



Partnership

2026 Annual County

Data Report

Marin County

Executive Summary

Partnership HealthPlan of California services 24 counties to help our members and the communities we serve, be healthy. Partnership supports this mission by providing these Partnership 2026 Annual County Data Reports to county health departments and other stakeholders, with data which they can use to prioritize public health interventions and policies.

Members represented within this report are the most vulnerable population within the communities we serve, those who are most likely to have poor health outcomes and need more resources for intervention planning.

As an adjunct, to support efforts to reduce health disparities, Partnership is launching its first American Indian/Alaskan Native (AIAN) data report in collaboration with the California Rural Indian Health Board (CRIHB) and California Tribal Epidemiology Center (CTEC) in 2026.

The data provided is a piece of the puzzle and should not be used in isolation. Rather, it can be combined with other data sources to make inferences about the healthcare status of our members in all 24 counties.

Additional sources of community data that can be used with this report include:

- Partnership's Community Needs Assessment (CNA)
- Community Health Assessments (CHA) produced by each county
- Community Health Improvement Plans (CHIP) produced by each county
- Partnership Health Plans Population Needs Assessment (PNA)
- US Census
- County Health Rankings & Roadmaps
- California Healthy Places Index
- California Department of Public Health
- California Health Interview Survey (CHIS)

Partnership data report should be analyzed in conjunction with these other data sources to get the most holistic understanding of each county.

This report presents data for key measures and indicators over several years, 2021-2025 (as data permits), to aid with comparison and to easily identify differences across people, area, and time:

- Demographics
- Special Populations
 - Child Welfare
 - Obstetric/maternal demographics and conditions
- Chronic Conditions
- Access to Dental Services
- Substance Use Disorder (SUD)
- Utilization of Services
- Health Disparities
- Supplementary Data

Suggestions for changes to future additions should be submitted through the County Health Officer of each county.

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About Partnership HealthPlan of California

- Partnership HealthPlan of California is a nonprofit community-based organization. Partnership contracts with the state of California to administer Medi-Cal (Medicaid) benefits through local community care providers.
- In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba.
- As of December 2025, Partnership had about 894,000 members in 24 counties located in the North of California: Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, and Yuba.
- Partnership is a County Organized Health System (COHS), a Commission of the State of California. Partnership's Board of Commissioners are selected by the County Board of Supervisors of the 24 counties we serve, along with three consumer representatives.
- Within our service area, Partnership contracts with 48 Acute Care Hospitals, 370 Primary Care sites in 126 organizations including Tribal Health Centers, 117 Long Term Care/Skilled Nursing facilities, and over 24,000 specialists in care centers (including tertiary care centers).

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Introduction

Overview

Partnership operated in 14 counties from 2013 to 2023. In 2024, it expanded to 10 new counties for a total of 24. Where relevant, historical data for the original 14 counties is typically presented from 2021-25. For the 10 expansion counties, only 2024-25 data is available.

Partnership divides 24 counties into six regions, based on the location of its six offices:

Auburn Region:

- Nevada County*
- Placer County*
- Plumas County*
- Sierra County*

Chico Region:

- Butte County*
- Colusa County*
- Glenn County*
- Sutter County*
- Yuba County*

Eureka Region:

- Del Norte County
- Humboldt County
- Lake County
- Mendocino County

Fairfield Region:

- Napa County
- Solano County
- Yolo County

Redding Region:

- Lassen County
- Modoc County
- Shasta County
- Siskiyou County
- Tehama County*
- Trinity County

Santa Rosa Region:

- Marin County
- Sonoma County

** Indicates 2024 expansion counties*

Introduction

Partnership's Regional Structure



Eureka Office Region

Del Norte, Humboldt, Lake, and Mendocino counties.



Vicky Klakken, Regional Director
vklaakken@partnershiphp.org



Chico Office Region

Butte, Colusa, Glenn, Sutter, and Yuba counties.



Rebecca Stark, Regional Director
rstark@partnershiphp.org



Santa Rosa Office Region

Marin and Sonoma counties.



Leigha Andrews, Regional Director
landrews@partnershiphp.org



Redding Office Region

Lassen, Modoc, Shasta, Siskiyou, Tehama, and Trinity counties.



Jayme Bottke, Regional Director
jbottke@partnershiphp.org



Auburn Office Region

Nevada, Placer, Plumas, and Sierra counties.



Jill Blake, Regional Director
jblake@partnershiphp.org



Fairfield Office Region

Napa, Solano, and Yolo counties.



Kathryn Power,
Director of Regional Operations
kpowers@partnershiphp.org



Last updated on June 2026

Introduction

Marin County Overview

Marin County joined Partnership HealthPlan in 2011 and is in Partnership's Santa Rosa office region. With a total of 46,025 members, 5.1% of all Partnership members reside in Marin as of December 31, 2025.

Partnership members in Marin County are assigned to about 14 primary care provider (PCP) groups in Marin. As of December 31, 2025, all 14 Marin provider sites are open for member assignments and 81.6% of Partnership members in Marin have Medi-Cal as a primary form of insurance (Medi-Cal Prime). There are five community hospitals and one Kaiser Hospital in Marin County (Source: www.californiacountyoffices.com).

Marin has the third highest population of Hispanic race and ethnicity among Partnership's total members at 3.2% (28,1930 Hispanic members). Hispanic race and ethnicity are 62.8% of Marin Partnership members, while White race is 21.5%. However, 41.7% of Marin members selected English as a preferred language, while 55.0% selected Spanish.

Marin has a high rate of uncategorized Partnership members by county, which includes mixed race category. A total of 9% of member race/ethnicity in Marin are uncategorized as Other race at 3.3% and Unknown race at 5.7%. Marin's age and sex demographics are similar to regional and plan wide.

Special populations

Partnership special populations include pregnant women, child welfare, and homeless or those experiencing housing insecurity.

The population of homeless Partnership members or those experiencing housing insecurity in Marin has remained stable but high over the years ranging from 5.9% to 6.7%. Currently, homeless members are at 6.7% (3,669 members).

Adverse Childhood Experiences (ACEs) screenings help detect and prevent adverse health outcomes among children in Marin, including special population children among Marin Partnership members. Marin's ACEs screening rate has fluctuated over the years, with a high in 2022 and then going down to less than five screenings per month from 2023 to 2024. Marin's ACEs screenings have increased once again and as of December 31, 2025 there were 358 children screened.

Special populations include the Child Welfare population, about 0.5% of the total eligible Partnership member population in Marin in 2025. Child Welfare has most claims dedicated to primary care at 51.9%, well-child visits at 36.6%, and emergency department visits at 25.9%. Mental health services, both specialty and non-specialty, follow at 25.5% and 15.6% respectively. The highest number of CalAIM registered child welfare community support claims in 2025 is housing support.

Marin has one of the lower numbers of deliveries paid for by Partnership compared to other counties. Deliveries have increased from 302 in 2016 to 621 in 2025. Homeless mothers have decreased over the years from 7% in 2021 to 4% in 2025. Chronic diseases (both medical and mental) in pregnant and new mothers up to one year (maternal population) have increased from 13.6% to 35.7%. Mental chronic diseases remain high among the maternal population compared to other chronic medical diseases. Pregnant and postpartum members in Marin have a pattern of higher stimulant and alcohol substance use disorder (SUD) compared to Partnership members as a whole as a whole, which have a higher rate of pregnant patients with opioid use disorder.

Medical and Mental Services

Marin members have a 2.5 to 3.0 average office visit utilization per member per year, above the Partnership target of 2.2. Marin has about 29% of PCP visits conducted by video or telephone, reported as a telehealth visit. Emergency Department (ED) Visit rate is about 1 visit per 2 members per year.

In Adults in 2025, mental chronic conditions as a group had the highest number of claims per 1,000 members in Marin. Anxiety at 169 and Trauma/Stress at 116 were the highest per 1,000 members in 2025. Medical chronic conditions peaked with hypertension at 217 and Diabetes 109 per 1,000 members in Marin, while kidney disease is at 84 per 1,000 in 2025. Congestive Heart Failures were at 34 per 1,000 members, seen as one of the complications of coronary artery disease at 6 per 1,000 in 2025. In children, Asthma has a higher rate at 32 than adults at 18 per 1,000 members in 2025.

Marin had more alcohol SUD claims member count and paid claims per member per year per 1,000 Partnership Marin members, compared to all Partnership members in 2025.

Access to Medical and Dental Services

About 1% of Marin Partnership members utilized Non-Medical and Non-Emergency Medical Transportation (NMT/NEMT) in 2025. NMT/NEMT was calculated at a rate of 62 trips per 1000 members per month (PMPM) for Marin members (or .062 trips PMPM), with a total of 2,868 completed trips in 2025. For Marin, the average trip distance was 10.7 miles, less than half the Partnership average of 24.8 miles. About 35% of Marin transportation users were over 65 years of age, compared to 25.4% among all Partnership members.

Partnership member dental services are paid for by the state of California as Medi-Cal Dental and fee-for-service payments.

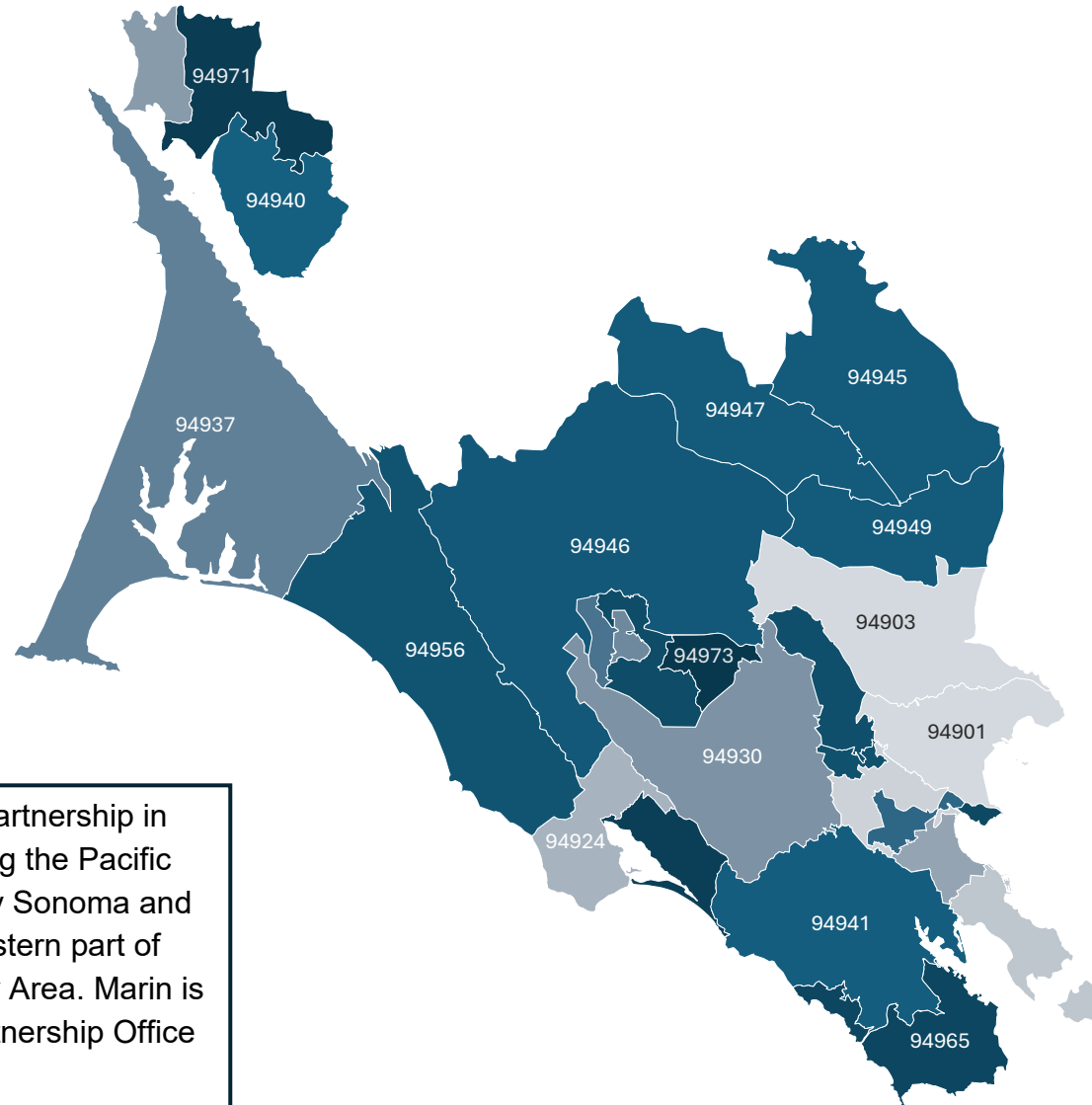
In 2025, Marin had 21 dentists and six 6 hygienists serving about 46,559 Partnership members, lower than the United States 2021 report of an average of 60.84 dentists per 100,000 residents.

In Marin, September 2025 had the highest number of dental services reported in claims: 17,559 services for 12,678 members. Prevention and Early Detection services were at 44.2% with 5,610 total members served (child and adults), Support and Other services were 38.5% with 4,877 members served, and Treatment and Intervention was 17.3% with 2,191 members served. Note, these are not mutually exclusive services even though they are in the same category and year.

Introduction

County Overview

Map of Marin County



Marin County joined Partnership in 2011. It is located along the Pacific Coast and bordered by Sonoma and located in the northwestern part of the San Francisco Bay Area. Marin is in the Santa Rosa Partnership Office Region.

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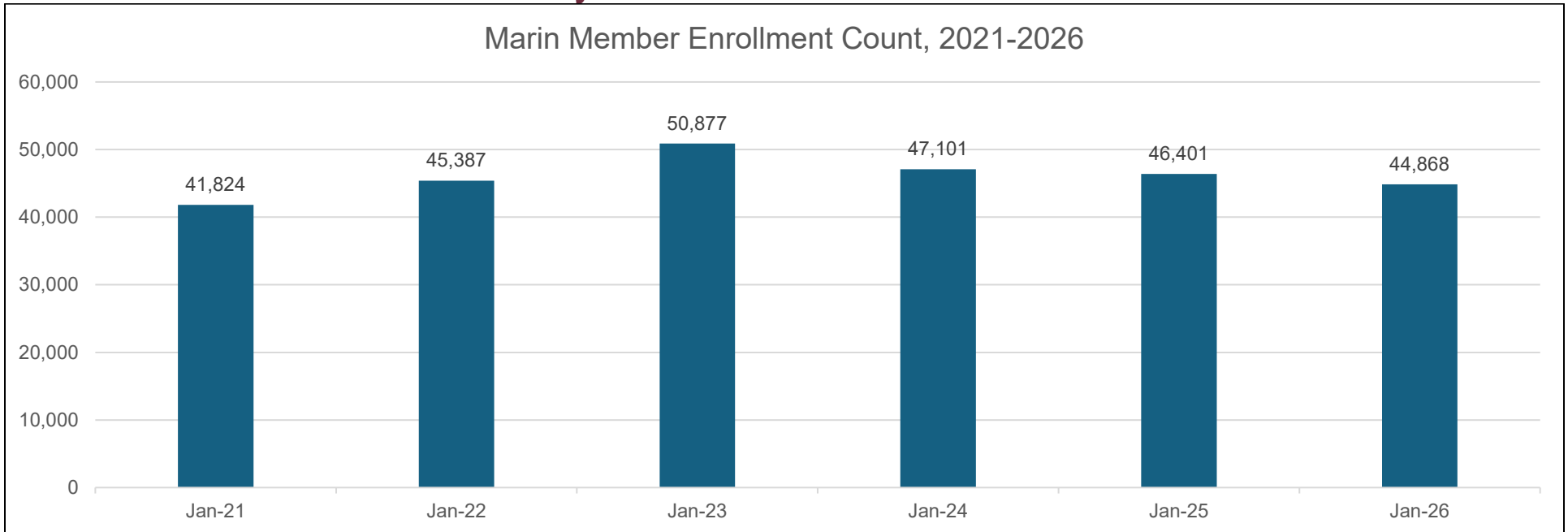
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For more information, see [Demographics](#) in the [Appendix](#)

Demographics

County Member Enrollment Trend



Highlights of County Member Enrollment Trend

Data shows point-in-time view of the number of Marin residents who are enrolled in Partnership over the past six years. Data is captured on January 1 of each year from 2021-2026.

Definition:

- Membership: [Partnership members](#) are California [Medicaid](#) members also called [Medi-Cal members](#) assigned to Partnership by various criteria and eligibility status determined by the United States (U.S.) [Centers for Medicare and Medicaid Services \(CMS\)](#) and the state of California [Department of Health Care Services \(DHCS\)](#).
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Partnership members are Medi-Cal enrolled members and could be Direct or Assigned members.
 - [Direct Members](#): Direct Partnership members are enrolled members who are allowed to select their Primary Care Providers (PCP) and or Specialty Providers, while Partnership pays in form of paid claims.

- o Assigned Members: Assigned Partnership members are enrolled members who are assigned to a PCP or Specialty Providers upon enrollment and are encouraged to visit these providers for their health and care. Assigned members may be assigned to a Physician, Physician-Group, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Indian Health Service Clinic (Federal) or Tribal FQHC.

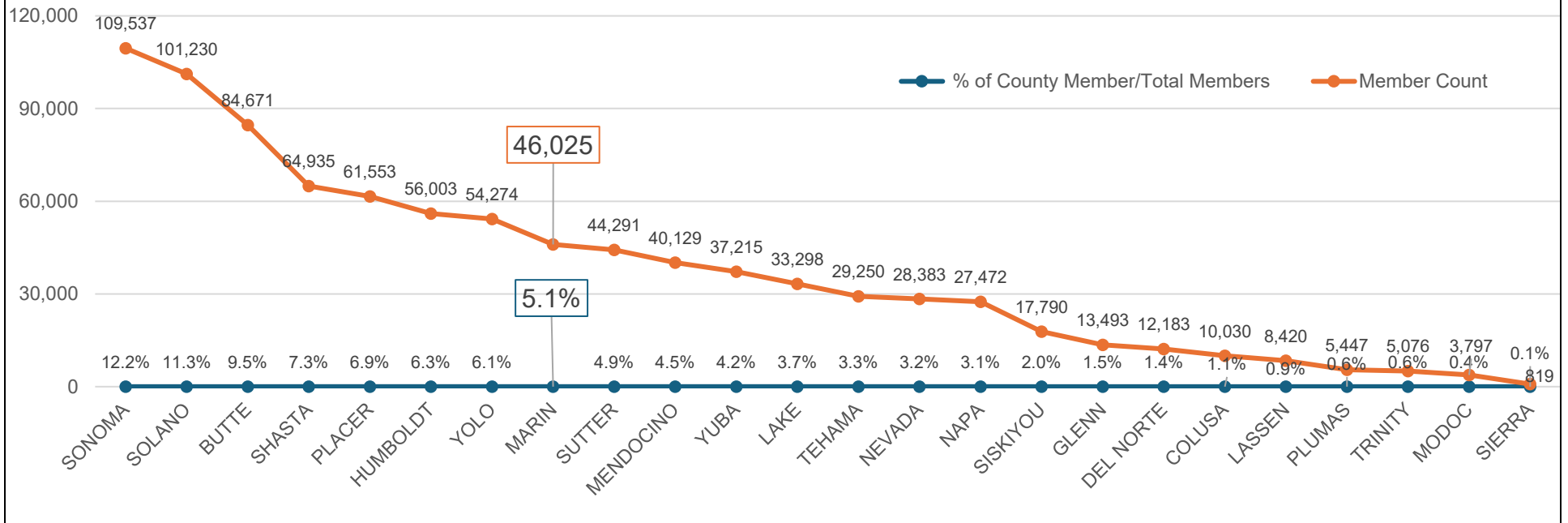
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment and Claims data

Demographics

Current County Enrollment

Membership by County,
Current County Enrollment, December 2025



Highlights of Current County Enrollment

Data shows point-in-time view of the number of Marin enrolled residents compared to other Partnership counties, captured on December 31, 2025.

Definition:

- Current Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Partnership members are Medi-Cal enrolled members and could be Direct or Assigned members.
- Calculated:
 - Percentage of County Members is the total number of enrolled individual county members divided by the total number of enrolled Partnership members from all counties multiplied by 100 (%)

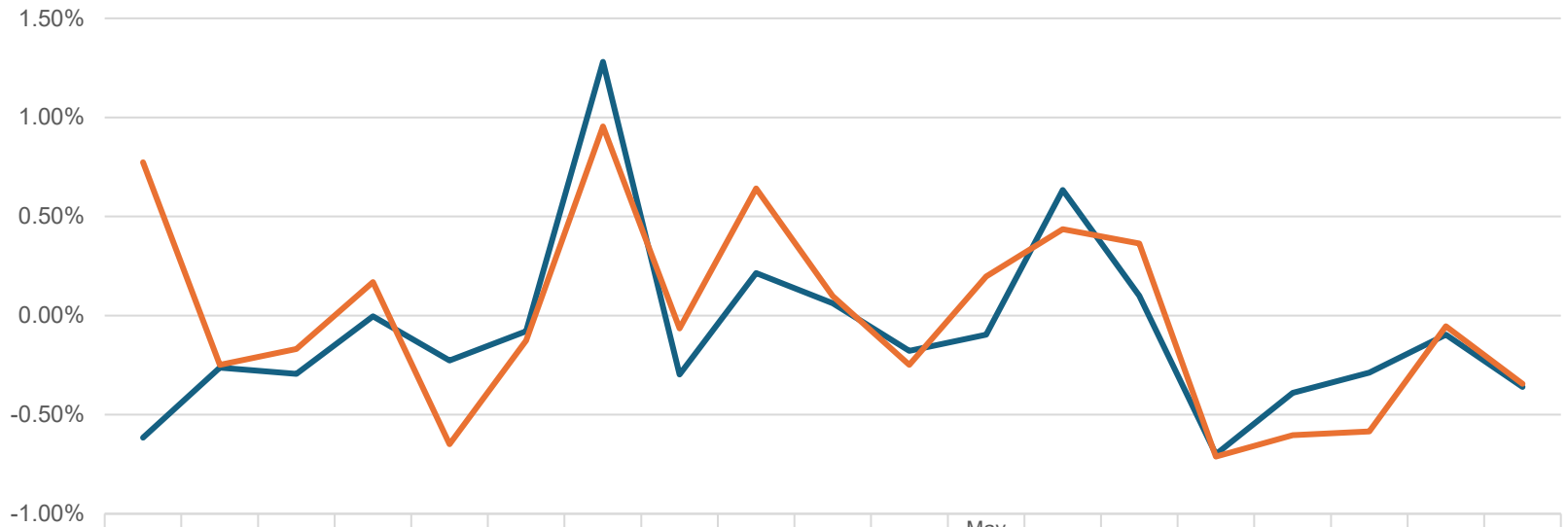
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members

Demographics

Membership Enrollment Fluctuation

Partnership Versus Marin Enrollment Percent of Net Difference,
June 2024 to December 2025



	Jun 24'	Jul 24'	Aug 24'	Sep 24'	Oct 24'	Nov 24'	Dec 24'	Jan 25'	Feb 25'	Mar 25'	Apr 25'	May 25'	Jun 25'	Jul 25'	Aug 25'	Sep 25'	Oct 25'	Nov 25'	Dec 25'
Partnership % Net Difference	-0.62%	-0.26%	-0.29%	0.00%	-0.23%	-0.08%	1.28%	-0.30%	0.21%	0.06%	-0.18%	-0.10%	0.63%	0.10%	-0.70%	-0.39%	-0.29%	-0.10%	-0.36%
Marin % Net Difference	0.77%	-0.25%	-0.17%	0.17%	-0.65%	-0.13%	0.95%	-0.06%	0.64%	0.10%	-0.25%	0.20%	0.44%	0.36%	-0.71%	-0.60%	-0.59%	-0.05%	-0.34%

Highlights of Membership Enrollment Fluctuation

Data shows fluctuations in “All Partnership” enrollment (blue) versus Marin residents enrolled as Partnership members (orange) from June 31, 2024, to December 31, 2025. Partnership and Marin enrollment fluctuations have relatively similar patterns.

Definition:

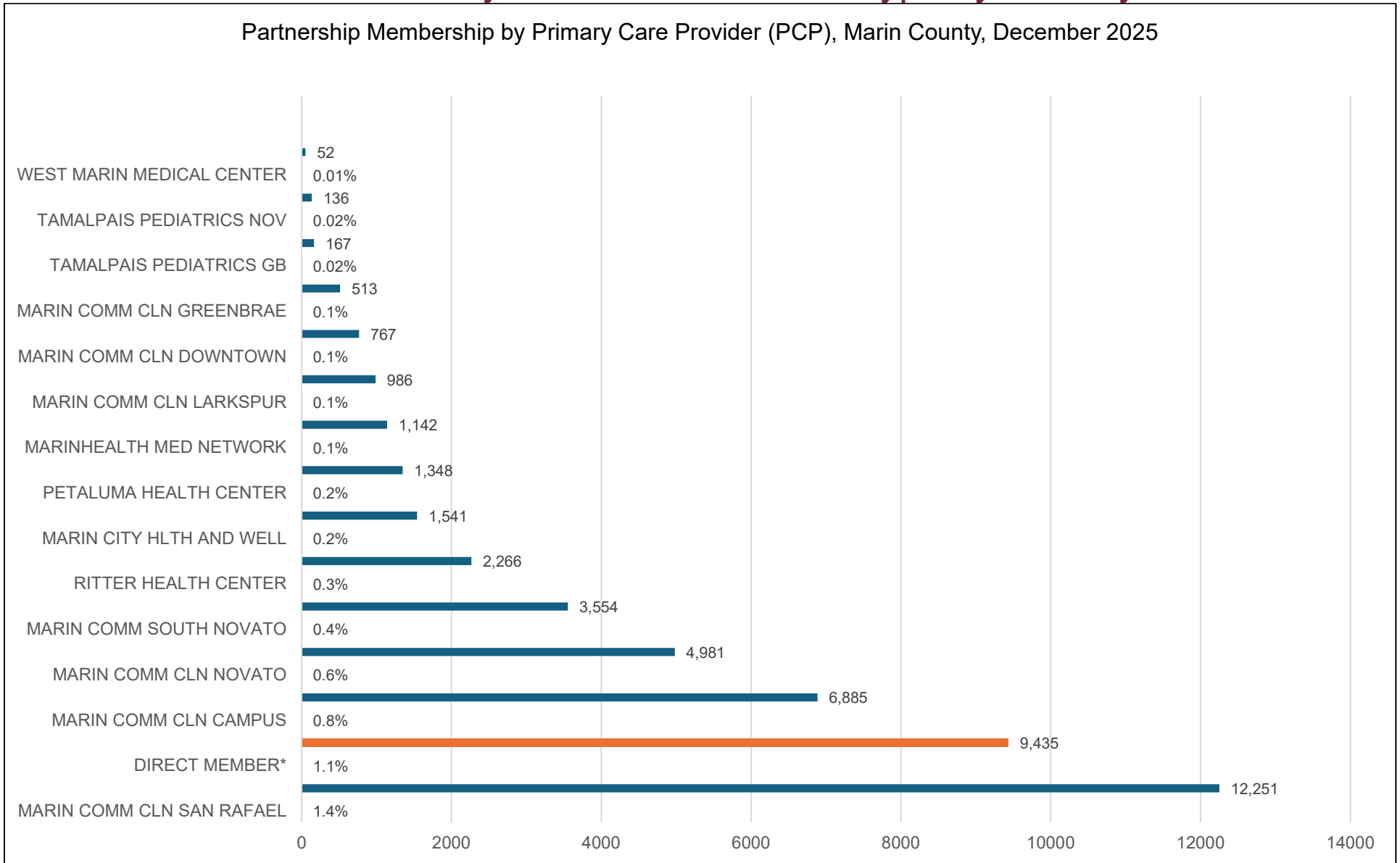
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties. Partnership members are Medi-Cal enrolled members and could be Direct or Assigned members.
- Calculations:
 - % Net Difference is the difference in the number of enrollments between the current month, and the previous month divided by the current month enrollment numbers and multiplied by 100 (%)

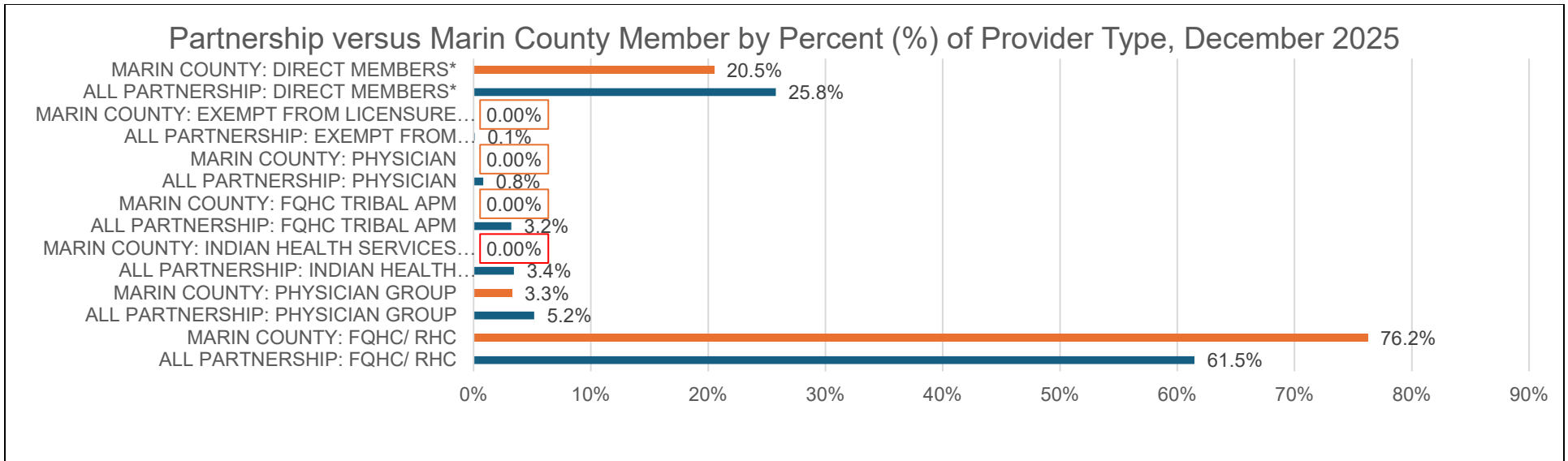
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members

Demographics

Marin Member Primary Provider & Member Type by Primary Provider





Highlights of Marin Member Primary Provider & Member Type by Primary Provider

Data shows a list of point-in-time (i.e., December 31, 2025) Marin Partnership Primary Care Providers (PCP) with the number of Partnership members residing in Marin who use these providers adding up to a total of 46,025 members and a total percentage (%) of 5.1% of all Partnership members. Partnership members (i.e., dark blue color) are divided into Direct Member at 25.8% (230,659 members) and Marin (i.e., orange color) at 20.5% (9,434 Members). All other members are Assigned.

Definition:

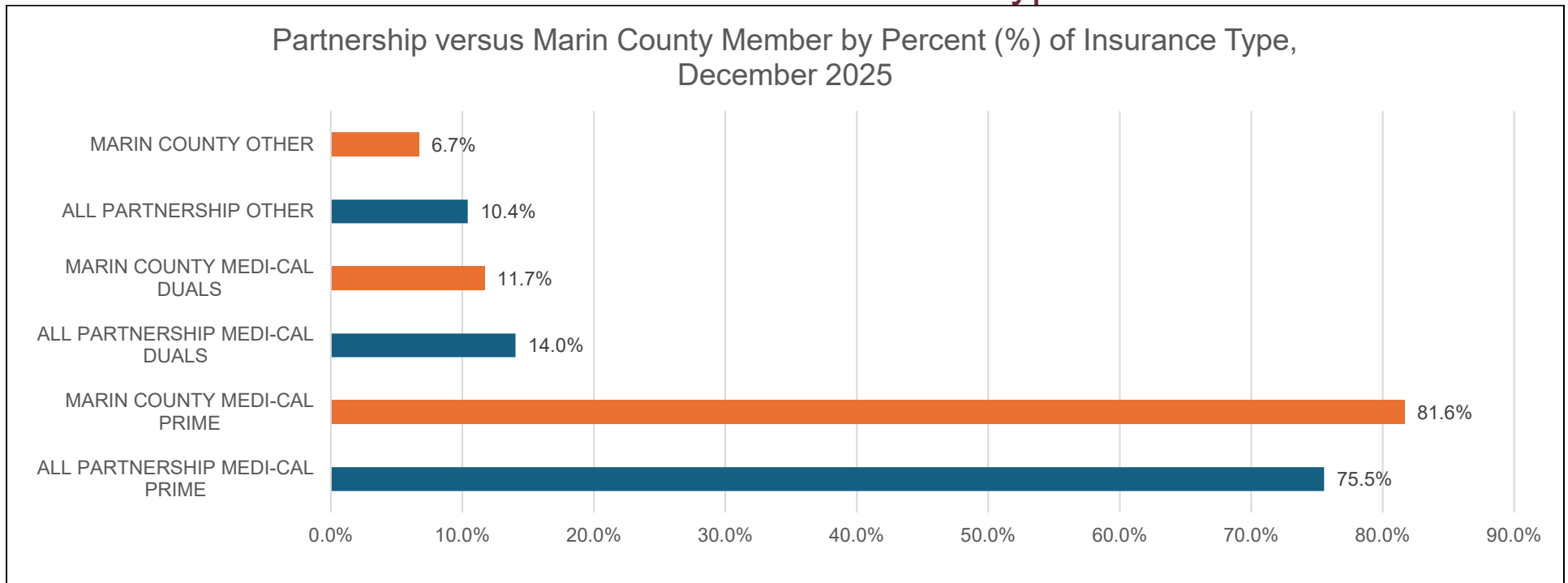
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Direct Members:** Direct Partnership members are enrolled members who are allowed to select their Primary Care Providers (PCP) and or Specialty Providers, while Partnership pays in form of paid claims.
 - Assigned Members:** Assigned Partnership members are enrolled members who are assigned to a PCP or Specialty Providers upon enrollment and are encouraged to visit these providers for their health and care. Assigned members may be assigned to a Physician, Physician-Group, Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), Indian Health Service Clinic (Federal) or Tribal FQHC.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment and Claims data

Demographics

Marin Member Insurance Type



Highlights of Marin Member Insurance Type

Data shows Partnership Members versus Insurance type by Marin Partnership Primary Care Providers (PCP) at a point-in-time (i.e., December 31, 2025). All Direct Partnership members have Medi-Cal Prime Insurance, Medi-Cal being the primary source of medical bill payment as a payer of last resort. Assigned members could have Medi-Cal Prime, Other insurance or Dual Insurance (i.e., both Medicaid and Medicare insurance) also called “Medi-Medi” with Medi-Cal being the medical bill payer of last resort.

Definition:

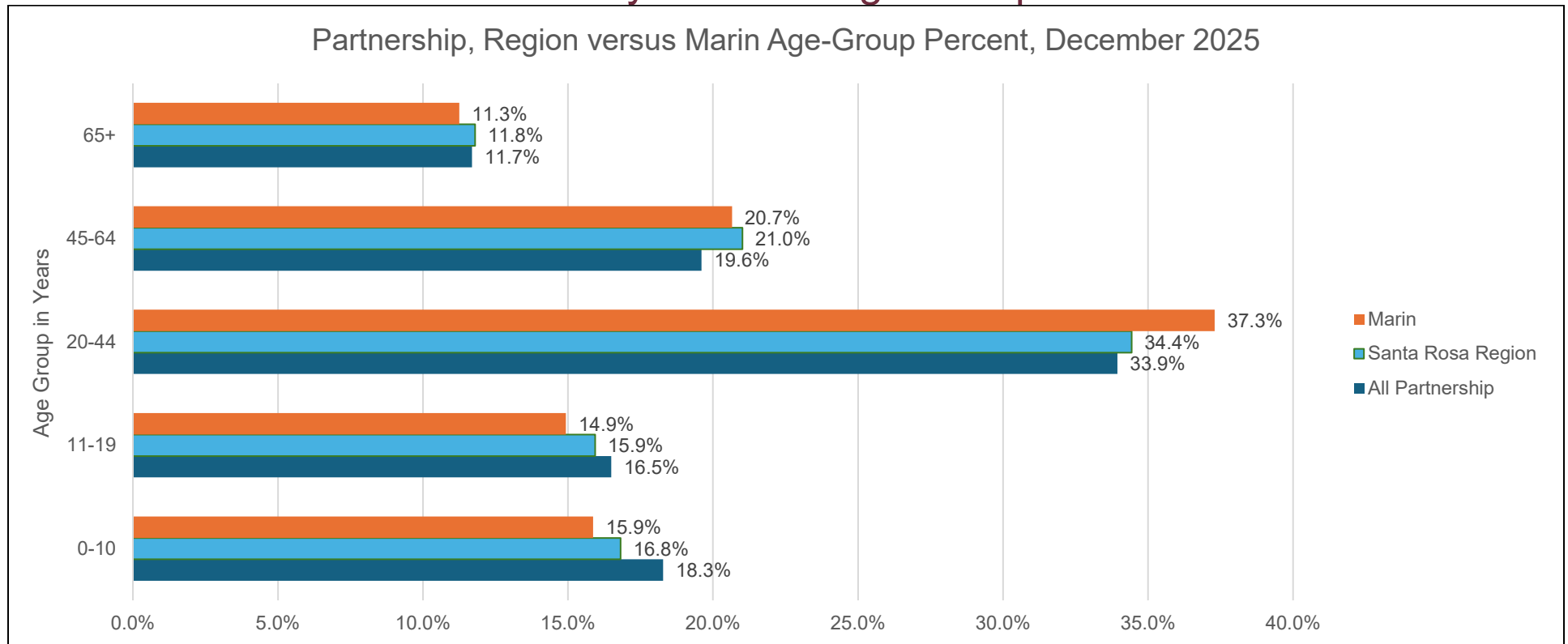
- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties. Partnership members are Medi-Cal enrolled members and could pay claims depending on the type of insurance enrollment:
 - Medi-Cal Prime: Enrolled individuals are eligible for Medi-Cal and Medi-Cal is the primary medical bill payer
 - Medi-Cal Duals: Enrolled individuals are eligible for both Medicaid and Medicare insurance
 - Medicaid and Medicare (i.e., Medi-Medi)
 - Other Insurance: Enrolled members have other forms of insurance and Medi-Cal is the payer of last resort, secondary to all other payers.
 - Private Insurance
 - Fee-for-Service

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment and Claims data

Demographics

County Member Age Groups



Highlights of County Member Age Groups

Data shows “All Partnership” enrolled members (dark blue) versus Partnership members in Santa Rosa Office Region (light blue) versus Marin residents enrolled in Partnership (orange) as of December 31, 2025. Age groups include 0-10, 11-19, 20-44, 45-64 and 65 and above years. Similar percentage (%) of members are seen in all age groups except 20-44years where Marin is 37.3% compared to all of Partnership at 33.9%.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

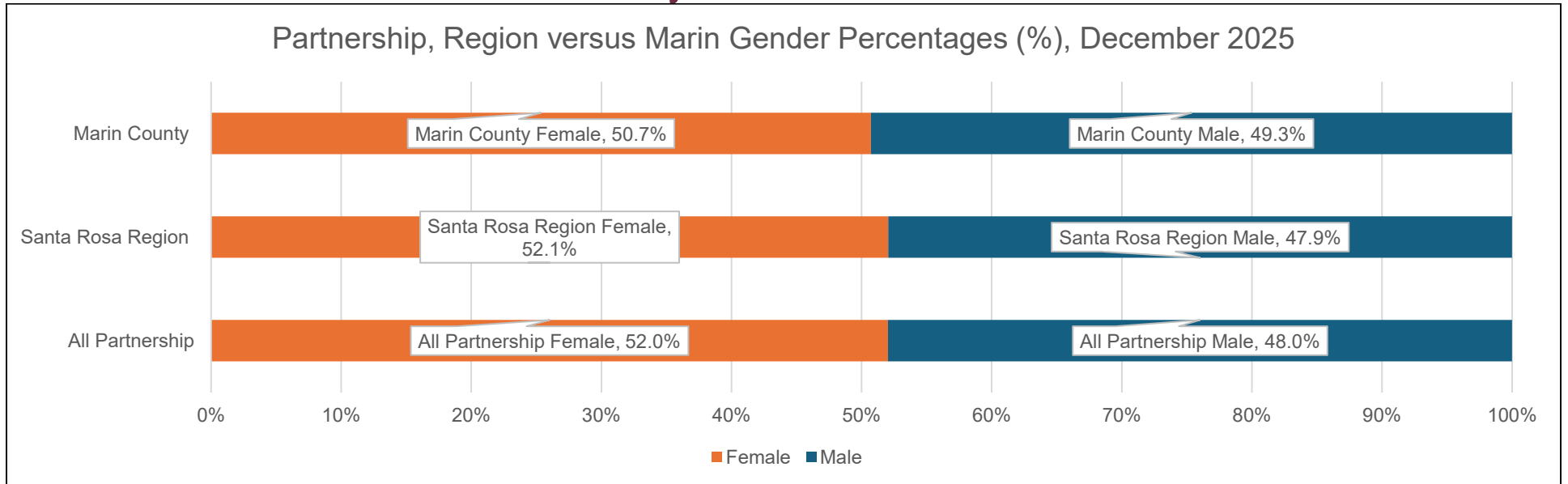
Definition:

- Current Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- Calculations:
 - % Age Group is the number of enrolled members in the individual age group (i.e., 0-10, 11-19, 20-44, 45-64 and 65 and above years), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all age-groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members

Demographics County Member Gender



Highlights of County Member Gender

Data shows gender distribution among “All Partnership” versus Partnership members in Santa Rosa Office Region versus Marin County residents enrolled as of December 31, 2025. Gender includes sex designated at birth – male enrolled members in dark blue and female enrolled members in orange. Similar percentage (%) of members are seen among male gender and female gender by location (i.e., Marin County, or Santa Rosa Region or All Partnership).

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

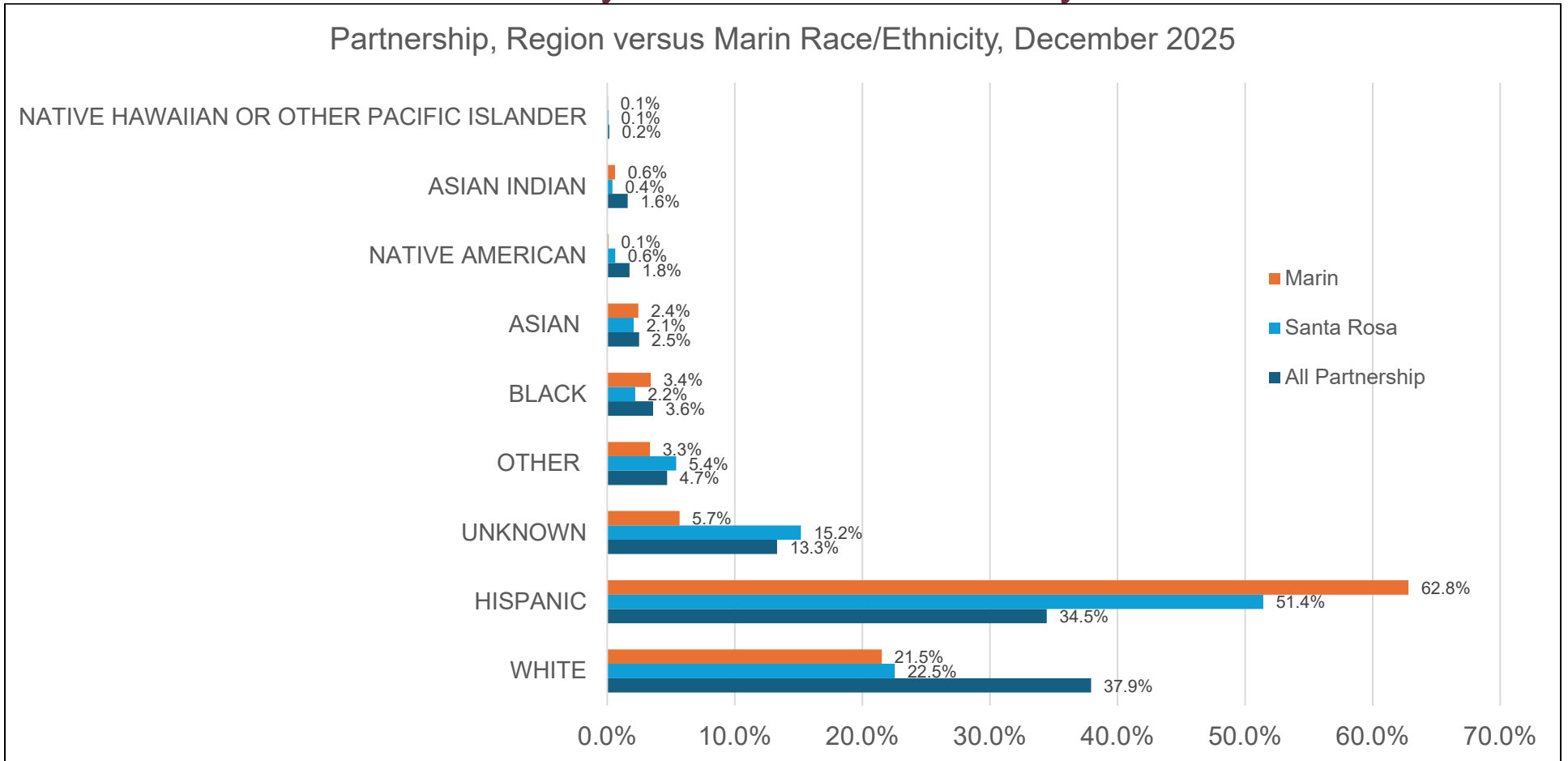
- Current Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- Gender is defined as sex designated at birth – male or female. Gender is completed during enrollment by the state of California DHCS and Partnership’s 24 individual counties and determined by California DHCS. Enrollment files for Partnership members are populated and sent to Partnership by the state of California DHCS. Partnership does not determine member gender.
- Calculations:
 - % Gender is the number of enrolled members in the individual gender (i.e., male or female), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all gender (i.e., male and female) in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members

Demographics

County Member Race/Ethnicity



Highlights of County Member Race/Ethnicity

Data shows race ethnicity for “All Partnership” enrolled members (dark blue) versus Partnership members in Santa Rosa Office Region (light blue) versus Marin residents enrolled in Partnership (orange) as of December 31, 2025. Race/Ethnicity include White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander. The percentage of White are less in Santa Rosa 22.5% and Marin 21.5% compared to All Partnership 37.9%, and so are Black 2.2%, 3.4% and 3.6%, Asian 2.1%, 2.4%, and 2.5%, Native American 0.6%, 0.1%, and 1.8% respectively. Marin Hispanic, Race/Ethnicity at 62.8% is however similar to Santa Rosa region at 51.4%, both larger when compared to All Partnership Hispanic population at 34.5%.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Current Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- Race/Ethnicity is voluntarily completed during enrollment by the state of California DHCS and Partnership’s 24 individual counties and determined by California DHCS. Enrollment files for Partnership members are populated and sent to Partnership by the state of California DHCS. Partnership does not determine member Race/Ethnicity category.
- Calculations:
 - % Race/Ethnicity is the number of enrolled members in the individual race/ethnicity group (i.e., White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all race/ethnicity groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members

Demographics

County Member Preferred Language

Partnership, Region versus Marin Preferred Language, December 2025			
Preferred Language	All Partnership	Santa Rosa Region	Marin County
ENGLISH	76.0%	55.3%	41.7%
SPANISH	20.5%	42.4%	55.0%
RUSSIAN	0.6%	0.2%	0.5%
PUNJABI	0.5%	0.04%	0.02%
TAGALOG	0.3%	0.1%	0.0%
UKRAINIAN	0.1%	0.005%	0.009%
HINDI	0.02%	0.022%	0.04%
OTHER	2.0%	1.9%	2.7%

MARIN COUNTY <u>OTHER</u> LANGUAGES	% MEMBERS WITH PREFERRED LANGUAGE
VIETNAMESE	0.754%
PORTUGUESE	0.432%
OTHER NON ENGLISH	0.313%
NO VALID DATA REPORTED MEDS GENERATED	0.291%
MANDARIN	0.243%
FARSI	0.243%
CANTONESE	0.115%
ARABIC	0.063%
KOREAN	0.056%
THAI	0.039%
FRENCH	0.037%
TURKISH	0.017%
SAMOAN	0.013%
CAMBODIAN	0.013%
NO RESPONSE, CLIENT DECLINED TO STATE	0.011%
ITALIAN	0.007%
CHINESE	0.007%
ASL AMERICAN SIGN LANGUAGE	0.007%
ARMENIAN	0.007%
LAO	0.004%
HEBREW	0.002%
BLANK	0.002%

*Note: *American Sign Language ASL and other sign language are used for deaf Partnership members*

Highlights of County Member Preferred Language

Data shows preferred language for “All Partnership” enrolled members versus Partnership members in Santa Rosa Office Region versus Marin residents enrolled in Partnership as of December 31, 2025. Top preferred languages across All Partnership include English, Spanish and Russian, however in Marin, Punjabi, Hindi, Vietnamese, Portuguese, Mandarin, Farsi, Cantonese, , Arabic, Korean, Thai, French, Turkish, Samoan, Cambodia, Italian, Chinese, Armenian, Lao, and Hebrew are either 0.1% or reported as other preferred languages. American Sign Language (ASL) and other sign languages are used for deaf Partnership members.

Definition:

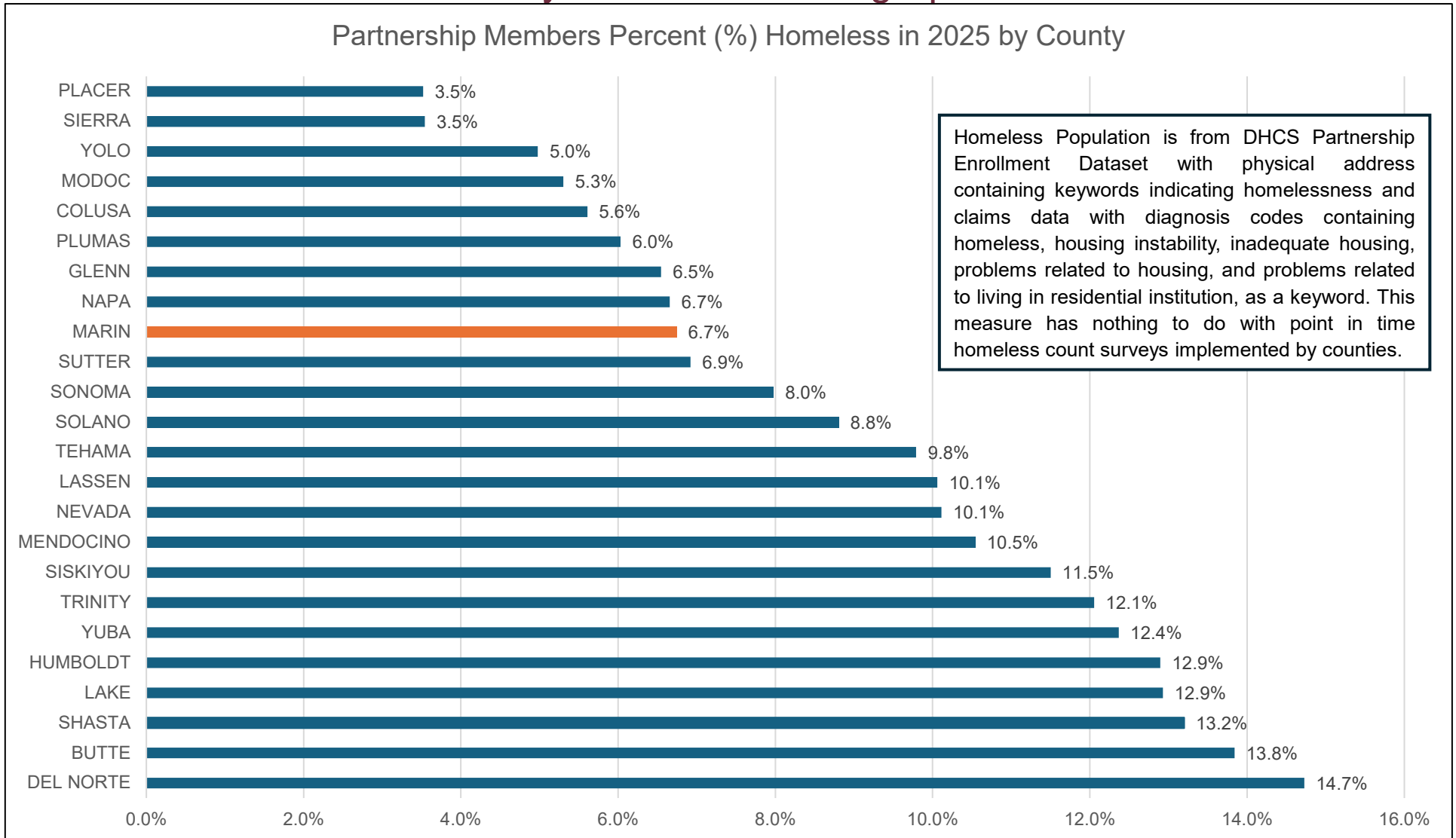
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- Preferred Language is completed during enrollment by the state of California DHCS and Partnership’s 24 individual counties and determined by California DHCS. Enrollment files for Partnership members are populated and sent to Partnership by the state of California DHCS. Partnership does not determine member preferred language category.
- Calculations:
 - % Preferred Language is the number of enrolled members in the individual preferred language group (i.e., English, Spanish, Russian, Other), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all preferred language groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

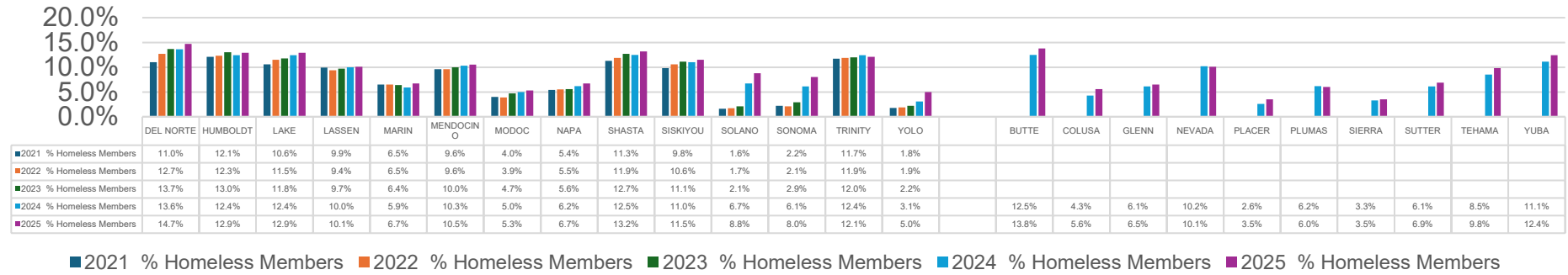
- DHCS Enrollment dataset for Partnership Member

Demographics

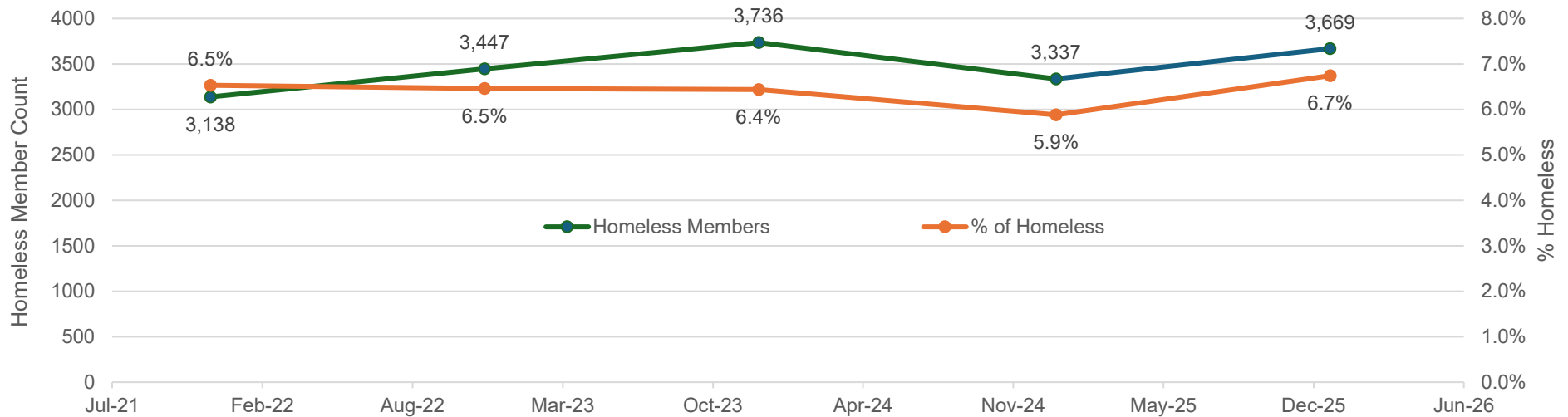
County Homeless Demographics



Partnership Homeless Member Percent (%) by County, 2021-2025



Partnership Homeless Member Number and Percent (%) in Marin, 2021-2025



Highlights of County Homeless Demographics

Data shows homeless members distribution among Partnership County residents enrolled from 2021 to 2025. Partnership Homeless population in Marin County has increased over the years from 6.5% in 2021 to 6.7% in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Homeless, also called members experiencing housing insecurity is defined as individuals with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing homeless, housing instability, inadequate housing, problems related to housing or living in residential institution, as a keyword.
 - This has nothing to do with point-in-time homeless count surveys implemented by counties.
 - Chronic Homelessness is homelessness for >180 consecutive days.
- Calculations:
 - % Homeless is the number of enrolled members with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing homeless, housing instability, inadequate housing, problems related to housing or living in residential institution, as a keyword in the location category (i.e., County) at the particular point-in-time in question, (i.e., Year 2025; as of December 31, 2025) divided by the total number of members in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Child Welfare Demographics

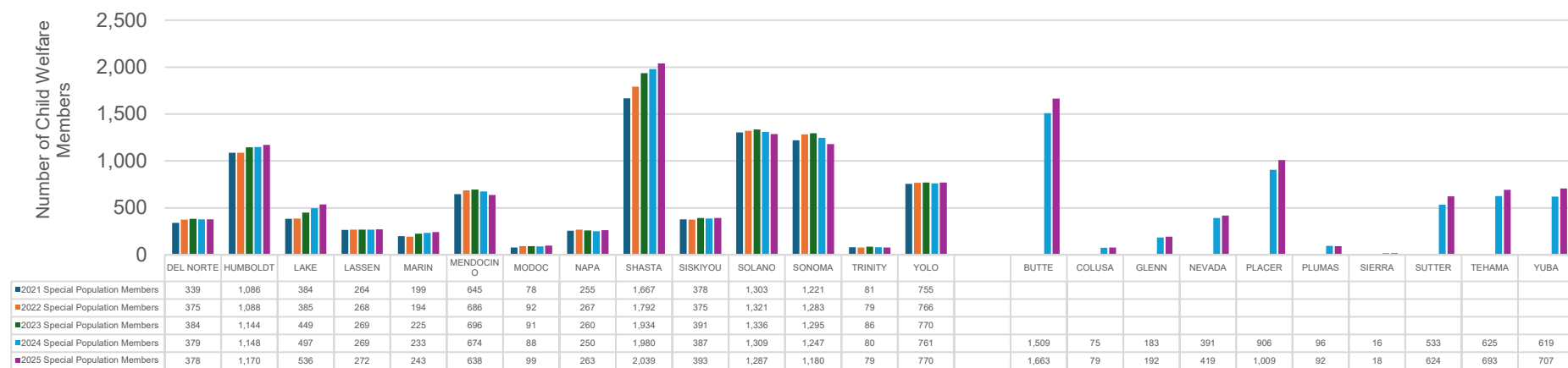
Members by County	40
Percent (%) of Members by County	42
Partnership, Santa Rosa Region, and Marin Members by Age Group	44
Partnership, Santa Rosa Region, and Marin Members by Race	45
Members by Service Category and Community Support Services	47

For more information, see [Child Welfare Demographics](#) in the [Appendix](#)

Child Welfare Demographics

Members by County

Partnership Child Welfare Members by County, 2021-2025



Highlights of Members by County

Data shows Partnership Child Welfare members as a Partnership special population distribution among Partnership County residents enrolled from 2021 to 2025. Partnership Child Welfare members in Marin County have been stable over the past five years, 2021-2025 with a range from 194 to 243.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

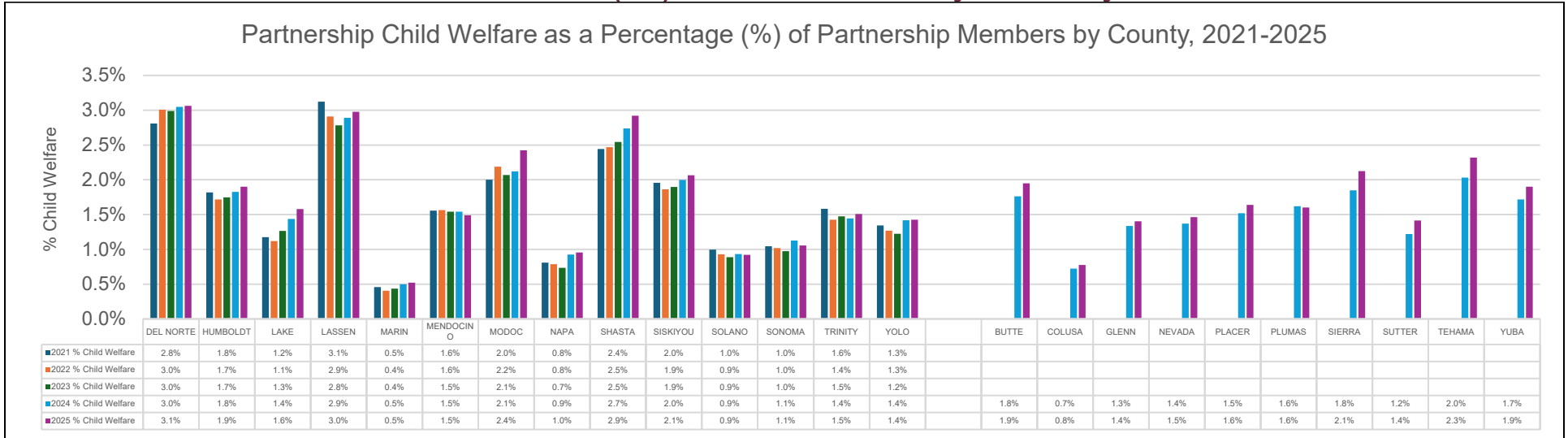
- Child Welfare Members: Child Welfare Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Enrollment follows [Medi-Cal Aid Codes](#) used to classify Child Welfare as a special population including Adoption, Aged Out Foster Care, Current Foster Care and Relative Caregiver codes. Enrolled Child Welfare members residing in Partnership 24 counties are assigned to Partnership.
- There are three major categories of Child Welfare:
 - Children under 21 years currently in foster care
 - Children under 21 years and Adopted
 - Children under 21 years who received foster care within the last 12 months
 - Other Categories include:
 - Young Adults who are currently 18-26 years and aged out of foster care after 18 years
 - Adults 27 years and older who have been in foster care at some point in time are also tracked within these systems

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Child Welfare Demographics

Percent (%) of Members by County



Highlights of Percent (%) of Members by County

Data shows Partnership Child Welfare members as a percentage (%) of Partnership population in each county from 2021 to 2025. Partnership Child Welfare members in Marin County although high in number, over the past five years, 2021-2025 with a range from 194 to 243, is one of the lower percentages 0.4% to 0.5% of Partnership Child Welfare members in individual counties (i.e., Marin County).

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

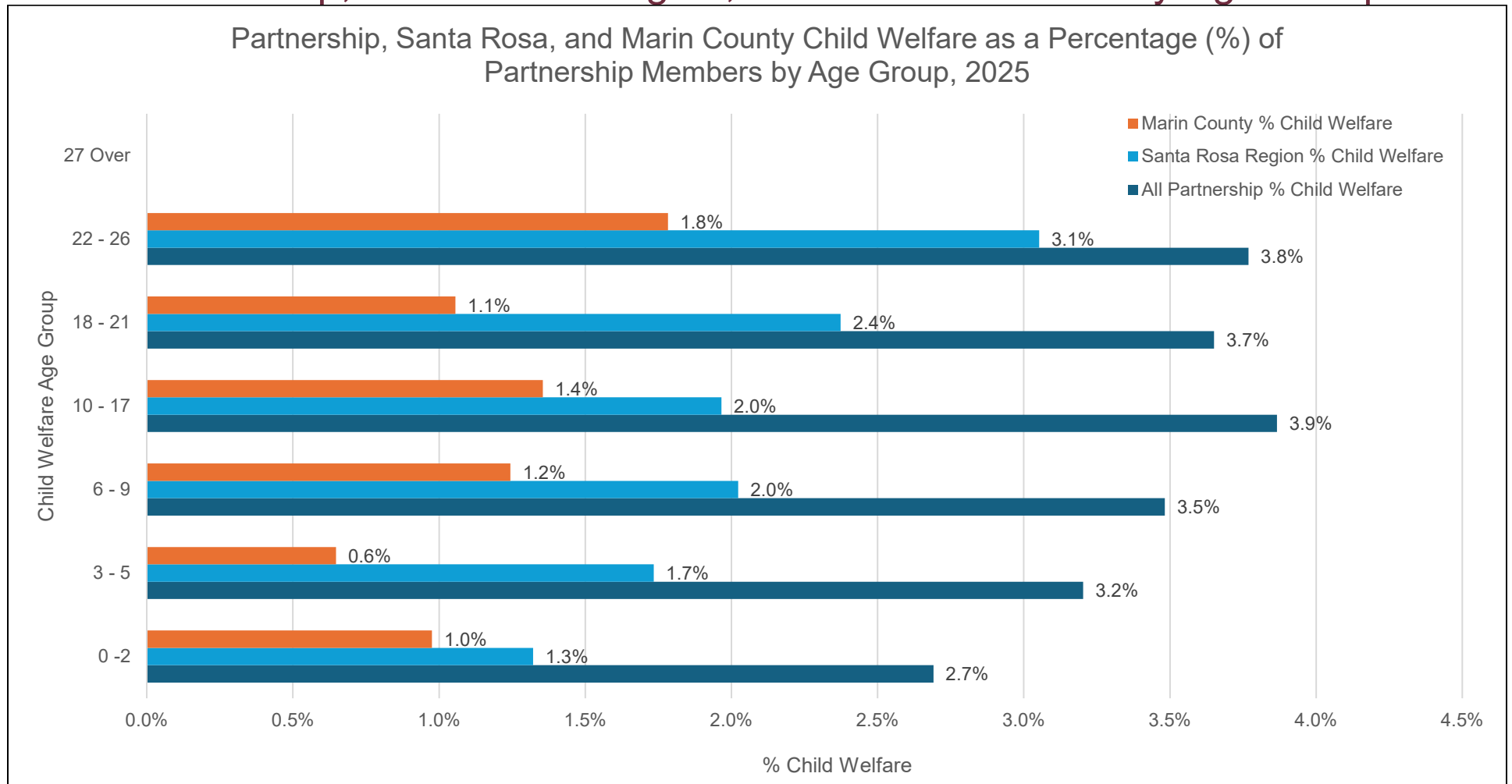
- Child Welfare Members: Child Welfare Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Enrolled Child Welfare members residing in Partnership 24 counties are assigned to Partnership.
- Calculations:
 - % Child Welfare by County:
 - Numerator: Number of Partnership Child Welfare members in individual county
 - Denominator: Total number of Partnership members in individual county
 - Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

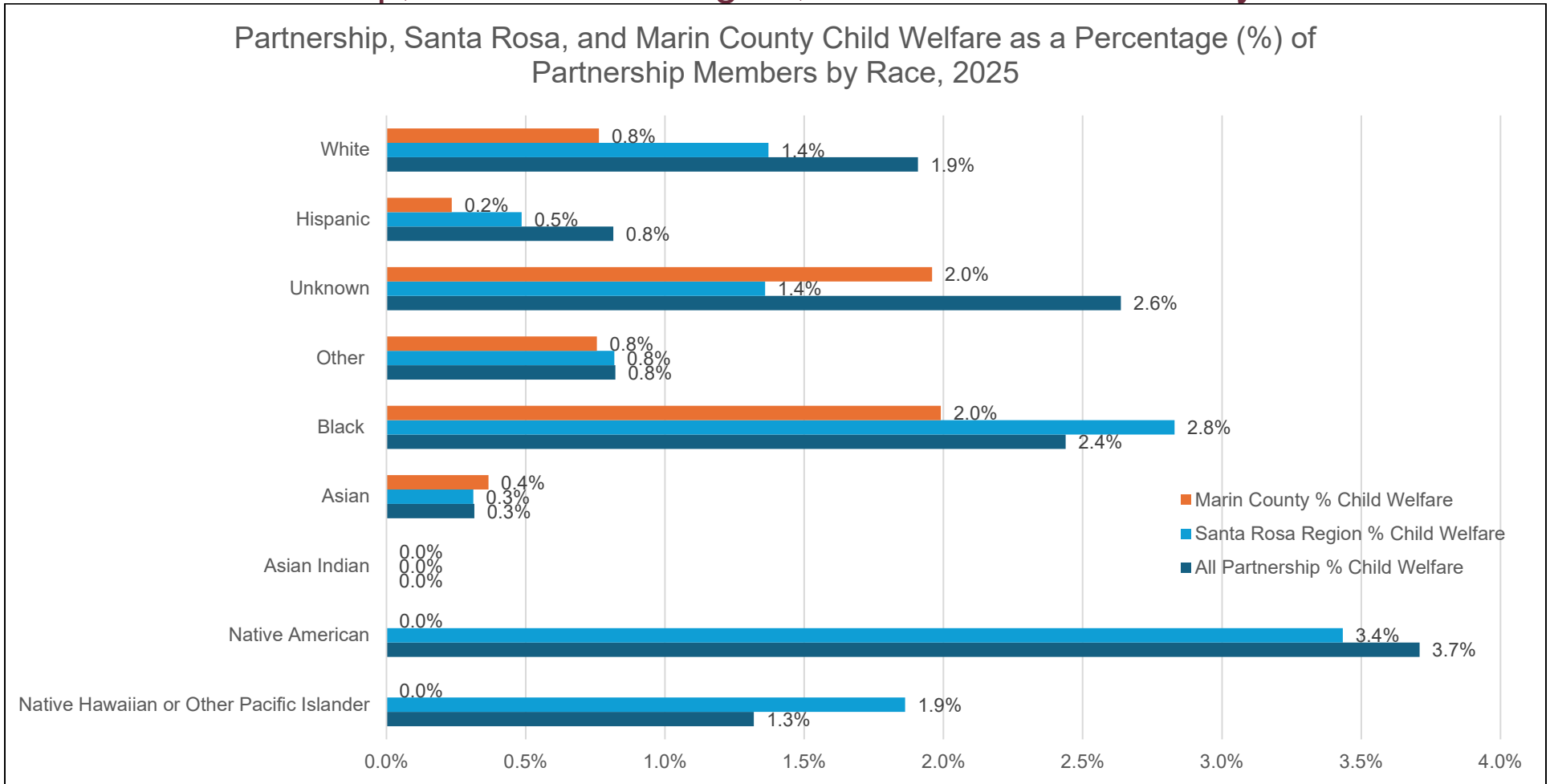
Child Welfare Demographics

Partnership, Santa Rosa Region, and Marin Members by Age Group



Child Welfare Demographics

Partnership, Santa Rosa Region, and Marin Members by Race



Highlights of Partnership, Santa Rosa Region, and Marin Members by Age Group and Members by Race

Data shows Partnership Child Welfare members as a percentage (%) for “All Partnership” enrolled members versus Partnership members in Santa Rosa Office Region versus Marin County residents enrolled in Partnership as of December 31, 2025. Compared to All Partnership, by age group, there are less percentage (%) of Child Welfare members in each age group in Marin County even though Marin County has one of the lowest populations of Child Welfare in Partnership. The 27 and over age group is currently 0%.

