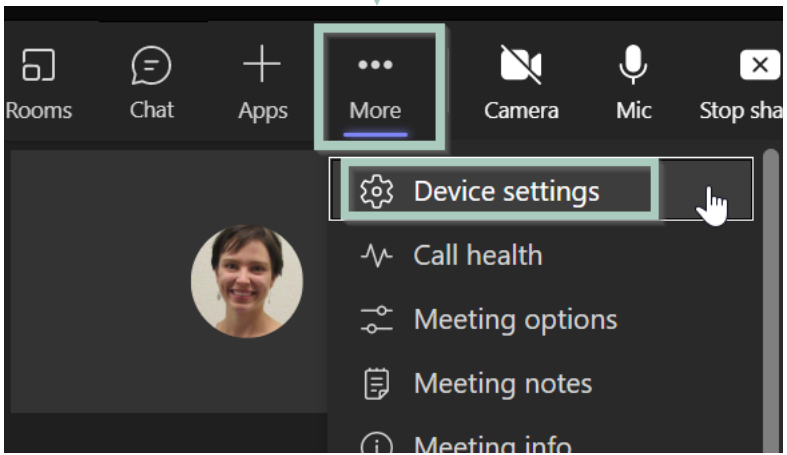
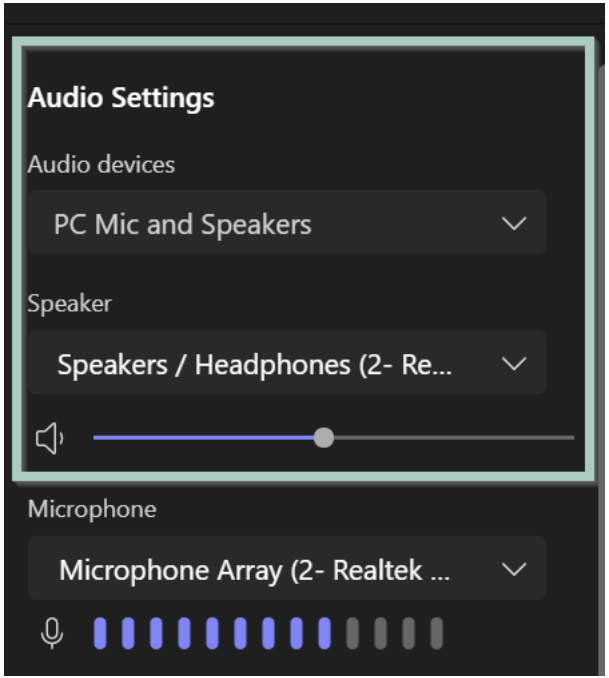
# 2023 CARE-BASED INCENTIVE

Kristen Rohlf, MPH
Annecy Majoros, BA
Jo Pirie, BS

# Housekeeping

- Use Chat to submit questions
- For audio troubleshooting



# Today's Host and Guests

**Jo Pirie**
Quality Improvement Program Advisor II

**Mao Moua**
Quality and Health Programs Supervisor

**Dale Bishop MD**
Medical Director

# Today's CBI Presenters

**Kristen Rohlf**
Quality Improvement
Program Advisor IV

**Annecy Majoros**
Quality Improvement
Program Advisor II

# Agenda



# CBI 2022 Reminder - Payment Adjustment

- Managed Care Plans (MCP) must meet:
  - Department of Health Care Service's (DHCS) Minimum Performance Level (MPL) for their Managed Care
  - MPL = the national Medicaid 50th percentile

- MCPs that fail to meet MPLs are subject to:
  - Plan Do Study Act (PDSA) and/or Performance Improvement Projects (PIPs)
  - Sanctions
  - Corrective Action Plans (CAPs)

*CBI Payment Adjustment impacts Quality of Care metrics*

# CBI 2022 Reminder - Payment Adjustment

- For Quality of Care measures below the 50th percentile, payment will be adjusted as follows

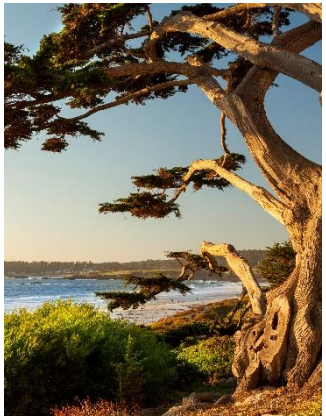
| Tier | Performance <50th Percentile | CBI Programmatic Payment Adjustment |
|---|---|---|
| 1 | 1-3 measures >25th and <50th and no metrics <25th | Payment reduction of 25% |
| 2 | 4 or more measures >25th and <50th and no metrics <25th | Payment reductions of 50% |
| 3 | 1-3 measures <25th | Payment reduction of 75% |
| 4 | 4 or more measures <25th | No CBI Payment |

# Program Overview

Established: 2010

Purpose:

- Encourage PCPs to promote and implement the Patient Centered Medical Home model
- Improve access to care
- Promote delivery of quality high-value care



# Fee-for-Service vs Programmatic

## Fee-for-Service

- A single payment incentive paid quarterly
- No rate calculation
- No minimum eligible member requirements

