jarvis Taxpayers Association sees this as a loophole that needs to be closed.

Health Care Union Transparency, Accountability and Union Member Right to Vote Act (25-0021A1)
Prohibits certain large health care unions from political spending over specified amounts on state or local ballot measures without following certain member consent requirements. This ballot initiative is California Hospital Association's (CHA) direct response to the above union backed measures. Labor unions have spent hundreds of millions of dollars of their union members' dues on multiple unsuccessful ballot measures in recent elections. The CHA approach would force the labor unions to reckon with possible member dissatisfaction or revolt over political strategy and wasteful spending. At the very least this measure, if passed, would create administrative and bureaucratic hurdles to future ballot-box legislating by the union.

CMS Recommended Changes to Medicaid Quality Measures

In March 2026, CMS proposed a major decrease in the number of quality measures that they require. The biggest change is a removal of all vaccination measures from the list. Here is the proposed list:

MAC QRS MY26 Clinical Measures Applicable to MCPs

MY2026 Mandatory Clinical Measures	Steward	MCMC
Preventive Care and Screening: Screening for Depression & Follow-Up Plan (CDF) * **	CMS	✅ Yes
Contraceptive Care – Postpartum Women (CCP) * **	OPA	✅ Yes
Use of 1st-Line Psychosocial Care for Children/Adolescents on Antipsychotics (APP)	NCQA	✅ Yes
Initiation and Engagement of Substance Use Disorder Treatment (IET)	NCQA	✅ Yes
Follow-Up After Hospitalization for Mental Illness (FUH)	NCQA	✅ Yes
Well-Child Visits in the First 30 Months of Life (W30)	NCQA	✅ Yes
Child and Adolescent Well-Care Visits (WCV)	NCQA	✅ Yes
Breast Cancer Screening (BCS-E)	NCQA	✅ Yes
Cervical Cancer Screening (CCS / CCS-E)	NCQA	✅ Yes
Colorectal Cancer Screening (COL-E)	NCQA	✅ Yes
Prenatal and Postpartum Care (PPC)	NCQA	✅ Yes
Glycemic Status Assessment for Patients with Diabetes (GSD)	NCQA	✅ Yes
Controlling High Blood Pressure (CBP)	NCQA	✅ Yes

***** Indicates measures not currently collected by MCPs for MCAS or NCQA HPA.**

This represents an opportunity to advocate to DHCS to change the NCQA vaccine measure that is used for MCAS, from CIS-10 to a vaccine combination that does not include influenza and rotavirus, like the Combo 3, which has seven vaccinations against 11 different diseases. The CIS-3 is missing the Flu, Rotavirus and Hepatitis A vaccines, compared to the CIS-10. If you like this suggestion, we recommend advocacy to DHCS through your trade organizations.

Access to Safe Perinatal Services and Obstetrical Care

For the first time in many years, no hospital in the Partnership service area stopped providing maternity services.

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

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

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

1. Policy changes: governmental, health plan, and local health systems
2. Educational programs that optimize local health care workforce capacity

3. Adjustment of reimbursement models to support diverse settings of care
4. Deepening community partnerships that reinforce collaboration
5. Better data collection and analysis to guide thoughtful decision making

Much has been accomplished in the three years since Partnership's focus on obstetrical access and quality began.

Provider Recruitment to Support Perinatal Providers

In 2025, a survey of the Partnership network found that 30% of all positions for maternity care providers (including physicians, midwives, and nurse practitioners) are currently vacant and under active recruitment. A vacancy is defined as a job opening in which active recruitment is underway, with exam room capacity and funding available to pay the clinician, if one is found.

Maternity care providers are eligible for Partnership's recruitment incentive program.

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

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

A Licensed Midwife Associate Degree program is starting at Cerro Coso Community College in Ridgecrest. This is a 2 year Associated of Science program that participants enter after meeting prerequisites of at least 20 college credits. Licensed Midwives can provide midwifery, women's health and early newborn care as allowed by their scope per the Medical Board of California. It is on track to welcome its first class in the fall of 2026. It plans an innovative hybrid program that combines online learning with regionally-based clinical training.

Rural Nursing Education to Train Rural Nurses in OB Nursing

In the summer of 2024, Christi Myers, the director of the registered nurse training program at Lassen College, highlighted the way that the program provides a well-rounded, hands-on training experience for registered nurses. Graduates of the program can practice in multiple hospital settings in rural hospitals. She presented this program at Partnership's annual Hospital Quality Symposium in August. Meyers stated that a close partnership between Lassen College and nearby Banner Lassen Hospital was a key to the strength of the program. Another highlight is a high-quality simulation lab for teaching hands-

on skills using mannequins before trying them on patients. Partnership hopes that RN training programs in other rural community colleges will collaborate with nearby rural hospitals with the same goal: to produce well-trained nurses who are able to work in multiple settings in the hospital.

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

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

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

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

Basic Life Support in Obstetrics (BLSO) is a variation of ALSO that targets first responders, doulas, physicians, and nurses that practice in the emergency department or outpatient setting. These individuals may be the only medical personnel available to assist with delivery in rural areas. The training includes material covering normal delivery and routine newborn care, as well as the basics of managing uncommon obstetrical emergencies. This is a 4-to-8-hour online training followed by 7.5 hours of in-person training. The focus of the practice sessions can be adapted to meet the specific scope of the trainees.

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

Partnership offers all three training programs in our rural service area, training physicians, midwives, doulas, nurse practitioners, and respiratory therapists. If

you are interested in scheduling a training course in your community or hospital, please reach out to your local Partnership Regional Medical Director to be connected to our training coordinator.

Support for Doulas

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

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

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

Once contracting and credentialing are complete, Partnership schedules monthly trainings for doulas to learn about Partnership benefits and how to submit a claim. The Partnership Claims team works closely with newly contracted doulas to facilitate timely and smooth claims and reimbursement processing. Partnership covers the cost for doulas to use claims submission (Office Ally) that simplifies the process for claims submissions.

In addition to direct outreach to doulas, we partner with community-based organizations, public health departments, clinical practices and hospitals to share information regarding the doula benefit. Partnership has sponsored informational doula gatherings and doula trainings on different clinical topics. Partnership also provides educational awareness activities directed at members, hospitals, and maternity care teams and collaborates with several county-based organizations to recruit and train new doulas.

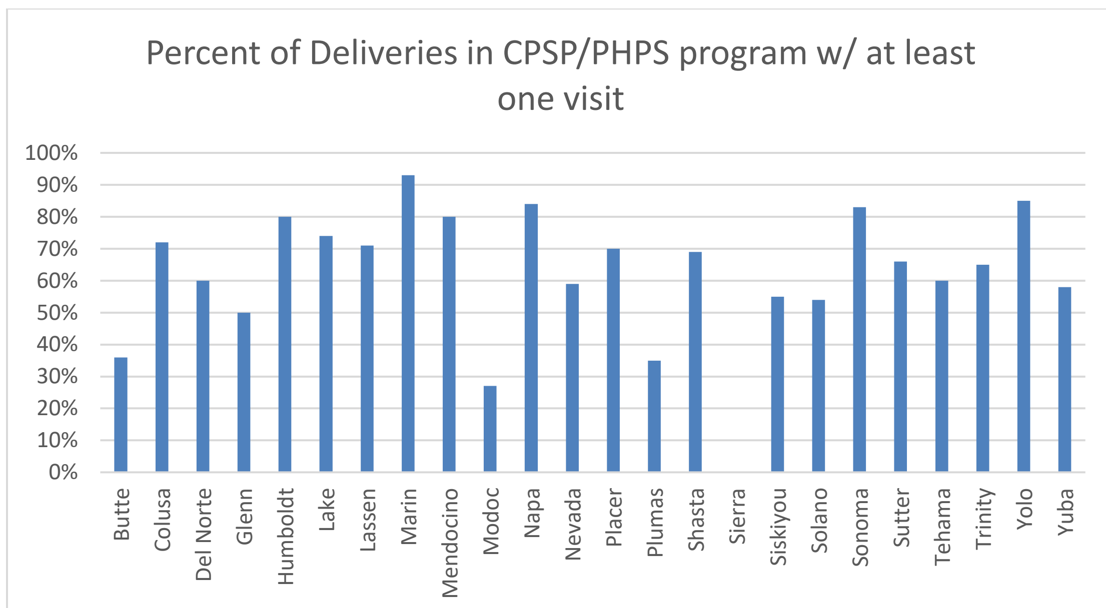
The Partnership Population Health Team reaches out to pregnant members to offer pregnancy education including information about the doula benefit and contracted doulas in a member’s county.

Partnership HealthPlan Perinatal Services (PHPS) Updates

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

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

We are rolling out PHPS to the network, with perinatal provider meetings, review of applications, and updating our site review process. We are tracking member utilization of each type of service to better understand the network and members' access to perinatal services. In the coming year we will be working to fill network gaps for perinatal case management and setting up the infrastructure for ongoing enhancement of quality of care provided by the network.



Tribal Perinatal Support

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

The Partnership service area includes 21 Tribal Health Clinics serving 51

federally recognized Tribes, more than any other managed care plan in California. Tribal health leaders and clinicians serve on Partnership's Board of Commissioners, Physician Advisory Committee, Quality Utilization Advisory Committee, and Community Advisory Committee.

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

Tribal Health programs have shared impacts with one reporting that they have seen incredible growth and feel fortunate to be able to offer comprehensive, full-scope prenatal and postpartum care as well as provide key maternity supplies that they wouldn't otherwise be eligible for through Medi-Cal. Another program shared that they have successfully launched a dynamic and growing Tribal Perinatal Program and multidisciplinary team that is making a meaningful impact on health outcomes. Through the Tribal Perinatal Program, they have completed high-quality training and have built a team structure consisting of a medical director, RN/PHN, LVN, Perinatal Health Program Manager, and Family Spirit Educator.

Quality Improvement Activities Related to Perinatal Care

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

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

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

Future Activities

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

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

Rural Health Policy

Rural Health Transformation Program

H.R. 1 (2025) included a $50 Billion allocation to support the rural health care delivery system, which will be expected to be severely affected by the Medicaid cuts contained in the bill. California's application to CMS for a generous portion of funding was strong, and California announced that it has been awarded $233 Million for the first of five years, for 2026. The California Department of Health Care Access and Information (HCAI) will be administering the program.

Reviewing HCAI's application to CMS, the funding may not be used for provider salaries, new construction, changing of one EMR to another, Research and Development or Duplicate Billing Systems. Funding falls into three large categories with several sub-categories.

A. Transformative care
    a. Establishing Regional Hub and Spoke Networks to promote specialty access and to shore up struggling rural hospitals.
    b. Expanding rural workforce
    c. "Transformational payments" to distressed rural hospitals for hub and spoke models.
B. Workforce Development
    a. Recruitment and retention incentives and wrap arounds
    b. Strengthen training pathways for health-related careers
    c. Development of a mapping and planning tool
C. Technology
    a. Support of IT projects of various types in various ways

<u>Risks:</u>

1. More urban interests apply for the grants in the name of rural areas, for projects not likely to make much real difference for rural residents or the rural health care delivery system.
2. The best ideas are not promoted by a good grant writer or a strong fiscal sponsor, so the good ideas go unfunded.
3. Universities and others good at grants write grants without robust input from rural providers and leaders.

Ideas to consider:

1. Perinatal case manager/doula training curriculum built by an academic center willing to offer this training.
2. Funding a study of what it would take to reopen the most rural hospitals to OB
3. Funding to support rejuvenating the specialties in most need in rural areas: oncology, rheumatology, nephrology, neurology, endocrinology.
4. Funding to promote a more in-depth training for family physicians planning to practice in Frontier areas.
5. Funding for rural RN training programs at rural community colleges to produce well rounded and well-trained generalist nurses suitable for working in various departments in rural hospitals.
6. A traveling shared simulation and mannikin learning network for rural hospitals in Northern California.
7. Leadership training for Clinician/Administration teams

Recommendations:

1. Develop coalitions to put together strong proposals early, identifying experienced grant writers and lead agencies.

Obstetrical related bills passed last year:

California SB 669 (McGuire, 2025) allows for a pilot project that designates a "standby perinatal unit" in remote rural hospitals. This model contrasts the standard model of continuous OB unit staffing used in hospitals. This pilot will provide an example of a solution that emphasizes a well-trained, capable local team of professionals who provide high-quality maternity and labor and delivery care. Emphasizing the training and systems required in this model, we have been able to garner support for SB 669 by all stakeholders.

A key part of advocating for this bill is that family physicians with specialized, supplemental OB training are critical to the success and sustainability of this staffing model in rural hospitals. Urban specialists may be unaware of the enhanced skills and experience that family physicians bring to rural settings; rural communities' needs are different than urban areas. Our current health systems, policy, and regulations are based on serving dense, urban populations with a broad network of resources. Urban specialists often drive the standard and models of care beyond the city limits. However, when an urban mindset drives solutions for rural areas, the unique rural circumstances and resources may not be fully considered.

California AB 55 (Bonta, 2025) changed the requirements related to licensing alternative birth centers in California. Medi-Cal requires that birth centers be licensed, but private patients may deliver in non-licensed facilities, which are often accredited by the Commission for the Accreditation of Birth Centers (CABC). This bill made multiple changes in licensing requirements, which would allow many accredited birthing centers to start accepting Medi-Cal, making obstetric care more accessible in California.

Inequitable Policies for Rural Californians: Structural Urbanism

Just as the COVID-19 infections began to spread in December 2019, a seminal article was published in Health Affairs, coining the term: structural urbanism.

In the article Structural Urbanism Contributes to Poorer Health Outcomes for Rural America, the authors define structural urbanism as "elements of the current public health and health care systems that disadvantage rural communities."

The COVID-19 pandemic consumed our attention for several years, contributing to changes in the way we think, teach, learn, work, and act on public policy. In the Spring of 2020, a series of police killings sparked national protests seeking greater racial equity and a governmental and corporate focus on racial justice. As rural hospital obstetric unit closures continued and Glenn Medical Center closed altogether in 2025, it has become more significant that the Partnership counties reframe the way we think about rural health policy.

To re-ground us in this reframing of rural health policy in February 2026, here is the January 2020 lead newsletter article on this topic, lightly edited and updated. The Health Affairs article referenced above is available online for free and is highly recommended for reading. The reflections below become an inspiration on how structural urbanism impacts Partnership and our rural clinicians and members.

In January 2019, the California Department of Health Care Services (DHCS) decided that all providers that contract with Partnership HealthPlan of California and other Medi-Cal managed care plans must apply to the state of California and be accepted as official Medi-Cal providers. Previously, Partnership could contract with specialists outside the state in Oregon and Nevada, which is closer to our members that live in border counties. These out-of-state specialists are excellent physicians to partner with and are recognized by Medicare and the state Medicaid organizations in which they practiced. The DHCS decision was not required by the federal government, but it was based on administrative convenience. The needs of Medi-Cal beneficiaries in border regions were not considered sufficient enough to alter the policy. This is an example of structural urbanism.

This can include policies and regulations, such as the rule on out-of-state specialists which limits access to care for those in rural communities. It can also include the fee-for-service payment methodology, which pays hospitals based on volume. Smaller rural hospitals have far more fixed costs per admission, so an "equal" payment arrangement becomes a disadvantage for smaller rural hospitals, contributing to financial instability and hospital closures. This is yet another example of structural urbanism.

It can also extend to state grant programs, like the Public Hospital Redesign and Incentives in Medi- Cal (PRIME) program. This specific program designated payments to public hospitals, which are all situated in counties with large urban populations. While some version of this may be adapted to smaller counties, at best, only medium-sized counties have the infrastructure to access these funds, and yet again, serves as another example of structural urbanism.

Structural urbanism impacts county social services infrastructure which, in turn, affects health status.

Structural urbanism affects primary care access. National Health Service Corps loan repayment eligibility is dependent on the Health Professional Shortage Area score (HPSA score), which supposedly measures the relative need for physicians in a particular area. The score in parts of urban Los Angeles County is higher than many rural areas in Northern California. While urban health centers serving low-income areas need providers, the providers are able to commute from areas with higher average income. In contrast, rural California health centers need to convince new clinicians to move to a new area. The scoring methodology does not account for this, which is another example of structural urbanism.

Decades ago, sociologists coined the term "structural racism" to describe the historic, political, and social structures that perpetuate racial inequality. Structural racism contributes to persistent health disparities experienced by marginalized racial and ethnic communities. Opposition to a structural racism framework often centers on the belief that persistent inequities stem from individual choices, reflecting the assumption that personal motivation alone can overcome systemic barriers.

Racism is not always just structural, resulting from implicit bias, but is sometimes explicit. Similarly, we may encounter examples of explicit urbanism. Here are three examples:

1. With today’s political polarization and the increased association of rural areas with support of conservative voting patterns (including in California), some policymakers are explicit in not wanting to prioritize rural areas in any way due to political affiliations.
2. In the medical field, I have encountered Obstetrician / Gynecologist (OB/GYN) specialists and OB nurses who believe that becoming pregnant while living in rural areas is a high-risk choice for women rather than a policy challenge to rectify. (This explicit urbanism is not universal. Many other OB/GYN specialists and OB nurses have expressed understanding and support for policy and structural solutions to ensure rural OB services are available and safe given inevitable volume and distance influences.)
3. In state government, we have heard a policymaker remarking on rural specialty access challenges with the suggestion that people who need specialty care should move to large metropolitan areas (indicating a deep lack of commitment to restoring robust specialty access to rural areas).

There is a conceptual similarity between structural racism and structural urbanism. Health outcomes in rural populations have complex and interrelated structural factors. Are worse health outcomes due to the “choice” to live in rural areas? Are they due to poverty itself? If so, why do low-income populations in urban and suburban communities have better outcomes than low-income populations in rural areas? How does differential access to social services, charitable organizations, and health care providers associated with rural areas contribute to differential outcomes? These many factors are the manifestations of structural urbanism.

We can measure worse health outcomes in rural counties. Each year, after conducting our annual audit of the Health Effectiveness Data Information Set (HEDIS®), we stratify the results based on the demographic information we have available. Specifically, we are looking for different outcomes associated with any race, ethnic or language group, and geography. Since 2014, we have found outcomes vary by geography more than race, ethnic or language groups, with the exception of outcomes in the Black and Tribal populations.

Studies suggest rural health inequities are driven by several factors, including less availability of
health care and social services, higher poverty levels, higher rates of substance use disorders (SUD), and different health beliefs and practices. These are incompletely balanced with resiliency factors associated with living in small, tighter knit communities. HEDIS® outcomes in rural areas have improved gradually year over year, but the geographic disparities remain.

How do we achieve better outcomes for rural counties? How do we overcome structural urbanism?

The Health Affairs review article mentioned above has several recommendations:

- **Access:** Maintain and increase availability of health care providers and institutions in rural areas.
- **Conceptualization:** Change the conception of the provision of health in rural areas from being a service to being infrastructure. Decades ago, rural hospitals were funded by the federal government as infrastructure and were able to grow and thrive. Since the conversion to a fee-for-service environment, rural hospitals are closing and quality measures for rural hospitals (which previously were equal to urban hospitals, in aggregate) have steadily declined.
- **Resources:** Additional financial resources can help reduce rural inequities. The National Health Service in England created such a financial redistribution method in the 1970s and 1980s to provide additional resources to rural areas, resulting in decreased access disparities from 22% to 6% in a 12- year period.

Partnership is dedicated to addressing structural urbanism at multiple levels: interventions to increase provider access; leveraging funding mechanisms to provide differential support to rural health care providers; and addressing social issues which impact health (like housing instability, substance use, and justice-involved status). We will also strive to give policy input and feedback from a rural perspective to DHCS and other state agencies, whenever possible.

Correcting many other contributors to structural urbanism will require legislative and regulatory changes at the state and federal levels. Defining a prioritized policy agenda will require us to work together with our partners in rural areas.

Acting on a rural policy agenda is challenging, as organizations working in rural areas often have fewer staff and less resources available to do advocacy compared to urban organizations. For example, compare the organizational structure and capacity of the Consortium of Clinics of Los Angeles County with the California State Rural Health Association (CSRHA). These differential capabilities are also examples of structural urbanism, but organizations representing rural health policy interests are arguably the key to changing the discussions around rural health.

We need organized, effective advocacy to promote rural health equity. Organizations such as the CSRHA, the California Rural Indian Health Board, and the California Critical Access Hospital Network need more active members and leaders to build infrastructure and generate the policy influence to counteract structural urbanism.

The boards of state-wide organizations like California Health Care Foundation (CHCF), The California Endowment, and the Blue Shield of California Foundation need vocal rural representation to help vet priorities and proposals from a rural lens.

It takes a stronger effort for leaders living in rural areas to engage personally in such organizations, compared to their urban colleagues. This is partly due to travel time, but additionally, rural hospitals and clinics may have a smaller core leadership team who also need to optimize care and operations locally.

Building rural health care leadership is thus a key prerequisite.

Summary of Actions to address Structural Urbanism in Health Care

1. Join and be active in advocacy groups that represent organized health care professionals and organizations. For physicians, it is essential that state-wide organizations, like the California Medical Association consider and account for a Rural Health perspective as part of their legislative and regulatory advocacy activities. The same is true for organized nursing, physician assistants, midwives, hospital associations, etc.

2. Work with your local legislators to support specific State legislation requiring the following:
   a. As State departments develop regulation, a rural analysis must be performed that identifies any challenges in applying the policy equally and equitably in rural communities. This analysis should include direct feedback from key advisors and associations that represent rural communities.
   b. If a challenge affecting rural application is identified, the policy shall be amended to equitably impact rural areas, with accommodations in regulations and requirements that remedy these challenges. When necessary, this may include a higher level of funding for rural areas compared to urban areas so that the policy can be applied equitably.
   c. The documentation of each policy that is promulgated attests that the above process has been followed.

POLST Registry

Cal EMSA is moving very slowly on developing the POLST Registry. They are at some stage of a pilot with Cedar-Sinai in Los Angeles, and they are working on a solution for absorbing paper-based POLST form data. For details, or to sign up for their newsletter, see https://emsa.ca.gov/polst/.

CMA House of Delegates Asserts its Autonomy (2025)

The October in-person convening of the California Medical Association (CMA) brought two major categories of recommendations to the House of Delegates (HOD) for discussion and debate. The first category was a series of recommendations responding to the current threats to public health, access to health care, and interference with the delivery of health care to patients. The greatest debate among these was the degree to which the CMA should advocate for immigration policies, which indirectly affect the health status and mental health of the patients they serve. Led by amendments from the student and resident caucus, with moving testimony from many physicians – some of whom were immigrants – the final resolutions contained more specific language on immigration policy changes for which the CMA should advocate and referred these recommendations to the American Medical Association (AMA) to take national action.

The second category of action was a series of recommended changes to the CMA bylaws, which returned more deliberative responsibility to the CMA HOD while maintaining some regional medical society responsibilities for the appointment of national delegates. In the last 30 years, the CMA has mirrored many state and national legislative bodies in changing rules to decrease the time and effort taken for deliberation and granting more authority for decision-making to a more powerful executive and/or legislative leadership.

For the CMA, this meant shortening the annual HOD meeting from five days to two, eliminating the reference committees deliberating on resolutions before sending them to the HOD, and moving approval of resolutions from the HOD to the Board of Trustees. CMA made these changes 20 years ago to make the process more efficient and less time-consuming for physician leaders. The consequence was that a very small group of physician leaders (the Board of Trustees) did the majority of the deliberating and then customized the recommendations as they saw fit. This resulted in many neutralized resolutions being submitted to the board with milder statements of principles, rather than resolutions that had previously come from the raucous democratic body of the HOD; the CMA Board of Trustees amended these resolutions to be more palatable and less controversial.

After a two-year process of membership engagement by the CMA Governance Reform Technical Advisory Committee (GTAC) – a sort of CMA Constitution convention – a series of bylaw changes were debated and ultimately passed by the HOD. These changes will create a policy review process in between the old way (five-day HOD meeting with reference committees and every resolution debated) and the more recent way (all resolutions go to the Board of Trustees, with one or two major topics of discussion / collections of related resolutions brought to a two-day HOD). Going forward, resolutions submitted year-round will be sorted for consideration by the Board of Trustees or the HOD, with the latter meeting twice per year.

Unrelated to the GTAC recommendations, the Board of Trustees submitted a request to the HOD to change the way the CMA delegates to the AMA were selected. These changes to bylaws would remove regional selection of a

portion of AMA delegates, allowing the Board of Trustees to have final say in selecting all delegates and filling all vacancies. After spirited debate with testimony noting the importance of democracy for promoting productive dissent, inclusiveness of minority viewpoints, and preventing centralization of power, the HOD voted down these proposed changes by a nearly two-thirds vote. Despite the dissent, the HOD discussion remained respectful and appreciative of those who proposed the unadopted change.

