ALL PRACTICE TYPES

Primary Care Provider

Quality Incentive Program (PCP QIP) Specifications

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MEASUREMENT YEAR

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

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I. Quality Incentive Program Contact Information

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II. Program Overview

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

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

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

Guiding Principles

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

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

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

Program Timeline: Calendar Year

The measurement year begins on January 1 and ends on December 31 of the current year. Please see Appendix V for details on deadlines specific to any measures. Payment is sent out 120-150 days after the program period ends, in the month of April-May the following year.

Definitions

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

Primary Care Provider Site (PCP Site): A clinic location that has been designated with a unique PCP ID with members actively assigned by Partnership HealthPlan of California. Eligibility and requirements for Primary Care Provider sites are listed in the PHC Policy MPQP1023, (Access Standards and Monitoring), subject to California Health and Safety Code 1206(h) and HRSA regulations on intermittent sites. All Primary Care Provider Sites are listed in the Provider Directory.

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

Eligibility for PHC Program

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

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

Definition of Good Standing:

PHC has the sole authority to determine if a provider is in Good Standing based on the criteria set forth below.

1. Provider is open for services for PHC members.
2. Provider is financially solvent (not in bankruptcy proceedings).
3. Provider is not under financial or administrative sanctions, exclusion or disbarment from the State of California, including the Department of Health Care Services (DHCS) or the federal government including the Centers for Medicare & Medicaid Services (CMS). If a provider appeals a sanction and prevails, PHC will consider a request to change the provider status to good standing.
4. Provider is not pursuing any litigation or arbitration against PHC.
5. Provider has not issued or threatened to issue a contract termination notice, and any contract renewal negotiations are not prolonged.
6. Provider has demonstrated the intent to work with PHC on addressing community and member issues.
7. Provider is adhering to the terms of their contract (including following PHC policies, quality, encounter data completeness, and billing timeliness requirements).
8. Provider is not under investigation for fraud, embezzlement or overbilling.
9. Provider is not conducting other activities adverse to the business interests of PHC.

Clinical Measures

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

- PCP sites joining Partnership without affiliation to an existing QIP participant site (standalone new practice or new PCP PO):
    - Must be contracted with members assigned for at least nine (9) months.

- PCP sites joining Partnership as part of a PCP PO where members from an existing QIP participant (an existing primary care site) are potentially being reassigned to the new site (example – new site opens within multi-site FQHC model)
    - Must be contracted with members assigned by October 1.
    - New PCP sites enrolled by October 1 will be eligible for the clinical measures. Member enrollment at other sites within the PCP parent organization will be used to support continuous enrollment requirements for Clinical Measures.

Non-Clinical Measures

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

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

Eligible Member Population

The eligible population used to calculate the final scores for all measures is defined as capitated or assigned medical home Medi-Cal members. These members are eligible to be included in PCP sites' denominator lists assuming other denominator criteria are met. Member month assignments will also count towards the member month totals used for payment calculations.

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

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

Measure Development and Selection

The measurement set for the QIP is reviewed and developed annually. In order to maintain a clinically relevant alignment with key external healthcare measurement entities, and a stable measurement set, major changes occur only when significant changes are made across a majority of the key external healthcare measurement entities measurement sets.[1] With input from the network, the Provider Advisory Group, and internal departments, the measurement set requires approval from the Physician Advisory Committee. Once approved, the finalized set for

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

the next year is shared with the network and specifications are developed. It is possible for the measurement set to change slightly during the measurement year due to new information becoming available (i.e., a measure's retirement from the Department of Health Care Services Managed Care Accountability Set, evaluation of the previous program year, or a change in financial performance). Any mid-year changes to the measurement set will be communicated through e-mail to all providers as well as through the program's quarterly newsletter.

Measures may evaluate a PCP site's utilization of a certain service or provision of treatment. PHC recognizes the potential for underutilization of care and services and takes appropriate steps to monitor for this. The processes utilized for decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not offer incentives or compensation to providers, consultants, or health plan staff to deny medically appropriate services requested by members, or to issue denials of coverage.

Payment

The PCP QIP is comprised of two (2) measurement sets, each with its own payment methodology.

The PCP QIP Core Measurement Set includes measures in the Clinical, Appropriate Use of Resources, Operations and Access, and Patient Experience domains. For these measures, performance is rewarded based on the points earned and the number of member months accumulated throughout the year. The amount per member per month (PMPM) available in the PCP QIP will vary by site, according the principles noted below. The number of member months is multiplied by the site's PMPM to determine the maximum amount an individual site can earn. That amount is then multiplied by the percentage of points earned through the Core Measurement Set to determine the actual incentive amount.

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

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

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

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

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

For the Unit of Service Measurement Set, the payment is independent of, and distinct from, the financial incentives a site receives from the Core Measurement Set. A PCP site receives payment according to the measure specifications if the requirements for at least one (1) Unit of Service measure are met.

Billing

The QIP uses administrative (claims and encounter) data to identify denominator and numerator inclusion for clinical and non-clinical measures. Specific codes for clinical measures are listed in measure specific Code Sets specified within each measure and can be found in the Diagnosis Crosswalk in eReports. Specific codes for non-clinical measures are listed in non-clinical specifc Code Sets and specified within each measure. These codes are not wholly representative of reimbursable codes of PHC. Any codes outside of the clinical and non-clinical Code Sets are not used for measure evaluation and credit.

eReports

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

Small Denominators

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

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

The three (3) outreach attempts must include:

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

Evidence of documentation must be submitted on a **Small Denominator Exclusion Template**. This template will be provided by the QIP Team. Please send a request to the QIP Inbox: qip@partnershiphp.org. Documentation must be clear and submitted to the QIP team via email

or fax between **January 15 – 31,** the following measurement year. Note: Guardian/Patient refusal is not an acceptable exclusion.

Non-clinical Measures: For PCP sites with less than 500 (<500) assigned members, the Risk Adjusted Readmission and Ambulatory Care Sensitive Admission measures will not apply. Points will be re-distributed to remaining measures.

Partnership Quality Dashboard

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

Modifications of PCP QIP for PCP Parent Organizations with Very Low PCP QIP scores

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

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

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

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

Payment Dispute Policy

Data accessible by providers prior to payment is considered final. You can access performance data throughout the measurement year and during the validation period following the end of the measurement year. Providers are strongly encouraged to review their year-end data closely during the Preliminary Report Review and eReports validation periods as this data is used to finalize point earnings. If a provider does not notify PHC of a calculation or point attribution error during these periods, resulting in a potential under or over payment, the error may be corrected by PHC post-payment through a formal appeal process. The formal appeal process is available for **up to 30 days after the PCP has received their final payment statement**. Additionally, PHC may recoup overpayments any time after payment is distributed. Appeals received regarding any of the following five (5) scenarios will not be considered by

the PHC Executive team. Final payment appeals must fall outside the following descriptions to be considered for review:

1. **QIP Scores on eReports:** eReports refreshes data twice per week and providers have access to eReports through the well-published grace period (i.e., several days following the close of the measurement year) to check for data discrepancies. Additionally, providers have access to eReports during the one-week validation period, after the grace period closes, to verify that all data manually submitted correctly corresponds to resulting scores. Each site is responsible for its own data entry and for validating the outcome of uploads. At the discretion of the QIP team, PHC may assist a provider with uploading data before the close of the grace period, if prior attempts have failed. In these cases, providers are still responsible for verifying successful uploads. If a provider does not alert the QIP of any potential issues, data shown in eReports at the end of this validation period will be used to calculate final payment. After this period, post-payment disputes specific to eReports data will not be considered.

2. **Exclusions on eReports:** Some approved exclusions involve a manual process by PHC staff. Providers are responsible for checking if members are correctly excluded. Post-payment disputes related to member eligibility for specific measures will not be considered. The deadline for exclusion requests, which need to be executed by the QIP Team, is January 15 following the measurement year.

3. **Data Reported on the Year-End Preliminary Report:** At the end of the measurement year, before payment is issued, QIP will send out a Preliminary Report detailing the earnings for Unit of Service measures. Providers will be given one week, commonly referred to as Preliminary Report Review Period, to review this report for calculation discrepancies.

4. **Practice Type Designations:** Each PCP site is categorized as either: Internal Medicine, Family Practice, or Pediatric Practice according to the accepted age groupings listed in the Provider Directory and a historical review of member months. Each practice type is responsible for different QIP measures. Requests to change a designation post-payment cannot be addressed for the measurement year reflected in the payment.

