Care-Based Incentive (CBI) 2024 Workshop Webinar Frequently Asked Questions

1. **The data posted on our CBI is Q1 2023. When will the Q2 and Q3 be posted?**
   Quarter 2 CBI provider portal data will be released shortly in October and quarter 3 CBI data is expected to be out in late December, early January 2024. The delay in timing comes from several validation steps prior to the data being released. Our monthly quality reports on the Provider Portal will have more up-to-date information for the majority of the measures in CBI.

2. **Is there a dummy code for refusing to receive vaccines such as an influenza in the combo 10?**
   There are no dummy codes for refusing vaccinations.

3. **Is BMI for children and adolescence retired? If so, why is it still on our CBI practice profile?**
   BMI for Children and Adolescents will be retired from the CBI program in 2024.

4. **I am interested in knowing more about SDOH.**
   In the CBI 2024 Workshop Workbook is a tip sheet called, "Social Determinates of Health, Diagnosis Accuracy, and CPT II Coding Tip Sheet" that includes a number of resources including the priority codes, best practices, and resources like the American Academy of Family Practice EveryONE Project toolkit for implanting SDOH into practice.

5. **Are there dummy codes for patients refusing to schedule or for removing patients from the list that are being seen at other facilities such as Kaiser?**

   Unfortunately, the only dummy code that we can receive is for the outreach attempts for scheduling the Initial Health Appointment visit, which is allowed by DHCS during their annual audit. Most of the nationally recognized measures do not count patient refusal of services. If they are being seen at another facility, please contact your provider relations representative for additional assistance to review if they need to be relinked or have a status change.

6. **Patients listed as non-compliant for immunizations that they refuse such as mentactra, and HPV how can they fall off our list so that we can be compliant?**

   Patient refusals are not incorporated into the NCQA HEDIS measures, so there is not a way to remove them from the member rosters.

7. **Why is the CBI performance report on a rolling year for example July 1, 2022, to June 30, 2023?**

   CBI is set up to review who is eligible for the measure in a 12-month span. Our finalized programmatic rates match the calendar year of January 1st to December 31st, but in order to provide earlier rate tracking and member information for outreach, we use a rolling 12-month measurement for each of the quarters that that you can see your rates and member information throughout the year.

8. **If the member got fluoride varnish by our dental department and only D1206 code was submitted can this member qualify for numerator?**

   The application of fluoride varnish measure reviews whether the fluoride varnish was applied at the PCP office, and not by dental departments. CDT Code D1206 is no longer a Medi-Cal benefit as of 4/1/2023.

9. **Can we use DST to submit for ACE screenings in 2024?**

   The DST is not currently set up to accept ACE screenings at this time for 2024.

10. **Previously breast cancer screening was done every year, is it now every 2 years?**

    The measure follows the NCQA HEDIS specifications, measuring the percentage of women 50 – 74 years of age who had a for a mammogram to screen for breast cancer on or between October 1st two years prior to the measurement period to the end the measurement period. That would mean that for the CBI program, we are going back two years to look for a mammogram done within this time period.

11. **If a patient declined to schedule an IHA appointment, can we bill the dummy code 99499?**

    Yes, during the IHA outreach if the member declines to be seen for the IHA, include that in the medical record with the documented attempts to schedule the member. For more tips on the IHA dummy code, access our tip sheet.

Initial Health Assessment Tip Sheet - Central California Alliance for Health (thealliance.health)

12. Can we use dummy codes for IHA if patient cancels like we do for no show patients?

Yes, if a member no shows or cancels to an appointment ***two more attempts*** to reschedule the member ***must be made***, then the IHA dummy code can be used.

13. If no phone number is listed for IHA patients, will it suffice that we send out 3 letters to attempt to reach the patient?

Yes, make sure to document in the medical record that member's phone number is disconnected or absent.

14. What is an acceptable timeframe between the 3 letters?

You will want to make sure outreach and provider portal submission are completed before the member reaches 120 days of enrollment in Medi-Cal.

15. For IHA: If they are not our patient and do not have a phone number can they fall off our list?

Members that are not assigned to your clinic will not show up on your 120 day newly eligible member list.

16. Patients get assigned to us after having one sick visit with us and they have another clinic they go to then they refuse to have their routine WCC with us, but they are in our list as a non-compliant with us. This affects us negatively since they will never schedule?

Unfortunately, member refusals are not counted in most of the national measure specifications and will count as non-compliance. To change the PCP linkage, Members will need to change their PCP using the online form or by calling Member Services at 800-700-3874 (TTY: Dial 711). Providers can alternatively submit the Request for Member Reassignment Form. Member reassignments that are exempt and do not count against the PCP site in CBI include:

- Medication Management (BA).
- Abusive/Disruptive Behavior (AB).
- Fraud (FR).

- Aged Out (AO).
- Member Requested (MI).
- Non Medi-Cal member reassignments.

17. For Depression screening and follow up metric, will this be updated to match CQM? The definition changed this year that allows providers to document a follow up plan on a positive depression screen up to 2 days from when the patient was screened/visit date.

For 2024, we will be moving toward LOINC codes for screening for depression which are a non-claims-based coding process and will require the LOINC code for the specific screening test, as well as the numerical screening sore. Sites will need to document the test, score, and applicable follow-up in the medical record. We will be working to ensure LOINCs can be submitted through the data submission tool, and in the future, we would like to capture these codes through health information exchanges when they become available.