In the face of vigorous and passionate deliberation, it was inspiring to witness the level of respect shown among colleagues who hold different viewpoints expressed toward each other. The discourse reminded me that for a democratic body to thrive, it needs to be engaged and reflective; it needs to debate differences respectfully, drawing upon logic and principles. While many of us may disagree with some decisions of our leaders in organized medicine, the organizations themselves are worthy of our pride and membership.

Improving Health Outcomes in California Tribal Communities

As noted in the Health Equity section, clinical quality outcomes in the self-identified Native American population is the largest category of ethnicity inequity within partnership. Two thirds of Native American members are cared for by Tribal health centers; most of the remaining one third are cared for by one of the larger Federally Qualified Health Centers.

Partnership's major strategy for eliminating these inequities starts with a deep engagement with our Tribal health centers and Tribes. The goals are to build trust and to strengthen the economic, infrastructure and leadership capability of tribal health centers.

Areas of engagement currently are:
1. In-person relationship building
2. Annual joint meetings to discuss larger strategic issues
3. Engagement around quality outcomes
4. Tribal perinatal initiative
5. Building Tribal consultation into the change process
6. Tribal-specific approach to support of Tribal health centers that are part of the Equity-Practice Transformation program
7. Training Partnership Staff on the history of California Tribes and the legal and financial policies affecting Tribal health centers
8. Supporting the Implementation of the DHCS Traditional Healer / Natural Helper Benefit (waiver over in December 2026).

Partnership currently recruiting for a new Tribal liaison. In the interim, messages to the interim tribal liaison can be sent to triballiaison@partnershiphp.org

Partnership Policy Reminders

Grievance and Appeals Process

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

Provider Grievances

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

Member Grievance/Appeal

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

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

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

Potential Quality Issues and Peer Review

What is a Potential Quality Issue (PQI) and how are they identified?
A PQI is a suspected deviation from provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care concern or opportunity for improvement exists. Partnership

identifies PQIs through the systematic review of a variety of data sources, including but not limited to:

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

What happens when a PQI is identified?

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

After investigation, when a Partnership Medical Director determines that a significant lapse in quality has occurred, the case is referred for review to the Peer Review Committee (PRC). The PRC includes external practitioners (representing PCPs and board-certified specialists) and internal Partnership physicians, nurses and pharmacists. The PRC investigates member or practitioner complaints about the quality of clinical care provided by any provider or facility caring for a Partnership member and makes recommendations for opportunities for improvement and/or corrective action plans. The definition and description of Corrective Action Plan (CAP) was recently redefined for clarity: "A CAP is a directive from the Peer Review Committee specifying required actions/ activities to be undertaken by a provider of concern. CAPs are given to educate the provider/facility on the identified issue/concern, with the goals of helping to prevent identified issues from recurring and improving member safety. CAPs contain clearly stated goals and timeframes for completion. Cases with significant concerns are communicated to the Credentials Committee at the recommendation of the Peer Review Committee.

How can a PQI be referred?

1. Partnership Health Plan external website->Providers->Quality and Performance Improvement->Patient Safety-Potential Quality Issues

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

What's "Carved-Out" to DHCS or Counties?

1. Dental benefits (Partnership covers dental anesthesia, jaw MRI, and a few oral maxillofacial services, such as jaw trauma and cancer-related services)
2. Serious mental illness, especially inpatient hospitalization (but Partnership partially covers eating disorder treatment, see below)
3. Substance use disorder treatment (outside the 7 county Wellness and Recovery pilot, see below; Partnership also covers medical problems caused by SUD and medical exams conducted in conjunction with admission to a SUD detox program)
4. Pharmaceuticals and related supplies, provided through community pharmacies, such as blood glucose monitors and vaccinations (some exceptions are on our direct distribution program, see below). In addition, all medications specifically for HIV treatment or prevention and for hemophilia are carved out to DHCS, regardless of where administered.
5. Medical Aid in Dying is carved out to DHCS for both the payment of professional services and the medications.

PCP Requests for Member Disenrollment

As required by DHCS, Partnership has a policy and procedure (MP316) governing the process for considering provider requests to disenroll a member. Criteria for disenrollment include:

1. Illegal manipulation of prescriptions (alteration, theft)
2. Physical or sexually abusing provider or office staff
3. Threatening behavior
4. Credible threat to pursue legal action against provider
5. In some cases, refusal to follow recommended medical treatment
6. Partnership determination that clinician patient relationship is irreparably harmed
7. Disruptive or verbally inappropriate behavior, with corrective action ineffective
8. Three or more missed appointments, with details outlined in the policy
9. The discharge request may be from a specific site or from the Parent Organization as a whole.

Two special cases worth mentioning:

For patients discharged from a practice due to a history of assault or abuse or other threatening behavior, the patient will not be transitioned to a new PCP until that prospective PCP leadership is contacted by a Partnership Medical Director to discuss the circumstances around the disenrollment, to give the receiving practice the opportunity to set up an agreement around conditions of care (e.g. requiring a patient to go to a specific location or to a specific provider

or to have a safety escort at all visits).

Some Pediatric Practices do not accept new patients where parents refuse all vaccination. We require the pediatric provider to engage with these members to discuss their hesitancy, and if the parents do not trust the PCP sufficiently to accept recommended vaccination, that the absence of clinician-patient trust affects the ability to maintain a relationship. A patient-centered process for easing them to a new PCP who will accept patients not willing to vaccinate their children, possibly involving Partnership's Care Coordination team, is required.

Monthly Newsletter for PCP Clinical Leaders

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

Past newsletters can be perused on our website at: http://www.partnershiphp.org/Providers/HealthServices/Pages/CMO-Newsletters.aspx

Primary Care Blog

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

List of PPS Covered Services

Federally Qualified Health Center (FQHC) Medical Directors: Have you wondered what is carved out of the Prospective Payment System (PPS) reconciliation process?

About 92% of primary care for Partnership members is provided by FQHCs, Rural Health Centers (RHCs), and Tribal health centers. These all have a form of PPS, where payments for most visits for Medi-Cal and Medicare are made based on a per-visit payment rate, regardless of the intensity of the services provided.

Only certain provider types are eligible for PPS reimbursed visits:

Professional Visit Type	Non-Tribal FQHC/RHC	Tribal FQHC	Tribal: HIS/MOA type
Physicians (MD, DO)	PPS rate	OMB rate	OMB rate
Podiatrists	PPS rate	OMB rate	OMB rate
Optometrists	PPS rate	OMB rate	OMB rate
Doctors of Chiropractic (D.C.)	PPS rate	OMB rate	OMB rate
Nurse practitioners	PPS rate	OMB rate	OMB rate
Physician assistants	PPS rate	OMB rate	OMB rate
Certified Nurse Midwives	PPS rate	OMB rate	OMB rate
Visiting Nurses	PPS rate	OMB rate	OMB rate
Dentists	PPS rate	OMB rate	OMB rate
Dental hygienists	PPS rate	OMB rate	OMB rate
Licensed clinical social workers	PPS rate	OMB rate	OMB rate
Marriage and Family Therapists	PPS rate	OMB rate	OMB rate
Licensed Professional Clinical Counsellors	PPS rate	OMB rate	OMB rate
Psychologists	PPS rate	OMB rate	OMB rate
CPSP visits (Registered Dietician, Nurses, Case Managers)	PPS rate	OMB rate	OMB rate
ASW, AMFT, APCC, when supervised	ASW and AMFT only	OMB rate	
Acupuncture Services	PPS rate	OMB rate	OMB rate
Physical Therapy	Not counted at reconciliation	OMB rate	OMB rate
Occupational Therapy	Not counted at reconciliation	OMB rate	OMB rate
Speech Pathology	Not counted at reconciliation	OMB rate	OMB rate
Audiology	Not counted at reconciliation	OMB rate	OMB rate
Drug and Alcohol Visits	?FFS rate?	? FFS rate?	OMB rate
Enhanced Care Management	Negotiated Rate	Negotiated Rate	Negotiated Rate
Community Support	Negotiated Rate	Negotiated Rate	Negotiated Rate
Community Health Workers	Not counted at reconciliation	Negotiated Rate	Negotiated Rate
Doulas	Not counted at reconciliation	Negotiated Rate	Negotiated Rate

There are many caveats within this framework, which include some key differences in rules and regulations between FQHCs, RHCs, and Tribal health centers. For example, Tribal health centers are reimbursed at a nationally standardized, per-visit rate for many types of visits, while FQHCs and RHCs have nationally standardized rates for Medicare-only visits and site-specific rates for patients with Medi-Cal. Exceptions to the PPS system also vary between these systems. For example, Tribal health centers, but not FQHCs or RHCs, can be paid for Community Health Workers (not affiliated with Enhanced Care Management programs) outside of the PPS process, although there are some administrative steps, such as credentialing and contracting, that are needed to make this work.

The California Primary Care Association (CPCA) has a living document listing exceptions to PPS reimbursement mechanisms for FQHCs, available on the CPCA website here and reproduced below. Last updated 1/20/2026. Contact eshipman@cpca.org for questions.

Service	Reimbursement	Authority and Notes
Screenings and Services Paid on Top of Medi-Cal PPS: Costs Included in PPS; Revenue Not Reconciled.		
ACEs Screening	Supplemental to PPS at FFS rate of $29.	SPA 21-0045. Frequency limits apply (annually for children; once per lifetime for adults)
Developmental Screening	Supplemental to PPS at FFS rate of $59.90.	SPA 21-0045; FFS Rate: $59.90, frequency limits apply. See Medi-Cal Trauma and Developmental Screenings Slides and Policy, Bright Futures Periodicity Schedule
Same Day Dyadic	Supplemental to PPS at FFS rates ranging from $20.11-$116.39 , (including services provided to non-Medi-Cal parent/caregiver).	SPA 23-0010; Dyadic Services Manual; FFS Rate: multiple dyadic codes applicable ranging from $20.11-$116.39. Reimbursement for dyadic services stacked. Non-same day dyadic is PPS.
Incentives/Alternative Payments Paid on Top of Medi-Cal PPS: Costs Included in PPS; Revenue Not Reconciled.		
Pay-for-performance arrangements with Managed Care Plans or IPAs	Supplemental to PPS, incentive payment methodology	WIC 14132.100(h); Payments negotiated when contracting with MCPs/IPAs.
CalAIM Dental Initiative – P4P Preventative Services	Supplemental to PPS, incentive payment methodology.	SPA 21-0019; Monthly lump sum based on previous month's claims. See SPA for detailed algorithm.

Non-Hospital 340B Supplemental Payment Program	Supplemental per-encounter add on.	Pending SPA 23-0031 (July 2023 – June 2024). Pending SPA 24-0045 (July – December 2024). Ended 12/31/24. Reconciliation process to occur upon SPA approval.
Community Clinic Directed Payment (e.g. Non-Hospital 340B Directed Payment)	Directed payment based on the following formula: 90% Supplemental per-qualifying encounter add on + 10% value measure.	Beginning 1/1/25; payments not active until CMS approval. Budget negotiation between clinics and DHCS to mitigate the loss of 340B revenue when the state transitioned to Medi-Cal Rx. Pre-print in review with CMS.
Service	**Reimbursement**	**Authority and Notes**
Equity and Practice Transformation Provider Directed Payment	Directed payment to clinics based on maximum payment formula and Milestone achievement.	California state budget 2024-2025. Practices selected by application only, one time application process.
Service Lines Paid Outside of Medi-Cal PPS: Costs Carved Out of PPS; Revenue Not Reconciled.		
Pharmacy	Option to keep in PPS or carve out at FFS rate. When carved out, CHWs may be utilized and billed under the carved out pharmacy.	For pharmacy carve out option: state law (Welfare and Institutions Code); For CHWs within carved out pharmacies: SPA 24-0037.
Drug Medi-Cal	Supplemental to PPS, county/state contracted rate.	Drug Medi-Cal Overview Page
Specialty Mental Health Services	Supplemental to PPS, county contracted rate.	Specialty Mental Health Services Overview Page
Enhanced Care Management	Supplemental to PPS, MCP-negotiated rate.	CalAIM ECM and CS FAQ from August 2022, Question 62
Community Supports	Supplemental to PPS, MCP-negotiated rate.	Pending further guidance from DHCS. CalAIM ECM and CS FAQ from August 2022, Question 62
Justice Involved Pre-Release	Supplemental to PPS, FFS/MCP-negotiated rate.	DHCS guidance here. CalAIM JI Policy and Operations Guidance
Certified Wellness Coaches	Supplemental to PPS, FFS/MCP-negotiated rate.	Pending implementation by DHCS.

Partnership Website Highlights for Clinicians

The Partnership website is packed with useful references and resources. We

recommend bookmarking the launch page in your internet browser: http://Partnershiphp.org

Website highlights include:

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

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

Note: The Partnership Website is due for a major revision in 2026. We will gather feedback on this process at the in-person meetings.

Benefits Updates for Partnership Members

Blood Pressure Devices and Cuffs through Community Pharmacies

Partnership members in need of a blood pressure monitoring kit may obtain blood pressure devices and cuffs through Partnership's Medical Equipment Distribution Services (PMEDS) Program or through community pharmacies.

To receive blood pressure devices and cuffs through the PMEDS program, contracted clinical providers may submit requests to Partnership using the Medical Equipment Distribution Form.

Blood pressure monitoring devices and cuffs are also available through community pharmacies as a covered benefit under Medi-Cal Rx. The Contracted Personal Blood Pressure Monitoring Devices and Blood Pressure Cuffs list includes blood pressure devices and cuffs that are eligible for coverage under Medi-Cal Rx when billed by pharmacy providers. Medi-Cal Rx allows one blood pressure monitoring kit (monitor plus cuff) every 5 years and one additional cuff every year. TARs will not be accepted for blood pressure devices and cuffs that are not on this list. Covered products include standard blood pressure monitors, monitors with talking functions, and monitors with Bluetooth connectivity and remote patient monitoring capabilities. Please refer to the Medi-Cal Rx Covered Drugs and Covered Products Lists for additional information.

To help reduce provider disruptions stemming from coverage limitations, we recommend placing orders for blood pressure monitoring kits using a generic description (e.g., "BP Monitor – Large Cuff") to allow the pharmacy to dispense covered kits that are readily available. An exception: if you want a specific connected device you will want to specify the exact device.

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

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

Medical Equipment Distribution Program

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

Providers contracted with Partnership can request equipment from the PMEDS program without the need of a TAR, pharmacy fulfillment, or any cost to the member. The ordering clinician simply completes the request form by providing some basic member demographic information, equipment selection(s), diagnosis code(s), and clinic contact information, then fax or securely email the form to us. Requests can be submitted 24 hours a day, 7 days a week. Orders received by 3 p.m. on a business day are processed that same business day and ship the following business day via USPS Certified Mail. Equipment is typically received by the member within 5-7 days of the date the request was submitted for processing. Program Guidelines are found on the Partnership website.

Equipment available includes:

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

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

Care Coordination Services at Partnership

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

- These services are voluntary, provided at no cost to the member or provider,

and the member can opt-out at any time.

- Most of our teams' work is done telephonically, with the possibility of face-to-face engagement in select instances.
- When we connect with members, we assign them an Acuity Level that best matches their needs and level of intensity for case management services.
- The lowest level is for our members that need help accessing their benefits or providers. The highest levels are for those members from high-risk populations that transition from one care setting to another, have multiple unmanaged complex conditions, and/or for those who have difficulty navigating the health care system without intensive support of a case manager.

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

Southern Region Office
Fairfield, CA
CCHelpDeskSR@partnershiphp.org
Northern Region Office
Redding, CA
CCHelpDeskNR@partnershiphp.org
Eastern Region Office
CCHelpDeskEA@partnershiphp.org

Intensive Outpatient Palliative Care Benefit

The current Medi-Cal Palliative Care Benefit was based on Partnership's Palliative Care Pilot program, conducted about a decade ago.

Covered conditions for Partnership's Intensive Outpatient Palliative Care program include advanced cancer, advanced liver disease, congestive heart failure, chronic obstructive lung disease, progressive degenerative neurologic disease, or other serious pre-terminal conditions that result in frequent hospitalizations. This benefit is designed for Partnership members with limitations in function and limited life expectancy who are at a late stage of illness who have received maximal member-directed therapy or therapy is no longer effective. As patients' health declines, they may become eligible for the more comprehensive Hospice benefit. Other types of palliative care are also covered: primary palliative care covered as a routine part of primary care, and episodic specialty palliative care (fee for service).

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

Counties Served	Organization	Referrals (if contracted)
Del Norte, Humboldt, Lassen, Modoc, Placer, Plumas, Sierra, Siskiyou, Shasta, Solano, Sutter, Trinity, Tehama, Yuba	Vynca/Resolution Care	Phone: 707-442-5683
Butte, Glenn	Adobe Ca Medical Group	Phone: 1-877-633-9331
Chico area of Butte	Butte Home Health and Hospice (Contract in place, but no enrolled members yet)	Phone: 530-895-0462
Colusa, Yolo	Yolo Care	Phone: 530-758-5566
Humboldt	Hospice of Humboldt	Phone: 707-267-9880
Lake	Hospice Services of Lake County	Phone: 707-263-6270 ext. 140
Mendocino, plus western Lake	Madrone Care Network	Phone: 707-380-5080
Napa, Sonoma, Solano (Vallejo)	Providence Palliative Care Napa Valley	Phone: 707-258-9080
Marin, Sonoma	By the Bay Health	Phone: 415-444-9210
Sonoma	St. Joseph Home Care Network	Phone: 707-522-4307
Nevada (Grass Valley, Nevada City) plus limited areas of Placer (Auburn) and Sierra (Downieville)	Foothills Compassionate Care	Phone: 530-272-5739

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

Hospice Provider Network

Hospice services are voluntary for members whose physician attests that their projected life expectancy is up to 6 months. Partnership is in the process of narrowing our network of contracted Hospice agencies. Here is a list of the agencies in this new Partnership Hospice Quality Network:

Region	Hospice Provider
Contracted, in County Hospices	
Butte, Glenn	Butte Home Health and Hospice
Del Norte	Coastal Hospice Inc.
Humboldt	Hospice of Humboldt
Lake	Hospice of Lake County
Lake, Mendocino	Adventist Home Health and Hospice
NE corner of Shasta county, NW corner of Lassen, SW corner of Modoc	Mayers Memorial Hospice
Shasta County	Interim Healthcare
Northern Siskiyou County	Madrone hospice
Marin, Sonoma	By the Bay Health and Hospice
Sonoma	Sutter Home Health and Hospice
Napa, Sonoma, Solano	Compassus/Providence Home Health and Hospice
Napa, Solano	Continuum Care
Solano County	NorthBay Health at Home and Hospice; Adya Hospice and Palliative Care
Eastern Placer, Nevada, Sierra counties	Tahoe Forest Hospice
Western Nevada, central Nevada and Placer	Hospice of the Foothills
Western Placer	Sutter Roseville Home Health and Hospice
Western Placer, Yolo County	UC Davis Hospice
Yolo, Colusa	YoloCares
Yolo, Shasta, Tehama, Siskiyou	Dignity Home Health and Hospice
Sutter, Yuba	Adventist Home Health and Hospice
Children's Hospice Only	
Alameda (Associated with Oakland Children's)	George Mark Children's House
Volunteer Hospices in Areas with no Contractable Options	
Lassen	Honey Lake Hospice
Trinity	Dawn Hospice
Southern Humboldt	Heart of the Redwoods Community Hospice
Plumas	Plumas Community Hospice

Some contracted Palliative Care agencies can offer a higher level of care for their palliative care patients, similar to hospice care. Madrone Palliative Care in Mendocino and Lake counties and Vynca Care in most other frontier counties may be able to provide services.

Telemedicine Services

Partnership has a robust Telemedicine policy governing all aspects of telemedicine. Even before the COVID-19 pandemic, we covered a wide range of services, from eConsult to synchronous telemedicine, for all ages, and a variety of ancillary medical services. We have partnered with ConferMED for eConsult, TeleMed2U for adult specialty care and UC Davis for pediatric specialty care. Highlights are listed below.

We have gathered together many resources about all aspects on Telemedicine into a single Toolkit, available on our website. Also, our newest resource, TelehealthEssentials comes packed with best practices and FAQs in a single document.

eConsult: ConferMED

Partnership HealthPlan of California is contracted with the eConsult vendor, ConferMED. ConferMED is interoperable with electronic health records to allow for peer-to-peer communication with 75% of the patients' needs being addressed through consultation.

A primary care provider (PCP) can consult with a specialist about a patient electronically instead of referring the patient for a face-to-face visit. A referral, along with clinical information, images, lab results, and other content from the medical record, is sent directly to a specialist, with a complete consult returned within two business days.

eConsults do *not* require prior authorizations.

ConferMED does not charge the PCP for an interface, although your EHR vendor may do so. If you want to use ConferMED with non-Partnership patients, they are able to bill Medicare and private insurance for these services. You would need to have an agreement with them to set it up.

All specialists are Board certified in a specialty or subspecialty and licensed in California. ConferMED eConsult specialties are listed in the table below.

If you are interested in learning more about ConferMED, contact Partnership's telemedicine team at telemedicine@Partnershiphp.org.

Adult Specialty Telemedicine

In “traditional” synchronous telemedicine, the patient is physically located in the PCP office and the specialist is remote (embedded clinics). The PCP office will coordinate the appointment, check vitals, and may require the PCP or another clinician to step in to examine the patient or speak with the specialist.

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

Another option is to use Partnership’s contracted adult telemedicine specialty provider, called Telemed2U. They do have some ancillary providers, such as registered dieticians, available as well. To begin utilizing services through TeleMed2U, contact our telemedicine program team at: telemedicine@Partnershiphp.org

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

Direct-to-Member Specialty Telemedicine

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

Many community specialists have adopted direct to member telemedicine which are being provided by “TeleMed2U” for a select set of specialties. More Information can be found here.

Hepatology was recently added in November as an offering through Direct-to-Member for Partnership members 18 years of age and older. Since its inception, there have been 246 completed visits across 37 providers, with consistent growth.

Here is a quick reference of the Telemedicine Modalities available for **adults**:

Specialty and Modality	Block Time	Open Scheduling	DTM	eConsult
Adolescent				
Allergy and Immunology				x
Behavioral and Development				
Cancer Center				
Cardiology			x	x
Complex Primary Care				x
Dermatology			x	x
Diabetes Care Program			x	
Endocrinology	x	x	x	x
ENT/ Otolaryngology				x
Gastroenterology			x	x
Genomic Medicine				
Geriatric Medicine				x
Hematology/ Oncology				x
Hepatology			x	
Infectious Disease			x	x
Medical Oncology				x
Neonatology				
Nephrology		x	x	x
Neurology	x		x	x
Neuromuscular Disease Medicine				
Nutrition	x		x	
Obesity Medicine				x
OB/GYN				x
Ophthalmology				
Orthopedics				x
Pain Management				x
Palliative Care				
Psychiatry			x	x
Physical Therapy			x	
Pulmonology	x		x	x
Retinal Reading				x
Rheumatology	x	x	x	x
Surgery and Trauma Care				
Transgender Care				
Urology				x

Pediatric Specialty Telemedicine

Partnership and UC Davis Health (UCD) have partnered to expand access to pediatric specialty care services which are now available through Partnership Telehealth Program. Thirty specialties representing every major pediatric subspecialty area are covered. For more information, please visit the Pediatric Telehealth Page, on our website.
Contact telemedicine@Partnershiphp.org to learn more.

Here is the matrix of telemedicine services available for children:

Specialties Offered*	Block Time**	Direct Specialty Telehealth Services	eConsult
Adolescent	x	x	
Allergy & Immunology		x	x
Behavior and Development		x	
Cancer Center		x	
Cardiology	x	x	x
Dermatology		x	x
Endocrinology	x	x	x
ENT/ Otolaryngology		x	x
Gastroenterology	x	x	x
Genomic Medicine		x	
Gynecology (ages 15+)			x
Hematology/ Oncology		x	x
Infectious Disease		x	x
Neonatology		x	
Nephrology	x	x	x
Neurology	x	x	x
Neuropsychology			x
Neuromuscular Disease Medicine		x	
Ophthalmology		x	
Orthopedics		x	x
Pain Management		x	
Palliative Care		x	
Physical Therapy		x	
Psychiatry			x
Pulmonology	x	x	x
Retinal Reading			x
Urology	x	x	x

Diabetes Education and Nutrition Counseling

Diabetes education and nutrition counselling are important components of diabetes care that give patients an opportunity to better understand their condition and master the tools needed to manage nutrition, activity, and medications. The American Diabetes Association recommends that all people with diabetes participate in diabetes self-management and education to support better outcomes.