The races with the highest rate (%) of Child Welfare in Marin County are Black 2.0% and Unknown 2.0% even though these amount to fewer children at 32 and 50 children. These children could be easily targeted for intervention. White Child Welfare has the highest number at 77 and average rate of 0.8%, as of December 31, 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Child Welfare Members: Child Welfare Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties. Enrolled Child Welfare members residing in Partnership’s 24 counties are assigned to Partnership.
- Calculations:
 - % Child Welfare by Age Group:
 - Numerator: Number of Partnership Child Welfare members in specific age group in individual county
 - Denominator: Total number of Partnership members in all age group categories in individual county
 - Rate: Multiplied by 100 (%)
 - % Child Welfare by Race/Ethnicity Group:
 - Numerator: Number of Partnership Child Welfare members in specific race/ethnicity group in individual county
 - Denominator: Total number of Partnership members in all race/ethnicity group categories in individual county
 - Rate: Multiplied by 100 (%)

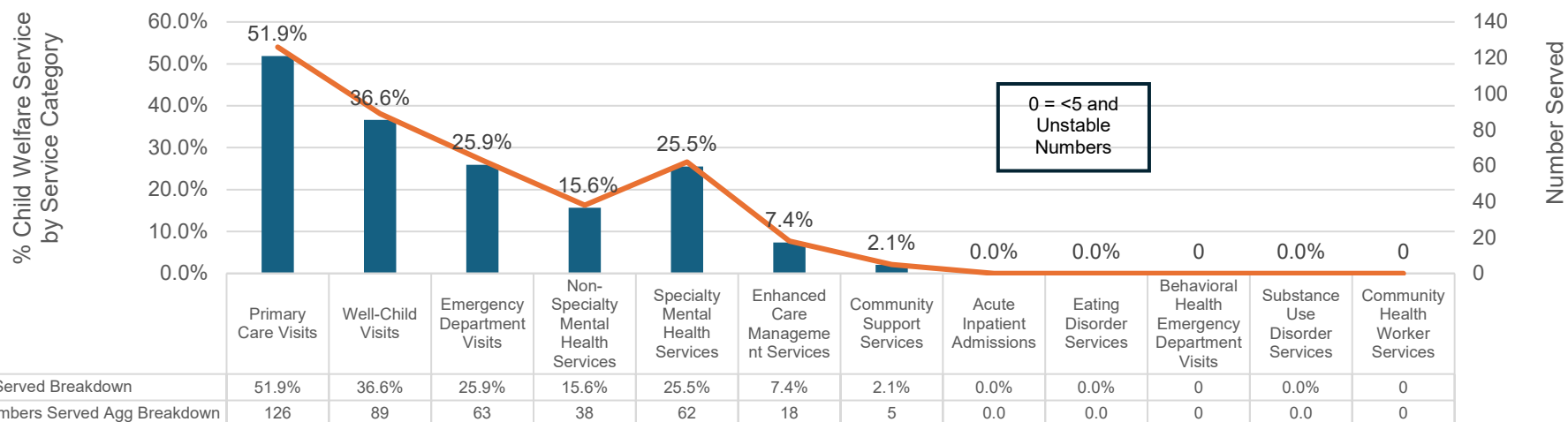
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

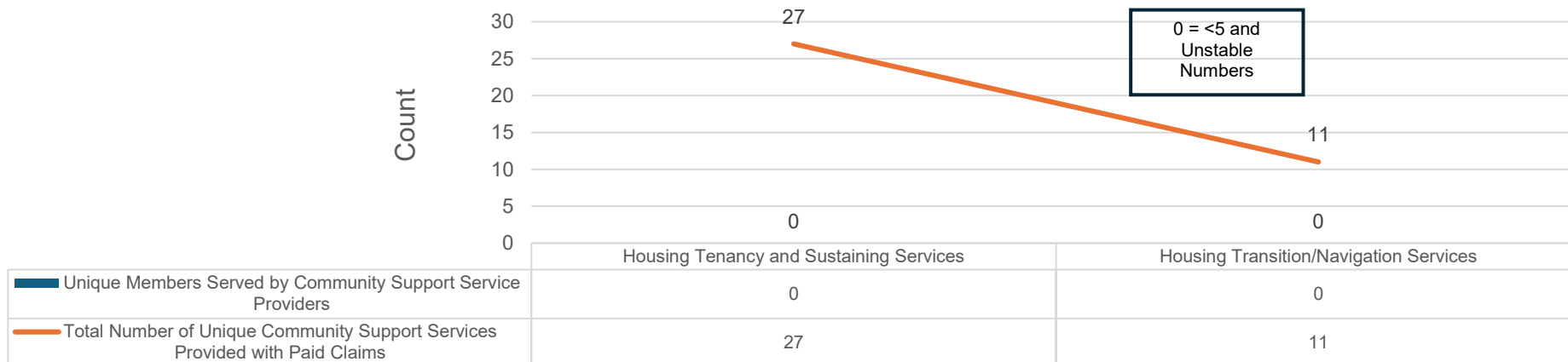
Child Welfare Demographics

Members by Service Category and Community Support Services

Partnership Marin County Percent (%) and Number of Child Welfare Served by Service Category, 2025



Partnership Marin County Child Welfare CalAIM Registered Members by Community Support Services, 2025



Highlights of Members by Service Category and Community Support Services

Data shows Partnership Child Welfare members and the percentage (%) of claims and services by service category as of December 31, 2025. Marin County reports top three medical service as Primary Care Visits (51.9%), Well-Child visits (38.4%) and Emergency Department (ED) visits (32.5%) for Partnership Child Welfare members. Mental Health, both Specialty at 25.5% and Non-specialty at 15.6%, is only second to Primary Care visits for Child Welfare members in Marin. The most community services provided include Housing services in 2025. Note: Unique members served can have multiple services and have claims from several service locations within the same year; hence, these members are not mutually exclusive over service category of diagnosis and location of service.

*Agg means Aggregate.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Child Welfare Members: Child Welfare Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Enrolled Child Welfare members residing in Partnership 24 counties are assigned to Partnership.
 - Services Provided: Services are provided in collaboration with [California Department of Social Services \(CDSS\)](#).
 - Well Child Visits
 - Non-Specialty Mental Health Services
 - Specialty Mental Health Services: Members who had a county mental health service within the last 12 months
 - Community Supports
 - Enhanced Care Management
 - Community Health Workers
 - Emergency Department
 - Behavioral Health Emergency Department
 - Inpatient Hospitalization
 - Substance Use Disorder: Members who received Wellness & Recovery services or SUD related services within the last 12 months
 - Eating Disorders
 - [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:

- Office Visit
- Outpatient
- Emergency Department (ED)
- Inpatient Hospital
- Substance Use Facility
- Nursing Facility
- Mental Health Treatment Facility
- Transportation Services
- Calculations:
 - Number of Unique Services: Number of Distinct services
 - % Child Welfare Members by Service Category and Community Support Services:
 - Numerator: Number of Distinct Partnership County Child Welfare Population Served by Service Category
 - Denominator: Total Number of Distinct Partnership County Child Welfare Population Service Claims
 - Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data and [CalAIM](#): Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services
- Carelon Claims for Behavioral Health Services

Obstetric/Maternal Demographics and Conditions

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For more information, see [Obstetric/Maternal Demographics and Conditions](#) in the [Appendix](#)

Marin Maternal Health System Review

- Marin Hospitals with maternity services (does not include Kaiser):
 - MarinHealth Medical Center: 576 Partnership members delivered, 1,371 deliveries total in 2024; About 42% of deliveries covered by Partnership
- Marin County births by residence of mother in 2024: 2,056 (Source: CDPH)
- Marin County Partnership member deliveries by residence of mother in 2024: 613
- Marin CPSP/PHPS Patients in 2025: 580
- Marin prenatal care providers:
 - Marin Community Clinic
 - MarinHealth OB/GYN
 - [TeleMed2U](#) (Telehealth by self-referral: Perinatal Nutrition Care)
- Sweet Success Program (as of 2022 sunset):
 - East Bay Physicians Medical Group – Endocrine
 - Washington Hospital Healthcare Systems
- Birth Centers in Marin:
 - MarinHealth Medical Center – Mark & Stephanie Robinson Family Birth Center, part of MarinHealth Medical Center
 - Marin Family Birth Center (non-accredited or not licensed)

Note: This section is about the Partnership Maternal Population whose deliveries were paid for by Partnership

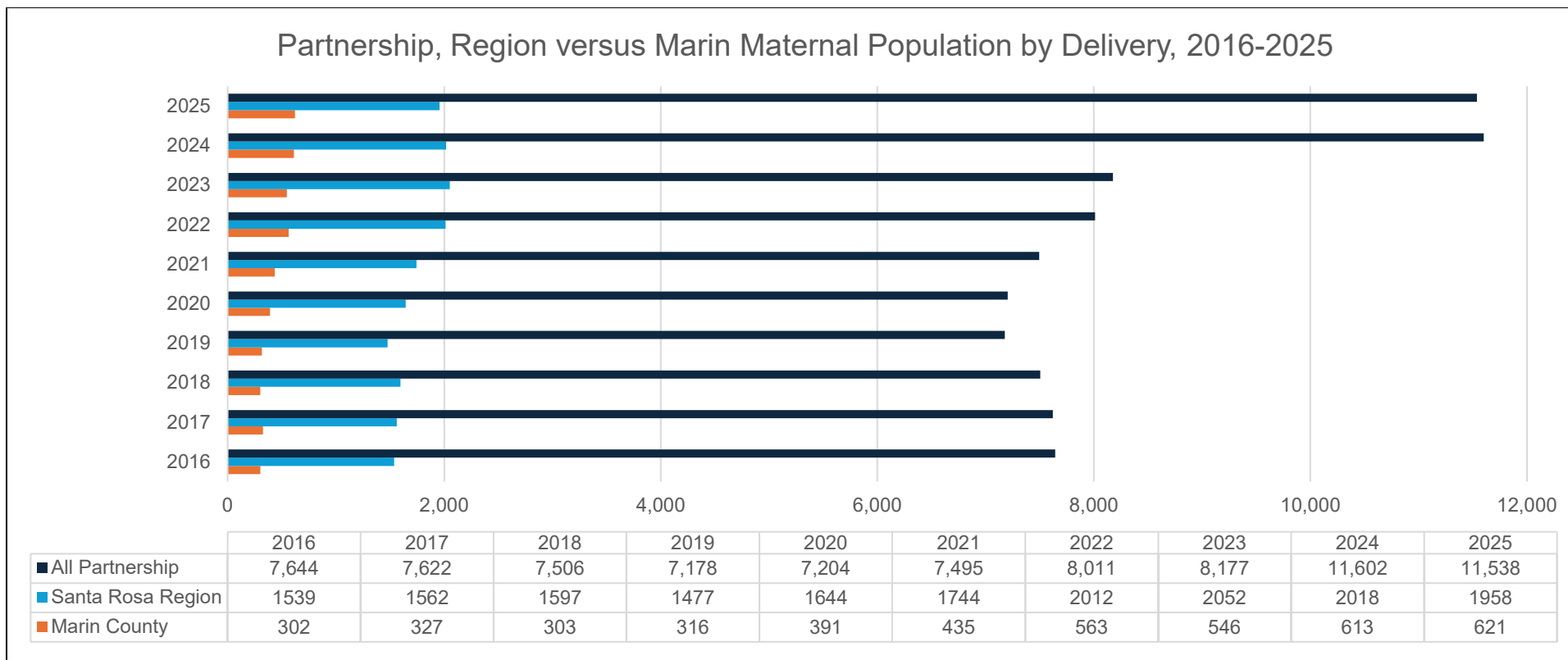
Obstetric/Maternal Demographics and Conditions

Partnership County Maternal Delivery Comparison 2016-2025

County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
SOLANO	1,527	1,584	1,538	1,446	1,504	1,564	1,675	1,774	1,274	1,190
SONOMA	1,237	1,235	1,294	1,161	1,253	1,309	1,449	1,506	1,405	1,337
SHASTA	992	1,030	972	935	923	904	917	1,021	940	928
YOLO	768	736	691	704	679	684	740	729	630	647
HUMBOLDT	777	716	747	734	707	715	674	650	657	679
MENDOCINO	556	553	510	502	464	506	525	508	566	536
MARIN	302	327	303	316	391	435	563	546	613	621
LAKE	457	440	425	410	395	387	411	387	474	424
NAPA	337	319	314	342	296	354	397	458	362	384
SISKIYOU	249	248	250	240	215	220	225	220	211	184
DEL NORTE	187	170	181	162	153	163	177	153	166	156
LASSEN	146	144	152	125	130	133	143	122	115	127
TRINITY	63	76	80	47	55	69	70	60	72	52
MODOC	46	44	49	54	39	52	45	41	56	51
BUTTE									1,075	1,095
SUTTER									679	674
PLACER									635	720
YUBA									521	543
TEHAMA									425	467
NEVADA									254	292
COLUSA									153	159
GLENN									244	203
PLUMAS									66	65
SIERRA									9	0 = <5 and Unstable Numbers

Obstetric/Maternal Demographics and Conditions

Partnership, Santa Rosa Region, & Marin Maternal Population by Delivery 2016-2025



Highlights of Maternal Deliveries & Comparison 2016-2025

Data shows Partnership Maternal Delivery Count over 10 years by county. Marin County has one of the mid-delivery counts among those whose deliveries Partnership paid for in the Delivery Claims dataset.

Note: Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in delivery count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (up to one year postpartum).

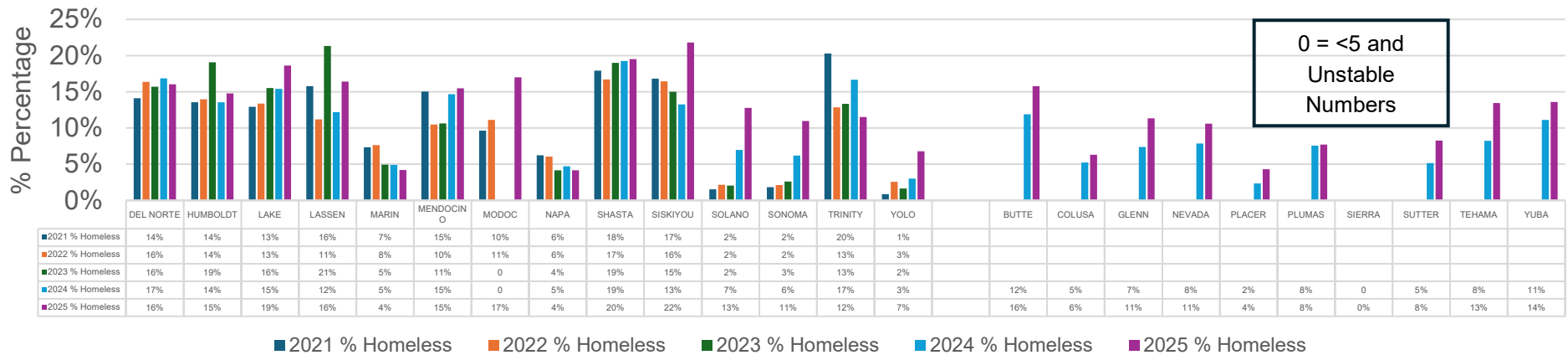
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data

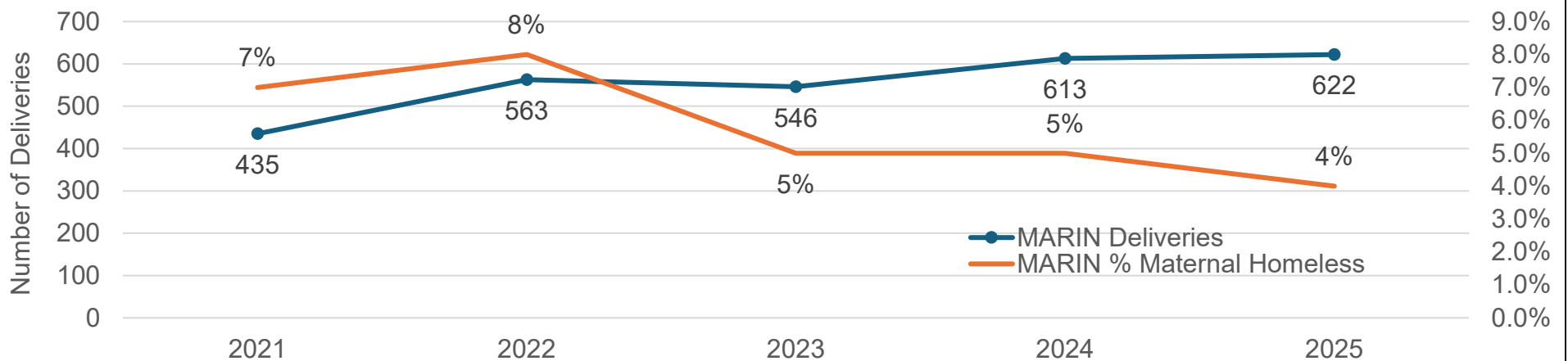
Obstetric/Maternal Demographics and Conditions

Maternal Homelessness

Partnership Member Maternal Percent (%) Homeless by County, 2021-2025



Partnership Member Maternal Deliveries and Percent (%) Homeless by Marin County, 2021-2025



Highlights of Maternal Homelessness

Data shows Partnership Maternal homeless population as a percentage (%) over the past five years, 2021 to 2025 among those whose deliveries Partnership paid for in the Delivery Claims dataset. Marin County has had an increase in number of births and a decrease in the number of Maternal homeless population from 7% in 2021 to 4% in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset.
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (i.e., Up to one year postpartum).
- Maternal Homeless
 - Homeless, also called members experiencing housing insecurity is defined as individuals with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing homeless, housing instability, inadequate housing, problems related to housing or living in residential institution, as a keyword.
 - This has nothing to do with point-in-time homeless count surveys implemented by counties.
 - Chronic Homelessness is homelessness for >180 consecutive days.
- Calculations:
 - % Maternal Homeless Deliveries:
 - Numerator: Number of Distinct Partnership County Homeless Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset

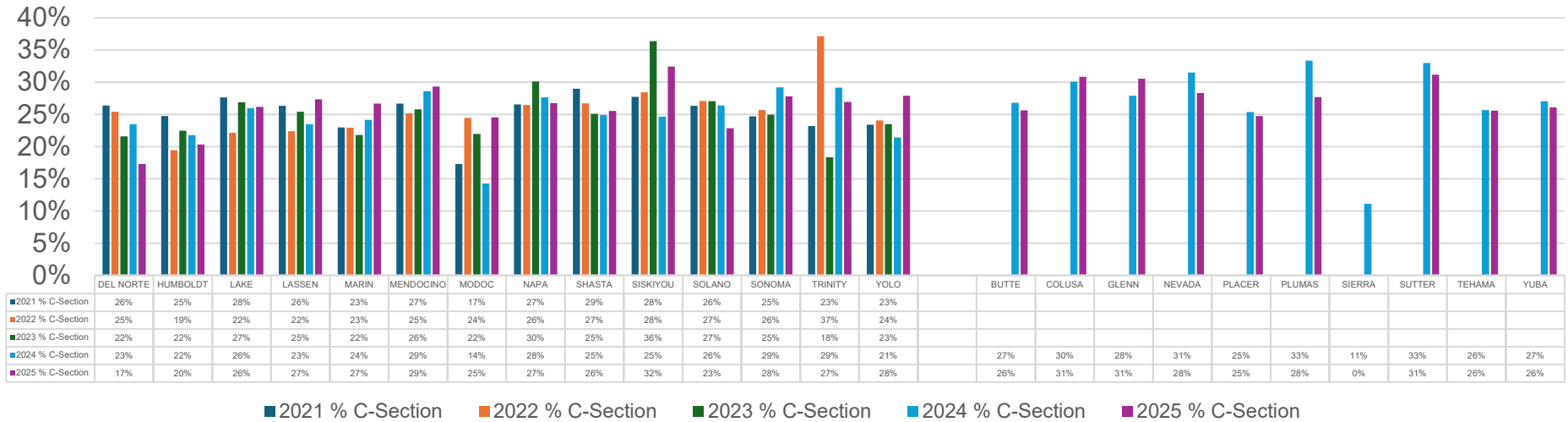
- Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

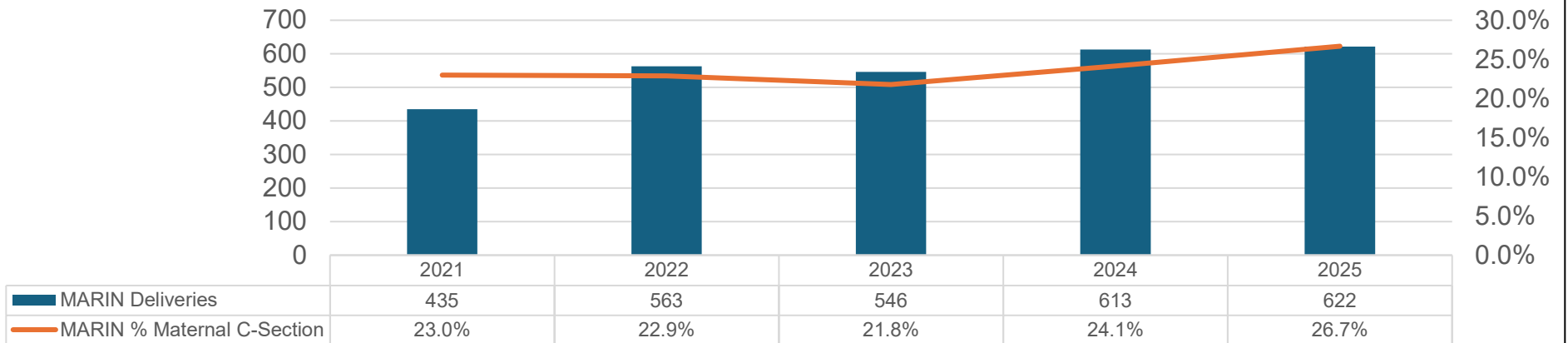
- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data
- [CalAIM](#): Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services
- Carelon Claims for Behavioral Health Services

Obstetric/Maternal Demographics and Conditions Maternal Delivery Caesarean Section (C-Sections)

Partnership Member Maternal Percent (%) C-Section by County, 2021-2025



Partnership Member Maternal Deliveries and Percent (%) C-Section by Marin County, 2021-2025



Highlights of Maternal Delivery Caesarean Section (C-Sections)

Data shows Partnership Maternal Population with a Caesarean Section (C-Sections) as a delivery procedure in percentage (%) out of all delivery claims for each year, 2021 to 2025, among those whose deliveries Partnership paid for in the Delivery Claims dataset. Marin County C-Section rate increased over the past five years from 23.0% in 2021 to 26.7% in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (i.e., up to one year postpartum).
- Calculations:
 - % Maternal Delivery Caesarean Section (C-Sections):
 - Numerator: Number of Distinct Partnership County Caesarean Section Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Rate: Multiplied by 100 (%)

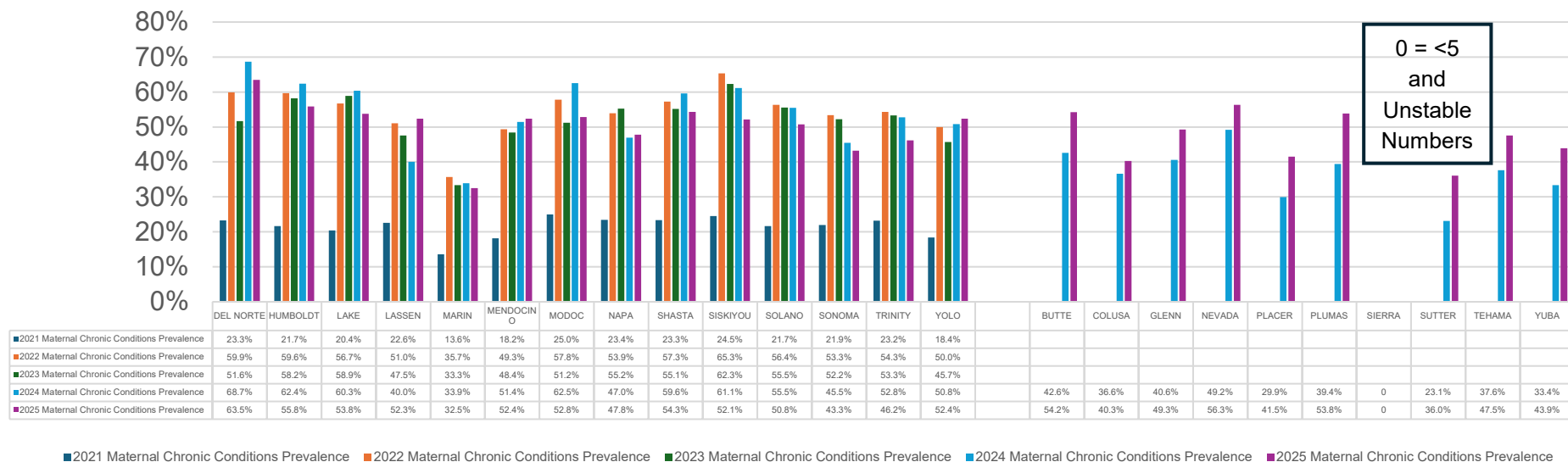
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data

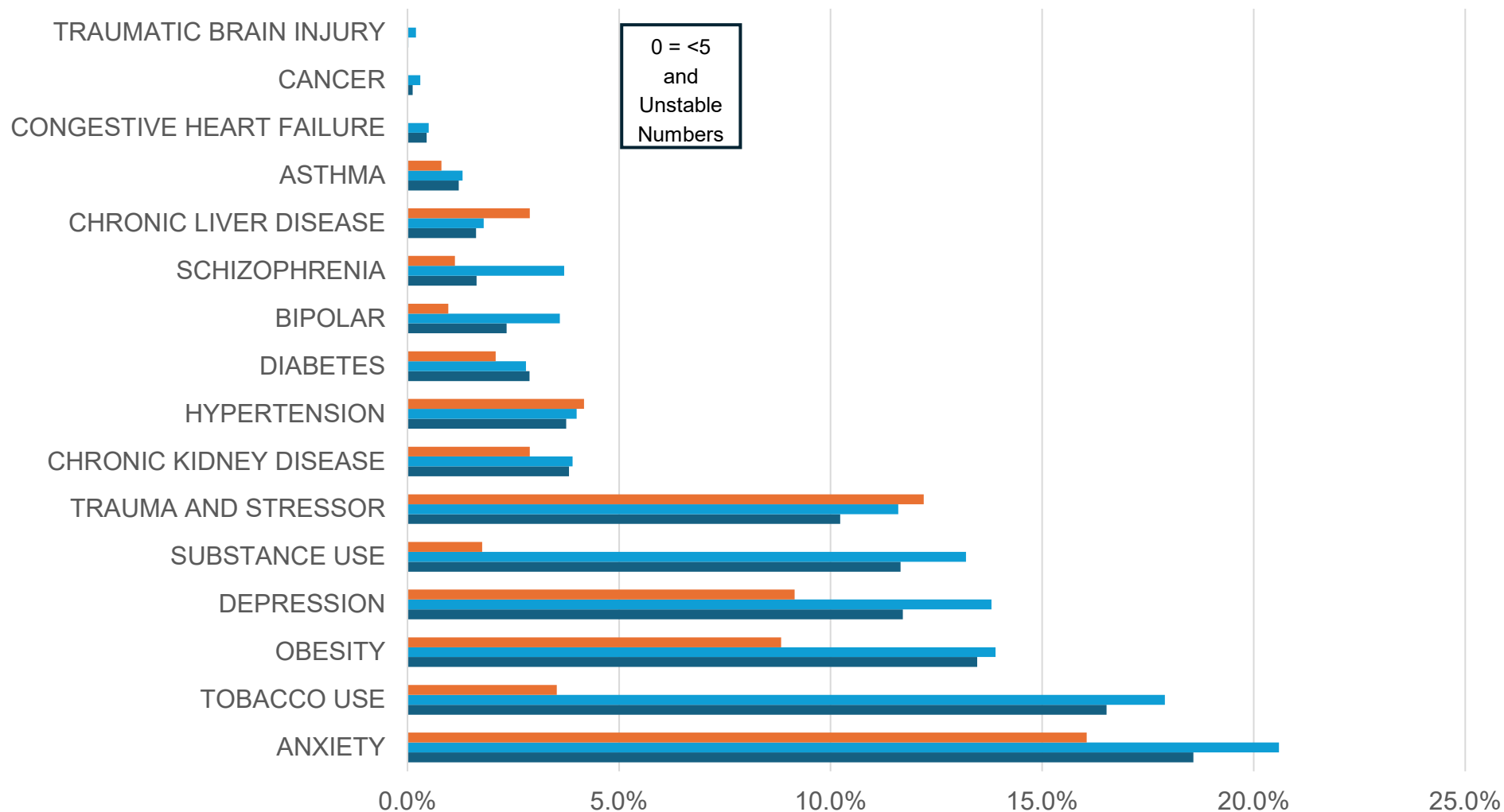
Obstetric/Maternal Demographics and Conditions

Maternal Chronic Conditions

Partnership Member Percent (%) Maternal Chronic Condition by County, 2021-2025



Partnership Member Percent (%) Maternal Chronic Condition by Marin County, Partnership Average and Total, 2025



	ANXIETY	TOBACCO USE	OBESITY	DEPRESSION	SUBSTANCE USE	TRAUMA AND STRESSOR	CHRONIC KIDNEY DISEASE	HYPERTENSION	DIABETES	BIPOLAR	SCHIZOPHRENIA	CHRONIC LIVER DISEASE	ASTHMA	CONGESTIVE HEART FAILURE	CANCER	TRAUMATIC BRAIN INJURY
2025 Marin County Partnership Member %	16.1%	3.5%	8.8%	9.1%	1.8%	12.2%	2.9%	4.2%	2.1%	1.0%	1.1%	2.9%	0.8%	0	0	0.0%
2025 Average Partnership County %	20.6%	17.9%	13.9%	13.8%	13.2%	11.6%	3.9%	4.0%	2.8%	3.6%	3.7%	1.8%	1.3%	0.5%	0.3%	0.2%
2025 Partnership Total %	18.6%	16.5%	13.5%	11.7%	11.7%	10.2%	3.8%	3.7%	2.9%	2.3%	1.6%	1.6%	1.2%	0.5%	0.1%	0.0%

Highlights of Maternal Chronic Conditions

Data shows Partnership Maternal Population chronic disease as a percentage (%) of maternal population as of December 31, 2025. In 2021, Corona Virus Pandemic (COVID-19) lockdowns caused a data lag. Data collected was “catch-up” data and incomplete. From 2022-2025, Partnership counties Maternal Chronic Conditions range from 20% to 75% among those whose deliveries Partnership paid for in the Delivery Claims dataset. The highest chronic condition seen in Partnership Maternal population is Anxiety followed by tobacco use at 20.6% and 17.9% average for all counties in 2025. Marin County maternal anxiety and tobacco use are however at 16.1% and 3.5% respectively, in 2025. Marin Maternal population have one of the lower chronic conditions among those whose deliveries Partnership paid for in the Delivery Claims dataset range from 13.6% to 35.7% over the past five years, 2021-2025. However, Chronic Liver Disease and Trauma and Stressor in Marin County at 2.9% and 12.2% are higher than Partnership average for counties at 1.8% and 11.6% respectively.

Note:

- Any one Chronic condition is counted as any Chronic Condition in the Partnership Maternal Population. These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions. Here, any Maternal individual with any one chronic condition is counted as a Maternal chronic condition.
- The Maternal population are Partnership members who are pregnant and those who have delivered up to one year after delivery (up to one year postpartum). Those who have had these conditions before, during, and/or up to two years after delivery are included in the count for each chronic condition. Pregnancy-related conditions that are not up to two years postpartum are not included here.
- Small numbers have been masked among maternal population with 0 = <5 and Unstable Numbers.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.

- o Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal clinical characteristics, also known as indicators, being measured.
- o Delivery Claims datasets contain all Partnership pregnant and those who have delivered up to one year after delivery (up to one year postpartum).
- o Maternal Chronic Conditions:
 - Maternal chronic conditions are defined as any of the conditions listed below, found in either diagnosis or procedure ICD10 codes of any individual in the Partnership Maternal population.
 - Maternal Population includes pregnant people and those who have delivered up to one year after delivery and at least twice over a two-year period.
 - Maternal chronic conditions do not include pregnancy-related conditions (i.e., various classifications of hypertension in pregnancy, when high blood pressure returns to normal right after delivery) and could be diagnosed before, during, or after delivery (up to one year postpartum) and within two years of claims data information gathered.
- o Maternal Chronic Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety
 - Tobacco Use
 - Obesity
 - Depression
 - Substance Use
 - Trauma and Stressor
 - Chronic Kidney Disease
 - Hypertension
 - Diabetes
 - Bipolar
 - Schizophrenia
 - Chronic Liver Disease
 - Asthma
 - Congestive Heart Failure
 - Cancer

- Traumatic Brain Injury
- Calculations:
 - % Maternal Chronic Conditions:
 - Numerator: number of distinct Partnership county chronic condition maternal deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Denominator: total number of distinct Partnership county maternal deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Rate: multiplied by 100 (%)

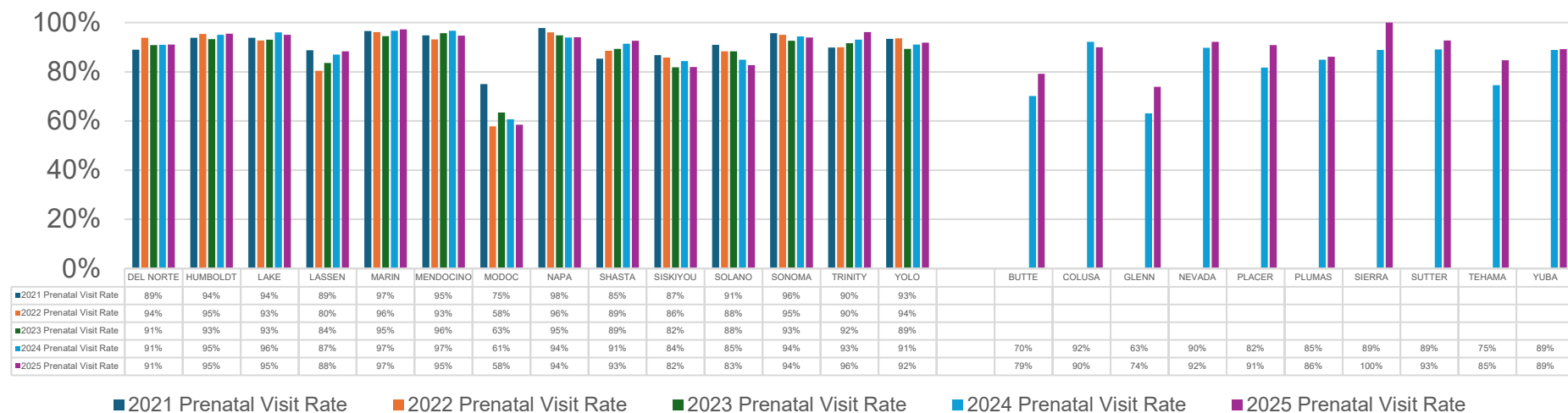
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Obstetric/Maternal Demographics and Conditions

Maternal Prenatal & Postnatal Visits

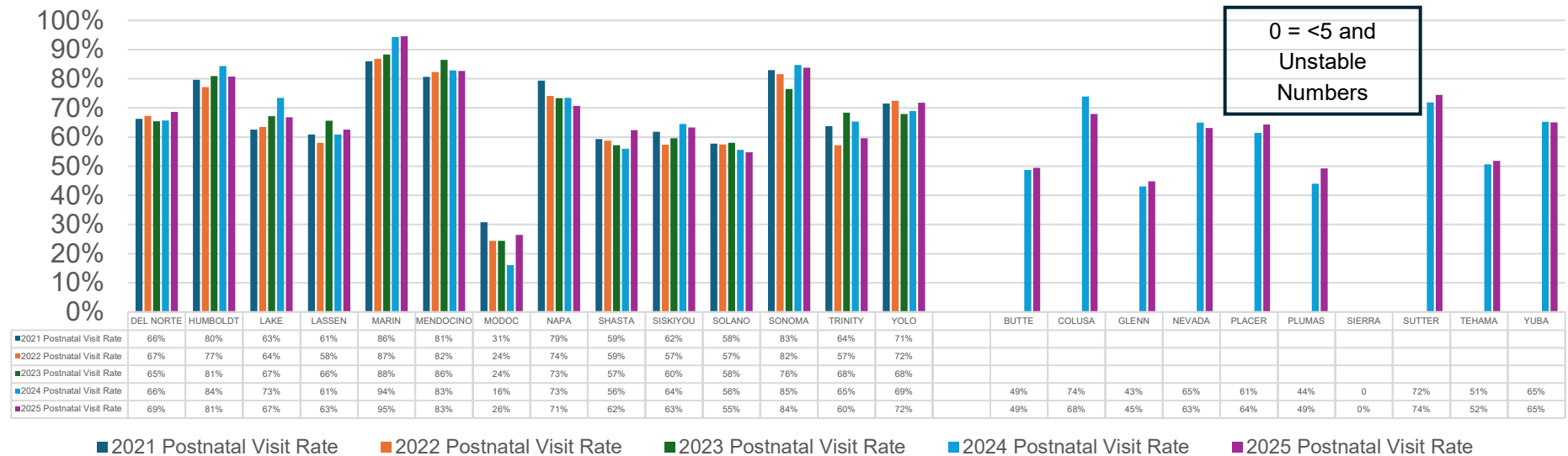
Partnership Prenatal Visit Rate by Delivering Members and County, 2021-2025



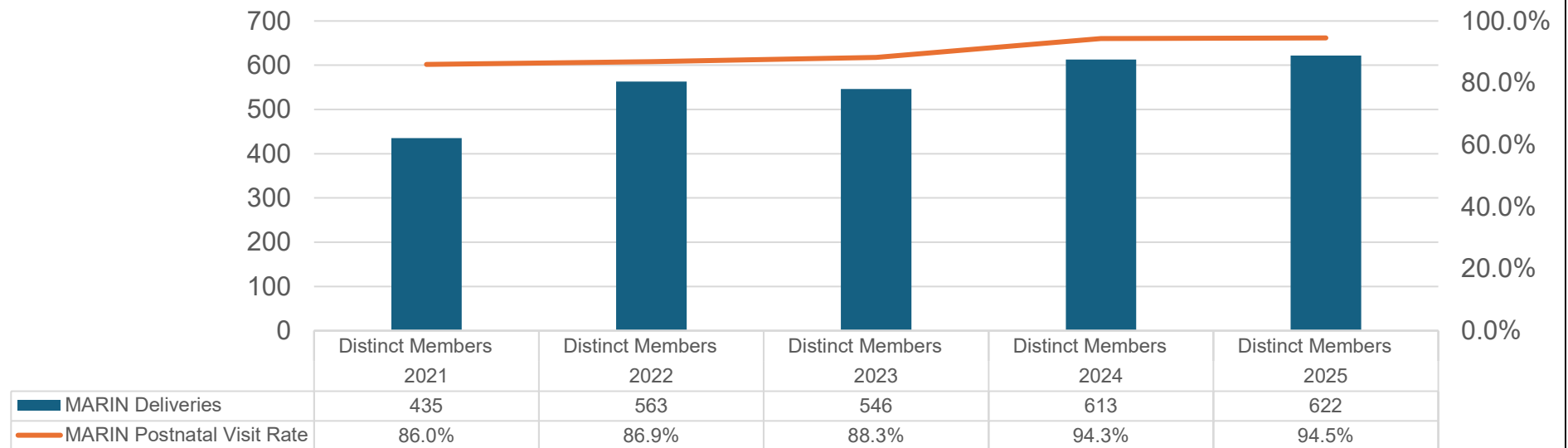
Partnership Prenatal Visit Rate by Delivering Members by Marin County, 2021-2025



Partnership Postnatal Visit Rate by Delivering Members and County, 2021-2025



Partnership Postnatal Visit Rate by Delivering Members by Marin County, 2021-2025

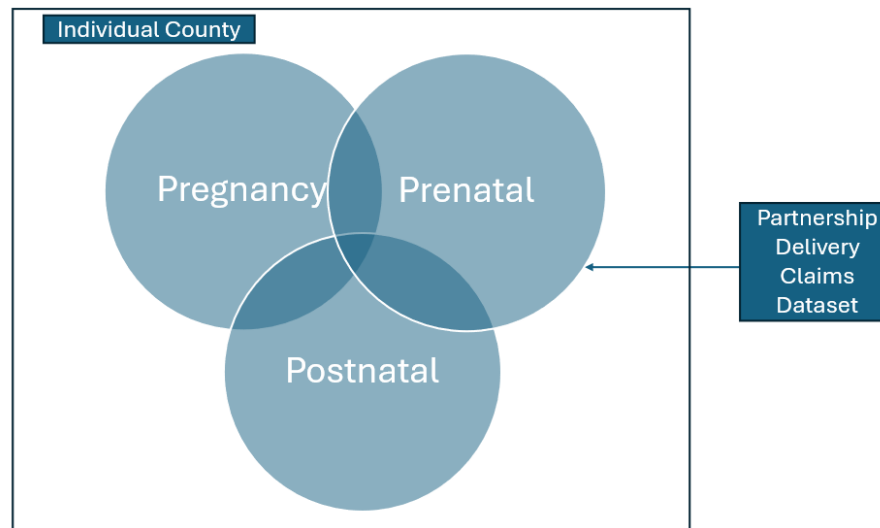


Highlights of Maternal Prenatal & Postnatal Visits

Data shows Partnership Maternal Population as a percentage (%) of prenatal and postnatal visits from 2021 to 2025, among those whose deliveries Partnership paid for in the Delivery Claims dataset. For this Partnership Maternal population, prenatal visits range from 58% to 100%. In Partnership's smallest county, Sierra, postnatal visits range from 16% to 94%. Please note that any mother or expectant woman may join Partnership while pregnant, during delivery, or after delivery and may become ineligible while pregnant or after delivery. This data only shows the maternal population whose delivery Partnership paid for.

Marin County prenatal and postnatal rates have been constant (prenatal) and increasing (postnatal) from 2021 to 2025. The highest increase is seen in postnatal care in 2025 at 95%, among those whose deliveries Partnership paid for in the Delivery Claims dataset.

Partnership Delivery Claims Dataset



The data presented is **not** from the Partnership Healthcare Effectiveness Data and Information Set (HEDIS®) for prenatal visit and postnatal visit estimates. HEDIS data includes medical claims data for all prenatal and postnatal visits for both those whose deliveries were paid for by Partnership and those whose deliveries were not paid by Partnership. To summarize, HEDIS combines All Partnership member data in Medical Claims, Delivery Claims, and Clinical Setting datasets. Partnership hosts HEDIS reports on its web page at www.partnershiphp.org/Providers/Quality/Pages/HEDISLandingPage.aspx, under Annual Summary of Performance (See “MCAS” version).

Note: % Maternal Prenatal Visits are population-based calculations and should not be compared to % visits from statistical sampled population estimates stratified by county or service providers and clinics, as subset of the population estimates as seen in Partnership HEDIS or Partnership Quality Incentive Programs prenatal or postnatal visit estimates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (up to one year postpartum).
- Calculations:
 - % Maternal Prenatal Visits (**Any One Visit**):
 - Numerator: Number of Any Distinct Count of Partnership County Prenatal Visits Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Rate: Multiplied by 100 (%)
 - % Maternal Postnatal Visits (**Any One Visit**):
 - Numerator: Number of Any Distinct Count of Partnership County Postnatal Visits Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries whose deliveries Partnership paid for in the Delivery Claims dataset

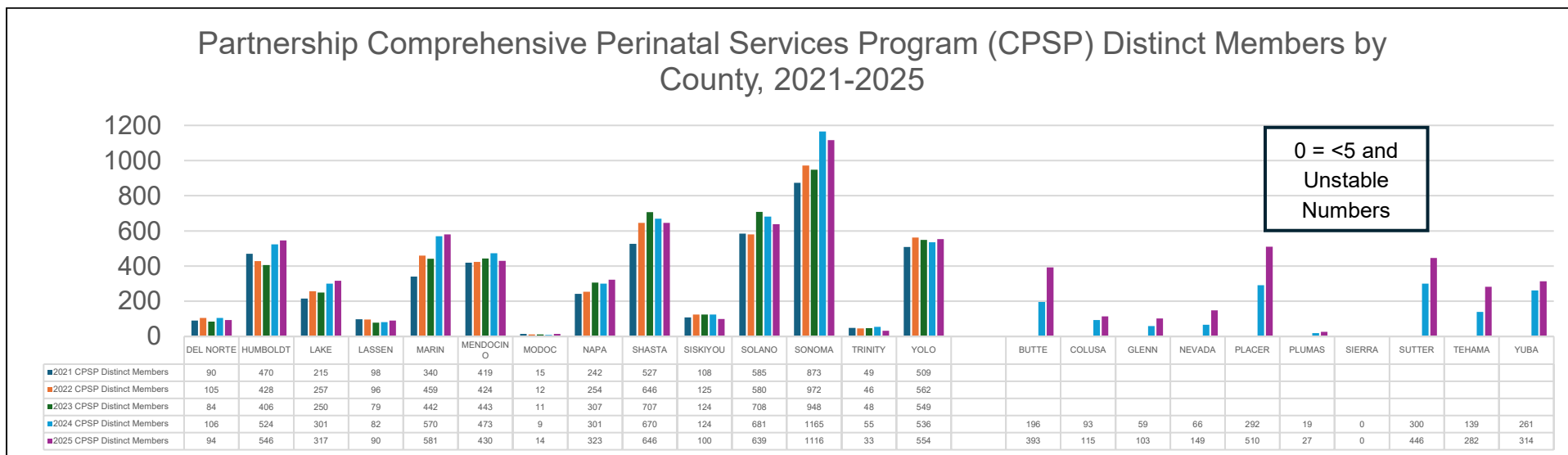
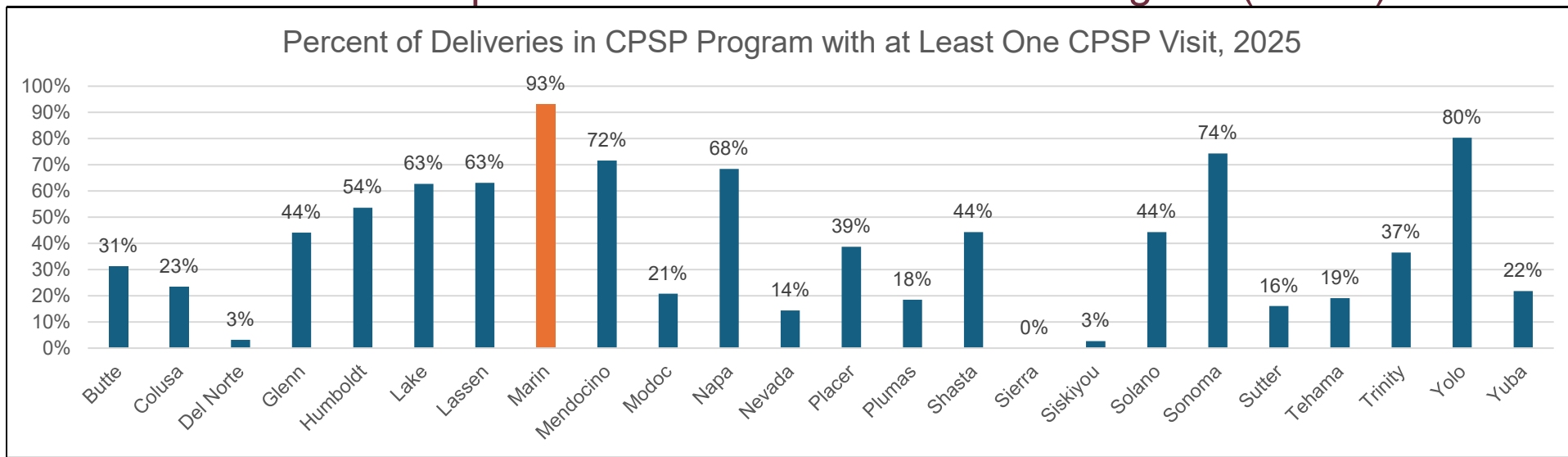
- Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

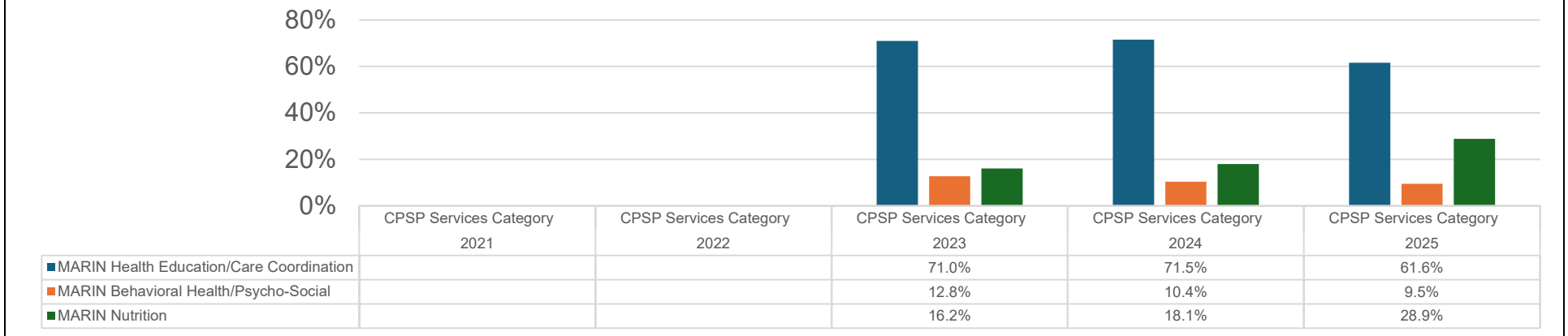
- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data

Obstetric/Maternal Demographics and Conditions

Maternal Comprehensive Perinatal Services Program (CPSP)



Partnership Comprehensive Perinatal Services Program (CPSP) Service Category by Marin County, 2021-2025



Highlights of Maternal Comprehensive Perinatal Services Program (CPSP)

Data shows Partnership Maternal Comprehensive Perinatal Services Program (CPSP) service in percentage (%) of claims for services provided by certified community health providers by delivery count from 2021 to 2025, among those whose deliveries Partnership paid for in the Delivery Claims dataset. CPSP services to Maternal population in Marin County have been improving over the years (2021 to 2025) and continue to improve. Marin County CPSP service category in 2025 was 61.6% Health Education, 9.5% Behavioral Health and Psychosocial assessment and 28.9% Nutrition.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.

- Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
- Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (up to one year postpartum).
- Calculations:
 - Number of Unique Services: Number of Distinct services
 - Maternal Comprehensive Perinatal Services Program (CPSP) Count: Number of Distinct Partnership County CPSP Service by Maternal Delivery.
 - CPSP services are divided into:
 1. Health Education/Care Coordination
 2. Behavioral Health/Psychosocial
 3. Nutrition
 - % Maternal Comprehensive Perinatal Services Program (CPSP) Service:
 - Numerator: Number of Distinct Partnership County CPSP Service to Maternal Deliveries
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries
 - Rate: Multiplied by 100 (%)
- CPSP services are divided into:
 1. Health Education/Care Coordination
 2. Behavioral Health/Psychosocial
 3. Nutrition

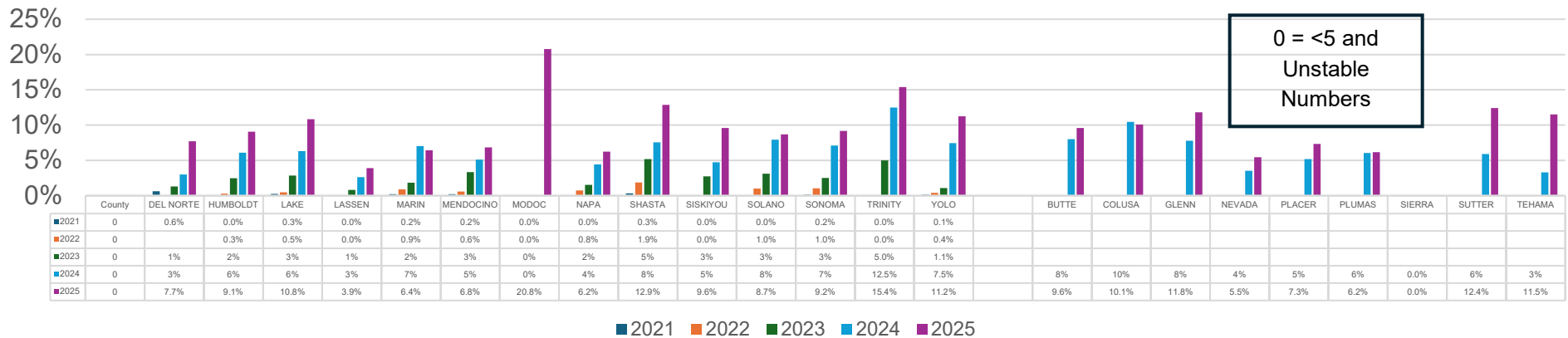
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data
- [CalAIM](#): Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services

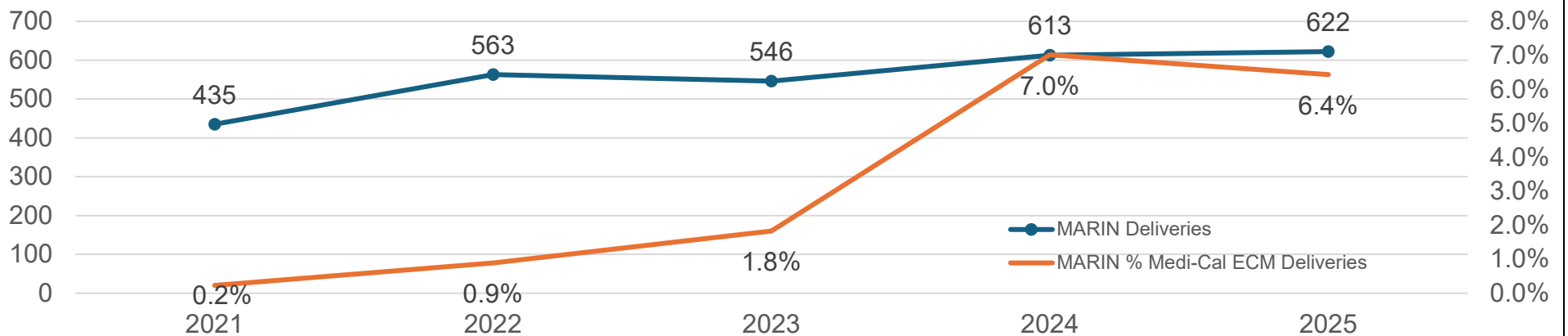
Obstetric/Maternal Demographics and Conditions

Maternal Enhanced Care Management (Medi-Cal ECM)

Partnership Member Percent (%) Maternal Enhanced Care Management (Medi-Cal ECM) by County, 2021-2025



Partnership Member Percent (%) Maternal Deliveries Versus Enhanced Care Management (Medi-Cal ECM) by Marin County, 2021-2025



Highlights of Maternal Enhanced Care Management (Medi-Cal ECM)

Data shows Partnership Maternal Enhanced Care Management (Medi-Cal ECM) service in percentage (%) of claims for services provided by certified community health providers by delivery count from 2021 to 2025, among those whose deliveries Partnership paid for in the Delivery Claims dataset. Most counties started counting Medi-Cal ECM services for Partnership paid deliveries in 2021 and the numbers have been improving over the years (2021 to 2025) and continue to improve. Marin County Medi-Cal ECM services to Partnership maternal population have increased from 0.2% in 2021 to 6.4% in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

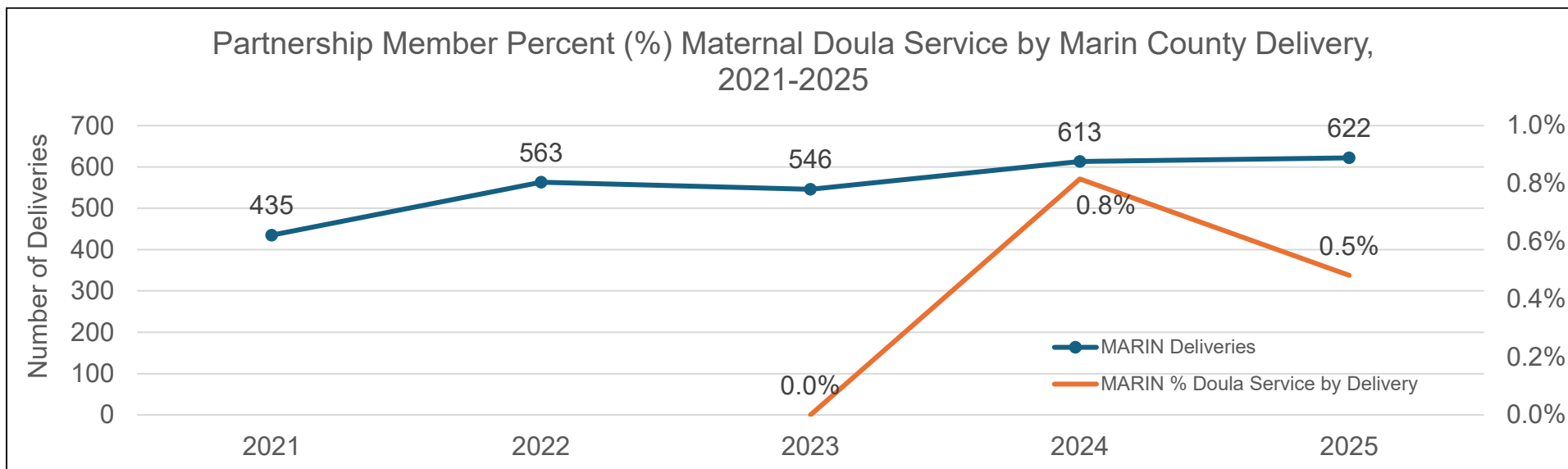
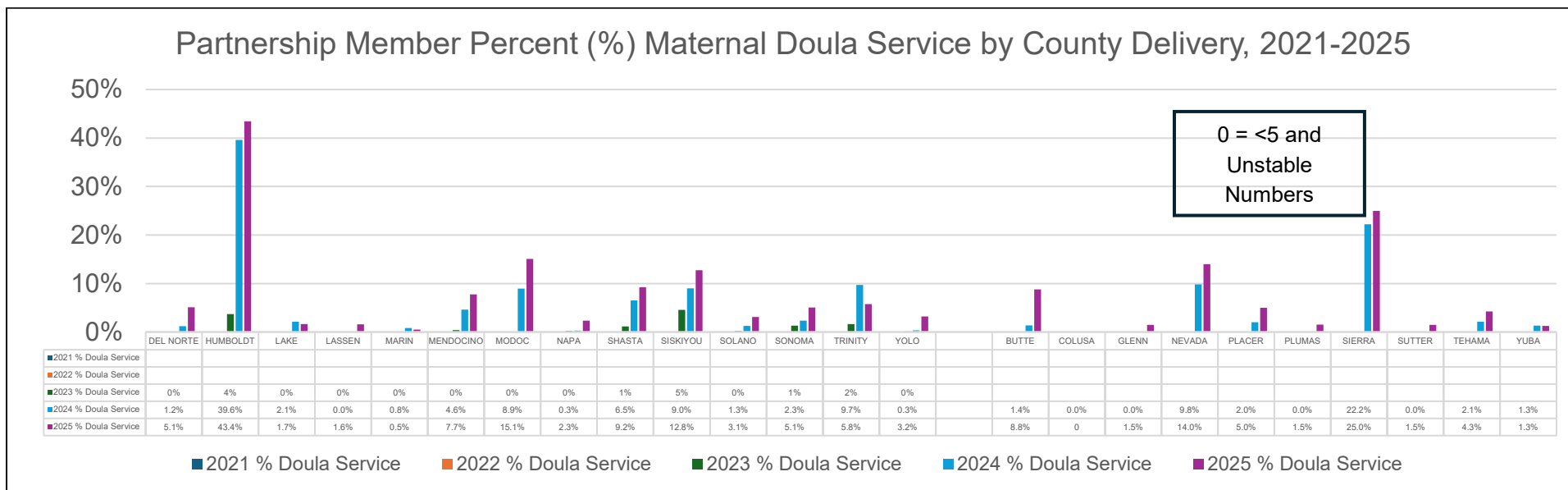
- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (up to one year postpartum).
- Calculations:
 - % Maternal Enhanced Care Management (Medi-Cal ECM) Service:
 - Numerator: Number of Distinct Partnership County ECM Service to Maternal Deliveries
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries
 - Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data
- [CalAIM](#): Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services

Obstetric/Maternal Demographics and Conditions

Maternal Doula Service Data



Highlights of Maternal Doula Service Data

Data shows Partnership Maternal Doula service in percentage (%) of claims for services provided by Doula providers by delivery count from 2021 to 2025, among those whose deliveries Partnership paid for in the Delivery Claims dataset. Most counties started counting Doula services for Partnership paid deliveries in 2023 and the numbers have been improving over the years (2024 to 2025) and continue to improve. Marin County Doula services to Partnership maternal population have increased from 0.0% in 2023 to 0.5% in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Partnership Maternal Population: is defined as the Maternal Delivery Count.
 - Partnership Maternal Delivery: deliveries Partnership paid for in the Delivery Claims dataset
 - Partnership Maternal Delivery Count is from the DHCS delivery claims data. If a mother has two deliveries in one year, both deliveries will be counted.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
 - Delivery Claims datasets contain all Partnership Pregnant and those who have delivered up to one year after delivery (up to one year postpartum).
- Calculations:
 - % Maternal Doula Service:
 - Numerator: Number of Distinct Partnership County Doula Service to Maternal Deliveries
 - Denominator: Total Number of Distinct Partnership County Maternal Deliveries
 - Rate: Multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Delivery Claims data
- DHCS Medical Claims data
- CalAIM: Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services

Obstetric/Maternal Demographics and Conditions

Maternal Measures in Hospital Quality Improvement Programs

Measure Rating Scale Based off of HQIP Targets					
Measure	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

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	Below Avg					2.3	Average	15.5	Average	Yes	0.0%
Tahoe Forest Hospital	Auburn	14.6	Superior			5	Average	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	Below Avg					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	Below Avg					0.9	Above Avg		Not Offered	No	0.0%

Highlights of Maternal Measures in Hospital Quality Improvement Programs

The table compares performance of Hospitals in the Partnership region of 24 Counties reported in the Hospital Compare database with data from California Maternal Quality Care Collaboration (CMQCC) and the California Department of Public Health (CDPH).

Definition:

- 2024 California deliveries reported to the California Maternal Quality Care Collaboration (CMQCC) Maternal Data Center
- NTSV CS: Nulliparous, Tern, Singleton, Vertex (NTSV) Cesarean Section (CS) Birth Rate, a method of delivery abstracted from California Hospital Discharge and Vital Records data, a CMQCC measure.
- Episiotomy Rate: Mothers with maternal birthing surgical cuts to avoid birthing tears during birthing process and prevent excessive bleeding. A CMQCC measure abstracted from California Patient Discharge Data with performance category developed by California Hospital Compare
- VBAC: Vaginal Birth After Cesarean Section (VBAC) are vaginal births after a previous CS. A CMQCC measure abstracted from California Patient Discharge Data with performance category developed by California Hospital Compare.
- Deliveries by Certified Nurse Midwives: A CMQCC measures abstracted from California Patient Discharge Data linked to Birth-Vital Records data with performance category developed by California Hospital Compare.
- Calculations: Performance Scores
 - Number/Total number of live births X 100 (%) for that period (i.e., 2024)
 - State Average: Represents 95% of 2024 California deliveries reported to CMQCC Maternal Data Center
 - Depending on the measure, a five scale or three scale rating is used
 - Five Scale Rating:
 - Superior
 - Above
 - Average
 - Below average
 - Poor
 - Three Scale Rating:
 - Superior
 - Average
 - Poor

Data Source:

- [California Hospital Compare](https://calhospitalcompare.org): calhospitalcompare.org
- [California Maternal Quality Care Collaboration \(CMQCC\)](https://cmqcc.org): cmqcc.org

Chronic Conditions

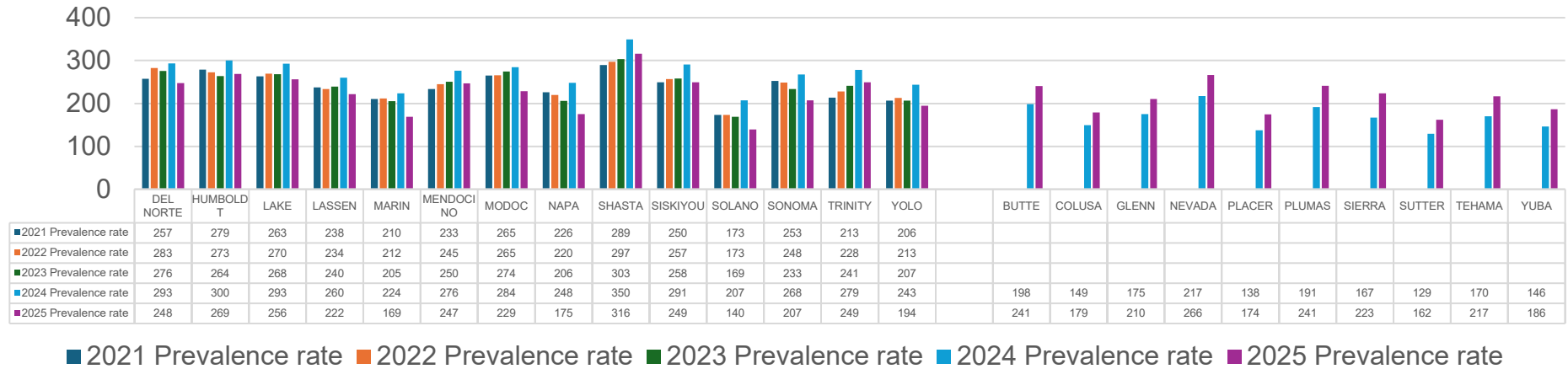
Anxiety	80
Bipolar Disorder	83
Schizophrenia	86
Trauma & Stress	89
Asthma	92
Cancer.....	95
Kidney Disease	98
Liver Disease	101
Congestive Heart Failure.....	104
Chronic Obstructive Pulmonary Disease (COPD)	107
Coronary Artery Disease	110
Diabetes Mellitus	113
Hypertension	116
Traumatic Brain Injury	119

For more information, see [Chronic Conditions](#) in the [Appendix](#)

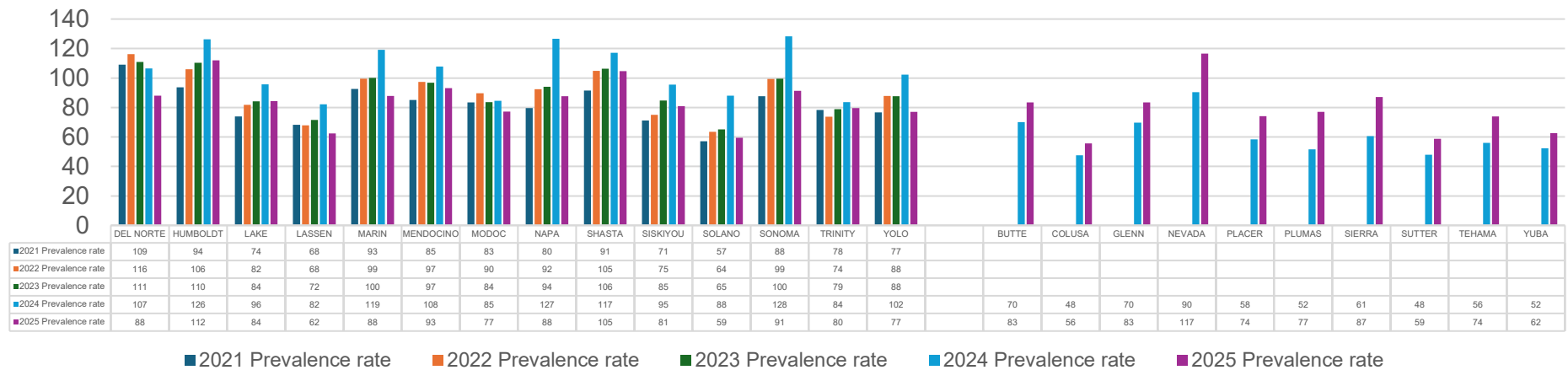
Chronic Conditions

Anxiety

Partnership Adult Member Anxiety Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Member Anxiety Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Anxiety

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Anxiety is the highest rate of chronic disease condition among Partnership adult and child members per 1,000. Partnership members in Marin County are at an Anxiety rate range of adult 205-224 per 1,000 adult members and child 88-119 per 1,000 child members from 2021 to 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and Health Effectiveness Data and Information Set (HEDIS) specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - **Anxiety**, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:
 - Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County

- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

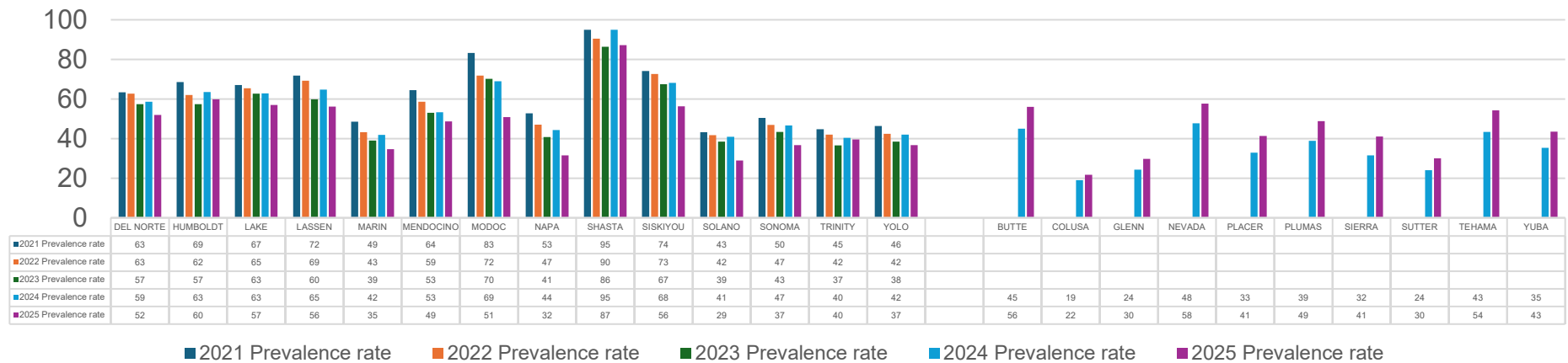
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions

Bipolar Disorder

Partnership Adult Member Bipolar Disorder Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Member Bipolar Disorder Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Bipolar Disorder

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Bipolar is seen in more adults than children as a chronic disease condition among Marin County Partnership members. Partnership members in Marin County are at a Bipolar rate range of adult 35-49 per 1,000 adult members and child 5-9 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, **Bipolar**, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

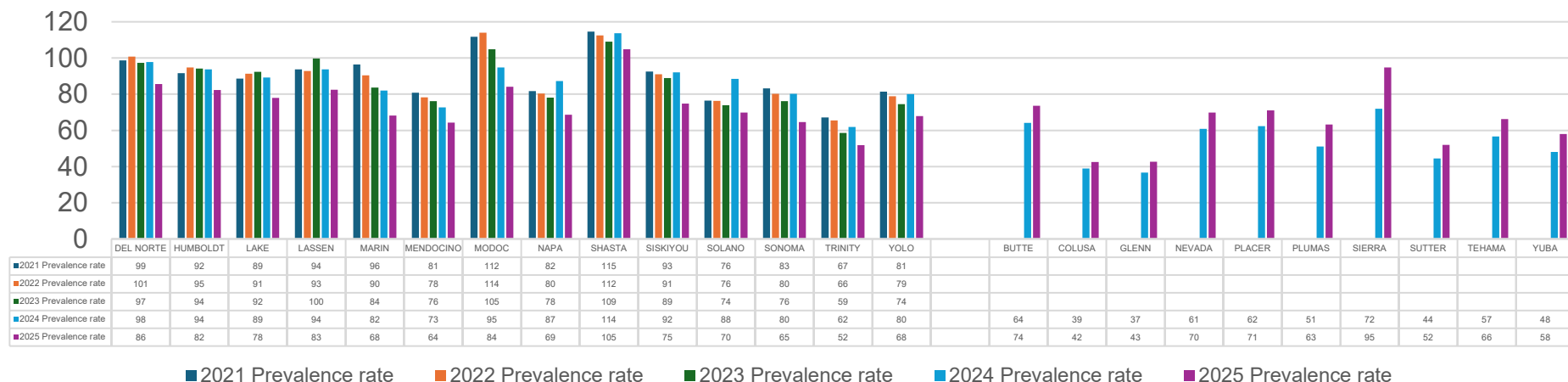
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

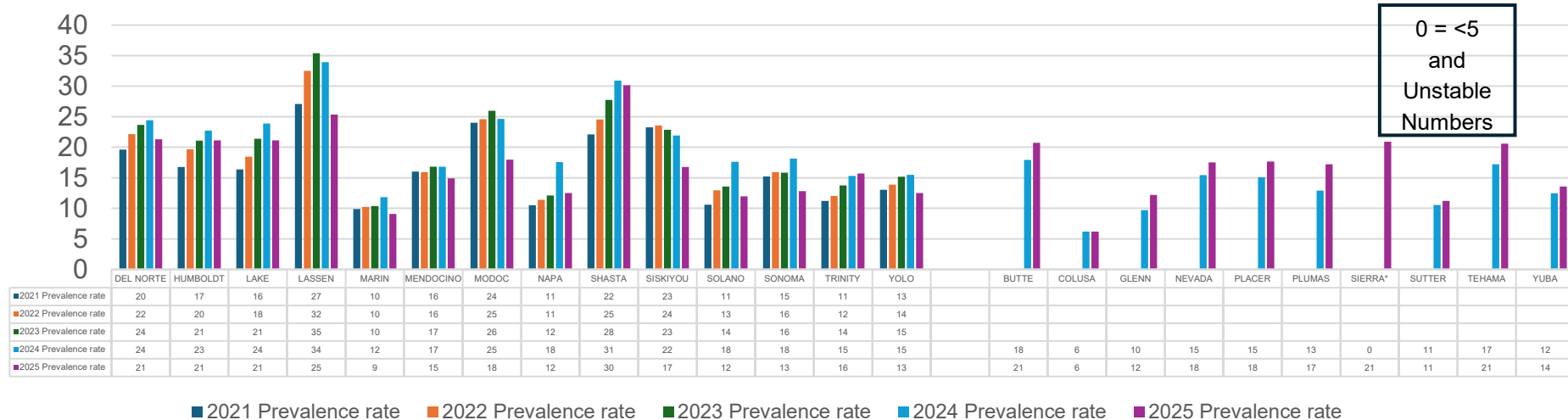
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Schizophrenia

Partnership Adult Schizophrenia Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Schizophrenia Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Schizophrenia

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Schizophrenia is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a Schizophrenia rate range of adult 68-96 per 1,000 adult members and child 9-12 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, **Schizophrenia**, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

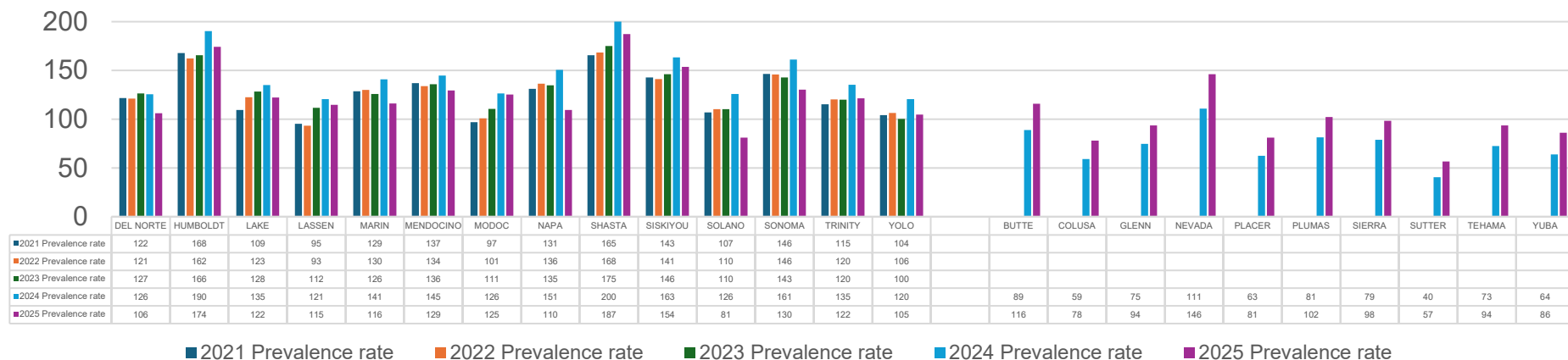
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

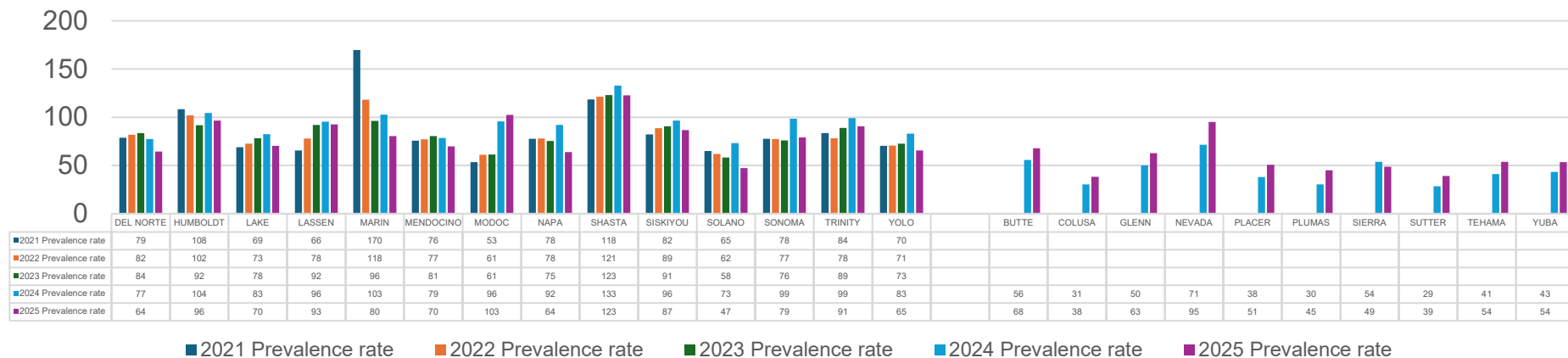
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Trauma & Stress

Partnership Adult Trauma & Stress Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Trauma & Stress Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Trauma & Stress

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Trauma and Stress is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a Trauma and Stress rate range of adult 116-141 per 1,000 adult members and child 80-170 per 1,000 child members from 2021 to 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, **Trauma and Stressor**, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:
 - Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County

- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

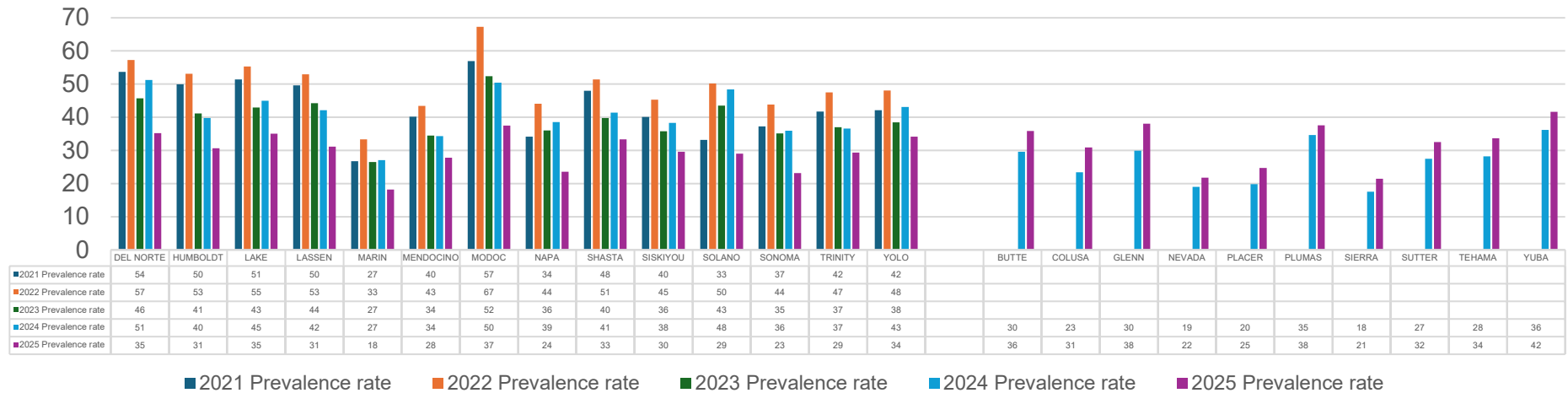
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

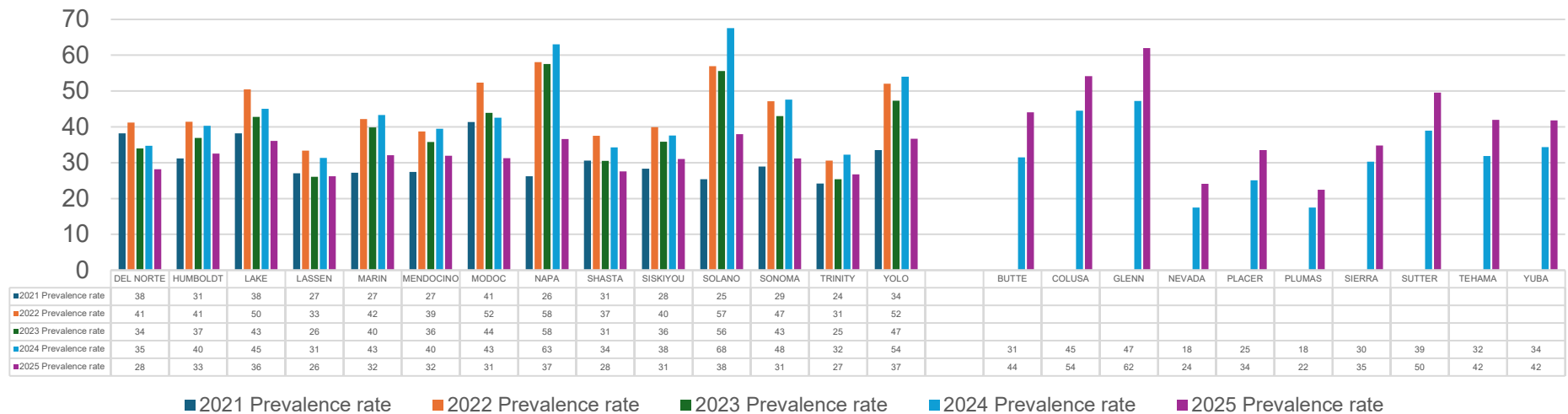
Chronic Conditions

Asthma

Partnership Adult Asthma Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Asthma Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Asthma

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Asthma is seen in more children than adults as a chronic disease among Marin County Partnership members. Partnership members in Marin County are at an Asthma rate range of 18-33 per 1,000 adult members and child 27-43 per 1,000 child members from 2021 to 2025.