## % Programmatic

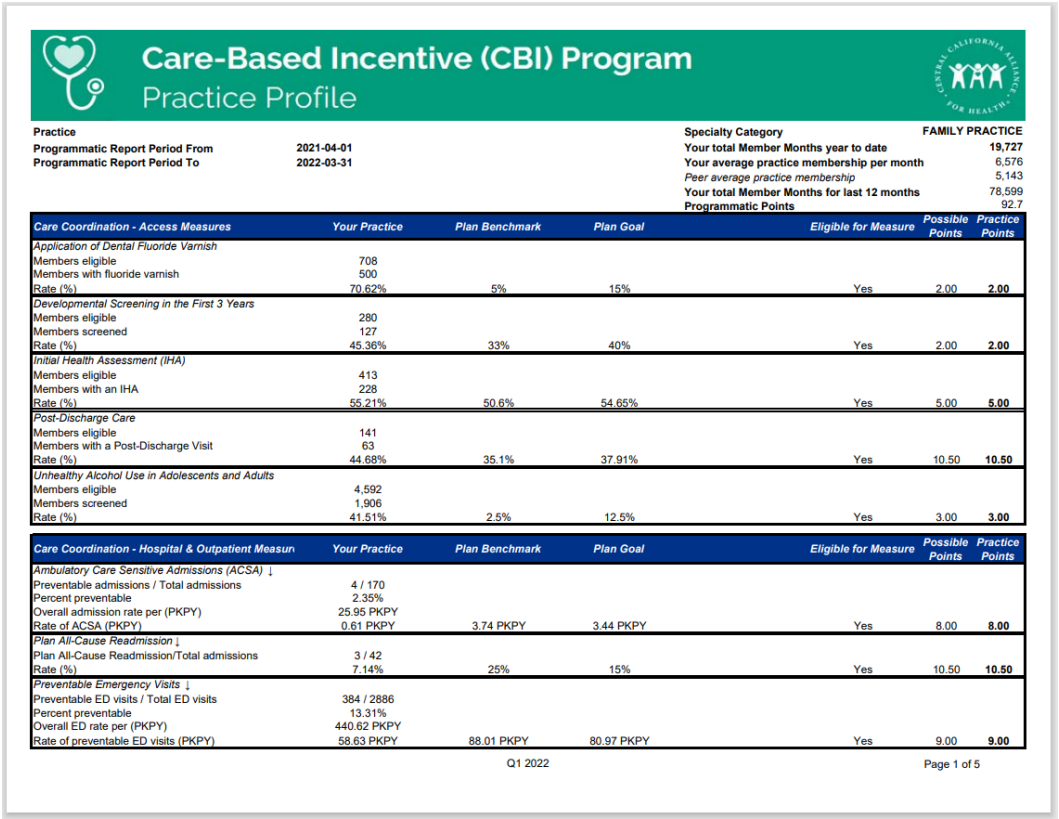
- Payment is based on
  - Comparison Group Performance
  - CBI score
  - Eligible member months
  - Risk stratification score
- Payment occurs annually (end of Q4)
- Quarterly rates for the measures
- Rolling 12-month measurement period

| Measure Type | Measure | Points |
|---|---|---|
| **Care Coordination Access** | Adverse Childhood Experiences (ACEs) Screening in Children & Adolescents | 3 |
| | Application of Dental Fluoride Varnish | 2 |
| | Developmental Screening in the First Three Years | 2 |
| | Initial Health Assessment | 4 |
| | Post-Discharge Care | 10.5 |
| **Care Coordination Hospital & Outpatient** | Ambulatory Care Sensitive Admissions | 7 |
| | Plan All-Cause Readmissions | 10.5 |
| | Preventable Emergency Visits | 8 |
| **Quality of Care** | BMI Assessment: Children & Adolescents | 38 points/ number of measures you qualify for |
| | Breast Cancer Screening | |
| | Cervical Cancer Screening | |
| | Child and Adolescent Well-Care Visits | |

| Measure Type | Measure | Points |
|---|---|---|
| **Quality of Care Continued** | Diabetic HbA1c Poor Control >9.0% | 38 points/ number of measures you qualify for |
| | Immunization: Adolescents (Combo 2) | |
| | Immunizations: Children (Combo 10) | |
| | Screening for Depression and Follow-up Plan | |
| | Well-Child Visits First 15 months of Life | |
| **Health Equity** | Health Equity: Child and Adolescent Well-Care Visit | 5 |
| **Performance Target** | Performance Improvement | 10 |
| | Member Reassignment Threshold | N/A |
| **Exploratory** | Chlamydia Screening in Women | Do not qualify for points |
| | Controlling High Blood Pressure | |
| | Immunization: Adults | |
| | Lead Screening in Children | |

| Measure Type | Measure | Payment |
| --- | --- | --- |
| **Fee-For-Service** | Adverse Childhood Experience (ACEs) Training and Attestation | $200 |
| | Behavioral Health Integration | $1,000 |
| | Patient Centered Medical Home (PCMH) Recognition | $2,500 |