Patients with diabetes require these services to receive the support needed and gather knowledge that improve decision-making for diabetes self-care. Referrals to Registered Dietitians (RDs) and Certified Diabetes Educators (CDEs) offer your patients focused consultations to move the dial on glycemic control through health education and self-management using motivational interviewing and other standardized tools.

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

Medical Nutrition Therapy (with a Partnership credentialed CDE or RD) that takes place in the PCP office, with community RD or CDE in person or via telehealth, is a covered Partnership benefit. If your practice does not offer these services, your patient can access Medical Nutrition Therapy (MNT) within the Partnership network of specialty providers. Partnership Network providers for MNT include: *The Northern California Center for Wellbeing* in Sonoma County and *As You Are Nutrition* in Napa County. A new, all telemedicine provider FoodSmart is being set up and will be available soon throughout the network. These practices may offer flexibility for in-person or telehealth visits. Some practices offer individual and/or group visits. Another option, TeleMed2U offers direct telehealth-only visits for Partnership members over three years old. Direct telehealth visits for members are available with referral to TeleMed2U Nutrition through Partnership's Online Services. Referral coordinators can direct referrals via an eRAF or faxing for MNT using the Provider Directory and the Partnership Provider Portal. Please have your referrals team contact your local Partnership Provider Relations representative for more information on details of referring to MNT if they are not familiar with these systems.

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

Behavioral Health

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

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

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

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

Mild to Moderate Mental Health: Carelon Behavioral Health

Partnership contracts with a third-party Mental Health administrator, Carelon Behavioral Health, to manage the network of mental health providers and pay claims. However, late last year, Partnership insourced the call center and care coordination activities related to behavioral health and will serve as the first point of contact for primary care providers and patients seeking mental health services including connecting . patients with severe mental illness to local County Mental Health Services.

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

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

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

Hints for Getting an Appointment with a Carelon Provider

Scenario: You are seeing a patient who is depressed and anxious and is receptive to mental health counseling. You give them Partnership's behavioral health access line contact number 855-765-9703 C to reach an Access Guide to support setting up an appointment with a mental health network provider. .. This is not the only option, however.

Here are more options:

1. Fill out this referral form (linked to Partnership's website) and email it to Partnership's BH-Access@Partnershiphp.org. or fax it to 707-914-0453. This ensures Partnership's Behavioral Health Access team works directly with the patient to link them to services and keeps you in the loop.
2. Coach your patient to specifically ask Partnership for assistance in contacting the Mental Health Professionals to make an appointment by calling 855-765-9703.. Partnership's BH Access team is here to ensure patients get connected to available network providers.

Wellness and Recovery Program

In 2020, Partnership began providing comprehensive substance use treatment (SUD) services through our new Wellness and Recovery Program in seven of our counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano. We remain the only managed care plan in California to administer this benefit. For details see the Partnership website or use this referral form to refer a patient for services.

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

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

Starting in January, 2027, due to regulatory changes and county requirements at the State level, the seven counties above will be taking over managing their own SUD treatment services.

High Complexity Eating Disorders

Partnership has an internal team for case managing patients with complex eating disorders, for whom you are having difficulty finding treatment options. Our internal team can help facilitate assessments for patients with established or suspected eating disorders, as well as connections with multiple levels of care for eating disorder treatment including outpatient, residential, inpatient, and telehealth-based services.

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

Supporting Behavioral Health Needs in Children

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

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

Resources:
• CAPP Services and FAQ
• CAPP Fact Sheet

Online Behavioral Health Resources for Caregivers and Youth

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

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

- No costs attached
- No insurance required
- No referrals needed
- Video or chat-based

- 1:1 coaching (diverse, bilingual coaches
- On-demand digital tools
- Care Guides to manage complex needs and provide referrals

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

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

Webinars on Topics Related to Substance Use Disorder

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

- Medication treatment options for Methamphetamine Use Disorder
- Safety and Correct Disposition when Performing a Medical Clearance Exam for Alcohol Withdrawal
- Marijuana in Pregnancy
- Cannabis Use and Cannabis Use Disorder in the Setting of Legalization
- Trauma Informed Care and Addiction
- Inpatient Alcohol and Drug Detoxification Materials
- Pharmacology of Treating Alcohol Use Disorders
- Benzodiazepines
- ASAM Criteria Training
- Gabapentanoids: A Wolf in Sheep's Clothing
- Nitrous Oxide: It's No Laughing Matter

Obtaining Psychological and Neuropsychological Testing

Partnership covers psychological and neuropsychiatric testing though our mental health provider network managed by Carelon.

To request this testing, the PCP should complete the this referral form and request testing for a member. Check the box at the bottom of the form, labeled "Request for Psychological or Neuropsychological testing." The referral form is emailed Partnership BH Access team at BH-Access@Partnershiphp.org or faxed to 707-914-0453 to conduct member outreach to assist with linkage to a psychologist. The psychologist will complete an intake assessment to determine if testing is indicated. Partnership BH Access team will send a notification back to the PCP with the outcome of the request.

If your patient requires additional assistance in getting connected and coordinating their neuropsych evaluation, please indicate care coordination is needed on the referral form.

Bright Heart Health: On-Demand Behavioral Health

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

Partnership Health and Carelon contract with Bright Heart Health for:

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

In conjunction with County mental health plans, members may also receive intensive outpatient eating disorder services involving a team of specialists from Bright Heart Health.

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

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

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

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

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

Supplemental Benefits

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

Covered by Partnership but not DHCS

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

- Enuresis Alarms (through medical equipment distribution system, see above)
- Non-custom compression garments

Expanded Coverage

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

Transportation Benefit

Medi-Cal offers transportation to and from appointments for services covered by Medi-Cal. This includes transportation to medical, dental, mental health, physical therapy, dialysis, and substance use disorder appointments (including for opioid treatment centers), and to pick up prescriptions and medical supplies. Importantly, members are who drive themselves or own cars are not eligible.

There are two types of transportation for medically necessary appointments.

- Non-emergency medical transportation (NEMT) is transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation
  - Wheelchair, Gurney/Litter, Ambulance or Air ambulance
  - These options require a Provider Certification Statement (PCS)
    - The PCS must be signed by the physician overseeing care and be fully completed
    - A copy of our PCS can be requested via email at transportationhelpdesk@Partnershiphp.org
- Non-medical transportation (NMT) is transportation by private or public vehicle for people who do not have another way to get to their appointment.
  - Includes Taxi and Lyft transportation

Partnership manages the Transportation Benefit directly. The plan's responsibility is to get members to their medically necessary Medi-Cal covered services using the least costly method of transportation that meets the member's needs. Members may request transportation by calling our toll-free number for Transportation Services, **(866) 828-2303**

If you as a **provider** are encountering problems or challenges, you can reach us by phone at **(866) 828-2303** (option 3), or by email transportationhelpdesk@Partnershiphp.org.
Please make sure your case managers and others that help members with transportation are aware of this method to arrange transportation! If you know of any transportation provider in your community interested in contracting with Partnership, you can also let us know through this email.

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

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

Medi-Cal Benefits: Recent Changes

CalAIM: Enhanced Care Management and Community Supports

Two components of CalAIM that began in January 2022 are Enhanced Care Management (ECM) and Community Supports (CS), (formerly known as In Lieu of Services).

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

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

ECM target populations:

The following populations are currently approved:

1. Adults and children at risk for institutionalization with serious mental illness (SMI), substance use disorder (SUD) with co-occurring chronic health conditions, or children with serious emotional disturbance (SED),
2. Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.

3. High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
4. Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
5. Individuals at risk for institutionalization who are eligible for long-term care services.
6. Nursing facility residents who want to transition to the community.
7. Perinatal population of African American, Native American and Pacific Islander ethnicity.
8. Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. (Note: many individuals in this population may qualify sooner if they have one of the above other conditions.)

Community Support (CS) Services covered by Partnership include the following:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Meals/Medically Tailored Meals
- Personal Care and Homemaker Services
- Day Habilitation *
- Sobering Centers *
- Transitional Rent (1/1/2026)
- Asthma Remediation (1/1/2026)

  *(*established programs only)*

If you wish to refer a patient for consideration for ECM and/or CS services, have your care coordinator contact:

- ECM: ECM@partnershiphp.org
- CS: CommunitySupports@partnershiphp.org.

Additional components of CalAIM of interest to Primary Care Providers:

1. A new *transitions of care* requirement, DHCS expects Partnership to be more actively involved in the discharge planning of all inpatients.
2. *Data collection and reporting*, DHCS has created a platform called Medi-Cal Connect to work on data availability and risk assessment models. DHCS plans to require health plans to absorb this risk data and act upon it, including passing it on to our PCP network to act upon. More to come on this in the months to go.

3. *Behavioral Health:* Proposal to steadily integrate behavioral health services with the rest of the health care system.

Transitional Rent

Transitional Rent (TR) provides up to six months of rental assistance for eligible Medi-Cal members experiencing or at risk of homelessness who meet additional eligibility criteria. Covered costs include rent, as well as housing-related fees such as storage, amenities, and landlord-paid utilities that are part of the rent payment. TR is currently the only Community Support that MCPs are required to provide as a benefit for eligible members.

The Behavioral Health POF is the first population launched for TR. County Behavioral Health Agencies (BHAs) play a critical role in identifying and connecting eligible members to TR, including people who are eligible for Behavioral Health Services Act (BHSA) funding to support rental sustainability following the TR benefit.3 There is an expectation that TR recipients will be connected to BHSA resources after TR if no other ongoing subsidy is secured.

Who is Eligible for Transitional Rent?
Medi-Cal members must meet ***all three*** of the following eligibility criteria:
1. Have one or more of the qualifying clinical risk factors; **and**
2. Be experiencing or at risk of homelessness; **and**
3. Be part of specified "transitioning populations" or living unsheltered or Full-Service Partnership (FSP) eligible.

Note that per DHCS, TR cannot be used to pay back rent (rent in arrears) nor prospective rent for any housed member.

How are Transitional Rent Services Provided?
MCPs must partner with a network of transitional rent providers to issue rental payments and, in some cases, directly provide housing. DHCS has required MCPs to first contract with county BHAs and then may contract with other provider such as affordable housing providers, supportive housing providers, other providers of services for individuals experiencing homelessness.

Transitional rent providers are responsible for helping eligible members find an appropriate and habitable housing setting/unit; review, understand, and execute their lease agreement; develop a rent payment agreement with the landlord or property owner; issue timely rent payments; and coordinate with supportive services providers.

Transitional rent may be provided in:
Permanent settings (with a renewable lease of at least one month):
- Single family/multi-family homes
- Apartments
- Housing in mobile home communities

- Accessory dwelling units (ADUs)
- Shared housing
- Project-based or scattered site PSH
- Recovery housing
- License-exempt room and board

Interim settings:

- Hotels/motels being used as a primary residence
- Transitional and recovery housing with no lease agreement.

How does transitional rent Interact with Other CalAIM Housing-Related Services?
Members authorized for transitional rent are automatically authorized for Enhanced Care Management (ECM) and the housing-related Community Supports (the "Housing Trio": Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services). Members are not required to use ECM or the Housing Trio, but they become automatically eligible once TR is approved.

Are there any restrictions on transitional rent?
The federal waiver authorizing transitional rent requires that the three "Room and Board" services – Recuperative Care, Short-Term Post-Hospitalization Housing (STPHH), and Transitional Rent – are subject to a "global cap." This global cap limits assistance to no more than a combined six months (182 days) of STPHH, Recuperative Care, and TR during any rolling 12-month period. Transitional rent is subject to an additional cap of six months per household during this demonstration period.

GLP-1 Criteria and Fibroscanning for a Diagnosis of MASH.

Effective January 1, Medi-Cal Rx removed weight-loss GLP-1 agents from its formulary. Coverage for GLP-1 medications in non-diabetic patients now requires an approved prior authorization (PA). All PA requests will be reviewed individually based on medical necessity and on the drug's FDA-approved indications outside of weight management. These indications currently include: Wegovy for Major Adverse Cardiovascular Event (MACE) reduction in patients with established cardiovascular disease; Wegovy for Metabolic Dysfunction–Associated Steatohepatitis (MASH); Zepbound for the treatment of Obstructive Sleep Apnea (OSA),
<u>Prior Authorization Required:</u>

- Zepbound for OSA: Include documentation of sleep study with AHI ≥ 15 and justification for why CPAP is insufficient in managing patient's OSA (ex. tried and failed > 6 months without symptom control). Additionally, include the BMI and the date the BMI was recorded.
- Wegovy for MACE reduction: Include on Prior Authorization diagnosis and evidence of previous cardiovascular event (MI, Stroke, revascularization procedures).

No TAR required

- Covered with Diagnosis Code of Diabetes (Example E11.9): Ozempic, Rybelsus, Mounjaro, Victoza, Byetta, Bydureon, or Trulicity
- Wegovy for MASH: covered if submitted with diagnosis code K76.0 or K75.8 must be included on the prescription.

Testing for MASH:

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

Who needs evaluation? Assessing level of fibrosis in patients with

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

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

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

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

Broadly, these tests will indicate one of the following:

- Probably no fibrosis
- Probably extensive fibrosis
- Intermediate result

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

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

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

In both cases, special equipment is needed (a regular ultrasound machine or

MRI scanner by itself cannot be used)

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

Reference:
Curr Hepatol Rep. 2025 Nov 27;24(1):10.1007/s11901-025-00713-7. doi: 10.1007/s11901-025-00713-7 **Transient Elastography and Fibroscan: Stethoscope of a Hepatologist in Today's World**
https://pmc.ncbi.nlm.nih.gov/articles/PMC12781356/

Within the hospitals contracted by Partnership, only a few offer either ultrasound-based elastography and/or MRI-based elastography. This list was confirmed in March 2026; please send us any updates you become aware of.

Bay Area Counties:

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

Northern Counties: the following Oregon hospitals have ultrasound elastography:

- Mayers Memorial (Shasta): MR elastography only
- St. Elizabeths (Tehama): ultrasound elastography only
- Banner Lassen (Lassen): both ultrasound and MR elastography
- Providence St. Joseph (Humboldt): ultrasound elastography only
- Asante in Medford, OR, for ultrasound elastography
- Asante in Grants Pass, OR, for ultrasound elastography
- Sky Lakes Medical Center in Klamath Falls, OR (ultrasound elastography)
- DDA/Enloe GI office in Chico for ultrasound elastography "referral for FibroScan"

Eastern Counties:

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

Tertiary Care Centers:

- UCSF has both ultrasound elastography and MRI elastography.
- CPMC (San Francisco): Mission Bernal: MR elastography; Van Ness: Ultrasound elastography
- Alta Bates (Alameda): ultrasound elastography only

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

Other Medi-Cal Rx Updates

Starting Fall, 2026, an ICD-10 diagnosis code(s) will be required for all pharmacy claims. Have your Electronic Health Records team test to be sure this is activated and is successfully transmitting this data to your community pharmacies.

Effective June 26, 2026, every prescriber must be **enrolled** in Medi-Cal Fee for Services using a Type 1 NPI (individual NPI), or claims submitted by pharmacies and TARS for Medi-Cal beneficiaries will not be processed. Have your credentials team check all your clinicians on the State Medi-Cal enrollment website to ensure they all are enrolled under their own NPI.

Coverage for Community Health Workers

Community Health Workers (CHWs) are covered. Here are some highlights of this benefit.

Some highlights:

1. CHW services no longer require a referral by any medical provider.
2. Encounters must be documented in a medical record system of some sort, including the topics discussed and the duration of the encounter.
3. CHW must meet minimum requirements by either a certification pathway or a work experience pathway. Six hours of annual continued education is required.
4. DHCS specified covered and non-covered services in their policy document.
5. The only billing codes that are acceptable are for face-to-face self-management education and training: 98960 for individuals and 98961 or 98962 for groups of patients.

Special note for FQHCs and RHCs: FQHCs and RHCs are unable to bill for CHW services per DHCS. Tribal health centers are eligible for a FFS payment for CHWs, but not their OMB rate.

Genetic Testing

The number of genetic tests available is growing rapidly, as is the complexity of deciding which test to order and how to interpret the results. While the prices are starting to drop, many cost several thousand dollars, and we find that many

clinicians are ordering the wrong tests for the wrong reasons. Thus, these lab tests often require a Treatment Authorization Request (TAR) to be paid.

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

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

Another resource for the large majority of our network that uses Quest Diagnostics is to contact Quest's genetic counselors to get advice on the correct test to order for a patient's particular circumstances. The phone number is: 1-866-GENE-INFO (1-866-436-3463).

Partnership Updates

New Core Claims Processing System

For a health plan, the claims processing system is the single most important IT software system in the organization. Tens of millions of claims are processed each year, over $5 billion worth at Partnership. All our providers count on that system to be paid accurately and timely.

After several delays, Partnership is on track to change from our legacy system, called Amysis, to a new system called Health Edge Health Rules Payer (HRP) around June of 2026. All electronic data interfaces from PCPs and other providers will need to be re-directed to HRP and tested in Spring of 2026. If you use a claims clearinghouse, they will do this testing for you.

Prior Authorizations in Primary Care

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

Another way Partnership prevents fraud, waste and abuse is through the configuration of our claims processing system, which is configured to deny claims exceeding logical or reasonable limits. When such denials are appealed, on the basis that the claim represented a medically necessary service, the

resulting review is retrospective, sometimes called a retro-TAR. Since the service was already provided, a denied retro-TAR results in a service being provided that will not be reimbursed.

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

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

- Enhanced Care Management
- Community Supports
- Physical Therapy/Occupational Therapy/Speech Therapy for adults for more than 12 visits, and for all children
- Chiropractic Services if more than 2 per month
- Acupuncture services if more than 2 per month
- Any procedure which may be performed for either cosmetic reasons or reconstructive purpose

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

- Certain genetic blood tests, most commonly cancer screening tests
- Facility-based sleep studies
- Hospice and Palliative Care

Mobile Mammography

Partnership contracts with Alinea Medical Imaging to bring mobile breast cancer screenings to provider organization locations within the Partnership service area where mammography access is constrained, and mammography rates are low.

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

- Located in Partnership regions and counties below the 50th percentile benchmark for breast cancer screening
- Provider locations far below the 50th percentile benchmark

- Provider locations in imaging center “deserts”
  (Patients’ travel to imaging center is unusually long or difficult.)
- Provider locations with lack of access at nearby imaging centers
  (More than one month to Third Next Available Appointment.)
- Provider locations with Partnership care gaps to support desired event
  (A full day event would require at least 60 - 90 Partnership members with mammogram care gaps. Providers can also consider partnering with nearby provider organizations in the Partnership network to meet the volume needed for a successful event. The majority of patients served at a Partnership-sponsored event should be Partnership members.)

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

Partnership is exploring new ways to improve breast cancer screening rates. Performance in this measure is expected to drop as the U.S. Preventive Services Task Force (USPSTF) lowered the recommended age for initiating breast cancer screening from age 50 years to 40 years in April 2024.

In a survey of fixed radiology center conducted in early 2026, counties without fixed mammography units include Sierra, Modoc, Glenn, Colusa, and Trinity Counties.

Locations with the longest current waits for mammograms are Grass Valley, Redding, Mount Shasta, and Garberville.

3d units are quickly replacing 2d units. The current ratio is 3:1.

Partnership Provider Recruitment Program (PRP)

To help increase the supply of Primary Care providers seeing Partnership members, we offer a generous signing bonus program, plus other recruiting support. The current 2025/2026 PRP agreement is open to applications until June 30th, 2026. A new agreement will be available thereafter.
Current PRP highlights include:

Providers

- $100,000 signing bonus for physician candidates (Primary care specialties plus OB/GYN and Psychiatry) payable over 5 years
- $120,000 for medical residents training in Partnership’s 24-county region ($20K payable in program year 3 with a five-year commitment post-graduation)
- $50,000 signing bonus for NP/PA/CNM candidates payable over five years
- Enhanced bonus disbursed over a five-year term

Behavioral Health

- $20,000 signing bonus for licensed behavioral health professionals: licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and licensed clinical psychologists (bonus disbursed over 2-year term)
- $4,000/$5,000 signing bonus for certified substance use disorder (SUD) and bilingual certified SUD counselors (bonus disbursed over 1-year)

Key Criteria

- Candidates must not have accepted an offer to practice at a partner site under the previous PRP version.
- If the candidate is currently practicing, they must be from outside of Partnership's 24 counties.
- Exceptions:
  - Currently working for Kaiser within one of Partnership's counties
  - Providers in training or residency programs within Partnership's 24 counties
- Requests for program support should be provided to Partnership before formal offers are made to candidates.
- Please see Partnership's PRP webpage for additional important program criteria.

Organizations not currently participating in the PRP must have executed a grant agreement to submit requests for grant funds.

Please contact the Workforce Development team with any questions or requests: wfd@Partnershiphp.org

Provider Retention Initiative (PRI)

The PRI is intended to recognize clinicians who have devoted their careers to the safety net, while helping to incentivize additional years of service from them. This program began in January 2024 and is currently open to applications until June 30, 2026.

Provider Program Highlights / Incentives Available:

- $45,000 award for physicians (Primary care specialties plus OB/GYN and Psychiatry) payable over three years
- $30,000 award for APCs (nurse practitioner (NP) / physician assistant (PA) / certified nurse midwife(CNM) payable over three years

Key Criteria:

- Provider (MD/DO/NP/PA/CNM) has provided services with organization for 15 years or more and has confirmed commitment for practicing at least three more years.

- Provider eligibility is limited to family medicine, internal medicine, obstetrics, pediatrics, and psychiatrists.
- Provider must serve in a leadership or mentorship capacity within organization.
- Given funding limitation, provider organization must complete a competitive grant application.
- Provider organization must have a signed Provider Recruitment Program agreement.

An FAQ for the PRI is linked here.

Partnership Clinic Leadership Academy

Building Leadership Capacity Across Northern California's Safety-Net

Partnership HealthPlan of California is partnering with the Health Force Center at UCSF to offer a no-cost, high-impact leadership development program designed to strengthen leadership capacity across Northern California's safety-net health system. This academy equips leaders with the skills, confidence, and resilience needed to effectively lead teams and improve care delivery.

Applications closed on April 4. The first in-person training is planned for June.

Pearls on Referrals

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

This same principle applies to unassigned Partnership members who may be seen in your PCP office. Specialists appreciate that you screen patients for appropriateness and the RAF is reassurance that they will be paid. Since the RAF system cannot be used for members unassigned to your office or parent organization, you will need to use your electronic health system to generate the referral for Direct (unassigned) members.

One quick note on tertiary care centers in Northern California. Partnership is contracted with all tertiary care centers in Northern California **except for Stanford University for Adults**. This is especially true for transplants. Adults needing tertiary care should be referred to any Sacramento Hospital including Sutter, Dignity, or UC Davis, to a San Francisco based hospital including UCSF or California Pacific Medical Center. Children may be referred to Shriner's Hospital in Sacramento (for problems requiring specialized surgery), Children's Hospital Oakland, UC Davis, Lucille Packard Children's Hospital, or UCSF.

Strategies for Difficult Referrals

Partnership strives to contract with every willing specialist in our geographic area. Over the last 20 years, there has been a steady decrease in the number of specialists available in rural and many suburban areas. To preserve the specialty network we have, and prevent them from burning out, it is critically important to ensure that referrals are judicious and the referral process is completed efficiently and respectfully. Here are some best practices and hints:

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

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

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

3. Local specialists will develop their own rules about pre-reviewing and approving referrals. This is usually done because inappropriate

referrals have been made in the past, so PCPs should honor the requests of the specialists and try to re-earn trust in appropriateness of referrals. Which specialists want what type of review before referrals varies by community. Often these are communicated at Partnership-sponsored referral roundtables. Be sure your referral coordinator attends these (and potentially office manager and a clinician leader as well).

4. The medical director or CMO should make an effort to engage with specialists on referral appropriateness on a regular basis. Please let your Partnership Regional Medical Director know of any specific specialists or specialties which are a challenge in your area, so we can assist.

5. If you are able to secure a needed in-person specialty appointment further away from the patient's home, keep the transportation benefit in mind to help the patient go to that appointment. Closer care or virtual care is preferred to seeing a specialist located far away, but that is sometimes the only option.

