2025 Care-Based Incentive Workbook

PROVIDER INCENTIVES

PROVIDER WORKSHOPS

Alliance Vision: Healthy people. Healthy communities.

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

INSIDE WORKBOOK

Incentive Summary

Tip Sheets

WELCOME!

Use this workbook during the 2025 Care-Based Incentive (CBI) workshop.

This year's focus is:

- Program overview
- Measure changes
- Retired measures
- What's new
- 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 on the 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 of 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 2024 and 2025 CBI Technical Specifications. **For general questions, talk with your Provider Relations Representative or call Provider Services at (800) 700-3874, ext. 5504**.

2025 Summary of Changes

New Programmatic Measures

- The following measures were moved from exploratory to programmatic measures:
    - Chlamydia Screening in Women.
    - Colorectal Cancer Screening
    - Well-Child Visits for Age 15 Months–30 Months of Life

Measure Changes

- Diabetic HbA1c Poor Control >9% changed to Diabetic Poor Control >9%. The measure was modified to review the most recent glycemic status received through hemoglobin A1c [HbA1c] or glucose management indicator [GMI] testing.

Post-Discharge Care

- This measure was updated to:
    - Accept follow-up care by specialists.
    - Exclude members that were admitted to a Skilled Nursing Facility (SNF) on the same day of discharge.

Preventable Emergency Visits

- This measure was updated to remove urgent care visits.

Point Allocation Changes

- Total allowable points for Quality of Care measures changed from 38 points to 53 points.

Retired Measures

- Health Equity: Child and Adolescent Well-Care Visit
- Performance Improvement Measure

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 of age 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 who receive a comprehensive initial health appointment within 120 days of enrollment with the Alliance.	≥5 eligible linked members continuously enrolled within 120 days of enrollment (4 months)	DHCS MMCD Policy Letter 22-030 For a full list of codes, see the Initial Health Appointment Tip Sheet	4
Post-Discharge Care**	Members who receive a post-discharge visit within 14 days of discharge from a hospital inpatient stay by a linked primary care provider (PCP) or specialist. 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, 9934-99350, 99381-99385, 99391-99395, 99429	10.5

* New measure for 2025 ** Measure change for 2025

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 Readmissions	The number of members 18 years of age and older with acute inpatient and observation stays during the measurement year that was followed by an unplanned acute readmission for any diagnosis within 30 days.	≥100 eligible linked members	Plan All-Cause Readmissions Tip Sheet For a full list of codes see the CBI Technical Specifications	10.5
Preventable Emergency Visits	The rate of preventable ED visits per 1,000 members per year.	≥100 eligible linked members	Alliance Case Management and Care Coordination Programs Preventable Emergency Visits Tip Sheet Preventable Emergency Visits Diagnoses Tip Sheet	8

* New measure for 2025 ** Measure change for 2025

Quality of Care Measures				
Measure	**Summary Definition**	**Member Eligibility**		**Points Possible: 53**
Breast Cancer Screening	The percentage of members 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	The percentage of members 21-64 years of age who were screened for cervical cancer using any of the following criteria: • Members 21-64 years of age who had cervical cytology performed within the last 3 years. • Members 30-64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Members 30-64 years of age who had cervical cytology and human papillomavirus testing performed within the last 5 years.	≥30 eligible linked members	Cervical Cancer Screening Tip Sheet Cervical Cancer Screening Codes: Q0091 - using this code ensures 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
Chlamydia Screening in Women*	The percentage of women 16-24 years of age who are identified as sexually active and had at least one test 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	Varies

* New measure for 2025 ** Measure change for 2025

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: 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350 Colonoscopy codes: • CPT: 44388-44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 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	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	Varies
Diabetic Poor Control >9%*	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent glycemic assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9% in the measurement year. **The measure goal is for members to be non-compliant by having an HbA1c or GMI of less than 9% and being in good control** (a lower rate indicates better performance). Members with no lab or no lab value submitted, a claim without an HbA1c value, or an HbA1c value >9 % will be considered compliant for this measure.	≥30 eligible linked members	Diabetic Poor Control >9% Tip Sheet Health Education and Disease Management Programs CPT Codes: 83036, 83037 (Non Medi-Cal benefit code) LOINC Codes: 17855-8, 17856-6, 4548-4, 4549-2, 96595-4, 97506-0 CPT II Results (Point of Service Labs): 3044F, 3046F, 3051F, 3052F	Varies

* New measure for 2025 ** Measure change for 2025

Immunizations: Adolescents	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one dose of Tdap vaccine, and have completed the HPV vaccine series on or by their 13th birthday.	≥30 eligible linked members	Immunizations: Adolescents Tip Sheet Immunization Codes: Meningococcal – 90619, 90733, 90734 Tdap - 90715 HPV – 90649, 90650, 90651	Varies
Immunizations: Children (Combo 10)	The percentage of children who received all the following vaccines (Combo 10) on or by their 2nd birthday: • 4 DTaP (first dose after 42 days after birth) or anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine. • 3 IPV or anaphylaxis due to the IPV vaccine (first dose after 42 days after birth). • 1 MMR (on or between child's 1st and 2nd birthday), history of measles, mumps and rubella illness, or anaphylaxis due to the MMR vaccine. • 3 Hib (first dose after 42 days after birth) or anaphylaxis due to the Hib vaccine. • 3 HepB (first dose 0-4 weeks), history of hepatitis B vaccine, or anaphylaxis due to the hepatitis B vaccine. • 1 VZV (on or between child's 1st and 2nd birthday), history of varicella zoster (e.g., chicken pox) illness, or anaphylaxis due to the VZV vaccine. • 4 PCV (first dose after 42 days after birth) or anaphylaxis due to the pneumococcal conjugate vaccine. • 2 or 3 Rotavirus (first dose after 42 days after birth) or anaphylaxis due to the rotavirus vaccine. • 1 HepA (on or between child's 1st and 2nd birthday), history of hepatitis A illness, or anaphylaxis due to the hepatitis A vaccine. • 2 Flu (vaccines given after 180 days after birth up to or on the child's 2nd birthday) or anaphylaxis due to the influenza vaccine.	≥30 eligible linked members	Immunizations: Children (Combo 10) Tip Sheet For a full list of codes see the CBI Technical Specifications	Varies