5. **Thresholds:** Thresholds are generally set at the beginning of the measurement year and only changed based on unusual circumstances, on input from the QIP governance structure. Network-wide and site-specific thresholds can be reviewed in the QIP measurement specification document and on eReports throughout the measurement year. The QIP may consider adjusting thresholds mid-year based on quantified circumstances as reviewed by QIP governance and approved by PHC's Executive Team. Post-payment disputes related to thresholds, however, cannot be accommodated.

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

Governance Structure

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

- ***PCP Provider Network*:** PCP Providers provide feedback on program structure and measures throughout the measurement year. During the measure development cycle, proposed changes are released to the network for public comment.

- ***QIP Technical Workgroup*:** The QIP internal workgroup comprised of representatives from Quality Improvement, the Office of the CMO, Finance, Provider Relations, Regional Offices, and IT Departments reviews program policies and proposes measure ideas.

- ***QIP Advisory Group*:** The QIP external advisory group is comprised of physicians and administrators from all practice types and counties. Their purpose is to provide recommendations on measures and advise on QIP operations.

- ***PHC Physician Advisory Committee*:** The Brown Act committee with board certified physicians is responsible for approving measures.

- ***PHC Board of Commissioners*:** The PHC Board approves the financial components of the QIP and reviews and approves the actions of the Physician Advisory Committee, including the QIP measures.

III. Summary of Measures

2024 Primary Care Provider Quality Improvement Program Summary of Measures

For the tables below, please refer to these notes:

1: For most existing clinical measures, the full-point target is set at the 90th percentile performance of all Medicaid health plans reporting to the National Committee for Quality Assurance (NCQA); sites can receive partial points on these measures if the 50th percentile performance is met. For most new clinical measures, the full-point target is set at the 50th percentile performance, with no partial points available. No points through relative improvement are available for new measures.

2: For most existing clinical measures, sites can also earn points based on relative improvement (RI). Please note that if a provider site was not eligible for payment for a specific measure in the previous measurement year, the site is not eligible for earning points through relative improvement in the current measurement year. Relative improvement measures the percentage of the distance the provider has moved from the previous year's rate toward a goal of 100 percent. The method of calculating relative improvement is based on a *Journal of the American Medical Association* article authored by Jencks et al in 2003, and is as follows:

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

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

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure

  - AND -

- **Have an RI score of 15% or higher**, as compared to the previous year's performance, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 90th percentile, to earn full points.

3: Non Clinical targets will be communicated to the provider network in spring 2024.

4: Most of the clinical measures use performance percentiles obtained from the National Committee for Quality Assurance (NCQA) national averages for Medicaid health plans reported in 2023 as targets.

2024 Primary Care Provider Quality Improvement Program Summary of Measures

Core Measurement Set – Family Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening	90th Percentile (63.37%)	50th Percentile (52.20%)	6	5
Cervical Cancer Screening	90th Percentile (66.48%)	50th Percentile (57.11%)	6	5
Child and Adolescent Well Care Visits	90th Percentile (61.15%)	50th Percentile (48.07%)	9	8
Childhood Immunization Status: Combo 10	90th Percentile (45.26%)	50th Percentile (30.90%)	6	5
Colorectal Cancer Screening	50th Percentile (%)-TBD	25th Percentile (%)-TBD	5	-
Comprehensive Diabetes Care: HbA1c Control	90th Percentile (60.34%)	50th Percentile (52.31%)	6	5
Comprehensive Diabetes Care - Retinal Eye Exams	90th Percentile 63.33%)	50th Percentile (52.31%)	5	4
Controlling High Blood Pressure	90th Percentile (72.22%)	50th Percentile (61.31%)	6	5
Lead Screening in Children	50th Percentile (62.79%)	N/A - New measures do not qualify for partial points in the first measurement year	6	N/A
Immunizations for Adolescents – Combo 2	90th Percentile (48.80%)	50th Percentile (34.31%)	6	5
Well-Child Visits in the First 15 Months of Life	90th Percentile (68.09%)	50th Percentile (58.38%)	9	8
NON-CLINICAL DOMAIN: APPROPRIATE USE OF RESOURCES[2]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	Score <1.0	Score ≥ 1.0-1.2	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4

PCP Office Visits	Greater than 1.9 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	5 points each are available for: 50th Percentile (Access 41.97%) 50th Percentile (Communication 70.31%)	4.5 points each are available for: 25th Percentile (Access 34.83%) 25th Percentile (Communication 65.12%)	10	9
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is at or above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

2024 Core Measurement Set – Internal Medicine

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Breast Cancer Screening	90th Percentile (63.37%)	50th Percentile (52.20%)	15	13
Cervical Cancer Screening	90th Percentile (66.48%)	50th Percentile 57.11%)	15	13
Colorectal Cancer Screening	50th Percentile- TBD	25th Percentile- TBD	12	-
Comprehensive Diabetes Care: HbA1c Control	90th Percentile 60.34%)	50th Percentile (52.31%)	12	11
Comprehensive Diabetes Care - Retinal Eye Exams	90th Percentile (63.33%)	50th Percentile (52.31%)	6	5
Controlling High Blood Pressure	90th Percentile (72.22%)	50th Percentile (61.31%)	10	9
NON-CLINICAL DOMAIN:APPROPRIATE USE OF RESOURCES[3]				
Ambulatory Care Sensitive Admissions	TBD	TBD	5	4
Risk Adjusted Readmission Rate	Score < 1.0	Score ≥ 1.0-1.2	5	4
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS				
Avoidable ED Visits	TBD	TBD	5	4
PCP Office Visits	Greater than 1.9 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	5	4
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	5 points each available for: 50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	4 points each are available for: 25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	10	8
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

2024 Core Measurement Set – Pediatrics

Measure Name	Full Point Target	Partial Point Target	Full Points	Partial Points
CLINICAL DOMAIN: CLINICAL MEASURES				
Child and Adolescent Well Care Visits	90th Percentile (61.15%)	50th Percentile (48.07%)	20	17
Childhood Immunization Status: Combo 10	90th Percentile (45.26%)	50th Percentile (30.90%)	12	11
Lead Screening in Children	50th Percentile (62.79%)	N/A - New measures do not qualify for partial points in the first measurement year	12	N/A
Immunizations for Adolescents – Combo 2	90th Percentile (48.80%)	50th Percentile (34.31%)	12	11
Well-Child Visits in the First 15 Months of Life	90th Percentile (61.19%)	50th Percentile (55.72%)	12	10
NON-CLINICAL DOMAIN: ACCESS AND OPERATIONS [4]				
Avoidable ED Visits	TBD	TBD	10	8
PCP Office Visits	Greater than 1.6 visits per member per year on average	Between 1.6 and 1.9 visits per member per year on average	10	8
NON-CLINICAL DOMAIN: PATIENT EXPERIENCE				
Patient Experience (CAHPS)	6 points each available for: 50th Percentile (Access 45.19%) 50th Percentile (Communication 69.69%)	5 points each available for: 25th Percentile (Access 37.86%) 25th Percentile (Communication 66.34%)	12	10
Patient Experience (Survey)	Submits Parts 1 and 2	Submits Part 1 or 2		
		TOTAL POINTS	**100**	**75**

PCPs in new PHC counties will receive full points if the clinical measure performance is at or above the 50th percentile, for 2024 only. In these cases, no partial point thresholds apply.

[5] National Quality Forum (NQF) Breast Cancer Screening (#2372). http://www.qualityforum.org

Unit of Service Measures – All Practice Types

Measure	Incentive
Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000 per site • $100 per Advance Directive/POLST, maximum payment $10,000 per site
Extended Office Hours	**For Capitated PCPs only**. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). Non-capitated PCPs will have additional funding added to the Core measure set.
PCMH Certification	$1000 yearly per site, for achieving or maintaining PCMH accreditation.
Peer-led Group Visits	$1000 per group, either new or existing. (Maximum of 15 groups per parent organization).
Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. This incentive is available at the parent organization level.
Health Equity	$2000 per parent organization for submission of Health Equity implementation initiative or an annual updated Health Equity report.
Dental Fluoride Varnish	$1,000 per parent organization for submission of proposed plan to implement fluoride varnish application in the medical office. $5 per application when the minimum of 2% of sites assigned members 6 months to 5 years old received DFV administered by a non-dental practitioner at least once in the measurement year.
Tobacco Screening	$5.00 per tobacco use screening or counseling of members 11– 21 years of age after 3% threshold of assigned members screened.

