2024 Care-Based Incentive Workbook

PROVIDER INCENTIVES

CENTRAL CALIFORNIA ALLIANCE FOR HEALTH

PROVIDER WORKSHOPS

Alliance Vision: Healthy people, Healthy communities.

Alliance Mission: Accessible, quality health care guided by local innovation.

INSIDE WORKBOOK

WELCOME!

Use this workbook during the 2024 Care-Based Incentive (CBI) workshop.

This year's focus will be:

- Program Overview
- What's New?
- Modified Measures
- Exploratory Measures
- Retired Measures
- Resources

Use the index on the left to follow along during the workshop.

Care-Based Incentive (CBI) Summary

The Central California Alliance for Health's Care-Based Incentive (CBI) program is comprised of a set of measures encouraging preventive health services and connecting Medi-Cal members with their primary care provider (PCP).

The CBI Program consists of Provider Incentives that are paid to qualifying contracted provider sites, including family practice, pediatrics and internal medicine. Provider incentives are broken into:

- **Programmatic** measures which are paid annually based their rate of performance in each measure.
- **Fee-For-Service (FFS)** measures which are paid quarterly when a specific service is performed, or a measure is achieved.

The Alliance also offers incentives to members through the **Health Rewards Program,** which are paid directly to members. Members are eligible for these incentives if they are enrolled with Medi-Cal through the Alliance. Additional information on member incentives can be found on the Health Rewards web page.

This incentive summary provides an overview the CBI program. For more information about provider incentive payments refer to the CBI Programmatic Measure Benchmarks & Performance Improvement and the Alliance Provider Manual. For additional information on the CBI Program, refer to the program year specific 2023 and 2024 CBI Technical Specifications. **For general questions, talk with your Provider Relations Representative or call Provider Services at (800) 700-3874 ext. 5504**.

2024 Summary of Changes

New Programmatic Measures:

- Lead Screening in Children: This measure was moved from exploratory to a programmatic measure.

New Fee-For-Service (FFS) Measures:

- Diagnostic Accuracy and Completeness Training.
- Cognitive Health Assessment Training and Attestation.
- Social Determinants of Health (SDOH) ICD-10 Z-Code Submission.
- Quality Performance Improvement Projects

Measure Changes:

- Initial Health Assessment has been changed to Initial Health Appointment.
- Screening for Depression and Follow-up Plan has been changed to Depression Screening for Adolescents and Adults.
- Health Equity Measure: This is a health plan performance measure, using the

Child and Adolescent Well-Care Visit measure. Points will be awarded if well-child visit rates are improved for all race/ethnicities.

Retired Measures:

- Body Mass Index (BMI) Assessment: Children & Adolescent
- Immunizations: Adults

New Exploratory Measures:

- Well-Child Visits for Age 15 Months – 30 Months

2023 Summary of Changes

New Programmatic Measures:

- Adverse Childhood Events (ACEs) Screening in Children and Adolescents has been moved from an exploratory to programmatic measure.
- Health Equity is a new measure category, replacing the health plan health disparity exploratory measure.

Measure Changes:

- Points from the Unhealthy Alcohol use in Adolescents and Adults have been redistributed to the Adverse Childhood Events (ACEs) Screening in Children and Adolescents.
- Points from Ambulatory Care Sensitive Admissions (ACSA), Preventable Emergency Visits, Initial Health Assessment (IHA), and Quality of Care measure have been redistributed to the Health Equity measure.

New Exploratory Measure:

- Colorectal Cancer Screening.

New Fee-For-Service (FFS) Measure:

- Adverse Childhood Experiences (ACEs) Training and Attestation.

Retired Measures:

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

Programmatic

Care Coordination Measures - Access Measures

Measure	Summary Definition	Member Eligibility	Resources	Points Possible: 21.5
Adverse Childhood Experiences (ACEs) Screening in Children and Adolescents*	The percentage of members ages 1-20 years of age who are screened for Adverse Childhood Experiences (ACEs) annually using a standardized screening tool.	≥5 Eligible Linked Members	Adverse Childhood Experiences (ACEs) in Children and Adolescents Tip Sheet Screening codes: G9919 - Screening performed – results positive and provision of recommendations provided G9920 - Screening performed – results negative	3
Application of Dental Fluoride Varnish	The percentage of members ages 6 months to 5 years (up to or before their 6th birthday) who received at least one topical fluoride application by staff at the PCP office during the measurement year.	≥5 Eligible Linked Members	Application of Dental Fluoride Varnish Tip Sheet Fluoride Application Code: CPT 99188	2
Developmental Screening in the First 3 Years	The percentage of members ages1-3 years screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	≥5 Eligible Linked Members	Developmental Screening in the First 3 Years Tip Sheet Developmental Screening Code: 96110	2
Initial Health Appointment	New members that receive a comprehensive initial health appointment within 120 days of enrollment with the Alliance.	≥5 Linked Members continuously reenrolled within 120 days of enrollment (4 months)	DHCS MMCD Policy Letter 22-030 For a full list of codes see the IHA Tip Sheet.	4
Post-Discharge Care	Members who receive a post-discharge visit within 14 days of discharge from a hospital inpatient stay. This measure pertains to acute hospital discharges only. Emergency room visits do not qualify.	≥5 Eligible Linked Members	Post-Discharge Codes: 99202-99215, 99241-99245, 99341- 99350, 99381-99385, 99391-99395, 99429	10.5
Care Coordination Measures – Hospital and Outpatient Measures				
Measure	**Summary Definition**	**Member Eligibility**	**Resources**	**Points Possible: 25.5**
Ambulatory Care Sensitive Admissions	The number of ambulatory care sensitive admissions (based upon Plan-identified AHRQ specifications) per 100 Eligible Members per year.	≥100 Eligible Linked Members	Ambulatory Care Sensitive Diagnosis For a full list of codes see the CBI Technical Specifications	7
Plan All-Cause Readmission	The number of members 18 years of age and older with acute inpatient and observation stays during the	≥100 Eligible Linked Members	Plan All-Cause Readmission Tip Sheet For a full list of codes see the CBI Technical Specifications	10.5

	measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days.			
Preventable Emergency Visits	The rate of preventable ED and urgent visits per 1,000 members per year. **Urgent Visits count as half the value as ED visits**	≥100 Eligible Linked Members	Alliance Case Management and Care Coordination Programs Preventable Emergency Visits Tip Sheet Preventable Emergency Visit Diagnosis Tip Sheet	8
Quality of Care Measures				
Measure	**Summary Definition**	**Member Eligibility**	**Resources**	**Points Possible: 38**
Breast Cancer Screening	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.	≥30 Eligible Linked Members	Breast Cancer Screening Tip Sheet Breast Cancer Screening Codes: 77061-77067 For a full list of codes see the CBI Technical Specifications	Varies
Cervical Cancer Screening	Women 21-64 years of age who were screened for cervical cancer using either of the following criteria: • 21-64 years of age who had a cervical cytology performed within the last 3 years, beginning at age 21; or • 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years; or • 30-64 years of age who had cervical cytology/HPV co-testing performed within the last 5 years	≥30 Eligible Linked Members	Cervical Cancer Screening Tip Sheet Cervical Cancer Screening Codes: Q0091 - using this code will ensure compliance obtaining, preparing and conveyance of cervical smear to a laboratory rather than relying on the lab to submit the claim. **To exclude members from the measure:** **Z90.710 -** absence of both cervix and uterus **Z90.712 -** absence of cervix with remaining uterus **Q51.5** - agenesis and aplasia of cervix (Can be used for a male-to-female transgender person) For a full list of codes see the CBI Technical Specifications	Varies
Child and Adolescent Well-Care Visits (3-21 years)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	≥30 Eligible Linked Members	Child and Adolescent Well-Care Visits Tip Sheet Well-Visit Codes: 99382-99385, 99392-99395, Z00.00-Z00.01, Z00.121-Z00.129, Z01.411, Z01.419, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	Varies
Depression Screening for Adolescents and Adults	The percentage of members 12 years of age and older who are screened for clinical depression using an age appropriate standardized tool, performed between January 1 and December 1 of the measurement period.	≥30 Eligible Linked Members	Depression Screening for Adolescents and Adults Tip Sheet LOINC Codes: 89208-3, 89209-1, 89205-9, 71354-5, 90853-3, 48545-8, 48544-1, 55758-7, 44261-6, 89204-2, 71965-8, 90221-3, 71777-7	

Diabetic HbA1c Poor Control >9.0%	Members age 18-75 who had a HbA1c test during the last 12 months, and whose most recent HbA1c test had result of >9.0%. **Members with no lab result submitted will be considered non-compliant for this measure.** (This is a reverse measure: lower rate is better)	≥30 Eligible Linked Members	Diabetic HbA1c Poor Control >9% Tip Sheet Health Education and Disease Management Programs HbA1c Test Codes: 83036, 83037 (non-benefit) HbA1c Results: 3044F - 3046F, 3051F, 3052F	Varies
Immunization: Adolescents	Adolescents turning 13 years of age who have received the following vaccinations by the time of their 13th birthday: • 1 dose meningococcal conjugate • 1 dose tetanus, diphtheria, and pertussis (Tdap) • 2 doses of human papillomavirus (HPV)	≥30 Eligible Linked Members	Immunizations: Adolescents Tip Sheet Immunization Codes: Meningococcal – 90619, 90733, 90734 Tdap - 90715 HPV – 90649, 90650, 90651	Varies
Immunization: Children (Combo 10)	Toddlers turning 2 years of age who have received all of the following vaccinations by on or by their 2nd birthday: 4 diphtheria, tetanus, acellular pertussis (DTaP); 3 inactivated polio vaccine (IPV); 1 measles, mumps and rubella (MMR); 3 haemophilus influenza type B (HiB); 3 hepatitis B (HepB); 1 varicella (VZV); 4 pneumococcal conjugate (PCV) 2 or 3 rotavirus (RV) 1 hepatitis A (HepA) 2 influenza (flu)	≥30 Eligible Linked Members	Immunizations: Children (Combo 10) Tip Sheet **For a full list of codes see the** CBI Technical Specifications	Varies
Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday	≥30 Eligible Linked Members	Lead Screening in Children Tip Sheet Lead Screening Codes: 83655 For a full list of codes see the CBI Tech Specs.	Varies
Well-Child Visit in the First 15 Months	Members age 15 months old who had 6 or more well-child visits with a PCP during the first 15 months of life.	≥30 Eligible Linked Members	Well-Child Visit First 15 Months Tip Sheet Well-Child Visit Codes: 99381, 99382, 99391, 99392, 99461, Z00.110-Z00.129, Z00.2 Z02.5, Z76.1, Z76.2	Varies