* New measure for 2025 ** Measure change for 2025

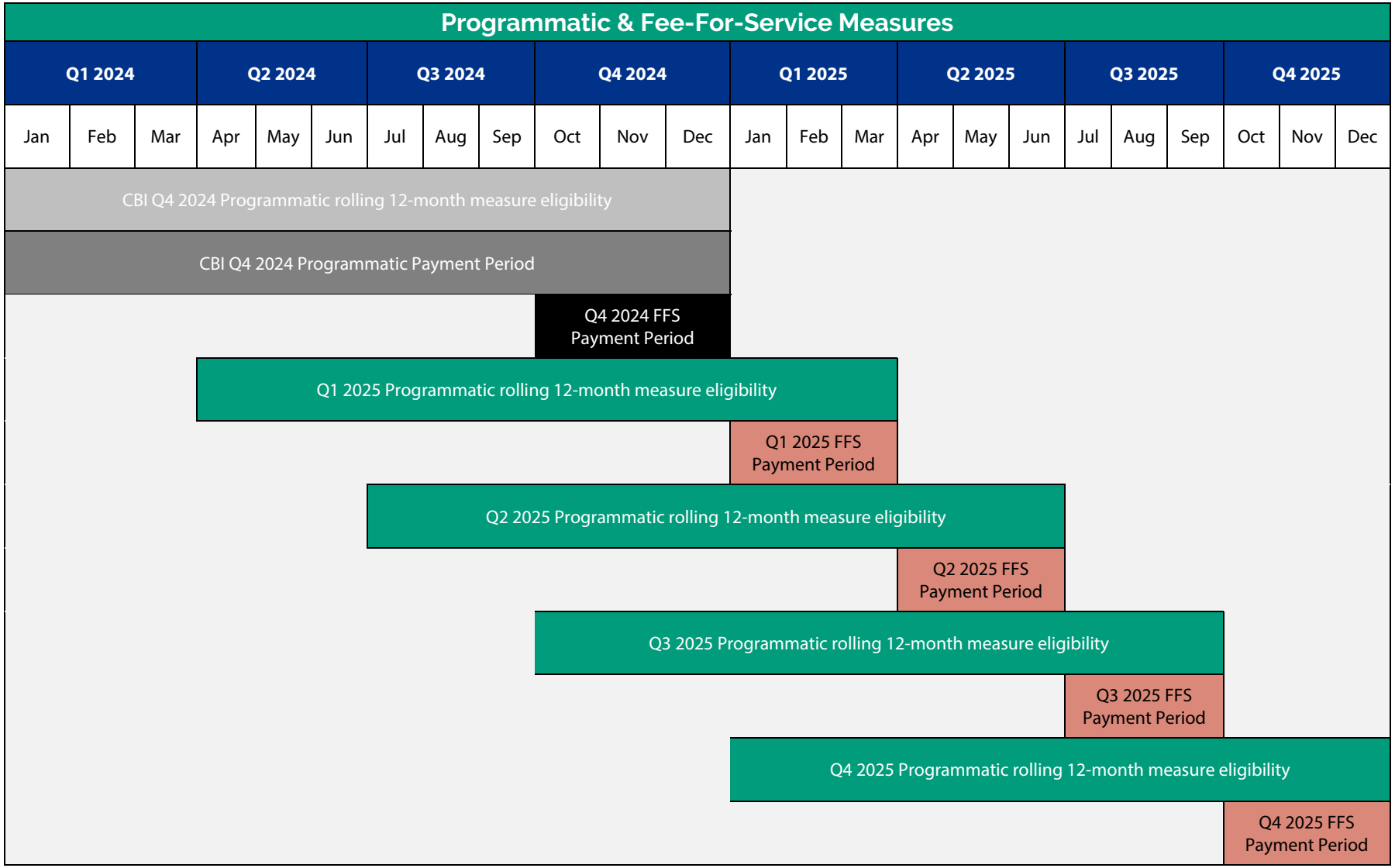
Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	≥30 eligible linked members	Lead Screening in Children Tip Sheet Lead Screening Code: 83655 For a full list of codes see the CBI Technical Specifications	Varies
Well-Child Visits in the First 15 Months	The percentage of members aged 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
Well-Child Visits for Age 15 Months-30 Months of Life*	The percentage of members aged 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 Months-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	Varies

Exploratory Measure				
Measure	**Summary Definition**	**Member Eligibility**	**Resources**	**Points Possible**
Controlling High Blood Pressure	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (< 140/90 mm Hg) in the last 12 months.	≥30 eligible linked members	Controlling High Blood Pressure Tip Sheet Controlling High Blood Pressure Codes: 3074F, 3075F 3077F, 3078F, 3079F, 3080F	N/A

* New measure for 2025 ** Measure change for 2025

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 2024 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-CM Z codes.	$250 quarterly payments for claims submissions with priority SDOH Z codes, with $1,000 maximum payment.


Programmatic & Fee-For-Service Measures
Q1 2024
Q2 2024
Q3 2024
Q4 2024
Q1 2025
Q2 2025
Q3 2025
Q4 2025
Jan
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CBI Q4 2024 Programmatic rolling 12-month measure eligibility
CBI Q4 2024 Programmatic Payment Period
Q4 2024 FFS Payment Period
Q1 2025 Programmatic rolling 12-month measure eligibility
Q1 2025 FFS Payment Period
Q2 2025 Programmatic rolling 12-month measure eligibility
Q2 2025 FFS Payment Period
Q3 2025 Programmatic rolling 12-month measure eligibility
Q3 2025 FFS Payment Period
Q4 2025 Programmatic rolling 12-month measure eligibility
Q4 2025 FFS Payment Period

Member Health Rewards Program

Alliance members can earn rewards for getting routine care. Learn about which programs or services offer rewards on the Member Health Rewards Program Page.