Electronic Clinical Data System (ECDS)	$5,000 per parent organization with vendor support; $10,000 per parent organization with no vendor support Allowance of data exchange from Provider Electronic Health Records to PHC in order to capture clinical screenings, follow-up care and outcomes. Participation to include data collection of the following clinical components for all PHC members within your organization. 1. Alcohol Screening and Counseling (11 years and older) 2. Depression Screening 3. HEDIS ROADMAP (5 & 5a)
Early Administration of 1st HPV Dose	Administer the first HPV dose by the age of 12 in order to have the required 6-month pause between the first and 2nd dose and another 6 months to administer the 2nd HPV dose before the 13th birthday $50 per HPV dose given before age 12.
Early Administration of Initial Flu Vaccine Series (Two Doses)	Early administration of influenza *and* to complete administration of the 2nd dose within 60 calendar days of the 1st dose. $50 per two dose series completed by 15 months of age, with the 2 doses up to 60 days apart.

IV. Clinical Domain

Measure 1. Breast Cancer Screening[5]

Description

The percentage of continuously enrolled Medi-Cal women 50-74 years of age who had a mammogram to screen for breast cancer.

Points and Thresholds by Practice Type

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

***Denominator**

The number of continuously enrolled assigned members 52 – 74 years of age as of December 31 of the measurement year (DOB between January 1, 1950 and December 31, 1972).

Numerator

The number of members from the eligible population in the denominator with one or more mammograms any time on or between October 1, 2022 and December 31, 2024

Exclusions

- Members receiving palliative care (Palliative Care Encounter Value Set) during the measurement year.
- Bilateral mastectomy any time during the member's history through December 31, 2024.
- Mammography in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of breast ICD10 = Q83.8) to exclude from denominator. Transgender males or gender non-conforming individuals who were born female, and currently with gender identity of male, should be screened for breast cancer, but they will not be part of the official denominator for this measure due to system constraints.

Measure Rationale and Source

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

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

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Prevention and

[5] National Quality Forum (NQF) Breast Cancer Screening (#2372). http://www.qualityforum.org

Screening, MCAS, NQF Breast Cancer Screening (#2372), and UDS Breast Cancer Screening (CMS125v8).

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

IV. Clinical Domain

Measure 2. Cervical Cancer Screening[6]

Description

The percentage of continuously enrolled women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women age 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.

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled assigned women 24 - 64 years of age as of December 31 of the measurement year (DOB between January 1, 1960 and December 31, 2000).

Numerator

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

Exclusions

These are based on:

- Hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member's history through December 31 of the measurement year.
- Documentation of "complete," "total" or "radical" abdominal or "vaginal hysterectomy" date meets the criteria for hysterectomy with no residual cervix any time during the member's history through December 31 of the measurement year.
- Documentation of a "vaginal Pap smear" in conjunction with documentation of "hysterectomy" date any time during the member's history through December 31 of the measurement year.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening date any time during the member's history through December 31 of the measurement year.
- Members receiving palliative care (Palliative Care Encounter Value Set) during the measurement year.
- Cervical Cancer Screening in Transgender Individuals: Transgender females (born males but currently with gender identity of female), may use diagnosis of congenital absence of cervix ICD10 = Q51.5) to exclude from denominator. Transgender males or gender non-conforming individuals who were born females and currently with gender identity of male should be screened for cervical cancer if their cervix is still intact, but they will not be part of the official denominator for this measure due to system constraints.

[6] National Quality Forum (NQF) Cervical Cancer Screening (#0032). http://www.qualityforum.org

Measure Rationale and Source

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

DHCS requires PHC to report this as part of the annual report of MCAS measures.

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

Partnership acknowledges that the American Cancer Society updated their guidelines to recommend cervical cancer screening via HPV testing starting at age 25 years. Partnership continues to follow the USPSTF and NCQA standards as written above. We also note that self collection is likely to become acceptable for this measure sometime in 2024; specifications will be updated if and when this occurs.

IV. Clinical Domain

Measure 3. Child and Adolescent Well-Care Visits[7]

Description

The percentage of members continuously enrolled 3 - 17 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members 3-17 years of age as of December 31 of the measurement year (DOB between January 1, 2007 and December 31, 2021).

Numerator

The number of children in the eligible population with at least one (1) well-care visit with a PCP or OB/GYN during the measurement year (January 1, 2024 and December 31, 2024).

Because this well-care visit measure is administrative only, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2023 n.d).

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

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

Here are some of the benefits of well-care visits:

[7] 2022 HEDIS measure criteria for Child and Adolescent Well Care with the allowable adjustments.

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such as development, behavior, sleep, eating or relations with other family members. Present your top three (3) to five (5) questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

DHCS requires PHC to report this as part of the annual report of MCAS measures.

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including NCQA Accreditation, HEDIS measure Utilization and Risk Adjusted Utilization, and MCAS.

IV. Clinical Domain

Measure 4. Childhood Immunization Status – Combo 10[8]

Description

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

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2022 and December 31, 2022).

Numerator

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

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

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

[8] National Quality Forum (NQF) Childhood Immunization Status (#0038). http://www.qualityforum.org

14 Days Rule:

***There must be at least 14 days between each date of service, excluding the MMR vaccination. For example, If the first date of service (DOS) was completed on 12/1, the next date of service would have to be 12/15 (first DOS + 14 days) or later.**

The purpose for this rule: is to avoid duplication of events when only assessing administrative data or when combining administrative and medical record data.

Exclusions (only if not numerator hit)

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

Measure Rationale and Source

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

DHCS requires PHC to report this as part of the annual report of MCAS measures.

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

IV. Clinical Domain

Measure 5. Colorectal Cancer Screening[9]

Description

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled assigned members 46-75 years of age by December 31 of the measurement year (DOB between January 1, 1949 and December 31, 1978).

Numerator

The number of assigned members 46–75 years of age who had one or more screenings for colorectal cancer according to clinical guidelines.

Exclusions (only if not numerator hit)

Excludes members with a history of colorectal cancer or total colectomy. This measure also excludes members receiving palliative care any time during the measurement year.

Measure Rationale and Source

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

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

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

[9] National Quality Forum (NQF) Colorectal Cancer Screening (#0034). http://www.qualityforum.org

IV. Clinical Domain

Measure 6. Comprehensive Diabetes Management – HbA1C Good Control [11]

Description

The percentage of continuously enrolled assigned members 18-75 years of age who had a diagnosis of diabetes with evidence of HbA1c levels at or below the threshold.

For PHC's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled assigned members 18-75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1949 and December 31, 2006).

Numerator

The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1c ≤9.0% during the measurement year.

Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2023 – December 31, 2024), and who meet either of the following criteria:

- Members receiving palliative care during the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports. See Appendix V for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VI for the Diabetes Exclusions Flow Chart.
- Members prescribed certain diabetes medications for weight loss (with no diagnosis of diabetes), during the measurement year or the year prior to the measurement year.

Measure Rationale and Source

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

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

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

IV. Clinical Domain

Measure 7. Comprehensive Diabetes Management – Retinal Eye Exam[10]

Description

The percentage of continuously enrolled members 18-75 years of age who had a diagnosis of diabetes who have had recommended retinal eye exams, screening for diabetes related retinopathy.

For PHC's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members 18-75 years of age (DOB between January 1, 1949 and December 31, 2006) with diabetes identified as of December 31 of the measurement year.

Numerator

An eye screening for diabetic retinal disease as identified by administrative data.

Exclusions

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

- Members receiving palliative care during the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports. See Appendix V for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VI for the Diabetes Exclusions Flow Chart.
- Members prescribed certain diabetes medications for weight loss (with no diagnosis of diabetes), during the measurement year or the year prior to the measurement year.

[10] National Quality Forum (NQF) Comprehensive Diabetes Care: Eye Exam (#0055). http://www.qualityforum.org

- **Measure Rationale and Source**

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

IV. Clinical Domain

Measure 8. Controlling High Blood Pressure[11]

Description

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled assigned members 18-85 years of age as of December 31 of the measurement year (DOB between January 1, 1939 and December 31, 2006) who had at least two (2) visits on different dates of service with a diagnosis of hypertension on or between January 1 of the year prior to the measurement year and June 30 of the measurement year (01/01/2023 – 06/30/2024).