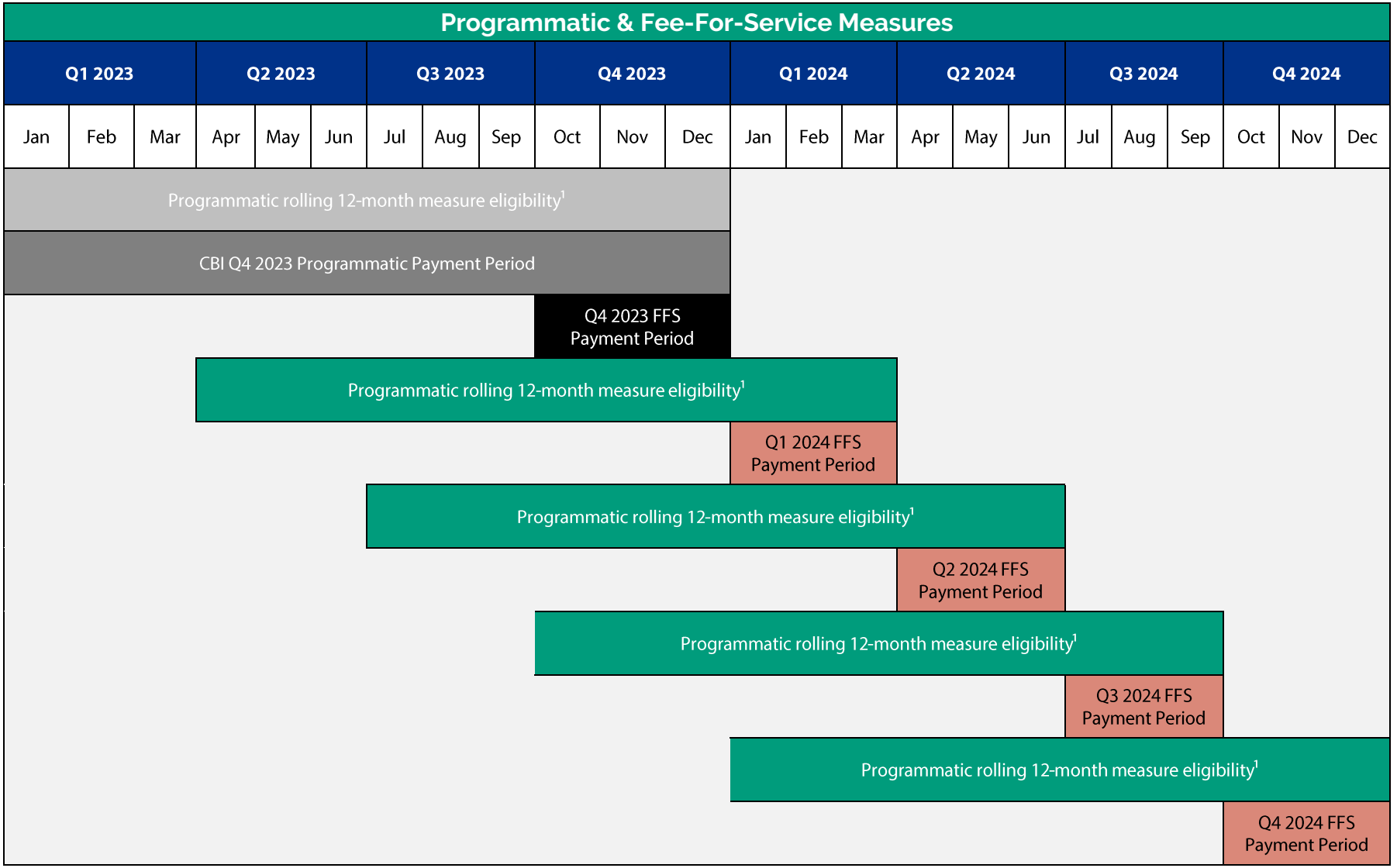
Performance Target Measure				
Measure	**Summary Definition**	**Member Eligibility**	**Resources**	**Points Possible**
Performance Improvement Measure	Providers can receive Performance Improvement points for every measure they qualify for by either: Meeting the Plan Goal **or** Achieving a 5% improvement compared to the prior year.	Measure specific member eligibility requirements	Programmatic Measure Benchmarks & Performance Improvement	10
Exploratory Measures				
Measure	**Summary Definition**	**Member Eligibility**	**Resources**	**Points Possible**
Chlamydia Screening in Women	Women 16 to 24 years old who are identified as sexually active and who had at least one screening for chlamydia during the measurement year	≥30 Eligible Linked Members	Chlamydia Screening in Women Tip Sheet Chlamydia Screening Codes: 87110, 87270, 87320, 87490-87492, 87810	N/A
Controlling High Blood Pressure	Members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (140/90 mm Hg) in the last 12 months. **BP reading must occur on or after the date of the second HTN diagnosis**.	≥30 Eligible Linked Members	Controlling High Blood Pressure Tip Sheet Controlling High Blood Pressure Codes: 3074F, 3075F 3077F, 3078F, 3079F, 3080F	N/A
Colorectal Cancer Screening	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. For Members 46-75 years use any of the following criteria: • Fecal occult blood test within the last year. • Flexible sigmoidoscopy within the last 5 years. • Colonoscopy within the last 10 years. • CT colonography within the last 5 years. Stool DNA (sDNA) with FIT test within the last 3 years.	≥30 Eligible Linked Members	Colorectal Cancer Screening Tip Sheet Fecal occult blood test CPT codes: 82270, 82274 Flexible sigmoidoscopy CPT codes: 45330-45350 Colonoscopy codes: • CPT: 44388-44394, 44397, 44401-44408, 45355, 45378-45393, 45398 • ICD-9: 45.22-45.23, 45.25, 45.42-45.43 CT colonography CPT codes: 74261-74263 Stool DNA (sDNA) with FIT CPT code: 81528	N/A
Well-Child Visits for Age 15-30 Months of Life	The percentage of members age 30 months old who had 2 or more well-child visits with a PCP between the child's 15-month birthday plus one day and the 30-month birthday.	≥30 Eligible Linked Members	Well-Child Visits for Age 15-30 Months of Life Tip Sheet Well-Child Visit Codes: 99382, 99392, 99461, Z00.121, Z00.129, Z00.2, Z76.1, Z76.2, Z02.5	N/A
Health Equity Measure				

Measure	Summary Definition	Member Eligibility	Resources	Points Possible
Health Equity*	This is a health plan performance measure, using the Child and Adolescent Well-Care Visit measure. Points will be earned for 5 – 10% improvement for each ethnicity.	30	CBI Technical Specifications Child and Adolescent Well-Care Visits Tip Sheet Well-Visit Codes: 99382-99385, 99392-99395, Z00.00-Z00.01, Z00.121-Z00.129, Z01.411, Z01.419, Z00.2, Z00.3, Z02.5, Z76.1, Z76.2	5

Fee-for-Service

Practice Management Measures		
Measure	**Summary Definition**	**Resources**
Adverse Childhood Experiences (ACEs) Training and Attestation	Plan shall pay providers, which includes mid-level providers, for completing the DHCS ACEs training and attestation. The plan will pay each CBI group $200 that the provider practices under.	$200 one-time payment Single time payment after receipt of State notification of training and attestation completion. Payments do not reoccur yearly or quarterly. CBI Technical Specifications
Behavioral Health Integration	Plan shall pay a $1,000 one-time payment to providers for achievement of NCQA Distinction in Behavioral Health Integration. Payments are made a single time after distinction is received by the Alliance. Payments do not reoccur yearly or quarterly.	CBI Technical Specifications
Cognitive Health Assessment Training and Attestation	Plan shall pay providers, which includes mid-level providers, for completing the DHCS cognitive health assessment training and attestation. The plan will pay each CBI group $200 that the provider practices under.	$200 one-time payment Single time payment after receipt of State notification of training and attestation completion. Payments do not reoccur yearly or quarterly. CBI Technical Specifications
Diagnostic Accuracy and Completeness Training	Plan shall pay providers for completing the CMS Diagnostic Accuracy and Completeness Training.	$200 one-time payment Single time payment after receipt of certification notification of training completion.
Quality Performance Improvement Projects	Plan shall pay providers $1000 for each office that completes an Alliance offered Quality Performance Improvement Project. Only offices with metrics that are below the minimum performance level, measured at the 50th percentile for the 2023 year programmatic payment are eligible for payment for completion of Quality Performance Improvement Projects.	$1,000 one-time payment after notification of project completion.

Patient Centered Medical Home (PCMH) Recognition	Plan shall pay a one-time payment of $2,500 to providers for achievement of NCQA recognition or The Joint Commission (TJC) certification. A copy of the recognition/ certification must be received by the Alliance. Payments do not reoccur yearly or quarterly.	For providers submitting their initial application for NCQA PCMH Recognition, use Alliance discount code **CCAAHA** to **save 20%** on your initial application fee. CBI Technical Specifications
Social Determinants of Health (SDOH) ICD-10 Z Code Submission	Plan shall pay clinics who submit DHCS Social Determinants of Health (SDOH) priority ICD-10 Z-codes.	$250 quarterly payments for claims submissions with priority SDOH Z-codes, with $1,000 maximum payment.