Questions?
Contact your Provider Relations Representative at 800-700-3874, ext. 5504.

Diabetic Poor Control >9% Tip Sheet

Measure Description

The percentage of members 18–75 years of age with diabetes (type 1 and type 2) whose most recent glycemic assessment (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was >9% in the measurement year.

The measure goal is for members to be non-compliant by having an HbA1c or GMI of less than 9% and being in good control (a lower rate indicates better performance).

Members with no lab or no lab value submitted, a claim without an HbA1c value, or an HbA1c value >9% will be considered compliant for this measure.

Note: Laboratory claim exclusions to identify frailty, advanced illness, and diabetes are only applicable to CBI 2025, as well as minor changes to the frailty and advanced illness criteria. Changes to the pharmacy data method to identify eligible members are only applicable to CBI 2025.

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.

Eligible Members

Members with diabetes are identified by either claim/encounter data or by pharmacy data.

- **Claim/encounter data:** Members who had at least two diagnoses of diabetes on different dates of service during the measurement year or the year prior to the measurement year.
- **Pharmacy data:** Members who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year and have at least one diagnosis of diabetes during the measurement year or the year prior to the measurement year.

Note: Laboratory claims with POS 81 will not be included in identifying eligible members with diabetes.

Exclusions

- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year who meet both frailty **and** advanced illness criteria:
    - Frailty**:** At least two indications of frailty with different dates of service during the measurement year.
    - Advanced illness: One of the following during the measurement year or the year prior to the measurement year:
        - Encounter with an advanced illness diagnosis on at least two different dates of service.
        - Dispensed dementia medication.

Note: Laboratory claims with POS 81 will not be included in identifying eligible members with diagnostic codes for frailty or advanced illness.

Coding Requirements

CPT Codes: 83036, 83037 (Non Medi-Cal benefit code)
LOINC Codes: 17855-8, 17856-6, 4548-4, 4549-2, 96595-4, 97506-0

CPT Category II codes are tracking codes that, when submitted through point of service lab claims, can be used for performance measurement. Here are the defining the HbA1c ranges. They may not be used as a substitute for Category I codes.

Code	Definition
3044F	Most recent hemoglobin A1c (HbA1c) level less than 7% (DM)
3046F	Most recent hemoglobin A1c level greater than 9% (DM)
3051F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7% and less than 8% (DM)
3052F	Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8% and less than or equal to 9% (DM)

Note: Do not include CPT II codes with a modifier.

Data Collection

Data for this measure is collected using claims, laboratory data, DHCS Fee-For-Service encounter claims, and provider data submissions via the Data Submission Tool (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. For example, download your monthly Diabetes Care Quality report or your Care-Based Incentives Measure Details report on the Provider Portal and compare it to your 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 an HbA1C test every 3 months on patients whose therapy changed or who are not meeting glycemic goals (>9% HbA1c).
  - Set appropriate individualized A1C goals based on relevant comorbidities, demographic factors, and other considerations.
- Health Education
  - Enroll members in Alliance Disease Management Programs using the Health Program Referral Form.
    - The **Diabetes Prevention and Self-Management Education Program** provides members with education and resources for diabetes management. Services include referrals to Alliance-approved clinical diabetes management education providers who can help members access comprehensive diabetes prevention and self-management education**.**
    - The **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 chronic conditions. It can also help with goal setting, nutrition, exercise, medication usage, emotional support, and communication with doctors and family members. **Members who participate in this program receive a $50 Target gift card.**

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
  - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
  - Telephonic Interpreter Services – available to assist in scheduling members.
  - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
  - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Enhanced Care Management and Community Supports.
  - Refer Alliance members through the Alliance Provider Portal, email (listecmteam@ccah-alliance.org), mail or fax, or by phone at 831-430-5512.
  - For Complex Care Management and Care Coordination, call the Care Management team at 800-700-3874 (TTY: Dial 711).
- Alliance Nurse Advice Line to talk to a nurse.
  - 844-971-8907 (TTY: Dial 711).
  - Educate all members to use the Alliance Nurse Advice Line that is available to all Alliance members 24 hours a day, 7 days a week to discuss health concerns to avoid hospital readmissions and preventable emergency visits.
  - Add to your phone-tree and route after-hours calls from Alliance members.

- Alliance Transportation Services for patients with transportation challenges.
    - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
    - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Pharmacist-Led Academic Detailing (PLAD) is an effective, multi-faceted educational program designed to support Alliance primary care clinicians and their patients. PLAD aims 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 the members specific needs and interests, making it a personalized and effective experience. 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,"* or "*PLAD*," in the subject line.

Care-Based Incentive (CBI)

PROVIDER INCENTIVES

Post-Discharge Care Tip Sheet

Measure Description
Members who receive a post-discharge visit within 14 days of discharge from a hospital inpatient stay by a linked primary care provider (PCP) or specialist. This measure pertains to acute hospital discharges only. Emergency room visits do not qualify.

Note: Providers contracted with the Alliance as specialists qualify as a compliant follow-up visit for CBI 2025 only.

Incentive
Incentives will be paid to the linked primary care provider (PCP) on an annual basis, following the end of Quarter 4. Providers will receive full points if they have zero (0) admissions during the measurement period. For additional information, refer to the CBI Technical Specifications.

Exclusions
- Postpartum and healthy newborn care visits are excluded. NICU newborns are included.
- Discharged and admitted to a Skilled Nursing Facility (SNF).

Data Collection
Data for this measure will be collected using claims.

Provider Portal
The Linked Member Inpatient Admissions report provides a real-time report of your members with inpatient admissions or recent discharges at regional hospitals using eCensus data.

Note: Not all hospitals participate in eCensus.