Numerator

The number of assigned members population whose most recent BP reading taken during an outpatient visit, a nonacute inpatient encounter, or remote monitoring event was <140/90 mm Hg during the measurement year.

The BP reading must occur **on or after** the date of the second (2nd) diagnosis of hypertension.

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

Exclusions

- Exclude from the eligible population all members with evidence of end-stage renal disease, dialysis, nephrectomy or kidney transplant; history of kidney transplant on or prior to December 31 of the measurement year.
- Exclude from the eligible population female members with a diagnosis of pregnancy during the measurement year.
- Exclude members receiving palliative care during the measurement year.

Measure Rationale and Source

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

- Nearly 1 in 3 adults (about 67 million) have high blood pressure;

[11] National Quality Forum (NQF) Controlling High Blood Pressure (#0018). http://www.qualityforum.org

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

High blood pressure is a major risk factor for heart disease and stroke, both of which are leading causes of death in the US (Getting Blood Pressure Under Control, 2012). Nearly one-third of all American adults have high blood pressure and more than half of them don't have it under control (Getting Blood Pressure Under Control, 2012). Blood pressure control means having a systolic blood pressure less than 140 mmHg and a diastolic blood pressure less than 90 mmHg, among people with high blood pressure (Getting Blood Pressure Under Control, 2012). Many with uncontrolled high blood pressure don't know they have it. Millions are taking blood pressure medicines, but their blood pressure is still not under control (Getting Blood Pressure Under Control, 2012). There are many missed opportunities for people with high blood pressure to gain control (Getting Blood Pressure Under Control, 2012). Doctors, nurses and others in health care systems should identify and treat high blood pressure at every visit (Getting Blood Pressure Under Control, 2012).

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

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

IV. Clinical Domain

Measure 9. Lead Screening in Children[12]

Description

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members within last 12 months, who turn 2 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2022 and December 31, 2022).

Numerator

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

Exclusions

Exclude members receiving palliative care during the measurement year.

Measure Rationale and Source

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

The only way to know if a child is lead poisoned is to obtain a BLL. Young children from six months to six years (particularly those at one and two years) are at greatest risk. Under California regulations, providers must give anticipatory guidance on lead poisoning prevention at each periodic health assessment from the age of six months up to 72 months. California statute requires that health care providers inform parents and guardians about the risks and effects of childhood lead exposure, the requirement that children enrolled in Medi-Cal receive blood lead tests, and the

[12] Add webite to site measure rationale and source

requirement that children not enrolled in Medi-Cal who are at high risk of lead exposure receive blood lead tests. The provider must order BLLs at the ages of one and two years and whenever a child under six years is identified as having missed the required tests, a change in circumstances has put the child at risk, or if requested by the parent or guardian and medically indicated. (Blood Lead Testing and Anticipatory Guidance – DHCS July 2023).

IV. Clinical Domain

Measure 10. Immunizations for Adolescents[13]

Description

The percentage of continuously enrolled Medi-Cal adolescents 13 years of age who had one (1) dose of meningococcal conjugate vaccine, one (1) tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and two (2) doses of the human papillomavirus (HPV) vaccine by their 13th birthday.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members who turn 13 years of age between January 1 and December 31 of the measurement year (DOB between January 1, 2011 and December 31, 2011).

Numerator

The number of assigned adolescents who had at least one dose of meningococcal vaccine; at least one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and the HPV vaccination series completed by their 13th birthday.

Centers for Disease Control and Prevention (CDC): Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2022

Exclusions

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

Measure Rationale and Source

Thirty-five million American adolescents fail to receive at least one recommended vaccine (Schaffer et al., 2005). This gap exists despite specific adolescent immunization recommendations from the U.S. Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) (Schaffer et al., 2005). Low immunization rates in adolescents have a wide array

[13] National Quality Forum (NQF) Immunizations for Adolescents (#1407) http://www.qualityforum.org

of implications—outbreaks of vaccine-preventable diseases, negative effects on quality of life and increased disease associated costs (Schaffer et al., 2005). Importantly, low immunization rates establish reservoirs of disease in adolescents that can affect others, including high-risk infants, elderly persons and persons with underlying medical conditions (Schaffer et al., 2005).

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

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

IV. Clinical Domain

Measure 11. Well-Child Visits in the First 15 Months of Life[14]

Description

The percentage of continuously enrolled Medi-Cal members who turned 15 months old during the measurement year and who had six (6) or more well-child visits with a PCP during their first 15 months of life.

Here are some helpful links for information regarding PHC's Pediatric Preventive Care:

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

Points and Thresholds by Practice Type

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

Denominator

The number of continuously enrolled Medi-Cal members who turn 15 months old between January 1 and December 31 of the measurement year (DOB between October 3, 2022 and October 2, 2023).

Numerator

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

14 Days Rule:

There must be at least 14 days between each date of service for this measure. For example, If the first date of service (DOS) was completed on 12/1, the next date of service would have to be 12/15 (first DOS + 14 days) or later.

If date of service violates the 14-day rule, the logic is built to skip the date of service in violation and look for the next date of service which is compliant with the 14-day rule logic.

For Example: If the first date of service (DOS) was completed on 12/1, the second DOS is 12/10 and third is 12/15 then only first DOS 12/1 & third DOS 12/15 would count towards the measure.

The purpose for this rule: is to avoid duplication of events when only assessing administrative data or when combining administrative and medical record data.

[14] National Quality Forum (NQF) Well-Child Visits in the First 15 Months of Life (#1392) http://www.qualityforum.org

Because Well-Child Visits in the First 15 Months of Life is an administrative measure, the services and documentation in the supplemental data (e.g., medical record) must be clinically synonymous with the codes in the measure's administrative specification (HEDIS MY 2023 n.d.).

Services that occur over multiple visits may be counted, as long as all services occur in the time frame specified by the measure.

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

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

Here are some of the benefits of well-child visits:

- Prevention. Your child gets scheduled immunizations to prevent illness. You also can ask your pediatrician about nutrition and safety in the home and at school;
- Tracking growth and development. See how much your child has grown in the time since your last visit, and talk with your doctor about your child's development. You can discuss your child's milestones, social behaviors and learning;
- Raising concerns. Make a list of topics you want to talk about with your child's pediatrician such development, behavior, sleep, eating or relations with other family members. Present your top three (3) to five (5) questions or concerns to the pediatrician at the start of the visit;
- Team approach. Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) supports well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child (Sturgeon, 2015).

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

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

V. Appropriate Use of Resources

Measure 12. Ambulatory Care Sensitive Admissions[15]

Description

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

Sites must have a minimum of 500 eligible members by December 1st of the measurement year to be eligible for this incentive measure.

Points and Thresholds by Practice Type

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

Denominator

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

Numerator

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

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

Calculation:

$$Ambulatory\ Care\ Sensitive\ Admissions\ (ACSA) = \frac{\text{Total \# of ACSA days}}{\text{Total \# of All Inpatient Admission days}}$$

[15] Agency for Healthcare Research and Quality (AHRQ). PQI and PDI Measures. Retrieved from: https://www.qualityindicators.ahrq.gov/Modules/all_resources.aspx

Exclusions

Factors and indicators qualifying for exclusion:

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

Measure Rationale and Source

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

Inclusion of this measure and benchmark determination is supported by alignment with external healthcare measurement entities, including Agency for Healthcare Research and Quality (AHRQ) PQI and PDI Measures.

V. Appropriate Use of Resources

Measure 13. Risk Adjusted Readmissions[16]

Description

For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays* (denominator)
2. Observed Readmissions: Count of 30-Day readmissions (numerator)
3. Expected Readmissions: Sum of adjusted readmission risk (numerator)
4. Ratio of Observed/Expected Readmissions

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (e.g., on or between January 1 and December 1).

Sites must have a minimum of 500 eligible members by December 1st of the prior measurement year to be eligible for incentive.

Points and Thresholds by Practice Type

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

Denominator

The number of acute inpatient or observation stays (Index Hospital Stay) on or between January 1 and December 1 of the measurement year by members age 18 to 64 years of age continuously enrolled for at least 90 days prior to the admission date and at least 30 days after the admission date.

Numerator

Observed 30-Day Readmission: The number of acute unplanned readmissions for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay on or between January 3rd and December 31 of the measurement year by members included in the denominator

Calculation: $\text{Observed 30 Day Readmissions Rate} = \frac{\text{Observed 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$

Note: Inpatient stays where the discharge date from the first setting and admission date to the second setting must be two (2) or more days apart and considered distinct inpatient stays.