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

Public Health Data Review

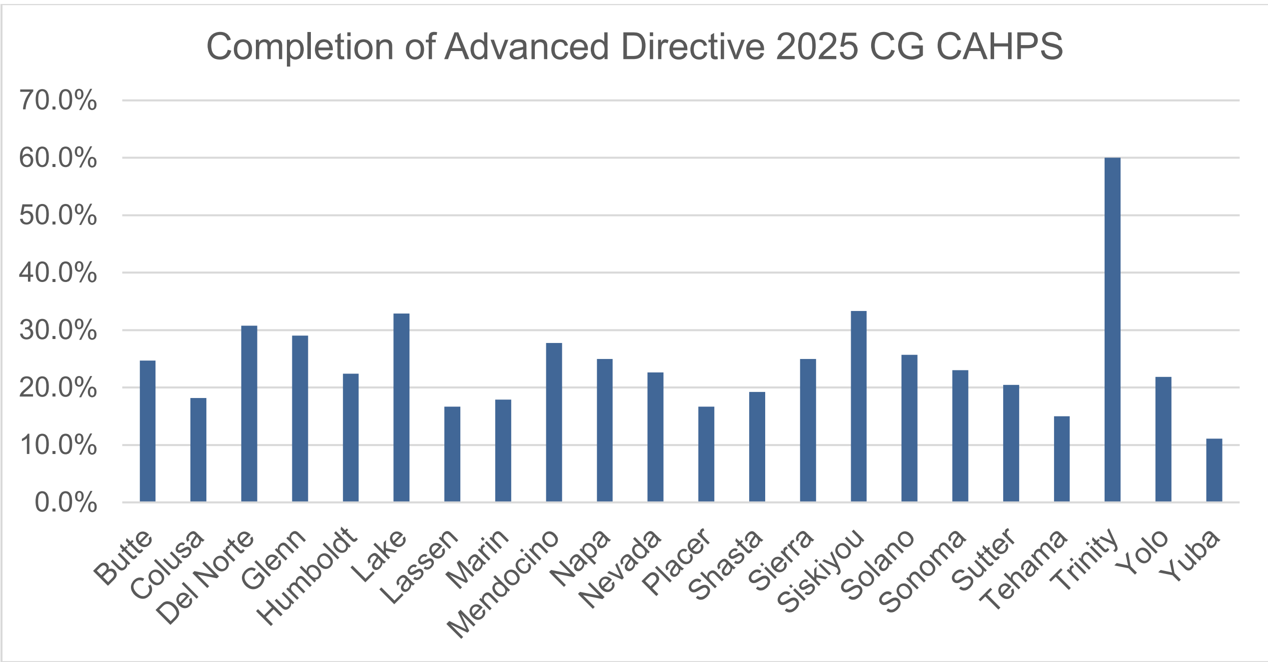
County Profiles and HEDIS Results from 2024

County Profiles are an annual compilation of data from Partnership and from publicly available resources. They are under development and will be posted on the Partnership website in early May. Below are a few data elements that will be included.

The results of the annual HEDIS audit for 2024 are distributed at the meeting and are viewable on the Partnership website.

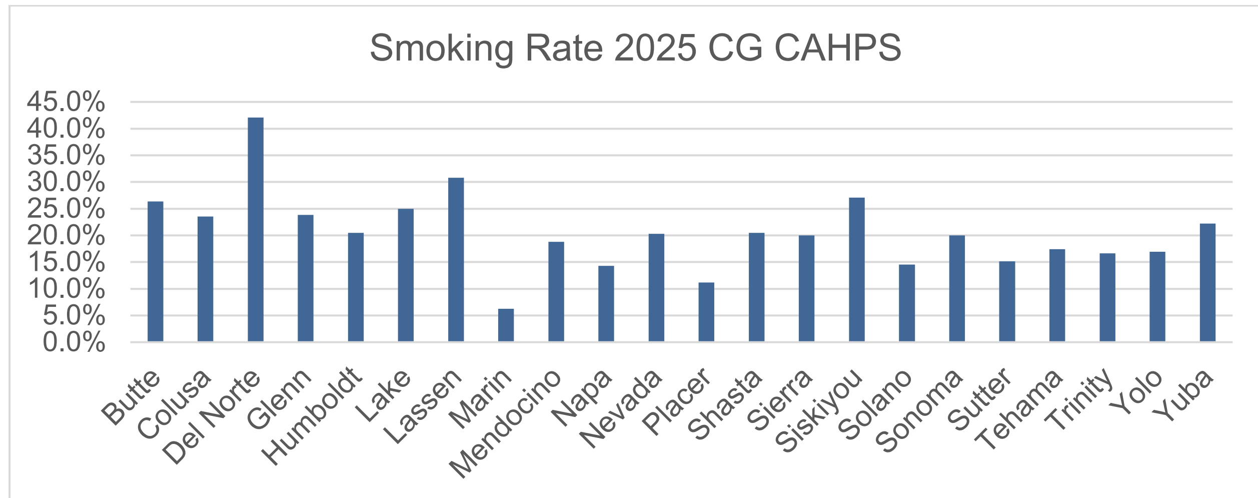
Advance Directive Completion

Data source: CG-CAHPS supplemental Data, from 2025 survey



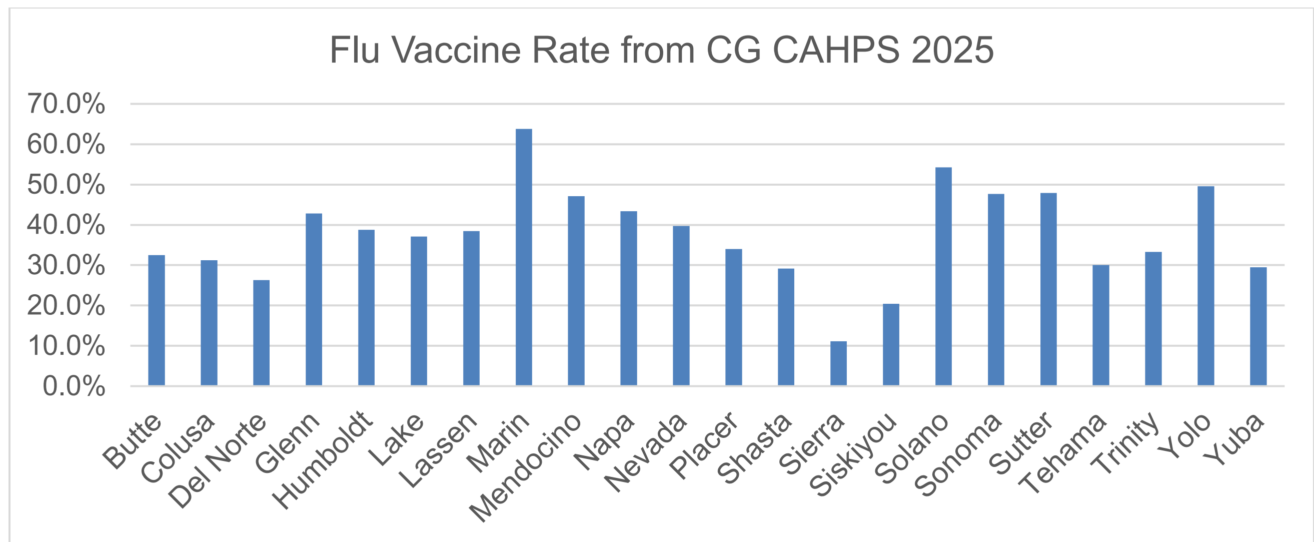
Smoking Rate

Data source: CG-CAHPS supplemental:



Adult Flu Vaccination

Data source: CG-CHAPS



Tobacco screening and referral rates

Data source: Partnership Claims data for Calendar Year 2024

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

QIP as a unit of service measure.

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

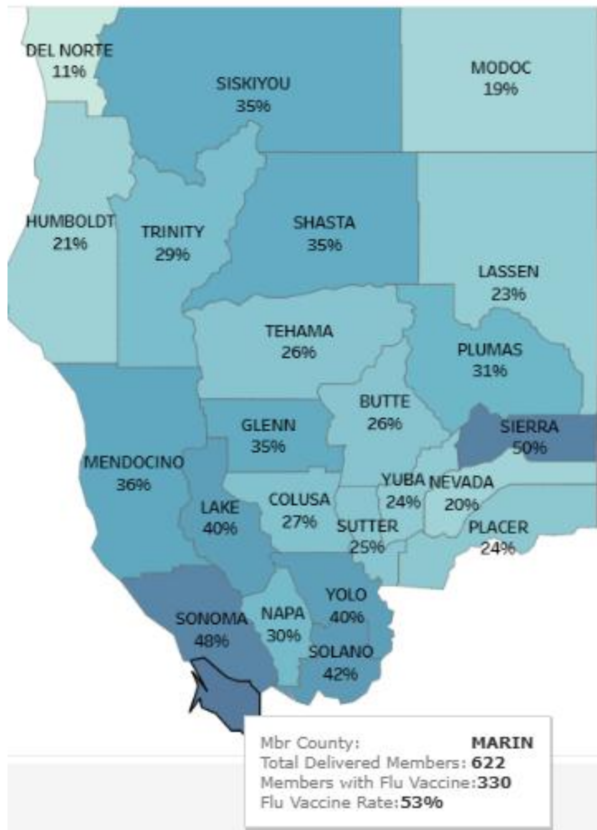
- 99406.25: Smoking + tobacco use cessation counseling visit: 3-10min
- 99407.25: Smoking + tobacco use cessation counseling visit: >10 min
- 1036F: Current tobacco non-user.
- **Preferred: 4004F:** Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy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

Here were the PCPs with the highest screening rates for children in 2024:

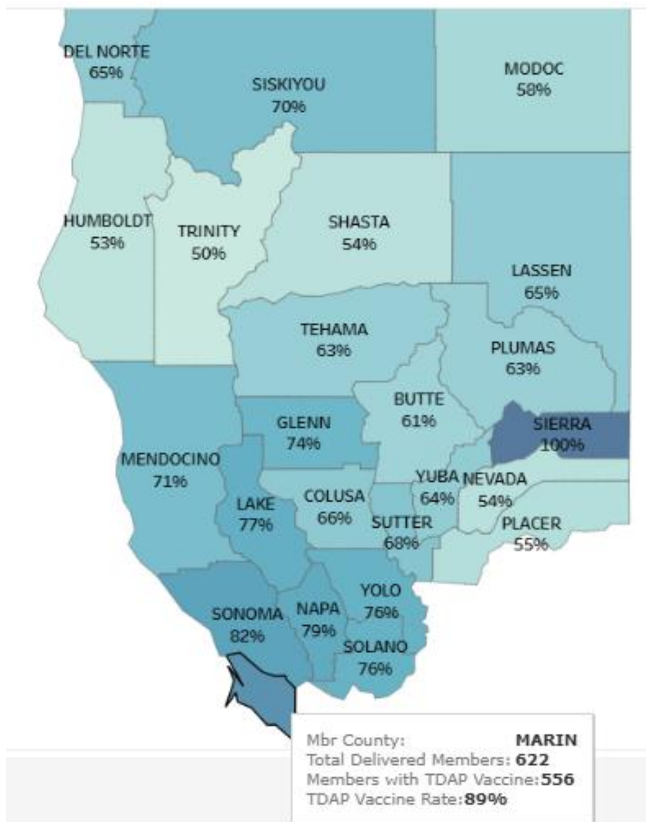
	2024	
	Members with TSR	%
PEACH TREE HEALTHCARE	1,720	25.4%
SHASTA COMM HEALTH CENTER	1,160	9.6%
SRCH PEDIATRIC CAMPUS	1,011	18.8%
LASSEN MEDICAL CLINIC	998	22.5%
VISTA FAMILY HEALTH CENTER	642	17.3%
SRCH LOMBARDI CAMPUS	598	13.8%
AMPLA HEALTH YUBA CITY PEDS	532	6.8%
CHUKWUEMEKA NDULUE	431	9.2%
SRCH DUTTON CAMPUS	419	14.0%
HARMONY HEALTH MEDICAL CLINIC	331	24.4%
ANDERSON FAMILY HLTHCTR	278	15.7%
AMPLA HEALTH RICHLAND MED	249	8.2%
AMPLA HEALTH CHICO MEDICAL	221	5.4%
SONOMA PLAZA PED MED GRP	215	38.7%
SOLANO COUNTY HLTH SVC	194	1.6%
PROVIDENCE MED GROUP SONOMA	178	13.1%

Vaccination in Pregnancy:

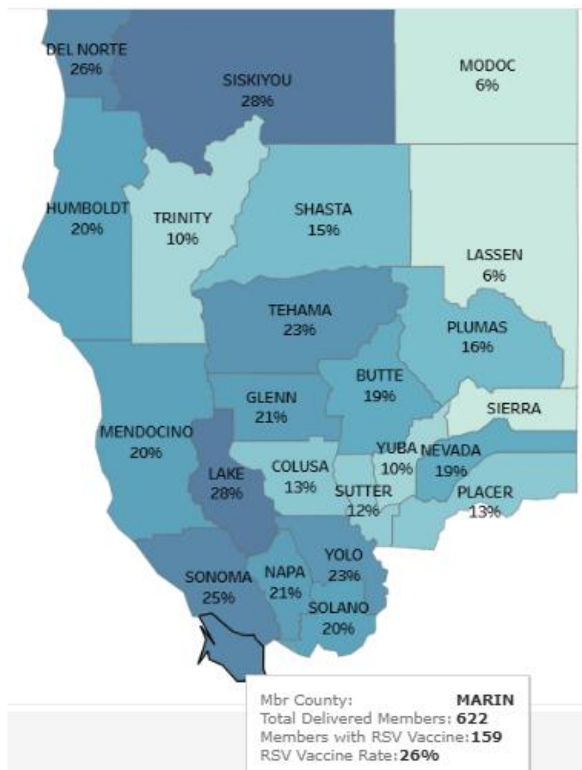
2025 Influenza Vaccine rates :



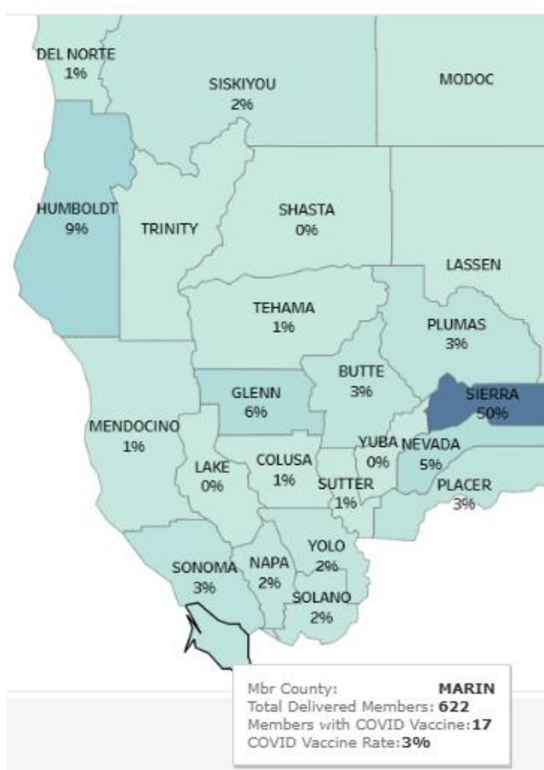
2025: TDAP vaccine rate:



2025: RSV Vaccine



2025: COVID Vaccine



CT Scan Usage by Emergency Departments:

Data source: Partnership Claims Data, comparing 2022 to 2024
Trends: The trend has changed over the years; currently the highest rates are UC Davis Medical Center, Sutter Santa Rosa, Orchard Hospital, Sutter Roseville. The lowest rates were in Adventist system Emergency Rooms, Queen of the Valley Hospital, and several small rural hospitals.

ER Visits with CT Scans from 2022 to 2024

Top 50 Hospitals by Number of ER Visits

	% Visits with CT scan			% Change in % Visits with CT scan from Previous Year		
Facility	2022	2023	2024	2022	2023	2024
ROSA REG HOSP SUTTER SANTA	16.2	17.6	18.5		8.05%	5.43%
MEDICAL CENTER UC DAVIS	18.6	20.9	18.2		12.48%	-12.71%
HOSPITAL ORCHARD	14.3	13.6	17.7		-4.55%	30.07%
ROSEVILLE HOSP SUTTER	18.1	23.3	17.6		28.73%	-24.56%
HOSPITAL OROVILLE	4.0	3.5	16.8		-12.20%	380.84%
HEALTH ENLOE	12.9	15.2	16.8		18.02%	10.29%
VALLEY HOSP PETALUMA	12.4	15.0	15.9		20.89%	5.79%
SUTTER DAVIS HOSPITAL	13.5	13.6	15.1		0.93%	11.25%
HOSPITAL TAHOE FOREST	19.7	26.7	14.4		35.56%	-46.09%
MEDICAL CENTER MARINHEALTH	10.7	12.0	14.1		12.33%	17.38%
JOSEPH HOSP PROVIDENCE ST	12.9	14.0	13.6		8.49%	-2.84%
CENTER SAC SUTTER MEDICAL	11.6	12.0	13.4		3.12%	11.60%
MEDICAL CENTER NORTHBAY	12.2	14.6	13.2		19.39%	-9.38%
CENTER REDDING MERCY MEDICAL	14.2	13.5	12.9		-5.38%	-4.36%
MEMORIAL HOSP WOODLAND	12.2	10.2	12.7		-16.52%	24.99%
HOSPITAL VACAVALLEY	13.2	14.7	12.4		11.85%	-15.48%
SONOMA VALLEY HOSPITAL	11.1	11.0	11.3		-1.33%	2.73%
LAKESIDE HOSP SUTTER	10.8	11.7	10.9		7.78%	-6.30%
ROSEVILLE KAISER	9.3	7.7	10.7		-16.43%	38.82%
MEMORIAL HOSP PROVIDENCE SR	8.2	10.2	10.6		24.29%	3.67%
MEM MINERS HOS SIERRA NEVADA	7.6	5.9	10.5		-22.03%	77.47%
WOOD MEM HOSP PROVIDENCE RED	9.0	10.0	10.5		11.70%	4.32%
ST HELENA ADVENTIST HLTH	7.8	6.3	10.0		-19.74%	58.82%
FAITH HOSP SUTTER AUBURN	11.0	11.6	10.0		5.35%	-13.97%
COMMUNITY HOSP ST ELIZABETH	14.3	12.3	9.9		-13.93%	-19.78%
KAISER VACAVILLE	11.8	6.7	9.8		-43.50%	46.65%
KAISER VALLEJO	7.4	7.8	9.7		6.03%	23.64%
CLEARLAKE ADVENTIST HLTH	8.4	9.4	9.6		11.52%	2.16%
COMMUNITY HOSP MAD RIVER	9.0	9.9	9.5		9.38%	-4.13%
CTR MT SHASTA MERCY MEDICAL	9.7	10.3	9.5		5.91%	-7.91%
KAISER MED CTR SANTA ROSA	8.4	8.4	9.4		-0.06%	11.84%
MENDO COAST ADVENTIST HLTH	8.1	8.0	9.4		-0.99%	17.00%
MEDICAL CENTER FAIRCHILD	10.0	9.9	9.3		-0.37%	-6.21%
SUTTER SOLANO MEDICAL CENTER	8.4	9.3	9.3		11.20%	-0.28%
HOSPITAL NOVATO COMMUN	8.4	8.9	8.9		6.27%	0.32%
COAST HOSPITAL SUTTER	8.8	10.1	8.8		14.27%	-12.97%
MEDICAL CENTER SHASTA REG	7.8	7.1	8.7		-8.61%	21.64%
MEMORIAL HOSP MAYERS	6.5	6.3	8.6		-3.88%	37.64%
HOWARD MEM ADVENTIST HLTH	6.9	7.7	8.5		12.28%	9.89%
UKIAH VALLEY ADVENTIST HLTH	6.7	7.7	8.1		15.18%	6.02%
KAISER FOUND HOSP SANRAFAEL	7.0	6.2	7.8		-10.95%	24.97%
MEDICAL CENTER BANNER LASSEN	8.2	8.3	7.4		1.86%	-10.97%
HOSPITAL HEALDSBURG	5.7	6.4	7.1		12.17%	11.87%
HEATH RIDEOUT ADVENTIST	6.2	5.7	7.0		-7.30%	22.65%
HOSPITAL TRINITY	8.3	6.6	7.0		-20.77%	6.12%
QVMA MED CTR PROVIDENCE	6.9	9.3	6.3		33.83%	-31.81%
CENTER MODOC MEDICAL	5.9	5.7	6.2		-2.95%	9.29%
DISTRICT HOSP EASTERN PLUMAS			4.9			

Hospital Obstetrical Data:

Data source: California Hospital Quality Compare (data from CMQCC), 2024

2024 Mother & Baby Data		NTSV C-Section Rate		Breastfeeding Rate (CDPH)		Early Elective Delivery		Episiotomy Rate		VBAC Rate		VBAC Routinely Available	CNM Delivery Rate
HOSPITAL NAME	Partnership Region	Score [%]	Rating	Score [%]	Rating	Score [%]	Rating	Score [%]	Rating	Score [%]	Rating	Yes/No	Percent of Deliveries
Dignity Health Sierra Nevada Memorial Hospital	Auburn	35.2	Poor	90.1	Above Avg			2.4	Average		Not Offered	No	7.3%
Sutter Roseville	Auburn	24.6	Average					2.3	Average	15.5	Average	Yes	0.0%
Tahoe Forest Hospital	Auburn	14.6	Superior			5	Below Avg	1.5	Average		Not Offered	No	0.0%
Adventist Health Rideout Hospital	Chico	21.5	Above Avg					0.8	Above Avg	14.6	Average	Yes	0.3%
Enloe Medical Center - Esplanade Campus	Chico	17.2	Superior	87.45	Above Avg	2.5	Below Avg	0.4	Above Avg	24.2	Average	Yes	12.7%
Oroville Hospital	Chico		Not Rated		Not Rated		Not Rated		Not Rated		Not Rated		
Adventist Health Clear Lake	Eureka	15.4	Superior	81.9	Above Avg	0	Above Avg	0.9	Above Avg		Not Offered	No	0.0%
Adventist Health Ukiah Valley	Eureka	22.9	Average	77.17	Above Avg	2.1	Below Avg	1.5	Average	11.4	Average	Yes	46.6%
Providence St. Joseph Hospital Eureka	Eureka	17.7	Superior	85.25	Above Avg	0	Above Avg	3.3	Average	16.7	Average	Yes	12.4%
Sutter Coast	Eureka	24.2	Average					5.3	Below Avg		Not offered	No	0.0%
Sutter Lakeside	Eureka	15.5	Superior					3.8	Average		Not Offered	No	8.0%
Dignity Health Woodland Memorial Hospital	Fairfield	27.1	Below Avg	80.4	Above Avg	0	Above Avg	0.7	Above Avg		Not Offered	No	0.0%
NorthBay Medical Center	Fairfield	31.7	Poor			0	Above Avg	1	Above Avg	16.6	Average	Yes	0.0%
Providence Queen of the Valley Medical Center	Fairfield	18.8	Above Avg	71.95	Average	6.5	Below Avg	1	Above Avg	28.9	Above Avg	Yes	0.0%
Sutter Davis	Fairfield	15.3	Superior					1	Above Avg	27.6	Above Avg	Yes	57.5%
Banner Lassen Medical Center	Redding	22.4	Average			0	Above Avg	1.4	Above Avg		Not Offered	No	0.0%
Dignity Health Mercy Medical Center Mt. Shasta	Redding	17.8	Superior	80.39	Above Avg	0	Above Avg	2.4	Average		Not Offered	No	0.0%
Dignity Health Mercy Medical Center Redding	Redding	19.6	Above Avg	78.54	Above Avg	1.64	Average	1.9	Average	7.8	Below Avg	Yes	0.0%
Dignity Health St. Elizabeth Community Hospital	Redding	28.2	Below Avg	74.95	Average	0	Above Avg	2.7	Average		Not Offered	No	9.4%
Fairchild Medical Center	Redding	38.6	Poor	71.30%	Average	0	Above Avg	3.2	Average	20	Average	Yes	0.0%
Marin Health Medical Center	Santa Rosa	20.6	Above Avg	84.3	Above Avg	0	Above Avg	0.5	Above Avg	32.3	Above Avg	Yes	48.1%
Santa Rosa Memorial Hospital (Providence)	Santa Rosa	21	Above Avg			2.8	Below Avg	0.3	Above Avg	38.5	Above Avg	Yes	44.8%
Sutter Santa Rosa	Santa Rosa	25.3	Average					0.9	Above Avg		Not Offered	No	0.0%

Measure Rating Scale Based off of HQIP Targets					
Meausre	Poor	Below Average	Average	Above Average	Superior
NTSV C-Section	30% or greater	24.0-29.9%	22.0-23.9%	18.0 to 21.9%	10 to 18%
Breastfeeding	<60%	60 to 69.9%	70-75%	>75%	NA
Episiotomy	NA	>5.0%	1.5 – 5%	<1.5%	NA
VBAC	NA	<10%	10-25%	>25%	NA
Early Elective Delivery (add from data from CMQCC for HQIP site only)	NA	>2%	1-2%	<1%	NA
CNM Delivery rate	NA	<10%	NA	>10%	NA

Clinical Practice Guidelines and Best Practices

Preventive Services Updates

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

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

In anticipation of Partnership Advantage, added references to Preventive Care for Medicare recipients. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
All adult vaccinations recommended by the California Department of Public Health apply.