Programmatic & Fee-For-Service Measures
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Q1 2024
Q2 2024
Q3 2024
Q4 2024
Jan
Feb
Mar
Apr
May
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Jul
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Programmatic rolling 12-month measure eligibility[1]
CBI Q4 2023 Programmatic Payment Period
Q4 2023 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q1 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q2 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q3 2024 FFS Payment Period
Programmatic rolling 12-month measure eligibility[1]
Q4 2024 FFS Payment Period

Child and Adolescent Well-Care Visits Tip Sheet

Measure Description

The percentage of enrolled members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Incentive

Incentives will be paid to the linked PCP on an annual basis, following the end of Quarter 4. For additional information, refer to the CBI Technical Specifications.

Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

Documentation Requirements

Documentation must include a note indicating the visit was with a PCP or OB/GYN, and evidence of **all** of the following:

- **Health history:** assessment of the member's history of disease or illness (allergies, medications, immunization status).
- **Physical developmental history:** assessment of the member's specific age-appropriate physical developmental milestones.
- **Mental developmental history:** assessment of specific age-appropriate mental developmental milestones.
- **Physical exam.**
- **Health education/anticipatory guidance:** given by the PCP to the member and/or parents or guardians in anticipation of emerging issues that a child/adolescent and family may face.

Coding Requirements

Well-visit CPT Codes:
New Patients: 99382, 99383, 99384, 99385
Established Patients: 99392, 99393, 99394, 99395
Well-visit ICD-10 Codes: Z00.121, Z00.129, Z00.00, Z00.01
Additional ICD-10 Codes: Z00.2, Z00.3, Z02.5, Z01.411, Z01.419, Z76.1, Z76.2

Billing Frequency:

- 3-17 years: Well-visits payable every 180 days.
- 18-21 years: Well-visits payable once every 12 months.

Please refer to the AMA coding guidelines for billing well-care visits with office visits in the same day. Be

advised that medical records would need supportive documentation to reflect services outside of the well-care visit

Data Collection

Data for this measure will be collected using claims, DHCS Fee-For-Service encounter claims, and provider data submissions via the Data Submission Tool (DST) on the Provider Portal.

1. Run a report from your EHR system; or
2. Manually compile patient data (Example: Download your Care-Based Incentives Measure Details report on the Provider Portal and compare to your EHR/paper charts).

How to Submit Data

This measure allows providers to submit well-child visits from the clinic EMR/EHR system or paper records to the Alliance by the DST contractual deadline. This includes well visits that were completed before the member was eligible for Medi-Cal or during a gap in coverage. To submit, you may upload data files to the DST on the Provider Portal. To be accepted, data must be submitted as a CSV file. Step-by-step instructions are available in the Data Submission Tool Guide on the Provider Portal.

Best Practices

- The American Academy of Pediatrics (AAP) and Bright Futures recommend annual well-care visits during childhood and adolescence. See the Bright Futures Periodicity Schedule for a comprehensive schedule up to 21 years of age. Bright Futures also offers guidelines for early childhood (1-4 years), middle childhood (5-10 years) and adolescent (11-21 years) well-care visits.
- **Utilize telehealth visits** for patients that do not feel comfortable coming into the clinic.
- **Utilize Medical Assistants to create pending orders** in the EHR for each immunization due during every visit. The clinician must manually uncheck the immunization order during each visit if they are unable to provide the vaccination due for the child. This is a method of ensuring reminders for needed vaccinations are present during every visit.
- **Leverage missed opportunities** (episodic and sick visits) to increase preventive services (immunizations), as well as convert acute visits into well-visits (sports physicals).
- **Schedule the next well-visit** before the member leaves the clinic, including when they come in for a sick visit.
- **Partnering with key community stakeholders** like school-based clinics.
- **Monitor the Provider Portal** reports as a tool for identifying members that are due for their well-visit.
- **Create a template** or use age-specific standardized templates in your EHR to maximize documentation of Bright Futures requirements and trigger reminders for the next well visits.
- **Encourage teen-centered care** with adolescent-friendly material and ensured confidentiality through private consultation time with the adolescent.
- **Promote healthy behaviors** and assess for risky behaviors to detect conditions that may interfere with physical, social and emotional development.
- **Grouping child and adolescent well-care visits** has been shown to be as effective as individual well-visits: Parents had longer visits with more content, which was associated with more anticipatory guidance, family-centered care and parent satisfaction.[1]
- **Alliance interpreting services are available to network providers:**
  - **Telephonic interpreting services** are available to assist in scheduling members.
  - **Face-to-face interpreters** can be requested to be at the appointment with the member.
- Route after-hours calls from Alliance members to the **Alliance's Nurse Advice Line: 844-971-8907.**
- Refer patients that have transportation challenges to the **Alliance's Transportation Coordinator at 800-700-3874 ext. 5577**. This service is not covered for non-medical locations or appointments that are not medically necessary.

Resources

- Get to Know Bright Futures Guidelines and Core Tools.
- Integrate Bright Futures Into Your Electronic Health Record System.
- Practical Tips for Implementing Bright Futures in Clinical Practice from Bright Futures.
- Promoting Health for Children and Youth with Special Health Care Needs from Bright Futures.
- Integrating Social Determinants of Health into Health Supervision Visits from Bright Futures.
- Equitable Health Toolkit from Washington Chapter of the American Academy of Pediatrics.
- American Academy of Pediatrics (AAP) A Pediatrician's Guide to an LGBTQ+ Friendly Practice
- AAP Family-Centered and Equitable Care Approaches
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures

[1] Coker, T., Windon, A., Moreno, C., Schuster, M., Chung, P. Well-Child Care Clinical Practice Redesign for Young Children: A Systematic Review of Strategies and Tools. *Pediatrics*. 2013 Mar; 131(Suppl 1): S5–S25.

Depression Screening for Adolescents and Adults Tip Sheet

Measure Description

The percentage of members 12 years of age and older who are screened for clinical depression using an age appropriate standardized tool, performed between January 1 and December 1 of the measurement period.

Incentive

Incentives will be paid on an annual basis, following the end of Quarter 4. For additional information refer to the CBI Technical Specifications.

Exclusions

Members will be excluded from the measure if they have a history bipolar disorder any time during the member's history through the end of the year prior to the measurement period.

Members with depression that starts during the year prior to the measurement period.

Members in hospice or using hospice services any time during the measurement period.

Members who died during the measurement year.

To view applicable diagnosis codes for the exclusion, see the CBI Technical Specifications.

Documentation Requirements

Medical records must document:

- The name of the depression screening tool and result. If the screening is positive, follow-up should occur on or up to 30 days after the first positive screen.