Expected 30-Day Readmission**:** An Expected Readmission applies stratified risk adjustment weighting. Risk adjusted weighting is based on the stays for surgeries, discharge condition, co-morbidities, age, and gender.

[16] National Quality Forum (NQF) Plan All-Cause Readmissions (#1768) http://www.qualityforum.org

Calculation: $\text{Expected 30 Day Readmissions Rate} = \frac{\text{Expected 30 Day Readmissions}}{\text{Total Count of Index Hospital Stays}}$

Final Measure Calculation:

$$\text{Ratio of Observed/Expected Readmissions} = \frac{\text{Observed 30 Day Readmissions}}{\text{Expected 30 Day Readmissions}}$$

Ratios:
1.0 means the number of readmissions is equal to the number predicted.
<1.0 means the number of readmissions is less than predicted.
>1.0 means the number of readmissions is greater than predicted.

Exclusions

Exclusions for Numerator and Denominator:

- Discharges for death
- Pregnancy condition
- Perinatal condition
- Stays by members with 4 or more index admissions in the measurement year

Exclusions for Numerator:

- Planned admission using any of the following:
  - Chemotherapy
  - Rehabilitation
  - Organ Transplant
  - Planned procedure without a principal acute diagnosis

Measure Rationale and Source

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

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

VI. Access and Operations

Measure 14. Avoidable Emergency Department (ED) Visits/1000 Members per Year[17]

Description

The rate of assigned members with "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by PHC.

Points and Thresholds by Practice Type

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

Denominator

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

Numerator

The number of assigned members 1 year of age or older with "avoidable ED visits" with a primary diagnosis that matches the diagnosis codes selected by PHC.

Calculation:

$$Avoidable\ ED\ Visits\ per\ Member\ per\ Year\ X\ 1000 = \frac{\text{Avoidable ED Visits}}{(\text{Sum of Member Months}) * 12{,}000}$$

A three (3) month run-out of data from the measurement period is applied in order to increase the completeness of encounter data. For example, dates of service from January 1 to March 31 are not reported until June 30.

Exclusions

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

Measure Rationale and Source

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

[17] (June 2012) Statewide Collaborative Quality Improvement Project. Reducing Avoidable Emergency Room Visits. Final Remeasurement Report: January 1, 2010 – December 31, 2010. Retrieved from: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/EQRO_QIPs/CA2011-12_QIP_Coll_ER_Remeasure_Report.pdf

VI. Access and Operations

Measure 15. PCP Office Visits

Description

The number of Primary Care Provider visits per member per year by PHC eligible members with participating QIP providers.

PHC will extract the total number of PHC office visits, telephone visits, and video visits from claims and encounter claims data submitted by primary care sites for services provided to assigned members or on-call services provided by another primary care site.

Thresholds

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

Denominator

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

Numerator

The total number of visits during the measurement year with any PCP in PHC's network. PCP Visits include face-to-face, video or telephonic services in provider's office, or patient's home or private residence settings.

Calculation:

$$PCP\ Office\ Visits\ PMPY = (\#\text{PCP Visits} \div \text{Sum of eligible Member Months}) \times 12$$

Codes Used

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

Exclusions

This measure excludes the following:

- Medicare-Medi-Cal dual capitated members

VII. Patient Experience

Measure 16. Patient Experience[18]

Description

This measure aims to improve the patient experience.

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

Thresholds

Please see the Summary of Measures Table for points, thresholds, and relative improvement criteria. There are two (2) ways in which to earn points:

1) **CAHPS**

   Providers that have sufficient PHC patient volume, or for PCPs who operate in counties with no provider meeting this threshold and see the largest number of PHC members in that county, can earn up to a maximum of 10 points for meeting performance thresholds in key measures in the Clinician & Group CAHPS 3.0 survey.

2) **Survey Option**

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

Submission Process

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

Exclusions

This measure does not have any exclusions.

Measure Rationale and Source

According to Agency for Healthcare Research and Quality (AHRQ), improving patient experience has an inherent value to patients and families and is therefore an important outcome in its own right (Why Improve Patient Experience, n.d.). But good patient experience also is associated with important clinical processes and outcomes (Why Improve Patient Experience, n.d.). Measures of

[18] National Quality Forum (NQF) CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child (#0005) http://www.qualityforum.org

patient experience also can reveal important system problems, such as delays in returning test results and gaps in communication that may have broad implications for clinical quality, safety, and efficiency (Why Improve Patient Experience, n.d.).

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

- Good patient experience is associated with lower medical malpractice risk. A 2009 study found that for each drop in patient-reported scores along a five-step scale of "very good" to "very poor," the likelihood of a provider being named in a malpractice suit increased by 21.7 percent.14;
- Efforts to improve patient experience also result in greater employee satisfaction, reducing turnover. Improving the experience of patients and families requires improving work processes and systems that enable clinicians and staff to provide more effective care. A focused endeavor to improve patient experience at one hospital resulted in a 4.7 percent reduction in employee turnover;
- Patients keep or change providers based upon experience. Relationship quality is a major predictor of patient loyalty; one study found patients reporting the poorest-quality relationships with their physicians were three (3) times more likely to voluntarily leave the physician's practice than patients with the highest-quality relationships (Why Improve Patient Experience, n.d.).

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

VIII. Units of Service

$20,000 Maximum per Site

Measure 1. Advanced Care Planning

Description

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

Thresholds

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

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

Measure Requirements

ACP discussions must take place between January 1 and December 31 of the measurement year in order to be eligible for this measure.

Advance Directive and/or POLST:
If a patient has a previously completed Advance Directive or POLST and does not wish to make any changes, documentation of a conversation during the measurement period confirming that no changes are needed will qualify.

Attestation:
Only one conversation per patient per measurement year. The following components are required to be documented in the chart for a provider to attest to the completion of an ACP discussion:

- Documented discussed of social supports, patient preferences and likely course of action for acute illness, a long term chronic illness or a terminal illness, and “what ifs” for serious accidents (Advance Care Planning, n.d.).
- Documented discussed review of Advance Directive or POLST already on file and updates as needed in the member’s life as health status and living circumstances change (Advance Care Planning, n.d.).
- In order to receive credit for Attestation and/or Advanced Directive/POLST, the member must be assigned to the PCP provider where the discussion or documentation is taking place.

Submission Process

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

patients.

Exclusions

ACP is a covered benefit and can be reimbursed using CPT codes, 99497 or 99498. If any of these two CPT codes are billed via Claims, then the upload will be excluded.

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

Measure Rationale and Source

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

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

VIII. Units of Service **10% of Capitation**

Measure 2. Extended Office Hours

Description

For Capitated PCPs only. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter. **Non-capitated PCPs** are not invited to participate in this measure.

Definition of regular business hours:
Total open office hours equals at least nine (9) hours between the hours of 8 a.m. and 5 p.m. OR 9 a.m. and 6 p.m., Monday through Friday. Being open and seeing patients during lunch does not count toward the extended hours. The site must be open to scheduled visits during the extended office time to receive credit.

Thresholds

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

Measure Requirements

PCP sites must have at least eight (8) extended office hours for a full quarter listed in the PHC Provider Directory for Provider Relations to confirm.

PCP sites that are part of a large organization AND within a five (5) mile or less radius of each other are eligible for the incentive payment equal to 10% of capitation.

- Example 1:
  If site A (qualifying site) has the extended office hours offering at least eight (8) extended office hours, **AND** is willing to see members from sites B, C, D, etc. **WHO ARE** within the five (5) mile or less radius of site A (qualifying site), **THEN** sites B, C, D, etc. are eligible for extended office hours due to meeting the minimum distance requirement from site A (qualifying site). Lastly, site A (qualifying site) needs to have the at least eight (8) extended office hours listed for a full quarter in the PHC Provider Directory for Provider Relations to confirm, not a combination/summation of hours amongst sites is acceptable.

- Example 2:
  Site A and Site B are located 15 miles apart. Only Site A holds extended office hours and meets the criterion. In this scenario, Site A is eligible for the payment but Site B is not eligible for the payment.

PHC sites with less than 2,000 members and more than a 30-minutes' drive to the nearest ED will need to demonstrate the following:

- Have on-call arrangements available where by the on-call physicians come to the office to see urgent problems (arrangement to be submitted in writing annually to the PR representative of your county, including what types of urgent issues will be seen in the office) after hours. Deadline to submit arrangement is March 30 of the measurement year.