In 2025, there were fewer wildfires in North of California than 2021-2024, hence the relatively lower rates noticed in 2025 across all counties.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, **Asthma**, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:

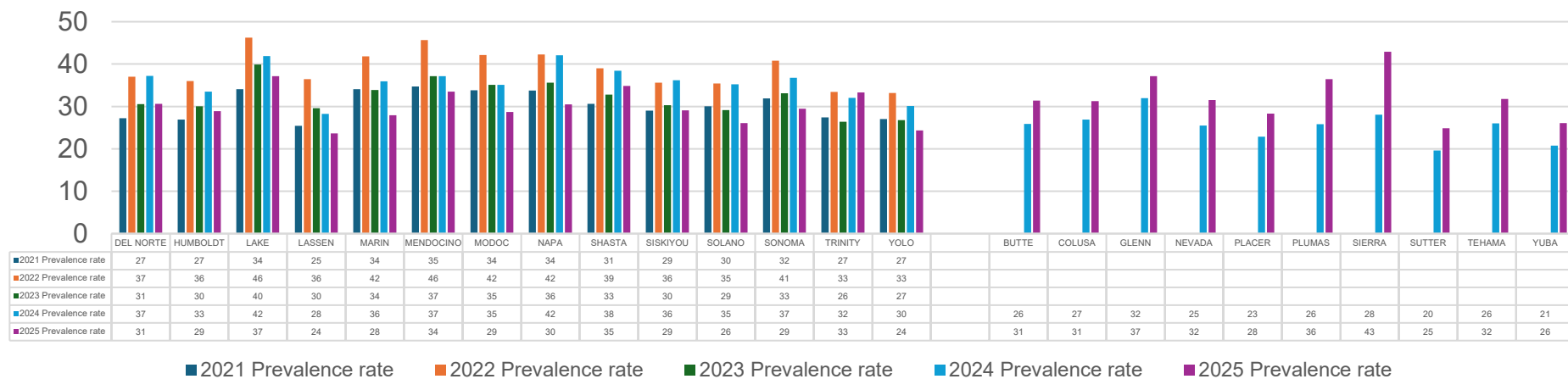
- o % Adult or Child Chronic Conditions:
 - Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
 - Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
 - Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

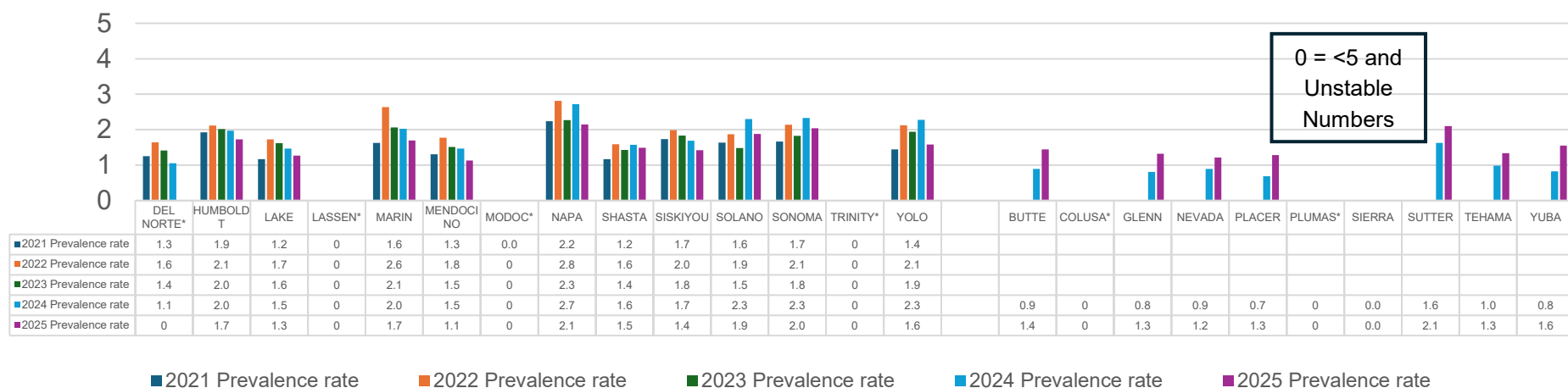
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Cancer

Partnership Adult Cancer Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Cancer Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Cancer

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Cancer is seen in more adults than children as a chronic disease among Marin County Partnership members. Partnership members in Marin County are at a Cancer rate range of adult 28-42 per 1,000 adult members and child 2-3 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

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- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, **Cancer**, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

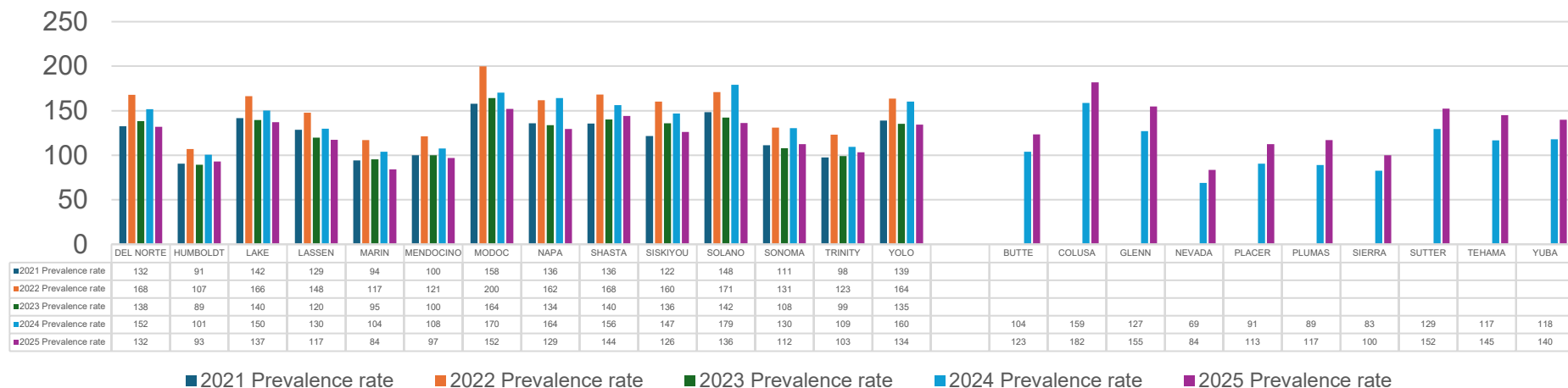
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

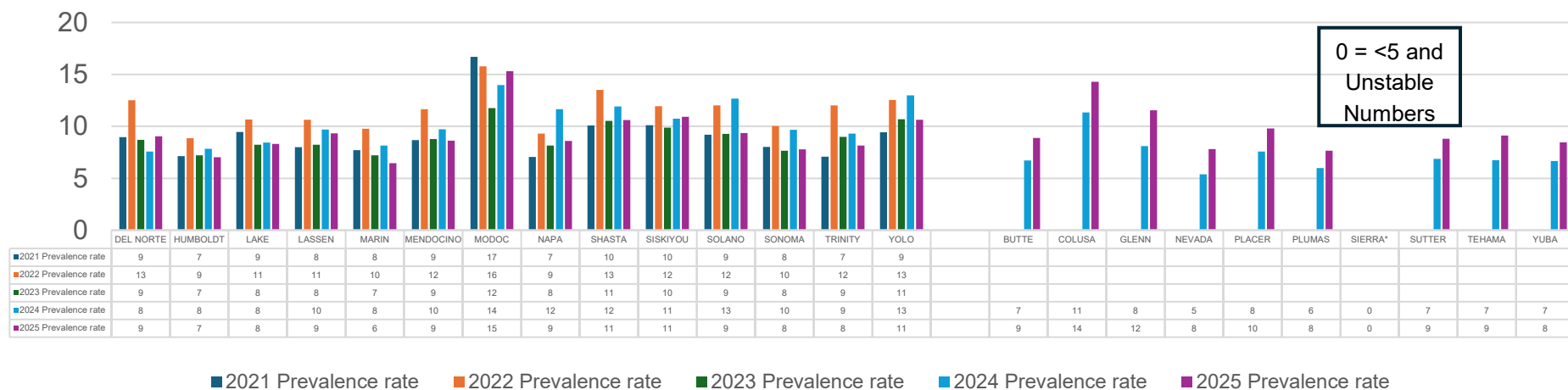
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Kidney Disease

Partnership Adult Kidney Disease Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Kidney Disease Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Kidney Disease

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Chronic Kidney Disease is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a chronic kidney disease rate range of adult 84-117 per 1,000 adult members and child 6-10 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, **Chronic Kidney Disease**, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

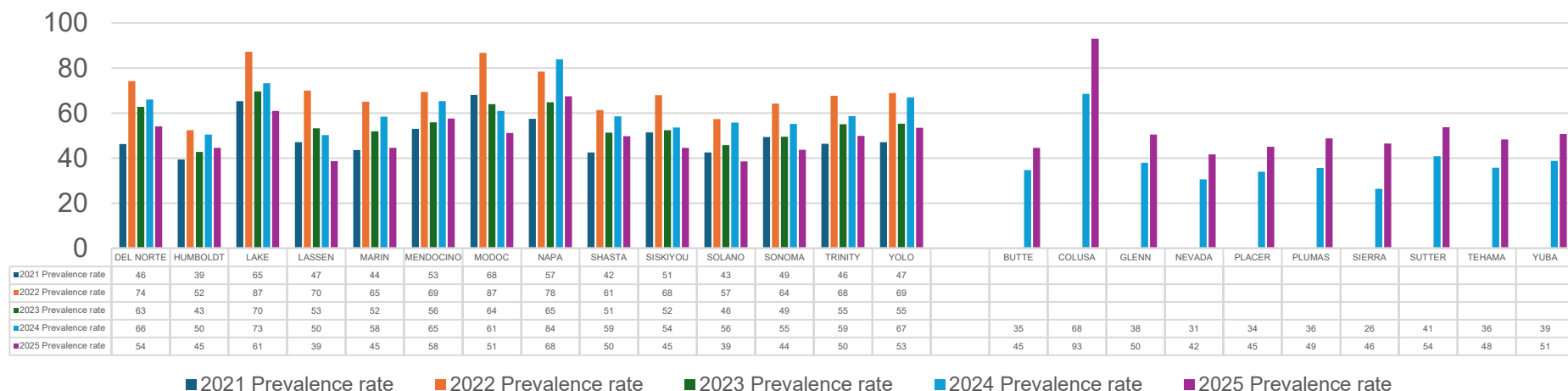
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

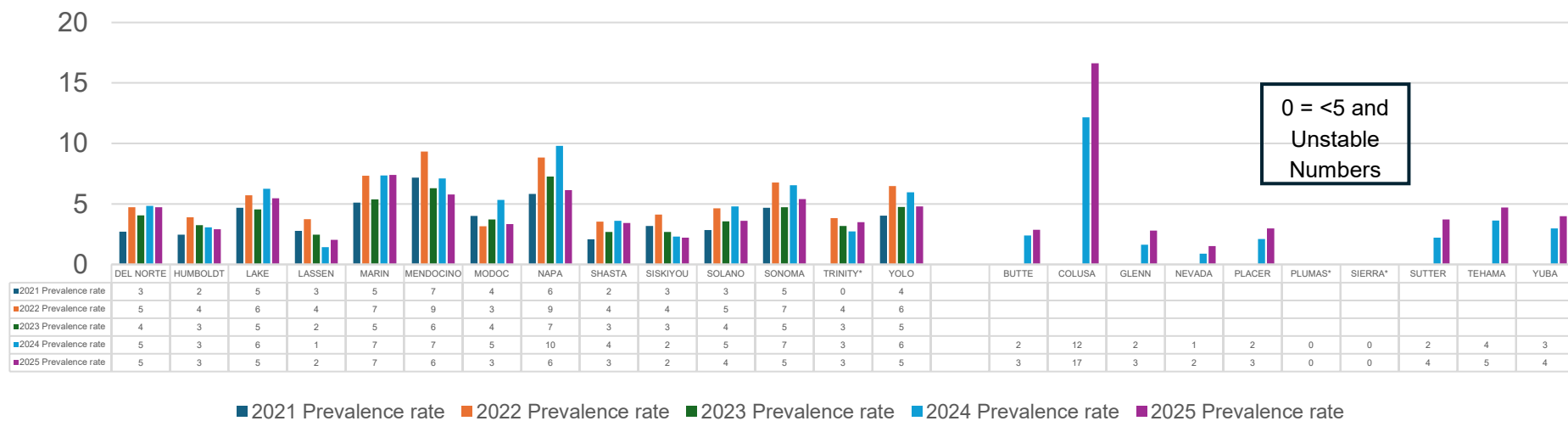
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Liver Disease

Partnership Adult Liver Disease Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Liver Disease Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Liver Disease

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Chronic Liver Disease is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a chronic liver disease rate range of adult 44-65 per 1,000 adult members and child 5-7 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, **Chronic Liver Disease**, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

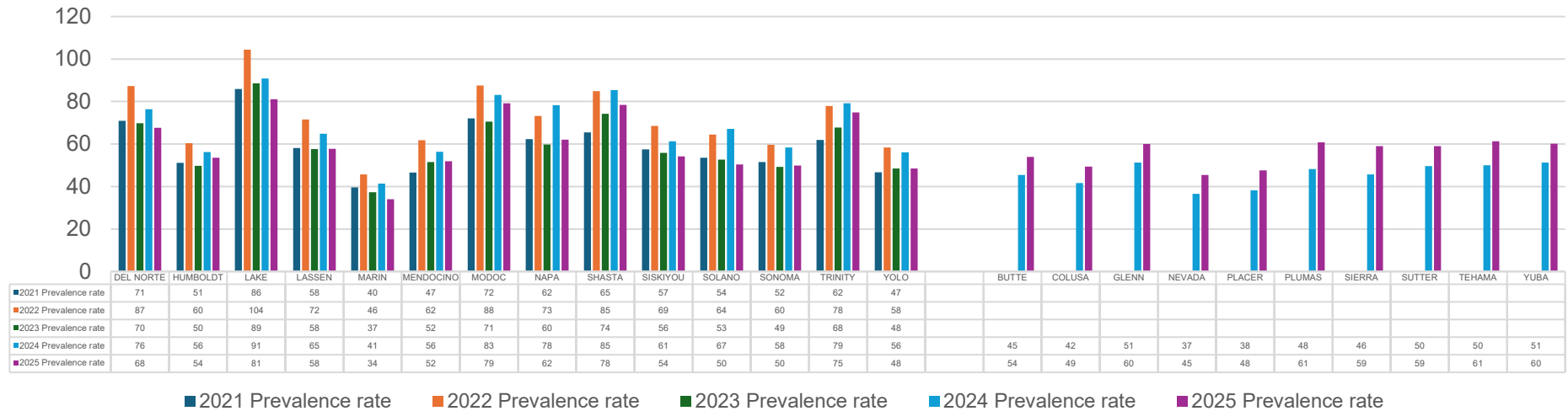
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Congestive Heart Failure

Partnership Adult Congestive Heart Failure Condition Prevalence per 1,000 Members by County, 2021-2025



Note: Partnership Child Congestive Heart Failure Condition prevalence data is too small to interpret.

Highlights of Congestive Heart Failure

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Congestive Heart Failure is seen in more adults than children. The child rates have been removed because they are small and unstable. Partnership members in Marin County are at a Congestive Heart Failure adult rate range of 34-46 per 1,000 adult members from 2021 to 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), **Congestive Heart Failure**, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:
 - Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County

- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

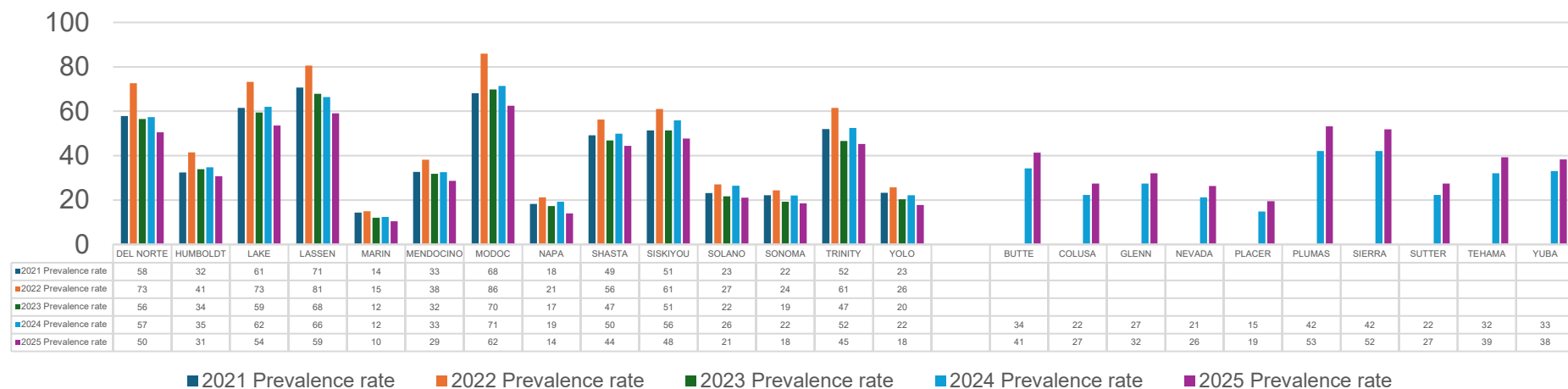
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions

Chronic Obstructive Pulmonary Disease (COPD)

Partnership Adult Chronic Obstructive Pulmonary Disease (COPD) Condition Prevalence per 1,000 Members by County, 2021-2025



Note: Partnership Child Chronic Obstructive Pulmonary Disease (COPD) Condition prevalence data is too small to interpret.

Highlights of Chronic Obstructive Pulmonary Disease (COPD)

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Chronic Obstructive Pulmonary Disease (COPD) is seen in more adults than children. The child rates have been removed because they are small and unstable. Partnership members in Marin County are at a COPD adult rate range of 10-15 per 1,000 adult members from 2021 to 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

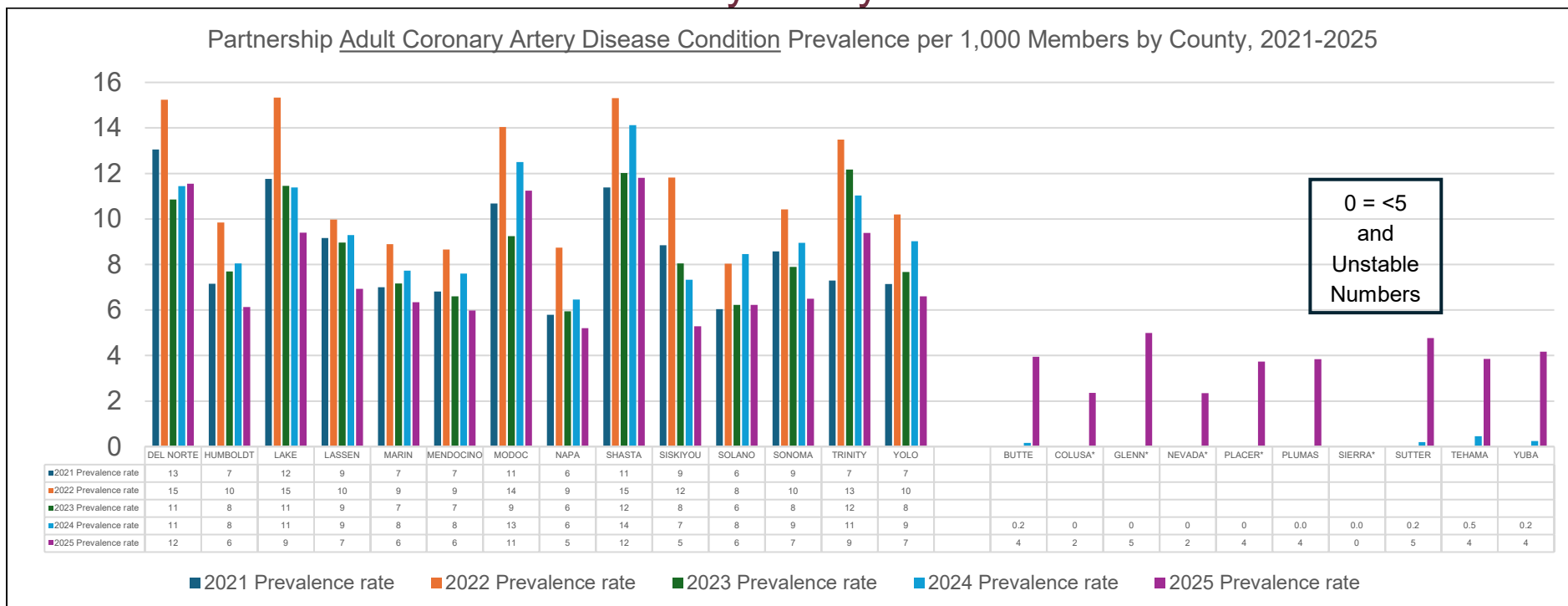
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, **Chronic Obstructive Pulmonary Disease (COPD)**, Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:
 - Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County

- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Coronary Artery Disease



Note: Partnership Child Coronary Artery Disease Condition prevalence data is too small to interpret.

Highlights of Coronary Artery Disease

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Coronary Artery Disease is seen in more adults than children. The child rates have been removed because they are small and unstable. Partnership members in Marin County are at a coronary artery disease adult rate range of 6-9 per 1,000 adult members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, **Coronary Artery Disease**, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

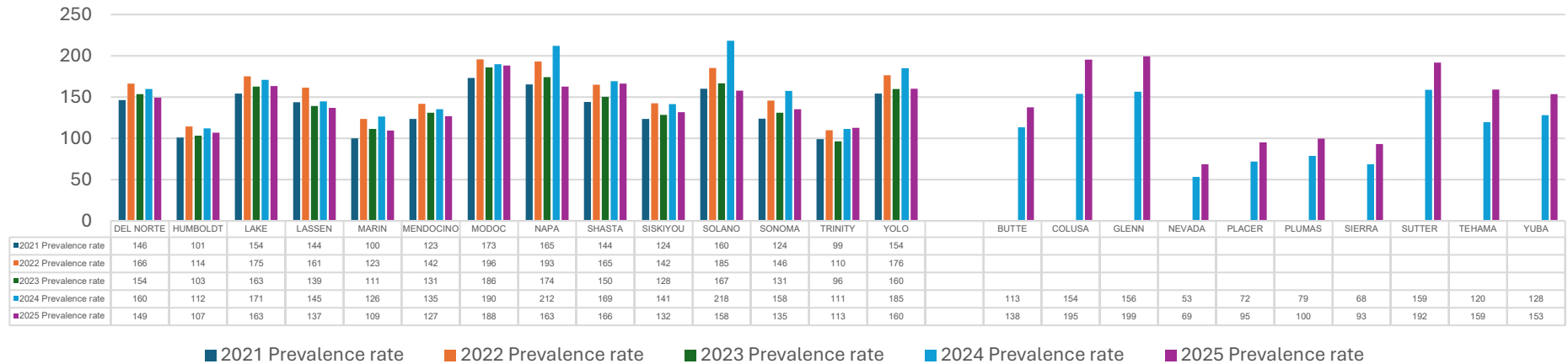
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

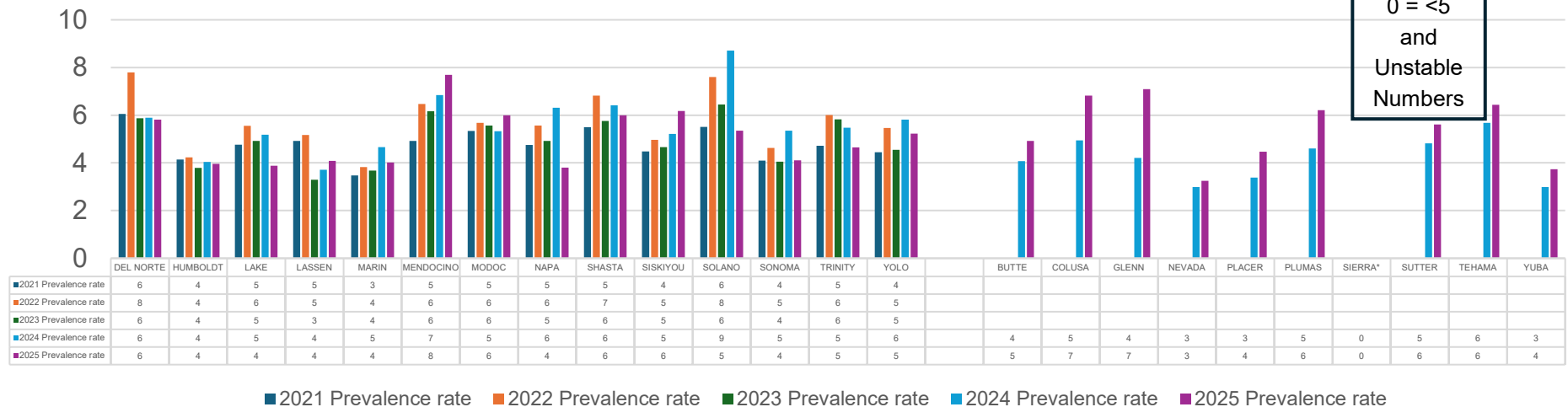
Chronic Conditions

Diabetes Mellitus

Partnership Adult Diabetes Mellitus Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Diabetes Mellitus Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Diabetes Mellitus

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Diabetes Mellitus is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a Diabetes Mellitus rate range of adult 100-126 per 1,000 adult members and child 3-5 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, **Diabetes**, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

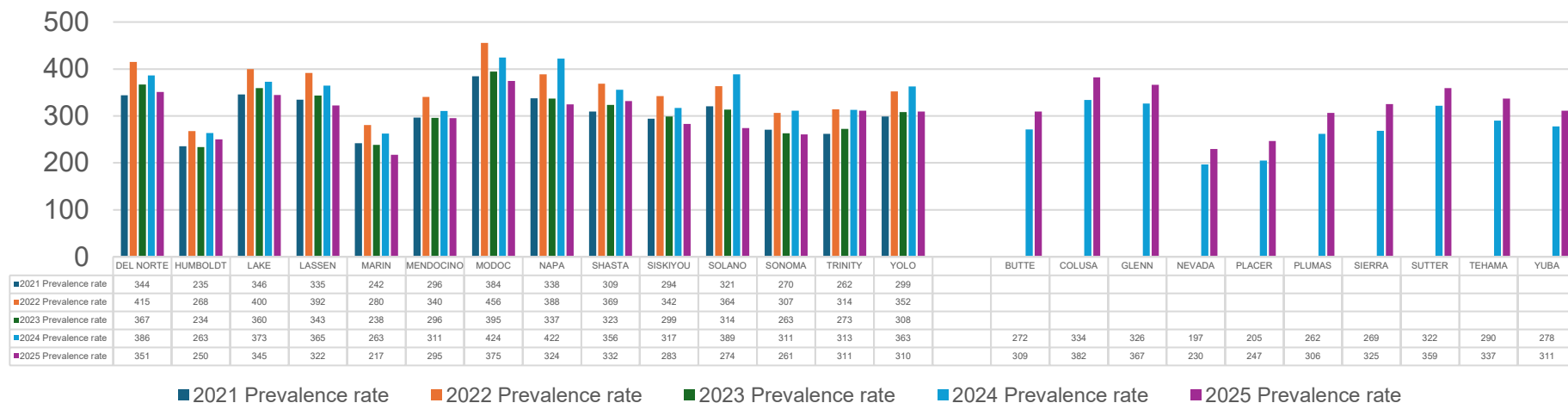
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

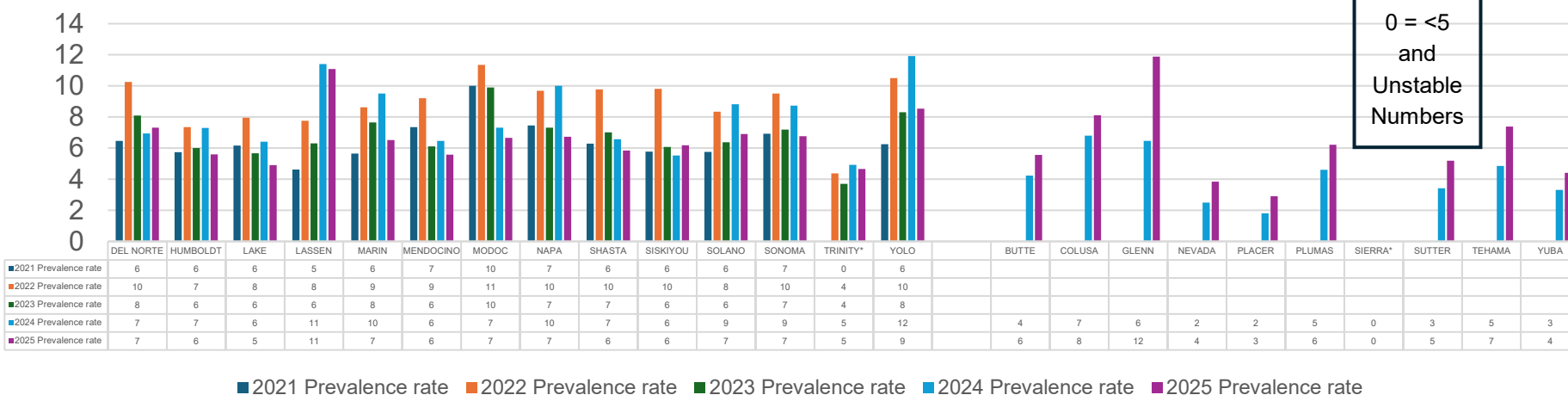
Chronic Conditions

Hypertension

Partnership Adult Hypertension Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Hypertension Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Hypertension

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Hypertension is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a Hypertension rate range of adult 217-280 per 1,000 adult members and child 6-10 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, **Hypertension**, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, Traumatic Brain Injury.
- Calculations:
 - % Adult or Child Chronic Conditions:

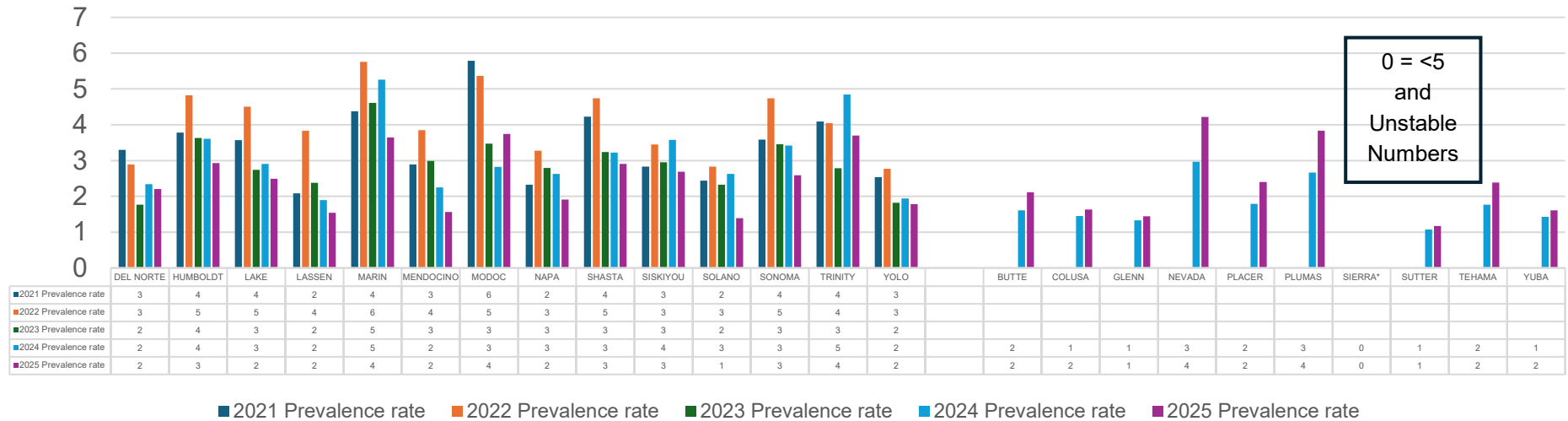
- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

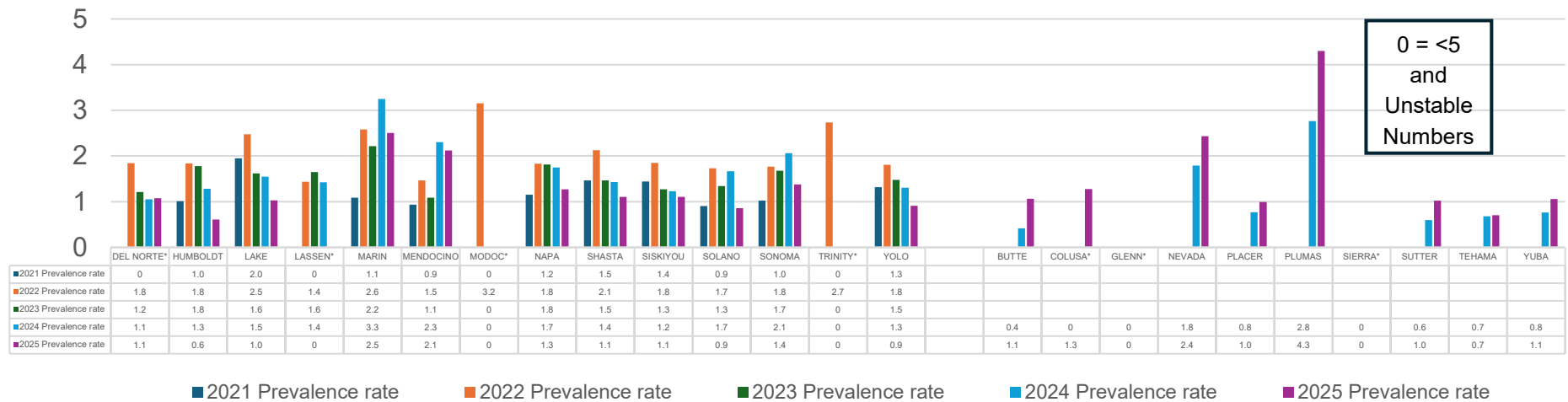
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

Chronic Conditions Traumatic Brain Injury

Partnership Adult Traumatic Brain Injury Condition Prevalence per 1,000 Members by County, 2021-2025



Partnership Child Traumatic Brain Injury Condition Prevalence per 1,000 Members by County, 2021-2025



Highlights of Traumatic Brain Injury

Data shows Partnership member chronic disease conditions as a percentage (%) of the total number of Partnership members in each county per year from 2021 to 2025. Any-one Chronic Disease Condition is counted as “Any-Chronic Condition.” These conditions are not mutually exclusive in each individual, as one individual may have several chronic conditions, hence any-one is counted as a chronic condition. Partnership member chronic disease has been divided into two categories, adult and child. Children are members 0-21 years of age. Traumatic Brain Injury is seen in more adults than children among Marin County Partnership members. Partnership members in Marin County are at a Traumatic Brain Injury rate range of adult 4-6 per 1,000 adult members and child 1-3 per 1,000 child members from 2021 to 2025.

Note: * County reports numbers <5 and unstable rates.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
 - Chronic Conditions:
 - Chronic conditions are defined as any of the conditions listed below found in either diagnosis or procedure ICD10 codes of any Partnership member claims data at least twice over a two-year period.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and HEDIS specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one-to-two-year.
 - Chronic Disease Conditions are coded using ICD10 codes listed in the Appendix, and include:
 - Anxiety, Tobacco Use, Obesity, Depression, Substance Use, Trauma and Stressor, Chronic Kidney Disease, Hypertension, Diabetes, Bipolar, Schizophrenia, Chronic Liver Disease, Asthma, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure, Cancer, **Traumatic Brain Injury**.
- Calculations:
 - % Adult or Child Chronic Conditions:

- Numerator: Number of Distinct Adult or Child Chronic Condition in Partnership members per County
- Denominator: Total Number of Distinct Partnership members per County (i.e., adult or child)
- Rate: Multiplied by 1,000 (i.e., per 1,000 adult or child Partnership Members)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Pharmacy Claims data
- Carelon Claims for Behavioral Health Services and County Mental Health for Mental Health related Chronic Conditions

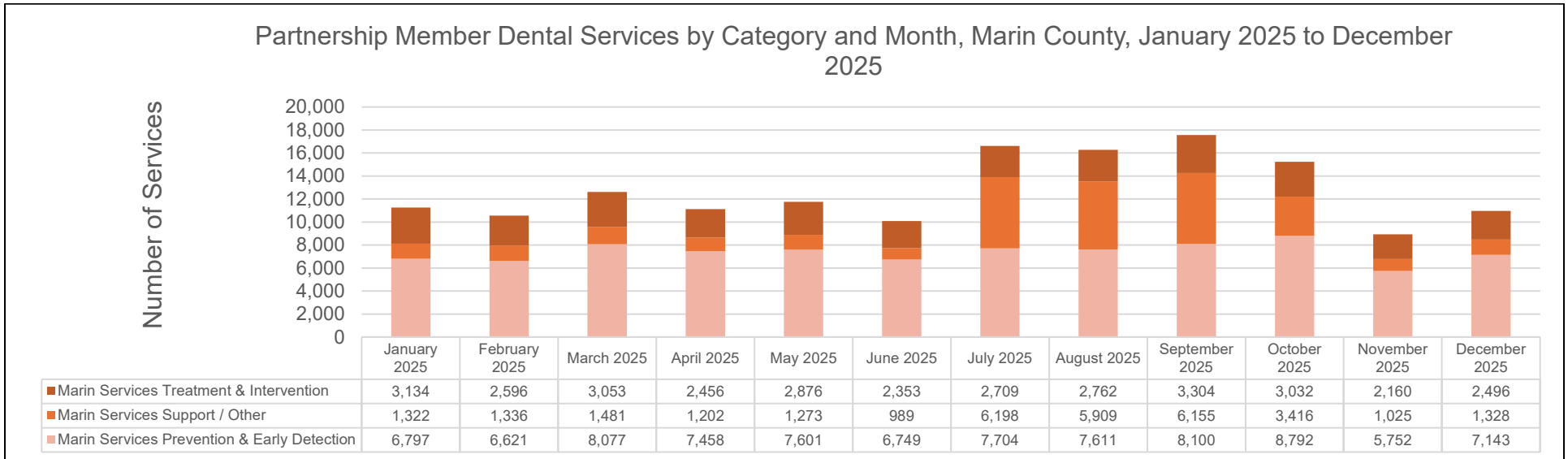
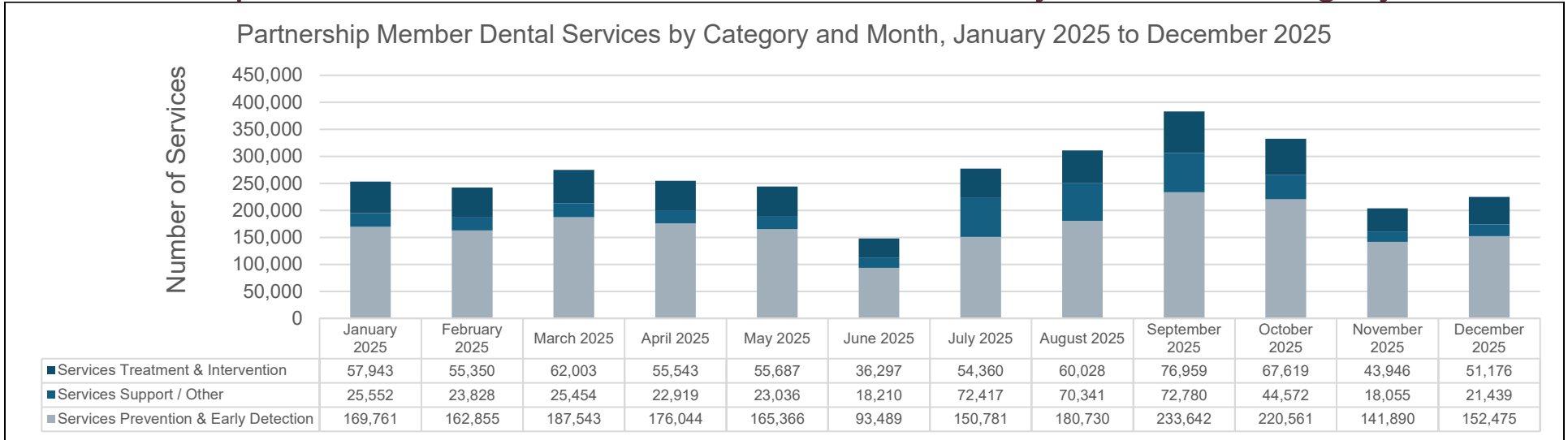
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For more information, see [Access to Dental Services](#) in the [Appendix](#)

Access to Dental Services

Partnership and Marin Dental Service to Members by Service Category/Month



Highlights of Partnership and Marin Dental Service to Members by Service Category/Month

Data shows Partnership member Dental services reported as dental services in 3 categories by Month. The services in each of the categories are unique for that month only.

Note:

- A member may go for support services in January, Diagnostic services in June and Treatment services in November or have all three services in one day. The services should not be added across months to make a year; services here should only be interpreted by month.
- Data released to Partnership by DHCS are three months behind.
- Data for the months of June and November are incomplete and may upload and update in the future.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

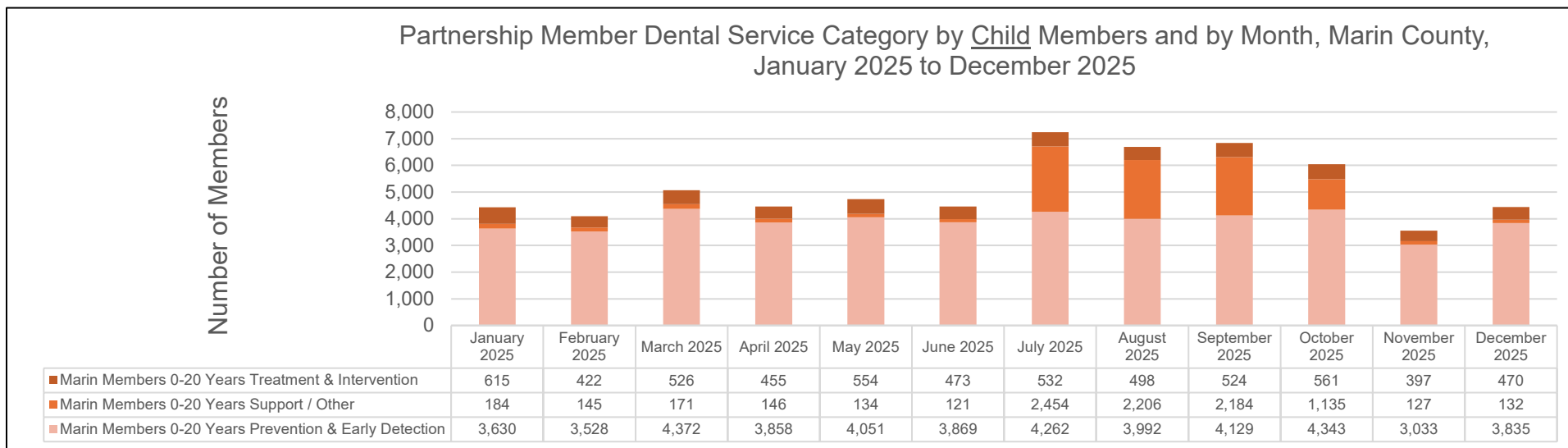
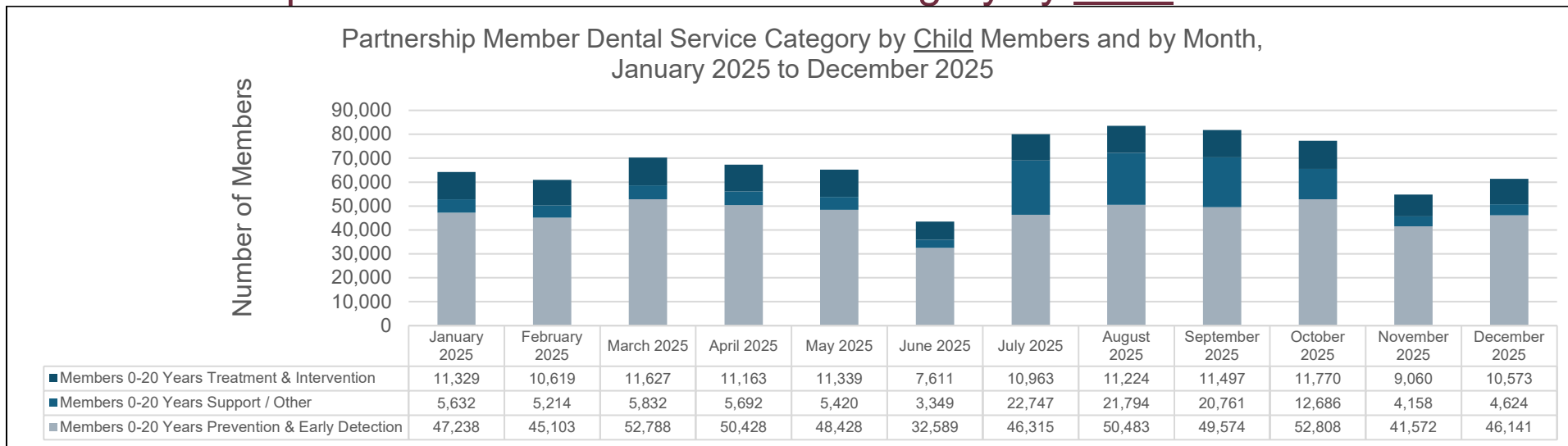
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Dental Services
 - Partnership Member Dental Service information is determined by algorithms from the American Dental Association code on Dental Procedures and Nomenclature, called Dental codes (D-Codes) and the International Classification of Disease, 10th Revision (ICD10 Codes) in medical claims.
 - Dental categories were determined from the American Dental Association code on Dental Procedures and Nomenclature, 2022 and include: Diagnostic Services; Preventive Services; Restorative Services; Specialized Services; Adjective Services; Unclassified Services
 - For the purpose of this publication, Dental categories have been simplified into three categories below:
 - **Prevention & Early Detection:** Preventive Diagnostic & Preventive
 - **Treatment & Intervention:** Restorative & Specialized
 - **Support / Other:** Adjunctive General & Uncategorized
 - The data is three-Months behind: The state of California DHCS/Capitated members or Fee-for-Service (FFS) pays for the service reported in the Partnership dental database, with insurance varying from Medicaid for adults and for children, to Medicare Part A and B for senior citizens

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data (ICD10 Codes)
- DHCS Dental Claims data (D-Codes)

Access to Dental Services

Partnership and Marin Dental Service Category by Child Members/Month



Highlights of Partnership and Marin Dental Service Category by Child Members/Month

Data shows Partnership members served reported by dental services in 3 categories by Month. The unique members in each service category are unique for that month only. Members have been divided into Child, 0-20 years and Adult, 21+ years.

Note:

- A unique member may go for support services in January, Diagnostic services in June and Treatment services in November or have all three services in one day. The unique members should not be added across months to make a year; unique members here should only be interpreted as unique by month.
- Data released to Partnership by DHCS are three months behind.
- Data for the months of June and November are incomplete and may upload and update in the future.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

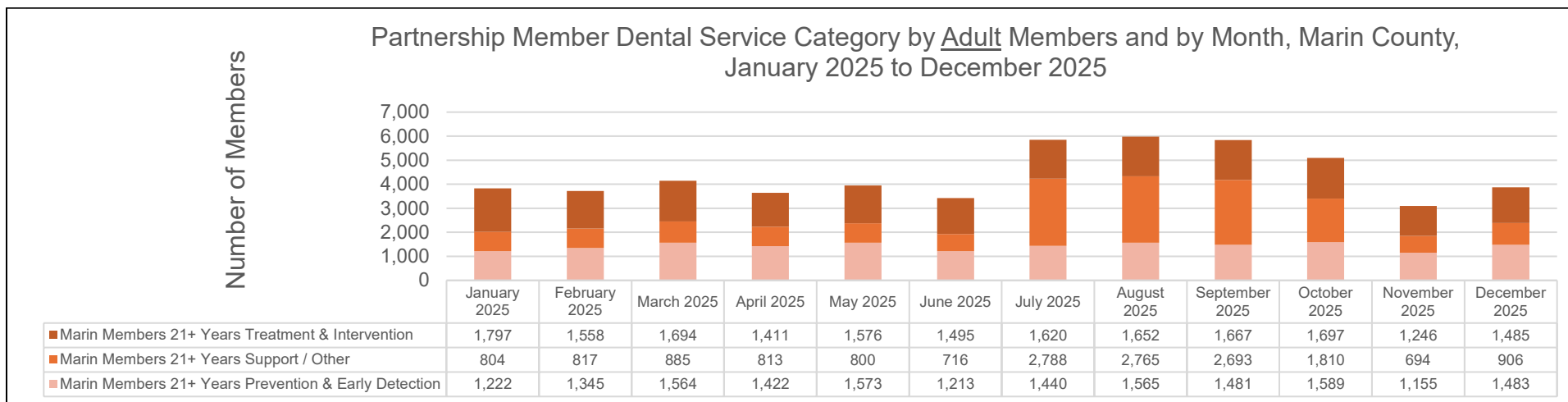
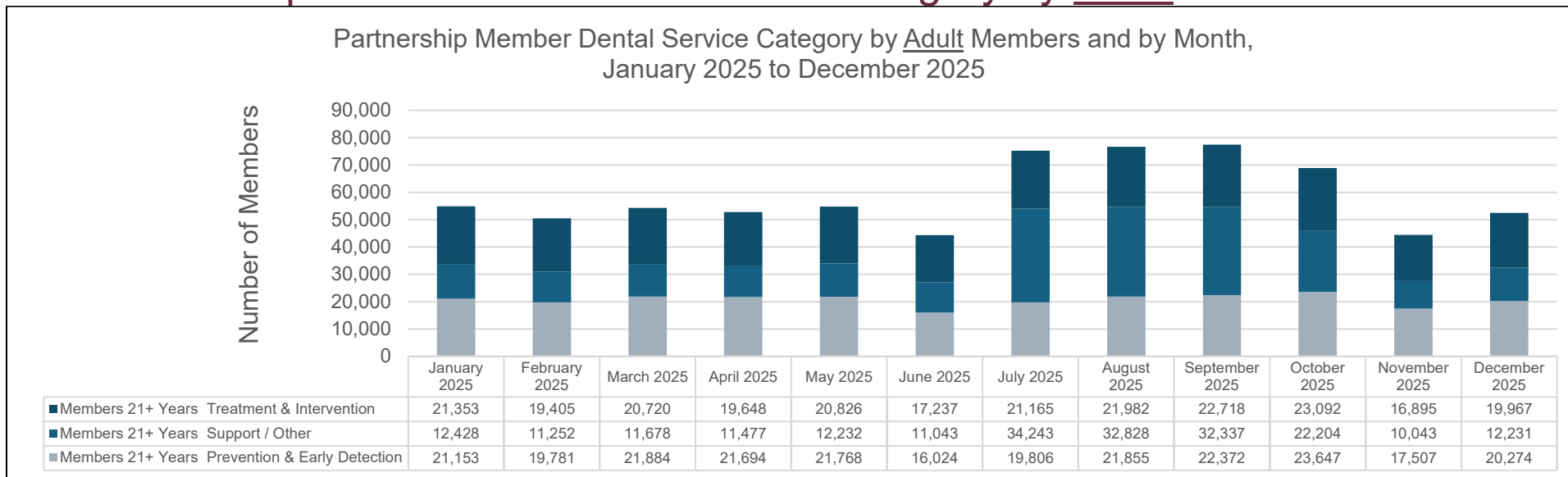
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Dental Services
 - Partnership Member Dental Service information is determined by algorithms from the American Dental Association code on Dental Procedures and Nomenclature, called Dental codes (D-Codes) and the International Classification of Disease, 10th Revision (ICD10 Codes) in medical claims.
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 - For the purpose of this publication, Dental categories have been simplified into three categories below:
 - **Prevention & Early Detection:** Preventive Diagnostic & Preventive
 - **Treatment & Intervention:** Restorative & Specialized
 - **Support / Other:** Adjunctive General & Uncategorized
 - The data is three-Months behind: The state of California DHCS/Capitated members or Fee-for-Service (FFS) pays for the service reported in the Partnership dental database, with insurance varying from Medicaid for adults and for children, to Medicare Part A and B for senior citizens

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Dental Claims data

Access to Dental Services

Partnership and Marin Dental Service Category by Adult Members/Month



Highlights of Partnership and Marin Dental Service Category by Adult Members/Month

Data shows Partnership members served reported by dental services in 3 categories by Month. The unique members in each service category are unique for that month only. Members have been divided into Child, 0-20 years and Adult, 21+ years.

Note:

- A unique member may go for support services in January, Diagnostic services in June and Treatment services in November or have all three services in one day. The unique members should not be added across months to make a year; unique members here should only be interpreted as unique by month.
- Data released to Partnership by DHCS are three months behind.
- Data for the months of June and November are incomplete and may upload and update in the future.

Limitation:

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Definition:

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- Dental Services
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 - Dental categories were determined from the American Dental Association code on Dental Procedures and Nomenclature, 2022 and include: Diagnostic Services; Preventive Services; Restorative Services; Specialized Services; Adjective Services; Unclassified Services
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 - **Prevention & Early Detection:** Preventive Diagnostic & Preventive
 - **Treatment & Intervention:** Restorative & Specialized
 - **Support / Other:** Adjunctive General & Uncategorized

- o The data is three-Months behind: The state of California DHCS/Capitated members or Fee-for-Service (FFS) pays for the service reported in the Partnership dental database, with insurance varying from Medicaid for adults and for children, to Medicare Part A and B for senior citizens.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- DHCS Dental Claims data

Access to Dental Services

Partnership Member Population per Dentist by County & Members per Hygienist by County

Partnership Member Population per Dentist by County				
Member County	2025 Partnership Members	Dentists	Member per Dentist Ratio	Rank
Sierra	715	1	1:715	1 st Best
Plumas	5,500	6	1:917	2 nd
Modoc	3,747	3	1:1,249	3 rd
Yolo	54,197	39	1:1,390	4 th
Colusa	10,005	7	1:1,429	5 th
Mendocino	40,319	27	1:1,493	6 th
Placer	61,762	40	1:1,544	7 th
Tehama	29,377	17	1:1,728	8 th
Siskiyou	17,667	9	1:1,963	9 th
Sonoma	110,586	54	1:2,048	10 th
Lassen	8,273	4	1:2,068	11 th
Lake	33,381	16	1:2,086	12 th
Marin	46,280	21	1:2,204	13th
Glenn	13,540	6	1:2,257	14 th
Sutter	44,266	19	1:2,330	15 th
Humboldt	56,603	23	1:2,461	16 th
Solano	102,090	41	1:2,490	17 th
Napa	27,558	11	1:2,505	18 th
Shasta	64,884	25	1:2,595	19 th
Del Norte	12,099	4	1:3,025	20 th
Nevada	28,383	9	1:3,154	21 st
Butte	84,554	22	1:3,843	22 nd
Trinity	5,099	1	1:5,099	23 rd
Yuba	37,250	5	1:7,450	24 th

Members per Hygienist by County			
County	Membership	Selected Measure: Hygienist	Member per Hygienist Ratio
Sonoma	110,858	19	1:5,834.6
Solano	102,536	13	1:7,887.4
Butte	84,621	13	1:6,509.3
Marin	46,559	6	1:7,759.8
Shasta	64,810	16	1:4,050.6
Placer	61,889	11	1:5,626.3
Yolo	54,275	8	1:6,784.4
Sutter	44,421	8	1:5,552.6
Humboldt	56,850	10	1:5,685.0
Yuba	37,493	3	1:12,497.7
Tehama	29,532	12	1:2,461.0
Mendocino	40,430	13	1:3,110.0
Lake	33,369	6	1:5,561.5
Napa	27,660	0	N/A
Nevada	28,481	5	1:5,696.2
Colusa	10,102	5	1:2,020.4
Siskiyou	17,766	6	1:2,961.0
Glenn	13,568	4	1:3,392.0
Del Norte	12,197	2	1:6,098.5
Lassen	8,229	3	1:2,743.0
Trinity	5,003	1	1:5,003.0
Plumas	5,610	3	1:1,870.0
Modoc	3,784	5	1:756.8
Sierra	680	0	N/A

Highlights of Partnership Member Population per Dentist by County & Members per Hygienist by County

In United States, the number of Dentists per 100,000 resident population is 60.84 Dentists per 100,000 (60.84:100,000) as of 2021, according to [Centers for Disease Control and Prevention](#)'s (CDC) map of the American Dental Association Health Policy Institute article on Supply of Dentists in U.S. 2001-2021. This is the same as one Dentist per 1,643 resident-population (1:1,643) as of 2021. Marin county ranks 13th out of 24 Partnership counties when access to dental services is assessed. As of 2025, the member per dentist ratio for Marin County was one Dentist per 2,204 Marin County Partnership members (1:2,204). Marin County reported 21 dentists serving 46,280 Partnership members. Marin County also reports that 6 hygienists served 46,559 Partnership member residents in 2025. That is, one hygienist per 7,759.8 resident population (1:7,759.8).

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Dental Services
 - Partnership Member Dental Service information is determined by algorithms from the American Dental Association code on Dental Procedures and Nomenclature, called Dental codes (D-Codes) and the International Classification of Disease, 10th Revision (ICD10 Codes) in medical claims.
 - Dental categories were determined from the American Dental Association code on Dental Procedures and Nomenclature, 2022 and include: Diagnostic Services; Preventive Services; Restorative Services; Specialized Services; Adjective Services; Unclassified Services For the purpose of this publication, Dental categories have been simplified into three categories below:
 - **Prevention & Early Detection:** Preventive Diagnostic & Preventive
 - **Treatment & Intervention:** Restorative & Specialized
 - **Support / Other:** Adjunctive General & Uncategorized
- Calculations: Access to Dentist or Hygienists Ratio (i.e., Dentist: Population)
 - Numerator: Number of Dentists or Hygienists in Location
 - Denominator: Total Number of Eligible Partnership Member Population in Location (i.e., All of Partnership or Individual County)

Data Source:

- DHCS Enrollment dataset for Partnership Members
- Data was also collected by the Partnership Dental Liaison from Partnership member Dental Providers by phone call:
 - Number of Dentists and Number of Dental Hygienists
 - Number of Dental Chairs
 - Monthly Volume of Patients
 - Calculated Ratio Number of Dentists: Number of Member Population
 - Calculated Ratio Number of Hygienists: Number of Member Population

Access to Dental Services

Marin Medi-Cal Dental Providers

Parent Org	Site Name	Specialty	Children only	Address	Phone	County	# of Dental Chairs	# of Dentists	# of Hygienists	Payer Mix	Monthly Patient Volume	Estimated Medi-Cal Volume/ Month	Currently Accepting New Medi-Cal Dental Patients	Location Type	Type
PETALUMA HEALTH CTR, INC	COASTAL HEALTH ALLIANCE			65 THIRD ST, STE 13, POINT REYES STATION, CA 94956	(415) 787-1123	MARIN	4 Chairs	2 Dentists	1 Hygienist	85% Denti-Cal	2785	208	Yes for 21 and younger or pregnant, 21+ must establish on medical side before being seen for dental	FQHC/ GROUP	Tribal
	EHSAN KARIMIAN DDS, MSD, INC.	ORTHODONTIST		912 GRAND AVE STE 203, SAN RAFAEL, CA 94901	(415) 457-2440	MARIN	4 Chairs	0 Dentists, 1 orthodontist	0 Hygienists	10% Denti-Cal, 40% Private Insurance, 50% out of pocket	800	752	Yes - Orthodontist office	SOLO	Private
MARIN CITY HLTH & WELLNS CTR	MARIN CITY HLTH & WELLNS CTR			100 PHILLIPS DR, MARIN CITY, CA 94965	(415) 339-8813	MARIN	4 Chairs	4 Dentists	1 Hygienist	Denti-Cal 55%, Self-Pay 29%, Private dental 7%, other 9%	330	202	Yes - Using waitlist	FQHC/ GROUP	Tribal
MARIN COMMUNITY CLINIC	MARIN COMMUNITY CLINIC			6090 REDWOOD BLVD, SUITE D, NOVATO, CA 94945	(415) 448-1500	MARIN	9 Chairs	4-5 Dentists	1 part time	Medi-Cal and sliding scale	1400	48	Yes	FQHC/ GROUP	Tribal
MARIN COMMUNITY CLINIC	MARIN COMMUNITY CLINIC			411 4TH ST., SAN RAFAEL, CA 94901	(415) 448-1500	MARIN	17 Chairs	7 Dentists	3-4 part time	Medi-Cal and sliding scale	3100	3100	Yes	FQHC/ GROUP	Tribal
MARIN COMMUNITY CLINIC	MARIN COMMUNITY CLINIC			3110 KERNER BLVD, SAN RAFAEL, CA 94901	(415) 448-1500	MARIN	9 Chairs	4-5 Dentists	0 Hygienists	Medi-Cal and sliding scale	1200	270	Yes	FQHC/ GROUP	Tribal
	NOVATO PEDIATRIC DENTISTRY	CHILDREN - REFERRAL ONLY FOR DEEP SEDATION		7428 REDWOOD BLVD 101, NOVATO, CA 94945	(415) 897-5566	MARIN	7 Chairs	2 Dentists	0 Hygienists	10% Denti-Cal, 90% Private Insurance	350-400	600	Referral only for pts that need deep sedation	GROUP	Private

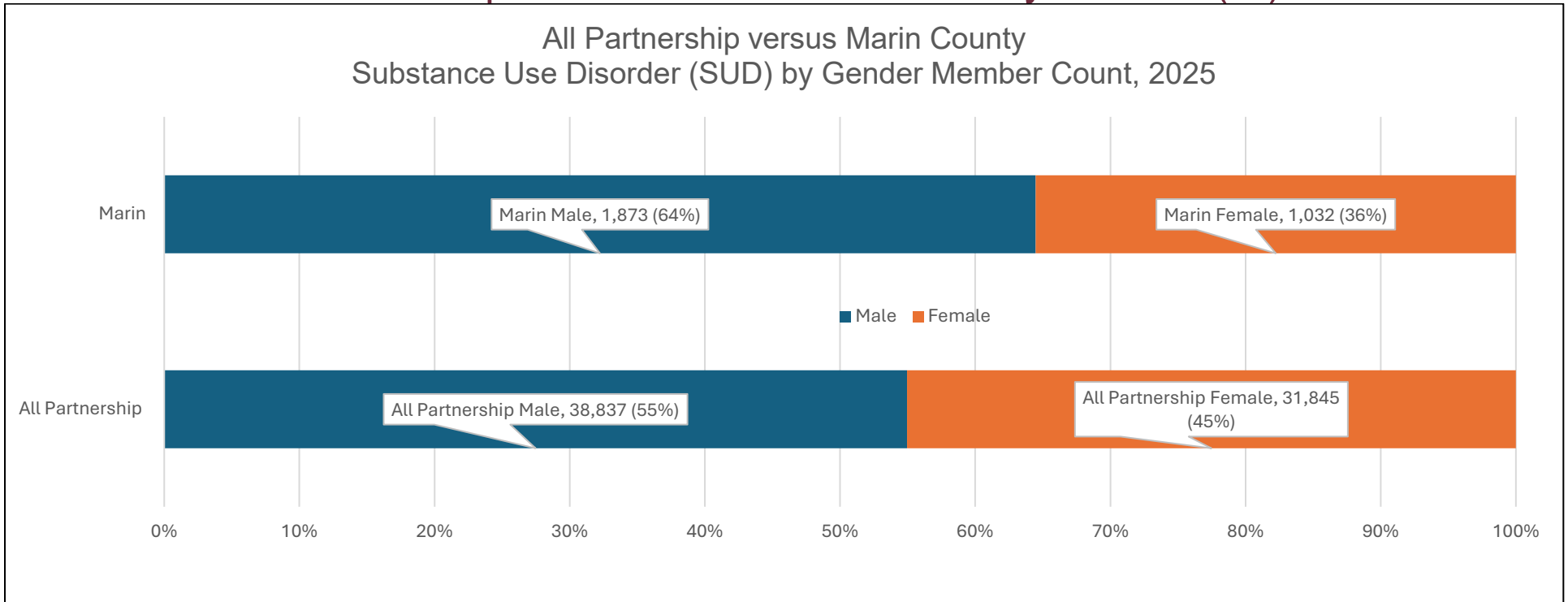
Note: this data comes from internal references, which may not be up to date or accurate. To confirm information, readers are encouraged to go to the [Medi-Cal Dental](#) list of providers or to contact providers directly.