Documented follow-up can include:

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication OR
- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Screening Tools

Screening is only reimbursable with a validated screening tool. Screening tools do *not* need to be sent to the Alliance and must be maintained in the patient's medical record. Example tools include:

Instruments for Adolescents (≤17 years)	Results Considered as Positive Finding
Patient Health Questionnaire (PHQ-9)	Total Score ≥ 10
Patient Health Questionnaire Modified for Teens (PHQ-9M)	Total Score ≥10
Patient Health Questionnaire-2 PHQ2	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)	Total Score ≥ 8
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Edinburgh Postnatal Depression Scale (EPDS)	Total Score › 10
PROMIS Depression	Total Score (T Score) ≥ 60

Instruments for Adults (18+ years)	Results Considered as Positive Finding
Patient Health Questionnaire 9 (PHQ-9)	Total Score ≥ 10
Patient Health Questionnaire-2 PHQ2	Total Score ≥ 3
Beck Depression Inventory-Fast Screen (BDI-FS)	Total Score ≥ 8
Beck Depression Inventory (BDI or BDI II)	Total Score ≥ 20
Center for Epidemiologic Studies Depression Scale-Revised (CESD-R)	Total Score ≥ 17
Duke Anxiety-Depression Scale (DUKE-AD)	Total Score ≥ 30
Geriatric Depression Scale Short Form (GDS)	Total Score ≥ 5
Geriatric Depression Scale Long Form (GDS)	Total Score ≥ 10
Edinburgh Postnatal Depression Scale (EPDS)	Total Score ≥ 10
My Mood Monitor (M-3)	Total Score ≥ 5
PROMIS Depression	Total Score (T Score) ≥ 60
Clinically Useful Depression Outcome Scale (CUDOS)	Total Score ≥ 31

Coding Requirements

The measure uses non-billable LOINC codes, which need a corresponding result in order for the screening to count in the measure.

Code Type	Code	Code Description
LOINC	89208-3	Beck Depression Inventory Fast Screen total score [BDI]
LOINC	89209-1	Beck Depression Inventory II total score [BDI]
LOINC	89205-9	Center for Epidemiologic Studies Depression Scale-Revised total score [CESD-R]
LOINC	71354-5	Edinburgh Postnatal Depression Scale [EPDS]
LOINC	90853-3	Final score [DUKE-AD]
LOINC	48545-8	Geriatric depression scale (GDS) short version total
LOINC	48544-1	Geriatric depression scale (GDS) total
LOINC	55758-7	Patient Health Questionnaire 2 item (PHQ-2) total score [Reported]
LOINC	44261-6	Patient Health Questionnaire 9 item (PHQ-9) total score [Reported]
LOINC	89204-2	Patient Health Questionnaire-9: Modified for Teens total score [Reported.PHQ.Teen]
LOINC	71965-8	PROMIS-29 Depression score T-score
LOINC	90221-3	Total score [CUDOS]
LOINC	71777-7	Total score [M3]

Data Collection

Data for this measure will be collected using claims. To find gaps in data:

- Run a report from your Electronic Health Record (EHR) system.
- Manually compile patient data (Example: Download the CBI report on the Provider Portal and compare to EHR).

Best Practices

- Complete screening annually in addition to clinical judgment, consideration of risk factors, comorbid conditions, and member life events (e.g. pregnancy).
- For those with a history of depression, screen at each visit.
- Medical Assistant administers initial depression screen and documents results.
- Screen patients at least once during the perinatal period for depression and anxiety symptoms.
- Screen for postpartum depression at the infant's one, two, four, and six-month well-child visits and beyond.
- Utilize collaborative care interventions involving multifaceted care team approaches (e.g. primary care physician, case manager with mental health background, psychiatrist, etc.).
- Implement a call back program for reaching out to patients with positive screens to keep engagement.
- Refer **Alliance members to Care Management services**, including Complex Case Management and Care Coordination, by calling Case Management at **800-700-3874, ext. 5512**.
- Refer **Alliance members to Enhanced Care Management (ECM) Services and Community Supports** through the Alliance Provider Portal, email (**listecmteam@ccah-alliance.org**), mail or fax, or by phone at **831-430-5512**.
- **Alliance interpreting services are available to network providers**:
    - **Telephonic interpreting services** are available to assist in scheduling members.
    - **Face-to-face interpreters** can be requested to be at the appointment with the member.

  For information about our Cultural and Linguistic Services Program, please call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at **listcl@ccah-alliance.org**.
- Refer patients who have transportation challenges to the **Alliance's Transportation Coordinator at 800-700-3874, ext. 5577**. This service is not covered for non-medical locations or for appointments that are not medically necessary.

Resources

- Alliance Behavioral Health website
- Carelon Behavioral Health Primary Care Provider (PCP) Referral Form
- Carelon Care Management Referral Form

Care-Based Incentive (CBI)

PROVIDER INCENTIVES

Diabetic HbA1c Poor Control >9% Tip Sheet

Measure Description
The percentage of members 18–75 years of age with diabetes (type 1 and type 2) with an HbA1c score of >9%. **Members with no lab result submitted, claim without a HbA1c value or HbA1c value >9% will be considered non-compliant for this measure** (A lower rate indicates better performance).

Incentive
Incentives will be paid to the linked primary care provider (PCP) on an annual basis, following the end of Quarter 4. For additional information, refer to the CBI Technical Specifications.

Exclusions
Members who do not have a diagnosis of diabetes in any setting during the measurement year or the year prior **and** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or year prior.

Members in hospice or receiving hospice services or palliative care during the measurement year.

Members who died any time during the measurement year.

Members 66 years of age and older as of December 31 of the measurement year with frailty **and** advanced illness:

- At least one encounter for frailty during the measurement year.
- At least one of the following during the measurement year or year prior to the measurement period:
    - At least **two** outpatient visits, observation visits, ED visits, e-visits or virtual check-ins, nonacute inpatient encounter, or nonacute inpatient discharge on a different date of service (DOS), with an advanced illness diagnosis. Visit type need not be the same for the two visits.
    - At least one acute inpatient encounter or one acute inpatient discharge with an advanced illness diagnosis.
    - A dispensed dementia medication.

Coding Requirements
CPT Codes: 83036, 83037 (Non Medi-Cal benefit code)
LOINC Codes: 17856-6, 4548-4, 4549-2, 96595-4

CPT Category II codes are optional tracking codes that can be used for performance measurement, here defining the HbA1c range. They may not be used as a substitute for Category I codes.

Code	Definition
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)

3046F	Most recent hemoglobin A1c level greater than 9.0% (DM)
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)

Data Collection

Data for this measure is collected using claims, laboratory data, DHCS FFS encounter claims, and provider data submissions via the DST on the Provider Portal. To find gaps in data:

- Run a report from your electronic health record (EHR) system; ***or***
- Manually compile patient data (Example: Download monthly diabetes care quality report or your Care-Based Incentives Measure Details report on the Provider Portal and compare to EHR/paper charts.

How to Submit Data

This measure allows providers to submit HbA1c test results from the clinic EHR system or paper records to the Alliance by the DST contractual deadline . To submit, you may upload data files to the DST on the Provider Portal. To be accepted, data must be submitted as a CSV file. Step-by-step instructions are available in the Data Submission Tool Guide on the Provider Portal.