The quarterly CBI Reports in the Provider Portal provides a roster of compliant and non-compliant members, trending graphs, and comparisons to benchmark performance.

If you do not have a Provider Portal account, you can submit a Provider Portal Account Request Form. For questions or concerns regarding the Provider Portal, please contact the Provider Portal Support Specialist at 831-430-5518 or email PortalHelp@ccah-alliance.org.

Best Practices

- Designate a care team member to use the Alliance Provider Portal to create a recall list for patients and attempt to schedule them for their post-discharge appointment within 14 days.
- Designate appointment slots specifically for post-discharge follow-up.
- Incorporate regular reviews of the Linked Member Inpatient Admissions report into front office procedures.
- Members should have a follow-up visit with their PCP after admission, even if the member had a follow-up with a specialist.
- Review discharge instructions with members to ensure they understand their post-discharge care and have assistance at home during their recovery.

Coding Requirements

View the full list of post-discharge care codes in the CBI Technical Specifications.

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
    - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
    - Telephonic Interpreter Services – available to assist in scheduling members.
    - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
    - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Enhanced Care Management (ECM) and Community Supports.
    - Refer Alliance members through the Alliance Provider Portal, email (listecmteam@ccah-alliance.org), mail or fax, or by phone at 831-430-5512.
    - For Complex Care Management and Care Coordination, call the Care Management team at 800-700-3874 (TTY: Dial 711).
- Alliance Nurse Advice Line to talk to a nurse.
    - 844-971-8907 (TTY: Dial 711).
    - Educate all members to use the Alliance Nurse Advice Line that is available to all Alliance members 24 hours a day, 7 days a week to discuss health concerns to avoid hospital readmissions and preventable emergency visits.
    - Add to your phone-tree and route after-hours calls from Alliance members.
- Alliance Transportation Services for patients with transportation challenges.
    - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
    - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).

Preventable Emergency Visits Tip Sheet

Measure Description

The rate of preventable emergency department (ED) visits per 1,000 members per year. This measure is derived from the Statewide Collaborative Quality Improvement Project: Reducing Avoidable Emergency Room Visits.

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.

Common Preventable Emergency Visit Diagnoses

Members are frequently seen at the ED for screening services and general examinations. Below is a list of common preventable ED diagnoses derived from the Statewide Collaborative Quality Improvement Project: Reducing Avoidable Emergency Room Visits.

- Acute bronchitis, nasopharyngitis, upper respiratory infection, pharyngitis
- Sore mouth or throat (e.g., thrush, tonsillitis), ear infections
- Allergies, sinusitis, conjunctivitis
- Back pain
- Headache
- Skin problems/infections (scabies, miliaria, tinea corporis)
- Urinary tract infection
- Vaginitis

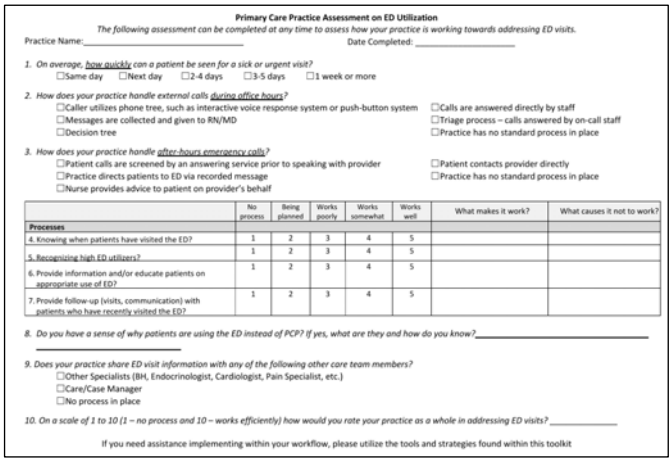
For a full list of preventable diagnoses, refer to the Preventable Emergency Visit Diagnosis Tip Sheet on the website and the CBI Technical Specifications.

Best Practices

- Educate members to always call the PCP office for an appointment before going to the ED.
- Monitor the Linked Member ED Visit report in the Provider Portal to track linked members who were recently seen in the ED, as well as the Linked Member High ED Utilizers report for members seen in the ED three or more times within a 90-day period. There may be members who are assigned and never been seen to whom you can provide additional outreach.
- Contact members seen for preventable ED visits and bring them in for follow-up.
- Review day-of-the-week trends and open additional appointment times based on trends.
- Look at your third next available appointment times. If appointments are too far out, patients are more likely to use the ED.
- Orient all new members on your office hours, how to reach you after hours, and what kinds of conditions you will see urgently.
- Identify high utilizers of the ED and bring them in to review their problem list.

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
  - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
  - Telephonic Interpreter Services – available to assist in scheduling members.
  - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
  - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Enhanced Care Management (ECM) and Community Supports.
  - Refer Alliance members through the Alliance Provider Portal, email (listecmteam@ccah-alliance.org), mail or fax, or by phone at 831-430-5512.
  - For Complex Care Management and Care Coordination, call the Care Management team at 800-700-3874 (TTY: Dial 711).
- Alliance Transportation Services for patients with transportation challenges.
  - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
  - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Carelon Behavioral Health Primary Care Provider (PCP) Referral Form.
- Impacting Use of the Emergency Department Physician Toolkit and PCP Assessment Tool:



Primary Care Practice Assessment on ED Utilization

The following assessment can be completed at any time to assess how your practice is working towards addressing ED visits.