Substance Use Disorder

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For more information, see [Substance Use Disorder](#) in the [Appendix](#)

Substance Use Disorder Partnership and Marin SUD Member by Gender (%)



Highlights of Partnership and Marin SUD Member by Gender (%)

Partnership members' substance use disorder (SUD) claims, both male (55%) and female (45%), are similar to Marin County at 64% male and 36% female. Marin male SUD claims being more than female.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

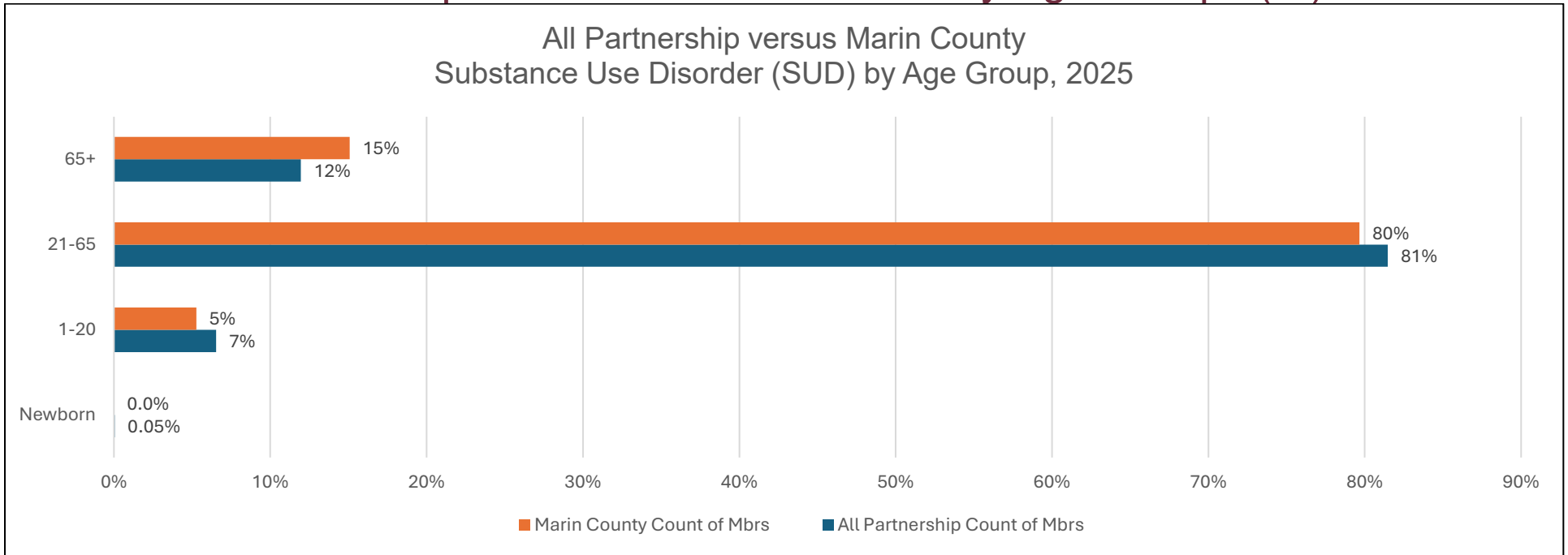
Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services.
- **% Gender** is the number of enrolled members in the individual gender (i.e., male or female), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all gender (i.e., male and female) in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder Partnership and Marin SUD Member by Age Groups (%)



Highlights of Partnership and Marin SUD Member by Age Groups (%)

Partnership's members with SUD claims are reported as 12% over 65 years, 81% ages 21-65, 7% ages 1-20, and 0.05% newborn, while Marin member claims by age group are reported as 15% over 65 years, 80% ages 21-65, 5% ages 1-20, and 0.0% newborn.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

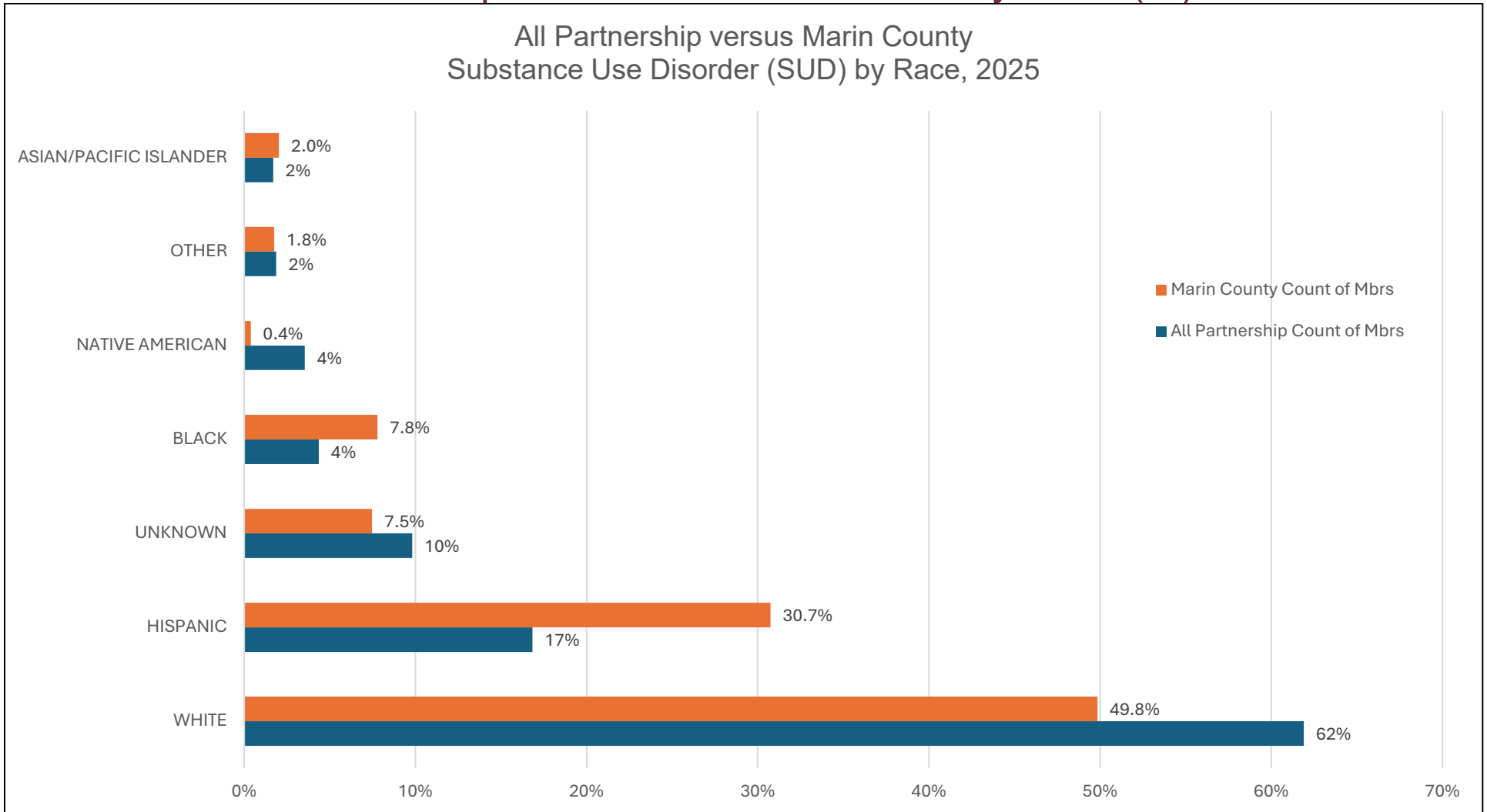
Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services.
- **% Age Group** is the number of enrolled members in the individual age group (i.e., 0-20, 21-65 and over 65 years), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all age-groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder Partnership and Marin SUD Member by Race (%)



Highlights of Partnership and Marin SUD Member by Race (%)

Marin County makes up 4% of all Partnership members with SUD claims with White member SUD claims making up 49.8% (vs. Partnership at 62%). Marin had a higher SUD claim race category reported for Black at 7.8% and Hispanic at 30.7% compared to all of Partnership at 4% and 17% respectively.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Race/Ethnicity is voluntarily completed during enrollment by the state of California DHCS and Partnership's 24 individual counties and determined by California DHCS.
- **Member Count:** Unique Partnership member count utilizing services.
- **% Race/Ethnicity** is the number of enrolled members in the individual race/ethnicity group (i.e., White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all race/ethnicity groups in that particular location currently enrolled, multiplied by 100 (%)

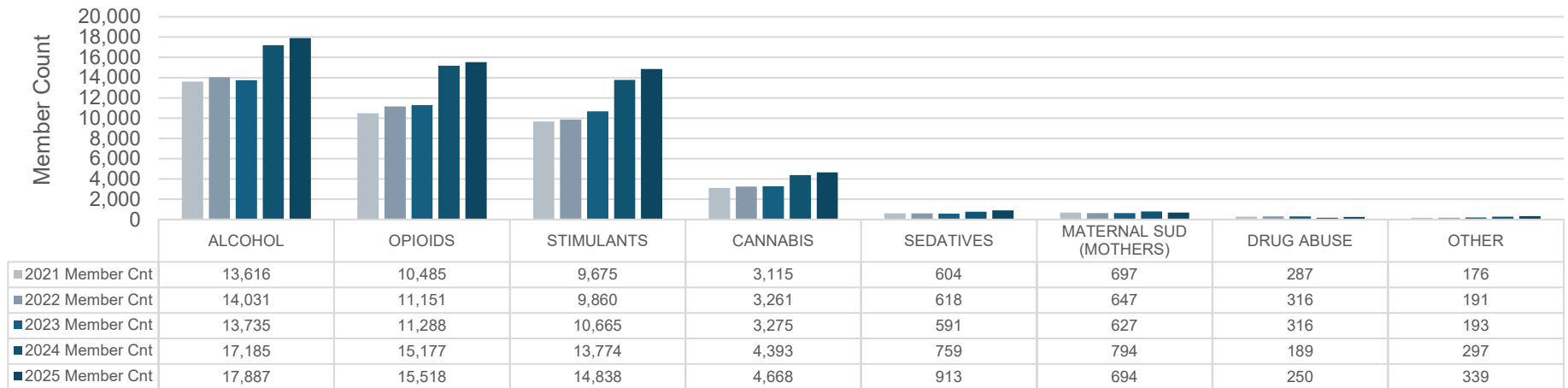
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

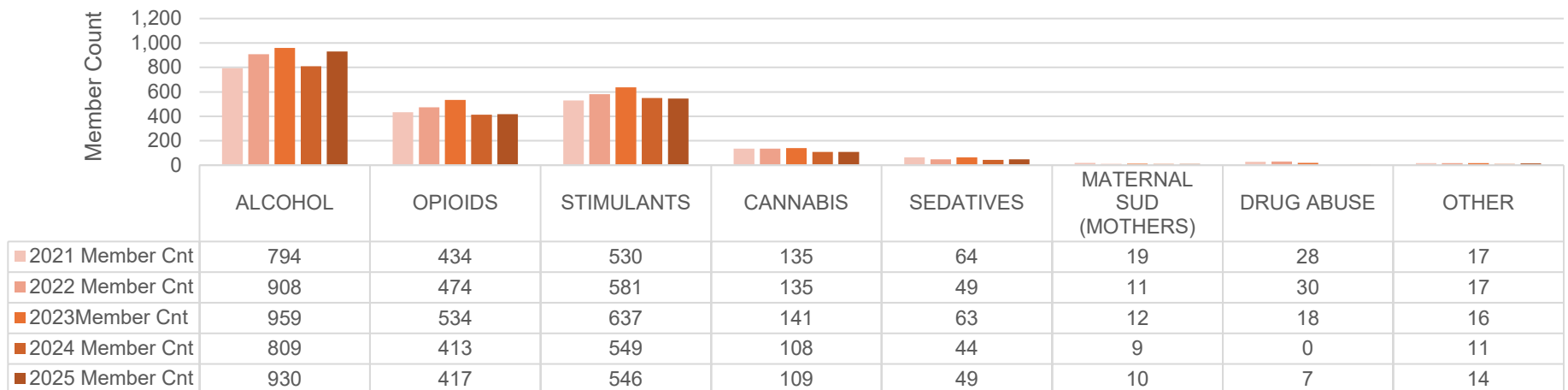
Partnership and Marin Member Counts by SUD Diagnosis

Partnership Substance Use Disorder (SUD)
by Member Count, 2021-2025



Note: Ten (10) more Counties were added to Partnership in 2024-2025

Partnership Marin County Substance Use Disorder (SUD)
by Member Count, 2021-2025



Highlights of Partnership and Marin Member Counts by SUD Diagnosis

The graphs present SUD Member Count, unique Partnership member count utilizing services rendered by diagnosis claims. Comparing Marin to all of Partnership, both have similar pattern of alcohol, Opioids and stimulant SUD claims member count.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Member Count: Unique Partnership member count utilizing services by diagnosis claims.
 - The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):
 - Alcohol
 - Opioids
 - Stimulants
 - Cannabis
 - Sedatives
 - Drug Abuse including nonspecific diagnosis of drug abuse and dependence
 - Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates

Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

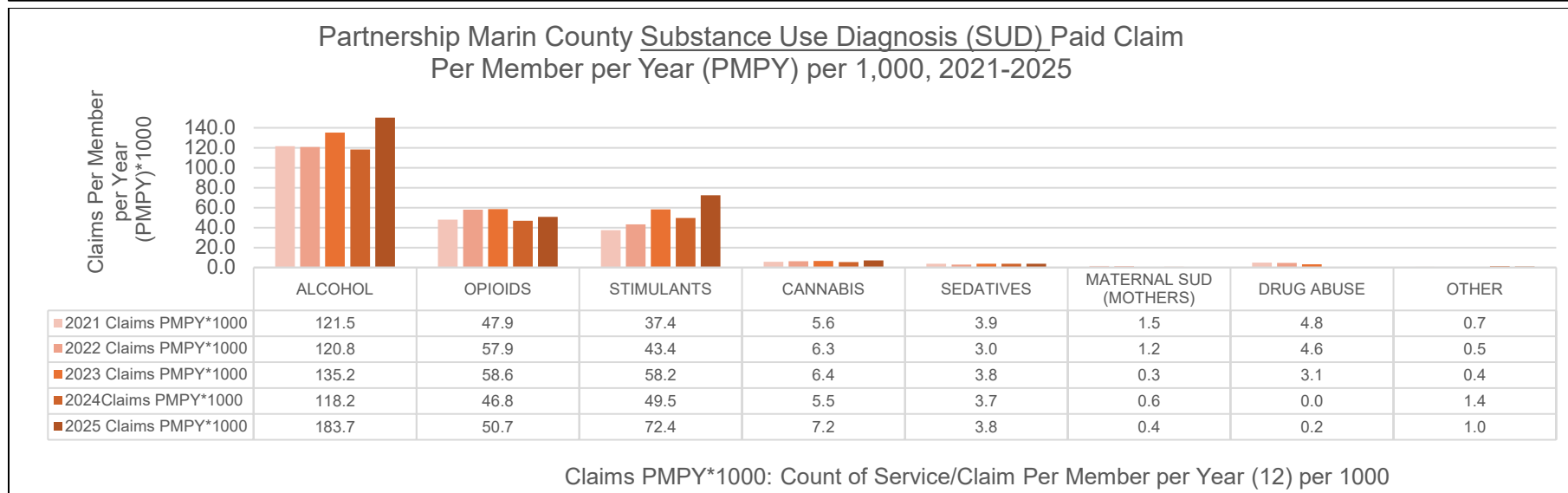
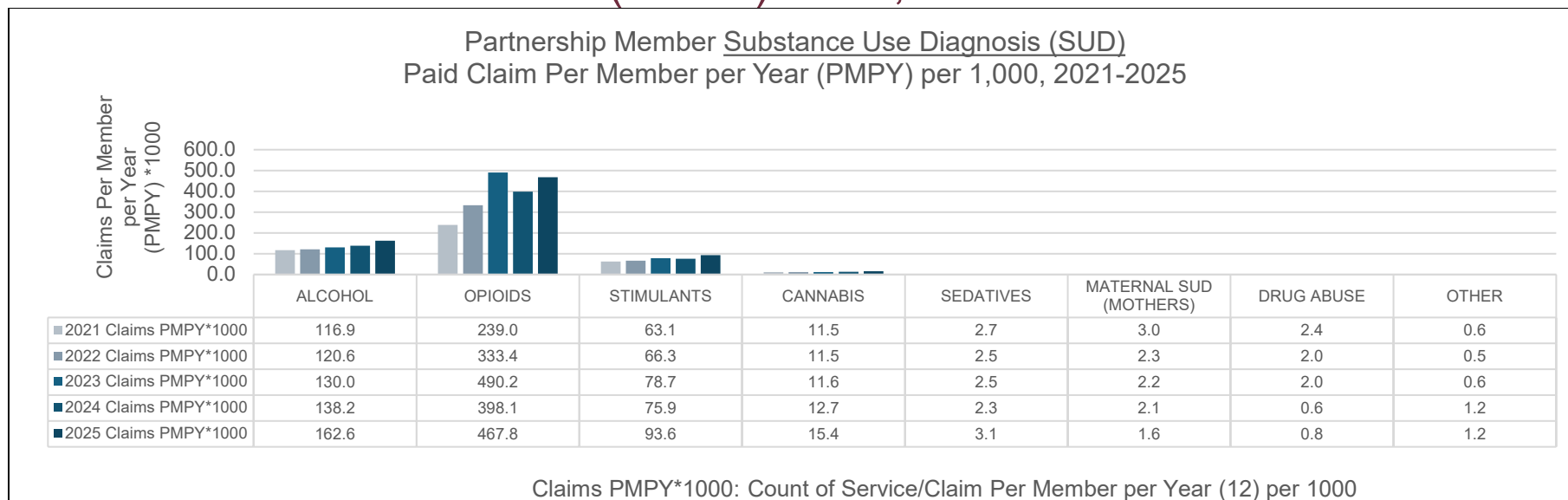
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin SUD Diagnoses Paid Claims Per Member Per Year (PMPY) Per 1,000



Highlights of Partnership and Marin SUD Diagnoses Paid Claims Per Member Per Year (PMPY) Per 1,000

The graphs present SUD Paid Claims: Number of Substance Use services rendered by diagnosis claims. Marin has more alcohol SUD claims paid per member per year per 1,000 Partnership Marin County members in 2025, while Opioid rates in Marin County are lower than all Partnership numbers from 2021 to 2025.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services rendered by diagnosis claims.
- **Paid Claims:** Number of Substance Use services rendered by diagnosis claims.

The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):

- o Alcohol
- o Opioids
- o Stimulants
- o Cannabis
- o Sedatives
- o Drug Abuse including nonspecific diagnosis of drug abuse and dependence
- o Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates
- **Calculations:**
 - o Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members.

- Count of Service (i.e., SUD) paid in claims in particular location, at the particular point-in-time divided by the Total Number of paid claims in particular location, at the particular point-in-time per Member per Year (12) per 1000 Members in particular location.
 - This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

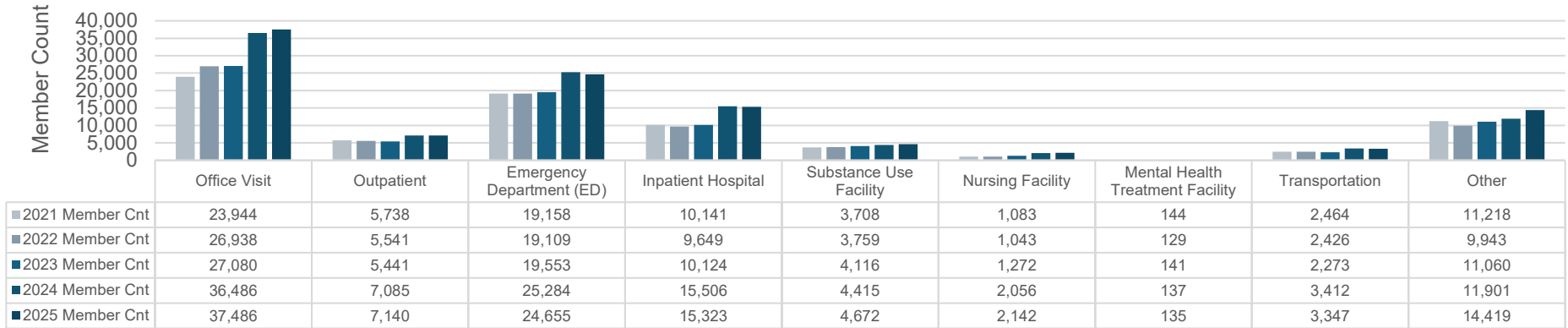
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Caredon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

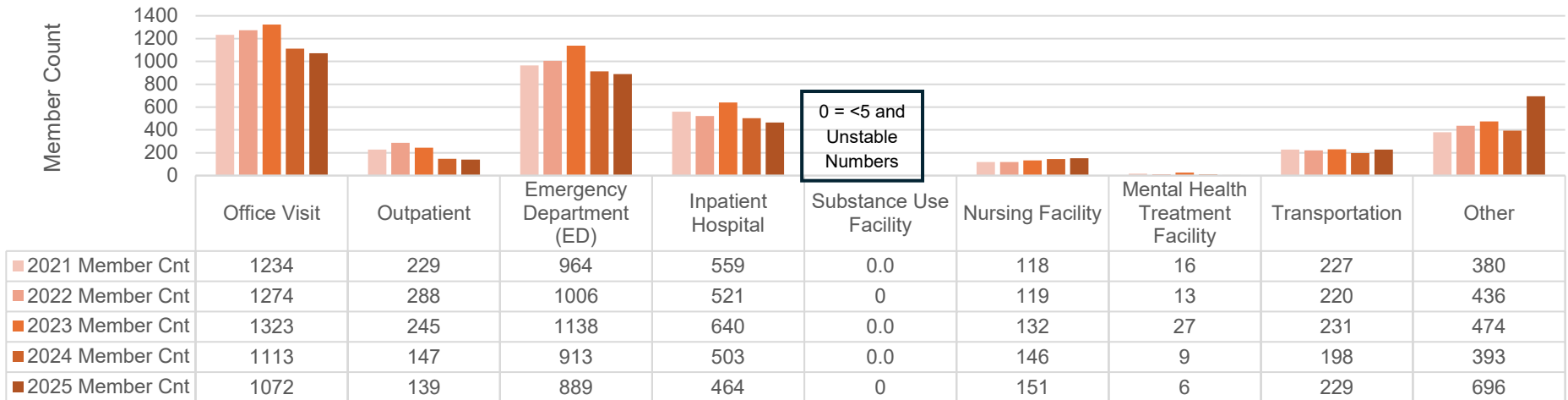
Partnership and Marin Member Count by SUD Service Location

Partnership Service Location for Substance Use Disorder (SUD)
by Member Count, 2021-2025



Note: Ten (10) more Counties were added to Partnership in 2024-2025

Partnership Marin County Service Location for Substance Use Disorder (SUD)
by Member Count, 2021-2025



Highlights of Partnership and Marin Member Count by SUD Service Location

The graphs present SUD Member Count, unique Partnership member count utilizing services rendered by location claims. Most of Marin's SUD claim members were seen at Provider Office Visits and the Emergency Department (ED), similar to all of Partnership. Places of service marked as "Other" are defined by the [CMS Place of Service Code Set](#) as unidentified service locations.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services by location claims.
 - The substances treated are monitored in the following [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:
 - Office Visit
 - Outpatient
 - Emergency Department (ED)
 - Inpatient Hospital
 - Substance Use Facility
 - Nursing Facility
 - Mental Health Treatment Facility
 - Transportation Services
 - Maternal SUD is also monitored for all pregnant and/or mothers within a year after delivery.

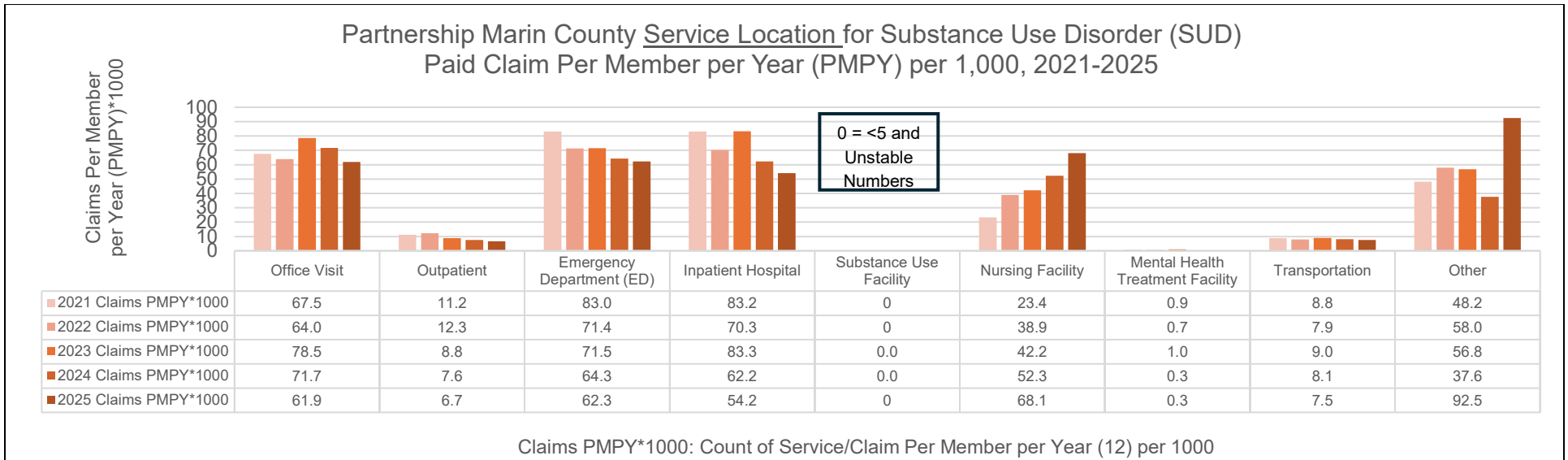
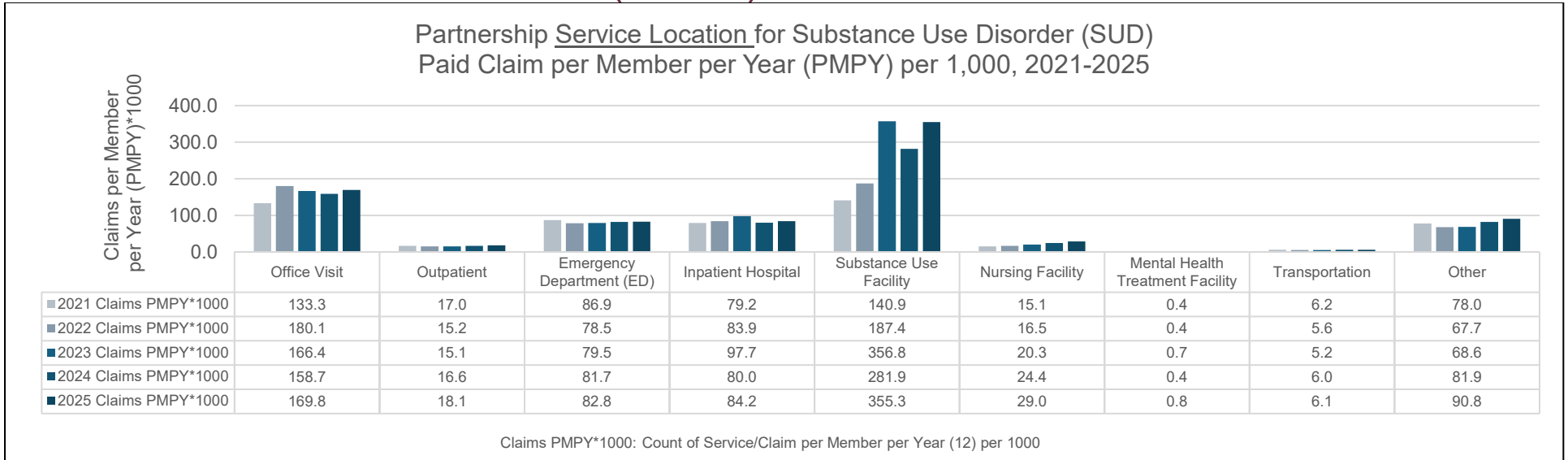
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin SUD Service Location Paid Claims Per Member Per Year (PMPY) Per 1,000



Highlights of Partnership and Marin SUD Service Location Paid Claims Per Member Per Year (PMPY) Per 1,000

The graphs present SUD Paid Claims: Number of Substance Use services rendered by location claims. In Marin, the most claims paid per member per year per 1,000 were for services located at the Emergency Department (ED), Provider Office, and Inpatient Hospital stay. For all of Partnership, the most claims paid were for Substance Use Facilities and Provider Office Visits. Very few claims were recorded for Substance Use Facilities in Marin County.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services by location claims.

The substances treated are monitored in the following [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:

- Office Visit
- Outpatient
- Emergency Department (ED)
- Inpatient Hospital
- Substance Use Facility
- Nursing Facility
- Mental Health Treatment Facility
- Transportation Services
- Maternal SUD is also monitored for all pregnant and/or mothers within a year after delivery.

- Calculations:
 - Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Count of Service (i.e., SUD) paid in claims in particular location, at the particular point-in-time divided by the Total Number of paid claims in particular location, at the particular point-in-time per Member per Year (12) per 1000 Members in particular location.
 - This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

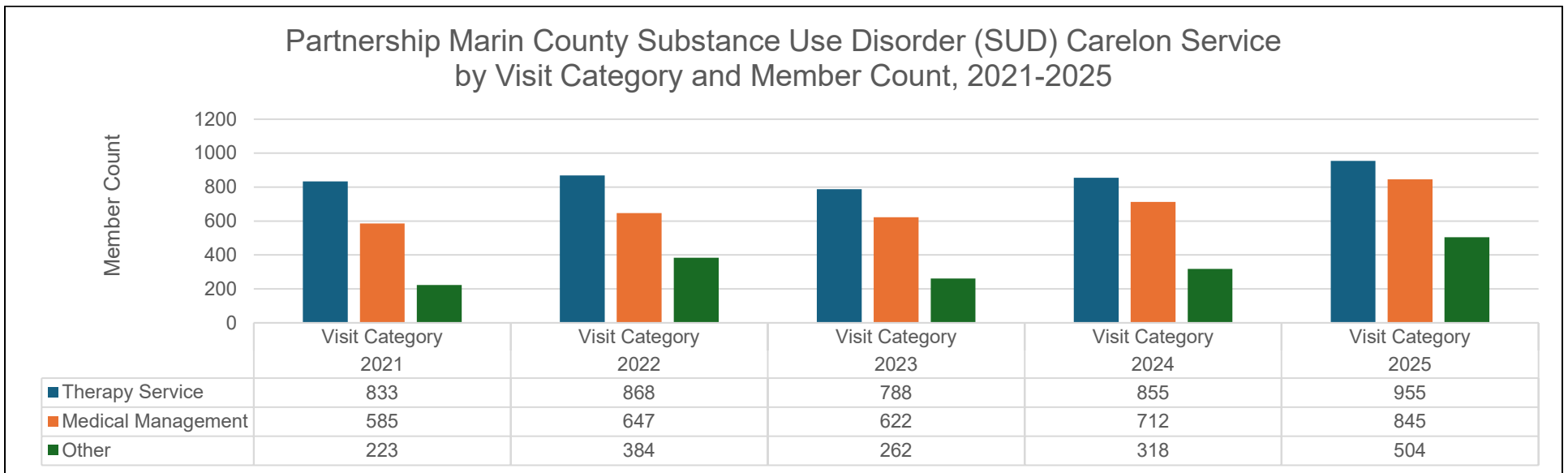
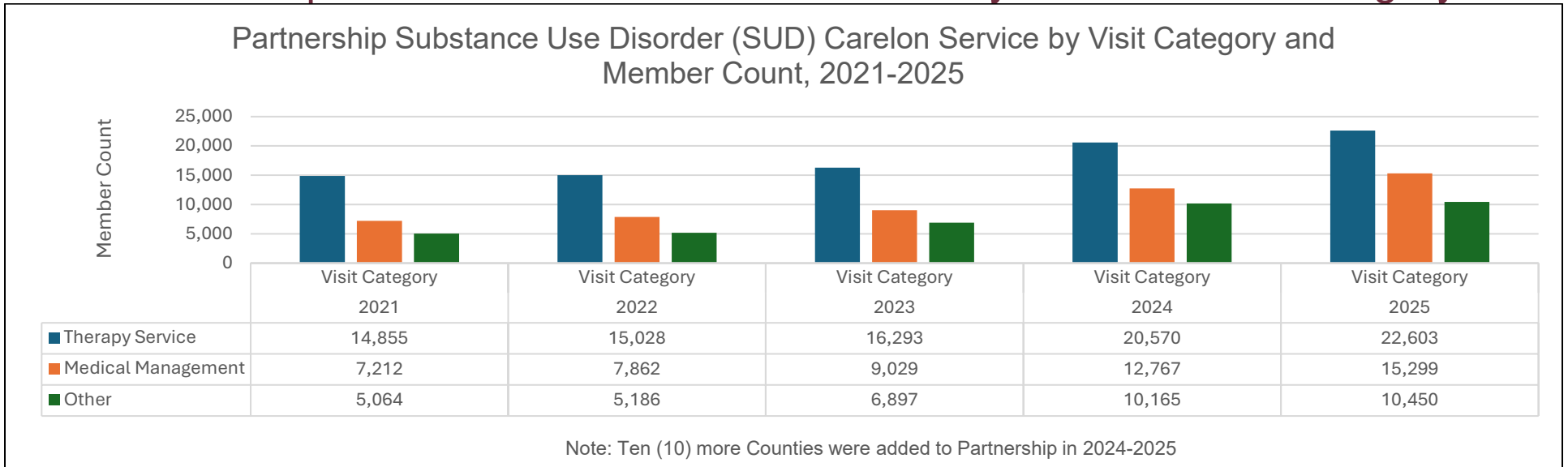
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership & Marin Caredon Member Count by SUD Service Category



Highlights of Partnership & Marin Carelon Member Count by SUD Service Category

The graphs present SUD Member Count, unique Partnership member count utilizing services rendered by Carelon Healthcare Services. For both Partnership's and Marin's Carelon Healthcare services, the most offered services were Therapy Services, followed by Medical Management. Partnership members getting Therapy Services could also be receiving Medical Management, so these services are not mutually exclusive and cannot be added up.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services rendered by Carelon Healthcare Services.
- Carelon divides SUD visits into the following categories:
 - Therapy Service
 - Medical Management
 - Other, which includes visits that are neither for therapy nor medical management

Note: for the purpose of serving our members, Partnership offers Behavioral Healthcare Services through contracts with Carelon Healthcare Services and so monitors these services as Carelon claims.

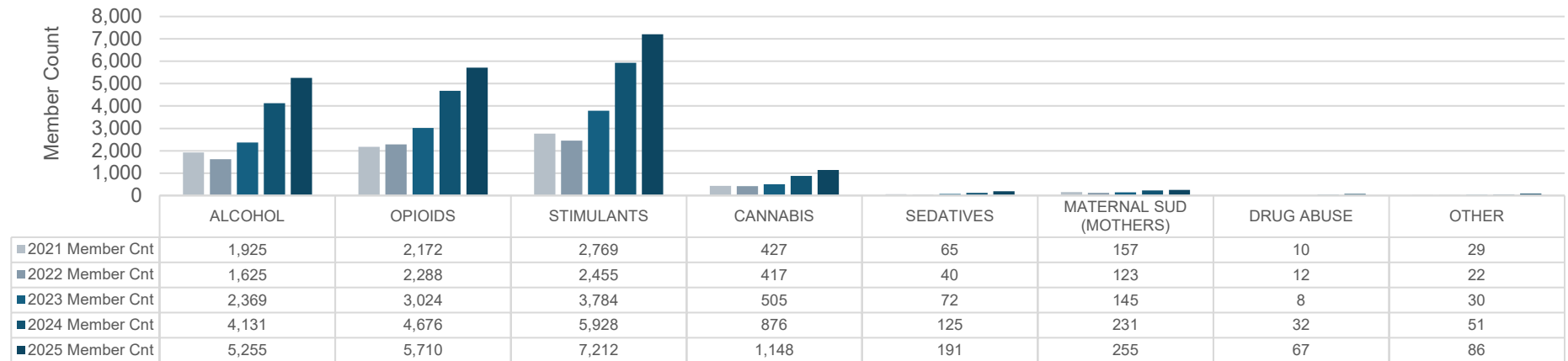
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- **Carelon Healthcare Services claims**
- DHCS Medical Claims data
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

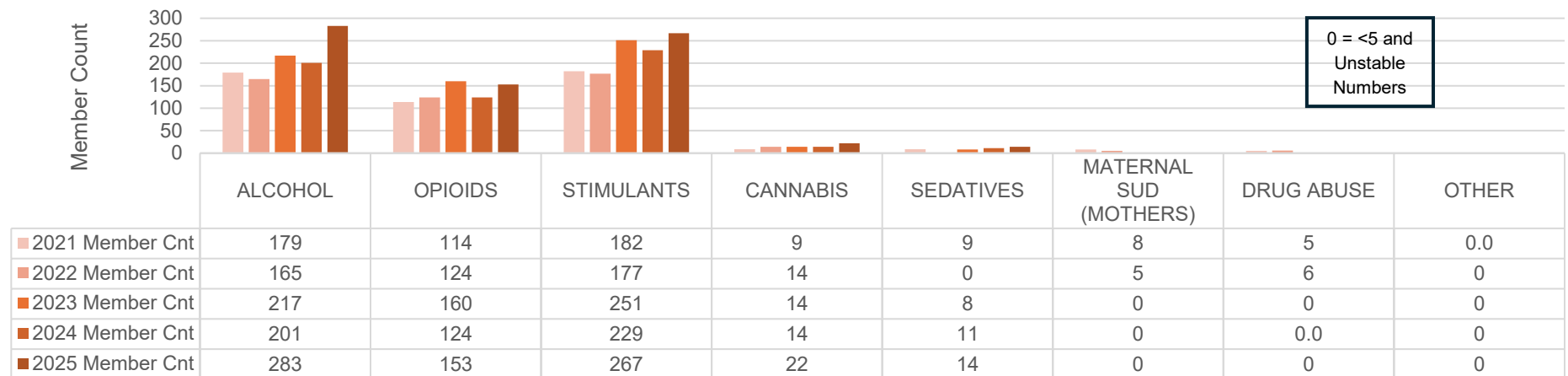
Partnership & Marin Homeless Member Count by SUD Diagnosis

Partnership Substance Use Disorder (SUD)
by Homeless Member Count, 2021-2025



Note: Ten (10) more Counties were added to Partnership in 2024-2025

Partnership Marin County Substance Use Disorder (SUD)
by Homeless Member Count, 2021-2025



Highlights of Partnership & Marin Homeless Member Count by SUD Diagnosis

The graphs present SUD Homeless Member Count, unique Partnership member count utilizing services rendered by diagnosis claims. Partnership and Marin Homeless Members with SUD had Stimulants, Alcohol and Opioids as the highest substances by claim count.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Homeless Member Count: Unique Partnership member count utilizing services rendered by diagnosis claims, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.
 - The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):
 - Alcohol
 - Opioids
 - Stimulants
 - Cannabis
 - Sedatives
 - Drug Abuse including nonspecific diagnosis of drug abuse and dependence
 - Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates

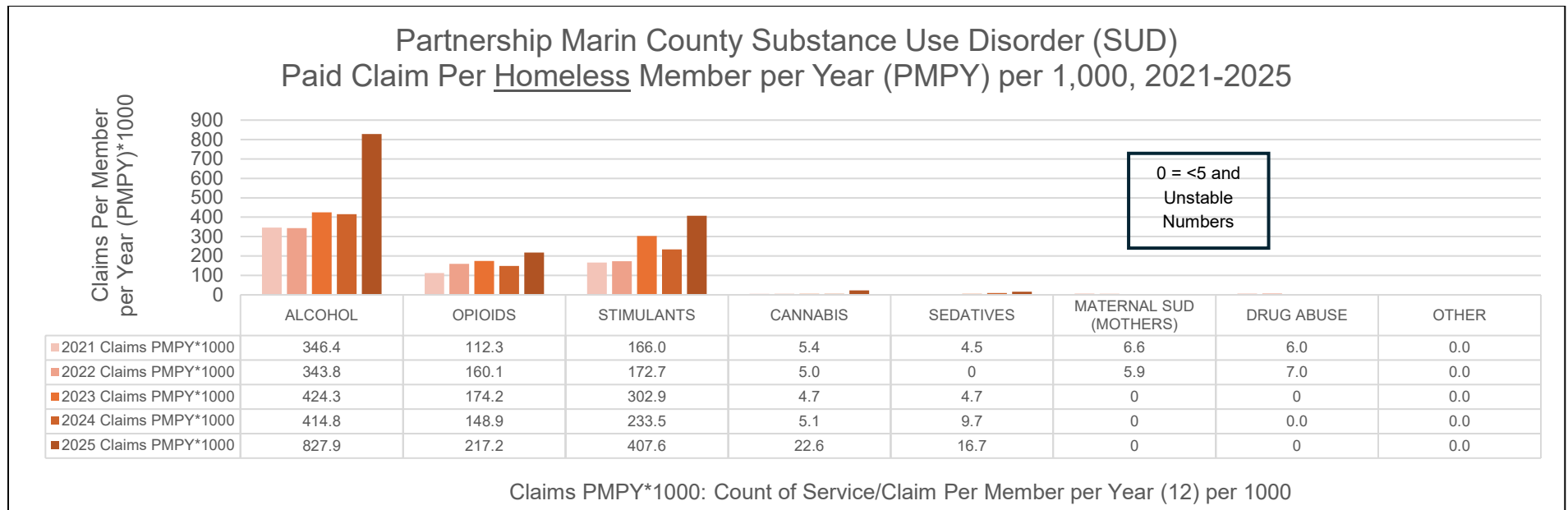
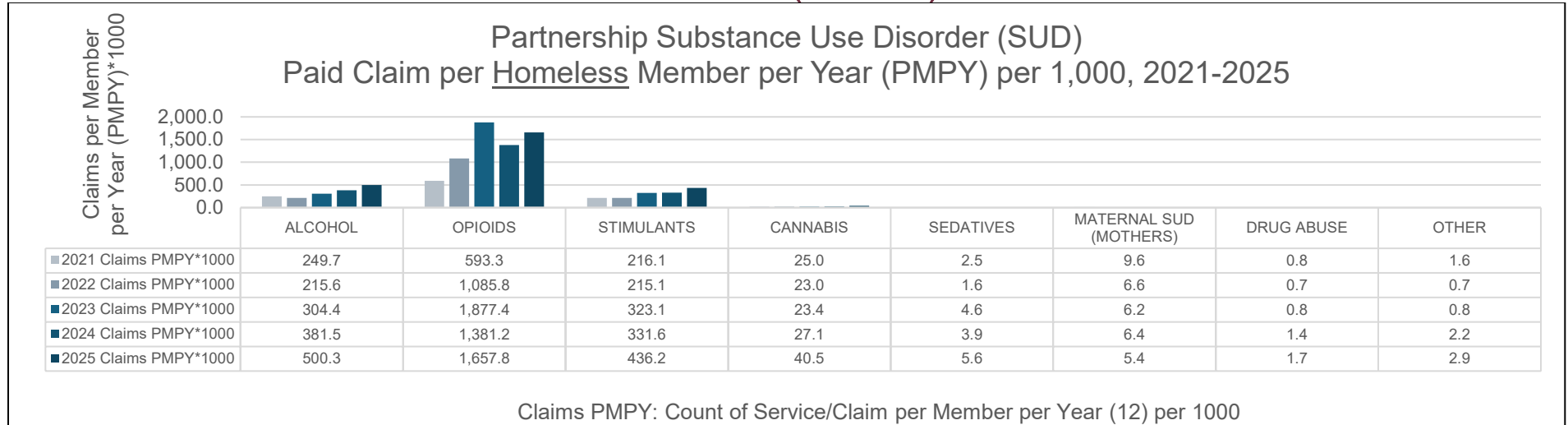
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Caredon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership & Marin Homeless Member SUD Diagnoses Paid Claims Per Member Per Year (PMPY) Per 1,000



Highlights of Partnership & Marin Homeless Member SUD Diagnoses Paid Claims Per Member Per Year (PMPY) Per 1,000

The graphs present Homeless SUD Paid Claims: Number of Substance Use services rendered by diagnosis claims. Marin homeless have more alcohol claims paid per member per year per 1,000 than Partnership Marin County members, while Partnership has a higher Opioid claim rate.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Homeless Member Count:** Unique Partnership member count utilizing services rendered by diagnosis claims, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.
- **Paid Claims:** Number of Substance Use services rendered by diagnosis claims.
 - The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):
 - Alcohol
 - Opioids
 - Stimulants
 - Cannabis
 - Sedatives
 - Drug Abuse including nonspecific diagnosis of drug abuse and dependence
 - Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates
- Calculations:

- o Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Count of Service (i.e., SUD) paid in claims in particular location, at the particular point-in-time divided by the Total Number of paid claims in particular location, at the particular point-in-time per Member per Year (12) per 1000 Members in particular location.
- o This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

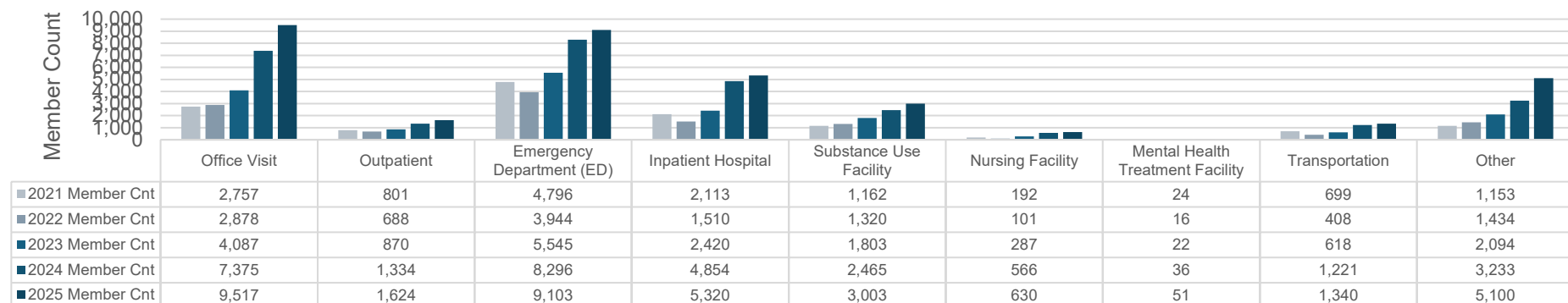
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

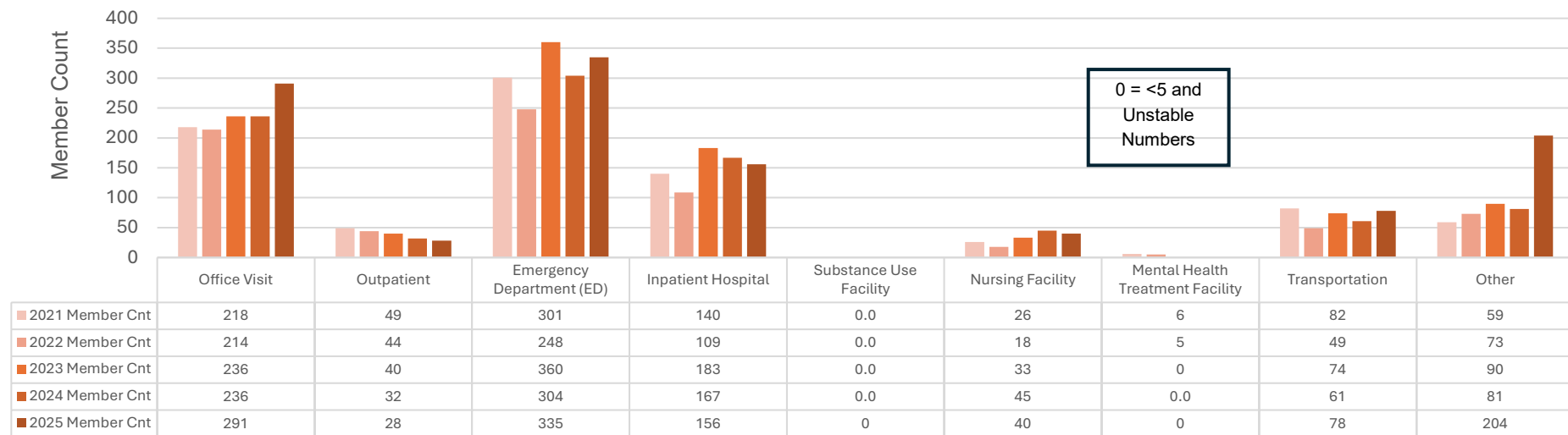
Partnership & Marin Homeless Member Count by SUD Service Location

Partnership Service Location for Substance Use Disorder (SUD)
by Homeless Member Count, 2021-2025



Note: Ten (10) more Counties were added to Partnership in 2024-2025

Partnership Marin County Service Location for Substance Use Disorder (SUD)
by Homeless Member Count, 2021-2025



Highlights of Partnership and Marin Homeless Member Count by SUD Service Location

The graphs present SUD Homeless Member Count, unique Partnership member count utilizing services rendered by location claims. Homeless member count by location of service for homeless in all of Partnership and Marin County have similar patterns. Places of service marked as “Other” are defined by the [CMS Place of Service Code Set](#) as unidentified service locations.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- **Homeless Member Count:** Unique Partnership member count utilizing services rendered by location claims, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.
- **Member Count:** Unique Partnership member count utilizing services by location claims.
 - The substances treated are monitored in the following [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:
 - Office Visit
 - Outpatient
 - Emergency Department (ED)
 - Inpatient Hospital
 - Substance Use Facility
 - Nursing Facility
 - Mental Health Treatment Facility
 - Transportation Services
 - Maternal SUD is also monitored for all pregnant and/or mothers within a year after delivery.

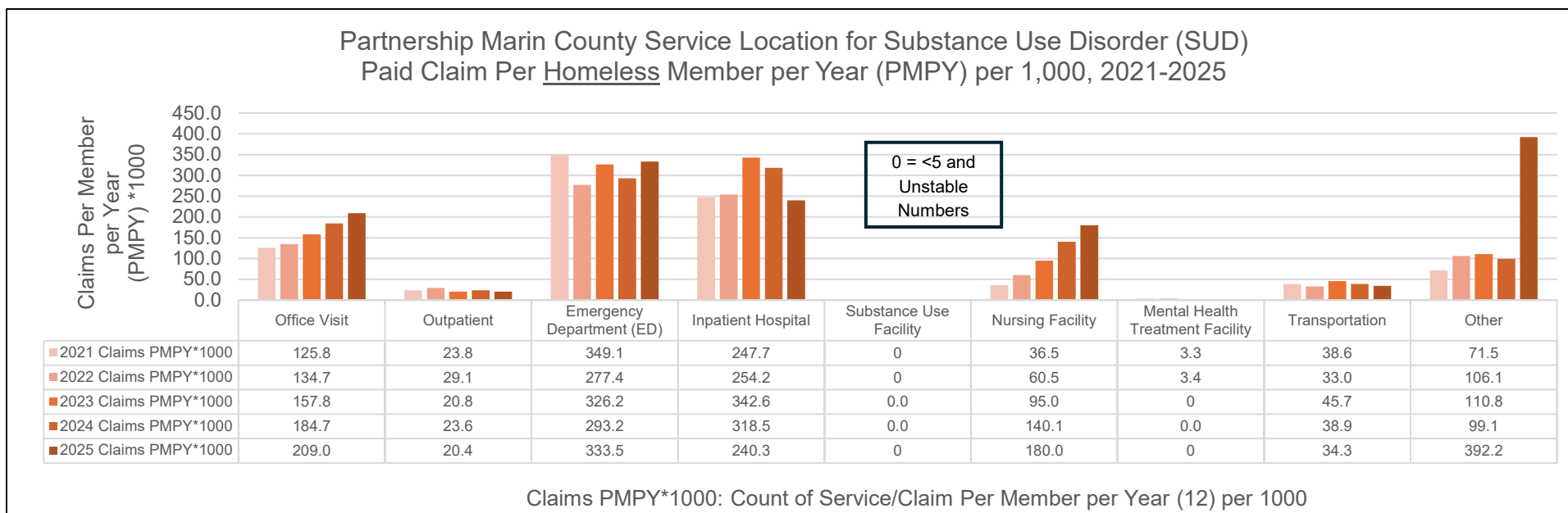
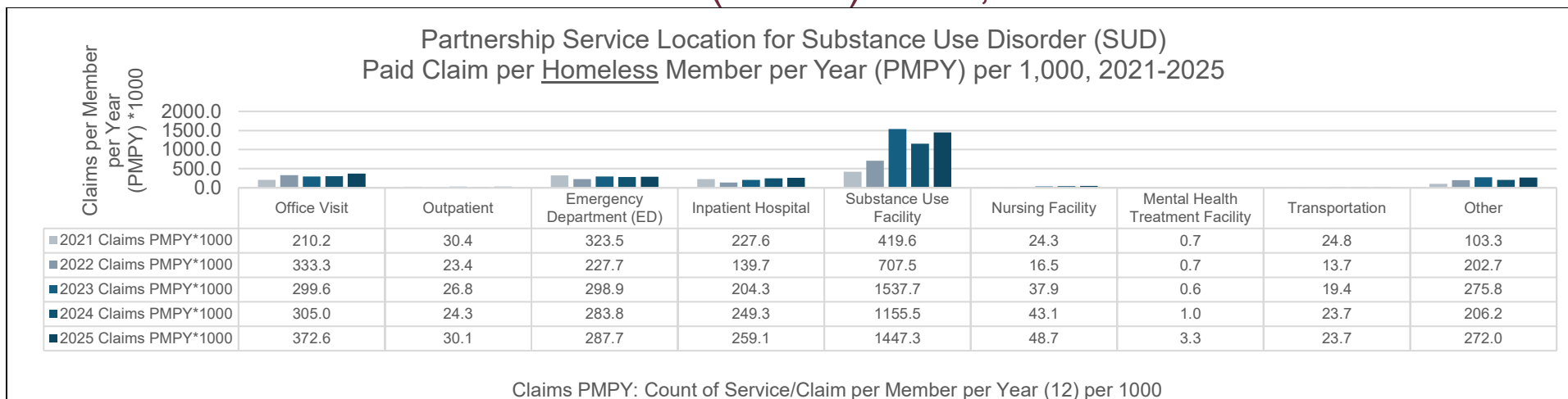
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership & Marin Homeless SUD Service Location Paid Claims Per Member Per Year (PMPY) Per 1,000



Highlights of Partnership and Marin Homeless SUD Service Location Paid Claims Per Member Per Year (PMPY) Per 1,000

The graphs present Homeless SUD Paid Claims: Number of Substance Use services rendered by location claims. In Marin, the most Homeless claims paid per member per year per 1,000 were for services located at the Emergency Department (ED), Inpatient Hospital stay, and Provider Office visit. For all of Partnership, the most Homeless claims paid were for Substance Use Facilities. Very few Homeless claims were recorded for Substance Use Facilities in Marin County. Places of service marked as “Other” are defined by the [CMS Place of Service Code Set](#) as unidentified service locations.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership’s 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services by location claims.
- **Homeless Member Count:** Unique Partnership member count utilizing services rendered by location claims, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.

The substances treated are monitored in the following [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:

- Office Visit
- Outpatient
- Emergency Department (ED)
- Inpatient Hospital
- Substance Use Facility
- Nursing Facility
- Mental Health Treatment Facility

- Transportation Services
- Maternal SUD is also monitored for all pregnant and/or mothers within a year after delivery.
- Calculations:
 - Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Count of Service (i.e., SUD) paid in claims in particular location, at the particular point-in-time divided by the Total Number of paid claims in particular location, at the particular point-in-time per Member per Year (12) per 1000 Members in particular location.
 - This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

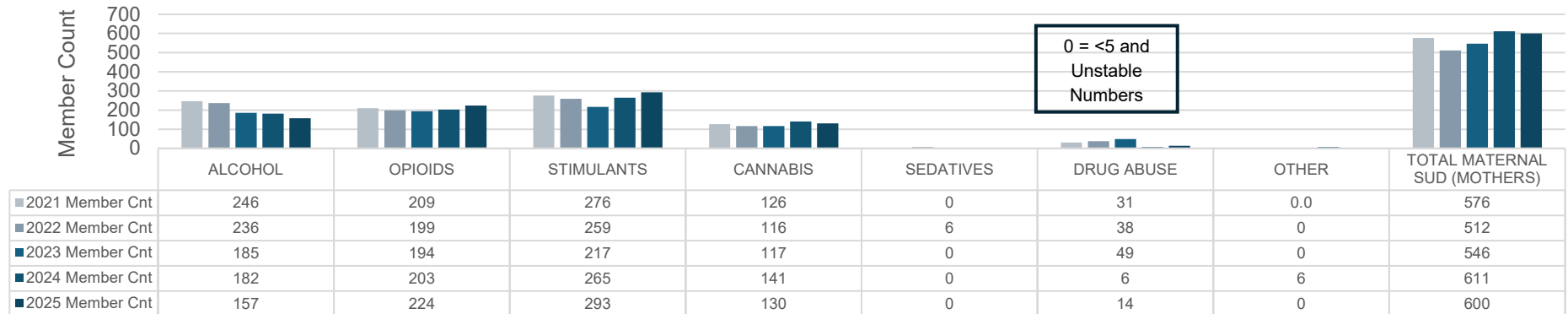
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

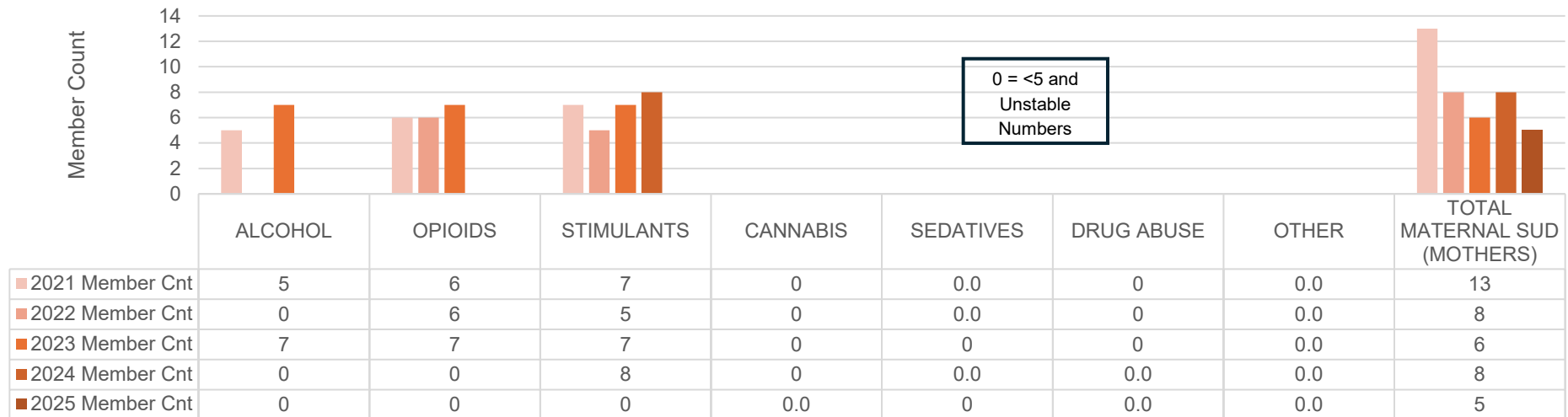
Partnership & Marin Maternal Member Count by SUD Diagnosis

Partnership Substance Use Disorder (SUD) by Maternal Member Count, 2021-2025



Note: Ten (10) more Counties were added to Partnership in 2024-2025

Partnership Marin County Substance Use Disorder (SUD)
by Maternal Member Count, 2021-2025



Highlights of Partnership and Marin Maternal Member Count by SUD Diagnosis

The graphs present Maternal SUD Member Count, unique Partnership member count utilizing services rendered by diagnosis claims. The Maternal Partnership population's (pregnant women and mothers within one year of delivery) top three categories among those whose deliveries Partnership paid for in the Delivery Claims datasets are stimulant, opioids and alcohol SUDs in Marin County, similar to all of Partnership.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services by diagnosis claims.
- **Maternal population:** are Partnership members who are pregnant and those who have delivered up to one year after delivery (up to one year postpartum). Those who have had these conditions before, during, and/or up to two years after delivery are included in the count for SUD.
- **Total Maternal SUD:** Maternal population among those whose deliveries Partnership paid for in the Delivery Claims datasets who have been diagnosed with SUD.
- The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):
 - Alcohol
 - Opioids
 - Stimulants
 - Cannabis
 - Sedatives
 - Drug Abuse including nonspecific diagnosis of drug abuse and dependence

- o Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates

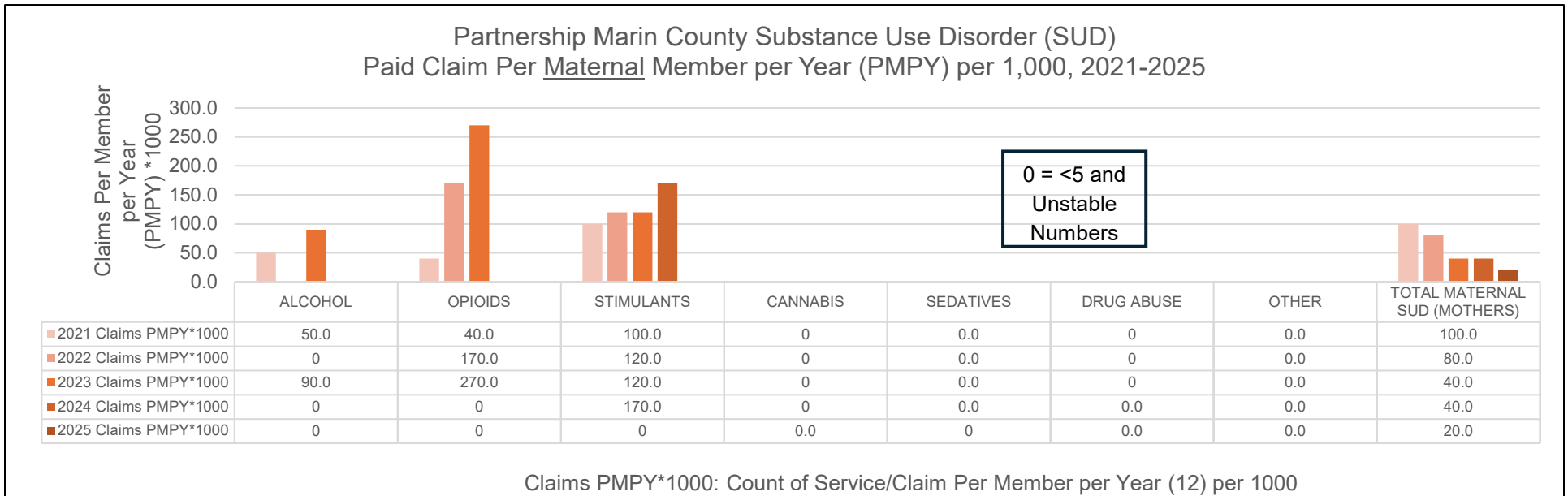
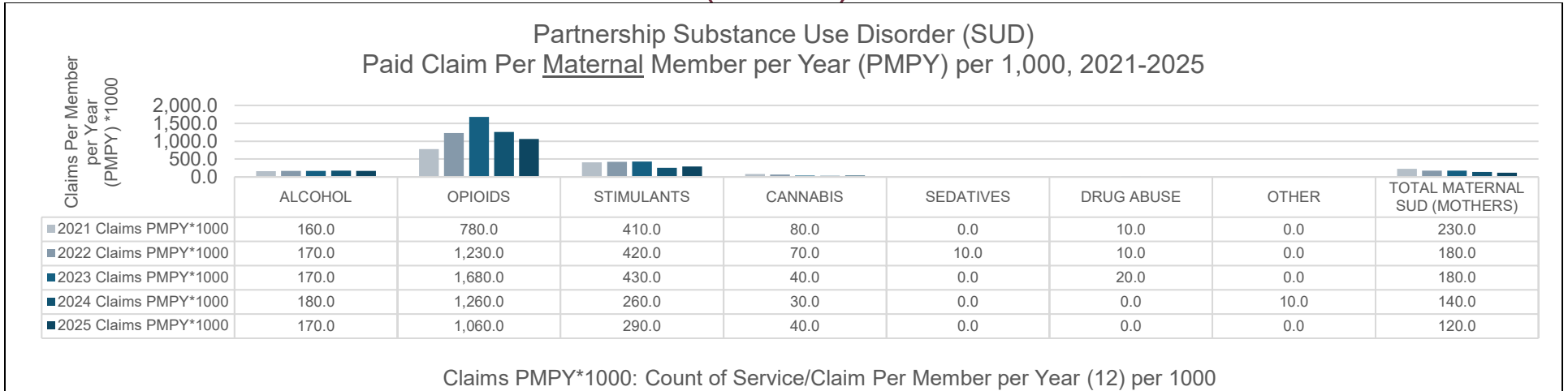
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership & Marin Maternal Member SUD Diagnosis Paid Claims Per Member Per Year (PMPY) Per 1,000



Highlights of Partnership and Marin Maternal Member SUD Diagnosis Paid Claims Per Member Per Year (PMPY) Per 1,000

The graphs present Maternal SUD Paid Claims: Number of Substance Use services rendered by diagnosis claims. Marin County maternal member rate of claims paid per member per year have similar patterns to all Partnership maternal members.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services rendered by diagnosis claims.
- **Maternal population:** are Partnership members who are pregnant and those who have delivered up to one year after delivery (up to one year postpartum). Those who have had these conditions before, during, and/or up to two years after delivery are included in the count for SUD.
- **Total Maternal SUD:** Maternal population among those whose deliveries Partnership paid for in the Delivery Claims datasets who have been diagnosed with SUD.
- **Paid Claims:** Number of Substance Use services rendered by diagnosis claims.
- The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):
 - Alcohol
 - Opioids
 - Stimulants
 - Cannabis
 - Sedatives
 - Drug Abuse including nonspecific diagnosis of drug abuse and dependance

- Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates
- Calculations:
 - Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Count of Service (i.e., SUD) paid in claims in particular location, at the particular point-in-time divided by the Total Number of paid claims in particular location, at the particular point-in-time per Member per Year (12) per 1000 Members in particular location.
 - This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

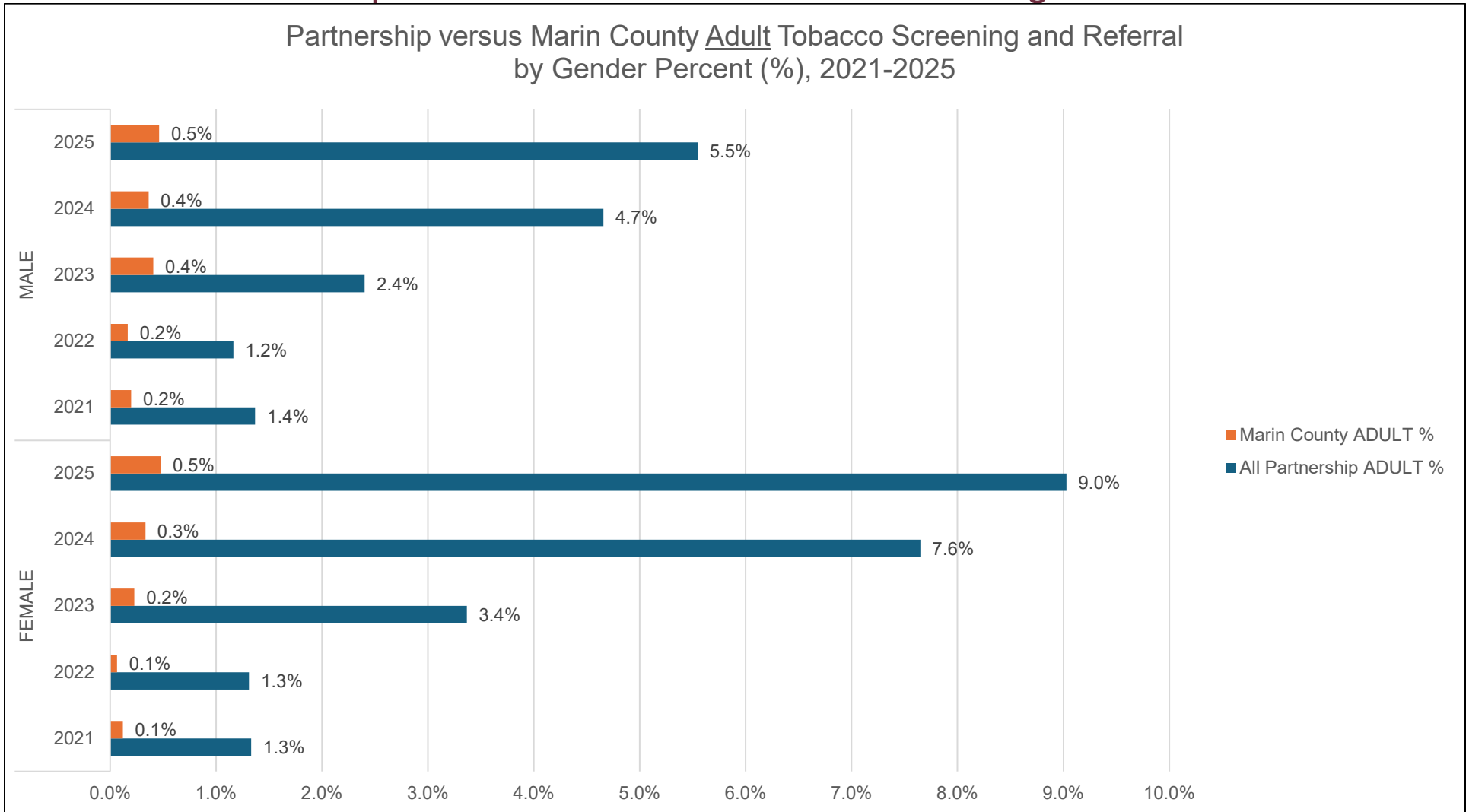
Note: Unique members can have multi-drug SUD and have claims from several service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin Adult Tobacco Screening and Referral



Highlights of Partnership and Marin Adult Tobacco Screening and Referral

The graph presents Marin County tobacco screening and referral compared to all of Partnership. Marin County has very few tobacco use screening claims for adults.

Note:

- Tobacco screenings before 2023 were low before a concerted effort to have PCPs report tobacco screening was instituted, with a pay for performance incentive.
- In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services rendered by Tobacco use diagnosis paid claim
 - Current Procedural Terminology (CPT) codes considered include
 - 99406, 99407 — Tobacco Cessation Counselling visit,
 - 4004F – Tobacco Cessation Intervention Counselling,
 - 1036F – Current Tobacco non-user.
- **% Gender** is the number of enrolled members in the individual gender (i.e., male or female), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all gender (i.e., male and female) in that particular location currently enrolled, multiplied by 100 (%)
 - Tobacco Screening and Referral Members are divided into two categories:
 - Adult (over 21 years of age)
 - Child (ages less than 21 years).
 - Inclusion/Exclusion Criteria:
 - Included only members who are assigned or capitated to a PCP site.

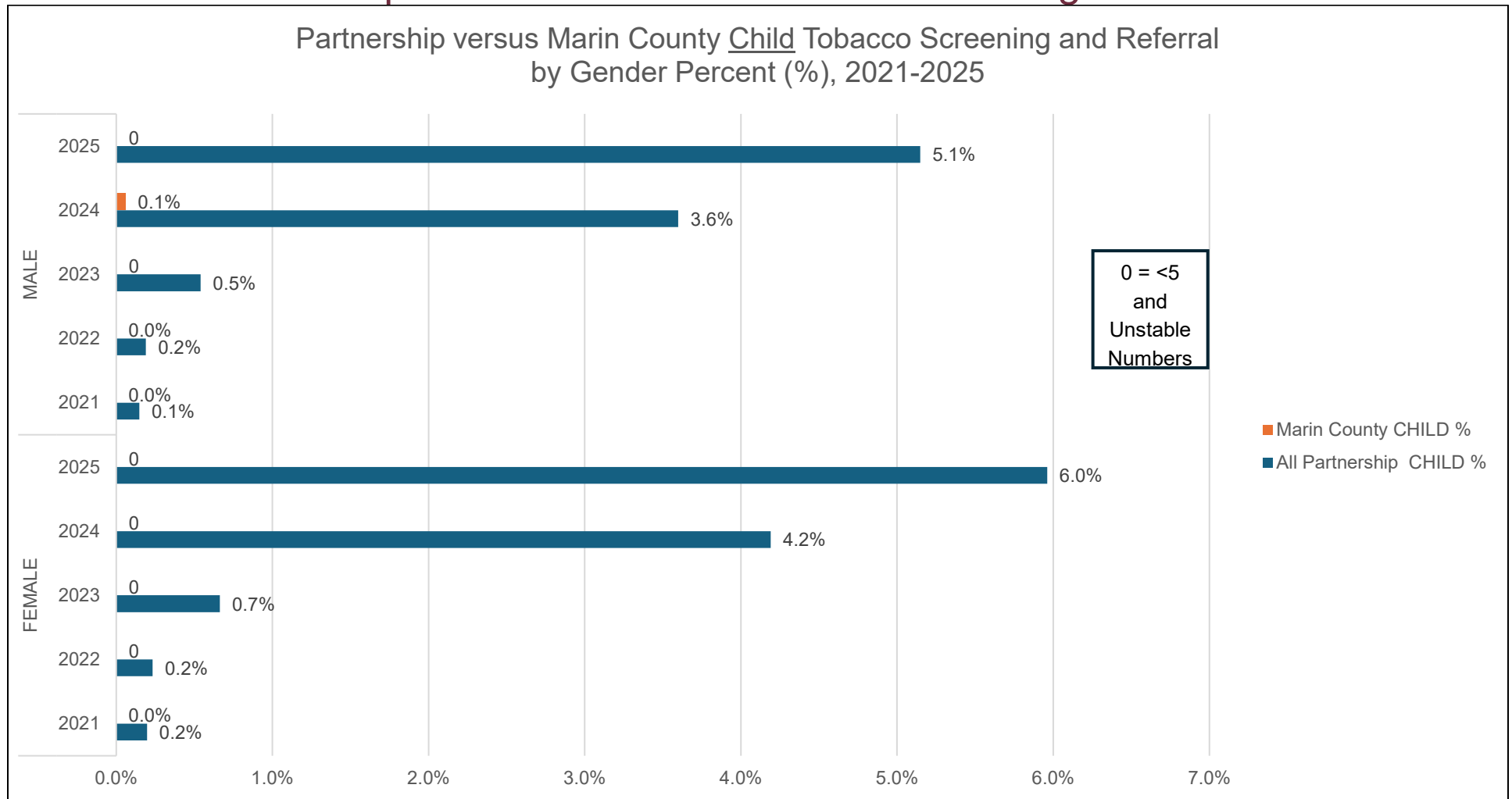
- Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin Child Tobacco Screening and Referral



Highlights of Partnership and Marin Child Tobacco Screening and Referral

The graph presents Marin County tobacco screening and referral compared to all of Partnership. Marin County has very few tobacco use screening claims for children.

Note:

- Tobacco screenings before 2023 were low before a concerted effort to have PCPs report tobacco screening was instituted, with a pay for performance incentive.
- In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- **Member Count:** Unique Partnership member count utilizing services rendered by Tobacco use diagnosis paid claim
 - Current Procedural Terminology (CPT) codes considered include
 - 99406, 99407 – Tobacco Cessation Counselling visit
 - 4004F – Tobacco Cessation Intervention Counselling
 - 1036F – Current Tobacco non-user
- **% Gender** is the number of enrolled members in the individual gender (i.e., male or female), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all gender (i.e., male and female) in that particular location currently enrolled, multiplied by 100 (%)
 - Tobacco Screening and Referral Members are divided into two categories:
 - Adult (over 21 years of age)
 - Child (ages less than 21 years)
 - Inclusion/Exclusion Criteria:
 - Included only members who are assigned or capitated to a PCP site.
 - Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.