18. How can we remove male born patients from cervical cancer lists/mammogram lists that are not transgender?

The measures are calculated based on the state information received through the Medi-Cal enrollment forms. The member would need to reach out to their county Medi-Cal Office to change their information if incorrect. Members can update their information online at https://benefitscal.com/ or call:

- Santa Cruz County: (888) 421-8080
- Monterey County: (866) 323-1953
- Merced county: (209) 385-3000

19. At what age will routine mammograms be covered?

There are different benefit guidelines depending the which screening you are thinking of doing. Please reach out to your Provider Relations Representative if there is a specific screening that you would like more information on.

20. For elective vaccines are we looking at updating the measures so that we can have better compliance?

Immunization measure guidelines come from NCQA and are selected for health plan reporting by the California Department of Health Care Services (DHCS). We have not seen any changes in the vaccine combinations for next year's the upcoming 2024

specifications.

21. Is there an update regarding the inpatient admission list, where often the discharge date does not populate on the portal, but the patient was already discharged? This means when the portal finally updates the information, it's already too late (past the 14 days) to get the post discharge care credit.

Available data is voluntarily shared through the provider portal using eCensus data, where participating hospitals show when there was an emergency room or hospital admission through text-based fields. Internal staff at The Alliance are working towards increasing data sharing opportunities for admission, discharge, and transfer (ADT) data, with a goal of creating some initial workflows for 2024.

22. Do you know if the COVID/RSV will be added to the combo 10?

NCQA will not add Covid-19 or RSV vaccines to the childhood immunizations cobo-10 requirements for next year's measurement.

23. How can we exclude patients that have mistakenly been identified as female for metrics such as Breast CA screening/Cervical CA screening?

Members are placed into the measures based on their Medi-Cal enrollment information with the state, so it's best that the information is corrected by contacting the county to update the information on file. There is also a separate code for a member who transitioned male-to-female that will remove them from the cervical cancer screening measure. For additional assistance, please reach out to your Provider Relations Representative.

24. Is there a dummy code we can submit via the portal that is standard across metrics to indicate that a patient is deceased and should be excluded from the metric? If not, could one be created?

There is no dummy code that can be submitted to exclude a member from a measure, and there are no plans at this time to create one. New to NCQA HEDIS measures, is the required exclusion for members who have passed away during the measurement year, which will be added to the NCQA measures in CBI. Family members of the deceased need to contact Medi-Cal to remove their enrollment with the program, or providers can reach out to their Provider Relations Representative for additional assistance.

25. Is it possible to get a more up to date list of combo 10 vaccines?

The Childhood Immunization quality report in your Provider Portal account is updated weekly with claims and DST information, and monthly with CAIR or RIDE information. The report share information for children 18-24 months, but in 2024, the report will be updated to include Members starting at 3 months of age.

26. The report that gets uploaded into the CCAH portal for COMBO 10 vaccines includes children starting at 18mo, by this time children that are due for Rotavirus are impossible to meet due to aging out of the recommended administration age.
Alliance staff are working on a report request that will include Members 3-24 months in 2024.

27. Will COVID vaccinations be included in vaccine requirements for CBI in 2024?

No – while highly recommended for members 6 months and older, Covid vaccines will not be included in childhood or adolescent immunization measure requirements next year.

28. Is the RSV Vaccine covered?
As of 10/11/23, RSV vaccines (Arexvy, GSK & Abrysvo, Pfizer) are covered, without a prior authorization in a pharmacy setting (through Medi-CalRx). We are waiting for Medi-Cal to approve vaccine CPT codes 90679 (Arexvy, GSK) and 90678 (Abrysvo, Pfizer) as a benefit in a provider setting. Once a benefit, a prior authorization will be required.

29. How can we remove deceased patients from our assigned patient lists without having to contact family members to avoid reminding them of a passed loved one?
The provider can reach out to their CCAH provider relations representative with the date of death who can then forward the information to the Member Services Operation Team for additional assistance. The family can also update the local county Medi-Cal enrollment office with information so that the member can be removed from eligibility for Medi-Cal.

30. How does an organization get patients off the roster when patients are no longer being followed by our practice?

There is a form online to request that Alliance member be reassigned to a new primary care provider (PCP). Examples include abusive or disruptive behaviors or non-

compliance with case management. If the member has moved outside of the service area, and need to transfer their Medi-Cal to a new county you could use the Request for Administrative Member Status form. For additional questions, please contact your Provider Relations Representative.

Request for Member Reassignment Form

31. Can we change the patient's eligibility to Admin Member when they have primary insurance and CCAH as secondary?

Yes. There is a form online that clinics can use to submit information on other health care coverage. Once OHC is verified by Alliance staff, OHC status will change to admin, and the member will be removed from the CBI program:

Other Health Coverage OHC Referral Form

Request for Administrative Member Status

32. New codes for post discharge services?

Effective 01/01/2023, transitional care management codes **99495 and 99496** were added to the post discharge measure! For more details, please check out our provider digest article #27.
Provider Digest | Issue 27 - Central California Alliance for Health (thealliance.health)

33. Is there a contact at CCAH we could reach to if we have a member with 2 Alliance IDs?

Please reach out to your Provider Relations representative who can assist you through the process of retiring one of the member IDs. The Member Services Operations Team will be able to work with the particular county in rectifying such a matter.