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

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

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

Updated existing guidelines include:

- Vaccination - Based on age and risk factors. For updated schedule, reference the CDPH guidelines. CDPH Vaccination Guidelines

- ***NEW*** Cognitive Health Assessments (CHA) for Members 65 years of age and older – The USPSTF (February 2020 – currently under review) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults.
DHCS, however, per APL 22 025, REQUIRES an annual cognitive health assessment (CHA) for Medi-Cal Members 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an Annual Wellness Visit through the Medicare Program. The annual CHA is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards

for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). (The additional requirement that Medi-Cal Providers must complete the DHCS Dementia Care Aware CHA training to be eligible for billing for this service is expected to be eliminated in 2026.)

- Screening for Perinatal Depression - Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services. *(CPSP was replaced with PHPS)*

- Cervical Cancer Screening – Additional notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025)
    - Clinician collected specimens are preferred and self-collected vaginal specimens are acceptable
    - Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years
    - Repeat testing each 3 years following a negative HPV test using self-collected vaginal specimens
    - Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for clinician-collected cervical specimen
    - Self-collection is not recommended for high-risk individual, including those with immunosuppression
    - Use only FDA-approved collection devices and HPV assays

Clinical Practice Guidelines

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

Specific Pediatric Guidelines

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

Topical Fluoride Varnish for Children

DHCS added the CMS measure of 2 fluoride varnish applications per year for children ages 1 – 20 years to its Managed Care Accountability Set (MCAS) in MY2022. Partnership's very low performance on this measure in MY2023 is due to a data completeness issue with Denti-Cal data that Partnership receives from DHCS. Without complete Denti-Cal data, most of the fluoride varnish services completed in FQHC, RHC, and Tribal Health Dental Centers are not being counted towards this measure.

DHCS and Partnership have identified a work-around to this data issue: Dental Centers must use the ICD code Z29.3 (Encounter for prophylactic fluoride administration) combined with CDT codes (D1206 or D1208) when billing fluoride varnish services to Denti-Cal. **Effective November 30, 2025, DHCS made this a requirement for all FQHCs, RHCs, and Tribal Health Centers.**

For questions and technical assistance with issues around coding fluoride varnish services, please contact dentalsupport@partnershiphp.org.

Lead Screening Requirements

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

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

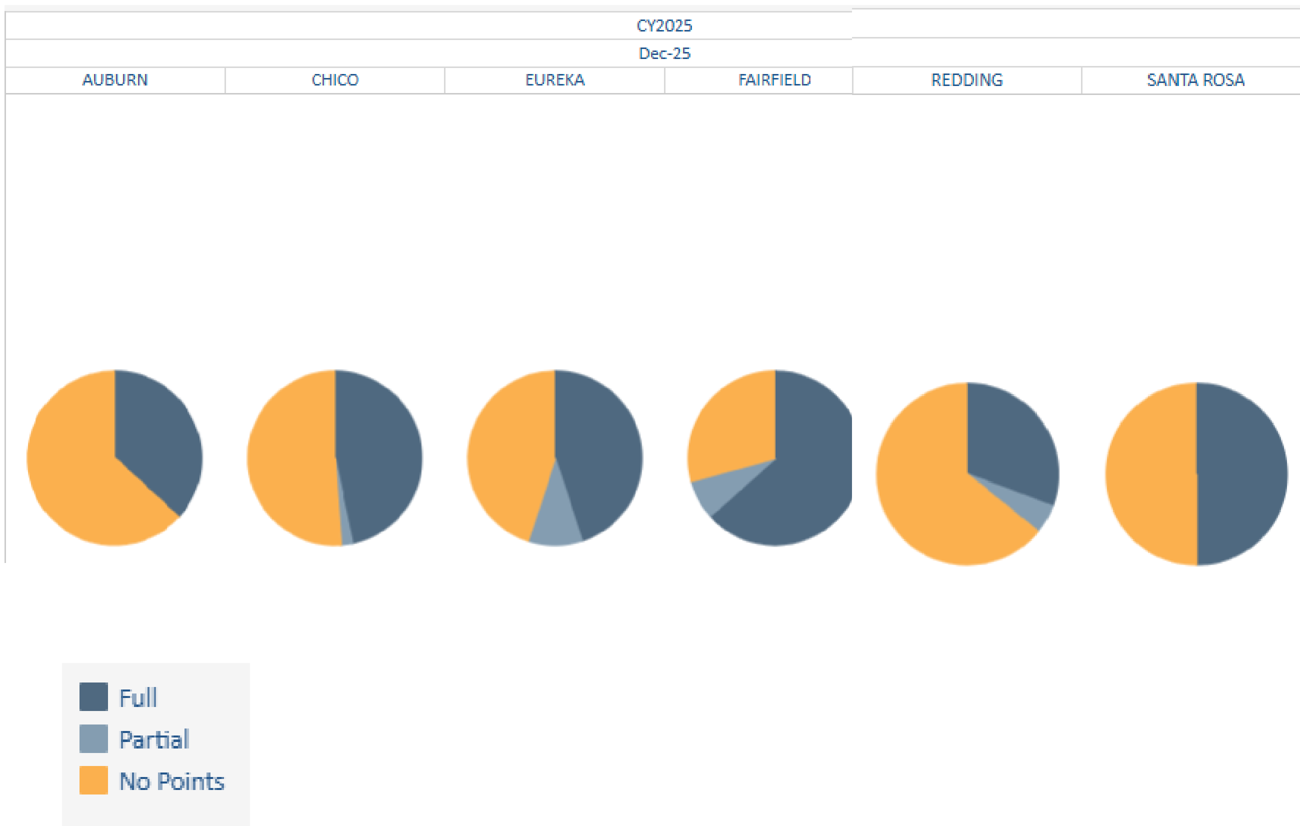
DHCS added the HEDIS measure of blood lead screening by age 2 to its Managed Care Accountability Set (MCAS) in MY2022. Performance on this measure was low before COVID and dropped during COVID. Despite educational interventions, sharing lists of patients due for lead screening with providers, and posting comparative data, the rates remained low. The rates increased steadily to 2024 to be above the 75th percentile.

This notable improvement is the result of a number of improvement activities Partnership has undertaken in the past three years to support more universal lead screening:

- Blood lead screening is now a core measure for the PCP QIP.
- Supporting providers who wish to move to providing lead testing on site, using point of care devices.
- Ensure education for clinical practices include both information on, and the importance of, billing for lead testing
- Doing more follow up with providers on their efforts to reach out to children overdue for screenings, with potential corrective action plans if actions are not taken by PCPs.

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

2025 PCP QIP measure: Lead Screening between age 1-2 years old



Testing for Streptococcal Pharyngitis

The standard of care for treatment of streptococcal pharyngitis is to confirm infection with a rapid strep test or throat culture prior to prescribing antibiotics, or at the latest concurrent with antibiotic treatment.

Both UpToDate and the Cochrane Library summary support this standard.

NCQA has a HEDIS measure that looks at the lack of any strep test associated with antibiotic prescription for strep pharyngitis, called “Appropriate Testing for Pharyngitis” or CWP. Nationally, the 33rd percentile for this measure was 69% percent in Medicaid in 2023.

The overall rate for Partnership was 70% in 2024, which is between the 33rd and 66th percentile. We ask you all to create processes to allow strep testing even if visits are done virtually, such as sending them to a lab for testing, or dropping into the office for testing only.

Referral for Routine Dental Care

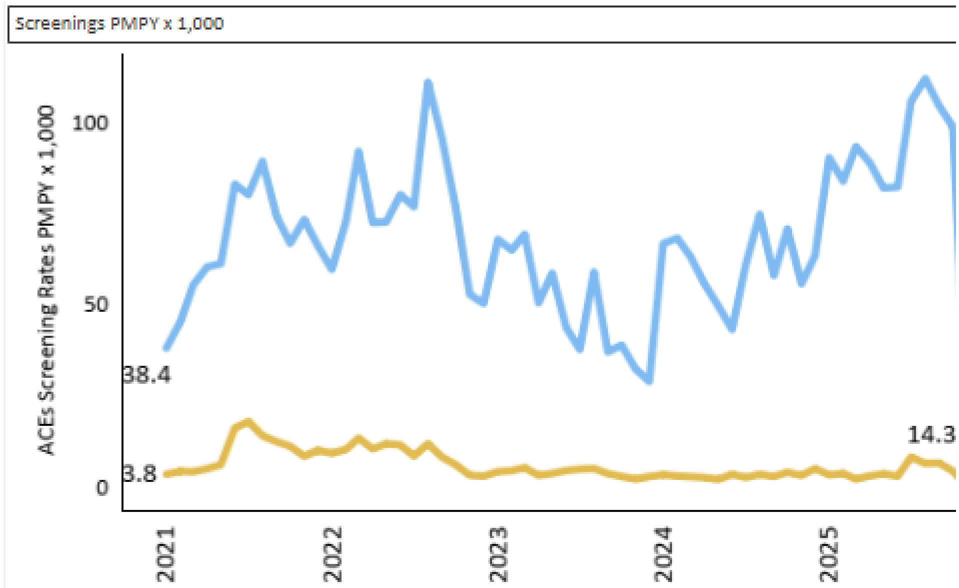
Denti-Cal payment rates were stabilized about 10 years ago, so dental access is better than it was before that. Medi-Cal covers two dental hygiene visits per year; this is especially important for children and pregnant women. Unfortunately, the State is currently planning to slash DentiCal rates to private dentists on July 1, 2026, which we project will cause a sudden loss of Dentists accepting DentiCal and an access crisis. Advocacy to delay this cut is ongoing.

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

ACEs Screening

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

ACEs screening per capita bumped up for adults and children in late 2025.



Here are the PCPs with the highest number of screenings:

Screenings by Member Assigned Providers (2025)

	0 - 18			19 & Over		
	ACE Screenings	Estimated Assigned Members	ACE Screening Rates PMPY x 1,000	ACE Screenings	Estimated Assigned Members	ACE Screening Rates PMPY x 1,000
Roseville Ped Medical Group	3,114	3,896	871.98	18	72	271.02
Avala Pediatrics	2,521	3,264	842.65	0	98	0.00
Lassen Medical Clinic	2,051	4,450	502.77	1	2,069	0.53
Srch Pediatric Campus	1,940	4,672	452.95	2	299	7.29
Marin Comm Cln San Rafael	1,721	5,805	323.41	49	6,758	7.91
Eureka Comm Health Center	1,587	3,776	458.52	4	4,294	1.02
West Sac Ped Medical Group	1,183	1,405	918.36	17	88	210.74
Healthplan Partnership	958	26,376	39.62	31	33,078	1.02
Marin Comm Cln Campus	861	2,406	390.39	63	4,306	15.96
Marin Comm South Novato	831	2,679	338.36	6	653	10.02
Alliance Medical Center	401	1,780	245.75	417	3,932	115.68
Mendocino Coast Peds Mg	735	1,475	543.74	1	130	8.40
Member Direct	666	5,096	142.58	70	10,293	7.42
Harvest Pediatrics	640	783	891.88	40	110	396.04
Community Med Ctr 210 Vaca	554	3,698	163.44	0	73	0.00
Vista Family Health Center	517	3,318	170.00	5	6,976	0.78
Western Sierra Medical Clinic	457	5,234	95.25	8	10,731	0.81
Alliance Med Ct Windsor	242	1,479	178.44	200	3,016	72.33
Srch Lombardi Campus	399	3,318	131.18	15	8,269	1.98
Baechtel Creek Medical Clinic	251	590	463.81	79	714	120.67
Sonoma Plaza Ped Med Grp	317	447	773.33	3	49	66.42
Healthplan Ccs-Wholechild	258	2,433	115.67	2	278	7.84
Gravenstein Comm Hlth Ctr	74	613	131.63	158	1,364	126.35
Srch Dutton Campus	166	2,265	79.97	13	6,106	2.32
Healthplan Sonoma	122	3,519	37.82	30	6,472	5.06
Russian River Health And Wel	50	169	323.45	99	671	160.93
Feather River Tribal Health	84	1,318	69.53	49	3,326	16.07
Redwood Peds Medical Group	117	3,004	42.48	0	190	0.00
Shasta Cascade Hlth Dunsmuir	48	200	262.06	66	447	160.94

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

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

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

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

ACES Screening Controversies (Reprinted from December 2025 Newsletter)

Six years ago, California's first Surgeon General, pediatrician Dr. Nadine Burke Harris, secured **legislative approval** to create a supplemental payment for providers to screen adults and children for Adverse Childhood Experiences (ACES) – traumatic events in childhood that can include violence, neglect, abuse, and growing up in a home with substance use and/or mental health challenges. To be able to be paid the $29 reimbursement for screening, clinicians needed to complete a

standardized training, which includes some basics on a related topic: trauma-informed care.

The rollout of the ACES screening has been turbulent. However, a moderate amount of screening state-wide has been done, with 29% of the overall Medi-Cal population and 12% of Partnership members having been screened since January 1, 2020. There are different billing codes for low-risk (scoring 0-3 on the ACES screen) and high-risk screening results (scoring 4-10). This allows the Department of Health Care Services (DHCS) to report on the proportion of those who are screened with different risk scores. This year, they reported that 7% of children and 18% of adults had ACES scores of 4 or higher across all Medi-Cal-managed care plans.

The Surgeon General's program, **ACES Aware**, also funded several studies and implementation projects. Ostensibly, these grants were supposed to develop an evidence base for the effectiveness of interventions to address ACES and potentially mitigate their effects. In practice, these many studies brought forth many interesting insights, anecdotes, and ideas around ACES and trauma-informed care, but little evidence on outcomes.

One of these **studies** – which documents a series of interviews of clinicians working in Tribal health centers – notes that the ACES screening tool is not very helpful for Native American populations (Garrow and Wimsatt, 2021). This is because certain kinds of trauma, such as historical trauma, transgenerational trauma, and efforts at cultural erasure, are pervasive undercurrents experienced by our Tribal communities and are not covered in the ACES screening tool. The ACES screening tool was first designed in the late 1990s by Kaiser San Diego for insured adults in an urban setting. **The Suscol Intertribal Council** offers an excellent online course that encompasses the vital nature of California's history through the lens of our California Tribes and the effects of colonization through the **Native American Historical Trauma and Traditional Healing Project.**

Despite the lack of studies showing benefits of ACES screening, ACES Aware and the DHCS websites both authoritatively assert that ACES screening is a vital component of addressing underlying trauma. In addition, DHCS considers ACES screening as an option for a standardized risk assessment expected to be performed by primary care providers on their patients, evaluated as part of the triennial Partnership Medical Review process.

The other options are routine screening for Social Determinants of Health and performing a standardized cognitive health assessment for members aged 65 and older.

Other national organizations are more skeptical. The US Preventive Services Task Force and the Cochrane Collaborative have no recommendations about ACES screening or trauma-informed care. These organizations have endorsed screening for intimate partner violence and depression based on evidence screening, which can lead to interventions and improve outcomes. In January 2022, American Academy of Family Physicians (AAFP) recommended a **“universal precautions” approach to trauma-informed care** with no screening requirement:

> *“Providing trauma-informed care does not require individuals to disclose their specific trauma history. Family physicians should approach trauma-informed care itself as a universal precaution by utilizing trauma-informed practices in all patient interactions, even if a patient’s experiences with trauma are unknown. The AAFP urges its members to understand and incorporate trauma-informed care into clinical practice.”*

In an effort to review the evidence base more systematically, the US Agency for Healthcare Research and Quality commissioned a study sponsored by the National Institute of Health, released in 2025, titled **“Trauma Informed Care: A Systematic Review.**” A summary of this study can be found in the November edition of the American Family Physician Journal, **Trauma-Informed Care: Evidence and Pragmatic Approaches** on page 474.

The summary found that the studies that were reviewed had a high risk of bias and high variability of interventions. The studies were not structured to disprove the null hypothesis: that ACES screening and trauma-informed care have no effect. Partly for this reason, the investigators concluded, “the evidence was insufficient to reach any conclusions about the effects of trauma-informed care for any outcome (Nguyen-Feng, et. al, 2025, p. 9).”

Of course, absence of evidence is not the same as evidence that something doesn’t work. However, the amount of money and effort dedicated to a particular intervention deserves to be linked, at least somewhat, to the level of evidence behind that intervention.

In the last decade, it seems many well-intentioned researchers that believe a particular fact have been negligently unaware of how their biases affect their study design and validity. Economist Ronald Coase once said, “If you torture the data long enough, it will confess.” Following this logic, we cannot insist on “following the evidence” for the effectiveness of vaccines and the safety of acetaminophen in pregnancy, for example, while following a different standard about interventions that address the important issue of ACES screening and trauma-informed care.

With the absence of outside studies showing a benefit, I encourage you to consider analyzing your own experience. If you are regularly performing ACEs screening, consider gathering your own data on the follow-up of this screening. If positive outcomes are being observed, understand the sequence of activities that led to these outcomes. If you find unintended negative consequences, embrace the opportunity to dive deeper into the drivers of these consequences. Make every effort to follow the data to whatever conclusions they reveal.

In the meantime, the AAFP-recommended approach – assuming that any given patient may have trauma impacting their care experience – of providing universal trauma-informed care seems patient-centered and sensible (although this too is not rigorously supported by evidence). The benefit of universal ACEs screening itself remains unproven, although perhaps learning about the association between a high ACEs score, chronic disease, and poor health outcomes can help motivate our teams to study and understand the principles of trauma-informed care more diligently. Additionally, the $29 per screening in supplemental income from universal screening can help subsidize counseling and staff education around trauma-informed care.

Developmental Screening

The importance of screening

One of the most important responsibilities for providers that care for Pediatric patients is monitoring development and making sure children with delays get the right therapy as quickly as possible. As with almost any medical condition, early identification and treatment yields the best results in the long run.

Every well check is an opportunity to assess a child's development, especially in the first three years, where changes are happening rapidly. Using screening tools, like the well-known ASQ or MCHAT screens, providers can discover early and sometimes subtle changes that an exam or parental interview might not. These screenings are incentivized with supplemental payments to primary care providers.

California Lags Behind Many Other States in Supporting Infants and Toddlers. An estimated 1 in 6 children in the US have a developmental disability. Yet, in California, only 3% of infants and toddlers receive early intervention services. In comparison, 10% of infants and toddlers in Massachusetts receive services.

The low rate of infants and toddlers receiving early intervention services in

California is due to myriad factors. One major issue is that not enough children receive developmental screenings. Screening is the critical first step in connecting children with early intervention services. Partnership's rate of Developmental screening (based on claims data which likely understates the true rate), was 30% in 2024 (the rate in 2025 is pending).

When potentially abnormal findings are found many providers are sometimes unclear where to refer these children for proper follow-up given the systems to support these needs are somewhat varied and occasionally siloed.

For children with isolated motor or speech delays, depending on your community, there may be PT/OT or ST providers that can address and resolve these issues.

For children with more varied or global concerns, especially for children with concerns for autism, one of the most important community resources is your local Regional Center. These are **state-funded, nonprofit agencies that coordinate services and supports for individuals with developmental disabilities**. They serve as the primary entry point for accessing publicly funded developmental disability services in California, collectively called the California Early Start Program.

(Map of Regional Centers in Partnership region: https://www.dds.ca.gov/wp-content/uploads/2019/09/DDS_RCMap.pdf)

One additional community resource for children over 3 years of age that have speech issues is the local public school district. Parents can request an evaluation for speech services directly from any local public elementary school, regardless of whether the child is enrolled there. A referral from the PCP is not needed.

If you encounter any barriers to referrals for suspected developmental issues, please reach out to the Care Coordination team at Partnership or your regional Partnership Medical Director for assistance in making a warm handoff to your local regional center.

The roles for primary are clear:

1. Screen every young child for Developmental Delays!
2. Refer those who fail screening!

Getting Paid for Developmental Screening

FQHCs, RHCs, Tribal health and other PPS providers are eligible, for supplemental payments for developmental screening of children in certain age ranges, but they **MUST bill with a Type 1 (individual NPI) in one of the available fields (rendering, ordering, prescribing, billing) or they will not**

be paid! This incentive is paid through claims, but the incentive payment will supplement the usual fee for these services.

g. Developmental screening:
    i. Paid based on use of CPT code: 96110, without a modifier, once for each age group: 2 months -1-year-old, 1 - 2 years old, and 2 - 3 years old.
    ii. Rate: $59.50
    iii. Nine standardized tool options as defined in CMS Core Measure Set Specifications (not the same as AAP). Most commonly used is the Ages and Stages Questionnaire (ASQ). Any claim for 96110 without a KX modifier MUST be for the use of one of these nine specified tools.
    iv. Any other tool used (such as the MCHAT for autism screening), must add a KX modifier. These will be paid the usual claim rate, but not be eligible for the bonus payment. **Early audits are showing that many providers are neglecting to use the KX modifier for autism screening.**
    v. **Many providers continue using the MCHAT screening tool, which is not approved for use by DHCS for billing with 96110 without a modifier. The approved tools include the following:**
        1. Ages and Stages Questionnaire (ASQ) - 4 months to age 5
        2. Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
        3. Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
        4. Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
        5. Brigance Screens-II - Birth to 90 months
        6. Child Development Inventory (CDI) - 18 months to age 6
        7. Infant Development Inventory - Birth to 18 months
        8. Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
        9. Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)

Misuse of Developmental Screening Code

In 2019, DHCS set new rules around the use of CPT Code 96110 to document comprehensive developmental screening. More than half of pediatric and family medicine providers had not performed a comprehensive developmental screening when the 96110 code was used. While several developmental screening tools are allowed, the most commonly used is the Ages and Stages Questionnaire (ASQ).

In most cases, the charts associated with use of the 96110 code documented a

screening for autism with a tool such as the M-CHAT, neglecting to use the required KX modifier. Prior to 2019, the modifier was not required for autism screening.

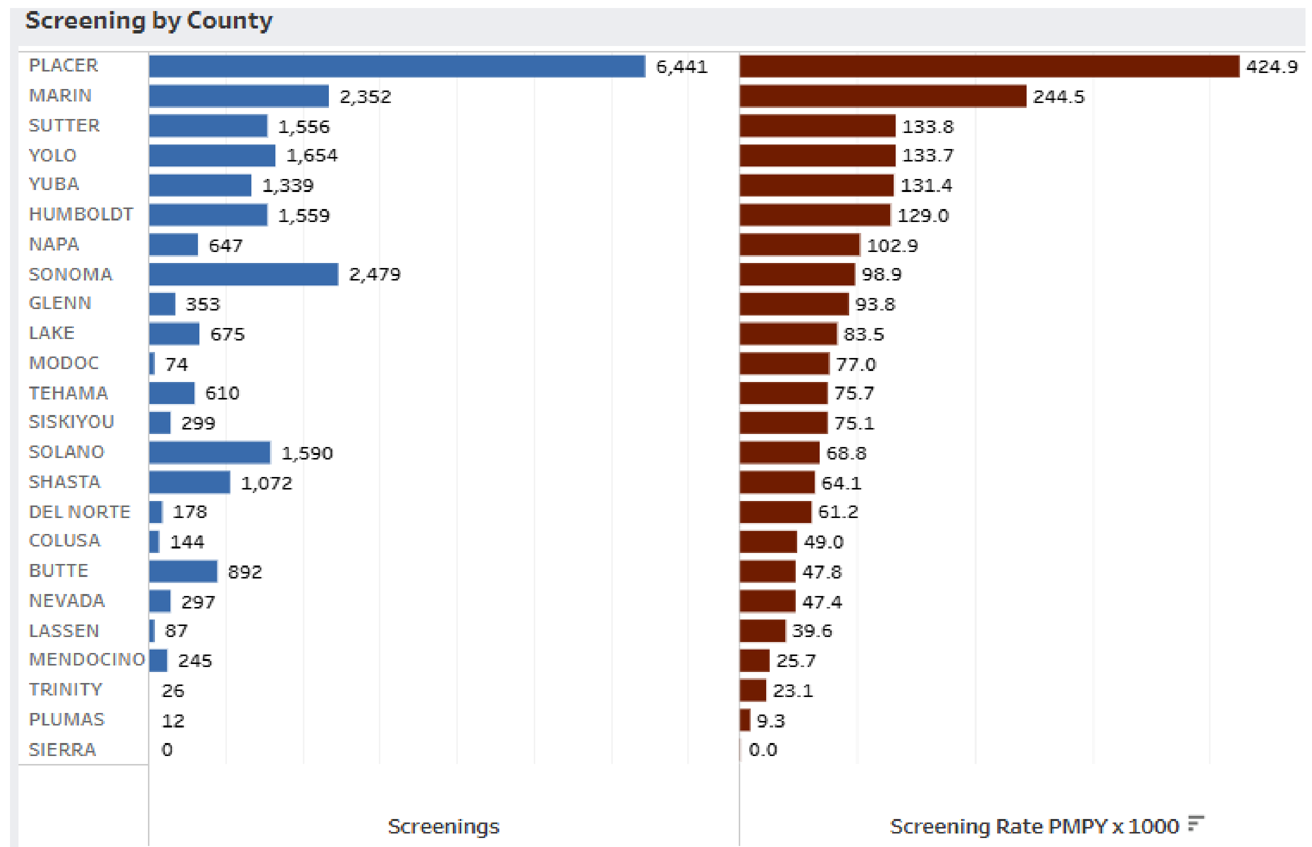
When autism screening is provided **in addition to** a comprehensive developmental assessment, both 96110 without a modifier and 96110.KX may be billed together.