Practice Name:_____ Date Completed: _____

1. *On average, how quickly can a patient be seen for a sick or urgent visit?*
   ☐Same day ☐Next day ☐2-4 days ☐3-5 days ☐1 week or more

2. *How does your practice handle external calls during office hours?*
   ☐Caller utilizes phone tree, such as interactive voice response system or push-button system
   ☐Messages are collected and given to RN/MD
   ☐Decision tree
   ☐Calls are answered directly by staff
   ☐Triage process – calls answered by on-call staff
   ☐Practice has no standard process in place

3. *How does your practice handle after-hours emergency calls?*
   ☐Patient calls are screened by an answering service prior to speaking with provider
   ☐Practice directs patients to ED via recorded message
   ☐Nurse provides advice to patient on provider's behalf
   ☐Patient contacts provider directly
   ☐Practice has no standard process in place

	No process	Being planned	Works poorly	Works somewhat	Works well	What makes it work?	What causes it not to work?
Processes							
4. Knowing when patients have visited the ED?	1	2	3	4	5		
5. Recognizing high ED utilizers?	1	2	3	4	5		
6. Provide information and/or educate patients on appropriate use of ED?	1	2	3	4	5		
7. Provide follow-up (visits, communication) with patients who have recently visited the ED?	1	2	3	4	5		

8. *Do you have a sense of why patients are using the ED instead of PCP? If yes, what are they and how do you know?*_____

9. *Does your practice share ED visit information with any of the following other care team members?*
   ☐Other Specialists (BH, Endocrinologist, Cardiologist, Pain Specialist, etc.)
   ☐Care/Case Manager
   ☐No process in place

10. *On a scale of 1 to 10 (1 – no process and 10 – works efficiently) how would you rate your practice as a whole in addressing ED visits?*_____

If you need assistance implementing within your workflow, please utilize the tools and strategies found within this toolkit

Reference: Harvey, MD, B. Washington Chapter. American Academy of Pediatrics. Retrieved from https://wcaap.org/wp-content/uploads/2021/09/Impacting-Use-of-the-Emergency-Department-final.pdf.

Updated 11/20/2024

Preventable Emergency Visits Diagnoses Tip Sheet

Condition Description

The list of preventable emergency department (ED) diagnoses is derived from the Statewide Collaborative Quality Improvement Project: Reducing Avoidable Emergency Room Visits.

- **Acute Conditions**
  - Bronchitis
  - Laryngopharyngitis
  - Nasopharyngitis (Common Cold)
  - Pharyngitis Unspecified or Due to Other Specified Organisms
  - Upper Respiratory Infection, Unspecified
  - Vaginitis
  - Vulvitis
- Candida Of Skin And Nail
- **Candidal**
  - Balanitis
  - Cheilitis
  - Cystitis And Urethritis
  - Otitis Externa
  - Stomatitis
- Candidiasis of Vulva and Vagina or Unspecified
- Chlamydial Cystitis And Urethritis
- **Cystitis**
  - Acute with/without Hematuria
  - Interstitial (Chronic) with/without Hematuria
  - Other Chronic with/without Hematuria
  - Other Cystitis with/without Hematuria
  - Unspecified Hematuria with/without Hematuria

- **Chronic Conditions**
  - Adenoiditis
  - Disease Of Tonsils And Adenoids, Unspecified
  - Nasopharyngitis
  - Pharyngitis
  - Rhinitis
  - Tonsillitis
  - Tonsillitis and Adenoiditis

- **Conjunctivitis**
  - Acute Atopic Conjunctivitis
  - Acute Follicular Conjunctivitis
  - Angular Belpharoconjunctivitis
  - Chronic Follicular Conjunctivitis
  - Chronic Giant Papillary Conjunctivitis
  - Contact Blepharoconjunctivitis
  - Due to Acanthamoeba
  - Ligneous Conjunctivitis
  - Other Chronic Allergic Conjunctivitis
  - Other Conjunctivitis
  - Other Mucopurulent Conjunctivitis
  - Pseudomembranous Conjunctivitis
  - Serous Conjunctivitis
  - Simple Chronic Conjunctivitis
  - Unspecified Acute Conjunctivitis
  - Unspecified Blepharoconjunctivitis
  - Unspecified Chronic Conjunctivitis
  - Unspecified Conjunctivitis
  - Vernal Conjunctivitis

- COVID-19

- Dorsalgia, Unspecified

- **Examination For**
  - Driving License
  - Insurance Purposes
  - Comparison and Control in Clinical Research Program
  - Participation in Sport
  - Period of Delayed Growth in Childhood with or Without Abnormal Findings
  - Recruitment To Armed Forces
  - Blood Pressure With or Without Abnormal Findings
  - Ears And Hearing With Other or Without Abnormal Findings
  - Eyes And Vision Without Abnormal Findings
  - Potential Donor Of Organ And Tissue

- Follow-Up Examination After Completed Treatment For Malignant or Conditions Other Than Malignant Neoplasm

- General Adult Medical Examination With or Without Abnormal Findings

- General Psychiatric Examination, Requested By Authority

- Gynecological Examination (General) (Routine) With or Without Abnormal Findings

- **Encounter For**
  - Administrative Examinations, Unspecified
  - Adoption Services
  - Allergy Testing
  - Blood Typing
  - Blood-Alcohol and Blood-Drug Test
  - Cervical Smear to Confirm Findings of Recent Normal Smear Following Initial Abnormal Smear
  - Dental Exam and cleaning with/without abnormal Findings
  - Disability Determination
  - Exam and Observation for Other Specified or Unspecified Reasons
  - Admission to Educational or Residential Institution
  - Hearing Conservation and Treatment
  - Issue Of Other Medical Certificate
  - Hearing Examination Following Failed Hearing Screening
  - Issue Of Repeat Prescription

- **Encounter For Other**
  - Administrative Examinations
  - Pregnancy Test
  - General Examination
  - Preprocedural Examinations
  - Specified Special Examinations
  - Paternity Testing
  - Pre-Employment Examination

- Female Infertility Of Other Origin
- Headache
- **Hypertrophy**
  - Adenoids
  - Tonsils With Hypertrophy Of Adenoids
  - Tonsils
- Inflammatory Disease Of Cervix Uteri
- Low Back Pain, Unspecified
- **Miliaria**
  - Crystallina
  - Profunda
  - Rubra
  - Unspecified
- Muscle Spasm Of Back
- Other Acariasis
- Other Chronic Diseases of Tonsils and Adenoids