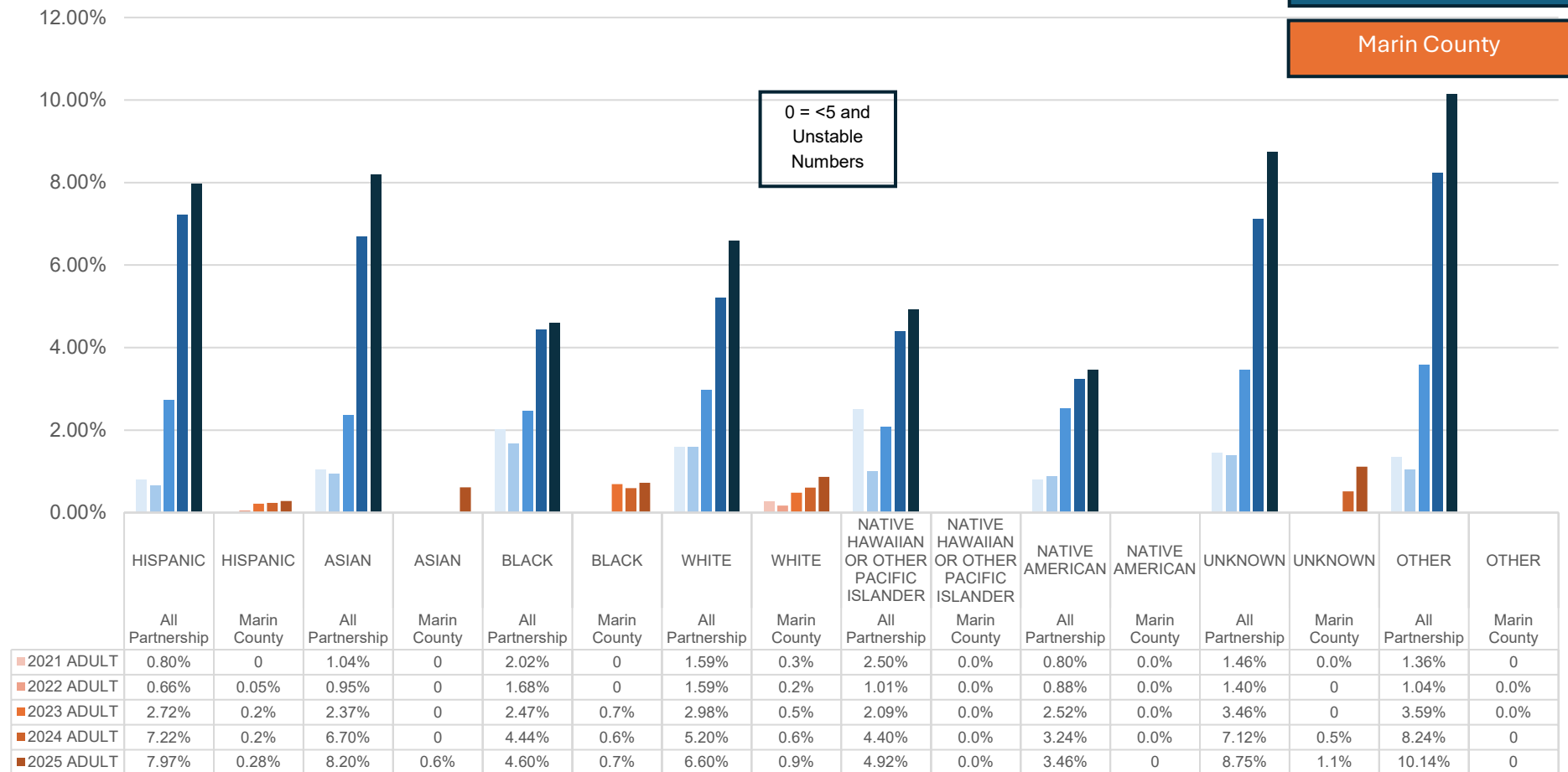
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin Adult Tobacco Screening and Referral by Race

Partnership versus Marin County Adult Tobacco Screening and Referral
by Race Percent (%), 2021-2025



Highlights of Partnership and Marin Adult Tobacco Screening and Referral by Race

The graph presents Marin County Adult tobacco screening and referral compared to all of Partnership by race. Marin County has very few tobacco use screening claims for adults.

Note:

- Tobacco screenings before 2023 were low before a concerted effort to have PCPs report tobacco screening was instituted, with a pay for performance incentive.
- In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Race/Ethnicity is voluntarily completed during enrollment by the state of California DHCS and Partnership's 24 individual counties and determined by California DHCS.
- **Member Count:** Unique Partnership member count utilizing services rendered by Tobacco use diagnosis paid claim
 - Current Procedural Terminology (CPT) codes considered include
 - 99406, 99407 — Tobacco Cessation Counselling visit,
 - 4004F – Tobacco Cessation Intervention Counselling,
 - 1036F – Current Tobacco non-user.
- **% Race/Ethnicity** is the number of enrolled members in the individual race/ethnicity group (i.e., White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all race/ethnicity groups in that particular location currently enrolled, multiplied by 100 (%)
- Tobacco Screening and Referral Members are divided into two categories:
 - Adult (over 21 years of age)
 - Child (ages less than 21 years).

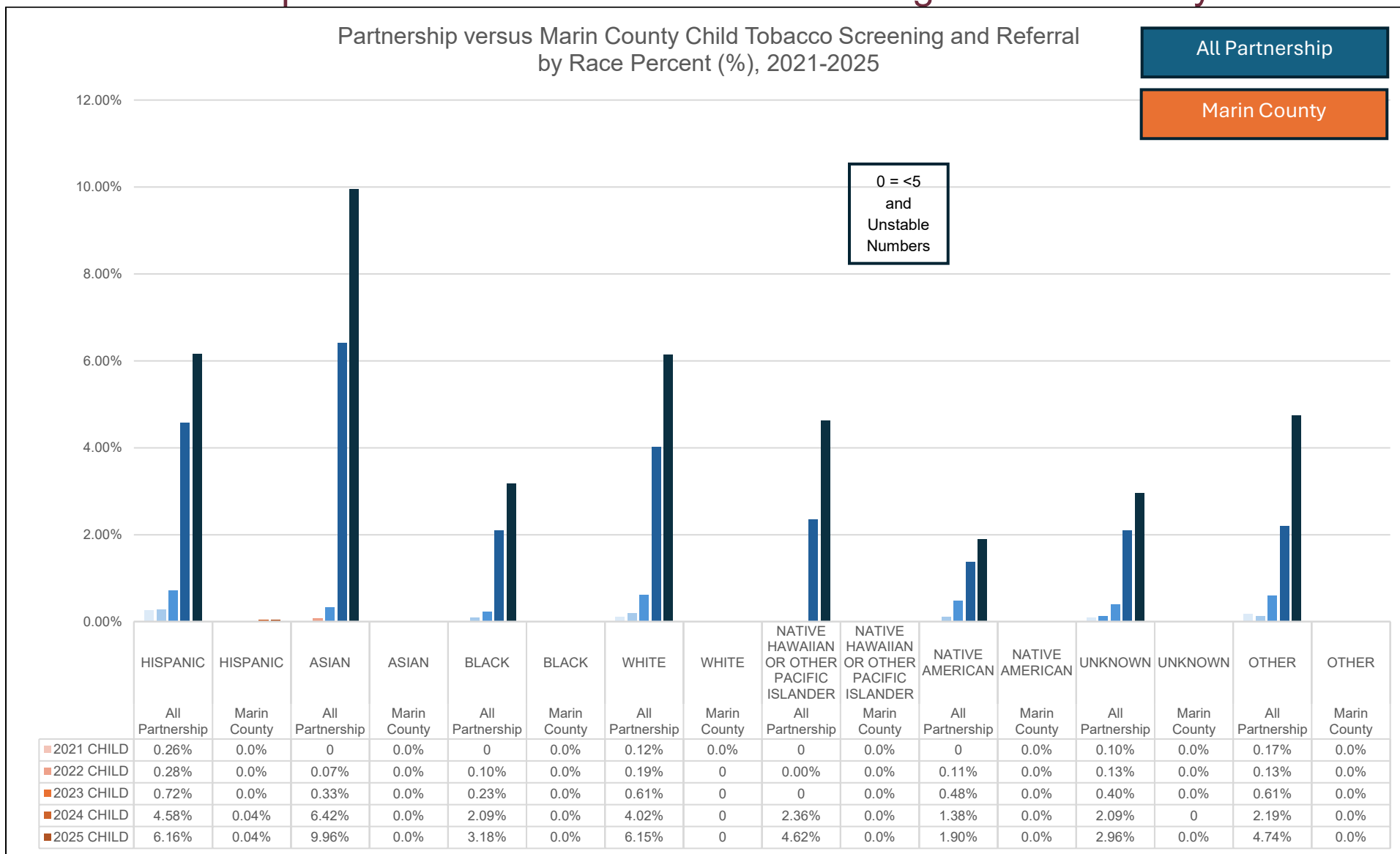
- Inclusion/Exclusion Criteria:
 - Included only members who are assigned or capitated to a PCP site.
 - Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Pharmacy (Rx) claims

Substance Use Disorder

Partnership and Marin Child Tobacco Screening and Referral by Race



Highlights of Partnership and Marin Child Tobacco Screening and Referral by Race

The graph presents Marin County Child tobacco screening and referral compared to all of Partnership by race. Marin County has very few tobacco use screening claims for children.

Note:

- Tobacco screenings before 2023 were low before a concerted effort to have PCPs report tobacco screening was instituted, with a pay for performance incentive.
- In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- **Enrollment:** Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Race/Ethnicity is voluntarily completed during enrollment by the state of California DHCS and Partnership's 24 individual counties and determined by California DHCS.
- **Member Count:** Unique Partnership member count utilizing services rendered by Tobacco use diagnosis paid claim
 - Current Procedural Terminology (CPT) codes considered include
 - 99406, 99407 — Tobacco Cessation Counselling visit,
 - 4004F – Tobacco Cessation Intervention Counselling,
 - 1036F – Current Tobacco non-user.
- **% Race/Ethnicity** is the number of enrolled members in the individual race/ethnicity group (i.e., White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander), in the location category (i.e., Marin County, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all race/ethnicity groups in that particular location currently enrolled, multiplied by 100 (%)
- Tobacco Screening and Referral Members are divided into two categories:
 - Adult (over 21 years of age)

- Child (ages less than 21 years).
- Inclusion/Exclusion Criteria:
 - Included only members who are assigned or capitated to a PCP site.
 - Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.

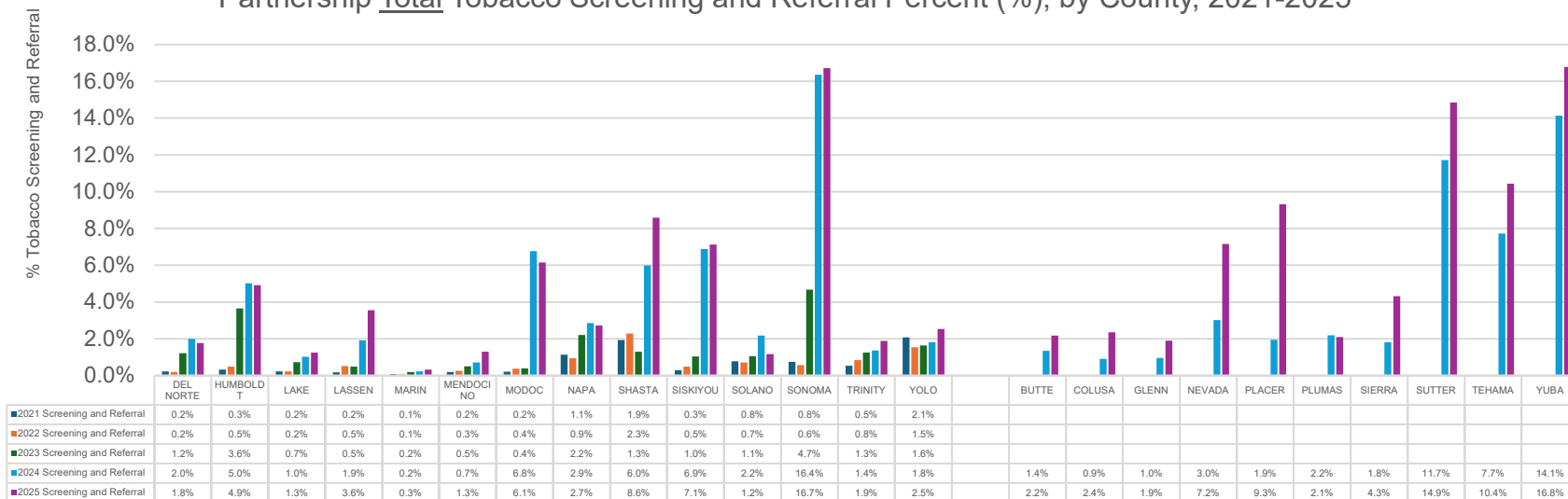
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Pharmacy (Rx) claims

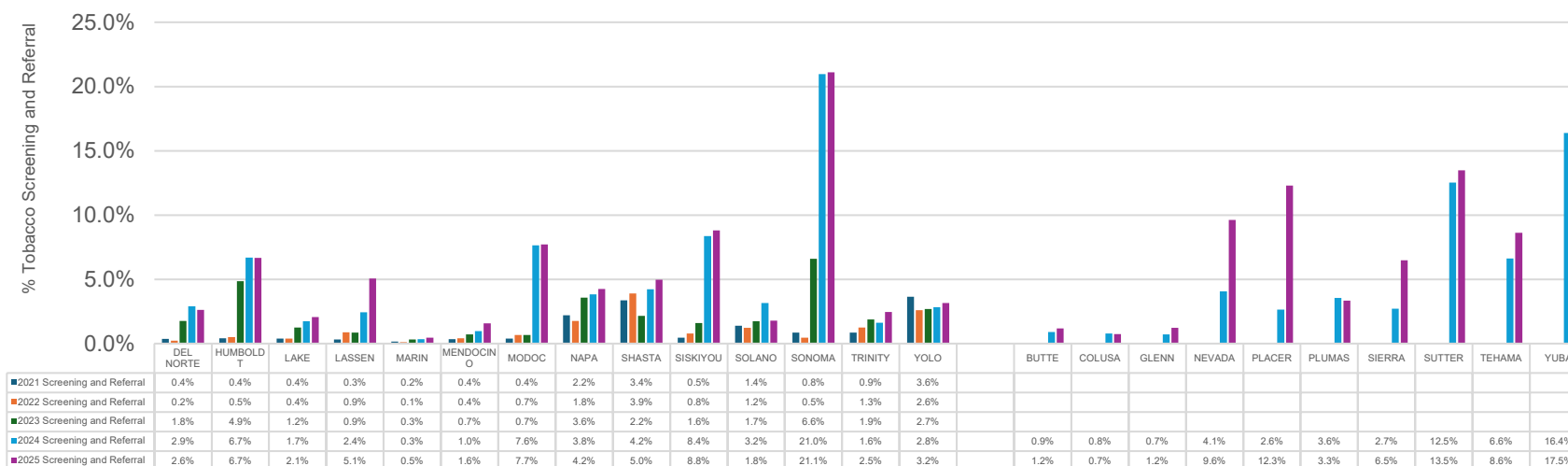
Substance Use Disorder

Tobacco Screening and Referral by County

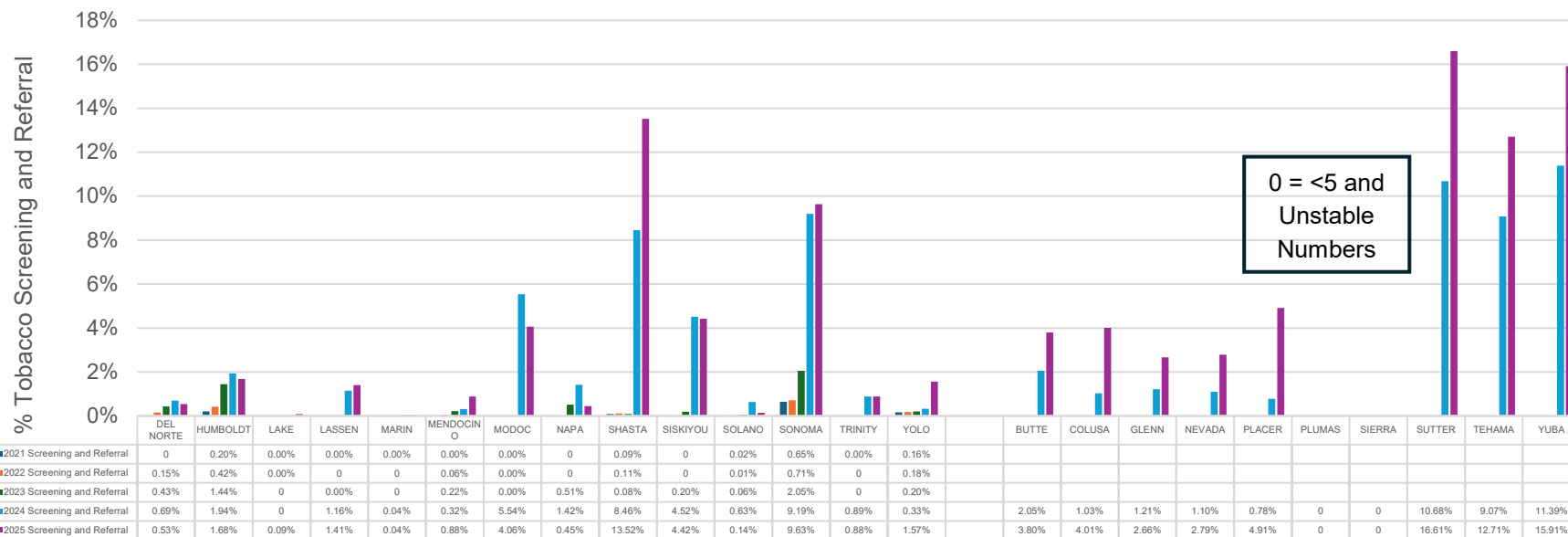
Partnership Total Tobacco Screening and Referral Percent (%), by County, 2021-2025



Partnership Adult Tobacco Screening and Referral Percent (%), by County, 2021-2025



Partnership Child Tobacco Screening and Referral Percent (%), by County, 2021-2025



Highlights of Tobacco Screening and Referral by County

The graph presents Marin County tobacco screening and referral compared to all of Partnership by county. Marin County has one of the lower tobacco screening and referral claims rate (%) for both adult and child Partnership members.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
- Member Count: Unique Partnership member count utilizing services rendered by Tobacco use diagnosis paid claim
 - Current Procedural Terminology (CPT) codes considered include
 - 99406, 99407 — Tobacco Cessation Counselling visit,
 - 4004F – Tobacco Cessation Intervention Counselling,
 - 1036F – Current Tobacco non-user.
- Tobacco Screening and Referral Members are divided into two categories:
 - Adult (over 21 years of age)
 - Child (ages less than 21 years).
- Inclusion/Exclusion Criteria:
 - Included only members who are assigned or capitated to a PCP site.
 - Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.
- Calculations:
 - Tobacco screening and referral to treatment Percentage (%) by:
 - Count of distinct members (i.e., by adult or child category) who received at least one tobacco screening and referral (numerator) divided by the count of distinct eligible members in the calendar year (denominator) (i.e., by adult or child category) X 100 (%).

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Pharmacy (Rx) claims

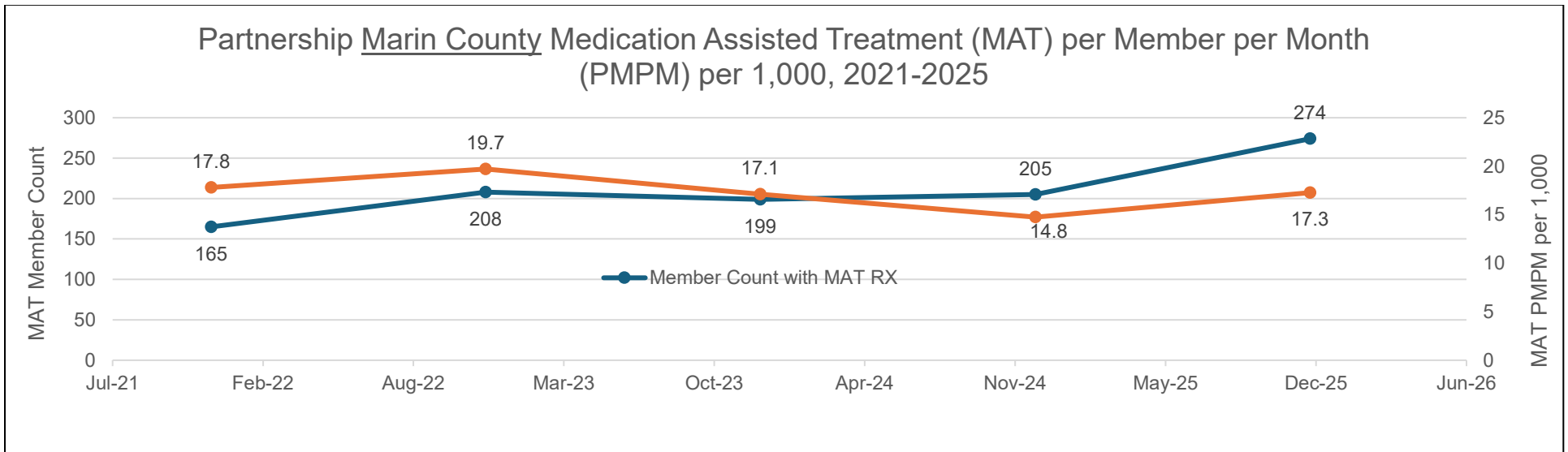
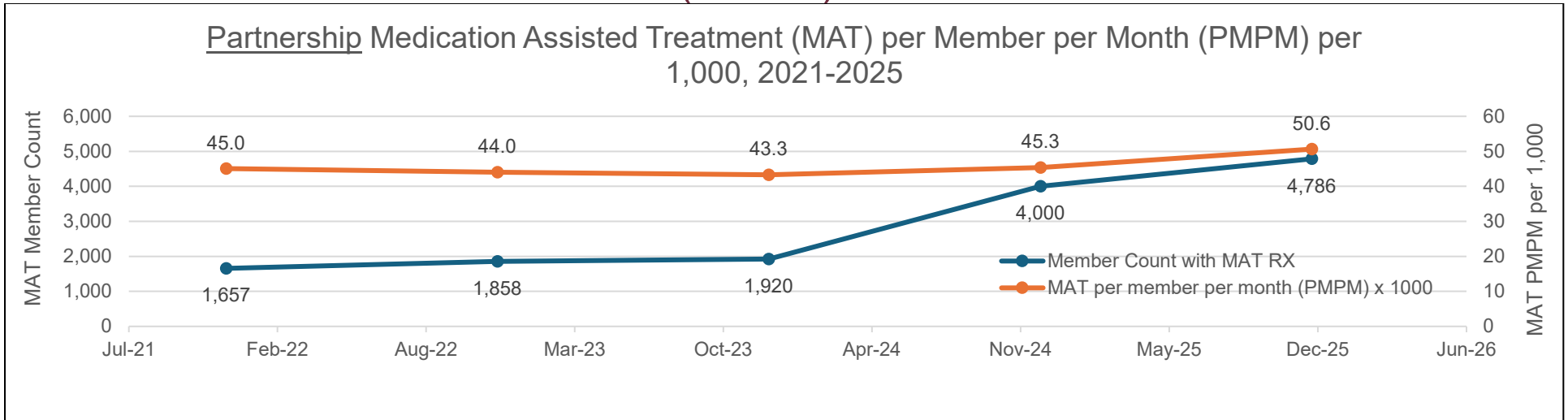
Utilization

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For more information, see [Utilization](#) in the [Appendix](#)

Utilization: Services Provided

Partnership & Marin Medication Assisted Treatment (MAT) Per Member Per Month (PMPM) Per 1000



Highlights of Partnership & Marin Medication Assisted Treatment (MAT) Per Member Per Month (PMPM) Per 1000

Medicated Assisted Treatment (MAT) among Partnership members has been relatively stable over the last five years, only increasing in 2024-2025 due to the increase in Partnership members from 10 new Partnership Counties. Marin County MAT has also remained constant over the past five years, with a range from 14.8 to 19.7 MAT per member per month (PMPM) per 1,000 Marin County Partnership members from 2021 to 2025, except for 2024 when the numbers decreased to 14.8 MAT PMPM per 1,000.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in SUD count during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- MAT services are licensed alcoholism and drug abuse recovery or treatment facilities and certified programs ensuring members have access to medications for the treatment of substance use disorders.
- Member Count: Unique Partnership member count utilizing Pharmacy Medication (Rx) services.
- For Partnership healthcare service Utilization, places of service are defined by the [CMS Place of Service Code Set](#).
- Calculations:
 - MAT PMPM*1,000: Rate calculated from the number of members utilizing MAT per Member per Month (member months) per 1,000 Partnership members. $\text{MAT PMPY} \times 1,000: [\text{sum}(\text{MAT}) / \text{sum}(\text{member} \times 12 \text{ months})]$ per 1,000 Partnership members.
 - This is calculated so Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per month.
 - $\text{MAT PMPM} \times 1,000: [\text{sum}(\text{MAT}) / \text{sum}(\text{member months})]$ per 1,000 Partnership members.

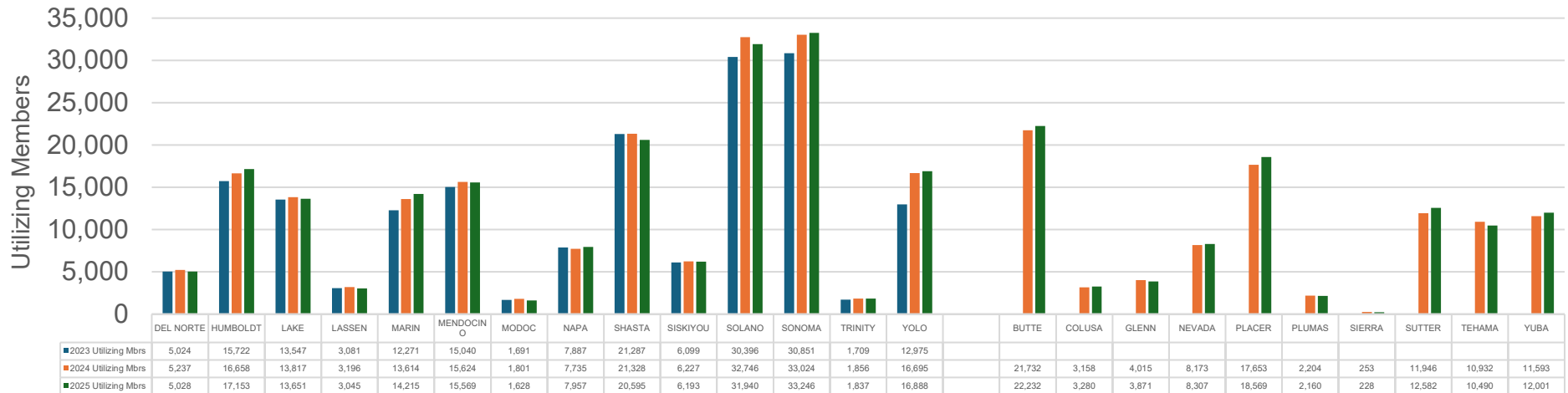
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims

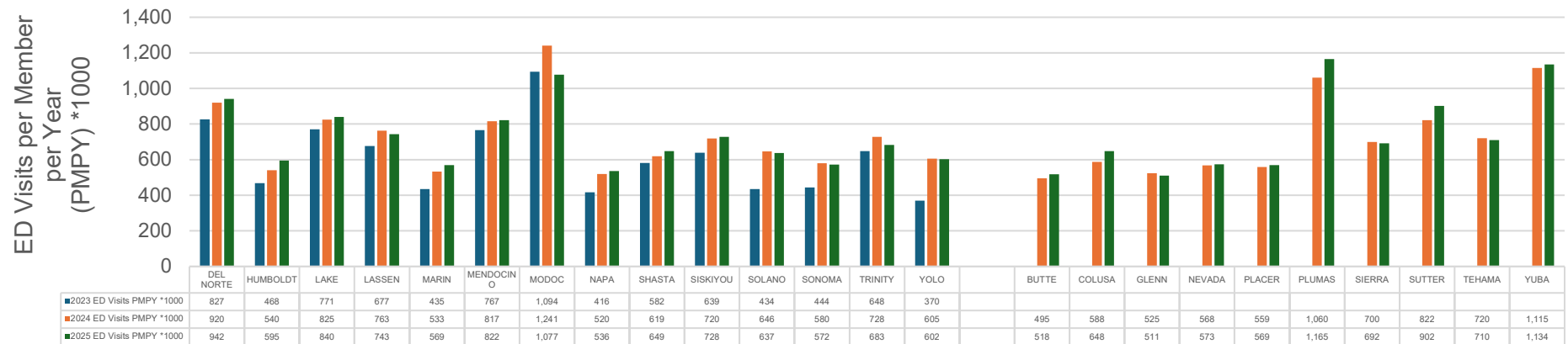
- County Mental Health data
- Pharmacy (Rx) claims

Utilization: Services Provided Emergency Department Visits

Partnership Emergency Department Utilization by Utilizing Members and by County, 2023-2025



Partnership Emergency Department (ED) Utilization by Visits
per Member per Year (PMPY) per 1,000 Members and by County, 2023-2025



Emergency Department (ED) Visits PMPY *1000: The number of Emergency Department visits per Member per Year per 1000 Members
 $\text{SUM(ED Visits)/SUM(Member Months)*12 per 1000}$

Highlights of Emergency Department Visits

The Emergency Department (ED) Visit rate per Partnership member per year in Marin County is average compared to other counties. The rate per 1,000 members per year went from 435 to 569 from 2023 to 2025 and is about 0.4 to 0.6 visits per member per year (1 member: 0.4-0.6 visit) or about 1 visit per 2 members per year. Hence, on estimate, every other Partnership member may end up going to the emergency room once a year in Marin County. Compared to the Partnership target of 2.2 visits for primary care provider visits per year to establish a Medical Home, Marin County ED visits are high.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

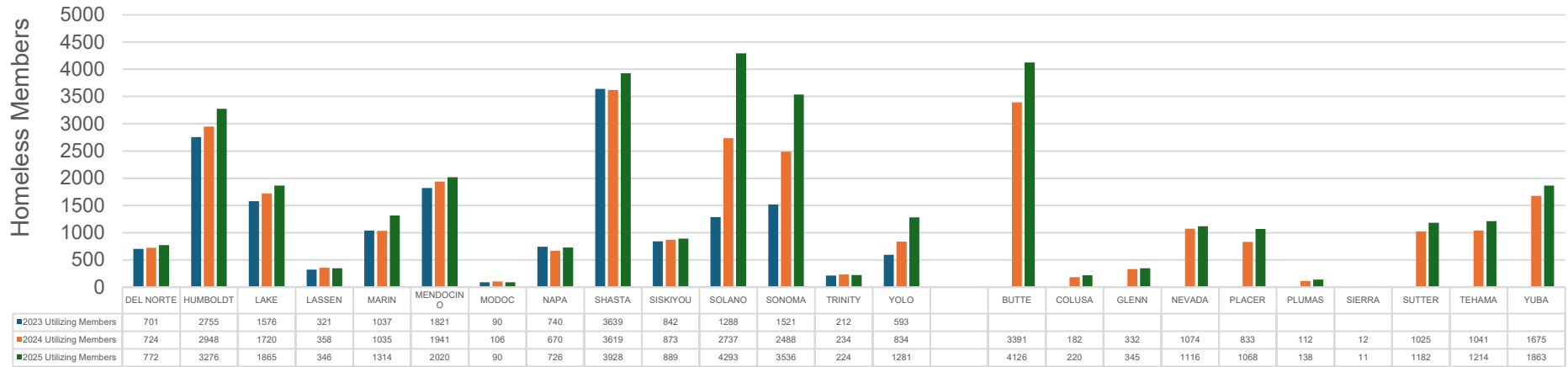
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services
 - Utilizing Members: Unique Members who have an ED visit claim in the Partnership medical claims dataset.
 - For Partnership healthcare service Utilization, places of service are defined by the [CMS Place of Service Code Set](#).
 - Note: These include only Fee for Service and Capitated Members.
- Calculations:
 - Visit PMPY*1,000: Rate calculated from the number of Visit Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Numerator: Number of Visit Claims in that particular location at the particular point-in-time.
 - Denominator: Total number of Visit Claims by Member Month in that particular location at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.
 - For Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per year.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

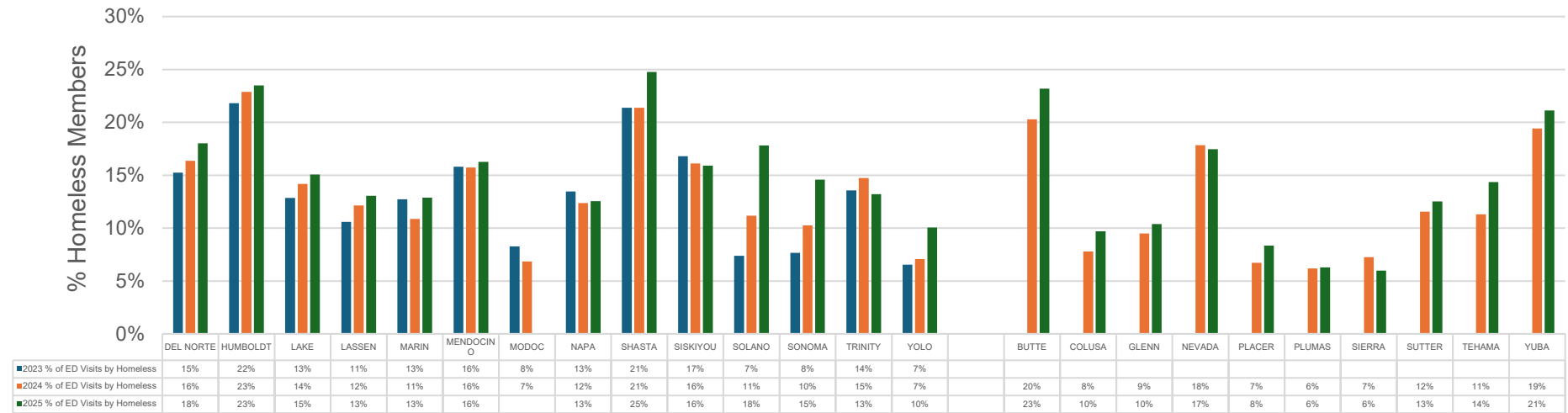
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Utilization: Services Provided Homeless Emergency Department Visits

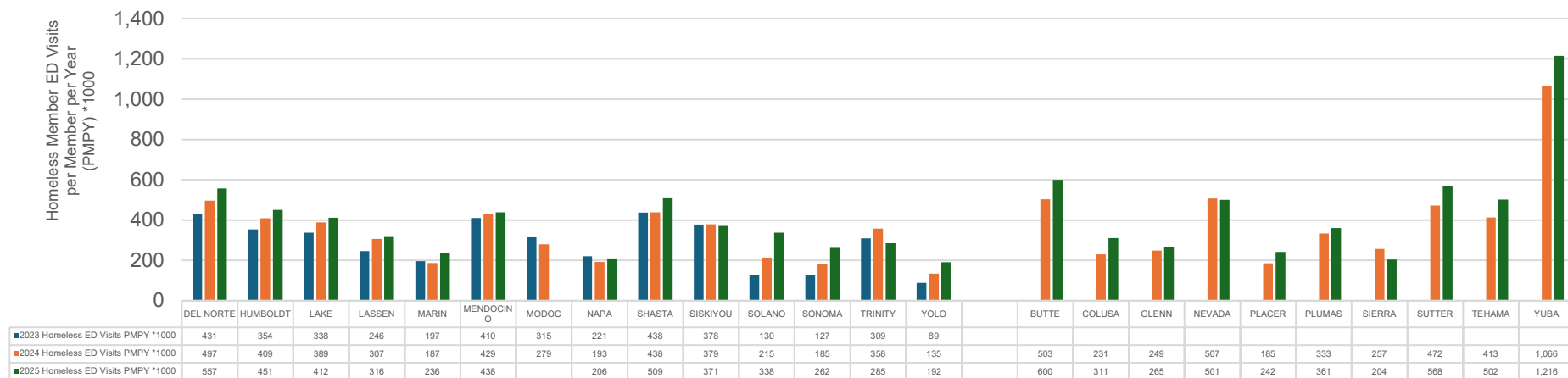
Partnership Emergency Department Utilization by Homeless Members and by County, 2023-2025



Percentage (%) of Partnership Emergency Department Visits by Homeless Members and by County, 2023-2025



Partnership Emergency Department Utilization by Visits per Homeless Member per Year per 1,000 Members, and by County, 2023-2025



Emergency Department (ED) Visits PMPY *1000: The number of Emergency Department visits per Member per Year per 1000 Members

$$\frac{\text{SUM(ED Visits)}}{\text{SUM(Member Months)} * 12 \text{ per } 1000}$$

Highlights of Homeless Emergency Department Visits

Out of all ED visits, 11-13% of ED visits are by Homeless members in Marin County, a rate per 1,000 homeless members of 187 to 236 from 2023 to 2025 per member per year.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

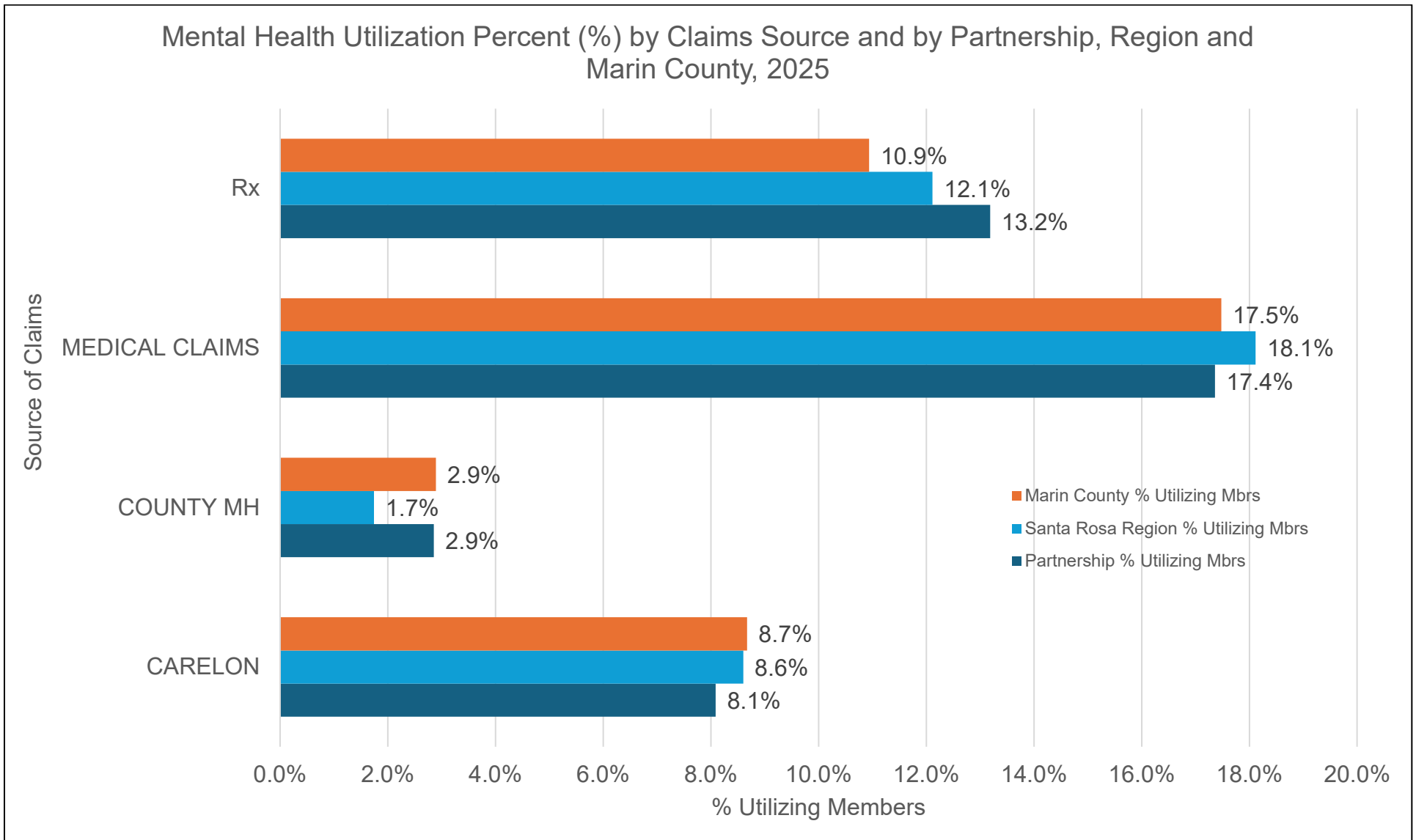
- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Homeless: Unique members who have an ED visit claim in the Partnership medical claims dataset, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.
 - Member Count: Unique count of Partnership members utilizing services.
 - Utilizing Members: Unique Members who have an ED visit claim in the Partnership medical claims dataset.
 - For Partnership healthcare service Utilization, places of service are defined by the [CMS Place of Service Code Set](#).
 - Note: These include only Fee for Service and Capitated Members.
- Calculations:
 - Percent (%) Homeless: Unique Homeless Members who have an ED visit claim in the Partnership medical claims dataset, in that particular location, at the particular point-in-time divided by the Total Number of ED Visits in that particular location, at the particular point-in-time X100 (%). Visit Rate: Total number of ED visits by Homeless member / Total Utilizing Members X100 (%).
 - Visit PMPY*1,000: Rate calculated from the number of Homeless Visit Claims per Member per Year (12 months) per 1,000 Partnership Members.
 - Numerator: Number of Homeless Visit Claims in that particular location, at the particular point-in-time.
 - Denominator: Total number of Visit Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.
 - For Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per year.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

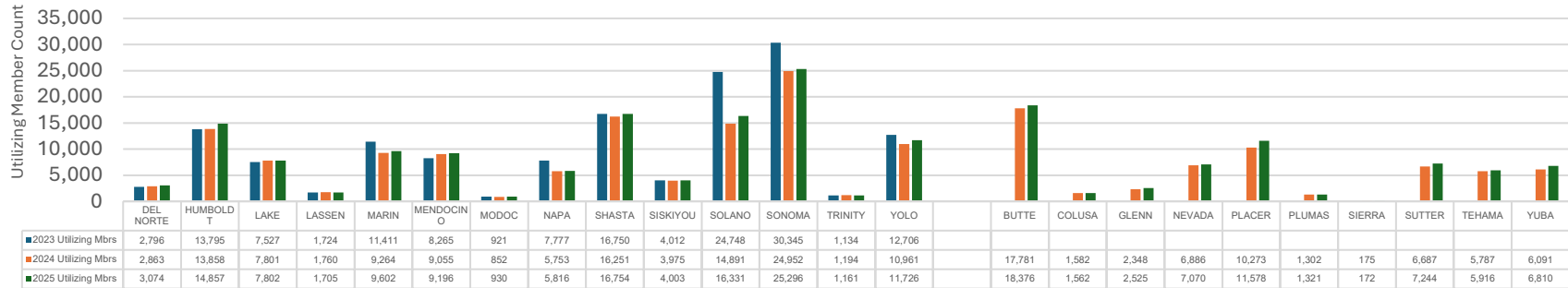
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Utilization: Services Provided

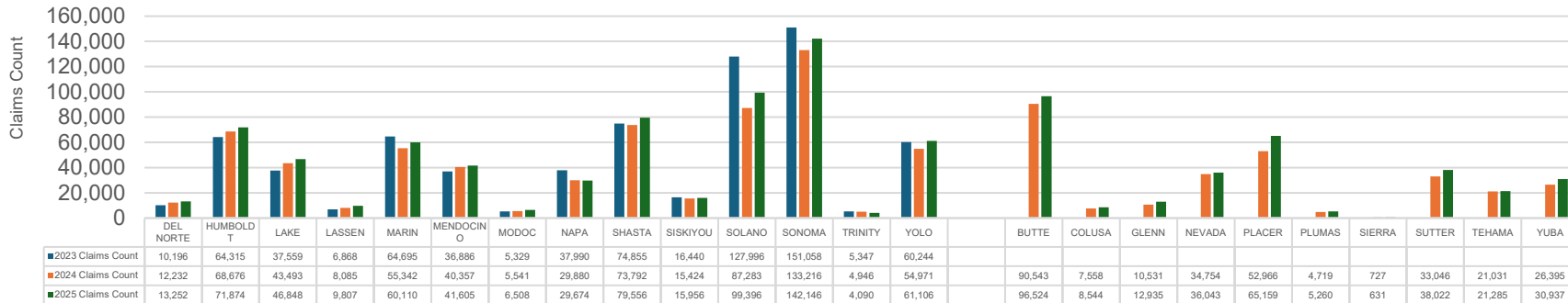
Mental Health: Medical Claims



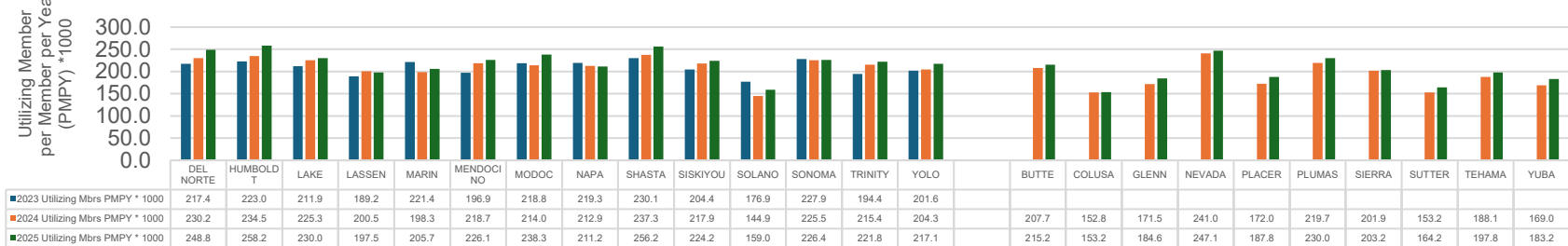
Partnership Mental Health Utilization Medical Claim Source by Member Count, and by County, 2023-2025



Partnership Mental Health Utilization Medical Claim Source by Claims Count, and by County, 2023-2025



Partnership Mental Health Utilization Medical Claim Source by Utilizing Member per Member per Year per 1,000, and by County, 2023-2025



Utilizing Member PMPY *1000: The number of Utilizing Member per Member Year per 1000 Members
 $\text{SUM(Utilizing Members)/SUM(Member Months)*12 per 1000}$

Highlights of Mental Health: Medical Claims

Mental Health Services utilization for Marin shows similar rates compared to the Santa Rosa Region and all of Partnership. For County Mental Health services Marin is at 2.9%, compared to all of Partnership at 2.9%. Marin had medical claim rates ranging from 198.3 to 221.4 from 2023 to 2025 per member per year per 1,000 Marin Partnership members.

Mental Health Service Provider claims sources include:

- Medical claims
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services Each Mental health service provider source is assessed for the following indicators:
 - Claims Count: Distinct visit to mental health provider, a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize services provided by Medical (i.e., Primary Care Providers).
- Calculations:
 - Utilizing Member Visit PMPY*1,000: is the rate calculated from the number of Utilizing Member per Member per Year (12 months) per 1,000 Partnership Members. Utilizing Member PMPY*1,000: $[\text{sum}(\text{Utilizing Member}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.
 - Numerator: Number of Utilizing Member Claims in that particular location, at the particular point-in-time.
 - Denominator: Total number of Utilizing Member Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

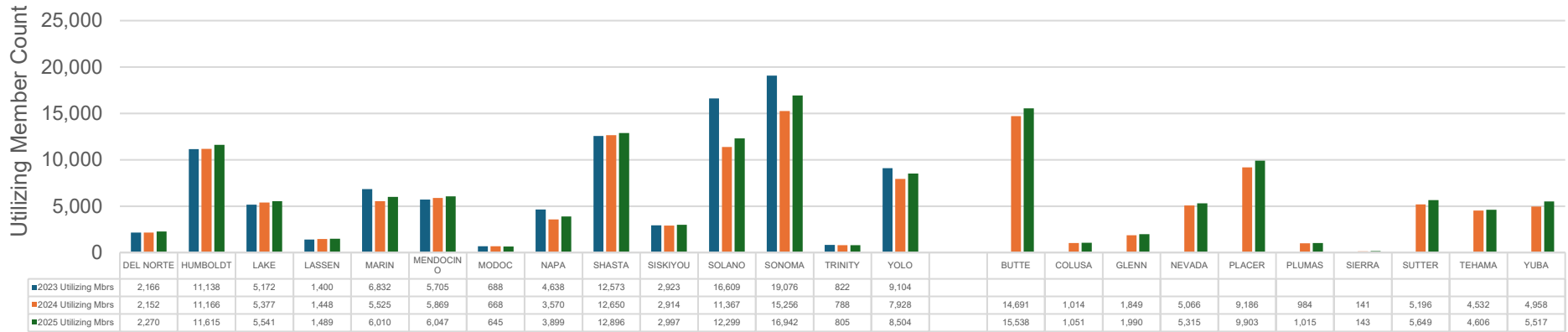
- DHCS Enrollment dataset for Partnership Members and DHCS Medical Claims data

- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims; Note: From 2022, all pharmacy data (Carved In/Out) comes from Magellan datasets called Carved Out (excluding Carved In data).

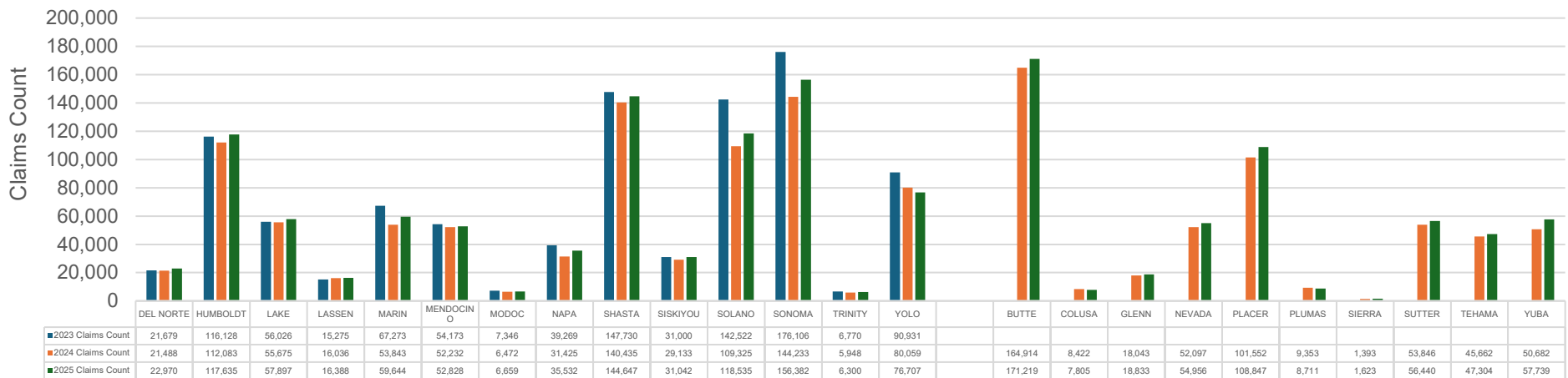
Utilization: Services Provided

Mental Health: Pharmacy (Rx) Claims

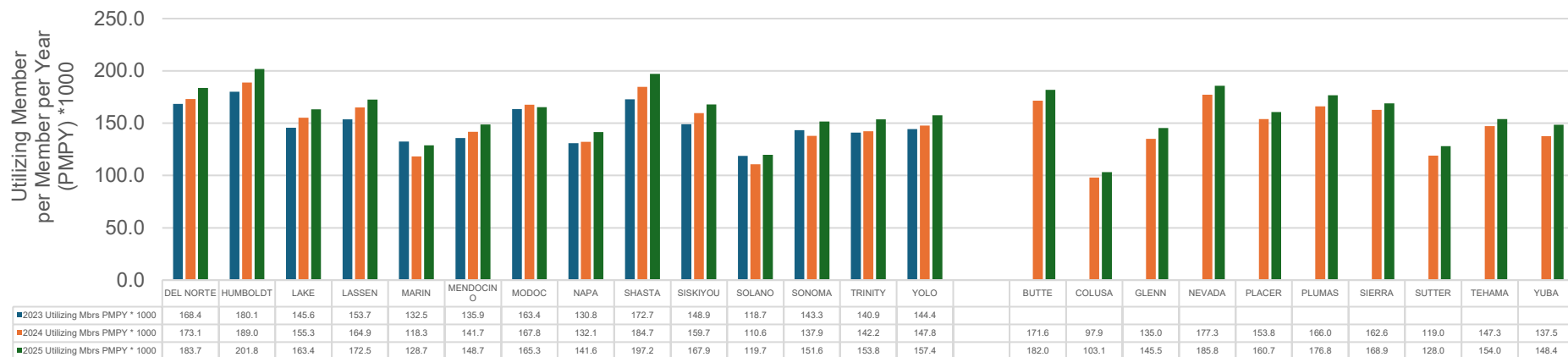
Partnership Mental Health Utilization Pharmacy (Rx) Claim Source by Member Count, and by County, 2023-2025



Partnership Mental Health Utilization Pharmacy (Rx) Claim Source by Claims Count, and by County, 2023-2025



Partnership Mental Health Utilization Pharmacy (Rx) Claim Source by Utilizing Member per Member Year per 1,000, and by County, 2023-2025



Utilizing Member PMPY *1000: The number of Utilizing Member per Member Year per 1000 Members
 $\text{SUM(Utilizing Members) / SUM(Member Months) * 12 per 1000}$

Highlights of Mental Health: Pharmacy (Rx) Claims

Marin also had average rate range of Pharmacy utilization at 118.3 to 132.5, per member per year per 1,000 Marin Partnership members from 2023 to 2025, compared to other counties. An average utilization compared to other counties

Mental Health Service Provider claims sources include:

- Medical claims
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services Each Mental health service provider source is assessed for the following indicators:
 - Claims Count: Distinct visit to mental health providers, a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize services provided by the Pharmacy (Rx).
- Calculations:
 - Utilizing Member Visit PMPY*1,000: is the rate calculated from the number of Utilizing Member per Member per Year (12 months) per 1,000 Partnership Members. Utilizing Member PMPY*1,000: $[\text{sum}(\text{Utilizing Member}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.
 - Numerator: Number of Utilizing Member Claims in that particular location, at the particular point-in-time.
 - Denominator: Total number of Utilizing Member Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.

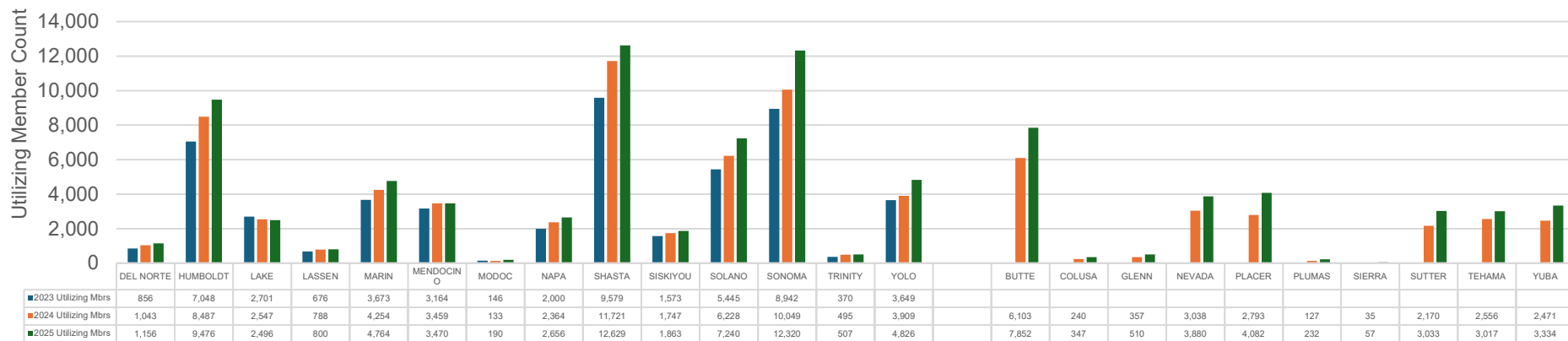
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members and DHCS Medical Claims data
- Caredon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims; Note: From 2022, all pharmacy data (Carved In/Out) comes from Magellan datasets called Carved Out (excluding Carved In data).

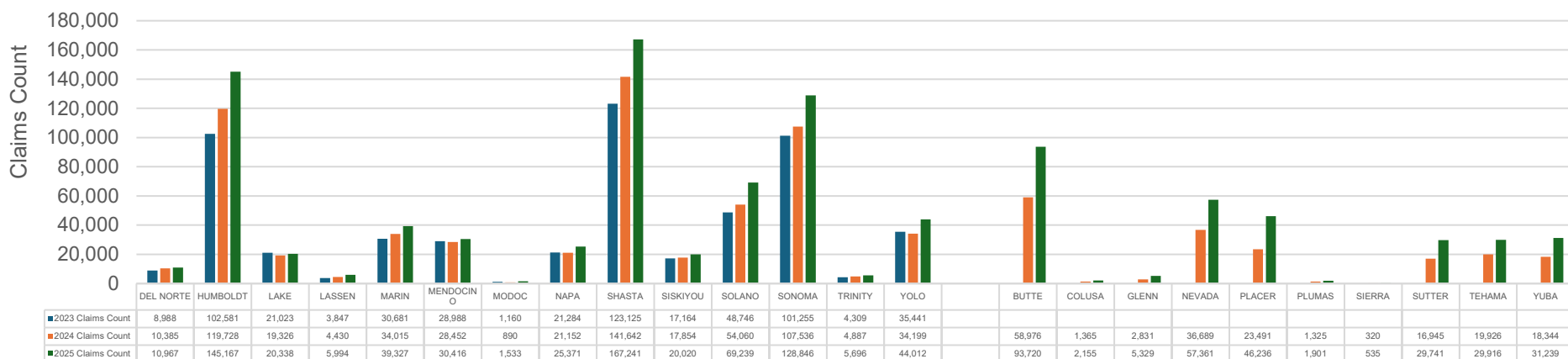
Utilization: Services Provided

Mental Health: Carelon Healthcare Services Claims

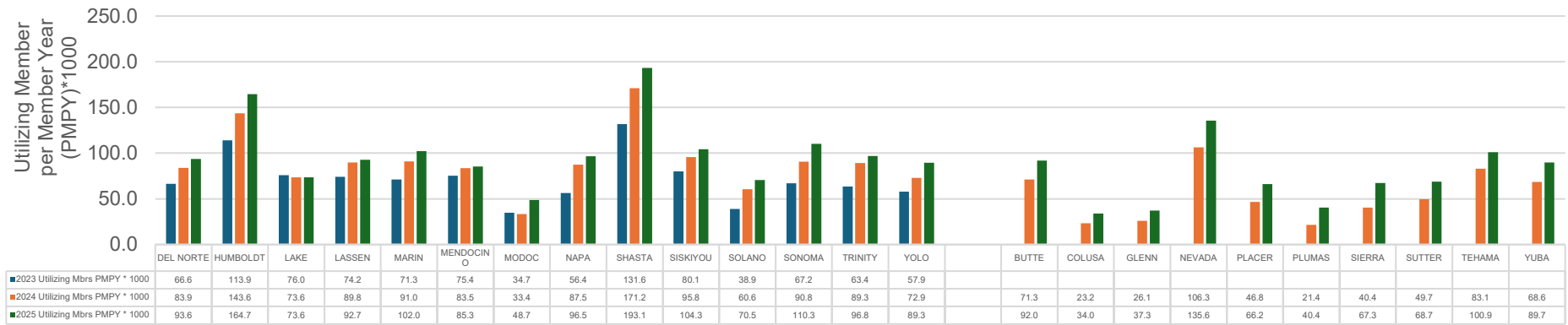
Partnership Mental Health Utilization Carelon Healthcare Services Claim Source by Member Count, and by County, 2023-2025



Partnership Mental Health Utilization Carelon Healthcare Services Claim Source by Claims Count, and by County, 2023-2025



Partnership Mental Health Utilization Carelon Healthcare Services Claim Source by Utilizing Member per Member Year per 1,000, and by County, 2023-2025



Utilizing Member PMPY *1000: The number of Utilizing Member per Member Year per 1000 Members

$$\text{SUM(Utilizing Members)} / \text{SUM(Member Months)} * 12 \text{ per } 1000$$

Highlights of Mental Health: Carelon Healthcare Services Claims

Marin Carelon utilization was at 71.3 to 102.0 per member per year per 1,000 Marin County members from 2023 to 2025. An average utilization compared to other counties.

Mental Health Service Provider claims sources include:

- Medical claims
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services Each Mental health service provider source is assessed for the following indicators:
 - Claims Count: Distinct visit to mental health providers, a distinct combination of member, service date, and provider
 - Utilizing Members: Unique Members who utilize services provided by Carelon Healthcare Services
- Calculations:
 - Utilizing Member Visit PMPY*1,000: is the rate calculated from the number of Utilizing Member per Member per Year (12 months) per 1,000 Partnership Members. Utilizing Member PMPY*1,000: $[\text{sum}(\text{Utilizing Member}) / \text{sum}(\text{member months})]$
* 12 per 1,000 Partnership members.
 - Numerator: Number of Utilizing Member Claims in that particular location, at the particular point-in-time.
 - Denominator: Total number of Utilizing Member Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.

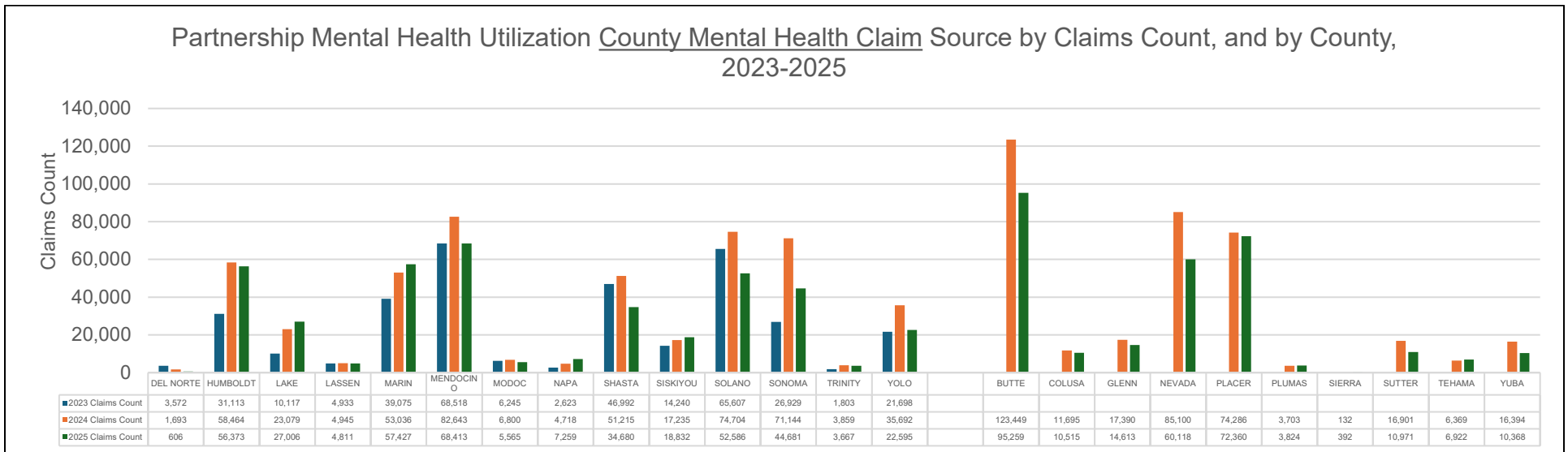
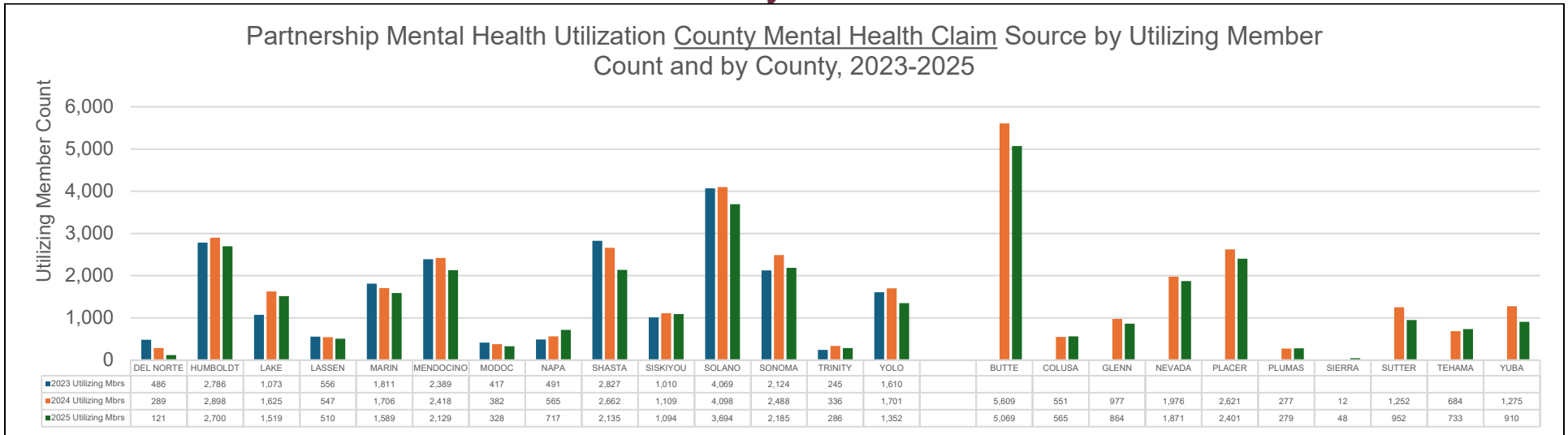
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members and DHCS Medical Claims data
- Carelon Healthcare Services claims

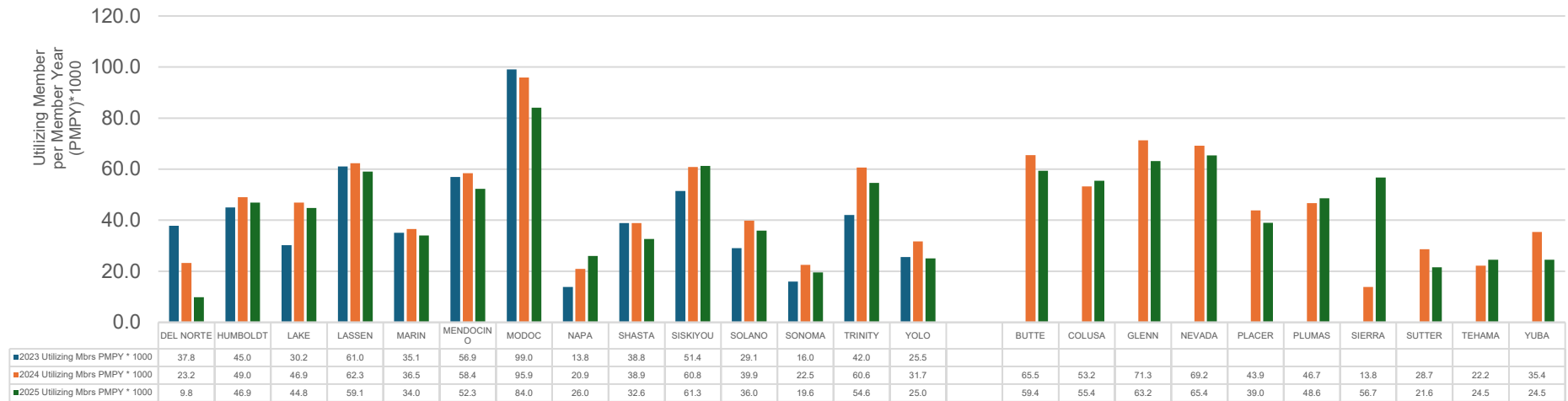
- County Mental Health data
- Pharmacy (Rx) claims; Note: From 2022, all pharmacy data (Carved In/Out) comes from Magellan datasets called Carved Out (excluding Carved In data).

Utilization: Services Provided

Mental Health: County Mental Health Claims



Partnership Mental Health Utilization County Mental Health Claim Source by Utilizing Member per Member Year per 1,000, and by County, 2023-2025



Utilizing Member PMPY *1000: The number of Utilizing Member per Member Year per 1000 Members
 $\text{SUM(Utilizing Members) / SUM(Member Months) * 12 per 1000}$

Highlights of Mental Health: County Mental Health Claims

For County Mental Health, Marin has a lower rate compared to other counties at 34.0-36.5 utilizing members per member year per 1,000 members compared to Modoc County with a rate range from 84 to 99 utilizing member per member year per 1,000 members, 2023-2025.

Mental Health Service Provider claims sources include:

- Medical claims
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services Each Mental health service provider source is assessed for the following indicators:
 - Claims Count: Distinct visit to mental health provider, a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize services provided by the County Mental Health Service.
- Calculations:
 - Utilizing Member Visit PMPY*1,000: is the rate calculated from the number of Utilizing Member per Member per Year (12 months) per 1,000 Partnership Members. Utilizing Member PMPY*1,000: $[\text{sum}(\text{Utilizing Member}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.
 - Numerator: Number of Utilizing Member Claims in that particular location, at the particular point-in-time.
 - Denominator: Total number of Utilizing Member Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Member per Year (12 months) per 1,000 Partnership Members.

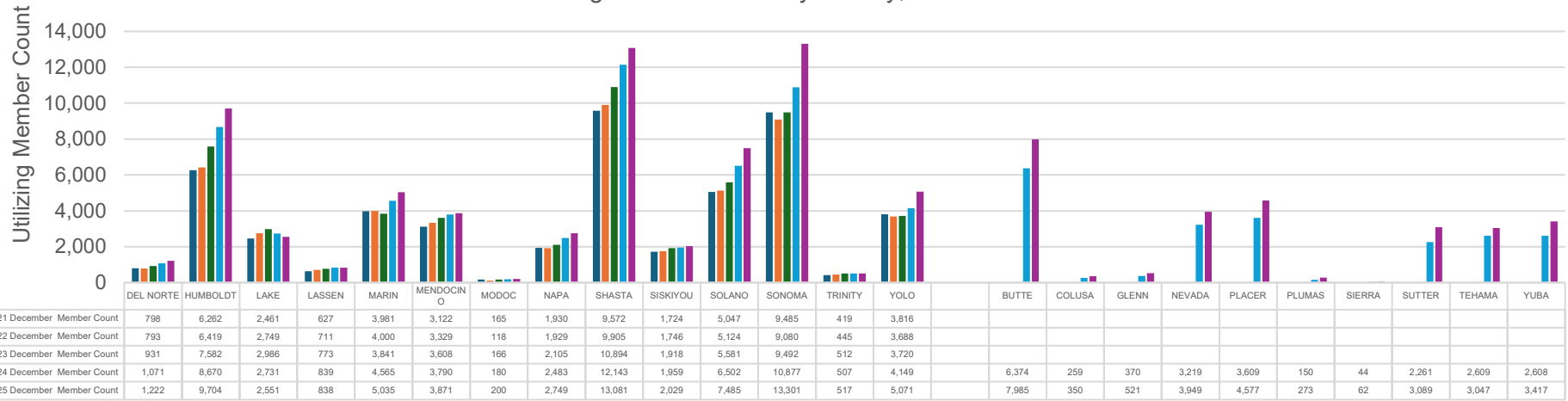
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members and DHCS Medical Claims data
- Carelon Healthcare Services claims
- County Mental Health data
- Pharmacy (Rx) claims; Note: From 2022, all pharmacy data (Carved In/Out) comes from Magellan datasets called Carved Out (excluding Carved In data).