Submission Process

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

Exclusions

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

Measure Rationale and Source

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

VIII. Unit of Service $1,000 per site

Measure 3. Patient-Centered Medical Home Recognition (PCMH)

Description

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

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

Thresholds

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

Measure Requirements

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

Submission Process

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

Exclusions

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

Measure Rationale and Source

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

VIII. Unit of Service — $15,000 Maximum per Parent Organization

Measure 4. Peer-Led and Pediatric Group Visits

Description

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

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

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

Thresholds

The parent organization is eligible to earn $1,000 per group, maximum 15 groups, to the parent organization.

- The peer-led self-management or pediatric well-care visit group must meet at least four (4) times and have at least 16 PHC total member visits per group, confirmed via sign-in sheets.
- Documentation will be reviewed and approved by PHC's CMO or physician designee.

Measure Requirements

Qualifying peer groups must have a peer-facilitation component and a self-management component via face-to-face, telephonic, or video meetings.
The following components have to be submitted in order to qualify for this incentive:

1. Name of group
2. Name and background information/training of group facilitator for peer-led group. Name of Pediatric Group Well-Visit Coordinator.
3. Site where group visits took place
4. Narrative on the group process that includes: location and frequency of the group meetings
5. List of major topics/themes discussed at each meeting
6. A description of the way that self-management support is built into the groups. For Pediatric Group Well-Care visits, a description of the cohort.
7. An assessment of successes and opportunities for improvement of the group
8. Documentation of minimum of 16 PHC patient visits, via list of attendees with DOB and dates of meetings. Pediatric well-care visits should be billed administrively (date of service must also appear as they occurred in eReports). **Completion of this UOS template does <u>not</u> guarantee credit in the W15 QIP clinical measure.**

Proposed groups may submit elements 1-7 above prospectively for review and feedback at any time in the year, before groups start, to ensure the program will be eligible for the incentive.

Submission Process

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

Exclusions

Unapproved groups that do not meet the measure requirements, as determined by PHC's CMO or physician designee.

Submission(s) received after the close of the "grace period" that ends on January 31 following the measurement year.

Measure Rationale and Source

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

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

VIII. Unit of Service **$3,000 Maximum per Parent Organization**

Measure 5. Health Information Exchange Participation

Description

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

Thresholds

The PCP parent organizations will be reimbursed for participating:

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

Measure Requirements

In order to qualify for the incentive PHC will validate the data exchange by working directly with the specified HIE to confirm the linkage. Linkage will be verified by confirming your organization is performing one or more of the following:

- Sending an HL7 Patient Visit Information to the HIE
    - The HL7 PV1 segment contains basic inpatient or outpatient encounter information and consists of various fields with values ranging from assigned patient location, to admitting doctor, to visit number, to servicing facility.

OR

- Sending CCD document to the HIE
    - The Continuity of Care Document summarizes a patient's medical status for the purpose of information exchange. The content may include administrative (e.g., registration, demographics, insurance, etc.) and clinical (problem list, medication list, allergies, test results, etc.) information. This component defines content in order to promote interoperability between participating systems such as Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Practice Management Applications and others.

OR

- Retrieving clinical information (such as labs, images, etc.) from the HIE.

Recognized Community Health Information Exchange organizations include the following:

- Sac Valley Med Share
- North Coast Improvement and Information Network (NCHIIN)
- Jefferson HIE

Linkage to other HIEs may also qualify for the incentive; submission of justification will be reviewed on a case-by-case basis.

Submission Process

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

Exclusions

Unapproved HIE connections that do not meet the measure requirements.

Measure Rationale and Source

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

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

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

VIII. Unit of Service **$2,000 Maximum Per Parent Organization**

Measure 6. Health Equity Implementation

Description

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

Thresholds

$2,000 per Parent Organization for either:

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

Measure Requirements

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

1. Make HE a leader-driven priority.
2. Identify specific health disparities, then act to close the gaps.
3. Confront institutional racism.
4. Develop processes that support equity (health systems/dedicated resources, oversight).
5. Partner with community organizations.

Submission Process

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

VIII. Unit of Service **Incentive Amount Varies by Performance Outcome**

Measure 7. Dental Fluoride Varnish Use

Description

The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Studies show that low-income young children are often at higher risk for dental decay. According to the American Dental Association (ADA), the combination of drinking local public water that provides fluoridation and applying dental fluoride varnish is the best method to reduce early tooth decay. Primary care exams occur earlier and more frequently with young children compared to dentistry. Early detection of dental disease and opportunities for varnish application during annual check-ups are more likely to occur in the PCP office.

Denominator

Assigned members aged 6 months to 5 years during the measurement year. (DOB between January 1, 2019 and July 1, 2024).

Thresholds

Incentive to improve dental fluoride application at site level or submission of protocol and implementation plan.

Part 1: $1,000 per Parent Organization (only eligible for this Part if it was not completed in prior years) Parent Organization (PO) submission of proposed plan to implement fluoride varnish application in the medical office. The protocol should accomplish the following objectives:

- A plan to identify children at risk for, dental decay and who would benefit from fluoride varnish.
- Provide an education plan that will afford consultation and written member (parent or guardian) information on the importance of dental hygiene and fluoride varnish use.
- Provide clinical staff training on varnish application.
- Implementation target date.

Part 2: Minimum 2% of the site's assigned members in the age range above must receive fluoride varnish administered by a non-dental practitioner at least once in the measurement year. The incentive payment amount for reaching this threshold is $5.00 per application. (Credit will go to the assigned PCP for the member)

- Numerator: The percentage of members 6 months to 5 years of age within the measurement year having at least one or more dental varnish application during the measurement year.

Measure Requirements

PHC will extract claims data within the measurement year recognizing codes affiliated with dental varnish application: CPT code: 99188 (Non-dental practitioner).

VIII. Unit of Service **$5.00 Per Screening**

Measure 8. Tobacco Use Screening

Description

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

Denominator

Assigned members aged 11– 21 years of age during the measurement year. (DOB between January 1, 2003 and December 31, 2013)

Numerator

Assigned members 11– 21 years of age who had tobacco use screening or counseling one or more times during the measurement year.

Thresholds

Incentive to improve early detection of and intervention toward tobacco use.

Incentive payment: $5.00 per screening. Minimum 3% of the site's monthly assigned members receives one or more tobacco screenings in the measurement year.

- Assigned members 11– 21 years of age who had tobacco use screening or counseling one or more times during the measurement year.

Measure Requirements

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

VIII. Unit of Service **$50 Per Early Admin with Completion of Series**

Measure 9. Early Administration of the 1st HPV Dose

Description

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

Denominator

Assigned members who turn 12 years of age during the prior and current measurement year (DOB between January 1, 2011 and December 31, 2012).

Numerator

Assigned members who received their 1st HPV dose by 12 years of age and completed their 2nd dose by their 13th birthday during the measurement year.

Thresholds

Incentive to improve completion rates of HPV vaccination series:

Incentive payment: $50.00 per Early Administration with Completion of HPV series.

- Assigned members 13 years of age who received their 1st HPV by 12 years of age and completed their 2nd dose by their 13th birthday during the measurement year.

Measure Requirements

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

VIII. Unit of Service $50 Per Early Admin with Completion of Series

Measure 10. Early Administration of the Initial Flu Vaccine Series

Description

In 2022, 57% of PHC's members turning 2 years of age did not complete the two dose series of influenza vaccinations. The ACIP recommends two influenza vaccinations, at least 4 weeks apart starting in children aged 6 months. This initial two dose series provides protection for children under 2 years of age, all of whom are considered at high risk for serious influenza infections. The purpose of this new UOS measure is to incentivize early administration of influenza *and* to complete administration of the 2nd dose within 60 calendar days of the 1st dose.

Denominator

Assigned members who turn 1 year of age during the prior and current measurement year (DOB between January 1, 2023 and December 31, 2024).

Numerator

Assigned members who received their 1st Influenza dose and completed their 2nd dose within 60 calendar days of the 1st dose, by their 2nd birthday during the measurement year.

Thresholds

Incentive to improve completion rates of HPV vaccination series:

Incentive payment: $50.00 per Early Administration with Completion of Initial Flu Vaccine series.

- Assigned members 2 years of age who received their 1st initial Influenza dose and completed their 2nd dose within 60 calendar days of the 1st dose, by their 2nd birthday during the measurement year.