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

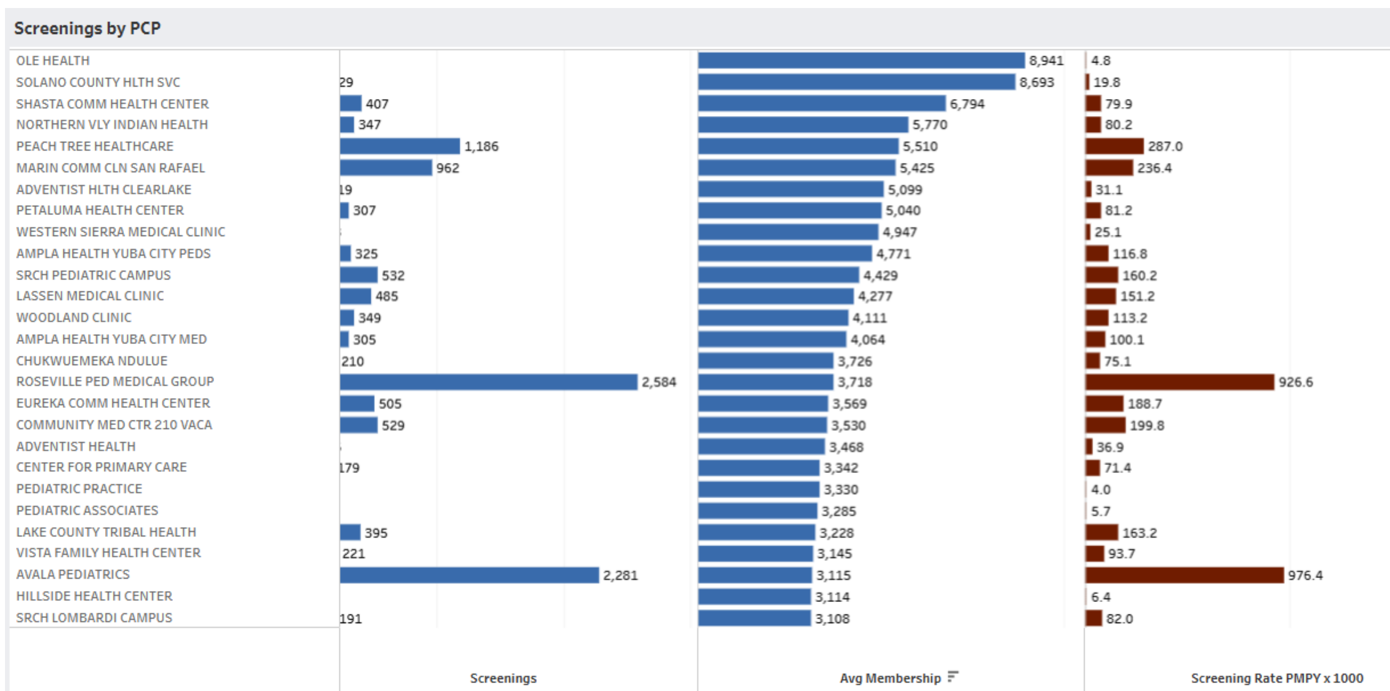
Like ACES screening, developmental screening is carved out of the PPS reconciliation process, so an additional $59.50 is paid when a comprehensive developmental screen is done, regardless of provider type. Many FQHCs are not billing 96110 at all, meaning either that they are doing developmental screening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

Developmental Screening Rate Data

Data source: Partnership Claims Data counties, 2025



Developmental Screening Rates in Children, 2025, Largest Providers



Adult Guidelines

Colorectal Cancer Screening

Screening for colorectal cancer remains on the DHCS Managed Care Accountability Set (MCAS) and the Primary Care Provider Quality Improvement Program. Partnership's PCP QIP is now utilizing the NCQA Medicaid Colon Cancer Screening Standards (COL HEDIS) resulting in an increase in benchmark targets. 2025 QIP year targets are currently set at 50th percentile for partial points and 75th percentile for full points, with the following measurement years' benchmarks set to rise to 75th and 90th respectively. Members between the ages of 45 – 75, by December 31st of the measurement year, need to have appropriate screening done for colorectal cancer. American Cancer Society's (and others) goal is to raise the screening rate to 80% in all populations.

Qualifying Screening Tests:

- **Colonoscopy:** Within the last 10 years.
- **FIT (Immunochemical):** Annual.
- **FIT-DNA combined test (Stool DNA):** Within the last 3 years.
- **gFOBT (Guaiac-based):** Annual.
- **CT Colonography:** Within the last 5 years.
- **Flexible Sigmoidoscopy:** Within the last 5 years.

While colonoscopies are preferred for multiple reasons (such as screening AND risk reduction with polyp removal, and they are performed every 10 years in the low risk population) access to low risk screening colonoscopy in most of the Partnership Regions continues to be extremely limited while colon cancer cases continue to rise in those under 50 (becoming the number 1 cause of cancer death in this population). For this reasons, many of us are encouraging large scale, early adoption of Colon Cancer Screening with Stool Based Studies in the low risk population (age 45-75, no personal history or first degree relative with polyp, colon cancer or inflammatory bowel disease, no known high risk genetics for colon cancer, and no colon cancer symptoms- such as blood in the stool). Any positive stool screening is followed by high risk screening colonoscopy. The goal is to relieve some of the volume of low risk screening in the network, while saving endoscopy capacity for positive stool studies.

We find the focus in the entire clinical setting from schedulers, to MAs, to Nurses, and Practitioners of all levels is integral to the success of this effort. Clinics that are focusing efforts on meeting this measure are finding great success, potentially doubling the screening rates. There are many coordinated efforts in the network with "Gap List" bulk ordering of studies, currently collaborated through Exact Sciences, to capture members who are remiss in office visits or who fail proactive testing plans. There is early planning to Partner with a Public Health Department in one county to be the ordering

agency with coordinated follow-up with clinics and specialists. To discuss bulk ordering for Cologuard, you can reach out to Exact Sciences at phc@exactsciences.com .

Below is the performance by region. The benchmarks are rising each year.

Measure Information

- Definition: The percentage of continuously enrolled assigned members 45–75 years of age who had appropriate screening for colorectal cancer.
- Importance of measure: DHCS sanction eligible

QIP MY2025	National Benchmark
25th percentile	31.58
50th percentile	38.07
75th percentile	43.17
90th percentile	49.35

Region	QIP MY2025*	Position relative to 2025 national benchmarks
Auburn	32.52	25th percentile
Chico	36.70	25th percentile
Redding	34.11	25th percentile
Eureka	39.41	50th percentile
Fairfield	40.01	50th percentile
Santa Rosa	45.87	75th percentile

*based on December QIP data

COPD Exacerbation Management

Key Points from the 2025 Global Initiative for Chronic Obstructive Lung Disease (GOLD) report for management of exacerbations include:

- Systemic corticosteroids can improve lung function (FEV1), oxygenation and shorten recovery time and hospitalization duration. The duration of therapy should not normally be more than 5 days.
- Short-acting inhaled beta2-agonists, with or without short acting anticholinergics are recommended as initial treatment of acute exacerbation.
- Long acting bronchodilators should be continued if the patient is using them at baseline, but GOLD does not recommend adding long acting bronchodilators for acute exacerbations of COPD. This is in contrast with asthma exacerbations, in which quick acting but long-lasting formoterol containing MDIs are an option.

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

Maintenance therapy with long-acting bronchodilators should be initiated as soon as possible before hospital discharge.

Statin Therapy in Patients with Cardiovascular Disease or Diabetes

In 2024, about 35% of Partnership members with diabetes were not being prescribed recommended cholesterol-lowering medications. For patients with diagnosed cardiovascular disease, about 19% had not received statin therapy.

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

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

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

Cognitive Health Assessments Required Annually for Patients over age 65

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

1. For Medi-Cal beneficiaries over the age of 65 who do not have Medicare, a CPT2 code (1494F) has been designated to be used to indicate that such a cognitive screening was performed. If billed with the visit, an enhanced payment will be paid on a fee-for-service basis.
2. DHCS has added additional options for which cognitive assessment tools may be used. The mini mental status exam (MMSE) is commonly used but not universally thought to be the best tool. Other options are the General Practitioner Assessment of Cognition (GPCOG), the Mini-cog, the Informant Interview to Differentiate Aging and Dementia, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

Of note, Cognitive Health Assessments are required for all MediCare patients as well.

Reminder on Screening for Tuberculosis

Health care providers are required to offer a tuberculosis risk assessment and screening (if appropriate) to all adult patients seen in a setting where primary care services are provided.

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

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

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

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

An individualized diagnostic evaluation is needed to ensure that the patient does not have active TB.

The four risk factors for latent TB are:

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

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

Health Equity

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

Mandatory CARES Training

DHCS is requiring Medi-Cal Managed Care Plans to mandate and monitor regular trainings around cultural diversity for all patient-facing staff working in the primary care and specialty setting. Partnership calls this training **CARES which stands for Community, Access, Respect, Engagement and Service**. This is available online.

- Practitioners (Primary Care and Specialty Providers), who are directly credentialed with Partnership, are strongly encouraged to complete the training within 90 days of their credential
- Practitioners or Staff members, who are reported to participate in discriminatory action per analysis of our grievance and HE team, will be encouraged to complete the training within 90 days
- Currently Partnership has an overall training completion rate of 4.9% of all newly credentialed/recredentialed practitioners from July 2025 to January 2026.

Health Inequity Measurement

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

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

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

a. Disability
b. Gender
c. Gender identity
d. Sexual orientation
e. Income
f. National origin

g. Geography, especially rural vs. suburban/urban and neighborhood-based
h. Educational attainment

The biggest drivers are geography, race, disability, and education. Organizations should consider using multifactor approach to stratify if they are not seeing any differences when they do simple stratifications by 1 factor. For example, if a stratification of Breast Cancer Screening by race does not reveal any disparities, you might consider stratification by zip code to identify a geographic inequity.

Major findings of inequities

The most important administrative measures for detecting racial inequities (compared to the white population) are the following HEDIS measures:

A. Mammogram
B. Colorectal Cancer
C. Well Child Visit

HEDIS Equity Analysis: Measurement Year 2024

Breast Cancer Screening Inequities

2024

- In all 6 regions of 2024, **Asian / Pacific Islanders** significantly improved to exceed MPL and was “significantly” higher than the white population
- In majority of 6 regions of 2024, **American Indian / Alaska Natives** continue lowest rates of screening.
- In majority of 6 regions of 2024, **Hispanic Community** had highest rates of screening.

Well Child Visits Inequities

2024

- Majority of race groups are below MPL (50th Percentile). Only Hispanic group is above the MPL (50th Percentile) for WCV
- Inequity continues notably with **Black Population.**

CIS-10 Childhood Immunization Measure

2024

- Hispanic and Asian/Pacific Islander had the highest rates of CIS-10 and were near the 75th percentile
- The American Indian population continues to remain as the one with the lowest CIS-10 rate (8.58%) next to the white population (11.66%)

PCP QIP Equity Analysis (2025)

Here is a brief summary of disparity analysis:

- Breast Cancer Screening: American Indian Rate (45%) continues to remain as the only race below the white rate (47%)
- Cervical Cancer Screening: American Indian Rate (44%) continues to remain as the only race below lower than the white rate (45%)
- Well Child/Adolescent Visits: Black Rate (47%) continues to remain as the only race below the white rate (49%)
- Childhood Immunization (CIS-10: American Indian rate improved to 10% but still remains lower than the white rate (13%)
- Colorectal Cancer Screening: American Indian (28%) and Black (33%) rates continue to be less than the white rate (35%)
- Blood Pressure Control: American Indian rate (50.73)% is trending downward from previous year and is the only rate less than the white rate (58%)
- Diabetes Good Control: Both American Indian rate (61%) and Black rate (65%) have improved but both still remains below the white rate (69%)
- Diabetes Retinal Eye Exam: Only American Indian rate (45%) remains below the white rate (49%).
- Adolescent Immunization (IMA-2): No inequities continues with the white population continuing to perform the worst at 23% when compared to all other race groups.
- Lead Screening in Children: The East Asian (44%) performed worse than the White community (66%)
- Well Child Visits in the First 15 months of life: American Indian rate (36%) continues to remain below the white rate (43%)

Summary by Race

- Native American: Number of inequities have remained stable when comparing 2024 to 2025 QIP measures. Number of inequities generally remaining stable from **10/11** in 2022, **8/11** in 2024 to **8/11** in 2025
- Black / African American: Number of inequities have improved from 5/11 in 2022, to 4/11 in 2024, to 3/11 in 2025. The key disparity that was eliminated in 2025 was CBP.
- East Asian: The East Asian (China, Japan, South Korea, North Korea, Mongolia, and Taiwan,) community had 0 disparities in 2022 and 2024. However, data suggests at least 1/11 disparities in 2025 regarding lead screening.

Interventions

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

- QIP Disparity Bonus Program
- Barbershop CHW Initiative for Blood Pressure management
- Maternal Photoshoot Initiative
- Tribal Perinatal Initiative
- Pregnancy Transportation Pilot

2024 Population Needs Assessment

Partnership's 2024 Population Needs Assessment (PNA) is now available and can be accessed on the About Us page on our website. It includes a review of population health parameters from a variety of sources and analyzes these parameters to inform Partnership's population health activities.

Health Equity/Practice Transformation (EPT) Directed Payment Program

In January 2024, DHCS announced awardees of the long-awaited Equity Practice Transformation (EPT) Directed Payment program. Practices will receive payments for achieving population health management milestones by completing specified deliverables. These direct payments will enable the practices to implement improvements across their infrastructure, data collection capabilities and care management processes to promote patient well-being, address racial and ethnic inequities, and deliver whole person care.
.
Of the 56 organizations in the Partnership service area that applied, 27 were accepted into the program, a higher success rate than any other health plan in California. In May 2024, DHCS recalculated the final award amounts due to state budget revisions and reduced the program term from 5 year to 3 years. Awards were weighted based on the sociodemographic risk of their population, and based on selecting specified elective activities, with some accounting for geographic distribution.

At the beginning of 2026, the program begins the third and final year. At this time, 22 of Partnership's provider organizations remain in the program with eligible awards totaling $10,915,077.

Name of Organization Awarded	Health Center Type
Ampla Health	FQHC
Alexander Valley Healthcare	FQHC
Harmony Health Medical clinic and Family Resource Center	FQHC
Mountain Valleys Health Centers	FQHC
Northeastern Rural Health Clinics Inc.	FQHC
Open Door Community Health Centers	FQHC
Peach Tree Healthcare	FQHC
Petaluma Health Center, Inc.	FQHC
Redwood Coast Medical Services	FQHC
Shasta Community Health Center (SCHC)	FQHC
West County Health Centers Inc.	FQHC
Western Sierra Medical Clinic, Inc.	FQHC
St. Elizabeth Hospital Lassen Medical Clinic	Rural-Hospital
Eastern Plumas Health Care	Rural-Hospital
Southern Humboldt Community Healthcare District	Rural-Hospital
Baechtel Creek Medical Clinic	Rural-Independent
Stallant Medical Group Inc.	Rural-Independent
Chapa-De Indian Health Program	Tribal
Kimaw Medical Center	Tribal
Pit River Health Service, Inc.	Tribal
Round Valley Indian Health Center	Tribal
Sonoma County Indian Health Project, Inc.	Tribal

General Quality Updates

How PCP QIP drives HEDIS

DHCS Quality Oversight

The accountable measures in the DHCS Managed Care Accountability Set (MCAS) for reporting year RY2027 (measurement year MY2026) are:

#	Measure Required of MCP	Measure Acronym	Measure Steward	Methodology	Held to MPL[i]
	Behavioral Health Domain Measures				
1	Follow-Up After ED Visit for Mental Illness—30 days*[iv]	FUM	NCQA	Administrative	Yes
2	Follow-Up After ED Visit for Substance Use—30 days*	FUA	NCQA	Administrative	Yes
3	Depression Screening and Follow-Up for Adolescents and Adults-Screening*	DSF-E-DS	NCQA	ECDS	Yes

#	Measure Required of MCP	Measure Acronym	Measure Steward	Methodology	Held to MPL[i]
	Children's Health Domain Measures				
4	Child and Adolescent Well-Care Visits*	WCV	NCQA	Administrative	Yes
5	Childhood Immunization Status—Combination 10*	CIS-10-E	NCQA	ECDS	Yes
6	Developmental Screening in the First Three Years of Life	DEV-CH	CMS	Hybrid/Admin**	Yes
7	Immunizations for Adolescents—Combination 2*	IMA-2-E	NCQA	ECDS	Yes
8	Lead Screening in Children	LSC-E	NCQA	ECDS	Yes
9	Topical Fluoride for Children	TFL-CH	DQA	Administrative	Yes[iii]
10	Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits*	W30-6+	NCQA	Administrative	Yes
11	Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits*	W30-2+	NCQA	Administrative	Yes
	Chronic Disease Management Domain Measures				
12	Controlling High Blood Pressure*[iv]	CBP	NCQA	Hybrid/Admin**	Yes
13	Glycemic Status Assessment for Patients With Diabetes (>9%)*[iv]	GSD	NCQA	Hybrid/Admin**	Yes

#	Measure Required of MCP	Measure Acronym	Measure Steward	Methodology	Held to MPL[i]
	Reproductive Health Domain Measures				
14	Prenatal and Postpartum Care: Postpartum Care*	PPC-Post	NCQA	Hybrid/Admin**	Yes
15	Prenatal and Postpartum Care: Timeliness of Prenatal Care*	PPC-Pre	NCQA	Hybrid/Admin**	Yes
16	Postpartum Depression Screening and Follow-Up-Screening*	PDS-E-DS	NCQA	ECDS	Yes
17	Prenatal Depression Screening and Follow-Up-Screening*	PND-E-DS	NCQA	ECDS	Yes
	Cancer Prevention Domain Measures				
18	Breast Cancer Screening*[ii]	BCS-E	NCQA	ECDS	Yes
19	Cervical Cancer Screening*	CCS-E	NCQA	ECDS	Yes
20	Colorectal Cancer Screening*	COL-E	NCQA	ECDS	Yes

Note: DSF-E-DS, PDS-E-DS, and PND-E-DS are new to accountability in MY2026 and subject to financial sanctions and enforcement actions by DHCS. These measures cannot be captured via claims and require a data aggregator (see next section on DataLink). COL-E is also new to accountability but has been in the PCP QIP prior to MY2026.

Low achievement on these measures at the county level results in financial sanctions and increased dollars from any financial margin the health plan has to go towards Community Reinvestments (see DHCS website for evolving details).

Withhold Measures

A subset of MCAS measures, plus the CAHPS member experience measures discussed later are subject to a larger financial withhold: 1% of total revenue from the state, which can be earned back by the Health Plan through closing equity gaps in the well child visit measure.

The withhold measures are:

2026 DHCS Withhold Measures

Measure Category	Measure Name
Chronic Care	Controlling High Blood Pressure (CBP)
	Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD)
Perinatal Care	Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)
	Prenatal and Postpartum Care: Postpartum Care (PPC-Pst)
Pediatric Care	Child and Adolescent Well-Care Visits (WCV)
	Well-Child Visits in the First 30 Months of Life: First 15 Months (W30-6)
	Well-Child Visits in the First 30 Months of Life: 15–30 Months (W30-2)
	Childhood Immunization Status – Combination 10 (CIS-10)
	Immunizations for Adolescents (IMA)
Patient Experience (CAHPS)	Getting Care Quickly – Adult
	Getting Care Quickly – Child
	Getting Needed Care – Adult
	Getting Needed Care – Child

DataLink and ECDS Measures

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

ECDS reporting is part of NCQA's larger strategy to enable a Digital Quality System and is aligned with the industry's move to digital measures. NCQA has announced plans to convert all hybrid HEDIS measures to ECDS measures by 2029, which would replace chart sampling with the ECDS reporting standard. ECDS measures are indicated by a "-E" after the measure name.

<u>The following MY2026 accountable ECDS measures require data collection using only ECDS data standards:</u>

- Lead Screening for Children (LSC-E) – **NEW to ECDS**
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Prenatal Depression Screening and Follow-Up-Screening (PND-E)
- Postpartum Depression Screening and Follow-Up-Screening (PDS-E)
- Childhood Immunization Series 10 (CIS-10-E)
- Immunizations for Adolescents (IMA-2-E)
- Breast Cancer Screening (BCS-E)
- Cervical Cancer Screening (CCS-E)
- Colorectal Cancer Screening (COL-E)

In 2024-2025, Partnership successfully piloted use of an NCQA Certified Data Aggregator, DataLink, to collect data for its ECDS measures. DataLink ingests clinical chart data in a structured format (FHIR or CCD), that are extracted from EHR's and posted on a Secure FTP site. For most EHR's, the clinical data extraction process is a configuration task for the EHR administrator and can be automated. Our pilot showed that DataLink is uniquely able to extract clinical data that show Point of Care test, vital signs, depression screens, and other screen completion, which results in higher measure performance for many of Partnership's most prioritized measures.

Partnership intends to scale the use of DataLink throughout our provider network, and to leverage clinical chart data to replace manual QIP uploads starting in 2027. As we scale our use of this important new source of clinical data, we urge you to begin the contracting process with DataLink in 2026.

Contracting with DataLink is a UOS measure in the PCP QIP. For PCP QIP participants, please contact the QIP team at qip@partnershiphp.org to begin the contracting process if you are not already participating.

Contracting with DataLink and beginning data extraction by 6/30/2026 is a gateway measure for the MY2025-26 Perinatal QIP. Perinatal QIP practices should contact the Perinatal QIP team at PerinatalQIP@partnerhsiphp.org to begin the contracting process if you are not already participating. There is no charge to practices in Partnership's provider network for adopting DataLink.

Facility Site Review

A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Records Review (MRR) using tools developed by the California Department of Health Care Services (DHCS) and Managed Care Plans collectively. Contracted sites are reviewed as a condition of participation in our provider network and are conducted for credentialing and re-credentialing purposes.

DHCS is expected to release a new site review tool in 2026. The release date is unknown currently. Once more is known, the Inspections team will educate the network about any changes.

New training courses are available:

- Comprehensive Health Interventions for Lifelong Development (CHILD) Training (formerly CHDP) is now offered on the Partnership Website.
    - For facilities that see pediatric patients (under 21 years old), the facility staff are responsible for conducting hands-on-preventive screening and must demonstrate competency and appropriate application of these screenings/services. (DHCS Facility Site Review Standards page 20)
- Step by Step video: fluoride application

Training and Site Review Tools can be located here: https://www.partnershiphp.org/Providers/Quality/Pages/Site-Review-Resources.aspx

If you are interested in a more elaborate training related to site review please email the FSR inbox at FSR@partnershiphp.org.

Improving the Patient Experience

Plan Wide Patient Experience Survey (CAHPS)

Each year, Partnership is required to perform a regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is separate and distinct from the survey administered for the PCP QIP Patient Experience Measure, which is the Consumer Groups CAHPS or CG-CAHPS.

Typically, the regulated survey is conducted in February of each calendar year (called the Reporting year), and members are asked to share their experiences over the past six months, representing dates of service between the months of July and December of the prior year (called the Measurement year).

Both surveys pose several core question topics. Table A is a comparison between the different survey types.

Table: A

	CAHPS Health Plan: Partnership	**CG-CAHPS Partnership Provider Network: Parent Organization**
Core Survey Topics		
Access to care	• Getting needed care • Getting care quickly	• Getting timely appointments, care, and information
Communication between patients and providers	• How well doctors communicate	• How well providers communicate with patients
Care coordination		• Providers' use of information to coordinate patient care
Customer service	• Health plan customer service	• Helpful, courteous, and respectful office staff

The next page shows the results for Measure Year (MY) 2024 / Report Year (RY) 2025 CAHPS survey samples (Adults and Children listed separately. You will note that this small planwide sample shows some significant opportunities for improvement.