# Program Overview



## Care-Based Incentive (CBI) Program
Practice Profile

| | | | |
|---|---|---|---|
| **Practice** | | **Specialty Category** | **FAMILY PRACTICE** |
| **Programmatic Report Period From** | **2021-04-01** | **Your total Member Months year to date** | **19,727** |
| **Programmatic Report Period To** | **2022-03-31** | **Your average practice membership per month** | 6,576 |
| | | *Peer average practice membership* | 5,143 |
| | | **Your total Member Months for last 12 months** | 78,599 |
| | | **Programmatic Points** | 92.7 |

| *Care Coordination - Access Measures* | *Your Practice* | *Plan Benchmark* | *Plan Goal* | *Eligible for Measure* | *Possible Points* | *Practice Points* |
|---|---|---|---|---|---|---|
| *Application of Dental Fluoride Varnish* | | | | | | |
| Members eligible | 708 | | | | | |
| Members with fluoride varnish | 500 | | | | | |
| Rate (%) | 70.62% | 5% | 15% | Yes | 2.00 | **2.00** |
| *Developmental Screening in the First 3 Years* | | | | | | |
| Members eligible | 280 | | | | | |
| Members screened | 127 | | | | | |
| Rate (%) | 45.36% | 33% | 40% | Yes | 2.00 | **2.00** |
| *Initial Health Assessment (IHA)* | | | | | | |
| Members eligible | 413 | | | | | |
| Members with an IHA | 228 | | | | | |
| Rate (%) | 55.21% | 50.6% | 54.65% | Yes | 5.00 | **5.00** |
| *Post-Discharge Care* | | | | | | |
| Members eligible | 141 | | | | | |
| Members with a Post-Discharge Visit | 63 | | | | | |
| Rate (%) | 44.68% | 35.1% | 37.91% | Yes | 10.50 | **10.50** |
| *Unhealthy Alcohol Use in Adolescents and Adults* | | | | | | |
| Members eligible | 4,592 | | | | | |
| Members screened | 1,906 | | | | | |
| Rate (%) | 41.51% | 2.5% | 12.5% | Yes | 3.00 | **3.00** |

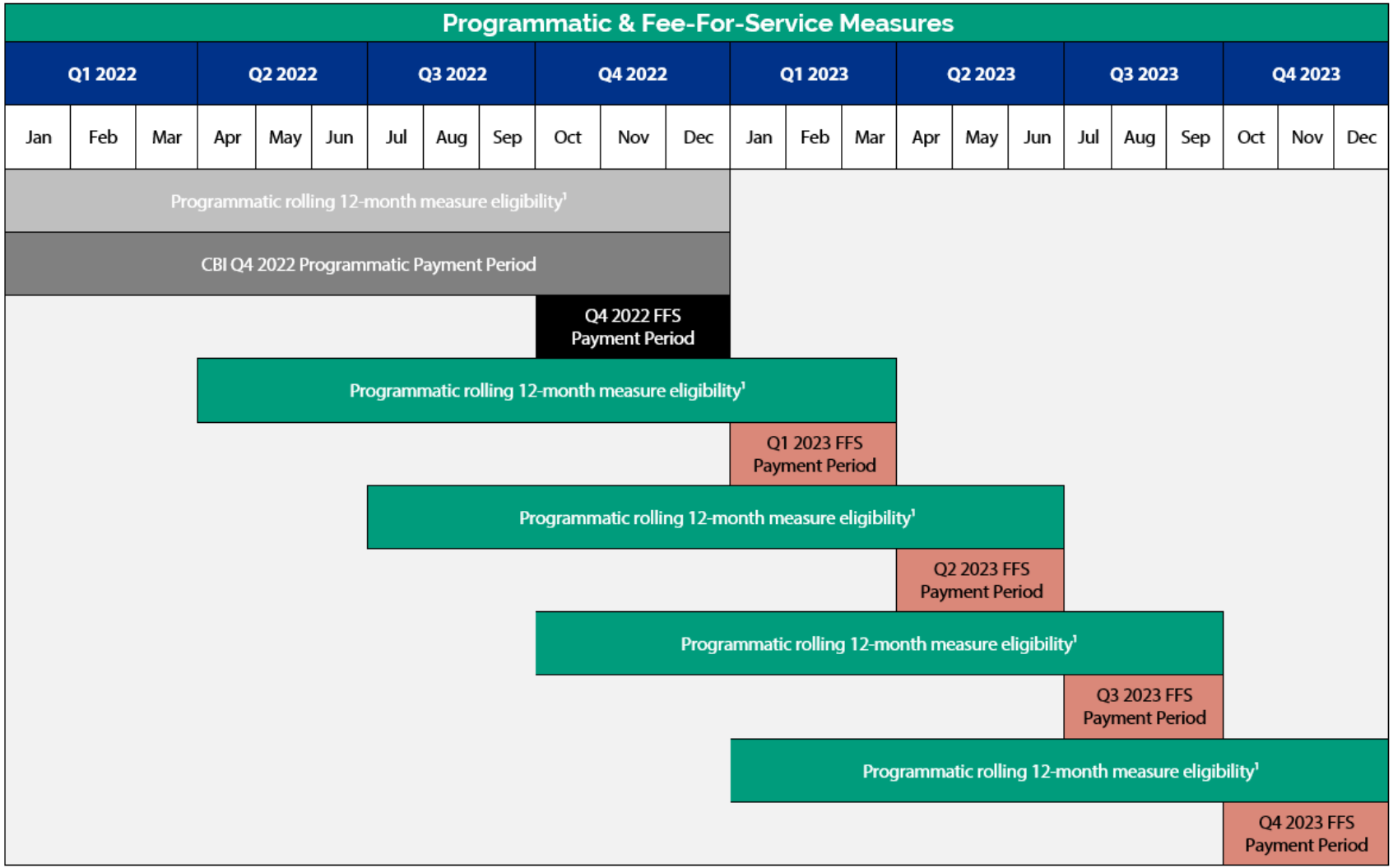
| *Care Coordination - Hospital & Outpatient Measun* | *Your Practice* | *Plan Benchmark* | *Plan Goal* | *Eligible for Measure* | *Possible Points* | *Practice Points* |
|---|---|---|---|---|---|---|
| *Ambulatory Care Sensitive Admissions (ACSA)* ↓ | | | | | | |
| Preventable admissions / Total admissions | 4 / 170 | | | | | |
| Percent preventable | 2.35% | | | | | |
| Overall admission rate per (PKPY) | 25.95 PKPY | | | | | |
| Rate of ACSA (PKPY) | 0.61 PKPY | 3.74 PKPY | 3.44 PKPY | Yes | 8.00 | **8.00** |
| *Plan All-Cause Readmission* ↓ | | | | | | |
| Plan All-Cause Readmission/Total admissions | 3 / 42 | | | | | |
| Rate (%) | 7.14% | 25% | 15% | Yes | 10.50 | **10.50** |
| *Preventable Emergency Visits* ↓ | | | | | | |
| Preventable ED visits / Total ED visits | 384 / 2886 | | | | | |
| Percent preventable | 13.31% | | | | | |
| Overall ED rate per (PKPY) | 440.62 PKPY | | | | | |
| Rate of preventable ED visits (PKPY) | 58.63 PKPY | 88.01 PKPY | 80.97 PKPY | Yes | 9.00 | **9.00** |