Best Practices

HbA1c Testing

- Perform A1C test every 3 months in patients whose therapy has changed or who are not meeting glycemic goals (≥9.0 HbA1c).
- Set appropriate individualized A1C goals based on relevant comorbidities, demographic factors and other considerations.
- Point-of-care testing for A1C provides the opportunity for more timely treatment changes.

Health Education

- Recommend lifestyle changes as appropriate (e.g. stress management, exercise and better eating habits).
- Enroll members into Alliance Health Education and Disease Management Programs using the Health Education and Disease Management Program Referral Form.
    - **Live Better with Diabetes program** covers diabetes education for all ages and provides tools for diabetes management.
    - **Diabetes Self-Management Education program (DSME**) connects members diagnosed with diabetes with up to 20.5 hours of education during the initial 12 months following the diagnosis. The program also includes up to two hours of follow-up each year with pre-approved education providers (i.e. Certified Diabetes Educators).
    - **Diabetes Prevention Program (CDC-DPP)** is an evidence-based curriculum for members diagnosed with pre-diabetes that connects members to lifestyle coaches.
    - **Healthier Living Program (HLP)**, is a six-week series of self-management workshops that focus on health, wellness and problems that are common to individuals suffering from any chronic conditions.

Alliance Resources

- Refer **Alliance members to Care Management services**, including Complex Case Management and

Care Coordination, by calling Case Management at **800-700-3874, ext. 5512**.

- Refer **Alliance members to Enhanced Care Management (ECM) Services and Community Supports** through the Alliance Provider Portal, email (**listecmteam@ccah-alliance.org**), mail or fax, or by phone at **831-430-5512**.

- **Alliance interpreting services are available to network providers:**
  - **Telephonic interpreting services** are available to assist in scheduling members.
  - **Face-to-face interpreters** can be requested to be at the appointment with the member.

  For information about our Cultural and Linguistic Services Program, please call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at **listcl@ccah-alliance.org**.
- Refer patients who have transportation challenges to the **Alliance's Transportation Coordinator at 800-700-3874, ext. 5577**. This service is not covered for non-medical locations or for appointments that are not medically necessary.

Clinic Education

Pharmacist-Led Academic detailing (PLAD) is an effective, multi-faceted educational program designed to support Alliance primary care clinicians and their patients. We aim to improve the quality of care provided to patients with diabetes by collaborating with clinicians to implement evidence-based pharmacologic clinical guidelines in diabetes care management. The interactive sessions with clinicians are tailored to their specific needs and interests, making it a personalized and effective approach. Sessions involve interactive discussions, case studies, and useful tools for implementing best practices in the clinical setting. For more information, please email pharmacy@ccah-alliance.org and include the phrase **"Pharmacist-Led Academic Detailing"** in the subject line.

Lead Screening in Children Tip Sheet

Measure Description
The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Measure Change for 2024
The Lead Screening in Children measure has moved from an Exploratory measure in 2023 to a paid measure in 2024.

Incentive
Incentives will be paid to the linked primary care provider (PCP) on an annual basis, following the end of Quarter 4. For additional information, refer to the CBI Technical Specifications.

Exclusions
Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

Documentation Requirements
Document in the medical record the date the test was performed and test result or finding.

California law requires a blood lead test for Medi-Cal members at 12 and 24 months of age and requires health care providers performing blood lead analysis to report all results to the California Department of Public Health (CDPH) Childhood Lead Poisoning Prevention Branch. Providers should perform a catch-up test for children 24 months to 6 years who were not tested at 12 and 24 months.

DHCS also requires that providers give oral or written anticipatory guidance to parents/guardians of a child at each periodic health assessment from 6 to 72 months, which includes information related to the harms of lead.

Network providers are not required to perform a blood lead screening test if either of the following applies:

a) In the professional judgment of the provider, the risk of screening poses a greater risk to the child member's health than the risk of lead poisoning. **This must be documented in the medical record.**
b) If a parent/guardian or other person with legal authority withholds consent to the screening, the provider must obtain a **signed statement of voluntary refusal** or document the reason for not obtaining a signed statement in the child's medical record (Example: When services are provided via telehealth modality or party declines to sign).

Coding Requirements
CPT Code: 83655

Data Collection

Data for this measure will be collected using claims and DHCS Fee-for-Service encounter claims. To find gaps in data:

- Run a report from your Electronic Health Record (EHR) system; or.
- Manually compile patient data (Example: Download the Lead Screening in Children quality report or your Care-Based Incentives Measure Details report on the Provider Portal and compare to your EHR/paper charts).

Reasons to Check Lead Levels

- **Exposure to lead in children can cause damage to the brain** and other vital organs, as well as intellectual and behavioral deficits.
- Research suggests **there is no safe blood lead level (BLL)** and its effects are irreversible. Chelating agents that intend to remove lead may reduce fatality rates but have not been demonstrated to improve IQ or behavioral consequences of lead exposure. See CDC's Lead Poisoning Prevention web page for more information.
- Children exposed to lead have **no obvious symptoms**; as a result, lead poisoning often goes unrecognized.
- Elevated blood lead levels primarily **affect children with a lower socioeconomic status** and from minority communities because of the increased risk of housing-related exposure (U.S. Preventive Services Task Force).

Best Practices

- **Conduct an environmental assessment prior to blood lead screening** of children at risk for lead exposure. These assessments can include toys, pottery, cosmetics, folk remedies, food, and candy. In some subpopulations, imported products, foods and folk remedies may be more commonly found and are a more substantial contributor to lead exposure.
- **Screening types:**
  - **Initial screen:** point of care testing; capillary.
  - **Confirmatory testing:** venous sample.
- **CDC recommends screening all immigrant, refugee and internationally adopted children when they arrive in the U.S.** due to their increased risk.
- Help parents identify if their child has been exposed or has continuous exposure (paint chips, regular visits to houses built before the 1950s, lead in soil, water, pottery and candies from other countries, etc.) and encourage parents to avoid possible lead exposures.
- **Monitor all children with a confirmed BLL ≥3µg/dL** for subsequent increase or decrease in BLL until all recommended environmental investigations and mitigation strategies are complete. New CDC limit is <3.5 (2023).
- **Primary prevention is the most important** and significant strategy for reducing BLLs.
- **Provide nutritional guidance and recommend a well-balanced diet**. Calcium, iron and vitamin C play a specific role in minimizing lead absorption.
- **Accumulation of lead can begin during pregnancy**. Conduct initial and follow-up screening of pregnant and lactating persons.
- When interacting with affected families, **offer simple information about the meaning of BLL results**, and relevant and culturally sensitive messages about the impact of lead levels.