Improvements in plan-wide customer experience requires improvements by providers across the 24 counties, in the areas of access and communication.

Table: I: Survey Results for Adults (RY 2025)

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	19th	Not Met	Improvement
Rating of Health Care (% 8, 9, 10)	35th	Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	30th	Not Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	96th	Met	Improvement
Getting Needed Care (% Always or Usually)	5th	Not Met	Decline
Getting Care Quickly (% Always or Usually)	11th	Not Met	Improvement
Care Coordination (% Always or Usually)	9th	Not Met	Decline
How Well Doctors Communicate (% Always or Usually)	8th	Not Met	Decline
Customer Service (% Always or Usually)	12th	Not Met	Decline

Table: II Survey Results for Children (RY 2025)

Measure Domain	Plan Performance		
	MY 2024 HEDIS QC Ranking	Plan Benchmark Target ≥33rd Percentile Ranking	MY 2024 Ranking Compared to MY 2023
Rating of Health Plan (% 8, 9, 10)	44th	Met	Decline
Rating of Health Care (% 8, 9, 10)	21st	Not Met	Improvement
Rating of Personal Doctor (% 8, 9, 10)	73rd	Met	Decline
Rating of Specialist Seen Most Often (% 8, 9, 10)	31st	Not Met	Improvement
Getting Needed Care (% Always or Usually)	13th	Not Met	Decline

Getting Care Quickly (% Always or Usually)	13th	Not Met	Improvement
Care Coordination (% Always or Usually)	52nd	Met	Improvement
How Well Doctors Communicate (% Always or Usually)	36th	Met	Decline
Customer Service (% Always/Usually)	74th	Met	Decline

For reference, the following are the questions that feed into the four composite measures.

Access: Getting Needed Care

Q9 Easy for respondent to get necessary care, tests, or treatment
Q20 Respondent got appointment with specialists as soon as needed

Access: Getting Care Quickly

Q4 Respondent got care for illness/injury as soon as needed
Q6 Respondent got non-urgent appointment as soon as needed

How Well Doctors Communicate

Q12 Doctor explained things in a way that was easy to understand
Q13 Doctor listened carefully to enrollee
Q14 Doctor showed respect for what enrollee had to say
Q15 Doctor spent enough time with enrollee

Health Plan Customer Service

Q24 Customer service gave necessary information/help
Q25 Customer service was courteous and respectful

Note that this last category is the only one directly under the control of the health plan. A number of internal activities are underway to improve Health Plan customer experience.

We urgently ask all of our providers to boost their own activities around customer experience. See below for an approach to this.

Primary Care Patient Experience Survey Results (2025)

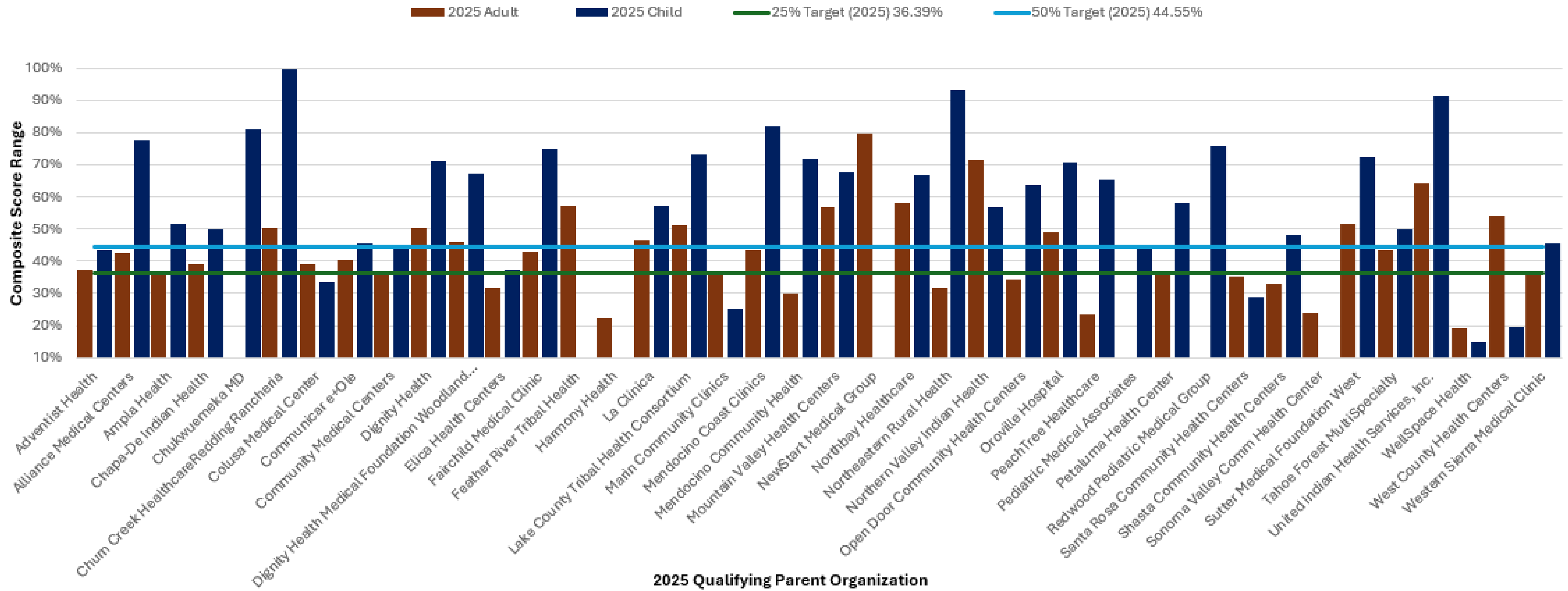
Each spring, as part of our Primary Care Provider Pay for Performance Program (PCP QIP), we utilize a certified vendor to conduct the Agency for Healthcare Research standardized patient experience survey called the Clinician and Group – Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey, for our PCP Parent Organizations with at least one visit by 2400 unique Partnership members. The QIP performance is based on the overall group score, as individual site scores often have too low a denominator to be statistically valid. Parent organizations of less than 2400 members may earn points based on conducting a survey of their own and acting to improve the patient experience using the results of the survey. The Patient Experience Measure is worth 10% of the PCP QIP.

Two benchmarks are listed, for the 25th percentile and the 50th percentile based on our Partnership results.

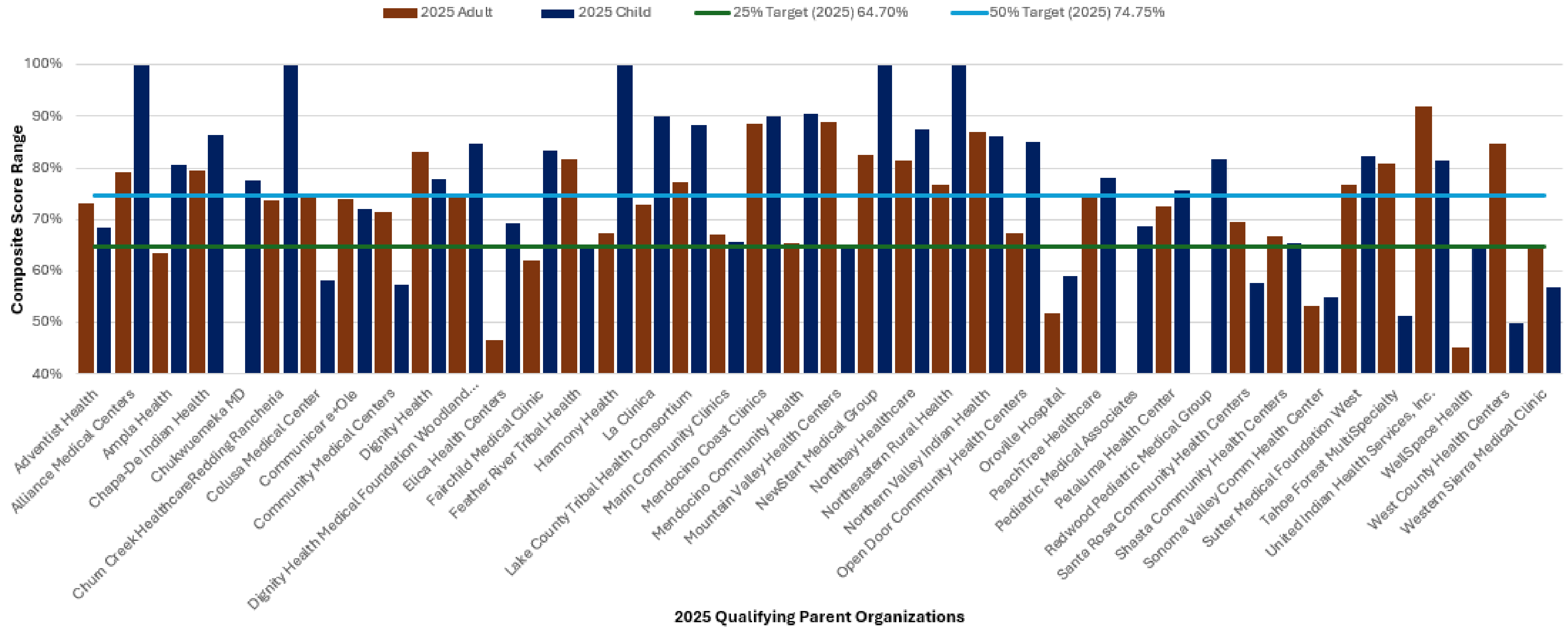
Up to four results are noted for each PCP: Adult and Caregiver on behalf of child are the age categories, and Communication and Access are the two composite scores reported for each. Two other composite scores will be sent to the PCP, but not used for scoring: Coordination of Care and Office Staff.

Here are the results for our 24 counties, for the Access and Communication Composite Scores.

Access Scores:
Highest scores for Children: Churn Creek Healthcare – Redding Rancheria, Northeastern Rural Health, United Indian Health Services
Highest scores for Adults: Newstart Medical Group, Northern Valley Indian Health, United Indian Health Services



Communications Scores:
Highest for Children: Alliance Medical Centers, Churn Creek Healthcare – Redding Rancheria, Harmony Health, NewStart Medical Group, Northeastern Rural Health
Highest for Adults: United Indian Health Services, Mendocino Coast Clinics, Mountain Valley Health Centers



Reflections on Improving Patient Experience

Think for a moment of the last time you needed to interact with the health care system. What were the things that made you like or not like the way that care was delivered?

Having amazing patient experience is not an easy lift. There are many factors which can impact it. Fundamentally, there is a constant tension between optimizing clinician productivity (with shorter visits) and having optimal access and communication (this is one reason for the rise of concierge medicine, where a few patients have great access and communication, if they can afford it). If there is a large demand for services, the balance is between shutting down access altogether to some patients to give better access and service to a smaller group. For the most part this is not aligned with the mission of health centers, so they are continuously working to find the best balance possible between productivity, access and communication.

Here are some of the many factors that busy practices need to keep track of to have optimal customer experience:

On the access side, here are some factors that you could ask your patients (or assess as if you are in your patient's shoes):

1. How reliably can patients reach a human when they call your office?
2. How easy and fast is it to get through to the office on the phone?
3. How easy is it to make an appointment at a time that works for you? Are there options for care in the evening or the weekend? Did the staff ask if you needed help with transportation to the visit?
4. How easy is it to get medical advice during the day? After hours?
5. How long did you wait in the waiting room to be seen?
6. How long did you wait in the exam room to be seen?
7. Once the doctor/clinician saw you, was the visit efficient or drawn out?
8. How easy is it to get needed medication refills?
9. Were you offered the option of a virtual visit?
10. Is there a well-functioning internet-based portal that allows you to do many things yourself?
11. Were you able to see your personal PCP or did you see someone else for your visit?

12. If you needed to see a specialist, how easy was it to get an appointment?
13. Was the specialist appointment as soon as you wanted it, or was it far in the future?
14. Was the specialist visit close to home or did it require traveling a longer distance?

On the communication side, here are some factors that impact your experience:

1. When you communicate with your doctor’s office by phone, text or email, was the interaction professional, polite, and respectful?
2. When you arrive to the doctor’s office for a visit, do the receptionist and medical assistant and other support staff, interact with you in a professional, polite, respectful and warm way?
3. If your wait was long in either the waiting room or the exam room, did someone keep you up to date on the status and offer to reschedule if the wait was too long?
4. Is the building where the visit occurs in good repair, clean, and inviting?
5. Does it feel like the staff in the doctor’s office communicate with each other, so you don’t have to repeat yourself?
6. If English is not your first language, did the office staff speak your language understandably? If not, were you offered video or phone translation?
7. Does your doctor/clinician:
    a. Seem to care about you as a person. (Make eye contact, smile, show curiosity about you as a person).
    b. Ask questions to find out what the reason for the visit is, and about your symptoms (collect a good history)
    c. Examine you (at a minimum the part of your body with symptoms or related to your problem)
    d. Clearly Explain what your diagnosis/problem is
    e. Clearly explain their recommendations for treatment, answering all questions you have about this.
    f. Describe what symptoms or changes should prompt you to call or return sooner than scheduled.

We are all patients and customers at when we need to access health care. The questions above may seem a stretch for your practice, but they reflect the service you deserve and also what our patients deserve.

When a patient answers a CAHPS survey indicating that access or communication was below average, that survey is not sufficiently granular to know which one or more of the above factors was the reason. For this reason, it is essential to not use the CG-CAHPS as the only tool for deciding what interventions are needed to improve the customer experience. More detailed questions from a sample of your patients is one way to do this. Having office staff hyper-attuned to the experience of care is another (think of the staff of the Ritz Carlton Hotel or Disneyland). Having some patients who are “secret shoppers” is another. The key is to be continuously looking for ways to get better, not being complacent and thinking, “well this is the way it is; there isn’t anything we can do to make it better,” or “I don’t believe that survey, our patients all say they are happy.”

Regardless of the method used to get the granular detail, you can see that broadly interventions can be grouped by these main drivers, which are in approximate order of increasing effort.

1. Optimize the Physical Space for Healing: Keep the parking lot, building, waiting rooms, exam rooms, hallways and restrooms clean, bright, odor-free and inviting. (Design, upgrades, maintenance)
2. Workforce: If your clinician or non-clinician staffing is insufficient to meet the needs, work to increase staffing hours (adjusting hours; recruitment and retention)
3. Operational Activities:
    a. Develop systems and policies that make the office run as efficiently as possible, reducing non-value added waiting time for patients and clinicians. (Office workflows and scheduling practices)
    b. Arrange your systems so that patients can see their personal doctor/clinician instead of another clinician as much as possible[1] (empanelment and balancing supply and demand).
4. Optimize interpersonal interactions:
    a. Support Staff: Ensure all support staff are trained, retrained, and proficient in communicating warmly, clearly, accurately, and respectfully. (Monitor and look for ways to improve in daily huddles, evaluating any challenging encounters. Customer service training from service industry)
    b. Clinical Staff:
        i. Ensure your clinical staff are resilient, happy, and feel valued for their work. (burnout prevention activities)
        ii. Help your clinical staff improve the clarity and accuracy of their communication. (coaching, review of video/audio interactions, training, self-learning)
        iii. Help your clinical staff improve their non-verbal and verbal communication of attention, respect and caring for the patients. (same as ii, plus staff training/coaching conducted by behavioral health professionals; Medical Improv; business trainers)

The first three main drivers (physical space, staffing, and operational activities), and optimizing the interpersonal interactions of support staff require clinical leaders to partner closely with the overall office/clinic leadership. This relationship between the clinical leader and the organizational/operational leadership is essential, and must be nurtured and developed over time, in an environment of mutual respect and teamwork.

Optimizing the interpersonal interactions of the clinical staff is one of the

[1] A Kaiser study from the 2000s showed that having a patient appointment with their personal primary care physician was the single factor that predicted a higher response on all other questions of patient satisfaction.

major responsibilities of their clinical leader. While they will need some support from administration, it is the clinical leaders who need to own and lead these efforts, serving as mentors and coaches, bringing in outside resources as needed.

An underlying principle is that clinical and non-clinical leaders must strive to promote a culture of continuously striving for excellent (and improving) customer service. Specific actions that can promote this culture may include:

- Develop a team culture committed to high customer service standards.
- Daily team huddles, less than 5 minutes.
- Patient care affirmations to nurture positive workspace.
- Daily touchpoints to reset and closeout the day.
- Create a thoughtful and empathic culture, both outward and inward.

Quality Improvement Program Description, Evaluation, and Work Plan

Each year, Partnership updates three core documents: the Quality and Performance Improvement Program Description, the Annual Quality Improvement Evaluation, and annual update of our QI Work Plan. If you are interested in reviewing these documents, they are available here: Quality page

Pay for Performance Program for Primary Care (PCP QIP)

PCP QIP Overview

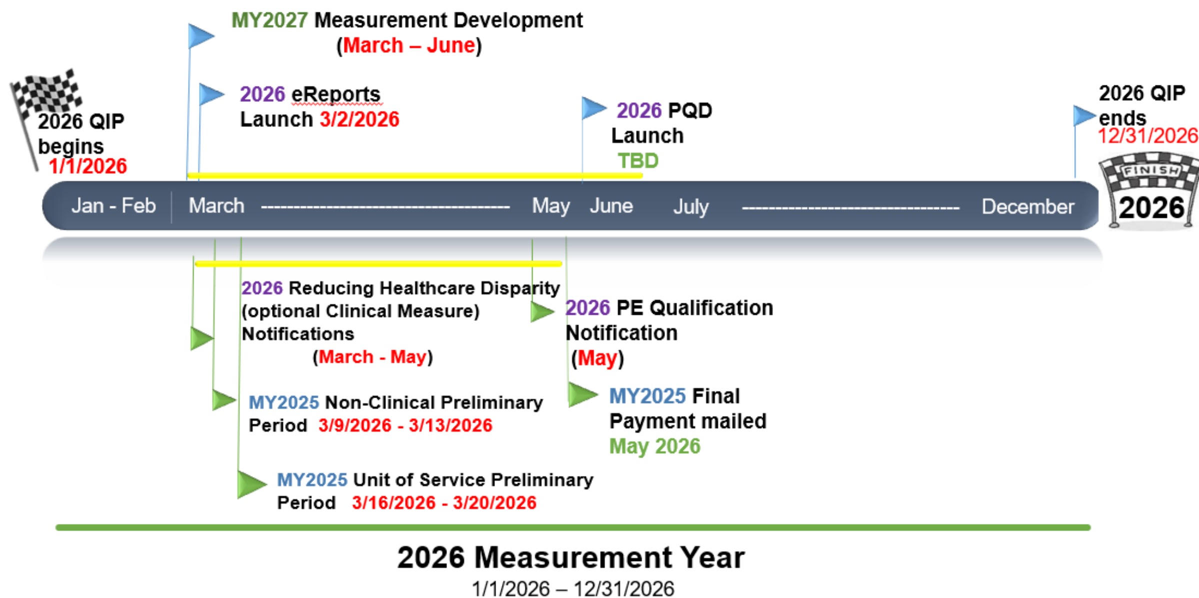
Partnership's Primary Care Provider Quality Incentive Program (PCP QIP) has been in place for more than 26 years, and has evolved over that time period. Designed in collaboration with our PCP provider network, the goal is to align Partnership and our Primary Care Providers on Quality Goals, and to transfer substantial resources to PCPs that they can leverage to improve quality.

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

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

The abridged specifications for the 2026 PCP QIP measurement year can be found here. The detailed specifications are housed in eReports. You can also request the detailed version from the PCP QIP team who will send the document via Secure email.

2026 PCP QIP Measurement Year Timeline Activities



PCP QIP Measure Sets

PCP QIP Measurement Year 2026 Changes and Updates

Clinical Domain:

- **Change** –
  - **Breast Cancer Screening (40-74yo) –** Combined measures based on age ranges 40-51yo and 52-74yo into one measure for the population of 40-74yo.
  - **Chlamydia Screening (16-24yo)** – Became an active measure for Family and Internal Medicine.
- **New** –
  - **Kidney Evaluation in Patients with Diabetes** (Family and Internal Medicine only) **-** The purpose of this new clinical measure is to incentivize providers to complete a kidney health evaluation for 18-85yo members who have diabetes, during the measurement year.

Non-Clinical Domain – No measure set changes

Unit of Service

- **Retired** –
  - **Early Administration of the 1st HPV dose**
  - **Early Administration of the Initial Flu Vaccine Series**

Targets

- **Changes:**
  - **Breast Cancer Screening** (Family and Internal Medicine) - Treating as new measure. See criteria below.
  - **Colorectal Cancer Screening and Diabetes Management: HbA1c Good Control** (Family and Internal Medicine) - Thresholds increased to the 75th percentile for partial points and the 90th percentile for full points
  - **Chlamydia Screening and Well-Child Visits in the First 15-30months of Life** (Pediatrics **only**) - Thresholds increased to the 75th percentile for partial points and the 90th percentile for full points
  - **New Clinical measures** - targets for full points are set at the 50th percentile and no partial points available.
  - **Patient Experience** (Non-Clinical Measure, **applicable to all practice types who qualify for 2026 CG CAHPS**) – Being held to meeting both access and communications targets in order to earn points

Pharmacist Visits to PCP sites

A Unit-of-Service Measure

Most clinicians believe that they are diligently applying best practices when they manage the medications or their patients. As clinical leaders, you know that the only way to see if this is true or not is to look at **comparative data:** how do the prescribing patterns of your clinicians compare, in areas where there is consensus on standard of care?

Generating such comparative data is somewhat complex and nuanced. Fortunately, the Partnership Pharmacy department has decades of experience with sorting through a high volume of prescription data and distilling this down to a few core important measures, at the individual prescriber level! When we meet with your team to review this data, we call this **Clinical Education on Improving Medication Management** (in contrast to the sales-oriented detailing performed by representatives of pharmaceutical companies).

The objective of Clinical Education on Improving Medication Management is to analyze Medi-Cal Rx prescription claims data to identify data-driven actionable

opportunities for performance improvement of quality measures impacted by medication management. This is done by Sharing Medi-Cal Rx prescription drug data with our clinical leaders and quality improvement leaders of primary care organizations.

Measures covered at Pharmacist Visits

- Asthma: appropriate use of controller medications
- Diabetes and Cardiovascular Disease: appropriate use of statins
- Controlling High Blood Pressure
- Blood sugar control for patients with diabetes
- Opioid disorder – if interested

The data we provide at Clinical Education on Improving Medication Management includes: Rates of adherence to national guidelines at the individual prescriber level as well as at your clinic site/organization level. In some cases we can share gap lists of members who should be evaluated for eligibility for certain therapy based on diagnosis data we have for patients with appropriate prescriptions provided by the PCP but who are not filling the medications regularly. We have compliance reports we will share.

We know that you and your clinicians are busy, so **we are offering a bonus payment** through the PCP QIP for organizations that invite us to do this analysis and meet twice with your clinicians or clinical leaders. Reach out to the pharmacy team to schedule your initial visit soon!

Email our director of pharmacy to let us know your availability!
Sleung@partnershiphp.org

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

Timeline for Addressing 2026 and 2027 PCP QIP Measures

2026				2027
Quarter 1 January – March	Quarter 2 April – June	Quarter 3 July - September	Quarter 4 October – December	Quarter 1 January – March

Year-round: On-call system to reduce emergency visits, hospital follow-ups to prevent readmissions, and control of congestive heart failure and chronic obstructive pulmonary disease to reduce admissions.

Annual Measures (Quarter 1 – Quarter 2)

- **Childhood Immunization Status** (0-2 years)
- **Well-Child Visits** (0-30 months)
- **Lead Screening in Children** (0-2 years)
- **Controlling High Blood Pressure** (18-85 years)
- **Diabetes Management: HbA1C good control** (18-75 years)
- **Child** (3-11 years) **and Adolescent** (12-17 years) **Well Care Visits**
- **Chlamydia Screening** (16-24 years)
- New: **Kidney Evaluation for Patient with Diabetes** (18-85 years)
- **Reducing Healthcare Disparity**
  Improve performance in a specific group in one of the following measures, in order of priority:
  - **Child and Adolescent Well Care Visits**
  - **Breast Cancer Screening**
  - **Controlling High BP**
  - **Colorectal Cancer Screening**

Multi-Year Measures (Quarter 3)

- **Breast Cancer Screening** (40-75 years)
- **Cervical Cancer Screening** (21-64 years)
- **Colorectal Cancer Screening** (45-75 years)
- **Adolescent Immunization** (10-12 years)
- **Diabetes Management: Retinal Eye Exams** (18-75 years)

Early Measures (Quarter 4)

- ***Well-Child Visits** (0-30 months)
- ***Lead Screening in Children** (0-2 years)

*Schedule visits with January – March birthdays, in Q4

- **Childhood Immunization Status** (0-2 years)
- **Adolescent Immunization** (13 years)

Annual measure gaps are closed using eReports uploads before CE and RI are applied in January.