Q1 2022

Page 1 of 5

## CBI Practice Profiles

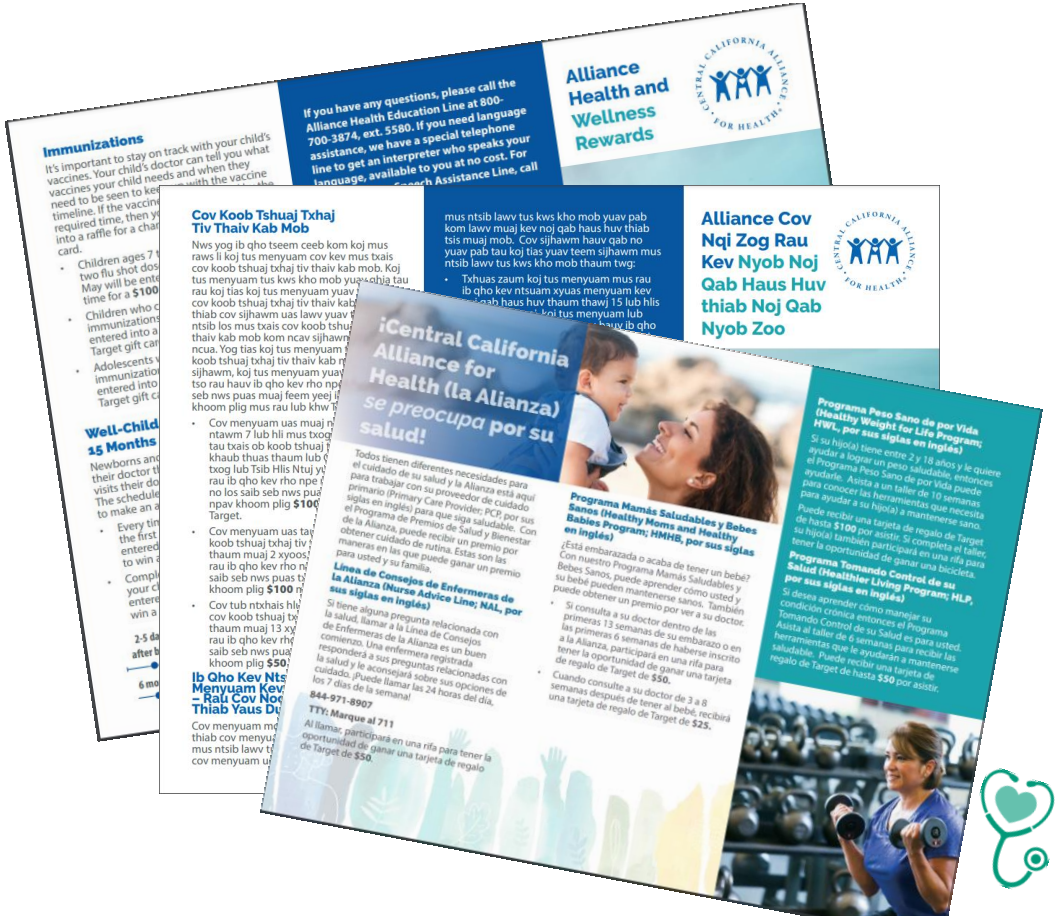
- Available Quarterly
- Distributed by your Provider Relations Representative
- Indicate any eligible FFS payment in the quarter


Programmatic & Fee-For-Service Measures
Q1 2022
Q2 2022
Q3 2022
Q4 2022
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Programmatic rolling 12-month measure eligibility[1]
CBI Q4 2022 Programmatic Payment Period
Q4 2022 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q1 2023 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q2 2023 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q3 2023 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q4 2023 FFS Payment Period

# Member Health and Wellness Rewards

## Reward Programs

- Well-Child Visits First 15 Months of Life
- Childhood and Adolescent Immunizations
  - Infant 2nd flu dose
- Healthy Moms and Healthy Babies Program
- Healthy Weight for Life
- Healthier Living Program



# Population Health

## Low Risk

## Moderate Risk

## High Risk

# 2021 CBI Top Performers

## Santa Cruz County

Pediatric Medical Group of Watsonville
Plazita Medical Clinic
Melissa Z Lopez-Bermejo

## Monterey County

St Junipero Clinic Inc
Romie Lane Pediatrics
Santa Lucia Medical Group

## Merced County

Newman Medical Clinic
Merced Faculty Associates Medical Group
Long Thao, M.D. INC.