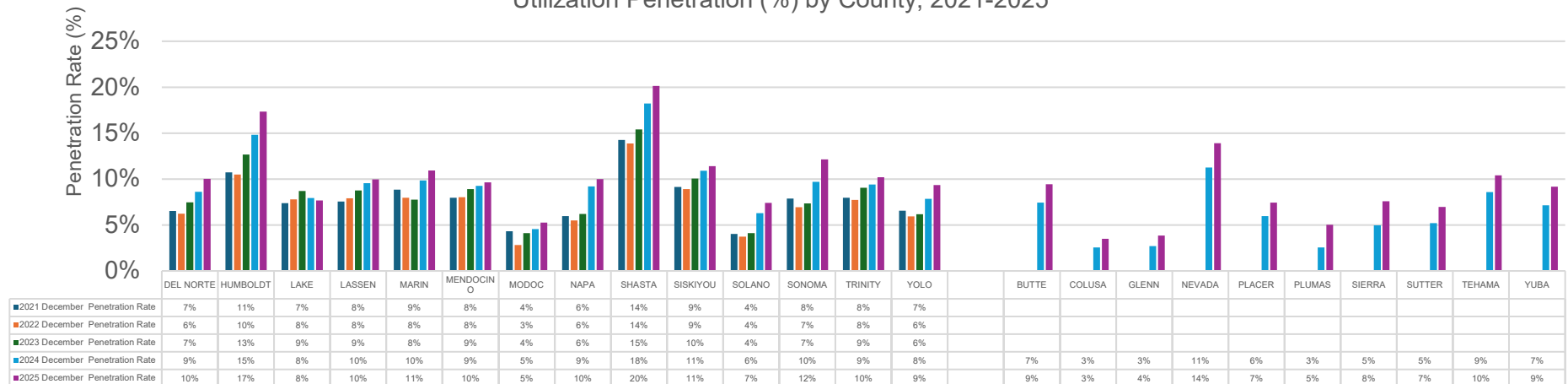
Utilization: Services Provided

Behavioral Health: Carelon Healthcare Services

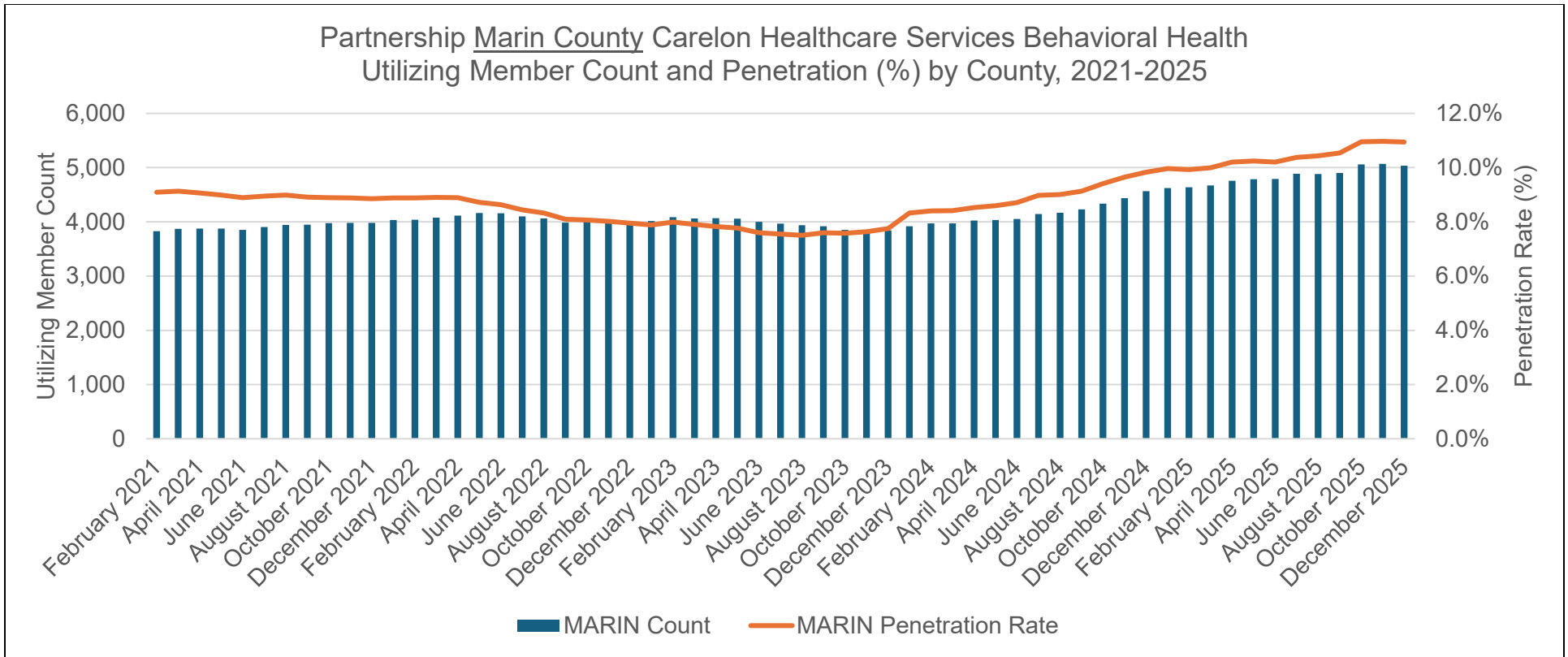
Partnership Carelon Healthcare Services Behavioral Health
Utilizing Member Count by County, 2021-2025



Partnership Carelon Healthcare Services Behavioral Health
Utilization Penetration (%) by County, 2021-2025



Penetration Rate (%): sum of (new members receiving service over the span of 12 months)/(member months) X 100



Carelton Healthcare Services: Partnership versus Marin County, 2025							
All of Partnership				Marin County			
Age Group	2025 Distinct Providers	2025 Distinct Utilizing Members	2025 Distinct Visits*	Age Group	2025 Distinct Providers	2025 Distinct Utilizing Members	2025 Distinct Visits*
21+	2910	65225 (72%)	756478 (75%)	21+	597	3485 (72%)	31176 (79%)
18-21	1428	6642 (7%)	63749 (6%)	18-21	114	296 (6%)	2085 (5%)
<18	1441	19227 (21%)	194467 (19%)	<18	127	1037 (22%)	6215 (16%)

Highlights of Behavioral Health: Carelon Healthcare Services

Partnership contracts with Carelon Behavioral Health to offer mild to moderate Behavioral Health services, and monitors them through Carelon claims. Members utilizing Carelon have been divided into age groups for less than 18 years, 18-21 years and over 21 years. Marin distinct Carelon Behavioral Health utilizing members and distinct visits by age group show similar patterns to Partnership members as a whole.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services. Each Behavioral Health Services provider (Carelon) source is assessed for the following indicators:
 - Claims Count: Distinct visit counts to Behavioral Health Service providers, defined as a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize behavioral health services provided by Carelon
- Calculations:
 - Penetration Rate (%): DHCS treats penetration rate as the percentage of Medi-Cal Members utilizing Health services divided by the number of Medi-Cal eligible members for that county X100.
 - Partnership defines the measure as a rolling sum of unique members in the first month of measurement period plus unique new members in each of the following months: The sum of (new members receiving service over the span of 12 months)/(member months) X 100.

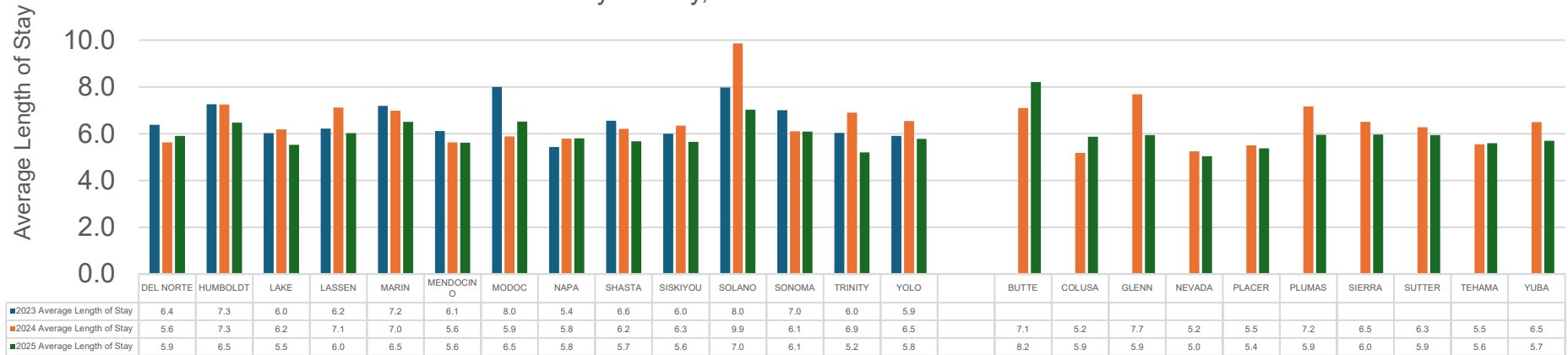
Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data
- Carelon Healthcare Services claims

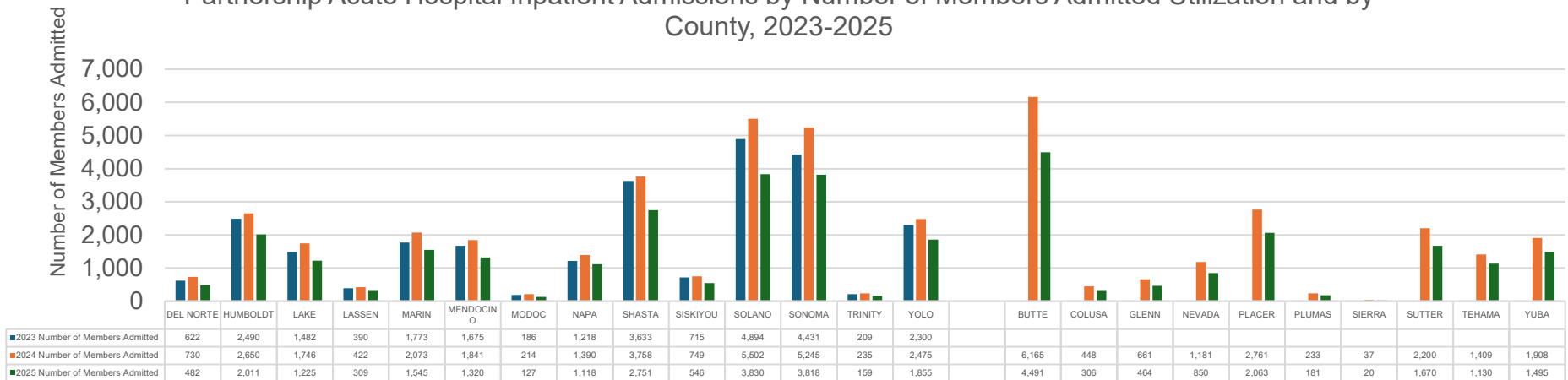
Utilization: Hospital Admissions

Acute Inpatient Utilization

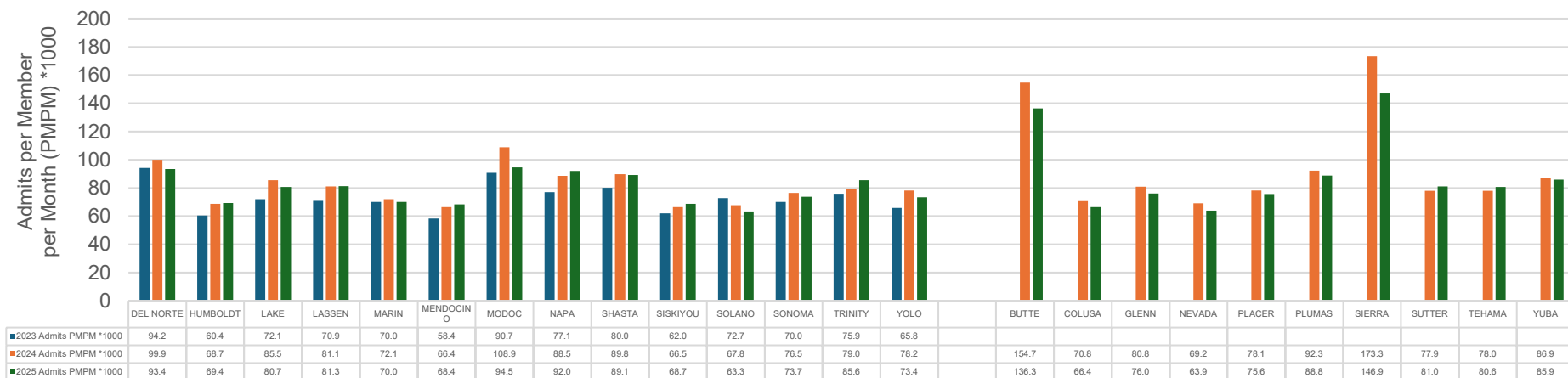
Partnership Acute Hospital Inpatient Admissions by Average Length of Stay (LOS) Utilization and by County, 2023-2025



Partnership Acute Hospital Inpatient Admissions by Number of Members Admitted Utilization and by County, 2023-2025



Partnership Acute Hospital Inpatient Admissions per Member per Month (PMPM) per 1,000 and by County, 2023-2025



Admits PMPM*1000: Count of Admits Per Member per Month (PMPM) per 1000
[sum(Admits) / sum(member months)] per 1000

Highlights of Acute Inpatient Utilization

Hospital Admissions for Acute Inpatient Utilization in Marin County went from an average rate of 70 to 72.1 from 2023 to 2025 per member per month per 1,000 members. Average length of hospital stay (LOS) is about a week, which is seven days. Marin County had a 6.5 to 7.1 day average from 2023 to 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services. Each Acute Inpatient Service provider source is assessed for the following service indicators:
 - Claims Count: Distinct visit counts to Acute Inpatient Service providers, defined as a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize Acute Inpatient Services
- Calculations:
 - Acute Inpatient Utilization or Admissions: Acute inpatient episodes include both acute and administrative days (prescheduled admissions), measures reported as inpatient over last two years. Transfers to a different facility during an episode are counted as two episodes. Episodes remain active until a discharge date is received from any one of the data sources with evidence of the member receiving non-inpatient care after admission.
 - Episodes are excluded if:
 - The Length of Stay (LOS) is over 180 days.
 - Multiple active episodes for a member occur at the same time – only one episode is kept.
 - There are overlapping admission or discharge dates with other episodes of the same source or across data sources – only one episode is kept.
 - Note:
 - Data Sources are combined: Claims data. All have some gaps, but when combined we estimate accuracy to be 99%.
 - The majority of Medicare Part A and Kaiser members are counted under Kaiser.

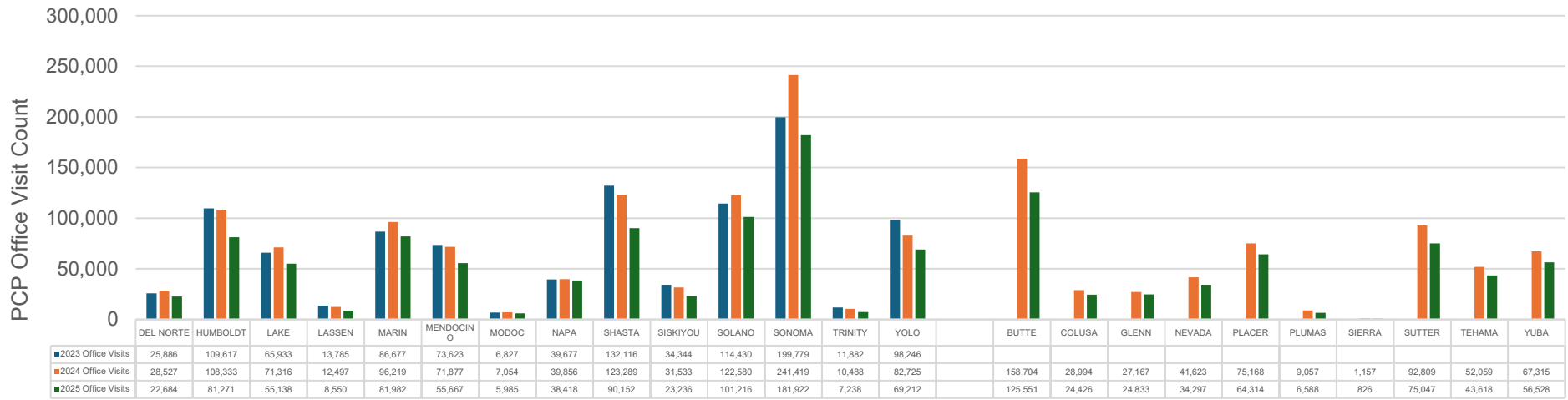
- o Length of Stay (LOS): Also known as Hospital Length of Stay, LOS is the number of days between admission and discharge dates for completed episodes and between admission and the last ran date for ongoing episodes. These include admin days (scheduled admissions) and will be counted as a 1-day stay if less than 24 hours.
- o Admits PMPM*1,000: The rate calculated from the number of utilizing Members Admitted per Member per Month (member months) per 1,000 Partnership Members. Admits PMPM*1,000: $[\text{sum}(\text{Admits}) / \text{sum}(\text{member months})]$ per 1,000 Partnership members.
 - Numerator: Number of utilizing members Admission Claims in that particular location, at the particular point-in-time
 - Denominator: Total number of utilizing members Admission Claims by Member Month in that particular location at the particular point-in-time
 - Rate: per 1,000 Partnership Members.
 - This is calculated so that for every 1,000 Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per month.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Utilization: Primary Care Provider PCP Office Visits

Partnership Member Primary Care Provider (PCP) Office Visit Utilization by County, 2023-2025

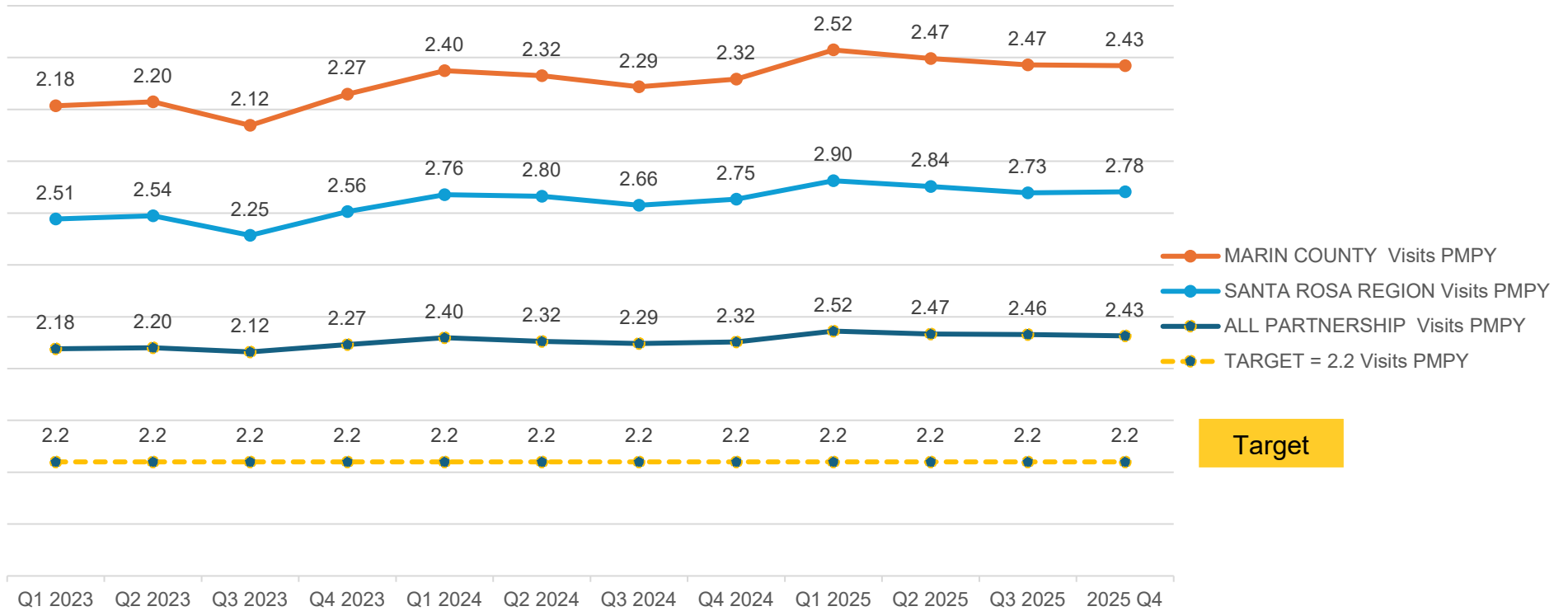


Partnership Member Primary Care Provider (PCP) Office Visit Utilization per Member per Year (PMPY) per 1,000, and by County, 2023-2025



PCP Office Visit PMPY*1000: Count of Primary Care Provider (PCP) Office Visit Per Member per Year (PMPY)
[sum(office visits) / sum(member months)] * 12 per 1000

Partnership Member Primary Care Provider (PCP) Office Visit Utilization per Member per Year (PMPY) and Quarter by All Partnership, Santa Rosa Region and Marin County, 2023-2025



Highlights of PCP Office Visits

Partnership's target primary care provider (PCP) office visit utilization is 2.2 per member per year. That is 2,200 per member per year per 1,000 Partnership members. Marin is also average going from 2,502.3 to 2,854.8 from 2023 to 2025 per member per year per 1,000 members. Marin members have a 2.5 to 3.0 average office visit utilization per member per year, above the Partnership target of 2.2, which works towards a PCP Medical Home, an approach to providing coordinated comprehensive primary care to individuals members as a form of patient-centered care (i.e., Resource: [American Academy of Pediatrics/Medical Home](#)).

Note: None of the utilization rates or numbers are mutually exclusive, as one Marin County Partnership member may have several acute and chronic diseases at the same time. That could require multiple visits to primary care, acute inpatient admissions, ED, and mental health in one month and through the calendar year (PMPY -per Member per Year). These visits will be counted as one utilizing member per facility utilized.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services. Each PCP source is assessed for the following service indicators:
 - Claims Count: Distinct visit counts to PCP, defined as a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize PCP
- Calculations:
 - PCP Office Visits are defined by applying the following criteria to Partnership medical claims data:
 - Place of service (Location Code defined by the CMS Place of Service Code Set) is an Office code
 - Current Procedure Terminology (CPT) Code maintained by the [American Medical Association/American Academy of Professional Coders](#) includes Office Visit (i.e., 992, 993, 994, or CH01)
 - Treatment Type AA or AB (Office Visits)

- o PCP Office Visit PMPY*1,000: is the rate calculated from the number of Visit Claims per Member per Year (12 months) per 1,000 Partnership Members. PCP Office Visit PMPY*1,000: $[\text{sum}(\text{office visits}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.
 - Numerator: Number of Visit Claims in that particular location, at the particular point-in-time
 - Denominator: Total number of Visit Claims by Member Month in that particular location, at the particular point-in-time
 - Rate: per Year (12 months) per 1,000 Partnership Members.
 - This is calculated so for every 1,000 Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per year.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

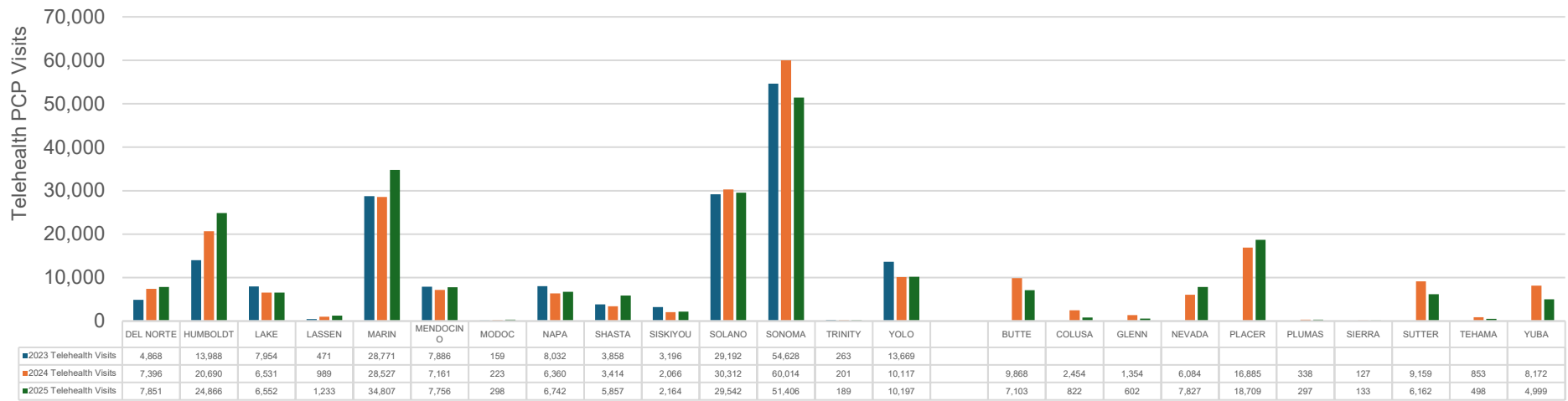
- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Note: Medicare Part A and Kaiser members are excluded.

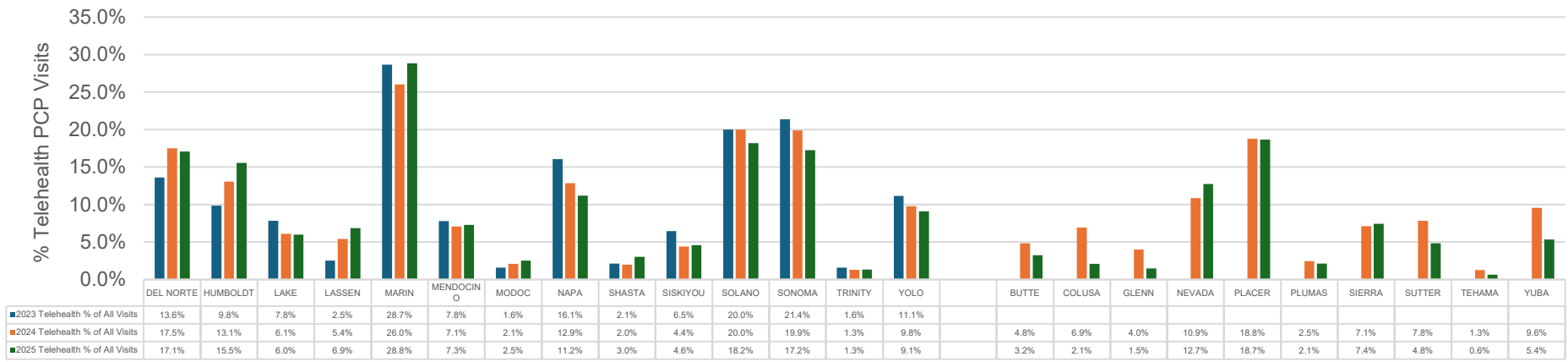
Utilization: Telehealth

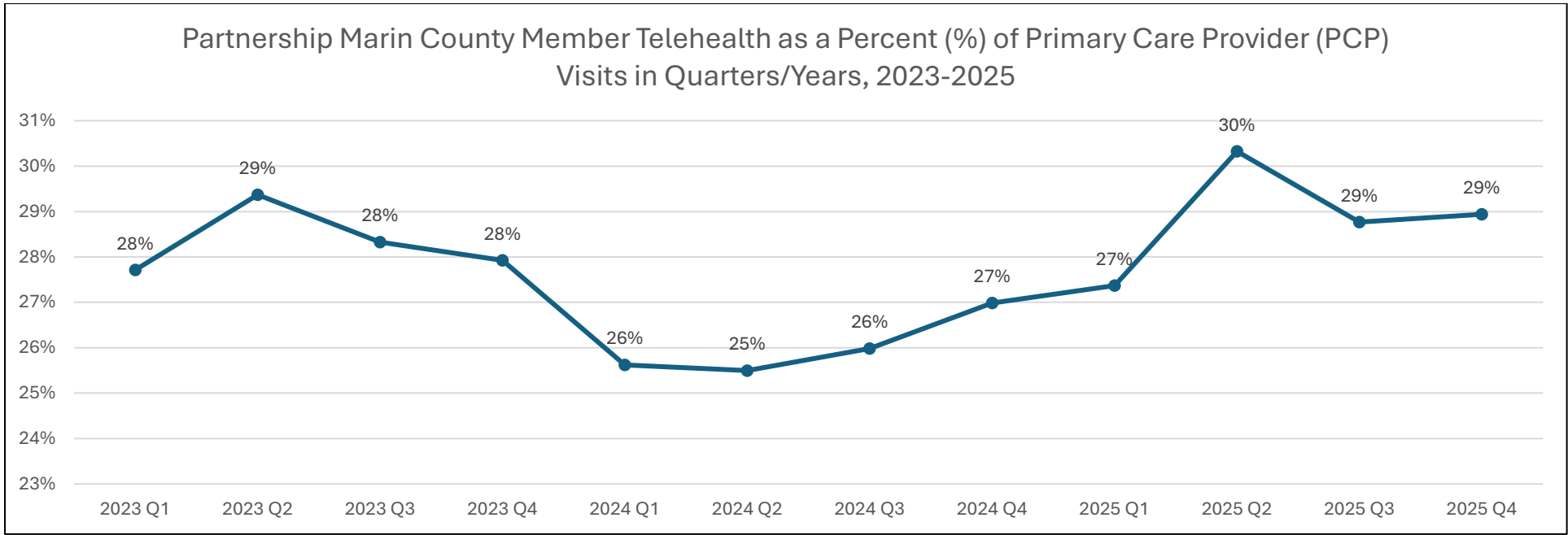
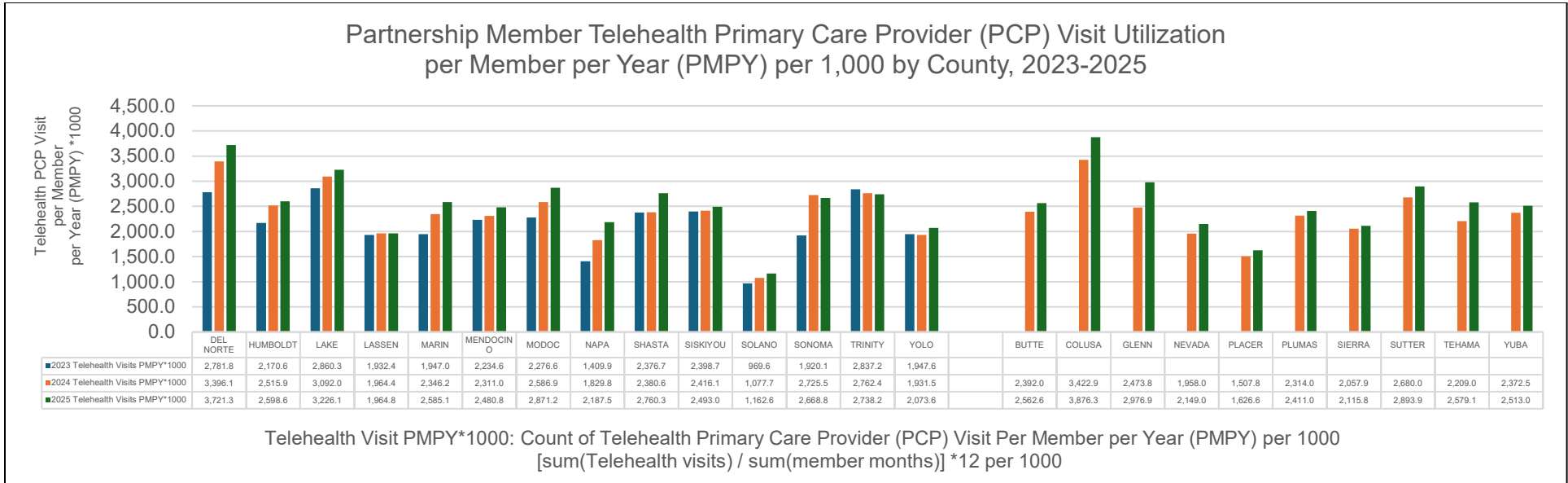
Telehealth PCP Visits (Count), Percent (%), & per Member per Year (PMPY) per 1,000

Partnership Telehealth Primary Care Provider (PCP) Visits by County, 2023-2025



Partnership Telehealth Percent (%) of Primary Care Provider (PCP) Visits by County, 2023-2025





Highlights of Telehealth PCP Visits & Diagnoses

Marin telehealth utilization as a percentage of primary care provider visits has remained stable over the years (2023-2025) with a range from 28.7% in 2023 to 26.0% in 2024, to 28.8% in 2025. From 2023-2025 by quarter (i.e., Q1, Q2, Q3, Q4), remaining stable at 28% in Q1 2024 to 29% in Q4 2025. Partnership counties where 1 of every 5 (1 out of 5) PCP visits are reported as a telehealth visit include Marin, Sonoma, and Solano counties.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services. Each Telehealth Visit source is assessed for the following service indicators:
 - Claims Count: Distinct visit counts to Telehealth Visits, defined as a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize Telehealth Visits
 - Telehealth Visits are defined by:
 - Location Code 02, 10 as defined by the [CMS Place of Service Code Set](#).
 - [CMS Telemedicine and Remote Monitoring](#)
 - Modifier Code 1: 'GQ', 'GT', '95', '93'
 - Procedure Code 1: '99451', 'G0071', 'G2012', '92250', '92227', '99444'
 - Percentage (%) of Telehealth Visits: Number of Telehealth Visits/Total Number of PCP Visits X 100 (%)
 - Telehealth Visit PMPY*1,000: is the rate calculated from the number of Telehealth Visit Claims per Member per Year (12 months) per 1,000 Partnership Members. Telehealth Visit PMPY*1,000: $[\text{sum}(\text{Telehealth visits}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.
 - Numerator: Number of Visit Claims in that particular location, at the particular point-in-time in question.
 - Denominator: Total number of Visit Claims by Member Month in that particular location, at the particular point-in-time.
 - Rate: per Year (12 months) per 1,000 Partnership Members.

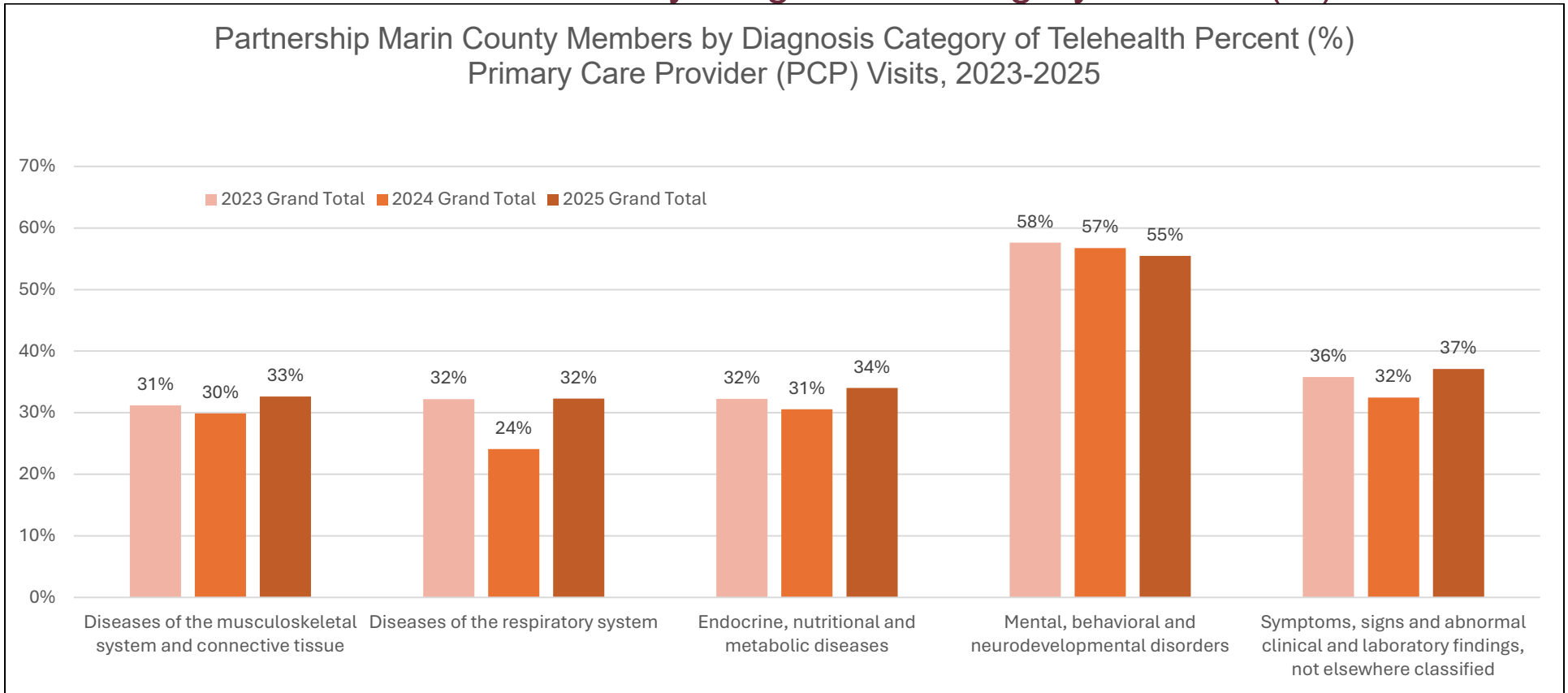
- This is calculated so for Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members per member per year.

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

Utilization: Telehealth

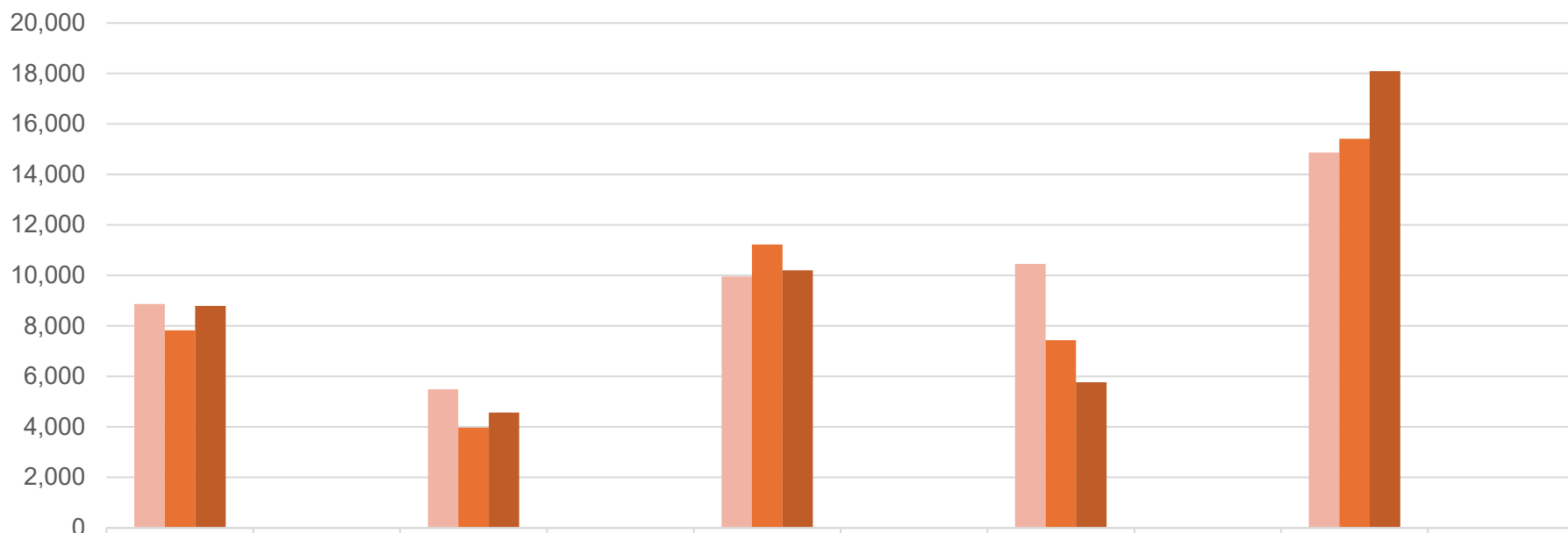
Telehealth PCP Visit by Diagnoses Category Percent (%)



Utilization: Telehealth

Telehealth PCP Visit by Diagnoses Category Count

Partnership Marin County Members by Diagnosis Category of Telehealth Percent (%) Primary Care Provider (PCP) Visits, 2023-2025



	Diseases of the musculoskeletal system and connective tissue	Diseases of the musculoskeletal system and connective tissue	Diseases of the respiratory system	Diseases of the respiratory system	Endocrine, nutritional and metabolic diseases	Endocrine, nutritional and metabolic diseases	Mental, behavioral and neurodevelopmental disorders	Mental, behavioral and neurodevelopmental disorders	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
2023 Grand Total	8,874	31%	5,491	32%	9,964	32%	10,460	58%	14,873	36%
2024 Grand Total	7,832	30%	3,976	24%	11,229	31%	7,443	57%	15,410	32%
2025 Grand Total	8,789	33%	4,575	32%	10,208	34%	5,776	55%	18,095	37%

Highlights of Telehealth PCP Visits Diagnoses Category Percent & Count

Top three Telehealth services diagnosis categories for both Partnership and Marin County (2023, 2024, 2025) include:

- Mental, behavioral and neurodevelopmental disorders (58%, 57%, 55%)
- Endocrine, Nutrition and Metabolic Disease (32%, 31%, 34%)
- Disease of the musculoskeletal system and connective tissue (31%, 30%, 33%)

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Enrollment: Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties.
 - Member Count: Unique count of Partnership members utilizing services. Each Telehealth Visit source is assessed for the following service indicators:
 - Claims Count: Distinct visit counts to Telehealth Visits, defined as a distinct combination of member, service date, and provider.
 - Utilizing Members: Unique Members who utilize Telehealth Visits
- Calculations:
 - Telehealth Visits are defined by:
 - Location Code 02, 10 as defined by the [CMS Place of Service Code Set](#).
 - [CMS Telemedicine and Remote Monitoring](#)
 - Modifier Code 1: 'GQ', 'GT', '95', '93'
 - Procedure Code 1: '99451', 'G0071', 'G2012', '92250', '92227', '99444'
 - Percentage (%) of Telehealth Visits: Number of Telehealth Visits/Total Number of PCP Visits X 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- DHCS Medical Claims data

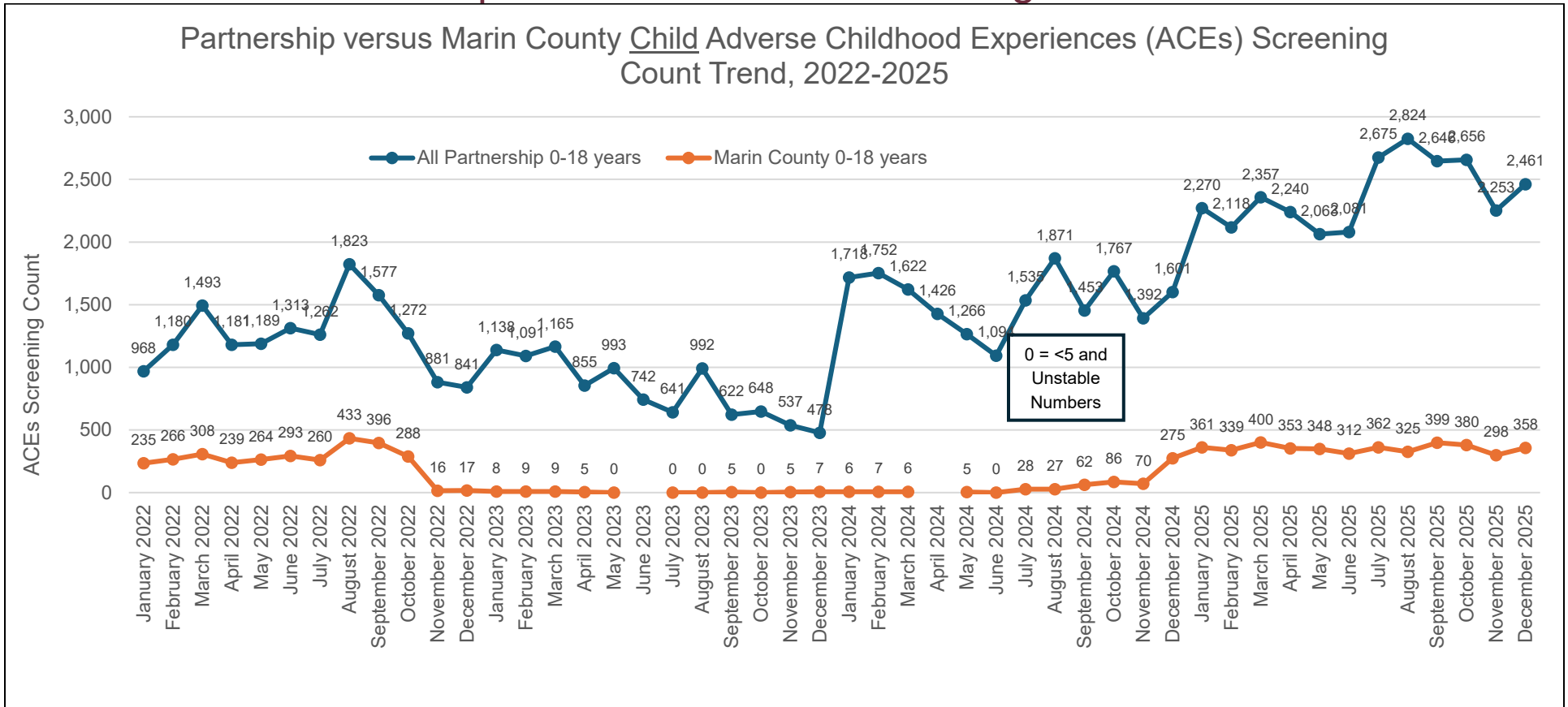
ACEs Screenings

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For more information, see [ACEs Screenings](#) in the [Appendix](#)

ACEs Screenings

Partnership and Marin ACEs Screening Count Trend



Highlights of Partnership and Marin ACEs Screening Count Trend

The Adverse Childhood Experiences (ACEs) screening tool is used to assess the likelihood of having increased risk of an adverse response to toxic stress, due to trauma experienced in the past from birth to 18 years old, such as abuse, neglect, or household dysfunction. Toxic stress can affect both physical and mental health, and manifest in violence, drug abuse, self-harm, and other issues.

Children under the age of 20 are usually assessed in various ways, and different methods, an attempt to reduce the risk of toxic stress by intervention, preventing adverse physical and mental health outcomes. Adults ages 20-64 are assessed less frequently to determine past exposures and tailor appropriate intervention.

Data is collected from Medical Claims using Healthcare Common Procedure Coding System (HCPCS) codes:

- G9919 – Positive or High Risk (ACEs Screening Score 4 or greater)
- G9920 – Negative or Low Risk (ACEs Screening Score 0-3)

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, explaining the increase in Partnership ACEs Screening during this period.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Data originally tracked as a result of California Prop 56 which enhanced payments for ACEs to in-network providers
- Number of ACEs Screenings (Count)
 - For the purpose of this report, children are categorized as ages 0-18, while adults are categorized as age 19+. Both children and adults are allowed one billable ACEs assessment per year by Managed Health Plan providers.

Data Source:

Medical Claims (Amisys) and Membership Eligibility data used for ACEs Screenings exclude:

- All Kaiser (in 2024, Kaiser became its own health plan), Medi-Medi, deceased, newborns, and Wellness & Recovery members.
- All Caredon Healthcare Services ACEs Screenings are excluded from the data.
- Membership data as of last record of eligibility on file in each year (i.e., December of each year).

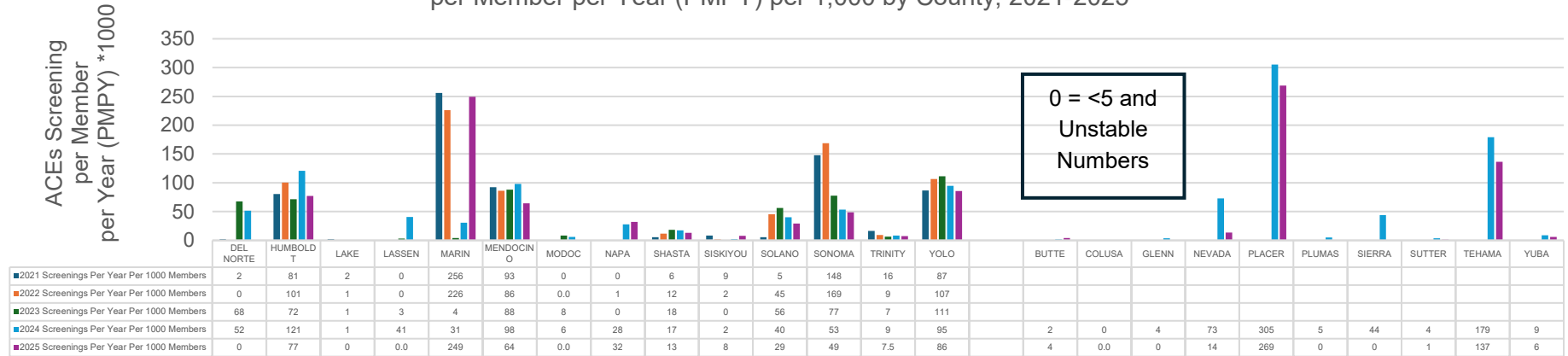
ACEs Resources:

- <https://providerlibrary.healthnetcalifornia.com/medi-cal/provider-manual/adverse-childhood-experiences.html>
- www.cdc.gov/violenceprevention/aces/about.html
- Rariden C, SmithBattle L, Yoo JH, Cibulka N, Loman D. Screening for Adverse Childhood Experiences: Literature Review and Practice Implications. J Nurse Pract. 2021 Jan;17(1):98-104. doi: 10.1016/j.nurpra.2020.08.002. Epub 2020 Sep 18. PMID: 32963502; PMCID: PMC7498469.

ACEs Screenings

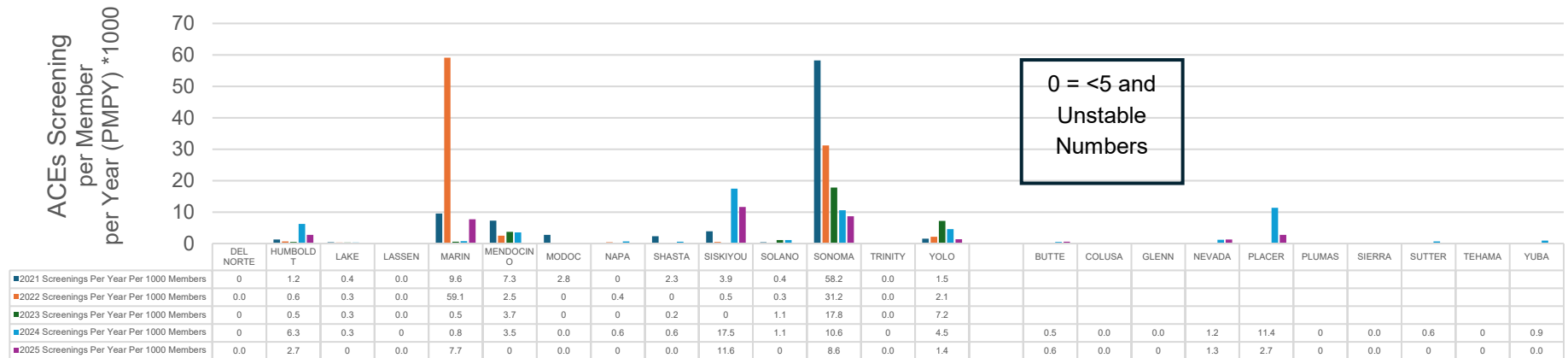
ACEs Screenings by County

Partnership Child Adverse Childhood Experiences (ACEs) Screening
per Member per Year (PMPY) per 1,000 by County, 2021-2025



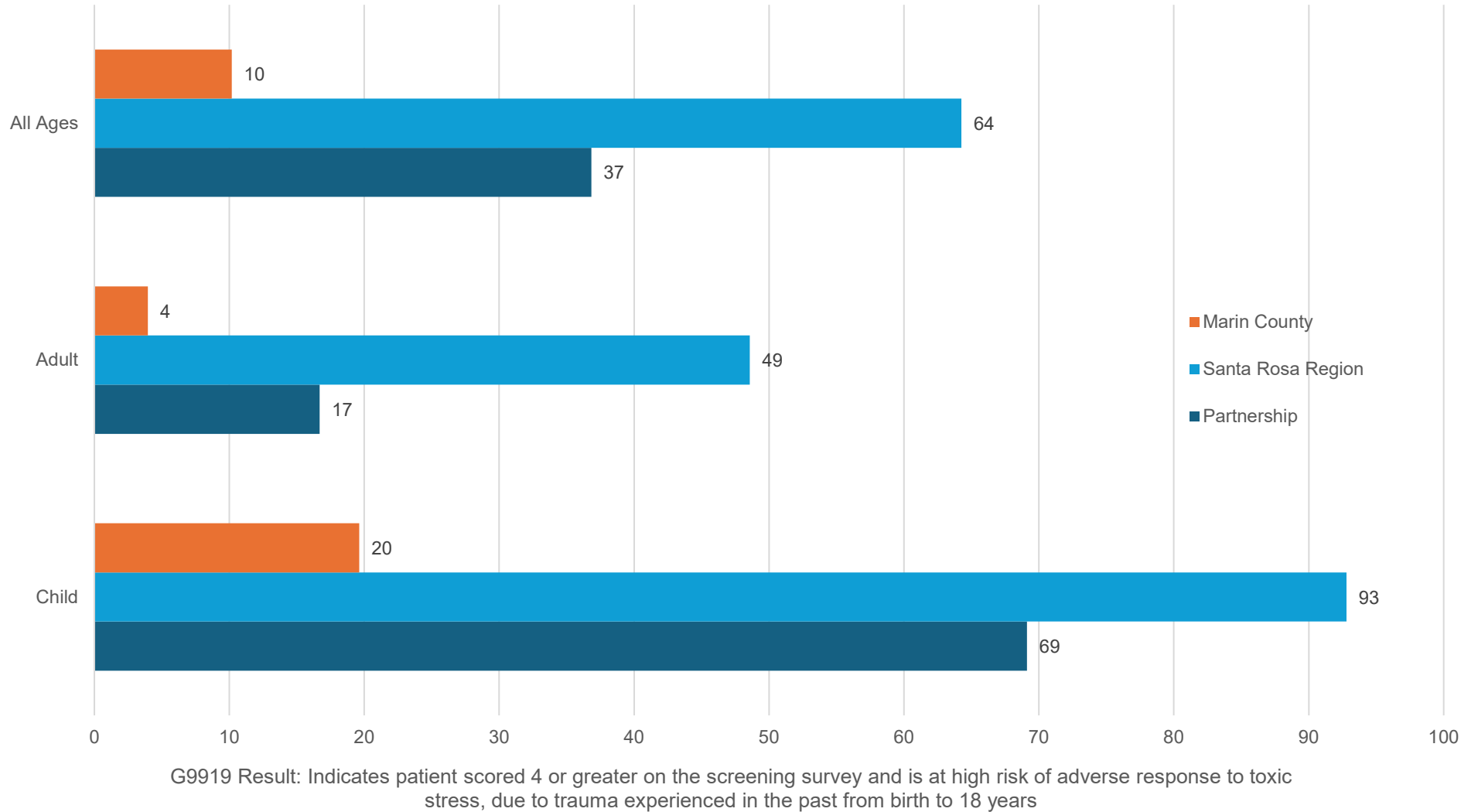
ACEs Screening PMPY*1000: Count of ACEs Screening Per Member per Year (PMPY) per 1000
[sum(ACEs Screening) / sum(member months)] *12 per 1000

Partnership Adult Adverse Childhood Experiences (ACEs) Screening
per Member per Year (PMPY) per 1,000 by County, 2021-2025

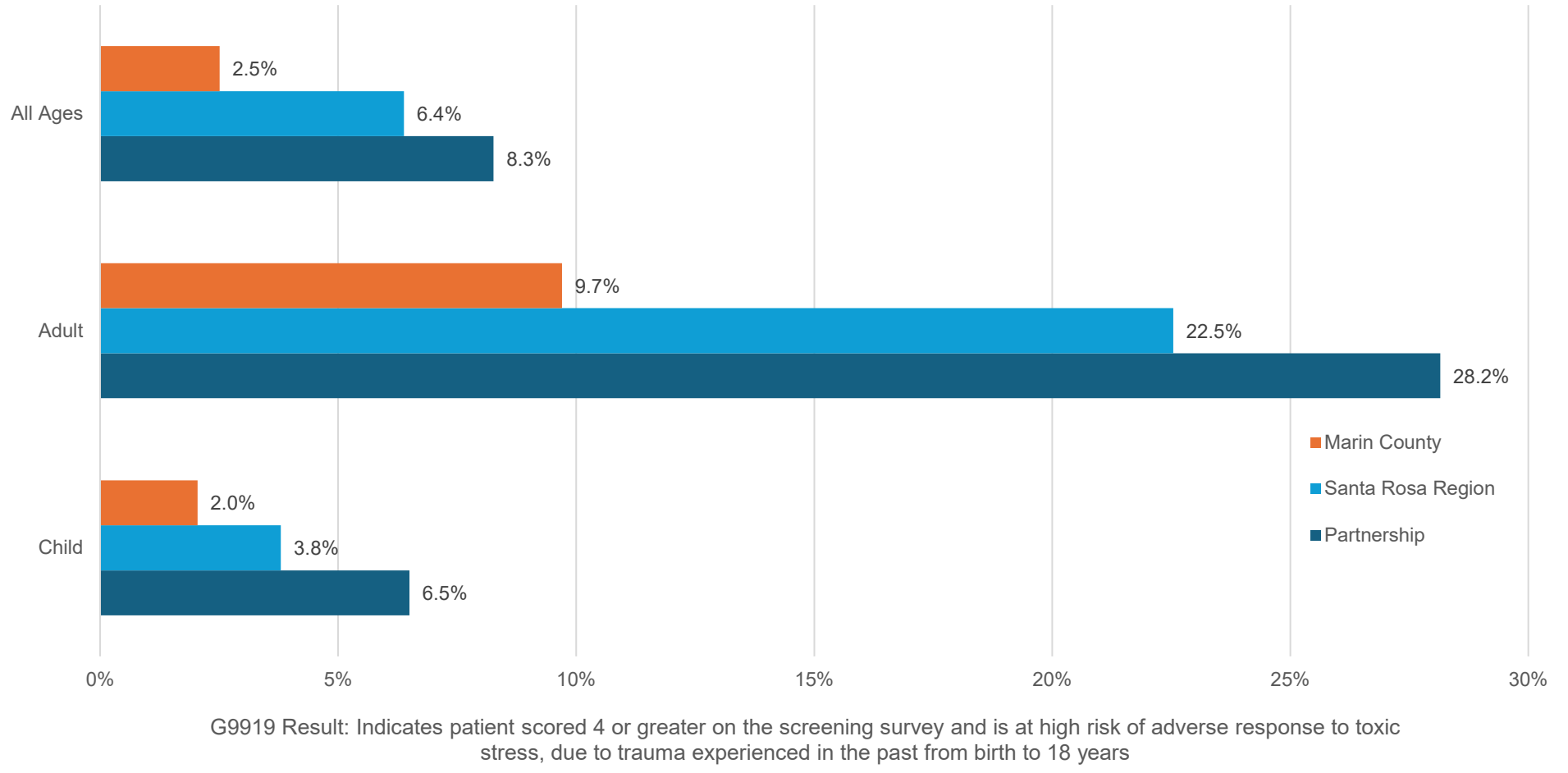


ACEs Screening PMPY*1000: Count of ACEs Screening Per Member per Year (PMPY) per 1000
[sum(ACEs Screening) / sum(member months)] *12 per 1000

Partnership, Santa Rosa and Marin, Adverse Childhood Experiences Screenings (ACES) High Risk Result PMPY per 1,000 by Age, 2025



Partnership, Santa Rosa and Marin, Adverse Childhood Experiences Screenings (ACES) Screenings Percent (%) with High Risk Result by Age, 2025



Highlights of ACEs Screenings by County

The Adverse Childhood Experiences (ACEs) screening tool is used to assess the likelihood of having increased risk of an adverse response to toxic stress, due to trauma experienced in the past from birth to 18 years old, such as abuse, neglect, or household dysfunction. Toxic stress can affect both physical and mental health, and manifest in violence, drug abuse, self-harm, and other issues.

Children under the age of 20 are usually assessed in various ways, and different methods, an attempt to reduce the risk of toxic stress by intervention, preventing adverse physical and mental health outcomes. Adults ages 20-64 are assessed less frequently to determine past exposures and tailor appropriate intervention.

Data is collected from Medical Claims using Healthcare Common Procedure Coding System (HCPCS) codes:

- G9919 – Positive or High Risk (ACEs Screening Score 4 or greater)
- G9920 – Negative or Low Risk (ACEs Screening Score 0-3)

Data shows Marin child ACEs screening compared to all of Partnership and Santa Rosa Office Region by age group. Marin County screens less High Risk Results among Partnership child members (2.0%) and adult members (9.7%) than Santa Rosa Office 3.8% and 22.5% respectively.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Data originally tracked as a result of California Prop 56 which enhanced payments for ACEs to in-network providers
- Number of ACEs Screenings (Count)
 - For the purpose of this report, children are categorized as ages 0-18, while adults are categorized as age 19+. Both children and adults are allowed one billable ACEs assessment per year by Managed Health Plan providers.
- Calculations:
 - ACEs Screenings PMPY x 1,000
 - Numerator: number of ACEs Screening Claims
 - Denominator: per Member per Year (12 months) per 1,000 Partnership Members.

- $[\text{sum (ACEs Screening)} / \text{sum (member months)}] * 12 \text{ per } 1,000 \text{ Partnership members}$
- Percent (%) Utilizing Members:
 - Numerator: Number of High Risk (Positive) ACEs Screening in Claims out of the Total Number of Unique Partnership members
 - Denominator: Total Number of Unique Partnership members who Completed ACEs Screening in Claims within a given Period (e.g., calendar year 2025).
 - Rate: Percentage X100 (%)

Data Source:

Medical Claims (Amisys) and Membership Eligibility data used for ACEs Screenings exclude:

- All Kaiser (in 2024, Kaiser became its own health plan), Medi-Medi, deceased, newborns, and Wellness & Recovery members.
- All Caredon Healthcare Services ACEs Screenings are excluded from the data.
- Membership data as of last record of eligibility on file in each year (i.e., December of each year).

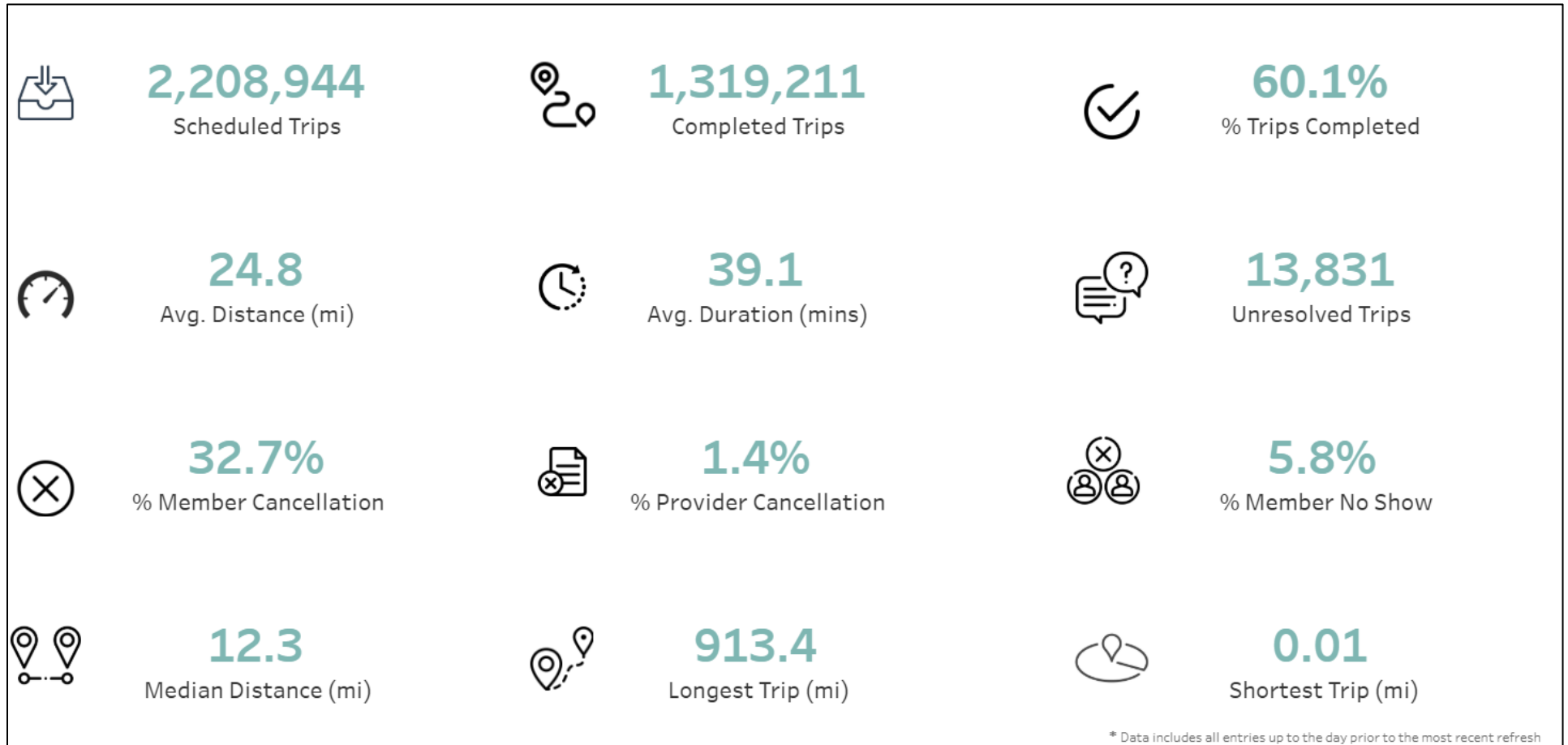
Transportation Services

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For more information, see [Transportation Services](#) in the [Appendix](#)

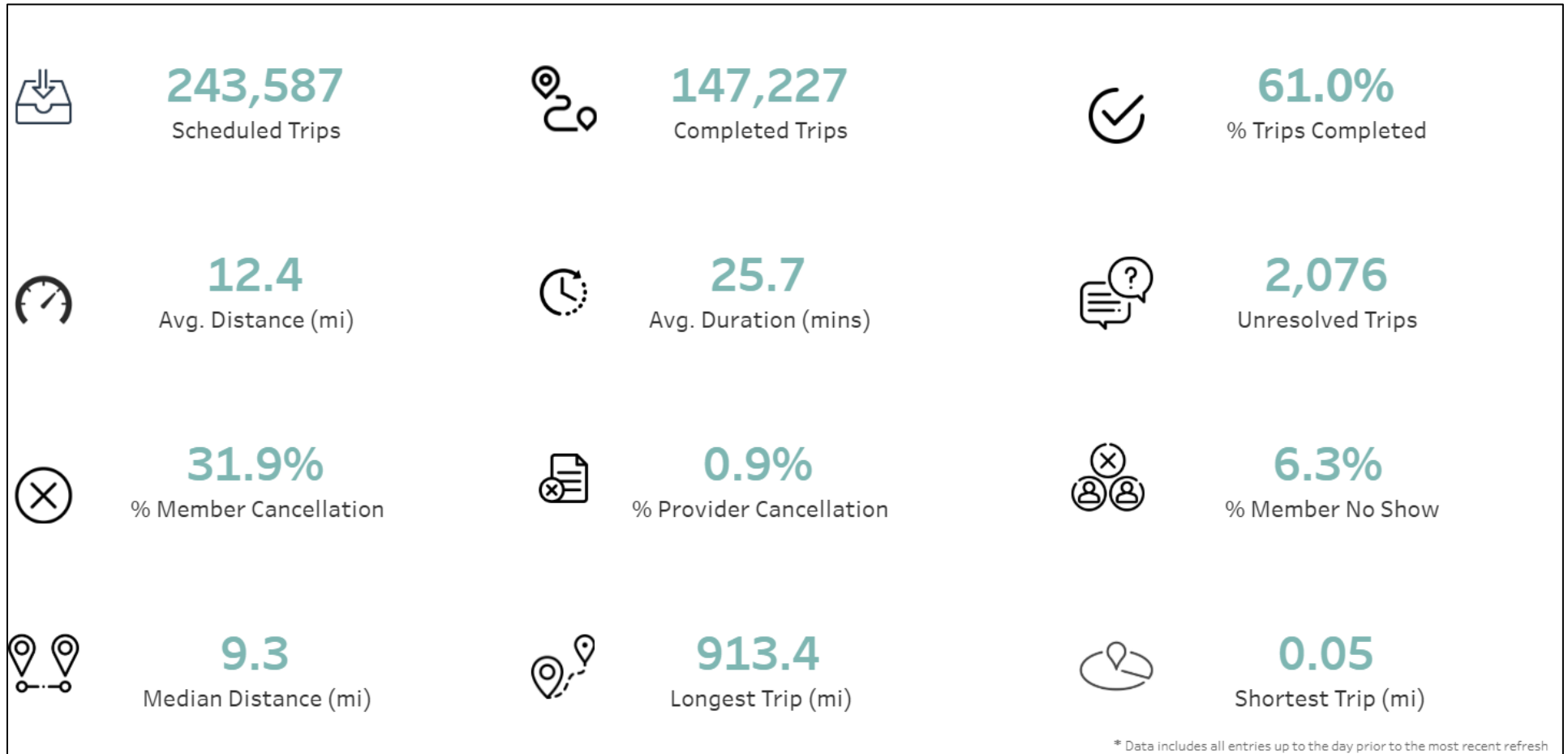
Transportation Services Partnership Trips

All Partnership Key Performance Indicator (KPI) for Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) Services, 2025



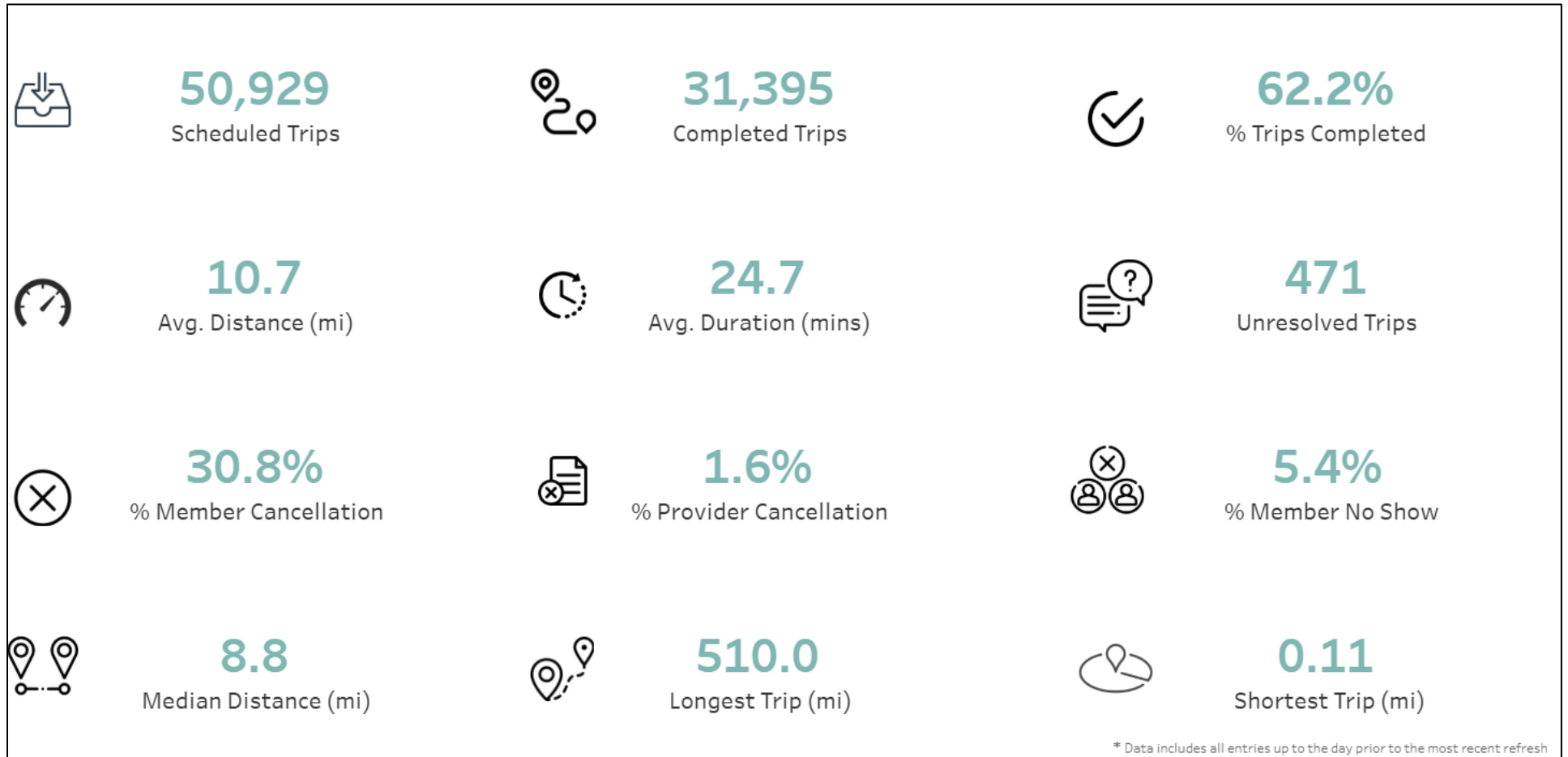
Transportation Services Santa Rosa Region Trips

Santa Rosa Region Key Performance Indicator (KPI) for Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, 2025



Transportation Services Marin Trips

Marin County Key Performance Indicator (KPI) for Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) services, 2025



Highlights of Partnership, Santa Rosa Region, and Marin Trips

Access to healthcare is one of the main priorities of all Partnership counties. Most counties are rural and have tracking progress in transportation as one of the indicators for access to healthcare. Transportation is a Partnership intervention that is offered to members to increase access to care, early detection, timely and adequate treatment of disease. Marin has 5.1% of the Partnership member population, but only 2.3% of the total number of completed trips in Partnership for the year 2025. The longest trip completed in Marin in 2025 was 510.0 miles, while the longest trip in Partnership was 913.4 miles.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

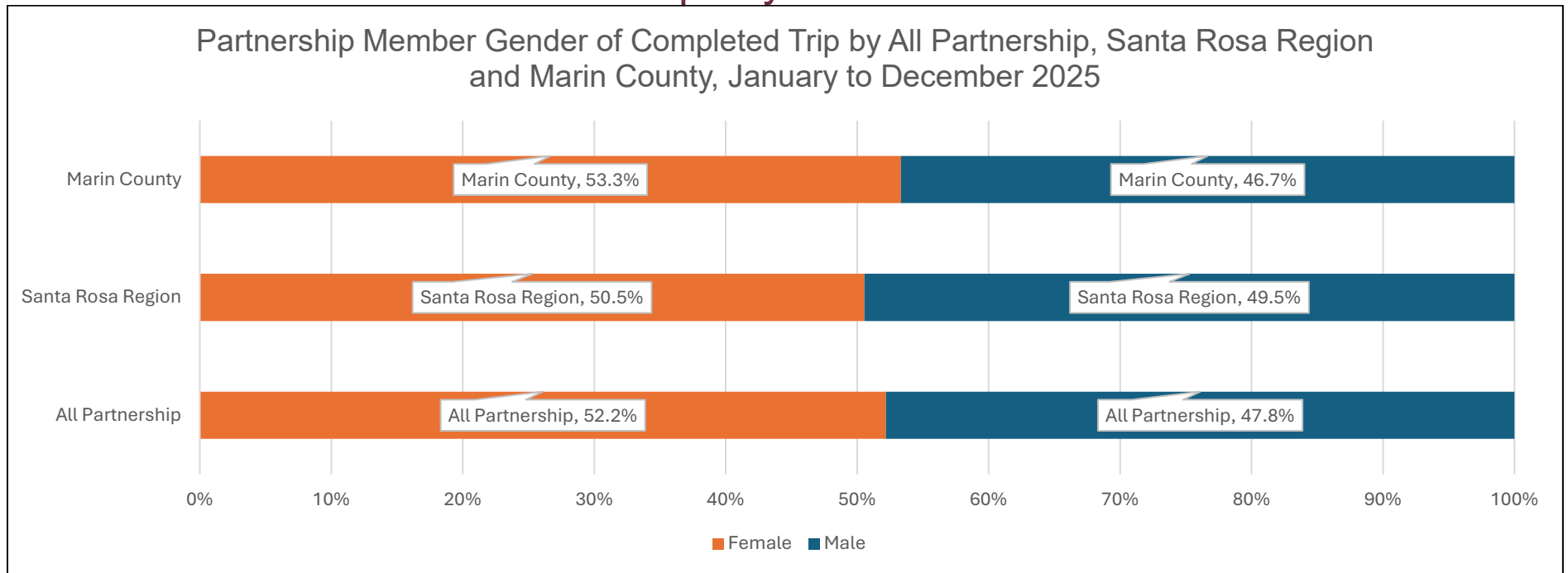
- Transportation is divided into:
 - NMT: Non-Medical Transportation helps members who do not have any other way of getting to their appointments and back to their residence. NMT includes passenger cars, taxis, buses, trains, or other public transportation.
 - NEMT: Non-Emergency Medical Transportation helps members who need door-to-door service – help with getting in and out of the home, vehicle, and medical office. NEMT may include non-emergency ambulances, gurney vans, wheelchair vans, or medical air transport.
- Key Performance Indicators (KPI) follow standards set by [Centers for Medicare and Medicaid Services \(CMS\)](#) and [DHCS](#) for NMT and NEMT services booked and used by members, including:
 - Scheduled Trip: The total of all trips that were placed in the scheduling system
 - Completed Trip: Trip status of Completed, Assignment Exported
 - Non-Completed Trip: Trip status of Requester Cancelled/Patient Cancelled, No Show, Provider Cancellation/Denied
 - Resolved Trip: Trip status of Completed, Requester Cancelled, Patient Cancelled, No Show, Denied, Approval Denied, Assignment Exported
 - Unresolved Trip: Trip status of Approval Pending, Assignment Accepted, Assignment Dispatched, Assignment Pending, En Route, Expired, Ready to Assign
 - Member Cancellation: All Member Cancellation classifications are defined as user caused
 - Member No Show: All Member No Show classifications are defined as user caused
 - Provider Cancellation: All Provider Cancellation classifications are defined as provider caused

- Date of Service is defined as the Scheduled Trip Pick Up Date
- Transportation Key Performance Indicators (KPI):
 - Number of Scheduled Trips
 - Average Distance Traveled (miles)
 - Average Duration of Trip (minutes)
 - Median Distance Traveled (miles)
 - Shortest Distance of Trip (miles)
 - Longest Distance of Trip (miles)
- Calculations:
 - Percent (%) Completed Trip: Number of Completed Trips divided by Total number of Trips X100 (%)
 - Percent (%) Member No Show: Number of No-Show Trips divided by Total number of Trips X100 (%)
 - Percent (%) Member Cancellation: Number of Cancelled Trips divided by Total number of Trips X100 (%)
 - Percent (%) Provider Cancellation: Number of Cancelled Trips by Transportation Provider divided by Total number of Trips X100 (%)
 - The following Measures are also tracked in percentage (%) and rate:
 - Percent (%) Utilizing Members:
 - Number of unique Partnership members who schedule and complete trips within a given period (e.g., calendar year 2025).
 - Unique Members Completing Trip divided by Total Partnership Population X100 (%)
 - Trip Rate PMPM per 1,000:
 - NMT/NEMT services are also tracked per member per month (PMPM) per 1,000 Partnership Member Month
 - Completed Trips per Month divided by Total Partnership Population per Month X 1,000 (per Partnership Member per Month).