- Controlling High Blood Pressure
- Diabetes Management: HbA1C good control
- Kidney Evaluation for Patients with Diabetes

Grace Period: January 11-29 (2027 Quarter 1)

- Review eReports data after CE and RI applied.
- Upload missing data in eReports for prior measurement year.

Revised 11/24/2025

Scheduling Well-Child Visits: Taking Demand for Acute Visits into Account

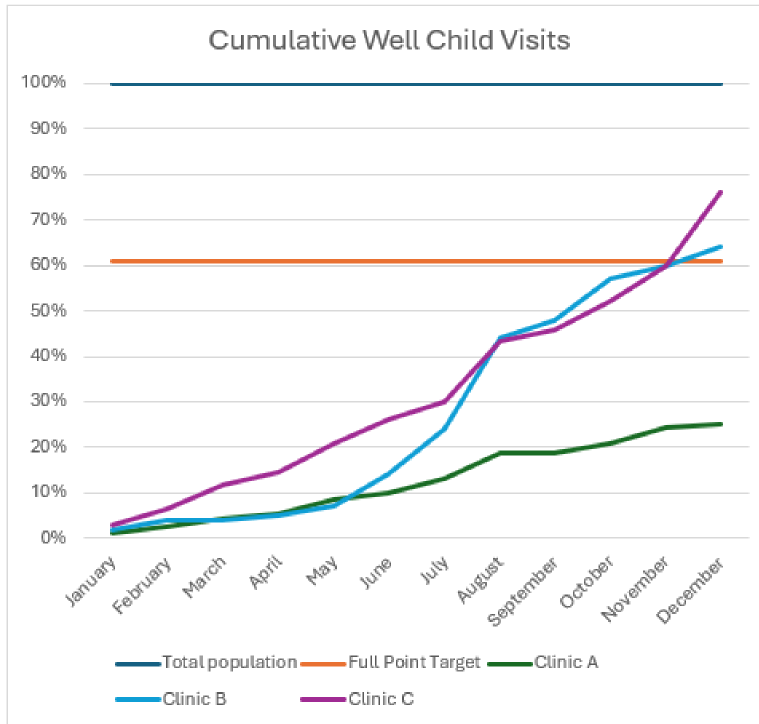
Many clinical quality measures lend themselves to year-end “sprints” where staff call up patients to encourage them to complete mammograms, cervical cancer screening, blood pressure checks, blood tests, etc. - typically from early October through December 31.

Theoretically, well-child visits could also be the focus of a year-end “sprint,” but this rarely works, for several reasons:

1. Toward the end of the year, holiday plans mean families would rather wait until the following year to schedule the visit.
2. Clinicians also take needed time off for the holidays, leaving the covering team understaffed while caring for acute problems with reduced capacity to deliver preventive care.
3. By November and December, respiratory infections start increasing sharply, constraining the number of available appointments for well-child visits.
4. So few well-child visits are completed within the first nine months of the year, that it causes many children to be overdue at the end of the year without enough time in the remaining schedules for them all to be seen.

The last scenario is common for Quality Improvement teams at Primary Care Provider (PCP) offices visited by Partnership’s Performance Improvement team. Several practices feel a sense of hopelessness towards the idea of catching up before the new year begins. (See Clinic A below)

Real data from three sites in 2024 shows this pattern of visits for Clinics A, B, and C, shown below:



Clinic A averaged just 2.1% of their total population with a well-child visit each month, steadily maintaining that rate throughout the year with no discernable effort to catch up. Their scheduling of well-child visits was rigidly inadequate with possibility for flexing the schedule to catch up. When they analyzed their gap in *September*, they were so far from target that they had no hope of catching up, so they did not try.

Clinic B had a slow and steady rate from January through May, with a concerted effort to increase visits in June through August. From September through December, the rate continued to rise steadily, achieving the goal in December.

Clinic C averaged 3.4% of their total population through July. At that continued rate, they would never have reached their target. However, they began a big push for August through December, with an average of 9% for the last five months of the year, ultimately beating the target by 15%.

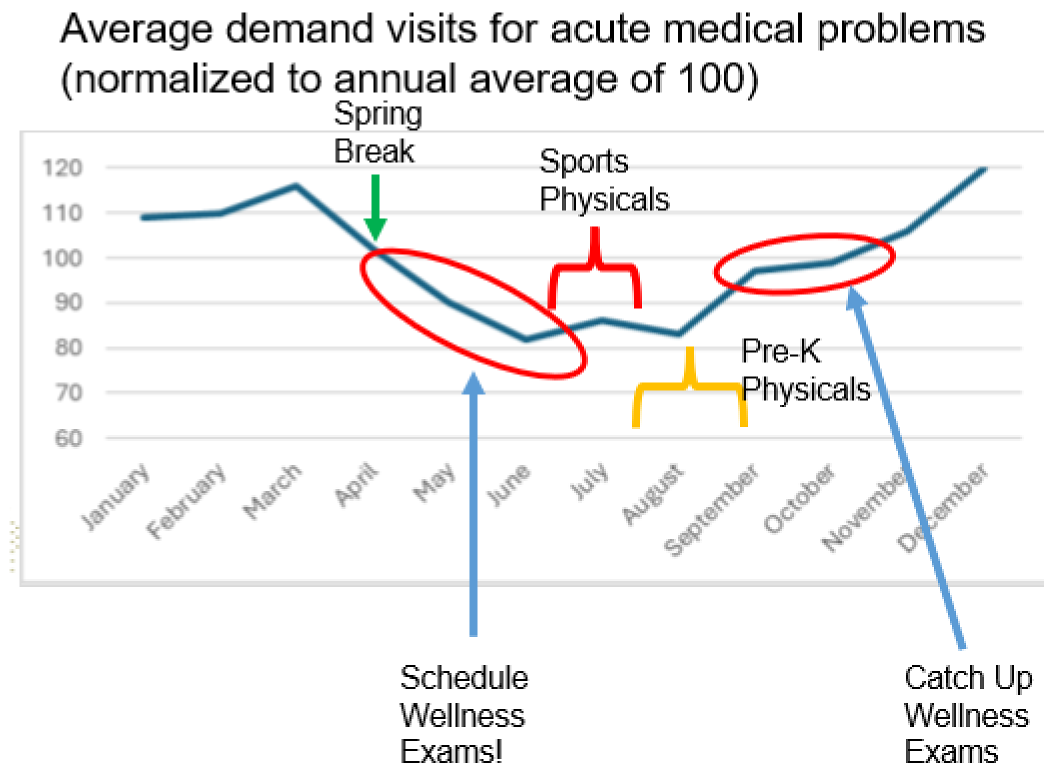
A practice that was determined to achieve the target, but to have a completely steady number of well-child visits per month, would have to see 5.1% of their pediatric patients aged 3-17 every month to achieve the goal of 61% by the end of the year. I could not identify any primary care office in Partnership's 24 counties that had 5% per month or more of their pediatric patients with a well-child visit in the first few months of the year.

While Clinics B and C reached the target, they expended significant effort to

catch up in the second half of the year, starting in June and August, respectively. This corresponds to the summer break from school, when scheduling well-child visits is a bit easier. However, in both cases, significant effort continued from September through December to achieve the full point target.

How does this scheduling pattern compare to the demand for visits for acute illnesses?

In their article measuring the demand for same day visits for acute problems in 2001, Forjuob et al (2001) describe that such visits varied significantly by month of the year:



In this normalized data, same day appointment demand ranges from a low of 80 to a high of 120 visits per day. Starting in late April, you may see a reprieve from the scheduling pressures due to seasonal upper respiratory infections.

The lowest demand for visits for acute problems is between May and August. November through March has the highest demand for such visits, corresponding to the typical pattern of seasonal respiratory illness.
Not shown in this graph is the variation by day of the week, with Monday having an average annual demand of 123 and Wednesday having an average annual demand of 91.

In developing a weekly schedule, fewer well-child visits should be scheduled on Monday. You can access an Excel spreadsheet with the daily data here.
Why don't well-child visits start rising in April, as the respiratory infection season starts easing? This would seem to be a logical time to start increasing well-child visits, instead of waiting until the busiest month of the year (December) to heroically reach the target.

The answer is *recency bias*, in which our minds give greater importance to the most recent event. In March, when we are opening our schedules for the next few months, we are in the fourth month of very busy schedules, working late every day. It seems like it will keep going like this forever. We forget we are on a predictable downslope in demand and don't start ramping up our summer schedule for appointments until we notice fewer people are calling in for same-day appointments; same-day appointments are not always full. We then adjust our schedules to accommodate more well-child visits, keeping this schedule into November or December to achieve our preventive-health-visit targets, even as the schedule starts getting busy again.

Planning ahead for the predictable decrease in demand for acute/same-day visits *starting in late April*, and then steadily increasing the number of well-child visit appointments from April through June, will help spread out the workload. This can make a big dent in the number of well-child visits needed, so an end-of-the-year sprint has a better chance of succeeding.

Planning your schedule for well-child visits at the beginning of the year, taking into account demand for same-day visits as well as staff time off, can set your office up for success in reaching the target! From late April through June, consider a mid-year sprint effort focused on scheduling well child visits before summer vacation schedules begin to limit appointment access.

Online Tools for Quality Measurement and Reporting

Partnership offers two primary online tools for monitoring quality performance at your sites: eReports and the Partnership Quality Dashboard (PQD).

High priorities for immediate attention:

1. Children turning 2 years old in January through May: looking for opportunities to get their vaccines caught up, especially to offer the primary series of two flu vaccines.
2. Adolescents turning 13 years old in January through May: looking for opportunities to get their vaccines caught up, especially the second HPV vaccine.
3. Infants turning 15 months old in January through May, to ensure they are being scheduled for regular well child exams, catching up with some shorter time intervals if needed to reach 6 visits by 15 months.

4. Children turning 30 months old in January through May, to ensure they are being scheduled for regular well child exams, catching up with a shorter time interval, if behind, to reach 2 visits between 15 and 30 months.

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 in two ways: through Provider Online Services, which has a link at the top of the main Partnership webpage or by webpage link emailed by the PCP QIP team. Provider Online Services is a password protected part of the Partnership webpage, allowing access to patient-specific information related to billing and quality.

Generally, one person at each PCP site (often someone from the billing or IT department) is the administrator for Partnership's Provider Online Services, and this administrator manages access and assignment of passwords for other staff at their organization. If you have questions about access to Partnership's Provider Online Services, contact your assigned Provider Relations Representative to help.

Access to eReports requires a unique, secret key assigned to each organization. Generally, one person at each organization acts as the eAdmin for all PCP sites dependent on the size of the organization. The function of the eAdmin allows the organization to add new users and enable/disable user accounts to their organization's eReports platform.

The launch date of eReports typically falls within the first quarter of the measurement year to ensure availability of data throughout the year. eReports launched on March 2, 2026. PCP sites have access to eReports for the reporting measurement year from the launch date through the end of the grace period. The grace period is defined as the period between the close of the measurement year and the close of eReports, i.e. January 9th – 31st following the measurement year, and is intended to allow for final data collection and uploads.

With each new measurement year the PCP QIP hosts an eReports Kick Off Webinar. For the launch of the 2026 eReports, a Kick Off Webinar was held on February 26, 2026. You can find the PowerPoint presentation and link to the recorded webinar here on the PCP QIP Partnership webpage.

CLINICAL MEASUREMENT SET:

Measure	Upload Period
Cervical Cancer Screening	MAR 02, 2026 - JAN 29, 2027
Childhood Immunization Status - Combo 10	MAR 02, 2026 - JAN 29, 2027
Comprehensive Diabetes Care - Retinal Eye Exams	MAR 02, 2026 - JAN 29, 2027
Colorectal Cancer Screening	MAR 02, 2026 - JAN 29, 2027
Lead Screening in Children	MAR 02, 2026 - JAN 29, 2027
Immunizations for Adolescents - Combination 2	MAR 02, 2026 - JAN 29, 2027
Comprehensive Diabetes Care - HbA1c Control (A1c)	OCT 01, 2026 - JAN 29, 2027
Controlling High Blood Pressure	OCT 01, 2026 - JAN 29, 2027
Well-Child Visits in the First 15 Months of Life	OCT 01, 2026 - JAN 29, 2027
Well-Child Visits in the First 15-30 Months of Life	OCT 01, 2026 - JAN 29, 2027
Breast Cancer Screening	JAN 11, 2027 - JAN 29, 2027
Child and Adolescent Well Care Visits	JAN 11, 2027 - JAN 29, 2027
Chlamydia Screening	JAN 11, 2027 - JAN 29, 2027
Kidney Health Evaluation in Patients with Diabetes NEW	JAN 11, 2027 - JAN 29, 2027

Note: ***No uploads will be accepted for Topical Fluoride in Children***

Partnership Quality Dashboard (PQD)

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

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

Important note about the launch of 2026 PQD and go-live activities for Partnership's new claims system, Health Rules Payor (HRP). PQD is planned to launch in May 2026; however, with the go-live of HRP taking place in summer, 2026 PQD may be taken down for a few weeks to complete this transition. During that time, you will still be able to track your Clinical measure performance in eReports. Please keep in mind eReports will also be down for a short amount of time for cut-over activities but these cut-overs activities should not occur at the same time to minimize disruption. The PCP QIP team will be communicating timelines around HRP go-live activities as we get closer to launch.

Payment Methodology for Core Measure Set

How much payment can you expect from the PCP QIP?

Partnership's PCP QIP program is one of the most generous pay for performance or pay for value programs in California.

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

The following 4 steps are used for calculating the payment for the core measure set:

1. The dollars put into the QIP pool depends first on the monthly assigned members for each PCP site. This $4 per assigned member per month (or $4 PMPM) is put into the pool for all primary care sites.
2. *Additional* dollars are put into the pool, as an "equity adjustment." The details of the components of the equity adjustment are listed in the next section. The range of additional funds are projected to range from $0 to $19.25 PMPM for 2025. Added to the $4 PMPM base rate, the range of projected payouts is estimated to range from $4 to $23.25 PMPM.
3. At the end of the year, a score is calculated on the Core Measure set, from 0% to 100%, based on the performance of each measure. In 2024, the weighted average score was 59%, with the range from 0% to 100% per site.
4. The total dollars in the pool (1 and 2 above) are multiplied by the quality performance on the Core Measure set, giving the amount that each site is paid. This payment will be sent out during the month of May, in the year after the close of the measurement year.

Equity Adjustment of the Core Measure Set

Components of the additional dollars in the Equity Adjustment:

- Gateway
  - Must have at least 100 assigned members as of December 1, 2025
- Core adjustments
  - Acuity of patient panel
  - Socio-demographic risk, at patient level, rolled up to PCP site level
  - Site difficulty in recruiting PCP physicians
  - Lower than average baseline per visit resources available to PCP
- Disaster Adjustment
  - Site closed and unusable due to external factor, such as fire, earthquake, flood, etc. for at least five consecutive days in the year
- Pediatric Access Adjustment
  - Additional resources for providers struggling to provide pediatric access

Here is the weighting of the four core adjustments:

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

Factors under the control of the practice

Factors more intrinsic to the practice setting/population served

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

Factor	Description	Level of adjustment	Adjustment Method	Zero Adjustment	Max Adjustment	Data Source
1a	Acuity: Number of diagnoses	PCP Site	Continuous	<2.5 diagnoses/ encounter	>4 diagnoses/ encounter	Partnership Claims Data; Denominator=claims from PCP site
1b	Acuity: Non Utilizer rate	PCP site	Continuous	>20%	<10%	Partnership Claims Data; Denominator=assigned patients with some utilization in past 2 years
2	Sociodemographic Factors	Rolled up member risk to PCP site	Continuous	>0.8	< -0.4	Address of each Resident (homeless patients assigned to Partnership location for address)
3a	Physician Shortage area- Frontier Location	Location of PCP Site (Frontier)	full credit for frontier level 2 (all or nothing)	Non-frontier	Frontier Level 2	USDA
3b	Physician Shortage area PCP density in county	County of PCP site (PCPs/1000 residents	Continuous	Greater than 1.05 PCPs/1000 residents	0.4 or less PCPs/1000 residents	County Health Rankings (Updated data source)
4	Structurally unfavorable per visit reimbursement	Site level	Continuous	> $230	< $160	DHCS, Partnership contracts

Hint: Focus on improving Acuity Adjustment

Partnership recommends you immediately use your EMR to measure your

baseline number of diagnosis codes per encounter, and work to improve this number through provider training and system changes.

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

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

Consequences of Poor Performance on the PCP QIP

PCP Parent Organizations who score less than 25% on the PCP QIP Core Measure Set may be subject to additional requirements, collectively called Enhanced Provider Engagement. The main components of this are:

1. Submit a formal plan for performance improvement focusing on four low performing clinical measures in the PCP QIP. This plan needs acknowledgement of support by health center medical and administrative leadership.
2. Mandatory regular meetings, at least monthly, with a Performance Improvement coach from Partnership.
3. Practices that do not engage in the above activities may not be invited to participate in the following year’s Quality Incentive Program.

Training Resources for Quality and Performance Improvement

Pediatric Well Visits: Required Training

Department of Health Care Services (DHCS) required all managed care plans to ensure network providers complete Early and Periodic Screening, Diagnostic and Treatment (EPSDT) specific training no less than every two years. In order to stay compliant with DHCS requirements, Partnership HealthPlan of California is requesting all contracted/credentialed providers that provide services to members under the age of 21 to complete the DHCS Medi-Cal for Kids and Teens training. This training is available through the LMS training platform, Rival. For questions, please contact the Provider Network Education and Training team at PartnershipProviderEducation@partnershiphp.org .

Resources:

APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf

DHCS training materials: https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Documents/EPSDT-Provider-Training-BD-June-2024.pdf

Partnership instructions to access Rival Training: https://www.partnershiphp.org/Providers/Medi-Cal/Documents/OnDemandTrainingWebinars/Flyers_and_Bulletins/Partnership%20Provider%20Training%20LMS%20Platform_%20update%202026_COMSFinal.pdf

Improvement Academy Trainings

Looking for more educational opportunities? The Quality and Performance Improvement department has many pre-recorded,on-demand courses and live trainings available to you.

Trainings include:

- **ABCs of Quality Improvement:** An introduction to the basic principles of quality improvement.
- **Advanced Access Webinar Series** for Primary Care Providers.
- **The Role of Leadership in Quality Improvement Effort:** Leaders from top performing organizations share how they were able to build a culture of quality.
- **Improving Measure Outcomes Webinar Series:** An overview of clinical measures including improvement strategies and tools.
- **Micro-learnings:** short form educational videos on important topics like eReports and preventative care reports, running morning huddles, etc.

- Incorporating Patient Experience in Quality Improvement Projects and Plans.
- **QI Project Training Program**: A six-session virtual training series that provides participants with the tools, best practices, and structured approach needed to successfully manage QI projects from initiation to closure. The series helps participants apply concepts in real time and develop the skills required to plan, launch, implement, measure, and sustain impactful QI initiatives.

You can find these courses, and more, on our Improvement Academy Webpage.

A Quick Guide to Starting Your Quality Improvement Projects

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

You can find the guide on the Partnership's Partnership Improvement Academy webpage, under ABCs of QI Toolkit. Measure Best Practices Documents

Each year Partnership updates and publishes measure best practices documents that cover the important details in each of the PCP QIP. Topics include Partnership tools available, supporting programs, outreach strategies, clinical process tips, and equity strategies. The documents were just updated for 2026 and now include the Follow-Up After ED Visits for Substance Use and Mental Health measures. While not incentivized measures, they are part of the state Managed Care Accountability Set.

Improving the Patient Experience through Communication Workshops

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

Consider a communication training workshop!

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

1. Trauma informed de-escalation
2. Motivational interviewing Part 1 and Part 2
3. Helping people with Addictive Disorders
4. Building Trust

5. Enhancing Trust
6. Empathic Communication at Home and at Work
7. Telehealth: best practices for communication
8. Custom Communication Workshops

For more information email: contact@emorrisonconsulting.com

Cologuard Care Gap Orders

To improve access to colorectal screenings, Partnership continues to collaborate with Exact Sciences, the maker of Cologuard (FIT-DNA test). This collaboration expands access to colorectal cancer screenings by offering care-gap options for sites that have eligible members as identified by their primary care provider (PCP). When placing a care-gap order, each eligible patient is enrolled in Exact Sciences' Patient Navigation Program which provides outreach and follow-up at no cost to the PCP.

Enrollment in a “Program" and/or pre-approval from Partnership is not required since all providers are eligible to participate in this offering. If your organization is interested in participating, you can email Exact Sciences at phc@exactsciences.com to initiate your order! Together, we can help make colorectal cancer screenings more accessible to our members, which can aid in early detection and save lives.

More information, including how to place Care-Gap orders, visit our Cologuard Bulk Orders webpage.

Upcoming trainings

ABCs of Quality Improvement Training

Date: May 14, 2026
Time: 8 a.m. to 4 p.m.
Location: Auburn

Program Overview
This training is designed to introduce participants to key Quality Improvement (QI) methodologies, with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings.

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

Course topics include:

- Basic Principles of Quality Improvement
- Introduction to the Model for Improvement
- Creating an Aim Statement
- Using Data to Measure and Drive Improvement
- Developing Change Ideas
- Testing Changes with the Plan-Do-Study-Act Cycle

Registration: https://www.eventbrite.com/e/abcs-of-quality-improvement-qi-auburn-tickets-1975622403792?aff=oddtdtcreator

Suggested “To Do” List

Medical Directors/Clinic Directors

1. Work with your Executive Leadership and Consortia leadership to prepare strong proposals for the Rural Health Transformation Program.
2. Sign up your physicians with your local Medical Society. If possible, subsidize their membership.
3. Ask your Nurses, Nurse Practitioners, Physician Assistants, and Nurse Midwives to join their California trade organizations. If possible, subsidize their membership. Ask them to be active in promoting a rural perspective in these organizations.
4. Invite the Partnership Pharmacy team to visit with your clinicians. The pharmacists will use individual prescriber data to show individualized ways to improve care and outcomes through medication interventions based on best practices/standards of care.
5. Select a clinician to lead efforts to meet with local specialists to agree on referral criteria/workups needed/retro-RAF practices.
6. Prioritize Well Child Visits from April to July, to take advantage of the decrease in demand for acute visits during this time.
7. Check to be sure all your clinicians are enrolled in Medi-Cal FFS so their prescriptions will work after June 26, 2026.
8. If your GC-CAHPS scores are not universally high, consider an all provider training on improving communication skills.
9. Let your clinicians know about the preferred Hospice and Palliative Care programs serving your area.
10. Encourage your providers to prescribe GLP-1 medications for all patients covered by Medi-Cal Rx. Let them know about the options for liver fibrosis scanning in your region.
11. Distribute the abbreviated Clinician Version of these detailed notes to your front-line clinicians, once available on the Partnership website (end of March).

Quality Leaders

1. When the 2026 Partnership Quality Dashboard goes live in Q2, set up a meeting with your quality team to look at the disparity dashboard for your sites. Identify the largest inequities and start thinking about how can address these inequities. When the Partnership webinar on the disparity dashboard is announced, ensure a clinician with an interest in health equity and a QI leader attends to learn more.

2. Make sure you, your medical director and your CEO have access to Provider Online Services (username and password).

3. Convene a group within your organization to prioritize annual activities to assess your patients' experience and prioritize interventions to improve this.

4. Read the version of the PCP QIP specifications on the eReports website (the one "behind the firewall") **very carefully,** noting especially the timelines for various activities. Put calendar reminders for these deadlines on your calendar so you won't miss any (and cost your organization thousands of dollars).

5. Train and retrain your clinicians on better diagnosis coding practices!

6. Review Partnership's preventative care dashboards within eReports, continually, throughout the year to assure no one is being missed. Prioritize patients who need final visits and immunizations early in the next measurement year to avoid missing numerator hits. Also review dose-level immunization data to identify frequently missed immunizations.

7. Test your EMR's prescription transmission to community pharmacies, to be sure the ICD-10 code is being successfully transmitted.

8. If your rates of developmental screening are low, ask your EMR vendor to configure routine developmental screening into well child visits, and including the proper CPT code for this screening in the claim for the visit.

9. If you are at all unsure on how to move forward with your quality work, reach out to your Regional Director or Medical Director to request a regular meeting with your Regional Performance improvement team. We will meet with your leadership team or board if you feel it would be helpful in gaining alignment.

10. Sign up for the Cologuard Colon Cancer Screening program, if you haven't already!

11. Sign up for all of Partnership's Measure Score Improvement Webinars, to pick up new information and ideas to raise your health center's performance.