Resources

- **Alliance interpreting services are available to network providers:**
  - **Telephonic interpreting services** are available to assist in scheduling members.
  - **Face-to-face interpreters** can be requested to be at the appointment with the member.

For information about our Cultural and Linguistic Services Program, please call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at **listcl@ccah-alliance.org**.

- Refer patients who have transportation challenges to the **Alliance's Transportation Coordinator at 800-700-3874, ext. 5577**. This service is not covered for non-medical locations or for appointments that are not medically necessary.
- County Department of Public Health (CDPH) Blood Lead Testing flyer
- California Management Guidelines on Childhood Lead Poisoning for Health Care Providers
- Standard of Care Guidelines on Childhood Lead Poisoning for California Health Care Providers
- All-Plan Letter 20-16

Social Determinates of Health, Diagnosis Accuracy, and CPT II Coding Tip Sheet

Social Determinates of Health

Social Determinates of Health (SDOH) are environmental factors that can influence health outcomes. SDOH are conditions where people are born, live and work, these factors can include housing, transportation, discrimination, education, literacy, and access to food.

Screening members for SDOH helps providers understand the complexity of the members they serve. It also helps members improve their relationship and trust with their healthcare team. Additional benefits include the creation of a realistic care plan once the clinician understands the member's available resources and current stressors.

Measure Description

The addition of SDOH Z-codes will support the development of Alliance health equity and population health programs. The SDOH codes will aid in the coordination of services based on member health and social needs, as well as close gaps in reporting.

Each quarter will have a $250 fee-for-service payment available for claims submissions showing Department of Health Care Services high priority Z-Codes, with a total of $1000 for four quarterly submissions.

Coding Requirements

Data will be collected through the use of appropriate diagnosis from claim submissions

ICD-10 Code	Code Description
Z55.0	Illiteracy and low-level literacy
Z58.6	Inadequate drinking-water supply
Z59.00	Homelessness
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.1	Inadequate housing (lack of heating/space, unsatisfactory surroundings)
Z59.3	Problems related to living in residential institution
Z59.41	Lack of adequate food and safe drinking water
Z59.48	Other specified lack of adequate food

Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.89	Other problems related to housing and economic circumstances (foreclosure, isolated dwelling, problems with creditors)
Z60.2	Problems related to living alone
Z60.4	Social exclusion and rejection (physical appearance, illness or behavior)
Z62.819	Personal history of unspecified abuse in childhood
Z63.0	Problems in relationship with spouse or partner
Z63.4	Disappearance & death of family member (assumed death, bereavement)
Z63.5	Disruption of family by separation and divorce (marital estrangement)
Z63.6	Dependent relative needing care at home
Z63.72	Alcoholism and drug addiction in family
Z65.1	Imprisonment and other incarceration
Z65.2	Problems related to release from prison
Z65.8	Other specified problems related to psychosocial circumstances (religious or spiritual problem)

Best Practices

- Utilize pre-populated questionnaires in EMR systems.
- Screening tools like PRAPARE can be used to screen members for SDOH.
- This measure will be captured through claims submission and diagnosis must be present on claim to qualify for payment.

Resources

- APL 21-009: Collecting Social Determinants of Health Data.
- Protocol for Responding to and Assessing Patients Assets, Risks and Experiences (PRAPARE).
- PRAPARE Tool kit.
- AAFP Health Equity for EveryONE- Online CME.
- AAFP The EveryONE Project Assessment and Action Toolkit.
- AAFP The EveryONE Project Neighborhood Navigator- search and connection to local resources.
- CMS Accountable Health Communities Health-Related Social Needs Screening Tool.
- CMS Z Codes Infographic.
- Quality Insights Quick guide to SDOH ICD-10 Codes.
- Rural Health Information Hub SDOH Assessment Tools.
- Healthy People 2023 SDOH Workgroup.
- Indiana Primary Health Care Association (IPHCA) Z Codes, SDOH and PRAPARE resource video.
- Social Determinants of Health (SDOH) Screening Provider Bulletin article.

Diagnosis Accuracy

ICD-10-CM is used to report the diagnosis and mortality data of patients. Diagnosis accuracy is crucial for improving patient care, claims payment, audit outcomes, healthcare financial predictions and data collection.

Coding specificity is coding to the most specific code that the medical record documentation supports. Utilizing diagnosis that are unspecified should be reserved for when clinical information is not known or available.

Common conditions that have over utilized unspecified codes include:

- Alcohol and drug use, abuse, and dependence
- Anemia
- Anxiety
- Arthritis
- Asthma
- Back pain
- Depression
- Disorders of the endocrine system (Hyper/hypotension, Diabetes, Hyper/Hypolipidemia, Vitamin-D deficiency)
- Epilepsy
- Generalized Pain
- Injuries
- Migraines
- Neoplasms
- Pneumonia
- Respiratory failure and infection

Measure Description

This measure aims to support providers in improving diagnostic coding accuracy in preparation for future rate adjustments. Providers that complete a CMS Medicare Learning Network (MLN) diagnosis training with a score of 70% or higher will receive a one-time payment of $200. Providers must submit the certificate of completion in order to qualify.

Best Practices

- Avoid unspecified diagnosis codes
- Utilize coding guidelines to appropriately assign diagnosis codes
- Review claims for unspecified diagnosis and query provider if additional information is needed

Resources

- CMS MLN Web training- Diagnosis Coding
- Coding Guidelines 2023

CPT Category II Codes

CPT Category II codes are used to measure performance on quality metrics in the Healthcare Effectiveness Data and Information Set (HEDIS) and the Care-Based Incentive (CBI) program. The Alliance uses them to track and fulfill your CBIs.

CPT Category II Codes always consists of:

CPT current procedural terminology II codes were developed by the American Medical Association (AMA) as a supplemental performance tracking set of procedural codes in addition to the Category I and III coding

sets. Category II codes are optional and cannot be used to replace Category I codes for billing purposes.

The Alliance highly encourages clinical office and billing staff to use CPT Category II codes for performance measurements in order to decrease the need for provider data submission, record abstraction and chart review - your payments, faster!

CPT Code Functions

Category I Codes	E&M, ANES, SURG, RAD, LAB
Category II Codes	TRACKING
Category III Codes	EMERGING TECH

CPT II Codes

Hemoglobin A1c Control for Patients with Diabetes (HBD)	
HbA1c Test Result	
HbA1c level <7.0%	3044F
HbA1c level 7.0-7.9%	3051F
HbA1c level 8.0-90%	3052F
HbA1c level >9.0%	3046F

Controlling Blood Pressure (CBP)	
Systolic <130 mm Hg	3074F
Systolic 130-139 mm Hg	3075F
Systolic ≥140 mm Hg	3077F
Diastolic <80 mm Hg	3078F
Diastolic 80-89 mm Hg	3079F
Diastolic ≥90 mm Hg	3080F

Well-Child Visits for Age 15-30 Months of Life – Exploratory Measure Tip Sheet

Measure Description
The percentage of members age 30 months old who had 2 or more well-child visits with a PCP between the child's 15-month birthday plus one day and the 30-month birthday.