Measure Requirements

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

VIII. Unit of Service **$5,000 or $10,000 Per Parent Organization**

Measure 11. Electronic Clinical Data Systems (ECDS)

Description

This measure supports the allowance of data exchange from Provider Electronic Health Records to PHC in order to capture clinical screenings, follow-up care and outcomes. ECDS implementation is a vital component of furthering the quality of care for covered PHC members. Note that NCQA plans to convert most hybrid measures to ECDS measures in the coming years. DHCS continues to make PHC accountable to several ECDS measures, this process will continue to increase in emphasis.

Thresholds

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

1. $10,000 per PO for sites with no support from their Electronic Medical Record (EMR) vendor, and thus need to use an outside vendor to extract the data.
2. $5,000 for POs whose EMR vendor generates the report for ECDS data submission
3. The payment will *only* be made if the PHC HEDIS and IT team is able to accept and ingest both a test file in the autumn of 2024 and the final year end file in January of 2025.

Measure Requirements

Note: these specifications will be updated and re-published by summer 2024.

Participation to include data collection of the following clinical components for all PHC members within your organization.

1. Alcohol Screening and Counseling (11 years and older)
2. Depression Screening

The updated ECDS submission data reporting templates, SQL code, specifications are available on the eReports user Help Page. The data reporting templates will be reviewed each summer and housed within eReports. The HEDIS Roadmap template will be supplied by PHC's HEDIS Team. Please note, each will need to be adapted/mapped to your individual electronic medical record system.

A note for OCHIN Members: OCHIN members can request a report for ECDS data directly from OCHIN. Please use the following Jira language to request this report:

We are hereby requesting a ECDS report, please reference the OPT-122198.

Submission Process

Incentive for the ECDS measure includes a multi-step process and can be achieved by participating in the following criteria:

- Generate ECDS test file output and completed HEDIS Roadmap document via Secure File Transfer Protocol (sFTP) by **October 15, 2024**
- Any corrections to the data must be completed by **November 1, 2024**.
- Submit final data file (using the exact programming used for the test file) via sFTP between **January 7, 2025** and **January 14, 2025**

ECDS Data Submission Criteria:

1. Acceptance by PHC IT department of a test file using updated 2023 ECDS specifications by **October 15, 2024;** this submission also requires completion of the HEDIS Roadmap 5 template (This will be supplied by our HEDIS team). The test file must be completed using the PHC approved 2023 updated ECDS template and should include data from **January 1, 2023 – date the data is run**. No modifications to the template or manually manipulated data will be accepted.
2. The test file will be validated by the PHC HEDIS team. If data errors are found or the template has been modified, the HEDIS team will notify the PCP site. Sites will have until **November 1, 2024** to fix the data and/or correct the ECDS template.
3. A final report based on all patients seen who are covered by PHC (whether assigned or direct members) for **all of 2024**, must be submitted between **January 7, 2025** and **January 14, 2025**. The reporting programming and template format must be the same as the final approved version of the **test file** outlined in number 1 above. No manually manipulated final data will be accepted.
4. PHC's HEDIS team will be randomly auditing a few records from each provider to validate the mapping process in the fall of 2024 and the winter of 2025 known as Primary Source Verification. **Sites must cooperate with PHC HEDIS team Primary Source Verification to qualify for the ECDS incentive.**

Validation and Audit Process

Providers will be required and available for timely collaboration to validate data submissions ***prior*** to PHC data integration and be available ***after*** data integration to collaborate with PHC HEDIS team to conduct data audit and validation activities.

Step-by-Step ECDS Process for Implementation, Data Submission and Data Acceptance

(***Providers who have already completed Steps 1 & 2, please start with Step 3***)

A Note for OCHIN Members: OCHIN members can request a report for ECDS data directly from OCHIN. Please use the following Jira language to request this report:

We are hereby requesting a ECDS report, please reference the OPT-122198.

Step 1: Contact the PCP QIP team to let us know of your intent to implement ECDS and set-up an sFTP account: qip@partnershiphp.org

- Please provide the following details in an email to the PCP QIP inbox:
    - Name of Parent Organization
    - Contact name (**one (1) contact per parent organization**)
    - Contact phone number
    - Contact email address

Step 2: sFTP Account Set-Up (Must be completed by **October 1, 2024)**

- Once your contact information is received, an account will be generated in order to submit test files using the PHC ECDS Depression/Alcohol Screening & Counseling Templates.
    - An email will be sent to you from PHC's EDI team with log in credentials to access your new sFTP account

Step 3: Test File Submission (Data for January 1, 2024 – date the data is run)

- Acceptance of test file *and* HEDIS Roadmap 5 template via sFTP is due by **October 15, 2024**.
- The test file must include all data elements on the ECDS Depression/Alcohol Screening & Counseling Templates.
- The PHC HEDIS team will provide confirmation your test file has been received.
- The PHC HEDIS team will also provide HEDIS Roadmap 5 template and answer any questions related to this template.
- If the test file data does not pass the HEDIS review, PCP sites will have until **November 1, 2024** to correct the data
- In November and December, PHC's HEDIS team will reach out to PCPs to perform preliminary Primary Source Verification on a sample of data submitted.

Step 4: Final Data File Submission (Data for all of 2024)

- For incentive of the ECDS measure, acceptance of the final data file via sFTP is due between **January 7, 2025 – January 14, 2025**.
- Final data files must include all data elements on the ECDS Depression/Alcohol Screening & Counseling Templates for **all of 2024 (Jan 1 – Dec 30).**
- All PCP sites submitting final data are required to participate in the PHC HEDIS team Primary Source Verification Process.

What is the HEDIS Roadmap and Primary Source Verification?

Yearly completion of the current Roadmap is a required component of the NCQA HEDIS Compliance Audit process. The Roadmap's tables provide auditors with the preliminary information they need to conduct the NCQA HEDIS Compliance Audit.

All information requested in the Roadmap is essential to the HEDIS audit process, and auditors require the PHC to answer or update each question accurately and completely.

- All Roadmap questions relate to the measurement year systems and processes, unless otherwise indicated.
- **Template for *Roadmap Section 5 will be required from ECDS Providers** in order to obtain HEDIS Auditor approval to integrate the data for HEDIS regulatory compliancy.

5. Supplemental Data.	Complete a separate Section 5 for each supplemental data source. Vendor data described in Section 1 does not need to be added here.

*****The HEDIS team will be responsible to contact and work with each ECDS provider to facilitate and support the completion of the HEDIS ROADMAP process for successful Primary Source Verification.**

IX. Appendices

Appendix I. Patient-Centered Medical Home Documentation Template

4665 Business Center Dr.
Fairfield, CA 94534

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

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

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

Additional Notes/Comments:

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

4665 Business Center Dr.
Fairfield, CA 94534

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

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

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

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

Appendix III: Submission Template for Pediatric Group Visits

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

4665 Business Center Dr.
Fairfield, CA 94534

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

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

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

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

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

Appendix IV: Submission Template for HIE

If your organization is linked to an HIE during or prior to the 2024 Measurement year, you may qualify for an incentive for the 2023 PCP QIP. Please complete all of the following fields on this form and submit by **January 31 following the measurement year** and send to:

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

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

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

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

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

3) Type of incentive
   - ☐ Linkage: First joined HIE *during* 2024 (list date) _____
   - ☐ Maintenance: First joined HIE *prior to* 2024 (list date) _____

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

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

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

Appendix V: 2024 PCP QIP Submission and Exclusion Timeline

2024 QIP Uploads and Unit of Service Submissions

DEADLINE DATES	QIP MEASURES	REPORTING TEMPLATES
January 31 2025, by 5pm (Close of Business)	All Clinical Domain Measures and Advanced Care Planning	Found in eReports
January 31, 2025	PCMH Recognition	Appendix I
January 31, 2025	Peer-led Self-Management Support Group	Appendix II
January 31, 2025	Health Information Exchange	Appendix III
January 31, 2025	Health Equity Implementation Plan	N/A
January 14, 2025	ECDS – Final Report	Found in eReports
October 15, 2024	ECDS – Test Files	Found in eReports