- **Other**
  - Dorsalgia
  - Low back pain
  - Pruritus
  - Urogenital Candidiasis
  - Sites Of Candidiasis
- **Otitis Media**
  - Acute Suppurative With or Without Spontaneous Rupture
  - Chronic Atticoantral Suppurative
  - Chronic Tubotympanic Suppurative
  - Other Chronic Suppurative
  - Otitis Media, Unspecified
  - Suppurative Otitis Media, Unspecified
- Pruritus, Unspecified
- Sacrococcygeal Disorders, Nec
- Scabies
- **Sinusitis**
  - Chronic Ethmoidal Sinusitis
  - Chronic Frontal Sinusitis
  - Chronic Maxillary Sinusitis
  - Chronic Pansinusitis
  - Chronic Sinusitis, Unspecified
  - Chronic Sphenoidal Sinusitis
  - Other Chronic Sinusitis
- Subacute And Chronic Vaginitis
- Tinea Corporis
- Tinea Imbricata
- Trigonitis With or Without Hematuria
- Urinary Tract Infection, Site Not Specified
- Vascular Headache, Not Elsewhere Classified

Chlamydia Screening in Women Tip Sheet

Measure Description

The percentage of women 16-24 years of age who are identified as sexually active and had at least one test for chlamydia during the measurement year.

Note: Laboratory claim exclusions to identify sexual activity are only applicable to CBI 2025.

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.

Eligible Members

Members who are 16 to 24 years of age at the end of the measurement year and identified as sexually active. **Sexual activity is determined by**:

- Pregnancy test or diagnosis.
- Claim/encounter noting sexual activity.
- Contraceptive medication (see CBI Technical Specifications for a full list of medications).

Note: Laboratory claims with POS 81 will not be included in identifying eligible members through claims with a sexual activity diagnosis.

Exclusions

- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- Members identified as eligible for the measure based on a pregnancy test alone will be removed from the measure for either of the following:
  - A pregnancy test during the measurement year and an X-ray on the date of the pregnancy test or six days after the pregnancy test.
  - A pregnancy test during the measurement year and a prescription for isotretinoin (retinoid) on the date of the pregnancy test or six days after the pregnancy test.

Coding Requirements

Chlamydia Screening CPT Codes

- 87110, 87270, 87320, 87490, 87491, 87492, 87810.

View the full list of chlamydia screening and exclusion codes in the CBI Technical Specifications.

Data Collection

Data for this measure will be collected using claims, laboratory data, pharmacy data, and provider data submissions via the Data Submission Tool (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. For example, download your monthly Chlamydia and Gonorrhea Screening report or Care-Based Incentives Measure Details report from the Provider Portal and compare it to your EHR/paper charts.

How to Submit Data

This measure allows providers to submit chlamydia 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

- **Screen members 16-24 years of age annually,** as well as older adults who are at an increased risk for infection.
- **Screen patients who are prescribed birth control.** Review the Chlamydia and Gonorrhea Screening report on the Provider Portal to determine members who are identified as sexually active.
- Consider using the opt-out approach to screening. Additional information shared in the American Academy of Pediatrics 2022 publication, "**Testing for Sexually Transmitted Infections: Providers Cannot Opt Out of the Conversation**."
- Discuss sexual activity and remind members of safe sex practices. Screen if member mentions a new sexual partner or other risk factors.
- Follow the United States Preventive Services Task Force (USPSTF) recommendation for chlamydia and gonorrhea screening:
    - **Screening adolescents and young adults <25 years of age:** Annual chlamydia and gonorrhea screenings should be performed for women <25 years of age and older women at risk. Syphilis, HIV, chlamydia, and hepatitis B screenings should be given to all pregnant women. Gonorrhea screenings should be given to pregnant women at risk.
    - **HIV screening**: Should be performed for everyone 15-65 years of age. *Younger adolescents and older adults who are at an increased risk of infection should also be screened.*
- **Develop and follow a written policy and protocol** for staff and physicians.
- Establish routine clinic processes for chlamydia screenings and ensure time alone with adolescents, and time to confidentially collect specimens if they're accompanied by parents.
- Consult the Chlamydia Screening Starter Guide for more strategies and guidelines.
- **Establish a patient recall system using the Chlamydia and Gonorrhea Screening report on the Provider Portal to get them scheduled for a test:**
    - Members missing screenings: Let them know they need to return to the office to provide a urine sample. At that time, discuss the importance of the screening.
    - Cross-reference your list to those that are due for their annual well-visit. Put in a standing order for a urine test for when they come in for their visit.
- Consider the community you serve and consult the local health department to identify groups that are at increased risk in your area.
- Order a chlamydia test when a pregnancy test is administered.

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
  - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
  - Telephonic Interpreter Services – available to assist in scheduling members.
  - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
  - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Transportation Services for patients with transportation challenges.
  - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
  - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Opt-Out Chlamydia Screening Should Be Part of Routine Adolescent Health Care Services - Contemporary Pediatrics 2021 report.
- Chlamydia - Center for Young Women's Health.
- Improving Chlamydia Screening Strategies from top performing health plans – NCQA.
- Screening Recommendations and Considerations Referenced in Treatment Guidelines and Original Sources – CDC.
- A Guide to Taking a Sexual History for a sample of discussion points and questions to ask – CDC.
- Sexually Transmitted Infections Treatment Guidelines, 2021 for up-to-date clinical guidelines – CDC.
- Screening for Chlamydia and Gonorrhea – USPSTF.

Colorectal Cancer Screening Tip Sheet

Measure Description

The percentage of members 45-75 years of age who had appropriate screening for colorectal cancer. For members 46-75 years of age, 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.

Note: Laboratory claim exclusions to identify frailty and advanced illness are only applicable to CBI 2025, as well as minor changes to the frailty and advanced illness criteria.