Exploratory Measure
This is an exploratory measure; there is no payment for 2024. For additional information, refer to the CBI Technical Specifications.

Exclusions
Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

Documentation Requirements
Documentation must include a note indicating the visit was with a PCP, and evidence of **all** of the following:

- **Health history:** assessment of the member's history of disease or illness (allergies, medications, immunization status).
- **Physical developmental history:** assessment of the member's specific age-appropriate physical developmental milestones.
- **Mental developmental history:** assessment specific age-appropriate mental developmental milestones.
- **Physical exam**
- **Health education / anticipatory guidance:** given by the PCP to parents / guardians in anticipation of emerging issues that a child and family may face

Coding Requirements
Well-visit CPT Codes: 99382, 99392, 99461
Well-visit ICD-10 Codes: Z00.121, Z00.129, Z00.2, Z76.1, Z76.2, Z02.5
Billing Frequency: For members 0-24 months, well-visits are payable every 14 days

Please refer to the AMA coding guidelines for billing well-care visits with office visits in the same day. Be advised that medical records would need supportive documentation to reflect services outside of the well-care visit.

Data Collection

Data for this measure will be collected using claims, DHCS Fee-For-Service encounter claims, and provider data submissions via the Data Submission Tool (DST) on the Provider Portal.

- Run a report from your EHR system; or
- Manually compile patient data (Example: Download your Care-Based Incentives Measure Details report on the Provider Portal and compare to your EHR/paper charts).

How to Submit Data

This measure allows providers to submit well-child visits originally billed under the mom's Medi-Cal ID as well as visits that were completed during a gap in coverage from the clinic EMR/EHR system or paper records to the Alliance by the DST contractual deadline. To submit, you may upload data files to the DST on the Provider Portal. To be accepted, data must be submitted as a CSV file. Step-by-step instructions are available in the Data Submission Tool Guide on the Provider Portal.

Best Practices

- **Infants and Medi-Cal** – Infants are born and listed under the mother's ID for the month of birth and the following month. Parents are encouraged to sign their infant up for Medi-Cal in a timely manner to ensure that there are no gaps in coverage for their care. There is no penalty for applying for infant's coverage before coverage from the mother runs out. County resources linked below:
  - Merced County
  - Monterey County
  - Santa Cruz County
- Well-visits should occur at the following intervals:

Birth (at the hospital)	9 Months Old
3-5 days (after hospital discharge)	12 Months Old
1 Month Old	15 Months Old
2 Months Old	18 Months Old
4 Months Old	24 Months Old
6 Months Old	30 Months Old

See the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule for a comprehensive schedule up to 21 years of age, as well as materials and tools.

- **Schedule the next 6-month visits before the member leaves the exam room or clinic** and provide an overview of what will be covered at the next visit. This is to ensure the child stays on schedule for the necessary visits.
- **Utilize telehealth visits** for patients that do not feel comfortable coming into the clinic.
- **Utilize Medical Assistants to create pending orders** in the EHR for each immunization due during every visit. The clinician must manually uncheck the immunization order during each visit if they are unable to provide the vaccination due for the child. This is a method of ensuring reminders for needed vaccinations are present during every visit.
- **Leverage missed opportunities** (episodic and sick visits) to increase preventive services (immunizations), as well as convert acute visits into well-visits (sports physicals).
- **Monitor the Provider Portal** reports as a tool for identifying members that are due for their well-visit.
- **Create a template** or use age-specific standardized templates in your EHR to maximize documentation of Bright Futures requirements and trigger reminders for the next well visits.
- **Promote healthy behaviors** and assess for risky behaviors to detect conditions that may interfere with physical, social and emotional development.
- **Ensure that all children receive developmental**

screenings at minimum occurring at 9 months, 18 months, 24 or 30 months of age. If the child is at a higher risk for developmental problems may need additional screenings.

- **Group well-child visits** have been shown to be as effective as individual well visits. Parents had longer visits with more content, which associated with more anticipatory guidance, family-centered care, and parent satisfaction.[1]
- Refer to the CDC's recommended immunization schedule and website for talking points with parents.
- **Alliance interpreting services are available to network providers:**
    - **Telephonic interpreting services** are available to assist in scheduling members.
    - **Face-to-face interpreters** can be requested to be at the appointment with the member.

  For information about our Cultural and Linguistic Services Program, please call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at **listcl@ccah-alliance.org**.
- Refer patients who have transportation challenges to the **Alliance's Transportation Coordinator at 800-700-3874, ext. 5577**. This service is not covered for non-medical locations or for appointments that are not medically necessary.

Resources

- The Child & Adolescent Health Measurement Initiative (CAHMI) Family Resource Sheets by child age
- Medicaid Maternal Infant Health Initiative: Infant Well-Child Visit Learning Collaborative
- Center for Health Care Strategies (CHCS) Improving Preventive Care Services for Children Toolkit
- AAP's A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population
- AAFP Remove Roadblocks and Improve Access to Preventive Care
- "Medi-Cal for Kids and Teens" DHCS developed child and teen focused brochures

[1]Coker, T., Windon, A., Moreno, C., Schuster, M., Chung, P. Well-Child Care Clinical Practice Redesign for Young Children: A Systematic Review of Strategies and Tools. *Pediatrics*. 2013 Mar; 131(Suppl 1): S5–S25.

Care-Based Incentive (CBI)

PROVIDER INCENTIVES

Additional Resources

Alliance Care-Based Incentive Webpage
https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/

Alliance Care-Based Incentive Resources
https://thealliance.health/for-providers/manage-care/quality-of-care/care-based-incentive/care-based-incentive-resources/

Alliance Immunization Resources
https://thealliance.health/for-providers/manage-care/quality-of-care/immunization-resources/

Health Education and Disease Management Webpage
https://thealliance.health/for-providers/manage-care/health-education-and-disease-management/

Alliance Members Rewards Program Webpage
Health Rewards Program - Central California Alliance for Health (thealliance.health)

Dementia Care Aware Webpage
DCA – Dementia Care Aware

All Plan Letter 21-009: DHCS List of SDOH Codes
APL 21-009 (ca.gov)

Alliance Webinars and Training Webpage (Click on the drop-down link to the Practice Transformation Academy)
Webinars and Training - Central California Alliance for Health (thealliance.health)

Alliance Enhanced Care Management (ECM) and Community Supports Webpage
Enhanced Care Management (ECM) and Community Supports Provider Information - Central California Alliance for Health (thealliance.health)