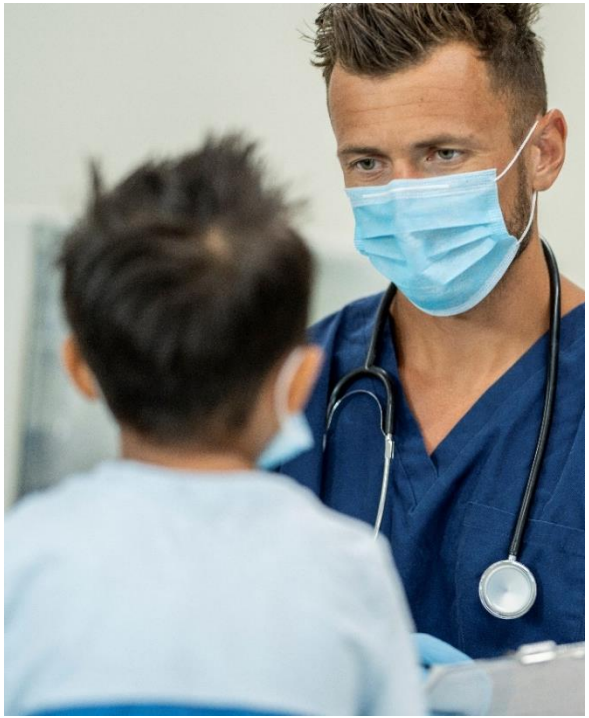
# Agenda



# California ACEs Aware Initiative

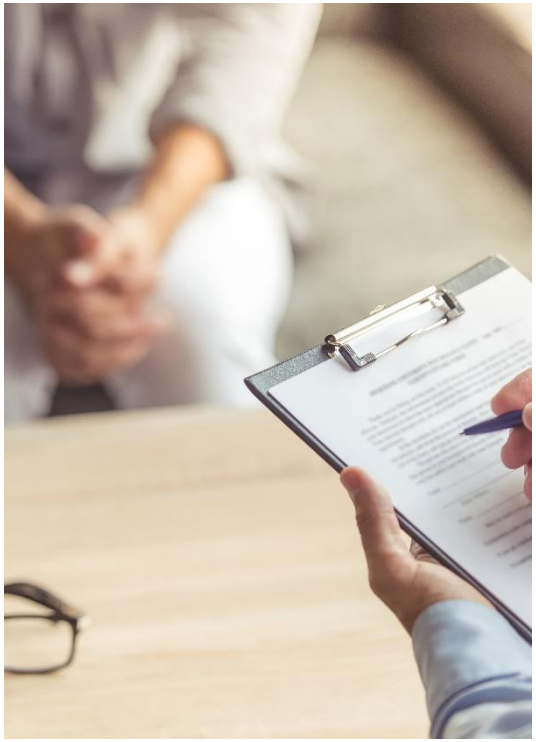
- Launched by California Surgeon General & DHCS
- Provides training, clinical protocols, screening tools and resource information
- ACE Screening Implementation Guide
- Community grants
- Mandated Reporters & ACE screenings

aces aware
SCREEN. TREAT. HEAL.



ACEs Aware Website: https://www.acesaware.org/

# Fee-For-Service: ACEs Training and Attestation



**Measure**

This measure is intended to provide compensation for time to complete the ACE training and attestation

**Payment**

$200 for PCPs and non-physician medical practitioners, credentialed as primary care providers, and/or qualifying residents

**Qualification**

- Completed "Becoming ACEs Aware in California" Core Training
  - https://www.acesaware.org/learn-about-screening/training/
- Submitted Training Attestation
  - National Provider Identifier (NPI); Clinic name and address
  - https://www.medi-cal.ca.gov/TSTA/TSTAattest.aspx

# Agenda



# Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents

$ 29.00

## Measure

Percentage of members 1 – 20 years of age who were screened for Adverse Childhood Experiences (ACEs), using a standardized screening tool, during the measurement period.

**Codes**

- **G9919** – score **4 or greater (high risk)**, results are positive
- **G9920** - score **between 0 – 3 (lower risk)**, results are negative

**For FQHCs, ACEs screening will need to be submitted on a separate claim from the visit.**

# Health Equity Measure

**Measure**

This is a health plan performance measure, using the Child and Adolescent Well-Care Visit measure to determine whether different ethnic groups had or did not have equitable access to primary care