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 had colorectal cancer or a total colectomy any time during the member's history through December 31 of the measurement year.
- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- Members 66 years of age and older as of December 31 of the measurement year who meet both frailty **and** advanced illness criteria:
    - Frailty: At least two indications of frailty with different dates of service during the measurement year.
    - Advanced illness: One of the following during the measurement year or year prior to the measurement year:
        - Encounter with an advanced illness diagnosis on at least two different dates of service.
        - Dispensed dementia medication.

Note: Laboratory claims with POS 81 will not be included in identifying eligible members with diagnostic codes for frailty or advanced illness.

Coding Requirements

Fecal occult blood test (FOBT)

- **CPT:** 82270, 82274

Flexible sigmoidoscopy

- **CPT:** 45330-45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350

Colonoscopy

- **CPT:** 44388-44394, 44401-44408, 45378-45382, 45384-45386, 45388-45393, 45398
- **ICD-9:** 45.22, 45.23, 45.25, 45.42, 45.43

CT colonography

- **CPT:** 74261-74263

Stool DNA (sDNA) with FIT

- **CPT:** 81528

Additional screening codes and exclusion codes are located in the CBI code set located in the CBI Technical Specifications.

Data Collection

Data for this measure will be collected using claims, laboratory data, DHCS Fee-for-Service encounter claims, and provider data submissions via the Data Submission Tool (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. For example, download your Care-Based Incentives Measure Details report from the Provider Portal and compare it to your EHR/paper charts.

How to Submit Data

This measure allows providers to submit colorectal cancer screenings, evidence of colorectal cancer or total colectomy 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

Identify Patients Due

- Run population health management reports out of your EHR, including either active and inactive members, or another time-bound filter. Many practices make patients inactive after 18, 24 or 36 months, which may miss patients due for their colorectal cancer screening.
- Develop prompts or flags that pop up to alert care teams when members are due for preventive health screenings during chart prep, or when a member presents in your health center.

Outreach for Patient Engagement

- Designate a care team member to outreach to patients due for colorectal cancer screening.
- Send targeted mailings, text messages or emails, and follow up with telephone calls to chronically noncompliant patients. Studies have shown that the best way to reach patients is by combining a variety of methods, so don't just stop with the old reminder postcard. Pick up the phone or send a text.
- Promote test choice. Studies have shown that when provided with options, many patients choose stool-based testing over colonoscopy for colorectal cancer screening and are more likely to adhere to regular screening when they have a choice of tests

When Patient Presents for Care

- Display culturally appropriate posters and brochures at an appropriate literacy level in patient areas to encourage patients to talk to providers about colorectal cancer screening.
- Ensure screening is ordered when it is due, regardless of the reason for the visit.
- For patients who completed their colorectal cancer screening at an outside clinic, assess and document the date, location and result of their last screening, and ask the patient to sign a release of records.
- Empower your medical assistants and nurses with standing orders to screen and identify patients currently due or past due for their colorectal cancer screening.
- Don't forget to assess health literacy. A lack of understanding and/or language differences may create barriers in following a recommended care plan.
- A patient may choose to decline screening even if strongly encouraged by the health care team. A patient should be periodically reassessed and supported to complete screenings as per current guidelines.
- Document the current care plan and routinely provide a copy to the patient.

Post-Visit Follow Up

- Create prompts for screening in your EMR that do not turn off until results are received, rather than when a test is ordered.
- Initiate a patient follow-up recall system and/or log to ensure screening follow-through and results are received.

Creating an Inclusive Culture

- Access is key! Offer extended hours on weekends and evenings.
- Hire clinicians to accommodate language needs, gender preference and LGBT sensitivity of patients served.
- Encourage continuing medical education (CME) for providers that support culturally competent screening, culturally competent education and diagnosis screening follow up per national guidelines.
- Remember, cultural competence is not just limited to race, ethnicity and culture. Perceptions, values, beliefs and trust can also be influenced by factors such as religion, age, sexual orientation, gender identity and socioeconomic status.

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
  - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
  - Telephonic Interpreter Services – available to assist in scheduling members.
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  - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Tailoring Colorectal Cancer Screening Messaging: A Practical Coalition Guide.
- 2022 Messaging Guidebook for Black & African American People: Messages to Motivate for Colorectal Cancer Screening.
- 2017 Asian Americans and Colorectal Cancer Companion Guide.
- 2016 Hispanics/Latinos and Colorectal Cancer Companion Guide.
- A Provider's Guide to Colorectal Cancer Screening.
- Colorectal cancer resource library.

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

Measure Description

The percentage of members aged 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.

Note: Laboratory claim exclusions for identifying well-child encounters is only applicable to CBI 2025.

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, receiving hospice services or palliative care, or who died during the measurement year.

Documentation Requirements

Documentation must include a note indicating the visit was with a PCP and evidence of ***all*** 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 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. To find gaps in data:

- Run a report from your electronic health record (EHR) system; or
- Manually compile patient data. For example, download your Care-Based Incentives Measure Details report from the Provider Portal and compare it to your EHR/paper charts).

How to Submit Data

This measure allows providers to submit well-child visits billed under the mother's Medi-Cal ID, as well as visits that were completed during a gap in coverage, 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

- Well-visits should occur at the following intervals:
  - Birth (at the hospital)
  - 3-5 days (after hospital discharge)
  - 1 month old
  - 2 months old
  - 4 months old
  - 6 months old
  - 9 months old
  - 12 months old
  - 15 months old
  - 18 months old
  - 24 months old
  - 30 months old

  See the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care for a comprehensive schedule up to 21 years of age, as well as the Bright Futures Materials and Tools.
- **Schedule the next 6-month's visits before the member leaves the exam room or clinic** and provide an overview of what is covered during the next visit. This ensures the child stays on schedule for the necessary visits.
- **Use telehealth visits** for patients that do not feel comfortable coming into the clinic.
- **Use 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 to ensure reminders for needed vaccinations are present during every visit.
- **Leverage missed opportunities** (episodic and sick visits) to increase preventive services (immunizations) and convert acute visits into well-visits (sports physicals).