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services Trips by Gender



Highlights of Trips by Gender

Marin has similar gender distribution among those completing trips compared to Santa Rosa and all of Partnership as a whole. There are more females than males using Partnership transportation services with a range of 47% to 53%, in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition: Non-Medical Transportation and Non-Emergency Medical Transportation (NMT/NEMT) Service

Calculations:

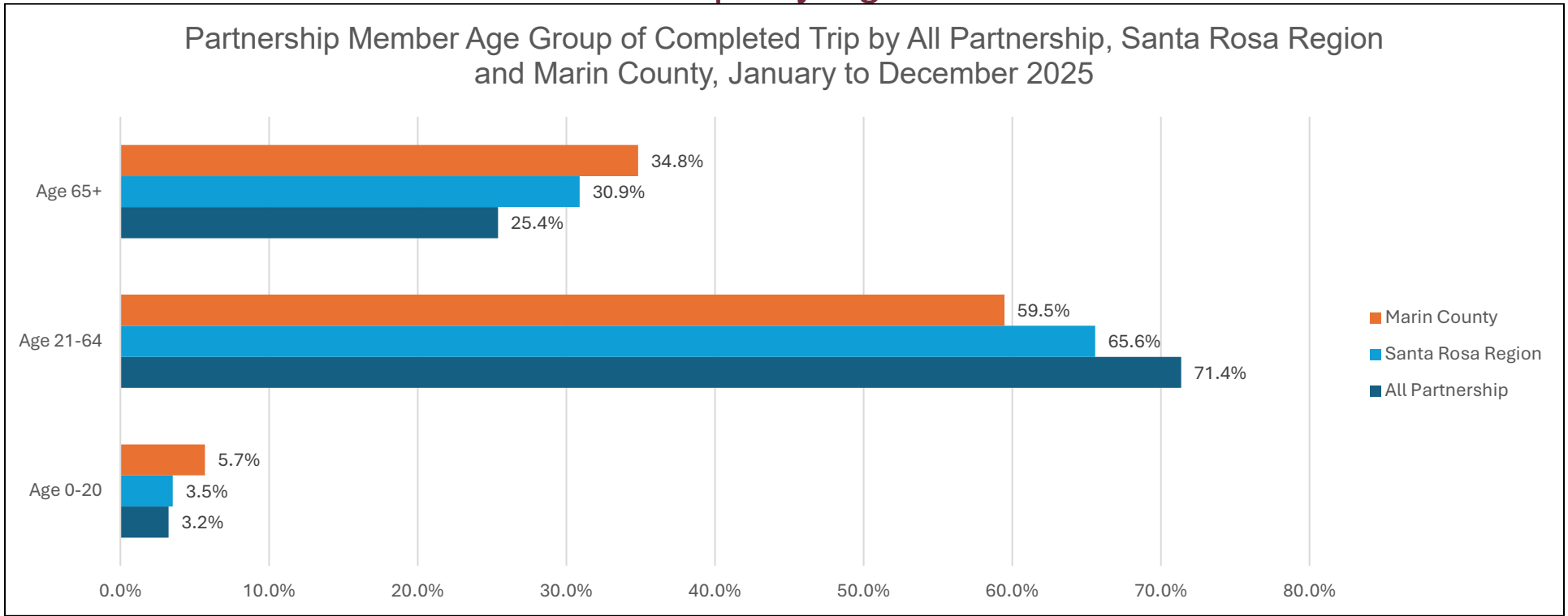
- % Gender is the number of enrolled members in the individual gender (i.e., male or female), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all gender (i.e., male and female) in that particular location currently enrolled, multiplied by 100 (%)

Data Source:

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services

Trips by Age



Highlights of Trips by Age

Marin has more transportation among ages 0-20 years and 65+ years at 5.7% and 34.8% completing trips compared to Santa Rosa at 3.5% and 30.9%, and all of Partnership as a whole, at 3.2% and 25.4% respectively.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition: Non-Medical Transportation and Non-Emergency Medical Transportation (NMT/NEMT) Service

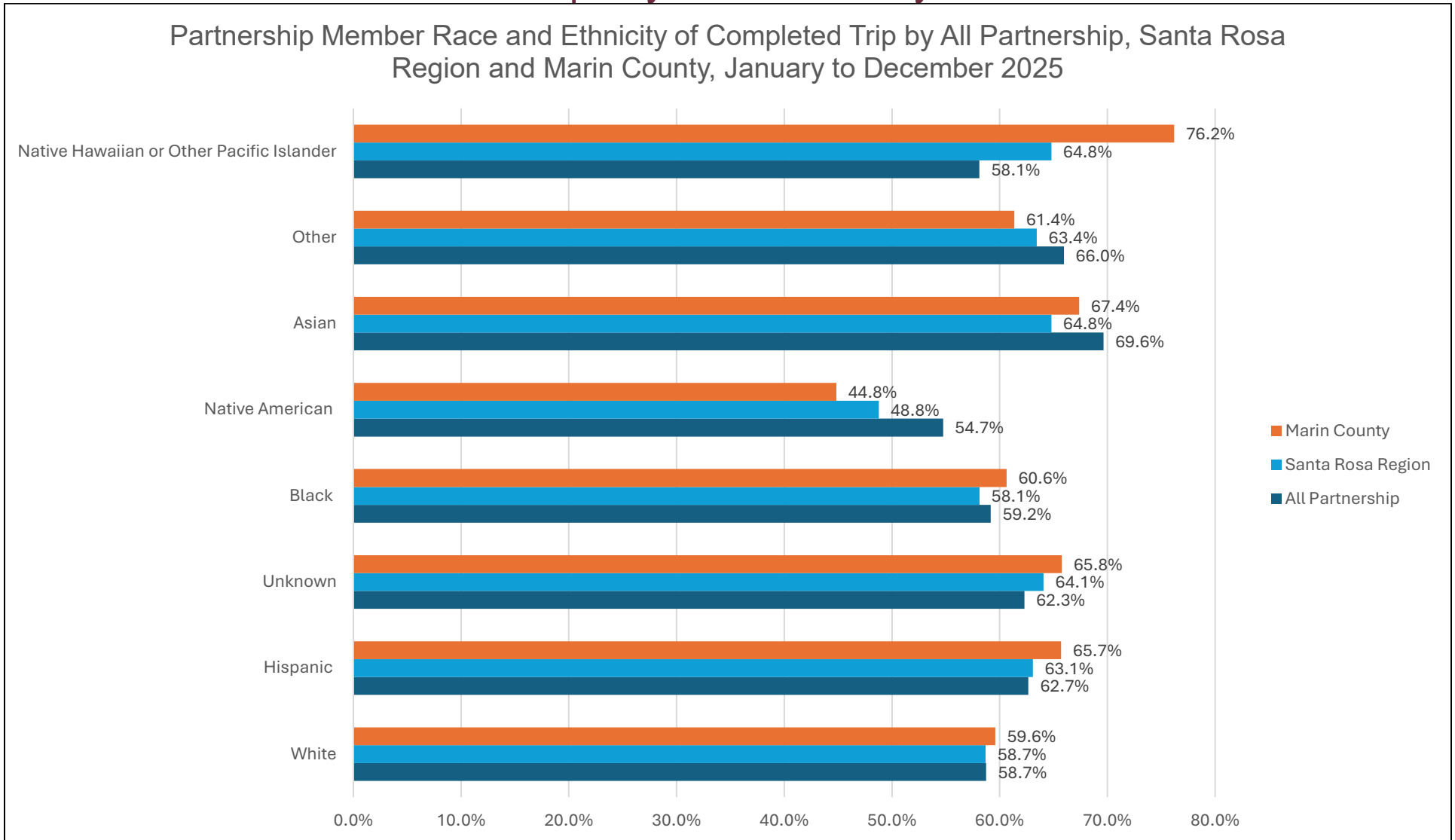
Calculations:

- % Age Group is the number of enrolled members in the individual age group (i.e., 0-20, 21-64 and 65 and above years), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all age-groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source:

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services Trips by Race/Ethnicity



Highlights of Trips by Race/Ethnicity

Marin has one of the higher number of Hispanics race/ethnicity residents who are Partnership members at 62.8%. For Transportation, Marin has the highest percentage (%) of completed trips is seen in Native Hawaiian or Other Pacific Islanders (76.2%), Asian (67.4%) and Hispanic (65.7%). Other and Unknown race members at an estimated rate of 61.4% and 65.8%. Black and White have rates at 60.6% and 59.6% respectively, while Native American races have the lowest completed trips at 44.8%, in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

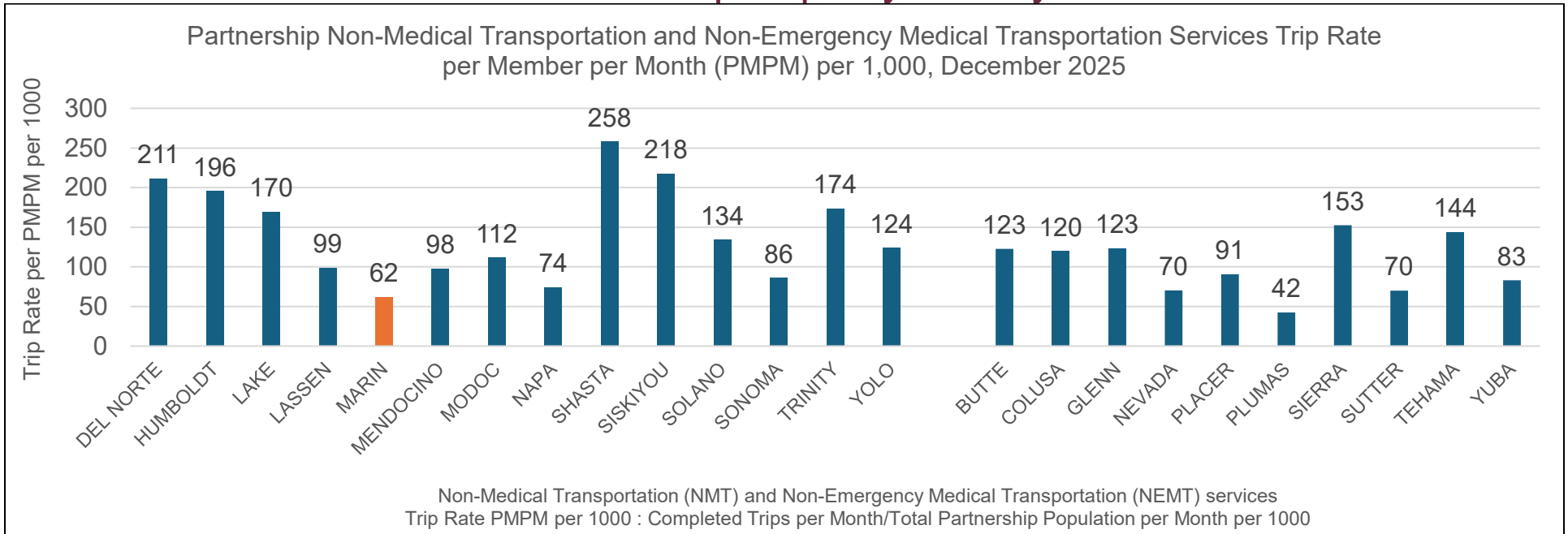
Definition:

- Non-Medical Transportation and Non-Emergency Medical Transportation (NMT/NEMT) Service
- Enrollment is performed by the state of California DHCS and Partnership's 24 individual counties. Race/Ethnicity is voluntarily completed during enrollment by the state of California DHCS and Partnership's 24 individual counties and determined by California DHCS. Enrollment files for Partnership members are populated and sent to Partnership by the state of California DHCS. Partnership does not determine member Race/Ethnicity category.
- Calculations:
 - % Race/Ethnicity is the number of enrolled members in the individual race/ethnicity group (i.e., White, Hispanic, Unknown, Other, Black, Asian, Native American, Asian Indian and Native Hawaiian or Other Pacific Islander), in the location category (i.e., County, Region, or All Partnership) at the particular point-in-time in question, (i.e., December 31, 2025) divided by the total number of members in all race/ethnicity groups in that particular location currently enrolled, multiplied by 100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services Partnership Trips by County



Highlights of Partnership Trips by County

This graph shows Marin as a county with low NMT/NEMT transportation at 62 completed trips per member per month (PMPM) for 1,000 members. For every 1,000 members in Marin, about 62 members completed NMT/NEMT transportation trips within a month compared to Shasta with the highest PMPM at 258 members per 1,000 members per month, in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition: Completed Trip is Trip status of Completed, Assignment Exported

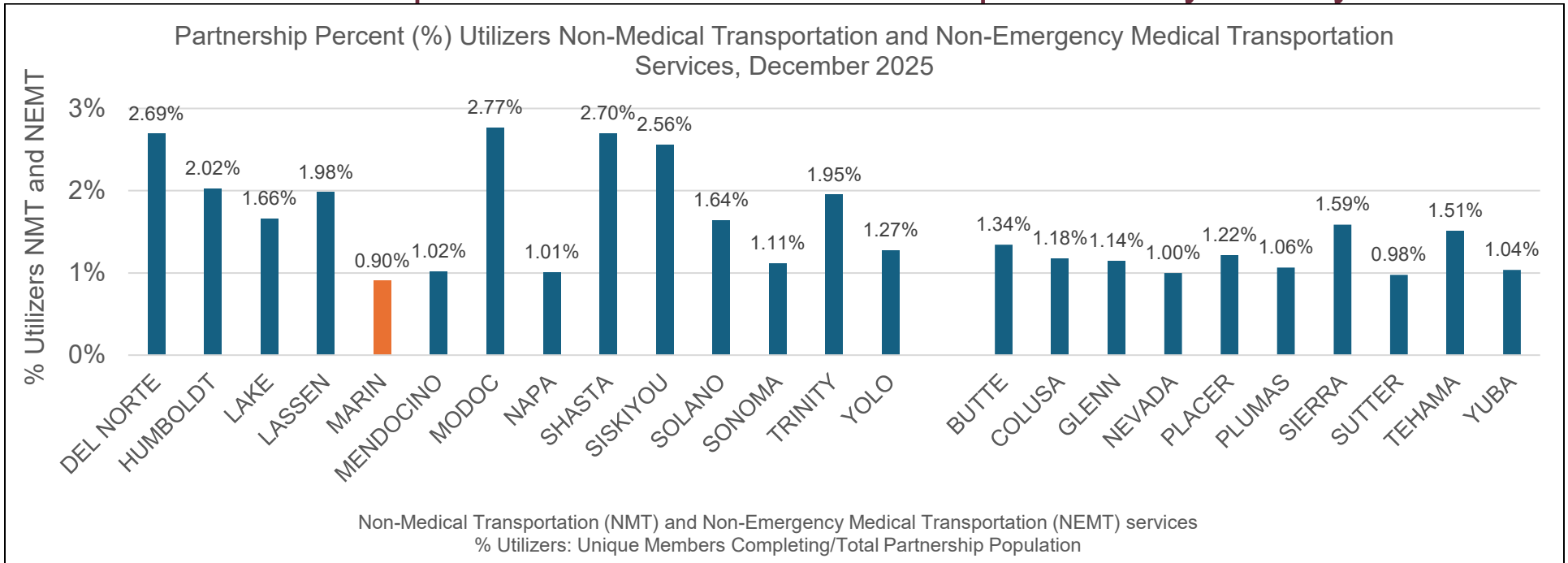
- Transportation is divided into:
 - NMT: Non-Medical Transportation helps members who do not have any other way of getting to their appointments and back to their residence. NMT includes passenger cars, taxis, buses, trains, or other public transportation.
 - NEMT: Non-Emergency Medical Transportation helps members who need door-to-door service – help with getting in and out of the home, vehicle, and medical office. NEMT may include non-emergency ambulances, gurney vans, wheelchair vans, or medical air transport.
- Calculation: Trip Rate PMPM per 1,000
 - NMT/NEMT services are also tracked per Member per Month (PMPM) per 1,000 Partnership Member Month
 - Completed Trips per Month divided by Total Partnership Population per Month X 1,000 (per Partnership Member per Month).

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services

Partnership Member Utilization of Transportation by County



Highlights of Partnership Member Utilization of Transportation by County

Marin member population using NMT/NEMT transportation services is about 1% of the total number of Partnership Marin County members, in 2025.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

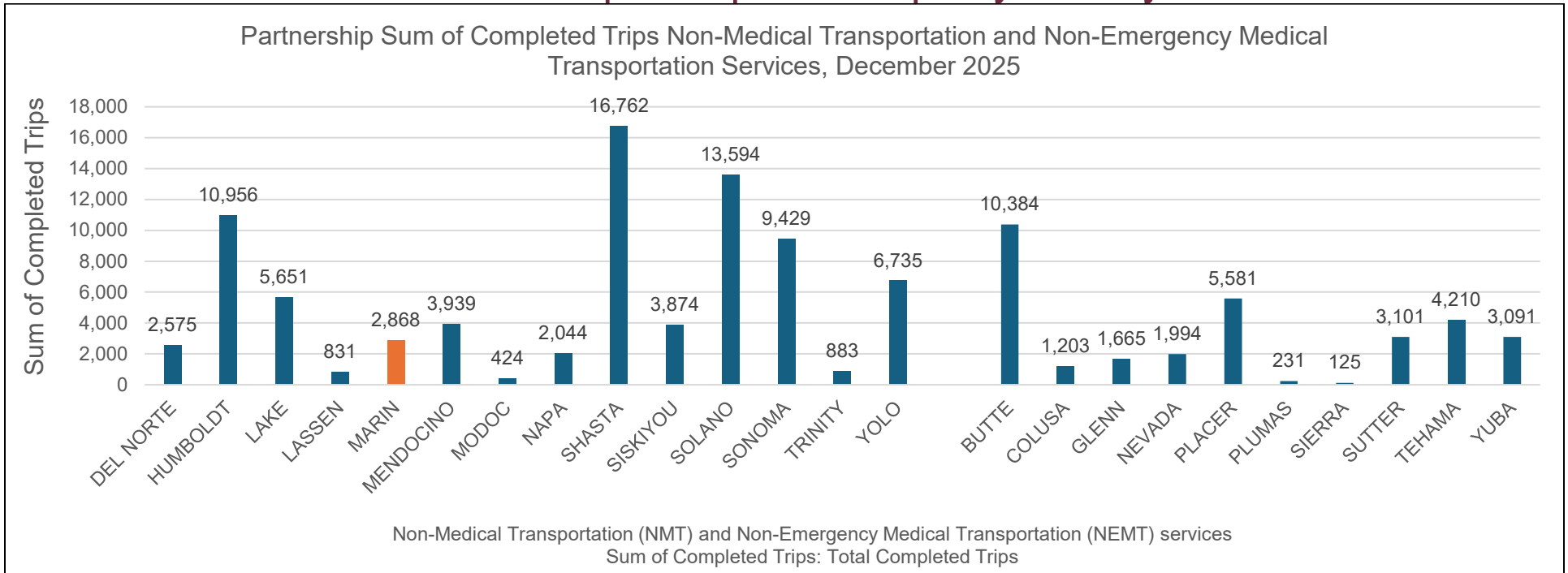
Definition: Completed Trip is the trip status of Completed, Assignment Exported

- Transportation is divided into:
 - NMT: Non-Medical Transportation helps members who do not have any other way of getting to their appointments and back to their residence. NMT includes passenger cars, taxis, buses, trains, or other public transportation.
 - NEMT: Non-Emergency Medical Transportation helps members who need door-to-door service – help with getting in and out of the home, vehicle, and medical office. NEMT may include non-emergency ambulances, gurney vans, wheelchair vans, or medical air transport.
- Key Performance Indicators (KPI) follow standards set by [Centers for Medicare and Medicaid Services \(CMS\)](#) and [DHCS](#) for NMT and NEMT services booked and used by members, including:
- Calculations: Percent (%) Utilizing Members
 - Number of unique Partnership members who Schedule and Complete Trips within a given Period (i.e., calendar year 2025)
 - Unique Members Completing Trip divided by Total Partnership Population in that particular Location, currently enrolled (i.e., Marin County) within the same Period
 - Rate: Percentage X100 (%)

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Transportation Services Partnership Completed Trips by County



Highlights of Partnership Completed Trips by County

Though Marin Partnership members using transportation services were 1% of Marin Partnership population in 2025, estimated at 62 members per month per 1,000 members, a total of 2,868 NMT/NEMT trips were completed, compared to 16,762 completed trips in Shasta.

Limitation:

- Ideally, a true increase or decrease in point estimate is estimated from a P-value or non-overlapping confidence interval (95% CI), which determines statistically significant difference in point estimates between years. These have not been included here. Increase or decrease in point estimates have been determined for program improvement purposes only.

Definition:

- Transportation is divided into:
 - NMT: Non-Medical Transportation helps members who do not have any other way of getting to their appointments and back to their residence. NMT includes passenger cars, taxis, buses, trains, or other public transportation.
 - NEMT: Non-Emergency Medical Transportation helps members who need door-to-door service – help with getting in and out of the home, vehicle, and medical office. NEMT may include non-emergency ambulances, gurney vans, wheelchair vans, or medical air transport.
- Key Performance Indicators (KPI) follow standards set by [Centers for Medicare and Medicaid Services \(CMS\)](#) and [DHCS](#) for NMT and NEMT services booked and used by members, including:
 - Completed Trip: Trip status of Completed, Assignment Exported

Data Source: Partnership Health Analytics Team linked and merged the following datasets by identifiers

- DHCS Enrollment dataset for Partnership Members
- Transportation trip information is tracked by the Partnership Transportation Department. Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data

Health Disparities

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For more information, see [Health Disparities](#) in the [Appendix](#)

Health Disparities

Race/Ethnicity Disparities (Partnership-Wide)

Health Disparity Focus Measures by Race, Measurement Year (MY) 2024, 2025

Breast Cancer Screenings: White: Below MPL Asian/Pacific Islander: Below MPL Native American: Below MPL	Controlling Blood Pressure: Black: Below MPL Asian/Pacific Islander: Below MPL White: Below MPL Native American: Below MPL
Breast Cancer Screenings: White: Below MPL Asian/Pacific Islander: Below MPL Native American: Below MPL	Well-Care Visits: Black: Below MPL Native American: Below MPL White: Below MPL
Diabetes Mellitus Poor Control (A1c >9%): No groups are below MPL.	Colorectal Cancer Screenings: Asian/Pacific Islander: Below MPL Black: Below MPL White: Below MPL Native American: Below MPL

Note: Only groups below MPL are shown.

Highlights of Race/Ethnicity Disparities (Partnership-Wide)

Partnership recently received the National Committee for Quality Assurance (NCQA) Health Equity Accreditation (HEA), June 2025. In order to continue to improve health disparities, certain Healthcare Effectiveness Data and Information Set (HEDIS®), Managed Care Accountability Set (MCAS) measures are selected by the Partnership Quality Improvement Health Equity Committee (QIHEC) which oversees the Quality Improvement and Health Equity Transformation Program (QIHETP), charged to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to Partnership members. Annual Performance Measures and Reports are submitted to the state DHCS for continued HEA.

Definition:

Benchmarks and Targets are set as

- MPL: means the minimum performance level (MPL) based on the NCQA's quality compass, 50th national Medicaid percentile. Measures can be -Below MPL- (below target)
- HPL: means the high performance level (HPL) based on the NCQA's quality compass 90th national Medicaid percentile. Measures can be -Above HPL- (above target)

Health Disparities is reported to DHCS via the MCAS data reports with data from the year before:

- Measure Year (MY) is the data collection year (i.e., MY 2024)
- Report Year (RY) (i.e., RY 2025)

Health Disparity Data Analysis

- Comparing prior year data to currently available data, calculated gaps to be filled by measure and race
- Compared race stratification by MPL
- Chi-Square analysis was performed comparing each race stratification to the White race stratification

HEDIS Measures Selected:

- Breast Cancer Screenings (BCS-E): The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
- Cervical Cancer Screening (CCS): The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
 - Women 21–64 years of age who had cervical cytology performed within the last 3 years
 - Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years

- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
- Diabetes Mellitus Poor Control (HbA1c poor control: A1c >9%) for Patients with Diabetes (HBD): The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed.
 - HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
- Controlling Blood Pressure (CBP): The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (
- Well-Care Visits (WCV): The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
 - Total: The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.
- Colorectal Cancer Screenings (COL-E) The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer from January 1- December 31 of the measurement year.

Data Source:

Health Disparities are measured using HEDIS measures are from various DHCS claims datasets for data completeness purposes and to overcome limitations of data collected. Data collected could be divided into:

- Administrative from DHCS Medical claims data ONLY
- Hybrid from DHCS Medical claims data and Data Abstraction from case notes

Health Disparities

Partnership HEDIS Disparities

Select Report Year
Report Year 2025; Measurement Year 2024

Category
Estimated Race

HEDIS Disparity Analysis Summary Dashboard - MCAS County Oversampling Data
Report Year 2025; Measurement Year 2024

Performance Relative to Quality Compass® Medicaid Benchmarks

Note: Planwide rate won't match HEDIS Annual Static Dashboard that is using HEDIS Planwide Data



● **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● **Below MPL** (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Measure Name	American Indian and Alaska Native	Asian/Pacific Islander	Black	Hispanic	Multiracial	Other/Unknown	White	Planwide Rate	50th	90th
Asthma Medication Ratio (AMR) Total, 5 to 64 Ratios > 0.50	59.18	79.86	65.89	69.19	59.95		59.84	64.71	66.24	76.65
Breast Cancer Screening ECDS (BCS-E) Non-Medicare Total	44.66	57.09	50.60	69.52	52.91		48.18	56.29	52.68	63.48
Cervical Cancer Screening (CCS)	45.65	54.67	50.05	58.52	50.05		46.97	52.16	57.18	67.46
Childhood Immunization Status (CIS) Combination 10	8.58	34.10	18.48	35.09	0.00		11.66	23.49	27.49	42.34
Chlamydia Screening in Women (CHL) Total	54.34	54.01	64.46	58.08	50.05		51.92	55.58	55.95	69.07
Controlling High Blood Pressure (CBP) Non-Medicare Total	57.86	58.74	53.57	64.24	50.05		59.95	61.14	64.48	72.75
Developmental Screening in the First Three Years of Life (DEV-CH) Total All Ages	13.86	40.15	28.71	31.79	31.24	14.30	25.85	29.65	35.70	
Follow-Up After Emergency Department Visit for Mental Illness (FUM) 30 Days Total	39.49	26.95	22.00	28.49	20.02		31.02	29.73	53.82	73.12
Follow-Up After Emergency Department Visit for Substance Use (FUA) 30 Days Total	30.14	23.43	20.35	25.85			36.85	32.90	36.18	49.40
Hemoglobin A1c Poor Control for Patients With Diabetes (GSD) HbA1c Poor Control (>9%)	40.48	33.99	51.15	34.21	0.00		37.07	35.96	33.33	27.01
Immunizations for Adolescents (IMA) Combination 2	27.28	37.95	23.54	48.40	12.54		20.57	33.99	34.30	48.66
Lead Screening in Children (LSC)	65.78	79.53	53.68	78.43	40.04		65.56	71.65	63.84	79.51
Prenatal and Postpartum Care (PPC) Postpartum care	80.30	86.24	76.56	89.87	83.38		82.83	86.11	80.23	86.62
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	81.84	74.36	74.47	80.52	50.05		79.20	79.47	84.55	91.85
Topical Fluoride for Children (TFL - CH) Numerator 1 Total	2.09	20.79	10.34	15.18	17.16	0.00	8.14	12.40	19.30	
Well Care Visits (WCV) Total	45.76	51.04	40.48	53.79	53.13	21.45	43.12	48.83	51.81	64.74
Well Child 30 (W30) Well child visits for age 15-30 months	69.08	69.08	52.03	78.54	76.23	0.00	66.44	72.22	69.43	79.94
Well Child 30 (W30) Well child visits in the first 15 months	61.05	63.47	53.90	70.95	42.90	42.90	62.81	67.05	60.38	69.67

Health Disparities

Partnership North Bay Area Key Disparities, 2024

North Bay Area

Sonoma, Marin, Napa, Solano, Yolo



Breakdown of Measures with Statistically Worse Disparity

Group	Measure	Geo-level	Performance Rate	Comparator Group (White; English Language)
Race: Black	Follow-Up After Emergency Department Visit for Mental Illness (FUM) 30 Days Total	North Bay	23.32	32.34
	Follow-Up After Emergency Department Visit for Substance Use (FUA) 30 Days Total	North Bay	21.50	36.41
	Well Care Visits (WCV) Total	North Bay	40.33	45.10
	Well Child 30 (W30) Well child visits for age 15-30 months	North Bay	50.70	64.02
Language Group: Spanish	Follow-Up After Emergency Department Visit for Substance Use (FUA) 30 Days Total	North Bay	21.45	31.68

Supplementary Data

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Supplementary Data

Partnership HEDIS Performance: CAHPS

Select Report Year
 Measurement Year 2024; Report Year 2025

**HEDIS HPA All Plan Performance
 with CAHPS Measures**
Measurement Year 2024; Report Year 2025
 Performance Relative to Quality Compass® Medicaid Benchmarks



- Above 66.7th Percentile
- Below 33.3th Percentile

All Plan Performance - CAHPS Measures

CAHPS Benchmarks

NCQA_Category	Measure Name	All Plan MY2024	10TH	33TH	66TH	90TH
PATIENT EXPERIENCE	Adult: Getting Care Quickly (Usually+Always)	74.02%	73.26%	78.80%	82.98%	86.40%
	Adult: Getting Needed Care (Usually+Always)	74.54%	75.52%	79.75%	83.73%	86.12%
	Adult: Rating of All Health Care (9+10)	55.43%	50.00%	55.07%	59.47%	63.36%
	Adult: Rating of Health Plan (9+10)	55.76%	53.41%	59.44%	64.05%	68.54%
	Adult: Rating of Personal Doctor (9+10)	65.75%	63.01%	67.32%	71.05%	74.42%
	Child: Getting Care Quickly (Usually+Always)	80.04%	78.92%	84.62%	89.35%	92.10%
	Child: Getting Needed Care (Usually+Always)	77.87%	76.79%	81.10%	85.70%	89.41%
	Child: Rating of All Health Care (9+10)	66.40%	62.29%	67.49%	71.90%	76.27%
	Child: Rating of Health Plan (9+10)	72.87%	64.03%	69.01%	73.76%	78.19%
	Child: Rating of Personal Doctor (9+10)	78.64%	70.66%	74.42%	78.53%	82.63%

* Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population.

** ECDS Measures: ECDS Measures are calculated using claims and encounter data as well as supplemental data sources such as Health Information Exchanges, Immunization Registries, and Data Aggregator vendors.

^ Survey Measures: CAHPS survey responses are collected by member survey between February - May 2023 for the CAHPS measures included in the MY2024 HPA.

Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD).

Plan All-Cause Readmissions (PCR) is a ratio, and a lower ratio indicates higher performance.

Note: The Follow-Up After Hospitalization for Mental Illness— 7 days (FUH) weighted HEDIS measure has been designated a "Not a Benefit" (NB) measure for Partnership by NCQA and removed from Partnership's NCQA HPA measure set in MY2024.

Supplementary Data

Partnership HEDIS Performance: Clinical Measures

Select Report Year
 Measurement Year 2024; Report Year 2025

**HEDIS HPA All Plan Performance
 with Clinical Measures**
Measurement Year 2024; Report Year 2025
 Performance Relative to Quality Compass® Medicaid Benchmarks



- Above 66.7th Percentile
- Below 33.3th Percentile

All Plan Performance - Clinical Measures

National Medicaid Benchmarks

NCQA_Category	NCQA_SubCategory	Measures	All Plan	10Th	33Th	66Th	90Th
			2024				
PREVENTION AND POPULATION	Cancer Screening	**Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	56.29%	42.86%	49.24%	56.66%	63.48%
		**Colorectal Cancer Screening (COL-E) - Non-Medicare All Ages (All Data)	32.99%	27.27%	34.30%	41.59%	49.35%
		Cervical Cancer Screening (CCS)*	58.64%	43.31%	52.07%	60.10%	67.46%
	Children and Adolescent Well-Care	Childhood Immunization Status (CIS) - Combination 10*	28.22%	18.25%	24.39%	31.32%	42.34%
		Immunizations for Adolescents (IMA) - Combination 2*	39.66%	25.41%	31.39%	38.69%	48.66%
		Weight Asses and Counseling for Nutr and Phys Act for CHI/ADO (WCC) - BMI Total*	76.16%	66.91%	76.89%	86.20%	91.24%
	Other Preventive Services	**Adult Immunization Status ECDS (AIS-E) - Influenza Total	14.33%	7.39%	12.55%	17.91%	26.40%
		**Adult Immunization Status ECDS (AIS-E) - Pneumococcal 66+	44.03%	21.04%	38.73%	55.03%	68.07%
		**Adult Immunization Status ECDS (AIS-E) - Td/Tdap Total	32.96%	21.26%	33.40%	47.30%	57.67%
		**Adult Immunization Status ECDS (AIS-E) - Zoster Total	14.47%	2.23%	7.15%	13.49%	20.56%
		Chlamydia Screening in Women (CHL) - Total	55.58%	43.53%	52.40%	61.46%	69.07%
	Women's Reproductive Health	**Prenatal Immunization Status ECDS (PRS-E) - Combo	29.36%	8.42%	15.96%	24.92%	35.60%
		Prenatal and Postpartum Care (PPC) - Postpartum Care*	88.81%	68.63%	77.37%	82.48%	86.62%
		Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	84.43%	73.48%	81.94%	86.89%	91.85%
TREATMENT	Behavioral Health—Access, Monitoring and Safety	**Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Continuation & Maintenance Phase	40.36%	37.19%	48.94%	56.83%	63.49%
		**Metabolic Monitoring for CH and ADO on Antipsychotics (APM) - Glucose and Chol Combined - All Ages	32.18%	25.86%	30.92%	41.41%	52.57%
		Diabetes Screen for Schizophrenia or Bipolar Disorder w/Antipsychotic Meds (SSD)	83.85%	75.46%	79.51%	83.51%	87.27%
		Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement Total (All Ages)	7.63%	6.08%	10.51%	16.78%	26.72%
		Use of First-Line Psychosocial Care for CH and ADO on Antipsychotics (APP) - Total	41.38%	41.57%	54.55%	64.10%	74.14%
	Behavioral Health—Care Coordination	Follow-Up After ED Visit for Substance Use (FUA) - 7 Day Total Ages	22.88%	12.73%	18.76%	27.62%	37.47%
		Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 Day Total Ages	13.39%	21.19%	33.01%	44.33%	59.95%
		Follow-Up After High-Intensity Care for Substance Use (FUI) - Total 7 Days	29.83%	15.91%	26.90%	37.64%	50.80%
	Behavioral Health—Medication Adherence	Adherence to Antipsychotic Meds for Indiv w/Schizophrenia (SAA) - Non-MCR 80% Coverage	68.58%	44.65%	58.60%	66.15%	74.83%
		Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	48.04%	31.52%	41.00%	48.16%	61.06%
		Pharmacotherapy for Opioid Use Disorder (POD) - Total	15.84%	12.05%	21.36%	29.01%	36.71%
	Diabetes	#Glycemic Status Assessment for Patients w/Diabetes—Glycemic Status (<8%) (GSD) - Non-Medicare HbA1c Control (<8%)*	54.26%	44.25%	54.50%	59.64%	63.50%
		Blood Pressure Control for Patients w/Diabetes (BPD) - Non-Medicare*	70.56%	58.15%	65.32%	71.78%	77.37%
		Eye Exam for Pts w/Diabetes (EED) - Non-Medicare Eye Exam*	52.31%	40.39%	49.15%	57.09%	64.06%
		Kidney Health Evaluation for Pts w/Diabetes (KED) - Non-MCR Members Total	40.88%	26.79%	33.00%	42.10%	49.72%
		Statin Therapy for Patients w/Diabetes (SPD) - Non-MCR Statin Adherence	67.90%	53.23%	64.18%	70.91%	79.73%
	Heart Disease	Statin Therapy for Patients w/Diabetes (SPD) - Non-MCR Statin Therapy	64.93%	51.96%	62.66%	67.01%	71.41%
		Controlling High Blood Pressure (CBP) - Non-Medicare Total*	61.80%	54.61%	61.43%	67.40%	72.75%
		Statin Therapy for Patients w/Cardiovascular Disease (SPC) - Non-MCR Adherence Total	70.33%	59.95%	67.42%	74.07%	81.79%
		Statin Therapy for Patients w/Cardiovascular Disease (SPC) - Non-MCR Statin Therapy Total	81.06%	66.64%	79.82%	83.00%	85.89%
	Other Treatment Measures	Use of Imaging Studies for Low Back Pain (LBP) - Total	73.67%	64.77%	67.84%	72.74%	78.72%
	Respiratory	Appropriate Testing for Pharyngitis (CWP) - Total	70.27%	61.35%	76.71%	85.11%	89.17%
		Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	64.71%	54.56%	62.35%	70.56%	76.65%
		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total, All Ages	56.00%	49.48%	56.76%	67.03%	77.66%
		Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilators	86.18%	67.25%	80.19%	86.54%	89.96%
		Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroids	70.93%	55.28%	66.86%	74.78%	82.88%
TREATMENT	Risk-Adjusted Utilization	##Plan All-Cause Readmissions (PCR) - Total Medicare	0.9945	1.1783	1.0290	0.9124	0.8188

* Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population.

** ECDS Measures: ECDS Measures are calculated using claims and encounter data as well as supplemental data sources such as Health Information Exchanges, Immunization Registries, and Data Aggregator vendors.

* Survey Measures: CAHPS survey responses are collected by member survey between February - May 2023 for the CAHPS measures included in the MY2024 HPA.

Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HBD).

Plan All-Cause Readmissions (PCR) is a ratio, and a lower ratio indicates higher performance.

Note: The Follow-Up After Hospitalization for Mental Illness—7 days (FUH) weighted HEDIS measure has been designated a "Not a Benefit" (NB) measure for Partnership by NCQA and removed from Partnership's NCQA HPA measure set in MY2024.

Supplementary Data

HEDIS Performance by County/Region

Select Report Year
 Measurement Year 2024; Report Year 2025

Partnership Region
 Santa Rosa

HEDIS HPA Performance by Counties - Partnership Region
Measurement Year 2024; Report Year 2025
 Performance Relative to Quality Compass® Medicaid Benchmarks



- Above 66.7th Percentile
- Below 33.3th Percentile

Partnership Region - Santa Rosa					National Medicaid Benchmarks			
NCQA_Category	NCQA_SubCategory	Measures	MARIN	SONOMA	10Th	33Th	66Th	90Th
			2024	2024				
PREVENTION AND POPULATION	Cancer Screening	**Breast Cancer Screening ECDS (BCS-E) - Non-Medicare Total	63.44%	59.17%	42.86%	49.24%	56.66%	63.48%
		**Colorectal Cancer Screening (COL-E) - Non-Medicare All Ages (All Data)	34.44%	38.68%	27.27%	34.30%	41.59%	49.35%
		Cervical Cancer Screening (CCS)*	71.43%	68.00%	43.31%	52.07%	60.10%	67.46%
	Children and Adolescent Well-Care	Childhood Immunization Status (CIS) - Combination 10*	35.14%	34.25%	18.25%	24.39%	31.32%	42.34%
		Immunizations for Adolescents (IMA) - Combination 2*	57.14%	53.85%	25.41%	31.39%	38.69%	48.66%
		Weight Asses and Counseling for Nutr and Phys Act for CHIADO (WCC) - BMI Total*	90.91%	69.49%	66.91%	76.89%	86.20%	91.24%
	Other Preventive Services	**Adult Immunization Status ECDS (AIS-E) - Influenza Total	21.41%	18.25%	7.39%	12.55%	17.91%	26.40%
		**Adult Immunization Status ECDS (AIS-E) - Pneumococcal 66+	49.58%	40.21%	21.04%	38.73%	55.03%	68.07%
		**Adult Immunization Status ECDS (AIS-E) - Td/Tdap Total	40.27%	31.66%	21.26%	33.40%	47.30%	57.67%
		**Adult Immunization Status ECDS (AIS-E) - Zoster Total	27.44%	13.98%	2.23%	7.15%	13.49%	20.56%
		Chlamydia Screening in Women (CHL) - Total	77.63%	51.89%	43.53%	52.40%	61.46%	69.07%
	Women's Reproductive Health	**Prenatal Immunization Status ECDS (PRS-E) - Combo	46.87%	39.15%	8.42%	15.96%	24.92%	35.60%
		Prenatal and Postpartum Care (PPC) - Postpartum Care*	100.00%	96.67%	68.63%	77.37%	82.48%	86.62%
		Prenatal and Postpartum Care (PPC) - Timeliness of Prenatal Care*	100.00%	90.00%	73.48%	81.94%	86.89%	91.85%
TREATMENT	Behavioral Health—Access, Monitoring and Safety	**Follow-Up Care for Children Prescribed ADHD Medication (ADD) - Continuation & Maintenance Phase	50.00%	31.82%	37.19%	48.94%	56.83%	63.49%
		**Metabolic Monitoring for CH and ADO on Antipsychotics (APM) - Glucose and Chol Combined - All Ages	51.72%	35.29%	25.86%	30.92%	41.41%	52.57%
		Diabetes Screen for Schizophrenia or Bipolar Disorder w/Antipsychotic Meds (SSD)	78.61%	85.90%	75.46%	79.51%	83.51%	87.27%
		Initiation and Engagement of Substance Use Disorder Treatment (IET) - Engagement Total (All Ages)	5.39%	8.69%	6.08%	10.51%	16.78%	26.72%
		Use of First-Line Psychosocial Care for CH and ADO on Antipsychotics (APP) - Total	77.78%	31.48%	41.57%	54.55%	64.10%	74.14%
		Follow-Up After ED Visit for Substance Use (FUA) - 7 Day Total Ages	21.33%	18.89%	12.73%	18.76%	27.62%	37.47%
	Behavioral Health—Care Coordination	Follow-Up After Emergency Department Visit for Mental Illness (FUM) - 7 Day Total Ages	20.50%	16.83%	21.19%	33.01%	44.33%	59.95%
		Follow-Up After High-Intensity Care for Substance Use (FUI) - Total 7 Days	10.53%	22.86%	15.91%	26.90%	37.64%	50.80%
		Adherence to Antipsychotic Meds for Indiv w/Schizophrenia (SAA) - Non-MCR 80% Coverage	77.88%	68.80%	44.65%	58.60%	66.15%	74.83%
	Behavioral Health—Medication Adherence	Antidepressant Medication Management (AMM) - Effective Continuation Phase Treatment	49.81%	45.43%	31.52%	41.00%	48.16%	61.06%
		Pharmacotherapy for Opioid Use Disorder (POD) - Total	5.19%	12.62%	12.05%	21.36%	29.01%	36.71%
	Diabetes	#Glycemic Status Assessment for Patients w/Diabetes—Glycemic Status (<8%) (GSD) - Non-Medicare HbA1c Control (<8%)*	52.63%	44.83%	44.25%	54.50%	59.64%	63.50%
		Blood Pressure Control for Patients w/Diabetes (BPD) - Non-Medicare*	89.47%	67.24%	58.15%	65.32%	71.78%	77.37%
		Eye Exam for Pts w/Diabetes (EED) - Non-Medicare Eye Exam*	63.16%	65.52%	40.39%	49.15%	57.09%	64.06%
		Kidney Health Evaluation for Pts w/Diabetes (KED) - Non-MCR Members Total	50.23%	47.24%	26.79%	33.00%	42.10%	49.72%
		Statin Therapy for Patients w/Diabetes (SPD) - Non-MCR Statin Adherence	69.25%	62.65%	53.23%	64.18%	70.91%	79.73%
		Statin Therapy for Patients w/Diabetes (SPD) - Non-MCR Statin Therapy	67.69%	68.61%	51.96%	62.66%	67.01%	71.41%
	Heart Disease	Controlling High Blood Pressure (CBP) - Non-Medicare Total*	62.07%	62.67%	54.61%	61.43%	67.40%	72.75%
		Statin Therapy for Patients w/Cardiovascular Disease (SPC) - Non-MCR Adherence Total	72.84%	70.46%	59.95%	67.42%	74.07%	81.79%
		Statin Therapy for Patients w/Cardiovascular Disease (SPC) - Non-MCR Statin Therapy Total	89.01%	82.29%	66.64%	79.82%	83.00%	85.89%
	Other Treatment Measures	Use of Imaging Studies for Low Back Pain (LBP) - Total	72.67%	77.55%	64.77%	67.84%	72.74%	78.72%
	Respiratory	Appropriate Testing for Pharyngitis (CWP) - Total	80.68%	82.89%	61.35%	76.71%	85.11%	89.17%
		Asthma Medication Ratio (AMR) - Total, 5 to 64 Ratios > 0.50	61.27%	70.42%	54.56%	62.35%	70.56%	76.65%
		Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) - Total, All Ages	88.02%	77.33%	49.48%	56.76%	67.03%	77.66%
		Pharmacotherapy Management of COPD Exacerbation (PCE) - Bronchodilators	86.84%	87.42%	67.25%	80.19%	86.54%	89.96%
		Pharmacotherapy Management of COPD Exacerbation (PCE) - Systemic Corticosteroids	55.26%	71.52%	55.28%	66.86%	74.78%	82.88%
	TREATMENT	Risk-Adjusted Utilization	##Plan All-Cause Readmissions (PCR) - Total Medicare	0.9704	0.8308	1.1783	1.0290	0.9124

* Hybrid Measures: Measure rates are calculated using a systematic sample drawn from the eligible population.

** ECDS Measures: ECDS Measures are calculated using claims and encounter data as well as supplemental data sources such as Health Information Exchanges, Immunization Registries, and Data Aggregator vendors.

* Survey Measures: CAHPS survey responses are collected by member survey between February - May 2023 for the CAHPS measures included in the MY2024 HPA.

Before MY2024, the GSD measure was referred to as Hemoglobin A1c Poor Control for Patients with Diabetes (HED).

Plan All-Cause Readmissions (PCR) is a ratio, and a lower ratio indicates higher performance.

Note: The Follow-Up After Hospitalization for Mental Illness—7 days (FUH) weighted HEDIS measure has been designated a "Not a Benefit" (NB) measure for Partnership by NCQA and removed from Partnership's NCQA HPA measure set in MY2024.

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Demographics

Data Information

- **Who does this report represent?**
 - [Partnership members](#) are [Medi-Cal members](#) assigned to Partnership by various criteria and eligibility status.
- **What do these measures mean?**
 - Partnership member enrollment (count) by various categories
 - Partnership member demographic information is provided determined by individuals during registration by the State of California or their County. The final Partnership member demographics, including race, is determined by California's Department of Health Care Services (DHCS).
- **Where are the locations represented in these datasets?**
 - Data is for all Partnership counties.
- **When were these datasets collected?**
 - Enrollment from 2022-2025
 - Current enrollment as of February 2026
 - Enrollment fluctuations by month from April 2024 to February 2026
 - Homeless population as of December 2025
 - Maternal population by delivery from 2016-2025
- **Why does partnership keep track of this data?**
 - As a Medi-Cal Managed Care Plan, Partnership is responsible for monitoring the performance of its work, providers, and other delegates to quantify its performance and the health of its members.
- **How does Partnership serve its members?**
 - Partnership offers various [healthcare services and benefits](#) to its members, including routine and preventive care, and other medically necessary services. Other healthcare services are carved out to the State, such as pharmacy and dental services, or to counties, such as serious mental health and certain substance use treatment services.
- **Which datasets were used?**
 - Demographics data was sourced from various datasets from DHCS, including:
 - Current Enrollment from DHCS Partnership Enrollment Dataset.
 - Partnership's Health Analytics team utilizes DHCS enrollment and claims data to support population insights. This includes identifying members experiencing homelessness, defined as individuals with

address fields containing keywords associated with homelessness, as well as those with claims that include diagnoses codes related to homelessness, housing instability, inadequate housing, or residential living challenges.

- Of note, homelessness rate are not based on point-in-time homeless count surveys implemented by counties. Chronic homelessness is defined as homelessness lasting more than 180 consecutive days.
- Maternal Population by Delivery are derived from Partnership Delivery Claims Data and data reported by hospitals to HCAI to California Hospital Compare.

Child Welfare Demographics

Data Information

Definitions

- Partnership considers Child Welfare members a special population with benefits and services.

There are 3 categories of Child Welfare and one related adult category:

- Children under age 21 currently in foster care
- Children under age 21 and adopted
- Children under age 21 who received foster care within the last 12 months
- Young Adults who are currently 18-26 and aged out of foster care after 18

Other Related Categories of Special Population tracked include:

- Adults age 27 and older who have been in foster care at some point in time are also tracked within these systems
- Relatives/Caregivers (non-parents) who also have Medi-Cal qualifying for certain Medi-Cal benefits or services
- School Based Children: Members between 5 and 19 years old during the reporting period within the last 12 months
- First 5: Children under 6 years old or Members under 71 months old during the reporting period

Measures

- Number of Special Population/Child Welfare (Count)
- Number Served (Count): Number of Distinct Child Welfare Population Receiving Services
- Number of Paid Claims: Number of Paid Claims per Service Type
- Number of Unique Services (Count): Number of Distinct services
- % of Child Welfare: Child Welfare as a Percentage (%) of Partnership Member by County
- % of Child Welfare: Child Welfare as a Percentage (%) of Partnership Member by Age
- **When were these datasets collected?**
 - Enrollment and Services from 2021-2025
 - Current Enrollment and Services as of December 2025
- **Which datasets were used?**
 - Demographic data was sourced from various DHCS datasets including:

- Current Enrollment from DHCS Partnership Enrollment Dataset by the following Medi-Cal Aid Codes used to classify Child Welfare special populations.
- Services were captured using Claims data:
 - Partnership Paid Claims for Primary Care, Hospital, Specialist encounters and related services
- CalAIM: Paid claims for Community Health Workers as Certified Providers, Community Support Services and Enhanced Care Management Services
- Carelon Claims for Behavioral Health Services
- DHCS Medical Claims for Behavioral Health Services

Obstetric/Maternal Demographics and Conditions

Data Information

- **Who does this report section represent?**
 - The following data represents all Partnership members who delivered, plan-wide and specific to Marin. The final Partnership member demographics, including race, are determined by California's Department of Health Care Services (DHCS).
- **What do these measures mean?**
 - Partnership member maternal deliveries (count) by various categories.
 - Partnership Member Maternal Delivery information is determined by individual deliveries during a given year or period. Each delivery is counted once in each category of maternal characteristic.
- **When were these datasets collected?**
 - Maternal Population by Delivery from 2021-2025.

Note: This section is about the Partnership Maternal Population whose deliveries were paid for by Partnership

Chronic Conditions

Data Information

- **What do these measures mean?**

- Partnership member chronic disease has been divided into two categories, adult and child.
 - Partnership member chronic disease information is determined by algorithms from the Chronic Conditions List from the Centers for Medicare & Medicaid Services (CMS) and Health Effectiveness Data and Information Set (HEDIS) specifications. The criteria used to define the different chronic conditions was based on the presence of diagnoses, procedures, or standard therapeutic classification Service Type Codes (STC) in those data sources during a look-back period that varies depending on the disease, usually one year.
- Prevalence is the number of members with a given condition in a given year divided by the average membership during the same year, multiplied per 1000. That is, prevalence is the number of members with a condition per 1000 Partnership members.

- **When were these datasets collected?**

- Chronic conditions from Claims data from 2021-2025

- **Which datasets were used?**

Chronic Disease data was sourced from various datasets including:

- Partnership Claims data from DHCS Claims Data
- Pharmacy Data
- County Mental Health (for Mental Health related Chronic Conditions)

Access to Dental Services

Data Information

- **What do these measures mean?**

- Partnership Member Dental Services in various categories
- Dental data has been divided into two categories, dental services and dental members served.
- Partnership Member Dental Service information is determined by algorithms from the American Dental Association code on Dental Procedures and Nomenclature, called Dental codes (D-Codes) and the International Classification of Disease, 10th Revision (ICD10 Codes) in medical claims.
- Dental categories were determined from the American Dental Association code on Dental Procedures and Nomenclature, 2022 and include: Diagnostic Services; Preventive Services; Specialized Services; Adjective Services; Unclassified Services

For the purpose of this publication, Dental categories have been simplified into three categories below:

- **Prevention & Early Detection:** Preventive Diagnostic & Preventive
- **Treatment & Intervention:** Restorative & Specialized
- **Support / Other:** Adjunctive General & Uncategorized

- **When were these datasets collected?**

- Dental data from DHCS Dental Claims data were from October 2024-2025

- **Which datasets were used?**

Dental data was sourced from various datasets including:

- Partnership Member, Medical Claims data and DHCS Medical and Dental Claims File
- Data was also collected by the Partnership Dental Liaison on all Partnership member dental facilities and service providers by Partnership County including:
 - Number of Dentists and Number of Dental Hygienists
 - Number of Dental Chairs
 - Monthly Volume of Patients
 - Calculated Ratio Number of Dentists: Number of Member Population
 - Calculated Ratio Number of Hygienists: Number of Member Population

Substance Use Disorder

Data Information

- **What do these measures mean?**

Substance Use Disorders (SUDs) are measured by:

- o Member Count: Unique Partnership member count utilizing services with claims in the diagnosis and location of service.
- o Paid Claims: Number of substance use services provided.
- o Claims PMPY*1,000: The rate calculated from the number of Claims per Member per Year (12 months) per 1,000 Partnership Members. This is calculated so for every 1,000 Partnership members with any diagnosis, in any service location, and any county, rates can be compared in the same way per 1,000 Partnership members per Member per Year.

The treatment of the following most frequently occurring substances are monitored using the International Classification of Disease, 10th Revision for medical claims based on diagnosis (ICD10 Codes):

- o Alcohol
- o Opioids
- o Stimulants
- o Cannabis
- o Sedatives
- o Drug Abuse including nonspecific diagnosis of drug abuse and dependance
- o Other, including Psychodysleptic/Hallucinogenic drugs, Lysergic Acid Diethylamide (LSD), Barbiturate, and Methylphenidates

The substances treated are monitored in the following [Centers for Medicare and Medicaid Services \(CMS\) Place of Service Code Set](#), defining the location of Service:

- o Office Visit
- o Outpatient
- o Emergency Department (ED)
- o Inpatient Hospital
- o Substance Use Facility
- o Nursing Facility
- o Mental Health Treatment Facility
- o Transportation Services

Maternal SUD is also monitored for all pregnant and/or mothers within a year after delivery.

Note: Unique members can have multi-drug SUD and have claims from several

service locations within the same year; hence, these members are not mutually exclusive between category of diagnosis and location of service.

Tobacco screening and referral to treatment is measured in Percentage (%) by:

- Division into adults (over 21 years of age) and children (ages less than 21 years).
- Count of distinct members who received at least one tobacco screening and referral (numerator)/Count of distinct eligible members in the calendar year (denominator) X 100.
- The Paid Claims Current Procedural Terminology (CPT) codes considered include 99406, 99407, 4004F – Tobacco Cessation Intervention Counselling, or 1036F – Current Tobacco non-user.
 - Included only members who are assigned or capitated to a PCP site.
 - Excluded members who are partial/full duals, wellness and recovery only members, newborns, Kaiser members, deceased members.
- **When were these datasets collected?**
 - Medical claims, MedImpact Pharmacy claims, State Pharmacy (Rx) claims, Caredon Healthcare Services claims, and membership data are from 2020.
 - For the purpose of this report, the data is reported from 2021-2025.

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.

- **Which datasets were used?**

SUD data was sourced from various datasets including:

- Medical claims, MedImpact Pharmacy claims, State Pharmacy (Rx) claims, Caredon Healthcare Services claims, Membership data, and DHCS claims

Note: for the purpose of serving our members, Partnership offers Behavioral Healthcare Services through contracts with Caredon Healthcare Services and so monitors these services as Caredon claims. Caredon divides SUD visits into the following categories:

- Therapy Service
- Medical Management
- Other, which includes visits that are neither for therapy or medical management

Utilization

Data Information

- **What do these measures mean?**

For Partnership healthcare service Utilization, places of service are defined by the [CMS Place of Service Code Set](#). Explanations of services and metrics follow:

Note: Rates per member per month -PMPM and per member per year -PMPY are calculated so Partnership members with any type of visit or diagnosis, in any service location and any county, rates can be compared in the same way per 1,000 Partnership members.

Medicated Assisted Treatment (MAT)

MAT services are licensed alcoholism and drug abuse recovery or treatment facilities and certified programs ensuring members have access to medications for the treatment of substance use disorders.

- **Member Count:** Unique Partnership member count utilizing Pharmacy Medication (Rx) services
- **MAT PMPM*1,000:** Rate calculated from the number of members utilizing MAT per Member per Month (member months) per 1,000 Partnership members.. MAT PMPM*1,000: $[\text{sum}(\text{MAT}) / \text{sum}(\text{member months})]$ per 1,000 Partnership members.

Emergency Department Visits

- **Member Count:** Unique count of Partnership members utilizing services
- **Utilizing Members:** Unique Members who have an ED visit claim in the Partnership medical claims dataset.
- **Visit Rate:** Total number of ED visits / Total Utilizing Members
- **Visit PMPY*1,000:** Rate calculated from the number of Visit Claims per Member per Year (12 months) per 1,000 Partnership Members.
- **Percent (%) Homeless:** Unique members who have an ED visit claim in the Partnership medical claims dataset, with physical address containing keywords indicating homelessness and claims data with diagnosis codes containing the following keywords: homeless, housing instability, inadequate housing, problems related to housing or living in residential institution.
- **Percent (%) Maternal:** Unique Pregnant Members and/or Mothers within a year after delivery who have an ED visit claim in the Partnership medical claims dataset.

Note: These include only Fee for Service and Capitated Members

Mental Health Services

Mental Health Service Provider claims sources include:

- o Medical claims
- o Carelon Healthcare Services claims
- o County Mental Health data
- o Pharmacy (Rx) claims

Each Mental health service provider source is assessed for the following indicators:

- o **Claims Count:** Distinct visit counts to mental health providers, defined as a distinct combination of member, service date, and provider.
- o **Utilizing Members:** Unique Members who utilize services from the Mental Health Service Provider claims sources
Note: From 2022, all pharmacy data (Carved In/Out) comes from Magellan datasets called Carved Out (excluding Carved In data).
- o **Utilizing Member Visit PMPY*1,000:** is the rate calculated from the number of Utilizing Member per Member per Year (12 months) per 1,000 Partnership Members. Utilizing Member PMPY*1,000: $[\text{sum}(\text{Utilizing Member}) / \text{sum}(\text{member months})] * 12$ per 1,000 Partnership members.

Behavioral Health Services

Partnership contracts with Carelon Behavioral Health to offer mild to moderate Behavioral Health services, and monitors them through Carelon claims.

- o **Utilizing Member Count:** Unique Members who utilize behavioral health services provided by Carelon.
- o **Penetration Rate (%):** DHCS treats penetration rate as the percentage of Medi-Cal Members utilizing Health services divided by the number of Medi-Cal eligible members for that county. Partnership defines the measure as a rolling sum of unique members in the first month of measurement period plus unique new members in each of the following months: The sum of (new members receiving service over the span of 12 months)/(member months) X 100.

Hospital Admissions: Acute Inpatient Utilization

- o **Acute Inpatient Utilization or Admissions:** Acute inpatient episodes include both acute and administrative days (prescheduled admissions) measures reported as “inpatient” over last two years look back. Transfers to a different facility during an episode are counted as two episodes. Episodes remain

active until a discharge date is received from any one of the data sources with evidence of the member receiving non-inpatient care after admission.

- o Episodes are excluded if:
 - The Length of Stay (LOS) is over 180 days.
 - Multiple active episodes for a member occur at the same time – only one episode is kept.
 - There are overlapping admission or discharge dates with other episodes of the same source or across data sources – only one episode is kept.
- o Note:
 - Data Sources are combined: Claims data. All have some gaps, but when combined we estimate accuracy to be 99%.
 - The majority of Medicare Part A and Kaiser members are counted under Kaiser.
- o **Length of Stay (LOS):** Also known as Hospital Length of Stay, LOS is the number of days between admission and discharge dates for completed episodes and between admission and the last ran date for ongoing episodes. These include admin days (scheduled admissions) and will be counted as a 1-day stay if less than 24 hours.
- o **Admits PMPM*1,000:** The rate calculated from the number of utilizing Members Admitted per Member per Month (member months) per 1,000 Partnership Members. Admits PMPM*1,000: $[\text{sum}(\text{Admits}) / \text{sum}(\text{member months})] \text{ per } 1,000 \text{ Partnership members.}$

Primary Care Provider (PCP)

- o PCP Office Visits are defined by applying the following criteria to Partnership medical claims data:
 - Places of service (Location Code defined by the [CMS Place of Service Code Set](#) is an Office Visit code. Classified as Office Visit in Medical Claim
 - Current Procedure Terminology (CPT) Code maintained by the [American Medical Association/American Academy of Professional Coders](#) includes Office Visit (i.e., 992, 993, 994, or CH01)
 - Treatment Type AA or AB (Office Visits)
- o **PCP Office Visit PMPY*1,000:** is the rate calculated from the number of Visit Claims per Member per Year (12 months) per 1,000 Partnership Members. PCP Office Visit PMPY*1,000: $[\text{sum}(\text{office visits}) / \text{sum}(\text{member months})] * 12 \text{ per } 1,000 \text{ Partnership members.}$
 - Note: Medicare Part A and Kaiser members are excluded.

Telehealth

- **Telehealth Visits** are defined by:
 - Location Code 02, 10 as defined by the [CMS Place of Service Code Set](#).
 - [CMS Telemedicine and Remote Monitoring](#)
 - Modifier Code 1: 'GQ', 'GT', '95', '93'
 - Procedure Code 1: '99451', 'G0071', 'G2012', '92250', '92227', '99444'
- **Percentage (%) of Telehealth (Primary Care Provider -PCP) Visits:**

$$\text{Number of Telehealth PCP Visits} / \text{Total number of PCP Visits} \times 100$$
- **Telehealth Visit PMPY*1,000:** is the rate calculated from the number of Telehealth Visit Claims per Member per Year (12 months) per 1,000 Partnership Members
- Telehealth Visit PMPY*1,000: $[\text{sum}(\text{Telehealth visits}) / \text{sum}(\text{member months})] \times 12$ per 1,000 Partnership members
- **When can we say these datasets were collected?**
 - Membership data from 2020
 - Medical claims
 - Emergency Department data from 2022
 - Carelon Healthcare Services claims from 2018
 - County Mental Health data from 2017
 - Pharmacy (Rx) claims from 2017
 - For the purpose of this report, the data is reported from 2021-2025

Note: In 2024, Partnership expanded from 14 to 24 counties, adding Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba. Data from the 10 expansion counties became available to Partnership in 2024-2025, so these years may appear larger than other years monitored.
- **Which datasets were used?**
 Substance Use Disorder data was sourced from various datasets including:
 - Membership data
 - Medical claims
 - Emergency Department data
 - Acute Inpatient Care (including PointClickCare/Collective Medi-Cal)
 - Carelon Healthcare Services claims
 - County Mental Health data
 - Pharmacy (Rx) claims

ACEs Screenings

Data Information

- **What do these measures mean?**

The Adverse Childhood Experiences (ACEs) screening tool is used to assess the likelihood of having increased risk of an adverse response to toxic stress, due to trauma experienced in the past from birth to 18 years old, such as abuse, neglect, or household dysfunction. Toxic stress can affect both physical and mental health, and manifest in violence, drug abuse, self-harm, and other issues.

Children under the age of 20 are usually assessed in various ways, and different methods attempt to reduce the risk of toxic stress by intervention, preventing adverse physical and mental health outcomes. Adults ages 20-64 are assessed less frequently to determine past exposures and tailor appropriate intervention.

For the purpose of this report, children are categorized as ages 0-18, while adults are categorized as age 19+. Both children and adults are allowed one billable ACEs screening assessment per year by Managed Health Plan providers.

- **Which datasets were used?**

Data is collected from Medical Claims using Healthcare Common Procedure Coding System (HCPCS) codes:

- o G9919 – Positive or High Risk (ACEs Screening Score 4 or greater)
- o G9920 – Negative or Low Risk (ACEs Screening Score 0-3)

Medical Claims (Amisys) and Membership Eligibility data used for ACEs Screenings exclude:

- o All Kaiser (in 2024, Kaiser became its own health plan), Medi-Medi, deceased, newborns, and Wellness & Recovery members.
- o All Caredon Healthcare Services ACEs Screenings are excluded from the data.
- o Membership data as of last record of eligibility on file in each year (i.e., December of each year).

Measures:

- Number of ACEs Screenings (Count)
- ACEs Screenings PMPY x 1,000: is the rate calculated from the number of ACEs Screening Claims per Member per Year (12 months) per 1,000 Partnership Members.

- ACEs Screening PMPY*1,000: [sum (ACEs Screening) / sum (member months)] * 12 per 1,000 Partnership members

ACEs Resources:

- <https://providerlibrary.healthnetcalifornia.com/medi-cal/provider-manual/adverse-childhood-experiences.html>
- www.cdc.gov/violenceprevention/aces/about.html
- Rariden C, SmithBattle L, Yoo JH, Cibulka N, Loman D. Screening for Adverse Childhood Experiences: Literature Review and Practice Implications. J Nurse Pract. 2021 Jan;17(1):98-104. doi: 10.1016/j.nurpra.2020.08.002. Epub 2020 Sep 18. PMID: 32963502; PMCID: PMC7498469.

Transportation Services

Data Information

- **What do these measures mean?**

Transportation is divided into:

- NMT: Non-Medical Transportation helps members who do not have any other way of getting to their appointments and back to their residence. NMT includes passenger cars, taxis, buses, trains, or other public transportation.
- NEMT: Non-Emergency Medical Transportation helps members who need door-to-door service – help with getting in and out of the home, vehicle, and medical office. NEMT may include non-emergency ambulances, gurney vans, wheelchair vans, or medical air transport.

Key Performance Indicators (KPI) follow standards set by [Centers for Medicare and Medicaid Services \(CMS\)](#) and [DHCS](#) for NMT and NEMT services booked and used by members, including:

- **Scheduled Trip:** The total of all trips that were placed in the scheduling system
- **Completed Trip:** Trip status of Completed, Assignment Exported
- **Non-Completed Trip:** Trip status of Requester Cancelled/Patient Cancelled, No Show, Provider Cancellation/Denied
- **Resolved Trip:** Trip status of Completed, Requester Cancelled, Patient Cancelled, No Show, Denied, Approval Denied, Assignment Exported
- **Unresolved Trip:** Trip status of Approval Pending, Assignment Accepted, Assignment Dispatched, Assignment Pending, En Route, Expired, Ready to Assign
- **Member Cancellation:** All Member Cancellation classifications are defined as user caused
- **Member No Show:** All Member No Show classifications are defined as user caused
- **Provider Cancellation:** All Provider Cancellation classifications are defined as provider caused

- **Date of Service** is defined as the Scheduled Trip Pick Up Date

Transportation measures are Key Performance Indicators (KPI):

- Number of Scheduled Trips
- Average Distance Traveled (miles)
- Average Duration of Trip (minutes)
- Median Distance Traveled (miles)
- Shortest Distance of Trip (miles)

- Longest Distance of Trip (miles)
- Percent (%) Completed Trip
- Percent (%) Member No Show
- Percent (%) Member Cancellation
- Percent (%) Provider Cancellation

The following Measures are also tracked in percentage (%) and rate:

- Percent (%) Utilizing Members: Number of unique Partnership members who schedule and complete trips within a given period (e.g., calendar year 2025).
Unique Members Completing Trip/Total Partnership Population X100
- Trip Rate PMPM per 1,000: NMT/NEMT services are also tracked per member per month (PMPM) per 1,000 Partnership Member: Completed Trips per Month/Total Partnership Population per Month per Month per 1,000 Partnership Members.

- **When were these datasets collected?**

- Transportation data collection began in June 2024. NMT/NEMT data is arranged in a monthly fashion. All trips scheduled will be counted as occurring on the NMT/NEMT data arranged at the monthly level, and all trips for the month will show as occurring on the first of each appropriate month.
- This report uses NMT/NEMT data reported from January to December 2025. Note: Data for the newer Partnership Counties (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, and Yuba) were only collected from 2024-2025, so these years may appear larger than other years monitored. In 2024, Partnership expanded its services from 14 to 24 counties.

- **Which datasets were used?**

- Transportation trip information is tracked by the Partnership Transportation Department
- Member and Trip details including demographics and eligibility by month come from datasets received from Kinetic Transportation Data
- Member Database

Health Disparities

Data Information

- **What do these measures mean?**

Partnership recently received the National Committee for Quality Assurance (NCQA) Health Equity Accreditation (HEA), June 2025. In order to continue to improve health disparities, certain Healthcare Effectiveness Data and Information Set (HEDIS®), Managed Care Accountability Set (MCAS) measures are selected by the Partnership Quality Improvement Health Equity Committee (QIHEC) which oversees the Quality Improvement and Health Equity Transformation Program (QIHETP), charged to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to Partnership members. Annual Performance Measures and Reports are submitted to the state DHCS for continued HEA.