**Metric**

NCQA HEDIS Child and Adolescent Well-Care Visit

**Goal**

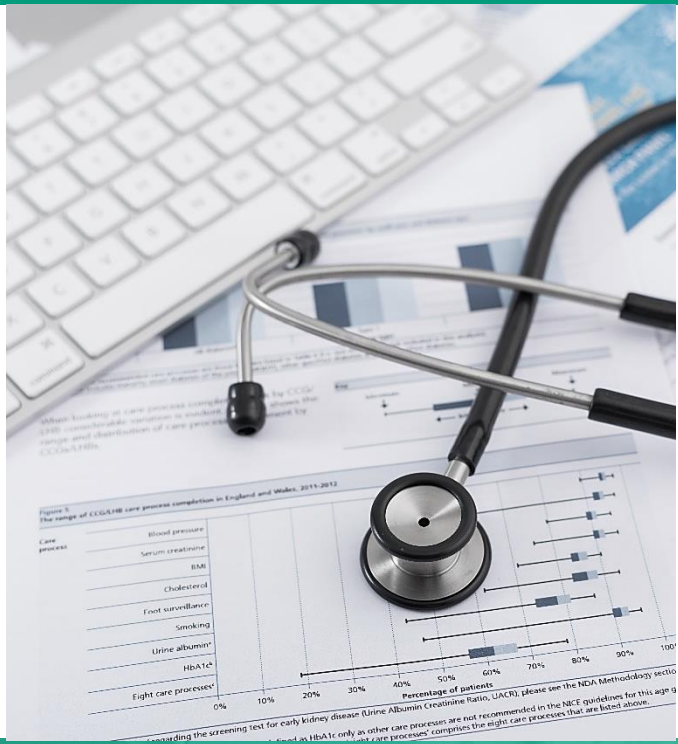
50% gap closure to 50$^{th}$ or 75$^{th}$ percentile

**Baseline**

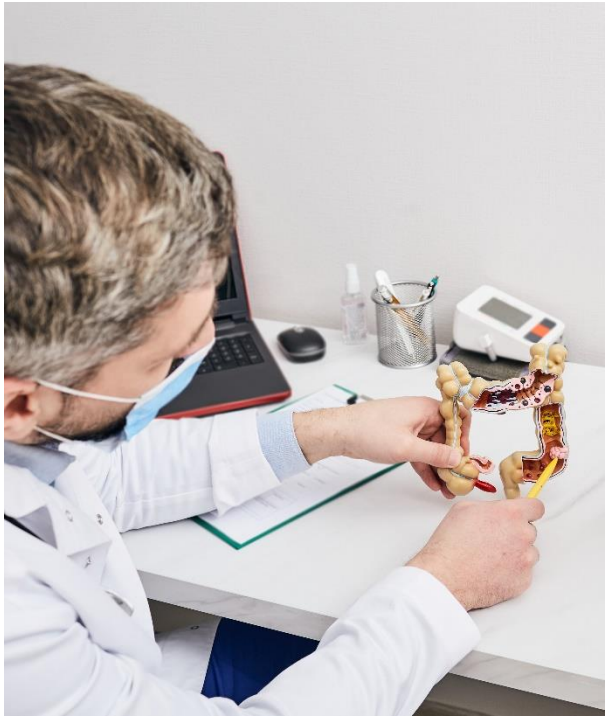
Quarter 4, 2022 CBI rates

# Agenda






# Colorectal Cancer Screening



## Measure

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

## Tips!

- Identify members who are due for screenings through EHR including active and inactive members
- Submit history of colorectal cancer screening via Data Submission Tool

# Agenda



# Retired Measures

- Unhealthy Alcohol Use in Adolescents and Adults
- Asthma Medication Ratio
- 90-Day Referral Completion
- Tuberculosis (TB) Risk Assessment

# Agenda



*"Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship."*

Hall JA, Roter DL, Rand CS. Communication of affect between patient and physician. J Health Soc Behav. 1981;22(1):18–30

# EFFECTIVE MEMBER AND PROVIDER COMMUNICATION

## OBJECTIVES:

1. Defining Effective Member Communication
2. Addressing Effective Communication
3. Tips and Strategies
4. Questions

# Defining Effective Member Communication

- Effective communication is bidirectional between members and healthcare systems
  - Members need to be able to convey information about their health
  - Providers must be able to adequately comprehend and interpret the health information being shared by members

# Addressing Effective Member Communication

Three-pronged approach:

1. Member Health Literacy
2. Cultural Competency
3. Language Barriers

# Health Literacy

Health literacy is defined as the member's ability to obtain, comprehend, communicate and understand basic healthcare information and services.

- Poor health literacy = higher rates of emergency and inpatient healthcare
- Low health literacy = affects the quality of member interaction with healthcare system

# Important Healthy Literacy Facts

- The average reading level of someone with Medi-Cal is?
  - **4th – 6th grade**
- Most health-related material is written at which reading grade level?
  - **10th grade**
- **Hispanic adults** have the lowest average health literacy scores of all racial/ethnic groups, followed by blacks
- **Nearly 9 out of 10 adults** struggle with health literacy,
  - They are more likely to: have poor health outcomes, make medication errors, and skip preventative services

# Cultural Competency

Cultural competency is a strategy to eliminate racial and ethnic disparities in healthcare.

- Cultural sensitivity and cultural awareness
- Patient and Member Relationship:
  - Race-and-socioeconomic-status-concordant providers = meaningful interactions with their members
  - Members with race-concordant relationships with their provider = greater satisfaction with the care than those who did not
  - Changing from a one-size-fits all approach.

# Language Barriers

- Language barriers are not always immediately evident
- All staff should be trained to use the language services, and services should be integrated operations
- Use qualified interpreters
- Limited English Proficiency (LEP) Members:
  - Someone who does not speak English as their primary language with a limited ability to read, write, or understand English

# Recognizing LEP Members

A LEP member might:

- Have their child/friend/family member call to make their appointment
- Speak to the bilingual receptionist in Spanish (or other non-English language)
- Have difficulty filling out paperwork
- Ask few questions and avoid initiating conversation
- Nod or simply say “yes” to most questions or comments
- Give unusual or inconsistent answers

***Remember: Someone who is not fluent in English will have even greater difficulty understanding medical information in English.***

# The Importance Of Using Qualified Interpreters

Why use Interpreter Services?