- **Monitor the Provider Portal** reports as a tool to identify 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 my interfere with physical, social and emotional development.
- **Ensure that all children receive developmental screenings,** at minimum, at 9 months, 18 months, 24 or 30 months of age. If the child is at a higher risk for developmental problems, there may need to be additional screenings.
- **Group well-child visits** have 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 Recommended Child and Adolescent Immunization Schedule and Vaccines for Your Children for talking point with parents.

[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.

Resources

- Alliance Cultural and Linguistic Services are available to network providers.
  - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
  - Telephonic Interpreter Services – available to assist in scheduling members.
  - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
  - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Transportation Services for patients with transportation challenges.
  - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
  - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Family Resource Sheets by child age or well-visit focus area – CAHMI.
- Well-Child Care: Improving Infant Well-Child Visits – Medicaid.gov.
- Improving Preventive Care Services for Children Toolkit – CHCS.
- A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population – AAP.
- Remove Roadblocks and Improve Access to Preventive Care – AAFP.
- Medi-Cal for Kids and Teens resources – DHCS.

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 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 have a history of bipolar disorder any time during the member's history through the end of the year prior to the measurement period.
- Members with depression that started during the year prior to the measurement period.
- Members in hospice, receiving hospice services or palliative care, or who died during the measurement year.
- To view applicable diagnosis codes for exclusions, see the CBI Technical Specifications.

Documentation Requirements

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

Documented follow-up can include any of the following:

- 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.
- 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 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; or
- Manually compile patient data. For example, download your Care-Based Incentives Measure Details report from the Provider Portal and compare it to your EHR/paper charts.

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.
- Ask Medical Assistant to administer initial depression screen and document results.
- Screen patients at least once during the perinatal period for depression and anxiety symptoms.
- Screen patient for postpartum depression at the infant's one, two, four, and six-month well-child visits and beyond. **If submitting DST data, report this under the person who received the depression screen's Medi-Cal ID**
- Use collaborative care interventions that involve multifaceted care team approaches (e.g., primary care physician, case manager with mental health background, psychiatrist, etc.).
- Implement a call-back program to reach out to patients with positive screens and keep engagement.

Resources

- Alliance Behavioral Health.
- Alliance Cultural and Linguistic Services are available to network providers.
    - Language Assistance Services – request materials at 800-700-3874, ext. 5504.
    - Telephonic Interpreter Services – available to assist in scheduling members.
    - Face-to-Face Interpreter Services – can be requested for the appointment with the member.
    - For information about the Cultural and Linguistic Services Program, call the Alliance Health Education Line at 800-700-3874, ext. 5580 or email us at listcl@ccah-alliance.org.
- Alliance Depression Tool Kit.
- Alliance Enhanced Care Management (ECM) and Community Supports.
    - Refer Alliance members through the Alliance Provider Portal, email (listecmteam@ccah-alliance.org), mail or fax, or by phone at 831-430-5512.
    - For Complex Care Management and Care Coordination, call the Care Management team at 800-700-3874 (TTY: Dial 711).
- Alliance Transportation Services for patients with transportation challenges.
    - Non-emergency medical transportation (NEMT), call 800-700-3874, ext. 5640 (TTY: Dial 711).
    - Non-medical transportation (NMT), call 800-700-3874m ext. 5577 (TTY: Dial 711).
- Carelon Behavioral Health Primary Care Provider (PCP) Referral Form.
- Carelon Care Management Referral Form.

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

Social Determinants of Health

Social Determinants 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 supports the development of Alliance health equity and population health programs. The Z codes aid in the coordination of services based on member health and social needs, and 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 $1,000 for four quarterly submissions.

Coding Requirements

Data will be collected using appropriate diagnoses from claim submissions.

ICD-10-CM Z 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
Z59.7	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

- Use pre-populated questionnaires in EMR systems.
- To screen members for SDOH, you can use the:
  - PRAPARE Screening Tool;
  - Social Needs Screening Tool – short version; and
  - AHC Health-Related Social Needs Screening Tool.
- This measure is captured through claims submission and diagnosis must be present on the 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 Implementation and Action Toolkit
- Health Equity for EveryONE - Online CME
- The EveryONE Project Assessment and Action Toolkit
- The EveryONE Project Neighborhood Navigator
- The Accountable Health Communities Health-Related Social Needs Screening Tool
- Using Z Codes Infographic
- Rural Health Information Hub SDOH Assessment Tools
- Healthy People 2030 SDOH Workgroup
- Indiana Primary Health Care Association Z-Codes, SDOH and PRAPARE presentation
- Social determinants of health (SDOH) screening - Provider Bulletin article (page 9)

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. Using diagnoses that are unspecified should be reserved for when clinical information is not known or available.

Common conditions that have overused unspecified codes include:

- Alcohol and drug use, abuse, and dependence
- Anemia
- Anxiety
- Arthritis
- Asthma
- Back pain
- Depression
- Diabetes
- Epilepsy
- Generalized Pain
- Hyper/hypotension
- Hyper/hypolipidemia
- Injuries
- Migraines
- Neoplasms
- Pneumonia
- Respiratory failure and infection
- Vitamin D deficiency

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 to qualify.

Best Practices

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

Resources

- MLN Web-based training course - Diagnosis Coding: Using the ICD-10-CM
- ICD-10-CM Official Guidelines for Coding and Reporting

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 CBI.

CPT Category II codes always consist of:

CPT Category 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 to decrease the need for provider data submission, record abstraction and chart review.

CPT Code Functions

Category I Codes	E&M, ANES, SURG, RAD, LAB
Category II Codes	TRACKING QUALITY OF CARE
Category III Codes	EMERGING TECHNOLOGY

CPT II Codes

Diabetic Poor Control >9%	
HbA1c test result	
HbA1c level <7%	3044F
HbA1c level ≥7 and <8%	3051F
HbA1c level ≥8 and ≤9%	3052F
HbA1c level >9%	3046F

Controlling Blood Pressure	
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