Benchmarks and Targets are set by:

- MPL: means the minimum performance level (MPL) based on the NCQA's quality compass, 50th national Medicaid percentile. Measures can be -Below MPL- (below target)
- HPL: means the high performance level (HPL) based on the NCQA's quality compass 90th national Medicaid percentile. Measures can be -Above HPL- (above target)

HEDIS Measures Selected:

- Breast Cancer Screenings (BCS-E): The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
- Cervical Cancer Screening (CCS): The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:
 - Women 21–64 years of age who had cervical cytology performed within the last 3 years
 - Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years
 - Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years

- Diabetes Mellitus Poor Control (HbA1c poor control: A1c >9%) for Patients with Diabetes (HBD): The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed.
 - HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
- Controlling Blood Pressure (CBP): The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled.
- Well-Care Visits (WCV): The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
 - Total: The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.
 - Colorectal Cancer Screenings (COL-E) The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer from January 1- December 31 of the measurement year.
- **When were these datasets collected?**

Health Disparities is reported to DHCS via the MCAS data reports with data from the year before:

 - Measure Year (MY) is the data collection year (i.e., MY 2024)
 - Report Year (RY) (i.e., RY 2025)
- **Which datasets were used?**

Health Disparities are measured using HEDIS measures are from various DHCS claims datasets for data completeness purposes and to overcome limitations of data collected. Data collected could be divided into:

 - Administrative from DHCS Medical claims data ONLY
 - Hybrid from DHCS Medical claims data and Data Abstraction from case notes

Health Analytics Codes

Category	Codes	Other Notes
<u>Demographics</u>		
Homeless / House Insecure	ICD10 Codes: Z590, Z5900, Z5901, Z5902, Z591, Z593, Z598, Z59811, Z59812, Z59819, Z5989, Z599	
<u>Child Welfare</u>		
	Aid codes: 03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P3, 2R3, 2S3, 2T3, 2U3, 4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L	•Children under 21 years old who are currently receiving foster care •Children under 21 years old who received foster care within the last 12 months •Young Adults who are currently 18 - 26 years old and aged out of foster care after 18 years old
<u>Obstetric/Maternal Demography and Conditions</u>		
Deliveries	CPT Codes: 59400 59409 59410 59412 59414 59510 59514 59515 59610 59612 59614 59618 59620 59622 ICD10 Proc Codes: 10D00Z0 10D00Z1 10D00Z2 10D07Z3 10D07Z4 10D07Z5 10D07Z6 10D07Z7 10D07Z8 10E0XZZ 10D18Z9 Rev Codes: 0720 0721 0722 0724 0729 0112 0122 0132 0142 0152	
C-Section	ICD10 Codes: Z3801 Z3831 Z3862 Z3864 Z3866 Z3869 O82 O820 O821 O822 O828 O829 CPT Codes: 59510 59514 59515 59525 59618 59620 59622 ICD10 Proc Code: 10D00Z1 10D00Z0	
Doula	CPT Codes: 59409 59612 59620 59840 T1032 T1033 Z1032 Z1034 Z1038	Modifier for CPT codes: XP

Category	Codes	Other Notes
CPSC	CPT Codes: S0197 Z1032 Z6200 Z6202 Z6204 Z6206 Z6208 Z6300 Z6302 Z6304 Z6306 Z6308 Z6400 Z6402 Z6404 Z6406 Z6408 Z6410 Z6412 Z6414 Z6500	
Prenatal visits	ICD10 Codes: O0900 O0901 O0902 O0903 O0910 O0911 O0912 O0913 O09211 O09212 O09213 O09219 O09291 O09292 O09293 O09299 O0930 O0931 O0932 O0933 O0940 O0941 O0942 O0943 O09511 O09512 O09513 O09519 O09521 O09522 O09523 O09529 O09611 O09612 O09613 O09619 O09621 O09622 O09623 O09629 O0970 O0971 O0972 O0973 O09811 O09812 O09813 O09819 O09821 O09822 O09823 O09829 O09891 O09892 O09893 O09899 O0990 O0991 O0992 O0993 O09A0 O09A1 O09A2 O09A3 Z340 Z3400 Z3401 Z3402 Z3403 Z348 Z3480 Z3481 Z3482 Z3483 Z349 Z3490 Z3491 Z3492 Z3493 CPT Codes: 59400 59425 59426 59510 59610 S0197 Z1032 Z1034 Z1036 Z3436 Z6400 Z6500	
Postpartum visits	ICD10 Codes: Z391 Z392 CPT Codes: 0503F 59400 59430 59510 59610 59618 Z6208 Z6308 Z6414	
Chronic Conditions		
Anxiety	ICD10 Codes: F064 F4000 F4001 F4002 F4010 F4011 F40210 F40218 F40220 F40228 F40230 F40231 F40232 F40233 F40240 F40241 F40242 F40243 F40248 F40290 F40291 F40298 F408 F409 F410 F411 F413 F418 F419 F930 F938 F939 F940	
Bipolar Disorder	ICD10 Codes: F0633 F30 F301 F3010 F3011 F3012 F3013 F302 F303 F304 F308 F309 F31 F310 F311 F3110 F3111 F3112 F3113 F312 F313 F3130 F3131 F3132 F314 F315 F316 F3160 F3161 F3162 F3163 F3164 F317 F3170 F3171 F3172 F3173 F3174 F3175 F3176 F3177 F3178 F318 F3181 F3189 F319 F338 F3481 F3489 F349 F39 HIC3 Codes: H2M	
Schizophrenia	ICD10 Codes: F060 F061 F062 F20 F200 F201 F202 F203 F205 F208 F2081 F2089 F209 F21 F22 F23 F24 F25 F250 F251 F258 F259 F28 F29 F323 F333 F4489 HIC3 Codes: H2G H7O H7P H7T H7U H7X H8W	
Trauma & Stress	ICD10 Codes: F43 F430 F431 F4310 F4311 F4312 F432 F4320 F4321 F4322 F4323 F4324 F4325 F4329 F438 F439 F941 F942 F948 F949	
Asthma	ICD10 Codes: • Inclusion: J4521 J4522 J4530 J4531 J4532 J4540 J4541 J4542 J4550 J4551 J4552 J45901 J45902 J45909 J45990 J45991 J45998 • Exclusion: 27700 27701 27702 27703 27709 49120 49121 49122 4920 4928 49320 49321 49322 496 5181 5182 51881 E840 E8411 E8419 E848 E849 J430 J431 J432 J438 J439 J440 J441 J449 J9600 J9601 J9602 J9620 J9621 J9622 J982 J983 HIC3 Codes: A1B A1D J5A J5D Z2L Y7A Z2F Z4B J5G Z4E J5J Z2X B6M B6W B60 B6Y B6Z B61 Z20	

Category	Codes	Other Notes
Cancer	ICD10 Codes: 140 1400 1401 1403 1404 1405 1406 1408 1409 141 1410 1411 1412 1413 1414 1415 1416 1418 1419 142 1420 1421 1422 1428 1429 143 1430 1431 1438 1439 144 1440 1441 1448 1449 145 1450 1451 1452 1453 1454 1455 1456 1458 1459 146 1460 1461 1462 1463 1464 1465 1466 1467 1468 1469 147 1470 1471 1472 1473 1478 1479 148 1480 1481 1482 1483 1488 1489 149 1490 1491 1498 1499 150 1500 1501 1502 1503 1504 1505 1508 1509 151 1510 1511 1512 1513 1514 1515 1516 1518 1519 152 1520 1521 1522 1523 1528 1529 153 1530 1531 1532 1533 1534 1535 1536 1537 1538 1539 154 1540 1541 1542 1543 1548 155 1550 1551 1552 156 1560 1561 1562 1568 1569 157 1570 1571 1572 1573 1574 1578 1579 158 1580 1588 1589 159 1590 1591 1598 1599 160 1600 1601 1602 1603 1604 1605 1608 1609 161 1610 1611 1612 1613 1618 1619 162 1620 1622 1623 1624 1625 1628 1629 163 1630 1631 1638 1639 164 1640 1641 1642 1643 1648 1649 165 1650 1658 1659 170 1700 1701 1702 1703 1704 1705 1706 1707 1708 1709 171 1710 1712 1713 1714 1715 1716 1717 1718 1719 172 1720 1721 1722 1723 1724 1725 1726 1727 1728 1729 173 1730 17300 17301 17302 17309 1731 17310 17311 17312 17319 1732 17320 17321 17322 17329 1733 17330 17331 17332 17339 1734 17340 17341 17342 17349 1735 17350 17351 17352 17359 1736 17360 17361 17362 17369 1737 17370 17371 17372 17379 1738 17380 17381 17382 17389 1739 17390 17391 17392 17399 174 1740 1741 1742 1743 1744 1745 1746 1748 1749 175 1750 1759 176 1760 1761 1762 1763 1764 1765 1768 1769 179 180 1800 1801 1808 1809 181 182 1820 1821 1828 183 1830 1832 1833 1834 1835 1838 1839 184 1840 1841 1842 1843 1844 1848 1849 185 186 1860 1869 187 1871 1872 1873 1874 1875 1876 1877 1878 1879 188 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 189 1890 1891 1892 1893 1894 1898 1899 190 1900 1901 1902 1903 1904 1905 1906 1907 1908 1909 191 1910 1911 1912 1913 1914 1915 1916 1917 1918 1919 192 1920 1921 1922 1923 1928 1929 193 194 1940 1941 1943 1944 1945 1946 1948 1949 195 1950 1951 1952 1953 1954 1955 1958 196 1960 1961 1962 1963 1965 1966 1968 1969 197 1970 1971 1972 1973 1974 1975 1976 1977 1978 198 1980 1981 1982 1983 1984 1985 1986 1987 1988 19881 19882 19889 199 1990 1991 1992 200 2000 20000 20001 20002 20003 20004 20005 20006 20007 20008 2001 20010 20011 20012 20013 20014 20015 20016 20017 20018 2002 20020 20021 20022 20023 20024 20025 20026 20027 20028 2003 20030 20031 20032 20033 20034 20035 20036 20037 20038 2004 20040 20041 20042 20043 20044 20045 20046 20047 20048 2005 20050 20051 20052 20053 20054 20055 20056 20057 20058 2006 20060 20061 20062 20063 20064 20065 20066 20067 20068 2007 20070 20071 20072 20073 20074 20075 20076 20077 20078 2008 20080 20081 20082 20083 20084 20085 20086 20087 20088 201 2010 20100 20101 20102 20103 20104 20105 20106 20107 20108 2011 20110 20111 20112 20113 20114 20115 20116 20117 20118 2012 20120 20121 20122 20123 20124 20125 20126 20127 20128 2014 20140 20141 20142 20143 20144 20145 20146 20147 20148 2015 20150 20151 20152 20153 20154 20155 20156 20157 20158 2016 20160 20161 20162 20163 20164 20165 20166 20167 20168 2017 20170 20171 20172 20173 20174 20175 20176 20177 20178 2019 20190 20191 20192 20193 20194 20195 20196 20197 20198 202 2020 20200 20201 20202 20203 20204 20205 20206 20207 20208 2022 20220 20221 20222 20223 20224 20225 20226 20227 20228 2023 20230 20231 20232 20233 20234 20235 20236 20237 20238 2024 20240 20241 20242 20243 20244 20245 20246 20247 20248 2025 20250 20251 20252 20253 20254 20255 20256 20257 20258 2026 20260 20261 20262 20263 20264 20265 20266 20267 20268 2027 20270 20271 20272 20273 20274 20275 20276 20277 20278 2028 20280 20281 20282 20283 20284 20285 20286 20287 20288 2029 20290 20291 20292 20293 20294 20295 20296 20297 20298 203 2030 20300 20301 20302 2031 20310 20311 20312 2038 20380 20381 20382 204 2040 20400 20401 20402 2041 20410 20411	

Category	Codes	Other Notes
	20412 2042 20420 20421 20422 2048 20480 20481 20482 2049 20490 20491 20492 205 2050 20500 20501 20502 2051 20510 20511 20512 2052 20520 20521 20522 2053 20530 20531 20532 2058 20580 20581 20582 2059 20590 20591 20592 206 2060 20600 20601 20602 2061 20610 20611 20612 2062 20620 20621 20622 2068 20680 20681 20682 2069 20690 20691 20692 207 2070 20700 20701 20702 2071 20710 20711 20712 2072 20720 20721 20722 2078 20780 20781 20782 208 2080 20800 20801 20802 2081 20810 20811 20812 2082 20820 20821 20822 2088 20880 20881 20882 2089 20890 20891 20892 209 2090 20900 20901 20902 20903 2091 20910 20911 20912 20913 20914 20915 20916 20917 2092 20920 20921 20922 20923 20924 20925 20926 20927 20929 2093 20930 20931 20932 20933 20934 20935 20936 2097 20970 20971 20972 20973 20974 20975 20979 230 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 231 2310 2311 2312 2318 2319 232 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 233 2330 2331 2332 2333 23330 23331 23332 23339 2334 2335 2336 2337 2339 234 2340 2348 2349 25802 25803 28411 2853 3383 52801 78951 99981 C00 C000 C001 C002 C003 C004 C005 C006 C008 C009 C01 C02 C020 C021 C022 C023 C024 C028 C029 C03 C030 C031 C039 C04 C040 C041 C048 C049 C05 C050 C051 C052 C058 C059 C06 C060 C061 C062 C068 C0680 C0689 C069 C07 C08 C080 C081 C089 C09 C090 C091 C098 C099 C10 C100 C101 C102 C103 C104 C108 C109 C11 C110 C111 C112 C113 C118 C119 C12 C13 C130 C131 C132 C138 C139 C14 C140 C142 C148 C15 C153 C154 C155 C158 C159 C16 C160 C161 C162 C163 C164 C165 C166 C168 C169 C17 C170 C171 C172 C173 C178 C179 C18 C180 C181 C182 C183 C184 C185 C186 C187 C188 C189 C19 C20 C21 C210 C211 C212 C218 C22 C220 C221 C222 C223 C224 C227 C228 C229 C23 C24 C240 C241 C248 C249 C25 C250 C251 C252 C253 C254 C257 C258 C259 C26 C260 C261 C269 C30 C300 C301 C31 C310 C311 C312 C313 C318 C319 C32 C320 C321 C322 C323 C328 C329 C33 C34 C340 C3400 C3401 C3402 C341 C3410 C3411 C3412 C342 C343 C3430 C3431 C3432 C348 C3480 C3481 C3482 C349 C3490 C3491 C3492 C37 C38 C380 C381 C382 C383 C384 C388 C39 C390 C399 C40 C400 C4000 C4001 C4002 C401 C4010 C4011 C4012 C402 C4020 C4021 C4022 C403 C4030 C4031 C4032 C408 C4080 C4081 C4082 C409 C4090 C4091 C4092 C41 C410 C411 C412 C413 C414 C419 C43 C430 C431 C4310 C4311 C43111 C43112 C4312 C43121 C43122 C432 C4320 C4321 C4322 C433 C4330 C4331 C4339 C434 C435 C4351 C4352 C4359 C436 C4360 C4361 C4362 C437 C4370 C4371 C4372 C438 C439 C44 C440 C4400 C4401 C4402 C4409 C441 C4410 C44101 C44102 C441021 C441022 C44109 C441091 C441092 C4411 C44111 C44112 C441121 C441122 C44119 C441191 C441192 C4412 C44121 C44122 C441221 C441222 C44129 C441291 C441292 C44131 C441321 C441322 C441391 C441392 C4419 C44191 C44192 C441921 C441922 C44199 C441991 C441992 C442 C4420 C44201 C44202 C44209 C4421 C44211 C44212 C44219 C4422 C44221 C44222 C44229 C4429 C44291 C44292 C44299 C443 C4430 C44300 C44301 C44309 C4431 C44310 C44311 C44319 C4432 C44320 C44321 C44329 C4439 C44390 C44391 C44399 C444 C4440 C4441 C4442 C4449 C445 C4450 C44500 C44501 C44509 C4451 C44510 C44511 C44519 C4452 C44520 C44521 C44529 C4459 C44590 C44591 C44599 C446 C4460 C44601 C44602 C44609 C4461 C44611 C44612 C44619 C4462 C44621 C44622 C44629 C4469 C44691 C44692 C44699 C447 C4470 C44701 C44702 C44709 C4471 C44711 C44712 C44719 C4472 C44721 C44722 C44729 C4479 C44791 C44792 C44799 C448 C4480 C4481 C4482 C4489 C449 C4490 C4491 C4492 C4499 C45 C450 C451 C452 C457 C459 C46 C460 C461 C462 C463 C464 C465 C4650 C4651 C4652 C467 C469 C47 C470 C471 C4710 C4711 C4712 C472 C4720 C4721 C4722 C473 C474 C475 C476 C478 C479 C48 C480 C481 C482 C488 C49 C490 C491 C4910 C4911 C4912 C492 C4920 C4921 C4922 C493 C494 C495 C496	

Category	Codes	Other Notes
	C498 C499 C49A0 C49A1 C49A2 C49A3 C49A4 C49A5 C49A9 C4A C4A0 C4A1 C4A10 C4A11 C4A111 C4A112 C4A12 C4A121 C4A122 C4A2 C4A20 C4A21 C4A22 C4A3 C4A30 C4A31 C4A39 C4A4 C4A5 C4A51 C4A52 C4A59 C4A6 C4A60 C4A61 C4A62 C4A7 C4A70 C4A71 C4A72 C4A8 C4A9 C50 C500 C5001 C50011 C50012 C50019 C5002 C50021 C50022 C50029 C501 C5011 C50111 C50112 C50119 C5012 C50121 C50122 C50129 C502 C5021 C50211 C50212 C50219 C5022 C50221 C50222 C50229 C503 C5031 C50311 C50312 C50319 C5032 C50321 C50322 C50329 C504 C5041 C50411 C50412 C50419 C5042 C50421 C50422 C50429 C505 C5051 C50511 C50512 C50519 C5052 C50521 C50522 C50529 C506 C5061 C50611 C50612 C50619 C5062 C50621 C50622 C50629 C508 C5081 C50811 C50812 C50819 C5082 C50821 C50822 C50829 C509 C5091 C50911 C50912 C50919 C5092 C50921 C50922 C50929 C51 C510 C511 C512 C518 C519 C52 C53 C530 C531 C538 C539 C54 C540 C541 C542 C543 C548 C549 C55 C56 C561 C562 C569 C57 C570 C5700 C5701 C5702 C571 C5710 C5711 C5712 C572 C5720 C5721 C5722 C573 C574 C577 C578 C579 C58 C60 C600 C601 C602 C608 C609 C61 C62 C620 C6200 C6201 C6202 C621 C6210 C6211 C6212 C629 C6290 C6291 C6292 C63 C630 C6300 C6301 C6302 C631 C6310 C6311 C6312 C632 C637 C638 C639 C64 C641 C642 C649 C65 C651 C652 C659 C66 C661 C662 C669 C67 C670 C671 C672 C673 C674 C675 C676 C677 C678 C679 C68 C680 C681 C688 C689 C69 C690 C6900 C6901 C6902 C691 C6910 C6911 C6912 C692 C6920 C6921 C6922 C693 C6930 C6931 C6932 C694 C6940 C6941 C6942 C695 C6950 C6951 C6952 C696 C6960 C6961 C6962 C698 C6980 C6981 C6982 C699 C6990 C6991 C6992 C70 C700 C701 C709 C71 C710 C711 C712 C713 C714 C715 C716 C717 C718 C719 C72 C720 C721 C722 C7220 C7221 C7222 C723 C7230 C7231 C7232 C724 C7240 C7241 C7242 C725 C7250 C7259 C729 C73 C74 C740 C7400 C7401 C7402 C741 C7410 C7411 C7412 C749 C7490 C7491 C7492 C75 C750 C751 C752 C753 C754 C755 C758 C759 C76 C760 C761 C762 C763 C764 C7640 C7641 C7642 C765 C7650 C7651 C7652 C768 C77 C770 C771 C772 C773 C774 C775 C778 C779 C78 C780 C7800 C7801 C7802 C781 C782 C783 C7830 C7839 C784 C785 C786 C787 C788 C7880 C7889 C79 C790 C7900 C7901 C7902 C791 C7910 C7911 C7919 C792 C793 C7931 C7932 C794 C7940 C7949 C795 C7951 C7952 C796 C7960 C7961 C7962 C797 C7970 C7971 C7972 C798 C7981 C7982 C7989 C799 C7A C7A0 C7A00 C7A01 C7A010 C7A011 C7A012 C7A019 C7A02 C7A020 C7A021 C7A022 C7A023 C7A024 C7A025 C7A026 C7A029 C7A09 C7A090 C7A091 C7A092 C7A093 C7A094 C7A095 C7A096 C7A098 C7A1 C7A8 C7B C7B0 C7B00 C7B01 C7B02 C7B03 C7B04 C7B09 C7B1 C7B8 C80 C800 C801 C802 C81 C810 C8100 C8101 C8102 C8103 C8104 C8105 C8106 C8107 C8108 C8109 C811 C8110 C8111 C8112 C8113 C8114 C8115 C8116 C8117 C8118 C8119 C812 C8120 C8121 C8122 C8123 C8124 C8125 C8126 C8127 C8128 C8129 C813 C8130 C8131 C8132 C8133 C8134 C8135 C8136 C8137 C8138 C8139 C814 C8140 C8141 C8142 C8143 C8144 C8145 C8146 C8147 C8148 C8149 C817 C8170 C8171 C8172 C8173 C8174 C8175 C8176 C8177 C8178 C8179 C819 C8190 C8191 C8192 C8193 C8194 C8195 C8196 C8197 C8198 C8199 C82 C820 C8200 C8201 C8202 C8203 C8204 C8205 C8206 C8207 C8208 C8209 C821 C8210 C8211 C8212 C8213 C8214 C8215 C8216 C8217 C8218 C8219 C822 C8220 C8221 C8222 C8223 C8224 C8225 C8226 C8227 C8228 C8229 C823 C8230 C8231 C8232 C8233 C8234 C8235 C8236 C8237 C8238 C8239 C824 C8240 C8241 C8242 C8243 C8244 C8245 C8246 C8247 C8248 C8249 C825 C8250 C8251 C8252 C8253 C8254 C8255 C8256 C8257 C8258 C8259 C826 C8260 C8261 C8262 C8263 C8264 C8265 C8266 C8267 C8268 C8269 C828 C8280 C8281 C8282 C8283 C8284 C8285 C8286 C8287 C8288 C8289 C829 C8290 C8291 C8292 C8293 C8294 C8295 C8296 C8297 C8298 C8299 C83 C830 C8300 C8301 C8302	

Category	Codes	Other Notes
	C8303 C8304 C8305 C8306 C8307 C8308 C8309 C831 C8310 C8311 C8312 C8313 C8314 C8315 C8316 C8317 C8318 C8319 C833 C8330 C8331 C8332 C8333 C8334 C8335 C8336 C8337 C8338 C8339 C835 C8350 C8351 C8352 C8353 C8354 C8355 C8356 C8357 C8358 C8359 C837 C8370 C8371 C8372 C8373 C8374 C8375 C8376 C8377 C8378 C8379 C838 C8380 C8381 C8382 C8383 C8384 C8385 C8386 C8387 C8388 C8389 C839 C8390 C8391 C8392 C8393 C8394 C8395 C8396 C8397 C8398 C8399 C84 C840 C8400 C8401 C8402 C8403 C8404 C8405 C8406 C8407 C8408 C8409 C841 C8410 C8411 C8412 C8413 C8414 C8415 C8416 C8417 C8418 C8419 C844 C8440 C8441 C8442 C8443 C8444 C8445 C8446 C8447 C8448 C8449 C846 C8460 C8461 C8462 C8463 C8464 C8465 C8466 C8467 C8468 C8469 C847 C8470 C8471 C8472 C8473 C8474 C8475 C8476 C8477 C8478 C8479 C849 C8490 C8491 C8492 C8493 C8494 C8495 C8496 C8497 C8498 C8499 C84A C84A0 C84A1 C84A2 C84A3 C84A4 C84A5 C84A6 C84A7 C84A8 C84A9 C84Z C84Z0 C84Z1 C84Z2 C84Z3 C84Z4 C84Z5 C84Z6 C84Z7 C84Z8 C84Z9 C85 C851 C8510 C8511 C8512 C8513 C8514 C8515 C8516 C8517 C8518 C8519 C852 C8520 C8521 C8522 C8523 C8524 C8525 C8526 C8527 C8528 C8529 C858 C8580 C8581 C8582 C8583 C8584 C8585 C8586 C8587 C8588 C8589 C859 C8590 C8591 C8592 C8593 C8594 C8595 C8596 C8597 C8598 C8599 C86 C860 C861 C862 C863 C864 C865 C866 C88 C880 C882 C883 C884 C888 C889 C90 C900 C9000 C9001 C9002 C901 C9010 C9011 C9012 C902 C9020 C9021 C9022 C903 C9030 C9031 C9032 C91 C910 C9100 C9101 C9102 C911 C9110 C9111 C9112 C913 C9130 C9131 C9132 C914 C9140 C9141 C9142 C915 C9150 C9151 C9152 C916 C9160 C9161 C9162 C919 C9190 C9191 C9192 C91A C91A0 C91A1 C91A2 C91Z C91Z0 C91Z1 C91Z2 C92 C920 C9200 C9201 C9202 C921 C9210 C9211 C9212 C922 C9220 C9221 C9222 C923 C9230 C9231 C9232 C924 C9240 C9241 C9242 C925 C9250 C9251 C9252 C926 C9260 C9261 C9262 C929 C9290 C9291 C9292 C92A C92A0 C92A1 C92A2 C92Z C92Z0 C92Z1 C92Z2 C93 C930 C9300 C9301 C9302 C931 C9310 C9311 C9312 C933 C9330 C9331 C9332 C939 C9390 C9391 C9392 C93Z C93Z0 C93Z1 C93Z2 C94 C940 C9400 C9401 C9402 C942 C9420 C9421 C9422 C943 C9430 C9431 C9432 C944 C9440 C9441 C9442 C946 C948 C9480 C9481 C9482 C95 C950 C9500 C9501 C9502 C951 C9510 C9511 C9512 C959 C9590 C9591 C9592 C96 C960 C962 C9620 C9621 C9622 C9629 C964 C965 C966 C969 C96A C96Z D00 D000 D0000 D0001 D0002 D0003 D0004 D0005 D0006 D0007 D0008 D001 D002 D01 D010 D011 D012 D013 D014 D0140 D0149 D015 D017 D019 D02 D020 D021 D022 D0220 D0221 D0222 D023 D024 D03 D030 D031 D0310 D0311 D03111 D03112 D0312 D03121 D03122 D032 D0320 D0321 D0322 D033 D0330 D0339 D034 D035 D0351 D0352 D0359 D036 D0360 D0361 D0362 D037 D0370 D0371 D0372 D038 D039 D04 D040 D041 D0410 D0411 D04111 D04112 D0412 D04121 D04122 D042 D0420 D0421 D0422 D043 D0430 D0439 D044 D045 D046 D0460 D0461 D0462 D047 D0470 D0471 D0472 D048 D049 D05 D050 D0500 D0501 D0502 D051 D0510 D0511 D0512 D058 D0580 D0581 D0582 D059 D0590 D0591 D0592 D06 D060 D061 D067 D069 D07 D070 D071 D072 D073 D0730 D0739 D074 D075 D076 D0760 D0761 D0769 D09 D090 D091 D0910 D0919 D092 D0920 D0921 D0922 D093 D098 D099 D4701 D4702 D4709 D47Z2 D490 D491 D492 D493 D494 D495 D49519 D4959 D496 D497 D4981 D4989 D499 D61810 D6481 D701 E8792 E9331 G131 G731 G893 J910 K1231 M8500 R180 R530 T451 T451X T451X5 T451X5A T451X5D T451X6 T451X6A T451X6D T451X6S T80810 T80810A T80810D T80810S V073 V0739 V580 V581 V5811 V5812 V661 V662 V671 V672 Z510 Z511 Z5111 Z5112 HIC3 Codes: Q5N V1D V1E V1F V1K V1M V1O V1V V1Q V3A V3C V3E V3F V3L V3M V3U V3X V32 V37 V1W	

Category	Codes	Other Notes
Kidney Disease	ICD10 Codes: A1811 A5275 B520 C641 C642 C649 C689 D3000 D3001 D3002 D4100 D4101 D4102 D4110 D4111 D4112 D4120 D4121 D4122 D593 D5930 D5931 D5932 D5939 E0821 E0822 E0829 E0865 E0921 E0922 E0929 E1021 E1022 E1029 E1065 E1121 E1122 E1129 E1165 E1321 E1322 E1329 E748 E74810 E74818 E74819 E7489 I120 I1311 I132 I701 I722 K767 M1030 M10311 M10312 M10319 M10321 M10322 M10329 M10331 M10332 M10339 M10341 M10342 M10349 M10351 M10352 M10359 M10361 M10362 M10369 M10371 M10372 M10379 M1038 M1039 M3214 M3215 M3504 N000 N001 N002 N003 N004 N005 N006 N007 N008 N009 N00A N010 N011 N012 N013 N014 N015 N016 N017 N018 N019 N01A N020 N021 N022 N023 N024 N025 N026 N027 N028 N029 N02A N02B1 N02B2 N02B3 N02B4 N02B5 N02B6 N02B9 N030 N031 N032 N033 N034 N035 N036 N037 N038 N039 N03A N040 N041 N042 N0420 N0421 N0422 N0429 N043 N044 N045 N046 N047 N048 N049 N04A N050 N051 N052 N053 N054 N055 N056 N057 N058 N059 N05A N060 N061 N062 N0620 N0621 N0622 N0629 N063 N064 N065 N066 N067 N068 N069 N06A N070 N071 N072 N073 N074 N075 N076 N077 N078 N079 N07A N08 N131 N132 N1330 N1339 N140 N141 N1411 N1419 N142 N143 N144 N150 N158 N159 N16 N170 N171 N172 N178 N179 N181 N182 N183 N1830 N1831 N1832 N184 N185 N186 N189 N19 N250 N251 N2581 N2589 N259 N261 N269 Q6102 Q6111 Q6119 Q612 Q613 Q614 Q615 Q618 Q620 Q6210 Q6211 Q6212 Q622 Q6231 Q6232 Q6239 R944	
Liver Disease	ICD10 Codes: 06L20ZZ 06L23ZZ 06L24ZZ 06L30ZZ 06L33ZZ 06L34ZZ 0D9S30Z 0D9S3ZZ 0D9S40Z 0D9S4ZZ 0D9T30Z 0D9T3ZZ 0D9T40Z 0D9T4ZZ 0D9V30Z 0DL57DZ 0DL58DZ K700 K7010 K7011 K702 K7030 K7031 K7040 K7041 K709 K7111 K7200 K7201 K7210 K7211 K7290 K7291 K740 K741 K742 K743 K744 K745 K7460 K7469 K750 K751 K7581 K760 K761 K762 K763 K765 K766 K767 K7681 K7689 K769 K77 K8030 K8031 K8032 K8033 K8034 K8035 K8036 K8037 K830 R160 R162 Z4823 Z944	
Congestive Health Failure	ICD10 Codes: 4250 42511 42518 4252 4253 4254 4255 4257 4258 4259 4280 4281 42820 42821 42822 42823 42830 42831 42832 42833 42840 42841 42842 42843 4289 I0981 I110 I130 I132 I420 I421 I422 I423 I424 I425 I426 I427 I428 I429 I43 I501 I5020 I5021 I5022 I5023 I5030 I5031 I5032 I5033 I5040 I5041 I5042 I5043 I50810 I50811 I50812 I50813 I50814 I5082 I5083 I5084 I5089 I509	
Chronic Obstructive Pulmonary Disease (COPD)	ICD10 Codes: J410 J411 J418 J42 J430 J431 J432 J438 J439 J440 J441 J449 J470 J471 J479	
Coronary Artery Disease	ICD10 Codes: 0210083 0210088 0210089 021008C 021008F 021008W 0210093 0210098 0210099 021009C 021009F 021009W 02100A3 02100A8 02100A9 02100AC 02100AF 02100AW 02100J3 02100J8 02100J9 02100JC 02100JF 02100JW 02100K3 02100K8 02100K9 02100KC 02100KF 02100KW 02100Z3 02100Z8 02100Z9 02100ZC 02100ZF 0211083 0211088 0211089 021108C 021108F 021108W 0211093 0211098 0211099 021109C 021109F 021109W 02110A3 02110A8 02110A9 02110AC 02110AF 02110AW 02110J3 02110J8 02110J9 02110JC	Pharmacy Claims Data (Rx) use GenericName='CLOMIPHENE'

Category	Codes	Other Notes
	02110JF 02110JW 02110K3 02110K8 02110K9 02110KC 02110KF 02110KW 02110Z3 02110Z8 02110Z9 02110ZC 02110ZF 0212083 0212088 0212089 021208C 021208F 021208W 0212093 0212098 0212099 021209C 021209F 021209W 02120A3 02120A8 02120A9 02120AC 02120AF 02120AW 02120J3 02120J8 02120J9 02120JC 02120JF 02120JW 02120K3 02120K8 02120K9 02120KC 02120KF 02120KW 02120Z3 02120Z8 02120Z9 02120ZC 02120ZF 0213083 0213088 0213089 021308C 021308F 021308W 0213093 0213098 0213099 021309C 021309F 021309W 02130A3 02130A8 02130A9 02130AC 02130AF 02130AW 02130J3 02130J8 02130J9 02130JC 02130JF 02130JW 02130K3 02130K8 02130K9 02130KC 02130KF 02130KW 02130Z3 02130Z8 02130Z9 02130ZC 02130ZF 0270346 027034Z 0270356 027035Z 0270366 027036Z 0270376 027037Z 02703D6 02703DZ 02703E6 02703EZ 02703F6 02703FZ 02703G6 02703GZ 02703T6 02703TZ 02703Z6 02703ZZ 0270446 027044Z 0270456 027045Z 0270466 027046Z 0270476 027047Z 02704D6 02704DZ 02704E6 02704EZ 02704F6 02704FZ 02704G6 02704GZ 02704T6 02704TZ 02704Z6 02704ZZ 0271346 027134Z 0271356 027135Z 0271366 027136Z 0271376 027137Z 02713D6 02713DZ 02713E6 02713EZ 02713F6 02713FZ 02713G6 02713GZ 02713T6 02713TZ 02713Z6 02713ZZ 0271446 027144Z 0271456 027145Z 0271466 027146Z 0271476 027147Z 02714D6 02714DZ 02714E6 02714EZ 02714F6 02714FZ 02714G6 02714GZ 02714T6 02714TZ 02714Z6 02714ZZ 0272346 027234Z 0272356 027235Z 0272366 027236Z 0272376 027237Z 02723D6 02723DZ 02723E6 02723EZ 02723F6 02723FZ 02723G6 02723GZ 02723T6 02723TZ 02723Z6 02723ZZ 0272446 027244Z 0272456 027245Z 0272466 027246Z 0272476 027247Z 02724D6 02724DZ 02724E6 02724EZ 02724F6 02724FZ 02724G6 02724GZ 02724T6 02724TZ 02724Z6 02724ZZ 0273346 027334Z 0273356 027335Z 0273366 027336Z 0273376 027337Z 02733D6 02733DZ 02733E6 02733EZ 02733F6 02733FZ 02733G6 02733GZ 02733T6 02733TZ 02733Z6 02733ZZ 0273446 027344Z 0273456 027345Z 0273466 027346Z 0273476 027347Z 02734D6 02734DZ 02734E6 02734EZ 02734F6 02734FZ 02734G6 02734GZ 02734T6 02734TZ 02734Z6 02734ZZ I200 I202 I208 I2081 I2089 I209 I2101 I2102 I2109 I2111 I2119 I2121 I2129 I213 I214 I219 I21A1 I21A9 I21B I220 I221 I222 I228 I229 I230 I231 I232 I233 I234 I235 I236 I237 I238 I240 I248 I2481 I2489 I249 I2510 I25110 I25111 I25112 I25118 I25119 I255 I256 I25700 I25701 I25702 I25708 I25709 I25710 I25711 I25712 I25718 I25719 I25720 I25721 I25722 I25728 I25729 I25730 I25731 I25732 I25738 I25739 I25750 I25751 I25752 I25758 I25759 I25760 I25761 I25762 I25768 I25769 I25790 I25791 I25792 I25798 I25799 I25810 I25811 I25812 I2582 I2583 I2584 I2585 I2589 I259 I6320 I63211 I63212 I63213 I63219 I6322 I63231 I63232 I63233 I63239 I6329 I6350 I63511 I63512 I63513 I63519 I63521 I63522 I63523 I63529 I63531 I63532 I63533 I63539 I63541 I63542 I63543 I63549 I6359 I6501 I6502 I6503 I6509 I651 I6521 I6522 I6523 I6529 I658 I659 I6601 I6602 I6603 I6609 I6611 I6612 I6613 I6619 I6621 I6622 I6623 I6629 I663 I668 I669 I672 I701 I70201 I70202 I70203 I70208 I70209 I70211 I70212 I70213 I70218 I70219 I70221 I70222 I70223 I70228 I70229 I70231 I70232 I70233 I70234 I70235 I70238 I70239 I70241 I70242 I70243 I70244 I70245 I70248 I70249 I7025 I70261 I70262 I70263 I70268 I70269 I70291 I70292 I70293 I70298 I70299 I70301 I70302 I70303 I70308 I70309 I70311 I70312 I70313 I70318 I70319 I70321 I70322 I70323 I70328 I70329 I70331 I70332 I70333 I70334 I70335 I70338 I70339 I70341 I70342 I70343 I70344 I70345 I70348 I70349 I7035 I70361 I70362 I70363 I70368 I70369 I70391 I70392 I70393 I70398 I70399 I70401 I70402 I70403 I70408 I70409 I70411 I70412 I70413 I70418 I70419 I70421 I70422 I70423 I70428 I70429 I70431 I70432 I70433 I70434 I70435 I70438 I70439 I70441 I70442 I70443 I70444 I70445 I70448 I70449 I7045 I70461 I70462 I70463 I70468 I70469 I70491 I70492 I70493 I70498 I70499 I70501 I70502 I70503 I70508 I70509 I70511 I70512 I70513 I70518 I70519 I70521 I70522 I70523 I70528 I70529	CITRATE' for those with Coronary Disease

Category	Codes	Other Notes
	I70531 I70532 I70533 I70534 I70535 I70538 I70539 I70541 I70542 I70543 I70544 I70545 I70548 I70549 I7055 I70561 I70562 I70563 I70568 I70569 I70591 I70592 I70593 I70598 I70599 I70601 I70602 I70603 I70608 I70609 I70611 I70612 I70613 I70618 I70619 I70621 I70622 I70623 I70628 I70629 I70631 I70632 I70633 I70634 I70635 I70638 I70639 I70641 I70642 I70643 I70644 I70645 I70648 I70649 I7065 I70661 I70662 I70663 I70668 I70669 I70691 I70692 I70693 I70698 I70699 I70701 I70702 I70703 I70708 I70709 I70711 I70712 I70713 I70718 I70719 I70721 I70722 I70723 I70728 I70729 I70731 I70732 I70733 I70734 I70735 I70738 I70739 I70741 I70742 I70743 I70744 I70745 I70748 I70749 I7075 I70761 I70762 I70763 I70768 I70769 I70791 I70792 I70793 I70798 I70799 I7092 I75011 I75012 I75013 I75019 I75021 I75022 I75023 I75029 I7581 I7589 T82855A T82855D T82855S T82856A T82856D T82856S CPT Codes: 33510 33511 33512 33513 33514 33516 33517 33518 33519 33521 33522 33523 33530 33533 33534 33535 33536 37220 37221 37224 37225 37226 37227 37228 37229 37230 37231 92920 92924 92928 92933 92937 92941 92943 HCPCS Codes: C9600 C9602 C9604 C9606 C9607 S2205 S2206 S2207 S2208 S2209 S4015 S4016 S4018 S4020 S4021 PCS Codes (hosp): 0210083 0210088 0210089 021008C 021008F 021008W 0210093 0210098 0210099 021009C 021009F 021009W 02100A3 02100A8 02100A9 02100AC 02100AF 02100AW 02100J3 02100J8 02100J9 02100JC 02100JF 02100JW 02100K3 02100K8 02100K9 02100KC 02100KF 02100KW 02100Z3 02100Z8 02100Z9 02100ZC 02100ZF 0211083 0211088 0211089 021108C 021108F 021108W 0211093 0211098 0211099 021109C 021109F 021109W 02110A3 02110A8 02110A9 02110AC 02110AF 02110AW 02110J3 02110J8 02110J9 02110JC 02110JF 02110JW 02110K3 02110K8 02110K9 02110KC 02110KF 02110KW 02110Z3 02110Z8 02110Z9 02110ZC 02110ZF 0212083 0212088 0212089 021208C 021208F 021208W 0212093 0212098 0212099 021209C 021209F 021209W 02120A3 02120A8 02120A9 02120AC 02120AF 02120AW 02120J3 02120J8 02120J9 02120JC 02120JF 02120JW 02120K3 02120K8 02120K9 02120KC 02120KF 02120KW 02120Z3 02120Z8 02120Z9 02120ZC 02120ZF 0213083 0213088 0213089 021308C 021308F 021308W 0213093 0213098 0213099 021309C 021309F 021309W 02130A3 02130A8 02130A9 02130AC 02130AF 02130AW 02130J3 02130J8 02130J9 02130JC 02130JF 02130JW 02130K3 02130K8 02130K9 02130KC 02130KF 02130KW 02130Z3 02130Z8 02130Z9 02130ZC 02130ZF 0270346 027034Z 0270356 027035Z 0270366 027036Z 0270376 027037Z 02703D6 02703DZ 02703E6 02703EZ 02703F6 02703FZ 02703G6 02703GZ 02703T6 02703TZ 02703Z6 02703ZZ 0270446 027044Z 0270456 027045Z 0270466 027046Z 0270476 027047Z 02704D6 02704DZ 02704E6 02704EZ 02704F6 02704FZ 02704G6 02704GZ 02704T6 02704TZ 02704Z6 02704ZZ 0271346 027134Z 0271356 027135Z 0271366 027136Z 0271376 027137Z 02713D6 02713DZ 02713E6 02713EZ 02713F6 02713FZ 02713G6 02713GZ 02713T6 02713TZ 02713Z6 02713ZZ 0271446 027144Z 0271456 027145Z 0271466 027146Z 0271476 027147Z 02714D6 02714DZ 02714E6 02714EZ 02714F6 02714FZ 02714G6 02714GZ 02714T6 02714TZ 02714Z6 02714ZZ 0272346 027234Z 0272356 027235Z 0272366 027236Z 0272376 027237Z 02723D6 02723DZ 02723E6 02723EZ 02723F6 02723FZ 02723G6 02723GZ 02723T6 02723TZ 02723Z6 02723ZZ 0272446 027244Z 0272456 027245Z 0272466 027246Z 0272476 027247Z 02724D6 02724DZ 02724E6 02724EZ 02724F6 02724FZ 02724G6 02724GZ 02724T6 02724TZ 02724Z6 02724ZZ 0273346 027334Z 0273356 027335Z 0273366 027336Z 0273376 027337Z 02733D6 02733DZ 02733E6 02733EZ 02733F6 02733FZ 02733G6 02733GZ 02733T6 02733TZ 02733Z6 02733ZZ 0273446	

Category	Codes	Other Notes
	027344Z 0273456 027345Z 0273466 027346Z 0273476 027347Z 02734D6 02734DZ 02734E6 02734EZ 02734F6 02734FZ 02734G6 02734GZ 02734T6 02734TZ 02734Z6 02734ZZ	
Diabetes Melius	ICD10 Codes: E1010 E1011 E1021 E1022 E1029 E10311 E10319 E10321 E103211 E103212 E103213 E103219 E10329 E103291 E103292 E103293 E103299 E10331 E103311 E103312 E103313 E103319 E10339 E103391 E103392 E103393 E103399 E10341 E103411 E103412 E103413 E103419 E10349 E103491 E103492 E103493 E103499 E10351 E103511 E103512 E103513 E103519 E103521 E103522 E103523 E103529 E103531 E103532 E103533 E103539 E103541 E103542 E103543 E103549 E103551 E103552 E103553 E103559 E10359 E103591 E103592 E103593 E103599 E1036 E1037X1 E1037X2 E1037X3 E1037X9 E1039 E1040 E1041 E1042 E1043 E1044 E1049 E1051 E1052 E1059 E10610 E10618 E10620 E10621 E10622 E10628 E10630 E10638 E10641 E10649 E1065 E1069 E108 E109 E1100 E1101 E1110 E1111 E1121 E1122 E1129 E11311 E11319 E11321 E113211 E113212 E113213 E113219 E11329 E113291 E113292 E113293 E113299 E11331 E113311 E113312 E113313 E113319 E11339 E113391 E113392 E113393 E113399 E11341 E113411 E113412 E113413 E113419 E11349 E113491 E113492 E113493 E113499 E11351 E113511 E113512 E113513 E113519 E113521 E113522 E113523 E113529 E113531 E113532 E113533 E113539 E113541 E113542 E113543 E113549 E113551 E113552 E113553 E113559 E11359 E113591 E113592 E113593 E113599 E1136 E1137X1 E1137X2 E1137X3 E1137X9 E1139 E1140 E1141 E1142 E1143 E1144 E1149 E1151 E1152 E1159 E11610 E11618 E11620 E11621 E11622 E11628 E11630 E11638 E11641 E11649 E1165 E1169 E118 E119 E1300 E1301 E1310 E1311 E1321 E1322 E1329 E13311 E13319 E13321 E133211 E133212 E133213 E133219 E13329 E133291 E133292 E133293 E133299 E13331 E133311 E133312 E133313 E133319 E13339 E133391 E133392 E133393 E133399 E13341 E133411 E133412 E133413 E133419 E13349 E133491 E133492 E133493 E133499 E13351 E133511 E133512 E133513 E133519 E133521 E133522 E133523 E133529 E133531 E133532 E133533 E133539 E133541 E133542 E133543 E133549 E133551 E133552 E133553 E133559 E13359 E133591 E133592 E133593 E133599 E1336 E1337X1 E1337X2 E1337X3 E1337X9 E1339 E1340 E1341 E1342 E1343 E1344 E1349 E1351 E1352 E1359 E13610 E13618 E13620 E13621 E13622 E13628 E13630 E13638 E13641 E13649 E1365 E1369 E138 E139 O24011 O24012 O24013 O24019 O2402 O2403 O24111 O24112 O24113 O24119 O2412 O2413 O24311 O24312 O24313 O24319 O2432 O2433 O24811 O24812 O24813 O24819 O2482 O2483 CPT Codes: 90791 90792 90832 90834 90837 97110 97112 97113 97124 97140 97161 97162 97163 97164 98925 98926 98927 98928 98929 98940 98941 98942 98960 98961 98962 98966 98967 98968 98970 98971 98972 98980 98981 99078 99202 99203 99204 99205 99211 99212 99213 99214 99215 99221 99222 99223 99231 99232 99233 99234 99235 99236 99238 99239 99241 99242 99243 99244 99245 99251 99252 99253 99254 99255 99281 99282 99283 99284 99285 99291 99304 99305 99306 99307 99308 99309 99310 99315 99316 99341 99342 99343 99344 99345 99347 99348 99349 99350 99381 99382 99383 99384 99385 99386 99387 99391 99392 99393 99394 99395 99396 99397 99401 99402 99403 99404 99411 99412 99421 99422 99423 99429 99441 99442 99443 99455 99456 99457 99458 99483 99492 99493 99494 99510 NDC Codes: 00002143301 00002143380 00002143401 00002143480 00002751001 00002751017 00002751101 00002751201 00002751601 00002751659 00002771227 00002771401 00002771459 00002771501 00002771559 00002821501 00002821517 00002821591 00002831501 00002831517 00002831591 00002850101 00002871501 00002871517 00002871591 00002872501 00002872559 00002873001 00002873059 00002877001 00002877059	

Category	Codes	Other Notes
	00002879301 00002879359 00002879401 00002879459 00002879701 00002879759 00002879801 00002879859 00002879901 00002879959 00002880301 00002880359 00002880501 00002880559 00002882427 00002951501 00003142711 00003142811 00003421411 00003421421 00003421511 00003421521 00003421531 00003421541 00003422111 00003422216 00003422311 00006007861 00006007862 00006007882 00006008061 00006008062 00006008082 00006008131 00006008154 00006008182 00006011201 00006011228 00006011231 00006011254 00006022101 00006022128 00006022131 00006022154 00006027701 00006027702 00006027728 00006027731 00006027733 00006027754 00006027774 00006027782 00006053331 00006053354 00006053531 00006053554 00006053731 00006053754 00006057552 00006057561 00006057562 00006057582 00006057761 00006057762 00006057782 00006075331 00006075354 00006075382 00006075731 00006075754 00006075782 00006077331 00006077354 00006077382 00007314813 00007314913 00007315113 00007315213 00007315313 00007316318 00007316418 00007316718 00007316818 00009034101 00009035201 00009035204 00009344901 00009344903 00009501201 00009501301 00009501401 00024586901 00024586903 00024587102 00024587490 00024588236 00024588463 00024589463 00024592410 00024592505 00026286148 00026286151 00026286251 00026286351 00029315818 00029315900 00029315913 00029316013 00029316059 00039005110 00039005150 00039005210 00039005250 00039005270 00039005305 00039022110 00039022210 00039022211 00039022310 00039022311 00049017001 00049017402 00049017403 00049017807 00049017808 00049155066 00049155073 00049156066 00049156073 00049162030 00049411066 00049412066 00054014025 00054014120 00054014125 00054014225 00078035105 00078035205 00087607211 00087607311 00087607411 00087607731 00087607831 00087608131 00088221905 00088222033 00088222052 00088222060 00088250033 00088250052 00088250205 00088502005 00088502101 00093204605 00093204656 00093204698 00093204705 00093204756 00093204798 00093204805 00093204856 00093204898 00093504906 00093504986 00093505006 00093505086 00093571001 00093571005 00093571019 00093571093 00093571101 00093571105 00093571119 00093571193 00093571201 00093571205 00093571219 00093571293 00093725401 00093725501 00093725601 00093725652 00093727105 00093727156 00093727198 00093727205 00093727256 00093727298 00093727305 00093727356 00093727398 00093745501 00093745601 00093745701 00093767706 00093767786 00093767806 00093767886 00093803401 00093803501 00093803505 00093803601 00093834201 00093834301 00093834305 00093834310 00093834398 00093834401 00093834405 00093834410 00093834419 00093834493 00093834498 00093936401 00093936405 00093936410 00093943301 00093943305 00093947753 00115115001 00115115002 00115115101 00115115102 00115115201 00115115202 00115164801 00115164901 00115164902 00115165001 00115165002 00143991801 00143991901 00143991905 00143992001 00143992005 00143992010 00169001771 00169008181 00169008183 00169008281 00169008283 00169008481 00169008483 00169009201 00169009301 00169183302 00169183311 00169183317 00169183402 00169183411 00169183417 00169183418 00169183702 00169183711 00169183717 00169183718 00169231321 00169231421 00169231721 00169255013 00169266015 00169280013 00169280015 00169320111 00169320415 00169330312 00169347318 00169347418 00169347718 00169368213 00169368512 00169368712 00169369619 00169406012 00169406013 00169633810 00169633910 00169643810 00169643897 00169643910 00169750111 00172364900 00172364910 00172364960 00172365000 00172365010 00172365060 00172365070 00172571060 00173083418 00173083513 00173083613 00173083718 00173083818 00173083918 00173084018 00173084113 00173084213 00173084313 00173084413 00173084513 00173086118 00173086313 00173086413	

Category	Codes	Other Notes
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Category	Codes	Other Notes
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Category	Codes	Other Notes
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Category	Codes	Other Notes
	55111069610 55111069701 55111069710 55289006690 55289006697 55289012530 55289017142 55289018797 55289026590 55289028130 55289028160 55289028186 55289028190 55289030190 55289030193 55289042430 55289054030 55289060630 55289060690 55289077907 55289080614 55289080630 55289080660 55289080686 55289080690 55289080693 55289086215 55289086230 55289089201 55289089214 55289089215 55289089230 55289089260 55289089286 55289089290 55289089293 55289089297 55289089298 55289093830 55289097601 55289097614 55289097630 55289097660 55289097690 55289097693 55887006230 55887006330 55887010030 55887017330 55887017990 55887021290 55887022230 55887027330 55887033930 55887033960 55887033990 55887036896 55887053501 55887053530 55887053560 55887053590 55887053660 55887053690 55887064630 55887064660 55887064690 55887065730 55887065760 55887069301 55887069330 55887069360 55887069390 55887072701 55887072730 55887072760 55887084530 55887084560 55887096530 57237002001 57237002101 57237002105 57237002199 57237002201 57237002205 57237002299 57237002301 57237002305 57237002401 57237002405 57237002501 57237002505 57237015701 57237015801 57237015901 57237021760 57237021781 57237021860 57237021881 57237021905 57237021930 57237022005 57237022030 57237022105 57237022130 57237022190 57664039813 57664039818 57664039888 57664039913 57664039918 57664039988 57664068488 57664068588 57664068688 57664072488 57664072588 57664072788 57664074513 57664074588 57664074713 57664074788 57866640901 57866640902 57866640903 57866640904 57866640905 57866640906 57866646201 57866646202 57866646301 57866646302 57866707301 57866707302 57866707401 57866707402 58016000500 58016000530 58016000560 58016000590 58016005800 58016005830 58016005860 58016005890 58016008100 58016008130 58016008160 58016008190 58016008200 58016008230 58016008260 58016008290 58016033400 58016033402 58016033430 58016033460 58016033490 58016037030 58016037600 58016037602 58016037630 58016037660 58016037690 58016037699 58016037800 58016037802 58016037830 58016037860 58016037890 58016037899 58016041100 58016041102 58016041130 58016041160 58016041190 58016046700 58016046730 58016046760 58016046790 58016084400 58016084430 58016084460 58016084490 58016087600 58016087610 58016087612 58016087614 58016087615 58016087620 58016087621 58016087624 58016087628 58016087630 58016087640 58016087650 58016087660 58016478801 58864002714 58864002790 58864016130 58864022460 58864022493 58864067014 58864067030 58864068730 58864068760 58864068930 58864068960 58864070530 58864074515 58864074530 58864085830 58864086230 58864095230 58864095330 58864095630 58864095730 59060183302 59060183402 59060183702 59060231704 59762054001 59762054101 59762054102 59762054201 59762054202 59762233007 59762233106 59762233108 59762233206 59762233208 59762372706 59762372707 59762503101 59762503201 59762503202 59762503301 59762503302 59762702009 59762702105 59762702109 59762702205 59762702209 60429043401 60429043501 60429048401 60429048501 60429048601 60429091801 60429091901 60429092001 60505014100 60505014101 60505014102 60505014108 60505014200 60505014201 60505014202 60505014204 60846088201 60846088401 61392006345 61392006354 61392006391 61392006445 61392006451 61392006454 61392006491 61392011730 61392011731 61392011732 61392011739 61392011745 61392011751 61392011754 61392011760 61392011790 61392011791 61392011930 61392011931 61392011932 61392011939 61392011945 61392011951 61392011954 61392011960 61392011990 61392011991 61392012045 61392012051 61392012054 61392012091 61442011501 61442011505 61442011601 61442011605 61442011701 61442011705 62037087201 62037087205 62037087301 62037087305 62682500403 62682500408 62682500603	

Category	Codes	Other Notes
	63304025430 63304025490 63304025505 63304025530 63304025590 63304026130 63304026190 63304031105 63304031130 63304031190 63304031205 63304031230 63304031290 63304031305 63304031330 63304031390 63304042501 63304042601 63304042701 63629125501 63629125502 63629139201 63629139202 63629139203 63629139301 63629139302 63629139303 63629139401 63629139402 63629139403 63629139801 63629139802 63629139803 63629279301 63629279302 63629279303 63629279304 63629290701 63629290702 63629304301 63629304302 63629315801 63629315802 63629315803 63739011610 63739011910 63874031601 63874031602 63874031604 63874031605 63874031610 63874031612 63874031614 63874031615 63874031620 63874031621 63874031624 63874031628 63874031630 63874031650 63874031660 63874031681 63874031690 63874031701 63874031702 63874031704 63874031710 63874031712 63874031714 63874031715 63874031720 63874031724 63874031728 63874031730 63874031740 63874031750 63874031760 63874031790 63874043201 63874043202 63874043204 63874043210 63874043214 63874043220 63874043221 63874043224 63874043228 63874043230 63874043250 63874043260 63874043281 63874043290 63874051001 63874051010 63874051030 63874051090 63874058801 63874058804 63874058810 63874058814 63874058820 63874058830 63874058860 63874058880 63874058890 63874066501 63874066504 63874066510 63874066514 63874066530 63874066560 63874066590 63874093901 63874093910 63874093930 63874093960 64380075806 64380075906 64380076006 64720012310 64720012410 64720012411 64720012510 64720012511 64720014010 64720014050 64720014110 64720014150 64720014210 64720014250 64764012103 64764012303 64764012403 64764012530 64764015104 64764015105 64764015106 64764015518 64764015560 64764015818 64764015860 64764025030 64764025103 64764025303 64764025403 64764030114 64764030115 64764030116 64764030230 64764030430 64764031030 64764033560 64764033760 64764045124 64764045125 64764045126 64764051030 64764062530 64980027903 64980028001 64980028101 65862002801 65862002901 65862002905 65862003001 65862003099 65862008001 65862008005 65862008101 65862008105 65862008201 65862008205 65862051230 65862051330 65862051430 65862052518 65862052560 65862052618 65862052660 65862067001 65862067101 65862067201 65862088830 65862088901 65862088905 65862089001 66105014501 66105014503 66105014506 66105014509 66105014515 66105014603 66105015901 66105015903 66105015906 66105015909 66105015915 66105065203 66105098403 66105098406 66105098410 66105098411 66105098450 66105098503 66105098506 66105098510 66105098511 66105098550 66105098603 66105098606 66105098610 66105098611 66105098650 66143751005 66267010030 66267010060 66267010330 66336002830 66336026930 66336031930 66336057330 66336066230 66336066260 66336073030 66336073060 66336078430 66336093830 66336093860 66780011001 66780011502 66780012102 66780021007 66780021008 66780021201 66780021901 66780021902 66780021904 66780022601 66789021902 66993016202 66993016302 66993016402 66993082130 66993082230 67046023530 67046024030 67046024060 67251046011 67251046050 67253046010 67253046011 67253046050 67253046110 67253046111 67253046150 67253046210 67253046211 67253046250 67544029670 67544041770 67544051170 67544051194 67544065353 67544065380 67544066141 67544080860 68001017700 68001017703 68001017800 68001017803 68001017900 68001017903 68084011101 68084011111 68084011201 68084011211 68084013601 68084013611 68084013701 68084013711 68084013801 68084013811 68084029511 68084029521 68084032601 68084032611 68084032701 68084032711 68084045811 68084045821 68084045911 68084045921 68084062901 68084062911 68084063001 68084063011 68084063101 68084063111 68084064901 68084065201 68084066001 68084074525 68084078821 68084078825	

Category	Codes	Other Notes
	68084078895 68084080701 68084087801 68084087811 68084095425 68084095495 68084096725 68084096795 68115015490 68115015630 68115015730 68115015830 68115015930 68115015960 68115016090 68115016190 68180049001 68180049101 68382018401 68382018501 68382018601 68382065301 68382065305 68382065401 68382065405 68382065501 68382065505 68382065601 68382065701 68382065705 68382065801 68382065805 68382065810 68382072116 68382072216 68645015054 68645015159 68645021054 68645021154 69452012820 69452012830 69452012920 69452012930 69452013020 69452013030 69543012010 69543012011 69543012110 69543012111 69543012210 69543012211 69543012310 69543012350 69543012410 69543012450 69543012510 69543012550 70882010556 76439012010 76439012011 76439012110 76439012111 76439012210 76439012211 76439012310 76439012410 76439012510 Lab Proc Codes: 83036 83037 3044F 3045F 30451F 30452F 3046F LOINC Codes: 17856-6 4548-4 4549-2	
Hypertension	ICD10 Codes: I10 I119 I129 I1310 I160 I161 I169	
Traumatic Brain Injury	ICD10 Codes: F43 F430 F431 F4310 F4311 F4312 F432 F4320 F4321 F4322 F4323 F4324 F4325 F4329 F438 F439 F941 F942 F948 F949	
Dental		
Prevention and Early Detection (Diagnostic and Preventive)	ICD10 Codes: K023 K0251 K0261 K036 K0500 K0501 K051 K0510 K0511 Z012 Z0120 Z0121 Z293 Z299 Z98810 CPT Codes: 99188 CDT Codes: D0100-D0999, D1000-D1999	
Treatment & Intervention (Restorative and Specialized)	CDT Codes: D2000-D2999, D3000-D8999	
Support / Other (Uncategorized and Adjunct. General)	ICD10 Codes: 00003; T1015 CDT Codes: D9000-D9999	

Category	Codes	Other Notes
Substance Use Disorder (by Diagnosis)		
Alcohol	ICD10 Codes: E244,F10,F101,F1010,F1011,F1012,F10120,F10121,F10129,F10130,F10131,F10132,F10139,F1014,F1015,F10150,F10151,F10159,F1018,F10180,F10181,F10182,F10188,F1019,F102,F1020,F1021,F1022,F10220,F10221,F10229,F1023,F10230,F10231,F10232,F10239,F1024,F1025,F10250,F10251,F10259,F1026,F1027,F1028,F10280,F10281,F10282,F10288,F1029,F109,F1090,F1091,F1092,F10920,F10921,F10929,F10930,F10931,F10932,F10939,F1094,F1095,F10950,F10951,F10959,F1096,F1097,F1098,F10980,F10981,F10982,F10988,F1099,G312,G621,G721,I426,K292,K	
Opioids	ICD10 Codes: F11,F111,F1110,F1111,F1112,F11120,F11121,F11122,F11129,F1113,F1114,F1115,F11150,F11151,F11159,F1118,F11181,F11182,F11188,F1119,F112,F1120,F1121,F1122,F11220,F11221,F11222,F11229,F1123,F1124,F1125,F11250,F11251,F11259,F1128,F11281,F11282,F11288,F1129,F119,F1190,F1191,F1192,F11920,F11921,F11922,F11929,F1193,F1194,F1195,F11950,F11951,F11959,F1198,F11981,F11982,F11988,F1199,R781,T400,T400X,T400X1,T400X1A,T400X1D,T400X1S,T400X2,T400X2A,T400X2D,T400X2S,T400X3,T400X3A,T400X3D,T400X3S,T400X4,T400X4A,T40	
Stimulants	ICD10 Codes: F14,F141,F1410,F1411,F1412,F14120,F14121,F14122,F14129,F1413,F1414,F1415,F14150,F14151,F14159,F1418,F14180,F14181,F14182,F14188,F1419,F142,F1420,F1421,F1422,F14220,F14221,F14222,F14229,F1423,F1424,F1425,F14250,F14251,F14259,F1428,F14280,F14281,F14282,F14288,F1429,F149,F1490,F1491,F1492,F14920,F14921,F14922,F14929,F1493,F1494,F1495,F14950,F14951,F14959,F1498,F14980,F14981,F14982,F14988,F1499,F15,F151,F1510,F1511,F1512,F15120,F15121,F15122,F15129,F1513,F1514,F1515,F15150,F15151,F15159,F1518,F15180	
Cannabis	ICD10 Codes: F12,F121,F1210,F1211,F1212,F12120,F12121,F12122,F12129,F1213,F1215,F12150,F12151,F12159,F1218,F12180,F12188,F1219,F122,F1220,F1221,F1222,F12220,F12221,F12222,F12229,F1223,F1225,F12250,F12251,F12259,F1228,F12280,F12288,F1229,F129,F1290,F1291,F1292,F12920,F12921,F12922,F12929,F1293,F1295,F12950,F12951,F12959,F1298,F12980,F12988,F1299,T407,T407X,T407X1,T407X1A,T407X1D,T407X1S,T407X2,T407X2A,T407X2D,T407X2S,T407X3,T407X3A,T407X3D,T407X3S,T407X4,T407X4A,T407X4D,T407X4S,T407X5,T407X5A,T407X5D,T407X5S,	
Sedatives	ICD10 Codes: F13,F131,F1310,F1311,F1312,F13120,F13121,F13129,F13130,F13131,F13132,F13139,F1314,F1315,F13159,F1318,F13180,F13181,F13182,F13188,F1319,F132,F1320,F1321,F1322,F13220,F13221,F13229,F1323,F13230,F13231,F13232,F13239,F1324,F1325,F13259,F1326,F1327,F1328,F13280,F13281,F13282,F13288,F1329,F139,F1390,F1391,F1392,F13920,F13921,F13929,F1393,F13930,F13931,F13932,F13939,F1394,F1395,F13959,F1396,F1397,F1398,F13980,F13981,F13982,F13988,F1399,T424,T424X,T424X1,T424X1A,T424X1D,T424X1S,T424X2,T424X2A,T424X2D,T4	
Drug Abuse	ICD10 Codes: Z7151	

Category	Codes	Other Notes
Other	ICD10 Codes: E242,F13150,F13151,F13250,F13251,F13950,F13951,F16,F161,F1610,F1611,F1612,F16120,F16121,F16122,F16129,F1614,F1615,F16150,F16151,F16159,F1618,F16180,F16183,F16188,F1619,F162,F1620,F1621,F1622,F16220,F16221,F16229,F1624,F1625,F16250,F16251,F16259,F1628,F16280,F16283,F16288,F1629,F169,F1690,F1691,F1692,F16920,F16921,F16929,F1694,F1695,F16950,F16951,F16959,F1698,F16980,F16983,F16988,F1699,F18,F181,F1810,F1811,F1812,F18120,F18121,F18129,F1814,F1815,F18150,F18151,F18159,F1817,F1818,F18180,F18188,F1819	
Maternal Substance Use Disorder	ICD10 Codes: O354,O354XX0,O354XX1,O354XX2,O354XX3,O354XX4,O354XX5,O354XX9,O355,O355XX0,O355XX1,O355XX2,O355XX3,O355XX4,O355XX5,O355XX9,O9931,O99310,O99311,O99312,O99313,O99314,O99315,O9932,O99320,O99321,O99322,O99323,O99324,O99325	
Tobacco Screening and Referral	Tobacco Cessation Counselling visit: 99406, 99407 Tobacco Cessation Intervention Counselling: 4004F Current Tobacco non-user: 1036F	
Substance Use Disorder Locations:		
Office Visit	LOCCODE in ('1','11','20','49','50','71','72','08','9','15','07')	
Outpatient	LOCCODE in ('22','24','65','5','19')	
Emergency Department (ED)	Loccode ='23'	
Inpatient Hospital	Loccode in ='21'	
Substance Use Facility	LOCCODE in ('55','57')	
Nursing Facility	LOCCODE in ('31','32','4')	
Mental Health Treatment Facility	LOCCODE in ('52','53','54','56','51')	
Transportation	LOCCODE in ('41','42') or (loccode='90' and serv_provtype ='30')	

Category	Codes	Other Notes
Utilization		
Medication Assisted Treatment (MAT):	STC Codes: 0164, 0268, 7689, 0274 HIC3 Codes: H3T, H3W, C0D Tracking Medications: Acamprosate Calcium, Buprenorphine, Buprenorphine-Naloxone, Disulfiram, Naloxone, Naltrexone	
Emergency Department Visits:	LocationCode = 23 ServProvCategoryCode = 15/61/22	
Mental Health:	ICD10 Codes: F03, F0390-F0391, F20, F200-F203, F205, F208, F2081, F2089, F209, F21-F25, F250-F251, F258-F259, F28-F30, F301, F3010-F3013, F302-F304, F308-F309, F31, F310-F311, F3110-F3113, F312-F313, F3130-F3132, F314-F316, F3160-F3164, F317, F3170-F3178, F318, F3181, F3189, F319, F32, F320-F325, F328, F3281, F3289, F329, F33, F330-F334, F3340-F3342, F338-F339, F34, F340-F341, F348, F3481, F3489, F349, F39, F4000-F4002, F4010-F4011, F40210, F40218, F40220, F40228, F40230-F40233, F40240-F40243, F40248, F40290-F40291, F40298, F408-F411, F413, F418-F419, F42, F422-F424, F428-F429, F43, F430-F431, F4310-F4312, F432, F4320-F4325, F4329, F438-F442, F444-F447, F4481, F4489, F449-F451, F4520-F4522, F4529, F4541-F4542, F458-F459, F481-F482, F488-F489, F5000-F5002, F502, F508, F5081-F5082, F5089, F509, F5101-F5105, F5109, F5111-F5113, F5119, F513-F515, F518-F521, F5221-F5222, F5231-F5232, F524-F526, F528-F529, F53, F530-F531, F54, F59, F600-F607, F6081, F6089, F609, F630-F633, F6381, F6389, F639-F642, F648-F654, F6550-F6552, F6581, F6589, F659, F66, F6810-F6813, F688, F68A, F69, F800-F802, F804, F8081-F8082, F8089, F809-F810, F812, F8181, F8189, F819, F82, F840, F842-F843, F845, F848-F849, F88-F89, F900-F902, F908-F913, F918-F919, F930, F938-F942, F948-F952, F958-F959, F980-F981, F9821, F9829, F983-F985, F988-F989, F99, R4585, R45851, T1491, T1491XA, T1491XD, Z69010-Z69011, Z69020-Z69021, Z6911-Z6912, Z6981-Z6982, 29384, 30000-30002, 30009-30010, 30020-30023, 30029, 30921, 31323, 2961, 2967, 29600-29606, 29610-29616, 29640-29646, 29650-29656, 29660-29666, 29680-29682, 29689-29690, 30113, 311, 3004-3005, 29620-29626, 29630-29636, 29699, 3124, 3129, 31200-31203, 31210-31213, 31220-31223, 31230-31235, 31239, 31281-31282, 31289, 31381, 3006, 30012-30016, 3071, 30750-30754, 30759, 3026, 30285, 2900, 2903, 2908-2909, 2930-2931, 2939-2940, 3319, 29010-29013, 29020-29021, 29281, 29410-29411, 29420-29421, 3073, 3079, 3151-3152, 3154-3155, 3158-3159, 29900-29901, 29910-29911, 29980-29981, 29990-29991, 30720-30723, 2948-2949, 3009, 3141-3142, 3148-3149, 29510-29515, 29520-29525, 3020-3024, 3029, 30281-30284, 30289, 3010, 3013-3014, 3016-3017, 3019, 3100-3102, 3109, 30120-30122, 30150-30151, 30159, 30181-30184, 30189, 31321-31322, 31382-31383, 2970-2973, 2978-2984, 2988-2989, 29381-29382, 29389, 29500-29505, 29530-29535, 29540-29545, 29550-29555, 29560-29565, 29570-29575, 29580-29585, 29590-29595, 316, 30089, 30110-30112, 3080-3084, 3089-3091, 3093-3094, 3099, 30924, 30928-30929, 30981-30983, 30989, 31389, F0150-F0151, F02, F0280-F0281, F05, F060-F062, F0631-F0634, F064, F068, F07, F070, F078, F0789, F079, F09, Z915, F01511, F01518, F0152-F0154, F01A0, F01A11, F01A18, F01A2-F01A4, F01B0, F01B11, F01B18, F01B2-F01B4, F01C0, F01C11, F01C18, F01C2-F01C4, F02811, F02818, F0282-F0284, F02A0, F02A11, F02A18, F02A2-F02A4, F02B0, F02B11, F02B18, F02B2-F02B4, F02C0, F02C11, F02C18, F02C2-F02C4, F03911, F03918, F0392-F0394, F03A0, F03A11,	

Category	Codes	Other Notes
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Category	Codes	Other Notes
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Category	Codes	Other Notes
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Behavioral Health Services:	ICD10 Codes: E242, E244, F10, F101, F1010-F1012, F10120-F10121, F10129-F10132, F10139, F1014-F1015, F10150-F10151, F10159, F1018, F10180-F10182, F10188, F1019, F102, F1020-F1022, F10220-F10221, F10229, F1023, F10230-F10232, F10239, F1024-F1025, F10250-F10251, F10259, F1026-F1028, F10280-F10282, F10288, F1029, F109, F1090-F1092, F10920-F10921, F10929-F10932, F10939, F1094-F1095, F10950-F10951, F10959, F1096-F1098, F10980-F10982, F10988, F1099, F11, F111, F1110-F1112, F11120-F11122, F11129, F1113-F1115, F11150-F11151, F11159, F1118, F11181-F11182, F11188, F1119, F112, F1120-F1122, F11220-F11222, F11229,	

Category	Codes	Other Notes
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Category	Codes	Other Notes
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Acute Inpatient:	Place of Service Codes: '3','21','61','51'	

Category	Codes	Other Notes
Telehealth Visits:	Location Code: 02, 10 as defined by the CMS Place of Service Code Set. CMS Telemedicine and Remote Monitoring Modifier Code 1: 'GQ', 'GT', '95', '93' Procedure Code 1: '99451', 'G0071', 'G2012', '92250', '92227', '99444'	
<u>ACEs Screenings</u>		
Positive or High Risk (ACEs Screening Score 4 or greater):	HCPCS Codes: G9919	
Negative or Low Risk (ACEs Screening Score 0-3):	HCPCS Codes: G9920	
<u>Transportation Services</u>		
		Partnership contracts with Kinetic for Transportation coding

Note: Categories for which there are no known codes are not shown.

HEDIS

Data Information

- **What do these measures mean?**

Partnership's Quality Improvement (QI) Program continues to focus on improving quality measures defined by the National Committee for Quality Assurance (NCQA) and the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS). Partnership received Health Plan Accreditation (HPA) from National Committee for Quality Assurance (NCQA) in 2019. NCQA Health Plan Accreditation (HPA) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys both used to generate Partnership's Health Plan Rating using the NCQA Five-Star rating methodology. Partnership's 2025 Health Plan Rating (HPR) is Three out of Five Stars: ★ ★ ★ .

Measures: Healthcare Effectiveness Data and Information Set (HEDIS®) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results.

- **When were these datasets collected?**

Measure stratifications by race and ethnicity, which are used to identify health disparities, are reported to NCQA and DHCS via MCAS measure reporting with results from the measurement:

- Measure Year (MY) is the data collection year (i.e., MY 2025)
- Reporting Year (RY) (i.e., RY 2026)

- **Which datasets were used?**

HEDIS measure rates, including race and ethnicity stratifications, are generated from various data sources, including claims and encounters, immunization registries, lab vendor data, Health Information Exchanges, and Electronic Clinical Data Systems (ECDS) data. Most HEDIS measures generate rates using these data sources applied to the entire eligible population for the measure. A subset of HEDIS measures generate rates using the hybrid methodology, which relies on Medical Record Review of a systematic sample of medical records as well as the data sources listed above.

HEDIS Data Collection Methods:

- Administrative Measures: data is collected from claims and encounters (transaction data)

- Hybrid Measures: data is collected from clinical medical record data using a systematic sample of the eligible population to supplement the administrative data collected.
- Electronic Clinical Data Systems (ECDS) measures: data is collected through provider's EHRs, health information exchanges (HIEs) or clinical registries, case management systems, and administrative data.

Note: Partnership also use HEDIS-like measures for Quality Incentive Programs using measure specifications that are closely aligned with the NCQA Technical Specifications.

HEDIS Managed Care Accountability Set (MCAS) Measure

Partnership HealthPlan of California
Measurement Year 2024 / Reporting Year 2025



9.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
*Asthma Medication Ratio (AMR)	Total	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
*Breast Cancer Screening (BCS-E)	Non-Medicare Total	The percentage of women 52–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS)	Total	- The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women 21–64 years of age who had cervical cytology performed within the last 3 years - Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years - Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
*Child and Adolescent Well-Care Visits (WCV)	Total	- The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. - Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

Partnership HealthPlan of California
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HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS)	Combination 10	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
*Chlamydia Screening in Women (CHL)	Total	- The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. - Total: the sum of the age stratifications.
Controlling High Blood Pressure (CBP)	Total	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
*Developmental Screening in the First Three Years of Life (DEV_CH)	Total All Ages	- Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. - This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	Total	- The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

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HEDIS Measure	Measure Indicator	Measure Definition
*Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	Total	- The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA)	Combination 2	- The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. - Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (HBD)	HbA1c poor control (>9.0%)	- The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. - HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC)	Total	- The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. - At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

**Partnership HealthPlan of California
Measurement Year 2024 / Reporting Year 2025**



HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. ○ Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. ○ Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
*Topical Fluoride for Children (TFL-CH)	• Total ages 1 through 20	• Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. • This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
*Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months.	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: • Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. • Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

**-Administrative Measures. The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)*

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