- Improve communication, meet member needs and achieve better outcomes
- Expand cultural awareness
- Increase member & provider satisfaction
- Comply with state law and contract requirements

# Tips and Strategies

Improve Member Communication with All Staff.

Strategies for clear communication:

- Give a warm greeting
- Maintain eye contact
- Listen carefully
- Be aware of member's body language and their own
- Speak slowly, use plain language, and avoid the use of medical jargon
- Use graphics and demonstrations when appropriate
- Schedule ahead and using qualified interpreters

# Tips and Strategies

Strategies for effective communication:

- BATHE Protocol
  - **B**ackground: What is going on in your life?
  - **A**ffect: How does that affect you?
  - **T**roubles: What troubles are you experiencing?
  - **H**andling: How are you handling them?
  - **E**mpathetic Statement: That must be very difficult for you

- Teach Back Method
  - Ask the member to repeat back what they have been told in their own words

# Agenda



# The Alliance's Practice Coaching Program

**Goal**

To engage and support individual clinics in quality improvement work

**Benefits**

- Support in QI methods
- Technical assistance for Data & EHR optimization
- Access to QI-related tools and assistance with selecting/adapting
- Enhanced connections to Alliance resources

**Questions?** pc@ccah-alliance.org

Naomi

Veronica

Eleni

# The **ABC's of Quality Improvement** Video Series

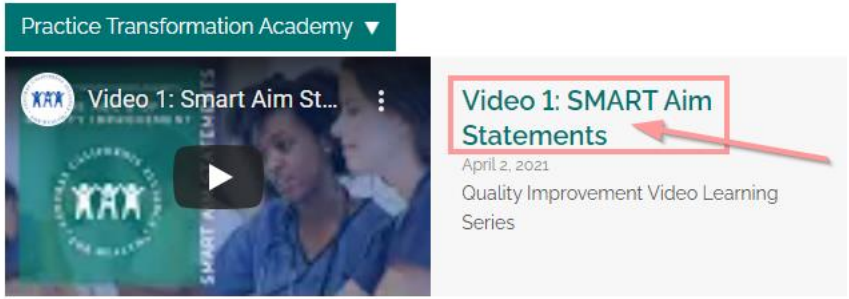
**Support clinic teams** with Quality Improvement efforts

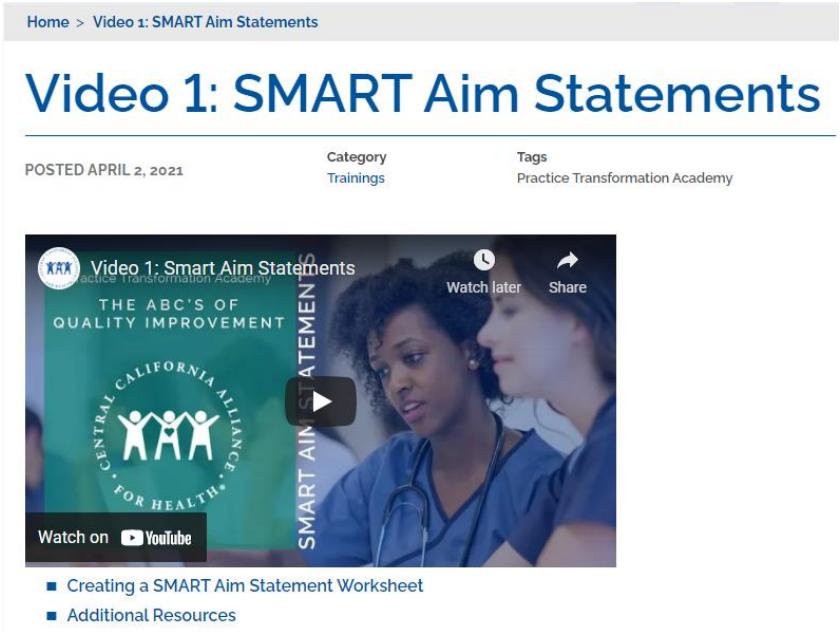
**Guide your QI project,** provides framework

**Available videos**

- SMART Aim Statements
- Project Charters
- Process Maps
- Lean Wastes
- Data *(coming October 2022!)*

**Link:** https://thealliance.health/for-providers/resources/training/
**Questions?** Contact pc@ccah-alliance.org



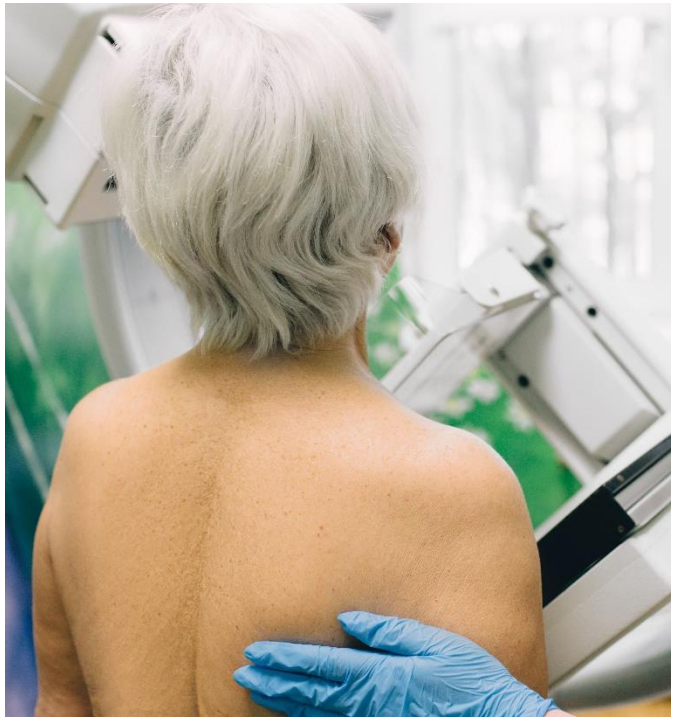



# Enhanced Care Management (eCM)

- New benefit from CalAIM
- Current populations
  - Individuals and Families Experiencing Homelessness
  - High Utilizer Adults
  - Adults who have SMI/SUD conditions
- Community Supports