2024 QIP Exclusions

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

Appendix VI: Data Source Table

PCP QIP Core Measures	Practice Type	Data Source[19]	System Used for Data Monitoring	System Used for Data Submission
	Clinical Domain			
1. Breast Cancer Screening	Family and Internal	PHC and Providers		eReports
2. Cervical Cancer Screening	Family and Internal			
3. Child and Adolescent Well Care Visits	Family and Pediatrics			
4. Childhood Immunization Status, Combination 10	Family and Pediatrics			
5. Colorectal Cancer Screening	Family and Internal			
6. Comprehensive Diabetic Care – HbA1c Control	Family and Internal			
7. Comprehensive Diabetic Care – Eye Exams	Family and Internal			
8. Controlling High Blood	Family and Internal			
9. Lead Screening in Children	Family and Pediatrics			
10. Immunization for Adolescents – Combination 2	Family and Pediatrics			
11. Well-Child Visits in the First 15 Months of Life	Family and Pediatrics			
	Appropriate Use of Resources Domain			
1. Ambulatory Care Sensitive Admissions	Family and Internal	PHC	PQD	Claims
2. Risk Adjusted Readmissions	Family and Internal			
	Access/Operations Measures Domain			
1. Avoidable ED Visits	Family, Internal, Pediatrics	PHC	PQD	Claims
1. PCP Office Visits	Family, Internal, Pediatrics	PHC	PQD	Claims
	Patient Experience Domain			
Survey Option (sites not qualified for CAHPS)	Family, Internal, Pediatrics	PHC and Provider	PQD	Submission Template
CAHPS Survey (for qualified sites)	Family, Internal, Pediatrics	PHC Vendor		PHC Vendor

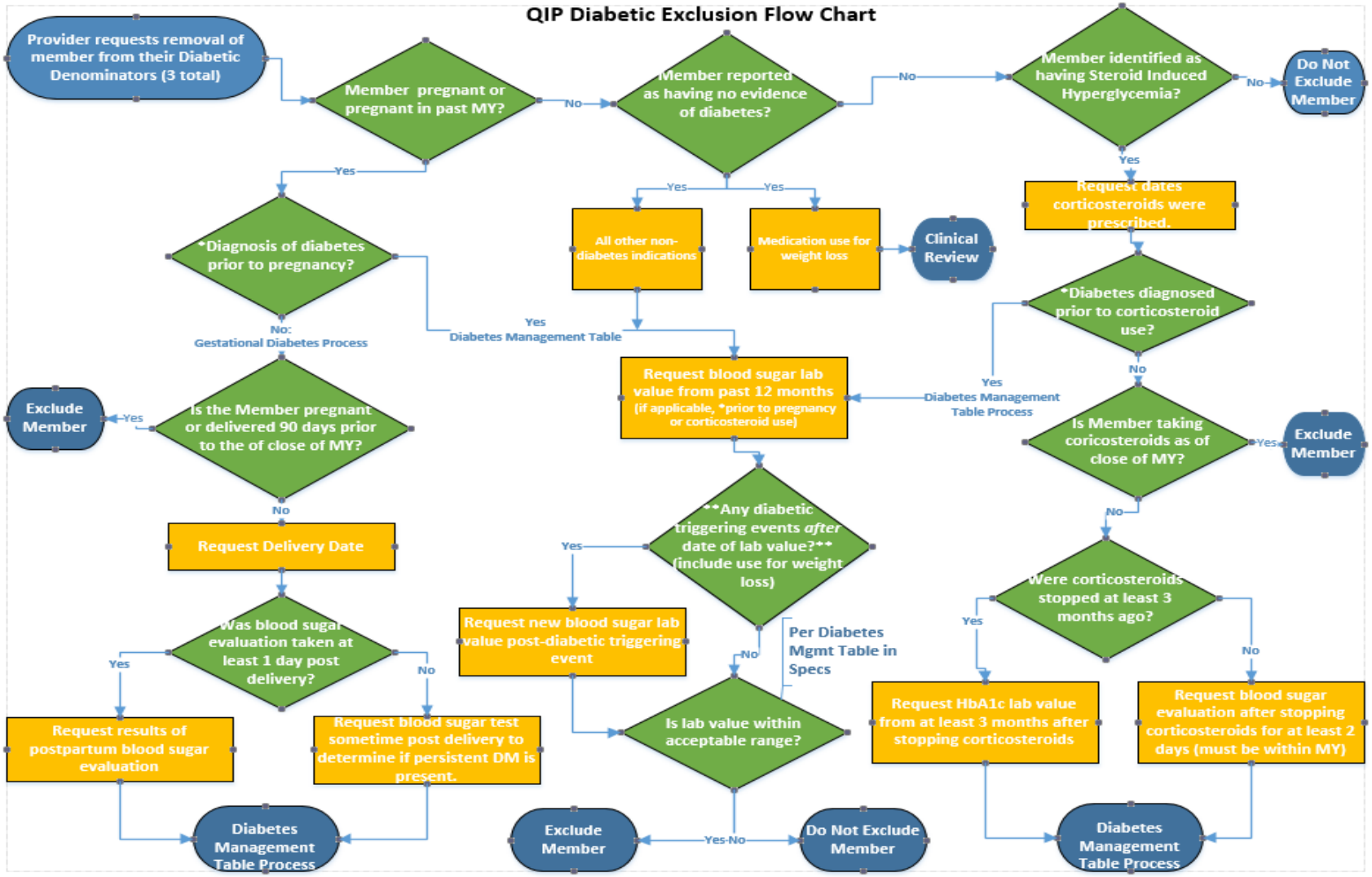
[19] For any measure, if "PHC" is the only data source, Providers may not submit uploads for the measure through eReports. PHC uses administrative data (Claims/Encounter/RxClaims) for these measures only.

Appendix VII: Diabetes Management Table

The table below indicates lab values that the QIP accepts as evidence that the member is not diabetic and thus should be considered for exclusion from the diabetes management measures. In addition to the values, please refer to the flow chart on the next page to understand the exclusion protocol. For this measure, members may only be excluded by presenting lab values indicating no Diabetes, and only labs that take place *after* the date of diagnosis will be considered.

Lab	**Description**	**Value accepted for diabetes exclusions**
HbA1c value (%)	-	< 6.5%
Fasting blood sugar test (mg/dL or mmol/L)	Blood sample taken after an overnight fast.	< 126 mg/dL or 7 mmol/L
Oral glucose tolerance test	Overnight fast, and the fasting blood sugar is measured, then the patient drinks a sugary liquid, blood sugar levels tested periodically for the next two (2) hours.	< 200 mg/dL or 11.1 mmol/L after two (2) hours

Appendix VIII: QIP Diabetes Exclusion Flow Chart



Appendix IX: Patient Experience Survey Submission Template

4665 Business Center Dr.
Fairfield, CA 95434

Quality Improvement Program – Patient Experience
Survey Submission Template and Example

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

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

Survey: Part I Submission Template

(Due July 31 of the measurement year)

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

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

Survey: Part II Submission Template

(Due January 31 following the measurement year)

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

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

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

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

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

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

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

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

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

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

Dear Patient,

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

Please rank the following statements based on your visit today:

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

2. Provide descriptions for the following

   a. Population surveyed:

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

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

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between March 1, 2024 and May 1, 2024, our site mailed a survey to all our adult patients who came in for an office visit between January 1 and April 1, 2024. The first mailing was sent on March 1, followed by a second mailing on April 15. 500 surveys were mailed and 250 surveys were returned; yielding a 50% response rate.

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

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

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

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

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

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

Submitted by Elizabeth Jones (QI Director) (Name & Title) **on** July 10, 2024 (Date)

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

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

   We had a consultant train our site over a two-month period (June- July 2024) on how to add same day appointments. The trainings included improvements to our scheduling system such as reducing the number of appointment types from 50 to 4. We developed and implemented scripts for the front desk staff so that they can educate our patients on the change in scheduling. We also collected data daily on our patient demand, supply and activity. This helped us determine where we can shift appointment slots based on our demand and corresponding supply. We also tried extending visit intervals for our well controlled patients with diabetes. Rather than bringing them in every 3 months, we now bring them in every 6 months.

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

   a. Population surveyed:

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

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

   d. Total number of surveys distributed:

   e. Total number of survey responses collected/received:

   f. Response Rate:

   Between October 15, 2024 and November 1, 2024, our site mailed a survey to all our adult patients who came in for an office visit between September 1 and October 1. We were only able to do one re-measurement cycle. The mailing was sent on October 15. Two hundred surveys were mailed and 110 surveys were returned; yielding a 55% response rate.

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

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

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

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

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

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