**eCM:** https://thealliance.health/for-providers/enhanced-care-management-provider-referral-form/
**Community Supports:** https://thealliance.health/for-providers/community-supports-provider-referral-form/

# PDSAs in Practice - Breast Cancer Screening Project



## Measure

The percentage of women 50 – 74 years of age who had a mammogram to screen for breast cancer on or between October 1 two years prior to the measurement period and the end of the measurement period.

## Tips!

- Utilize Provider Portal to identify members due for screenings
- Submit history of mastectomy and mammograms via Data Submission Tool
- Create standing orders

# Controlling High Blood Pressure

**Measure**

The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled.

**New Pharmacy Benefit!**

As of 6/1/22, personal home use blood pressure monitors and cuffs will be covered.

- No diagnosis of HTN needed
- No prior authorization required
- No age restrictions

# Developmental Screening Billing Best Practices

## Developmental Screening

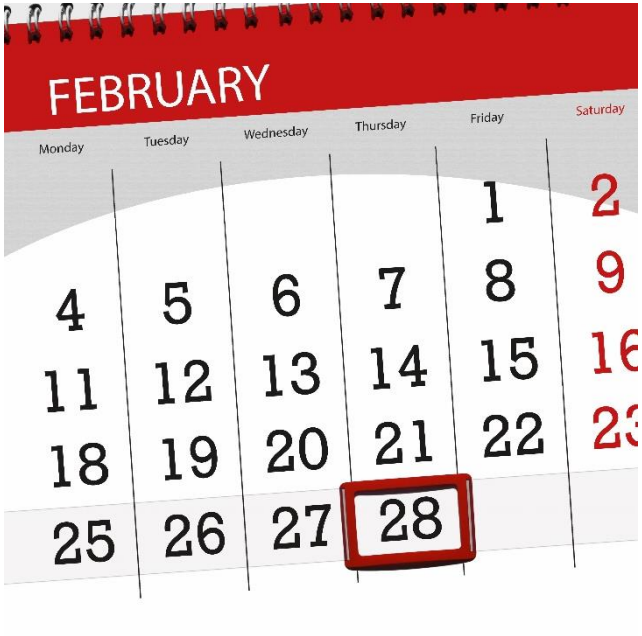
- Ages: 9, 18 and 30 months
- Validated Tools: ASQ-3, PEDS, PEDS-DM, SWYC, BDI-ST, BINS, CDI
- Frequency: twice in a 12-month period (only one test administered per day)
- CPT: 96110

## Autism Spectrum Screening

- Ages: 18 and 24 months
- Validated Tools: MCHAT
- Frequency: twice in a 12-month period (only one test administered per day)
- CPT: 96110
- Modifier: KX

# Submission Timeline

| Quarterly | Supplemental Data Due Date |
|---|---|
| **2022 – Quarter 4** | **February 28, 2023** |
| **2023 – Quarter 4** | **February 29, 2024** (leap year!) |




## Best Practice

Submit data **monthly** or **quarterly** to track progress

# Immunization Resources

**Flu reminders**

- Members 6 months – 8 year-olds need 2 doses when receiving flu vaccine for first time
- 2nd flu dose incentive for 7 months – 2 year-olds

**COVID-19 reminders**

- 6 months and older eligible
- Patients 6 months – 4 years need to be seen at PCP
- Regulatory vaccines can be given at the same time

**Vaccine reminders**

- Start cancer prevention HPV series at 9 years
- Child and adolescent member incentive raffles
- Adults need Zoster, Pneumococcal, Tdap & Flu
- Make strong recommendations

**RULE**

**R**esist the urge to correct
**U**nderstand their perspective
**L**isten with empathy
**E**mpower

# Key Points & Takeaways


- Utilize the **CBI Incentive Summary** and **Tip Sheets** as a guide to rate improvement
- Access the Provider Portal to **keep track of quarterly performance**
- **Schedule virtual CBI Forensics** to review your trends and performance
- View **Practice Transformation Academy Videos** via the Provider Webpage
- Curious about **Practice Coaching**? Reach out to **pc@ccah-alliance.org**!

# Questions?

# Contact Information


## CBI Team

Main email: cbi@ccah-alliance.org
Kristen Rohlf, MPH: krohlf@ccah-alliance.org
Annecy Majoros, BA: amajoros@ccah-alliance.org
Alex Sanchez, MPH: asanchez@ccah-alliance.org
Britta Vigurs, BFA: bvigurs@ccah-alliance.org

## Cultural & Linguistic Services

Main email: listcl@ccah-alliance.org

Mao Moua, MPA: mmoua@ccah-alliance.org

## Provider Relations Representative

Main phone: 800-700-3874 ext. 5504